



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

SHANOSS

SURNAME

JAMIE WILFORD

GIVEN NAMES

An Inquest was held at The Prince George Law Courts, in the municipality of Prince George

in the Province of British Columbia, on the following dates: September 17-20, 2018

before: Donita Kuzma, Presiding Coroner.

into the death of Shanoss (Last Name), Jamie (First Name), Wilford (Middle Name), 51 (Age), [X] Male [] Female

The following findings were made:

Date and Time of Death: November 21 / 2016 (Date), 00:36 am to 02:48 am (time)

Place of Death: 455 Victoria Street (Location), Prince George BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Acute Alcohol Poisoning

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: Cocaine Use

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

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

Donita Kuzma

Presiding Coroner's Printed Name

[Handwritten Signature]

Presiding Coroner's Signature



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PARTIES INVOLVED IN THE INQUEST:

| | |
|-----------------------------------|---|
| Presiding Coroner: | Donita Kuzma |
| Inquest Counsel: | John McNamee |
| Court Reporting/Recording Agency: | Verbatim Words West Ltd. Andrew Kemp, Counsel for the Attorney General with respect to the Royal Canadian Mounted Police and its members |
| Participants/Counsel: | Mitch Hoag, Counsel for City of Prince George Marie (Mimi) Willcock, Counsel for BC Emergency Health Services |

The Sheriff took charge of the jury and recorded 13 exhibits. 12 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.

A family member testified that as a child, Jamie Wilford Shanoss lived in Gistegukla then moved to Kitimat. He was a well-mannered boy who grew up with his grandparents. Mr. Shanoss was taught to hunt in the traditional ways with empathy and respect. He was helpful to other people and would assist the elders by hunting for them. He had a brother with whom he was close. His death was a great loss for his family and community.

On the evening of November 20, 2016, at 11:30 PM, Mr. Shanoss was at the Ket So Yoh Shelter in Prince George. He was described as intoxicated when he arrived at the shelter. He went into a room with three other people who were sleeping but remained awake and was talking to himself, which caused the others in the room to wake up. A staff member told Mr. Shanoss he had to remain quiet so the others could sleep. At 11:50 PM, Mr. Shanoss left the shelter and told the staff member he was going to walk to another shelter located in the downtown area.

The staff member was concerned that Mr. Shanoss was outside in the cold weather so he called the other shelter. When Mr. Shanoss did not arrive at the other shelter, the Royal Canadian Mounted Police (RCMP) were notified.

RCMP members responded to the call and patrolled the area looking for Mr. Shanoss. They located him at approximately 12:20 AM on November 21, a few blocks away from the shelter. He was found lying on the sidewalk, asleep but rousable and appeared to be intoxicated with alcohol. He was unsteady on his feet, but cooperative. The officers took



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him in to custody for being intoxicated in public and placed him into a police car. Officers testified that he was taken into custody because of the risk of harm to him due to the cold weather and his intoxicated state. He was then taken to the Prince George RCMP Detachment to be placed in cells for the night until he was no longer intoxicated and could be safely released. RCMP in Prince George have the option to take an intoxicated person to the hospital if they assess the level of intoxication as requiring medical attention. On that night, Mr. Shanoss was not assessed as requiring medical attention. Apart from hospital or cells, witnesses said that there was no other place to take an intoxicated person who does not have a safe place to stay.

Mr. Shanoss was taken to the booking area in the cells of the Prince George RCMP Detachment, where he sat on a bench. The process of being placed into cells was explained to him, and he was searched. His shoes and belt were removed from him. Mr. Shanoss was not asked how much he had to drink that night nor when did he consume his last drink of alcohol.

At 12:32 AM, he was taken to the cell designated for people who were intoxicated. He lay down on the floor, on his side, with his face facing away from the camera located in the upper corner of the cell. It appeared he fell asleep soon after laying down. The guards knew Mr. Shanoss since he had been arrested and placed into the same cell on previous occasions. They described him as being friendly and cooperative whenever that met him. There were three other people in the same cell with Mr. Shanoss.

