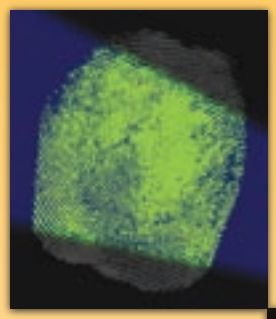
BC Coroners Service

Ministry of Public Safety and Solicitor General

Annual Report 2007



BRITISH COLUMBIA

PSSG08-024

Posted: September 30, 2008
www.pssg.gov.bc.ca/coroners/

Message from the Chief Coroner

On behalf of the men and women of the British Columbia Coroners Service, I have the pleasure of presenting the 2007 Annual Report. This report represents the Service's commitment to provide the public with information relevant to all aspects of our operation, in a timely manner. Our report has also been formatted in order to share our activities during the calendar year 2007, as well as the outcomes of those efforts, in a way that provides clear, usable information that goes beyond statistical numbers and comparators.

2007 was a significant year for the Coroners Service with the introduction of an updated and thoroughly modernized new *Coroners Act*, the implementation of our GPS/GIS location and tracking system, and the introduction of a revised organizational structure, among a list of other improvements.

We remain committed to providing the very highest level of community safety and to maintaining the highest possible quality of life for all British Columbians. This report will also be posted to the BCCS website so that it will be conveniently available to everyone. We invite everyone to visit our website at www.pssg.gov.bc.ca/coroners/ and to provide us with their suggestions and comments in order to assist us in continuing to further improve our services to the public.

Terry P. Smith
(Chief Coroner of British Columbia)

VISION

Our communities and homes are safe places.

MISSION STATEMENT

Providing exceptional public service through independent, factual death investigation to improve community safety and quality of life.

VALUES

Integrity, Respect, Inclusiveness, Accountability, Quality Service, Healthy Work Environment

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Part 1
History of the British Columbia Coroners Service

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. Formerly, the coroner was a protector of Crown revenue, responsible for bringing suspects to trial. The coroner was known as a "Keeper of the pleas of the Crown" or "Crowner" from which the term "coroner" evolved.

Coroners have been investigating death in British Columbia for over 100 years. B.C. inherited the English Coroners Act (of 1848) when it became a province in 1871. Coroners conducted their work independently through their own municipalities, as there was no provincial organization.

In 1932, the City of Vancouver built the first "Coroner's Court" building. The building contained a court room, where coroner's Inquests were held, a morgue and autopsy facilities. The building was also shared with the City Analyst's Laboratory. The analysts performed toxicological analysis for the Coroners Department (of Vancouver).

Coroners worked independently until the appointment of a Supervisory Coroner, Glen McDonald, who served in this capacity from 1969 to 1979.

Figure 1. First Coroner's Court Building at 240 East Cordova Street, Vancouver BC.

The first BC Coroners Act was enacted into law in 1979. At this time, the Vancouver Coroners Department/Office came under the authority of the province and was declared a provincial service. The first Chief Coroner, Dr. William McArthur, was appointed in 1979.

In 1980, the Vancouver Coroners Department was moved from the Coroner's Court building into a provincial Coroners Service building. The morgue was moved to Vancouver General Hospital because the morgue at the Coroner's Court building was limited in size. The coroner's area of the building remained vacant for six years before being occupied by its current tenants, the Vancouver Police Museum.

Figure 2. Chief Coroners of British Columbia.

1. Glen McDonald
First Supervisory Coroner (1969-1979)

2. Dr. William McArthur
First Chief Coroner (1979- 1981)

3. Robert Galbraith
Chief Coroner (1981-1988)

4. Vincent Cain
Chief Coroner (1988-1996)

5. Larry Campbell
Chief Coroner (1996-2001)

6. Terry Smith
Chief Coroner (2001-present)

Part 2
The BC Coroners Service in 2007

A. Organization Highlights

- Investigated 7,474 deaths across BC.
- Enacted a new Coroners Act on September 26, 2007.
- Held Inquests into the deaths of 29 individuals.
- Distributed 684 recommendations issued by inquest juries and coroners.
- Issued a number of Public Safety Bulletins to further injury and death prevention efforts.
- Produced new informational brochures for family members of deceased in three languages.
- Planned and held first international forensic science conference, "The Crowner", in BC.
- Held a Coroners Basic Training Course for new coroners and representatives of external agencies.
- Refined inquest process and training of 15 presiding coroners.
- Developed Missing Persons and Unidentified Bodies website (targeted for launch in 2008).
- Launched the Geographic Information System (GIS) by equipping all coroners with a Global Position System (GPS) unit.
- Established a Disaster Victim Identification BC Taskforce.
- Implemented the use of video-conferencing at BCCS headquarters and five regional offices.
- Completed the BCCS Strategic Plan and Organizational Risk Assessment.
- Established a corporate operating model with a five person Executive under the overall leadership of the Chief Coroner.
- Relocated BCCS headquarters to allow amalgamation of all headquarters function in one central location.
- Recognition of the Interior, Island and Northern Regional Offices, who received some of the highest employee engagement ratings among BC provincial government agencies.

Figure 3. The BCCS Office of the Chief Coroner, Burnaby BC.

B. Organization Structure

The BCCS is an agency within the Ministry of Public Safety and Solicitor General (PSSG). The PSSG works to maintain and enhance public safety across the province. Branches, divisions and programs within the PSSG in 2007 include the BC Lottery Corporation, the Insurance Corporation of BC, the Crystal Meth Secretariat, Liquor Control and Licensing, and the Office of the Superintendent of Motor Vehicles. Emergency Management British Columbia (EMBC) is an agency established within the ministry in 2006 that oversees the integrated planning, mitigation, response and recovery activities for the threat and occurrence of natural and other disasters. The BC Coroners Service, the Provincial Emergency Program and the Office of the Fire Commissioner are all overseen by EMBC.

The Chief Coroner, whose office is located in Burnaby, oversees the BCCS. There are a total of five regional offices, one in each of five BCCS regions within the province. These regions approximate the BC Health Authority Regions (Fraser Health Authority, Interior Health Authority, Vancouver Island Health Authority, Northern Health Authority, and Vancouver Coastal Health Authority) although there are some differences in the regional delineations. The regional offices are located in Victoria, Vancouver, Surrey, Kelowna, and Prince George. Each of these offices is led by a Regional Coroner.

Fraser Region: Burnaby to the Coquihalla Highway Toll Booth, east to Manning Park and north to Jackass Mountain bordering Merritt.

Interior Region: Includes the region north to 100 Mile House and Blue River, east to the Alberta border, south to the USA border and west to the Manning Park gate, including Ashcroft, Lytton and Lillooet.

Island Region: Includes all of Vancouver Island, the Gulf Islands and Powell River.

Figure 4. The BCCS Provincial Regions.

Northern Region: Includes the region north, east and west from Williams Lake to all Provincial borders, Bella Bella, and the Queen Charlotte Islands/Haida Gwaii.

Vancouver Metro Region: Includes Sunshine Coast, Sea to Sky Corridor, North Shore, Vancouver, UBC, Delta and Richmond.

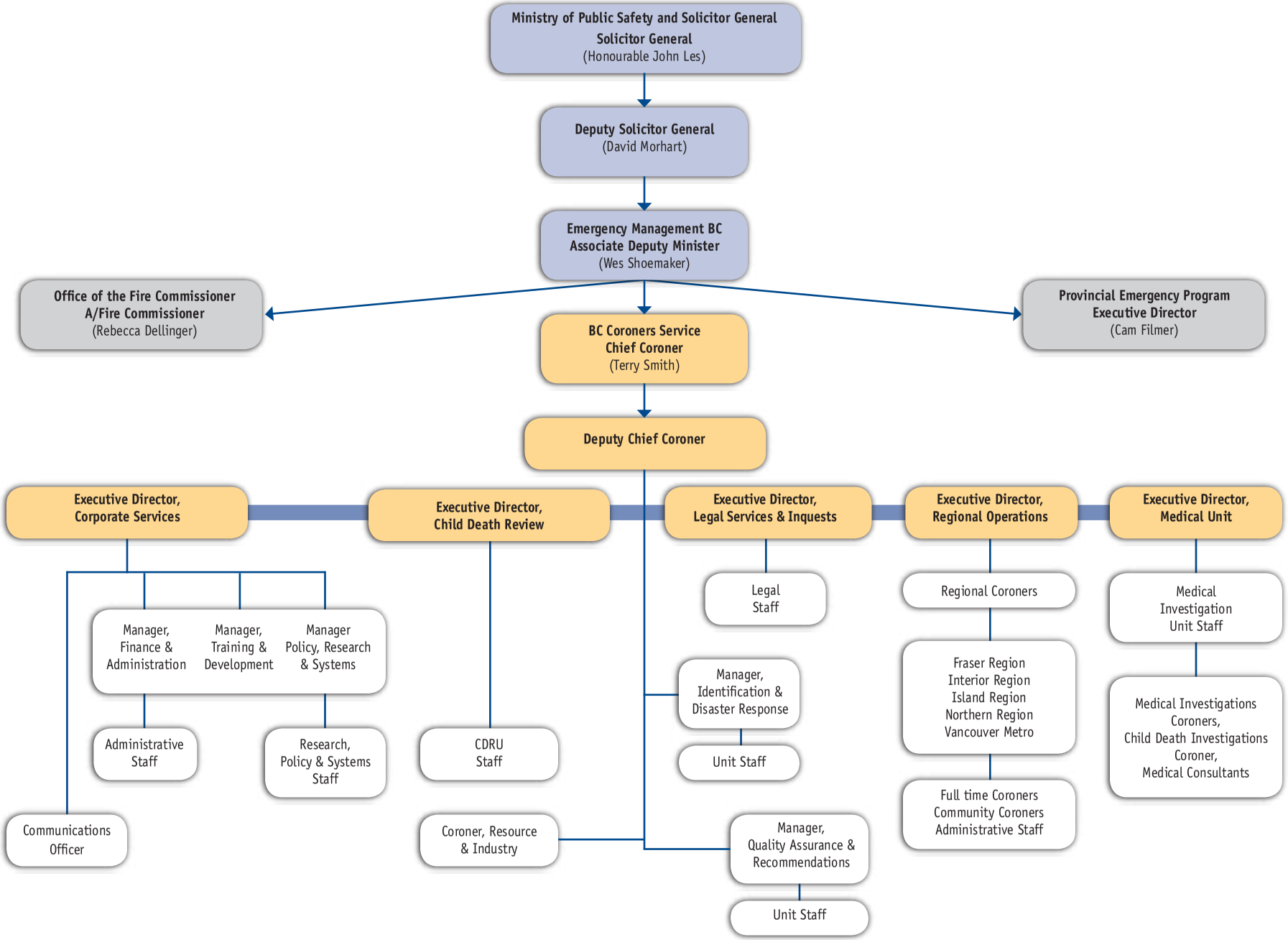


Figure 5. The Structural Organization of the BCCS.

C. Function

There are both Coroner and Medical Examiner systems in Canada. British Columbia, along with Ontario, Saskatchewan, Quebec, New Brunswick, Prince Edward Island, Nunavut, the Northwest Territories and Yukon, operates under a coroner system. Medical examiner systems operate in Alberta, Manitoba, Nova Scotia and Newfoundland. Coroners are not necessarily medical specialists, though many have some medical training. Conversely, all medical examiners in Canada are physicians. Coroners in British Columbia have varied backgrounds including medical, investigative, legal and social scientific.

The responsibilities and functions of the BCCS include:

- ascertaining and clarifying the facts of all sudden and unexpected deaths in BC to determine the identity of the deceased, and how, when, where and by what means the death occurred;
- reviewing all deaths of children under the age of 19 in the province;
- ensuring that no death is overlooked, concealed or ignored;
- producing a judicial document[1], either a Coroner's Report or a Verdict at Coroner's Inquest, that reports on the findings of the coroner's investigation;
- 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;
- 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; and
- collecting death information and conducting statistical analyses.

Prevention of death forms a critical part of the overall mandate of the BCCS.

[1] *The Coroner's Report or Verdict at Coroner's Inquest form, which is the official record of the identity of the deceased and how, when, by what means and where he or she died. The medical cause of death and classification are noted. See appendix 1 for definitions of classifications of death.*

D. Coroner's Investigations

Coroners conduct a careful examination of the circumstances surrounding a death to determine identity and understand how, when, where, and by what means an individual died. Pathologists, toxicologists and specialized investigators may be consulted to provide assistance in an investigation.

Pathology Services (Autopsy)

An autopsy is a complete internal and external examination of the body after death. An autopsy is ordered when the cause of death cannot otherwise be determined, or if mandated by policy. For cases in which autopsy is not mandatory, if a reasonable and probable cause can be deduced on the basis of the deceased's medical history, the circumstances surrounding a death and a careful examination of the body, an autopsy may not be necessary. The BCCS retains the services of pathologists who conduct autopsies on a fee-for-service basis.

An autopsy can be forensic or non-forensic. Non-forensic autopsies are performed in cases where the death appears to be due to natural causes, or a result of a non-criminal or accidental injury. A forensic autopsy may be required for several reasons:

- to determine the cause of death when it cannot otherwise be determined;
- to collect evidence from the body;
- to clarify the time and circumstances of death; and
- to identify artefacts of violence or trauma that may be used to support a criminal investigation.

In 2007, the BCCS ordered 2,251 autopsies.

Toxicology

Toxicology is the study of the nature, effects and detection of poisons and the treatment of poisoning. The pathologist may collect specimens for toxicological analysis if the cause of death is not obvious at autopsy, if poisoning or drug or alcohol use is suspected, or if mandated by policy.

Toxicology testing is most often 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 Forensic Laboratory conducts toxicology testing. The BCCS may also make use of toxicological tests performed at regional hospitals.

In 2007, the Coroners Service ordered 2,153 toxicological tests.

E. A Day in the Life of a Vancouver Metro Coroner

Slightly over 1400 deaths are reported to the Metro Vancouver region per year, or an average of 3-4 deaths per day. Mark Coleman is one of 5 full-time Coroners in the Region. He has worked for the Coroners Service for 2 years.

Hours of work

My hours of work vary. I'm typically on call for 7 days every month, three or four days at a time. During those on-call days I carry a pager around with me and need to be available 24 hours a day. On an average on-call day, I will have 3 or 4 deaths reported to me—but this is extremely variable. Some days can yield twice as many cases, while on others I won't get a single new case. We also get paged by people looking for information on cases, especially at night and on the weekend when our office is closed. When I'm not on call, I work regular office hours in our Regional Office.

Challenges of the job

When you're on call, you cannot anticipate what will happen at any given time. This uncertainty is part of what makes the job so interesting, but it can also be challenging. I might not get a call all day, or I could get three within the span of 10 minutes that require me to travel from Vancouver to Delta to the North Shore. One day's cases might all involve an elderly or chronically ill person dying of a natural disease process. The next days might be a fatal motor vehicle incident, a suicide or even a homicide. Another challenge is educating people on the role of the Coroner. Many people either don't know what we do or have unrealistic expectations of what we can do because of what they see on TV.

Most difficult death to investigate

The most difficult deaths to investigate are child deaths. Not only do they frequently require detailed and lengthy investigations to find out exactly what happened and whether a death was preventable, but these cases tend to have the biggest emotional impact on all involved, including the Coroner.

Most common investigation

The most common type of death scene we attend is that of people who die at home of natural causes. While these individuals may not have been expected to die at that precise time, as might be the case with someone living with a terminal illness, they typically do have some significant medical issues.

Investigative tools

The two things I use at every scene are latex gloves and a camera. We take pictures of the deceased and the scene at every case we attend. A flashlight is often useful as well. I use a laptop computer all the time for inputting and accessing information about my cases. Many other items in my "scene bag" will be used with varying degrees of frequency. These items range from safety equipment like work boots and a hardhat, to tools like a utility knife or pair of scissors. I carry the more commonly used items into every scene and the remainder stay in the vehicle where they are accessible if I need them.

Length of an investigation

The length of an investigation varies greatly. Natural deaths taking place within the home, for example, may only take a couple of hours to conclude. In more complex cases we spend many hours reviewing medical records, meeting with and interviewing people, liaising with other investigative agencies (such as the police, the Transportation Safety Board or WorkSafeBC) and doing whatever else is necessary to ensure we can determine how and by what means someone died and, if appropriate, make strong, practical recommendations. In some cases we have to wait for reports from other investigating agencies before we can complete our investigation. Although all investigations have some things in common, each case is different and we need to do what is most appropriate in order to investigate any given case.

Typical day

When I'm on call I may spend a large part of the day attending scenes. If I have just been on call for the previous three or four days, I will usually spend the next day or two calling doctors, family members and others involved in relation to the cases, as well as completing the necessary forms to order autopsies and toxicology testing and to seize medical records. On other days I will be following up with ongoing investigations or writing the reports with which we conclude cases.

Most common public misperception

There are quite a few myths out there, but the one I encounter most relates to establishing time of death. We often estimate the time of death based on post-mortem changes that occur within the body. Unfortunately the rate at which these changes can occur is highly variable. On TV, a coroner will often examine a body and say something like "he died between 1:00 and 2:00 AM this morning". The only way that I could give such a precise estimate is if the person was last seen alive at 1:00, and was found dead at 2:00. In addition to assessing the body, we will look for other clues that might indicate when the person may have died - including when the person was last seen alive, if anyone has been trying to contact them since a particular time, if that morning's newspaper was brought in, and so on. In the end we are generally only able to give estimated time range, usually spanning at least several hours.

F. Divisions/Units

The BCCS has developed specialized investigation units, due to the complexity of many death investigations. These include the Medical Unit, Child Death Investigation Unit, Identification and Disaster Response Unit, and the Resource Industry Unit. To illustrate the function of these units, brief descriptions of each and highlights of their 2007 activities are included below. The Training and Development and Child Death Review Units are two additional non-investigative units that serve important functions for the BCCS.

Medical Investigation Unit

The Medical Investigation Unit provides coroners with guidance and assistance in investigating medical issues and in obtaining relevant medical information. Cases with complex medical issues are transferred to the Medical Investigation Unit for investigation and completion.

The unit serves as a liaison with medical and nursing staff and health authorities. It functions to provide consistency in the management of investigation of deaths with complex medical issues, through the development and use of medical investigation protocols. The unit also identifies, via aggregate review, common factors that contribute to death, which may require subject-specific review.

In addition, the unit represents the BCCS on the Perinatal Mortality Review Committee. The committee is managed by the BC Perinatal Health Program, under the Provincial Health Services Authority. The unit also participates in meetings of the Vancouver section of the Canadian Community Epidemiology Network on Drug Use.

During 2007, the Medical Unit investigated a variety of deaths, including deaths in hospitals involving physical restraints, deaths of patients diagnosed with psychiatric conditions, and child deaths.

Child Death Investigations

Deaths of children require special consideration for several reasons, particularly the significant physiological differences between children and adults. Child deaths are often the most complex and difficult cases coroners are asked to investigate. Thorough scene investigations, post mortem examinations and investigative interviews to gather the child's history are basic requirements.

The most significant change in 2007 in child death investigation was due to the enactment of the revised Coroners Act in September of that year. The Act now requires that all child deaths are reported to a coroner. Previously, only sudden unexpected child deaths were reported.

When done accurately, thoroughly and consistently, child death investigation will generate a single, reasonable explanation for the cause, manner, and mechanism of death. The goals of Child Death Investigations at the BCCS are to:

- assist the pathologist, police, and coroners in ruling in or ruling out natural causes of death, child abuse or neglect, or injury;

[2] *Hanzlick R, Parrish RG. The role of medical examiners and coroners in public health surveillance and epidemiological research. Ann Rev Public Health. 1996;17:383-409.*

- identify public health threats, such as those related to consumer products or unsafe health practices;
- contribute to the understanding of the cause and risk factors and to develop preventive strategies; and
- provide information to epidemiologists and agencies with an interest in the welfare of children (e.g. Representative for Children and Youth).

Although the ultimate objective of a scene investigation is to accurately assign a cause of death, other goals are to identify health threats posed by consumer products and to understand the associated risk factors. These duties are performed using standardized investigative procedures, data collection instruments, and training for scene investigations, and they underscore the central role of medical examiners and coroners in public health surveillance and epidemiologic research of sudden unexpected infant and child deaths.[2]

Identification and Disaster Response Unit

Consistent with the BCCS mandate to investigate all sudden and unexpected deaths, the Identification and Disaster Response Unit (IDRU) is a specialized unit responsible for facilitating the recovery, identification and repatriation of all human remains in the event of a mass fatality incident. In accordance with the agency's authority to determine identity in cases of sudden and unexpected death, the IDRU either directly provides or coordinates the delivery of forensic services, strengthening the overall analytical and investigative functions of the BCCS.

In 2007, the IDRU met a number of objectives related to both the identification and disaster response components of the unit. Highlighted achievements include launching the Geographic Information Systems (GIS) initiative and equipping all coroners in the province with Global Positioning System (GPS) units. GIS software technology was also acquired, enabling the unit to conduct spatial analysis of case information. The initiative, in partnership with the British Columbia Institute of Technology (BCIT), will continue its development throughout 2008, allowing the IDRU to expand its analytical capabilities as a specialized unit of the Coroners Service.

As a joint initiative with the Ontario Provincial Police and the Office of the Chief Coroner for Ontario, the IDRU also developed the Missing Persons and Unidentified Bodies (MPUB) website. The public component of this website is scheduled to launch in 2008. The database phase of this collaboration was instrumental in the IDRU's investigation into a number of historical cases in 2007, which resulted in successful identifications of three previously unidentified decedents. The IDRU also established in-house facial reconstruction capabilities, to further enhance the identification process.

Key disaster response objectives were also achieved in 2007, such as establishment of the Disaster Victim Identification (DVI) BC Taskforce, consisting of provincial experts in forensic pathology, anthropology, odontology, policing, government and emergency management. IDRU and executive personnel also attended the New York 9/11 mass disaster site and participated in a tour of the New York City Medical Examiner's Office.

The IDRU actively took part in a large-scale federal-level exercise in Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) training and joined the Integrated Public Safety Unit for development of a strategic, collaborative approach to emergency response throughout BC.

Resource Industry Unit

The Resource Industry Unit is dedicated to the investigation of deaths in the forest industry and related sectors. In addition to examining the circumstances related to a specific death, the unit considers forestry fatalities within the historical and provincial context of the industry.

Although the main focus is on fatal incidents in the forestry sector, the unit provides coroners across the province with assistance in investigations of complex industrial cases in other areas such as transportation, construction, and in the oil and gas industry. The unit also investigates non-workplace deaths involving tree falling, bucking and related activities such as those undertaken by homeowners on private land.

Deaths associated with the specific work activities in Table 2 may have occurred either during normal procedure, or while engaged in a related activity such as mechanical trouble-shooting. Additionally, the 'historical accident' category refers to deaths in which an injury incurred in a forestry-related incident many years previously was contributory to the death.

