CORRECTIONS BRANCH
Critical Incident Review

Subject: In-custody Death

s.15, 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.15, s.22 (the subject) was admitted to for charges of These charges were consistent with In addition, he also had He was sentenced

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

s.15, s.22

Due to his the subject was classified to LU 4C on and bunked in cell 8 with inmate (the roommate), who was on the program. Entries in the subject's client log reflect that there were minimal issues for the next six days. The subject's 'Alerts' in CORNET included concerns, concerns and that stated "never to be housed with a program inmate" as the subject was not on the program and had

On October 19, 2010, 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 1-6 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 0717 hours, dispensed medication to two inmates, and left at 0720 hours to radio healthcare when she discovered that there was no on the cart. When it was realised that the was left behind on the counter in health care, rather than the nurse and the runner retrieving the the health care correctional officer was asked by the nurse in health care to deliver the 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 The subject is seen to approach the front door where she was located. While the CCTV camera with the nurse, 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 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 get water on two occasions, finally ingesting the at 0729 hours. After drinking water he was placed in the TV room. The second inmate ingested his dose and and water before being secured in the TV room at 0731 hours. The subject is seen via CCTV appearing hyperactive, pacing around the room, talking animatedly and laughing. During the distribution process the unit remains unlocked, and the roommate is witnessed standing by the table the subject had been sitting at earlier.

The nurse distributing the 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 had called in sick and, also, was called away to do some blood work on another inmate.

There is no direct observation of the recipients 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.15, s.22 he should have been locked at 0800 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 an hour and a half. It was also revealed during review team interviews that sometime during the shift, unit staff discussed whether the appropriate inmate received 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 0930-0950 hours. The subject was allowed out at 1020 hours to make a lawyer call, securing again at 1028 hours. Images captured on CCTV in the common area do not indicate any signs of intoxication, but the subject has a towel over his head obscuring his face while on the phone.

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.
staff do not recall, it is unclear if the subject ate lunch. The unit was secured at 1150 hours for formal count, remaining locked until 1400 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 health care for routine follow-up appointments regarding unrelated medical issues. 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 health care. He made no response, and staff report he made snoring-like sounds. His roommate was taken to health care. During the return escort from health care, the roommate mentioned at least twice to the runner that the subject was really tired as he had stayed up all night watching TV so likely would not want to go see the doctor. There does not appear to have been any subsequent attempts to determine if the subject wished to attend and health care was notified he had declined. It was confirmed with the attending physician that it was not essential that he attend, so it was logged that he had declined.

Following the missed visual checks first thing 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 8 to facilitate a one hour time out as per

At no time is the subject seen outside of the cell during this ablution period. Cell 8 was secured at 1548 hours.

The dinner meal cart arrived at approximately 1615 hours, and two trays were delivered by staff to cell 8. An inmate is seen on CCTV at 1630 approaching the area of cell 8. 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. It was reported by this inmate when he was interviewed that he told the subject's roommate to dump the subject's dinner into a bowl as it was not being eaten. No further activity near this cell is witnessed until after the unit is unlocked at approximately 1820 hours following staff dinner breaks.

Numerous inmates are then seen walking over to the area where cell 8 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 8. 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 thirty seconds the first responder entered the unit followed by 3 more staff over the next forty five seconds. Health care arrived within a minute and a half. After conducting a cursory assessment of the subject in the cell and determining that he was cold, pale and cyanotic with no pulse or breathing, he was carried from his top bunk and placed on the floor of the common area. At 1846 hours chest compressions were started; however, they were stopped and started again as oxygen was applied and the ambubag was introduced. Sustained CPR commenced at 1850 hours. Inmates, including the subject's roommate, indicated to staff that it was a s.15, s.22 overdose so Narcan was initiated at 1853 with an additional three doses given. Four firemen were escorted to the unit at about 1859 immediately taking over CPR, inserting an airway and attaching the automatic external defibrillator (AED). At 1900 hours the paramedics arrived. They continued to monitor the AED while starting an IV but no activity was detected in the heart. 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 Royal Columbian Hospital.

Findings:

- The subject received prescribed to
- the subject ingested which was not prescribed for him.
- The ingestion of the was planned and deliberate.

