THE BC CORONERS SERVICE ANNUAL REPORT (2005)

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For more information or additional copies of this report, please contact:

Office of the Chief Coroner
Suite 2035 - 4720 Kingsway
Burnaby, BC V5H 4N2

Tel: (604) 660-7745
Fax: (604) 660-7766

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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; and

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 2005, the BCCS ordered 1,917 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 2005, 1,876 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.

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.

[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

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[3]

In 2005, BC Coroners sent approximately 275 recommendations from inquests and Coroner's inquiries to private agencies, as well as agencies and ministries of government, addressing a variety of public safety issues. The BCCS had a 64% response rate to recommendations that were sent for action (i.e., requiring a response), with 80% 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.

[3] The BCCS operates in a 'live' database environment. Therefore, statistics are subject to change as responses to recommendations are received and data is updated.

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 drowning 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 investigation of the Coroner serves the purpose of answering who the deceased was and when, where, and by what means their 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. 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	1,314
Homicide	102
Natural	5,615
Suicide	484
Undetermined	188
Total	**7,703**

Regional Distribution

Region	ACCIDENT	HOMICIDE	NATURAL	SUICIDE	UNDETERMINED
Fraser	299	42	1,505	138	43
Interior	310	16	1,338	100	42
Island	266	9	1,302	105	39
Metro	281	26	1,076	98	40
Northern	158	9	394	43	24
Total	**1,314**	**102**	**5,615**	**484**	**188**

Regional Caseload

Region	2005	2004	2003	2002	2001	2000[4]
Fraser	2,027	1,703	1,786	1,779	1,920	1,973
Interior	1,806	1,738	1,746	1,616	1,361	1,422
Island	1,721	1,695	1,618	1,596	1,443	1,364
Metro	1,521	1,361	1,315	1,455	1,279	1,260
Northern	628	620	638	599	526	579
Total	**7,703**	**7,117**	**7,103**	**7,045**	**6,529**	**6,598**

[4] 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		
	Hang Glider	1
	Other Aircraft	7
	Ultra-Light Aircraft	2
LAND		
	Horseback Riding/Polo	1
	Hunting	1
	Motobike/ATV/Offroad	7
	Mountain Biking	1
	Street Bike	1
SNOW	Heliskiing	2
	Snowboarding	3
	Snowmobiling	8
	Snowskiing	6
WATER		
	Canoe	1
	Dinghy (Boating)	2
	Diving	2
	Fishing	4
	Kayak	1
	Power Boating	4
	Sailboat/Sailboard	2
	Scuba Diving	4
	Swimming	8
	White-Water Rafting	1
OTHER		
	All other	7
	Total	**84**

Occupational	Cases
Business Site	3
Commercial Hunting/Fishing/Other Vessel	4
Commercial Scuba Diving	1
Construction Site: Commercial	3
Construction Site: Residential	6
Electrical/Powerlines	1
Excavating/Paving/Grading	4
Farm Worksite	2
Forestry Sites	26
Helicopter Logging	3
Industrial	8
Industrial - Material Handling	1
Mine, Quarry, or Oil/Gas	4
Other Place of Work	10
Policing - Police Officer	1
Railway Sites	3
Yardwork	3
Total	**83**

Other Accidents	Cases
Motor Vehicle	454
Alcohol/Drug Poisoning	324
Fall	190
Other	41
Airway obstruction	35
Fire	28
Not yet determined	26
Exposure	14
Drowning[5]	13
Air Crash	12
Skytrain or railway	5
Carbon monoxide	5
Total	**1147**

[5] Does not include drownings counted in the Recreational category, i.e., swimming

ACCIDENTAL MOTOR VEHICLE DEATHS

Victim Type

Victim Type	Cases
Driver	208
Passenger	102
Commercial Truck Driver	11
Commercial Truck Passenger	1
Motorcycle / Moped	48
Pedestrian	68
Pedal Cyclist	7
Other	9
Total	**454**

Regional Distribution

Victim Type	Fraser	Interior	Island	Metro	North
Driver	57	62	25	26	38
Passenger	25	29	21	9	18
Commercial Truck Driver	2	3	0	0	6
Commercial Truck Passenger	0	1	0	0	0
Motorcycle / Moped	14	18	9	4	3
Pedestrian	21	11	5	26	5
Pedal Cyclist	4	1	0	1	1
Other	0	7	1	0	1
Total	**123**	**132**	**61**	**66**	**72**

CHILD DEATHS (Ages 0 – 18 yrs)

Total Cases Reported

Death Class	2005	2004	2003	2002	2001
Accident	61	69	100	88	95
Homicide	5	5	10	13	5
Natural	70	53	75	59	67
Suicide	14	25	19	24	11
Undetermined	36	22	24	27	15
Total	**186**	**174**	**228**	**211**	**193**

Age Distribution

Age Group	2005	2004	2003	2002	2001
0 to 11 months	69	57	65	59	48
1 to 4 years	17	15	30	20	23
5 to 9 years	10	10	18	18	20
10 to 14 years	21	24	27	37	24
15 to 18 years	69	68	88	77	78
Total	**186**	**174**	**228**	**211**	**193**

Accidental Child Deaths by Means of Death[6]

Means of Death	2005	2004	2003	2002	2001
Motor Vehicle Accident	35	35	62	47	41
Drowning	9	7	11	9	12
Alcohol / Drug Poisoning	5	5	3	4	5
Airway Obstruction	0	4	5	3	3
Fall	2	2	1	3	3
Fire	1	2	1	2	13
Exposure	1	2	0	1	2
Dirt Bike / ATV / Snowmobile	1	3	2	1	5
Other	7	9	15	18	11
Total	**61**	**69**	**100**	**88**	**95**

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

SUICIDE DEATHS

Suicide Rate per 100,000 persons

Case Year	Cases	Rate per 100,000
2005	484	11.4
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

Age Category

Age Category	2005	2004	2003	2002	2001
12 and under	0	1	1	2	0
13 - 19 years	19	27	28	29	15
20 - 29 years	57	71	71	71	55
30 - 39 years	90	96	104	97	99
40 - 49 years	112	105	102	131	116
50 - 59 years	106	108	78	101	95
60 - 69 years	40	52	47	51	43
70 - 79 years	38	36	29	37	28
80 and over	22	29	18	18	19
Total	**484**	**525**	**478**	**537**	**470**

Gender	2005	2004	2003	2002	2001
Female	135	127	120	132	107
Male	349	398	358	405	363
Total	**484**	**525**	**478**	**537**	**470**

Region	2005	2004	2003	2002	2001
Fraser	138	135	129	154	147
Interior	100	112	93	107	94
Island	105	109	92	104	81
Metro	98	124	124	132	110
Northern	43	45	40	40	38
Total	**484**	**525**	**478**	**537**	**470**

Suicides by Method of Death	2005	2004	2003	2002	2001
Hanging	152	163	155	167	123
Suffocation / Smothering / Other	20	15	15	13	8
Carbon Monoxide Poisoning	44	43	37	42	40
Drowning	21	19	19	31	20
Fall	27	27	28	36	35
Firearms	83	86	84	90	90
Stabbing / Incised Injuries	12	30	17	15	23
Alcohol / Drug Poisoning	103	107	96	114	111
Other Poisoning	5	6	5	6	6
Skytrain or Railway	5	4	6	2	6
Motor Vehicle Accident	6	7	5	8	1
Fire	1	3	4	3	4
Other	5	15	7	10	3
Total	**484**	**525**	**478**	**537**	**470**

