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

File Number: 2018-0753-0061

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
JOSEPH	Alexander Charles

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

in the Province of British Columbia, on the following dates: August 9, 10, 11, 12, 13, 2021

before: Lyn Blenkinsop, Presiding Coroner.

into the death of Joseph (Last Name) Alexander (First Name) Charles (Middle Name) 36 (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: October 4, 2018 (Date) late am hours (time)

Place of Death: Corrections Vehicle
Highway: Highway 97 near Quesnel (Location) BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Mixed Drug Overdose

Due to or as a consequence of

Antecedent Cause if any: b) Fentanyl and Methamphetamine

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last.

(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 13th day of August AD, 2021

LYN BLENKINSOP
Presiding Coroner's Printed Name

L. Blenkinsop
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Lyn Blenkinsop
Inquest Counsel:	John M. Orr, Q.C
Court Recorder:	Verbatim Words West Ltd.
Participants/Counsel:	Rolf Warburton and Johnny Van Camp, counsel for Ministry of Public Safety and Solicitor General (Corrections Branch, Adult Custody)

The Sheriff took charge of the jury and recorded 6 exhibits. 21 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.

This inquest dealt with the death of Alexander Charles Joseph who died on Highway 97, near Dunsmuir Road, near Lac La Hache, of a mixed drug overdose due to Fentanyl and Methamphetamine use, during transport in a Corrections vehicle.

The jury heard testimony about the events leading up to Mr. Joseph's death, and the Correctional Officers' response.

Mr. Joseph was described by family as someone who was always on the go and loved life and that he was taken away from his family and First Nations Community as a child.

Mr. Joseph's Probation Officer supervised him, wrote his pre-sentencing report and supported the Band's goal to help him rehabilitate and bring about change while he was at Prince George Regional Correctional Centre awaiting court. Mr. Joseph had started using substances at 13 years of age and was interested in attending treatment. He appeared motivated and forward-looking. The Probation Officer also testified that the Gladue Report required by the Supreme Court of Canada was not yet in effect in BC at the time Mr. Joseph was sentenced, however, it is now in place and a full sentencing review of Indigenous persons is conducted.

The Correctional Officer driving the vehicle used to transport Mr. Joseph and nine other inmates arrived at Prince George Correctional facility before 0700 hours on October 4, 2018, and prepared, with the assistance of another officer, to drive a prisoner transport van to the Fraser Correctional Centre, with a planned stop in Kamloops, a six-hour drive away.

He got the equipment he required and with the assistance of his passenger, a second Correctional Officer, performed a vehicle inspection. The vehicle was equipped with an audio/visual system and, with the other officer, he determined that the cameras monitoring the prisoners were working and that the audio system was not working well. He determined that the audio was unnecessary except when performing checks, as the inmates could be noisy and could jam up the audio box with the materials in their compartments. Regular physical checks on the prisoners in their compartments were not required and the checks were done using the video system. Each prisoner's compartment in the van had an outside door which could only be opened when the vehicle was in a secure facility as per policy in place in 2018. If there was a crisis, officers would phone 911 who would then contact Corrections Headquarters. There was no physical check done on this occasion and the officers did not talk to the prisoners after the vehicle started moving.

The officer who drove the van testified that new practice since this incident is to open the doors every half hour to forty-five minutes and to talk to the prisoners, and that the audio system is now working. The officer also testified that when the prisoners were loaded into the vehicle they were handed a lunch, made by other prisoners or contractors, and some water and Mr. Joseph advised he was going to sleep. Mr. Joseph was travelling in a compartment with one other prisoner. The compartment contained a bare metal bench and there were no seatbelts.

Both Correctional Officers,(the driver, and the front seat passenger), testified that there may or may not have been a log of the video checks done on the prisoners and that they were unaware of the timing of mandatory video checks but that checks were performed every five to thirty minutes.

When the vehicle passed through a construction area, about thirty minutes after they left Prince George, the Correctional Officers felt banging from the rear compartment.

The officers stopped for a break about two hours later. They left the vehicle one at a time, at a fast-food establishment near Williams Lake, and felt vibrations and banging coming from the compartments and noticed that there were four or five members of the public nearby. The driver moved the vehicle so that the prisoners would stop bothering the public. He checked the video and didn't notice anything unusual and proceeded to drive on towards Lac La Hache. He pulled the vehicle over about forty-five minutes later as the other officer commented that something was wrong. The other prisoners were trying to signal to them by waving at the camera. They checked the cameras and contacted Headquarters who approved opening the compartment.

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The Correctional Officers found Mr. Joseph in a fetal position on the floor and one of the other prisoners advised them that he had taken something which was in his lunch bag. They checked Mr. Joseph's vitals, which they determined were absent. One of the officers ran to a police car which was parked nearby and asked for assistance. They then moved Mr. Joseph to the ground and started cardio-pulmonary resuscitation (CPR) and the police officer administered Naloxone.

A passing physician pulled his car over and rendered aid.

An ambulance arrived on scene at approximately 1325 hours and took over CPR. After four rounds of CPR, and in conjunction with the physician who had stopped to assist, they contacted an Emergency Physician remotely and Mr. Joseph was determined to have died.

Several of the other prisoners in the compartments in the rear of the Correctional vehicle testified that all the prisoners were searched down to their underwear before being loaded into the Correctional van. The prisoners tried on a number of occasions to alert the guards that Mr. Joseph was unresponsive and that he had fallen to the floor when the vehicle hit a pothole in the parking lot of the fast-food restaurant. They attempted to get the officers attention by standing up, waving at the cameras, and banging on the rear wall behind the officers' seats with their feet and handcuffs. Although there is no way to tell time in the compartments of the transport vehicle, one of the prisoners felt that Mr. Joseph lay on the floor for several hours before they were able to get the guards' attention.

A pathologist testified that there was no significant anatomic cause of death at autopsy. There were no injuries other than some bruising and no venipuncture sites. Two wrapped foreign bodies were located in the rectum. Toxicology testing showed high and potentially toxic levels of fentanyl and methamphetamine as well as the presence of morphine, amphetamine, bupropion, methylphenidate and acetaminophen. The pathologist determined that a mixed drug overdose with fentanyl and methamphetamine was the cause of death.

The jury heard from additional witnesses who talked about procedures and training in Correctional facilities.

Two additional witnesses spoke about the impact to the family caused by Mr. Joseph's death, and their concerns around communication with the family and community about the Inquest process.

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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 Director, Adult Custody, BC Corrections Branch

1. To review procedures to ensure that 20 minute video checks are logged for each inmate being transported.

   Presiding Coroner Comment: *The jury heard evidence that the Correctional Officers were unaware of the timing and logging of video checks on the prisoners.*

2. That when prisoners are being transported, physical wellness checks be undertaken at a safe location at least hourly.

   Presiding Coroner Comment: *The jury heard evidence that there were no scheduled physical wellness checks planned until Kamloops, which is 6 hours away.*

3. Prepare plans for potential emergency situations that could occur during transportation of prisoners and conduct drills on a periodic basis to ensure those plans are adequate.

   Presiding Coroner Comment: *The jury stated that the evidence showed that the transporting officers were not adequately prepared for an emergency.*

4. To consider adapting the transportation vehicles in a manner that would provide a safer and more comfortable environment for inmates.

   Presiding Coroner Comment: *Evidence was heard that the prisoners' compartments were not suitable for long-distance transportation of inmates.*

To: The Chief Coroner, BC Coroners Service

5. That consideration be given to updating information regarding the Coroners Inquest process for family and support workers.

   Presiding Coroner Comment: *The jury heard evidence that family and community support felt that they were not given sufficient information.*