- The unit was not locked down during s.15, s.22 distribution.
- Direct observation of those who had received 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 when delivering morning medications due to unexpected staff absence.
- 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 4C.
- The 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 to 3C.
- The quality of the phone card picture and the diminished lighting in the area where was distributed in this case may have contributed to the subject's ability to deceitfully receive medication that was not prescribed to him.
- Visual cell checks were not done for the first hour and a half 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 someone on the program was not adhered to.
- A white board on the unit details the for each 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
- Unit staff suspected a dose was ingested by a person for whom it was not prescribed. 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 1028 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 health care 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 sustained CPR.
- Dosing of Narcan was not consistent with cardiac life support guidelines in the community.
- There is discrepancy between nurses' recollection of how many doses of Narcan were administered.
- 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 frisking of inmates prior to receipt of s.15, s.22
- Correctional supervisors were unfamiliar with local policy requiring their presence on the living units when medication is distributed.
- There is confusion amongst correctional staff and health care personnel as to responsibility for checks after and medications are ingested by inmates.

Recommendations:

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

2. The health care contractor and FRCC management should review current 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 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.

Deaths of Inmates of Correctional Facilities in British Columbia, 2004 – 2011

Office of the Chief Coroner
Metrotower II, Suite 800 4720 Kingsway Avenue, Burnaby BC V5H 4N2
Phone: 604-660-7745 Fax: 604-660-7766

Table of Contents

Deaths of Inmates of Correctional Facilities....3
Introduction....3
Summary of Key Findings & Recommendations....3
Deaths of Inmates: By Classification, Gender and Age....4
Deaths of Inmates: By Facility Name....5
Deaths of Inmates: By Means of Death....6
Deaths of Inmates: Means of Death by Jurisdiction....7
Recommendations Resulting from Deaths of Inmates....8
Summary: Coroner and Jury Recommendations....8
Summary: Recent Recommendations by the BC Correction Branch....8
Cases: Federal Facilities....9
Cases: Provincial Facilities....11

Deaths of Inmates of Correctional Facilities
2004 – 2011

Introduction

This report reviews all deaths of inmates of Federal and Provincial correctional facilities in BC that occurred between 2004 and 2011. Deaths of inmates transferred to hospital for medical treatment are included. Deaths at halfway houses, or those occurring in police custody, such as in a municipal police or RCMP prison or lock-up, are not included in this report.

- **Federal** facilities in BC include Ferndale Institution, Kent Institution, Kwìkwèxwelhp Healing Lodge, Matsqui Institution, Mission Institution, Mountain Institution, Pacific Institution, Regional Treatment Centre, and William Head Institution.

- **Provincial** facilities include Alouette Correctional Centre for Women, Ford Mountain Correctional Centre, Fraser Regional Correctional Centre, Kamloops Regional Correctional Centre, Nanaimo Correctional Centre, North Fraser Pretrial Centre, Prince George Regional Correctional Centre, Surrey Pretrial Services Centre, and Vancouver Island Regional Correctional Centre.

An amendment to the Coroner's Act in 1999 made deaths in Correctional facilities discretionary inquests rather than mandatory. Inquests have been held into 5 deaths of inmates that occurred between 2004 and 2011.

Summary of Key Findings & Recommendations

There were 102 deaths of inmates of correctional facilities in BC between 2004 and 2011:

- 63.7% occurred in Federal facilities, while 36.3% occurred in Provincial facilities.
- 58.8% were natural deaths.
- 94.1% were male and 5.9% were female.
- Key recommendations made by Coroners and Juries included:
    - Initiation and administration of the Methadone Maintenance Program
    - Suicide Risk Assessment/Monitoring
    - Changes/upgrades to facilities (e.g. to reduce opportunity for self-harm, camera placement)
    - Response to medical emergency
    - Development and administration of release plans
    - Dispensing prescription medications

Following two recent Critical Incident Reviews, the BC Corrections Branch also made recommendations for improved safety at Provincial facilities, which are summarized on page 8.

