CORRECTIONS BRANCH
Critical Incident Review

Subject:

Inmate on inmate assault

Date of Incident:

May 19, 2010 – Fraser Regional Correctional Centre (FRCC)

Review Team:

Lisa Martin	Chair	Deputy Warden, Alouette Correctional Centre for Women
Earl Preiss	Member	Assistant Deputy Warden, FRCC
s.22	Member	FRCC Community Advisory Board
Lyall Boswell	Participant/Observer	Inspector, Investigation and Standards Office
Dr. Paul Beckett	Consultant	Medical Director, Corrections Branch

Review Dates:

May 25 to 27, 2010 at Fraser Regional Correctional Centre.

Mandate and Scope of Review:

The assistant deputy minister requested that a critical incident review be conducted to examine the circumstances surrounding an inmate on inmate assault at Fraser Regional Correctional Centre (FRCC) and to specifically address the following:

- Compliance with Adult Custody policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at FRCC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The team was directed to report their findings and recommendations to the provincial director by June 11, 2010. An extension was granted and the report was submitted on June 16, 2010.

The Maple Ridge RCMP was contacted prior to the commencement of the review to ensure it would not compromise their investigation. Clearance was granted and the review proceeded.

Background:

Inmate s.22 is a s.22 inmate with s.22 and a s.22 He was transferred to FRCC on s.22 from s.22

Inmate s.22 ("the subject") was transferred to FRCC s.22 after being s.22 He is a inmate with s.22

Upon admission, the subject was interviewed and assessed for internal placement by a classification supervisor and placed on general population unit 2C. He was then escorted by a records officer to unit 2C, entering the unit at approximately 15:21 hours. For the short duration he was on unit 2C he talked to two different inmates in the common area. The gym officer then escorted the unit 2C inmates to the gym, leaving the unit at approximately 15:31 hours. Both inmate s.22 and the subject were in the group escorted to the gym. A review of digital video recording (DVR) footage indicates there was no interaction between these two inmates on the unit or on the way to the gym.

According to a review of DVR footage, the gym officer opened the door to the weight room at 15:32:26 and the inmates filed in. Inmate s.22 accompanied another inmate in selecting workout equipment in one section of the gym. The subject stood in another area of the weight room looking around. At 15:33:12 the subject walked over to inmate s.22 and from behind touched inmate s.22 on the right elbow, then leaned to inmate s.22 right. Inmate s.22 then turned square to the subject and immediately at 15:33:16 s.22 s.22 The subject instantly fell to the ground where inmate s.22 Inmate s.22 started to s.22 s.22 and then exited the weight room area. (When additional staff arrived on the scene, the gym officer pointed inmate s.22 out to other officers, who s.15 him. He was escorted to health care and then segregation.)

While in the gym office, the gym officer noticed s.22 at approximately 15:33:33 and s.15 and called a code yellow over the radio. The gym officer entered the weight room at 15:33:45 and took control of the situation by yelling at all the inmates to get to one wall. The gym officer was unable to safely intervene prior to the arrival of first responders to the gym. s.15 first responders entered the weight room at s.15 additional responders arrived s.15 seconds later. Several responders, upon seeing the subject, called a code blue. The responders noted that the subject was s.22 and s.22 .

The first officer who reached the subject noted s.22 . Other responders

s.22

Simultaneous to the response in the weight room, the acting assistant deputy warden (ADW) of regulation responded to control and viewed live camera footage and advised the deputy warden of programs of the situation.

The health care responders arrived and immediately asked for an ambulance to be called. The registered psychiatric nurse did a further assessment and s.22 With the corrections staff still maintaining control, the nurses s.22

The ADW of standards and communications relieved the A/ADW of regulation to enable her to coordinate the escort and other duties related to the response, including contacting the Maple Ridge Royal Canadian Mounted Police (RCMP).

Fire services responded at 15:53 and ambulance services arrived at 15:55. Ambulance personnel left the weight room with the subject at 16:02 and the weight room was secured for preservation of evidence.

The A/ADW of regulation contacted a Critical Incident Response Team (CIRT) member at 16:30 to attend the centre and was briefed on the situation and did initial debriefing with the staff involved. Further debriefing was done later as well.

The correctional supervisor videotaped the weight room at 17:00 with a handheld video camera. The Maple Ridge RCMP police arrived at the FRCC weight room at 21:46 and left at 22:55 after processing the scene.

As of s.22

Findings:

- Classification procedures were followed and an inmate assessment completed by a qualified and designated classification officer. All alerts were taken into consideration and the subject was appropriately placed on unit 2C.

- A review of the subject's s.22 file requested post-incident through also yielded no information that would have impacted his placement on unit 2C. There was s.22 that was not already on CORNET; however, this would not have made any change to his placement. There is no requirement to check s.22 upon intake.

- There was no behaviour noted by any officer who had contact with either inmate suggesting that something of this nature was going to occur.

- The gym officer s.15 and simultaneously initiated a code yellow immediately upon noticing the assault, less than 20 seconds after it began.

- The response was timely s.15 of the code yellow); with sufficient numbers; triggered an immediate code blue; and, complied with FRCC standard operating procedures.

- s.22

- Dr. Beckett, medical director, Corrections Branch viewed the DVR of the incident and found that the corrections staff managed the trauma in a timely and appropriate manner assessed as greater than that of a community standard of care for bystanders. He also inspected the contents of the s.22 used at FRCC and determined it contained all the appropriate equipment. Dr. Beckett also found that the health care staff managed the trauma in a timely and appropriate manner consistent with a community standard of care for nursing personnel.
- Simultaneous to the first aid response to the subject by correctional staff, inmate s.22 was isolated, secured and moved to segregation.

- As per FRCC standard operating procedures, the assistant deputy warden responsible for the building reported to control, made the appropriate notifications, and carried out all the duties required in such an incident.
- Health care response was timely, with the appropriate responders and equipment. The ambulance was called for immediately and with appropriate notification of s.22

- While having no causal impact on the incident, there were some FRCC staff, including a non-correctional staff, who entered the area of the incident despite having no responsibilities for responding to the incident.

- The Adult Custody Policy (ACP) protection of evidence policy was followed, including: protection of the scene; photos of scene and inmates; seizing of inmate s.22 's clothing; seizing cell effects of both inmates; and video of scene.

- All staff directly involved in the incident submitted the required reports. It is noted that these were delayed by a power outage.

- Timely critical incident notification requirements were made to the warden and headquarters and RCMP was notified as required.

- The ADW in charge of the incident, coincidentally also FRCC's critical incident team co-ordinator, contacted a CIRT member and provided initial debriefing and follow up as required.

- While having no causal significance to the incident or response overall, it was noted that with the simultaneous return of outside work crews there was some unrelated non-emergency radio communication.

- The motivation for the assault remains unknown. It is alleged that s.22 immediately after the assault s.15 to the unit 2C officer. However, s.15, s.22 indicates that this assault may have been related to s.22

Recommendations:

The critical incident review team agreed that there were no recommendations to put forward.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Inmate Death – s.22
at Fraser Regional Correctional Centre

Date of Incident:

July 8, 2010

Review Team:

Matt Lang	Chair	Deputy Warden, North Fraser Pretrial Centre
Carol Niemela	Member	Assistant Deputy Warden, Fraser Regional Correctional Centre
Dr. Paul Beckett	Member	Medical Director, Corrections Branch
Dr. Maureen Olley	Member	Director, Mental Health Services, Corrections Branch
Lyall Boswell	Participant/ Observer	Inspector, Investigation and Standards Office

Review Dates:

July 12, 13, 14 and 15, 2010 at Fraser Regional Correctional Centre

Mandate and Scope of Review:

On July 09, 2010 the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the death of an inmate that occurred in the segregation unit at Fraser Regional Correctional Centre (FRCC) and to address the following:

- Compliance with Adult Custody policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to the incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at FRCC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The team was directed to report its findings and recommendations to the provincial director, Adult Custody Division, by July 30, 2010.

The Maple Ridge RCMP was contacted prior to commencement of the review to ensure it would not compromise its investigation. Clearance was granted and the review proceeded.

Background:

On July 8, 2010 at approximately 0708 hours a code blue was called within the segregation area of FRCC. Inmate s.22 (the subject) was found unresponsive within segregation medical observation cell . The doctor attended and pronounced the subject's death at 0713 hours.

The subject had been in custody since s.22 having received s.22 . He was s.22 transferred to FRCC on s.22 for classification. Upon review of the subject's offence s.22 and his assessment as s.22 the subject was classified to s.22 He was transferred to s.22 on s.22 . On s.22 he was transferred back to FRCC for s.22 and The subject remained at until s.22 when he was transferred back to FRCC due to s.22 . The subject s.22 and had been s.22 The subject s.22 He remained at FRCC until his death on July 8, 2010.

On July 6, 2010 at approximately 1620 hours on living unit 3D, the subject approached a correctional officer indicating that he was experiencing s.22 The correctional officer discussed the subject's concerns with a licensed practical nurse (LPN) who was

on the unit distributing medication at the time. The LPN asked the subject to come and talk with her, s.22
The subject told the nurse that he was experiencing s.22 The nurse advised the correctional officer to have the subject taken to health care for further assessment. At 1635 hours, the subject was taken to health care where he received a closer medical evaluation by a registered nurse (RN). s.22 and the subject was released back to living unit 3D. During the interview the nurse did not recall specifics of the examination and thought that she may have seen the subject for s.22 as she had entered that information into the Primary Assessment and Care (PAC) healthcare information system, The nurse noted that he was scheduled to see the doctor the next day. However, that appointment was for s.22 and healthcare did not create a new appointment regarding s.22

The subject was seen in healthcare by the doctor on the morning of July 7, 2010 but was not assessed for s.22

On July 07, 2010 at approximately 1635 hours, the subject approached the living unit officer in some distress, s.22 . The LPN, from the previous evening, was in the unit distributing medications again and the subject spoke to her s.22 The correctional officer took the subject to healthcare for further assessment. The RN from the previous evening assessed the subject's medical situation and decided, in view of the subject's obvious distress, to place him in segregation under medical observation as a precaution. The nurse discussed the rationale for placing the subject in segregation with the correctional supervisor and indicated that s.15 checks and suicide prevention clothing were not required. The nurse did not make a Client Log entry regarding this placement, as she had discussed reasons with correctional staff and understood that a Client Log entry was not required.

At 1810 hours the subject was placed in a medical observation cell s.22 in the segregation unit under section 17 of the Correction Act Regulation (CAR). He does not appear to have been strip searched prior to placement. In the correctional supervisor's CAR 17 form he noted that the separate confinement was prompted by s.22 No notation was made regarding s.22 The reason entered on the CAR 17 form is not consistent with information entered on PAC, and both PAC and CORNET differ from a notation on a healthcare internal information log.

From 1810 hours until s.22 at 2110 hours, the subject is seen to be s.22 and is described by segregation staff as s.22 The subject

s.22 at 2110 hours. The s.22 nurse did not

s.22

According to the segregation unit roster the subject was checked s.15 times at s.15 intervals between s.15 hours on July 7 and s.15 hours on July 8. Two inconsistencies have been noted between log book entries and digital video recording (DVR) evidence. The DVR records s.15 checks completed between s.15 hours on July 7 and s.15 hours on July 8. Checks recorded in the unit roster for s.15 hours and s.15 hours were not evidenced by DVR. The officer who recorded these checks as being completed acknowledged this error in an updated incident report.

The DVR evidence indicates that the subject moved from lying on his left side to his back at approximately 0004 hours on July 8 and there is no further movement detected through review of DVR information. DVR and log entries indicate he was reported to have been seen s.15 times by four different staff members from s.15 hours until s.15 hours. No one officer was on the unit to observe movement for longer than s.15 During this time he remained s.22 until he was discovered during medication rounds when a code blue was called at 0708 hrs on July 8, 2010.

The code blue response was prompt and involved appropriate numbers of responders: s.15 correctional staff and s.15 healthcare staff. Dr. Legge, who was in the adjacent health care unit at the time, attended at s.15 hours. The body was reported to be cold and stiff. Resuscitation was not attempted. Dr. Legge pronounced the subject dead at 0713 hours.

The cell was then sealed, a scribe appointed, and photos taken.

The RCMP and the coroner were called, with the former arriving at 0815 hours and the latter at 0922 hours. The inmate's cell on the living unit was searched and his items seized and retained by FRCC. A s.22 was seized in the subject's LU cell. This s.22 was not retained as an exhibit but was returned to s.22 for disposal.

At present the cause of death is unknown. As reported by Dr. Beckett, the "preliminary findings of autopsy show no obvious anatomical cause of death".

Findings:

- Entries in the segregation unit log book were inaccurate and were not completed as recorded.

- FRCC standard operating procedures regarding segregation cell checks require that breathing/ movement is observed. DVR information confirms that no movement was detected shortly after 0000 hours on July 8. The inability to confirm movement/ breathing is compounded as a result of numerous staff conducting cell checks and impacting the ability to notice movement or lack of movement.

- Contrary to FRCC standard operating procedures, the subject was not strip searched, nor were his personal effects searched, upon admission into segregation.

- Adult Custody Policy (ACP) concerning protection of evidence was not followed in relationship to seizing and securing all cell effects. s.22 left in the subject's cell on 3D was not secured.

- ACP does not outline that the authority for being placed in segregation for medical reasons comes under section 17 of CAR and that the approval rests with corrections staff.

- The corrections code blue response was timely, with sufficient staff attendance, and complied with FRCC standard operating procedures.

- The healthcare code blue response was timely with appropriate staff and equipment. The ambulance was called immediately and discontinued once pronouncement of death by the attending doctor. Dr. Beckett, medical director, Corrections Branch reviewed the healthcare code blue response and determined it was appropriate.

- Coroner notification and body removal arrangements were appropriate.

- As per FRCC standard operating procedures, staff responded appropriately with notifications and carried out all of the duties required in such an incident.

- Critical Incident Response Team (CIRT) support was offered and followed up with both healthcare contractor and corrections staff. The healthcare contractor does not have a formalized CIRT process.

- Corrections staff followed appropriate provincial and local policies regarding referring inmates to healthcare.

- Healthcare staff failed to properly record in the Client Log the reasons for which the subject was placed under medical observation.
- Healthcare failed to make entries on vitals in PAC on July 7, 2010 as indicated by policy.
- Health Care Services Manual (HCSM) requires frequent monitoring to be initiated in PAC. This was not done in this instance.
- Nursing staff did not properly address the subject's medical concerns on July 6 or July 7, 2010.
- s.22 information was not recorded in PAC following the nurse's assessment on July 6 or July 7, 2010.
- Reasons written for placement in segregation under section 17 of CAR were inconsistent with healthcare entries in PAC.

Recommendations:

1. FRCC management should review with staff the standard operating procedures concerning the use of segregation.

2. FRCC management should review procedures for staff break relief in the segregation unit to ensure that the same staff members are providing relief throughout a shift.

3. FRCC management should review with staff adult custody policy concerning protection of evidence.

4. The provincial director should ensure that Adult Custody Policy reflects that the authority for being placed in segregation for medical reasons is section 17 of CAR.

5. The healthcare contractor should review HCSM policy with their staff regarding the requirements for making record entries in CORNET and PAC.

6. The healthcare contractor should establish a process to ensure that affected staff have access to healthcare-specific critical incident debriefing.

7. The healthcare contractor should establish a quality assurance mechanism which ensures communications/ documentation requirements are in place and being followed.

CORRECTIONS BRANCH
Critical Incident Review

Subject: In-custody Death

s.22

Date of Incident: October 19, 2010 at
Fraser Regional Correctional Centre, Living Unit 4C

Review Team:

Dawn Kelly, Chair
Deputy Warden, Alouette Correctional Centre for Women

Carol Niemela, Member
Assistant Deputy Warden, Fraser Regional Correctional Centre

s.22 Member
Community Advisory Board, Fraser Regional Correctional Centre

Dr. Paul Beckett, Member
Medical Director, Corrections Branch

Jim Shalkowsky, Participant/Observer
Deputy Director, Investigation and Standards Office

Review Dates: October 25 to 28, 2010
Fraser Regional Correctional Centre

Mandate and Scope of Review:

On October 20, 2010 the assistant deputy minister, Corrections Branch, requested that a critical incident review be conducted to investigate the circumstances surrounding the death of an inmate while in custody at Fraser Regional Correctional Centre (FRCC) and to specifically address the following:

- compliance with Adult Custody policy and procedures;
- the provision of emergency procedures; and
- any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at Fraser Regional Correctional Centre.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The team was directed to report their findings and recommendations by November 12, 2010.

The report and findings were provided to the provincial director on November 10, 2010.

Prior to the commencement of the review, the Ridge Meadows RCMP was contacted to ensure this review would not compromise any investigations that department may have been conducting. Clearance was granted and the review proceeded.

Background:

s.22 (the subject) was admitted to s.22 for charges of s.22 These charges were s.22 He was s.22

He was initially housed in s.22 due to upon admission. s.22 he remained in s.22 until s.22 Having completed s.22 the subject was transferred from to FRCC where he was placed on Living Unit (LU) 4C s.22
His status was reviewed regularly as per Adult Custody policy and by s.22

s.22

Due to s.22 the subject was classified to LU 4C s.22 and bunked in cell with inmate s.22 (the roommate), who was s.22 Entries in the subject's client log reflect that there were s.22 for the next six days. The subject's 'Alerts' in CORNET included s.22 concern that stated "never to be housed with s.22

On s.22 staff commenced their shift on LU 4C at approximately 0708 hours and spent the next six minutes in the office. (All times are approximate as there appears to have been a discrepancy of 10 minutes between the times of the DVR footage reviewed and unit clocks and staff watches.) Cells s.22 were unlocked and immediately re-locked as a page via the intercom indicated the nurse would be attending for medication rounds. The nurse arrived at s.15 hours, dispensed medication to two inmates, and left at s.15 hours to radio healthcare when she discovered that there was no s.22 on the cart. When it was realised that the s.22 was left behind on the counter in health care, rather than the nurse and the runner retrieving the s.22 the health care correctional officer was asked by the nurse in health care to deliver s.22 to LU 3C. The unit was unlocked and the subject is first seen, via CCTV at 0722 hours, appearing to wait with his roommate for someone or something to come to the front door. He eventually retrieved his breakfast tray, sitting at a table at the far end of the unit by the kitchen area. The nurse returned to the unit at 0728 hours and was granted access to distribute s.22 The subject is seen to approach the front door where she was located. s.15 s.15 both the nurse and the health care runner report that the nurse diligently performed the required identity check via a phone card he presented, then ensured the name and CS number were consistent with the information on the s.22 It is important to note that there was some resemblance between the subject and the photo on the phone card he presented to the nurse. He was sent to s.22 at 0729 hours. After s.22 , he was placed in the TV room. The second inmate on s.22 before being secured in the TV room at 0731 hours. The subject is seen via CCTV s.22 During the s.15 the unit remains unlocked, and the roommate is witnessed standing by the table the subject had been sitting at earlier.

The nurse distributing the s.22 was on her second shift at the centre and should have been shadowing the regular nurse rather than working on her own. The regular nurse was busy trying to do a call out to replace a nurse who s.22 and, also, was called away to do some s.22 on another inmate.

There is no direct observation of s.22 in the TV room as the officers deliver breakfast to those secured in their cells and perform other duties. Seventeen

minutes after the second inmate was placed in the TV room, and nineteen minutes after the first, they were released, at which point the subject's roommate greets him in the common area and throws an arm around his shoulder. As the subject was on s.22 he should have been locked at s.15 hours but instead was allowed to attend yard with six other inmates. They were escorted off the unit at 0818 hours and returned at 0926 hours. Contrary to Adult Custody policy, no count was conducted nor was a visual check completed of the inmates in this unit for over s.15 It was also revealed during review team interviews that sometime during the shift, unit staff discussed whether the appropriate inmate received s.22 however, no further action was taken or reported.

The subject made a phone call and is finally secured in his cell along with his roommate at 0932 hours. s.15) Staff secured the rest of the unit for their coffee break from s.15 hours. The subject was allowed out at 1020 hours to s.22 securing again at s.15 hours. Images captured on CCTV in the common area do not indicate any signs of s.22 but the subject s.22

The lunch meal cart arrives shortly after 1100 hours, and two trays are delivered by staff to the subject's cell at 1106 hours. Staff report the subject was lying on the top bunk on his left side facing the wall. s.22 and staff do not recall, it is unclear if the subject ate lunch. The unit was secured at hours for formal count, remaining locked until s.15 hours to facilitate staff meal breaks and training. During this lock down period, at 1223 hours, the subject and his roommate were both requested to attend s.22 When the runner and unit staff accessed the cell, the roommate immediately stated he would go first as the subject was sleeping. The subject was asked if he wanted to attend s.22 . He made no response, and staff report he made snoring-like sounds. His roommate was taken to s.22 . During the return escort from s.22 the roommate mentioned at least twice to the runner that the subject s.22 There does not appear to have been any subsequent attempts to determine if the subject wished to attend and s.22 was notified he had declined. It was confirmed with the s.22 that it was not essential that he attend, so it was logged that he had declined.

Following the missed visual checks s.15 in the morning, it appears that for the remainder of the day, afternoon and evening, these checks were conducted as per local centre standing orders and Adult Custody policy with staff reporting during the interviews that the subject was always seen lying on the top bunk on his left side facing the wall. At 1435 hours the afternoon shift officer arrived, completed shift exchange and at 1442 hours unlocked cell s.22 to facilitate a s.15, s.22 time out as per their phase level on ESP. The roommate exited the cell and spent time chatting with other inmates. Between 1456 and 1503 hours he and an inmate housed in cell s.22 appear to go in and out of cell s.22 on three separate occasions, but it is not known what they were doing. At no time is the subject seen outside of the cell during this ablution period. Cell s.22 was secured at s.15 hours.

The dinner meal cart arrived at approximately 1615 hours, and two trays were delivered by staff to cell s.22 An inmate is seen on CCTV at 1630 approaching the area of cell s.22 As he is still present in that area when staff collected the trays at 1641 hours, he carries two empty trays back to the meal cart. s.15, s.22

No further activity near this cell is witnessed until after the unit is unlocked at approximately s.15 hours following staff dinner breaks.

Numerous inmates are then seen walking over to the area where cell s.22 is located but none spend much time there. The tray packer who had been at the cell earlier returned to the area again for about twelve minutes and then alerted one of the staff that she should to check on one of the inmates in cell s.22 The officer appears to attend the cell at approximately 1836 hours and then goes into the office while her partner goes to the cell. She briefly returned to the cell and then entered the office where she called the CS to report that the subject was unresponsive. Upon being told to physically attempt to rouse the subject she returned to the cell and shortly thereafter at 1841 hours, a code blue was called by her partner. The unit began to lock up and the roommate was removed from the cell and secured in the TV room.

Within s.15 the first responder entered the unit followed by s.15 more staff over the next s.15 Health care arrived within s.15 After conducting a cursory assessment of the subject in the cell and determining that he was s.22 with no pulse or breathing, he was carried from his top bunk and placed on the floor of the common area. At 1846 hours s.22

Inmates, including the subject's roommate, indicated to staff that it was s.22 so s.22 was initiated at 1853 with an additional s.22 Four firemen were escorted to the unit at about 1859 immediately s.22

At 1900 hours the paramedics arrived. They continued to monitor the A call was placed to the ER physician at 1906 hours and he pronounced the subject dead at approximately 1908 hours. All emergency protocols were terminated, equipment was removed and the body was covered by 1912 hours. Just prior to this, staff removed the subject's roommate from the TV room, placing him in an empty cell and began covering the cell windows.

