BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

File No.:2011:0727:0038

An Inquest was held at Williams Lake Court House, in the municipality of Williams Lake

in the Province of British Columbia, on the following dates May 6, 7, 8, 2013

before Donita L Kuzma, Presiding Coroner,

into the death of SARGENT, BLAINE CONRAD (Last Name, First Name, Middle Name) 19 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: September 21, 2011 at 1945 hours

Place of Death: University Hospital of Northern B.C. (Location) Prince George, British Columbia (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Methamphetamine Overdose

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 9th day of May AD, 2013.

Donita L Kuzma
Presiding Coroner's Printed Name

Presiding Coroner's Signature

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Donita L Kuzma

Coroner Counsel: Rodrick MacKenzie

Court Reporting/Recording Agency: Verbatim Words West LTD.

Participants/Counsel: B.C. Corrections and B.C. Sheriffs : Pamela Manhas

The Sheriff took charge of the jury and recorded three exhibits. Twenty four 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.

On August 31, 2011, Blaine Conrad Sargent was arrested in Williams Lake for bail breach. He was taken to the Prince George Regional Correctional Centre (PGRCC) where he stayed until September 13. On that day bail was posted for Mr. Sargent. Mr. Sargent was directed to report to a bail supervisor in Williams Lake. He failed to do so.

On September 15, 2011, at about 4:00 pm, Mr. Sargent appeared at the Prince George Community Corrections office with no place to stay. He was sent to the local hostel, with instructions to return the next morning. He failed to return as requested.

On September 17, 2011, Mr. Sargent turned himself in to Prince George RCMP respecting his failure to report in Williams Lake as required. He was placed in RCMP cells where he spent the night. On September 18, a bail hearing was conducted and Mr. Sargent was remanded in custody. On the morning of September 19, Mr. Sargent was taken to the PGRCC. A metal object wrapped in electrical tape and containing tobacco was found in Mr. Sargent's cell.

Upon admission to PGRCC, a nurse performed a health assessment on Mr. Sargent. He advised her that he had been using alcohol and illicit drugs in recent days: therefore, he was placed on an alcohol/drug withdrawal protocol. As per the protocol, Mr Sargent would receive regular doses of Valium and Gravol.

Mr. Sargent was scanned with an Ion scan - used to detect the presence of drugs. The guard who did this scan told the jury that the test was positive for the presence of drugs at a level that indicated casual contact with drugs. It was not at an "alarm" level.

Mr Sargent spent the night of September 19, 2011 and the morning of September 20 in the health care unit at PGRCC with symptoms of stomach pain and nausea. An inmate who also spent the night in the

health unit testifed that Mr. Sargent told him he had received a package of "crystal meth" (methamphetamine) while he was in Prince George and had brought it into PGRCC concealed in his rectum. He further testified that during the time they were both in the health unit Mr. Sargent advised him he was removing some of the methamphetamine from his rectum and was "hooping" it. (Hooping is a drug using activity that involves wrapping a drug in a small piece of tissue and then swallowing it.)

On September 20, 2011, Mr. Sargent was taken by B.C. Sheriffs to Williams Lake for a hearing the following day regarding his failure to report to a bail supervisor. He spent the night in the RCMP cells. He told the guards he was not feeling well. One of the guards became concerned and the Watch Commander was notified. The Watch Commander spoke to Mr. Sargent and detemined that he was not in any medical distress. Mr. Sargent was not sent for medical examination.

On September 21, 2011, the Provincial Court Judge in Williams Lake ordered that Mr. Sargent be detained; therefore, Mr. Sargent was transported by Sheriffs Service to PGRCC. Upon arrival at PGRCC, correctional staff placed Mr. Sargent in a large cell where he was alone for about 30 to 40 minutes. Then another group of several inmates were placed in the cell with him. Two of the cellmates who joined Mr. Sargent in the large cell testified at the Inquest they noticed when they entered the cell, Mr. Sargent was not well. He told them that he had just taken some "crystal meth". As well, they testified that Mr. Sargent started to act strangely and his eyes were moving quickly. He was talking but seemed confused as to where he had been during the day. One of the inmates said Mr. Sargent told him he received the package of methamphetamine while he was in Williams Lake. The cellmates became concerned and summoned a guard. Mr. Sargent told the guard that he had to use the toilet. While Mr. Sargent was being moved across the hall to a cell with a toilet, he collapsed. The nurse was called. She testified that she administered oral Gravol to Mr. Sargent. He appeared in medical distress and was moving his limbs about uncontrollably. She asked staff to call for an ambulance and at 6:07 pm, 911 was called.

