BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

File No.: 2011:0216:0350

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

in the Province of British Columbia, on the following dates January 20 – 23, 2014

before Margaret Janzen, Presiding Coroner,

into the death of MALHI Surinder Pal Singh 58 ☒ Male ☐ Female
(Last Name, First Name, Middle Name) (Age)

and the following findings were made:

Date and Time of Death: December 30, 2011 at 2153

Place of Death: Surrey Memorial Hospital (Location) Surrey/BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Chronic ethanol (alcohol) abuse

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: Hypertensive atherosclerotic cardiovascular disease

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

The above verdict certified by the Jury on the 23rd day of January AD, 2014.

Margaret Janzen
Presiding Coroner's Printed Name

M. Janzen.
Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT INQUEST

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

FILE NO.: 2011:0216:0350

MALHI	Surinder Pal Singh
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:

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Margaret Janzen

Coroner Counsel: Rodrick H. MacKenzie

Court Reporting/Recording Agency: Verbatim Words West Ltd.

Participants/Counsel: Anthony Capuccinello/City of Surrey, Michelle Shea/Attorney General of Canada/RCMP

The Sheriff took charge of the jury and recorded 9 exhibits. Twenty five witnesses were duly sworn in 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 Surinder Pal Singh Malhi was a 58 year old male with a 41 year history of alcohol use. He developed alcoholism, cardiomyopathy, hypertension, and alcohol withdrawal with delirium tremens when abstinent. He was estranged from his family. On the evening of December 23rd, 2011, he was arrested for breaching a Family Relations Act Order prohibiting contact with his spouse. He was taken to the Surrey RCMP cells and booked in at approximately 2318 hours without incident.
Mr. Malhi stated that he had two glasses of whisky prior to his arrest when asked. The prisoner sheet was checked as 'intoxicated'. The C13 Form that tracks detention details recorded liquor as a possible cause of impairment, fumbling actions, fair balance, placid state of mind and a consciousness level rated as alert.
Mr. Malhi appeared before a Justice of the Peace on December 24, 2011, at approximately 1244 hours and was remanded in custody until December 27, 2013. He was taken back to the Surrey RCMP cells.
The RCMP member who escorted him to and from the hearing room noticed that Mr. Malhi had a tremor. He also checked him later that day when a guard reported that Mr. Malhi looked unwell. Mr. Malhi reported having stabbing right-sided chest pain, nausea, a headache and stomach cramps. He did not appear to be mentally ill and was responsive and cooperative. Mr. Malhi did not seem to be acutely ill but the member advised Mr. Malhi that an ambulance could be summoned then or in the future should he want him to call one. Mr. Malhi declined the ambulance at that time.

MALHI	Surinder Pal Singh
Surname	Given Names

Testimony and video captured by the cell camera showed that as the hours went on, Mr. Malhi's behaviour deteriorated and he began to display a number of symptoms of alcohol withdrawal. It progressed to where he was talking to himself, apparently hallucinating and unresponsive to questioning. On December 25, 2011, at approximately 2315 hours, his mattress, blanket, food and water were taken away after he would not stop throwing cups of water on his cells walls, stating that there was a fire. He also reported that there was another person in his cell with him. He was pacing and agitated.

No further assessment of Mr. Malhi's condition was undertaken. A guard stated that she called for a Car 67 assessment for Mr. Malhi on the morning of December 26, 2011. Car 67 was a mobile registered psychiatric nurse unit that was available between 1400 and 0200 hours daily to assess prisoners with psychiatric issues. While Mr. Malhi had no known psychiatric history, at some point during or after his booking, his C13 Form had been manually altered to show that he had mental health issues.

At approximately 1145 hours on December 26, 2011, a BC Ambulance Service primary care team of paramedics who were in the cells to see another patient assessed Mr. Malhi and stated that he should be taken to hospital. They left him in the cell and started to prepare to transfer him when the guard who was observing him on the monitor saw him twitch then lay still. The paramedics found that he had no pulse or respiration. They called for an Advanced Life Support (ALS) crew to attend.

Chest compressions were commenced immediately and continued until the arrival of the ALS crew at approximately 1215 hours. Mr. Malhi was successfully resuscitated and transferred to the Surrey Memorial Hospital. He went in to cardiac arrest once more and was resuscitated a second time. He was estimated to have had an approximately 45 minute 'down time'. He was diagnosed with a severe anoxic ischemic brain injury as a result of his arrests. He also had ischemic damage to other organs. Mr. Malhi was being maintained on life-support. After discussion with family regarding his poor prognosis life-sustaining therapies were withdrawn and he died on December 30, 2011.

The evidence showed that the guards and police officers were unaware at the time that a chronic alcoholic is in danger of going into withdrawal when they are abstinent and that, untreated, it can lead to death.

A core review of jail procedures and practises was undertaken following this incident which resulted in a number of changes. The manually filled in prisoner check sheets were revised and a Cells Shift Sheet was created. The guard training process was expanded, with alcohol withdrawal added as a topic of discussion. A section was added to the Standard Operating Procedures which requires guards to watch prisoners on the monitors in between cell checks. An improved monitoring system was installed as well.