In January 2007, the Coroners Service issued a public safety bulletin urging operators of logging and wood manufacturing machinery to complete proper lock-out and equipment immobilization procedures when performing maintenance or repairs. This was prompted by several deaths involving failure to lock-out or immobilize machinery and mobile equipment by experienced operators.

Additionally, in June 2007, the BCCS held an inquest into the death of a logging truck driver who died on a forest service road near Mackenzie in 2006. The inquest highlighted some of the challenges involved in ensuring safety of resource road users and explored the complex issue of responsibility for managing safety on these roads. On the basis of

Table 1. Summary of Forestry-Related Deaths (2007)

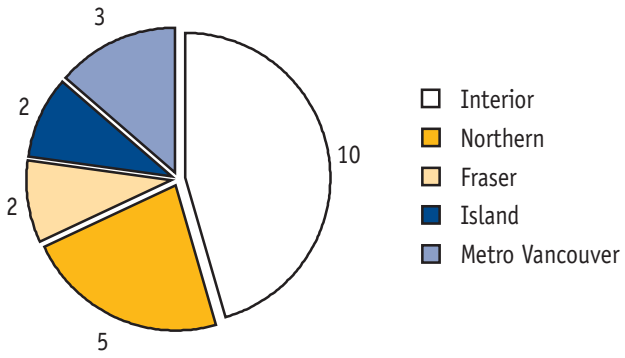
Number of Deaths	22
Average Age	50.8
Females	1
Non Forestry Workers	3

Table 2. Forestry-Related Deaths by Work Activity (2007)

Work Activity	#
Ground P/cable yarding	4
Residential/urban forestry	3
Sawmilling (mechanical)	3
Travel to/from work	3
Historical accident	2
Landing/log sorting	2
Forestry road construction	1
Log hauling/trucking	1
Manual tree falling	1
Other	2
Total	**22**

testimonies presented at the inquest by truck drivers, forest company representatives and government officials, the jury produced 17 recommendations which were directed at numerous organizations.

Figure 6. Forestry-Related Deaths in 2007, by Region.



Training and Development Unit

The Training and Development Unit assesses emerging trends and new developments that affect the training needs of BCCS staff. Educational programs are developed and provided that are comprehensive, timely and geared to ensuring BCCS staff are able to fulfil their responsibilities.

The unit also oversees the BCCS Occupational Health and Safety program and provides personal protective equipment and best practices for coroners in the field. Outreach and training is also provided to stakeholders and community groups.

In 2007, the unit managed several programs including the Coroners Basic Training Course and the Student Practicum Program. The Coroners Basic Training Course is an annual five day intensive training program which provides new coroners with an understanding of their role and authority under the Coroners Act. The Student Practicum Program placed a number of criminology and forensic science students in various units of the organization. Participating institutions include Simon Fraser University, University College of the Fraser Valley and the BC Institute of Technology. In addition to these training programs, the unit produced a training video and held monthly training seminars for BCCS staff.

The BCCS held its first annual international symposium in 2007. "The Crowner 2007: Beyond the Scene" was held in June. It featured presentations from forensic pathologists, forensic experts and police on a variety of current medico-legal death investigation topics. Participants were limited to medico-legal death investigators, Crown counsel, police officers and those employed in related disciplines.

Child Death Review Unit

The Child Death Review Unit (CDRU) is responsible for the comprehensive review of all child deaths in the province. Through the application of a child death review protocol, the multi-disciplinary review team identifies risk and protective factors related to a child's life and death, and uses that information to determine how similar deaths may be prevented in the future. The overall goal of review is to identify trends and themes, to inform the development of evidence-based recommendations aimed at improving the health and well-being of all BC children. The CDRU works closely with families, First Nations leadership, government ministries and other agencies to ensure recommendations are meaningful and based on best practices.

In 2007, the CDRU developed a framework for child death review based on the best practices of units from across North America. In July 2007, the CDRU released its first "Special Report"

on drowning deaths. In December 2007, the CDRU released the 2006 Annual Report, for which the deaths of 244 children were reviewed. Work began on two additional Special Reports on children who died due to suicide and children whose deaths were determined to be due to Sudden Infant Death Syndrome or Sudden Unexpected Death in Infancy. Finally, in 2007 the CDRU developed a Prevention, Education and Outreach Strategy, the first for the CDRU at the BCCS, which was based on a core set of principles consistent with a population health approach.

Legal Services and Inquests

The Legal Services and Inquests Unit operates under the direction of the Executive Director of Legal Services (Chief Counsel), assisted by the Legal Assistant/Inquest Coordinator. In addition, the unit employs the services of seven ad hoc legal counsel to serve as Inquest Counsel to Presiding Coroners. The main responsibility of this unit is to oversee the holding of inquests. In addition, the unit provides direction, training and assistance to Presiding Coroners and the Coroners Counsel. There are 15 trained and experienced Presiding Coroners.

The unit is responsible for the provision of legal advice on day to day issues related to the interpretation of the *Coroners Act* and the legal mandate of the British Columbia Coroners Service. The unit researches and prepares legal opinions, polices and procedures regarding issues that may arise within the British Columbia Coroners Service. The unit also researches and assesses legal trends and emerging issues in provincial, federal and international jurisdictions and provides legal advice on their potential impact on the British Columbia Coroners Service.

In cooperation with the provincial Legal Services Branch, the unit provides legal advice and guidance to the Chief Coroner on a broad range of corporate and operational issues including proposed legislative amendments, policy developments and administrative procedures. In 2007 the unit developed a system for retaining ad hoc counsel via formal written contracts. A list of available, qualified and experienced counsel was established.

In 2007, an Inquest Committee was established to review all potential inquest matters and to provide advice to the Chief Coroner. The committee works with the Regional Coroners to ensure that all potential inquest matters which require the attention of the Chief Coroner are brought forward. The committee provides recommendations and background information on inquest related issues to the Chief Coroner.

Also in 2007, the unit worked closely with provincial legislative counsel in the drafting of the *Coroners Act* [SBC 2007] Chapter 15. This new *Act* repealed and replaced, in its entirety, the *Coroners Act* [RSBC 1996] Chapter 72. The drafting process involved extensive consultation with Coroners to ensure that the updated Act will enhance their ability to fulfil their mandate.

Some of the changes brought in by the *Coroners Act 2007* are:

- coroners are now appointed by the Chief Coroner not via an Order-in-Council;
- a unit of the Coroners Service was authorized to review child deaths in British Columbia;
- requirement to report all child deaths to a coroner;

- coroners may now, without holding an Inquest, require a person to appear before them at a time and place set by the Coroner to answer questions under oath or affirmation;
- peace officers must now immediately report to a Coroner the facts and circumstances relating to all deaths resulting directly or indirectly from the act of a peace officer.

The *Coroners Act* can be viewed online at:

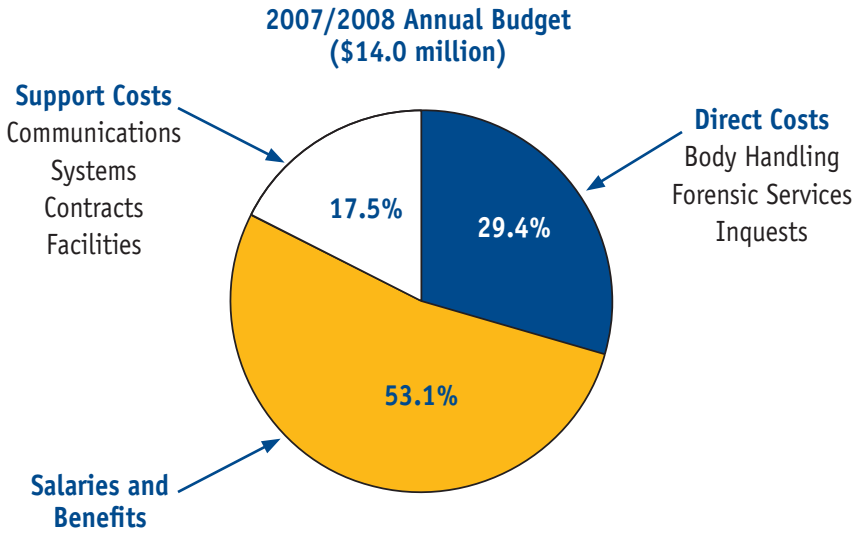
www.qp.gov.bc.ca/statreg/stat/C/07015_01.htm

G. Budget

The BCCS annual budget for 2007/2008 was $14.0 million (April 1st 2007 to March 31st 2008). It was spent in three areas: salaries and benefits, direct costs and support costs. Salary and benefits comprised approximately half of the total budget. In 2007, the BCCS employed 66 community coroners, 30 full-time coroners, and 34 other staff members.

Direct costs comprised almost one third of the budget and included expenses such as inquests (e.g. juries, court reporters and related inquest fees), forensic services (e.g. autopsies, toxicological analysis) and body handling (e.g. recovery, storage and transport costs). Support costs include expenses such as external contracts, systems, communications, and facilities.

Figure 7. BCCS Budget Expenditure for the 2007/2008 Fiscal Year.



H. Research

The BCCS is active in research, both within the organization and in collaboration with outside agencies. Most of this research is conducted to inform and advance injury and death prevention. A database system implemented in 2006 has significantly improved case management and the accessibility of BCCS data. Three examples of research projects the BCCS participated in, in collaboration with external agencies, are provided below.

Drugs and Motor Vehicle Incidents

A research study conducted in collaboration with a forensic toxicologist and current Director of the Toxicology and Drug Monitoring Laboratory at the Mayo Clinic (Rochester, MN) was completed in 2007. The objective of the project was to investigate drug use among drivers involved in fatal motor vehicle incidents. This research indicated that alcohol is the drug most frequently associated with driving fatalities, followed by cannabis and cocaine in that order.

Avalanche Fatalities in Western Canada

In 2007 the BCCS participated in an avalanche project conducted by researchers from the Mineral Springs Hospital in Banff Alberta, Simon Fraser University in Burnaby BC, and the University of British Columbia. The researchers reviewed avalanche-related deaths to determine if trauma is a significant cause of death in Western Canadian avalanches, and whether trauma varies between different activity groups or differs from European data. The results demonstrated that fatality patterns in Western Canadian avalanches differ significantly between activity groups and from those of European studies. This information will be valuable in exploring avalanche safety devices.

Illicit Drug Overdose Deaths

The BCCS contributed to a project on injection drug use that is currently underway at the BC Centre for Excellence in HIV/AIDS (CFEHA). The CFEHA has a broad mandate to investigate HIV and related illness. As injection drug use is one of the leading causes of HIV infection, the CFEHA has undertaken an assessment of its impact on public health. As part of this project, the CFEHA is investigating trends in overdose deaths over a five year period. The final results will be available on the CFEHA website (www.cfenet.ubc.ca) on completion of the project.

Part 3
Recommendations and Prevention

A. Recommendations

Part of the mandate of the BCCS is prevention of deaths. In addition to the recommendations that a jury may make following inquest proceedings, a coroner can also make recommendations, where appropriate and feasible, to both public and private agencies. These recommendations are made so that a similar death is less likely to occur in the future. During an investigation, a coroner may decide to make one of two types of recommendations:

1) "Action": a change is recommended to the agency and a response to this recommendation is requested by the BCCS. Recommendations may be directed to one or more agencies/ individuals.

2) "Information": no changes are recommended but the findings of the investigation are brought to the agency or individual's attention for informational purposes only. A response to the information is not requested, although a response may sometimes be received.

A response to action recommendations are requested within 90 days of distributing the recommendation. Positive responses include those where agencies acknowledge the recommendation(s), have already taken action or are going to be taking further action to implement the recommendation(s), or are taking the recommendation into consideration and evaluating further. A negative response includes those where agencies are unable to implement the recommendation. A negative response can sometimes be appropriate as the recommendation cannot be carried out by an agency due to legislative reasons, financial implications, or other circumstances.

Although the BCCS has no statutory authority to order change or otherwise ensure that recommendations are carried out, it is expected that recommendations will be given serious consideration by the agencies to which they are directed. The BCCS has been successful in having recommendations considered and implemented in the past, as indicated by the recommendation response rates summarized in the Statistics section of this report.

The Chief Coroner is responsible for bringing the findings and recommendations from coroner's investigations and inquest juries to the attention of appropriate individuals, agencies, the public, and ministries of government. As a direct result of coroner and jury recommendations, policies and procedures have been changed with the goal of preventing similar deaths in the future.

In 2007, the BC Coroners Service distributed a total of 684 recommendations made by juries at inquests or through coroner's investigations. The majority of the recommendations resulted from accidental deaths. This is an increase relative to the number of recommendations distributed in previous years, due in part to a greater number of inquests held in 2007, and the conclusion of a number of high profile cases.

Recommendation Statistics

Recommendation statistics represent the total number of recommendations distributed to individuals and agencies. One recommendation may be distributed to multiple recipients.

The Coroners Service had a 59% response rate to recommendations that were sent for action (i.e. requiring a response), with approximately 83% of responses being positive. *This response rate is expected to change significantly, as the response due dates for many recommendations issued in 2007 have yet to arrive.* Agencies receiving 15 or more recommendations in 2007 are listed in Table 4.

Table 3. Number of Recommendations Distributed by Type and Year (2004-2007)

Year	Type	#	Total
2004	Action	233	
	Information	49	282
2005	Action	228	
	Information	46	274
2006	Action	149	
	Information	38	187
2007	**Action**	**615**	
	Information	**69**	**684**

Table 4. Number of Recommendations Distributed by Classification (2007)

Death Classification	#
Accidental	423
Homicide	144
Natural	62
Suicide	17
Undetermined	38
Total	**684**

Table 5. Number of Recommendations Distributed by Source (2007)

Recommendation Source	#
Coroner	372
Jury	312
Total	**684**

Table 6. Recipients Receiving Fifteen or More Recommendations (2007)

Recipient	#
Ministry of Children and Family Development	47
College of Physicians and Surgeons	43
Interior Health Authority	41
Ministry of Public Safety and Solicitor General	33
Vancouver Coastal Health Authority	28
Royal Canadian Mounted Police	24
Ministry of Transportation and Highways	24
Fraser Health Authority	23
Vancouver Island Health Authority	23
Ministry of Health (Provincial)	22
BC Ambulance Service	21
BC Forest Safety Council	17

Table 7. Response Rate to Action Recommendations (2007)

Percent of recipients responding*	59%
Percent of responses that were positive	83%

* This percentage will rise, as responses are continuing to be received for recommendations distributed in 2007.

B. Coroner's Recommendations

In 2007, 220 recommendations were made by investigating coroners. These recommendations resulted from the investigations of 94 unique case files. Some recommendations were sent to more than one agency, resulting in 372 distributed recommendations. Of the 220 unique recommendations, 83% were Action (A) recommendations and 17% were Information (I) recommendations.

Figure 8. Topic of Coroner's Recommendations Distributed in 2007.

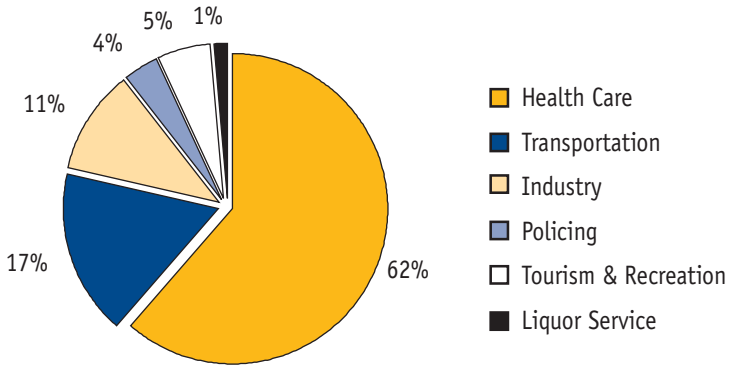


Table 8. Summary of Coroner's Recommendations Made in 2007

Topic	# of Cases	Type		Total
		A	I	
Health Care	64	99	36	135
Transportation	16	37	1	38
Industry	5	24	0	24
Policing	3	7	1	8
Tourism & Recreation	5	12	0	12
Liquor Service	1	3	0	3
Total	**94**	**182**	**38**	**220**

Selected Coroner Recommendation Case Summaries

Health Care

Case 1 of 14

On July 12, 2006, a 26-year-old male died at Nanaimo BC, due to Cryptococcus gatti infection. The male sought medical treatment several times over the three weeks preceding his death, but a diagnosis of this rare illness was not considered. He collapsed on his way to see his physician and died in hospital a short time later. The death was classified as Natural.

Recommendations:

Vancouver Island Health Authority consider that routine information briefs forwarded to service providers on Vancouver Island contain a reminder that Cryptococcus gatti infections have been identified in that region.

The Minister of Health consider mandatory reporting of Cryptococcus gatti infections across Canada to improve tracking of infections.

Response to Recommendations:

Vancouver Island Health Authority responded that three newsletters have been sent out since 2001 about Cryptococcus gatti on Vancouver Island, reviewing the potential for exposure, clinical presentation and the approach to diagnosis.

The Minister of Health responded that the Cryptococcus gattii issue will be presented to the Communicable Disease Control Expert Group for discussion, following a review of the current epidemiology of the disease in Canada.

Case 2 of 14

On June 25, 2006, an 85 year-old female died at Surrey BC due to congestive heart failure, as a consequence of clinical tetanus. The female did not receive prophylactic treatment for tetanus and was not questioned regarding tetanus immunization, during treatment for a wound sustained in a fall. The death was classified as Accidental.

Recommendations:

Fraser Health Authority and College of Registered Nurses ensure that triage nurses always check for tetanus immunization in patients with open wounds, and administer prophylactic treatment where necessary.

Response to Recommendations:

Fraser Health Authority responded that they have: reviewed and revised the medical directive regarding Tetanus toxoid and tetanus immunoglobulin; revised written patient discharge and referral instructions following tetanus or immunoglobulin administration; educated nursing staff regarding the revisions; and shared learnings with other Fraser Health sites.

Case 3 of 14

On September 4, 2006, an 87-year-old male died at Burnaby BC due to head injury sustained in an accidental fall. The male became agitated in hospital following a medical procedure and was physically restrained, prior to falling from his bed. The death was classified as Accidental.

Recommendations:

Fraser Health Authority and Burnaby Hospital discuss the policy of least restraint as applicable to a patient with family members, nursing staff and treating physician, with details of discussion documented in medical chart.

Response to Recommendations:

Burnaby Hospital responded that the recommendation is scheduled for internal discussion, a poster "alert" campaign will be undertaken, and they will be working with their nursing educators and clinical nurse specialist to ensure all staff follow appropriate procedures.

Case 4 of 14

On May 20, 2006, a 68-year-old male died at Port Moody BC, due to respiratory failure resulting from metastatic carcinoma. The male had a tracheostomy tube inserted to aid breathing while under going palliative cancer care. The tracheostomy tube became dislodged; when he began having respiratory difficulties nursing staff were unable to reposition the tube. The death was classified as Natural.

Recommendations:

Fraser Health Authority received two recommendations:

1) The protocol of tracheostomy care be reviewed to ensure the procedure for securing the device is clearly delineated.

2) Consider an educational review for staff regarding management of tracheostomy and emergency procedures for re-inserting the device.

Response to Recommendations:

Fraser Health Authority responded that the tracheostomy care protocol is currently under review, and an education review for staff is underway.

Case 5 of 14

On January 11, 2006, a 67-year-old female died at Vancouver BC, due to an adverse drug reaction. The female was given a sample package of medication to try in conjunction with her prescription medications. The sample medication was known to have the potential for adverse reaction with one of her prescribed medications, but she was not monitored for this. The death was classified as Accidental.

Recommendations:

Judgment to be reviewed by the College of Pharmacists, regarding capturing information on medication sample packages.

Response to Recommendations:

The College of Pharmacists responded that the Pharmanet database does capture physician office samples and is now routinely available for physicians but their access is voluntary.

Case 6 of 14

On February 6, 2006, a 78-year-old male died at Richmond BC, due to multiple blunt force injuries. The male was a resident of a care facility and had been displaying escalating periods of aggression and elopement. His history was not fully disclosed following transfer to another facility. The male was struck by a car after eloping from the second facility. The death was classified as Accidental.

Recommendations:

Richmond Hospital and Vancouver Coastal Health Authority should complete a specific risk assessment for elopement and wandering behaviours for all geriatric patients upon admission to residential care or hospital, to be updated upon change in behaviour that may affect risk for elopement or wandering.

Response to Recommendations:

Richmond Hospital and Vancouver Coastal Health Authority responded that the recommendation is under review.

Case 7 of 14

On October 5, 2006, a 1-day-old male died in Vancouver BC from hypoxic ischemic encephalopathy due to perinatal asphyxia. He was delivered by an emergency caesarean section following the deceleration of his heart rate during fetal monitoring. Aggressive resuscitation measures were undertaken, however subsequent tests revealed he had suffered extensive brain damage and a decision was made to withdraw medical support. The death was classified as Natural.

Recommendations:

Children's Hospital received two recommendations:

1) Review the death with respect to developing effective communication practices between nursing staff members when concerns are identified with a patients condition.

2) Consider adopting the practice of using intermittent auscultation with patients who prefer to labour in environments and/or positions precluding the use of external fetal monitoring.

Response to Recommendations:

Children's Hospital responded that they have reviewed the circumstances and are working to improve communication practices between nursing staff members, and that the hospital already has a policy on intermittent auscultation.

Case 8 of 14

On December 1, 2006, an 88-year-old female died at Vancouver BC, due to subdural hematoma resulting from an unwitnessed fall. The female was a resident of a rest home when the fall occurred. Following the incident, she was found to have an abrasion on the back of her head but was not assessed for head injury at that time. The following morning she was found to be in a semi-conscious state, and she passed away a few days later. The death was classified as Accidental.

Recommendations:

The Rest Home received two recommendations:

1) Circumstance of the case should be reviewed regarding improvement of fall protocol.

2) Consider educating staff regarding identification and reporting neurological symptoms after a fall.

Response to Recommendations:

The Rest Home responded that their medical coordinator provided a training session for nurses on identifying and reporting symptoms of neurological injury after a fall, and that they are completing a Falls Prevention and Management program in accordance with best practice guidelines at the VCH regional fall prevention initiative.

Case 9 of 14

On June 4, 2006, a 36-year-old female died at North Vancouver BC, due to morphine and cocaine intoxication. The female was admitted to hospital for treatment of a recurring illness. She was known to have a long history of substance abuse and was treated for withdrawal. There was concern among hospital staff that the she was continuing substance use while in hospital, but efforts to curb this were unsuccessful. Two weeks after being admitted to hospital, the female was found deceased in her hospital room. The death was classified as Accidental.

Recommendations:

Vancouver Coastal Health Authority received four recommendations:

1) Participate in a multidisciplinary aggregate review with Lions Gate Hospital of this case and other similar cases.

