BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

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 YELLLOWQUILL Stephen 55 ☒ Male ☐ Female
(Last Name, First Name Middle Name) (Age)

and the following findings were made:

Date and Time of Death: December 22, 2010 at 0335hr

Place of Death: Vancouver General Hospital (Location) Vancouver, BC (Municipality/Province)

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: ☒ 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

Presiding Coroner's Signature

BRITISH COLUMBIA

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:

YELLOWQUILL	Stephen
SURNAME	GIVEN NAMES

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.

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.