



VERDICT AT INQUEST

File No.: 2010:0276:0324

An Inquest was held at Burnaby Coroners Court, in the municipality of Burnaby in the Province of British Columbia, on the following dates October 24-26, 2011 before Owen Court, Presiding Coroner, into the death of YELLOWQUILL Stephen 55 Male into the death of and the following findings were made:

Date and Time of Death: December 22, 2010 at 0335hr Place of Death: Vancouver General Hospital Vancouver, BC

Medical Cause of Death

(1) Immediate Cause of Death: a) Smoke inhalation DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Exposure to fire DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death: Ethanol intoxication

Classification of Death: [X] Accidental [] Homicide [] Natural [] Suicide [] Undetermined

The above verdict certified by the Jury on the

26th day of October AD 2011

Owen Court Presiding Coroner's Printed Name

Handwritten signature of Presiding Coroner



VERDICT AT INQUEST

**FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST
INTO THE DEATH OF**

FILE NO 2010 : 0276 : 0324

YELLOWQUILL

Stephen

SURNAME

GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

- Presiding Coroner:** Owen Court
- Inquest Counsel:** Rodrick MacKenzie
- Participant / Counsel:** City of Vancouver / Iain Dixon
- Court Reporting Agency:** Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded three exhibits. Duly sworn witnesses testified over the course of the Inquest.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the Jury at the Inquest. This summary of the evidence is to assist the reader to more fully understand the Verdict and Recommendations of the Jury. It is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

Mr. Yellowquill and a number of other individuals resided in a house in East Vancouver. The house was designed as a single family dwelling, but its owner rented rooms to several people on a monthly basis. The Jury heard conflicting evidence regarding the number of people who resided in the residence; therefore, the actual number of occupants remains unclear.

The residence had come to the attention of City of Vancouver officials numerous times. The owner of the house was ordered by officials to make a variety of improvements to the house in order to bring it into compliance with existing bylaws. Evidence presented to the Jury established that the owner of the house was generally non-compliant with the orders issued to her.

On December 22, 2010, a fire occurred inside the house. Emergency officials attended and treated a number of injured individuals. Paramedics transported Mr. Yellowquill to Vancouver General Hospital, where he died shortly thereafter. The physician who treated Mr. Yellowquill and pronounced his death provided expert evidence to the Jury, indicating Mr. Yellowquill died as a result of smoke inhalation. A toxicologist also gave expert evidence that ethanol (alcohol) intoxication was a contributing factor.

Two other men also died as a result of this fire.

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:





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JURY RECOMMENDATIONS:

There is a clear need for a streamlining of certain processes involved in this case. We feel that our recommendations as listed below will assist in this.

To the City of Vancouver:

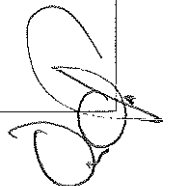
1. Inspection officials should be required to communicate with complementary inspection units (such as bylaw, building, electrical, plumbing, health and fire) in order to more quickly facilitate the safe operation of any property.
2. There should be a clear avenue for any tenant, landlord or owner to utilize governing bodies to report violations in order to provide a safe living environment. Governing agencies should be required to respond, assess and report as defined in point (1) above.
3. The requirement of "imminent life threat" was required to demand a ceasing of occupancy of this property. This requirement should be amended to "life threat" in order to provide greater ability to protect occupants of a property.

Coroner's Comment: The Jury heard evidence suggesting that communication between City departments was less than optimal. The Jury also heard evidence that officials were unable to order the owner of the house to remove her tenants because no "imminent" life threat existed.

To the City of Vancouver and the Vancouver Police Department:

4. Neighborhood liaison officials (police) should be notified of problem or bylaw infringing properties. These officials should have the authority to further investigate the properties, owners, landlords and tenants. Police should be required to notify any governing agencies of these properties, owners, landlords or tenants for accordance of their appropriate policies and follow-up of those agencies.

Coroner's Comment: The Jury heard evidence suggesting that police had limited powers to address issues pertaining to the residence at which Mr. Yellowquill's death occurred. The jury also heard that there is no formal system in place to ensure communication and collaboration between police personnel, City officials and social assistance workers.





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FILE NO 2010 : 0276 : 0324

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To the Attorney General, Province of British Columbia:

5. Inspection units should have the authority to issue immediate penalties through a fines or ticketing process. Further, an escalating penalty scale should be in place for repeat offenses. Maximum fines would need to be reviewed for this purpose. These penalties or any related charges should be governed by municipal court, specifically to accelerate the process.

Coroner's Comment: The Jury heard evidence from several City officials, who unanimously expressed frustration in navigating the penalty and court processes with problematic residences.

To the Minister of Health, Province of British Columbia:

6. Hospital policy should be reviewed for emergency drug administration procedures, specifically storage location and stock quantities.

Coroner's Comment: The Jury heard expert evidence from a Vancouver General Hospital emergency physician, who testified that while treating two patients for possible cyanide exposure from this fire, only one antidote was available to him. He was therefore forced to make a decision as to which patient had the greater need for it.