2) The care issues identified by the judgment be added as a topic for immediate in-service training for nurses and social workers.

3) Judgment to be reviewed by all physicians, nurses and social workers involved in this case, for information and education; no response required.

4) Judgment to be reviewed by all physicians providing care to Lions Gate Hospital patients, for information and education; no response required.

Response to Recommendations:

Vancouver Coastal Health Authority responded that they are prepared for aggregate review with Lions Gate Hospital, and that the judgment was distributed to the physicians, nurses and social workers involved in the case, as well as all physicians providing care to Lions Gate Hospital patients, and finally the judgment was forwarded to the individuals responsible for in-service training for addition to curriculum.

Case 10 of 14

On June 19, 2006, a 71-year-old female died at Vancouver BC, due to hypoxic ischemic encephalopathy as a consequence of respiratory arrest, due to central nervous system anesthesia. Following eye surgery, the female experienced pain and swelling and returned to the clinic over a week later for further treatment. The attending physician administered a retrobulbar anesthetic, which triggered respiratory collapse. Although she received emergency treatment very quickly, subsequent tests revealed extensive brain injury. She developed pneumonia and sepsis and died several weeks after the initial incident. The death was classified as Accidental.

Recommendations:

Vancouver Coastal Health Authority and UBC Hospital were jointly issued two recommendations:

1) All treatment rooms in the eye clinic should be equipped with resuscitation equipment and medications in keeping with College of Physicians and Surgeons guidelines.

2) The eye clinic should consider purchasing a portable Automatic External Defibrillator.

Response to Recommendations:

UBC Hospital responded that the *Eye Care Centre* meets the standard set for resuscitation equipment for office practice as issued by the College of Physicians and Surgeons, and a portable Automatic External Defibrillator has been purchased.

Vancouver Coastal Health Authority responded that the Eye Care Centre was under review.

Case 11 of 14

On July 3, 2006, a 77-year-old male died at North Vancouver BC, due to subdural hematoma resulting from an unwitnessed fall. The male was a resident of a care centre. He was found prone in a hallway during the early morning, apparently having fallen. He was assessed for injury and determined to be unhurt aside from minor bruising. Later that morning he was found unresponsive in his bed, and did not respond to intervention. The death was classified as Accidental.

Recommendations:

Vancouver Coastal Health Authority was issued four recommendations:

1) Take all reasonable measures to ensure that practice guidelines regarding Seniors Fall & Injury Prevention are communicated with necessary training to all seniors care facilities & staff.

2) The judgment and Seniors Fall & Injury Prevention practice guidelines should be distributed to all Provincial Health Authorities for review and implementation.

3) Add 'rate of falls resulting in head injury' as an indicator reportable by long-term and acute care facilities, to better assess the incidence rates and facilitate development of improved fall management and risk reduction Practice Guidelines.

4) The judgment should be forwarded to all staff of Vancouver Coastal Health Seniors Fall & Injury Prevention Initiative for education and review purposes.

The Care Centre received three recommendations:

1) Implement mandatory teaching sessions with staff to review Post Fall Assessment Policy and other fall management and risk reduction Practice Guidelines, and ensure compliance by staff with this policy.

2) Add 'rate of falls resulting in head injury' as an indicator reportable to better assess the incidence rates and facilitate development of improved fall management and risk reduction Practice Guidelines.

3) The judgment should be circulated to all management, supervisors, nurses and other health care staff for education and teaching purposes.

Response to Recommendations:

Vancouver Coastal Health Authority responded that the recommendations were forwarded to the Chief Operating Officer for consideration.

The *Care Centre* responded that the judgment and Post Falls Assessment policy was reviewed and discussed with all management staff and nurses, to ensure all staff are aware of the Policy and the importance of adhering to it, and the "Number of Falls resulting in head injury" was added as a reportable indicator.

Case 12 of 14

On April 27, 2006, an 85-year-old female died at Penticton BC, due to multiple organ failure, caused by complications following surgery to repair a hip fracture. The female had fallen and sustained a fractured hip. She initially recovered well from surgery to repair the fracture. After a few days, her condition began to deteriorate and she died despite aggressive intervention. The death was classified as Accidental.

Recommendations:

Interior Health Authority to review the medical and nursing care the decedent received in hospital.

Response to Recommendations:

Interior Health Authority responded that the case has been directed to key individuals for response, and they will provide a summary of the outcome of discussions.

Case 13 of 14

On January 21, 2006, a 22-year-old male died at Kamloops BC, due to Systematic Inflammatory Response Syndrome with multiple organ failure, as a consequence of pneumonia. The male was brought to hospital after flu-like symptoms worsened. Once in hospital, his condition deteriorated rapidly. Some acute changes in his condition went unrecognized or unreported, causing delays in treatment. The male suffered multiple organ failure. The death was classified as Natural.

Recommendations:

Interior Health Authority received three recommendations:

1) To review the case for quality assurance and education, with particular attention to documentation of vital signs, intake and output, transcription of doctors orders and communications of patient's condition to treating physician.

2) Consider development and implementation of sepsis protocol, including treatment plan and training sessions.

3) Provide staff education on symptoms and management of respiratory failure.

Response to Recommendations:

Interior Health Authority responded that the death has been reviewed for quality assurance purposes and education is currently taking place for staff, including use of communication tools to assist the nurses in communication with physicians. A sepsis protocol is under development for use in both tertiary and rural sites. Interior health has clinical nurse educators, who provide education to staff on a variety of specific topics as needed.

Case 14 of 14

On June 16, 2006, a 14-year-old male died at Vancouver BC, due to massive cerebral infarct, as a result of complications of medical treatment. The male was admitted to hospital after experiencing flu-like symptoms. His condition deteriorated rapidly, requiring aggressive intervention. He suffered an unsurvivable blood clot to his brain, a known risk of the treatment he was receiving. It was determined that he had Hantavirus Pulmonary Syndrome, likely due to exposure to mouse droppings in the basement of his home. The death was classified as Natural.

Recommendations:

Interior Health Authority received two recommendations:

1) Provide educational sessions to internists and emergency physicians regarding diagnosis of Hantavirus Pulmonary Syndrome.

2) Review communication of information regarding diagnosis of Hantavirus Pulmonary Syndrome from local public health offices to Interior Health Authority (majority of cases occur in this region).

Transportation

Case 1 of 7

On March 8, 2006, a 27-year-old male died at Powell River BC, due to cerebral trauma sustained during an aviation incident. The male was a co-pilot on a cargo flight from Vancouver to Powell River. The weather was inclement at the time of landing; windy with reduced visibility. The plane overshot the runway and hit a dirt berm before coming to rest in a field. The death was classified as Accidental.

Recommendations:

The City of Powell River grade the area beyond the end of runway 9 and level the dirt berm at this site to enhance survivability of future aircraft overrun incidents.

Response to Recommendations:

The City of Powell River responded that the specified area has been graded and the dirt berm leveled.

Case 2 of 7

On April 27, 2006, a 65-year-old male died at Hope BC, due to acute pulmonary embolism resulting from a single vehicle collision. The male was driving a commercial tractor-trailer that failed to negotiate a turn and rolled over. Speed and load shift due to inadequate load securement were both factors in the accident. The death was classified as Accidental.

Recommendations:

The Ministry of Transportation and Highways received two recommendations:

1) Consider reviewing transportation and securement of pulp bales; explore the possibility of meeting with pulp/paper industry to develop safe transportation for pulp-/paper products.

2) Consider developing a random enforcement program to monitor load securement, especially van trailers transporting pulp/paper products.

Case 3 of 7

On May 13, 2006, a 31-year-old male died at Kelowna BC, due to blunt force trauma as a consequence of a motor vehicle incident. The male was riding a motorcycle on a highway when he was involved in a collision with a truck turning onto the highway. The male's speed was considered contributory to the incident. The death was classified as Accidental.

Recommendations:

The Ministry of Transportation and Highways create raised channelization at the junction of Loyd Road with Highway 97 in Kelowna to prevent vehicles from turning left.

Response to Recommendations:

The Ministry of Transportation and Highways responded that this intersection is similar to several in the area allowing for left turns on to Highway 97, and local records indicate that this is not a high traffic accident area and would not support warrants to restrict left turn at this time. This area has been for future road extensions, and the Ministry will revisit the option of limiting access to Highway 97 at that time.

Case 4 of 7

On May 29, 2006, a 58-year old male and a 57-year-old female died at Kamloops BC, due to blunt force trauma resulting from a motor vehicle incident. The male was driving and the female, his wife, was in the front passenger seat. They were struck by another vehicle as he attempted to turn left from a side road onto a highway. The deaths were classified as Accidental.

Recommendations:

The Ministry of Transportation and Highways restrict left-turn travel from the side roads Okanagan Way and Chief Louis Way by physically preventing the movement with raised channelization on Highway 5.

Response to Recommendations:

The Ministry of Transportation and Highways responded that they will review the crash history and geometrics of the intersection to help determine if the removal of the left turn movement from the side roads is warranted.

Case 5 of 7

On December 2, 2005, a 26-year-old female died at Richmond BC, due to drowning following a motor vehicle incident. The female lost control of her vehicle on an icy road, and rolled into a water-filled ditch.

Recommendations:

The City of Richmond consider erecting a protective barrier between the roadway and east dyke in the 7000 block of Number 6 Road in Richmond.

Response to Recommendations:

The City of Richmond responded that they are actively seeking a suitable application and cost estimate to provide a protective barrier between the roadway and the east dyke

Case 6 of 7

On February 1, 2006, an 85-year-old male died at Vernon BC, due to head injury resulting from a motor vehicle incident. The male was making a left turn in his car, when he was hit by a truck traveling straight through the intersection. The death was classified Accidental.

Recommendations:

The Ministry of Transportation and Highways and the City of Vernon consider installation of a "prepare to stop when amber flashing" sign on the southbound exit lane of Highway 97 on the approach to the signal at the intersection of 27th Street, 58th Avenue and Anderson Way in Vernon.

Response to Recommendations:

The Ministry of Transportation and Highways responded that the intersection is under the jurisdiction of the City of Vernon.

The City of Vernon responded that city transportation engineering staff have proposed for consideration in the 2008 Capital Works Budget the installation of an advance warning sign on the north approach to the intersection of 58th avenue with 27th street.

Case 7 of 7

On June 11, 2005, a 23-year-old male died at Vernon BC, due to a fractured spine as a consequence of a motor vehicle incident. The male lost control of his motorcycle and struck a roadside barrier. He was thrown from the motorcycle and struck a road sign. The death was classified as Accidental.

Recommendations:

The Ministry of Transportation and Highways review the southbound curve on 39th Avenue between Mutrie Road and Black Rock Road in Vernon BC, with respect to visibility; specifically the painted centre line and visibility of the cement barrier

Response to Recommendations:

The Ministry of Transportation and Highways responded that increased signage has been added, to draw attention to the curve and the barrier.

Industry

Case 1 of 1

On May 11, 2005, a 44-year-old male died at Ucluelet BC, due to hypovolemic shock as a consequence of a massive vascular injury due to a commercial logging incident. The male was falling a tree that caused another tree to slide into him when it fell, pinning him against a stump. The death was classified as Accidental.

Recommendations:

WorkSafeBC received two recommendations:

1) Undertake regular inspections of small or remote work sites to ensure safe work practices are being adhered to.

2) Consider a review of the forest industry and Occupational Health and Safety Regulations regarding issues of non-compliance.

Response to Recommendations:

WorkSafeBC responded that they have implemented the Integrated Forest Safety Compliance Program which includes both a consultative and a strong enforcement approach. All Prevention Officers working in the forest industry have been directed to work with small firms to assist them in moving into compliance. Additionally, a review of the Occupational Health and Safety Regulation was conducted with a view to ensuring that the regulatory standards provide an effective enforcement tool that addresses the changing relationships within the industry. Regulatory changes as a consequence of this review came into effect on May 1, 2008.

Tourism and Recreation

Case 1 of 2

On July 19, 2006, a 27-year-old male died at Penticton BC, due to asphyxia as a consequence of drowning. The male did not know how to swim. He was playing with his son in shallow water at a public beach when he walked off a drop-off. Witnesses brought him to shore but he was unresponsive to CPR. The death was classified as Accidental.

Recommendations:

The City of Penticton to add warning signs to the general public regarding the dangers of a steep drop off area to existing sign posts on Skaha Park Beach.

Response to Recommendations:

The I responded that additional warning signs have been installed informing the public of the dangers of steep drop offs.

Case 2 of 2

On August 4, 2006, a 16-year-old female died at Barriere BC, due to asphyxia following an all terrain vehicle (ATV) incident. The female was a passenger on an ATV when it rolled over. A roll bar on the vehicle landed on her neck, fracturing several bones and compressing her airway. The death was classified as Accidental.

Recommendations:

The Ministry of Public Safety and Solicitor General and Ministry of Tourism, Sports and the Arts consider incorporating the following safety, education and enforcement options regarding the use of off-road vehicles:

1. mandatory helmet use;
2. education regarding the dangers of exceeding passenger capacity;
3. disclosure statement at point-of-sale regarding use of adult safety equipment by children;

4. required education for those 16 and under regarding seatbelt use;
5. appropriate enforcement legislation be established to enable compliance by police agencies and enforcement officers.

Response to Recommendations:

The Ministry of Tourism, Sports and the Arts responded that Cabinet has directed the Ministry to further analyze financial costs, rural impacts and best practices for implementation of an anticipated regulatory framework. The five recommendations will be considered in developing this framework.

The Ministry of Public Safety and Solicitor General responded that, as the recommendations are influenced by the *Motor Vehicle (All Terrain) Act*, the matter was referred to the Minister of Tourism Sports and the Arts.

Liquor Service

Case 1 of 1

On January 12, 2007, a 34-year-old male died at Pemberton BC, due to multiple blunt force injuries resulting from a motor vehicle incident. The male had been drinking at a hotel bar for several hours when he decided to drive home. He failed to negotiate a turn and the vehicle rolled down a steep embankment. The male was thrown from the vehicle. The death was classified as Accidental.

Recommendations:

The Hotel received three recommendations:

1) Hotel staff should be properly trained in the requirements of the Liquor Control Licensing Branch and liquor regulations.
2) Ensure a policy is in place to prevent over-service of alcoholic beverages.
3) Once policy and procedures are in place, ensure they are followed.

Response to recommendations:

The Hotel responded that they have upgraded all staff in the Serving It Right Program; regularly meet with staff to ensure they understand house and Liquor Board policies regarding patrons and when to discontinue service. Spot checks are carried out through the course of the night to assess compliance with policies.

C. Coroner's Recommendations on Emerging Public Safety Issues

The majority of coroner's recommendations are in response to a single case, as in the examples summarized above. A coroner may also decide to issue recommendations following multiple fatalities, when these have occurred under circumstances with implications for public safety.

For example, following the investigation of three deaths involving personal mobility vehicles (i.e. motorized scooters) in the Island region, a coroner produced several recommendations aimed at preventing similar deaths.

All three deaths involved elderly individuals. In 2004 a 94 year-old-male rode a motorized scooter onto a highway intersection at a crosswalk and was fatally injured when he was struck by a vehicle. Later in 2004, an 89 year-old-male was struck by a vehicle while riding his personal mobility vehicle in a marked crosswalk. Similarly, in late 2005, a 90 year-old-female was struck by a vehicle as she was riding her mobility vehicle in a crosswalk.

During the course of the investigation into these three cases, the coroner identified several areas of concern regarding the use of personal mobility vehicles. The low placement of the operator, safety lights and reflectors on the vehicle make it less visible for motorists. Also, as elderly or those with compromised health are often riders of mobility vehicles, even slow speed collisions can result in fatal injuries. There are no requirements for licensing or evaluating the ability of an individual to use a mobility vehicle. Furthermore, provincial police investigation reports do not allow for the specification of a 3 or 4-wheeled mobility vehicle. Incidents with these vehicles are specified as motor vehicle incidents involving a pedestrian, resulting in inaccurate data. Similarly, the provincial Medical Certificate of Death also does not allow for the specification of operators of mobility vehicles. Accurate statistics regarding incidents with these vehicles are essential in identifying safety issues. The *Motor Vehicle Act* does not provide a specific definition of personal mobility vehicles or specify whether a person operating a motorized wheelchair or mobility vehicle is a motorist or a pedestrian.

In 2007, the investigating coroner for the above three fatalities issued a total of eight recommendations to 17 agencies. Recipients of the recommendations included the Insurance Corporation of BC (ICBC), the Superintendent of Motor Vehicles, the Ministry of Transportation, the Union of BC Municipalities, the BC Association of Chiefs of Police, the BC Vital Statistics Agency, the College of Physicians and Surgeons and the BC Safety Council. The recommendations included amending the *Motor Vehicle Act* to add a definition of personal mobility vehicles, to consult with the Solicitor General regarding safety equipment standards and when and where such vehicles are used, and to increase illumination, signage and lighted warning devices at high-risk intersections.

The Superintendent of Motor Vehicles, ICBC and the Ministry of Transportation jointly responded that a legislative proposal has been developed to amend the *Motor Vehicle Act* to include the proposed definition of personal mobility vehicles. This will also clarify whether scooters are permitted on public roadways or highways. These proposed changes to the *Act* will permit the regulation of motorized scooters in terms of minimum required safety standards and equipment.

The Union of BC Municipalities responded that they are aware of safety issues and mobility vehicles through their work in their Seniors Program and their Traffic Safety Initiative. A Resolution B106 is to be considered at a convention in late 2007. The resolution asks that the provincial government be requested to establish province-wide guidelines for the safe operation of personal mobility vehicles.

The BC Medical Association will publish an article in their Journal highlighting to their members the hazards of cognitively impaired persons using scooters and the regulation and assessment of operators of scooters, similar to those used for the operation of motor vehicles.

D. Other Prevention Activities

Agency Collaboration

There are numerous deaths for which preventative changes are made by an agency or individual during an investigation, pre-empting the need for a formal recommendation to be issued. Coroners may work actively with agencies to develop prevention strategies, without the need to issue any formal recommendations. During the course of an investigation, a coroner may meet with various agencies to discuss the death. Agencies are often eager to make changes that will prevent similar deaths in the future. In these cases, the coroner may aid the agency by making suggestions for change. If implemented during the course of an investigation, no formal recommendations are issued to the organization. This informal recommendation practice is an important process through which the BCCS effects change in the community to prevent future deaths.

Public Safety Bulletins

To further its prevention efforts, the BCCS also issues public safety bulletins as part of its mandate to prevent deaths in B.C. These bulletins are released to the media province-wide and are also published on the BCCS website, at: www.pssg.gov.bc.ca/coroners/

There were seven public safety bulletins issued in 2007 on a variety of topics, in response to single incidents, environmental conditions or recent trends in preventable fatalities. These public safety bulletins are summarized below in order of release date.

January 25: Fatal Forestry Accidents Are Preventable.

Following a death in January of 2007 and 6 deaths in 2006 caused in part by failure to immobilize equipment, the BC Coroners Service urged all operators of forestry and wood manufacturing machinery to carry out proper immobilization procedures whenever performing any maintenance or repair.

March 20: Drugs Bought Online Can Be Deadly.

After pills purchased on the Internet were linked to the death of a BC woman, the BC Coroners Service released this bulletin warning consumers of the potential risks of purchasing medications online.

April 12: Avalanche Deaths Prompt Warning.

Five people died from avalanches in BC in the first quarter of 2007, prompting the Coroners Service to urge outdoor enthusiasts to be aware of the risks and take precautions.

May 30: Wild Mushrooms Can Be Deadly.

Following a fatal wild mushroom poisoning incident in 2006, the Coroners Service issued a warning to the public prior to the start of the 2007 mushroom picking season, on the dangers of eating wild mushrooms,.

August 21: Infant Dies After Recalled Playpen Collapses.

The Coroners Service warned parents and caregivers to check playpens following the death of an 11 month-old BC boy.

August 27: Student Fire Safety Can Prevent Needless Deaths.

The Office of the Fire Commissioner and the BC Coroners Service urged students to protect themselves and their friends from fire.

December 31, 2007: Avalanche Deaths Prompt Seasonal Warning.

Following the deaths of two people from an avalanche in BC, the Coroners Service urged backcountry skiers, snowmobilers and other outdoor enthusiasts traveling in mountain terrain to exercise caution.

Part 4
Statistics

On a typical DAY in 2007 in BC:

- 1.3 deaths were due to suicide
- 1.1 deaths resulted from motor vehicle incidents

In a typical WEEK in 2007 in BC:

- 1.8 deaths were due to homicides
- There were 1.4 deaths of pedestrians

In a typical MONTH in 2007 in BC:

- 3.8 deaths resulted from motorcycle accidents
- There were 17 child deaths, including 1 suicide

A. General Statistics

There were a total of 31,107[3] deaths in BC in 2007, of which 7,474 were reportable to the BCCS as required by the *Coroners Act*. Therefore, the BCCS investigated approximately 24% of all deaths in the province in 2007.

Table 9. Total Number and Classification of Deaths Reported to the BCCS in 2007

Classification of Death	#
Accidental	1,221
Homicide	96
Natural	5,338
Suicide	470
Undetermined	349
Total	**7,474**

Note: the statistics in this section are considered preliminary. The BCCS operates in a live database environment. Undetermined deaths may become classified as investigations progress. The data are subject to change until all investigations have been completed.

[3] *Total deaths in BC in 2007 from BC Vital Statistics, www.vs.gov.bc.ca. This is a preliminary estimate; official count to be published in the BC Vital Statistics 2007 Quarterly Digest issue 17, volume 4.*

Figure 9. Total Number of Deaths Reported to the BCCS, 2002-2007.

