Ministry of Justice

VERDICT AT CORONERS INQUEST

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

File No.:2012:0376:0109

CRANE	VICTOR
SURNAME	GIVEN NAMES

An Inquest was held at Burnaby Coroner's Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates December 8 & 9, 2014

before: Tara Devine, Presiding Coroner.

into the death of CRANE (Last Name) VICTOR (First Name) (Middle Name) 33 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: May 20, 2012 Estimated between 7am-9am

Place of Death: Fraser Regional Correctional Centre (Location) Maple Ridge, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Acute Heroin Toxicity

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 December AD, 2014

Tara Devine
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Tara Devine
Inquest Counsel:	Rodrick MacKenzie
Court Reporting/Recording Agency:	Barb Dault/ Verbatim Words
Participants/Counsel:	BC Corrections/Pamela Manhas

The Sheriff took charge of the jury and recorded 3 exhibits. 9 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 May 9, 2012, Mr. Crane was transferred to Fraser Region Correctional Centre (FRCC) from a Remand Centre in Kamloops, BC. The transfer was initiated due to an overcrowding issue. Correctional staff testified that Mr. Crane had a full assessment prior to being approved for the transfer from the Kamloops Centre. The jury heard that on arrival to FRCC, less intensive assessment was done at intake to the facility. No medical or mental health concerns were identified. Mr. Crane was placed in a living unit and housed with a cellmate. Correctional officers testified that while at FRCC, Mr. Crane mainly kept to himself watching television or sleeping in his cell.

On May 20, 2012, the jury heard that Mr. Crane did not leave his cell all day. Correctional officers testified that they conducted visual checks and counts throughout the day and they believed that Mr. Crane was sleeping and there were no concerns. The night shift correctional officer testified that he began his shift at 1845 hours. At approximately 1930 hours, the correctional officer thought that he viewed some suspicious behavior in the unit. He testified that Mr. Crane's roommate had left his cell with a towel and given it to another inmate and that several inmates appeared to be congregating in a certain area. The correctional officer testified that he radioed the control booth to view the unit from a different camera perspective to see if there was anything of concern taking place. The control officer reported back to the correctional officer that there was no suspicious activity.

The Correctional officer testified that at approximately 2050 hours, Mr. Crane's cellmate approached his desk and stated that Mr. Crane had not eaten his dinner and was unable to be roused. The correctional officer approached Mr. Crane's cell and stood in the doorway. He testified that he did not initially go inside the cell as he was alone on the unit and was concerned for his safety. Mr. Crane was lying prone on the upper bunk. The correctional officer testified that he was unable to elicit as response from Mr. Crane so he radioed for a code blue at 2052 hours. Additional correctional officers and health care staff came to assist the code blue. The jury heard that the health care nurse assessed Mr. Crane and confirmed his death upon her arrival; therefore, no resuscitation efforts were performed. The nurse testified that Mr. Crane appeared "cold", "stiff", and had some discoloration to his skin. The police and the Coroner attended FRCC to investigate his death. The police investigation concluded that there were no concerns of foul

play. The Coroner directed that Mr. Crane's body to be taken to Royal Columbian Hospital where an autopsy was later performed.

The jury heard from the pathologist who conducted the autopsy that the cause of death was due to acute heroin toxicity. The pathologist testified that there was no evidence of injuries or natural disease that contributed to his death. Additional evidence presented by the forensic toxicologist further indicated that morphine and its metabolite were detected in a lethal range. The presence of 6-monacetyl morphine (MAM) was also detected confirming that the source of the morphine was from heroin.

The jury heard evidence pertaining to the daily schedule and general functioning of Mr. Crane's living unit at FRCC. The correctional officers testified that it was standard operating procedure for visual checks to be performed every 45 minutes and that counts were conducted three times per day. These were to be documented accurately in a logbook. The jury heard that the purpose of checks and counts is to ensure order in the unit and to ensure all inmates are accounted for and safe. Correctional officers testified that inmate safety is assessed based on healthy appearance and/or a live breathing body. The Warden of Vancouver Island Regional Correctional Centre (hereafter referred to as the "Warden") testified that although the counts and checks were documented in the log book on May 20, 2012, a review of video footage from the unit revealed that many of these checks and counts were not completed and BC Corrections standard operating procedure (SOP) was not followed. The pathologist testified that he believed that Mr. Crane's death occurred approximately 12 hours prior to him being found.

Correctional officers testified that on May 20, 2012 Mr. Crane's roommate had picked up Mr. Crane's meals for breakfast, lunch and dinner. It was unclear as to whether Mr. Crane had consumed any of these meals. Correctional officers testified that at meal times, it was common for inmates to pick up meal trays for their cellmates and that distribution of meals was not overseen. The Warden testified that closely monitoring meal distribution could be another mechanism used to confirm the safety of inmates.

Evidence presented at the Inquest also addressed concerns surrounding inmate access to illicit drugs, signs of drug overdose, and medical treatment. The Warden testified that inmate access to illicit drugs (and other contraband) was an ongoing challenge for correctional staff. The jury heard that searches of Mr. Crane's cell and the living unit after the death resulted in no findings of drugs or drug paraphernalia. It remains unknown as to how Mr. Crane obtained heroin. The jury also heard that not all correctional Staff have equivalent levels of knowledge pertaining to signs, symptoms, and treatment of possible drug overdose. The health care nurse testified that health care staff was not available between the hours of 11pm and 7 am and that during these hours correctional officers are to call 911 in the case of a suspected medical event. The jury heard that only medical personnel who are specifically trained are able to administer Naloxone (Narcan) for a suspected overdose. A Critical Incident Review of Mr. Crane's death was conducted by FRCC. Recommendations and actions taken resulting from this review were provided to the Jury for their consideration.

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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: BC Corrections

1. To ensure that while random audits of visual and security checks are being performed, that they include conducting audits during at least one mealtime

Coroner's comments: The jury heard that the Correctional Internal Review made a recommendation that random audits of visual and security checks are regularly conducted to ensure compliancy of staff. The jury felt that audits should include at least one meal time to ensure that the meal count is consistent with standard operating procedure.

2. To consider reviewing the signs and symptoms of illicit drug use with Correctional staff for educational purposes and to consider Naloxone training for all BC Corrections Staff

Coroner's comments: The jury heard that when Correctional officers reviewed the CCTV video of the unit in the days before the incident, it showed behavior of some inmates to be uncharacteristic. The jury felt that if correctional staff was able to recognize irregular behaviors sooner they may be able to take action to prevent a possible overdose from occurring. The jury also heard that there are time periods when there is no medical staff present. The jury felt that training correctional staff to administer Naloxone may result in faster treatment for a suspected overdose.

3. To consider conducting a full and formal intake for all inmates entering each prison, including inmate transfers

Coroner's comments: The jury heard that a formal intake was done in Kamloops when Mr. Crane was transferred out and that it didn't appear that a full formal intake was conducted when arriving at the new facility. The jury felt that a full assessment should be done on arrival at the new institution.

4. To add extra Correctional Officer staff during the non-lock down time periods

Coroner's comments: The jury heard testimony that there are times when Correctional Officers are working alone in the unit. When working alone, officers are unable to enter an inmate's cell for safety reasons. The jury felt that additional staffing during non-lockdown periods would allow Correctional officers to manage the living unit more effectively.

5. To consider that during the intake procedure, a review of the education of inmates as to the consequences of illicit drug use

Coroner's comments: The jury heard that inmates are not necessarily aware of the dangers of drug use particularly with regards to tolerance due to changes in drug use patterns.