Deaths of Inmates: By Classification, Gender and Age

Classification of Death, 2004 - 2011*									
	2004	2005	2006	2007	2008	2009	2010	2011	**Total**
Accidental	4	1	1	2	1	1	2	0	**12**
Homicide	0	1	0	0	3	0	1	1	**6**
Natural	7	10	11	11	8	6	4	3	**60**
Suicide	4	2	2	5	1	3	0	0	**17**
Undetermined	0	1	0	0	1	0	1	0	**3**
Under Investigation	0	0	0	0	0	0	2	2	**4**
Total	**15**	**15**	**14**	**18**	**14**	**10**	**10**	**6**	**102**

Gender and Average Age of Inmates, 2004 - 2011*									
	2004	2005	2006	2007	2008	2009	2010	2011	**Total**
Female	1	1	0	0	2	1	1	0	**6**
Male	14	14	14	18	12	9	9	6	**96**
Average Age	44.9	48.3	50.0	54.4	45.8	49.4	47.0	49.4	**48.7**

Age of Inmates	
Age Group	Deaths
20 - 29	11
30 - 39	23
40 - 49	21
50 - 59	21
60 - 69	17
70 - 79	8
80+	1
Total	**102**

Notes:

- 58.8% were natural deaths
- 94.1% were male and 5.9% were female

**Includes closed cases, as well as those that remain under investigation. Counts for 2011 are preliminary, and may increase.*