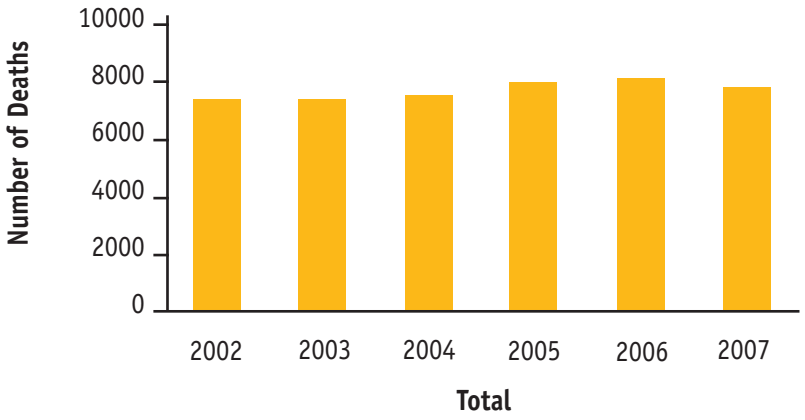
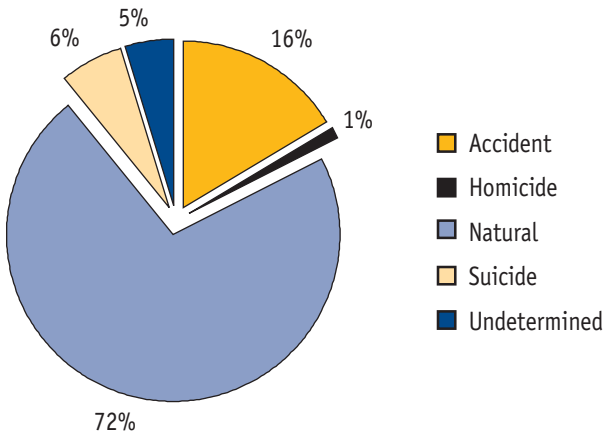


Table 10. Death Rate for BCCS Regions (2007)

Region	# of deaths	Population[4]	Rate per 10,000
Fraser	1,788	1,526,371	11.7
Interior	1,882	726,441	25.9
Island	1,717	749,626	22.9
Metro	1,438	1,087,167	13.2
Northern	649	290,651	22.3
Total	**7,474**	**4,380,256**	**17.1**

Figure 10. Classification of Deaths Reported to the BCCS, 2007.



[4] *Population estimates for 2007 by Health Authority area (BC Statistics Agency, www.bcstats.gov.bc.ca). Health Authority areas approximate the BCCS regions.*

Table 11. Classification of Deaths Reported to the BCCS by Region of Death (2007)

Region	Accidental	Homicide	Natural	Suicide	Undetermined	Total
Fraser	273	32	1,294	125	64	1,788
Interior	323	12	1,379	82	86	1,882
Island	258	10	1,265	92	92	1,717
Metro	226	36	1,000	124	52	1,438
Northern	141	6	400	47	55	649
Total	**1,221**	**96**	**5,338**	**470**	**349**	**7,474**

Table 12. Total Number of Deaths Reported to the BCCS by Region of Death (2002-2007)

Classification	2002	2003	2004	2005	2006	2007	Total
Fraser	1,779	1,786	1,703	2,027	2,064	**1,788**	11,147
Interior	1,616	1,746	1,738	1,806	1,813	**1,882**	10,601
Island	1,596	1,618	1,695	1,721	1,678	**1,717**	10,025
Metro	1,455	1,315	1,361	1,520	1,591	**1,438**	8,680
Northern	599	638	620	628	634	**649**	3,768
Total	**7,045**	**7,103**	**7,117**	**7,702**	**7,780**	**7,474**	**44,221**

B. Motor Vehicle Incidents

Table 13. Number of Motor Vehicle Incident Deaths by Gender (2002-2007)

Gender	2002	2003	2004	2005	2006	2007	Total
Female	137	151	135	151	119	**130**	823
Male	335	323	325	319	315	**286**	1,903
Total	**472**	**474**	**460**	**470**	**434**	**416**	**2,726**

Table 14. Number of Motor Vehicle Incident Deaths by BCCS Region and Type (2007)

Type	Fraser	Interior	Island	Metro	Northern	Total
Driver	44	69	24	23	39	199
Passenger	16	25	8	4	20	73
Commercial Driver	3	1	0	0	0	4
Commercial Passenger	0	1	0	0	0	1
Motorcycle/Moped	12	15	10	6	3	46
Pedestrian	20	7	17	20	6	70
Bicyclist	4	3	1	1	1	10
MVA/Train	2	0	0	0	0	2
Bus	0	2	0	0	0	2
Other	3	3	2	0	1	9
Total	**104**	**126**	**62**	**54**	**70**	**416**

C. Child Deaths

Table 15. Number of Child Deaths by Classification of Death (2002-2007)

Classification	2002	2003	2004	2005	2006	2007	Total
Accident	88	100	70	63	68	**62**	451
Homicide	13	10	5	5	16	**4**	53
Natural	59	76	54	71	86	**74**	420
Suicide	24	19	25	14	15	**12**	109
Undetermined	27	23	19	33	33	**54**	189
Total	**211**	**228**	**173**	**186**	**218**	**206**	**1,222**

Table 16. Number of Child Deaths by Gender (2002-2007)

Gender	2002	2003	2004	2005	2006	2007	Total
Female	72	91	66	60	90	**81**	460
Male	139	136	106	124	128	**125**	758
Unknown	0	1	1	2	0	**0**	4
Total	**211**	**228**	**173**	**186**	**218**	**206**	**1,222**

Figure 11. Total Number of Child Deaths Reported to the BCCS, 1996-2007

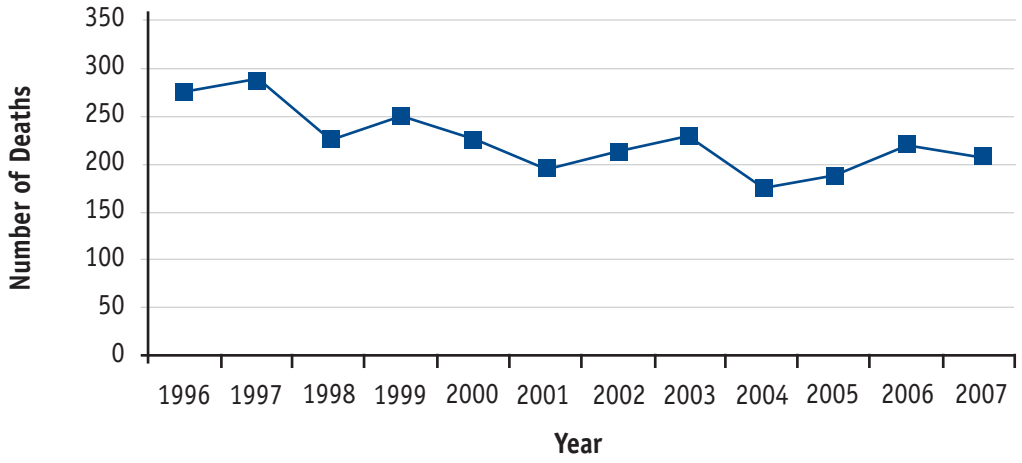


Figure 12. Child Deaths by Age Group, 2007

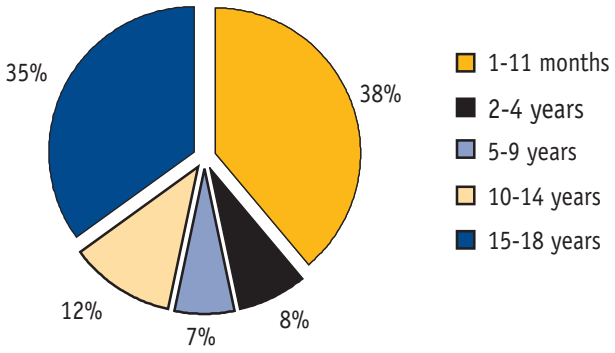


Table 17. Number of Child Deaths by Age Group (2002-2007)

Age Group	2002	2003	2004	2005	2006	2007	Total
0 - 11 months	59	65	56	69	70	**80**	399
1 - 4 years	20	30	15	17	22	**16**	120
5 - 9 years	18	18	10	10	16	**14**	86
10 - 14 years	37	27	24	21	25	**24**	158
15 - 18 years	77	88	68	69	85	**72**	459
Total	**211**	**228**	**173**	**186**	**218**	**206**	**1,222**

Table 18. Number of Child Deaths by Region (2002-2007)

Region	2002	2003	2004	2005	2006	2007	Total
Fraser	57	62	45	51	51	**49**	315
Interior	42	52	38	41	45	**39**	257
Island	47	42	43	31	39	**45**	247
Metro	40	36	21	31	42	**41**	211
Northern	25	36	26	32	41	**32**	192
Total	**211**	**228**	**173**	**186**	**218**	**206**	**1,222**

D. Suicides

Table 19. Number of Suicide Deaths by Gender (2002-2007)

Gender	2002	2003	2004	2005	2006	2007	Total
Female	132	120	128	135	105	**125**	745
Male	405	358	398	352	351	**345**	2,209
Total	**537**	**478**	**526**	**487**	**456**	**470**	**2,954**

Table 20. Number of Suicide Deaths by Region (2002-2007)

Region	2002	2003	2004	2005	2006	2007	Total
Fraser	154	129	135	138	119	**125**	800
Interior	107	93	112	101	84	**82**	579
Island	104	92	110	107	89	**92**	594
Metro	132	124	124	98	128	**124**	730
Northern	40	40	45	43	36	**47**	251
Total	**537**	**478**	**526**	**487**	**456**	**470**	**2,954**

Figure 13. Suicides per 100,000 people by Region, 2007

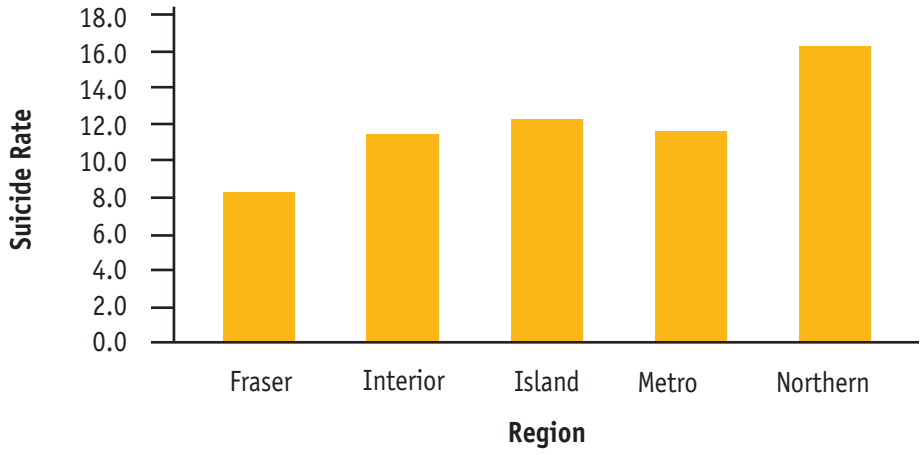
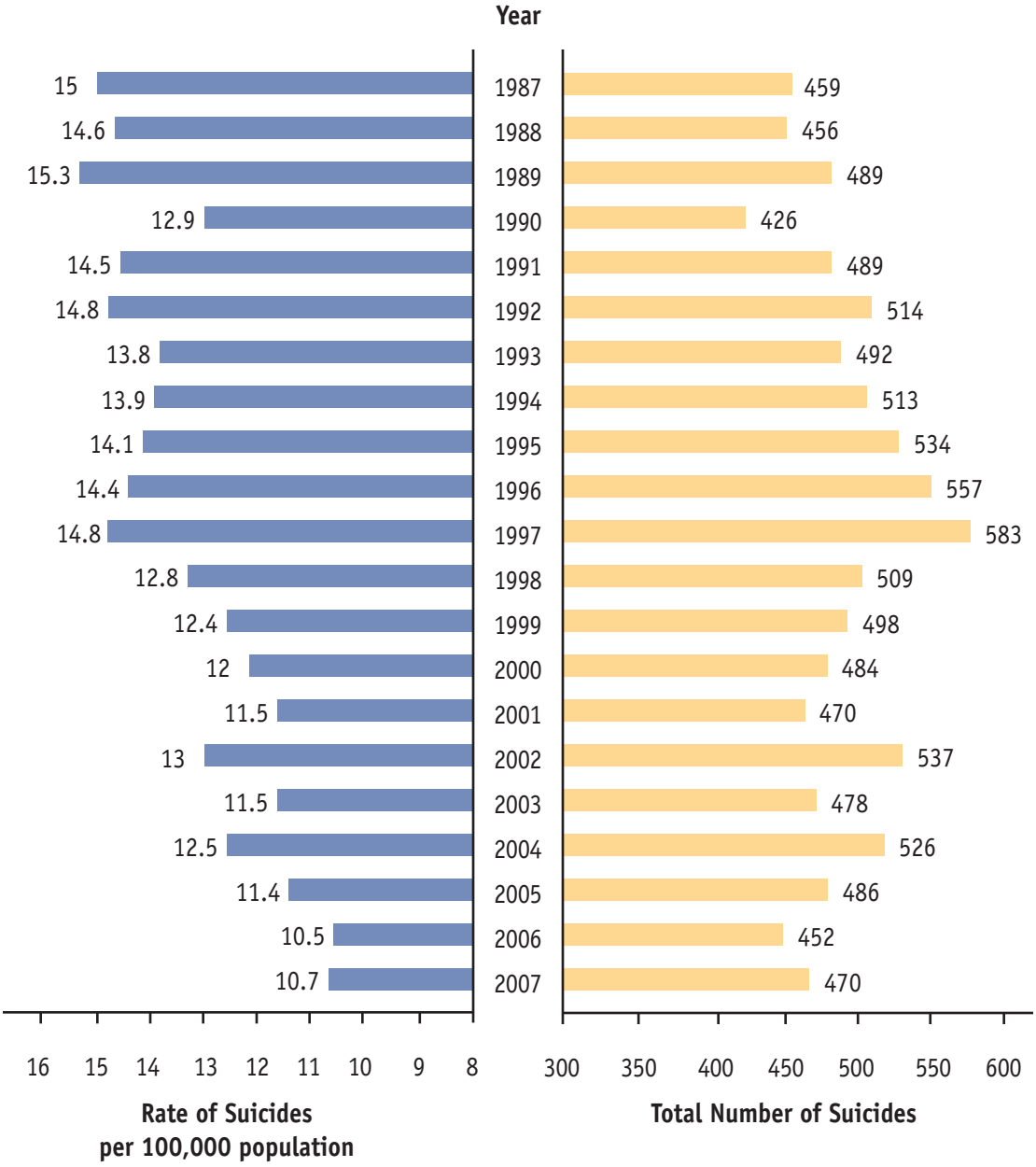


Figure 14. Rate (per 100,000 population) and Total Number of Suicides in BC, 1987-2007



Part 5
Inquests

A. The Inquest Process

When is an Inquest Held?

An inquest is a quasi-judicial hearing normally held in an open forum where witnesses are subpoenaed to testify under oath before a jury.

There are several reasons to hold an inquest which are outlined in the *Coroners Act* Sections 18(2), 18(3) and 19(1):

18(2) The chief coroner must direct a coroner to hold an inquest if the deceased person died in any of the circumstances described in section 3(2)(a) [deaths while in the custody of peace officers].

18(3) The chief coroner may direct a coroner to hold an inquest if the chief coroner has reason to believe that

(a) the public has an interest in being informed of the circumstances surrounding the death, or

(b) the death resulted from a dangerous practice or circumstance, and similar deaths could be prevented if recommendations were made to the public or an authority.

19 (1) The minister may order a coroner to hold an inquest if

(a) the coroner has not held an inquest but the minister is satisfied that it is necessary or desirable in the public interest that an inquest be held, or

(b) an inquest has been held already in respect of a death but the minister is satisfied that a second inquest is necessary or desirable in the public interest.

The Chief Coroner has established a committee consisting of the Chief Medical Advisor, the Deputy Chief Coroner and the Chief Counsel to review deaths and to provide advice regarding the exercise of the Chief Coroner's authority under Section 18(3).

Before an Inquest

Once it has been determined that an inquest will be held, the Presiding Coroner begins preparing for the inquest. Inquests are scheduled well in advance to ensure that witnesses, the venue and counsel are available. Other investigating agencies (e.g. WorkSafeBC, police) and interested persons are advised that an inquest is planned. Once dates are confirmed, next of kin, counsel and other involved agencies are officially notified of the inquest.

The *Coroners Act* authorizes the Presiding Coroner to issue a summons to any person, who, in the opinion of the Presiding Coroner, might be able to give material evidence on the matters to be inquired into at the inquest.

The *Coroners Act* also allows those whose interests may be directly and substantially affected by the findings of the jury to participate in the inquest. These individuals may be granted participant status and may appear personally or by counsel, cross-examine and re-examine witness and, with permission, lead evidence and examine witnesses.

Figure 15. The Courtroom at the Office of the Chief Coroner.

Anyone wishing to participate in an inquest should apply to the Presiding Coroner in writing.

Prior to the inquest, copies of relevant materials as determined by the Presiding Coroner are made available to participants or their counsel. This material remains the property of the Coroners Service and must be returned at the conclusion of the inquest.

At an Inquest

The *Coroners Act* states that the inquest must inquire into and determine who the deceased was, in addition to how, when, where and by what means he or she died.

The sheriff summons the jury. If a juror must be excused or discharged during the inquest, the Presiding Coroner may proceed with the remaining jurors. If the inquest is being held into the death of a worker for whom Part I of the *Workers Compensation Act* applies, reasonable effort must be made to ensure all or part of the jury is composed of persons familiar with the type of work for which the deceased was employed.

In addition to jurors, Sheriffs, court reporters, witnesses, family of the deceased and members of the general public are also present at the inquest. 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 Presiding Coroner reviews applicable sections of the *Coroners Act* for the information of the jury and Coroners Counsel gives a short summary of facts relating to the death. Jurors must be sworn in prior to the presentation of evidence. Witnesses are then called and examined by Coroners Counsel, participants and/or their counsel, the Presiding Coroner and members of the jury. Once all the evidence has been given, a summary is given to the jury by the Presiding Coroner. 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.

A jury may also make recommendations, although the *Coroners Act* provides no power to order implementation of recommendations. The Presiding Coroner submits the jury's recommendations to the Chief Coroner for dissemination to appropriate persons, agencies and government ministries. The jury's recommendations must be lawful, relevant and reasonable, with no finding of fault.

After an Inquest

The jury's findings and any recommendations are included in a public document entitled "Verdict at Coroner's Inquest". The Presiding Coroner prepares this document after the inquest is closed. It includes the Presiding Coroner's comments, a brief overview of the circumstances of the death and the evidence presented which supports the jury's recommendations. A copy of the Verdict at Inquest is available to the public upon request. Jury members are not permitted, at any time after the closing of the inquest, to discuss or reveal to anyone their deliberations, or the manner in which they reached their verdict.

B. Inquest Statistics

Note: In 2004, 2006 and 2007 inquests were held for multiple fatalities; in these years there are a greater number of deaths investigated by inquest than the number of inquests held.

Table 21. Number of Inquest and Deaths at Inquest by Year (2002-2007)

Year	2002	2003	2004	2005	2006	2007
Number of Inquests	11	11	13	15	23	**26**
Number Deaths	11	11	19	15	24	**29**

Table 22. Number of Deaths at Inquest by Classification of Death (2002-2007)

Classification	2002	2003	2004	2005	2006	2007
Accident	5	6	11	7	11	**19**
Homicide	0	0	6	3	7	**6**
Suicide	1	5	0	2	6	**0**
Natural	5	0	1	3	0	**1**
Undetermined	0	0	1	0	0	**3**
Total	**11**	**11**	**19**	**15**	**24**	**29**

Table 23. Number of Deaths at Inquest by Gender (2002-2007)

Gender	2002	2003	2004	2005	2006	2007
Male	11	10	14	14	19	**24**
Female	0	1	5	1	5	**5**
Total	**11**	**11**	**19**	**15**	**24**	**29**

Table 24. Cause of Death for Inquest Deaths as Determined by Jury's Verdict (2004-2007)

Cause of Death	2004	2005	2006	2007	Total
Gunshot wounds	6	5	4	**3**	18
Cocaine intoxication	1	1	2	**3**	7
Restraint associated death or excited delirium	3	1	5	**5**	14
Blunt force injury	0	1	4	**4**	9
Alcohol or drug related	0	3	3	**2**	8
Drowning	5	0	0	**1**	6
Head injury due to fall	2	2	0	**2**	6
Hanging	0	0	3	**0**	3
Intracerebral haemorrhage due to hypertension	0	2	0	**0**	2
Undetermined	0	0	0	**2**	2
Other	2	0	3	**7**	12
Total	**19**	**15**	**24**	**29**	**87**

Table 25. Type of Death and Totals for Inquest Deaths (2007)

2007 Inquests

Type of Death	#
Arrest - Lock-up	7
Arrest - No Lock-up	7
Police Shooting	1
Police Pursuit	1
Incarceration: Provincial Correctional Facility	1
Child Death	5
Industrial	2
Other	2
Total Number of Inquests	**26**
Total Number of Deaths	**29**
Total Number of Recommendations Made	**170**

C. 2007 Inquest Summaries

In 2007 there was one inquest in which four related deaths were investigated. Therefore, there were 26 inquests for the deaths of 29 individuals. These 26 inquests resulted in a total of 170 recommendations that were distributed to agencies and individuals, 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.

Arrest: No lock-up

Case 1 of 7

On January 18, 2007, an inquest was held at Vanderhoof BC, into the death of a 29-year-old male who died on December 19, 2004, due to gunshot wounds to the chest.

At inquest, witnesses testified that the male had consumed an excessive amount of alcohol on the evening of December 18, 2004, while at a bar. It was stated that he initiated a fight with another patron and was asked to leave the premises. The male was later witnessed to be intoxicated at a local residence. He initially refused to leave despite the wishes of the tenant, but eventually was persuaded to go.
In the early morning of December 19, police were contacted regarding an alarm at a pharmacy at a mall. Two police officers attended the mall in separate police cruisers. One officer saw a man running from the back of the mall and pursued in his vehicle and then on foot. The officer described the conditions as being extremely slippery due to ice. The officer stated at inquest that he was concerned for his safety as the male had been running with his hand in his jacket despite the slippery conditions. The officer indicated that the male eventually slowed to a walk and then turned toward the officer and walked towards him with his hands down. The officer began backing up, but slipped and fell on the slippery surface. He further reported that the male continued to advance toward him and uttered a threatening statement. As he feared for his life, the officer fired three shots while lying on the ground.

The second officer who responded to the alarm call followed the other officer as he updated her on his location by radio. She testified at inquest that she witnessed the other officer standing and shooting at an advancing male.

An ambulance was summoned; however, the male was found to be deceased upon their arrival at the scene. An RCMP Identification Officer, who was in charge of the initial collection of evidence from the scene, testified at inquest that he could not determine the position of the officer at the time of the shooting.

A pathologist testified regarding his findings from the autopsy that he had conducted on the male. He testified that he was able to map the trajectory of the three bullets, stating that each bullet had a downward trajectory of approximately 30-45 degrees. Furthermore, he indicated that all three chest wounds were potentially fatal.

An RCMP investigator and Staff Sergeant reviewed the circumstances and evidence of the incident. After reviewing all of the information, the RCMP did not believe there was evidence to support a request for charges to Crown Counsel. Crown Counsel also reviewed the provided evidence and did not believe it supported the filing of charges.

The jury found that the cause of death was gunshot wounds to the chest due to being shot by an RCMP Officer in the line of duty. The death was classified as a Homicide.

Recommendations:

The jury made seven recommendations to five agencies.

