BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

File No.: 2012:5003:0070

An Inquest was held at The Penticton Courthouse, in the municipality of Penticton

in the Province of British Columbia, on the following dates November 3/4/5, 2014

before Larry Marzinzik, Presiding Coroner,

into the death of Scott (Last Name) Steven (First Name) Joseph (Middle Name) 30 (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: August 10, 2012 0201 hours

Place of Death: 1168 Main Street (Location) Penticton, BC (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Asphyxia

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Terminal Aspiration Pneumonia

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Alcohol Withdrawal

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 5th day of November AD, 2014.

Larry Marzinzik
Presiding Coroner's Printed Name

Presiding Coroner's Signature

SCOTT	**Steven Joseph**
Surname	Given Names

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Larry Marzinzik

Inquest Counsel: Rodrick H. MacKenzie

Participants/Counsel: Department of Justice / David Kwan

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded seven (7) exhibits. Nineteen (19) 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 purpose of the summary 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 the morning of August 9, 2012, Mr. Scott was arrested for causing a disturbance and public intoxication in Penticton, BC. He was subsequently lodged in the Penticton RCMP cellblock at 0745 hours.

While in custody it was determined that Mr. Scott would remain in custody on an outstanding warrant. Mr. Scott appeared before a Justice of the Peace at 1630 hours via teleconference. During that hearing Mr. Scott indicated he required some medication. He would not reveal what type of medication he required when the police asked and offered to obtain the medication for him while he was in custody.

During the evening, at 1915 hours, Mr. Scott became vocal and requested to be taken to the hospital. The Watch Commander of Penticton Detachment spoke with Mr. Scott and determined Mr. Scott would not be taken to the hospital at that time. Mr. Scott received a number of juice boxes during the evening as he had previously advised he had 'low blood sugar levels'. Mr. Scott remained in cells resting for the duration of the evening while being monitored by the cellblock guard. The Watch Commander later enquired about Mr. Scott's condition via radio communication with the cellblock guard. The Watch Commander also later attended the cell block and spoke directly with Mr. Scott.

The cellblock Closed Circuit Video Equipment recorded, during the early morning hours of August 10, 2012, Mr. Scott moving about while lying on his cell bench until 0201 hours when his movements ceased. Mr. Scott remained lying in a fetal position facing the back wall of the cell until he was physically checked at 1040 hours. It was discovered at this time that Mr. Scott had died. During this period, between 0201 hours and 1040 hours, routine Closed Circuit Video Equipment visual checks were completed by guards without Mr. Scott's condition being noticed. There were only infrequent physical checks, the viewing of Mr. Scott directly through the cell door plexiglass window, and no rousabilty checks completed by the guards during this same time period.

The BC Ambulance Service was summoned and immediately attended the Penticton Detachment cellblock and confirmed Mr. Scott was deceased. The scene was secured for the Independent Investigations Office and the BC Coroners Service to attend to conduct their follow-up investigations.

An autopsy was performed which indicated that Mr. Scott's cause of death was terminal aspiration pneumonia due to aspiration of gastric contents. Toxicology results indicated Mr. Scott's level of intoxication from alcohol was still heavy after being in custody for approximately eighteen and a half hours prior to his death. Evidence was provided by the pathologist that symptoms and affects of alcohol withdrawal could take place many hours, and even days, after a person has consumed alcohol. The autopsy results indicated that death would have occurred within minutes of the aspiration of gastric contents which caused the aspiration pneumonia. During the Inquest, the pathologist revised Mr. Scott's cause of death to be asphyxia due to terminal aspiration pneumonia due to alcohol withdrawal.

Mr. Scott had received treatment for alcohol withdrawal approximately five months earlier at the Penticton Regional Hospital. Mr. Scott discharged himself against medical advice and without completing the recommended medical treatment. Mr. Scott had been taken for this treatment by the police from the Penticton RCMP Detachment cellblock where he was serving an intermittent sentence. The Watch Commander on duty at the time of Mr. Scott's death was aware of this previous transfer from the Penticton RCMP Detachment cells to the Penticton Regional Hospital while assessments were being made on August 9, 2012 to determine whether Mr. Scott required medical treatment. The Watch Commander was aware of the fact that Mr. Scott was Unlawfully at Large as the result of leaving the hospital on that previous occasion and not returning to custody to complete service of his sentence. The Watch Commander did not have access to the previous medical treatment information as evidence was presented that the medical information would only be reviewed if Mr. Scott had been taken to the hospital for treatment.

SCOTT	**Steven Joseph**
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 Commanding Officer of the RCMP (E Division) and Chiefs of all Municipal Police Departments in British Columbia, to:**

1. Review current practises and policies related to the number of guards, their shift duration and the possibility of overlapping shifts in all cell facilities with the organization's jurisdiction.

   Coroner's Comments:
   The Jury heard testimony that the detachment cellblock guards worked twelve hour shifts alone until a certain number of prisoners were booked into the facility. The Jury believed the duration of the shifts and absence of other guards may cause fatigue and inattention when monitoring the prisoners' welfare. The Jury believed it may be beneficial for multiple guard shifts, overlapping shifts or shorter shifts to be utilized.

2. Review the policy and training standards in relation to the police officers' and cell facility guards' awareness and knowledge of withdrawal symptoms exhibited by persons addicted to alcohol, and other substances, to enhance their ability to assess the need for medical treatment and intervention.

   Coroner's Comments:
   The Jury heard testimony that few RCMP members and none of the cellblock guards are adequately trained in the assessment of alcohol or substance withdrawal symptoms when monitoring prisoners and making decisions on the need for medical care. The Jury believed appropriate training would enhance the cellblock personnel's ability to make the required medical assessments and decisions.

