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

File No. 2016-0750-0040

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
WOOD	**EBONY AARON**

An Inquest was held at Quesnel Court House, in the municipality of Quesnel, BC

in the Province of British Columbia, on the following dates November 14-16, 2017

before: Donita Kuzma, Presiding Coroner.

into the death of Wood (Last Name) Ebony (First Name) Aaron (Middle Name) 36 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: November 7, 2016 1906 hours

Place of Death: Vancouver General Hospital (Location) Vancouver, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Blunt head trauma

Due to or as a consequence of

Antecedent Cause if any: b) Fall from ambulance

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 16th day of November AD, 2017

Donita Kuzma
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Ms. Donita Kuzma
Inquest Counsel:	Mr. Bryant Mackey
Court Reporting/Recording Agency:	Ms. Joanne Watson/Verbatim Words West Ltd.
Participants/Counsel:	Mr. Adam Howden-Duke for B.C. Emergency Health Services Mr. Andrew Kemp for the Royal Canadian Mounted Police

The Sheriff took charge of the jury and recorded 6 exhibits. 13 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.

On November 5, 2016, at approximately 0700 hours, Ebony Aaron Wood was operating a vehicle that did not belong to him, on a residential street in Quesnel, when the vehicle went into a ditch and rolled onto its side. Mr. Wood got out of the vehicle and left the scene. A police officer from the Quesnel RCMP detachment responded to a report of the incident that had been called in to 911. When the officer arrived on scene, Mr. Wood was located in the yard of a nearby residence. Mr. Wood appeared intoxicated, but the officer did not ask him if he was "high". The officer escorted Mr. Wood to a police vehicle and asked if he had anything on him. Mr. Wood provided her with a set of keys and a container of what appeared to be illicit drugs. Mr. Wood indicated to the officer that he had pain in his arm and chest area. The officer then called for an ambulance to attend the scene as she was concerned Mr. Wood had been injured. Mr. Wood waited with the officer in the police vehicle until the ambulance arrived. According to the officer, she released him at that time, but she did not tell Mr. Wood this.

B.C. Ambulance Services responded to the call and two paramedics attended the scene. Upon their arrival, Mr. Wood walked from the police vehicle to the ambulance; then entered it via the side door. He told the paramedics he had used cocaine and alcohol earlier that morning. He also expressed remorse about the events that led up to the vehicle going into the ditch. At first, he was seated on the chair inside the back of the ambulance. He was then moved to the stretcher and was belted in. Mr. Wood removed the belt several times and each time the attending paramedic put it back on. While this was occurring, the other paramedic went to the cab and started to drive the ambulance. At approximately 0738 hours, the driver asked the paramedic in the back for assistance as he was not familiar with the route to the hospital. The paramedic in the back turned toward the front to speak to the driver through the window. He then heard a click, and when he turned back, Mr. Woods was standing at the back of the ambulance. He was facing the front and his hand was on

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the back door handle. The door then opened and Mr. Wood went out of the vehicle. The paramedic immediately asked for the driver to turn the ambulance around. They drove back and found Mr. Wood, lying on the pavement, unresponsive. Trauma was noted to the back of the head. Mr. Wood was placed in a 'clam shell' stretcher. Then, the first RCMP officer arrived on scene with another police officer. Mr. Wood was placed in the ambulance, accompanied by both paramedics. One of the police officers then drove the ambulance to GR Baker Hospital.

Mr. Wood was admitted to the emergency room, where he was intubated and put on full life support. A computerized tomography (CT) scan revealed that he had sustained a severe brain injury. A neurosurgeon was consulted at the Vancouver General Hospital (VGH). A decision was made to transport Mr. Woods to VGH for more advanced care. Further testing done at VGH showed Mr. Wood had a non-survivable brain injury. His condition continued to deteriorate and he died on November 7, 2016 at 1906 hours.

An autopsy was conducted at VGH. The pathologist concluded that the cause of death was due to blunt head trauma. Toxicology testing, done on blood samples obtained when Mr. Wood was admitted to GR Baker Hospital, revealed the presence of cocaine, cocaine metabolite and alcohol.

The ambulance was inspected after the incident and the inspection determined that the rear door lock was not operating correctly at the time of the incident. The contact wire was frayed and this prevented it from locking automatically when the vehicle was moving. However, even if the door had automatically locked when the vehicle was put in gear, it could still be opened from within the ambulance by sliding the lock open manually.

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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 Ambulance Services

1. Implement changes to ambulance design that allow for two way communications between paramedics.

   Presiding Coroner Comment: *The paramedic in the back of the ambulance had to rise and leave the side of Mr. Wood in order to talk with the driver in the front.*

2. Routine check and inspection of ambulances should include features of the vehicle that are operational while the vehicle is in motion; this would require completing checks while the vehicle was in motion.

   Presiding Coroner Comment: *The back door of the ambulance did not automatically lock when the vehicle was in motion. This defect would not have been discovered on a routine check and inspection done when the vehicle was in park.*

3. Add visual indicators to the ambulance that informs the driver and the attending paramedic that all vehicle doors are closed and locked.

   Presiding Coroner Comment: *There were no display indicators in the ambulance what would have alerted the driver and attending paramedic of the back door being in an unlocked state or a locked door being unlocked or opened.*

4. Upgrade the GPS technology available to ambulance drivers to allow for different directional orientation of the mapping information.

   Presiding Coroner Comment: *The GPS technology in the ambulance did not allow for directional orientation of the map. Maps that display the direction the vehicle is traveling are easier to read and may have assisted the driver in determining the correct route to the hospital.*

5. Implement changes to the rear door lock locations, so as to limit the patient's access to the door locking mechanism.

   Presiding Coroner Comment: *The location of the lock for the back door was located near the inside door handle. Relocating the sliding lock to a location away from the handle would limit the opportunity for a passenger to unlock the door quickly.*

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To: BC Ambulance Services
Royal Canadian Mounted Police

6. Enhance mental health and substance use training provided to first responders that improves their ability to assess behavioral indicators of risk.

Presiding Coroner Comment: *Mr. Wood was intoxicated, making it more difficult for responding RCMP officers and attending paramedics to assess his behaviour and identify ways in which he might create risk of harm to himself or others.*

To: Royal Canadian Mounted Police

7. Ensure any behavioral issues that could endanger the patient or others are communicated to the BCAS (BC Ambulance Services) when care is transferred.

Presiding Coroner Comment: *The responding RCMP officer was aware that Mr. Wood had previously run away from the accident scene and had been acting erratically. The jury also heard that a criminal check was not run, which would have identified a previous incident of erratic behaviour when police were involved. Sharing information when care is transferred could assist with the safety of the patient or others.*