ILLICIT DRUG DEATHS

Year	Total
2005	211
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

REGION	2005	2004	2003	2002	2001
Fraser	60	48	55	47	74
Interior	30	27	34	23	25
Island	49	37	37	40	45
Metro	62	71	58	53	94
Northern	10	10	6	7	8
Yearly Total	**211**	**193**	**190**	**170**	**246**

GENDER	2005	2004	2003	2002	2001
Female	52	45	38	40	53
Male	159	148	152	130	193
Yearly Total	**211**	**193**	**190**	**170**	**246**

AGE	2005	2004	2003	2002	2001
20 and under	7	8	7	5	7
21 - 30	38	43	34	39	52
31 - 40	63	57	49	56	97
41 - 50	73	57	72	56	65
51 - 60	26	26	22	12	19
Over 60	4	2	6	2	6
Yearly Total	**211**	**193**	**190**	**170**	**246**

INQUESTS (2005)

Statistics

Classification of Death (number of fatalities)

Natural	3
Accident	7
Suicide	2
Homicide	3
Undetermined	0

Type of Death (number of fatalities)

Police Custody	
Arrest- No Lock-up	4
Arrest -Cell Lock-up	3
Drunk Tank	1
Police Shooting	4
Pursuit	1
Custody- Federal Correctional Facility	1
Other	1
Total # of fatalities	15

Total # of days	42

Summaries

In 2005, the BCCS held 15 inquests for the deaths of 15 individuals. The inquests resulted in a total of 43 recommendations, addressing a variety of issues. Included here is a summary of these inquests, the recommendations made by the jury and the responses provided by the relevant agencies to these recommendations. These inquest descriptions are categorized by the type of death.

Custody-Federal Correctional Facility

Case 1 of 1

On February 16th, 2005 an inquest was held in Chilliwack, BC, into the death of a 46-year old male who died on September 23rd, 2002, due to massive internal hemorrhage.

The man was serving a lengthy federal sentence at Mountain Institution. In early September 2002, the man was informed that he and other inmates at the facility would be required to share their cells (i.e., double-bunk) as inmates were being transferred from another facility due to a change in security classification. However, there were criteria that would allow an inmate to be considered for exemption of double-bunking. The man attended the Health Care Unit and spoke with a nurse and advised her that he was upset about the double-bunking and wished to be exempt because of his chronic headaches. The man was receiving medication for his migraines and received this medication in seven day supplies. He also stated he would take action to ensure his cell was not shared. The nurse was concerned by this and completed an Observation Report for submission to the Correctional Supervisor.

The man also relayed his concerns regarding the double-bunking to his parole officer, but declined an assessment by a psychologist. The man's behaviour was unusual for him and was discussed at staff briefings. The man was not selected to be exempt from double bunking.

A few days before his death, the man approached a correctional officer and asked that his cat be sent to his family as he was to be double bunked. The next day the cat was picked up and the man was visibly upset. The correctional officer contacted an inmate peer counsellor to speak with him. When asked if he

was going to hurt himself, he responded no and agreed to meet again. The peer counsellor reported back to the correctional officer that the man was in a better frame of mind. However, the man was again discussed at the next staff briefing and was to be monitored for any unusual activity.

On the evening of September 22nd a correctional officer conducted a count of the inmates. The officer testified at inquest that he did not observe the man in his cell, but continued on to complete the count. He returned to the man's cell location and called the centre console to advise that he could not been seen in his cell. The centre console officer immediately called for assistance.

The man was discovered unresponsive and was face down on the floor in his cell. The correctional officer with the most recent training initiated CPR. Ambulance paramedics arrived, but efforts were not successful. A two page handwritten note was found in the cell indicating the man's despondency and wish to end his life.

An autopsy did not reveal any natural disease process or trauma. A toxicologist advised the jury that analysis of post-mortem specimens indicated the presence of lethal amounts of prescribed medication.

A warden at the correctional facility informed the jury that since the man's death, CPR training and skill maintenance are now required for all correctional officers and supervisors.

The jury found that the death was due to acute multi-drug ingestion and classified the death as a Suicide.

Recommendations:

The jury made a total of five recommendations. Recommendations were directed to the **Commissioner of Correctional Services Canada** and the **Warden of Mountain Institution.**

It was recommended to the **Commissioner** that a registered nurse be on staff 24 hours a day, seven days a week. It was also recommended prescription drugs that could be lethal should never be given to an inmate for self-administration. Finally, it was recommended that simulations of emergency situations are implemented for first aid trained personnel in correctional facilities.

A recommendation was made to the **Warden at Mountain Institution** to implement a system to define various levels of monitoring of inmates and that copies of definitions be included in Standing Orders. It was also recommended that the person who conducts the "count" calls in the "count".

Response to Recommendations:

The **Commissioner of Correctional Service Canada** responded to each of the five recommendations. The response indicated that inmates have access to Health Services on a 24-hour basis and that each emergency is dealt with in a manner consistent with the level of service available to Canadian citizens. However, it was noted that the policy on Health Services was revised to add the obligations to provide first aid/CPR, to notify health services and to call for an ambulance. The commissioner responded that his office agreed with the remaining four recommendations. For example, medical scenarios were added to the Crisis Management Training Program.

Police Custody – Arrest-No Lock-up

Case 1 of 4

On May 2nd, 2005, an inquest was held in Smithers, BC, into the death of a 55-year old male who died on July 26th, 2004, due to a single gunshot wound.

The man was serving a conditional sentence order which required him to be confined to his residence 24 hours a day. However, his probation officer could allow him to leave his residence at specified times.

On July 26th, his probation officer decided to conduct a home visit after receiving information that the man may have violated conditions of his Sentence Order. The information indicated that while on approved leave, he violated the order to abstain from alcohol and not to have any contact with females under 16 years of age. It was also reported that he was in possession of a handgun.

The probation officer checked for updated conditions or restrictions prior to the visit and found firearms prohibition for the man on his file. She contacted Houston RCMP and requested their assistance at the home visit.

Upon arrival at the home, the man stated that he only had a BB gun and no other firearms and showed it to the officers. The police officers searched the home while the probation officer spoke with the man in the living room. In discussion with the probation officer, the man acknowledged that he had violated two orders while on leave and he did not have a handgun as was reported to the probation officer. The probation officer informed him that she would have to further investigate the circumstances and that there was a possibility that he could be breached for these infractions. The man then reached beside him into the side of the couch and pulled out a handgun. The probation officer left the room when she saw the handgun and heard a shot fired after she left the room.

The police officers called for an ambulance and performed two-person CPR. Resuscitative efforts were continued by ambulance personnel but were not successful.

The jury found that the death was due to a self-inflicted gunshot wound to the chest and classified the death as a Suicide.

Recommendations:

The jury made a total of three recommendations to the **Assistant Deputy Minister of Police Services and Public Safety**, the **Assistant Deputy Minister of the Corrections Branch**, and the **Assistant Deputy Minister of Court Services**, as well as the **Attorney General of BC**.

It was recommended to the **Assistant Deputy Minister, Police Services and Public Safety** that a standardized procedure should exist in any weapons search policy to determine if there are any prior gun-related offences.