Three recommendations were directed to the *Vanderhoof RCMP Detachment*. The jury recommended that the detachment consider possible modifications to staffing levels on weekend evenings and holidays, as well as improvements in training and equipment in regards to communication between officers involved in investigative incidents. It was also recommended that the detachment ensure that officers identify themselves, including the use of emergency lights where appropriate.

The jury recommended that the Ministry of Public Safety and Solicitor General (PSSG) ensure proper enforcement regarding sales of alcohol in licensed premises.

It was recommended that the Owners and Manager of the Mall ensure that all potential access sites on the roof be secured to restrict access by unauthorized individuals.

Similarly, it was recommended that the Owners and Operators of the Drug Store review and upgrade security measures within the dispensary area of the store.

The jury recommended that the North District RCMP Operations and Communications Centre ensure that as much detail as possible be provided to officers upon report of an alarm.

Response to recommendations:

The *PSSG* responded that their team of compliance and enforcement staff monitor liquor service in licensed establishments throughout the province. In many cases, proactive compliance meetings with operators prevent public safety issues and related sanctions. Staff also time and target inspections to when and where the risk to public safety is greatest. The response also indicated that the branch has begun publicizing the results of compliance and enforcement actions with local media in the hopes that this will serve as a further deterrent to other licensees.

The North District RCMP responded that a standard operating procedure currently exists and is followed by the operators.

➲ Case 2 of 7

On April 11, 2007, an inquest was held at Penticton BC, into the death of a 76-year-old male who died on November 7, 2004, due to severe pneumonia.

On October 28, 2004, an officer on patrol found the male unresponsive, lying on the ground in a public area. It was determined that he and two companions had been consuming alcohol and that he was significantly impaired. The officer arrested the male under the *Liquor Control and Licensing Act* and an ambulance was summoned. Paramedics assessed the male and determined that he was in suitable condition to be transferred to jail. Shortly after transfer began, the officer noted the male was unresponsive and an ambulance was again summoned. The male was taken to hospital in full cardiac arrest.

At hospital, medical intervention re-established cardiac function. Blood specimens were collected from the male for diagnostic purposes, but a toxicological analysis was not conducted. The male was found to have suffered brain damage and in consultation with family palliative care was ordered. On November 7 the male died in hospital.

An autopsy revealed the cause of death to be severe pneumonia. It was also determined that there had been a sudden cardiac event of an unknown origin. As hospital practice is to discard blood specimens seven days post admission, the pathologist stated that she did not have the benefit of toxicological data to aid in determination of cause of death.

The jury found that the cause of death was severe pneumonia. Substance abuse and a prior medical history were found to be significant factors contributing to the death. The death was classified as Natural.

Recommendations:

The jury directed one recommendation to the Interior Health Authority and the Chief Coroner of the BC Coroners Service. It was recommended that standard protocol should be to perform toxicology tests upon arrival at a hospital trauma unit.

Response to recommendations:

The Chief Coroner responded that the *BC Coroners Act* does not give a coroner authority to investigate a death and seize evidence until after a death has occurred. The Chief Coroner stated that it would be pre-emptive to order toxicology screening on all incoming trauma patients, despite the gravity of their conditions, in anticipation of a subsequent death investigation.

The Interior Health Authority responded that the development and implementation of a standard protocol would not be appropriate; but that they would consider any forthcoming information in support of protocol development in this area.

➲ Case 3 of 7

On August 22, 2007, an inquest was held at Kamloops BC, into the death of a 29-year-old male who died on July 11, 2006, due to cocaine overdose.

Shortly before noon on July 11, 2007, the male entered a hotel in a distressed state. He was wearing only shorts and was agitated and bleeding. He began shouting and appeared disoriented. The hotel staff called 911. Police arrived and found the male conscious, lying on the road outside the hotel. An ambulance was also requested. An officer noticed that the male appeared tense and agitated, and was frothing at the mouth and hyperventilating. The male indicated to officers that he was drunk. The officer questioned the male about using drugs, but he repeatedly denied drug use. The male tried to get up but was encouraged to stay on the ground as an ambulance was coming to assess him. The two attending officers decided to handcuff him to keep him from running away. However, the male then started “freaking out” and was advised he was under arrest for causing a disturbance.

Ambulance personnel arrived but the male was not cooperative with examination by paramedics. Because of the male’s agitated state it was decided that the police would transport him to hospital with the ambulance following to provide immediate medical assistance if required.

The police brought the male into the hospital through the main entrance where he was placed on the floor. A nurse administered a sedative injection on the instruction of an emergency room (ER) physician. At inquest it was noted by an officer, a paramedic and the ER physician that it may be better for police to bring combative or agitated patients through the ambulance bay, for the protection of the patient and the public.

The ER physician immediately recognized that the male was suffering from the effects of a cocaine and/or amphetamine overdose. The male was treated for overdose and eventually transferred from the trauma room to a monitored bed. However, a few hours later he began to convulse and intensive medical intervention was unsuccessful.

An autopsy revealed that the male had coronary artery disease. Toxicological analysis found a blood concentration of cocaine within the lethal range. The pathologist gave evidence that the male died as a result of a cocaine overdose, and stated that there was no evidence of chronic intravenous drug use.

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

Recommendations:

The jury made one recommendation, which was directed to the Interior Health Authority, BC Ambulance Service (BCAS) and the RCMP ('E' Division). It was recommended that these agencies work together to develop a protocol for the safer management of the intake of agitated and hard-to-handle patients in order to protect staff, public and the patient.

Response to recommendations:

The *RCMP* responded that they have initiated contact with the Health Authority on this issue. The *BCAS* responded that they have also contacted the Health Authority, to convey their intention to participate in discussion on the recommendation.

➲ Case 4 of 7

On September 11, 2007, an inquest was held at Vernon BC, into the death of a 35-year-old male who died on May 19, 2006, due to cocaine overdose.

In the early morning of May 19, 2006, two officers attended the male's home in response to a call regarding an "out of control" man and the stabbing of a child. Two ambulances were also dispatched. Upon arrival, the officers found the male's son in the driveway, with a small leg wound. He and his sister explained that their father was acting bizarrely. The male then appeared on the porch, shouting incoherently and waving his arms. One officer took the children aside, while the other approached the male. The officer noticed that the male had a wound on his thigh and did not appear to recognize the officer as a member of the police. As the male began to grab at his legs, the officer placed him in a double handcuff in order to secure him from further self harm. The officers testified that the male did not exhibit resistance to being handcuffed and was calm after being restrained.

The officer observed a change in the male's breathing but found it difficult to find a pulse or observe breathing. As the officer was alone with the male he decided not to remove the handcuffs or administer CPR, but wait for an ambulance instead. When the other officer returned,

the male's handcuffs were removed and he was placed in the recovery position. A second ambulance to be dispatched arrived first, as the first ambulance could not immediately locate the residence.

The paramedics testified that the male did not have a pulse and was not breathing. CPR was initiated. Injuries to the male's legs were assessed and found not to be life threatening. The male was transported to hospital and paramedics were informed by police that he may have used illicit drugs. Paramedics administered a drug to reverse the effects of narcotics en route to the hospital. Medical intervention was unsuccessful and the male was found to be deceased on arrival at the hospital.

At inquest, the pathologist that conducted the autopsy testified that the male had multiple self-inflicted stab wounds that were not life threatening. Cocaine was found in the gastric contents of the male. Toxicological analysis found a blood concentration of cocaine within the lethal range.

An expert witness described excited/agitated delirium and the challenges of medically treating individuals displaying these symptoms. In her opinion the male's bizarre behaviour, yelling and lack of recognition of first responders was indicative of excited delirium. She also testified on the need for emergency personnel to recognize the symptoms and administer timely medical aid to those in a state of excited delirium. She believed that there was a challenge to accessing advanced medical care for delirium in rural communities.

Emergency personnel testified regarding the difficulty in locating residences in rural areas. It was heard that some residences on the Okanagan Indian Band reserve do not have signage or house numbers. However, an officer stated that a map of the community is now posted in the detachment.

The jury heard that since the fatality, the RCMP has introduced formal first aid training protocols for their members. In addition, first aid kits and resuscitation masks are now kept in police vehicles.

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

Recommendations:

The jury made a total of 10 recommendations to the Vernon RCMP Detachment, RCMP 'E' Division, the BC Ambulance Service and the Okanagan Indian Band.

The Vernon RCMP Detachment received six recommendations regarding first aid equipment and training, training regarding excited delirium and related conditions, the assignment of an officer specifically for the Okanagan Indian Band and direct access to 911.

The jury recommended that the Okanagan Indian Band ensure that all residences have address numbers displayed at driveway entrances and that the band create a social services liaison available 24/7 to assist RCMP in situations where children are present.

A joint recommendation was directed at the RCMP 'E' Division and the BC Ambulance Service, to establish effective emergency communication allowing for contact during rural incidents.

Finally, it was recommended that the Vernon RCMP Detachment, the BC Ambulance Service, and the Okanagan Indian Band (Fire Chief) procure current, up-to-date maps, specifically for the Okanagan Indian Band #1 and Westside Road.

Response to recommendations:

The BCAS responded that they are working on a "Combined Events Radio Project" which will provide a common channel among BCAS, police and fire at event scenes. The project has been implemented in some areas of the Lower Mainland Region, is expanding to North Vancouver Island, and work continues to include all other areas of the province. Once operational, any of the emergency responders at a scene may initiate direct radio communication with the other agencies in attendance. The *BCAS* also noted that staff from the interior region are meeting with RCMP and the Okanagan Indian Band to coordinate efforts to update their maps.

➲ Case 5 of 7

On November 6, 2007, an inquest was held at Lytton BC, into the death of a 19-year-old male who died on April 29, 2005, due to drowning.

In the early evening of April 29, 2005, the male was arrested by an RCMP officer for being intoxicated in a public place. He was not secured with handcuffs. The arresting officer was walking behind the male, escorting him across a pedestrian walkway on a bridge over a river. A second officer was walking in front of the male. Part way across the bridge, the male climbed over a safety fence and jumped. The officers stated that the male struck a steel cable with his body before falling over 100 feet into the river below. Despite an extensive air, water and river bank search over the following weeks, the male was not found and is presumed dead.

Several issues associated with the death of the male were heard during the inquest. There is a need for an alternative to the "drunk tank" approach for intoxicated youth. The community requires development for the personal, familial, social and cultural benefit of its citizens; including the development of local protocols respecting police and community relations and jurisdiction, community issues and restorative justice. There is a need for timely inquests to promote healing. The community lacks a qualified and equipped Search and Rescue Service Team.

Additional issues of concern that were heard at inquest included the relationship between the community and the RCMP.

The jury found that the death was due to drowning. Significant conditions contributing to the death included hitting the cable on the bridge and alcohol consumption. The death was classified as Undetermined.

Recommendations:

The jury made a total of 15 recommendations directed to 32 agencies and individuals including: the Village of Lytton, several Indian Bands and First Nations organizations, Provincial and Federal Ministries, *the* RCMP, the Interior Health Authority, Health Canada, and a school board and board of trustees.

The jury recommended that a strategic plan and proposal be developed for the creation of a Treatment and Detoxification Centre. Further, development of an additional strategic plan and proposal was recommended to enhance recreational programs for children and youth in Lytton, and to improve interagency collaboration toward enhancing services for children and youth.

Regarding policing in the community, the jury recommended that a cultural/community awareness and sensitivity curriculum to train RCMP members in Lytton be developed.

Development of a proposal for an RCMP First Nations Community Policing Service was also recommended.

It was recommended that the RCMP (Lytton Detachment, 'E' Division) provide consistent school liaison officers for Lytton area schools so that there is a visible presence in schools. Review of several relevant policies, procedures and guidelines was also recommended.

The jury recommended that the Commission for Public Complaints Against the RCMP develop literature specific to First Nations Communities clarifying and explaining the process of filing a complaint against the RCMP.

Other recommendations made by the jury included reviewing policies, procedures and protocols of search and rescue services with the intent to form a qualified Search and Rescue Service Team; ensuring timely inquests; and investigation of 'in-custody' deaths by police outside of the police force involved.

Response to recommendations:

Health Canada responded that they are unable to consider funding a detoxification centre because this service falls under provincial jurisdiction. Due to limited funding, they are also unable to consider funding any new treatment centres as they presently fund 11 National Native Alcohol and Drug Abuse Program treatment centres in BC, including two youth and two family treatment centres.

The Lytton First Nation responded that they have formed a steering committee pursue the creation of a Treatment and Detoxification Centre. Currently they are estimating costs involved in developing and delivering a cultural/community awareness and sensitivity curriculum to train RCMP members posted in Lytton. The development of the curriculum will be achieved through community input and participation. The committee will request that the Village of Lytton assume a leadership role in working towards forming a "qualified Search and Rescue Service Team". Another steering committee has been mandated to pursue the enhancement of recreational programs and infrastructure for children and youth. A request has been submitted to the Federal Ministry of the Solicitor General to assist access to community policing services.

The Ministry of Public Safety & Solicitor General (PSSG) responded that they will be working with other Provincial, Federal and First Nations agencies to develop and implement evidence-based programs to bolster the protective factors and reduce the risk factors among children and youth.

The Nlaka'pamux Nation Tribal Council responded that the Lytton First Nation will be taking the lead in the community to work with the recommendations, and that they will be working very closely with Lytton First Nation in respect to their findings and recommendations.

The Ministry of Aboriginal Relations & Reconciliation and PSSG both responded that they are anticipating receipt of a proposal for the creation of a Treatment and Detoxification Centre from the Nlaka'pamux National Tribal Council, the Interior Health Authority and Health Canada. The Ministries will be collaborating with other Provincial, Federal and First Nations agencies in the review of the proposal. Further, both agencies will be working with the RCMP and the Aboriginal Policing Directorate of the Ministry of Public Safety Canada to develop a Community Tripartite Agreement for the Lytton First Nation, to provide an enhanced RCMP - First Nation Community Police Service that is culturally sensitive and responsive to the particular needs of the community.

The Commission for Public Complaints Against the RCMP responded that they are currently undertaking several initiatives to address the issue of providing First Nations Communities with literature that clarifies and explains the process of filing a complaint against the RCMP including: a Friendship Centre Pilot Project; BC specific initiatives such as distributing information to all 23 of the Communities and Media offices listed in the Guide to Aboriginal Organizations and Services in BC; and simultaneous Translation Services in 30 aboriginal languages.

➲ Case 6 of 7

On November 13, 2007, an inquest was held at Kelowna BC, into the death of a 38-year-old male who died on June 7, 2006, due to a myocardial infarction.

Shortly after midnight on June 7, 2006, the male entered his parent's bedroom and began shouting that the world was coming to an end and that they had to leave the residence. He broke a window and attempted to wrap his mother in a sheet. His step-father testified that he was unable to intervene, and the he thought his step-son was trying to kill his mother.

A tenant of the downstairs suite in the house heard a disturbance upstairs and went to the residence entrance. Upon seeing the male assaulting his mother, she called 911.

Two police officers arrived and were immediately engaged in a physical altercation with the male. Pepper spray, strikes and application of pressure to body points were ineffective in subduing the male. After a third officer arrived at the home, the three officers were able to handcuff the male and tie his feet together with a rope to his handcuffs. All three officers described him as having 'super human' strength.

The male was then placed on his side on the rear seat of the police vehicle and the rope was removed. He was observed to be sweating profusely. The tenant testified that she witnessed the male being placed into a police vehicle and saw his feet moving in the rear window.

BC Ambulance paramedics arrived and attended to the male's mother and also to officers who had received minor injuries. An officer then noticed that the male was not breathing and had no pulse. Paramedics immediately attended to the male, and his handcuffs were removed. One paramedic requested an Advanced Life Support ambulance as the male was in cardiac arrest. The male was brought to hospital, but resuscitative efforts were unsuccessful.

At inquest, a pathologist described the findings from the autopsy. While the male had multiple superficial lacerations, abrasions and bruising, none of these injuries contributed to the death. The pathologist found a recent injection mark on his arm. There was no evidence of a pre-existing heart disease or medical condition. Toxicological analysis found a blood concentration of cocaine within the lethal range. The cause of death was stated to be a myocardial infarction due to an overdose of cocaine. The pathologist also described the condition of excited delirium.

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

Recommendations:

One recommendation was made by the jury and directed to the RCMP 'E' Division. They recommended that, when an individual exhibits symptoms of excited delirium, an RCMP officer should remain in attendance with the suspect until emergency medical service is available.

Case 7 of 7

On November 27, 2007, an inquest was held at Victoria BC, into the death of a 45-year-old male who died on October 6, 2006, due to cocaine intoxication.

The male was alone in his car when he crashed into a highway divider on the evening of October 6, 2006. The vehicle became inoperable and the male was trapped inside. Two witnesses immediately called 911. The witnesses reported that the male was agitated and muttering incoherently.

Paramedics and police arrived and observed the male attempting to inject himself while still in his vehicle. He told them that he had cocaine in the syringe, and that he had just purchased a large amount of cocaine and used it all. Three officers removed the male from the vehicle. He was then handcuffed behind his back and placed face down on the roadway. Shortly thereafter, he became unresponsive. Although paramedics were able to regain a heart rate, he went into cardiac arrest before arriving at the hospital and could not be resuscitated.

The pathologist who conducted the autopsy testified that there was no natural disease process that caused or contributed to the death. Toxicological analysis found a blood concentration of cocaine within the lethal range. A toxicologist testified that the male died due to cocaine intoxication.

The male's sisters spoke at the inquest regarding their brother's long struggle with mental health and drug addiction. They felt that when he asked for help he didn't receive it and that mental health issues and addictions often co-occur and should be treated together.

The jury found that the male died due to cocaine intoxication. An enlarged heart due to prolonged drug use was contributory. The death was classified as Accidental.

Recommendations:

The jury made one recommendation, directed to the Minister of Health (Provincial), to fund treatment facilities for people with mental illness and/or drug related issues.

Response to recommendations:

The Minister of Health responded that the Government is committed to providing support for people facing challenges associated with mental illness and addictions. He noted that mental health and addictions expenditures have increased 30% since 2001. A total of $138 million in capital funding was committed to build new mental health facilities and expand existing facilities in communities across BC as part of the Riverview Redevelopment Project. They are moving ahead with plans to develop a stabilization unit in Burnaby that will provide services to clients suffering from the most severe mental health and addiction illnesses, opening in the summer of 2008.

Arrest: Lock-up

Case 1 of 7

On February 19, 2007, an inquest was held at Vancouver BC, into the death of a 31-year-old male who died on October 4, 2003, due to cocaine intoxication.

In the early morning of October 4, 2003, Vancouver police responded to a 911 call regarding a "fight with a gun and possible stabbing". The officers approached a male fitting the 911 dispatch description of one of the assailants who had fled the scene. The male was found to have in his possession a pellet gun, a knife and pepper spray.

At inquest, it was heard that the male admitted to officers that he was involved in using and selling drugs. He denied being in an altercation. An officer noted that the inside of the male's mouth was coated with a white film. The male denied ingesting any drugs despite repeated questioning by all officers present. The male appeared to be lucid and communicative.

A transfer wagon arrived to transport the male to the Vancouver Jail. The driver was advised to tell the jail nurse on arrival that the male may have ingested drugs. At the jail, the male was placed in a pre-hold cell before being searched. No medical concerns were recorded on the Jail Arrest Report Form. Once the search was complete, the male was placed in a holding cell. At inquest, officers stated that he did not appear to be intoxicated at this time.

Approximately an hour after arriving at the jail the male was observed having a seizure on the floor. An ambulance was summoned. The male was removed from the cell and placed in the hallway. Officers stated at inquest that the male demonstrated tremendous strength and it took four or five officers to control him. He was placed in handcuffs and leg restraint so that the jail nurse could assess him. She administered a shot of sedative to calm him down. Ambulance personnel arrived to transport the male to hospital. As they were loading him into the ambulance he ceased breathing. Resuscitation attempts were unsuccessful.

The pathologist that conducted the autopsy testified at inquest that she did not identify any trauma or natural disease that could have caused the male's death. Toxicological analysis found a blood concentration of cocaine within the lethal range. A toxicologist testified that there is no antidote for cocaine overdose and could not say whether earlier medical treatment could have been successful.

Finally, it was noted at inquest that the while the jail was formerly supervised and staffed by BC Corrections, the Vancouver Police Department now managed the jail and that changes had already been made to medical assessment of prisoners.

The jury found that the death was due to acute cocaine intoxication and classified the death as Accidental.

Recommendations:

The jury made three recommendations to the Vancouver Police Department. First, the jury recommended that the Jail Arrest Report Form be modified to include indication of suspicion of drug ingestion. It was also recommended that audio recording be investigated for use as part of the jail monitoring system. Finally, the jury recommended that all videotape footage of an incident be collected and preserved if it is requested.

The jury recommended that the Ministry of Labour and Citizen's Services utilize the highest quality of video cameras and time-stamped, real time storage of data.

Response to recommendations:

The Vancouver Police Department responded that they revised the Jail Arrest Report form as recommended. The jail is also taking steps to ensure that when footage is identified and collected by investigators, the original files are preserved. However, the department is unable to implement audio recording as it potentially requires prior judicial authorization or the consent of the person being taped.

The Ministry of Labour and Citizen's Services responded that cameras have been updated from analog to digital and a study has been approved to review and assess the current status of the system.

Case 2 of 7

On April 18, 2007, an inquest was held at Port Alberni BC, into the death of a 37-year-old female who died on October 27, 2005, due to cocaine overdose.

In the early morning of October 23, 2005, an officer on patrol observed the female walking along a sidewalk. He approached the female as he recognized her from a previous encounter and knew of an outstanding warrant for her arrest. He described her behaviour as erratic and hyper and believed she was under the influence of drugs. She was found to have pepper spray in her possession and was charged with carrying a weapon. She denied ingestion of any substances.

Before being placed in the patrol car she was warned that if any drugs were found in the backseat they would be assumed to have come from her. While being booked into police cells, evidence of cocaine was found in the patrol car and the female was charged with possession of an illegal substance. She was then strip searched and found to have a pocket knife and scale with white powder residue.

The female did not appear to be in any medical distress during booking into police cells. The guard on duty that night testified at inquest that he glanced up several times at the monitor and thought the female was resting in her cell. Subsequent review of the video showed her having a series of seizures with periods of resting. Approximately 15 minutes after she was placed in the cell the guard noticed odd hand movements and went to check on her. She was found unresponsive and an ambulance was summoned. When ambulance personnel arrived she had no pulse and was not breathing, but was resuscitated. However, it was determined that she had suffered irreversible brain damage and never regained consciousness. She was ultimately withdrawn from life support four days later.

An autopsy revealed features of seizure activity, but no recent trauma or disease process that would have contributed to her death. Toxicological analysis found a blood concentration of cocaine within the lethal range. A pathologist attributed the death to acute cocaine use.

