THE BC CORONERS SERVICE ANNUAL REPORT (2004)

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BACKGROUND

Mandate

The British Columbia Coroners Service (BCCS) is responsible by statute (*Coroners Act*) for the investigation and certification of all unnatural, sudden and unexpected, unexplained or unattended deaths. The BCCS is a fact-finding, not a fault-finding, agency. It makes recommendations to improve public safety and prevent deaths in similar circumstances.

Historic Development

The Office of the Coroner is one of the oldest common law institutions, with references dating as far back as the time of Saxon King Alfred in 925 A.D. The first detailed statute concerning Coroners was the *Statute of Westminster* of 1275. The Coroner was known as a "Keeper of the pleas of the Crown" or "Crowner" from which the term "Coroner" evolved.

The former utility of the Coroner as a protector of Crown revenue, or as an agency for bringing suspects to trial, is no longer a consideration. However, what does remain constant in the face of this evolution is the continuing concern with the fact of death and the unchanged interest of the public in the protection of its members. The death of a member of society is a public fact. The circumstances that surrounded that death and whether it could have been avoided are matters of interest to all members of the community. In this sense, the Coroner exists to provide a truly public service, both individually and collectively.

Each province and territory in Canada operates its own sudden death inquiry system. Coroners are governed by the BC *Coroners Act* proclaimed in 1979.[1]

Organizational Structure

The BCCS is an independent agency, and included in the Ministry of Public Safety and Solicitor General for administrative and budget purposes. The Chief Coroner, located in Burnaby, oversees the BCCS. There are a total of five regional offices, with one in each of the following cities: Victoria, Vancouver, Surrey, Kelowna, and Prince George. Each of these offices is led by a Regional Coroner.

Responsibilities

The responsibilities and functions of the BCCS include:

1. ascertaining and clarifying the facts of all unexpected and unnatural deaths in BC to determine the identity of the deceased, and how, when, where, and by what means the deceased died;

2. ensuring that no death is overlooked, concealed or ignored;

3. producing a judicial document, either a Judgement of Inquiry or a Verdict at Coroner's Inquest, that reports on the findings of the Coroner's investigation;

4. making recommendations, where appropriate and feasible, to both public and private agencies, so that a similar death is less likely to occur in the future;

5. conducting inquests (quasi-judicial court proceedings) when mandated by the *Coroners Act* or when there is a strong public interest in the circumstances of the death or potential for prevention of death in similar future circumstances;

6. collecting death information, conducting statistical analyses;

The Judgement of Inquiry or a Verdict at Coroner's Inquest form the official record of the identity of the deceased and how, when, and where he or she died. The medical cause of death and classification are noted. This serves the general public interest and adds to the sum of knowledge in the fields of forensic science, epidemiology, public safety, and public health.

Furthermore, prevention of death forms a critical part of the overall mandate of the BCCS.

[1] Legislative changes to the BC *Coroners Act* are expected in the fall of 2007.

An inquest publicly presents all evidence relating to the death, focuses community attention, and often makes recommendations which may help prevent future deaths.

PROGRAM AREAS

The three major program areas of the BCCS are investigative, judicial and preventative.

Investigative

Coroners require a careful examination of the circumstances leading up to a death to understand why the individual died. Pathologists, toxicologists, forensic investigators, and medical investigators may be used to provide assistance in an investigation.

Pathology

In deciding whether or not an autopsy is required, the Coroner must deem it necessary in order to determine the cause and manner of death. The autopsy must be considered to be in the public interest. In general, if a reasonable and probable cause can be deduced on the basis of the decedent's medical history, the circumstances surrounding a death and a careful examination of the body, an autopsy may not be necessary for the Coroner's mandate.

There is a great difference between a hospital autopsy and a forensic autopsy. The main function of a hospital autopsy is to substantiate the accuracy of a diagnosis and therapy instituted during the course of an illness as well as determine the immediate cause of death.

A forensic autopsy is a specialized autopsy. The Coroner authorizes a forensic, or medico-legal, autopsy for several reasons:

- to determine the cause of death when it cannot otherwise be determined,
- to collect evidence from the body,
- to document evidence useful for clarification of the time and circumstances of death,
- to obtain evidence to aid in the identification of the body, and
- to identify artifacts of violence and trauma that may be used to support a criminal investigation.

The BCCS retains the services of pathologists who conduct forensic autopsies on a fee-for-service basis.

In 2004, the BCCS ordered 1,563 autopsies, including 28 external autopsies. An external autopsy is a non-invasive, head to toe examination of the deceased.

Toxicology

Coroners authorize toxicology testing when it is required to establish or confirm the cause and manner of death. Most frequently, toxicology testing is provided on a fee-for-service basis at the Provincial Toxicology Centre, an accredited laboratory. For deaths in which there is also a criminal investigation in progress, the RCMP Crime Laboratory conducts toxicology testing. Toxicological testing can also be conducted at regional hospitals. In 2004, 1,726 toxicology tests were ordered by the BCCS.

Identification and Disaster Response

This unit of the BCCS has the responsibilities of mass fatality incident planning and forensic services. Consistent with the agency's mandate to investigate *all* sudden and unexpected deaths, this unit is responsible for facilitating the agency's recovery, identification and repatriation of all human remains in the event of a mass fatality incident. This is done with the help of the Disaster Team, which is made up of 10 members, most of whom are BCCS headquarters managers. Also consistent with the agency's responsibility to determine the identities of deceased persons who die of unnatural and unexpected causes, the Forensics Unit either directly provides or coordinates the delivery of forensic services for the purposes of identification in areas such as anthropology, osteology, odontology, and DNA.

Medical Investigations

The Medical Investigation Unit provides Coroners with guidance and assistance in investigation of medical issues and assistance in obtaining medical information. The unit also serves as a liaison with medical and nursing staff and Health Authorities and provides consistency in the management of investigation of deaths with complex medical issues through the development and use of medical investigation protocols. The latter function provides a provincial viewpoint for the identification of trends in health care factors which contribute to death and may be addressed through subject specific review. Finally, the medical unit represents the BCCS on provincial committees such as the Perinatal Mortality Review Committee.

Child Death Review[2]

In February of 2002, following the recommendation of the Attorney General, the Children's Commission and the Office of the Child, Youth and Family Advocate were eliminated, and an Office for Children and Youth was established to absorb a number of key functions, including the monitoring of services provided for children, advocacy, the investigation of complaints, education, and providing advice to the government on children and youth issues. On January 1st, 2003, the BCCS assumed the responsibilities related to Child Death Review. While the BCCS has always had the mandated responsibility of investigating *all* sudden, unnatural and unexpected deaths, including those of children, these changes resulted in the expansion of the BCCS responsibilities to include three new areas of responsibility:

- the tracking of child deaths, including a public reporting component,
- the establishment and maintenance of a Child Death Review Team, and
- the maintenance of a database for all child deaths.

[2] Further information on the BCCS Child Death Review process and be found on the following website: http://www.pssg.gov.bc.ca/coroners/child-death-review/index.htm

Judicial

A Coroner's investigation is concluded by either a Judgement of Inquiry or a Verdict at Coroner's Inquest.

Inquiry

Most frequently, a Coroner conducts an inquiry into a death and prepares a report for the Chief Coroner as mandated in Section 20 of the *Coroners Act*. A Coroner's inquiry is a quasi-judicial process conducted without a jury. The Coroner conducts a scene investigation, interviews witnesses, reviews all investigative documents gathered from other agencies, seizes and evaluates medical records and conducts other investigative tasks to determine the facts surrounding a death. The report states the facts of the death, the medical cause of death, and the classification of death (i.e., Natural, Accidental, Suicide, Homicide, or Undetermined). The Coroner can direct recommendations to specific individuals and/or agencies, suggesting changes or improvements so that similar deaths or injuries can be prevented.

Inquest

An inquest is a quasi-judicial hearing held in an open forum where witnesses are subpoenaed to testify under oath before a jury of five persons. An inquest is not a forum to resolve civil disputes or to conduct prosecutions. An inquest is not a trial and a Coroner is not a judge. The proceedings are investigational as opposed to accusatory or adversarial. There is no "accused" or "defendant".

There are several reasons to hold an inquest. The following sections of the *Coroners Act* outline the circumstances under which an inquest is held.

