BRITISH COLUMBIA

Ministry of Public Safety and Solicitor General

VERDICT AT INQUEST

File No.: 2011:0216:0023

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

in the Province of British Columbia, on the following dates February 5,6 & 7, 2013

before Mr. Vincent Stancato, Presiding Coroner,

into the death of GUIBOCHE, Ashley Christine (Last Name, First Name Middle Name) 18 (Age) ☐ Male ☒ Female

and the following findings were made:

Date and Time of Death: January 31, 2011 @ 23:35 Hours

Place of Death: Royal Columbian Hospital (Location) New Westminster, BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Multiple Blunt Force Traumatic Injuries

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Motor Vehicle Impact

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 7th day of February AD, 2013.

Vincent Stancato
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.: 2011:0216:0023

GUIBOCHE	ASHLEY CHRISTINE
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. Vincent M. Stancato
Inquest Counsel: Mr. Rodrick MacKenzie
Counsel/Participants: Ms. Michelle Shea, Counsel for the Attorney General of Canada/RCMP
Mr. Philip Huynh, Counsel for the City of Surrey

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded 6 exhibits as entered. Nineteen witnesses were duly sworn and testified. Inquest Counsel read in a statement on behalf of Ms. Guiboche's mother.

PRESIDING CORONER'S SUMMARY:

The following is a brief summary of the circumstances of the death as presented to the jury at the inquest. The summary and my comments respecting the recommendations, if any, are only provided to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

On January 31, 2011 at approximately 2100 hours, Ms. Ashley Christine Guiboche had finished working at the Metrotown Centre Mall in Burnaby. Shortly following her shift she picked up some groceries and travelled to Surrey via Sky Train. The jury saw a still picture taken from video footage which depicted Ms. Guiboche exiting the King George Sky Train Station at approximately 21:38 hours. She used the west exit and walked towards King George Boulevard. She often travelled this route by foot and was heading to her boyfriend's residence where she regularly visited.

Based on Ms. Guiboche's route of travel from the King George Sky Train station it appears that she crossed the northbound traffic lanes of King George Boulevard to the raised centre median, just south of a metal fence that had been erected upon the median. Ms. Guiboche then entered into the southbound traffic lanes in an attempt to get to the west sidewalk. As she was crossing the southbound lanes, she was struck by a marked police vehicle being operated by an on-duty police officer (Cst. Luk). The location where Ms. Guiboche crossed the street was not a marked pedestrian crosswalk and it was known as a common jaywalking area.

The raised metal fence located on the centre dividing median along King George Boulevard had been erected for the purpose of deterring pedestrians from jaywalking. The fence started at the north end near the intersection of 100 Avenue and ended within the collision scene area, approximately 90 meters from 98A Avenue and 180 meters from 98 Avenue. Of note, a sign posted on the fence at the south end, near where Ms. Guiboche would have crossed the street, advised pedestrians to use the signal crossing. Unfortunately, pedestrians would have already had to cross one section of King George Boulevard to see the sign. There were no other signs in the area that advised strictly against jaywalking or that this was a high incident location for pedestrian struck incidents. Of note, between 2010 and 2012 there had been 9 pedestrians stuck in this immediate area with 7 injured and 2 fatalities. Law enforcement and city officials have studied the area as it is known for extensive jaywalking. From

November 2010 to February 2011 one traffic enforcement team handed out over 150 violations for jaywalking in the area.

Cst. Luk was the lone occupant and driver of the police vehicle. He testified that he had just turned on to King George Boulevard southbound from Old Yale Road and was travelling in the general direction of where a car had been reported stolen, when a dark figure suddenly appeared in front of his vehicle. He testified that he did not have time to take any evasive action and struck the figure. Follow up investigation revealed that this was not an assigned call, nor was it an emergency. The investigation also determined that Cst. Luk did not have the vehicles emergency equipment (lights and/or sirens) activated at the time. A short time after the incident, Cst. Luk was assisted by his supervisor (Sgt. Burks) as Cst. Luk was noticeably distraught. Sgt. Burks testified that, without any provocation, Cst. Luk stated that he was travelling at a "high rate of speed"; "he looked at his MDT (Mobile Data Terminal)"; and he "didn't see anyone crossing the road".

Sgt. Burks testified that the MDT can't be manipulated to move up or down and is located in a position where one would have to divert there attention away from the road by looking low and right. An examination of MDT communications/transmissions on January 31, 2011 indicated that a transmission came through at 21:39:48 to all cruisers and it may have been this transmission that Cst. Luk was referring to when he indicated to his supervisor that he was looking at his MDT. This timing corresponds with the timing of the collision.

