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

File Number: 2017-0586-0060

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

Waddell	**Edward James**
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates: 12-June-2023 to 21-June-2023

before: Margaret Janzen, Presiding Coroner.

into the death of Waddell (Last Name) Edward (First Name) James (Middle Name) 40 (Age) ☑ Male ☐ Female

The following findings were made:

Date and Time of Death: 01-April-2017 (Date) 10:10am (time)

Place of Death: RCMP Lock-Up 350 Doyle Avenue (Location) Kelowna, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Fentanyl toxicity

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: Early dilated cardiomyopathy

Classification of Death: ☑ Accidental ☐ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 21st day of June AD, 2023

M. Janzen
Presiding Coroner's Printed Name

M. Janzen [signature]
Presiding Coroner's Signature

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	Steven Liu (John McNamee on part of June 19, 2023)
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Paul D. McLean, counsel for the BC Corps of Commissionaires, dba "Commissionaires BC"

The Sheriff took charge of the jury and recorded 18 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.

Edward James Waddell was a 40-year-old male who worked in the construction industry. He was reported to have a good sense of humour and be a friend to the less fortunate. At the time of his death, he was serving an intermittent sentence on weekends at the Kelowna RCMP detachment. He was to arrive at the detachment at 1800 hours on Fridays and was released on Sundays.

On Friday, March 31, 2017, he was involved in a motor vehicle incident at approximately 1650 hours while returning from paying his rent. The vehicle he was driving went off the road to the right, rolled once and then struck a tree.

When paramedics arrived, they found him apparently uninjured apart from a small abrasion on the bridge of his nose. They noted that he was somnolent (sleepy) and had pinpoint pupils. He was unable to recall the motor vehicle incident. Paramedics believed that Mr. Waddell was impaired by illicit drugs. Fire Department personnel informed the paramedics that they had observed a small piece of tinfoil in the vehicle.

An RCMP highway patrol officer/ drug recognition expert arrived at approximately 1727 hours and, based on his observations and information at the scene, arrested Mr. Waddell for impaired driving. The officer did not search the vehicle involved in the incident and it was not clear whether the tinfoil found in the vehicle was mentioned to him.

The arresting officer searched Mr. Waddell then took him to the detachment, arriving at approximately 1807 hours, and started the drug recognition evaluation process. At the end of the evaluation, Mr. Waddell complained of pain and asked to go to the hospital. A urine sample was collected for analysis and then the officer drove Mr. Waddell to the hospital.

While he was waiting to be seen, Mr. Waddell asked to use the washroom. The officer accompanied him to a single person washroom and stood outside the door until Mr. Waddell returned. Another police officer took over custodial duties from the arresting officer for a period of time while the arresting officer saw to another matter before returning to the hospital and taking custody of Mr. Waddell again.

Mr. Waddell was seen by a physician who examined him and ordered diagnostic tests which revealed no abnormalities which would prevent Mr. Waddell from returning to jail. No drug detection analysis was performed. He was noted to be somnolent. He was given two Advil tablets and advised to return if his condition worsened.

His previous medical history included sleep issues and previous visits to the emergency department for what appeared to be opioid overdoses. The physician did not relay this information to the police officer.

The arresting officer took Mr. Waddell back to the detachment, arriving at the booking area at approximately 2315 hours. Prisoner records called C-13s were kept for each prisoner and a new one was completed each time a prisoner was lodged in cells. These forms contained pertinent information about the prisoner, the reason for the incarceration, and some personal information. Prisoners serving intermittent sentences had an additional file. The arresting officer testified that he was given a previous C-13 to review to assist him to fill out the one for Mr. Waddell's current stay. Prior C-13s entered as exhibits at the inquest showed that Mr. Waddell had smuggled contraband into cells on previous stays. One of the documents suggested a strip search should be performed.

Testimony at the inquest from police officers was that a strip search is intrusive and there must be grounds to form the opinion that it is required. If grounds exist, the Watch Commander must be informed and agree, then special requirements for privacy and personal dignity must be followed.

The arresting officer also testified that the only way to find a small quantity of drugs would be to perform a cavity search. Cavity searches were never performed by police officers, only physicians in medical settings.

The officer testified that he did not feel he had grounds to request a strip search in this case, so Mr. Waddell underwent a basic search focusing on weapons or means of escape. Mr. Waddell removed his shirt and pants. He removed his socks and turned them inside out. His underwear was not removed or examined. He put his socks back on and was observed while he changed into a jumpsuit. He was allowed to choose a book from the detachment supply and then he was lodged in a cell with a cell mate at approximately 2318 hours.

