BRITISH COLUMBIA

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

WOOD	**Ebony Aaron**
SURNAME	GIVEN NAMES

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 19:06

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: xx 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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SURNAME	GIVEN NAMES
WOOD	**Ebony Aaron**

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 Service**

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

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

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

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

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

To: **BC Ambulance Service**
Royal Canadian Mounted Police

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

To: **Royal Canadian Mounted Police**

7. Ensure any behavioural issues that could endanger the patient or others are communicated to the BCAS when care is transferred.