Presiding Coroner's Comments

Background

Leon Joseph Marcel Nepper came to his death on September 23, 2018, in Whitehorse, Yukon Territory. At the time of his death, Mr. Nepper was on remand and being held at Whitehorse Correctional Center (WCC). On the morning of September 23, 2018, Mr. Nepper was found unresponsive in his cell. Resuscitative efforts were initiated by a nurse and correctional officers and eventually taken over by emergency medical services (EMS) who were able to regain his pulse. He was transported to Whitehorse General Hospital by EMS and his care was then transferred to medical staff. After further assessment and consultation with his family physician, it was determined that Mr. Nepper's condition was not recoverable. His death was pronounced at 13:25hrs.

The Jury's Findings

Leon Joseph Marcel Nepper had a medical history that included throat and lung cancer, emphysema, chronic pain syndrome, coronary artery disease, depression, and smoking. He underwent a mandibular surgery secondary to his cancer treatment and as a result, was able to consume pureed food. The jury heard that Mr. Nepper was treated by a family physician at a clinic in Whitehorse on a monthly basis from 2016 until September 2018. His physician testified that Mr. Nepper was prescribed several medications to address his chronic pain.

On August 8, 2018, Mr. Nepper underwent a Computed Tomography Scan (CT) which showed extensive coronary artery disease with moderate stenosis, signs of chronic pulmonary obstructive disease (COPD), and probable pulmonary infection (pneumonia) within the right lower lobe of his lung. When he was last seen by his physician, it was determined that he was asymptomatic, meaning not showing any signs of pneumonia such as fatigue or shortness of breath which are commonly associated with pneumonia. A follow-up CT angiogram was recommended and scheduled for September 21, 2018.

The physician testified that Mr. Nepper brought the topic of Medical Assistance in Dying (MAID) in November 2017; however, at the time, Mr. Nepper's medical condition would not have made him eligible for consideration. The physician testified that while he could not recall having discussions with Mr. Nepper about a do not resuscitate (DNR) order per se, it's likely they had given Mr. Nepper's raising the subject of MAID previously. There was no DNR documentation on file at WCC and the WCC physician said that this was a matter to be discussed with Mr. Nepper at an upcoming consultation.

On September 13, 2018, Mr. Nepper was arrested for attempted murder by the RCMP in Whitehorse, and the following day, he was remanded into custody and transported to WCC.

The jury heard that upon arrival at WCC, Mr. Nepper was seen by a Correctional Officer (CO) in the Admissions and Processing Unit where he was asked a series of questions as part of the standard intake process for new inmates to determine which unit the inmate was to be placed. The CO testified that Mr. Nepper had a number of prescribed medications with him and advised the that he was wearing fentanyl patches prescribed to him by his doctor. The CO testified that he shared the information obtained during the intake process with the nurse including that Mr. Nepper required pureed food and a meal supplement (i.e., Ensure) as well as gave Mr. Nepper's medications to the nurse. The CO testified that all inmates are required to be assessed by a nurse during the admissions process.

The jury heard that Mr. Nepper was seen by a nurse on September 14, 2018, as part of the admissions process at which time the nurse confirmed the information provided by the CO. A physician on contract to provide medical care to inmates at WCC testified that she received a phone call from the nurse at WCC on September 14, 2018, advising of Mr. Nepper's arrival, medication regimen, and general observations. The jury heard that this was general practise when an inmate was admitted to WCC.

At the time of Mr. Nepper's admission to WCC, the jury heard that there was both a secured living unit (SLU) and a segregation unit (SEG) and the determination of where an inmate would be placed~~,~~ was based on several factors such as physical health, emotional/mental well-being and general safety and security of the inmate. Witnesses testified that the decision of placement was made in consultation with WCC staff along with the nurse and physician. Inmates held in SEG were monitored by video 24 hours a day and would have checks completed on them at prescribed intervals.

On September 15, 2018, Mr. Nepper was placed in SEG where he remained for the remainder of his time at WCC. He was reported to be frail, underweight, unsteady on his feet, cooperative and kind with correctional center staff. Given his medical condition and prescription of fentanyl patches, witnesses testified that his placement on SEG was appropriate. Correctional staff testified that it was unusual to have an inmate at WCC with Mr. Nepper's medical conditions. The jury heard that most inmates at WCC present with medical issues such as substance use withdrawal symptoms and mental health issues.

