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

File Number: 2018-0380-0003

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

Patrick	**Samantha Nicole**
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: July 24 - 28, 2023

before: Margaret Janzen, Presiding Coroner.

into the death of Patrick (Last Name) Samantha (First Name) Nicole (Middle Name) 28 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: May 11, 2018 (Date) 14:53 hours (time)

Place of Death: Surrey Memorial Hospital (13750 - 96th Ave) (Location) Surrey, B.C. (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Anoxic / Ischemic Brain Injury

Due to or as a consequence of

Antecedent Cause if any: b) Fentanyl Toxicity

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 ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 28th day of July AD, 2023

Margaret Janzen
Presiding Coroner's Printed Name

M. Janzen
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	John McNamee
Court Reporting/Recording Agency:	Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded 20 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.

Samantha Nicole Patrick was a 28-year-old Cree woman who died while at the Surrey Memorial Hospital following her collapse while in the custody of the Surrey RCMP. A family member described her as a gentle person who loved her young son and had a special place in her heart for dogs. She took comfort in her traditions and was interested in fashion design. She began using illicit drugs and struggled to get free of her addiction. She had been in a recovery house but had been turned away after she relapsed in her drug use.

Ms. Patrick was arrested on May 5, 2018, at approximately 1506 hours in Surrey pursuant to outstanding warrants. At the time of her arrest, she advised the arresting officer that she had recently used fentanyl. She was transported to the Surrey Memorial Hospital where she was seen by a physician and medically cleared for detention.

Ms. Patrick was transported to the Surrey RCMP detachment where she underwent a basic search. A strip search was not conducted as the arresting officer did not feel he had sufficient grounds to ask for a more invasive search. She removed her street clothing apart from her underwear and replaced it with a disposable coverall. She was placed in a cell at approximately 1840 hours. She was cooperative throughout this time.

Guards testified at the inquest that they were required to do a personal check of all prisoners every 15 minutes. This was done by walking down the hallway and looking through the cell window to see that the prisoner was breathing. They were instructed to watch for the chest to rise and fall. This could be difficult to tell if the prisoner was covered by a blanket or lying on their side. Prisoners were not allowed to cover their heads with the blanket.

The time of their check, confirmation that breathing was observed, the position of the prisoner's body and a brief description of their observations were to be recorded in a logbook. Every two hours a check called the Four R's was to be conducted. The four Rs were recall, rousability, response to questions, and response to commands.

Each cell also had a camera which was continuously monitored by guards at their guard station. A small area directly in front of the door could not be seen on personal checks because of the viewing angle. Guards were not permitted to enter the cell. If they had concerns about a prisoner's wellbeing, they would speak to the prisoner or tap or bang on the door. If that failed to elicit a response, they were to notify the RCMP officer on cell duty who would investigate.

Prisoners were also seen by a nurse when they first arrived at the cells. Following that, the nurse would do rounds every hour to check the prisoners and was available to see prisoners if they had medical complaints. Ms. Patrick asked for and received pain medications from the on-duty nurse on May 6, 2018. She also had a bail hearing by telephone that day and was remanded until the next court date. Hallway video entered as an exhibit at the inquest showed her going to the telephone for the hearing and returning, at which time she appeared to be well.

The guards were not RCMP members, rather they were municipal employees. There was a guard supervisor and an RCMP officer assigned to cell duties. A sergeant was responsible for the overall operations of the jail. Guard training was primarily on-the-job.

Various duties relating to booking, policies, procedures, monitoring of prisoners, and cell checks were explained and demonstrated. There was no written exam or certification process. The guards who testified reported that they were not trained to recognize medical issues related to drug and alcohol use complications. They were, however, aware that many if not most of the prisoners in the jail had drug or alcohol issues. They were required to have basic first aid certification.

Cell video entered as an exhibit at the inquest showed that on the morning of May 7, 2018, Ms. Patrick was lying on her mattress on the floor in front of the door, covered by her blanket and apparently sleeping. Her feet were closest to the door.

At approximately 0814 hours she got up and used the washroom then lay back down on her mattress, this time with her head closest to the door. She covered herself with the blanket.

At approximately 0836 hours Ms. Patrick sat up and could be seen doing something with her hands. At approximately 0837 hours she appeared to have something white or light-coloured in her hands. At approximately 0838 hours, while sitting, she covered her head and body with the blanket. At approximately 0840 hours she drank from a cup. At approximately 0841 hours she lay down on the mattress, again with her head nearest the door. Something white could be seen in her hands. She covered her whole body except the top of her head with her blanket.

She could be seen making minor movements under the blanket, but it was not possible to see what she was doing. She moved under the blanket at approximately 0845 hours. There appeared to be very minor movement at approximately 0902 hours. This was the last movement that could be seen on the video.

A guard performed cell checks between then until approximately 0938 hours and made notations in the logbook that Ms. Patrick was breathing. At the last check the guard was not able to get a response from Ms. Patrick, so she went to the sergeant in charge of the cells and requested a prisoner wellness check.

The sergeant went to the cell and could not get a response either. He opened the cell door at approximately 0943 hours. He nudged her with his foot and still got no response. He told the guard to summon the nurse and tried to find a pulse. The nurse attended and could not find a pulse.

