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

File Number: 2016-0225-0181

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

Murphy	**John Michael**
SURNAME	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: November 12 – November 20, 2019

before: Larry Marzinik, Presiding Coroner.

into the death of Murphy (Last Name) John (First Name) Michael (Middle Name) 25 (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: August 4, 2016 (Date) 1:23a.m. (time)

Place of Death: Surrey Memorial Hospital (Location) Surrey, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Neck Compression

Due to or as a consequence of strangulation

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: [ ] Accidental [X] Homicide [ ] Natural [ ] Suicide [ ] Undetermined

The above verdict certified by the Jury on the 20th day of November AD, 2019

LARRY MARZINZIK
Presiding Coroner's Printed Name

[signature]
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Mr. Larry Marzinzik
Inquest Counsel:	Mr. Christopher Godwin
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mr. Rolf Warburton and Mr. Fernando de Lima, counsel for Ministry of Public Safety and Solicitor General (Corrections Branch) Mr. Bibhas Vaze, counsel for the Murphy family

The Sheriff took charge of the jury and recorded 19 exhibits. 25 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. Murphy was admitted to the Surrey Pretrial Service Centre on July 18, 2016, as the result of pending charges before the courts. After processing, he was placed in general population awaiting his next court date.

On July 27, 2016, Mr. Murphy and three other inmates entered another inmate's cell and allegedly assaulted the occupant. This incident was responded to by correctional officers. Mr. Murphy was subsequently placed in the segregation unit pending an internal disciplinary review. Mr. Murphy was assigned to segregation cell 209 with one of the other three inmates who participated with him in this alleged assault. Mr. Murphy and his segregation cellmate were known to each other. Neither had expressed any concerns in sharing the cell. The correctional officers who dealt with Mr. Murphy and his cellmate during their time sharing a segregation cell described them as having a friendly relationship, with no observed conflict.

During the late afternoon / early evening of August 3, 2016, the lone correctional officer at the segregation monitoring station was requested to escort an inmate to the disciplinary hearing room within the unit. The correctional officer incorrectly believed it was Mr. Murphy's cellmate being requested. At approximately 5:54 p.m. Mr. Murphy's cellmate was asked to exit segregation cell 209 to attend the disciplinary review room by the correctional officer. The correctional officer also spoke with Mr. Murphy at this time.

It was subsequently determined Mr. Murphy's cellmate was not required in the disciplinary hearing room, so he was escorted back to segregation cell 209 at approximately 5:56 p.m. Neither Mr. Murphy nor his cellmate appeared to have any concerns at that time. Unit visual checks of all segregation inmates are mandatory at irregular times at least every thirty minutes. The segregation log book and the correctional officers confirmed there was a unit visual check at 5:30 p.m. however no unit visual check was completed around 6:00 p.m. The next confirmed unit visual check was completed at 6:36 p.m.

After Mr. Murphy's cellmate was returned to segregation cell 209, they appeared to be relaxed in a cell video. Criminal proceeding testimony and the sentencing judge's summary of the facts of the case read into evidence during the inquest indicated shortly after 6:00 p.m. there was yelling from other cells. A specific inmate was advising Mr. Murphy to 'beat up' his cellmate due to his cellmate being considered a 'rat' (informant). Mr. Murphy was also warned that if he did not comply with these demands he would suffer the same fate. Cell video confirmed that several minutes after these demands were made Mr. Murphy initiated a physical altercation with his cellmate at approximately 6:14 pm. Mr. Murphy was the aggressor and his cell mate countered in self-defense. The altercation moved from close to the cell door to the bottom bunk and then back towards the cell door area. At this point Mr. Murphy had his cellmate in a headlock however his cellmate was able to release himself, get behind Mr. Murphy and place him in a choke hold. Mr. Murphy collapsed to the floor in a prone position with his cell mate on his back. Mr. Murphy's cellmate continued with the choke hold and Mr. Murphy went unresponsive at approximately 6:16 p.m. The cellmate remained on top of Mr. Murphy and continued to apply the choke hold until 6:28 p.m.

The altercation had gone unnoticed by the correctional officers until one viewed the unusual positioning of the cellmate on top of Mr. Murphy on the video feed from segregation cell 209 at 6:27 p.m. Two correctional officers attended segregation cell 209 at 6:28 p.m. and removed Mr. Murphy's cellmate from the cell. Mr. Murphy remained unresponsive and the corrections staff started CPR. A corrections staff nurse attended the cell at 6:30 p.m. to provide medical assistance. CPR was continued until the arrival of advanced life support paramedics at 6:39 p.m. Resuscitation efforts continued until Mr. Murphy's pulse returned. Mr. Murphy was transported to the Surrey Memorial Hospital and care was transferred to the hospital emergency department personnel at approximately 7:20 p.m.