On the morning of September 23, the jury heard that Mr. Nepper was checked every 30 minutes as required in SEG. During the morning checks, he was observed to be lying on his back and could be heard snoring through the door of his cell. At 1035 hours, two CO's entered Mr. Nepper's cell to bring his scheduled brunch. Upon entry, one of the CO's placed the food on the sink and the two COs attempted to wake Mr. Nepper by calling his name, shaking his leg lightly and tapping on the wall, none of which woke him. At the time, the COs reported that Mr. Nepper was still snoring.

The jury heard that after leaving Mr. Nepper's cell, the COs asked the nurse on shift to check on him as they were unable to wake him. At 1051hrs, video footage of Mr. Nepper's cell showed the nurse, two COs, and the Acting Manager of Corrections (AMC) enter his cell. The jury heard that upon entry into his cell, they found Mr. Nepper pale, cool to the touch, and not breathing. The nurse instructed one of the COs to obtain the crash cart from the nursing station and the AMC called a "cold blue" and requested a CO in the control room to call 911 and ask for EMS and police. This occurred at 1059hrs. The CO testified that she returned to the cell with the crash cart in approximately 90 seconds.

The nurse used a pen light to check Mr. Nepper's pupils which she testified were fixed and with the use of a stethoscope, determined that Mr. Nepper did not have a pulse. A CO and the nurse cut Mr. Nepper's shirt and CPR was initiated by the CO under the direction of the nurse. While CPR continued, the jury heard that an Automated Defibrillator Device (AED) was applied to Mr. Nepper with no shock advised. The COs and nurse rotated CPR until EMS arrived at the cell at 1107hrs and took over resuscitative efforts.

The jury heard that EMS was dispatched to WCC as a "priority 3" call which is considered a high priority call with lights and sirens. Upon assessment, the EMS attendant, a critical care paramedic, testified that Mr. Nepper was pulseless and not breathing. While the EMS attendant and her partner began resuscitative efforts on Mr. Nepper, a second EMS team arrived at the cell. The jury heard that Mr. Nepper was administered epinephrine through an intraosseous line and a second one three minutes

later. In addition, the EMS paramedic testified that she inserted a supraglottic airway device to assist with breathing. An RCMP officer arrived at WCC at approximately 1104 hrs and was escorted to Mr. Nepper's cell by a CO while EMS was working on Mr. Nepper.

Mr. Nepper regained a pulse at 1119 hrs and was moved from his cell to an ambulance and transported to WGH. While on route, the jury heard that Mr. Nepper's pupils remained fixed which the EMS paramedic testified can be indicative of poor neurological status. The EMS paramedic intubated Mr. Nepper while in the ambulance and he received another dose of epinephrine in an attempt to avoid him going into cardiac arrest as his blood pressure was getting low. Throughout the trip to hospital, Mr. Nepper's pupils remained fixed, indicative of poor neurological status.

The jury heard that once Mr. Nepper was removed from the cell by EMS, the RCMP officer asserted jurisdiction of the cell and scene and assigned other RCMP officers to assist, which included taking photographs, collecting documentation and gathering evidence from Mr. Nepper's cell for further examination. The RCMP officer testified that Mr. Nepper's death was initially treated as a criminal matter and as per normal practise, would continue until further investigation.

Upon arrival at WGH, Mr. Nepper's care was transferred to the emergency room physician and nursing staff. The emergency room physician testified that Mr. Nepper's condition was poor upon arrival and that he had a Glascow Coma Score (GCS) of 3 (the lowest score possible). GCS is a test to determine level of consciousness. He was unresponsive, did not respond to pain, and his pupils were not reactive to light. The physician testified that Mr. Nepper's condition was likely not recoverable and following further resuscitative efforts, his death was pronounced by the physician at 1325 hours.

Mr. Nepper underwent an autopsy at Vancouver General Hospital conducted by a forensic pathologist. The pathologist testified that Mr. Nepper had significant coronary atherosclerotic disease which on its own can place an individual at risk of a sudden cardiac event. The pathologist also found Mr. Nepper to have findings consistent with acute pneumonia. There was no evidence of injuries, and the pathologist determined the cause of death to be complication of cardiovascular and lung diseases. A forensic toxicologist testified that Mr. Nepper had a number of prescribed medications in his blood consistent with the medications prescribed to him and further, that the findings were not consistent with an acute overdose and therefore, did not contribute to his death.