Both the Ridge Meadows RCMP and the coroner attended the centre subsequent to the pronouncement of death, after which the body was removed to s.22

Findings:

- The subject received s.22
- This was not the first time the subject s.22
- s.22 was planned and deliberate.

- The unit was not locked down during s.22
- Direct observation of t s.22 did not occur and the required twenty minute observation period was not fully completed.
- The LPN involved was on her second orientation shift at FRCC but was not accompanied by her orientation supervisor s.15 due to unexpected staff absence.
- s.22 for distribution to the living units was not placed on the cart prior to medication rounds commencing, necessitating it be delivered after the fact on
- s.22 was transported by non-medical personnel which is inconsistent with health care policy.
- Control and the supervisor were not notified that staff was delivering the s.22 to 3C.
- The s.15 where s.22 was distributed in this case may have contributed to the subject's ability to deceitfully receive s.22
- Visual cell checks were not done for the first s.15 of the shift.
- Visual cell checks were not signed for by the officer completing them.
- The medical alert indicating the subject was never to be housed with s.22 was not adhered to.
- A white board on the unit details the s.22 levels for each s.22 inmate on the unit. A review of this board does not appear to have been conducted at the beginning of the shift, as the subject and his roommate were able to access the yard which was in contravention of the privileges offered those on s.22
- Unit staff suspected a s.22 The suspicion was neither confirmed by staff nor reported to supervisors.
- A count was not conducted prior to unlocking the unit.
- The subject was secured in his cell at s.15 hours and was seen in his cell, making snoring- like sounds, at approximately 1223 hours.
- It was logged in CORNET that the subject declined to attend s.22 when in fact he was non-responsive when asked.
- Code response by correctional staff and heath care personnel was timely and reports were completed as per policy.
- There was a delay in commencing s.22
- s.22 was not consistent with s.22 guidelines in the community.
- There is discrepancy between nurses' recollection of s.22

- Health care personnel did not have current medical information on the subject when they responded to the code and subsequently had to return to the clinic to retrieve information required by the paramedics.
- The review team was unable to determine precisely when the subject went into distress.

- Correctional staff and supervisors were unfamiliar with local policy regarding s.15 s.22
- Correctional supervisors were unfamiliar with local policy requiring their presence on the living units when s.22
- There is confusion amongst correctional staff and health care personnel as to responsibility for s.22

Recommendations:

1. The medical director, Corrections Branch should review the s.22 in terms of risks, benefits, and harm reduction strategies.

2. The health care contractor and FRCC management should review current s.22 distribution practices to ensure compliance with local standard operating procedures, Adult Custody policy and Health Care Services Manual policy. Staff should also be made aware of the potential effects of s.22 when taken by someone not prescribed to do so.

3. The health care contractor should consider implementing regular, on-going code response training which includes hands on administration of CPR.

4. The health care contractor should review staffing call-out practices and ensure that expectations for new staff orientation with appropriate supervision are clearly communicated.

5. The health care contractor should consider implementing the practice of assigning a scribe during code blue events.

6. FRCC management should ensure that staff is aware that unit logs and CORNET entries are records as defined by the *Freedom of Information and Protection of Privacy Act* and therefore they should be accurate and entered by the officer documenting the observation or action.

7. The Adult Custody Division should consider exploring an alternative means of inmate identification and in the interim ensure that pictures on the phone cards are updated when damaged or there are changes to the inmate's features.

8. The Adult Custody Division should ensure that classification officers maintain only current alerts in CORNET and take all alerts into consideration when classifying an inmate.

9. The Adult Custody Division should review the current availability of AED's in correctional centres.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Inmate Escape

Date of Incident:

April 16, 2011 – Fraser Regional Correctional Centre

Review Team:

Elliott Smith, Chair	Deputy Warden, North Fraser Pretrial Centre
Dawne McNaughton, Member	A/Assistant Deputy Warden, FRCC
s.22 Member	Community Advisory Board, FRCC
Lyall Boswell, Participant/ Observer	Inspector, Investigation and Standards Office

Review Dates:

April 26 to May 6, 2011

Mandate and Scope of Review:

On April 19, 2011 the acting assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the escape of an inmate from Fraser Regional Correctional Centre (FRCC) on April 16, 2011 and to address the following:

- Compliance with Adult Custody policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to the incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at FRCC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The team was directed to report its findings and recommendations to the acting provincial director, Adult Custody Division, by May 18, 2011.

The Maple Ridge RCMP was contacted prior to commencement of the review to ensure it would not compromise its investigation. Clearance was granted and the review proceeded.

Background:

On April 12, 2011, inmate s.22 (the subject) was admitted to Fraser Regional Correctional Centre (FRCC) from s.22

where he was s.22

The subject was interviewed upon admission to FRCC by a classification supervisor where he was determined to be suitable for an open custody placement. The appropriate inmate re-assessment form was completed including a brief summary of the inmate's history.

Following his classification interview on the subject was assigned to Sierra House which holds a capacity of ninety open custody inmates. The Sierra House compound includes fifty beds within a sprung structure and forty beds in temporary trailers within the area compound. The compound is contained by an s.15 fence. The subject was assigned to trailer s.22 and, upon placement, was interviewed by the Sierra House correctional supervisor. He was advised of the Sierra House rules, programs, and regulations, including the out of bounds areas and common areas, for the sprung structure and trailers.

From April 12 to April 16, the subject did not express any concerns nor were any noted by staff in the subject's client log.

On April 16, 2011, the subject was accounted for during the s.15 hours formal count. From s.15 hours to s.15 hours, the staff assigned to Sierra House noted in the unit log book that they had conducted s.15 visual checks of the Sierra House sprung structure and trailers.

At approximately 1620 hours, the living unit staff monitored the delivery of inmate meals and noted which inmates had not received meals. At the end of delivery, it was identified that three inmates, including the subject, had not received their meals. One officer was able to locate two of the inmates, both of whom were found sleeping. The officer was not able to find the subject.

This was the first indication from staff that an inmate under their care was missing. The correctional supervisor was in attendance and was made aware of the incident. Under the supervision of the Sierra House correctional supervisor, a formal count was conducted by the two unit officers. The correctional supervisor notified the assistant deputy warden (ADW) of the situation, who in turn directed the supervisor to conduct a name to face count. Following the name to face count and a search of the Sierra House compound, it was confirmed at 1700 hours with the ADW that the subject was missing.

Further review of the digital video recording (DVR) system identified the subject

s.15

Upon confirmation of the escape, the ADW initiated the centre's walkaway procedures via the Walkaway Check List which includes each step to be taken once a walkaway has been confirmed.

The Ridge Meadows RCMP arrived on site at approximately 1725 hours and consequently s.15 The RCMP officers were not successful in locating the subject.

A warrant for arrest was issued s.22 The subject was arrested in s.3, s.22 and returned to the custody of BC Corrections on

s.22

The subject was interviewed upon his return to custody. He disclosed that following his escape, s.15, s.22

s.15, s.22 The subject indicated that his decision to escape was s.22 The subject would not elaborate further on his rationale for escaping.

Findings:

- The subject was appropriately classified to open custody.
- The Sierra House rules and regulations were explained to the subject upon admission to Sierra House.
- There were no reports of unusual behaviour or peer concerns noted in the subject's client log.
- The subject indicated that his escape was s.22
- DVR shows the subject escaped by s.15
- The subject was identified as missing during meal distribution at 1620 hours. He was confirmed missing through a name to face count conducted at 1645 hours and confirmed escaped through a name to face count and area search completed at 1700 hours.
- FRCC standard operating procedures define a walkaway as an inmate who leaves, without authorization, either an onsite or offsite work crew, or an unrestrained supervised escort. An escape is defined as an inmate who leaves, without authorization, from the secure perimeter of the correctional centre or from a restrained supervised escort. A prison breach is an escape where violence or force is used. While notification, staff deployment, and reporting are the same for walkaways, escapes, and prison breaches, a "code red" is only announced for an escape or prison breach. A code red s.15

  While it is unclear whether or not Sierra House is located within the secure perimeter of FRCC, procedures were followed in response to a walkaway as defined in FRCC standard operating procedures.
- The term walkaway is not found in Adult Custody Policy (ACP).

- The staff assigned to Sierra House did not conduct informal counts, following the s.15 hours formal count, as defined in FRCC standard operating procedures. Informal counts are to be conducted frequently within s.15 intervals to confirm the number of inmates assigned to an officer's supervision.

- The staff assigned to Sierra House indicated in the unit log book that s.15 visual checks were completed. DVR evidence reveals that not all checks were completed as noted. Visual checks noting the presence of the inmate are to be conducted at s.15 within prescribed intervals and recorded in writing.

- FRCC standard operating procedures require all log book entries to be signed by the officer making the observations. This was not consistently followed by the living unit staff or the correctional supervisor.

Recommendations:

1. FRCC management should define the secure perimeter in FRCC standard operating procedures.

2. The provincial director should ensure that the management of correctional centres with open custody units has established escape response protocols suitable to the locations of the open custody units.

3. FRCC management should ensure all staff are reminded of policies regarding informal counts.

4. FRCC management should ensure all staff are reminded of policies regarding visual cell inspections.

5. FRCC management should ensure all staff are reminded of the documentation requirements for unit log books.

CORRECTIONS BRANCH
Critical Incident Review

Subject: Inmate Death

s.22

Date of Incident: May 20, 2012
Fraser Regional Correctional Centre

Review Team: Shauna Morgan, Chair
Warden, Vancouver Island Regional Correctional Centre

Carol Niemela, Member
Assistant Deputy Warden, Fraser Regional Correctional Centre

s.22 Member
Community Advisory Board, Fraser Regional Correctional Centre

Lyall Boswell, Participant/Observer
Inspector, Investigation and Standards Office

Review Dates: May 25 – June 5, 2012
Fraser Regional Correctional Centre

Mandate and Scope of Review

On May 23, 2012, the assistant deputy minister, Corrections Branch requested that a critical incident review be conducted to investigate the circumstances surrounding the death of an inmate at Fraser Regional Correctional Centre and to specifically address the following:

- Compliance with Adult Custody policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at Fraser Regional Correctional Centre.

An independent review by the Investigation and Standards Office of the Ministry of Public Safety and Solicitor General was conducted concurrently with this investigation. A separate report may be submitted by that office.

Prior to the commencement of the review the Maple Ridge RCMP were contacted to ensure this review would not compromise any investigation that department may have been conducting. Clearance was granted and the review proceeded.

Background

On s.22 (henceforth "the subject") was admitted to s.22 and the subject s.22 and was placed in . s.22

the subject was transferred to Fraser Regional Correctional Centre (FRCC) via s.22 due to bed load issues and was told that he could return to s.22 when bed space permits. Upon arrival at FRCC, the subject s.22 and was assigned to Unit 1A, a 37 bed unit housing non-working GP inmates.

s.22

The subject was from the s.22

Upon intake on s.22 the subject was seen by a registered nurse and by the mental health screener. As per policy, an inmate health assessment was completed. The subject was seen by s.22 health care on one occasion s.22 On s.22 FRCC health care reviewed the subject's health care file as per policy. The subject had no further encounters with health care until May 20, 2012 at FRCC when an emergency

"code blue" was initiated and health care staff attended and found the subject in cell s.22 without a pulse. As part of the critical incident review (CIR) process a review of the subject's medical file was conducted by the director, Health Services and the director, Mental Health Services. There were no health or mental health issues identified.

The subject's client log while at s.22 is limited and there is no indication of any issues while on s.22 from s.22 until his transfer on s.22 to FRCC. Client logs entered by unit officers at FRCC on s.22 describe the subject as having a low profile and s.22 A review of closed-circuit television (CCTV) from May 14 to 18, 2012 show that the subject spent a great deal of his time in his cell; however he regularly came out of his cell to receive meals. At meal times, the subject was more active and can be seen going in and out of his cell and on occasion spending time in the common area. He is not seen to associate with any other inmates and on May 17, 2012 he approached the unit officer's desk and engaged in a brief exchange. The unit officer does not recall the content of this discussion, nor does he recall any other discussions with the subject.

Upon placement on Unit 1A on s.22 the subject was housed with another inmate. On s.22 the other inmate moved to another cell and at 1439 hours a new inmate (henceforth "the cellmate") to the unit was placed in the lower bunk of the subject's cell s.22 . The unit officer recalls the subject s.22 The cellmate s.22

the cellmate had been housed in Unit 2C where he was described as being s.22 . He was assessed as s.22 and was moved to Unit 1A and housed with the subject. The cellmate states that s.22

May 18, 2012

A review of CCTV on May 18, 2012 shows the subject coming out of his cell at 1627 hours and standing in line in front of the unit officer's desk to get his dinner tray. He has a brief exchange with another inmate, gets his meal, gets a plastic bag from the officer's desk and returns to his cell at 1629 hrs. At 1630:44 hours the subject comes out of his cell again, and gets another plastic bag from the unit officer's desk and returns to his cell at 1630:52 hours. While the amount of time that the subject is out of his cell is limited, he does not present as being in any distress or discomfort. The subject is not seen outside of his cell again until his body is removed from cell s.22 at 0206 hours on May 21, 2012 under the direction of the coroner.

The cellmate is the only cell occupant that moves in and out of cel s.22 rom 1631 hrs to the hours lock-up on May 18, 2012. He talks with a number of different inmates and at one time is seen talking with several inmates just outside cell s.22. He "knuckle

bumps" a number of inmates and moves in and out of his cell, closing the door each time. Visual checks and counts are conducted with the exception of the s.15 hrs check which is logged, but not completed.

Upon lock-up at s.15 hrs on May 18, 2012 the cellmate is seen standing in the doorway of cell s.22 and as the unit officer exits cell s.22 moving towards cell s.22 the cellmate goes into the cell and closes the door behind him. The unit officer looks in the window and the porthole of cell s.22, but at this time does not access the cell to confirm the identification of the occupants. In cells that are not locked up, the unit officer enters or at least steps into the cells for this count. By his own admission the unit officer states that he does not follow FRCC standard operating procedures (SOP) which require the unit officer to confirm inmate identity by CORNET picture identification or the inmate phone card at the final (s.15 hours) lock-up. The unit officer states his usual practice is that he allows the cellmate to hold-up both phone cards; however, on the evening of May 18, 2012 he does not recall how he confirmed identity of the inmates in cell s.22. What the unit officer does recall is that there was nothing "out of the ordinary" that he observed that evening.

<u>May 19, 2012</u>

From 2150 to 0630 hours on May 19, 2012, the unit officer is responsible for visual checks and count in both Units 1A and 1B. CCTV shows the unit officer conducting the required counts in Unit 1A with the exception of the s.15 and s.15 hours checks. The log book indicates that the count was done at these times; however, CCTV indicates that they were not completed. The unit officer states that he may have missed a count and also states that he does not always put down the exact time that the check and count is done.

The unit officer on shift from 0700 to 1900 hours on May 19, 2012 is not a regular unit officer and states that he is not familiar with the subject or the cellmate. Although the log book indicates that a visual check and count were conducted at s.15 and s.15 hours before unlock at s.15 hours on May 19, 2012, CCTV does not support that the unit officer did check the locked cells during this time. At unlock at s.15 hours, the cellmate comes out of cell s.22 but the subject does not. The cellmate gets his breakfast and returns to his cell. He appears to take only one breakfast tray in and out of the cell. While the unit officer is observed counting trays on the meal cart when it arrives, he does not directly observe the distribution of meal trays nor does he count how many trays are put back in the cart at the end of the meal period.

The unit officer states that he has "never had a complaint" about distributing meals this way; however, given this practice, he is not able to tell us if all the meals were distributed to each inmate and if any meals were not picked up.

The inmate responsible for the meal carts was interviewed and stated that he places meals on tables for a group of inmates and cellmates are permitted to take another inmate's meal back to the cell. The inmate recalls the subject coming out for meals. He does not recall the subject's cellmate taking an extra meal on May 19 or 20, 2012.

The cellmate is very active around cell door s.22 from 1000 to 1030 hours on May 19, 2012. Each time he moves in and out of the cell he ensures that the cell door is closed behind him. s.15, s.22 he was lying on his stomach with his head on his hands.

At s.15 hours, the unit officer conducts a cell inspection and CCTV shows him entering cell s.22 for 17 seconds. The unit officer does not recall where the subject was at that time and cannot confirm that he was or was not in the cell during inspection. The unit officer informed the CIR team that if the cell meets the inspection requirements, that he may not have any interaction with the cell occupants. When asked if an inmate were sleeping would he wake him up, he replied that he would not wake him up unless he needed to address an inspection issue. The unit officer does not recall seeing anything of concern during cell inspections in the unit.

The cellmate is not in the cell during inspection and is sitting at a table closest to his cell door. Once the unit officer leaves cell s.22, the cellmate gets up from the table and goes into his cell. The other inmates sitting at the table appear to be watching where the unit officer is and watch the cellmate return to his cell. He is in the cell for 21 seconds and then returns to the table to play bridge.

A formal count is completed at s.15 hours. The visual check at s.15 hours is not done. At 1300 hours, the unit is unlocked for snack and an unknown inmate goes to the door of cell s.22 and appears to talk with someone inside. The cellmate comes out to get his snack and returns to the cell. The subject does not come out of the cell to collect his snack.

From unlock at 1300 to 1345 hours, the cellmate is once again very active just outside the door of cell s.22. At 1325 hours, a correctional supervisor (CS) comes on to the unit, walks by the cellmate, and acknowledges him as he is known to the CS. At 1329 hours, the cellmate returns to the cell with another inmate who steps inside cell s.22 while the unit officer and the CS are at the unit desk. The cellmate and the other inmate step out of the cell and stand in front of the door, blocking a view inside when the CS walks by on his way out of the unit. As soon as the CS leaves the unit, a third inmate enters into cell s.22 carrying a book and leaves the cell carrying what appears to be a bag. It would appear that at one point that several inmates start horseplay in front of the unit officer's desk in order to distract him while activity occurs in cell s.22. The cellmate talks with several inmates and exchanges "knuckle bumps" and shoulder contact before lock-

up at 1345 hours. The unit officer does not recall any unusual behaviour during this period and is not aware of the number of inmates that are in and out of cell s.22

The meal cart arrives on the unit and the officer counts the trays in and out, but does not directly observe the distribution of the meals. The subject is not seen coming out of cell s.22 to retrieve his meal.

At 1737 hours the laundry workers arrive on the unit and the laundry officer goes briefly into cell s.22 and comes out with a towel. The cellmate comes out to exchange laundry and the laundry officer goes back into cell s.22 for 12 seconds and emerges with another white towel. The laundry officer has no recollection of going into the cell and does not recall seeing anything unusual in Unit 1A on that date.

At 1824 hours the unit officer enters into cell s.22 for 12 seconds to enquire as to whether the inmates want to go to the gym or yard. The unit officer recalls asking the subject twice if he wanted to go to yard and he did not receive a response. He told the committee that he "thought for sure the subject was breathing" when he left the unit. His recollection is that the subject was lying on his stomach and his head was on the pillow. He did not smell anything nor did he see anything that would cause him concern. The unit officer felt that if there had been something going on in the unit that s.22 would have let him know. The unit officer did acknowledge to the CIR team that he may not have done all his visual checks, despite knowing and understanding the requirement to conduct checks every s.15 It is also noted that the unit log does not capture all movements as per FRCC SOP.

The unit officer on shift from 1900 hours on May 19, 2012 to 0700 hours on May 20 comes on to the unit at 1830 hours. This is the unit officer's regular unit having last worked the dayshift in 1A on May 17, 2012. At 1938 hours an inmate enters into cell s.22 for 19 seconds and again at 1944 for approximately 50 seconds and then runs back to the phone which he had left hanging off the hook prior to going into the cell. During this time, there is another correctional staff member at the desk with the unit officer. The subject is not seen out of the cell during this time frame and there is no more movement in or out of the cell after 2030 hours. At final lock-down the unit officer conducts a count and does not recall anything unusual or of concern in the Unit. The officer tells the review team, which is supported by the CCTV coverage, that he does not follow the SOP which requires the officer to confirm inmate identity by CORNET picture identification or the inmate phone card at the s.15 hours lock-up. The visual checks and counts occur during the night shift with the exception of s.15 hours and s.15 hours which are logged in the log book, but CCTV does not support them being conducted.

<u>May 20, 2012</u>

The unit officer on shift from 0700 to 1900 hours on May 20, 2012 comes on to the unit at 0700. Visual checks and counts are not completed as logged in the unit log for s.15

s.15 hours. At 1000 hours the inmates are unlocked and the cellmate exits the cell at 1009 hours. The meal cart arrives and the unit officer counts the meals in the food cart and notes that a lock is missing on the cart. He contacts the CS who in turn follows up with the kitchen to find out if they were aware that the lock was missing. The unit officer relays that once he has counted the meals into the unit, he turns the cart over to the inmate cleaner to distribute the meals. The unit officer does not provide direct supervision of the meals and believes that the cellmate took two meals from the cart. He states that he did not count the meal trays going out on the cart that date.

On May 20, 2012 the s.15 hours visual check and count is not completed and the s.15 hours cell inspection does not occur as the unit officer leaves the unit at 1101 hours to deal with another matter. The backfill unit officer does not do the inspection. A CS attends the unit at 1103 hours and sits in the office area with the unit officer until 1120 hours. The unit officer returns to his post at 1109 hours. He does not inform the CS that he has not completed the formal cell inspection. The visual check logged at s.15 hours does not occur. The backfill unit officer leaves the unit at 1133 hours. At 1152 hours the unit officer is seen at the closed door of cell s.22 The unit officer was calling for inmates who wanted to go to the yard and recalls the cellmate sitting on his lower bunk and saying "we're staying" in response. The unit officer does not go into the cell and does not recall where the subject was at that time.

The s.15 hours visual inspection written in the unit log book does not occur and the unit officer leaves the unit for break at 1231 hours. The officer tells the committee that he thought he saw the subject sitting up on his bunk in the morning, but cannot confirm it was the subject and states it could have been someone in cell s.22 He also notes that the inmate in cell s.22 was s.22 The unit officer did report to the CS that there was a sick inmate on the unit.

At 1248 hours the laundry officer comes on to the unit and proceeds to access the cells on her own to collect laundry. The cellmate comes out of the cell and collects clean laundry. The laundry officer enters cell s.22 for 9 seconds and comes out with a red item which she puts in the laundry bin. The laundry officer does not recall accessing the cell or the whereabouts of the subject. The log book does not indicate that the laundry officer came in and out of the unit.

At 1409 hours the unit officer attends cells to check on who is going to the yard or gym. He is seen at the door of cell s.22 and appears to talk to someone in the cell. He recalls the cellmate saying through the door that they would not be going to the gym. The cellmate and the subject are identified in the log book as remaining on the unit for the 1420 hours gym program. It would appear that there are no visual checks or count done between s.15 hours and s.15 hours. At s.15 hours another officer attends the unit and does a visual check. The unit officer does not recall seeing either the subject or the cellmate collecting their dinner trays during the meal period.

At the hours unlock the unit officer recalls seeing the subject lying face down on his bunk. He states that he had a blanket on him, and believes it was brown. He does not see the subject's face. This information is contrary to a number of other reports from correctional staff who state that the inmate was in his red shirt and pants, blue socks and there was no blanket on the inmate. The officer notes that upon reflection back on the day, that the door of cell was already closed or the cellmate was at the door of the cell each time the officer approached the cell.