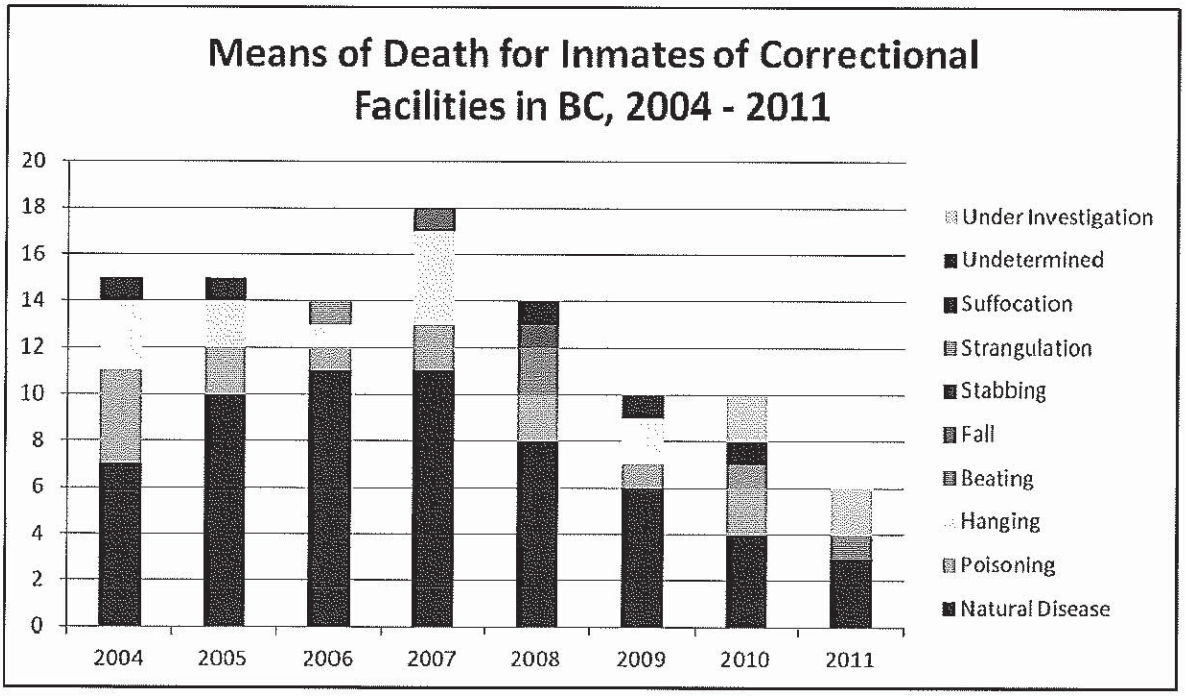
Deaths of Inmates: By Facility Name

Deaths of Inmates at Federal and Provincial Correctional Facilities in BC, 2004 - 2011*										
		Year								
Facility		2004	2005	2006	2007	2008	2009	2010	2011	**Total**
Federal	Chilliwack Community Correctional Centre			1						**1**
	Ferndale Institution	1	1			1			1	**4**
	Kent Institution		3	1		1	1		1	**7**
	Kwìkwèxwelhp Healing Village			1						**1**
	Matsqui Institution	1	3	1	1		1		1	**8**
	Mission Institution			1	1	1		1		**4**
	Mountain Institution	3		1	4	3	2	1		**14**
	Pacific Institution**	4	4	4	7	1	2	2	1	**25**
	William Head Institution						1			**1**
	Federal Total	*9*	*11*	*10*	*13*	*7*	*7*	*4*	*4*	*65*
Provincial	Alouette Regional Correction Centre for Women						1			**1**
	Fraser Valley Regional Correctional Centre	1	1		1	3		2	1	**9**
	Kamloops Regional Correctional Centre							2		**2**
	Nanaimo Regional Correctional Centre			1	1					**2**
	North Fraser Pretrial Centre			1		1			1	**3**
	Prince George Regional Correctional Centre		1							**1**
	Surrey Pretrial Services Centre	2	2		1	3		2		**10**
	Vancouver Island Regional Correctional Centre	3		2	2		2			**7**
	Provincial Total	*6*	*4*	*4*	*5*	*7*	*3*	*6*	*2*	*37*
Total		**15**	**15**	**14**	**18**	**14**	**10**	**10**	**6**	**102**

**Includes closed cases, as well as those that remain under investigation. Counts for 2011 are preliminary, and may increase.*

*** Pacific Institution houses the Federal Correctional Service medical facility, and as such, deaths recorded there include inmates of other facilities who were transferred for treatment.*

Deaths of Inmates: By Means of Death



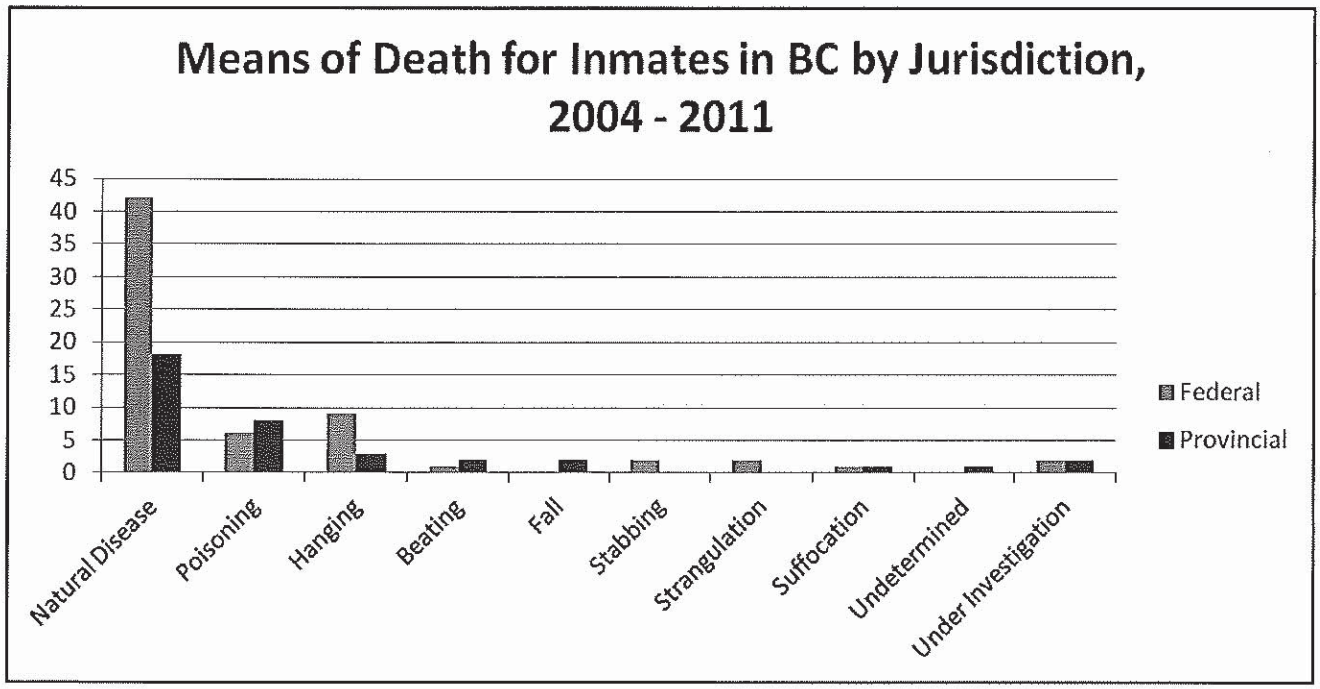
Means of Death for Inmates of Correctional Facilities in BC, 2004 - 2011*									
	2004	2005	2006	2007	2008	2009	2010	2011	**Total**
Natural Disease	7	10	11	11	8	6	4	3	**60**
Poisoning	4	2	1	2	2	1	2	0	**14**
Hanging	3	2	1	4	0	2	0	0	**12**
Beating	0	0	0	0	2	0	0	1	**3**
Fall	0	0	0	1	1	0	0	0	**2**
Stabbing	0	1	0	0	1	0	0	0	**2**
Strangulation	0	0	1	0	0	0	1	0	**2**
Suffocation	1	0	0	0	0	1	0	0	**2**
Undetermined	0	0	0	0	0	0	1	0	**1**
Under Investigation	0	0	0	0	0	0	2	2	**4**
Total	**15**	**15**	**14**	**18**	**14**	**10**	**10**	**6**	**102**

