Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2010:0274:0167

An Inquest was held at the Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates February 6th, 7th, and 8th, 2012

before Mr. Rodrick H. MacKenzie, Presiding Coroner,

into the death of PARROUTY Laurent Pierre 39 ☒ Male ☐ Female
(Last Name, First Name Middle Name) (Age)
and the following findings were made:

Date and Time of Death: August 23rd, 2010 at 18:40

Place of Death: 7577 Jasper Crescent Vancouver, British Columbia
(Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Sudden Unexplained Death In Epilepsy

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

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:

Classification of Death: ☐ Accidental ☐ Homicide ☒ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 8th day of February AD, 2012.

Rodrick H. Mackenzie
Presiding Coroner's Printed Name

Presiding Coroner's Signature

PARROUTY	Laurent Pierre
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. Rodrick H. MacKenzie

Court Reporting Agency: Verbatim Words West Ltd.

Participant/Counsel: Vancouver City/Police - Bronson Toy

The Sheriff took charge of the jury and recorded eight exhibits. Twenty one witnesses were duly sworn and testified.

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. Parrouty was a large man of 39 years with an IQ of 55 who functioned at the level of an eight year old child and lived in a residential care home. He suffered a generalized hypoxia at birth. Epilepsy was an ongoing problem and despite taking four different anti-seizure medications in large dosages he still experienced seizures. He had recently been diagnosed with cancer and was receiving chemotherapy. As well, there were some mental health issues that could lead to aggression.

In April, 2010 an issue of aggression was reported to Crown Counsel. Crown Counsel approved a charge of assault under Section 266 of the Criminal Code against Mr. Parrouty. He was arrested, brought before the court and released with a date to reappear. Testimony indicated that Mr. Parrouty was incapable of managing his own affairs and could not be expected to get himself to a court date and he did not appear as required. No one, not even those one might have expected to, assisted him. In any event, it appears he was ill at the time in question. As a result of the non appearance, an unendorsed warrant was issued for his arrest.

On August the 22nd, 2010 family members took him out for dinner without informing his caregivers. When the caregivers noticed he was absent they called the Vancouver Police and reported him as a missing person. The police searched for him until later advised that he had returned to the care home.

In the course of looking for detail to assist in their missing persons case the Police found the outstanding warrant. The police were advised by the family to avoid Mr. Parrouty as their presence as uniformed police officers would cause him stress. The police did not tell the family that they had found a warrant and in fact needed to arrest Mr. Parrouty and intended to take him to the Vancouver jail. Medical evidence introduced later in this proceeding indicated that stress can bring on conditions in a person like Mr. Parrouty that may lead to a seizure.

With some reluctance, but believing they were duty bound to do so the attending police officers arrested Mr. Parrouty, handcuffed him and placed him in the police wagon for transport to cells. The caregivers ensured that his prescribed medication properly blister packed and marked went with him together with instructions that contact be made by medical staff at the jail with his care coordinator.

No such contact was made nor was the medication provided passed to medical staff at the jail. Mr. Parrouty was taken from the police wagon by jail guards. He was brought into the jail at approximately 11:00 PM on the evening of August 22nd, 2010. He was subjected to a full body/strip search. He was formally booked in. He was assessed by a nurse. His inability to give a proper history hampered her assessment, but it was clear to the nurse that he suffered from seizures. The Nurse obtained a Pharmanet print out which showed all the medication he was to take.

He was placed in cells where he spent the night. He was given no medication or treatment, but was noted to be seen in the morning at the Doctor's Parade.

Early the next morning he was seen and assessed by the Jail Doctor. The Doctor authorized that he be given anti-seizure medication. The jail did not have on hand in their own stocks all of the medication that was indicated. Mr. Parrouty only received some of the medication that he had been prescribed.

Mr. Parrouty was processed by the jail and court systems. He was finally released shortly after 4:00 PM the afternoon of the following day. His care coordinator appeared outside the Sally Port to bring him home.

He arrived home tired, stressed and wanting a shower. His favorite meal was being prepared. His caregivers wanted him to rest on a couch. There was concern over him showering alone. He was not given any medication. At about 5:30 PM it was noted that he was not on the couch and that the bathroom door was closed. When the door was opened Mr. Parrouty was found down on the floor not breathing. He had been trying to have a shower. 911 was called.