It was recommended to all of the **Assistant Deputy Ministers** that better and more efficient interdepartmental links are established to ensure quicker access to information relevant to home visits for RCMP, Community Corrections and BC Court Services.

Finally, it was recommended to the **Attorney General** that before a conditional sentence is imposed, consideration be given to conditions of the Order relating to length of sentence and impact on the individual's mental state.

Response to recommendations:

The **Chief Judge of BC** responded to the recommendation forwarded to him by the **Attorney General**. The **Chief Judge** responded that the jury's recommendation did not disclose any practice not already required by law or any current practice of sentencing judges.

The **Assistant Deputy Minister of the Corrections Branch** responded that in February, 2005 the Corrections Branch launched Cornet, a web-based integrated client management system. In addition to improving system functionality, Cornet enables an electronic interface with the Court Service Justice Information System (JUSTIN). This interface significantly improves access to information entered by Court Services and Crown Counsel.

Case 2 of 4

On August 16th, 2005, an inquest was held in Penticton, BC, into the death of a 36-year old male who died on July 20th, 2004, due to congestive heart failure, diffuse cerebral edema consistent with acute cardiac arrhythmia.

The man had chronic, severe, back pain and presented at the emergency department with a complaint of back pain. He had been transported to hospital via ambulance. He was administered medication for pain relief. His x-rays were normal and he was to be released with a prescription for an anti-inflammatory drug.

Nursing notes indicate that the man was preparing for discharge at 1745 hours when it was noticed that a small square of paper fell from his clothing onto the floor. He retrieved this paper "flap" which is believed to have contained methamphetamine.

An hour later the man was being assessed by a physician when he became delirious and uncooperative. He made comments indicating that he believed the doctor was a police officer. The decision was made to admit him to hospital.

Over two lours later, the man ran out of the emergency department and was seen leaving the hospital property. The RCMP was contacted to assist with his return. At inquest, two witnesses reported that the man was taken into custody by police in a field near their hotel without incident. Three officers approached him in a field and they

testified that they handcuffed him behind his back and waited for an ambulance. The man became unresponsive while emergency personnel were preparing to place him into the ambulance. Resuscitative protocols were initiated but were unsuccessful.

An autopsy was performed and revealed congestive heart failure, cerebral edema with acute cardiac arrhythmia secondary to a lethal level of methamphetamine.

The jury found that the death was due to congestive heart failure, and diffuse cerebral edema consistent with acute cardiac arrhythmia as a consequence of a lethal level of methamphetamine and classified the death as Accidental.

Recommendations:

The jury made one recommendation to the **Interior Health Authority** to provide adequate training to Emergency Room staff on both the recognition of the packaging of illicit street drugs and of the symptoms and behaviours caused by the use of illicit street drugs.

Response to Recommendations:

The **Interior Health Authority** responded that the RCMP detachment in Penticton was contacted and an education session was scheduled for the ER staff and Physicians of Penticton Regional Hospital. The education session would be directed at identifying symptoms of illicit street drug use and packaging of these drugs.

Case 3 of 4

On September 19th, 2005, an inquest was held in Kamloops, BC, into the death of a 32-year old male who died on July 16th, 2004, due to a cocaine overdose.

The man was arrested and subsequently released for being intoxicated in a public place. An officer testified that he did not exhibit signs of intoxication or abnormal behaviour at the time of his release. However, a civilian guard testified that he appeared paranoid.

Later in the day, following his release, the man was observed running through traffic and in and out of places of business before finally seating himself on the roadway at an intersection. Two officers arrived at the intersection and witnesses observed an officer directing the man to roll onto his stomach and handcuff him without incident. At inquest, one officer testified that the man said he wanted to be taken to jail as someone was attempting to assault him. He also denied taking any drugs. While walking to the vehicle with officers, the man collapsed. He was carried to the vehicle and again denied consuming any illicit drugs. One officer testified that the man had wide open eyes and a white pasty substance on his lips. An ambulance was requested but it was decided that it would be faster to meet the ambulance crew at the detachment. Upon arrival at the detachment the man was unresponsive and officers began CPR until the ambulance arrived to transport him to hospital.

An autopsy revealed acute pulmonary congestion and edema and acute congestion of the liver consistent with heart failure. Toxicological analysis revealed a blood concentration of cocaine and its metabolite that exceeded the minimum lethal level. The autopsy and toxicological findings confirmed that the death was the result of a cocaine overdose.

The jury found that the death was due to a cocaine overdose and classified the death as Accidental.

Recommendations

A total of two recommendations were made, one to the **RCMP Deputy Commissioner Pacific Region and Commanding Officer, "E" Division** and one to the **Manager, Policy, Legal and Risk Management of the BC Ambulance Service (BCAS)**. Respectively, the recommendations were to upgrade and refresh the drug overdose protocol and that Advanced Life Support personnel are dispatched to possible full arrest situations.

Response to Recommendations:

The **BCAS** responded that had an Advanced Life Support (ALS) crew been available, the ALS crew may have been dispatched in addition to the ambulance crew that was dispatched. An important consideration in dispatching both crews would have been the ALS crew's ability to respond in a timeframe comparable to the responding crew's ability to transport the patient to the hospital. In this particular incident, the BCAS indicated that considering the proximity of the hospital, the responding crew determined the best course of

action was to immediately transport the man rather than summon an ALS team.

Case 4 of 4

On November 28th, 2005, an inquest was held in Burnaby, BC, into the death of a 25-year old male whose death on May 1st, 2004 was consistent with restraint-associated cardiac arrest.

The man's behaviour was noted by his girlfriend and another friend to be agitated and abusive and potentially dangerous to himself. A 911 call was placed and an ambulance initially dispatched. However, police intervention was requested when it was determined that the man was behaving irrationally.

The Vancouver Police were the first to arrive on the scene. At the inquest, officers stated that the man appeared sweaty, was not speaking coherently, was tense and was clenching his jaw. He did not consistently follow police instructions and therefore, a TASER was used. After two shocks from a TASER, the man was temporarily incapacitated and officers were able to handcuff him behind his back. However, he continued to struggle with police. The officers testified that the man exhibited superhuman strength. After five minutes of struggling with police he became unresponsive and a pulse could not be found. Paramedics, who had been waiting outside the apartment entered and started cardiopulmonary resuscitation, though unsuccessful.

An autopsy was conducted by a forensic pathologist. At the inquest, the pathologist testified that there were scrapes and bruises to the extremities of the deceased. She also reported that there was no evidence that the use of the TASER contributed to the death. There was also no evidence of any natural disease.

A toxicologist reviewed the effects of cocaine on the body and described the signs of excited delirium. Blood samples taken on admission of the man to hospital indicated a concentration of cocaine and its metabolite that was 11 times the minimum lethal level. It was also noted at the inquest that the blood samples were not collected in a container that stops the continued metabolism of cocaine. A toxicologist testified at the inquest that at the time of the man's cardiac arrest, the concentration of cocaine would have been greater. It was further stated that the concentration was high enough to cause death, regardless of the struggle with police.

An RCMP expert witness reviewed the development and use of the National Use of Force Model. Tools available to police to control an individual were discussed. Pepper spray, a baton or rubber bullets were determined to be inappropriate to control the man due to his mental state resulting from cocaine use. The expert testified that it is recognized that individuals with excited delirium are treated more as medical emergencies; however, paramedics are not trained in the use of control techniques. He also stated that he believed the TASER was the fastest and most appropriate method available to gain control of the man to allow paramedics to treat him.

