Ministry of Public Safety
and Solicitor General
Coroners Service
Province of British Columbia

File No. : 2015 : 0380 : 0014

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO SECTION 38 OF THE CORONERS ACT, [SBC 2007] C 15, INTO THE DEATH OF

SURNAME	GIVEN NAMES
VAUGEOIS	Rene Armand

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

in the Province of British Columbia, on the following dates February 20 – 23, 2017

before: Margaret Janzen, Presiding Coroner.

into the death of VAUGEOIS (Last Name) Rene (First Name) Armand (Middle Name) 88 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: September 23, 2015 7:45 am

Place of Death: 1525 Mackay Crescent (Location) Agassiz, British Columbia (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Hypertensive and atherosclerotic cardiovascular disease.

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: Incised wound to abdomen

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

The above verdict certified by the Jury on the 23 day of February AD, 2017

Margaret Janzen
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	Mr. Bryant Mackey
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mr. Makosz and Mr. McLeod for Attorney General of Canada, Mr. Riddell for Cheam Village Holdings, Mr. Howden-Duke for Fraser Health Authority

The Sheriff took charge of the jury and recorded 10 exhibits. 21 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 Findings 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 Findings and Recommendations.

Rene Armand Vaugeois was an 88 year old male who lived in the independent living section of the Residences at Cheam Village in Agassiz. Mr. Vaugeois had been taken to hospital by RCMP on September 16, 2015, after displaying uncharacteristically aggressive behaviour in the dining room of the Cheam Village the previous evening which included striking a staff member. He was apprehended under the *Mental Health Act* and transferred to Chilliwack General Hospital. He was discharged home later the same day with a recommendation that he have further assessment and treatment in the community.

On September 23, 2015, a care aide was asked to attend to Mr. Vaugeois' suite because he had complained about his smoke alarm going off. When she attended she found him sitting on his bed holding a knife to his abdomen and not responding to her questions. She called 9-1-1 at 0612 hours. Another staff member also responded to the situation and they waited together in the hallway for the RCMP to arrive, checking on Mr. Vaugeois from time to time.

The RCMP attended and attempted to speak to Mr. Vaugeois but he did not respond. They entered his suite and shortly thereafter he began to cut his abdomen. The RCMP sprayed him with pepper spray and handcuffed him behind his back. BC Ambulance Service personnel attended and he was transferred to an ambulance by stretcher. Paramedics found he had a very elevated heart rate and administered midazolam. His heart rate slowed but then he went into cardiac arrest at 0745 hours and could not be resuscitated. An autopsy was conducted which showed that Mr. Vaugeois died from hypertensive and atherosclerotic coronary artery disease. An incised wound of the abdomen was considered to be contributory.

The Independent Investigations Office investigated the incident and determined that no criminal offence had been committed by the subject RCMP members who dealt with him on September 23, 2015. The subject officers did not make notes of their dealings with Mr. Vaugeois.

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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 Cheam Village:

1. A system detailing all critical incidents should be implemented so all staff may review critical incident reports at the start of their shift.

Presiding Coroner Comment:
The jury heard evidence that the staff who responded to Mr. Vaugeois' suite on September 23, 2015, were not aware of the incident involving him on September 15/16, 2015.

2. Critical incident reports should be flagged to bring attention to incidents involving mental health issues.

Presiding Coroner Comment:
See number one above. This recommendation seeks to ensure employer notification to staff of critical incidents.

3. Critical incident reports should be dated, time stamped, and initialed when reviewed by staff.

Presiding Coroner Comment:
See number one above. This recommendation seeks to ensure staff compliance.

4. Debriefing of staff should be required after any critical incident whether on the Residential Care side of the facility or the Independent Living side.

Presiding Coroner Comment:
This recommendation is self-explanatory.

To Fraser Health Authority:

5. Patients who live alone and are arrested under Section 28 of the *Mental Health Act* should not be released from a facility until assessed by a mental health professional.

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Presiding Coroner Comment:

The jury heard evidence that Mr. Vaugeois lived alone. He was discharged from the Chilliwack Hospital on September 16, 2015, when he had been medically cleared even though he had not been seen by a mental health professional. The jury felt that a mental health professional would have been best suited to assess his mental health.

To RCMP:

6. Note-taking should be mandatory in respect of all incidents attended by RCMP officers.

Presiding Coroner Comment:

The jury heard evidence that note-taking was mandatory but the subject officers were advised not to make notes. This recommendation seeks to ensure transparency and accountability.

7. Mental health liaison units should be available for consultation by RCMP.

Presiding Coroner Comment:

The jury heard evidence that between 18 – 33% of the incidents that the RCMP attended involved mental health issues.