- Section 10, requires that an inquest is held into a death that occurred while an individual was in police custody.

- Section 18 allows a Coroner to hold an inquest when it is determined to be "necessary".

- Section 21 states that a Coroner conducting an inquiry may, for reasons specified in Section 21, change the inquiry to an inquest and summon a jury for that purpose.

Over time, Section 18 and 21 have been generally interpreted to call for an inquest for the following reasons:

- if the death resulted from a dangerous practice or circumstances and similar deaths could be prevented if recommendations were made to the public or an authority, or
- if the public has an interest in being informed of the circumstances surrounding the death.

Under special circumstances, the Attorney General may also direct that an inquest is held as provided in Section 23 of the *Coroners Act*. Inquest proceedings begin with the presiding Coroner explaining the purpose of the inquest to the jury and the jury's responsibilities under the *Coroners Act*. The Coroner reviews applicable sections of the *Coroners Act* for the information of the jury and gives a short summary of facts relating to the death. Witnesses are then called and examined by Coroner's counsel, the Coroner, members of the jury, and persons "granted standing". Persons are given "standing" if their interests may be affected by evidence presented at the inquest. Persons with standing, or their representative, may participate fully in the inquest by asking questions and introducing evidence. Once all the evidence has been given, a summation is given to the jury. The jury prepares a verdict, which may be unanimous or by majority. The verdict and findings must not make any finding of legal responsibility or express any conclusion of law.

The *Coroners Act* provides no power to order implementation of recommendations. However, the Coroner submits the jury's recommendations to the Chief Coroner for dissemination to appropriate persons, agencies, and ministries of governments. The jury's recommendations must be lawful and are expected to be relevant and reasonable with no finding of fault.

Preventative

The Chief Coroner is responsible for bringing the findings and recommendations from Coroner investigations and inquest juries to the attention of appropriate individuals, agencies, the public, and ministries of government to assist in improving public safety and in preventing similar deaths in the future.

The BCCS has no statutory authority to order change or to ensure that its recommendations will be carried out. However, the BCCS agency has been successful in having recommendations considered and acted upon. As a direct result of Coroner and jury recommendations, policies and procedures have been altered, more monitoring has occurred, and greater care and attention has been paid to conditions which might cause injury or death in the future. Through judicial recommendations, public awareness, and statistical analysis and research, the preventative role is affected.

Coroner Recommendations

In 2004, BC Coroners sent approximately 282 recommendations from inquests and Coroner inquiries to private agencies, as well as agencies and ministries of government, addressing a variety of public safety issues. The BCCS had a 61% response rate to recommendations that were sent for action (i.e., requiring a response), with 69% of these responses being positive. A summary of the recommendations and responses resulting from inquests are included in the Inquest Summaries portion of this report.

Research

A variety of agencies use data from Coroner files in a collective review of deaths in certain categories that can be useful in provincial and/or federal accident, suicide, and injury prevention strategies. These agencies are vetted by the BCCS and must sign a research agreement, which ensures security and confidentiality.

Those agencies use data from the BCCS in their own injury and/or death prevention strategies.

Red Cross

The Canadian Red Cross and The Royal Life Saving Society Canada have combined efforts to work with communities across BC and the Yukon to reduce the number of water-related fatalities and injuries. These agencies produce a joint provincial summary of drownings in BC and the Yukon. The Coroner's investigative file provides the necessary data to allow these agencies to fulfill their role in educating the public, and reducing injuries and death due to drowning.

Traffic Injury Research Foundation

The Traffic Injury Research Foundation of Canada (TIRF) has used data from the BCCS to research alcohol-use related to motor vehicle fatalities since 1974. A fatality database is maintained for all provinces across Canada. This database provides a comprehensive source of objective data on alcohol use among persons fatally injured in motor vehicle accidents. This database provides a means of monitoring changes and trends and is a valuable tool for research on alcohol-impaired driving.

Underwater Council of British Columbia

The Underwater Council of British Columbia is dedicated to furthering safe diving practices. The Council reviews all Coroner diving files on a yearly basis to produce a Recreational Diving Fatalities report, which summarizes circumstances and recommendations on diving deaths. This report is an invaluable reference for scuba instructors, educators and concerned scuba enthusiasts.

Canadian Agricultural Injury Surveillance Program

The Canadian Agricultural Injury Surveillance Program (CAISP) is a national program of the Canadian Agricultural Safety Association (CASA). CAISP was established in 1995 in response to the need for better information about fatal and hospitalized agricultural injuries. The BC Coroners Service provides the program with data annually on the above types of deaths. CAISP has recently published a research report entitled "Agricultural Rollovers in Canada for 1990 – 2000" which is in part based on data obtained from the BCCS.

CORONERS ACT AND NOTIFICATION REQUIREMENT

Section 9 of the *Coroners Act* states the requirement for reporting a death to the Coroner. This section of the *Coroners Act* requires that a person shall immediately notify a Coroner or a peace officer of the facts and circumstances relating to a death when there is reason to believe that a person has died under circumstances where an investigation may be required. The *Coroner Act* specifically requires the reporting of violent, unexplained or sudden and unexpected deaths; deaths in custody; and deaths of persons to whom the *Mental Health Act* applies.

The BCCS is responsible for the investigation of all reported deaths to determine the identity of the deceased and the facts as to when, where, and by what means the person died.

The scope of the Coroner's investigation has broadened over the years. Previously, the major emphasis was directed towards the investigation of the actual medical cause of death to the exclusion of practically all other aspects. Now, the medical cause of death is only one of many factors to be considered. The non-medical factors causing death are often equally important as the circumstances leading up to and surrounding the death.

When a death is reported, the Coroner focuses on who the deceased was and when, where, and by what means death occurred. The Coroner has extensive authority to collect information, conduct interviews and seize documents or other materials. The Coroner may also use information received from other agencies, such as the Workers' Compensation Board in industrial related deaths, or from the local police regarding deaths that may be crime related. The Coroner and the police will work

closely together when crime is a factor in a reported death. Conversely, forensic medical information obtained through autopsies or toxicological analysis may be important information for a criminal investigation.

STATISTICAL SUMMARY OF DEATHS

Cause of Death Codes

The primary definitions consist of the CAUSE OF DEATH and the MEANS OF DEATH:

CAUSES OF DEATH are all those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced the injuries.

The MEANS OF DEATH is the disease or injury which initiated the train of events leading directly to death or the circumstances of the accident or violence which produced the fatal injury.

It is vital to capture the precipitating event or Means of Death to provide researchers working on death prevention with meaningful data.

Vital Statistics

The *Vital Statistics Act* requires that a Coroner or physician provide a Medical Certificate of Death for each death in British Columbia. The certificate is filed with a District Registrar of Births, Deaths and Marriages within 48 hours of the death. The funeral director, or person acting as such, is required to complete the Registration of Death, collect the Medical Certificate of Death and file both with the District Registrar. If the cause of death cannot be determined within the time required, the Coroner provides a provisional certificate that is later updated with the appropriate cause of death information. In addition to requiring this information for official records, the Division of Vital Statistics Research Branch utilizes mortality data for various aspects of health planning and education. It provides valuable information to health care researchers, planners and providers.

Classifications of Death

As of October 1993, all deaths reported to and investigated by the BCCS have been classified, for statistical purposes, into one of five categories.

- A **Natural** death is one primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors.
- An **Accidental** death is due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident.
- A **Suicide** is a death resulting from self-inflicted injury, with intent to cause death.
- A **Homicide** is a death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.
- An **Undetermined** death is defined as one that, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as Natural, Accidental, Suicide, or Homicide

CASELOAD STATISTICS

Note: The BC Coroners Service works in a real-time database environment. Therefore, statistics are subject to change until all Coroners' investigations are completed.