The jail was staffed by an RCMP officer and municipal guards employed by a private company. Guard training consisted mostly of on-the-job experience combined with learning

company policies and RCMP policies and standard operating procedures. There was no formal training on how to do cell checks or how to fill out the C-13 form.

RCMP policy at the time of this incident was that prisoners should be personally checked by a guard every 15 minutes. The check consisted of walking down the hallway and looking through each occupied cell door window for breathing or movement. Checks on prisoners who appeared to be sleeping, especially if they were covered by a blanket and/or lying on their side, were more complex and took longer.

Guards and police were trained to watch for the prisoner's chest to rise and fall with breathing. If the guards had concerns, then they would speak to the prisoner, yell, tap on the window, or kick the door to make them move. Guards were not allowed to go into the cells with a prisoner. If they could not get a response from the prisoner, then they were to alert a police officer who would enter the cell and investigate. Guards were not expected to wake prisoners every 15 minutes.

In addition to personal checks, each cell was equipped with a camera which was continually monitored by the guards at their guard station. The jail also had a cell located adjacent to the guard station which was reserved for the most intoxicated persons who were felt to need closer observation. There could be multiple prisoners in this cell at one time.

The guards and RCMP officer were to record time of the checks, their observations, and all prisoner activities in a handwritten logbook.

The night and morning hours of April 1, 2017, passed uneventfully. The cell mate testified that he had spent approximately four weekends with Mr. Waddell as a cell mate. Both usually passed the time sleeping, reading, or napping.

Prisoners were served their breakfast that morning at approximately 0625 hours. Two trays were placed in front of the slot on Mr. Waddell's door. His cellmate retrieved both breakfasts as Mr. Waddell appeared to be sleeping. It was the cellmate's understanding that if the breakfast was not retrieved it would be removed eventually and Mr. Waddell might go without breakfast. He placed Mr. Waddell's breakfast on the cement bunk on which he was lying and went to his own bunk to eat.

Mr. Waddell arose at approximately 0924 hours and had something to drink. At approximately 0940 hours Mr. Waddell used the toilet in the cell. He finished at 0945 hours and then washed his hands for approximately two minutes. His movements during that time were described by witnesses as unusual and consistent with retrieving drugs from within his body.

He went back to his bunk and lay down again with his face to the wall. He covered himself with his blanket. Video evidence showed him moving, including bringing his knees up towards his chest for a brief time. He was last seen moving in the video at approximately 1010 hours. The cellmate had his back to Mr. Waddell during most of this time. He testified that before too long, Mr. Waddell could be heard making snoring noises.

Lunch was served to the prisoners at approximately 1307 hours. The cellmate retrieved Mr. Wadell's food for him on this occasion as well since he seemed to be sleeping again.

As time went on Mr. Waddell's cellmate became concerned at his lack of movement. When he observed Mr. Waddell, his colour did not look right.

The cellmate called for the guard at approximately 1403 hours. The guard alerted the supervisor and an RCMP officer went into the cell at approximately 1404 hours. Cardiopulmonary resuscitation commenced at approximately 1405 hours. Naloxone, a drug used to reverse opiate toxicity, was administered by an RCMP officer. Other police officers and guards could be seen in the video performing supportive and supervisory roles.

The Fire Department and Ambulance arrived at approximately 1410 hours. Paramedics took over care of Mr. Waddell and firefighters took over CPR. Paramedics administered more naloxone in addition to their usual resuscitative efforts.

At approximately 1438 hours the Emergency Physician on call advised paramedics to discontinue further efforts. At no time did Mr. Waddell demonstrate any vital signs. The paramedic's Patient Care Report noted cyanosis, lividity, and the onset of rigor mortis which suggested that Mr. Waddell had been deceased for some time.

An autopsy was conducted by a forensic pathologist who testified that during the external examination of the body a piece of tinfoil containing a white powder was located in Mr. Waddell's right sock.

Following the autopsy, in addition to the usual samples sent to the toxicology lab, the white powder was also sent for analysis. The white powder was analysed and found to contain primarily fentanyl. The toxicological analysis of the samples taken from Mr. Waddell's body at the time of the autopsy revealed fentanyl within a range where lethal outcomes have been reported.

There were no injuries associated with the motor vehicle incident that played a role in the death. Mr. Waddell had dilated cardiomyopathy, a heart disease that put him at additional risk of death from drug use. The cause of death was determined to be fentanyl toxicity. Dilated cardiomyopathy was considered to be contributory.

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 the RCMP were not involved, and no report was issued.

The IIO investigator noted a lack of detail in the logbook, something he testified that he has seen in other in-custody deaths. The Watch Commander did not sign as required by policy and there was no notation that he did cell checks.

