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

File Number: 2016-1004-0041

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
GRAHAM	BRADLEY GREGORY MARTINS

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

in the Province of British Columbia, on the following dates: May 21 – 24, 2019

before: Larry Marzinzik, Presiding Coroner.

into the death of Graham (Last Name) Bradley Gregory Martins (First Name) (Middle Name) 33 (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: March 6, 2016 (Date) 08:47 a.m. (time)

Place of Death: Victoria General Hospital (Location) Town of View Royal, B.C. (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Mixed drug 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: Aspiration pneumonia with lung abscess, Endomyocarditis

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

The above verdict certified by the Jury on the 24th day of May AD, 2019

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. John Orr, QC
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mr. Rolf Warburton, counsel for Ministry of Public Safety and Solicitor General (Corrections Branch)

The Sheriff took charge of the jury and recorded 4 exhibits. 18 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. Graham was placed in custody on December 31, 2015 and held at the Vancouver Island Regional Correctional Centre (VIRCC) pending court appearances as the result of legal issues unrelated to his death.

Mr. Graham had a history of illicit substance use and requested Suboxone treatment through medical services within the VIRCC. He was required to provide urine samples for testing on two occasions which revealed the use of non-prescribed Suboxone. His first request for Suboxone treatment was made on January 15, 2016 and the treatment had not yet been approved and implemented by the date of his death, March 6, 2016. Since Mr. Graham's death, BC Corrections has changed inmate medical treatment from a private healthcare provider to the BC Provincial Health Services Authority and Suboxone treatment is provided immediately upon the request of any inmate.

During the days prior to his death Mr. Graham and his cellmate consumed various quantities of illicit substances (methamphetamine and heroin/possibly fentanyl) within their cell. Two days prior to his death, his cellmate believed Mr. Graham had overdosed. The cellmate revived him by placing cold wet towels on his body. Corrections staff were not aware of these activities. The day prior to his death Mr. Graham spent an inordinate amount of time sleeping in his cell. This drew concern of some of the correctional officers in that one mentioned to another at shift change to 'keep an eye' on Mr. Graham, as he was usually quite active during the day. Neither Mr. Graham nor his cellmate provided the Corrections staff with any information relating to the illicit drug use or the prior possible overdose.

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During the evening before and the early morning hours of March 6, 2016, Mr. Graham's cellmate stayed awake for most of the night and early morning to ensure he was all right. The cell mate testified he would not have hesitated in alerting and advising Corrections staff if he thought Mr. Graham required medical assistance. The cellmate finally went to sleep after speaking with Mr. Graham during the early morning hours. The cell mate utilized Mr. Graham's bunk (top bunk) as Mr. Graham was sleeping in his (bottom bunk). At approximately 6:00 AM, Mr. Graham was observed breathing (back rising and falling) by a correctional officer as he was lying on the bottom bunk during a cell check. During the morning shift change (cell check/inmate count), at approximately 6:30 AM, the correctional officer noted Mr. Graham was not moving on the bottom bunk and they could not determine if he was breathing. After making attempts to awaken Mr. Graham by calling out to him and kicking the cell door, the correctional officer issued a Code Blue at 6:35 AM and additional Corrections staff (officers and a nurse) responded to the cell immediately to find Mr. Graham unresponsive. Mr. Graham's cellmate was removed from the area. Mr. Graham was moved from the lower bunk and placed on the floor, so the staff could perform CPR as Mr. Graham was not breathing and had no pulse at that time. Resuscitation efforts by Corrections staff continued until paramedics attended at 6:53 AM and took over the resuscitation efforts.

Mr. Graham was transported from VIRCC at 7:42 AM to Victoria General Hospital in View Royal. The ambulance arrived at 8:12 AM and Mr. Graham was attended to by an emergency room physician. Mr. Graham was declared dead at 8:47 AM and resuscitation efforts were discontinued.

Toxicological analysis determined Mr. Graham had a lethal level of fentanyl and a toxic level of methamphetamine within his blood when he was first admitted to the Victoria General Hospital on March 6, 2016. An autopsy confirmed the cause of death was mixed drug poisoning with contributory factors of aspiration pneumonia with lung abscess and endomyocarditis.

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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: Provincial Health Services Authority

1. To consider immediate referral of inmates who disclose drug use or who are visibly in withdrawal at intake.

   Presiding Coroner Comment: *Testimony heard by the jury indicated Mr. Graham presented with withdrawal symptoms at the time of his intake to VIRCC however was not referred for counselling, only provided with information regarding self-referral forms. The jury believed proactive referral to drug and alcohol counselling at the time of intake would result in improved counselling follow-up participation by the inmate.*

2. To consider joint mental health and medical assessments at intake to ensure the complete collection of all relevant inmate information.

