Ministry of Justice

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File No.:2011:0666:0062

LOHOUSE	BRETTON ROBERT KENT
SURNAME	GIVEN NAMES

An Inquest was held at Fort. St. John Courthouse, in the municipality of Ft. St. John

in the Province of British Columbia, on the following dates September 16 - 18, 2013

before: Donita L. Kuzma, Presiding Coroner.

into the death of Lohouse (Last Name) Bretton (First Name) Robert Kent (Middle Name) 46 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: September 9, 2011 between 2055 and 2110 hours

Place of Death: T1 cell at 10648 - 100 St. (Location) Fort. St. John (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Respiratory failure

Due to or as a consequence of

Antecedent Cause if any: b) Ethanol and mixed drug intoxication

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: severe focal coronary artery atherosclerosis

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

The above verdict certified by the Jury on the 18th day of September AD, 2013

Donita L. Kuzma
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Donita L. Kuzma
Inquest Counsel:	Rodrick MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	David Kwan counsel for the Royal Canadian Mounted Police

The Sheriff took charge of the jury and recorded 6 exhibits. 20 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. The following summary of the evidence as presented at the inquest is 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.

The jury heard evidence that Bretton Robert Kent Lohouse was a 46 year old man who had a history of alcohol abuse. He had no fixed address and moved between homeless shelters in Fort. St. John. At times he would also live in a makeshift campsite. He was in a relationship with a woman who told the jury that she considered her relationship with him as common law. On the afternoon of September 9, 2011, Mr. Lohouse and his common law spouse had been consuming alcohol and smoking marijuana when they had an altercation.

At 1723 hours, Fort. St. John RCMP received a report of that altercation and responded to a location in downtown Fort. St. John. Mr. Lohouse had taken some items from his girlfriend and had injured her. The responding officers told the jury that when they located Mr. Lohouse, he appeared to be intoxicated, but did not have any alcohol with him. He was sitting with a friend in an area downtown where street people tend to gather. When Mr. Lohouse stood up, a bottle of pills spilled onto the ground. He told the police these belonged to the friend. RCMP placed him under arrest for assault and transported him to the cells at the Fort. St. John Detachment. After Mr. Lohouse got out of the vehicle at the detachment, he was observed to be swaying but, could walk unassisted. At 1751 hours, Mr. Lohouse was booked into cells. When he realized he was being placed in Tank 1, otherwise known as the drunk tank, he asked why he was being placed in there. The plan was to move Mr. Lohouse over to a holding cell once he sobered up. The officer who booked him into cells told the jury that Mr. Lohouse did not appear to be in any medical distress and was able to answer questions. An on duty cell guard completed a prisoner report and Mr. Lohouse was placed into Tank 1 (T1). Mr. Lohouse proceeded to lay down on the floor between the toilet and the wall as there was no bed or mattress of any sort in the tank. The guard then went off shift.

Another cell guard came on shift at 1800 hours. She explained to the jury that guards are not allowed to enter cells without an officer. She would check on the prisoners every 15 minutes from the window through the cell door. At 1815 hours, she noted in the guards remarks that Mr. Lohouse was talking. At 1827 hours Mr. Lohouse was snoring loudly. Then at 1855 hours, she noted he was snoring. At 1928 hours, she again noted Mr. Lohouse was sleeping. The next note about Mr. Lohouse was at 2024 hours when he was snoring softly. At 2042 hours, the records indicated Mr. Lohouse was snoring sporadically;

loud then soft then loud again. At 2055 hours he was noted to have quit snoring and was quiet. Then at 2111 hours the guard was having difficulty seeing if Mr. Lohouse was breathing or not. He was behind the toilet and she could not see him directly so she called the Corporal to go in and move him.

The Corporal who entered the cell to check on Mr. Lohouse told the jury he found him not breathing. Mr. Lohouse was laying on his right side and there was fluid on the floor in front of him. He ran to get gloves and told someone to call for an ambulance. Once he had his gloves on he went back in, positioned Mr. Lohouse on his back and then started cardio respiratory resuscitation (CPR). Another officer entered the cell and proceeded to clear Mr. Lohouse's airway. He told the jury he noticed white foam around his mouth. CPR continued until firefighters from the Fort. St. John Fire Department arrived. They brought an Automated External Defibrillator (AED) and attached it to Mr. Lohouse. At no time was there a heart rhythm detected that could be shocked. B.C. Ambulance Services personnel then arrived. Resuscitation attempts were continued with no response. At 2138 hours an order to cease resuscitation was given over the phone by an emergency room physician.

A forensic pathologist testified that he conducted a full post mortem examination on September 13, 2011, at the Vancouver General Hospital. Body fluids were collected and sent to the RCMP Forensic Science and Identification Services laboratory. The pathologist said the cause of death was due to ethanol and mixed drug intoxication. The autopsy revealed that Mr. Lohouse had severe focal coronary artery atherosclerosis, and the pathologist said this condition would also have contributed to his death.

A toxicologist from the RCMP laboratory testified that toxicology testing performed on the body fluids collected at autopsy revealed a blood ethanol (alcohol) level that was 339 mg%, a level that is 4 times the legal alcohol limit to drive. The testing also revealed the presence of amitriptyline (antidepressant) and lorazepam (anti-anxiety medication), both of which can depress the respiratory center of the brain. The toxicologist said it was dangerous to consume alcohol with these medications. Delta-tetrahydrocannabinol – the active ingredient of cannabis was also detected.

The jury heard that the New Westminster Police (NWP) Force conducted an investigation of the circumstances around Mr. Lohouse's death. A Staff Sargent from NWP gave testimony at the Inquest. In an answer to a juror's questions, the Staff Sergeant explained that using breathalysers on people being placed in a drunk tank cannot be required.

The jury heard that since Mr. Lohouse's death occurred, the Fort. St. John RCMP officers and cell guards have received in-service training on how to assess novice and experienced alcohol users for medical emergencies while they are in cells.

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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: Commanding Officer, Fort. St. John Detachment RCMP

1. Improve coverage and picture quality respecting cell block video cameras.

Presiding Coroner Comment: *During the Inquest, the jury saw videos made of the cell blocks and found it difficult to visualize details as the picture quality was poor.*

2. Obtain an A.E.D. for the cell block and provide appropriate training.

Presiding Coroner Comment: *The jury heard that there was no Automated External Defibrillator at the Fort. St. John cells when the death occurred.*

3. Implement further education respecting all levels of intoxication; including experienced and social drinkers.

Presiding Coroner Comment: *The jury heard what in-service training on assessing intoxication levels has been done and wanted to see it continued.*

4. Install second viewing screen on Watch Commander's desk.

Presiding Coroner Comment: *The jury heard there was no viewing screen at the Watch Commander's desk showing live video from the cell blocks.*