A member of the Vancouver Police Department's Major Crime Section investigated the circumstances of the death. She testified at inquest that there was no evidence indicating excessive use of force.

The jury found that the cause of death was consistent with restraint-associated cardiac arrest as a result of acute cocaine intoxication and psychosis and classified the death as Accidental.

Recommendations:

The jury made a total of four recommendations. Recommendations were directed to the **Chief Constable of the Vancouver Police Department**, the **CEO of the BC Ambulance Service** and the **BC Minister of Health**.

The recommendation to consider using a strap restraint device as a control device for persons suffering an extreme agitated state was directed to the **Chief Constable of the Vancouver Police Department (VPD).**

Two recommendations were jointly directed to the **Chief Constable of the Vancouver Police Department** and the **CEO of the BC Ambulance Service (BCAS).** These agencies were directed to dispatch an Advance Medical Team rather than basic level paramedics when a call is received regarding acute cocaine intoxication or psychosis. They also received the recommendation to establish an ongoing joint committee of police, the medical community and other appropriate agencies to review current practice and procedures involving acute cocaine intoxication/psychosis.

It was recommended to the **BC Minister of Health** to implement a procedure of ante-mortem blood collection in tubes with sodium fluoride that would prevent further metabolism of cocaine to allow for more accurate toxicological findings in police-related cases.

Response to recommendations:

The **BC Minister of Health** responded that the Ministry supports the practice of using sodium fluoride blood collection tubes to preserve samples. The **Minister** requested compliance with this practice from the Provincial Toxicology Centre in addition to an update on actions taken on this issue. The Provincial Toxicology Centre responded that for many years their policy has been to collect specimens with a preservative. Specimens are collected post-mortem, usually by a pathologist. However, hospital collection with sodium fluoride containing collection tubes for use in medical care of a patient are unsuitable for many types of ante-mortem chemical analyses.

The **BCAS** responded that it is often impossible for dispatchers to determine if an excited state is due to cocaine. However, when that information is available, they would reinforce the need to send Advanced Life Support paramedics. It was also noted that the **BCAS** has initiated discussions with the **VPD** regarding the recommendation to form a joint committee.

The **VPD** responded that the use of a modified restraint device has been implemented on a test basis. If evaluated favourably, the device may be issued to all patrol members. The **VPD** also responded that they have requested that the BCAS identify a representative regarding the recommendation of a joint committee. A preliminary meeting was expected to take place in the near future.

Police Custody – Cell Lock-up

Case 1 of 3

On April 5th, 2005, an inquest was held in Port Alberni, BC, into the death of a 57-year old male who died on June 6th, 2004, due to a spontaneous intracerebral hemorrhage.

Emergency personnel responded to several 911 calls from bystanders indicating that a person was in need of medical assistance. The man was in a public location and appeared to have a head injury, was bleeding and appeared intoxicated. The man was taken to West Coast General Hospital and treated. He was then released into police custody for being drunk in a public place after being assessed fit for transfer to police cells.

A few hours later a jail guard heard the man fall in his cell and found him laying on the floor of the cell and mumbling. An ambulance was called and he was assessed as fit to remain in cells. He was left on the floor so that he was less likely to fall again.

Approximately three hours later the jail guard felt that the man's condition had deteriorated and again called an ambulance. The same ambulance crew returned and confirmed that his condition had deteriorated and he was taken to West Coast General Hospital in Port Alberni.

The emergency room physician indicated that the man had significant neurological changes and it was decided to transport him to Victoria for neurological care. At Victoria General Hospital, a computerized tomography (CT) scan confirmed a large intracerebral hemorrhage. The injury was deemed inoperable and lethal. Life support was removed and he died from the injury.

The pathologist who conducted the autopsy stated that the cause of death was indeed a spontaneous bleed in an area deep within the brain.

The emergency room physician at West Coast General Hospital testified at the inquest that the man had been admitted to the emergency department several times before for alcohol-related care and had also discharged himself before against medical advice. Therefore, on this occasion he was not admitted to hospital and was instead released to the police. This physician also indicated that there was no available bed. The physician also explained the unavoidable delay in the man's diagnosis or treatment because of the lack of a computerized tomography scanner at the hospital.

At inquest, the jury watched a video of the cell lock-up at the RCMP detachment. The video indicated that the man had difficulty in standing although this physical impairment was not conveyed to the ambulance attendants at their first visit. The ambulance attendants indicated that the man moved

his right leg purposefully; however, this was not supported by the video. In a written statement, one paramedic recalled that the man had signed a crew report refusing transport to the hospital. The video also did not support this statement.

A BC Ambulance Service Field Operations Policy was introduced as evidence at the inquest. This policy stated that when attending to people in cells, the hospital copy of the ambulance crew report is required to be left with the police. Police and ambulance personnel both stated that this policy was not typically adhered to. An RCMP Operations Policy was also introduced as evidence, regarding the assessment of individuals in police custody. The policy requires police to obtain written documentation, if possible, from a medical doctor that a person is fit to be incarcerated. The police testified that they have never previously received any documentation.

The jury found that the death was due to a spontaneous intracerebral hemorrhage, due to hypertensive cardiovascular disease and classified the death as Natural.

Recommendations:

The jury issued a total of seven recommendations directed to the **Vancouver Island Health Authority**, the **RCMP Deputy Commissioner Pacific Region and Commanding Officer "E" Division**, the **Manager Policy Legal and Risk Management of the BC Ambulance Service (BCAS)**, and the **City of Port Alberni**.

Four recommendations were directed to the **Vancouver Island Health Authority** regarding intoxicated individuals presenting at the hospital, bed availability to those who require hospital care, written discharge procedures and directions for follow-up care with RCMP and diagnostic equipment needs for West Coast General Hospital.

The **Deputy Commissioner** was recommended to distribute a memo to all RCMP members to review the policy regarding the assessment of individuals in police custody.

The **Deputy Commissioner** jointly with the **Manager Policy Legal and Risk Management** received the recommendation that if an ambulance is called for a person in cell lock-up, then the person should be transported to hospital and assessed and cleared by a physician in writing before being released into police custody.

The **Manager Policy Legal and Risk Management of the BCAS** received the recommendation that ambulance personnel need continuous training on policies.

Finally, the **City of Port Alberni** was recommended to ensure that guards employed at the RCMP cells should have a minimum of Occupational First Aid Level 3 certification.

Response to recommendations:

The **RCMP Chief Superintendent, "E" Division** responded that it is the responsibility of each Detachment Commander to ensure that all personnel under their command are familiar with policy requirements. It was also noted in this response that an independent review into the fatality was conducted and it was concluded that guards followed RCMP policy. The review indicated that care, diligence and compassion were displayed toward the man by all members and guards. Therefore, no additional policies were being considered.

The **Vancouver Island Health Authority** responded that following the first assessment, there was no medical necessity to hold the man in hospital. As he was clearly still intoxicated he was released to RCMP custody for observation until sober. Patients requiring hospital care are not discharged to RCMP cells. However, it was noted that the implementation of written discharge orders and information sheets outlining follow-up care to the RCMP when discharging a patient into custody would be reviewed. Finally, the Chief Medical Officer of the Health Authority responded that a CT scanner is identified as an acquisition for the West Coast General Hospital in the Health Authority's strategic plan.