The unit officer on shift from 1900 hours on May 20, 2012 to 0700 hours on May 21, 2012 comes on to the unit at 1830 hours. The officer conducts visual checks and counts at and hours. At 2000 hours lock-up for staff break the officer is greeted at the door of cell by the cellmate who exits the cell, retrieves a chair from the common room and returns to his cell closing the door. At the hours unlock, the unit officer unlocks the door, but does not open it. At 2028 hours the cellmate exits cell and goes into the common room where he speaks to a number of inmates who congregate around him. He returns to his cell and then goes back promptly at 2031 hours to the common room with a white towel in his hand. It appears that he gives something from the towel to another inmate and in turn that inmate leaves the common room and appears to go into cell on the upper tier.

Due to the increased activity and conversation on the unit the night shift officer contacts control at 2032 hours for a visual scan of the common room. Control does a visual check and reports back that nothing unusual is occurring.

The cellmate returns to cell at 2034 hours and stands in front of the cell door with a white towel in his hand. At 2050 hours on May 20, 2012 he approaches the unit officer desk and informs the night shift officer that he has not been able to wake up his roommate for dinner. The night shift officer attends cell grabs the socked foot of the subject and shakes it in an attempt to wake him up. When the subject does not reply, the night shift officer approaches the subject's head, sees and calls a code blue. He then exits the cell and instructs the unit to lock-up. The cellmate remains in cell and is removed later by a CS and is placed in a cell on the upper tier until he is later removed from the unit and housed in

Within CSs and a correctional officer attend the unit and, upon assessing the scene, they access cell The supervisors all noted They describe the inmate as He was wearing red clothing and did not have on a blanket.

Approximately s.15 after the officers arrived on the scene, a registered nurse (RN) and licensed practical nurse (LPN) attended. Upon their assessment of a

s.22 The RN informed the supervisor that the subject "was gone". She did note s.22 The director, Health Services participated in the CIR interview with the RN and confirms that the health care services applied in this situation were appropriate.

The RN and LPN were in cell s.22 for approximately three minutes and left the unit shortly after. The RN later spoke with the RCMP and coroner at their request.

The assistant deputy warden (ADW) on shift reported to FRCC Control when the code blue was initiated. A CS in Unit 1A maintained contact with the ADW by telephone from the unit officer's desk to provide updates on the situation. The ADW was advised that an ambulance would not be required and the RCMP and coroner's office were contacted. Direction was given to attending staff to cover the windows and portholes of the cells. The acting CS responsible for the west tower remained on the unit to provide direction to staff and to facilitate the RCMP and coroner's arrival. A correctional officer on site was appointed scribe. The east tower supervisor left the unit and assisted the ADW in contacting outside agencies, writing the briefing note, assigning the incident reports, running the rest of the centre, and providing staff with critical incident review team (CIRT) resources.

The programs supervisor, in consultation with the east tower supervisor, removed the cellmate from the unit and escorted him to segregation. Prior to placing him in segregation she conducted a brief interview with the inmate in an attempt to ascertain when he last saw the subject alive. The cellmate was vague in his responses and provided little information. The supervisor noted that the cellmate s.22 . The supervisor documented the interview and provided it to the east tower supervisor. She took the inmate to segregation where he was allowed to stay in his clothes and was placed in a cell on his own. The supervisor did not have the inmate seen by health care, despite her observations. The cellmate was interviewed by the CIR team and was s.22 He has not been co-operative with the police and most recently has s.22 .

Maple Ridge RCMP and the coroner attended the unit. They asked for reports from all those directly involved. Incident reports not yet approved by a supervisor were provided to the RCMP to assist with their investigation. The RCMP filmed the cell and its contents prior to the body being removed. At approximately 0206 hours on May 21, 2012, under the coroner's direction, the body was removed from the cell and the centre.

The east tower supervisor contacted the chaplain and CIRT providers to attend the centre to meet with the staff. A meeting was held in staff services and follow-up services were provided.

Findings

- The subject was transferred from s.22 to FRCC on s.22 He was s.22 s.22
-
- He was seen as per policy by health care personnel at s.22 and did not present any health concerns.
- Upon transfer to FRCC his health care file was reviewed as per policy and he was seen by classification and classified to Unit 1A cell s.22.
- Review of his FRCC CORNET Client Log describes the subject as "low profile", s.22
- The subject was assigned the upper bunk and acquired a new cellmate on s.22 The cellmate s.22
- Review of CCTV for May 14 to 18, 2012 indicates that the subject leaves his cell to collect meals and typically spends time in the common area around the meal period.
- All meals coming into the unit are counted in by the unit officer, but the distribution of meals is not supervised and meal trays are not all accounted for when sent back to the kitchen.
- CCTV indicates that the last time the subject is seen outside cell s.22 is on May 18, 2012 at 1630 hours when he collects his plastic bag.
- On several occasions there is cell visitation by various inmates. The door for cell s.22 is rarely left open, with the cellmate ensuring it is closed upon access and egress.
- The final evening counts on May 18 and 19, 2012 at s.15 hours are not conducted in accordance with FRCC SOP.
- It cannot be determined from the CCTV if staff comply with FRCC SOPs in completing visual cell inspections on May 18, 19 and 20, 2012.

- The unit officer working 0700 to 1900 hours on May 19, 2012 enters cell s.22 at s.15 hours for the required cell inspection. CCTV shows the officer in cell s.22 for 17 seconds. The officer does not recall where the subject was at that time and cannot confirm that he was or was not in the cell during inspection.

- The unit officer enters cell s.22 at 1824 hours to ask if inmates want to go to the yard. He asks the subject twice, but does not get a reply. The unit officer believes he saw the subject breathing.

- Cell inspection on the unit is not complete as the unit officer leaves the unit at 1102 to deal with another matter. The officer providing backfill does not do the inspection. The correctional supervisor is not informed.

- The actions of staff regarding the conducting of visual checks according to policy are open to review by FRCC management.

- Upon visual check at s.15 hours unlock the unit officer recalls seeing the subject lying face down on his bunk.

- The unit officer working the 1900 hours to 0700 hours shift starting on May 20, 2012 is a regular unit officer and feels that there is something going on in the unit after the s.15 hours unlock.

- The cellmate approaches the unit officer workstation at 2050 hours on May 20, 2012 and states that he cannot wake his cellmate up for dinner.

- Code blue is initiated by the unit officer at 2052 hours as he is unable to rouse the subject from the upper bunk.

- Correctional staff and health care staff arrive in a timely manner and respond appropriately.

- The programs supervisor did not have the inmate seen by health care despite her noted concern regarding observations of s.22

- Incident reports provided by the west and east supervisor could have been more fulsome so as to provide more details of the incident. It appears that all the tasks were completed as per policy.

- Incident reports not yet approved by a supervisor were provided to the RCMP to assist with their investigation.

- The unit is locked down and RCMP and the coroner attend the centre to conduct their investigations.

Recommendations

1. FRCC management should review with correctional staff on a regular basis the standard operating procedures for visual checks to ensure they understand their responsibility and accountability in meeting this policy.

2. The provincial director should consider implementing random audits of security and visual checks conducted by staff during daylight and evening hours to ensure that they are being conducted in accordance with Adult Custody Policy and correctional centre standard operating procedures.

3. FRCC standard operating procedures regarding meal distribution and supervision should be reviewed with staff to ensure that they understand their responsibility for this task.

4. FRCC management should ensure that staff are aware of the information that is to be logged in the living unit logs and that all entries are legible and accurate.

5. FRCC management should review the role of the correctional supervisor on the unit and consider having the correctional supervisor attend the unit during each shift to participate in a visual check and count with the unit officer.

6. The provincial director should consider initiating a review of all policy and practices relating to inmate checks and counts with a view to providing clear direction to, and accountability and expectations of, correctional officers and supervisors.

CORRECTIONS BRANCH
Critical Incident Review

Subject: Death of Inmate

s.22

Date of Incident:

July 3, 2010 at Kamloops Regional Correctional Centre (KRCC), Living Unit E

Review Team:

Joanne Hawkins – Chair
Warden, Prince George Regional Correctional Centre

Mike Seymour - Member
Assistant Deputy Warden, KRCC

s.22 Member
KRCC Community Advisory Board

Joan Parkin - Participant/ Observer
Inspector, Investigation and Standards Office

Dr. Paul Beckett – Member
Medical Director, Corrections Branch

Review Dates:

July 9, 2010 to July 11, 2010 at KRCC

Mandate and Scope of Review:

On July 5, 2010 the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the death of an inmate at Kamloops Regional Correctional Centre (KRCC), and to address the following:

- Compliance with Adult Custody policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the Public Service Act. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at KRCC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The team was directed to report their findings and recommendations to the provincial director, Adult Custody Division by August 5, 2010.

Prior to the commencement of the review, Corporal Mathieu of the Kamloops RCMP was contacted to ensure this review would not compromise any investigation that department was conducting. Cpl Mathieu advised that the information RCMP had collected was passed to coroner Cory Day of the Coroner's Office. Ms. Day provided clearance to proceed with the review.

Background:

On August 28, 2009 s.22 (the subject) was admitted to KRCC s.22 The subject s.22

KRCC is a provincial facility which accommodates remand male inmates in addition to sentenced male inmates completing provincial sentences of less than two years. Upon the subject's admission there were no health concerns or special diet needs noted, and he was given a s.22 rating and placed in general population. During the following months there were re-assessments completed, and he remained a s.22 inmate until s.22 when his security rating was changed to s.22

There appears to be no significant health issues for this inmate s.22

By all reports, the subject was a good worker on the unit and got along well with staff and peers. s.22 In March of 2010 his security rating was changed to s.22 and he was moved to J Unit.

s.22

The digital video recording (DVR) of J unit from the evening of July 2, 2010 shows the subject appear outside his cell with other inmates in the area and go in and out of his cell along with his roommate s.22 (the roommate). At that time the subject appeared to be interacting normally with other inmates. The inmates were locked and the formal count took place at s.15 hours. Counts throughout the night were completed appropriately.

At 0700 hours on July 3, 2010, a new officer took over supervision of J unit. The DVR view of the count taking place indicates that the staff member may not have looked properly into all cells. Shortly following the formal count, inmates were woken up to attend their jobs in the kitchen. At that time there was a global unlock of the cell doors so that inmates going to work could gather in the common area. The subject was not scheduled to work on July 3; however, the roommate was scheduled to do so. The officer did not check cells from which kitchen inmates had emerged. The inmates were not frisked as they left the unit on their way to the kitchen, therefore eliminating any close contact between staff and inmates for additional visual inspection. A note was made in the unit log book indicating that ten inmates had gone to the kitchen. At 0730 hours two more inmates left for the kitchen according to the same procedure. At 0800 hours the unit officer made an additional entry in the log book that indicates two inmates who left the unit at 0500 hours were not entered by the previous night shift officer. The entry was not correct, as inmates do not leave the unit at 0500 hours on weekend mornings. There was no complete unit count done at s.15 hours to verify the actual unit count. After 0700 hours there was no additional count completed or entered in the log book that accounted for all inmates in the unit until the dayshift officer took over after 0940 hours.

At about 0800 hours, the unit officer received a call from the kitchen contractor who stated that they needed an additional inmate to work, as they were sending a sick inmate back to the unit. The unit officer did not question the kitchen contactor as to the identity of the inmate or what was wrong with him. When the inmate arrived at the unit he was let in by control. The unit officer did not frisk him or ask the inmate what was wrong. The officer did not accompany the inmate, now identified as the roommate, to his cell to check on him or lock his door, thereby missing another opportunity to view the inside of the cell and the state of the subject. At this time there was an additional error made in the entry in the unit log; the roommate was misnamed.

At 0940 hours, the log book indicates that the keys to the unit were handed over to a day shift officer. The officer who took over is a new security officer who s.22 The new officer received some exchange and procedural information for J unit from the officer that he replaced. The new officer reviewed the log book and noted that there appeared to be some concerns. He conducted a count of the unit twice to arrive at a new, correct count. During his counts, the officer looked in the cells. At approximately 1010 hours, the unit was unlocked and shortly thereafter the officer went to each cell and checked that the doors were open. He did not look into cell s.22where the subject was housed but pushed the door past the pin to keep it from locking again. At that time neither the subject nor the roommate came out of the cell.

At 1016 hours, the meal cart arrived on the unit, but no one came out for meals from cell 15. After about five minutes, the inmate who looked after the food carts in the unit realized that there were extra meals left in the cart and that the subject and the roommate had not come for their meal. The inmate reported that he went to cell s.22and had a conversation from the door with the roommate and that the subject appeared to be sleeping face down on his bunk. Neither of the inmates from the cell emerged as a result of this conversation.

At 1028 hours a nurse from health care arrived in the unit with an officer escort to distribute medication. s.22
Approximately four minutes later at 1032 hours an inmate approached cell s.22and looked in. The roommate is seen exiting the cell, re-entering the cell, and then exiting again to call to an inmate who is in the common area on the main floor of the unit. The inmate then attended cell s.22, which is located on the top tier, and entered the cell. Both the roommate and the second inmate came out of the cell and then went back in. The second inmate reported that the subject s.22 and could not be woken up. There wa s.22 He told the roommate to push the call button but he was not sure if it was working. He then told the roommate to tell the guard to come to the cell.

At 1038 hours, the roommate came out of the cell and reported to the unit officer that he could not get his roommate to wake up or respond. The officer attended the cell with the roommate and tried to wake the subject up. The subject did not respond and a code blue was called to control by the unit officer. The officer noted s.22 He also noted that the roommate seemed s.22 . The call was made by the unit officer to control on the unit phone. Control then called the code to the portable radios, which are held by the unit support officers and correctional supervisors. The code was then relayed to health care on a wall speaker normally used for door access communication. The nurse in health care reported that she was half-way to the unit when she heard the 'all page' regarding the code blue over the jail intercom system.

Response to the code blue was less than s.15 The nurse on medication rounds with the escort officer was in the next unit and arrived at the same time as a correctional supervisor. They attended cell s.22 at the same time. The second nurse arrived with the emergency medical equipment bags less than s.15 later. Emergency services from the community (ambulance, paramedics and fire rescue) arrived approximately twelve minutes later at 1052 hours. It should be noted that there are time discrepancies between the time noted on the DVR and notes taken; however, the lengths of time between events are the same.

The first nurse, a licensed practical nurse (LPN), and the escort officer went into the cell. The LPN noted that the s.22

Within a very short period of time the second nurse, a registered nurse (RN), arrived with the emergency medical equipment bags and verified that an ambulance had been called. She stated that s.22

At 1052 hours the ambulance and firefighters arrived. At 1054 hours the subject was moved out of his cell and onto the floor of the walkway on the second tier. s.22 At 1117 hours, paramedics spoke with Dr. Vanzyl at s.22 who pronounced the subject deceased and provided direction to stop CPR.

Window coverings were put on other cell windows at 1115 hours, and counts and cell checks were completed approximately every s.15 . During the time that the subject was receiving emergency response services, the roommate was housed in cell s.22 with another inmate.

The RCMP arrived at KRCC at 1147 hours and were met by the assistant deputy warden on shift. They were taken to the living unit to commence their investigation. The RCMP found s.15, s.22 not yet identified at the time of this review.

Cory Day, coroner, arrived at 1418 hours and started her investigation of the body and the scene. The investigative teams finished their work in the unit shortly after 1500 hours. The critical incident response team was called to provide support to staff

members, and the chaplain attended to speak with inmates and later held a service for the inmates.

The roommate and the inmate that he was temporarily housed with were later strip searched and the cell was searched as the officers that attended the incident felt that the medical condition of the subject s.22 There were a number of indicators leading to this possibility, including s.22 and s.15, s.22

Findings:

- The subject did not have any health complaints for which he was seeking regular medical attention.
- The subject s.22
- The subject s.22
- The subject had been appropriately classified upon entry into the institution and, s.22 was appropriately reclassified according to provincial standards and practices.
- On the morning of the incident, the morning unit officer did not complete unit checks and counts as per policy, thus missing opportunities to note any health issues with the subject.
- Contrary to KRCC standard operating procedures, the inmates were not frisked when either entering or exiting the unit.
- The unit log book contains incorrect counts and entries.
- Visual contact with the inmates in cells was not made at all inmate counts.
- Correction of the unit count and the unit log book was completed by the oncoming officer.
- Appropriate action was taken by the unit officer when the subject was found unresponsive.
- The RN was contacted regarding the code blue by use of a wall speaker in health care. The general page did not happen for another short period of time. Standard operating procedures at KRCC state that communication during codes is to be announced to portable radios and through the paging system (no order of use is indicated). This did not impact the response to the incident.
- Unit officers s.15
- Unit officers s.15

- Upon death, it is common for s.22
- The emergency medical equipment bags are heavy, and the nurse may require help to move the equipment over a longer distance. One of the bags is located in s.15 and the other in s.15 and it is not clear if all staff members know the whereabouts of the bags.
- The code blue was responded to in a timely manner by both correctional officers and health care staff.
- The unit, including cell s.22 was searched July 2, 2010, the day prior to the incident, s.15 Cell s.22 was frisked again following the incident s.15

Recommendations:

1. KRCC management should review the process for unlocking inmates to ensure officer presence at the door of the cell, as this may assist in checking on the condition of the inmates upon unlock.

2. KRCC management should review Adult Custody Policy and KRCC standard operating procedures with staff regarding conducting and recording inmate counts, visual cell checks and other relevant inmate movements in and out of the unit.

3. KRCC management should review and update as necessary standard operating procedures regarding the process of calling health care staff to a code blue.

4. KRCC management should develop a plan to provide updated information to staff regarding the locations of emergency medical equipment bags and procedures for bringing the bags to an incident.

5. KRCC management should review the practice of placing remanded inmates in the kitchen work program.

6. The provincial director, in consultation with the medical director, Corrections Branch should consider deploying automatic external defibrillators (AEDs) at all BC correctional centres.

CORRECTIONS BRANCH

Critical Incident Review

Subject:

Inmate Assault

Date of Incident:

October 20, 2011 – Kamloops Regional Correctional Centre

Review Team:

Elliott Smith, Chair	Deputy Warden, North Fraser Pretrial Centre
Bill Bouthot, Member	Deputy Warden, KRCC
s.22 Member	Member, Community Advisory Board, KRCC
Shane Muldrew, Participant	Inspector, Investigation and Standards Office
Marcia Marchenski, Observer	Inspector, Investigation and Standards Office

Review Dates:

October 26 to 28, 2011 and November 4, 9 and 17, 2011

Mandate and Scope of Review:

On October 21, 2011 the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding an inmate assault at Kamloops Regional Correctional Centre (KRCC) on October 20, 2011 and to address the following:

- Compliance with Adult Custody policies and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to the incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at KRCC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The Kamloops RCMP was contacted prior to commencement of the review to ensure it would not compromise its investigation. Clearance was granted and the review proceeded.

Background:

On s.22 , inmate s.22 (henceforth, "the cellmate"), CS# s.22 , was admitted to Kamloops Regional Correctional Centre (KRCC)

s.22

s.22

The cellmate was interviewed upon admission to KRCC and, upon recommendation from a mental health screener and approval from an assistant deputy warden (ADW), was placed in s.22 s.22 The mental health screening interview appeared thorough and considered available information appropriately. An appointment with the s.22 was scheduled for s.22 for further assessment and placement.

On s.22 the cellmate was referred by the s.22 directly to the s.22 due to s.22 The centre's s.22 interviewed the cellmate and assessed him as s.22 The s.22 recommended placement in a regular living unit at the discretion of a correctional supervisor. The cellmate was removed from s.22 with a/ADW approval, classified as s.22 general population, and placed in living unit C.

On s.22 health care staff obtained the cellmate's written consent to Information from the cellmate's physician in s.22 was received on s.22 and was processed and documented in the Primary Assessment and Care (PAC) inmate health information system on s.22

s.22

The cellmate also reported that s.22 The collateral information from s.22 indicated that s.22 was indicated in the collateral documentation, including s.22 .

On s.22 contacted KRCC classification staff regarding s.22 During this conversation s.22 advised KRCC classification that he s.22 This information led to an alert being placed on the cellmate's record as " s.22 ".

The cellmate did not present any issues while on living unit C. On s.22 however, he did express to the unit correctional officer a concern with s.22

On October 13, 2011, inmate s.22 (hereafter, "the subject"), CS# s.22 was admitted to KRCC s.22 He was classified as s.22 general population and placed in living unit C, cell s.22 with the cellmate.

The subject did not present any issues or concerns from the time of his admission to s.22

On October 20, 2011 living unit C was on lock-up as per regular program. Cell checks were completed on a regular basis during the lock-up period. At the s.22 hours check an officer observed the subject and the cellmate playing a board game in their assigned cell.

At 1422 hours, the emergency cell call button was activated from cell s.22 in living unit C. Control officers responded to the alarm by dispatching a s.15 who arrived within s.15 at the noted cell. s.15 attended within s.15 and the s.15 observed the cellmate and the subject through the cell window. The s.15 officer observed the subject s.22 s.22 This officer initiated a "code blue" via the portable radio and waited for correctional supervisor (CS) authorization prior to accessing the cell door. s.15 CSs attended the unit at s.15 hours and upon assessing the scene accessed cell s.22 The cellmate was removed from the cell, placed in restraints and escorted to the health care centre. The subject remained in the cell pending medical response.

Approximately s.15 after the first officer arrived on the scene, s.15 health care staff attended the scene and upon their assessment requested ambulance services. Emergency medical services attended the scene at 1450 hours and removed the subject via stretcher at 1503 hours to s.22 Hospital s.22 .

The subject's original health assessment indentified s.22
Upon further medical assessment at s.22 it was identified that the subject s.22

Upon admission to health care the cellmate was attended to by medical staff. The assessment identified s.22 The cellmate was then classified to segregation and held on *CAR* 24 pending a discipline hearing for breach of *CAR* 21(1)(w) – an inmate must not assault another person.

Upon direction from the ADW, living unit C remained locked up, evidence of the incident was collected, and cell s.22 was secured under crime scene protocols. Kamloops RCMP were contacted to initiate a criminal investigation into the matter.

Living unit C remained on lock-up status from the time of the incident to 2030 hours on October 22 for the purpose of an "unit investigation" in accordance with centre policy. Thirty inmates were interviewed individually and the unit was searched thoroughly prior to it being re-opened. The investigation did not reveal any significant information.

All involved staff were offered the services of the KRCC critical incident response team on an individual basis.

The subject s.22 and was deemed medically fit for release. He was admitted to s.22

The cellmate s.22

Findings:

- On initial intake (s.22 the mental health screener referred the cellmate to the s.22 for s.22 . He was also recommended for s.22 s.22 due to s.22 .
  - The summary ratings for several sections of the mental health screening were not coded to reflect the details and identified concerns in those sections.
  - The cellmate's mental health screening was reviewed on s.22 by the s.22 There is no documentation to indicate that the mental health screening deficiencies noted above were identified or that actions were taken to correct them.
- The s.22 completed an assessment of the cellmate and supported placement in a regular living unit.
- The cellmate was classified by a qualified officer to s.22 general population and was deemed suitable for multiple occupancy.
- The cellmate was transferred from s.22 to living unit C; however, KRCC does not have clear internal placement procedures as required in Adult Custody Policy (ACP) section 4.2.7.
- The cellmate was not interviewed by classification prior to his initial inmate assessment being completed as per ACP section 4.4.4.
- The cellmate's s.22 record indicated s.22 but this information was not entered in the inmate assessment form. Classification staff indicated that they were not aware that s.22 information needs to be manually entered onto the form.
- Information from the cellmate's physician in s.22 was received on s.22 ; however, it was not processed and documented in PAC until s.22 The collateral information from s.22 indicated s.22

  There is no documentation of an assessment of the cellmate's s.22 history, or consideration of s.22

- The subject was classified to s.22 general population and deemed suitable for multiple occupancy.