Total Cases

Death Class	Total Cases
Accident	1,166
Homicide	108
Natural	5,213
Suicide	525
Undetermined	105
Total	**7,117**

Regional Distribution

Region	ACCIDENT	HOMICIDE	NATURAL	SUICIDE	UNDETERMINED
Fraser	256	26	1,268	135	18
Interior	313	20	1,276	112	17
Island	236	12	1,314	109	24
Metro	220	36	948	124	33
Northern	141	14	407	45	13
Total	**1,166**	**108**	**5,213**	**525**	**105**

Regional Caseload

Region	2004	2003	2002	2001	2000 [3]	1999
Fraser	1,703	1,786	1,779	1,920	1,973	2,710
Interior	1,738	1,746	1,616	1,361	1,422	1,868
Island	1,695	1,618	1,596	1,443	1,364	1,866
Metro	1,361	1,315	1,455	1,279	1,260	1,886
Northern	620	638	599	526	579	677
Total	**7,117**	**7,103**	**7,045**	**6,529**	**6,598**	**9,007**

[3] An amendment to the *Coroner's Act* in 2000, no longer requiring all deaths in Community Care Facilities to be reported to a coroner, has resulted in a decrease in the number of natural (expected) deaths reported to the Coroners Service

ACCIDENTAL DEATHS

Recreational		Cases
AIR		
	Other Aircraft	8
	Ultra-light Aircraft	1
LAND		
	Hiking/Climbing	8
	Horseback Riding/Polo	1
	Hunting	1
	Motorbike/Offroad/ATV	5
	Mountain Biking	1
	Mowing lawn	1
	Skateboarding	1
	Street Bike	1
SNOW		
	Snowboarding	2
	Snowmobiling	5
	Snowskiing	6
WATER		
	Canoe	5
	Diving	1
	Fishing	2
	Kayak	1
	Power Boating	8
	Rowboat	2
	Scuba Diving	3
	Swimming	14
OTHER		
	All other	5
	Total	**82**

Occupational	Cases
Business Site	2
Commercial hunting/Fishing/Other Vessel	7
Commercial Scuba Diving	3
Construction Site: Commercial	1
Construction Site: Residential	4
Electrical/Powerlines	1
Farm Worksite	2
Firefighting – Non Forest	2
Forestry Sites	6
Helicopter Logging	1
Industrial	6
Industrial – Material Handling	1
Mine, Quarry, or Oil/Gas	2
Other Place of Work	3
Policing - Police Officer	1
Railway Sites	2
School/University	1
Yardwork	1
Total	**46**

Other Accidents	Cases
Motor Vehicle	448
Alcohol/Drug Poisoning	270
Fall	147
Other	67
Airway obstruction	26
Drowning[4]	24
Fire	19
Carbon Monoxide	12
Exposure	11
Not yet determined	8
Air Crash	2
Firearms	2
Skytrain or Railway	1
Total	**1038**

[4] Does not include drownings counted in the recreational category, i.e., swimming.

ACCIDENTAL MOTOR VEHICLE DEATHS

Victim Type

Victim Type	Cases
Driver	214
Passenger	86
Commercial Truck Driver	15
Commercial Truck Passenger	1
Motorcycle/ Moped	47
Pedestrian	71
Pedal Cyclist	7
Other	7
Total	**448**

Regional Distribution

Victim Type	Fraser	Interior	Island	Metro	North
Driver	46	76	24	24	44
Passenger	25	24	11	13	13
Commercial Truck Driver	2	5	1	1	6
Commercial Truck Passenger	0	1	0	0	0
Motorcycle/ Moped	16	13	11	4	3
Pedestrian	23	14	12	17	5
Pedal Cyclist	3	1	1	0	2
Other	1	2	1	0	3
Total	**116**	**136**	**61**	**59**	**76**

CHILD DEATHS (Ages 0 – 18 yrs)

Total Cases Reported

Death Class	2004	2003	2002	2001	2000
Accident	69	100	88	95	100
Homicide	5	10	13	5	15
Natural	53	75	59	67	73
Suicide	25	19	24	11	30
Undetermined	22	24	27	15	6
Total	**174**	**228**	**211**	**193**	**224**

Age Distribution

Age Group	2004	2003	2002	2001	2000
0 to 11 months	57	65	59	48	53
1 to 4 years	15	30	20	23	19
5 to 9 years	10	18	18	20	12
10 to 14 years	24	27	37	24	24
15 to 18 years	68	88	77	78	116
Total	**174**	**228**	**211**	**193**	**224**

Accidental Child Deaths by Means of Death[5]

Means of Death	2004	2003	2002	2001	2000
Motor Vehicle Accident	35	62	47	41	60
Drowning	7	11	9	12	15
Alcohol / Drug Poisoning	5	3	4	5	4
Airway Obstruction	4	5	3	3	2
Fall	2	1	3	3	1
Fire	2	1	2	13	6
Exposure	2	0	1	2	1
Dirt Bike / ATV / Snowmobile	3	2	1	5	2
Other	9	15	18	11	9
Total	**69**	**100**	**88**	**95**	**100**

[5] Defined as the event leading to the death.

SUICIDE DEATHS

Suicide Rate per 100,000 persons

Case Year	Cases	Rate per 100,000
2004	525	12.5
2003	478	11.5
2002	537	13.0
2001	470	11.5
2000	484	12.0
1999	498	12.4
1998	509	12.8
1997	583	14.8
1996	557	14.4
1995	534	14.1
1994	513	14.0
1993	492	13.8
1992	514	14.8
1991	489	14.5
1990	426	12.9
1989	489	15.3
1988	456	14.6
1987	459	15.0

Age Category

Age Category	2004	2003	2002	2001	2000
12 and under	1	1	2	0	0
13 - 19 years	27	28	29	15	35
20 - 29 years	71	71	71	55	84
30 - 39 years	96	104	97	99	94
40 - 49 years	105	102	131	116	105
50 - 59 years	107	78	101	95	72
60 - 69 years	52	47	51	43	42
70 - 79 years	36	29	37	28	31
80 and over	29	18	18	19	20
Age unknown	0	0	0	0	1
Total	**524**	**478**	**537**	**470**	**484**

Gender	2004	2003	2002	2001	2000
Female	127	120	132	107	124
Male	398	358	405	363	360
Total	**525**	**478**	**537**	**470**	**484**

Region	2004	2003	2002	2001	2000
Fraser	135	129	154	147	127
Interior	112	93	107	94	95
Island	109	92	104	81	110
Metro	124	124	132	110	110
Northern	45	40	40	38	42
Total	**525**	**478**	**537**	**470**	**484**

Suicides by Method of Death	2004	2003	2002	2001	2000
Hanging	163	155	167	123	149
Suffocation / Smothering / Other	15	15	13	8	14
Carbon Monoxide Poisoning	43	37	42	40	50
Drowning	19	19	31	20	24
Fall	27	28	36	35	35
Firearms	86	84	90	90	84
Stabbing / Incised Injuries	30	17	15	23	14
Alcohol / Drug Poisoning	107	96	114	111	89
Other Poisoning	6	5	6	6	4
Skytrain or Railway	4	6	2	6	7
Motor Vehicle Accident	7	5	8	1	5
Fire	3	4	3	4	1
Other	15	7	10	3	8
Total	**525**	**478**	**537**	**470**	**484**

ILLICIT DRUG DEATHS

Year	Total
2004	193
2003	190
2002	170
2001	246
2000	248
1999	278
1998	417
1997	310
1996	312
1995	224
1994	317
1993	361
1992	164
1991	124
1990	82
1989	67
1988	39

REGION	2004	2003	2002	2001	2000
Fraser	48	55	47	74	78
Interior	27	34	23	25	24
Island	37	37	40	45	40
Metro	71	58	53	94	95
Northern	10	6	7	8	11
Yearly Total	**193**	**190**	**170**	**246**	**248**

GENDER	2004	2003	2002	2001	2000
Female	45	38	40	53	41
Male	148	152	130	193	207
Yearly Total	**193**	**190**	**170**	**246**	**248**

AGE	2004	2003	2002	2001	2000
20 and under	8	7	5	7	7
21 - 30	43	34	39	52	38
31 - 40	57	49	56	97	101
41 - 50	57	72	56	65	73
51 - 60	26	22	12	19	28
Over 60	2	6	2	6	1
Yearly Total	**193**	**190**	**170**	**246**	**248**

INQUESTS (2004)

Statistics

Classification of Death (number of fatalities)

Natural	1
Accident	11
Suicide	0
Homicide	6
Undetermined	1

Type of Death (number of inquests)

Police Custody/Lock-up	
Arrest and Cell Lock-up	2
Cell Lock-up	1
Arrest	5
Police Shooting	3
Drowning	1
Murder-Suicide	1
Total # of inquests	13

Total # of days	91

Summaries

In 2004, the BCCS held 13 inquests for the deaths of 19 individuals. The inquests resulted in a total of 91 recommendations, addressing a variety of issues. Included here is a summary of these inquests, the recommendations made by the juries and the responses to the recommendations provided by the relevant agencies. These inquest summaries are categorized by the type of death.