Although not listed as a recipient of recommendations, the Victoria Police Department was made aware of four recommendations by the **Vancouver Island Health Authority**. The police department responded that they are developing a protocol to manage post-discharge care.

The **BCAS** responded that the recommendation regarding transportation of a person in cells in consistent with their current policy and that the police have authority over and responsibility for

persons in their custody. It was stated that the **BCAS** will provide ambulance transportation for a person in cells when requested by the watch commander/guard. The **BCAS** also responded that continuing education and training on policy is provided to paramedics. All **BCAS** policies and protocols are available online and paramedics are individually notified when new material is introduced or amended.

Case 2 of 3

On April 11th, 2005, an inquest was held in Burnaby, BC, into the death of a 40-year old male who died on March 26th, 2003, due to an intracerebral hemorrhage.

The man was arrested at a mall and it was discovered that he was bound by Recognizance of Bail for a previous conviction. He was placed in a cell at the Burnaby RCMP detachment until he could be transferred to the custody of the sheriff for a court appearance the next day.

The man remained under video surveillance and the care of a civilian guard and was transferred to the Vancouver Jail the next morning. He was seen by a nurse for a medical assessment at the Vancouver Jail. It was determined that his blood pressure was quite high and he told the assessing nurse that he had hypertension. He stated that he had been in hospital two months earlier for high blood pressure and was prescribed medication, but did not take it regularly. The man complained of a headache and dizziness. The jail doctor was consulted and he advised that the man be taken to hospital by ambulance that morning, although the transfer was not deemed urgent.

The man was placed in a cell following intake and was later observed lying on his back on the floor of the cell. A nurse went to the cell and immediately recognized that he needed to be taken to hospital and requested an ambulance. An Advanced Life Support paramedic crew arrived at the jail and found the man semi-conscious. He was then transported to hospital.

At the inquest, an internal medicine specialist at the hospital stated that the man was exhibiting symptoms indicative of damage to the brain stem. A computerized tomography (CT) scan of his brain indicated a very large bleed, presumed to be the result of long-term uncontrolled hypertension. The prognosis of the man was very poor and he was given comfort care and later pronounced dead.

The forensic pathologist that conducted the autopsy stated at the inquest that the cause of death was an acute bleed in the brain due to chronic high blood pressure. The pathologist also testified that the man's brain hemorrhage would have been untreatable even if he had been sent for treatment when first assessed in the jail.

The jury found that the death was due to an intracerebral hemorrhage, due to hypertension and classified the death as Natural.

Recommendations:

The jury made a total of two recommendations to the **Assistant Deputy Minister of the Corrections Branch** of the **BC Ministry of Public Safety and Solicitor General**. The jury found that there was a lack of first aid and an unwillingness to use it. Therefore, the jury recommended upgraded first aid training for all correctional staff who work with inmates. It was also recommended that if advice from a physician is required for an assessment then an inmate should be kept in the nursing area until that advice is received. Finally, increased communication between medical staff and cell guards regarding potential medical problems was recommended.

Response to recommendations:

The **Assistant Deputy Minister of the Corrections Branch** responded that the Vancouver Jail managers conducted a review of occupational first aid requirements and determined that current first aid training meets appropriate workplace requirements. It was noted that there are always correctional or nursing staff members on duty with occupational first aid training. The **Assistant Deputy Minister** also responded that prisoners who are identified as exhibiting a potentially unstable medical condition are moved to treatment rooms pending hospital transfer or stabilization of their condition.

Case 3 of 3

On April 21st, 2005, an inquest was held in Penticton, BC, into the death of a 39-year old female who died on April 14th, 2004, due to terminal arrhythmia.

The woman was released unconditionally from custody on the evening of April 13th. She had been arrested earlier that day following a complaint of a disturbance at a residence. Early on April 14th, police responded to a complaint of a disturbance at that same residence. The officer identified the woman and escorted her from the property and took her to another residence. Her personal effects were retrieved from the residence and she was taken to the RCMP detachment and lodged for causing a disturbance. She was scheduled to be released unconditionally later that morning.

The prisoners were monitored regularly by the guard on duty. During a physical check, a guard observed that the woman did not appear to be moving and that her hand appeared to have changed to a darker colour. Police entered the cell and could not detect the woman's pulse. CPR was initiated and emergency health services were summoned. The woman was transported to hospital where she was pronounced deceased.

The pathologist who conducted the autopsy identified multiple anatomic abnormalities, many of which were associated with alcohol use. She testified at the inquest that the cause of death was the result of a terminal arrhythmia as a result of alcoholic cardiomyopathy. There were also changes within the liver that were consistent with Hepatitis C. Toxicological analysis revealed that the woman has consumed ethyl alcohol and acetaminophen. However, these substances did not contribute to the death.

It was heard at the inquest that the woman had been in rehabilitation at a treatment centre and was prescribed methadone as part of her addiction treatment.

An RCMP officer from the Southeast Subdivision Major Crime Unit testified that he conducted an investigation following this fatality. He attended the detachment and interviewed inmates and police officers and viewed the cell video tape. This officer also attended the autopsy of the woman. The officer testified at the inquest that there was no evidence of foul play.

The jury found that the death was due to terminal arrhythmia and classified the death as Natural and made no recommendations.

Police Custody-drunk tank

Case 1 of 1

On April 14th, 2005, an inquest was held in Oliver, BC, into the death of a 70-year old male who died on April 17th, 2003, due to closed head injury.

The man had consumed alcoholic beverages at a local pub and appeared to be impaired when he left the premises early on the morning of April 12th. An RCMP Citizen's Patrol Volunteer observed the man stagger and fall backwards onto the street. The volunteer examined the head of man and found no obvious injury or blood.

Two officers from the RCMP detachment arrived at the location. The officers testified at the inquest that they helped the man to the police vehicle without difficulty. He was not handcuffed and was placed in the rear seat of the vehicle and arrested for being drunk in a public place and transported to the RCMP detachment at 0140 hours. The officers also testified that prior to transport they observed no signs that the man was injured or required medical attention. He was detained to allow him to sober up, after which he would be released unconditionally.

At 0325 hours, a guard called the off-duty arresting officer to inform him that the man had vomited. The officer instructed the guard to confirm that the man's airway was clear and to place him in the recovery position.

At 0800 hours a guard and an officer attempted to wake the man when they arrived on shift, without success and decided to allow him to continue to sleep. The officer was aware that the man had fallen the previous evening, but was not aware of any injuries. The officer attempted again to wake the man at 1140 without success. The officer and guard entered the cell shortly after 1300 hours and noticed that the man eyes were bruised and swollen so an ambulance was summoned.

An Emergency Health Services attendant arrived at the detachment and noted that the man was breathing but had a decreased level of consciousness. He had no eye, verbal or motor response to stimuli. A computerized tomography scan identified a subdural hematoma that was causing the brain to swell, reducing blood flow to the rest of the brain. The man underwent surgery and was placed on a respirator and given supportive care until his death on April 17th, 2003.

The pathologist who conducted the autopsy identified brain injuries secondary to a closed head injury and a skull fracture consistent with a fall on the back of the head. Toxicological analysis indicated that blood samples taken on April 12th revealed ethyl alcohol. Based on these samples, the toxicologist estimated that his blood alcohol concentration at the time as he was taken into custody was quite high. A metabolite of the active chemical of cannabis was also detected, in addition to a subtherapeutic amount of codeine.