At approxmately 6:15 pm the Prince George Fire Department arrrived. A firefighter testified that shortly after their arrival, Mr. Sargent went into cardiac arrest. They started cardio-pulmonary resuscitation (CPR) and employed a defibrillator. A Basic Life Support crew from B.C. Ambulance Services (BCAS) arrived at 6:25 pm. An ambulance crew member told the jury they started an intravenous (IV) and gave one dose intravenously of Narcan; a medication that counteracts the effects of opiate drugs. At 6:36 pm, an Advanced Life Support (ALS) crew arrived on scene and an ALS paramedic testified they took over resuscitation activities. Full resuscitation was continued and at 7:10 pm, Mr. Sargent was transported to University Hospital of Northern British Columbia. At no time did Mr. Sargent have any return of vital signs. According to the paramedic, the ambulance arrived at the emergency department at approxinately 7:30 pm. The emergency room doctor who saw Mr. Sargent then testified that resuscitation attempts were continued until 7:45 pm at which time death was pronounced.

A forensic pathologist reported to the jury he conducted a full post mortem examination on September 23, 2011 at Royal Inland Hospital in Kamloops. The pathologist explained to the jury that no injuries or natural diseases were found that would have contributed to the cause of Mr. Sargent's death.

The pathologist advised the jury he discovered an intact package consisting of a white substance surrounded by cellophane in Mr. Sargent's stomach. The pathologist reported that he sent the package and bodily fluids to the Provincial Toxicology Centre for further examination.

The forensic toxicologist who examined the package and samples forwarded by the pathologist testified that the contents of the package found in Mr. Sargent's stomach contained a mixture of methamphetamine, cocaine, codeine, heroin, caffeine, and paraverine. The toxicologist confirmed the opinion of the pathologist that the cellophane wrapped package was intact and the combination of the drugs in the package were not present in the bodily fluids. This indicated the source of the methamphetamine that led to Mr. Sargent's acute methamphetamine overdose was not from the package found in his stomach and had to be from another source.

A senior staff member from the PGRCC testified that inmates still retain certain civil liberties when they are incarcerated. Inmates can be strip searched, but cannot be forced to submit to internal body cavity searches, medical x-rays or invasive medical interventions.

A Critical Incident Review of Mr. Sargent's death was conducted by PGRCC. Recommendations from this review were provided to the jury for their consideration.

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: Sentry Correctional Health Services Inc.

1. During the medical intake process of inmates, the health care professional explains in plain and simple language the risks of packing drugs. The medical professional explains if they are, it will be treated as a medical issue.

Presiding Coroner's Comment: The jury heard evidence that no explanation of the dangers of carrying drugs concealed in his body was provided to Mr. Sargent during the intake assessment carried out by the nurse upon his arrival to PGRCC.

2. Each health care professional participates in advanced drug awareness training or information session during orientation

Presiding Coroner's Comment: The jury heard evidence that it is not routine for nurses to ask new inmates specifically if they are carrying concealed drugs in their bodies.

To: Sentry Correctional Health Services Inc and B.C. Corrections

3. Routine emergency mock situations are practiced and discussed on a three month basis consistently

Presiding Coroner's Comment: The jury heard evidence that there were issues regarding notification of appropriate staff to respond to the "code blue" as Mr. Sargent went into medical distress.

To: B.C. Corrections and B.C. Sheriffs

4. To implement official 10 minute time checks on prisoners that have had notations that there are medical concerns

Presiding Coroner's Comments: The jury heard evidence that Mr. Sargent was alone for 30 to 40 minutes in the holding area of PGRCC, after he returned from Williams Lak.e

To: B.C. Corrections and Sentry Correctional Health Services Inc

5. If prisoners are leaving the correctional facility, but are still in custody of the RCMP or B.C. Sheriffs, they are re checked by a health care professional when returning to the facility

Presiding Coroner's Comment: The jury heard evidence that Mr. Sargent was not checked by a nurse when he returned to PGRCC from Williams Lake.

To: B.C. Corrections, B.C. Sheriffs and RCMP "E" Division

6. Continue to work on a information sharing system that shares pertinent information

Presiding Coroner's Comment: The jury heard evidence that there is no place on the documents used when inmates are transferred to record concerns about inmates carrying concealed drugs.

To: B.C. Corrections and RCMP "E" Division

7. Information posters on the danger of drug packing are made and placed in high visibility areas, both in RCMP cell blocks as well as in Correctional Centres. The posters are to be made in such a way that anyone can understand, including illiterate and non English speaking people

Presiding Coroner's Comment: The jury heard evidence that the PGRCC Critical Incident review recommended that information posters on the danger of drug packing be created and displayed in the intake area of the Centre. Evidence presented indicated this has not been acted on.

To: RCMP "E" Division

8. Make notation on the prison jail forms if they have any reason to suspect the inmate is packing drugs or has other medical issues

Presiding Coroner's Comment: The jury heard evidence that there is no place on the documents used when inmates are transferred to record concerns about medical issues or if the inmate is suspected of carrying concealed drugs.

9. A written assessment checklist be designed for the RCMP for use when a medical check has been requested

Presiding Coroner's Comment: The jury heard evidence that there is no written assessment checklist used by staff at the Williams Lake City cells when an inmate reports they are not feeling well.