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

Recommendations:

The jury made two recommendations which were directed to RCMP "E" Division. It was recommended that more thorough searches be done at a scene before placing a suspect into the back of a police vehicle. It was further recommended that police placing suspects in lock-up communicate directly to guards any suspicions regarding drug ingestion.

➲ Case 3 of 7

On April 30, 2007, an inquest was held at Cranbrook, BC, into the death of a 30-year-old male who died on January 1, 2006, due to an acute subdural hematoma.

On the evening of December 31, 2005, the male and his girlfriend hosted a party at their residence. The male had been drinking and was seen to be having a good time. Later in the evening, the male became upset over some personal matters and became increasingly agitated and violent. Several people at the party attempted to calm him down. An altercation with a friend occurred and the friend placed the male in a head lock and removed him from the residence. The friend released his grip when he heard a sound in the male's neck and the male went limp and fell backwards, hitting the back of his head on the concrete porch. The male was unconscious for a short period prior to police and ambulance personnel attending.

The male was arrested by police for mischief and placed in the patrol car. The officers testified that they were unaware that the male had been unconscious.

Two first responders from the fire department testified at inquest that they had little involvement at the scene. However, they did hear from a witness that when the male was in a headlock he may have been choked and may have lost consciousness. This information was later provided to the paramedics.

When the ambulance arrived, the male was able to walk unassisted to the ambulance for assessment by paramedics. The attending paramedic testified that the male indicated he was not hurt and did not have any pain. The paramedic was not aware that the male had struck his head or had received a possible neck injury. The male was cleared medically by the paramedics. The paramedic then heard from a witness that the male had been unconscious for a short time. This information was provided to the officers, who told the paramedic that there was a cell guard on duty 24 hours to observe the male. The paramedic stated that he emphasized that the male should be watched carefully while in custody. The paramedic acknowledged that the medical examination of the male would have been altered by the knowledge of a head injury.

The male was transferred to the RCMP detachment by police car and was able to walk unassisted into the cell block.

Two cell guards provided testimony at the inquest. It was heard that the male showed signs of impairment. The male vomited shortly after being placed in a cell and was checked by an officer and the guard. At this time a red mark was noticed on the back of the male's head. Subsequently, the male was observed every 15 minutes. The male was observed to fall twice and was told by the cell guard not to get up for his own safety as the cell floor was slippery.

Mid morning on January 1, 2006, the cell guard observed that the male was having difficulty breathing and called for police assistance and an ambulance. The Watch Commander initiated CPR and the male was transported to hospital via ambulance.

The emergency room physician testified at inquest that upon arrival at the hospital, the male exhibited symptoms of serious neurological insult. A CT scan revealed a skull fracture, cerebral edema and intracranial bleeding. Specialists were consulted and it was suggested that recovery was not likely. The male was removed from life support later that day and succumbed to his injuries.

The forensic pathologist who conducted the autopsy testified at inquest. He had viewed the video recordings of the male's falls in police cells. It was his opinion that none of the falls were consistent with the head injury that caused the skull fracture and subsequent subdural hematoma.

The jury found that the death was due to an acute subdural hematoma due to trauma to the back of the head due to a fall onto concrete. The death was classified as Accidental.

Recommendations:

The jury made a total of four recommendations.

Southeast District RCMP Headquarters *and* Emergency Communication for Southwest BC jointly received a recommendation that there be more accurate transfer of information from 911 dispatch to the emergency response teams.

It was recommended that the Southeast District RCMP Headquarters and the BC Ambulance Service (BCAS) review the protocol for patient/prisoner handling and the transfer of responsibility on scene. The jury also recommended that these two agencies, in addition to the Cranbrook Fire Department, review and improve the communication between emergency response teams on the scene.

The jury recommended that the RCMP Cranbrook Detachment confirm with all personnel the importance of continuing to treat each case as a unique situation.

Response to recommendations:

Emergency Communications responded that they have set rigorous standards in process, policy, skill competency and behaviour to ensure performance excellence. These standards are trained, reinforced by Team Managers, and assessed in regular performance assessments.

Southeast District RCMP Headquarters responded that they have emphasized the importance of transferring the call to the downstream agency for primary response as soon as possible. Headquarters also responded their existing policy regarding the handling of prisoners is believed to be fully adequate and satisfactory. After discussions with the other agencies, it was determined that there is a very good working relationship as well as effective lines of communication. Finally, the agency responded that all members of the Cranbrook Detachment have been reminded of the importance of continuing to treat each case as a unique situation.

The BCAS responded that policies related to roles and responsibilities of police and BCAS paramedics at the scene have been reviewed.

Case 4 of 7

On May 29, 2007, an inquest was held at Victoria BC, into the death of a 48-year-old female who died on February 7, 2006, due to an undetermined cause.

On February 6, 2006, the female was arrested for breach of a Conditional Sentence Order, for being in an area called the "Red Zone". The arresting officer did not find drugs on the female during a search of her person at the time of arrest.

The female was transported to the city police jail and placed in an interview room so she could make a phone call. She did not appear to be under the influence of drugs or alcohol. The female was searched more thoroughly before being taken to a cell.

On February 7, the female was brought to court and then returned to the jail. The jail Matron testified that she searched the female prior to returning her to her cell. Approximately 15 minutes later the female called the Matron to her cell to report that she had vomited blood. The matron advised her to call again immediately if she vomited again.

The police and the Matron returned to the cell to check on the female after noises were heard and found her in a semi-conscious state. Jail staff initiated CPR and an ambulance was summoned. A Basic Life Support Ambulance followed by an Advanced Life Support Ambulance arrived at the jail. However, resuscitative efforts by emergency personnel were not successful.

It was heard at inquest that while in jail the female was escorted to court twice, to attend a meeting with legal services and to two meetings with a lawyer. The intake worker and duty counsel testified that she did not appear to be in any medical distress or under the influence of drugs. Her probation officer stated that she had a history of drug use but was currently trying to reduce her use. At the time of her arrest she was on probation for a drug related offence. Paramedics stated that there was significant scarring on her arms consistent with a history of intravenous drug use.

A toxicologist testified at inquest that the female's blood contained a metabolite of cocaine, which suggested that she had access to cocaine while in custody. He stated that the level found was below the lethal range. The pathologist who conducted the autopsy testified that he was unable to determine what role if any, recent cocaine use may have played in the female's death. However, he stated it was reasonable to attribute her death to complications of chronic cocaine use.

It was heard at inquest that the only time a prisoner is not monitored is when they are in the interview rooms. A detective viewed video of the female's cell and noted a period when she may have been concealing an activity under a blanket.

An Inspector reviewed the circumstances of the fatality on behalf of Sheriff Services. He stated that there was no evidence on camera that she vomited or was passed drugs from another person. He also reviewed the searches conducted and provided a report that included six recommendations, two of which addressed search standards and policy.

The jury found that the death was due to an undetermined cause and classified the death as Undetermined.

Recommendations:

The jury made a total of five recommendations; four were directed to the Victoria City Police and one to the Court Services Branch of the Ministry of the Attorney General.

It was recommended that the Victoria City Police provide standard issue clothing to all prisoners and that search procedures are reinforced with all relevant personnel. The jury also recommended that relevant personnel should be trained at the appropriate frequency in the use of first aid equipment, and a policy should be created to have trained personnel maintain the first aid equipment.

The jury recommended that the Court Services Branch implement the recommendations in the report of the Inspector (Investigations and Standards Office).

Response to recommendations:

The Victoria City Police responded that the removal of clothing in exchange for police issued clothing is a violation of Section 8 of the Charter of Rights and Freedoms. The response also noted that since the inquest, additional first aid equipment has been purchased and is inspected weekly to ensure they are accounted for and functioning. It was indicated that the police have a policy regarding maintenance of the first aid equipment. Finally, the police noted that the Administrative Sergeant in charge of the cells will arrange for a semi-annual refresher related to search techniques.

The Court Services Branch responded that they fully implemented the recommendations resulting from the Inspector's investigation.

➲ Case 5 of 7

On June 19, 2007, an inquest was held at Kamloops BC, into the death of a 45-year-old male who died on October 13, 2006, due to a subdural hematoma.

On the afternoon of October 12, 2006, an officer responded to a call requesting assistance as a male was blocking an exit of a store. When she arrived, the officer noted that the male was initially unresponsive. She determined that he was intoxicated due to his appearance and manner as well as the smell of alcohol and the empty wine bottle nearby. The male was incoherent but cooperative, and was arrested for being drunk in a public place.

The male was brought to the detachment and placed alone in a cell, which was equipped with a video camera. For the first several hours in the cell, there was only one cell guard on duty. It was stated at inquest that a guard is required to check on the prisoners at intervals of no more than 15 minutes. It was also stated that the male was checked on through the cell door window, but nothing abnormal was noted. It was indicated that guards may miss events on camera while attending to other duties.

On the morning of October 13, two officers entered the male's cell in order to release him and found him unresponsive. An ambulance was called and the male was taken to hospital. A CT scan revealed a terminal subdural hematoma too extensive for medical treatment.

An autopsy was conducted and the cause of death was determined to be a subdural hematoma. The pathologist testified that there was also a skull fracture, but no visible external injury

relating to the fracture. The pathologist also commented on the toxicological findings and estimated that the male would have been heavily intoxicated at the time of arrest.

At inquest, video cell footage was shown to the jury. Approximately 30 minutes after arrival at the detachment, the male was observed pulling himself up then falling straight backwards and striking his head on the floor. This had not been witnessed by the cell guard. After the fall, the male remained motionless on the floor for about 30 minutes. An RCMP Primary Investigator testified that after approximately 2 hours in the cell, the male was not seen to move.

The jury found that the death was due to a subdural hematoma due to a head injury and classified the death as Accidental.

Recommendations:

The jury made three recommendations. One was directed to the City of Kamloops, recommending the purchase of a recording and viewing system to facilitate simultaneous playing/recording of activities in a cell block.

A second recommendation was also directed to the City of Kamloops in addition to the guard supervisor at the Kamloops RCMP Detachment and the RCMP "E" Division. It was recommended that the log sheet format and recording system be reviewed by the guard supervisor in consultation with the RCMP "E" Division to ensure standardization, consistency and accuracy of information recorded.

Finally, the jury recommended that the RCMP "E" Division and the Ministry of Health expand the "close watch" protocol to include a definition of acceptable time for "little or non movement".

Response to recommendations:

The City of Kamloops responded that it is reviewing the recommendations.

The Ministry of Health responded that through the Emergency Medical Assistant Licensing Branch, they will be pleased to consult with the RCMP regarding their "close watch" protocol and offer any suggestions that fall within our field of expertise.

➲ Case 6 of 7

On June 20, 2007, an inquest was held at Burnaby BC, into the death of a 20-year-old male who died on November 1, 2004, due to blunt head trauma.

On the evening of October 31, 2004, a police officer responded to a call at a park. He found the male semi-conscious, lying on his back. Another male was assisting him and informed the officer that he had fallen. The officer had spoken to the male 15 minutes earlier, and noted that the male appeared to be in a much more intoxicated state. He was in and out of consciousness and unable to get to his feet, and an ambulance was called.

At inquest, a witness to the events of that evening testified that he had been drinking and socializing with the male. He stated that the male had been punched in the face and had fallen to the ground, striking the back of his head.

Firefighters arrived at the scene first, followed by an ambulance. The officer informed them that the male had consumed alcohol and may have fallen or been assaulted. The officer stated at

inquest that he gave the ambulance personnel the same information. He also informed them that he had seen the male earlier at which time he appeared only mildly intoxicated.

A firefighter who had examined the male detected a lump on the male's head but did not detect alcohol. The firefighter testified at inquest that he communicated this information verbally to the ambulance personnel. An ambulance attendant assessed the male and found him to be fully conscious and did not detect head or facial injuries. He testified at inquest that his assessment was compromised by the male's uncooperative behaviour and poor lighting. The attendant concluded that the male was intoxicated and medically cleared to be brought to police cells.

At the jail, the officer gave the guard verbal instructions to keep close observation on the male and to make sure that he did not roll over. The jury heard that the current policy stipulates that medical advice is sought for prisoners who show signs of extreme intoxication after four hours of incarceration. It was heard at inquest that the prison policy was changed since the male's death to provide for checks of cells every 10 minutes, rather than every 15 minutes.

Approximately four hours after he had been brought to police cells, the male was observed by the officer to not have moved from his original position. He was found to be unresponsive and an ambulance was called. The male was pronounced deceased at the scene.

An autopsy revealed an epidural blood clot and facial injuries. The pathologist testified that the cause of death was blunt head trauma. Toxicological findings indicated a concentration of alcohol that would be considered as having mild to moderate effects in an experienced drinker.

The jury found that the death was due to blunt head trauma due to physical assault and classified the death as a Homicide.

Recommendations:

The jury made six recommendations, four of which were directed to the New Westminster Police Service and two to the BC Ambulance Service (BCAS).

The jury recommended that the New Westminster Police Service provide mandatory training and an annual review of policy so that officers are aware of policy and how to implement the policy. It was recommended that policy be amended to include a check of prisoners with questionable consciousness or extreme intoxication every two hours to assess their condition. Addition of a section to the Prisoner Record Form was recommended, to allow for special instructions or information. Finally, it was recommended that a set of policies is put in place for prison guards to follow.

The jury recommended that the *BCAS* consider compulsory completion of the First Responder Form and that a copy of the form be passed on to the police. It was also recommended that a policy be developed to specify which ambulance crew member is responsible for completing which sections of the crew report.

Case 7 of 7

On September 25, 2007, an inquest was held at Fort St. John BC, into the death of a 29-year-old male who died on September 27, 2006, due to methadone overdose.

The male had a long history of heroin and cocaine addiction and was subject to a probation order. On the morning of September 27, 2006, he was found behaving strangely outside a hotel. Two officers responded to a 911 call from a hotel employee. One officer recognized the male, who was rolling around on the ground in the parking lot and was partially undressed. He was arrested for causing a disturbance. He was cooperative and got into the back of the police vehicle unassisted for transportation to the RCMP detachment. At the detachment, he was placed in a cell without incident. Both officers believed that he was under the influence of drugs.

The detachment policy requires guards to physically check on prisoners every 15 minutes. At the end of his shift, approximately half an hour after the male's arrival, a guard noticed he had shallow breathing and indicated in the prisoner log that an extra watch should occur. The oncoming cell guard did not conduct regular monitoring checks as policy required, but instead relied on cell camera footage.

Early that afternoon, two officers checked on the male to determine fitness to attend court. He was found lying motionless on the floor, but responded to pain stimulus. It was determined that he was not fit for court and was left to continue sleeping. An hour and a half later, one of the officers returned to check on the male and summoned her supervisor. The male was without a pulse and respirations. An ambulance was summoned and resuscitation was started on the male. Resuscitation continued at hospital but was unsuccessful.

A forensic pathologist testified that the male had recent track marks on his arm, consistent with self-administered drug use. He further testified that the cause of death was methadone intoxication and fungal pneumonia. He stated that both can affect breathing and had the male been treated, he could possibly have survived. However, even without pneumonia his death that night was possible.

Toxicological analysis was positive for both methadone and cocaine. A toxicologist stated that the concentration of cocaine was low and did not play a contributory role in the death. The concentration of methadone was within the lethal range.

The detachment commander testified at inquest that the policy requiring cell guards to physically check on prisoners at 15 minute or less intervals was not followed on the day the male was brought in. He stated that there was no policy in place relating to rousing prisoners, although there was a flowchart which provided guidance in assessing responsiveness and when medical treatment should be sought. Finally, the commander informed the jury that he had recently received a copy of a proposed new policy which would require all prisoners to be roused every four hours.

The jury found that the death was due to methadone overdose with fungal pneumonia as a contributing factor and classified the death as Accidental.

Recommendations:

Two recommendations were made and were directed to the Commanding Officer, RCMP "E" Division. It was recommended that the proposed 4-hour rousability check become policy and that the RCMP develop guidelines pertaining to and defining "roused".

Police Shooting

Case 1 of 1

On May 22, 2007, an inquest was held at Houston BC, into the death of a 22-year-old male who died on October 29, 2005, due to a gunshot wound to the head.

On the evening of October 29, 2005, the male attended a hockey game with friends after having a couple of drinks at a nearby residence. The group returned to the residence during the first intermission. Witnesses reported that the male complained of heartburn and was not seen drinking.

Officers from the RCMP detachment were on a foot patrol of the arena that evening. There had been previous discussion at the detachment regarding the drinking and fighting that was common outside the arena.

One officer observed the male by the main entrance to the arena with an open bottle of beer. The officer initiated ticketing for open alcohol in a public place. Two other officers arrived and provided their cruiser to the officer to write up the ticket for the male. The officer asked the male his name and was given a name determined to be false. The officer informed the male that he could be charged with obstructing a police officer unless he provided his real name. The male then gave another name and birth date. The officer called RCMP dispatch to check the name and was told there was no driver's license associated with the name and birth date. The male indicated that he did not have a driver's license. A liquor ticket was issued under the second name.

The officer testified that he then heard someone outside the vehicle state another name for the male. The name was corroborated by others and the male admitted lying about his name. The male was then informed that he was being arrested for obstructing a police officer. Two of the officers decided to bring the male to the detachment where he would be released on a 'promise to appear in court'.

At the detachment, the male was brought to the interview room by the ticketing officer. Two other officers were called away from the detachment, leaving the officer and the male alone. The officer testified that the male signed the liquor ticket with his proper name and then unexpectedly struck him on the side of his face. The officer stated that he was repeatedly struck on the left side of his head. The male then placed him in a head lock from behind and because of this the officer started feeling signs of losing consciousness. The officer then reached back and pulled out his pistol and attempted to strike the male in the head with it. The pistol was discharged and the male was shot.

An RCMP blood spatter expert attended the detachment to analyze evidence. He testified that it was most likely that the male was struck several times in an inverted position consistent with the officer being positioned beneath. He also testified that the blood spatter evidence was consistent with the male's position behind the officer.

A different blood spatter expert testified on behalf of the family, based on examination of photographs of the detachment and the RCMP blood spatter expert's report. The expert testified that the evidence was not consistent with the officer's stated position of being directly beneath the male when the pistol was discharged.

A forensic pathologist who conducted the autopsy testified that the cause of death was a single gunshot wound to the head. He also stated that the gunshot wound was indicative of the muzzle of the gun being in partial contact with the male's head at the time of discharge. Other wounds on the male's head were consistent with being caused by the sight on the officer's gun. Toxicological analysis indicated that the male had a blood alcohol level of .17 percent.

A sergeant testified regarding the use of recording equipment in the interview room of the RCMP detachment. Although there was equipment present, it was only in use when a statement was being taken. It was heard that since the incident, the equipment has been upgraded to a digital system with a remote control.

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

Recommendations:

The jury made a total of four recommendations. The RCMP "E" Division received a recommendation that they establish a standard for audio and video equipment in all detachments. The equipment should be mandatory and minimize human intervention, and individuals brought to the detachment should be clearly advised that they are being recorded. The jury also recommended that the RCMP review current procedures with the goal of continuous improvement (e.g. continuing education plan).

The jury recommended that the RCMP "E" Division and the Houston RCMP detachment ensure that when someone is detained at the detachment that an additional staff member is present until the detained person is released, has exited or has been placed in a cell.

It was recommended that the Houston RCMP detachment and District of Houston jointly make an effort to educate the public on the criminal code with the aim of reducing violations of the law. Liquor violations, obstruction of justice, theft, assault and vandalism were provided as examples by the jury of areas in which education could be provided.

Response to recommendations:

The Houston RCMP detachment responded that they had contacted the District of Houston. They will be continuing with the DARE education program in the schools, and intend to stay highly involved in the community relations to help educate the public. Additionally, the Houston RCMP detachment reported that all detachment members have been instructed to call for assistance from another member if they are going to be dealing with an aggressive subject at the office or in any other location. It has been stressed that, whenever possible, two members or a detachment guard if available should be present at all times when prisoners are dealt with, until the time of their release.

Police Pursuit

Case 1 of 1

On November 13, 2007, an inquest was held at Victoria BC, into the death of a 37 year-old-male who died on February 3, 2007, due to a gunshot wound to the head.

Early in the evening on February 3, 2007, the male drove a stolen vehicle to a friend's residence and parked on the street. The friend testified at inquest that he believed the male had consumed illicit drugs. They each snorted a line of cocaine and after about 15 minutes the male left.

During this time, a police officer had identified the parked vehicle as stolen and placed the vehicle under surveillance, intending to arrest the driver upon return to the vehicle. One marked and one unmarked police vehicle waited at opposite ends of the street. After the male started the vehicle and began pulling out into the street, the unmarked and marked cars activated emergency equipment and pulled into the street to block the vehicle from passing. The male's vehicle rammed into the unmarked car and then reversed and rammed into the marked car.

The male escaped the police blockade in his vehicle and hit a tree before driving onto the grass verge. An additional unmarked police car had arrived at the scene and another attempt was made to blockade the vehicle. However, the vehicle evaded the blockade and proceeded at high speed down the street.

Witnesses testified that the vehicle was damaged due to the collision with the tree and was emitting sparks and appeared difficult to control. A police pursuit was initiated with the two unmarked cars.

The police department's road supervisor overheard the events as they were being broadcast on police radio. The road supervisor and his partner, both sergeants, drove their car to the projected path of the stolen vehicle. The sergeants parked their car in the middle of the street and exited to stand on the sidewalk. The stolen vehicle drove onto the sidewalk, nearly hitting the road supervisor.

Prior to moving out of the way, the road supervisor fired three shots at the stolen vehicle while the other sergeant fired two shots. Another police car had arrived and the officer had parked near the road supervisor's car and exited the vehicle. This officer fired three shots, aiming at the male as the vehicle drove by. The two sergeants had moved by foot to the other side of the intersection and each sergeant had fired two shots at the front passenger side tire and at the driver. Immediately after these shots were fired the stolen vehicle slowed and was pinned by the second police pursuit car. Radio transmissions indicated that the entire incident lasted approximately 2.5 minutes.

It was determined that the male was unresponsive and had likely suffered a head wound. He was removed from the vehicle and first aid was provided by police. An ambulance arrived and the male was taken to hospital. CT and MRI scans were obtained. A neurosurgeon was of the opinion that there was no prospect of survival, and the male was taken off life support.

An autopsy revealed a gunshot wound had caused major intracranial damage. There was also a gunshot wound of the upper arm, chronic hepatitis and crystals in the lungs. The latter two findings were identified as characteristic of chronic drug abusers. Toxicological analysis indicated the presence of cocaine, cocaine metabolites and morphine in moderate levels. The pathologist unequivocally identified the cause of death as a gunshot wound to the head.