An RCMP criminal investigation was conducted, due to the presence of a fatal injury and the fact that the man did not have his wallet. The investigation did not reveal any evidence of foul play.

RCMP policy states that anyone in custody suspected of having acute alcohol poisoning or is injured should be examined immediately by a medical practitioner. The RCMP detachment had three Rousability Flowcharts for Assessing Prisoner Responsiveness in the cell area. However, the cell guard was not required to conduct rousability checks.

The jury found that the death was due to a closed head injury, due a fall onto the back of the head and classified the death as Accidental.

Recommendations:

The jury made a total of two recommendations to the **RCMP Deputy Commissioner Pacific Region and Commanding Officer, "E" Division**. It was recommended that the RCMP officers and guard follow the rousability chart and conduct a check at least every four hours for detainees in the drunk tank. It was also recommended that the RCMP install camera equipment in cells, and especially the drunk tank.

Response to recommendations:

The **Chief Superintendent of "E" Division** responded to the recommendations. It was stated that the "E" Division Prisoners and Mentally Disturbed Persons Policy is being revised and the jury's recommendations would be considered in the revision process. It was also noted that the "E" Division will maintain its approved standard of prisoner monitoring. However, it was stated that detachments may exceed the standard if desired.

Police Pursuit

Case 1 of 1

On July 18th, 2005, an inquest was held in Victoria, BC, into the death of a 29-year old male who died on May 23rd, 2004, due to blunt force trauma of the head.

Victoria Police received a 911 call reporting a break and enter in progress. An attending officer received a description of a man (i.e., the man), his motorcycle and license plate number. Approximately 20 minutes later a Saanich Police officer saw the man on his motorcycle. The initial attending officer headed toward the area and initiated a pursuit. Lights and sirens were activated; however, the motorcycle did not stop.

Twice during the pursuit, the police cruiser made contact with the man's motorcycle. Once, the pursuing officer "tapped" the motorcycle from behind. A second time, the motorcycle struck the front of the cruiser while avoiding being boxed in by the police cruiser.

The pursuit proceeded at low speeds. The officer in pursuit testified that the man's behaviour was typical of those whose intention is to abandon their vehicle and run. Another officer blocked part of a road with his vehicle resulting in the man mounting the sidewalk to get around the vehicle. The pursuing officer stated at the inquest that the man drove off the sidewalk and attempted to turn right, then appeared to change his mind and continued straight. The officer attempted to avoid collision and came to a stop straddling the sidewalk and a parking lot curb. The officer exited his vehicle expecting to see the man fleeing on foot. However, he realized that he had hit him.

One of six fire-fighters who attended the scene testified that he assisted in lifting the weight of the police cruiser off of the man. Paramedics arrived and although resuscitation efforts were initiated, cardiac and respiratory functions ceased en route to hospital.

There were numerous civilian and police witnesses to the pursuit. All witnesses agreed that the pursuit proceeded at low speed.

A Saanich Police Department Collision Reconstructionist investigated the incident and determined that the motorcycle was in full rear braking prior to the collision. Markings suggested that the vehicle was already on the ground when it was hit by the cruiser. An engineer was asked to review the reconstructionist's report. The engineer testified that a rider can be thrown over the motorcycle if the brake is suddenly released. This was thought to be a probable explanation for the observed markings at the scene.

Saanich and Victoria Police communicate with their officers through different radio frequencies. However, there is a mutual aid frequency that can be used when an incident involves officers from different detachments. The officer who was in pursuit of the man indicated that he felt it unsafe to manually change the radio frequency to the mutual aid frequency so his radio remained tuned to the Victoria Police Department frequency. At the inquest, it was heard that police departments have recently started using the CREST radio system and that there are black spots in the coverage.

An Inspector from the Saanich Police Department who conducted a review of the incident made a recommendation that the Victoria Police Department Police Vehicle Emergency Operation Policy and the Use of Force Policy use language to refer to all types of "intentional contact" of a police vehicle with other vehicles.

The jury found that the death was due to blunt force trauma of the head, due to a motor vehicle incident and classified the death as Accidental.

Recommendations:

The jury made a total of nine recommendations. The **Chief Constables of the Victoria Police Department** and the **Saanich Police Department**, the **Director of the Police Services Division (Ministry of Public Safety and Solicitor General)**, the **General Manager of the CREST Radio committee**, and the **Chief Coroner of BC** received recommendations.

It was recommended to the **Chief Constable of the Victoria Police Department** that the word "ramming" is replaced with the words "intentional contact" in all department policies and procedures relating to use of force and vehicle pursuits.

The **Chief Constable of the Victoria and Saanich Police Departments** jointly received two recommendations as follows:

- that intentional contact is prohibited unless risks to others greatly outweigh risks resulting from this activity, or is approved by the supervisor; and
- that the definition of 'public' in policies relating to pursuits include the suspect and police.

Three recommendations were directed to the **Director of the Police Services Division (Ministry of Public Safety and Solicitor General).** It was recommended that a reasonable distance is maintained in a pursuit, that peer reviews of investigations are conducted independently from the investigating department and that video devices are installed in police vehicles to record activities during emergency operations.

The **Director** and the **General Manager of the CREST radio committee** received the recommendation that policies should be reviewed by CREST and police to ensure optimum communications during mutual aid situations. It was also recommended that the use of hands-free radios in police vehicles is reviewed.

Finally, it was recommended to the **Chief Coroner** that fatal motor vehicle incidents involving police vehicles are investigated by collision re-constructionists contracted by the **Chief Coroner**.

Response to recommendations:

The **Chief Constable of the Saanich Police Department** stated that current policy already reflects the jury's recommendations.

The **General Manager of CREST** stated that the recommendations will be reviewed and discussed with the police services in the Capital Region.

The **Victoria Police Department** stated to each recommendation, except two that were outside the purview of the department. It was responded that amendments to had been made to comply with the jury's recommendations, except for two recommendations in which it was stated that current policy already addressed the recommendation.

The **Assistant Deputy Minister and Director of Police Services** stated that the recommendation that a reasonable distance be maintained between

the suspects and pursuing vehicle could not be supported. However, it was stated that compliance with the *Emergency Vehicle Driving Regulations* was supported. It was also not agreed that every incident involving a police officer requires the appointment of an independent investigator. The Assistant Deputy Minister indicated that the Police Act provides the Solicitor General or Director of Police Services to conduct an investigation if the need was identified. It was stated that while useful to have every marked police vehicle equipped with an automatic recording device, the cost of obtaining and maintaining equipment for every police vehicle would be prohibitive.

The **BCCS** responded that as in any other type of death (e.g., avalanche, work-related), the Coroner may utilize special investigators, forensic services or other consultant services as required. This requirement is decided on a case by case basis. In the past, the **BCCS** has made use of independent collision re-constructionists in motor vehicle incident involving police vehicles. It was stated that in addition to the **BCCS**, other agencies, such as the police, have statutory obligations to investigate certain types of death. However, these investigations are generally concerned with the technical or criminal aspects of a case. It was emphasized that while the reports generated by these agencies may be of assistance to the Coroner, the Coroner conducts their investigation in an independent manner.

Police Shooting

Case 1 of 4

On January 10th, 2005, an inquest was held in Burnaby, BC, into the death of a 36-year old male who died on August 2nd, 2003, due to a massive internal hemorrhage.