- An incident occurred between the cellmate and the subject on October 20 which resulted in s.22

- No precursors to the incident were evident. Both individuals were seen playing a board game together shortly before the incident occurred.

- The emergency cell call button was activated for assistance and it functioned as expected.

- Control staff responded to the emergency cell call activation in accordance with KRCC standard operating procedures (SOPs) by acknowledging the activation and deploying staff to the area.

- Response to the cell call occurred within s.15 Upon assessment of the cell and two clients, staff initiated code blue protocols in accordance with centre SOPs.

- Additional correctional and health care staff were on the scene and attending to the incident within s.15 of the first officer attending the scene.

- Notification of emergency medical services was done in accordance with centre SOPs.

- The subject was taken to s.22 via ambulance services and s.22 The escort procedures were completed in accordance with ACP and centre policies.

- The cellmate was assessed by the s.22 on s.22 . He noted s.22

  Given the recent incident, he recommended single-cell status for the cellmate.

Recommendations:

1. The health care contractor should review the mental health screening procedure, including completing and reviewing the Mental Health Screening/ Jail Screening Assessment Tool in PAC, with all mental health screeners and mental health coordinators.

2. The health care contractor should review the process for evaluating collateral information, including documentation requirements for health care professionals reviewing collateral information.

3. KRCC management should develop internal placement procedures within the centre to ensure compliance with Adult Custody Policy section 4.2.7.

4. KRCC management should review with staff the process for initial classification interviews to ensure compliance with Adult Custody Policy section 4.4.4.

5. KRCC management should ensure qualified staff are trained in entering s.22 information on the inmate assessment form.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Hostage Taking at North Fraser Pretrial Centre
s.22

Date of Incident:

September 4, 2010 at North Fraser Pretrial Centre

Review Team:

Gordon Davis, Chair	A/ Warden, Surrey Pretrial Services Centre
Bill Palmer, Member	Assistant Deputy Warden, North Fraser Pretrial Centre
s.22 Member	Community Advisory Board, North Fraser Pretrial Centre
Dr. Maureen Olley, Member	Director, Mental Health Services, Corrections Branch
Larry Chow, Participant/ Observer	Investigation and Standards Office

Review Dates:

September 10, 13 and 17, 2010 at North Fraser Pretrial Centre.

Mandate and Scope of Review:

On September 7, 2010, the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the hostage taking of an inmate at North Fraser Pretrial Centre (NFPC) and to address the following:

- Compliance with Adult Custody Policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to the incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at NFPC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The Port Coquitlam RCMP was contacted prior to commencement of the review to ensure it would not compromise their investigation. Clearance was granted and the review proceeded.

Background:

At approximately 2147 hours on September 4, 2010 a correctional officer identified an apparent hostage taking in cell s.22 on living unit Alpha East at NFPC. Inmate s.22 (the subject) was holding a s.15 in a manner that threatened inmate s.22 (inmate A). Inmate A was s.15, s.22 , and the subject was standing behind him. Correctional staff were able to verbally intervene and resolve the issue.

The subject s.22

The subject had s.22

s.22

The correctional officer noticed the apparent hostage taking during s.15 on the unit. He immediately contacted his supervisors by radio to report the incident. Digital video recording (DVR) shows that s.15 attended at 2152 hours. Between s.15 s.15 officers were also present at various times throughout the incident. Between 2149 hours and 2159 hours, s.15 and healthcare staff were alerted.

The CS s.15 At approximately 2155 hours, the CS s.15 remained on the unit, including s.15 The subject expressed frustration with s.22 and asked for s.22

At approximately 2210 hours, the subject complied with direction to s.15, s.22 He was taken to segregation and s.15

Corrections staff released inmate A s.15 Healthcare staff completed an assessment of inmate A at the healthcare centre. No injuries were noted. Cell s.22 was searched and secured; no additional evidence was found.

At approximately 2220 hours, the ADW contacted the on-call manager, and the deputy warden (DW). The DW directed the ADW to s.15 . NFPC staff provided all requested evidence including the s.15 statements and DVR records.

Events were reported to the provincial director, Adult Custody Division, by e-mail on the morning of September 5, 2010.

Findings:

- Staff did not follow Adult Custody policy or NFPC standard operating procedures regarding response to hostage taking.
- Contrary to NFPC standard operating procedures, the subject was moved to segregation s.15, s.22
- Contrary to Adult Custody Policy, s.15
- s.15
- The provincial director, Adult Custody, was not notified by telephone in a timely manner.
- The subject was given an s.22 form and a case management plan indicating that the program details were explained to him. Neither form documents the process for the subject to progress through the program. Daily file entries and weekly s.22 reviews provided little detail to outline his progress through the program.
- NFPC practices related to s.22 inmates are different from the s.22 practices for s.22 inmates. The process for s.22 inmates to progress s.22 is not clearly defined.
- The subject cited frustrations regarding the s.22 as a factor leading to his actions.
- s.15, s.22
- The subject had minimal documented s.22 or s.22 contact since s.22 on s.22
- The subject s.22 following his return to NFPC.
- Inmate A was seen by healthcare professionals immediately following the incident. This encounter was not documented until after the critical incident review commenced.
- In our review we were unable to determine, with certainty, whether it was an actual hostage taking or an event that was staged by the two involved inmates.

Recommendations:

1) NFPC management should ensure staff awareness and compliance with relevant policies and procedures regarding hostage taking responses, the crisis management model, escort practices, preserving crime scenes and evidence, and critical incident reporting and notification.

2) NFPC management should review s.22 practices and policies with staff, particularly the standards that apply to the s.22 population, and ensure that inmates are aware of applicable processes.

3) NFPC management, in consultation with the director, Mental Health Services, should consider developing a cohesive process for case management of inmates with identified s.22 needs. This process could include the s.22
case managers and classification officers.

4) The healthcare contractor should remind staff of the need to complete documentation in a timely manner following an interaction with an inmate.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Hostage Taking at North Fraser Pretrial Centre
s.22

Date of Incident:

January 7, 2011 at North Fraser Pretrial Centre

Review Team:

Kate Watts, Chair	Deputy Warden, Fraser Regional Correctional Centre
Jack Stowe, Member	Assistant Deputy Warden, North Fraser Pretrial Centre
s.22 Member	Community Advisory Board North Fraser Pretrial Centre
Lyall Boswell, Participant /Observer	Investigation & Standards Office
Dr. Maureen Olley, Participant /Observer	Director, Mental Health Services Corrections Branch

Review Dates:

January 14 & January 18 to 19, 2011

Mandate and Scope of Review:

On January 12, 2011, the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the hostage taking of an inmate at North Fraser Pretrial Centre (NFPC) and to address the following:

- Compliance with Adult Custody policy and procedures;
- The provision of emergency procedures;
- Any other factors that may be relevant to the incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, recordings and transcripts, has been maintained at NFPC.

An independent review by the Investigation and Standards Office of the Ministry of Public Safety and Solicitor General was conducted concurrently with this investigation. A separate report may be submitted by that office.

Background:

Inmate s.22 (the subject) s.22

In s.22 NFPC classification, in consultation with the mental health liaison officer, decided to double bunk the subject s.22

s.22 , and the cellmate s.22

At approximately 2223 on January 7, 2011, a call was made to the s.22 office from central control stating they had received a cell call from unit AW, cell s.22 regarding a medical emergency. The segregation officer checked s.15 and noticed the subject s.22 The cellmate was s.22 The s.22 officer attended the cell to assess the situation. The officer observed the subject s.22 and heard the subject state that s.22 The s.22 officer immediately radioed for the correctional supervisor (CS) to attend the unit and bring responders.

The CS, as well as s.15 responders, attended the unit at approximately s.15 Through the cell window, the CS observed the subject s.22

s.15

The unit officer turned on the light in the cell, and the CS made the decision to access the cell for a better understanding of the situation. Once inside the cell, it was clear to the CS that the subject was s.22 and he viewed s.22 appeared to be s.15 The subject was s.22 asking for a warden and a hostage negotiator, as this was a hostage situation. The subject then s.22 . When the CS recognized that this was a hostage situation, he decided to remain in the cell rather than exiting.

At approximately 2229, the CS instructed one of the officers to contact the on-call manager and s.15 Instead of contacting the on-call manager, the officer contacted the assistant deputy warden (ADW) who had just left the centre. The ADW provided direction to contact the warden and on-call manager who, in turn, provided direction to seek out the NFPC crisis management binder s.15 The officer passed the duty of s.15 onto another officer who s.15 at 2310. Upon completion of the s.15 the officer called NFPC critical incident response team.

The CS stayed in the entryway to the cell s.15 and continued to talk calmly to the subject. The conversation continued for eleven minutes. The CS s.15 the subject stood up and walked out of the cell, with the CS, to the adjacent yard s.22 The CS instructed other staff to prepare new cells for both

inmates. s.15 responders remained on the other side of the glassed yard door in the event the subject became agitated again.

While in the yard, the subject s.15 The subject was s.22 He was s.15 placed into another cell at approximately 2255.

Health care staff immediately attended to the cellmate who was then escorted to health care for further assessment. s.22

Health care completed the assessment at 2303, and the cellmate was escorted to another cell in segregation shortly thereafter.

At 2258, cell s.22 was secured pending s.15 at 2345. Central control had not made the call s.15 until 2310, as they had received conflicting direction from the CS and the ADW. Staff provided all requested evidence, and the digital video recording was saved appropriately.

Events were reported to the provincial director, Adult Custody Division, immediately following the incident.

Findings:

- Staff did not follow Adult Custody policy or NFPC standard operating procedures regarding response to hostage taking, specifically the immediate contact s.15
- Contrary to Adult Custody policy, staff accessed the area where the hostage taking was occurring prior to s.15 The CS determined that this access was necessary in order to fully assess the situation.
- The subject s.22

- The subject was classified correctly; however, a case management plan was not readily accessible to all appropriate staff.
- The subject s.22 nor was this approach included in a case management plan.
- The cell mate did not receive a s.22 follow-up specifically regarding the incident.
- All other applicable Adult Custody policies and NFPC standard operating procedures were followed.

Recommendations:

1. NFPC management should ensure staff awareness and compliance with relevant policies and procedures regarding hostage taking responses, specifically regarding critical incident reporting to RCMP.

2. NFPC management, s.22 should continue to develop a cohesive process for case management of inmates with s.22 needs.

3. NFPC management should ensure that case management plans are attached to the CORNET Client Log.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Death of Inmate – s.22

Date of Incident:

January 14, 2011
North Fraser Pretrial Centre
Pronounced dead at Royal Columbian Hospital

Review Team:

Patrick Doherty, Chair
Deputy Warden, Vancouver Island Regional Correctional Centre

Bill Palmer, Member
Assistant Deputy Warden, North Fraser Pretrial Centre

s.22 Member
Community Advisory Board, North Fraser Pretrial Centre

Shane Muldrew, Participant/Observer
Inspector, Investigation and Standards Office

Dr. Paul Beckett, Member
Provincial Health Director, Corrections Branch

Review Dates:

January 21 to 25, 2011
North Fraser Pretrial Centre

This report and its contents contain personal & security-related information and are therefore strictly confidential and are not for further distribution or disclosure. Any requests for this report or information contained herein are to be referred to Information Access Operations, Shared Services BC, Ministry of Citizens' Services.

Mandate and Scope of Review:

On January 17, 2011 the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the death of an inmate at s.22 as a result of a medical emergency while at North Fraser Pretrial Centre (NFPC), and to address the following:

- Compliance with Adult Custody policy and procedures;
- Adequacy of response including health care response; and
- All other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the Public Service Act. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at NFPC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

Prior to the commencement of the review the Coquitlam RCMP was contacted to ensure this review would not compromise any investigation that their department may have been conducting. Clearance was granted and the review proceeded.

Background:

North Fraser Pretrial Centre (NFPC) staff received and admitted the subject, inmate s.22 into custody s.22 on s.22 The subject had s.22 His intake at NFPC was s.22

During the admission process, the subject met with classification and health care staff for intake assessments. All reported that he s.22 and that he s.22

The mental health screener noted the subject's age and s.22 and that he s.22 The screener recommended s.22 placement.

The classification officer noted that the subject s.22

Although the subject s.22 , the officer assigned him to the s.22 unit (C-North) because he believed that s.22

The intake nurse noted that the subject s.22

The nurse also noted that the subject was s.22

The subject s.22 due to court.

s.22

Operations and health care staff observed no causes for concern during their interactions with the subject after his admission, and he expressed no concerns to them before the date of the incident. The subject cooperatively followed staff direction and he s.22

The subject attended court s.22 , and sheriff deputies reported that he had no apparent difficulties nor expressed any concerns while in their custody that date. They returned the subject to NFPC late that afternoon, and NFPC records staff processed his return and gave him a packaged meal as he left the records area to return to his living unit.

The centre chaplain observed the subject walking slowly in the C-pod hallway. She joined him and asked him about his day. He s.22 The chaplain told him that s.22 and continued with him into the C-pod lobby.

A licensed practical nurse and several correctional officers were present when the subject entered the C-pod lobby. The chaplain advised them that the subject s.22 The nurse observed that he s.22 The subject s.22

The nurse had just completed medication rounds of the four C-pod living units and advised that she had s.22 for the subject. She provided it to him and he s.22 The nurse cleared him to return to his living unit, and she advised the subject and staff present to notify the health care unit if s.22 did not improve. She returned to the health care unit and reported the event to the registered nurse-in-charge before continuing with her medication rounds in the segregation unit.

The inmate services officer accompanied the subject directly to his cell after entering the living unit. The chaplain brought the replacement meal to the unit and spoke with the unit officer about the subject's condition.

The unit officer visually checked the subject during her routine living unit checks. She had also asked the subject's roommate to alert her if he observed the subject having any difficulties. The officer reported that the subject appeared to have no further s.22 difficulties and that neither he nor his roommate expressed any concerns.

The health care security officer called the unit officer at approximately 2110 hours. He advised her that the nurse wished to see the subject and he asked her to send him to the health care unit. The unit officer went to the subject's cell and woke him. She was not able to get a clear response from the subject, and it appeared that he did not want to go to the health care unit.

The unit officer called the inmate services officer for assistance. He attended the cell but could not get the subject to leave his bunk. He reported that the subject was s.22 The health care security officer came to the living unit and attended the subject's cell. He helped the inmate services officer s.22 A correctional supervisor also attended and he directed the two officers to s.22

The two officers s.22 from the records area, and they found the subject still sitting on his bunk when they returned to his cell. They assisted him s.22 The two officers then proceeded to move the subject to the health care unit, and the correctional supervisor accompanied them.

The s.22 The officers observed that he was conscious s.22 before continuing to the health care unit. They arrived at the health care unit at approximately 2130 hours, and the officer s.22 observed his condition had significantly deteriorated. The subject was unresponsive and appeared to be unconscious.

The registered nurse-in-charge led the officers with the subject into the treatment room. She assessed the subject and found him unresponsive. The nurse and the officers s.22 The nurse reassessed the subject, and a licensed practical nurse attended the treatment room to assist her. The registered nurse s.22 and left the room to retrieve the s.22 s.22 The licensed practical nurse continued to monitor and assess the subject. The registered nurse returned quickly with the s.15, s.22

At the direction of nurse-in-charge, the supervisor radioed control staff and requested an ambulance. Both nurses s.22 pending the arrival of emergency medical personnel.

Fire department first responders arrived at the centre at approximately 2136 hours and attended the health care unit. They continued emergency medical treatment s.22 BC Ambulance Service paramedics and advanced life support paramedics arrived at the centre at approximately 2146 hours and at approximately 2153 hours respectively. Each ambulance crew attended the health care unit where they further assessed the subject and continued emergency medical treatment.

Advanced life support paramedics s.22 and moved the subject to the sally port for transport to the hospital via ambulance. Paramedics and NFPC escort staff left the centre with the subject at approximately 2222 hours, and they arrived at the hospital at approximately 2240 hours. Emergency room medical staff pronounced the subject dead at approximately 2305 hours. NFPC escort staff contacted the centre, notified the assistant deputy warden-in-charge and then remained at the hospital until the subject's next-of-kin arrived at approximately 0200 hours to confirm the subject's identity.

The cause of death is unknown at this time as the autopsy and toxicology reports are still pending. However, based on the evidence available at this time, the medical director believes that the subject died from s.22

Findings:

- The subject was a s.22 with s.22
- Subject was s.22
- s.22 were not provided during intake for which the subject s.22
- There is not a PAC entry detailing s.22
- Intake classification processes were appropriate and in accordance with Adult Custody Policy. Unit placement was based on the needs and assessment of the subject.
- The subject was at court on s.22 and was assessed by s.22 The subject was s.22
- There are no reports of unusual behaviour, health issues or security incidents while housed in the living unit in the days leading up to the subject's death. There are no reports of unusual behaviour, health issues or security incidents while at court or in Sheriffs custody.
- The subject s.22 on January 12 and 13. The subject s.22 on the morning of January 14 prior to s.22
- A chart review was conducted on s.22 and s.22 by a centre physician.
- The subject s.22
- Upon his return from court on s.22, the subject was noted as s.22 while in the "C Pod" lobby. The licensed practical nurse responsible for dispensing medication spoke with him, issued him s.22 and she cleared him to return to his

living unit. This interaction was passed verbally to the nurse in charge but not initially recorded in PAC. The nurse did not have medical assessment tools that would have allowed for an assessment on the unit.

- The unit officer was advised to keep an eye on the subject and to report any issues to health care staff. The subject was checked as per Adult Custody Policy by living unit staff and there were no medical issues noted throughout the evening.
- At 2110 hrs the unit officer was unable to get the inmate to go to the health care unit when requested by health care staff. Other staff and the supervisor attended and determined the subject could not move to the health care centre on his own
- The subject was moved s.22 to the health care unit. En-route
- Upon arrival in the health care unit, nursing staff conducted an appropriate assessment and initiated appropriate emergency intervention.
- Corrections staff requested emergency services at the direction of health staff in a timely manner.
- There is no definitive cause of death pending release of coroner's report and toxicology review. s.22
- Critical notifications as required by local standard operating procedures and Adult Custody Policy occurred immediately.
- All involved corrections and health care personnel were offered a critical incident response team debrief.
- Reports, evidence and follow up information was collected as per policy.

Recommendations:

While implementation of the following recommendations may not have changed the outcome of this incident, they may improve overall operations and attention to patient care:

1. The health care contractor should conduct a quality assurance review of s.22 protocol for all new intakes to ensure that inmates are s.22 consistent with s.22

2. The health care contractor should review provisions for all nurses to carry appropriate medical assessment tools in order to allow for assessments and triage of inmates outside of the health care unit.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Inmate assault

Date of Incident:

September 7, 2011 at North Fraser Pretrial Centre

Review Team:

Kary Steele, Chair	Deputy Warden Fraser Regional Correctional Centre
Elliott Smith, Member	Deputy Warden North Fraser Pretrial Centre
s.22 Member	Community Advisory Board North Fraser Pretrial Centre
Lyall Boswell, Participant/Observer	Inspector Investigation and Standards Office

Review Dates:

September 21 to 23, 2011 at North Fraser Pretrial Centre

Mandate and Scope of Review:

On September 16, 2011, the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding an inmate assault at North Fraser Pretrial Centre (NFPC) and to address the following:

- Compliance with Adult Custody Policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at NFPC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The Port Coquitlam RCMP was contacted prior to the commencement of the review to ensure it would not compromise their investigation. Clearance was granted and the review proceeded.

Background:

On September 7, 2011, at approximately 0838 hours, a unit officer at North Fraser Pretrial Centre (NFPC) initiated a code blue. He was attempting to s.22 hereafter "the subject", for a s.22 The officer reports that s.22 appeared to be in medical distress.

The subject was assessed by responding centre health care staff who contacted emergency health services via 911. It has been documented that health care staff suspected he s.22 Health care staff also noted that the subject s.22

Shortly after the subject was sent off grounds via ambulance to hospital, the assistant deputy warden (ADW) notified the warden. The acting correctional supervisor (A/CS) began an investigation on the direction of the ADW.

It was initially suspected by investigating staff that the subject was assaulted in s.15 but, as the A/CS began to review digital video recording (DVR), he realized that the subject's injuries appeared to have been sustained two days earlier on September 5, 2011 between approximately 1816 and 1958 hours.

As part of the critical incident review, the following facts surfaced through review of DVR footage and subsequent interviews with staff:

September 5, 2011

- On September 5, 2011, at approximately 1816 hours, the subject accompanied by another inmate, walks from the area of cell s.22 in Charlie South (CS pod) into cell s.22
- For approximately the next hour and a half inmates are seen walking in and out of cell s.22 but the subject is not seen coming out.
- The unit staff remain at or near the staff station while the subject is in cell s.22
- The subject is carried by an inmate from cell s.22 back in to his assigned cell s.22 at approximately s.22 hours.
- When the subject is moved from cell s.22 to cell s.22, several inmates appear to distract the living unit staff from viewing the move.
- From approximately s.15 hours to s.15 hours, the s.22 s.22 inmates on CS pod are given time out of their cells. The unit officer does not conduct a check on inmates secured in their cells during that timeframe.
- At approximately s.15 hours, as the unit officer attempts to conduct an identification count, the breaker for the unit cell lights is tripped. He reported that he immediately informed his supervisor. He continued the identification count without the lights on and without a flashlight. When conducting the identification count, he does open the unit cell doors but does not step inside the cells.
- The supervisor attended the unit two times between 1800 hours and 2200 hours on September 5, 2011 and spent less than 3 minutes in total on CS pod.
- The cell lights were fixed during the night of September 5. This repair was not communicated to the oncoming day shift staff.

September 6, 2011

- Night shift staff conduct checks throughout the evening; they were not logged within s.15 as required in Adult Custody Policy (ACP).
- On September 6, the assigned living unit officer begins his shift at approximately 0630 hours.
- During the routine daily inspection of CS pod, the unit cell lights are tripped again, prior to the unit staff arriving at the subject's cell. At approximately 1013 hours, the unit officer steps inside the subject's cell for approximately 30 seconds. The unit officer stated that he was unaware that the lights were tripped and was under the impression that the cell lights were still out from the night before.
- Throughout the day and afternoon shifts on September 6, checks of the unit were conducted infrequently and not in accordance with ACP.

- Meals were taken to the subject by other inmates on the unit.
- The unit staff stepped in to cell s.22 for a moment at approximately 1723 hours. The officer reported that the inmate stated that s.22 but did not request medical assistance.
- At approximately s.15 hours the unit officer conducted an identification count; he opened the door for cell s.22 during the check. The lights were still not functioning. He again reported it to the supervisor who did not initiate a work order for repair and instead suggested that the unit be searched the following shift.
- Supervisors assigned to CS pod on September 6 visit the unit 3 times and spend minimal time directly supervising the unit staff. One ADW is noted as visiting the unit on September 6.