Civilian witnesses that were in the area of the collision reported that Ms. Guiboche was thrown quite a distance following contact and that Cst. Luk's cruiser continued in the same direction as Ms. Guiboche's body while trying to come to a complete stop. None of the witnesses saw lights or heard sirens prior to the incident, which was consistent with Cst. Luk's testimony.

Cst. Luk testified that he radioed for assistance very shortly after striking Ms. Guiboche. One witness thought that the officer had stopped in advance of the resting positon of the body and then re-positioned his car (possibly driving over Ms. Guiboche again). The witness testified that Cst. Luk stayed in his car for about 5 minutes after the incident and it looked as if he was on his radio. According to the witness, when Cst. Luk emerged from the car, he walked over to Ms. Guiboche but did not attempt resuscitation.

When first responders arrived at the scene at 21:44 hours, they found Ms. Guiboche unresponsive and pulseless, having sustained obvious multiple traumatic injuries. Advanced Life Support paramedics who arrived less than 10 minutes later were successful in getting a pulse back and she was rushed immediately to Royal Columbian Hospital. However, she went into cardiac arrest again shortly after arrival at hospital, and this time could not be resuscitated. She was pronounced dead on January 31, 2011 at 23:35 hours.

Toxicology analysis was conducted on specimens taken from Ms. Guiboche. Dr. Walter Martz, Forensic Toxicologist testified that tetrahydrocannabinol (THC) was detected in her blood and estimated that she likely consumed it within 24 hours of her death but that it was impossible to determine if she was under the influence of it at the time of death. An autopsy was conducted by Dr. J.D. Charlesworth who testified that the cause of death was Multiple Blunt Force Traumatic Injuries sustained as a consequence of impact by a motor vehicle.

BRITISH COLUMBIA

VERDICT AT INQUEST

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

FILE NO.: 2011:0216:0023

GUIBOCHE	ASHLEY CHRISTINE
SURNAME	GIVEN NAMES

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:

JURY RECOMMENDATIONS:

To: The City of Surrey
Her Worship Linda Hepner, Mayor
13450 - 104 Ave
Surrey BC V3T 1V8

Insurance Corporation of British Columbia
Mr. Mark Blucher, President and CEO
151WestEsplanade
North Vancouver BC V7M 3H9

TransLink
Mr. Don Rose, Board Chair
#400 – 287 Nelson's Court
New Westminster BC V3L 0E7

1. That the City of Surrey, Insurance Corporation of British Columbia and TransLINK cooperate to find a solution to the serious jaywalking problem identified along King George Boulevard, between 98th and 100th Avenues. It is recommended that the following options are considered: an overhead walkway parallel to the tracks at the King George Skytrain Station permitting pedestians to cross King George Boulevard and descend to the west sidewalk and /or a pedestrian activated crosswalk at 98B Avenue. This needs to be a priority. If there is any delay in the construction of either a walkway or a pedestrian controlled cross walk, that the following be done: the signage advising pedestrians to cross at the crosswalks be moved to the east and west sidewalks, and that the fence be extended from 98th to 100th avenues.

Coroners Comment:

The jury heard evidence that the only measure in place at that time to discourage pedestrians from jaywalking across King George Boulevard at this location is a fence that is erected between 100th Avenue south to approximately 98B Avenue, ending approximately 90 meters before 98A Avenue and another 90 meters before the next major intersection (98 Avenue). The jury also reveiwed exhibit evidence that showed between 2010 and 2012 there had been 9 pedestrians stuck in this immediate area with 7 injured and 2 fatalities. The jury also heard from law enforcement and city officials that the area has been studied and is known for extensive jaywalking. From November 2010 to February 2011 one traffic enforcement team handed out over 150 violations for jaywalking in the area. The distance from the skytrain station to 98A Avenue using the existing pedestrain route is approximately 400 meters which is cut down by half if jaywalked. The jury heard that jaywalking would continue to be an attractive alternative unless measures are put in place to discourage pedestrians from doing so.

Following the inquest three pedestrian advisory signs were erected to discourage jaywalking however a study conducted in 2014 recommended further signage in strategic locations. More recently, the City extended fencing southbound which now ends approximately 25 meters north of the north side of the crosswalk at 98 Avenue. Finally, in 2015, the City completed a pedestrian controlled crosswalk directly outside the skytrain station that allows for safe foot travel from the east side of King George Boulevard to the west side.