** Counts for 2011 are preliminary, and may increase.*

Notes:

- 58.8%% of deaths were classified by coroners/juries as natural.
- 13.7% of deaths were classified as poisoning, and 11.8% as hanging.
- Four cases are open/under investigation.

Deaths of Inmates: Means of Death by Jurisdiction



Means of Death for Inmates in BC by Jurisdiction, 2004 - 2011*											
Jurisdiction	Natural Disease	Poisoning	Hanging	Beating	Fall	Stabbing	Strangulation	Suffocation	Undetermined	Under Investigation	**Total**
Federal	42	6	9	1	0	2	2	1	0	2	**65**
Provincial	18	8	3	2	2	0	0	1	1	2	**37**
Total	**60**	**14**	**12**	**3**	**2**	**2**	**2**	**2**	**1**	**4**	**102**

**Includes closed cases, as well as those that remain under investigation.*

Note: The BCCS operates in a live database environment. The data are considered preliminary until all investigations have been completed. Data are subject to change.

Recommendations Resulting from Deaths of Inmates 2004 – 2011

Summary: Coroner and Jury Recommendations

There were 10 deaths of inmates between 2004 and 2011 that resulted in coroner/jury recommendations. Of these cases, 3 were deaths of inmates of Federal correctional facilities and 7 were deaths of inmates of Provincial correctional facilities. Inquests were held into 5 of the 10 deaths; 1 of these were inmates of Federal facilities and 4 were inmates of Provincial facilities.

One case may result in recommendations addressing more than one issue. The issues addressed by the recommendations were:

- Initiation and administration of the drug and alcohol treatment programs, including the Methadone Maintenance Program – 4 cases.
- Suicide Risk Assessment – 3 cases.
- Changes/upgrades to facilities (e.g. reduce opportunity for self-harm; camera placement) – 3 cases.
- Response to medical emergency – 2 cases.
- Development and administration of release plans – 1 case.
- Dispensing prescription medications – 1 case.

Summaries of individual cases follow on page 9.

Summary: Recent Recommendations by the BC Correction Branch

Following two recent Critical Incident Reviews, the BC Corrections Branch also made recommendations for improved safety at Provincial facilities. Recommendations focused on:

- Standard operating procedures revisions with respect to conducting and recording inmate counts, visual cell checks and other relevant inmate movements;
- Review of Code Blue procedures, location of emergency medical equipment bags and a consideration of the feasibility of having AEDs at all BC correctional centres;
- A review of standards for inmates in segregation for medical and mental health monitoring;
- Ongoing training and supervision for all health care staff with respect to clinical assessment, triage and communication processes;
- A more secure system of dispensing cleaning fluids to reduce the likelihood of inmates having access to undiluted products that may be potentially harmful if ingested.

Because the recommendations from the BC Corrections Branch directly addressed the issues surrounding these two deaths, the BC Coroners Service did not make further recommendations. These cases are not included in the following section.