3. Unless extraneous circumstances dictate, the Watch Commander should remain in the detachment for the duration of his shift.

   Coroner's Comments:
   The Jury heard testimony that the Watch Commander had numerous responsibilities which included leaving the detachment to supervise front-line officers. The absence of the Watch Commander at times left the cellblock guard without an officer to immediately attend the cellblock if required. The Jury felt the probable time delays in prisoners being physically attended to during medical emergencies should be minimized by having the Watch Commander on site at all times.

4. If an officer becomes aware of , or suspects, alcohol or substance abuse they should note it in the 'remarks' portion of the Master Index (MNI) on PRIME to ensure that during any subsequent arrests the arresting officers can take the necessary steps should alcohol and drug withdrawal, while in custody, become an issue.

   Coroner's Comments:
   The Jury heard testimony that it is feasible to document substance abuse observations within the MNI of PRIME and believed this information would be beneficial to police officers in making medical assessments when dealing with the documented person during future incidents.

5. When an Officer is booking a prisoner, they should review PRIME and note medical issues, including suspected chronic alcohol and substance abuse (collectively 'Medical Issues'), on the C-13. If Medical Issues are noted on a C-13 it should be printed in a colour or in a manner to distinguish it from other C-13's.

   Coroner's Comments:
   The Jury heard testimony that there was a section of the cellblock booking document (C-13) for documentation of medical issues. The Jury believed this information was vital enough for that section, or those entries, to be highlighted in some manner to ensure the recognition of medical concerns by the police officers and guards having contact with that person while in custody.

6. If a prisoner who is suspected of having a drug or alcohol addiction is detained longer than 12 hours a medical assessment, by a person trained to recognize withdrawal symptoms, shall be conducted.

   Coroner's Comments:
   The Jury heard testimony that the alcohol or substance withdrawal symptoms could be displayed well after the person was taken into custody. The Jury believed anyone with these medical concerns held for a long period should at some point receive a medical assessment to ensure they did not require medical attention.

To: **The Officer in Charge of the Penticton Royal Canadian Mounted Police and the City of Penticton:**

7. Consider the feasibility of establishing a mandatory two guard shift, overlapping shifts or reduced shift duration for the cell facilities within the Penticton Detachment.

   Coroner's Comments:
   The Jury heard testimony that the detachment cellblock guards worked twelve hour shifts alone until a certain number of prisoners were booked into the facility. The Jury believed the duration of the shifts and absence of other guards may cause fatigue and inattention when monitoring the prisoners' welfare. The Jury believed it may be beneficial for multiple guard shifts, overlapping shifts or shorter shifts to be utilized.

8. Consider the feasibility of updating the cell surveillance cameras to those that have the capability to zoom in to a subject.

Coroner's Comments:
The Jury heard testimony that the guards and police officers did not have the ability to check closely on the prisoners without rousing them or entering the cell. The Jury believed a capability to zoom the camera view in on the prisoner would assist in checking on the condition of the prisoner without disturbing them on a constant basis.

9. The person in charge of providing the training for all guards should have his or her own training updated quarterly. The trainer should also ensure the training manual is continuously updated and any changes conveyed to the guards.

Coroner's Comments:
The Jury heard testimony that policy changes occur on a regular basis. The Jury believes the trainer should be aware of these changes as soon as practical. The Jury also believed these changes should then be passed onto the guards immediately. The Jury believed these changes would ensure the instructor and guards were fully aware of training and policy updates.

10. Current jail guards should not provide the training for newly hired jail guards.

Coroner's Comments:
The Jury heard testimony that mentoring was utilized as a component of their training program. The Jury believed that this mentoring was not standardized and may lead to incorrect policies and procedures being transferred from the experienced guards to the newly trained personnel.

11. Study the feasibility of replacing municipal jail guards with prison guards trained to work in Provincial Correctional Institutions.

Coroner's Comments:
The Jury heard testimony that the municipal jail guards were not trained or permitted to enter a cell to interact with a prisoner without a police officer present. The Jury believed Provincial Correctional officers/guards are trained to deal physically with prisoners so hiring them would eliminate the need for a police officer to be present when dealing with medical concerns and emergencies.

12. Random/intermittent audits of cell surveillance video should be conducted to ensure that the physical checks recorded in the log books coincides with the surveillance on the video.

Coroner's Comments:
The Jury heard testimony that cellblock documentation can become routine and tedious, possibly leading to documentation that did not truly reflect proper procedures and the actual prisoner monitoring provided. The Jury believed video audits would ensure the guards are performing

their expected duties and the actual monitoring is being properly documented within the required logs and forms.

13. The lighting in the cell hallways should be upgraded to ensure the surveillance video can clearly show physical prisoner checks.

Coroner's Comments:
The Jury saw cellblock video that appeared blacked out or void of useful detail in cellblock corridor areas when the cellblock corridor lighting was turned off. The Jury believed better lighting would allow for more thorough review of the checks of and interactions with prisoners by guards and police officers.

To: **The Minister of Health, Province of British Columbia:**

14. That the provincial government study the feasibility of establishing an alcohol detoxification center in the South Okanagan or fund a partner agency to operate such a facility.

Coroner's Comments:
The Jury heard testimony that people from the South Okanagan with alcohol addictions, who agreed to treatment, were required to wait long periods of time before having access to remote detoxification programs in Kelowna or Kamloops. The Jury believed that having a local detoxification center situated in the Penticton area would assist in providing an appropriate program within reasonable time periods for the people of the South Okanagan area.