Police Custody-Arrest and Cell Lock-up

Case 1 of 2

On July 15th, 2004, an inquest was held in Vernon, BC, into the death of a 61-year-old male who died on June 24th, 2003, due to a brain hemorrhage.

The man was arrested on June 4th, 2003 for being drunk in a public place. He was taken to jail and was later found unresponsive in his cell. He was then transported to hospital where he was diagnosed with a head injury and remained in hospital until his death.

During the inquest, it was revealed that while at the hospital, a CT scan revealed large intracerebral hemorrhages. However, surgical intervention was not indicated. Toxicological analysis of the man's blood revealed alcohol but was negative for other drugs.

The pathologist testified at the inquest that photographs of the man taken on June 5th, 2003, indicated blunt force trauma classically associated with fall type injuries. The injuries were said to be present prior to the police arrest and consistent with those seen as a result of stumbling and falling.

The jury found that the death was due to bilateral intracerebral hemorrhages, due to right occipital blunt force trauma and classified the death as Accidental.

Recommendations:

One recommendation was made by the jury and was directed to the **RCMP Deputy Commissioner Pacific Region and Commanding Officer, "E" Division.** It was recommended that individuals in custody for being drunk in a public place, if not

apparently sober after four hours be physically examined to verify that they are recovering.

Case 2 of 2

On November 22nd, 2004, an inquest was held in Smithers, BC, into the death of a 32-year-old male who died on June 14th, 2003, due to a subglottic abscess.

The man had been sentenced to serve three days jail time for a previous offence. He had asthma and required medication which was brought to the jail at the time the sentence was served. His asthma worsened while serving the sentence and he was taken to a hospital for treatment. After treatment, he was returned to jail to finish serving his sentence. While in jail, he asked for medication but was refused as it was to be taken in the mornings only. However, he was having difficulties breathing so two officers directed him to use his inhaler and relax. The man was observed to collapse, CPR was started and an ambulance was called. The man died shortly thereafter.

At the inquest it was revealed that the autopsy found an obstructed airway due to a subglottic abscess. The abscess could have only been detected through a bronchoscopy and treated through prolonged antibiotics.

The jury found that the death was due to partial upper airway obstruction, due to a subglottic abscess and classified the death as Natural.

Recommendations:

A total of three recommendations were made by the jury and directed to the **Smithers RCMP detachment** and were as follows:

- that a review of policy be conducted regarding prisoner requests to get in touch with their family physician for medical reasons,
- that the camera location in cells be reviewed in an attempt to get a wider view of the cells, and
- that a better video recording system be adopted for quality purposes.

Response to recommendations:

The **Smithers RCMP** detachment responded that their policy already requires that a prisoner be brought to a medical doctor immediately when suspected of having an injury, illness or requiring medical attention. It was also noted that the current audio video equipment was deemed to be of high quality permitting the widest view possible of the cells. However, the VHS recorder and VHS tapes were replaced in an attempt to improve quality.

Police Custody – Cell Lock-up

Case 1 of 1

On November 8th, 2004, an inquest was held in Burnaby, BC, into the death of a 47-year-old male who died on July 7th, 2002, due to falling and striking his head.

The man had been out with friends the day before his death consuming alcohol and was reported to be argumentative at times. He was observed to fall twice that evening. After a second fall, 911 was called and it was reported that he had been assaulted. Witnesses reported that the man fell five to seven times during the evening. However, paramedics conducted an assessment and did not find evidence of neurotrauma. The police determined that the man was too intoxicated to be left alone and he was transported to and held at the Vancouver jail. Other men in the same jail cell with the man stated that he lay unresponsive on the floor. The Jail Arrest Record (JAR) did not note the assessment by paramedics but the paramedic Crew Report or Emergency Health Services report was attached to the JAR.

The man was observed every 15 minutes by corrections staff. A later assessment revealed him to be less responsive with un-reactive pupils. An ambulance was called and he was transferred to hospital, where he required a ventilator to breathe adequately. A CT scan revealed a skull fracture with a massive epidural hematoma (localized blood collection) that was compressing the brain. Surgery was performed to remove the hematoma. However, the man's condition deteriorated post-surgery until he died.

Toxicological analysis revealed the presence of alcohol and a cocaine metabolite. A toxicologist estimated the man's peak blood alcohol concentration to be between 208-328 milligrams per 100 millilitres of blood. This level would cause severe mental and motor dysfunction in the average

social drinker. The toxicologist also testified that cocaine would increase blood pressure, pulse and respiratory rate.

The jury found that the death was due to unnatural causes; blunt force trauma to the head due to falling and striking the head, and classified the death as Accidental.

Recommendations:

A total of seven recommendations were made by the jury and were directed to the **Vancouver Police Department (VPD)**, the **BC Ambulance Service (BCAS)**, and the **Corrections Branch** of the **Ministry of Public Safety and Solicitor General**.

It was recommended to the **VPD** that Emergency Health Services recommendations be recorded on the Vancouver Jail Arrest Record.

A related recommendation was made to the **BCAS** to change a box on the Crew Report to read "Diagnostic and Additional Comments or Recommendations".

Finally, five recommendations were made to the **Corrections Branch** of the **Ministry of Public Safety and Solicitor General**. The recommendations were the following:

- that information regarding medical issues be transferred to the inmate observation log,
- that the jail nurse wake the inmate every hour after four hours in jail to assess their medical condition,
- that video tapes of the inmate holding cell be held for at least 24 hours before they are taped over,
- that jail nurses receive additional training on drug and alcohol abuse and head injuries, and
- that a nursing supervisor be on duty at the jail throughout weekends.

Response to recommendations:

The **VPD** responded that their Jail Arrest Record was modified to include a field to specifically capture medical information to comply with the jury's recommendation.

The **BCAS** responded that they were in the process of reviewing the Crew Report form and that upon completion the form will be significantly different. It was stated that more information would be captured electronically or on an expanded form. In the meantime, paramedics were reminded to make recommendations to staff assuming custodial responsibility of patients.

The **Corrections Branch** responded that procedures were amended to ensure medical information is entered into inmate monitoring logs. Procedures were also changed to ensure that intoxicated inmates are awakened every four hours to assess medical condition. Video surveillance tapes from holding cells with intoxicated inmates will now be held for 15 days. The Corrections Branch also responded that nursing staff at the Vancouver jail and North Fraser Pre-trial Centre received training on drug and alcohol abuse with training eventually expanding to other centres. Finally, regarding weekend nursing staff, it was noted that changes were made to the daily routine to ensure that practices are in place to safeguard offenders under medical observation.

Police Custody – Arrest

Case 1 of 5

On June 23rd, 2004, an inquest was held in Burnaby, BC, into the death of a 37-year-old male who died on October 24th, 2000, due to a blow to the left side of the neck.

Two men entered a home, either entering to attempt a home invasion or entering due to a mistaken address. They were confronted by the owner and left the home. The two men then proceeded to a vehicle in the back alleyway of the home, in which two other men were waiting for them.

At the inquest it was revealed that although details of the incident were unclear, it was clear that the vehicle with the four males attempted to leave the alleyway but was stopped by a single officer with a dog in a police vehicle. Because of a locked door, the police officer was unable to utilize the dog. However, a back-up police vehicle with two officers arrived shortly thereafter. One man exited the vehicle, while the other men remained in the vehicle, and eventually ended up handcuffed on the ground. Some force was used to obtain control over the man, but it was uncertain what amount of force was used. Medical expert testimony at the inquest

revealed that apparent injuries to the man were consistent with inflicted trauma.

The jury found that the death was due to a traumatic aneurysm of the left carotid artery, due to a blow to the left side of the neck, and classified the death as a Homicide.

Recommendations:

A total of eight recommendations were made by the jury and were directed to the **Vancouver Police Department (VPD)**, the **Office of the Police Complaint Commissioner**, the **Justice Institute**, the **City of Vancouver**, the **Office of the Chief Coroner,** and the **Minister of Public Safety and Solicitor General**.