Cases: Federal Facilities

Federal Case 1: Coroner's Investigation

In October 2005, staff discovered a 51 year old male deceased on the floor of his living unit. He had been on a methadone maintenance program in the institution. Death was subsequently attributed to respiratory failure due to methadone and diphenhydramine, with Hepatitis C and Tuberculosis contributory. The death was classified as natural.

Coroner Recommendations

1. Correctional Service of Canada (CSC) consider a review of national health care policy in regards to the Methadone Maintenance Program. In particular the medical complications of methadone treatment on inmates diagnosed with infections diseases, e.g. Hepatitis C, Tuberculosis.

Response

CSC responded that they have Specific Guidelines for the Methadone Maintenance Treatment Program which requires a physical assessment, including infectious disease screening, for each inmate who requests initiation and/or continuation on methadone maintenance treatment.

Federal Case 2: Inquest

* The decedent was on parole from a Federal corrections facility, but is included in this summary as CSC was the recipient of recommendations arising from the inquest.

In December 2004, a 29 year old male was shot by police after resisting arrest. He had served two thirds of his federal sentence and was eligible for statutory release. He was transported to a community residential facility (CRF) where he was reminded of his release conditions and instructed on the rules of the CRF. He failed to return the first evening and a Canada wide warrant was issued. Three days later this man was approached by Vancouver police conducting routine street checks. He provided his name and admitted to the officers that he was engaged in drug related activities. The warrant alert came up on their system and as an officer was about to detain the man, he produced a knife and advanced towards them. The man sustained a number of fatal gunshot wounds. The jury ruled the death a homicide.

Jury Recommendations

Three recommendations were issued to CSC:

1. That the statutory release dates should not coincide with major holidays, and that there be a minimum 24 hour in-house supervision by CRF staff.
2. That a parole officer should meet with the parolee within 2 hours of his arrival at the CRF.
3. Research and implementation of additional CRFs outside the Lower Mainland with particular attention to aboriginal needs should occur.

Response

The CSC responded that, in the development of the release plan, the offender's needs and those relating to public safety are addressed. CRFs can establish, on a case by case basis, rules that require an offender to have limited access to the community during the first few days of release. These are tailored to each offender and

the circumstances surrounding their release including the appropriate combination of controls, privileges and supervision. Further, CSC recently decided to pursue "group home" type of options in the Lower Mainland and in the North.

Federal Case 3: Coroner's Investigation

In November 2005, a 35 year old male was found unresponsive in his living unit with a cloth ligature around his neck and fastened to window bars. A handwritten note indicating his intention to end his life was located nearby. The inmate had a history of self harm and suicide attempts in past years. A few days prior to his death, he had been diagnosed with a terminal illness. Psychological assessments determined he was understandably anxious but not suicidal, and increased staff observation was initiated. The death was classified as a suicide.

Coroner Recommendations
Two recommendations were issued to CSC:

1. Consider the implementation and/or placement of an observation cell within the main facility at the Regional Reception Assessment Centre of inmates who are not yet patients at the hospital but are awaiting assessment by a physician and/or psychologist.
2. Consider a review and/or revision of facility policy by all staff with regards to monitoring inmates with extra needs (eg: in cases where self-harm may be an issue) including the development of an educational program specific to suicide prevention for inmates as well as well as revised protocols for emergency situations.

Response
CSC has taken these recommendations under consideration.

Cases: Provincial Facilities

Provincial Case 1: Inquest

In May 2004, a 27 year old male was found deceased in his cell. It was subsequently determined that the inmate had a lethal concentration of heroin in his system at the time of his death. The jury heard evidence about how illicit drugs may enter the institution and be distributed. The jury found that the death was due to acute heroin intoxication and classified the death as accidental.

Jury Recommendations
Two recommendations were issued to the Provincial Director, Adult Custody Division:

1. That there is an increase in the use of dogs in drug searches in correctional facilities;
2. The methadone maintenance is initiated for heroin addicted inmates who are not on a methadone maintenance program upon intake.

Response
The Provincial Director responded that they have introduced policy that allows for the initiation of methadone in correctional centres according to certain criteria and procedures. A decision regarding the use of drug detection dogs will be made following completion of the drug interdiction strategy review.