   Presiding Coroner Comment: *The jury heard evidence that the intake process involved separate interviews by a corrections officer and a nurse. Questions with regards to health concerns were only asked by the nurse. The jury felt the combined collection of all the information in a joint assessment would lead to more proactive referrals for substance treatment and counselling.*

3. Through collaboration with other social agencies, enhance support for inmates' transition to the community upon release.

   Presiding Coroner Comment: *The evidence presented to the jury indicated there was a gap in treatment and counselling services once the inmate was released from custody. The jury believed a coordinated treatment and/or counselling plan that continued through community services support upon release would be beneficial for the inmates' recovery after release.*

4. Explore the feasibility of the community transition team providing more than 30 days of support if additional time is required.

   Presiding Coroner Comment: *Testimony heard by the jury indicated there were time limitations on the post-release treatment plans. The jury felt the treatment plans should be extended as required by the individual patient needs.*

5. To consider proactive nurse outreach in addition to current system of self and staff referral.

   Presiding Coroner Comment: *The jury heard evidence that Mr. Graham had health issues that the corrections and healthcare staff were not aware of and that he was feeling unwell for a couple of days. The jury felt proactive outreach by nursing staff could have identified health concerns earlier and provided treatment which may have prevented Mr. Graham's death.*

To: Vancouver Island Regional Correctional Centre

6. To review the policies and procedures with regards to the written documentation for sharing of inmate information between corrections staff at shift change.

   Presiding Coroner Comment: *The evidence presented to the jury indicated that not all staff were aware of concerns regarding Mr. Graham feeling unwell and that there were suspicions that illicit drugs may be on the unit. The jury believed this information should be documented so all employees are aware of these concerns when starting their shift.*

7. To review with Correctional Officers the importance of being aware of pertinent information regarding inmates under their supervision.

   Presiding Coroner Comment: *Testimony heard by the jury indicated a corrections officer did not wish to know the inmate's criminal background as they wished to treat each inmate as an individual with no preconceived or biased impressions. The jury felt the corrections officers should be aware of all pertinent information regarding the inmate's background regarding substance use and violence to assist in their assessment of unusual inmate behavior.*

8. To review policy with regards to punitive consequences to other inmates that may inhibit the use of the panic button in cases of emergency.

   Presiding Coroner Comment: *Testimony heard by the jury indicated the use of the cell panic button by the inmates leads to searches of all cells on the unit, thus a reluctance to activate the panic button. The jury believes consideration should be given in respect to the type of emergency when deciding if unit cell searches are required.*

9. To review the access procedures for emergency vehicles to ensure timely entry.

   Presiding Coroner Comment: *The evidence presented to the jury indicated there was a time delay in allowing access of the second ambulance (Advanced Care Team) to the facility. The Jury believes the access for emergency vehicles should be as seamless as possible.*

10. To ensure properly trained staff and appropriate equipment are available when no nurse is on duty within the facility.

    Presiding Coroner Comment: *Testimony heard by the jury indicated there are times when there is no nurse on duty within VIRCC and in this case, although there was a nurse present in this situation, there were eleven minutes of resuscitation until the arrival of the paramedics. The jury felt VIRCC should ensure all staff are properly trained and equipped to handle such delays when nurses are not on duty.*

11. To conduct a security review of any vulnerable locations for the importation of drugs into the facility.

    Presiding Coroner Comment: *The jury heard evidence from the present warden that the physical security of the facility grounds could be improved. The jury felt a review was warranted as the result of this opinion.*

To: BC Corrections and Provincial Health Services Authority

12. To gather and analyze the data on reported non-lethal overdoses for prevention purposes.

    Presiding Coroner Comment: *Testimony heard by the jury indicated no statistics are documented with relation to non-lethal illicit drug overdoses within VIRCC and other corrections facilities. They also heard that the healthcare staff are not required to report non-lethal overdose incidents to the corrections staff. Although there may be privacy restrictions, the jury believed these statistics would assist the corrections staff in assessing the risks to other inmates when these situations occur.*

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To: **Saanich Police Department**

13. To increase resources for intelligence gathering to reduce drug traffic into Vancouver Island Regional Correctional Centre.

    Presiding Coroner Comment: *The evidence presented to the jury indicated the most effective way of preventing drugs from entering VIRCC is intelligence collection by the local police. The jury felt additional resources should be considered to enhance this drug intelligence gathering.*