<u>September 7, 2011</u>

- During the night shift, staff conduct checks throughout the evening; they were not logged within s.15 as required in ACP.
- The unit is searched the morning of September 7 but, due to time constraints, the subject's cell is not searched.
- The subject remained in the cell, where he was single bunked, until he was found on September 7. At no time did the inmate alert staff to his condition despite speaking briefly with staff who entered his cell. It appears as though the subject actively sought to conceal his condition.
- On September 7, 2011, the unit officer opened cell s.22 and notified the subject of the s.22 prior to the subject s.22 and this led staff to initiate a code blue.
- At the conclusion of the critical incident review, the subject s.22

Findings:

- Visual cell checks were not conducted in accordance with Adult Custody Policy – specifically, checks were not conducted with appropriate frequency and documentation was insufficient.
- Identification counts were not conducted in accordance with NFPC Standard Operating Procedure (SOP) – specifically staff did not view the subject with the cell light on and did not rule out any emergent issues.
- Formal counts were not conducted in accordance with Adult Custody Policy – specifically requirement to document name and signature of staff member conducting the count.

- Meal distribution was not done in accordance with centre policy. The unit staff did not count meals and ensure that every inmate received a meal. Meals were taken to the subject by other inmates.
- The post job descriptions for the inmate services officer and operational correctional supervisor do not accurately reflect policy requirements.
- The subject appears to walk willingly in to another inmate's cell at approximately 1816 hours on September 5, 2011. He remains in the cell till approximately 1958 hours and is carried back to his cell. Unit staff do not conduct a unit check during the timeframe the subject is in the other inmate's cell.
- Staff were unable to properly identify the inmate who carried the subject back to his cell.
- The cell lights on CS pod were tripped during the identification count on September 5, 2011. The supervisor submitted a work order for the lights to be repaired and they were repaired that evening.
- The cell lights on CS pod were tripped again prior to the cell inspection on September 6, 2011. The supervisor was aware but did not submit a new work order. The lights were not repaired until approximately 1100 hours on September 7, 2011.
- NFPC SOPs require identification counts to be conducted with the cell light on. While the cell lights were out on September 5, 6 and 7, unit staff did not ask for nor were they given a flashlight, although they are known to be readily available.
- Based on information that classification and reports provided, the subject s.22
  The classification entry states,
  there is no specific information to suggest the subject was s.22
- From the time the subject is carried back to his cell on September 5 until the time staff informed him of s.22 on September 7, the subject does not come out of his cell.
- When the code blue was initiated, health care staff noted s.22 neither officer assigned to the unit detected the inmate's injuries. The code blue was handled appropriately and the subject was subsequently taken by ambulance to the hospital.
- The A/CS assigned to investigate the incident did not conduct a thorough investigation as while several inmates were seen entering the cell where the subject is suspected of being injured there was no investigative follow-up; other inmates are seen participating in distracting staff from their duties; and, staff reports were incomplete.

- During the course of the critical incident review, it is observed that correctional supervisors and an assistant deputy warden are not supervising unit staff regularly. The correctional supervisors do not conduct unit tours, including all cells, contrary to centre policy.
- During the review, we were unable to determine, with certainty, how the inmate sustained his injuries s.22

Recommendations:

1) NFPC management should ensure staff awareness and compliance with relevant policies and procedures regarding visual cell inspections, informal counts, identification counts, living unit policy and meal distribution.

2) NFPC management should review the post job descriptions of the inmate services officer and correctional supervisor and applicable local standard operating procedures and ensure that staff are aware of their responsibilities.

3) NFPC management should reinforce procedures for conducting an investigation following a significant or critical incident with acting and regular supervisors.

4) NFPC management should reinforce with their leadership team their expectations with respect to maintaining a supervisory presence generally on the living units, and specifically their responsibility as outlined in SOPs for supporting staff on the living units.

5) NFPC management should clarify and provide staff direction on when a flashlight is available to conduct visual cell inspections.

6) NFPC management should determine ways to prevent inmates from tripping cell lighting for the entire unit.

7) NFPC management should ensure that when an inmate is moved for a reason, the reason is specifically documented in the inmate's CORNET client log and/or alerts.

CORRECTIONS BRANCH

Critical Incident Review

Subject:

Death of Inmate s.22

Date of Incident:

April 3, 2012 at North Fraser Pretrial Centre

Review Team:

Lisa Martin	Chair	Deputy Warden Alouette Correctional Centre for Women
Richard Lacroix	Member	A/ Assistant Deputy Warden North Fraser Pretrial Centre
s.22	Member	NFPC Community Advisory Board
Lyall Boswell	Participant/ Observer	Inspector Investigation and Standards Office
Dr. Maureen Olley	Participant	Director Mental Health Services

Review Dates:

April 5, April 10 and April 11, 2012 at North Fraser Pretrial Centre

Mandate and Scope of Review:

The assistant deputy minister requested that a critical incident review be conducted to examine the circumstances surrounding an inmate death at North Fraser Pretrial Centre and to specifically address the following:

- Compliance with Adult Custody policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at North Fraser Pretrial Centre.

An independent review by the Investigation and Standards Office of the Ministry of Justice was conducted concurrently with this investigation. A separate report may be submitted by that office.

The Coquitlam RCMP were contacted and confirmed that the review would not compromise their investigation.

Background:

On s.22 inmate s.22 (the "subject") was admitted to North Fraser Pretrial Centre (NFPC) s.22

As part of the admission process, the subject was interviewed and assessed for classification and placement by an internal classification officer (ICO). The officer identified s.22

The intake nurse is a dually trained registered nurse and psychiatric nurse. The nurse had a very good recollection of the subject's intake because s.22 She noted that the subject s.22 She found him to be s.22

The mental health screener also had a good recollection of the subject, noting that s.22 The screener noted s.22

s.22 The mental health screener's summary comments indicated that s.22 It is also noted that During the review of the incident, the director of mental health services provided the following summary overview of the subject: s.22

Prior to his admission to NFPC, the subject had been booked in at s.22 There was a notation on the s.22 booking sheet that s.22 s.22 Follow-up with s.22 staff determined the s.22 comment was s.22 The subsequent initial health assessment done at s.22 was s.22 and alerts were not identified. NFPC health care staff received but did not review these s.22 records when the subject was admitted to NFPC.

With no identified concerns from a medical or psychological perspective, the ICO, based only on s.22 designated the subject s.22 and suitable for double-bunking. The subject was placed in Alpha West s.15 This placement and rationale were explained to and agreed to by the subject s.22 The ICO noted the subject had s.22 . The subject was placed in s.22 with a compatible inmate due to capacity limitations s.22

On the morning of s.22 the subject was seen by a nurse during segregation rounds to check for any medical or mental health concerns. There were no concerns noted. He later attended court.

On the morning of s.22 the subject was again seen by a nurse during s.22 rounds to check for any medical or mental health concerns. The inmate s.22

On s.22 another ICO reviewed the subject's classification, checked for any s.22 and met with the subject. This ICO found the subject to be s.22 with the ICO's only concern related to s.22 s.22 the subject was placed on Alpha North, s.22 unit that had similar types of inmates.

From s.22 until the last entry on s.22 the subject's CORNET Client Log is unremarkable. The subject s.22 s.22 As well, staff assisted him with s.22

The subject attended court on s.22 and s.22 and s.22 . The subject returned to Alpha North after court s.22 Follow-up with Crown Counsel revealed that the subject's s.22 court appearance was unremarkable.

s.22

On s.22 a formal count was completed at s.15 hours on Alpha North. Medication rounds occurred at 0700 hours. A review of digital video recordings (DVR) shows the living unit officer started to unlock the unit at 0800 hours. The officer unlocked cell s.22 on the second tier, the subject's cell, at 08:02:16 hours and proceeded on to the next cell. The subject exited his cell at 08:02:22 hours and paused. The living unit officer doubled back and looked back into the cell then proceeded again along the second tier, with cell s.22 and the subject behind the officer. The subject appeared to watch the officer and then s.22 hours. The subject s.15, s.22 The subject paused, looked around, and appeared to look at the cell behind him. On the rest of the unit the few inmates that had been unlocked so far had started moving about preparing for breakfast. At 08:03:29 hours the subject s.15, s.22

The living unit officer immediately called a code blue. Simultaneously, the inmate services officer (prowl) who was just entering the unit also called a code blue. Another officer entered the unit and inmates were immediately directed back to their cells and complied within seconds. The other inmate services officer arrived, followed by the assistant deputy warden (ADW) at s.15 hours, followed b s.15 health care responders at s.15 hours. One health care responder attempted to s.22 while another checked for vitals, which were absent.

It is not usual for a physician to respond to a code blue, nor is there a requirement to do so in policy; however, simultaneous to the incident, the doctor was doing his morning rounds next door in the segregation unit. Based on what the doctor viewed on the segregation unit monitor of the code blue, the doctor immediately attended Alpha North, arriving at 08:04:41. The nurse reported her findings to the doctor and the doctor medically confirmed that vital signs were absent and pronounced the subject deceased at approximately 08:06:20 hours.

Window coverings were put on the unit cell windows starting at 08:06:48 hours. The subject's identity was confirmed and his roommate was then removed from cell s.22 at 08:12:12 hours and relocated. The scene was photographed at 0823 hours and ambulance services arrived on the unit at 08:24:41 hours, followed by the RCMP at 08:33:30 hours.

The remainder of the centre was locked down at 0830 hours so all staff could report to Centre Hall for a debriefing. The debriefing was done by the ADW and deputy warden of operations. Several Critical Incident Response Team (CIRT) members attended to assist staff through the incident. Further staff debriefing was done following the incident on April 6, 2012.
The RCMP searched the subject's cell at 0840 hours and s.22 were discovered. The subject's roommate as well as an inmate in cell s.22, s.15 were interviewed separately by RCMP. The coroner arrived on the unit at 1007 hours, reviewing the scene, taking photos and looking in the subject's cell.

The subject's body was removed at 1100 hours.

At 1300 hours, once the RCMP and coroner were finished in the subject's cell, corrections staff took photos of the cell interior and the subject's personal effects were gathered. The s.22 was cleaned up by contracted Workplace Solutions Inc. (WSI) cleaners.

The mental health liaison officer, chaplain and psychologist attended the unit and talked to all Alpha North inmates, cell by cell. The unit returned to normal operations at 1510 hours.

A review of the Inmate Call Control System indicates the subject s.22

Findings:

- As per NFPC standard operating procedure (SOP), the internal classification officer (ICO) conducted an interview with the subject.

- The subject was also interviewed by the mental health screener, as per NFPC SOP and Adult Custody Division (ACD) Health Care Services Manual (HCSM) policy, and the Jail Screening Assessment Tool (JSAT) was completed. The inmate was not identified by the screener as being at risk for s.22

- The subject was also interviewed by the intake nurse and the Health Information form was completed as per NFPC SOP and ACD HCSM policy.

- With no placement needs due to health care concerns, the ICO appropriately rated the subject s.22 and placed him s.22

- As per HCSM policy, the subject was seen by a health care professional both mornings s.22 The subject raised no s.22 concerns.

- Once the s.22 concerns were alleviated, the subject was appropriately placed on Alpha North.

- The living unit officer and inmate services officer (prowl) initiated a code blue (medical emergency) immediately. All responders responded as per NFPC SOP within s.15 ; other inmates were directed to lock immediately; the correctional supervisor directed central control to call 911; and, the unit cell windows were covered.

- The health care response was very rapid with numbers of responding staff exceeding the NFPC SOP requirement. The doctor pronounced the subject to be deceased and the health care response ceased.

- As per Adult Custody Policy (ACP), critical incident notification requirements were made to the warden within seconds and within minutes to the provincial director at Adult Custody headquarters.

- As per NFPC SOP concerning inmate death/ coroner's inquest, the protection of scene and notifications were made as appropriate.

- ACP protection of evidence policy was followed, including: protection of the scene; photos of scene; removing the subject's roommate from cell s.22once the subject's identity was confirmed; assigning an officer to transcribe; and, seizing cell effects of the subject once the coroner and police were finished their work.

- All staff directly involved in the incident submitted the required reports.

- As per ACP, post-emergency measures were taken to care for staff, including immediate Critical Incident Response Team response for initial defusing. A subsequent debriefing was done off-site on April 6, 2012.

- As per ACP, post-emergency measures were taken to care for inmates by the chaplain, psychologist and mental health liaison officer.

- It is noted that the last CORNET Client Log entry on the subject was made on s.22 contrary to ACP and NFPC SOP which requires Client Log entries to be made once every four days.

- Post-incident, the NFPC assistant health care manager reviewed the Initial Health Assessment done at s.22 There were no concerns s.22

- A post-incident review of the subject's warrant file found no alerts on the s.22 booking sheet form or on the Sheriff's receipt for prisoner, prisoner's effects and documents.

- Both the intake nurse and the mental health screener did not review the s.22 booking sheet or the s.22 initial health assessment during or after intake. These documents were received by NFPC records and left in the health care box. Sometimes these types of documents from outside agencies (e.g. s.22 are reviewed by a nurse and sometimes they are just filed by the health care clerk.

- Review of the s.22 records post-incident by NFPC health care staff revealed that knowledge of the contents of these records would not have changed their initial assessments.

- The interviews by two NFPC ICOs, the intake nurse interview and assessment, the mental health screener interview and assessments, s.22 nurse visits, and s.22 did not identify any sign of s.22 by the subject while in corrections custody.

- s.22 clearly indicate that s.22 and did not apparently result from anything directly related to corrections, or more specifically, NFPC.

- A review of DVR from the time the subject returned from court the day before notes nothing remarkable; nor was there any behaviour noted by any of the officers who were assigned to that unit from the time the subject returned from court on s.22 until the time of his death.

- The subject's roommate s.22 so he was unavailable to the review team for an interview. The RCMP, however, advised that the roommate did not provide any insight when the RCMP interviewed him.

- The inmate s.22 was interviewed by the review team.

s.22

- There are no sweeping physical plant changes that can be thought of that would not have potentially unforeseen consequences to the overall operation of the correctional centre.

- There was a delay in receiving the subject's health care record as the NFPC health care manager was unaware of the policy related to critical incident reviews and health care records.

Recommendations:

1. NFPC management should ensure that CORNET Client Log entries are made on each inmate's file as per Adult Custody policy and NFPC standard operating procedures.

2. The health care contractor should review records management procedures to ensure documents received on inmates from outside agencies are reviewed upon receipt and prior to filing.

3. The health care contractor should remind staff of the protocol for securing the health care file in the event of an inmate's death and making it available to appropriate critical incident review team members upon request as per Health Care Services Manual policy.

4. NFPC management should consider s.15, s.22

CORRECTIONS BRANCH

Critical Incident Review

Subject: Inmate Death

s.22

Date of Incident: July 15, 2012
Living Unit Alpha East
North Fraser Pretrial Centre

Review Team:

Dawn Kelly	Chair	A/ Warden Alouette Correctional Centre for Women
Rick Lacroix	Member	A/ Assistant Deputy Warden North Fraser Pretrial Centre (NFPC)
s.22	Member	Member NFPC Community Advisory Board
Diane Shepherd	Member	Director, Health Services Adult Custody Division
Lyall Boswell	Participant/ Observer	Inspector Investigation and Standards Office

Review Dates:

July 20, 23 and 25, 2012 at North Fraser Pretrial Centre

Mandate and Scope of Review:

The assistant deputy minister requested that a critical incident review be conducted to examine the circumstances surrounding the death of inmate

s.22 at North Fraser Pretrial Centre and to specifically address the following:

- Compliance with Adult Custody policy and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at North Fraser Pretrial Centre.

An independent review by the Investigation and Standards Office of the Ministry of Justice was conducted concurrently with this investigation. A separate report may be submitted by that office.

Prior to the commencement of the review, the Port Coquitlam RCMP was contacted to ensure this review would not compromise any investigations that department may have been conducting. Clearance was granted and the review proceeded.

Background:

On s.22 (the subject) was admitted to North Fraser Pretrial Centre (NFPC) as s.22

As part of the admission process, the subject was interviewed and assigned for classification and placement by an internal classification officer (ICO). During the interview the subject s.22 s.22 As such, he was placed in Alpha West s.22 as overflow until bed space became available on a s.22 unit.

On July 14, 2012 a bed opened up on s.22 unit Alpha East (AE), so the subject was reviewed and transferred to that unit at 1610 hours with a double-bunked placement in cell s.22

Further to the admission process on s.22 the subject was assessed by the intake nurse and mental health screener. There were no s.22 concerns noted upon intake. This was confirmed by the s.22 services during a phone conversation prior to the review when s.22 advised that "The mental health screening was appropriate." and that "There were no signs of

The intake nurse did not have any significant concerns during her assessment other than s.22 and so there was some confusion over whether s.22 The following day the subject was s.22 s.22 The confusion surrounding his s.22 was resolved when the s.22 was contacted. He was also s.22

There are no entries in the s.22 AE log books, the shift summaries or the muster report indicating there were any issues with the subject on s.22 or s.22 However, the officer working the unit on advised during her interview that she suspected he s.22 but upon closer examination s.22 , a finding that was confirmed by a nurse s.22 just prior to final lock-up.

A review of all available documentation for July 15, 2012, including his Client Log, indicates that there were no concerns with the subject prior to the incident. Officers interviewed advised that he stayed in his room the majority of the time following his transfer to AE.

At approximately 1816 hours on July 15, 2012, following the staff dinner break, the officer assigned to AE began unlocking the unit. Cell s.22 was accessed at 1819 hours and the subject's roommate exited the cell immediately and proceeded to the weight room on the first floor of the unit. At 1821 hours an inmate enters the cell, remaining inside for approximately fifteen seconds. It appears this individual advised the subject it was time for s.22 as the subject immediately exits the cell heading to the Alpha pod lobby where He is off the unit for approximately two minutes and upon his return he stops and chats briefly with another inmate en route to the stairs and returns to his cell at 1825 hours. The subject is not seen again until 2009 hours when s.22

Three inmates are seen leaving cell s.22 at approximately 1832 hours; two proceed directly up to the third tier and hang around in the vicinity of cell s.22. The third individual briefly enters the shower area on the second tier. Upon exiting, it appears he s.15, s.22
while climbing the stairs. Over an eighteen second period at 1833 hours, the three inmates enter cell s.22 one at a time. What transpired in the cell is unknown but at 1838 hours one of the three inmates leaves the cell, appearing to s.15, s.22 He returns to the shower area on the second tier and appears to s.15, s.22 before going to the weight room, where he has a brief conversation with the subject's roommate. He returns to cell s.22 at 1840 hours and at 1842 hours all three inmates exit the cell, one at a time over a twelve second period. Two proceed directly to the weight room while the third walks around the unit before joining the others in that location. Little weight lifting activity occurs, but there does appear to be a lot of conversation between the four individuals in the room. One inmate s.22

before they exit the area at approximately 1845 hours.

At 1847 hours two different inmates enter cell s.22. What transpires in the eight minutes they are inside is again unknown but they both leave the cell at 1855 hours and proceed to the yard. Inmate presence in the yard increases significantly for the next 15 minutes as various individuals gather, walk, talk and disperse, only to gather again in different groupings. During the course of all this activity someone s.22
Shortly thereafter it appears that an inmate is s.15, s.22 and then the courtyard emptied.

Cell s.22

s.15

The prowl officer s.15
and headed immediately up to the third tier while the unit officer proceeded to the second tier as he had not seen the location.

At 1953 hours, cell s.22 was accessed and the light turned on. The officer reported the subject was s.22 and appeared to be in medical distress s.22 so a code blue was called and the remainder of the unit was directed to lock down. s.22
. The response to the code blue was immediate with heath care staff arriving on scene just seconds after the initial response of correctional staff. Upon initial assessment an ambulance was requested via s.15 by health care staff and s.22

s.22

Fire department personnel arrived on scene at 2004 hours and s.22 from the nurses. At 2007 hours the primary care paramedics arrived and continued with all protocols that had previously been started. At 2009 hours the subject s.22 The advanced life paramedics arrived at 2022 hours and s.22

After consulting with an emergency room physician all protocols were terminated and the subject was pronounced dead at approximately 2057 hours. By 2111 hours all emergency responders, except the RCMP, had left the unit.

During the initial minutes of the response the unit was secured, a count conducted and coverings placed over the windows of the other cells. Staff assisted as needed throughout, getting equipment for the nurses and performing checks to ensure the safety of the other inmates on the unit. It was during one of these checks that s.15, s.22

Anecdotal information, s.15, s.22 suggests that the subject s.22 s.22 He had s.22

It is of interest that a s.22 was observed on the desk when cell s.22 was accessed at 1953 hours.

The first RCMP officer had attended the unit at 2015 hours. Additional RCMP identification officers arrived at 2116 hours and more RCMP officers were subsequently dispatched to the correctional centre when it appeared the subject's death was not due to s.22 as originally thought. The Integrated Homicide Investigation Team was called in early in the morning of July 16, 2012 and their investigation continued until approximately 1330 hours on July 17, 2012.

The coroner first attended NFPC at 0010 hours on July 16, 2012 but left again at 0036 hours as the police were conducting an investigation into the subject's death and would not release the body. At 0705 hours the coroner returned and the body was removed at 0716 hours to s.22

Once the RCMP and coroner were finished in the subject's cell, corrections staff took photos of the cell interior and the subject's personal effects were collected.

The chaplain attended the unit and spoke to the inmates prior to it being unlocked and returned to normal unit program.

Findings:

- The placement of the subject was appropriate and as per Adult Custody Policy (ACP).
- The code blue response was timely and reports were completed as per ACP and local standard operating procedures (SOPs).
- Prior to the incident the subject's presence in the correctional centre was unremarkable.
- As per ACP and local SOPs, post-emergency measures were taken to care for staff with a Critical Incident Response Team defusing session the night of the incident and a formal debriefing on July 20, 2012.
- Post-emergency measures were taken to care for the inmates by having the chaplain attend the unit and speak to them prior to it being unlocked and returned to normal unit program as per ACP.
- Critical incident notifications to the warden, the provincial director, the RCMP and coroner were timely and as per ACP.
- Health care had no concerns about the subject's mental health or risk of self harm.
- Correctional staff, including a correctional supervisor, were unclear as to the time frames in which visual checks for those not on ESP were to be conducted.
- Correctional supervisors acknowledged not always completing unit tours s.15 as per their post job description.
- Not all correctional supervisors reviewed unit log books for accuracy of documentation or to ensure visual checks were being conducted as per policy.

- Documentation in unit log books was not as per ACP or local SOPs.
- Visual checks were not conducted as per ACP.
- s.22
- Protection of evidence was not maintained as per ACP and local SOPs as the RCMP were in charge of the crime scene.
- Loitering on tiers other than the one to which inmates were assigned and inter-cell visiting occurred frequently and without intervention prior to the incident in contravention of local SOPs.
- The review panel was unable to determine what transpired in cell s.22 that led to the subject's death.
- The actions of the unit officer with respect to conducting visual checks are open to review by NFPC management.

Recommendations:

1. NFPC management should ensure that staff are aware that visual checks must be completed at intervals not to exceed s.15 as per policy.
2. NFPC management should remind staff of the requirement for documentation in unit log books to be completed as per Adult Custody Policy and local standard operating procedures.
3. NFPC management should ensure that correctional supervisors are aware of their responsibilities to complete unit tours s.15 and to review unit log books for accuracy of documentation and completion of visual checks.
4. NFPC management should remind records staff of the need to ensure that all information, including next of kin contacts, is updated.