Provincial Case 2: Inquest

In June 2004, a 35-year old male was found unresponsive in his cell, with a ligature around his neck that was tied to the window bars. He was transferred to hospital. After three days the decedent's family agreed to withdraw life support and the decedent died. The decedent had indicated suicidal intent in the weeks prior to his death, however was not determined to be at high risk of suicide. The jury found that the death was due to anoxic brain injury as a consequence of self-harm and classified the death as a suicide.

Jury Recommendations
Five recommendations were issued:

1. To the Deputy Provincial Director, Adult Custody Division, that mental health and health care workers are directed to seek out and read all collateral information prior to meeting with a patient. Acknowledgment must be noted and signed upon completion of review of information.
2. To the Provincial Director, Adult Custody Division, to provide enhanced, formalized training to front line correction officers to recognize the signs of depression that may lead to self harm and how to correctly report such information.
3. To the Provincial Director, Adult Custody Division, to establish minimum training standards for both new and current employees.
4. To the Provincial Director, Adult Custody Division, to establish a training schedule for both new and current employees.
5. To the Vancouver Island Regional Correctional Centre Warden, to eliminate the gap between the Plexiglas and window bars to prevent a reoccurrence of this method of self-harm.

Response
The Provincial Director, Adult Custody Division responded to all of the recommendations. All recommendations were reported to have been implemented and completed, except that regarding the gap in the window. An

architect was consulted and two solutions were attempted; however neither guaranteed a secure alternative. Other alternatives were not feasible. It was noted that VIRCC policy directs staff to complete integrity checks of all windows on a weekly basis to identify potential problems.

Provincial Case 3: Coroner's Investigation

In September 2004, a 37 year old female was found deceased in her cell. She had recently been admitted to the methadone maintenance program. Her cellmate reported she had been ill the evening before but had not requested assistance from Correctional staff. It was subsequently determined that her death was due to respiratory failure, due to mixed drug toxicity of methadone, amitriptyline and fluoxetine, and was ruled accidental.

Coroner's Recommendations
Two recommendations were issued:

1. The Provincial Director, Adult Custody Division and the Director of Health Services, BC Corrections Branch, jointly received the recommendation that the recommendations resulting from the internal review and the investigation conducted by the Investigations and Standards Office be enacted.
2. The College of Physicians and Surgeons received the recommendation that the Judgment of Inquiry be reviewed for information and educational purposes.

Response
The Provincial Director, Adult Custody Division responded that all recommendations arising from the critical incident review conducted by the Corrections Branch have been addressed.

Provincial Case 4: Inquest

In May 2006, a 30 year old male was discovered unresponsive in his cell on rounds. He was transferred to hospital but was deceased on arrival. The jury heard evidence that the inmate had access to and expressed interest in drug and alcohol treatment, but that he had acquired an illicit supply of morphine and methadone and had been consuming it the day before his death. It was determined that the death was due to a morphine and methadone overdose. The jury ruled the death accidental.

Jury Recommendations
Five recommendations were issued to the Nanaimo Correctional Centre:

1. Improve the visibility on the unit affected, when Code Blue is called, the lights should be illuminated.
2. Have an Automatic External Defibrillator (AED) on site.
3. Include pocket masks as required equipment for staff to carry on their person at all times.
4. To continue with ongoing education for staff broadening the scope of crisis intervention to include role play and simulation.
5. To enforce the policies regarding securing the scene and crowd control.

Response
The Nanaimo Correctional Centre responded that all recommendations were adopted, with the exception of that suggesting an AED be available on site. The health care committee reviewed the AED policy, but does not recommend the addition of an AED to this site at this time. An annual review of AED deployment to centres has been implemented.

Provincial Case 5: Inquest

In February 2007, a 31 year old male was discovered suspended by a bed sheet ligature from a sprinkler head in the ceiling of his cell. The inmate had a lengthy history of attention seeking behaviour and there was no evidence of any suicidal suspicion on the part of staff or inmates prior to this incident. The jury ruled the death accidental.

Jury Recommendations
Three recommendations were issued:

1. To the Provincial Corrections Branch, to inspect sprinkler heads no less than once a year, to ensure the integrity of sprinkler heads have not been compromised and cannot be used as ligature points.
2. To the Provincial Corrections Branch, to add a clause to the Adult Custody Policy which would be 9.13.9.4: "When an inmate is placed on 15 minute self half watch, they are to be issued suicide prevention gown and blanket".
3. To the Vancouver Island Regional Correctional Centre, that camera placement within Segregation/Observation Units be reviewed by qualified external agency.