Four recommendations were made to the **VPD** and were as follows:

- that a review be conducted of the policies regarding officers without back-up when suspects are "Armed and Dangerous",
- that a review be conducted of policies relevant to dog masters to ensure readiness of the dog partner,
- that all incident reports and photos are dated and signed at the time of submission, and
- that regular mental and psychological assessments are required for all officers involved in high stress assignments.

It was also recommended to both the **VPD** and the **Office of the Police Complaint Commissioner** that a full review be conducted to determine if "due care" to the injured man was provided.

It was recommended to the **VPD**, **Office of the Police Complaint Commissioner,** the **Justice Institute,** and the **City of Vancouver** that officers are regularly re-trained in the application of force.

It was also recommended to the **Office of the Chief Coroner** that the jury of an inquest receive training/guidance in written form outlining roles and responsibilities of persons and procedures involved in an inquest.

And finally, it was recommended to the **Minister of Public Safety and Solicitor General** that legal counsel be made available for family members of the deceased.

Response to recommendations:

The **Office of the Police Complaint Commissioner** responded that they were awaiting the outcome of a public hearing into the death of the man, scheduled to take place in December, 2004.

The **Justice Institute** responded that the re-training of officers regarding the use of force is normally the responsibility of each municipal police department. However, the Justice Institute stated that they ensure that new recruits have received training in the use of force and situational assessment and have participated in a series of realistic simulations.

The recommendation directed to the **Minister of Public Safety and Solicitor General** was forwarded to the **Attorney General** for consideration. The **Attorney General** responded that public funding for legal counsel is available for those who meet income and eligibility criteria and where courts have determined that a party could suffer a breach of constitutional rights without counsel. These situations are not normally present for family members participating at an inquest.

The **BCCS** responded that in the Presiding Coroner's opening remarks to the jury, the jury is given information on the functions of an inquest, the process for giving evidence, the examination of witnesses, the expectations of the jury in determining the cause and classification of death, making recommendations in preventing future deaths, and the role of the counsel at the inquest. These opening remarks have been included in a standardized script which is being used by all Presiding Coroners in the Province.

Case 2 of 5

On July 7th, 2004, an inquest was held in Victoria, BC, into the death of a 32-year-old male who died on November 29th, 2003, due to acute cocaine intoxication.

While at his home, with two female relatives, the man instructed one of them to call the police and report that someone was attempting to harm him, although there was no one else in the home. At the inquest, his mother stated that she had seen this behaviour from him before and associated it with drug use. The RCMP arrived and removed the two female relatives from the home. The RCMP tried to

remove the man from the home. The RCMP did not comply with the man's request for identification. An attempt to subdue the man with a TASER was unsuccessful due to TASER malfunction. The man eventually allowed police to handcuff him but then began to struggle after being handcuffed. He began to call for police help indicating that he did not believe the four officers present were RCMP. The man continued to struggle until shortly before an ambulance arrived, at which time he suddenly ceased struggling. The ambulance personnel initiated CPR and he was transferred to the hospital where he died.

At the inquest it was revealed that toxicological analysis of blood and urine indicated lethal levels of cocaine. It was further revealed that these levels can result in agitated delirium. Autopsy results presented at the inquest indicated recent and historical intravenous drug use.

The jury found that the death was due to cocaine associated agitated delirium with police restraint and classified the death as Accidental.

Recommendations:

A total of four recommendations were made, three by the jury and one by the presiding coroner and were directed to the **RCMP Deputy Commissioner Pacific Region and Commanding Officer, "E" Division**, the **Minister of Public Safety and Solicitor General** and the **Minister of State for Mental Health and Addiction Services**.

It was recommended to the **RCMP Deputy Commissioner** and the **Minister of Public Safety and Solicitor General** that police carry picture identification and a badge that is readily available when requested. It was also recommended that drug use awareness training is included in ongoing education for law enforcement officers and paramedics.

It was recommended to the **Minister of State for Mental Health and Addiction Services** that the document *Crystal Meth and Other Methamphetamines: An Integrated BC Strategy* is revised to include a discussion of restraint as a contributory factor in sudden and unexpected deaths in individuals with agitated delirium psychosis.

Response to recommendations:

The **Assistant Deputy Minister and Director of Police Services** replied to the recommendations on behalf of the **Minister of Public Safety and Solicitor General.** The response indicated that provincial *Uniforms Regulations* require that all members wear and carry identification. At a meeting of the BC Association of Municipal Chiefs of Police it was agreed that when practical members would produce identification when requested. The Chiefs of Municipal Police were also issued a letter reminding them of this decision. However, it was indicated that identification issues regarding RCMP is under the jurisdiction of the Government of Canada.

The **Ministry of Health** stated that the **Mental Health and Addiction Branch** will be directed to revise *Crystal Meth and Other Methamphetamines: An Integrated BC Strategy* prior to future publication and distribution to incorporate the jury's recommendation.

Case 3 of 5

On September 16th, 2004, an inquest was held in Burnaby, BC, into the death of a 33-year-old male who died on August 1st, 2002, due to atherosclerotic cardiovascular disease.

While visiting in Vancouver, from Regina, the man began to experience bizarre and irrational episodes with delusional ideas. His partner tried to help him seek medical care at St. Paul's hospital but failed. After speaking with him on the phone, a colleague of the man's contacted emergency services in the lower mainland with concern for his well being. Officers visited the apartment where the man was staying and attempted to speak with him to make an assessment. The man sprayed the officers with beer and the officers responded with Oleoresin Capsicum spray without effect. Additional officers were called. After a struggle, he was eventually restrained and an ambulance called to transport him to hospital for psychiatric assessment. After resistance diminished it was discovered that the man was not breathing. Police initiated CPR which was continued, by the paramedics.

At the inquest, a pathologist testified that an autopsy revealed several contusions and abrasions on the face, neck and extremities of the man. There was also an occlusion of one of the coronary arteries. Toxicological analysis of the man's blood revealed

low levels of alcohol but no other drugs. It was further revealed that excited delirium could be caused by psychiatric illness and could precipitate sudden cardiac death.

The jury found the cause of death was neck compression and sudden death associated with restraint due to artherosclerotic cardiovascular disease and classified the death as Accidental.

Recommendations:

A total of 10 recommendations were made by the jury and were directed to the **Minister of Public Safety and Solicitor General,** the **Minister of Health,** the **Director of Mental Health for the Vancouver Coastal Health Authority** and the **Vancouver Police Department.**

It was recommended to both the **Minister of Public Safety and Solicitor General** and the **Minister of Health** to coordinate the integration of training of police officers to include the dangers of positional asphyxia and restraint.

Several recommendations were directed solely to the **Minister of Public Safety and Solicitor General for British Columbia** alone. These recommendations were as follows:

- that the existing Provincial Use of Force Coordinator position be filled;
- that training of police officers include the dangers of the headlock restraint, positional asphyxia, and takedown of combative subjects, with continual evaluation of additional and emerging restraint options;
- that an observer assess the subject in the process of being detained; and
- that disposable pocket masks are issued to CPR certified police officers.

The **Minister of Health** and the **Director of Mental Health** for the **Vancouver Coastal Health Authority** both received the recommendation that "Car 87" (a team of a police officer and mental health nurse that respond to calls where mental health concerns exist) and similar programs have access to provincewide health records.

Finally, it was recommended to the **Vancouver Police Department** that all lesson plans are kept up to date.

Response to recommendations:

The **Minister of Public Safety and Solicitor General** responded that there is intent to fill the Use of Force Coordinator position as soon as possible. It is also noted in the response that the BC *Use of Force Regulation* deal with the recommendations regarding use of force. It was also noted that the Solicitor General offers continued support for the web-based training resource for police titled "Police Intervention in Mental Illness Crisis". The recommendations were forwarded to the individual municipal police departments by the Ministry. Responses were received from the municipal police departments with most indicating that the recommendation was already addressed, or that changes would be considered. It was also stated that the relevant issues would be placed on the agenda at a meeting of BC Municipal Chiefs of Police to be held in September, 2005.

The **Minister of Health** responded that Car 87 and similar programs currently do not have access to provincewide health records due to privacy concerns under the *Freedom of Information and Protection of Privacy Act*.