CORRECTIONS BRANCH
Critical Incident Review

Subject: Assault of Inmate
s.22

Date of Incident: August 12, 2012
North Fraser Pretrial Centre
Living Unit Charlie West

Review Team:

Nedeljko Macesic	Chair	Deputy Warden, Fraser Regional Correctional Centre
Rajan Bahia	Member	Assistant Deputy Warden, North Fraser Pretrial Centre
Diane Shepherd	Member	Director, Health Services, Corrections Branch
s.22	Member	Community Advisory Board, North Fraser Pretrial Centre
Shane Muldrew	Participant/Observer	Inspector, Investigation and Standards Office

Review Dates:

August 14 to 21, 2012 at North Fraser Pretrial Centre

Mandate and Scope of Review:

On August 13, 2012, the assistant deputy minister, Corrections Branch requested that a critical incident review be conducted to investigate the circumstances surrounding an inmate assault at North Fraser Pretrial Centre and to specifically address the following:

- Compliance with Adult Custody policies and procedures;
- The provision of emergency procedures and notifications; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy all evidentiary material, including any original records, tapes and transcripts, has been maintained at North Fraser Pretrial Centre.

An independent review by the Investigation and Standards Office of the Ministry of Justice was conducted concurrently with this investigation. A separate report may be submitted by that office.

The North Fraser RCMP was contacted prior to the commencement of the review to ensure it would not compromise the investigation. Clearance was granted and the review proceeded.

Background:

Subject

On s.22 inmate s.22 (henceforth "the subject") was admitted to North Fraser Pretrial Centre (NFPC) s.22

Classification staff completed an inmate assessment (IA) for the subject upon intake. The IA identified him as being s.22 and it noted that s.22 The subject s.22 Classification staff applied a s.22 rating with a level s.22 escort security rating, but also noted that the inmate s.22

The police later advised the subject and correctional centre management that s.22 However, the subject

claimed the information was unfounded and he advised classification staff that he would not have any concerns with s.22

The subject was placed in living unit s.22 a general population unit, on s.22 and he was subsequently moved to living unit Charlie West (CW) also a general population unit on s.22 as he was s.22 His records indicated that he

s.22

Alleged assailant

On s.22 inmate s.22 (henceforth "the alleged assailant") arrived at NFPC as a s.22 from s.22

Based on s.22 classification staff considered him a s.22 level institutional management risk with a s.22 and a s.22 Staff rated the subject at a level s.22 escort rating.

The alleged assailant was assigned to living unit s.22 a general population unit, where he remained for approximately s.22 until s.22

s.22

Classification staff subsequently moved him to CW on s.22

s.15, s.22 the alleged assailant was s.22 Staff witnessed the alleged assailant s.22 and moved him to the s.22 unit. He s.22 and staff then moved him to living unit s.22 on s.22 Staff reported that he was not involved or suspected of s.22 Staff moved the alleged assailant to living unit s.22 after s.22 on s.22 He was subsequently moved to CW on s.22 as an administrative placement with no behaviour concerns.

The alleged assailant remained on CW until August 12, 2012 when he allegedly assaulted the subject. Staff had no recent concerns about interactions between the alleged assailant and the subject, or any other inmates.

Incident

At approximately 1254 hours on August 12, 2012, the CW prowl officer and the CW living unit officer heard s.22 come from the s.22

and attended the area immediately. The prowl officer observed the subject s.22 and witnessed the alleged assailant s.22 The officer gave the alleged assailant loud and clear verbal direction to stop his attack and to get down on the ground. The alleged assailant looked at the officer and hesitated, and then s.22 . The officer quickly s.15 at the alleged assailant and called a code yellow response.

The alleged assailant s.15 ceased his attack on the subject. He complied with direction as the s.15 officers secured him with s.15 and moved him away from the subject. s.15 officers observed that the subject s.22 s.15 staff responded to the code and assisted in securing the living unit and attending to the scene. The CW prowl directed responders to call a code blue for the injured subject s.22 Upon observing the subject s.22 an officer s.22 and he remained with the subject in the s.15 cell while waiting for health care staff to attend the scene. A supervisor began scribing the events on the unit, and several officers performed that function as roles and responsibilities changed during the incident.

Staff removed the alleged assailant from cell s.22 and escorted him from CW to the segregation unit. Staff secured the alleged assailant s.15 He received s.15 clean clothing and s.22 approximately 30 minutes later.

Supervisors observed that s.15, s.22

The supervisors directed staff to move the subject to the common space outside of cell s.22, s.15 Staff

after removing him from the cell. Staff secured cell s.22 to preserve evidence contained therein and to s.15

Health care staff entered the living unit at approximately hours as a supervisor directed central control to contact emergency health services and request that an ambulance be dispatched to NFPC. Health care staff attended the scene and immediately commenced s.22 and reinforced the need for an ambulance. The CW prowl, who had been assigned to assist with escorting the alleged assailant to AW, was quickly recalled to the

unit to provide nursing staff information regarding the cause of the subject's injuries.

At approximately 1313 hours, an EHS ambulance arrived at NFPC and the paramedics were immediately escorted to CW. The paramedics took over the medical treatment of the subject. Finding s.22 they called their dispatch for s.22 NFPC health care and correctional staff assisted paramedics, as directed, with caring for the subject in the interim.

s.22 paramedics arrived at the centre at approximately 1321 hours and joined the first ambulance crew in treating the subject. NFPC health care and correctional staff continued to assist as directed. Paramedics stabilized the subject and transported him from the centre to s.22 at approximately 1348 hours with an escort team. s.15

Prior to deploying the escort team, supervisors performed a review and risk assessment of the subject's escort level and deemed him to be a s.22 As police intelligence suggested that s.22 they contacted s.22, s.15 The supervisors also advised hospital security to s.22, s.15 The escort team also received the necessary information to conduct the escort.

s.22 received the subject at approximately 1405 hours. Hospital staff s.22 . An RCMP officer met the escort team upon their arrival at the hospital and advised that s.15

The escort team and the RCMP officer remained with the subject at all times, and they s.22

s.22

The escort team reported s.22 to their supervisor.

While treating the subject in s.15, s.22

s.15, s.22

The escort team remained at the hospital until replacement officers relieved them at approximately s.15 hours. They returned to the centre, submitted their reports and concluded their shifts. Neither officer received a debriefing with supervisors related to their participation in the emergency event.

At approximately 1430 hours, two RCMP officers attended NFPC and began their investigation into the assault of the subject. They released the subject's secured cell back to NFPC control at approximately 2140 hours and it remained secured pending further investigation.

At approximately 1430 hours, a supervisor and an assistant deputy warden (ADW) held a debriefing with all available staff that had been involved in the incident. Both acknowledged the officers' efforts and noted that health care staff, correctional staff and ambulance staff had worked as a combined team to preserve the subject's life. The supervisor also provided critical incident response team (CIRT) contact information to staff. The supervisor and ADW then attended the healthcare unit to debrief the nursing staff and provide CIRT information.

After the debriefing, correctional staff completed the required reports and records entries. As the centre's on-site manager, the ADW had immediately notified the acting warden of the incident, and provided him updates throughout its course.

Findings:

- Classification staff assessed the subject and the alleged assailant in accordance with Adult Custody Policy and the decision to house those inmates on the same living unit was appropriate.

- Staff's immediate response to the unusual sound and subsequent intervention s.15 prevented the alleged assailant from s.22

- Operations and health care staff responded to the respective emergency codes without delay, and they worked in an efficient, coordinated and professional manner to secure the unit and provide medical attention to the subject inmate.

- The officer who witnessed the assault was assigned to escort the alleged assailant to segregation and he had to be recalled to the unit to provide health care staff information about the cause of the subject's injuries.

- CW cell s.22 was immediately sealed and secured following the assault to protect evidence for investigative purposes.

- The alleged assailant was s.15, s.22 and medically assessed in accordance with policy.

- Over the course of the incident, different officers were assigned to document events. Their notes were undated and did not identify the scribe.

- Prior to the subject leaving the centre, correctional supervisors briefed the escort officers and performed all necessary security notifications s.15 in accordance with policy.

- The assistant deputy warden on shift notified the acting warden and provincial director immediately upon the onset of the incident and provided regular updates through its course in accordance with policy.

- Operations staff gathered information and completed reports in a timely manner post-incident.

- The health care contractor does not provide health care staff with clear direction regarding documentation requirements following an emergency or serious event. Not all nurses completed necessary reports and some were unaware of the requirements with respect to code blue incidents.

- The escort officers, supervisors and the ADW involved in the incident did not receive a debriefing.

- CW inmates were not advised of the availability of counselling following the incident. However, unit staff did monitor inmates for signs of stress/trauma post- incident.

Recommendations:

1. NFPC management should amend its standard operating procedure regarding scribes to ensure that notes are dated, times are accurate and identity of the scribe is legible.

2. The health care contractor should review with health care staff the documentation and reporting requirements for code blue incidents and other significant events.

3. The provincial director should ensure that in-house training at all correctional centres includes best practice information, developed in consultation with the director of health services, regarding s.22

4. NFPC management should review with all staff its standard operating procedure regarding code blue emergency responders to ensure that staff who first encounter an injured person remain at the scene to report their observations to medical staff.

5. NFPC management should ensure that all persons involved in an emergency, including supervisors and managers, receive a post-incident debriefing.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Inmate hostage taking by inmate s.22

Date of Incident:

June 9, 2012 at the Prince George Regional Correctional Centre

Review Team:

Evan Vike	Chair	Warden Kamloops Regional Correctional Centre
s.22	Member	Community Advisory Board Prince George Regional Correctional Centre
Maureen Olley	Member	Director of Mental Health Services Adult Custody Division
Robert Richard	Member	Assistant Deputy Warden Prince George Regional Correctional Centre
Diane Shepherd	Member	Director of Health Services Adult Custody Division
Marcia Marchenski	Participant/ Observer	Inspector Investigation and Standards Office

Review Dates:

June 13 to June 16, 2012 at the Prince George Regional Correctional Centre

Mandate and Scope of Review:

The assistant deputy minister requested that a critical incident review be conducted to examine the circumstances surrounding an inmate hostage taking at the Prince George Regional Correctional Centre, and to specifically address the following:

- Compliance with Adult Custody policies and procedures;
- Provision of emergency procedures and notifications; and
- Any other factors that may be relevant to the incident.

One of the potential consequences of any investigation is that findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in the review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at the Prince George Regional Correctional Centre.

An independent review by the Investigation and Standards Office of the Ministry of Justice was conducted concurrently with this investigation. A separate report may be submitted by that office.

Background:

On s.22 was admitted to Prince George Regional Correctional Centre (PGRCC) s.22

During the admission process the subject was interviewed by the classification officer (CO). The CO advised the review team that s.22

The CO reported that the subject was s.22 The inmate assessment (IA) document indicated that the subject was s.22 The IA also indicated that the subject was suitable for s.22

During the intake interview the CO observed the subject as being s.22 . Although the CO did not recall the particulars of the placement

decision, his practice would be to confer with both the mental health screener and nurse. No concerns related to contact with any of the other inmates on the s.22 unit, 4 West, were noted. It was noted that the subject s.22

The subject was also interviewed and assessed by the mental health screener (screener) on s.22 The screener informed the review team that her notes indicate the subject was s.22 The subject s.22 There was s.22 on hand to which the screener could refer. The screener's assessment did not reveal any major concerns. Her recommendation was to have the subject placed in the s.22 unit until s.22 could be reviewed by the s.22 she also referred the subject to s.22 The screener could not recall her conversation with the CO.

The intake nurse of s.22 advised the review team that the subject was s.22 . She identified the subject as s.22 and recalled that he was s.22 The intake assessment did not present any significant concerns. The nurse s.22 . The subject was seen by the on s.22 The s.22

As noted above, the subject was seen by s.22 During the review team's interview, the s.22 provided information from notes. s.22

On s.22 , the subject was noted s.22

The s.22 informed the review team that s.22 and had read the screener's assessment on s.22 the s.22 met

with the subject, s.22 The subject would not engage with the s.22 The subject, again, s.22 so the s.22 ended the meeting.

The s.22 told the review team that the s.22 team weekly meetings—the function being to review inmates with s.22 issues—had become less frequent. Since the subject's intake, his name never came up for discussion in these meetings. s.22 prior June 9, 2012, event. s.22

Shortly after midnight on s.22 the subject was placed on s.22 after s.22 Later that morning he was placed on s.22

On s.22 a code yellow was called. The subject and another inmate were s.22 , and the subject was s.22

On s.22 the subject s.22

On s.22 a code yellow was called. The subject s.15, s.22 He was placed in s.22 .

The s.22 who is also a unit officer on the s.22 unit, informed the review team that s.22

was surprised to hear about the subsequent events of June 9, 2012, as he had not observed any indication that there was an issue s.22 The s.22 further conveyed that the subject was doing well during the week leading up to the incident.

The s.22 unit officer of June 9, 2012 was interviewed by the review team. He relayed that the subject's behaviour was not remarkable that day; that he was quiet, calm and behaving well prior to the officer's rest break, at approximately 2200 hours.

The two unit relief officers were also interviewed. They recalled clearly the subject's behaviour on the evening of June 9, 2012. The first relief officer arrived in the s.22 unit at 2205 hours. While conducting his cell checks at s.15 hours the relief officer saw the subject laying on the mattress the subject had placed on the floor. After the cell checks were completed the officer returned to the subject's cell to inquire if everything was alright. The subject asked why the officer was watching him, and the relief officer informed the subject that he was merely doing his cell checks. Central Control (Control) informed the relief officer that the subject had pushed the cell call button; the relief officer subsequently questioned the subject regarding the subject's concerns. The subject s.22

The s.15 unit relief officer arrived at the s.22 unit at approximately 2230 hours and was informed by the former relief officer of the subject's concerns. She advised the review team that the unit was quiet for the first 10 minutes; then the subject started to s.22 The subject made no demands nor did he reference his cellmate. When the second relief officer was conducting cell checks she noted that the subject was at his door window and his cellmate was in the background sitting on his bed. The subject continued to s.22 for the duration of the relief officer's time in the unit.

The unit officer advised the review team that he returned from his break at approximately s.15 hours. He was surprised to hear from the relief officer that the subject had become agitated, and was s.22 The unit officer went to the subject's cell door to ascertain what the issue was. The subject was s.22 The unit officer explained that s.22 The subject continued to s.22 As the subject would not s.22 the unit officer called the acting correctional supervisor (supervisor). The supervisor arrived at the unit shortly after 2300 hours and talked to the subject for some time at the cell door window. He tried to s.22 but to no effect. The supervisor informed the unit officer that the subject was threatening his cellmate and that he was going to notify the on-call manager. That concluded the unit officer's direct involvement with the subject as he was reassigned to Control until the end of his shift at midnight. The supervisor informed him that s.15 had been called in to respond to the situation.

The supervisor conveyed to the review team that he clearly recalled the events leading up to the incident on June 9, 2012. When he was called to attend the MDO unit just after 2300 hours he observed the subject pacing in his cell, holding a pen in his hand, and threatening to kill his cellmate and anyone entering his

cell. The supervisor was unable to s.22 The subject informed the supervisor that it was a hostage situation and continued to

s.22

The cellmate informed the supervisor repeatedly that he needed to get out of the cell or the subject s.22 At 2356 hours the supervisor informed Control of the situation and asked for the on-call manager's phone number (the warden was the manager on call that night). The warden received the call at midnight and immediately s.15 to attend the centre. The supervisor informed s.15 of the situation.

The control officer told the review team that the supervisor informed her of the situation. She further noted that the warden called her at midnight, and directed her to: s.15 and inform him of the situation; call s.15 in; and provide the warden with the health care manager's phone number. The warden arrived at the centre at s.15 hours on June 10, 2012. At s.15 hours control was alerted that s.22 in the subject's cell had been broken.

The warden informed the review team that she recalled the supervisor calling her at home and informing her that the subject s.22 was s.22

With the information at hand, the warden considered the situation a cell extraction scenario rather than a hostage situation. She subsequently s.15 to be summoned to the centre.

When the warden arrived at the centre she was informed that the subject was s.22 and had been seen s.15, s.22 Upon receiving this new information, the warden called in both of her deputy wardens as they would be required if the scenario worsened and the crisis command centre needed to be activated. However, prior to the deputy wardens' arrival s.15 had completed the successful cell extraction of the subject. The warden noted that s.15

As the subject spent most of his time s.22 the warden assessed the situation as a cell extraction to isolate the subject, rather than a hostage situation. The warden called the Corrections Branch headquarters on-call phone number at 0124 hours. She was not aware that s.15 and as a result, she was not able to reach the headquarters contact. The warden did not pursue further contact attempts. s.15 was not called.

The health care manager (manager), s.22 informed the review team that the warden contacted her about the situation and the subject's s.22 The manager arrived at the centre at approximately s.15 hours to review the subject's medical file, determine if s.22 and assist with any resulting injuries. s.22
The manager informed the warden that that there was no on-call physician between 2300 and 1000 hours. The manager attended the s.22 unit on standby to treat any injuries resulting from the cell extraction. Once the subject was removed from the unit, the manager checked the cellmate who had sustained no injuries, s.22
The cellmate was s.15, s.22 The manager also assessed the subject in Segregation. Other than s.15, s.22 the subject had not sustained any injuries.

The s.15 advised the review team that he approached the situation as a cell extraction based on the information provided, including that the subject s.22 . The leader did not know about the subject's s.22 According to the leader, the warden was informed about the tactical plan including the use of s.15 At 0128 hours the extraction of the subject from his cell occurred without further incident. s.15 was deployed on the subject. Neither of the inmates was injured. The cellmate s.22 The leader learned about s.15 after the extraction was completed.

s.15 in the cell conveyed to the review team that s.15 was informed that the subject was threatening his cellmate s.22 Upon entering the subject's cell, s.15 observed the subject standing at the cell door s.22 and the cellmate was sitting on his bed. The subject was removed from the cell very quickly and the cellmate was secured in the cell. The subject was s.15, s.22 and placed in an Admission and Discharge holding cell.

During interviews with the subject and cellmate, the review team learned that the hostage taking was a complicit role play, concocted because s.22 The subject informed the review team that s.22 The subject also disclosed that some time prior to lock-up at s.15 on June 9, 2012, he s.22

The subject did not tell staff about his concerns regarding s.22 The subject asked two different officers to s.22

s.22 The inmate felt his request was not taken seriously. The subject was s.22

The subject's cellmate informed the review team that he and the subject were not having problems, nor was he a hostage; rather he was helping the subject to s.22 The subject informed the cellmate around 2330 hours that s.22 after which the cellmate placed his belongings in a plastic bag so they would not get wet, as he assumed the subject would s.15, s.22 The cellmate reported that at no time did he feel threatened or afraid.

On June 10, 2012, a nurse on dayshift assessed the subject for injuries and completed the required form; however, she did not document her findings in the Primary Assessment and Care inmate health information system (PAC).

Findings:

- The classification officer conducted an interview with the subject as per PGRCC standard operating procedure (SOP) and the Adult Custody Policy (ACP).

- The subject was interviewed by the mental health screener as per the ACD Health Care Services Manual (HCSM) policy. The mental health screener also completed the Jail Screening Assessment Tool (JSAT).

- The subject was interviewed by the intake nurse as per PGRCC SOP and the ACD HCSM policy.

- No risks related to the subject's placement in the s.22 unit were identified. The classification officer appropriately assigned the subject to that unit.

- The interviews and assessments by the classification officer, mental health screener, intake nurse, and s.22 did not identify any signs of the subject being s.22 Th s.22 and was not involved with the subject during this incarceration.

- The last CORNET Client Log entry made prior to the event was on June 4, 2012, contrary to ACP and PGRCC SOP, which requires client log entries to be made every s.15 days.

- The event occurred while the inmate population was locked down for the night.

- The supervisor was concerned that the subject might hurt his cellmate so the supervisor tried to settle the subject down. The subject

- The subject informed the supervisor that the event was a hostage situation and the subject wanted his demands met.

- The correctional supervisor notified the centre's on-call manager (the warden in this case) of the situation by telephone as per PGRCC SOP.

- The warden's final assessment was that the event was as an inmate extraction situation rather than a hostage situation. Therefore, the crisis command centre was not activated s.15 .

- s.15 were summoned to the centre to plan and execute a cell extraction. s.15 was tactically used on the subject. s.15 did not follow the inmate warning protocol as per ACP because s.15

- The warden phoned the provincial on-call contact number but was not able to connect. Further contact attempts were not made.

- All staff directly involved in the incident submitted the required reports.

- The subject and his cellmate were s.15 as per ACP and PGRCC SOP.

- The health care manager was available to treat any resulting injures, however, none occurred. The health care manager was not aware that the provincial on-call physician was available throughout the night.

- As per interviews of the subject and his cellmate, the event was a complicit role play by both in an attempt to s.15, s.22

Recommendations:

1. PGRCC management should review standard operating procedures regarding contingency planning specifically pertaining to dealing with hostage situations, including process and expectations and related notification requirements, to ensure conformity with provincial policy.

2. The health care contractor should ensure that medical staff has information on the roles, responsibilities, hours of availability and contact information for the provincial on-call physician.

3. PGRCC management should consider holding regular s.22 team meetings including, at minimum, the s.22 assistant deputy warden of programs and the health care manager to promote effective communication and enhance inmate s.22 care.

4. The health care contractor should ensure all new and existing staff are made aware of the requirement to document their actions in the Primary Assessment and Care (PAC) system at all times.

CORRECTIONS BRANCH

and

COURT SERVICES BRANCH

Critical Incident Review

Subject:

Death of Inmate – s.22

Date of Incident:

September 21, 2011 – Prince George Regional Correctional Centre
Pronounced dead at s.22

Review Team:

John Pastorek, Chair	*Warden,* *North Fraser Pretrial Centre*
Rob Allison, Member	*Assistant Deputy Warden* *Prince George Regional Correctional Centre*
s.22 , Member	*Community Advisory Board,* *Prince George Regional Correctional Centre*
Al Rosa, Member	*Inspector,* *Sheriff Services*
Dr. Paul Beckett, Member	*Medical Director,* *Corrections Branch*
Jim Shalkowsky, Participant/Observer	*Deputy Director,* *Investigation & Standards Office*

Review Dates: September 26, 27, 28 & 29, 2011 at Prince George Regional Correctional Centre.

Mandate and Scope of Review:

On September 23, 2011 the assistant deputy minister, Corrections Branch and the assistant deputy minister, Court Services Branch requested that a critical incident review be conducted jointly to investigate the circumstances surrounding the death of an inmate which occurred at the s.22 s.22 while he was in the custody of Prince George Regional Correctional Centre (PGRCC). Specifically, the following was to be investigated:

- Compliance with Adult Custody and Court Services policies and procedures;
- The provision of emergency procedures; and,
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at PGRCC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The Prince George RCMP were contacted prior to the commencement of the review to ensure it would not compromise any investigation that department may have been conducting. Clearance was granted and the review proceeded.

