



Province of British Columbia

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

FISHER SURNAME

William Ryan GIVEN NAMES

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

in the Province of British Columbia, on the following dates: July 17, 2018 to July 20, 2018

before: Larry Marzinzik, Presiding Coroner.

into the death of Fisher (Last Name), William (First Name), Ryan (Middle Name), 30 (Age), Male

The following findings were made:

Date and Time of Death: February 25, 2016 (Date), 1:19 PM (time)

Place of Death: Royal Columbian Hospital (Location), New Westminister, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Acute Methylenedioxyamphetamine (MDMA) toxicity.

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:

Classification of Death: [x] Accidental [] Homicide [] Natural [] Suicide [] Undetermined

The above verdict certified by the Jury on the 20 day of July AD, 2018

LARRY MARZINZIK Presiding Coroner's Printed Name

Presiding Coroner's Signature



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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. Larry Marzinzik
 Inquest Counsel: Mr. Bryant Mackey
 Court Reporting/Recording Agency: Verbatim Words West Ltd.
 Participants/Counsel: Ms. Pamela Manhas, counsel for BC Corrections

The Sheriff took charge of the jury and recorded 7 exhibits. 11 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. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

Mr. William Ryan Fisher was taken into custody at North Fraser Pretrial Centre, situated in Port Coquitlam, on February 19, 2016, as the result of sentencing on matters unrelated to his death.

There were no identified concerns with regards to Mr. Fisher during his intake process or after he was admitted to his living unit until the afternoon of February 21, 2016. Mr. Fisher was then observed by a correctional officer interacting with a number of other inmates. The correctional officer described Mr. Fisher as being upset during and after these interactions. The correctional officer approached Mr. Fisher immediately upon his return to his cell. Mr. Fisher was found to be in possession of plastic wrappings or bundles which contained suspected contraband (illicit drugs). The contraband was seized from Mr. Fisher and he was immediately moved to the segregation unit until the completion of an investigation.

Mr. Fisher was lodged with another inmate in the segregation unit cell. His cellmate observed Mr. Fisher ingest a quantity of an unknown powder, believed to be illicit drugs, which Mr. Fisher had concealed within a body cavity. The substance use continued through the evening into the morning of February 22, 2016. Mr. Fisher interacted with his cellmate throughout this time period and shared the substance, which Mr. Fisher indicated was "MDMA". The cellmate testified that Mr. Fisher "snorted ... an insane amount ... more than [he] had ever seen". Mr. Fisher's cellmate fell asleep around or shortly after midnight. The cellmate advised Mr. Fisher "seemed fine most of the night".



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From approximately 4:00 AM until 5:30 AM Mr. Fisher was restless and moving on the upper cell bunk. At 5:34 AM Mr. Fisher fell off his bunk and began staggering about the cell in an "incoherent state". His cellmate attempted to calm him by talking to him but became concerned for his welfare and pushed the cell call button to summon assistance from the correctional staff.

A number of corrections officers attended the cell, removing the cellmate and securing him in another location while attempting to assist Mr. Fisher. He was incoherent and resisted "soft hand" control attempts by the correctional officers. The officers physically removed Mr. Fisher from the cell into the hallway. He was actively resisting and the officers placed him on the hallway floor in a prone position to restrain him.

The correctional officers requested assistance from the facilities medical staff once he was restrained and moved to an area near to the unit's elevator. Mr. Fisher was checked by the facilities nurse while he was in a prone position at this location. The correctional supervisor instructed another staff member to call for an ambulance at the direction of the nurse. The nurse then left to obtain his medical records from the health unit on another floor.

At approximately 5:58 AM Mr. Fisher became unresponsive and cardiopulmonary resuscitation (CPR) was initiated by the corrections staff. The CPR continued until ambulance personnel attended to the scene at 6:25 AM. Mr. Fisher was assessed and transported by the paramedics at 6:27 AM.

Mr. Fisher was transported to Royal Columbian Hospital and treated for shock and multi-organ dysfunction as the result of illicit drug poisoning. During this medical treatment another plastic bundle of suspected illicit drugs was found within one of Mr. Fisher's body cavities. After initial treatment Mr. Fisher remained in a coma. On February 25, 2016 at 1:19 PM his doctors found an absence of intracranial blood flow confirming brain death and he was declared dead at that time

Toxicological analysis determined Mr. Fisher had a lethal level of methylenedioxymethamphetamine (MDMA) within his blood when he was first admitted to the Royal Columbian Hospital on February 22, 2016. An autopsy confirmed there were no other underlying causes for his death and the cause of death was acute methylenedioxymethamphetamine (MDMA) toxicity.



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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: Minister of Public Safety & Solicitor General and BC Corrections**

1. Review policies to ensure constant monitoring of inmates in the Segregation Units of correctional centres.

Presiding Coroner Comment: *Testimony heard by the jury indicated it was not policy for the inmates to be observed on the cell camera monitors constantly. The jury felt constant monitoring with regard to Mr. Fisher may have possibly led to an early detection of suspicious and/or abnormal behavior. They stated constant monitoring would possibly lead to earlier intervention in cases of medical emergencies.*

2. Increase staff to ensure constant monitoring of inmates in the Segregation Units of correctional centres.

Presiding Coroner Comment: *The jury heard testimony that the cell camera monitors were viewed by staff intermittently due to staffing levels and other duties. The jury indicated additional staff should be utilized to monitor segregation screens without interruptions on a twenty-four hour basis. This could assist in early detection and prevention of illicit drug use.*

3. Increase the number and size of the Central Control monitors in the Segregation Units of correctional centres.

Presiding Coroner Comment: *Testimony was heard by the jury that each monitor at the central monitoring area had camera views of fifteen cells. The jury believes that providing additional, and larger, monitors for the observation of inmates within the segregation units would allow the corrections staff a better opportunity to identify abnormal and/or suspicious inmate activity.*



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**To: BC Emergency Health Services, and
City of Port Coquitlam**

4. Consider establishing a paramedic station in Port Coquitlam.

Presiding Coroner Comment: *The jury heard testimony that the distance from the closest paramedic station to the North Fraser Pretrial Centre was a factor in the response time. The jury believes that an additional paramedic station would facilitate more timely emergency medical treatment responses to the North Fraser Pretrial Centre. The jury believed research could determine the most suitable location, with consideration for modifications being made to any existing first responder facility that is closer to the North Fraser Pretrial Centre.*

**To: Minister of Public Safety & Solicitor General,
BC Corrections, and
BC Emergency Health Services**

5. Develop and implement inter-agency training programming to ensure effective communication of medical emergency scene information, ensuring a timely and effective response.

Presiding Coroner Comment: *The jury had concerns with the testimony relating to the communication of information between the North Fraser Pretrial Centre staff and the 911 dispatcher. There was testimony that the 911 dispatcher may have sent different response personnel if more detailed information had been received from the correctional centre staff. Training in the use of specific medical terminology and specific dispatch questions to correctly assess the type of first responder response could lead to more timely and appropriate emergency medical assistance. Inter-agency training would help facilitate the understanding of each agency's information requirements and challenges during medical emergencies.*