In response to a recommendation the **Vancouver Police Department** replied that they had a lesson plan for positional asphyxia and excited delirium in place since 1996, which had been recently updated and presented to the Patrol Division in 2004.

Case 4 of 5

On October 12th, 2004, an inquest was held in Burnaby, BC, into the death of a 49-year-old male who died on May 12th, 2002, due to restraint associated cardiac arrest due to cocaine-agitated delirium.

The man had been at a bar in downtown Vancouver and parked his motorcycle in a spot already occupied by a motor vehicle, blocking removal of that vehicle. When the owner of the vehicle returned the man was alerted and returned to his motorcycle and verbally confronted the owner of the other vehicle. The vehicle owner identified himself as an off-duty RCMP officer and the verbal altercation diminished. The man returned to the bar.

Police arrived and the man reappeared but didn't comply with the officer's request to talk to him. The

officers followed him into the bar and out into the alleyway behind the bar. The man tripped and fell to the ground but would not obey police commands to remain on the ground. Witnesses testified that the officers kicked him and attempted to restrain him using their body weight.

Shortly after being handcuffed, the man's resistance suddenly diminished and officers could not find a pulse. Chest compressions, but not artificial respiration was initiated by the officers as no disposable first aid mask was available. An ambulance was called, but aggressive intervention was not successful.

Toxicological analysis revealed cocaine and its metabolites in the blood and urine samples of the man. At the inquest a toxicologist and clinical chemist described cocaine psychosis and stated that in numerous cases cocaine intoxicated individuals suffered sudden cardiac death while resisting officers. The Vancouver Police Department stated at the inquest that all operational officers will undergo a two-day course on first responder first aid and CPR and that first aid equipment will be standard equipment in vehicles.

The jury found that the man died from unnatural causes due to massive peripheral aspiration, due to restraint-associated cardiac arrest due to cocaine agitated delirium. The death was classified as Accidental.

Recommendations:

A total of eight recommendations were made by the jury and were directed to the **Minister of Public Safety and Solicitor General**, the **Vancouver Police Department** and the **Justice Institute of British Columbia**.

It was recommended to the **Minister of Public Safety and Solicitor General** that the Provincial Use of Force Coordinator position be filled. Six recommendations were directed to the **Minister of Public Safety and Solicitor General** and the **Vancouver Police Department**. Three recommendations suggested improvements to medical/first aid training for officers. It was also recommended that:

- that leg restraint devices become standard equipment in operational vehicles,
- that public relations campaigns are developed to improve the **Vancouver Police Department** image to facilitate understanding and cooperation from the general public, and
- that a review be conducted of current training on cocaine psychosis and consequences of police restraint.

A final recommendation was made to both the **Minister of Public Safety and Solicitor General** and the **Justice Institute of British Columbia** that leg wrap technology be reviewed and modified to make it more compact and functional.

Response to recommendations:

The **Minister of Public Safety and Solicitor General** replied that the job description for the Use of Force Coordinator was under review with the intent to fill the position as soon as possible. He also stated that the Police Act regulations require each police force to develop or adopt a protocol regarding use of force. The Minister stated that he would entrust the **Vancouver Police Department** with responding to the recommendation of a public campaign.

The **Vancouver Police Department** responded that each of the jury's recommendations had been implemented and that the department was in full compliance with all six recommendations.

Case 5 of 5

On October 18th, 2004, an inquest was held in Prince George, BC, into the death of a 33-year-old male who died on July 22nd, 2003, due to a cocaine overdose.

On July 21st, the Prince George RCMP received a complaint about a man causing a disturbance. At the inquest, several witnesses testified that they saw the man behaving erratically and that he had a knife, which was later discovered to be a cell phone.

One officer stated that when he arrived at the scene the man was approaching a fellow female constable and was unresponsive to her commands. He had blood and foam coming from his mouth. The officer drew his pistol and commanded the man to show his hands, who complied and advanced toward him with both hands raised in the air. The officer then holstered his weapon. The man was then taken

down, but was still struggling. A third officer kicked him in the chest twice to gain "pain compliance". The kicks were ineffective so he used pepper spray, also without effect. The officers testified that a rope was used to subdue the man and was used to tie his feet to the handcuffs on his wrists.

Officers testified that at the detachment the man was stunned with a TASER weapon as a struggle continued, though was without effect. An ambulance was called to the detachment on the suggestion that they could administer a sedative to calm the man. However, during transport to the hospital, he went into cardiac arrest.

A pathologist testified that the autopsy revealed evidence of former cardiac damage. Toxicological analysis revealed above lethal levels of cocaine and a cocaine metabolite in specimens from the man.

It was also stated that the Office of the Police Complaint Commissioner had ordered a review of issues similar to those raised at the current inquest. This review included the use of TASER technology, restraint use and the condition of agitated delirium. The review produced a preliminary report which included several recommendations.

The jury felt that the Police Complaints Commission report addressed some of their concerns and pre-empted potential recommendations. The jury found the cause of death was due to cocaine overdose and classified the death as Accidental.

Recommendations:

A total of four recommendations were made by the jury and were directed to the **Northern Health Authority**, the **Ministry of Public Safety and Solicitor General,** the **Prince George RCMP detachment**, the **Minister of Health Services**, the **RCMP Deputy Commissioner Pacific Region and Commanding Officer, "E" Division**, and the **Prince George Community Corrections, Corrections Branch**.

It was recommended that the **RCMP** and other Peace officers give consideration to the current commission on TASER use ordered by the BC Police Complaints Commission and to the five recommendations already outlined in their preliminary report. These recommendations were as follows:

- that police TASER training be standardized,
- that reporting of TASER use be mandatory,
- that new TASER technology be acquired,
- that drug use behavioural training be improved (specifically training regarding agitated delirium), and
- that restraint protocols are examined.

It was recommended that all of the aforementioned agencies plan and fund the implementation and construction of a safe, secure treatment room in the emergency department at the Prince George Regional Hospital. The room would be designated for treatment of violent, combative or resistant individuals who may require medical treatment and are in the custody of Peace Officers.

It was further recommended to the **RCMP** in Prince George that Emergency Health Services is called to attend to any situation involving an individual exhibiting behaviour consistent with symptoms of agitated delirium. It was also recommended that the **RCMP** Drug Awareness and Resistance Education (DARE) program develop a component on agitated delirium to deliver to Prince George students.

Response to recommendations:

The **RCMP Deputy Commissioner** responded to the recommendations from the preliminary report. The recommendation regarding TASER use was directed to the **Community, Contract and Aboriginal Policing Services (CCAPS)**. **CCAPS** is awaiting the outcome of two studies regarding standardization of TASER training. The Commissioner responded that mandatory reporting of TASER use will soon be reinstated. The Commissioner also replied that behavioural training was to be discussed by a newly formed "Use of Force Working Group" and an instructional video would be developed for use of the cord cuff restraint device.

Police Shooting

Case 1 of 3

On January 12th, 2004, an inquest was held in Burnaby, BC, into the death of a 46-year-old male who died on December 7th, 2002, due to multiple gunshot wounds.

A few days prior to the incident, the man arrived in Vancouver from Toronto. While seated in a stolen vehicle, he was confronted by two Vancouver Police Department members. With a firearm drawn, an officer commanded him to put his hands up. In non-compliance, the man locked the car door and appeared to try to start the vehicle. The officer testified at the inquest that the man later pulled out a glass crack pipe. The officer then broke the window with a baton. A second officer noticed a handgun in the man's jacket. The man realized that the butt of the gun was visible and reached into his jacket. An officer testified at the inquest that he discharged his firearm, as he feared for his safety and that of the other officer. The handgun was later discovered to be a plastic replica handgun.

It was reported at the inquest that toxicological analysis revealed the presence of methadone, cocaine and diazepam. The jury heard that the combination of the high levels of methadone and cocaine would have affected the man's ability to think clearly, rationally and obey commands.

The jury found that the death was due to multiple gunshot wounds and classified the death as a Homicide.

Recommendations:

A total of six recommendations were made by the jury and were directed to the **Minister of Public Safety and Solicitor General**, the **Justice Institute of British Columbia** and the **Vancouver Police Department (VPD)**.