Background:

Prince George Regional Correctional Centre (PGRCC) admitted inmate s.22 (hereafter "the subject") into custody on s.22

charged with s.22
He had s.22

s.22

The subject s.22 /

On the evening of s.22 the subject s.22 s.22 He was transported to PGRCC and admitted at s.22 hours the following day.

s.22

During the s.22 intake process the subject s.22 classified as a s.22 inmate and s.22

Staff report that the records department was very busy during the evening of s.22 as several new intakes were admitted. There were delays in the admission process and the subject had to wait in a holding cell for some time prior to being assessed by the intake nurse. While in the holding cell, the subject s.22 he was witnessed s.22 and, when it was his turn to be assessed by the nurse, had to be prompted several times before proceeding with that assessment.

The intake nurse did assess the subject and was concerned that he s.22 Based on the subject's presenting behaviour and the fact that s.22 corrections staff were concerned that the subject s.22 A decision was made to s.15 . Given this information, the intake nurse, classification officer and the operational supervisor discussed placement options and decided to place the subject in the health care unit where he may be more closely monitored, and have less contact with other inmates. One other inmate was assigned to this area.

As it was getting late in the evening, the intake nurse left a note for the day shift nurse to follow up on s.22 after discussing the issue with the on-call doctor. s.22 protocol was s.22 to the s.22 RCMP later in the day on s.22 as the subject was being transported there for a court appearance.

No concerns were noted overnight, and at 0910 hours on the morning of s.22 the subject was transferred to the sheriff's custody for transport to a court appearance in s.22 He was received at the s.22 RCMP lock-up at s.22 hours. While in the care of the RCMP, the subject received no visitors other than his lawyer. The subject consented to remain in custody and did not leave the s.22 RCMP lock-up. His lawyer appeared for him in s.22 Court.

At the time of transfer back to PGRCC on s.22 at 1203 hours, the jail guard at the s.22 RCMP cells informed the escorting sheriff staff that the subject had s.22 while in their care and had s.22 The subject was reluctant to return to PGRCC s.22 The escorting sheriffs were able to convince him to get into the escort vehicle and advised him that they would relay his concerns to corrections staff. He was closely observed on a digital video recording (DVR) camera during the return trip and no issues were noted.

The sheriffs verbally reported to corrections staff that the subject had had some earlier medical issues in lock-up but that he was fine on the trip back. A yellow sticky note that had been passed from the RCMP jail staff highlighting his medical issues was affixed to the sheriff's prisoner receipt travel document (s.15, s.22 and handed to corrections staff on the subject's return. A corrections staff member acknowledged receiving it, but did not retain it. He stated that he knew that the subject would be seen by the nurse s.22 As the subject was sent to s.22 on the morning of s.22 before s.22 This record, while used primarily to s.22 is also useful for outside agencies to document medical information while the inmate is in their care.

At 1654 hours on s.22 the subject was escorted into the centre along with another inmate, was frisked, and placed alone in a s.22 holding cell in the admissions area. The person who was accompanying him was identified as another s.22 inmate, as documented in the sheriff's records. When corrections staff attempted to place him in the s.22 cell with the subject, he

objected and the corrections officer placed him in a s.22 holding cell seemingly without checking further.

The correctional officer supervising the admissions area made frequent checks of the holding cell, including distributing bagged meals, and noticed nothing amiss.

At 1728 hours, five othe s.22 inmates were placed in the holding cell with the subject. At 1753 hours, staff responded to banging in the cell as the inmates in the area were attempting to summon assistance. The subject was removed from the holding cell, and sat down on the floor with his back to the wall. He was observed to be s.22 The intake nurse who was in the immediate area was summoned and a code blue was initiated. Central control called the code blue on portable radio but did not announce the code on the public address system. Correctional staff who were carrying radios responded immediately.

The correctional supervisor took charge of the incident and attempted to engage the subject in conversation and asked if the subject s.22 The subject responded s.22

The s.15 health care staff did not respond immediately because s.15 Staff were able to summon her s.15 a short time later.

The intake nurse requested that an ambulance be called which was relayed to control staff. She s.22 The subject s.22 and staff assisted him to a vacant holding cell directly across from where he was sitting. As he reached the door he s.22

At 1813 hours emergency responders from the fire department arrived on-site (within four minutes of being called) just as the subject s.22

At 1826 hours, the first of two ambulances arrived on the scene (seventeen minutes after the emergency call was made). A second s.22 unit arrived on scene at 1834 hours (twenty five minutes after the initial call). s.22 and the subject was transported to s.22

at 1907 hours. s.22 . The subject was treated s.22 at the hospital but was pronounced dead at 1925 hours.

Findings:

- The subject was classified appropriately to the health care unit on intake to better monitor his health issues and to limit his contact with others. No CORNET Client Log entry was made by correctional staff, indicating that there were some suspicions that s.22

- A Health Information (HEIN) report was completed by the intake nurse but contained some inaccuracies.

- As the subject was sent to s.22 s.22 an s.15, s.22 form (s.22) did not accompany him. This record, s.15, s.22 is also useful for outside agencies to document medical information while the inmate is in their care.

- Staff reports and DVR records indicate that the subject appeared fine on re-admission to PGRCC at s.22 hours on s.22 .

- The correctional officer supervising the admissions area placed an inmate that sheriff's had indicated as being classified to s.22 into a general population holding cell seemingly based on the inmate's account and objection.

- VISEN alerts utilized by the sheriffs and police and correction's alerts entered on CORNET are not always consistent and there does not appear to be a common practice in reconciling the information.

- A code blue was initiated in a timely manner and announced via portable radio but was not also enunciated on the public address system which is contrary to PGRCC SOP's. Corrections staff responded appropriately. The s.15 health care staff did not know of the code immediately as s.15

- The operations correctional supervisor and one correctional officer took charge of the situation and managed the incident very well. Other responding staff who were interviewed echoed this observation.

- The health care staff who attended the code blue response appeared uncertain about what to do and did not maintain presence with the subject for the duration of the incident.

- One of the responding health care staff self-reported during an interview that she had not completed all the sections of her staff orientation prior to assuming full duties.
- The responding health care staff did not enter information concerning the medical encounter into the Primary Assessment and Care (PAC) inmate health information system in a timely manner following the incident.

- Resuscitation efforts by the emergency responders were sustained and appropriate. The fire department arrived within four minutes of being summoned. The BC Ambulance Service arrived on scene in seventeen minutes.

- Correctional escort staff at the hospital were directed to return to the centre before the coroner arrived on scene.

- All notification as required by adult custody policy occurred in an appropriate and timely manner with the exception that the centre's chaplain notified the next of kin in s.22 without consulting with the local police as required in policy.

- The subject's medical file was seized by correctional centre management following the incident in an effort to preserve evidence. There are no clear policy directives with respect to this practice.

- The centre utilized a critical incident response team (CIRT) in a timely manner to deal with affected staff and provided support to those inmates who shared the holding cell with the subject.

- The centre did a thorough and complete investigation in consultation with the RCMP following the incident. They were able to determine that s.15

- Based on the evidence presented at the time of the review, the subject's death is quite likely attributable to s.22 however, the s.22 was not available.

- Based on the presenting symptoms s.22) and the subject's admission to responding staff, it is most likely that s.22

- The actions of the operations correctional supervisor and a correctional officer in responding to and handling this incident are open to review by PGRCC management for consideration of formal recognition of their performance.

Recommendations:

1. PGRCC management should remind staff to record pertinent, relevant information involving inmates in their respective CORNET Client Log.

2. The Corrections Branch should consider developing policy requiring mandatory referral and follow up by medical staff when s.22 are indicated. Awareness posters highlighting the potential dangers of s.22 could be displayed in inmate admission areas.

3. The health care contractor should review its protocol and expectations with its staff around the timeliness of s.22 and procedures around the use of the Court s.22 Record, as a consistent means of sharing medical information between responsible agencies.

4. PGRCC management should review its practices around the management of new intakes with respect to ensuring decisions regarding classification status (s.22 are made at the appropriate level.

5. Corrections Branch management and Court Services Branch management should consider reviewing the process whereby security information (VISEN and CORNET alerts) is updated and shared between the agencies.

6. PGRCC management should ensure that control staff announce code blues in accordance to local SOP's. PGRCC management should also ensure that all health care staff that are designated responders be issued and carry a s.15

7. The health care contractor should ensure that all of their staff are well versed in the management of code blue situations and develop protocols for responders that detail expectations around the assessment, taking charge of, and managing the code scene. Further, the health care contractor should establish procedures for conducting regular drills of codes and include scenarios for recognizing and treating s.22

8. The health care contractor should remind their staff to complete a detailed electronic medical record encounter in PAC following a code blue response on the same business day of the incident.

9. The health care contractor in consultation with the Corrections Branch should develop a checklist of topics to be covered during the orientation period and ensure that the orientation of new staff is complete before commencing full duties.

10. The Corrections Branch should consider its position and develop policy as necessary with respect to ongoing supervision of an inmate once death has been pronounced in a hospital setting pending the arrival and release to the coroner.

11. PGRCC management should remind the centre's chaplains of the need to consult with police before notifying the next of kin as defined in adult custody policy.

12. The Corrections Branch in consultation with the health care contractor should develop procedures for securing medical file information, both electronic and paper, following a critical incident pending a review.

CORRECTIONS BRANCH

Critical Incident Review

SUBJECT: Death of Inmate

s.22

DATE OF INCIDENT: January 21, 2010

Surrey Pretrial Services Centre, Living Unit D1

s.22 at s.22

February 1, 2010

REVIEW TEAM: Dina Green, Chair

Warden, Vancouver Island Regional Correctional Centre

Janet Ross, Member

Assistant Deputy Warden, Surrey Pretrial Services Centre

s.22 Member

Community Advisory Board, Surrey Pretrial Services Centre

Lynette Pineau, Participant/Observer

Inspector, Investigation and Standards Office

Dr. Maureen Olley, Member

Mental Health Director, Corrections Branch

REVIEW DATES: February 3 - 12, 2010

Surrey Pretrial Services Centre

MANDATE AND SCOPE OF REVIEW:

On February 2, 2010 the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the death of an inmate at s.22 as a result of s.22 while at Surrey Pretrial Services Centre (SPSC), and to address the following:

- Compliance with Adult Custody policy and procedures;
- Adequacy of response including health care response; and
- All other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the Public Service Act. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at SPSC.

An independent review by the Investigation and Standards Office of the Ministry of Public Safety and Solicitor General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The team was directed to report their findings and recommendations to the provincial director, Adult Custody Division by February 23, 2010. An extension was subsequently requested and granted, to February 26, 2010.

Prior to the commencement of the review the Surrey RCMP was contacted to ensure this review would not compromise any investigation that department may have been conducting. Clearance was granted and the review proceeded.

BACKGROUND:

On s.22 (the subject) was admitted to SPSC s.22 SPSC is a 286 bed secure remand facility housing both male and female inmates awaiting trial, individuals on immigration holds, as well as some sentenced females.
The subject was s.22

The subject s.22 The subject had the last court appearance being s.22

File information indicates that following her arrest on s.22 the subject was admitted to s.22 and was released to SPSC on s.22 and assessed by the intake nurse. Upon admittance, she was placed in a cell on s.22 , without a roommate. She was then seen by a mental health screener and centre physician on s.22 and by the

s.22

A few months later the subject was moved to Living Unit D1 (LUD1), s.22 While on LUD1 unit she had regular access to programs, visits and recreational activities. File entries indicate her behaviour was acceptable overall;

s.22

On the morning of s.22 , the subject attended s.22 adjacent to LUD1 (commonly referred to as the s.22 In this case the subject

s.22

She was

s.22

When an inmate is placed on the s.22

Part of the procedure for s.22 is regular review and follow up. The saw the subject on the initial day of s.22 , and was scheduled to see her again on s.22 the day after s.22 In the meantime s.22

Procedures regarding s.22 are outlined in the Adult Custody Division's (ACD) policy. As part of the s.22 and until the

s.22

Additionally, policy requires the inmate to s.22

s.22

. The staff are then to complete a s.22
From here the inmates are to be s.22
by custody staff to s.22

While supervision s.22 does occur, it became apparent during interviews that this policy is not consistently followed at the centre, with either the male or female inmate population by correctional or health care staff. This is in part due to the physical limitations of the centre, as well as staffing requirements and daily operational routines.

Following her attendance at the s.22 on the morning of January 21st, the subject returned to LUD1 where, for the next four hours, closed-circuit television (CCTV) footage shows she kept busy on the unit, s.22
She went to her cell at approximately 1128 hours where she remained until she was transported to hospital later that evening.

The inmates on LUD1 were then locked up from s.15 hours to accommodate staff training. At s.15 hours they were unlocked and were able to move about the unit. At approximately 1630 hours the inmates received their supper meal. CCTV footage shows the subject's roommate taking two meal trays into the subject's cell. The subject's roommate, however, was unable to recall whether the subject ate her meal; nor did staff recall seeing the subject's meal tray or notice whether or not the subject ate her meal that evening.

It is not clear what the subject did during the time in her cell, as there is no camera coverage inside living unit cells. Her roommate recalls the subject sleeping a lot that day and did not notice anything unusual until she attempted to wake the subject up in the evening. Inmates reported she watched television and slept; one of the unit officers relates she saw the subject upright but could not recall what time that was, other than it was in the afternoon. Another officer reports that when she entered the cell at approximately 1600 hours to speak to the subject's roommate, she saw the subject sleeping and heard her "snoring". The officer indicated she specifically recalled the subject's colour at that time was "normal" because she looked directly at her while discussing the "snoring" issue with her roommate.

Between s.15 hours the inmates were locked in their cells once again to accommodate another inmate who s.22 . At approximately s.15 hours, CCTV footage shows the unit officer going from cell to cell

unlocking the cells, and looking briefly into the subject's cell. When questioned, the unit officer indicated she did not notice anything unusual during her routine checks of the unit or of the subject's cell; that the subject appeared to be sleeping. Between s.15 and s.15 hours the required unit checks were conducted by staff as per local centre standing orders and ACD policy.

Upon unlock, the subject's roommate is seen via CCTV footage to come and go out of the cell a number of times. At approximately 1920 hours, it appears the inmates on LUD1 were called to attend the s.22 at the s.22 CCTV footage shows inmates began to move about the unit. At approximately 1922 hours the subject's roommate, who was standing at the door of her cell, reports she called to another inmate to attend the cell. The second inmate is seen to enter the subject's cell. That inmate described s.22 and that she shook the subject to rouse her, but to no avail. CCTV footage shows the roommate then calls to the unit officer; the officer is seen to attend and enter the cell at approximately 1923 hours; within a few seconds the officer calls a Code Blue and orders the inmates on the unit to lock up. The subject's roommate remained outside of the cell. At 1924 hours the centre's code responders arrive, attend the subject's cell and begin usual procedures to lock down the inmates and secure the unit.

Within one minute of the Code Blue being called s.15 health care personnel arrive with s.15 and enter the subject's cell. The registered nurse (RN) reported the subject was s.22 The RN reported the subject was unresponsive, s.22 The RN immediately directed an ambulance be called, directed the licensed practical nurse (LPN) to s.22

the subject. These s.15 health care staff report that within three minutes the subject's vitals returned to normal and s.22 She began breathing on her own, but s.22 The RN asked the subject questions in an attempt to find out what had happened to the subject, but received no response. She continued to check the subject elsewhere on her body for signs of causal factors but found nothing. CCTV footage then shows three fire rescue personnel arrive at approximately 1935 hours and proceed to the subject's cell. The RN then s.22 Health care staff report the firemen then s.22 These first responders did not assist the inmate with s.22

CCTV footage shows ambulatory staff arrive at approximately 1947 hours with a stretcher, followed by the s.22 paramedics at 1953 hours. At

approximately 1955 hours the subject is placed on a gurney and moved to the common area of the unit where she is seen making small movements on her own. Paramedics continue to monitor and tend to the subject. The subject is then moved off the unit at 2001 hours. All emergency personnel and most staff leave the unit at that time.

s.15 assigned to accompany the subject to the hospital, where s.15 remained until s.15 relieved of s.15 duties the next morning. Escort documentation was properly completed as per policy.

Following her removal from the unit, the subject's cell was searched. Except for some s.22 belonging to the subject's roommate, nothing of significance was found. Although a unit search was not completed, other required procedures following a critical incident were followed, with staff completing incident reports, and appropriate notifications made.

Subsequent to the subject's removal from the unit, inmates were interviewed by centre staff and again by the review team as part of the review in an attempt to determine the cause of the subject's distress. Information gathered from those interviews revealed

s.22

(Note: s.22

s.22

The subject s.22

(Note: At the timing of this report and as a result of this incident, SPSC has initiated a review of its practices regarding the supervision and monitoring of s.22 s.22)

FINDINGS:

- The subject was in custody s.22 She had stated s.22
- The subject s.22
- s.22
- Medical records reveal she s.22
- The subject s.22
- Placing the subject on s.22 was a s.22 to avoid having the subject s.22
- The subject s.22 .
- There are inherent risks in someone s.22
- There was no documentation on the Primary Assessment and Care electronic charting system indicating that s.22 s.22
- It appears there are inconsistencies in the manner in which supervision of s.22 and s.22 occurs, by both staff and health care personnel.
- Inconsistent or lack of full supervision provides an opportunity for inmates to s.15, s.22
- The subject was s.22
- On the morning of her distress the subject s.22
- It is not known whether the s.22 had anything to do with the subject's distress. This will likely not be known until the s.22 is completed.
- The subject remained in her cell following lock up at s.15 hours and was not seen again out of her cell until the paramedics rolled her out to the common area on the gurney.

- Centre staff did not notice anything unusual with the subject's behaviour during the time she was in her cell.
- Unit staff completed unit checks as per Adult Custody Division policy.
- Code response by centre and health care staff was timely and appropriate.
- A search of the subject's cell was completed upon her removal from the unit. Nothing of significance related to the subject's distress was found.
- A full unit search was not conducted.
- The review team was unable to determine precisely when the subject went into distress.
- The subject s.22

RECOMMENDATIONS:

1. Adult Custody Division management should review the process of monitoring both s.22 and s.22 for male and female inmates with a view to enforcing or altering current supervision practices as appropriate.

2. SPSC management should ensure full unit searches are completed following any significant incident to minimize potential for inmates to be at further risk.

3. The health care contractor should remind health care staff of the need for careful review of s.22 and proper documentation of s.22

4. Given the s.15, s.22 by inmates, the s.15 Corrections Branch should conduct a review to determine if there is an alternative s.22

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Inmate injury

Date of Incident:

August 15, 2011 at Surrey Pretrial Services Centre

Review Team:

Shane McGrath - Chair	Deputy Warden, Kamloops Regional Correctional Centre
Bill Palmer - Member	Assistant Deputy Warden, Surrey Pretrial Services Centre
s.22 - Member	Chair, Community Advisory Board
Jim Shalkowsky - Participant/ Observer	Deputy Director, Investigation and Standards Office

Review Dates:

August 22, 2011 to August 23, 2011, at Surrey Pretrial Services Centre

Mandate and Scope of Review:

On August 18, 2011, the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the injury of an inmate while secured in his cell at Surrey Pretrial Services Centre (SPSC) and to address the following;

- Compliance with Adult Custody policies and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at SPSC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

Background:

At SPSC on Monday, August 15, 2011 at 1528 a living unit officer and correctional supervisor secured living unit J inmates in their cells and left the unit for a coffee break. At 1537, control staff received a cell call from cell # s.22 in living unit J, an upper tier cell. s.15 officers were dispatched to investigate, s.15 entering the unit at 1538. They heard an inmate (the cell mate) calling from cell s.22 to the effect; s.22 . As they approached the cell the cell mate stated s.22 . The officers observed the cell mate standing by the door, and a second inmate (the subject) s.22 They accessed the cell and directed the cell mate to step out onto the tier and to stand by a window a short distance away.

The s.15 officer entered the cell and noted that the subject s.22 s.22 The officer initiated a code blue s.15 and stood by. A supervisor and approximately s.15 staff responded within s.15 The assistant deputy warden on shift (ADW) did not attend the unit.

Health care responders arrived on the unit at s.15 and began treating the subject. At 1546 an ambulance was called. The fire truck arrived at the centre at 1553 with the crew entering the unit at 1556. Two ambulances arrived at 1557 and 1558 respectively. The ambulance paramedics entered the unit at 1602 and removed the subject in a stretcher at 1630. The code blue was stood down at 1645. The subject was unconscious when he left the centre, and, s.22

The cell mate made several statements to staff while waiting on tier during the code blue. He stated that s.22 He further stated that s.22

At 1550 the correctional supervisor in charge of the code blue called the ADW on shift and was directed to treat cell s.22 as a potential crime scene. At 1551 the cell mate was placed in cell# s.22 with another inmate. At 1546 the meal cart was delivered to the unit. At 1555 the CS decided to release two inmates so they could start delivering meals to the secured unit. When queried regarding letting the inmates out of their cells, he stated that the unit was cooperative at that time, and he felt it prudent to feed them in case they became disruptive.

The incident was reported to the RCMP who obtained a warrant and attended the centre to investigate on August 17, 2011. A correctional supervisor conducted an internal investigation and interviewed every inmate on the unit. The investigation was inconclusive in determining how the subject was injured.

The subject is s.22 He was admitted to SPSC on s.22 A health assessment report completed on admission recorded that he was fit for all activities and work, with no physical or mental limitations, and no special housing required.

Findings:

- While the information on the uninjured inmate's inmate assessment contained s.22 there was no reason not to double bunk the two.
- The injured inmate had no medical condition noted on his medical file that precluded his placement s.22
- There was no indication of tensions or issues between the roommates in the period immediately before being secured in their cells, or during their morning on work crews.
- The officer who conducted the count and cell check after the inmates were secured did not look into each inmate's cell.
- Contrary to Adult Custody policy, responding officers did not s.15

- Neither of the two officers who discovered the injured inmate had current first aid training.

- The uninjured roommate was allowed relative freedom of movement and communication on tier for 13 minutes during the code blue.

- The uninjured inmate was s.15, s.22 and placed into a cell with another inmate s.22

- A count and cell check logged at s.15 could not be observed on the CCTV recording.

- Completion of an incident report and headquarters notification were deferred to the next day despite s.15, s.22

- Two inmates were released to tier while the code blue was in progress and emergency personnel and equipment were on the unit.

- None of the responders interviewed were offered CIRT debriefing after the incident.

- The unit log was not maintained in accordance with SPSC standard operating procedures (SOP) during the incident.

Recommendations:

1. SPSC management should review with all supervisors and acting supervisors their SOP governing code blue responses, particularly as they relate to inmate movements.

2. SPSC management should remind staff of policies surrounding counts, cell checks, and log book maintenance.

3. SPSC management should review incident notification requirements with all managers as detailed in adult custody policy.

4. SPSC management should provide training in evidence protection and safety to ADWs and supervisors.

5. The provincial director should reconcile the adult custody policy requirement for life preserving interventions with staff first aid training.

CORRECTIONS BRANCH
Critical Incident Review

Subject: Inmate Assault

s.22

Date of Incident:

August 15, 2012 at Surrey Pretrial Services Centre

Review Team:

Scott Vallance	Chair	Deputy Warden, Nanaimo Correctional Centre
Joyce Oates	Member	Assistant Deputy Warden, Surrey Pretrial Services Centre
s.22	Member	Member, Community Advisory Board, Surrey Pretrial Services Centre
Dr. Maureen Olley	Consultant	Director, Mental Health Services Corrections Branch
Diane Shepherd	Consultant	Director, Health Services Corrections Branch
Deanna Jung	Observer/ Participant	Inspector, Investigation and Standards Office

Review Dates: August 21, 22, 23, 24 and 28, 2012 at Surrey Pretrial Services Centre

Mandate and Scope of Review:

The assistant deputy minister requested that a critical incident review be conducted to examine the circumstances surrounding an inmate on inmate assault at Surrey Pretrial Services Centre and to specifically address the following:

- Compliance with Adult Custody policies and procedures;
- The provision of emergency procedures and notifications; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at Surrey Pretrial Services Centre.