Mr. Murphy remained in the custody of the corrections staff while at the hospital; however, the family was advised of his whereabouts by hospital staff, contrary to BC Corrections Service policy. Several family members attended the hospital requesting visits with Mr. Murphy. The attending critical care physician also voiced concerns with regards to the correctional officers' restrictions of visits by and information permitted to be provided to the family. The family were only allowed one short visitation with Mr. Murphy in the emergency department, prior to him being moved to the Intensive Care Unit for further treatment. These restrictions on visits and information sharing were due to the BC Corrections Service policy on in-custody supervised visits and incident disclosure with regards to the circumstances leading to Mr. Murphy's injuries.

As the result of the strangulation by the cellmate, Mr. Murphy suffered a number of cardiac arrests and subsequent brain injury which lead to his death at 1:23 a.m. on August 4, 2016. The forensic autopsy was conducted on August 8, 2016. The pathologist concluded the cause of death was neck compression, which restricted the blood flow to Mr. Murphy's brain. The pathologist testified this restricted oxygen supply to Mr. Murphy's brain lead to the subsequent cardiac arrests.

Mr. Murphy's cellmate subsequently entered a guilty plea to a manslaughter charge in relation to the incident which lead to Mr. Murphy's death.

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 Corrections

1. Reinforce, with additional and ongoing staff training, existing Standard Operating Procedures for Segregation Unit with respect to compliance regarding the safety and security for staff and inmates, specifically with reference to:

   (a) Log book documentation

   (b) Visual unit cell checks

   (c) Synchronization of video camera time displays

   (d) Exchange of critical information between staff during shift changes

   Presiding Coroner Comment: *The jury heard testimony and were provided documentary evidence that:*

   (a) entries in the segregation unit log book were missing or incomplete as per standard operating procedures (e.g. Chapter 1 of S.O.P. for Security and Control in Segregation: 1.21.2(3). The cellmate was removed and returned to Cell 209 with no log entry; 1.2.1.2(5) No log book reference to the Code Blue for this incident was noted).

   (b) visual unit checks were not always completed at irregular intervals, not greater than 30 minutes (Exhibit #6) and that the segregation unit was under staffed at given times which restricted compliance with standard operating procedures (e.g. one C.O. in the unit).

   (c) the time displays for the computerized video surveillance systems were not synchronized (SOP Chapter 1 – Security and Control, Electronic Security and Communication System 1.12).

   (d) correctional officers changing shifts did not recall receiving significant unit information such as visual checks not being completed (Chapter 6: Administration and Regulatory Services, 6.9.1).

2. Consider an expansion of the current use of the video monitoring system to supplement existing visual unit cell checks. Consider utilizing larger monitors and software that provides automated rotating cell views. Provide staff with training and guidance on the use of any new technology.

   Presiding Coroner Comment: *The jury heard evidence that the video surveillance camera views at the monitoring station are limited in size and fixed in number when on multiple screen view. They also heard testimony that the monitor displays must be changed manually by a correctional officer.*

3. Consider changing policy to prevent inmates who are involved in the same incident of violence, and are sent to segregation pending a disciplinary hearing, from being placed together in the same cell.

   Presiding Coroner Comment: *The jury was provided evidence during this inquest that indicated two inmates involved in the same violent incident in general population were placed together in segregation and a subsequent violent incident occurred between these individuals.*

To: BC Corrections and BC Ambulance Service

4. To collaborate to devise a plan to optimize speed of access for responding emergency personnel to all areas to the Surrey Pretrial Services Centre.

   Presiding Coroner Comment: *The jury heard testimony from the responding paramedic that the access time to the segregation unit was unusually short on the day of this incident however access normally takes much longer.*

To: BC Corrections, Fraser Health Authority, and Surrey Memorial Hospital

5. Collaborate to develop a mutually acceptable protocol for the handling and security of inmates in a hospital environment.

   Presiding Coroner Comment: *The jury heard evidence that there was conflict between medical and corrections staff with respect to security of the inmate/patient and the family's ability to visit with the inmate/patient in a non-secure environment.*