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

Recommendations:

The jury made a total of seven recommendations, jointly directed to the Ministry of Public Safety and Solicitor General (PSSG), the BC Association of Chiefs of Police and the Victoria Police Department. It was recommended that consideration be given to methods of securing or disabling stationary vehicles prior to active pursuit, and three further recommendations were made regarding changes to the Victoria Police Department Pursuit Policy. It was recommended that a clear policy be developed and adopted regarding termination of a pursuit, and that training and refresher training on the National Use of Force model continue. Finally, the jury recommended that the Victoria Police Department share the pursuit policy with the BC Chiefs of Police and the Ministry of Public Safety and Solicitor General with the intent that the policy be adopted province-wide.

Response to recommendations:

The PSSG responded that the BCACP Traffic Safety Committee has been charged with developing options regarding pursuit, and the Ministry will establish a working group to finalize the policy to ensure consistency among all police agencies in the province.

The Victoria Police Department responded that they have met with the Training and Traffic Sections to discuss this. The Traffic Section is tasked with conducting administrative reviews of all pursuits in the jurisdiction, and both Sections have been asked to conduct a literature review of current technology, techniques and tactics surrounding vehicle pursuits. This will be an ongoing process and both Sections remain committed to implementing those techniques and technologies which will best ensure the safety of both the public and the police. Any changes will be forwarded to the Policy & Audit Compliance Committee for further discussion and approval before being forwarded to the Police Board for final approval. The Training Section confirms that they conduct refresher training twice a year and that nearly 100% of sworn members participate. This training will continue to occur in the years to come.

Custody: Provincial Correctional Facility

Case 1 of 1

On May 15, 2007, an inquest was held at Nanaimo BC, into the death of a 30 year-old-male who died on May 19, 2006, due to drug intoxication of methadone and morphine.

On the evening of May 18, 2006, the male was an inmate at the Nanaimo Correctional Centre. At inquest, a security officer described the routine for evening shut down. By midnight, all inmates are required to be in their bed, with area lights turned off. A formal count of inmates then commences.

It was heard that two security officers entered the male's bed unit to perform the evening check and found him with his head over the side of the bunk. He had vomited and did not appear to be conscious. He did not respond to shouts, shaking or pain stimulus. A pulse could not be felt and he did not appear to be breathing.

A medical emergency was called to the control centre and CPR started by the security officers. A Senior Correctional Officer and a Correctional Officer attended immediately to provide assistance, and Advanced Care paramedics arrived shortly after. Use of an Automatic External Defibrillator indicated that there was no heart rhythm. The paramedic overheard inmates who had gathered discussing the possibility of drug use. The male was transported to hospital, and was intubated to assist with breathing. He was also administered drugs to stimulate his heart. Resuscitative efforts were unsuccessful, and the male was deceased on arrival at hospital.

A forensic toxicologist testified at inquest that there were significant amounts of morphine and methadone in the male's system. However, interpretation of toxicity required knowledge of the user's dosage and tolerance to the drugs. The pathologist who conducted the autopsy stated that he found no evidence of trauma, injury or disease to account for the death. Based on the toxicological findings and the male's incarceration history, the pathologist concluded that his tolerance to the drugs would have decreased and the drug amounts could be interpreted as lethal.

A Deputy Warden gave evidence at inquest regarding the access to drugs in prison. He stated that 70-80% of the inmates have alcohol and/or drug dependencies. He described the efforts of Corrections BC to prevent entry of drugs into prisons. It was heard that the male had access to drug and alcohol treatment and expressed interest in further treatment.

It was also heard that inmates at the prison indicated that the male had recently acquired an illicit supply of morphine and methadone and had been consuming it the day before his death.

The jury found that the death was due to methadone and morphine intoxication and classified the death as Accidental.

Recommendations:

A total of five recommendations were directed to the Nanaimo Correctional Centre. The jury recommended that the centre: improve visibility on the units, so that lights come on when medical emergencies are called; have an Automatic External Defibrillator on site; include pocket masks as required equipment for staff; continue education for staff, with the addition of role play and simulations in crisis intervention; and enforce policy regarding crowd control.

Child Deaths

Case 1 of 5

On June 11, 2007, an inquest was held at Prince George BC, into the death of a 4 year-old-female who died on November 2, 1999, due to craniocerebral trauma as a result of non-accidental injury.

On the evening of October 30, 1999, the child's mother left her four daughters at home with her boyfriend. She testified at inquest that her boyfriend called her at work to say that her daughter was hurt and she immediately went home. She also testified that she was told by her boyfriend that the girl may have fallen off her bunk bed. She confirmed that she was told at the hospital that her daughter's injuries were not consistent with the stated cause.

The mother's boyfriend testified that he had been drinking after work that evening. He did not think he was impaired. He stated the girls went downstairs after dinner. Later in the evening he called the girls for bedtime and heard the 4 year-old-female come up first, following by a commotion on the stairs. The eldest daughter then came up the stairs carrying the 4 year-old, stating that she had found the child at the bottom of the stairs. He recalled getting frozen vegetables for the lump on her head and taking her into the bathroom as she had thrown up. He testified that he was holding her facing him when he tripped and fell forward onto the child and the tub. As the child was unconscious and moaning, he stated he put her under a cold shower to revive her.

When the mother arrived, she and the boyfriend drove the 4 year-old-female to hospital. She arrived unresponsive, hypothermic, and had a significant head injury. She was later found to also have internal abdominal injuries and a broken collar bone.

The boyfriend confirmed he was arrested on October 31 and was kept at the RCMP detachment for 3 days. He denied shaking the girl violently and did not remember telling the police she had fallen off the bunk bed.

Hospital staff testified that they were told by the boyfriend that the girl had fallen from the top bunk, but that they believed her injuries were inconsistent with this explanation.

A pediatrician testified as an expert witness. She examined the child on the evening of October 30. A CT scan revealed a fractured skull and brain swelling. She stated that the clinical condition of the child was not consistent with the history she had been given. She attempted to speak with the family, but was told that the parents had left the hospital. She testified that she was told by the boyfriend that he had found the child at the bottom of the ladder of the bunk bed. The pediatrician stated that injuries the child received could not have occurred from the fall described by the boyfriend. An immediate transfer to BC Children's Hospital was arranged.

The attending pediatrician at BC Children's Hospital testified as an expert in child abuse and neglect. The physician stated that bruising and other injuries on the child were consistent with cases of violent shaking. A CT scan indicated a severe abdominal injury that would have required immediate surgery. Due to the severe brain injury and unstable condition, surgery could not be performed. She further stated that she did not believe either version of events presented by the boyfriend and that the child's injuries were consistent with Battered Child Syndrome.

On November 1, a hospital intensivist informed the family that the girl could not survive the brain injury. Tests confirmed brain death and she was removed from life support on November 2.

A forensic pediatric pathologist conducted an autopsy on the child and testified that she died from craniocerebral trauma as a result of non-accidental injury. He believed the injuries were the result of high energy impact. The presence of retinal hemorrhages in both eyes indicated to him a suspicion of shaking. He stated that linear bruises on the girl's side and back were indicative of a finger pattern. He did not believe that a fall down the stairs would cause the injuries he observed.

Following the child's death, her three sisters received grief counselling from the Ministry of Child and Family Development, by a licensed psychologist. The psychologist's summary report indicated that the children reported seeing their sister assaulted by their mother's boyfriend. However, the jury was cautioned by the presiding coroner to be mindful of the children's age when considering this evidence.

There was significant discussion and testimony at the inquest regarding the role of the Ministry of Children and Family Development (MCFD). A social worker in the Prince George Regional Office testified that the child's family first became known to the MCFD in 1991. Between 1991 and 1994 there had been 14 calls of concern regarding the family for reports of physical abuse and spousal violence. Between 1994 and 1997 there were no reports, until 1997 when MCFD involvement resumed.

In March 1999, a report of suspected physical abuse was made to MCFD. A child protection intake worker interviewed the mother and children. The child's mother denied the children's stories. Following another report the following day, an Immediate Safety Assessment was completed and the children deemed safe. Several additional reports to MCFD occurred regarding the children between March and the end of October. The intake worker also testified that in 1999 there were overwhelming case loads. A school youth care worker also testified regarding reports of physical abuse from the girls.

Following the child's death, the MCFD conducted a Director's Case Review to examine their role in the family's lives. Thirteen recommendations resulted from this review and it was confirmed by the Regional Director of Child Welfare that all of the recommendations were implemented and signed off as complete by June 25, 2003.

An RCMP officer testified that the child's home was examined on October 31 and photographs taken. The boyfriend was taken for breathalyzer analysis 7 hours after he had taken the child to the hospital. Based on that reading, his blood alcohol level was estimated to be 0.14% at the time the child was taken to hospital. A report was sent to Crown Counsel once the police investigation was complete. However, charges were not approved.

The jury found that the child died due to craniocerebral trauma as a result of non-accidental injury and classified the death as a Homicide.

Recommendations:

The jury made a total of four recommendations.

It was recommended to the Chief Coroner of the BC Coroners Service (BCCS) that the BCCS should hold coroner's inquests regarding questionable deaths in a timely manner.

The Ministry of Children *and* Family Development (MCFD) received three recommendations;

including a recommendation that a focus group be formed for all MCFD offices in BC with a mandatory action plan for addressing concerns in a timely manner. Continuous upgrading/ training for relevant staff on child protection, interviewing, investigation and risk assessment was recommended. Finally, it was recommended that the MCFD review their budget to increase resources aimed at child protection.

Response to recommendations:

The BCCS responded that several actions have been taken to improve timeliness of inquests. A full time in-house legal counsel has been hired; this individual is charged with ensuring that inquests are heard in a timely manner. A full time inquest coordinator has been hired to assist the legal counsel and the presiding coroners. Arrangements have been made with seven ad hoc legal counsel. An inquest review committee has been formed which will review questionable deaths. The committee will follow up to ensure that a presiding coroner and legal counsel are appointed early on and instructed to move forward with dispatch. A goal has been set that barring unavoidable circumstances, including but not limited to, ongoing criminal investigations and prosecutions, inquests will be held within one year of the date of the death.

The MCFD responded that they support the intent of the office focus groups. It was also noted that the MCFD provides training to social workers involved in providing services to children, youth and families through the mandatory Child Welfare training program that includes modules on child protection. Finally, their response indicated that funding has increased in the past two years.

➲ Case 2 of 5

On June 18, 2007, an inquest was held at Terrace BC, into the death of a 14 month-old male who died on August 16, 2002, due to diffuse cerebral edema.

On the evening of August 15, 2002, after the child awoke, his father took him into the living room to sleep so that his mother could get some rest. When the child awoke a second time, the father prepared a bottle and the child went back to sleep. The father testified at inquest that he slipped out from under the sleeping child when his older child awoke him and needed attention. When he returned to the couch, the child was still lying in the same position and was not breathing. The father called 911, while the mother started CPR.

A paramedic testified that when the ambulance arrived, the child's lips and limbs were cyanotic. The child was not breathing and there seemed to be an obstruction in the airway. The child was transported to hospital, but did not survive despite aggressive intervention.

The inquest heard that in June of 2002 the Ministry of Children and Family Development (MCFD) was contacted by a neighbour of the family regarding safety concerns. The MCFD had previously been involved with the child's older sibling, and the social worker assigned to the family was aware of the previous involvement. The social worker attended the residence to speak with the parents. She testified at inquest that she spoke to the family about safety issues and how they were coping with stress. She did not report any concerns regarding abuse or neglect. A follow-up visit was conducted and the file subsequently closed.

The pathologist who conducted the autopsy testified that there were no outward signs of injury.

She did not identify any natural disease or trauma to cause the death. She found that the child died due to cerebral edema with no underlying etiology. The pathologist described the signs of Shaken Baby Syndrome, also called Abusive Head Trauma. She also told the jury that the cerebral edema could have been caused by a single episode of aggressive shaking even in the absence of the other signs of the syndrome. It was heard that retinal hemorrhages are indicative of an aggressive shaking injury. However, the pathologist did not examine this possibility in the autopsy as the child had undergone prolonged resuscitation efforts which can also result in retinal hemorrhaging.

Two other physicians, a pediatrician and a pediatric trauma expert, both indicated that the effects of resuscitation and shaking on the retina can be differentiated. The pediatric trauma expert gave suggestions for what should be included in an autopsy for a suspected death due to child abuse. Finally, the expert testified that the timeline of events was consistent with an incident of shaking in the early morning hours of August 16.

The RCMP conducted a lengthy investigation. It was heard at inquest that the child's father provided a statement to police in which he indicated he may have shaken the child. The child's father stated at inquest that he had not shaken the child. He said that he was tired, confused and hungry during his interview with police, leading him to tell them that he may have shaken the child.

Finally, it was heard at inquest that since 2002 a significant amount of effort has been made by the MCFD to ensure that social workers are aware of the importance of considering a number of factors in the welfare of a child.

The jury found that the death was due to diffuse cerebral edema and classified the death as Accidental.

Recommendations:

The jury made a total of two recommendations. The Chief Coroner of the BC Coroners Service received the recommendation that protocols be established for mandatory testing during autopsy in the case of an unexplained death of a child.

It was recommended that the Ministry of Children and Family Development (MCFD) keep a file open when several issues have arisen regarding a family, and that periodic checks should continue for several years.

Response to recommendations:

The Chief Coroner responded that the forensic pathologists currently conducting examinations on suspected child abuse cases in BC have a significant level of expertise in interpretation of injury and cause of death. It was stated that a letter and copy of the Verdict has been forwarded to pediatric pathologists at the Royal Columbian Hospital and BC Children's Hospital.

The MCFD responded that current policy and standards are consistent with recommendations for providing protective services to a child and family.

Case 3 of 5

On February 5, 2007, an inquest was held at Port Coquitlam BC, into the death of a 3-year-old male who died on December 27, 2004, due to acute hemorrhage.

The child's family had two dogs, a rottweiler and a border collie. A family acquaintance temporarily staying at the home also had two rottweilers. On the evening of December 26, 2004, the acquaintance's dogs were left in the care of the child's mother while the acquaintance was out of town. The child's mother barricaded the dogs in the kitchen with plywood and instructed her boyfriend to place the dogs in the basement before going to bed. She brought the family's two dogs into her bedroom when she went to sleep.

The next morning the child was found by his brother in the living room, which was still separated from the kitchen by plywood. The dogs were present in the living room with the child. The child had been badly injured in an apparent dog attack. The inquest did not reveal how the dogs gained access to the living room. It was determined that the border collie was not involved in the attack.

A police Sergeant testified at inquest that a police investigation did not provide sufficient evidence for the offence of criminal negligence causing death.

An autopsy determined the cause of death to be acute hemorrhage.

It was heard at inquest that the family was known to the Ministry of Children and Family Development. The child's mother struggled with drug addiction and the family required frequent visits and monitoring. A social worker reported seeing a rottweiler in the home but did not view the dogs as a risk to the children's safety. The social worker last visited the home in September 2004 and considered the family to be at less risk than they had been in the past. The social worker was not aware that the family acquaintance and two rottweilers had moved into the home in November 2004.

City by-laws indicated that having more than three dogs requires that the owner obtains a kennel license. A dog behaviour expert testified that rottweilers should not be kept in homes with children. He further stated that he encouraged bite-proofing lessons for young children in schools as it can reduce biting incidences by as much as 80%.

The jury found that the child died due to acute hemorrhage due to multiple incised/puncture wounds due to an animal attack and classified the death as Accidental.

Recommendations:

The jury made six recommendations, four of which were directed to the Ministry of Children and Family Development (MCFD). Three of these were regarding Bite Prevention Evaluation, while the fourth addressed Comprehensive Risk Assessment

A recommendation was directed to the Ministry of Education suggesting development of an education program at the grade 3 level to minimize risk associated with dog interactions.

Finally, the jury recommended that both the Ministry of Health (Provincial) and the Ministry of Agriculture and Lands, in cooperation with the BC SPCA, medical professionals and law enforcement agencies, develop a registry to record incidents of serious dog bites and/or attacks.

Response to recommendations:

The MCFD responded that they support the recommendations in principle and current policy and standards address the recommendations.

The Ministry of Education responded that the curriculum for students K-7 includes a Safety and Injury Prevention component. The Minister of Education responded that they are currently evaluating a resource developed for Grades 1-5. They hope to have a decision on whether the Ministry will recommend this resource by the end of the school year.

The Ministry of Health responded that the responsibility to identify dangerous dogs resides with the municipalities of BC through bylaws providing for the licensing and control of animals. If the intention of a registry of this kind is to improve community safety by reducing the number of dog attacks, the mandate would reside with the Ministry of Public Safety and Solicitor General and therefore the recommendation has been referred to this agency.

➲ Case 4 of 5

On October 11, 2007, an inquest was held at Fort St. James BC, into the death of a 6 month-old-female who died on June 17, 2005, due to an undetermined cause.

On June 17, 2005, the BC Ambulance Service responded to a call for assistance at the child's home. Upon attending, a paramedic found the child clearly deceased. The paramedic testified that the baby's nasal passages were blocked.

At inquest, the child's mother testified that she went to sleep with the child on the couch on the evening of June 16. She stated that she had last breastfed just before going to sleep and that the child had not woken up during the night. The child's mother further stated that she had consumed approximately six cans of beer during the day and had a sleeping pill.

The pediatric pathologist who conducted the autopsy found that the child had no external injuries or signs of disease and no definitive cause of death. There were marks on the thymus and lungs, which can be caused by suffocation, but has also been found in deaths attributed to Sudden Infant Death Syndrome (SIDS). The pathologist stated that as there was some blockage of the nasal passages it would be possible for the baby to suffocate if just her mouth was covered. Finally, she stated that if the child hadn't been sleeping with her mother she would attribute the death to SIDS. However, there was a risk of overlaying, which was increased by the mother's consumption of alcohol and a sleeping pill.

Several witnesses testified at inquest regarding the role of the Ministry of Children and Family Development (MCFD) with the family. It was heard that in May 2005, a child protection complaint was made to MCFD regarding the child. The mother's cousin had complained because she did not think the child could be properly cared for. The complaint was coded as "Further Assessment Required". At inquest, it was heard that policy guidelines regarding obtaining information were not followed on one occasion. There was also some confusion regarding the city where the child resided. A child protection worker took on responsibility for the file and visited the home nine days later, with a representative of the band, who was also an aunt to the child's mother. A welfare worker was also present at the visit. The child's mother denied drug use to the workers. However, at inquest, she admitted her dishonesty regarding her drug use. The social worker decided to close the file without further investigation, a decision with which her team leader agreed with.

The mother's family physician also testified at inquest. He had prescribed the mother anti-depressant medication and sleeping pills. He testified that the mother told him she was no longer breastfeeding, as the medications were not suitable for nursing mothers.

The director of child welfare for the North Region testified at inquest regarding MCFD policy. He stated that he had conducted a review of the file. His review resulted in three recommendations, which have all been implemented.

The jury found that the death was due to an undetermined cause and the death was classified as Undetermined.

Recommendations:

The jury made a total of nine recommendations, eight of which were directed to the Ministry of Children and Family Development (MCFD). It was recommended that the MCFD develop standardized forms for first contact, requiring specific information from the reporter; that any and all information should be included in the file; and that contact efforts be logged by time and date. It was recommended that the MCFD provide resources for all needs, in consultation with participating agencies. First Nation elders should be given minimum formal training. Software should be developed to reduce the possibility of wrong information or codes being entered and allow full and proper access to information. The MCFD office in Fort St. James should be fully staffed with a team leader always available. Finally, the jury recommended that the social worker and team leader meet in person before a case is closed, and clearly document the decision to close a file.

The MCFD and Ministry of Health (Provincial) jointly received a recommendation to work together with concerned communities to establish an alcohol/drug treatment centre in the Fort St. James area.

Response to Recommendations:

The Ministry of Health responded that the current network of resources within the Northern Health Authority (NHA) includes withdrawal management (detox) and supported recovery following withdrawal. They are considering a number of initiatives to strengthen the network of withdrawal management and supported recovery services. For example, the NHA has been working closely with the MCFD to develop an Acute Response Protocol and clinical pathways. A meeting will be held to plan for joint training between MCFD staff and NHA staff. The training will address the development of treatment plans, collaboration with physicians and documentation standards.

➲ Case 5 of 5

On October 22, 2007, an inquest was held at Prince George BC, into the death of a 3 year-old-female who died on January 26, 2001, due to hypoxic ischemic brain injury.

The child died in hospital after being found unresponsive in her crib by her foster mother on January 24, 2001. At inquest, the foster mother testified that the child refused her evening meal and was put to bed in her crib with a bottle. Her foster mother noted she was having difficulty breathing and called 911 when her breathing worsened. The child was admitted to Prince George Regional Hospital and subsequently transferred by air ambulance to BC Children's Hospital where she died.

In the days preceding her death, the child had been kept home from her daycare program at the Childhood Development Centre (CDC), a Ministry of Children and Family Development (MCFD) resource program. Early childhood educators with the CDC testified that the child had developmental delays in several areas, but definite improvements had been noted. It was also heard at inquest that significant absences from the program were recorded for the last five months of the child's life. Bruising had been observed by one educator on the last day that the child was at the CDC prior to her death.

The foster mother described her involvement as a foster parent to the child and her long history as a foster parent for the MCFD. She stated that she had used a restraint harness on the child while sleeping, to deal with night terrors, on no more than 12 occasions, but did use it more frequently when the child was in a high chair to keep her safely secured. She also denied all allegations of inappropriate discipline being used against the children who had reported these instances to the MCFD.

At inquest, several medical professionals testified regarding the nature of the child's injuries. A consultant pediatric pathologist from BC Children's Hospital described the results of the autopsy. He concluded that the cause of death was hypoxic brain injury of undetermined cause. He reported external traumatic marks on the child, which he found concerning. He also found cerebral edema, low body temperature and decreased consciousness upon hospital admission, and low levels of sodium and potassium to be of concern.

The pediatrician at Prince George Regional Hospital also testified regarding her concerns over several findings. She was unable to reconcile the clinical findings. An expert witness, a pediatric clinician and professor with a specific expertise in child abuse, testified at the inquest. He testified that the cause of death was a hypoxic event with resultant hypoxic encephalopathy. It was his opinion that the hypothermia and metabolic imbalance resulted from the cerebral edema and were not the cause of the condition. Furthermore, he stated that the preceding event was either an intentionally inflicted manual suffocation or aspiration of the bottle or stomach contents. He concluded by stating that the context for abuse was present and that her death was preventable.

Another expert witness, a pediatrician with expertise in investigation of child abuse cases testified at inquest. She testified that although some of the bruises on the child were concerning, she was unable to conclude that they were definitely inflicted. Finally, a pediatric neuroradiologist testified that the child's cerebral edema was not the result of a focal injury, but of some type of injury involving the entire brain. He also stated that the injury occurred between 24-48 hours prior to the first CT scan. Although this type of diffuse cerebral edema is commonly seen in abuse cases, he was unable to definitively conclude that abuse was the cause of the anoxic injury. However, he was able to rule out a natural event as having causes the anoxia. He testified that "someone or something" asphyxiated the child.