Civilian cell guards are employed by the City of Prince George. Guard training includes reading the policy manual and completing four 12 hours shifts with another guard before a new guard works on their own. They are told to look for the 4 Rs of Rousability, which involve ensuring that a prisoner is healthy and breathing properly. Information posters with the 4 Rs are posted in several places in the booking area. Prisoner checks are to be long enough to ensure that everyone in the cell is breathing.

There is a video camera located in each cell that allows guards to watch the cell on a video screen located at the guard desk. The camera does not capture sounds in the cell. Video cameras assist the guards with making observations but are not to replace physical checks. If the guard can't establish if a person in a cell is breathing, or if they have concerns about the health and safety of that person, they are required to immediately notify an RCMP officer. The officer will then enter the cell to assess if the person requires medical attention. Cell guards are not permitted to enter a cell by themselves.

Guards record activities in a daily guard log. At the time this incident occurred, the guard recorded only anything that was out of the ordinary. This has since changed and guards now record incidents and observations about every person in the cells.



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The guard who was on shift November 21 was seen on video walking by the cell door every 10 minutes conducting prisoner checks, but only quickly looked at the window to the cell Mr. Shanoss was in. The guard testified that he could hear snoring in the cell that he thought was coming from Mr. Shanoss. A video recording showed that Mr. Shanoss last moved at 12:36 AM. The head civilian guard later testified the guard did not conduct the prisoner checks according to guard training.

RCMP officers conduct cell checks at the start, middle and at the end of their shift. At 2:06 AM an RCMP officer went to the cell door and called out. Mr. Shanoss did not respond or move. The cell door was opened and the officer went in and checked Mr. Shanoss. He noted his hand was cold and there was no pulse. The officer told the guard to call 911 immediately and then called on his radio to others for assistance and two officers responded. The officers entered the cell and Mr. Shanoss was dragged out into the hallway. This was done rather than lifting Mr. Shanoss, since it was the fastest and safest way to quickly remove him from the cell.

One of the officers started cardiopulmonary resuscitation (CPR). Another officer brought an automated external defibrillator (AED) and applied it. BC Ambulance personnel arrived at 2:15 AM and took over resuscitation. Resuscitation continued until 2:50 AM, when paramedics ceased their efforts, after a telephone consultation with a doctor, due to no return of life signs.

A full post mortem examination was conducted. Toxicology testing showed Mr. Shanoss had a blood alcohol level of 0.38%. The pathologist concluded that Mr. Shanoss died as a result of acute alcohol intoxication (poisoning). Some rib fractures consistent with injuries that can occur when CPR is done were found. An emergency room physician testified that use of cocaine may have contributed to the cause of death.

The RCMP and the Independent Investigations Office of BC conducted investigations into the death. Representatives from both agencies testified that no foul play was involved in Mr. Shanoss' death.

The inquest heard testimony about sobering centres; places where intoxicated people can go or be taken to, other than police cells and hospital emergency rooms, to safely sleep off the effects of alcohol intoxication. For example, the sobering centre located in Surrey is operated by the local health authority. The inquest was told there are currently no facilities of that type available in Prince George.



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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: The City of Prince George**

1. Review procedures and training for guards to ensure the prisoners are properly checked, following up with random viewing of video checks.

Presiding Coroner Comment: *The video recordings showed that prisoner checks by the civilian guard were not done according to policy or training.*

2. Perform mock training for the guards in cell emergencies.

Presiding Coroner Comment: *Mock emergency scenario training is not part of guard training or ongoing staff training and could be helpful to ensure that they are equipped to respond as quickly as possible in an emergency.*

To: Northern Health Authority and First Nations Health Authority

3. Explore creating a sobering centre.

Presiding Coroner Comment: *The jury heard testimony about sobering centres and that currently no facilities of that type are available in Prince George. The jury also heard that sobering centres are better suited to care for intoxicated persons where the only concern is the safety of that individual.*