Three recommendations to the **Minister of Public Safety and Solicitor General** were as follows:

- that a special investigations unit be established, independent of the police to investigate incidents involving police which result in serious injury, assault or death;
- that incidents involving the police which result in serious injury, assault or death are investigated by members of a police investigation team independent of the police force under investigation; and
- that a specific protocol be developed related to the investigation of police shootings.

It was recommended to the **Justice Institute of British Columbia** that the training program of officers is improved to include training that simulates real life situations.

The **VPD** received the following recommendations:

- that video cameras are installed in all police vehicles, or at least in any police vehicle occupied by only a single police officer, and
- that high risk areas in Vancouver are identified and patrolled by an officer with at least one other officer or a canine.

Response to recommendations:

The **Minister of Public Safety and Solicitor General** responded that he will not be taking any action at this time regarding the recommendations. The Minister stated that previously, during a Commission of Inquiry into policing in British Columbia, a structure similar to a special investigations unit had been considered. However, a decision was made to create the Office of the Police Complaint Commissioner, which is an independent office. The Minister also replied that the provincial *Use of Force Regulation* contains provisions regarding reporting and investigation of police shootings.

The **VPD** responded that they could not make a sound fiscal case clearly showing that the installation of video cameras would significantly enhance their operations. The **VPD** also stated that this particular incident could not have been significantly different had more officers been present, but that a minimum of 60% of the cars deployed are deployed as two-person cars.

Case 2 of 3

On October 4th, 2004, an inquest was held in Alert Bay, BC, into the death of a 40-year-old female who died on February 28th, 2003, due to gunshot wounds to the chest.

An officer had been sent to the home of the woman in response to a report of a domestic altercation. There are four members of the RCMP detachment at Alert Bay, two of whom must be on Comorant Island, where the incident occurred. The officer had been at the residence earlier that evening for the same reason but found no altercation. At that time, a

young girl had answered the door. The second time, the officer saw three people in the home. He witnessed the woman striking someone and threatening them with his life if he opened the door for police. The officer stated he could not gain access into the home although he tried to kick down the door. Through the back door the officer saw the woman with a knife making slashing stabs towards a male. Another male opened the door for the officer. The officer yelled at the woman to drop the knife, who then came toward the officer with the knife. The officer then shot her when she was three to five feet from him.

One of the men present at the home, an acquaintance of the couple, testified that he was threatened by the woman with a knife not to open the door for police. He heard her say that she was not going to let anybody take her kids. A Youth Outreach worker also testified that he had heard the gunshot and had previously visited the home for child protection issues.

At the inquest, the officer stated that he had aimed at the centre mass of the woman, as he was not trained to fire a warning shot. A back-up officer arrived and the two officers transported the woman to the hospital as they believed it would be faster than calling for an ambulance. The officer testified that he had received training in how to investigate domestic disputes.

At the inquest it was revealed from toxicological analysis that the woman's blood alcohol concentration was 180 mg%. The pathologist stated that in general, this level is associated with inebriation.

The jury found that the death was due to massive blood loss, due to a gunshot wound to the chest and classified the death as a Homicide.

Recommendations:

A total of four recommendations were made by the jury and were directed to the **RCMP Deputy Commissioner Pacific Region and Commanding Officer, "E" Division** and the **Alert Bay RCMP Detachment.**

It was recommended to the **Deputy Commissioner** that all RCMP officers receive extensive training in conflict resolution to better able them to assess and judge risk and apply necessary intervention in a disturbance.

Three recommendations were directed to the **Alert Bay RCMP** detachment as follows:

- that when an officer is called out to a disturbance, open radio contact be established and maintained with an officer on Cormorant Island until the called out officer is back at the station,
- that when officers stationed on Cormorant Island are not available, another officer from another detachment be brought in, and
- that all local RCMP review all resource manuals made available by the Namgis and Whe-La-La-U Nations and that this information be kept current.

Response to recommendations:

In response to the recommendations the **Alert Bay RCMP** detachment replied that keeping open radio contact is impractical. However, it was stated that all members have cell phones and when at all possible, two members attend all calls of domestic disputes or violence. It was further stated that it was impractical to have a member from another detachment available if needed, as the RCMP is lacking the personnel required. However, the detachment strictly ensures that at least two members are on the island at all times, even if they are on days off. It was also added that the detachment was scheduled to add a new First Nations position in the fall to address the number of members available at any one time. Finally, the detachment stated that manuals outlining the resources and policies of the community were already present. However, plans were underway to make an orientation package for new members to acquaint themselves with the community.

Case 3 of 3

On November 8th, 2004, an inquest was held in Victoria, BC, into the death of a 52-year-old male who died on February 24th, 2004, due to massive blood loss.

On the day of his death, the man had an appointment with his probation officer, but told his wife he wasn't going. His wife observed him pacing in the home and also observed him tuck a knife into his waist band. His wife went to a pay phone and called her sister who called 911. Three officers arrived at the man's home and attempted to engage

him in conversation. A side door was found ajar and when an officer pushed it open he observed the man with a knife. The man did not comply with requests to drop the knife. A second officer fired two shots from a TASER without effect on the man who had visible cuts on his neck and had a bloody knife. The man then moved toward one of the officers. A third officer fired two shots and the first officer fired one shot when the man was six to eight feet away. An ambulance was standing by at the scene at a safe distance and began treatment after officers had granted permission.

At the inquest, a clinical psychologist testified regarding a Crisis Intervention Team model that is often taught to officers, which results in fewer incarcerations, involuntary commitments and criminal offences.

Toxicological analysis revealed the presence of methadone. However, the pathologist stated that this level was not high in consideration of the fact that the man was registered in the Methadone Maintenance Program.

The jury found that the death was due to massive blood loss, due to multiple gun shot wounds and classified the death as a Homicide.

Recommendations:

A total of three recommendations were directed to all of the following: **Vancouver Island Health Authority,** the **RCMP Deputy Commissioner Pacific Region and Commanding Officer, "E" Division,** the **Minister of State for Mental Health and Addiction Services,** the **West Shore RCMP detachment**, and the **RCMP Commissioner (headquarters)**.

It was recommended that:

- there be continued support and increased funding for initiatives involving collaboration between peace officers, mental health professionals, and funding agencies;
- first responders in crisis situations be made aware of available resources; and
- a formal review be conducted of the Crisis Intervention Team model and its potential benefits to peace officers, health professionals and the community at large.

Response to recommendations:

The **West Shore RCMP** detachment responded that they have taken several steps toward compliance with the recommendations. Specifically, the detachment stated that they have endorsed the Integrated Mobile Crisis Response Team and would like to have this team work within their jurisdiction. Furthermore, front line supervisors were provided with information and encouraged to use the Crisis Team services. The Crisis Team has also had the opportunity to explain their services with members of the West Shore detachment. Information on this team has also been added to the orientation package.

The **RCMP headquarters** in Ottawa responded that the recommendations were more appropriately addressed by the **RCMP Deputy Commissioner** and re-directed the recommendations.

The **Vancouver Island Health Authority** responded that each recommendation had been specifically addressed and that changes were made to diminish the likelihood of a similar death occurring in the future.

Drowning

Case 1 of 1

On May 17th, 2004, an inquest was held in Burnaby, BC, into the deaths of five individuals, a 32-year-old male, a 40-year-old male, a 37-year-old female, a 12-year-old female and a 9-year-old male. These five individuals all died on August 13th, 2002 due to the capsizing of a boat, the Cap Rouge II.

The Cap Rouge II was a fishing vessel returning from a fishery in Juan De Fuca Strait en route to the Steveston docks in Richmond. The vessel capsized suddenly and without warning at the entrance to the Fraser River. Two of the seven passengers were able to abandon the vessel, while five individuals remained with the vessel and did not survive.

At the inquest, the master of the Cap Rouge II testified that the vessel was fitted with a large seine net and was packed with salmon. Suddenly, the vessel started to list to the right and an attempt to transfer water within the fish hold did not counter the list. The master jumped into and started the smaller escape vessel that the Cap Rouge II was towing. However, the vessel completely capsized with the

crew still on board. One crew member was found floating in the water and was pulled to safety.

It was revealed at the inquest that a sailing vessel nearby had witnessed the capsizing and called in a mayday. A Canadian Coast Guard (CCG) hovercraft was in training and responded to the mayday and made a call to the Department of National Defence for penetration divers from the 442 Squadron to attend the scene. The CCG divers onboard the hovercraft had an explicit directive not to participate in penetration dives. However, the CCG divers were able to conduct an external search of the capsized vessel and recovered the body of a 32-year old male.