A pediatrician in Prince George, who saw the child twice, testified regarding these two visits. He was concerned about the child's failure to thrive and had ordered further medical testing to investigate a decrease in her growth parameters. He was unaware that a restraint harness was being used on the child and was never approached by the child's foster mother regarding approval of restraint.

The child's mother gave testimony regarding her observation of bruising on the child during a scheduled visit and the steps she took to bring this to the attention of various social workers.

A team leader with the Family Services Team at the MCFD testified regarding the role of his team in managing the child's care as well as other events in which he was a participant. He spoke of some of the challenges which that region of the MCFD was facing. A member of this team discussed the various referrals that she made for the child and her frustration in accessing the resources she thought would be helpful to the child. She was unaware of the restraint harness, previous complaints regarding the foster home or bruising having been observed on the child's body. A social worker with the Family Services Team was responsible for the decision to temporarily approve the continued use of the restraint harness pending confirmation of medical approval. The foster mother advised the social worker that medical approval had been obtained. However, there was no independent confirmation of this information.

Other MCFD staff testified regarding allegations of inappropriate child discipline in the foster mother's home. However, these allegations were not investigated formally or independently. Finally, the decision to launch a formal Protocol investigation was made in November 2000. However, this investigation started only after the events immediately preceding the child's death had occurred. In December 2000, six additional children had been placed in the foster home on an emergent basis. The social worker who placed the children in the home was unaware of the Protocol investigation. It was heard at inquest that the MCFD system only tracks confirmed abuse or neglect findings and not allegations. The investigation was completed in May 2001 and the children in care were removed from the home and the home closed to any future placements.

The jury found that the death was due to hypoxic/ischemic brain injury due to cerebral edema due to suffocation and classified the death as a Homicide.

Recommendations:

The jury made a total of 26 recommendations to six agencies. Seventeen recommendations were directed to the Ministry of Children and Family Development (MCFD), three to the Child Development Centre of Prince George and District (CDC), two to the BC Ambulance Service (BCAS), two to the College of Physicians and Surgeons of British Columbia, one to the Ministry of Health (Provincial) and one to the City of Prince George Fire Department.

The MCFD received recommendations regarding their policies and procedures, investigation of child abuse and neglect allegations, information sharing and requirements of foster parents. Revisions to certain MCFD forms were also recommended.

The BCAS received two recommendations regarding recording of information on its Crew Report form. Similarly, the Prince George Fire Department received a recommendation regarding recording of information on its Fire, Rescue and Safety Report.

The CDC received three recommendations regarding notification and reporting to the MCFD regarding children in care.

It was recommended to the College of Physicians and Surgeons of BC that members provide MCFD with copies of consultation reports relating to patients who are children in care. In addition, a complete medical history of children in care should be obtained by physicians.

Finally, the jury recommended that the Ministry of Health consider development of a website which would provide a central repository for medical information regarding children in care.

Response to Recommendations:

The MCFD responded that the recommendations have been forwarded to the Provincial Director of Child Welfare for consideration.

The BCAS responded that a new initiative, the Patient Care Information Systems (PCIS), has been designed to improve the overall quality of patient care information. Patient care information is recorded and used by the BCAS dispatchers and paramedics while undertaking assessments and delivering appropriate treatments. Other health care providers use the information collected by BCAS to ensure high quality continuity of care.

The Ministry of Health responded that a primary consideration regarding the medical information of children in care is the need to take into account the provision of complete, accurate and timely information for care providers while maintaining the security and protection of extremely sensitive information. The ministry currently participates in a number of cross-government initiatives designed specifically to facilitate the secure transfer of sensitive information.

Industrial

Case 1 of 2

On June 18, 2007, an inquest was held at Prince George BC, into the death of a 52 year-old-male who died on March 20, 2006, due to blunt force and crushing force injury.

The male was hired as a temporary logging truck driver for a small business. He was responsible for hauling logs on a forest service road. The road was radio assisted and the use of radios is required by the Forest Service Road Use Regulation. The inquest heard that confusion often exists over radio procedures, as individual companies develop their own radio use protocols.

On the evening of March 20, 2006, the male was on a nightshift, hauling a load of logs to a mill. There were four other loaded trucks that were on the same road, traveling in the same direction. The male was second in the convoy, and the driver of the first truck was radioing location for all five drivers. However, distance grew between the first and second truck. The driver of the third truck in the convoy testified that the male's brakes were smoking, and was advised that his trailer brakes were not working and he was relying on his tractor brakes more. The first driver encountered an empty logging truck that had pulled into a turnout, as the driver had heard a radio call that there were loaded trucks coming down the road. The driver of the empty truck then heard the driver of the fourth truck in the convoy radio the location for two loaded trucks. The driver proceeded to drive his empty truck up the road as the location was a distance away, unaware that there were two additional loaded trucks on the road.

The empty truck met with the second loaded truck, driven by the male. The driver of the empty truck saw the headlights of the second truck and managed to get into a turnout. The two trucks passed each other without contact. However, the front wheel of the male's truck caught the snow shoulder, causing the vehicle to veer off the road and down an embankment. The truck came to an abrupt stop, causing the trailer and load of logs to crush the cab. Paramedics attending the scene found no pulse or signs of respiration. The male was declared deceased and no life-saving procedures were initiated.

The pathologist who conducted the autopsy testified that the cause of death was blunt and crushing force trauma due to a motor vehicle incident. She did not find any evidence of a natural disease process that would have caused or contributed to the death. Toxicological analysis found tetrahydrocannabinol, the active ingredient in cannabis in and its metabolite. The toxicologist testified that the concentration was consistent with administration a few hours before the incident. He suggested that the drug had a contributory effect to the death.

Inspection of the truck after the incident indicated that it did not meet the standards set out in the *Motor Vehicle Act and Regulations*. An inspector from the Commercial Vehicle Safety and Enforcement branch testified that had an inspection been conducted prior to the incident, brake adjustments would have been required.

Drivers testified that even though brake adjustment should be a part of the daily pre-trip inspections, it is often not completed.

At inquest, various issues surrounding road use and maintenance, truck overloading, speed limits, and the efforts of the BC Forest Safety Council in establishing log truck driver training and certification were discussed.

The jury found the death was due to blunt and crushing force injury due to a motor vehicle accident and classified the death as Accidental.

Recommendations:

The jury made a total of 17 recommendations. Eight recommendations were directed to the Ministry of Forests and Range, five to WorkSafeBC, three to the BC Forest Safety Council and one to the Insurance Corporation of BC (ICBC).

The jury made recommendations to the Ministry of Forest and Range regarding risk assessment of roads, Compliance and Enforcement, development of safety focused standards for construction and maintenance of resource roads, and standardization of forest service road signage.

It was recommended that WorkSafeBC assess safe load limits for off-highway trucks, establish the position of Road Marshall or Truck Foreman to monitor road safety, assess the feasibility of truck tracking and monitoring devices, and coordinate and implement two drug/alcohol resource road checks per logging season.

The BC Forest Safety Council received three recommendations regarding expediting efforts toward development of standardized radio use protocols, education of truck drivers about pre-trip inspections, and highlighting the issue of substance misuse in the forest industry.

Finally, the jury recommended that ICBC implement a forestry endorsement for commercial drivers.

Response to recommendations:

BC Timber Sales (BCTS), an independent organization within the Ministry of Forests and Range, responded that it continues to improve road safety administration in a manner that is compatible with the industry and the *BCTS* mandate, and a new safety program will address the recommendations.

It was also noted that the Ministry and BCTS are working together to implement two pilot projects on standardization of radio protocol and road signage. Finally, the Ministry responded that it shares a forest worker safety regulatory role with other provincial agencies and continues to work with WorkSafeBC to develop a compliance regime.

WorkSafeBC responded that the Engineering Department will assess load limits, or will retain external expertise to do so. The Road Marshall position is currently being considered by the Worker and Employer Services Division, which will also undertake a cost/benefit analysis to conduct a study of truck monitoring devices. If such a study is feasible, WorkSafeBC will contact external partners who wish to participate. WorkSafeBC noted that they do not have primary authority regarding road checks for drug or alcohol use, and so have referred this recommendation to the RCMP. WorkSafeBC would be willing to participate in joint road checks with the RCMP as it has in the past. Finally, WorkSafeBC is developing educational materials reminding drivers to be vigilant whenever behind the wheel.

ICBC responded that it is considering a variety of approaches to respond to the range of recommendations and initiatives

➲ Case 2 of 2

On July 9, 2007, an inquest was held at Kimberley BC, into the death of four individuals: a 48 year-old-male (worker 1), on May 15, 2006; and a 50 year-old-male (worker 2), a 44 year-old-female (paramedic 1), and a 21 year-old-male (paramedic 2), on May 17, 2006, all due to anoxia.

Worker 1 was an employee under contract to perform water quality monitoring at the closed Sullivan Mine in Kimberley. He went missing while on shift on the afternoon of May 15, 2006. On the morning of May 17, two workers (workers 2 and 3) went to the site where the vehicle of worker 1 was located. Worker 2 called 911 and reported a man down in shallow water in a sampling shed at the Sullivan Mine. The dispatcher made the initial determination that the call was that of a possible drowning and cardiac arrest.

Worker 2 then entered the sampling shed and collapsed. Worker 3 did not enter the shed. Two paramedics responded to the first 911 call. They had been provided with limited information when the call was dispatched. A dispatcher testified at inquest that emergency crews are dependent on dispatch for their safety and if an incident site is not safe, a dispatcher will instruct them not to enter or approach the site.

Upon discovering workers 1 and 2 collapsed, paramedic 1 asked worker 3 if there was a potential for gas to be involved. Worker 3 responded that he did not know, and paramedic 1 entered the shed and collapsed. Worker 3 informed paramedic 2 of his partner's collapse, and paramedic 2 then entered the shed and also collapsed within seconds. He was not aware of paramedic 1's question regarding the presence of gas.

Worker 3 called 911 and reported that a total of four individuals including paramedics 1 and 2 had collapsed inside the shed. He speculated that there may have been gas inside the shed, further speculating that it was hydrogen sulphide. Following this report, emergency personnel treated the site as hazardous.

Firefighters were instructed to stay out of the shed without proper breathing apparatus and harnesses. Once it was identified that the four individuals were inside a confined space, a

fire engine carrying breathing apparatus and harnesses was called from the fire hall. All four individuals were removed from the shed by fire personnel. Worker 2 and paramedics 1 and 2 were transported to hospital, but despite aggressive intervention, were pronounced deceased. Worker 1 was determined to be deceased upon removal from the shed.

Autopsies were conducted on all four individuals. At inquest, the pathologist testified that all four died of anoxia due to low atmospheric oxygen.

At inquest, the jury heard from several witnesses on the specific features that define a confined space. A confined space expert testified that the first sign that there is a hazard is the death or critical injury of a worker and/or of those attempting to render assistance. There was agreement that the sampling shed was a confined space.

An expert witness on geochemistry and mining testified regarding the geological and chemical factors that contributed to the deaths of the four individuals. It was stated that there was deoxygenated air that had entered the shed from the adjacent waste rock pile. The witness testified that the percent of oxygen inside the waster rock pile was almost 0% at the time of the incident.

The jury found that all four deaths were due to anoxia, due to low atmospheric oxygen and classified the deaths as Accidental.

Recommendations:

The jury made a total of 16 recommendations; eight recommendations were directed to BC Ambulance Service (BCAS), two to Teck Cominco Limited, a mining and metals company, and six to the Ministry of Mines, Energy and Petroleum Resources.

Four of the eight recommendations directed to the *BCAS* were regarding emergency medical dispatch services protocols and working conditions. Other recommendations included mandatory use of an oxygen sensor to be worn at all times by the senior ambulance attendant. Mandatory confined space training, and assigning staff to ensure training and compliance are maintained at the Kimberley station were also recommended.

It was recommended that Teck Cominco take responsibility for safety and training of all contractors on their sites. Following the incident the company created a technical panel to determine the mechanism of low oxygen development and transport. The jury recommended continued support of this panel.

The jury recommended that the Ministry of Mines, Energy and Petroleum Resources amend the *Mines Act* regulations to meet or exceed the WorkSafeBC standards in the Occupational Health and Safety regulations regarding confined space. It was recommended that the Ministry review the strategy to establish a minimum number of site visits per mine per year, and increase the penalty for non-compliance. All mines with confined space sites should identify the spaces with signage within six months of the inquest, and local fire/rescue stations should be notified of hazards at decommissioned mines. The directives the Chief Inspector of Mines issued following the incident should be incorporated in the mining code. Finally, it was recommended that the Ministry implement the recommendations in its Sullivan Mine Accident Report as soon as possible.

Response to Recommendations:

The BCAS responded that they have provided additional information and guidance to dispatchers to better identify the broad range of hazards paramedics can face on scene. The BCAS has been working with the Ministry of Energy, Mines and Petroleum Resources to provide Dispatch Centres with a 24/7 emergency contact number. They have reduced ambient noise in the Dispatch Centre, and implemented a procedure for dispatch staff to take formal breaks from their work stations. Expert opinion was sought regarding the use of O2 sensors by all paramedic teams. Sensors will not be utilized, instead paramedics will receive more education regarding recognition of potential hazards and improving decision-making in stressful situations with competing priorities. The BCAS has issued information to all staff regarding safety in confined spaces, and revised the training courses with specific information on confined spaces and hazard recognition which all staff will re-take. The Kimberley Station Unit Chief position will be filled with a permanent full time appointment. The BCAS remains committed to providing the families of the paramedics involved in this incident with updates on the work undertaken to improve paramedic safety.

Teck Cominco responded that all contractors on company sites are required to have an appropriate safety program to ensure the safety of their employees Furthermore, the safety performance of a contractor will be a priority evaluation metric in the selection of contractors. The company also replied that all contractors must develop a plan which identifies the training requirements and work place procedures required to allow safe completion of work assigned to contract employees at the site. Teck Cominco indicated that it continues to support the work of the technical panel in developing a complete understanding of the technical causes of the incident and in providing this information to the mining industry worldwide.

The Ministry of Mines, Energy and Petroleum Resources responded that the Mines Act will be revised to both adopt the confined space requirements described in current WorkSafeBC regulations and incorporate the directives issued by the Chief Inspector of Mines following this incident. Ministry has hired additional staff to increase inspections. A compliance and enforcement review of signage indicating potential hazards is underway.

Other

➲ Case 1 of 2

On August 13, 2007, an inquest was held at Victoria BC, into the death of a 22 year-old-male who died on October 17, 2006, due to cocaine overdose.

On the day of October 17, 2006, the male and a male friend were stopped by police in a routine road block enforcing seatbelt use, as neither was wearing a seatbelt. The friend was found to have an outstanding warrant and the vehicle was searched. Marijuana was found in the vehicle and as both males took responsibility for the drug, both were arrested.

The male had a pending charge for a recent arrest for drug possession for the purpose of

trafficking. The police searched the male as they suspected he was carrying drugs. Before they searched him he was afforded two phone calls to a lawyer and was left alone while in custody to place the phone calls.

As he was being searched by police, two empty plastic bags fell from his clothes, but as no drugs were found he was released with only a seatbelt violation ticket. He was warned to seek medical treatment if he had ingested any drugs.

Shortly after he arrived home, his father discovered him unresponsive on the bathroom floor. Full resuscitation attempts were made by ambulance personnel, but were unsuccessful. The male's brother testified at inquest that his brother called him after his release and told him he had ingested cocaine. The brother informed his father of this, which was relayed to the paramedics during resuscitation.

A toxicologist testified at inquest that the cocaine quantity in the stomach and the blood concentration were indicative of orally ingested cocaine. Toxicological analysis found a blood concentration of cocaine within the lethal range.

The male's friend who was arrested with him testified that his friend had told him he had two '8-balls' on him that day. He stated that his friend did not use cocaine and did not very often use any drug.

The male's lawyer was asked at inquest to answer questions, but invoked client lawyer privilege based on advice he was provided by the Law Society.

An RCMP officer, formerly a member of the street drug division testified that his opinion was that the male ingested the cocaine as he was afraid of being held in jail because of the pending drug charge against him.

The jury found that the death was due to respiratory arrest due to cocaine overdose due to ingesting cocaine while in police custody and classified the death as Accidental.

Recommendations:

The jury made six recommendations, directed to three agencies. It was recommended that the Law Society of BC review their bylaws or provide direction that would allow a lawyer to reveal pertinent information at an inquest when the client is deceased.

The jury recommended that the Ministry of Health prepare a pamphlet listing street drugs, their overdose symptoms, reactions and consequences. It was recommended that these pamphlets be available in medical, police and community agency offices.

The remaining four recommendations were directed to the Saanich Police Department. It was recommended that the department review protocols relating to possible courses of action when there is suspicion that a suspect has concealed contraband. They should ensure constant visual observation of the suspect while in the interview room and upgrade camera equipment to digital format so that pertinent information is easily retrievable and can be used in the appropriate setting. Finally, the jury recommended that, when drug ingestion is suspected, members should read the suspect information from the aforementioned pamphlet or consult with a supervisor before releasing the suspect.

Response to recommendations:

The Law Society of BC responded that the recommendation is under discussion by the Law Society's Ethics Committee.

The Ministry of Health responded that the recommendation will be tabled at a meeting of the Mental Health and Addictions Planning Council, which includes representation from the ministry and the six health authorities, in early 2008.

The Saanich Police Department responded that several policies have been reviewed since the fatality. It was stated that a strip search is conducted prior to the prisoner being allowed their right to counsel in order to preserve evidence. The issue of suspect observation has been dealt with through the education of the specific members involved in this incident and it has been brought to the attention of other offices. The department also responded that the process of upgrading the cameras to audio and video digital format in the cell block and interview area was underway at the time of the male's death. The project has been put on hold pending the results of the Police Services review of all holding cells in the province. Finally, the department responded that when the pamphlets become available they will be placed in the interview rooms and the cell block area and utilized as required given each individual circumstance.

Case 2 of 2

On December 18, 2007, an inquest was held at Kelowna BC, into the death of a 27 year-old-male who died on August 5, 2007, due to cocaine overdose.

In the early morning of August 5, 2007, the male flagged down an ambulance and told the paramedic that someone was trying to kill him and that he needed help. The paramedic described him as being in an agitated state, sweaty, pale and barefoot. The paramedic was en route to hospital with a patient and alerted the police.

Police officers were dispatched and approached the male. The male told them that someone was after him and voluntarily got into the back of the police car. He was noted to be highly agitated. One officer testified that it was difficult to communicate with him, but they were able to ascertain his name and that he had used cocaine. The officers decided to take him to the police station. It was also noted that his bare feet were significantly injured. When they arrived at the detachment, the male became unresponsive and had a seizure. An ambulance was summoned.

Upon arrival at the detachment an ambulance paramedic observed the male having a seizure. The paramedic testified that the male was combative at times. The ambulance drove a few blocks before stopping and requesting that a police officer travel in the back of the ambulance.

At inquest, an emergency physician testified that the male was highly agitated and felt very hot to the touch. The male was given a sedative and police helped restrain the male while an intravenous line was inserted. The male suddenly became unresponsive and CPR was started, but resuscitative efforts were not successful. The physician testified that he believed that the male was displaying the classic symptoms of excited delirium.

An emergency physician and expert in the field of excited delirium described the condition at inquest. She testified that the male's symptoms were consistent with the state of excited delirium. She also said that there was little research on the condition and that education of police and paramedics was critical to enable recognition of the condition.

The pathologist who conducted the autopsy testified that the male died as result of cardiac arrest due to a cocaine overdose. He stated that the male had an enlarged heart, which was a

contributing factor to the death, and a history of steroid abuse which also would have damaged his heart. Toxicological analysis found a relatively high blood concentration of cocaine. The toxicologist testified that the concentration fell within the overlap between recreational and lethal levels, as some people with that level would survive.

An officer testified at inquest regarding RCMP policy. He stated that was no stand-alone policy regarding dealing with excited delirium either nationally or provincially. However, the symptoms of excited delirium were described in the National Operational Manual dealing with conducted energy weapons. The "E" Division medical assistance policy now directed readers to the national manual. The officer further stated that the excited delirium was addressed in training which takes place every 3 years.

The jury found the death was due to cardiac arrest due to cocaine overdose and classified the death as Accidental. An enlarged heart and excited delirium were identified as significant factors contributing to the death.

Recommendations:

The jury made a total of six recommendations to two agencies. It was recommended to the RCMP Commissioner that RCMP National Operational guidelines include a specific stand-alone policy regarding the recognition and management of excited delirium. It was also recommended that excited delirium be part of the initial RCMP recruit training as well as refresher training.

It was jointly recommended to the RCMP Commissioner and the Ministry of Health (Provincial) that when an individual is identified as being in a state of excited delirium, that a police officer ride in the ambulance during transport to hospital.

Finally, the jury directed three recommendations to the Ministry of Health (Provincial). Additional training was recommended for BC Ambulance Service personnel and emergency room staff in recognition and management of excited delirium. It was also recommended that funding be provided for research on excited delirium.

Response to recommendations:

The RCMP Commissioner responded that a specific policy on excited delirium is under development. In addition, the excited delirium component of all Conducted Energy Weapon (CEW) training has been redrafted. Cadets at the Training Academy at Depot Division are receiving familiarization training in both CEW and excited delirium. Finally, CEW re-certification training is being changed from tri-annual to annual.

The RCMP also responded that situational factors dictate whether the presence of a member of the RCMP in an ambulance is warranted. The Ministry of Health responded that, balancing the need for timely patient care while ensuring paramedic safety, policy requires police assistance with patients who pose a risk to themselves or others, including during transport to hospital.

The Ministry of Health responded that they are developing an on-line learning module specifically addressing excited delirium. This initiative is augmented by case reviews, in person training, and regional and provincial directives. In addition, the ministry will be following up with its research partners to determine if more research is required and what the priorities should be. Any scientific research that is found will be shared with the police community, ambulance services and emergency room staff.

Appendix 1
Glossary

Autopsy: An examination of the body of a deceased person to determine the cause and manner of death and to evaluate any disease or injury that may be present.

Cause of Death: The immediate medical cause of death (e.g. head injury resulting from a motor vehicle accident, asphyxiation due to hanging).

Classification of Death: Classification of death as one of the following:

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

Coroner's Report: The coroner's official record of the identity of the deceased and how, when, where and by what means the deceased died. It is a public document that forms the official provincial record of the death. It may include recommendations to agencies to aid in prevention of future deaths.

Toxicology: The study of the adverse effects of chemicals on living organisms, particularly the symptoms, mechanisms, treatments and detection of the poisoning of people.

Verdict at Inquest: A summary of the jury's findings regarding how, when, where and by what means the deceased died. Recommendations made by the jury are also included in the Verdict at Inquest. The evidence presented at the inquest is summarized by the presiding coroner and is also included in the Verdict at Inquest. It is a public document that forms the official provincial record of the death.

Ministry of
Public Safety
and Solicitor General