At the time of the incident one guard might do a personal check and another guard would sign the logbook for them, a practice that has since been discontinued. The logbook entered as evidence showed that personal checks were not conducted every 15 minutes as required. The RCMP conducted an Internal Review as a result of this incident and made a number of changes addressing these matters.

The 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, 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 no formal training or certification for municipal police guards. Standardized training and certification could potentially be done at the Justice Institute of BC which currently does training for similar positions. The Director also testified that there are approximately five in-custody deaths annually. When asked, 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.

The Director of Policy and Modernization with the Policing and Security Branch of the Provincial Government testified that they were aware of the lack of independent oversight. It had been brought to their attention in 2018. The addition of a full-time position dedicated to advancing this issue would be of assistance.

The majority of the police officers who testified stated that strip searches were uncommon. Various officers and guards testified that many persons who are lodged in cells are intoxicated by drugs and/or ethyl alcohol. It was not uncommon to find illicit drugs in a prisoner's possessions during a search, although it was more common during a search incidental to arrest, which often has an element of surprise to it, compared to prisoners who are spending weekends in cells and can anticipate being searched.

Police officers and guards testified that some of the prisoners serving intermittent sentences at the jail would arrive at the detachment having taken drugs recently, presumably to 'get through' the weekend. Numerous officers and guards testified that they had not received training on symptoms of medical distress related to drug or alcohol use even though withdrawal and toxicity were known to be issues.

A retired Kelowna Fire Department Captain testified that at the time of the incident, the fire department would be called to the detachment approximately every six weeks for a medical emergency and that at least half the time it would be drug related.

In addition to the issues that the RCMP addressed following their internal review, several other changes had occurred since the time of this incident. The Kelowna RCMP had moved into a new detachment with a new jail. A dedicated jail officer position called a Cell CEO had been created. Prisoners serving intermittent sentences were no longer being housed in the Kelowna RCMP detachment but were going to the Okanagan Correctional Centre in Oliver.

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: Ministry of Public Safety and Solicitor General

1. Provide formal training and certification to municipal lock-up staff through the Justice Institute of British Columbia (JIBC) in order to ensure standardization and professionalism. Training should include drug impairment recognition.

   Presiding Coroner Comment: *The jury learned that standardized training/certification is not formally conducted for the lock-up staff.*

2. Establish independent oversight of municipal lock-up staff.

   Presiding Coroner Comment: *The jury heard testimony that there is currently no independent agency with legal authority to investigate complaints about the conduct of municipal lock-up staff in RCMP police municipalities.*

3. Permanently eliminate the practice of prisoners serving intermittent sentences in municipal detachments.

   Presiding Coroner Comment: *Lock-up staff and RCMP members repeatedly stated in their testimonies that municipal detachments are not designed for long-term sentencing and that many 'weekenders' self-medicate before reporting for their intermittent sentence. This increases pressure on the lock-up staff because prisoners tend to ingest or smuggle contraband. One RCMP member stated that "there should be no weekenders who are involved with drugs, at all".*

To: Deputy Commissioner, E-Division, Royal Canadian Mounted Police

4. Investigate modern technologies that will assist lock-up staff to monitor the health and well-being of individuals in custody in municipal detachment cells. For example, Fitbits or thermal imaging to monitor vital signs, iPads for standardized documentation of cell checks.

   Presiding Coroner Comment: *Testimony from lock-up staff and RCMP members stated that it is challenging to monitor, detect, and confirm proof of life when individuals in custody are under a blanket without having to rouse prisoners every 15 minutes.*

5. Expand the practice of providing on-site RCMP 'cell CEO's' to supervise cell block operations.

   Presiding Coroner Comment: *RCMP testimony indicated that supervisors generally book "weekenders" and that street duty members should not be called in to conduct cell checks.*

6. Enhance training on procedures relating to thorough searches when booking prisoners to include the review of prisoner logs (i.e., C-13 forms, cell logs) to determine whether a more comprehensive search is required or recommended.

   Presiding Coroner Comment: *It became apparent in testimony that notations in the C-13 forms and prisoner/weekender logs are sometimes vague or unauthenticated. The jury heard that searches are often done at the sole discretion of the booking officer which leads to inconsistent search procedures.*

7. Establish a standardized procedure for officers to conduct an appropriate level of search when an individual is suspected to be impaired.

   Presiding Coroner Comment: *Testimony indicated that Mr. Waddell was impaired ("on the nod") at the time of arrest, yet searching their environment or vehicle was deemed unnecessary due to the discretion of the arresting officer and is not a required procedure. The fentanyl was then found on his person during the post-mortem examination.*