An independent review by the Investigation and Standards Office of the Ministry of Justice was conducted concurrently with this investigation. A separate report may be submitted by that office.

The Surrey RCMP was contacted prior to the commencement of the review to ensure it would not compromise their investigation. Clearance was granted and the review proceeded.

Background:

Subject

Inmate s.22 (hereafter "the subject"), was admitted to Surrey Pretrial Services Centre (SPSC) on s.22 for charges of s.22

He was assessed by a classification officer and a mental health screener. It was observed that he s.22 but he stated during the interview that he s.22 Consequently, an s.22 was not added to the subject's file during this s.22 classification process.

s.22

There were no medical, institutional or mental health problems documented during this admission process. There were no noted contact concerns s.22 The alleged assailants specifically were not noted as contact concerns (but were added as such after the assault).

It was noted that s.22 the subject was s.22 However, because of the subject's s.22 he was given general population status and classified to Living Unit J (LUJ) which was regarded as a s.22

From s.22 while resident in unit LUJ, the subject was vocal with other inmates about s.22 Unit staff did not record this information, and placement of the subject was not reviewed in light of this prior to the incident. During the incident investigation, alert and contact concerns s.22 were added to the subject's file on August 20, 2012.

Alleged Assailant #1

s.22 (hereafter "alleged assailant #1") was admitted to SPSC on s.22 charged with s.22

He was assessed by classification and a mental health screener where it was reported he had no medical, institutional, or mental health problems. s.22 He claimed he s.22 The mental health coordinator assessed him the following day. He was initially assigned to but reassigned to LUJ following s.22

Alleged Assailant #2

s.22 (hereafter "alleged assailant #2") was admitted to SPSC on s.22 charged with s.22

He was assessed on s.22 by classification and a mental health screener where it was reported in the Inmate Assessment that he had no medical,

institutional or mental health problems. s.22 There was no indication that he s.22 and he was classified to general population status. A summary in the Primary Assessment and Care (PAC) inmate health information system indicates that s.22 He was s.22

Incident

A review of digital video recordings (DVR) revealed that on August 14, 2012 at 2137 hours alleged assailant #1 s.15 in LUJ. At 2141 hours he s.15 Staff are not observed searching s.15 during the evening shift of August 14, 2012.

On August 15, 2012 at 0724 hours the LUJ unit officer was supervising breakfast on the unit, checking his scheduled court movements and getting inmates ready for medication. A review of DVR footage revealed that on August 15, 2012 alleged assailant #2 and alleged assailant #1 each s.15 . Alleged assailant #2 is then seen entering the subject's cell (cell s.22) at 0724 hours. Alleged assailant #1 was sitting at the table closest to cell s.22 and at 0724 hours he too went into cell s.22 with s.15 and closed the door locking them in the cell.

The prowl officer entered the unit at 0726 hours and asked the unit officer to find an inmate for s.22 At the same time the unit officer was radioed to respond to a call button from cell s.22 . The unit officer and the prowl officer noted that someone was s.22 The unit officer attended the cell and looked through the cell window observing the two alleged assailants standing inside the door appearing anxious.

The unit officer unlocked the cell at 0726 hours allowing both alleged assailants to exit the cell. The unit officer stepped into the cell and observed s.22 The subject did not respond when the unit officer called out to him. The unit officer immediately returned to the common area of the unit and ordered the two alleged assailants to sit down in the common seating area, directed the other inmates in the unit to lock up, and asked the prowl officer to assist. The prowl officer s.15 call the correctional supervisor (CS) for assistance and then started locking the inmates in their cells.

The subject's cellmate returned to cell s.22 at 0727 hours, responding to the direction to lockup. The unit officer observed this and returned to cell s.22 to direct the cell mate to sit outside the cell. The unit officer again called to the subject, s.22 The unit officer observed s.22

The unit officer asked the subject if he was "OK", s.22

The CS responding to the s.15 call for assistance entered the unit at s.15 hours and was briefed by the unit officer. The CS viewed the subject's cell from the cell doorway and observed the subject lying on the top bunk. She asked him what happened and the subject s.22 The CS observed s.22 making a mental note that the subject s.22 The CS did not make any further assessment as she was aware that the licensed practical nurse (LPN) was just down the hall. She asked the prowl officer to call the LPN for assistance. The prowl officer returned to the unit desk and phoned the LPN and asked her to attend the unit. The prowl officer then contacted the health care officer requesting additional assistance and s.22 to be brought to the unit.

The assistant deputy warden (ADW) entered the unit at s.15 hours s.15 to the unit officer s.15 call for assistance and was briefed by the unit officer that an assault had occurred and additional staff were on the unit. The ADW directed that the two suspected assailants be moved to segregation. The ADW viewed the subject's cell from the cell doorway and noted s.22

The LPN also entered the subject's cell at s.15 hours, climbed on a chair to assess the subject on the top bunk, and determined the subject had s.22 The CS asked the LPN if she wanted a code blue called and the LPN confirmed "yes". The CS directed the unit officer to call a code blue. The code blue responders were in the elevator en-route to the unit when the code blue was announced. The code blue responders arrived on the unit at s.15 hours.

When the code blue responders arrived at the subject's cell, the subject was still lying on the top bunk. The subject s.22 The charge nurse noted there was a s.22

The charge nurse observed that the subject s.22 She determined that s.22 further assessment was not effective while the subject was in the top bunk. The subject was moved to the cell floor under direction of the charge nurse with assistance from correctional staff and the code blue responders by lifting the subject with his bed blanket. s.22 Once on the floor,

s.22

The centre physician was on duty in Health Care at the time of the incident and attended the unit at 0737 hours and assessed the subject. He noted the subject s.22 The doctor was satisfied with the response and actions of the first responders and stood by on the unit for further assistance if needed.

Surrey Fire Rescue arrived on the unit at 0748 hours. The rescue personnel delayed immediate treatment in the subject's cell due to s.22 treatment was initiated. Paramedics arrived at 0749 hours and began their treatment immediately. The subject was transported to s.22 Hospital via ambulance at 0816 hours.

During the escort to the hospital the subject s.22

Critical Incident Response Team (CIRT) debriefing was offered to correctional officers directly involved with this incident but they all declined. CIRT was not offered to nursing staff involved with this incident.

The unit remained locked down while the staff secured the scene. Staff observed s.15 in the subject's cell s.15 RCMP conducted an investigation on LUJ on August 15, 2012. The unit was unlocked and returned to regular routine at approximately 2030 hours.

Findings:

- s.22 alert and contact concerns were not added to the subject's file upon admission on s.22 .
- s.22 alert and contact concerns with s.22 were added to the subject's alert screen on August 20, 2012.
- The placement of the subject was not reviewed after living unit staff overheard him tell other inmates on LUJ that s.22

- SPSC standard operating procedure (SOP) for Internal Placement was reviewed and found to be out of date with current practices.

- SPSC SOP for Classification of Inmates to Living Units was reviewed and found to be out of date with current practices.

- At the time of the assault there were s.15, s.22 inmates living in LUJ that had contact concerns in general with s.15, s.22 on their alert screens. None of these s.15, s.22 inmates included the alleged assailants.

- SPSC SOP and e-mail memoranda direct staff to s.15 ; this was not completed on s.22

- A code yellow was not called for this assault.

- A code blue was not called in a timely manner until four minutes and 20 seconds after staff first observed possible injuries.

- Notification to the warden and to the provincial director was completed within policy timelines.

- The correctional officer called Health Care and requested the nurses to attend the unit; and a code blue was called when the nurses were part way to the unit. The nurse reported that they had all necessary code blue equipment with them.

- The subject was moved from the top bunk to the floor of the cell using a blanket. s.22

- s.15 nurses attended the unit, and only one nurse documented the incident in PAC. All three nurses documented the incident on a "Staff Incident Report" form and the forms were submitted to the health care manager.

- As part of the critical incident review process, a review of inmate medical files was conducted by the director, Health Services and the director, Mental Health Services. Both of the alleged assailants s.22

- CIRT was offered to correctional officers directly involved in this incident.

- CIRT was not offered to the nursing staff involved in this incident.

Recommendations:

1. SPSC management should review and update the SOPs for classification and internal placement, ensuring the requirement to note s.22 and contacts concerns upon admission, and review classification and placement in light of new information received following initial admission.

2. SPSC management should remind staff of the requirement to frisk and search common areas.

3. The health care contractor should review the standardization of documentation in PAC following a code blue.

4. The provincial director should ensure that in-house training at all correctional centres includes best practice information, developed in consultation with the director of health services, regarding the s.22

5. SPSC management should remind staff of emergency response codes procedures.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Staff Assault

Date of Incident:

March 16, 2010 – Vancouver Island Regional Correctional Centre (VIRCC)

Review Team:

John Pastorek, Chair	Warden, North Fraser Pretrial Centre
Myrna Luknowsky, Member	Assistant Deputy Warden, VIRCC
s.22 Member	Chair, Community Advisory Board, VIRCC

Larry Chow, Participant/ Observer Inspector, Investigation & Standards Office

Review Dates:

March 19, 22, 23, and 29, 2010 at VIRCC

Mandate and Scope of Review:

On March 17, 2010 the assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the assault of a staff member that occurred in the s.22 unit at Vancouver Island Regional Correctional Centre (VIRCC) and to address the following:

- Compliance with Adult Custody policy and procedures;
- initiatives required to prevent the occurrence of a similar incident; and,
- all other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at VIRCC.

An independent review by the Investigation and Standards Office of the Ministry of Public Safety and Solicitor General was conducted concurrently with this investigation. A separate report may be submitted by that office.

The team was directed to report their findings and recommendations to the provincial director, Adult Custody Division, by April 17, 2010.

The Saanich Police Department was contacted prior to the commencement of the review to ensure it would not compromise any investigation that department may have been conducting. Clearance was granted and the review proceeded.

Background:

On s.22 s.22 (the inmate) was admitted to VIRCC VIRCC is a 376 bed secure regional facility that houses male inmates awaiting trial, inmates serving a provincial sentence and individuals on immigration holds.

The inmate was s.22 was scheduled to appear in court on s.22 According to his s.22

During the admissions process the inmate was interviewed by the classification officer at approximately 1530hrs and s.22 He was subsequently rated to be a s.22 general population inmate and was slated to go to living unit LK. He was placed back into a holding tank in the admissions area. There was no mental health screener on duty at the time. At approximately 1830hrs, the mental health coordinator interviewed the inmate s.22 The coordinator assessed him s.22 and recommended a

s.22 placement to s.22 and be reassessed for the s.22 unit. At the conclusion of the interview, the coordinator placed the inmate back in the holding tank and advised a staff member at the admissions desk of his recommendation. He then made a notation in the Primary Assessment and Care (PAC) system. This information was not relayed to the classification officer. The inmate was received in living unit LK at approximately 1845hrs.

On the morning of March 16, 2010 at approximately 0730hrs, the inmate began s.22 , repeated use of the unit door call button) and s.22 and needed to be moved off the unit. The correctional supervisor responded to the unit, and the inmate was subsequently moved to s.22 He was appropriately placed s.22

The supervising correctional officer s.22 describes the morning as being busy and chaotic. The inmate, although initially quiet, was s.22 as the day progressed. This included s.22

were drawing negative attention from other inmates in the s.22 area.

As a result of this, and in an attempt to free up some bed space, the correctional officer and his partner decided to move the inmate to with another inmate. They did not want s.22

At approximately 1440hrs, the correctional officer unlocked the inmate's door to advise him of the move. Immediately, and without warning, the inmate s.15, s.22 The correctional officer attempted to s.22 s.22 The correctional officer's partner s.15 initiated a code yellow, and went directly to the correctional officer's aid. s.15

The first code yellow responder arrived s.15 , and s.15 responders were on the scene in short order. The correctional supervisor was not among the first through the door but arrived

quickly and took control of the situation. The inmate was controlled at the scene and s.15 It was evident that the correctional officer had s.22 A code blue was initiated, and health care staff responded s.15
As the area was congested, the correctional supervisor gave instruction for the inmate to be moved to the front of the staff office in order that the health care staff could attend the injured correctional officer. Health care staff simultaneously attended to the s.22 inmate.

At 1452hrs, the correctional officer was removed from the area s.22 and subsequently transported to hospital via a staff member. s.22

At approximately 1453hrs, the inmate was placed s.22 At 1520hrs staff re-entered s.22 and health care personnel further treated the s.22, s.15

Affected staff were offered, and received, support by the centre's critical incident response team (CIRT).

Saanich Police were contacted and an investigation is under way with consideration of s.15

Findings:

- The mental health coordinator, who had conducted the s.22 intake assessment, recognized that the inmate s.22

  Although this information was relayed to a desk officer in the admissions and discharge area and a notation was made in the inmate's PAC log, the classification officer was not alerted.

- The inmate was assigned to living unit LK by the classification officer after admission on s.22 On s.22 he was placed in

  s.22

- While in the s.22 unit, the inmate was s.22 The supervising staff decided on their own to place him in s.22 with another inmate so as not to further s.22

- When s.22 staff opened the subject's cell to move him to the observation area, he attacked one officer and was s.22

- While attempting to s.15, s.22 out of his cell, the correctional officer s.22 and both he, and the inmate, This resulted in s.22

- A code yellow was initiated by the second correctional officer in Although the response was timely and effective, it did not entirely comply with the centre's standard operating procedures (SOPs) in that no supervisor was present before responding staff were allowed access to the area.

- Appropriate use of force was employed to restrain the inmate who was combative and resistant to instruction from responding staff.

- A code blue was initiated in a timely manner when it was evident that medical attention was needed. Health care staff responded quickly and effectively and tended to the needs of the injured staff member and to the inmate.

- Not all responding/involved staff were assigned ICON reports to detail the incident. Several staff submitted statements to the Saanich Police in support of their investigation.

- CIRT support and follow up was offered to affected staff.

- No entry detailing the assault on staff was entered into the inmate's client log in a timely manner.

- s.22 logs/records do not completely reflect activity in the area such as visits by supervisors, managers or health care rounds. Consequently, it was more difficult to create a timeline for the purposes of this critical incident review.

- Correctional officers in have significant authority with respect to management of the unit. It was not clear from the centre's SOP's, or described practice, how much supervisory or management oversight is afforded this area.

- s.15

- Following the assault, the inmate was secured s.22

  VIRCC management may wish to further investigate this matter s.15, s.22

Recommendations:

1) VIRCC management and the health care contractor should review intake protocols with their staff to ensure that appropriate communication occurs regarding placement recommendations. SOPs and healthcare policy should be updated if necessary.

2) VIRCC management should review their standard operating procedures around responses to code yellows and ensure that their practices follow the described procedures; or, amend the SOP's to reflect more appropriate courses of action.

3) VIRCC management should ensure that involved staff are assigned responsibility to submit primary or supplementary eForms in ICON and that the appropriate client log entries are made following a significant event.

4) VIRCC management should review with staff the requirement to accurately and completely maintain unit records.

5) VIRCC management, along with a facilities service representative, should review the

6) VIRCC management should review their current SOPs for the area and consider further detailing their expectations concerning how much supervisory or management oversight should be afforded this area.

CORRECTIONS BRANCH
Critical Incident Review

Subject:

Attempted Escape

Date of Incident:

July 17, 2011 at Vancouver Island Regional Correctional Centre, Living Unit M

Review Team:

Lisa Anderson – Chair	Warden, Alouette Correctional Centre for Women
Stacey Trudgian – Member	Assistant Deputy Warden, Vancouver Island Regional Correctional Centre
s.22 – Member	Member, Community Advisory Board
Shane Muldrew – Participant/Observer	Inspector, Investigation and Standards Office
Deanna Jung – Participant/Observer	Inspector, Investigation and Standards Office

Review Dates:

July 22, 2011 to July 29, 2011 at Vancouver Island Regional Correctional Centre

Mandate and Scope of Review:

On July 19, 2011, the assistant deputy minister Corrections Branch requested a critical incident review be conducted to investigate the circumstances surrounding the attempted escape at Vancouver Island Regional Correctional Centre (VIRCC) and to address the following;

- Compliance with Adult Custody policies and procedures;
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

This report and its contents contain personal & security-related information and are therefore strictly confidential and are not for further distribution or disclosure. Any requests for this report or information contained herein are to be referred to Information Access Operations, Shared Services BC, Ministry of Citizens' Services.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at VIRCC.

An independent review by the Investigation and Standards Office of the Ministry of Attorney General was conducted concurrently with this investigation. A separate report may be submitted by that office.

Background:

the living unit officer proceeded to cell s.22 to investigate. The living unit officer identified s.15

The a/CS confirmed the s.15 and also noted the occupants of the cell were in their beds and appeared to be sleeping. The a/CS and then proceeded to the office of the assistant deputy warden (ADW) to inform him and the correctional supervisor (CS) of the situation.

Prior to other responding officers arriving on the living unit at 0709 hours, the living unit officer completed two brief visual checks of cell s.22 in addition to performing regular duties, both on and off the unit. Responding officers, under the direction of the CS, unlocked cell s.22 and the two occupants were s.15 and then escorted separately to the segregation unit. s.15

the cell to photograph s.15 The work program officer, who had been dispatched from the unit to s.15 returned and also entered the cell. s.15

The work program officer also noted that Evidence remained undisturbed until the arrival of the additional officers who were instructed to search the cell. The ADW left the unit when the search began and, at approximately 0824 hours, cell s.22 was secured following the removal of s.15 While the cell search was underway, at approximately 0810 hours, the formal count was called and subsequently cleared.

Following the completion of s.15

At approximately s.15 hours the ADW returned to the unit with s.15 members of the Saanich Police Department (SPD) who proceeded to inspect and photograph cell s.22

A member of SPD's Identification Unit attended VIRCC on the morning of s.15 The member was initially accompanied by VIRCC's maintenance team lead, an employee of Workplace Solutions Incorporated (WSI), into the s.15 where they identified additional physical evidence relating to the escape attempt. s.15

were found in this area. The maintenance team lead advised that s.15

The two occupants of cell s.22 were s.22 and s.22 hereafter referred to as subjects A and B respectively. Subject A was admitted to VIRCC on s.22 His next court date is scheduled for s.22 Subject B was admitted to VIRCC on s.22

Subject A occupied cell s.22 from s.22 until the date of incident. This cell has a single bunk; however, another inmate may be assigned periodically to sleep on a mattress on the floor. Subject B was assigned to cell s.22 on a mattress on the floor on the afternoon of s.22 . The two subjects s.22

From s.22 there were no documented behavioural concerns or reports of suspicious activities specific to the subjects or the living unit indicative of an escape attempt in progress. On Wednesday s.22 , the s.15 formal inspection which assesses the unit's and individual cells' levels of cleanliness was completed by the CS on LM. The CS did not enter cell s.22 during this inspection, as subject A was in the process of cleaning the floor immediately outside of his cell when the CS was inspecting the cells in that area of the unit. Every s.15 the s.15 physical inspection is expected to be completed, in which the assigned living unit officer checks all bars, locks, windows and other security features and equipment and completes an inspection report. On s.15, s.22 the officer did not enter any of the cells to complete the inspection. s.15 visual checks and informal counts appear to have been completed on an ongoing basis at the appropriately specified intervals; however, these functions were performed without a defined requirement or reported need to enter the cells.

During the s.15, s.22

s.15, s.22 the escape attempt had been in progress for s.15, s.22

s.15, s.22

Findings:

- Upon identification and confirmation of s.15 officers did not maintain line of sight on the cell or the subjects pending the arrival of responding officers.

- A formal count was initiated by the ADW at approximately 0810 hours, approximately an hour after the subjects were removed from the unit. An identification count for LM was not completed.

- Cell s.22 was not secured and evidence was not protected pending the attendance of SPD. Following photos s.15 being taken by the CS, the cell was searched and s.15, s.22

- Initial notification of the incident to the warden was completed at 0816 hours, approximately one and a half hours following the confirmation of s.15 of cell s.15, s.22

- The search of LM following the removal of the subjects did not include a strip search of any and all inmates assigned to the unit. Results of the search were not recorded on the VIRCC search report or on an incident form.

- Shift activity records were not consistently completed in accordance with VIRCC standard operating procedures. The shift activity records do not allow for one master chronological record of all pertinent information for a specified area, as informal counts and visual checks, inmate movement and the identification of other persons entering or leaving a unit, or other relevant information are recorded on three separate areas of the form.

- s.15

- s.15 were completed prior to the start of the critical incident review, eliminating the opportunity for the team to view s.15

- A review of various times of digital video recordings between s.15, s.22 of correctional officers conducting visual checks pre-incident shows them walking by all cells; however, they do not look into all cells. In some instances officers walk by and do not look in the direction of the cells.

- VIRCC's standard operating procedures requires informal counts to be conducted every s.15 VIRCC standard operating procedures for visual checks refers directly to Adult Custody policy which specifies the requirement for visual checks to be completed at intervals not exceeding s.15 when inmates are confined to their cells. Practice at VIRCC is that informal counts and visual checks are completed simultaneously and recorded as one entry on the shift activity record.

- Information from s.15 indicates the s.15

- s.15

- When conducting the formal inspection on LM on s.15 , the CS did not enter cell s.22 .

- The officer assigned to LM did not enter any cells to complete the physical security inspection on s.15

- A cell condition sheet was not completed when subject B was assigned to cell s.22 on s.22 contrary to VIRCC standard operating procedures.

- Correctional officers do not consistently sign and date entries in the living unit logs contrary to VIRCC standard operating procedures.

- The s.15 physical security inspection reports for all units for s.15 cannot be located.

- A s.15 visual check of security features noted in Adult Custody policy is not conducted. When interviewed, correctional officers indicated that VIRCC practice regarding s.15 cell inspection is a cleanliness inspection with the focus on the beds being made, toilets cleaned (where applicable), and garbage removed from the cell. Correctional officers indicated they do not generally enter the cell to complete this inspection. VIRCC's standard operating procedures regarding cell inspection include checking s.15

- The CS post description details the requirement for the CS to ensure "regular bar, window, door, locks and structure checks are made on a s.15 basis and in accordance with standards". There is no evidence to suggest these checks were made on a s.15 basis.

Recommendations:

1. VIRCC management should define expectations of s.15 cell inspections and s.15 physical security inspections to ensure compliance with Adult Custody policy.

2. VIRCC management should update visual cell check policy to include a need to enter cells when completing physical security checks and remind staff of this policy and relevant Adult Custody policy.

3. VIRCC management should review protection of evidence Adult Custody policy and VIRCC standard operating procedures with all staff.

4. VIRCC management should review the requirement for the use of cell condition sheets when assigning inmates to new cells.

5. VIRCC management should review the documentation requirements for shift activity records and unit logs with all correctional officers and correctional supervisors.

6. VIRCC management should work with the Corrections Branch Capital Team, WSI, and Shared Services BC to s.15 to meet secure custody standards, including s.15

7. VIRCC management should ensure managers and supervisors are aware of the priorities regarding notification of senior managers during incident management.

8. The provincial director should amend Adult Custody policy to include s.15 as an item subject to s.15 visual check for s.15