Response
The Provincial Corrections Branch responded that a requirement to have sprinkler heads inspected annually by a qualified technician has been added to the maintenance budget of each provincial correctional centre, and that Adult Custody Policy details factors that assist a designated authority in declaring an inmate to be at risk. At-risk designation results in the application, according to policy, of minimum standards for surveillance. A suicide gown and blanket may be utilized for at-risk inmates as determined on a case-by-case basis according to presenting circumstances and a risk assessment. Vancouver Island Regional Correctional Centre responded that a review of camera placement in the Segregation Unit resulted in the relocation of one camera and the addition of another in the lobby of the unit.

Provincial Case 6: Coroner's Investigation

In March 2008, a 20 year old male was found deceased in his cell. A critical incident review determined that cell inspections had not been performed as scheduled, and when performed had not been conducted properly. The inmate had a prior history of illicit drug use while in custody, and was subsequently determined to have a lethal concentration of heroin in his system at the time of his death. The death was classified as Accidental.

Coroner's Recommendations
Two recommendations were issued to the Fraser Regional Correctional Centre:

1. Revise the current criteria for determining the health of an inmate during current visual cell inspections to include observation of breathing (either auditory or via chest motion).
2. Consider regular re-training or testing of employees to ensure they are aware of the standard operating procedures regarding "Non-Daylight Hours Visual Cell Inspections".

Response
The Fraser Regional Correctional Centre responded that it is not operationally feasible to confirm the well-being of an inmate locked in a cell via auditory or visual observation of breathing. To do so on a consistent basis would require correctional staff to open the cell doors of inmates and get very close to them on every cell

inspection. This would create sufficient noise and disruption on the living unit at night time that inmates would likely be awakened, resulting in the potential for disorder and compromising safety and security of inmates and staff. Regular training will be provided to staff that addresses the requirements found in FRCC standard operating procedures concerning "Non Daylight Hours Visual Cell Inspections".

Provincial Case 7: Coroner's Investigation

In January 2009, a 32 year old male was found having difficulty breathing. The staff nurse summoned an ambulance after performing a preliminary assessment. When paramedics arrived, they initiated advanced life support protocols and transported the inmate to hospital. Despite aggressive intervention, he died a short time later. Death was attributed to mixed prescription and illicit drug toxicity, with an enlarged heart and atherosclerotic coronary artery disease contributing, and was classified as Accidental.

Coroner's Recommendations
Two recommendations were issued to the Provincial Director, Adult Custody Division, the Assistant Deputy Minister, and the Medical Director of the BC Corrections Branch:

1. That Drug and Alcohol Treatment and Addiction Services be placed under the jurisdiction of the Health Care Team, to improve visibility and utilization, and allow for both the mental and physical aspects of drug treatment to become integral parts of the Health Care Team approach.
2. That the Health Care Team maintain a database on commonly used medications and current trends for abuse in the prison setting, allowing health care providers to exercise harm reduction by considering medications that offer lower risk administration (i.e. those available to be crushed or administered in solution) and thereby reduce the after-dose exchange of pharmaceutical medications within the prison.

Response
The Adult Custody Division of the Corrections Branch is in the process of renewing the provincial contract for the provision of health services to inmates in provincial correctional centres. The new contract will include addictions (drug and alcohol) treatment as part of the health services delivery platform, and is anticipated to be in place in 2011.

The new health services contract will designate a health care professional responsible for centralized oversight of medication prescribing and distribution within provincial correctional centres, including collecting information and maintaining a database of commonly prescribed medications and tracking trends of their diversion and abuse within the correctional setting. They will also provide training to health care staff concerning trends in prescription drug abuse, prevalence of diversion, lower risk medication alternatives of equivalent therapeutic benefit, and lower risk dosage forms (i.e. powder and liquid), where possible. As an immediate interim measure, the current contractor will implement with health care staff at each centre the monitoring of all prescription medications with abuse potential. Information will be gathered and shared regularly at each centre regarding the current prevalence and nature of drug diversion among inmates, and medical staff will be apprised regularly of the findings so they may consider this information in their medication choices, dosage forms and patient treatment plans.