Ministry of Public Safety and Solicitor General

VERDICT AT CORONER'S INQUEST

File No.: 2007:1001:0026

An Inquest was held at Western Communities Courthouse, in the municipality of Colwood

in the Province of British Columbia, on the following dates January 30 and 31, 2008 and February 1, 2008

before Marj Paonessa, Presiding Coroner,

into the death of Wayne Allan TURNER (Last Name, First Name) 31 years (Age) ☒ Male ☐ Female

and the following findings were made:

Date and Time of Death: 22 February, 2007 at Time: 1933 hours

Place of Death: VIRCC, 4216 Wilkinson Road, (Location) Victoria (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Asphyxiation

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) hanging.

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 1st day of February AD, 2008.

MARJ PAONESSA
Presiding Coroner's Printed Name

Original signed by M. Paonessa
Presiding Coroner's Signature

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

FILE NO.: 2007:1001:0026

SURNAME	GIVEN NAMES
Wayne Allan	TURNER

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS

To: Mr. Brent Merchant
Provincial Director, Adult Custody Division
BC Corrections Branch
Ministry of Public Safety and Solicitor General
7th Floor, 1001 Douglas Street
Victoria, BC

1. To ensure a qualified sprinkler technician inspects institutional sprinkler heads no less than once a year. Said inspection is to ensure the integrity of sprinkler heads have not been compromised and cannot be used as ligature points.

2. Add a clause to the Adult Custody Policy which would be 9.13.9.4: "When an inmate is placed on 15 minute self harm watch, they are to be issued suicide prevention gown and blanket.

3. When recorded phone calls or any other form of recorded communication are required for investigative and/or court purposes, a complete transcription shall be done by a qualified, external transcription agency.

4. When an incident is going to a coroner's inquest, documentation pertaining to the inmate(s) involved is to be consolidated into one document and put into chronological order. This includes all logs, shift reports and medical information.

5. A detailed scale drawing showing all areas germane to the investigation be provided.

To: Warden
Vancouver Island Regional Correctional Centre
4216 Wilkinson Road
Victoria, BC V8W 9J1

6. Camera placement within Segregation/Observation Units be reviewed by a qualified external agency.