With respect to the RCMP investigation, the jury heard that the case was transferred to the Major Crimes Unit (MCU) of the Yukon RCMP for further investigation and eventually, upon review of all evidence, RCMP determined that Mr. Nepper's death was not suspicious.

The jury heard from the Director, Facility Based Corrections who testified that since Mr. Nepper's death, there have been a number of changes to WCC. For example, the jury heard that upon admission at WCC, inmates undergo an intake process that is more in-depth than the one Mr. Nepper would have received. The process helps to inform individualized care plans that every inmate receives that includes a trauma-informed process taking into account the inmates medical, social/emotional, and cultural needs. Within five days of being remanded, inmates are assigned a case manager who meets with the inmate to review their care plan and make arrangements for other things such as family visitation, etc. In addition, the jury heard that a mandatory medical assessment is completed by the Registered Nurse (RN) as a component of the inmate's care plan.

At the time Mr. Nepper was at WCC, the jury heard that the nurses employed by the correctional center were Licensed Practical Nurses. Since that time, all nurses hired at WCC are RN's and are advanced medical care trained which means they can perform such treatments as advanced airway management. The jury also heard that since 2018, every unit in WCC is equipped with a crash cart which includes medical equipment used to treat a person in or near cardiac arrest or other life-threatening conditions. In addition, the jury heard that there are 13 AED's available through WCC and that all medical equipment is monitored, upgraded and/or replaced when required.

Recommendation 1

To: Director, Facility Based Corrections of Whitehorse Correctional Center

a. *Recommendation to include a checkbox on the Medical Intake Assessment Form indicating Y/N whether an inmate has signed an Advanced Directive or DNR, and if so, where this documentation is held. This should also be written under "other" or included in "Health Information to be Disclosed": on the Consent to Share Medical Information.*
b. *If there are significant medical conditions present, and no AD/DNR, this should be flagged for follow-up and review with the inmate by a doctor.*

The jury heard that there is no policy in place for inmates who have a completed a DNR; however, if there was one in place at the time of inquest nursing staff would follow the order and not initiate resuscitative efforts. The Director testified that the subject of DNR remains under review by the WCC and is part of a broader branch plan scheduled for the next one to three years. The jury heard that a cross jurisdictional scan completed by the Department of Justice for Yukon found only one policy specific to DNR in correctional institutions and it was related to federal corrections.

Recommendation 2

To: Director, Facility Based Corrections of Whitehorse Correctional Center

Recommendation to offer more opportunities for Generalised Advanced Training with the goal of improving skillsets and providing higher levels of care and emergency intervention/response. For example, advanced airway management training (Corrections Officers) and high stress scenarios (Corrections Officers and Nurses).

The jury heard that at the time of Mr. Nepper's death, nurses employed by WCC were Licensed Practical Nurses. Since that time, all nurses hired at WCC are Registered Nurses (RNs) and are advanced medical care trained which means they can perform such treatments as advanced airway management. Correctional Officers are required to have successfully completed first aid training typically obtained through St. John's Ambulance but are not currently trained or certified in advanced airway management.

Recommendation 3

To: Director, Facility Based Corrections of Whitehorse Correctional Center

Recommendation to present Nepper incident in internal training to improve future response involving unresponsive inmates with medical concerns.

The jury heard that a formal review was not completed following Mr. Nepper's death. The Director testified that mock training for code yellow and blue exercises is conducted at WCC and includes nursing staff and COs.

Recommendation 4

> *To: Deputy Minister of Justice and Director, Facility Based Corrections of Whitehorse Correctional Center*
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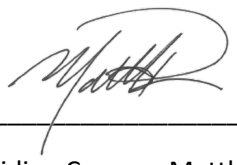
> *Recommendation to evaluate the suitability of facilities to house inmates with significant or serious medical conditions and how the existing policies and facilities might be improved with the goal of implementing these policy or facility changes.*

The jury heard that WCC no longer has the SEG or SLU units as a result of legislation and policy changes specific to segregation. Since Mr. Nepper's death, the previous SEG unit, now referred to as H-East Unit, can be used for inmates with medical or emotional needs where additional monitoring is determined to be required. The jury heard that given Mr. Nepper's medical condition, he would likely be placed in H-East.



Presiding Coroner Matthew Brown