Ms. Patrick had been lying on her front during this time, so they rolled her onto her back, looked for a pulse again, and, finding none, started CPR (cardiopulmonary resuscitation). The nurse retrieved oxygen and the AED (automated electronic defibrillator) and administered naloxone, a drug to reverse opiate toxicity. BC Ambulance Service and the Surrey Fire Department were summoned.

The Fire Department arrived first and took over CPR. During their initial head-to-toe examination, they discovered a white substance in a piece of paper in Ms. Patrick's hand. This was handed over to the RCMP.

Paramedics arrived at approximately 0956 hours and were at Ms. Patrick's side at approximately 0958 hours. An advanced life support paramedic testified that he assessed Ms. Patrick and found an absence of vital signs. He took over her care and after the administration of resuscitative drugs, including more naloxone, a pulse was detected at approximately 1006 hours.

She was then transported to the Surrey Memorial Hospital emergency department, arriving there at approximately 1038 hours. She was still not breathing on her own, had fixed and dilated pupils, and no response to any stimulus.

Ms. Patrick was admitted and referred to the Intensive Care Unit. The Intensive Care Unit specialist responsible for her care testified that there was already evidence of an anoxic brain injury (brain injury caused by lack of oxygen) seen on CT (computed tomography) when she arrived. She was placed on life support and diagnostic testing was completed which ruled out any other cause for her condition. Her neurological state was monitored but the injury to the brain was severe, and it progressed over time. No brain function was ever demonstrated. Brain death was declared on May 11, 2018, at 1453 hours.

A forensic pathologist testified that he conducted an autopsy which revealed no trauma or natural disease process sufficient to cause death. Toxicological examination was ordered on antemortem (predeath) samples from the Surrey Memorial Hospital. That analysis revealed the presence of fentanyl in a range where therapeutic and lethal levels overlap and prior use of methamphetamine. The cause of death was determined to be an anoxic/ischemic brain injury due to fentanyl toxicity.

Following the death, the Independent Investigations Office (IIO), who were mandated to investigate all instances of serious harm or death that may have been caused by police, were notified of this death. Their investigation determined that there were no reasonable grounds to believe any officer committed an offence and a public report was issued.

The Chief Civilian Director of the IIO testified that he had identified a gap in the oversight of municipal police guards. While special constables were subject to the jurisdiction of the IIO via the *Police Act*, municipal police guards were not, nor were they subject to the jurisdiction of the Ombudsperson's Office. This meant that there was no independent agency with legal authority to investigate complaints about municipal guards who work in RCMP jails.

There was also no formal training or certification for municipal police guards. Standardized training should include recognition of basic medical issues pertaining to prisoners' use of drugs and alcohol. He testified that the use of modern technology such as electronic monitoring equipment similar to a Fitbit that would record the pulse and respiration of a prisoner could assist the guards to monitor the wellbeing of prisoners. He also testified that the IIO is the logical body to have that oversight.

The Director of Policy and Modernization with the Policing and Security Branch of the Provincial Government testified that they were aware of this lack of independent oversight. It had been brought to their attention in 2018 and work was in progress, but the addition of a full-time position dedicated to advancing this issue would help it move forward more quickly.

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The jury also heard evidence that women stayed in the jail longer than men or youths. Men usually only stayed in the jail for approximately 18-24 hours before being taken to the remand centre, but the Alouette Correctional Facility for women would not receive prisoners after 1800 hours or on weekends.

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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: City of Surrey

1. Implement the use of individual electronic health metric monitors (similar to Fitbit) for detainees placed in Surrey Cells.

   Presiding Coroner Comment: *The Chief Civilian Director of the Independent Investigations Office (IIO) testified that the use of individual health metric monitors would be beneficial.*

2. Create a multi-disciplinary committee to review the conditions within Surrey Cells related to the safety and comfort of both detainees and staff.

   Presiding Coroner Comment: *Surrey Cell Guards and RCMP officers, in their testimony, outlined changes that could be made to improve health and safety in Surrey cells* from was presented at the inquest.

To: Alouette Correctional Centre for Women

3. Receive detainees 7 days per week.

   Presiding Coroner Comment: *An RCMP witness testified that detainees could not be transferred to Alouette Women's Correctional Facility in a timely manner.*

To: Minister of Public Safety & Solicitor General

4. Review and implement placing municipal cell guards under the *Police Act* for the purpose of, but not limited to the following: upgraded, standardized training including job training, first aid training, naloxone training and management of aggressive behaviour.

   Presiding Coroner Comment: *Testimony from the Director of Policy and Modernization of the Policing and Security Branch cited the recognition of a need to make changes to include cell guards under the Police Act*.

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5. Create an independent oversight agency (similar to the Independent Investigations Office) to oversee, investigate and hold accountable municipal cell guards, including creating a Memorandum of Understanding with the RCMP to agree to Provincial oversight.

   Presiding Coroner Comment: *Testimony from the Director of Policy and Modernization of the Policing and Security Branch cited the recognition of a need to create an oversight agency to oversee cell guards.*