A Vancouver Fire and Rescue crew and critical care qualified British Columbia Ambulance Service paramedics arrived almost immediately. Everything possible was done to attempt to save Mr. Parrouty. Efforts continued until direction was received from the ER Doctor on duty at Vancouver General Hospital.

The Forensic Pathologist found no definite anatomical cause of death.

He said in his report:

"Given his history of chronic seizures and the somewhat subtherapeudic concentrations of three of his four anticonvulsive medications, the most likely explanation for his death is a phenomenon known as SUDEP (sudden unexplained death in epilepsy). Individuals with a seizure disorder are at increased risk of sudden death, and accounts for 7-17% of deaths among people with epilepsy. However, the mechanism is unknown."

The Forensic Toxicologist stated in his report and confirmed in his testimony that all four medications were in fact (sub) therapeutic.

The Forensic Pathologist when questioned before the jury deferred to the toxicologist.

PARROUTY	Laurent Pierre
SURNAME	GIVEN NAMES

JURY RECOMMENDATIONS:

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 agencies:

To: Chief Constable Jim Chu
Vancouver Police Department
3585 Graveley Street
Vancouver, BC V5K 5J5

1. Review all jail procedures related to the intake, handling and release of low functioning individuals.

   Coroners Comments:

   Jail policy provided no direction to jail staff respecting the handling of individuals such as Mr. Parrouty.

To: Minister of Justice and Attorney General
Honourable Shirley Bond
PO BOX 9044 Stn Prov Govt
Victoria BC V8W 9E2

2. Provide a liaison between the court and the guardian of a low functioning individual to advise about future court dates and any legal obligations.

   Coroners Comments:

   The evidence revealed that Mr. Parrouty needed assistance dealing with the justice system. Involvement of guardians would assist. If those caring for Mr. Parrouty were aware of his court date his incarceration may have been avoided.

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3. Dedicated phone line to the medical staff at the jail for legal guardians, physicians, case workers, caregivers and/or nurses of the prisoner.

   Coroners Comments:

   The evidence revealed that Mr. Parrouty's care coordinator wanted contact with jail medical staff. A phone line would have facilitated this contact.

4. Medication should be given directly to the medical staff at the jail. Confirmation of receipt would be noted on the Prisoner Observation Log with signature and PIN #.

   Coroners Comments:

   Mr. Parrouty's prescribe medication was provided to the Police, but not passed on to jail medical staff. Jail medical staff did not have the prescribed medication to give Mr. Parrouty from their stock on hand. This medication was held and remained with his personal effects.

To: Director of Licensing
Community Care Facilities
Ministry of Health
4th Floor, 1515 Blanshard Street
Victoria, BC V8W 3C8

5. Sign in /out sheet at the caregiver's residence.

   Coroners Comments:

   If a sign in / out sheet policy were mandated, the police would not be called out needlessly. If Mr. Parrouty's caregivers knew he was with family they would not have called the police.

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6. Medical staff at the jail should have 24 hour access to a pharmacy.

   Coroners Comments:

   If this recommendation was in placed at the time of Mr. Parrouty's incarceration, medical staff could have obtained his prescribed medication.

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7. Education to Crown Counsel and law enforcement agencies regarding mental health and dealing with patients of mental health.

   Coroners Comments:

   Self explanatory.

To: Chief Constable Jim Chu
Vancouver Police Department
3585 Graveley Street
Vancouver, BC V5K 5J5

8. If required, the medical staff at the jail can contact the family practitioner of the prisoner to discuss medication and/or other special needs of the patient.

   Coroners Comments:

   Self explanatory.

9. Within 8 hours a caregiver or caseworker should be allowed to visit the prisoner for a brief period (approximately 15 minutes) for the purpose of advising him/her what is happening and to reassure them in order to assist in reducing their stress levels.

   Coroners Comments:

   This may serve to avoid needless distress on the part of low functioning individuals.

10. Upon release of the prisoner the medical staff should communicate to the caregiver/caseworker when the last dose of medication was given. The medical staff person should sign off that he/she has done this.

    Coroners Comments:

    Caregivers / caseworker need to know what medication has been given and when, so that they may resume proper supervision of the individuals treatment.