The 442 Squadron entered the water approximately two hours after the capsizing and removed the bodies of three victims from the vessel (a 40-year-old male, a 37-year-old female, and a 9-year-old male). The vessel was towed and stabilized, allowing for the recovery of the final victim (a 12-year-old female).

At the inquest, various individuals testified regarding modifications that had been done to the vessel, inspections of and stability of the vessel. It was heard that some of the modifications made to the vessel may have negatively impacted the stability of the vessel. It was revealed that previous recommendations resulting from inquests regarding inspections and stability had not been fully implemented by Transport Canada Marine Safety. Transport Canada Safety and Security testified that it would revise a directive to vessel owners requiring the reporting of modifications to Transport Canada on all fishing vessels.

The jury found that the deaths were due to drowning, due to capsizing of the Cap Rouge II and classified the deaths as Accidental.

Recommendations:

A total of 22 recommendations were made; 17 were made by the jury and five were made by the presiding Coroner. The recommendations were directed to the **Canadian Coast Guard (CCG), Safety** and **Security-Transport Canada, Department of Fisheries and Oceans** and the **Workers' Compensation Board (WCB,** presently **WorkSafeBC)**.

Five recommendations were made to the **CCG** regarding the maintenance, staffing and equipping of a Rescue Dive Program. Recommendations were also made regarding the communication of policy changes within and between the **CCG** and Department of National Defence Search and Rescue Team.

Five recommendations were directed to **Transport Canada**. The jury recommended that Transport Canada require a roll period test of all small fishing vessels without stability data. The presiding Coroner suggested that this recommendation could be strengthened by requiring that small fishing vessels at risk undergo full stability assessment.

The presiding Coroner further recommended the following:

- that a safe maximum load line be placed on the vessel,
- that an annual letter be sent to small fishing vessel owners to help create a safety-first culture among the fishermen,
- that **Transport Canada** encourage inspectors to communicate directly with the master and/or vessel owner regarding their findings, and
- that all small fishing vessels be required to record all maintenance/modification into a log that remains with the operating vessel.

Further recommendations made by the jury suggested that the contents of a pre-inspection report to be used as base line data. It was also recommended that **Transport Canada** encourage fishing vessel operators to consider several listed safety points.

Five recommendations were directed to the **Department of Fisheries and Oceans**. Three of these recommendations suggested coordination with **Transport Canada**. The recommendations were as follows:

- that a national strategy be developed for establishing, maintaining and promoting a safety culture within the fishing industry,
- that adoption of a code of best practices for small fishing vessels be encouraged through education and awareness programs to reduce unsafe practices,
- that all small fishing vessel masters, and in some cases crew members, undertake immersion drills in a capsized container,

- that in the next 10 years, Small Fishing Vessel (SFV) Masters Certification be linked with an ability to swim, and
- that training for the above certification present theories and principles in a manner that is practical and understandable for fishermen.

Several recommendations were directed to the **WCB** as follows:

- that emergency training drills and procedures are practiced and logged annually,
- that a survival course should be developed for all SFV masters and crew members to understand the dangers of sudden cold water immersion, and
- that the **WCB** consider the jury's recommendation in partnership with other relevant agencies and/or individuals.

The presiding Coroner further recommended that **WCB** develop and present education materials for small fishing vessels, including entrapment and man overboard situations.

Response to recommendations:

Transport Canada responded to all of the recommendations made by the jury. While most responses were positive, some recommendations were left for future consideration or deemed too difficult to implement. Transport Canada responded with the following:

- that inspection requirements are being reviewed for small fishing vessels and will be amended if appropriate to include verification of vessel stability,
- that the Ship Inspection Reporting System will be updated to include a field on vessel modifications and stability assessment,
- that digital photography by inspectors will be considered as a potential requirement,
- that a self-check program will be implemented whereby owners of fishing vessels will be required to complete an annual safety checklist and will be issued decals,
- that a project has been initiated as part of the *Canada Shipping Act* 2001 regulatory reform on fishing vessel safety,
- that proposed new stability test requirements are scheduled to come into effect in 2006,
- that the publication *Small Fishing Vessel Safety Manual* contains information on safety issues for fishing vessels and a draft document contains additional information on stability,
- that new *Fishing Vessel Safety Regulations* will come into effect in late 2006 and will reference a document titled *Small Fishing Vessel Standard*, and
- that Transport Canada has engaged in several activities to foster a safety-first culture in the fishing industry.

The **Department of Fisheries and Oceans** responded positively to all the recommendations with one exception. The recommendations were accepted and in place at the time of response, except for the recommendation that the **CCG** equip a hovercraft with the same set of advanced life support apparatus as an ambulance. It was suggested that ambulance crews are better trained and certified to a higher standard and that the recommendation exceeds the mandate of the **CCG**.

The **WCB** responded to the recommendations outlining the programs, initiatives and alliances with related agencies regarding occupational health and safety in the fishing industry. These were already in place at the time the recommendations were made. However, in collaboration with the BC Seafood Alliance, the WCB will explore the development of a fishing-specific health and safety program.

Murder-Suicide

Case 1 of 1

On September 27th, 2004, an inquest was held in Burnaby, BC, into the death of a 41-year-old female (woman A), her mother, a 67-year-old female (woman B), and her husband, a 52-year-old male. Both women died on May 20th, 2003 while the man died on May 23th, 2003. All three individuals died due to gunshot wounds.

Woman A and the man were married in 2002. In 2003, woman A was diagnosed with multiple sclerosis and was hospitalized. While in hospital she admitted to her sister and mother (woman B) that she had been threatened by her husband for some time and she had decided to go to the police as she feared for her safety.

At the inquest it was revealed that a newly recruited RCMP officer received their complaint at the local

detachment. Although previously supervised by a field coach, as it typically the case for new recruits, this RCMP officer was no longer under such supervision. The recruit took a statement at the hospital from woman A on audiotape and also wrote notes. The officer later completed a background and firearms check on her husband which revealed ownership of five registered firearms. It was later decided that no charges could be laid against him and the file was closed.

Woman A took immediate steps to obtain a lawyer to begin divorce proceedings and to obtain a restraining order against her husband. A social worker at the hospital told woman A to inform the hospital when the restraining order was in place as that gave them the authority to remove her husband from the hospital.

Once in place, the nurses at the hospital informed hospital security of the restraining order. Security advised the nursing staff to contact them immediately if woman A's husband was on the premises. Later, when her husband appeared at the hospital, security was called, who then advised that the police be called. Security observed the man fire a gun in the direction of woman B and heard additional shots. Both women died at the scene, and the man fled the scene.

Two days later police located the man with the aid of tracking dogs, in a wooded area. It was stated at the inquest that the man shot himself in the abdomen upon being found by a tracking dog, although the reported suicide was not witnessed. The man was without vital signs when he was assessed by an ambulance crew.

The jury found that the deaths of women A and B were due to gunshot wounds to the head and classified their deaths as Homicides. The jury also found that the death of the man was due to a gunshot wound and classified the death as Undetermined.

Recommendations:

A total of 10 recommendations were made by the jury and were directed to the **RCMP Headquarters** and to the **Minister of Health Services**.

Eight recommendations directed to the **RCMP** focused on increasing the supervision of new recruits by field supervisors. A second focus was the improvement of the **RCMP** policy on dealing with "Violence in Relationships" and in training new recruits on this policy.

It was recommended to the **Minister of Health Services** that hospitals have written policies and training to deal with serious incidents, including restraining orders and that BC hospital patients should be informed in writing of options available to them if they feel at risk.

Response to recommendations:

RCMP Headquarters re-directed the recommendations to the local RCMP detachment. The **RCMP "E" Division** responded that they would be consulting with the policy unit in Ottawa regarding the recommendations and responding again at a later date.

The **Minister of Health Services** responded with a copy of the approved policy on serious incidents entitled *Prevention and Management of Aggression and Violence in the BC Health System*. This policy was communicated and was being implemented in all health authorities in B.C. at the time of the response.

Ministry of Public Safety and Solicitor General
Emergency Management BC
BC Coroners Service