MALHI	Surinder Pal Singh
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Post mortem examination showed that Mr. Malhi had died as a result of chronic ethanol (alcohol) abuse, including but not limited to, the effects of acute alcohol withdrawal and cardiomyopathy as a consequence of chronic alcohol abuse. Hypertensive atherosclerotic cardiovascular disease was considered contributory. Toxicology analysis done at the time of his admission to hospital was unremarkable.

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:

MALHI	Surinder Pal Singh
Surname	Given Names

JURY RECOMMENDATIONS:

To: Bill Fordy, OIC
Surrey RCMP
14355 57 Ave.
Surrey, BC
V3X 1A9

To: Mayor and Council
City of Surrey
14245 – 56th Ave.
Surrey, BC
V3X 3A2

1. Written shift report at the end of every shift should include behavioural issues/changes noticed in prisoners. All shift reports should be written and passed on to the manager. This way, the manager is aware of cell activity and also has an opportunity to identify/follow-up on any issues.

Coroner's Comments: Mr. Malhi's prisoner sheet did not state that his mattress was taken away or why, nor that his water was shut off. It recorded the incident as "poured dinner out door into hall". His behavioural status was not recorded anywhere by either the RCMP or the guards.

To: Bill Fordy, OIC
Surrey RCMP
14355 57 Ave.
Surrey, BC
V3X 1A9

2. Electronic C13 forms that reflect health changes and show the author, date, and time of changes made. Only RCMP should be able to make changes to this form. All recommendations for changes/updates should be made through the sergeant.

Coroner's Comments: The jury heard evidence that a box indicating mental health issues was checked off manually on Mr. Malhi's C13 Form at some point during or after being booked into cells. This may have led to attribution of his unusual behaviour to a mental illness and a delay in recognition of the seriousness of his situation. Had approval for the change been required by the cell Seargent, Mr. Malhi's change in condition might have been recognized. Although both guards and RCMP had access to the C13 Form, accountability for the prisoner's fitness to remain in cells rested with the cell Seargent

in reliance upon the information provided. Evidence was led that wholly electronic C13 Forms would result in improved communication.

3. C13 forms should only be filled out on admission. Any changes/additions to this form after admission need to be made on an addendum, (changes need to be dated and signed). This way, there will be no confusion as to when/where changes in a prisoner's status occurred.

Coroner's Comments: See number two above.

4. RCMP should make notes pertaining to prisoners in a log book where all employees in contact with those prisoners can see it (this way there is a continuity of information and better communicaton).

Coroner's Comments: The Prisoner Log Book in which the guards recorded the times of their checks, location of prisoners and other notable events was not apparently used or consulted by the RCMP members during Mr. Malhi's incarceration, although it was apparently available for them to do so. Their shift pass-on information was verbal only. There was also a whiteboard in the office area where information was temporarily recorded.

5. Screening tool for alcohol withdrawal (e.g. CIWA scale) as this can be a serious issue and would be important to be identified early on to prevent any serious consequences.

Coroner's Comments: Evidence was led that a significant number of prisoners had drug, alcohol and/or mental health issues. They also heard that alcohol withdrawal is fairly common in alcoholics and can be fatal. The guards and RCMP members were not familiar with alcohol withdrawal at the time of the incident. Evidence showed that the guard training program had since been changed to include training around alcohol withdrawal, but that no medical professional was said to be currently available at the cells. A protocol such as the CIWA (Clinical Institute Withdrawal Assessment) scale would provide a basic, objective assesment tool for staff who are responsible for prisoner safety.

To: Mayor and Council
City of Surrey
14245 – 56th Ave.
Surrey, BC
V3X 3A2

6. Debrief after critical incidents with all city employee staff (guards, sergeants)

MALHI	Surinder Pal Singh
Surname	Given Names

Coroner's Comments: Self-explanatory.

To: Bill Fordy, OIC
Surrey RCMP
14355 57 Ave.
Surrey, BC
V3X 1A9

7. Notes should be made by RCMP and guards and available to all staff to ensure continuity of information/better communication and thereby aid in flagging issues that can occur.

Coroner's Comments: The RCMP members testified that they did not make notes anywhere, except on the C13 Forms and occasionally in their own notebooks in certain prescribed circumstances.

To: Mayor and Council
City of Surrey
14245 – 56th Ave.
Surrey, BC
V3X 3A2

8. 24 hour Medical Nurse or Medical Practitioner present at Surrey Cells to assess prisoners upon admission and during their stay. This would aid in all aspects of a prisoners welfare.

Coroner's Comments: Evidence was heard that the Surrey RCMP cells housed thousands of prisoners each year and would benefit by having a trained medical professional available to assess prisoners. They also heard that other jails did have a medical professional available 24/7. No practical obstacle to the implementation of this recommendation was articulated.

9. Ideally electronic notes should be used as soon as the software is available.

Coroner's Comments: Evidence was heard that electronic guard sheets were implemented at the cells but that the software could not record the quantity of information required. This recommendation affirms the benefits of electronic note-keeping.