The man lived with his mother and sister, both of whom had noticed that his mental status had been deteriorating, especially in the two weeks prior to his death. On August 2nd, 2003 the man's sister attempted to communicate with him when he pulled out a knife and cut himself.

The man's sister called the Crisis Centre and was advised that a psychiatric nurse and police officers would attend the residence. A psychiatric nurse at the Crisis Centre testified at the inquest that a program known as "Car 87" is a partnership between Vancouver Police and Vancouver Mental Health Services. An unmarked police car and officers and a psychiatric nurse respond to urgent mental health issues.

Three police officers and a nurse attended the home and approached the man who was sitting on the floor in the basement. The man's sister was asked to go upstairs. One officer told the man that she wanted to talk to him, but did not receive a response. The man asked for identification and the officer complied. The officer testified that suddenly, the man jumped up from the floor, reached in a pocket and pulled out a knife. He started swinging his arms over his head and opened the knife. All three police officers yelled at the man to drop the knife. A second officer deployed his TASER once without effect, and then a second time, again without effect. A third officer unholstered her weapon and the man advanced toward her and she subsequently shot him in the chest. Emergency Health Services were called for assistance; however, the man died from his injuries.

The jury found that the death was due to massive internal hemorrhage due to a gunshot wound and classified the death as Homicide. The jury made no recommendations.

Case 2 of 4

On February 21st, 2005, an inquest was held in Victoria, BC, into the death of a 33-year old male who died on July 11th, 2004, due to blood loss.

On the morning of July 11th, 2004, the man's wife called 911 to request an ambulance. She reported that the man was losing control of himself and that it was a medical issue. Police and an ambulance were dispatched to the residence.

At the apartment complex of the man, three police officers in addition to ambulance personnel observed smoke from a second story patio. The fire department was contacted.

The man's wife again called 911 from a neighbour's residence and informed dispatchers that the man had left in the family car. Police proceeded to leave the area. While waiting for the fire department to arrive the man appeared and attempted to enter the building.

An ambulance paramedic followed him as he left the building complex. Officers were called back to the

building complex and eventually caught up with him at a school where he was observed approaching a parked car, opening the trunk and retrieving a long cylindrical object. When officers commanded he come out from behind the car and get down on the ground, he initially complied. The man then ran back to the trunk and returned with two objects held high, one in each hand and advanced on the officer. The officer fired three shots at the man who then fell to the ground and was immediately handcuffed.

Two other officers and a paramedic arrived and immediately began resuscitation. An Advanced Life Support ambulance crew was requested. The ALS crew arrived and found the man without respirations or a pulse.

The man's wife testified at inquest that her husband had a previous hospitalization and an interaction with police. A psychiatrist who assessed and treated the man at that time stated that his symptoms were in part due to use of Tylenol 3, for an injury. He also stated that the man had been diagnosed with Delusional Disorder, persecutorial type.

The man's wife also testified that psychiatric symptoms had returned shortly prior to her husband's death and she called his physician to report the changes in his mood. She thought that he hadn't taken his medication for about one month.

The forensic pathologist who conducted an autopsy on the deceased identified the cause of death as a penetrating gunshot wound to the chest. The pathologist identified four wounds caused by three bullets and described how one bullet can cause two wounds.

The Saanich police officer responsible for use of force delivery at the Saanich Police Department testified that the officer who shot the deceased appeared to have been acting in the legal execution of his duties and acting on reasonable grounds.

RCMP officers conducted an external review of the incident and the jury heard that this review determined that the attending officer's response was appropriate.

At the inquest, there was a review of the Emergency Mental Health Services Mobile Outreach Team. The team is available seven days a week between 1300 to 2400 hours. Following the death, in November 2004 a pilot project began in which an armed, plain-clothed, police officer was added to the team. It was noted that the main obstacle to expanding the program was funding. One officer on the team testified that the training he received on mental health issues as a junior officer was not adequate.

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

Recommendations:

The jury made six recommendations, each recommended to multiple agencies. Recommendations were directed to the **Minister of Health,** the **Solicitor General, Vancouver Island Health Authority, BC Association of Municipal Chiefs of Police, Justice Institute of BC, Assistant Deputy Minister of Police Services and Public Safety, Provost Marshall of CFB Esquimalt.**

Recommendations were also directed to the **Chief Constables of the Victoria Police Department, the Saanich Police Department, the Oak Bay Police Department, Central Saanich Police Department.**

RCMP of Sidney/North Saanich Detachment, the Sooke Detachment and the Westshore Detachment also received recommendations.

It was recommended that the Emergency Mental Health Services Mobile Outreach Team expand operations to 24-hours a day to service all police agencies with the jurisdiction of the **Vancouver Island Health Authority's** region. Increased communication among police jurisdictions was recommended to increase awareness of mental health issues and the Emergency Mental Health Services team. It was also recommended that 911 operators and dispatchers are trained on the services provided by the Emergency Mental Health Services Team. Inclusion of mental health issues during daily roll calls in police departments, RCMP detachments was also suggested.

The jury also recommended increased mental health issue training for police officers and that municipal police and Greater Victoria RCMP recruits train with the Emergency Mental Health Services Team.

Response to Recommendations:

The **Vancouver Island Health Authority** responded that expanding the emergency team's hours of operation would require additional funding. However, they also responded that the emergency team has engaged in ongoing liaisons with regional police forces to increase awareness of the team's services.

The **Justice Institute of BC** responded that training of police officers pertaining to the awareness of mental health issues in policing was increased. However, they also responded that field training of new recruits with the emergency team is problematic to implement due to the scarce resources associated with emergency mental health.

The **RCMP-Sooke Detachment** responded that in meetings with an officer on the emergency team, a consensus was reached that a police member with some field experience would be better served than new recruits in receiving field training with the team. Furthermore, two members of the Sooke Detachment had already participated in training orientation with the team.

The **Victoria Police Department** responded that daily information of mental health issues during roll call was unnecessary as the department already has systems in place to address dissemination of this information. It was also noted that representatives of the Saanich Police Department and the emergency team met to address training recommendations. It was decided that the best practice would be to develop a two-hour educational module for recruits, serving members and 911 communication centre staff. Research was being conducted on how best to develop and present the module.

Case 3 of 4

On August 29th, 2005, an inquest was held in New Westminster, BC, into the death of an 18-year old male who died on July 14th, 2003, due to a gunshot wound to the chest.

A police officer was conducting a routine patrol and pulled into a gas station when two young women complained that a male driver had hit the back end of the their vehicle with his vehicle. The driver then exited his vehicle and stormed toward their vehicle with a machete, damaging the vehicle.

The male driver then drove into the gas station with two other male passengers. The police officer activated his lights and sirens and followed the car.

At the inquest, both the police and the passengers in the car testified that the man's vehicle was travelling at an excessive rate of speed. The man told his passengers that their car could outrun the police and stated while laughing that "we are all going to die".

An officer in an unmarked police car heard the broadcast of the police pursuit and was in a location to monitor the passing vehicle and reported its direction of travel. The man's vehicle entered a street which ends in a cul-de-sac. The unmarked police vehicle came up to the man's vehicle bumper to block the vehicle from exiting the street but reversed his vehicle when he was radioed that the passengers were armed.