To: Deputy Commissioner Craig Callens
Commanding Officer, RCMP 'E' Division
14200 Green Timbers Way
Surrey BC V3T 6P3

2. That the RCMP consider additonal and more frequent training to officers concerning the Motor Vehicle Act and Emergency Driving Regulations. This training needs to be consistent throughout the RCMP, with respect to not only the material, but the instruction of this material. In particular, all provisions respecting the appropriate use of police vehicles and when to/not to activate lights and sirens. As per the Motor Vehicle Act Emergency Driving Regulation, a peace officer may exceed the speed limit provided the officer activates their emergency light and siren, unless the risk of harm to members of the public entailed in operating an emergency siren or an emergency light and siren, outweighs the risk of harm to members of the public entailed in not operating them. Currently, driver related training is delegated to unit heads and is typically limited to distribution of new information/policy with a requirement for officers to review. It does not routinely involve practical driver training. Consideration should be given to in person training that is provided as part of required Block Training every three years in Chilliwack.

Coroner's Comment:

The jury heard that Cst. Luk did not activate his emergency equipment (lights and sirens) prior to the collision and the collision analyst estimated that Cst. Luk reached speeds of up to speed to be 106.9 km/hr on Old Yale Road prior to turning onto King George Boulevard and up to 89.6 km/hr while on King George Boulevard travelling southbound. The jury also heard that Cst. Luk was looking at his Mobile Data Terminal (MDT) just prior to the collision. Cst.Luk testified that he had training in Advanced Driver Techniques at RCMP Depot in Regina (2009) where they learn to push limits of the vehicle and drive safely at high speed. Cst. Luk also recalled safety lectures and some on-line training. Cst. Luk was unable to recall if he had any further driver training while stationed in British Columbia.

The Officer in Charge of Training testified that Emergency Vehicles are permitted to break rules of the road as per s. 122(1) of Motor Vehicle Act (MVA) and the decision to do so is subjective. Considerations usually include road conditions, weather, congestion/pedestrians. He testified that it is rare to respond at speed without lights and sirens to ensure public safety. The jury heard that the MVA Emergency Driving Regulation allows a peace officer to exceed the speed limit provided the officer activates their emergency lights and siren, unless the risk of harm to members of the public entailed in operating an emergency siren or emergency lights and siren outweighs the risk of harm to members of the public entailed in not operating them. The jury heard that in January 2011, new distracted driving legislation was introduced and police are

provided with an exemption but the exemption is not carte blanche. Police must first ensure public safety prior to engaging their electronic equipment. Of note, the Officer in Charge of Training testified that, at the time, no formal training on this the new distrated driving legislation had been initiated.

3. That the RCMP consider programming the MDTs to transmit audible text of all incoming messages as well as allow the officer to respond to these messages verbally, hands free, while the vehicle is in motion. As an alternate option, consider a smaller 'heads up' screen placed on the dash strictly for transmitting messages from dispatch. This would be supplementary to the MDT, which would still be used by the officer in a stationary vehicle.

Coroner's Comment:

The jury heard testimony from Cst. Luk's supervisor that he engaged in a brief conversation with Cst. Luk following the incident and that during the conversation Cst. Luk stated that he was looking at his Mobile Data Terminal (MDT) just prior to the incident and did not see anyone crossing the street.

4. That the RCMP consider equipping all police vehicles with cameras that automatically start to record when lights and/or sirens are activated.

Coroner's Comment:

The jury heard different versions of events from the witnesses at the Inquest. It is common for the comparative recollections of involved parties to fade over time. With respct to this incident, the jury heard that there was no front end camera affixed to Cst. Luk's police cruiser. A camera would have eliminated any variance in the comparative recollections of the witnesses and Mr. Luk.

5. That the RCMP consider increasing the length of time senior officers ride along with new officers from three months to one year.

Coroner's Comment:

The jury heard evidence that following Cst. Luk's recruitment training at RCMP Depot in Regina he was assigned to Surrey and engaged in required field training. The jury also learned through testimony that the field training period is currently 3 months in duration and that driver related training was delegated to unit heads and limited to distribution of new information/policy with a requirement for officers to review.

6. That a copy of the Verdict be distributed to every police officer in RCMP E - Division.

Coroner's Comment:

Self-explanatory.