The passengers reported that the man grabbed a machete and then got out of the vehicle and began running quickly towards the unmarked police car. One passenger also exited to try to intercept the man. Both passengers testified that they were not aware that the vehicle behind them was an unmarked police car. The front seat passenger who ran out of the vehicle stated that he heard the police officer shout "stop" which was followed by three gunshots.

The plain-clothed officer testified the males were coming toward him shoulder to shoulder at a fast run, with one carrying a raised weapon. The officer identified himself as police and ordered the males to stop. He fired his sidearm at the man; however, this did not slow him down. The officer then fired at the second male who fell and then fired again at the man who collapsed beside the officer.

Paramedics initiated resuscitative efforts and transported the man to hospital. However, no signs of life were present and efforts were ceased en route to the hospital.

The Inquest revealed that the deceased had been assessed by a psychiatrist as having depressive and psychotic symptoms with features of paranoia and impulsivity. He also had passive suicidal thoughts and had been hospitalized involuntarily. The deceased had been prescribed medication for treatment of depression but had failed to attend an

appointment with his psychiatrist earlier in the month of his death.

A Use of Force Expert witness who reviewed the incident testified that officers are trained to shoot at the centre mass of an individual to stop an assailant. He also stated that remaining in the vehicle would have been a danger to the officer. A second Use of Force Expert introduced by the family's legal counsel testified that neither lack of training nor lack of policy was an issue in the officer's actions.

The Port Moody police department conducted an investigation of this fatal incident. The investigation was reviewed by Vancouver Police Homicide detectives and was found to have been conducted in an outstanding manner.

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

Recommendations:

The jury made two recommendations. One recommendation was directed to the **BC Minister of Health** and the **Fraser Health Authority**. A second recommendation was directed to the **Solicitor General of BC**, the **RCMP Deputy Commissioner Pacific Region and Commanding Officer of "E" Division**, the **BC Association of Municipal Chiefs of Police** and the **Chief Constable of the Port Moody Police Department**.

To the **BC Minister of Health** and the **Fraser Health Authority** the jury directed the following recommendation:

- That all patients receive a reminder for appointment dates.

The **Solicitor General of BC**, the **Deputy Commissioner** the **BC Association of Municipal Chiefs of Police** and the **Chief Constable of the Port Moody Police Department** received the recommendation that all police vehicles should be equipped with emergency lights (e.g., a portable 'fireball' at the least) to allow unmistakable recognition of police presence.

Response to recommendations:

The **Solicitor General of BC** responded that all RCMP police transport vehicles are equipped with a siren and emergency lights and would ask for direct responses to the recommendation from the individual municipality police departments. The **BC Association of Municipal Chiefs of Police** forwarded the recommendation for response to all members.

The **Chief Constable of the Port Moody Police Department** responded that they have purchased emergency lights for each of their unmarked vehicles. The **Victoria Police Department**, the **Abbotsford Police Department**, the **West Vancouver Police Department**, and the **Stl'atl'imx Tribal Police** responded similarly. The **Delta Police Department** responded that they would make every effort to comply with the recommendation while the **Saanich Police Department** indicated that they would review the recommendation with senior managers.

The **Ministry of Health** responded that the recommendations have been forwarded to the Fraser Health Authority Vice Presidents of Mental Health with the direction to advise the **Ministry of Health** regarding how the recommendations will be implemented with an associated timeline.

Case 4 of 4

On September 7th, 2005, an inquest was held in Kamloops, BC, into the death of a 29-year old male who died on May 27th, 2004, due to spinal shock and vascular injuries.

The man was driving a minivan that crashed into a parked tractor trailer at a rest stop, and then hit a car before coming to rest in a ditch. The driver of the car testified at inquest that he retrieved a flashlight from his vehicle and saw the man seated in his vehicle. Loud music was heard from inside the van and the man did not respond to questions asking if he was injured. The man was seen removing a vial from a brown paper bag and consumed what appeared to be a pill. A 911 call was made.

An RCMP officer arrived and called to the man but did not receive a response. The van door was slightly open and music was playing loudly. The man was seen slamming his hands on the steering wheel. The officer informed him that an ambulance was en route and returned to his vehicle to call a tow truck.

The man exited the van and ran up the embankment. He appeared disoriented and began to act erratically and was informed by the officer that he could not leave and was asked to produce identification. The man returned to the van stating that he would retrieve his identification but then suddenly charged the officer with both hands held up in fists. He began to punch the officer in the face. The officer struck the man in the head with his flashlight, without effect and then fell backwards with the man falling on top of him. The officer drew his sidearm and discharged it twice at the man, first at his centre mass and second at his neck. The man collapsed after the second shot.

Eagle Valley Rescue, followed by the BC Ambulance Service arrived and attended to the man. CPR was initiated and the man was taken to hospital where he was pronounced deceased.

A pathologist who conducted the autopsy testified at the inquest that a number of injuries were consistent with a physical altercation. Toxicological analysis revealed the presence of oxycodone and tetrahydrocannabinol, the active chemical in marijuana, although the substances did not contribute to death.

Another RCMP officer with the Major Crime Unit testified at the inquest that he was assigned to investigate the incident. He determined that the minivan did not have any mechanical defects that would have caused the collisions. The van contained 24 litres of gamma hydroxybutyrate (GHB), a controlled substance used as a hypnotic. The investigating officer also determined that the attending officer was qualified and had received the proper training to use his firearm.

The jury found that the death was due to spinal shock and vascular injuries due to a gunshot wound to the left neck and classified the death as Accidental. The jury made no recommendations.

Others

Case 1 of 1

On February 21st, 2005, an inquest was held in Burnaby, BC, into the death of a 54-year old male who died on August 17th, 2003, due to a closed head injury and its sequelae.

On August 9th, 2003 the man was attended to by two paramedics who found him conscious, in a seated position on the side of road, with a minor abrasion to the head. Due to his intoxication, the paramedics contacted the Vancouver Police Department for assistance. The man refused hospitalization and was taken to Vancouver Detox, but was also refused admittance due to his uncooperativeness.

The man was transported to the Vancouver Jail and monitored at regular intervals. On the morning of August 10th, 2003 he was transported to St. Paul's Hospital where he was assessed and admitted. Information pertaining to his head injury was not relayed between the jail and the hospital. A computerized tomography scan was performed and revealed a brain hemorrhage. He was transferred to Vancouver General Hospital. His head injuries were deemed inoperable and his condition deteriorated. The man was provided with palliative care until he died from his injuries on August 17th, 2003.

At the inquest, the forensic pathologist who conducted the autopsy testified that the deceased's injuries were consistent with a fall striking the back of the head.

A Vancouver Police Detective reviewed all witness statements, reports and other documents and attended the deceased's residence. He found no evidence to suggest that the deceased had been injured by another person.

The jury found that the death was due to a closed head injury and sequelae resulting from a fall striking the back of the head and classified the death as Accidental.

Recommendations:

The jury directed one recommendation jointly to the **Chief Constable of the Vancouver Police Department (VPD)** and the **Provincial Director, Adult Custody**. It was recommended that information follows an individual when they are moved from one location to another.

Response to Recommendations:

The **VPD** responded that jail procedures have long required that all identified injuries and medical conditions must be clearly explained to the receiving agency. It was stated that policy has been introduced requiring the direction of jail nursing staff to prepare a medical report, in relation to any prisoner requiring hospitalization, and that report will accompany the prisoner to the hospital.

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