CORRECTIONS BRANCH
Critical Incident Review

Subject: Serious inmate injury

Date of Incident: at North Fraser Pretrial Centre

Review Team:

Harry Draaisma	Chair	Deputy Warden Fraser Regional Correctional Centre
Gord Negrin	Member	Assistant Deputy Warden North Fraser Pretrial Centre
	Member	Community Advisory Board North Fraser Pretrial Centre
Diane Shepherd	Member	Director, Health Services
Dr. Maureen Olley	Member	Director, Mental Health Services
Lyall Boswell	Participant/ Observer	Inspector, Investigation and Standards Office
Lynette Pineau	Participant/ Observer	Inspector, Investigation and Standards Office

Review Dates:

2013 at North Fraser Pretrial Centre

Mandate and Scope of Review:

On the assistant deputy minister, Corrections Branch requested that a critical incident review be conducted to investigate the circumstances surrounding by the subject at North Fraser Pretrial Centre (NFPC) and to specifically address:

- Compliance with Adult Custody policies and procedures;
- The provisions 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 Justice was conducted concurrently with this investigation. A separate report may be submitted by that office.

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

Background:

On (hereafter, "the subject") was admitted to North Fraser Pretrial Centre (NFPC) charged with

On this date, the subject had

The classification officer determined that the subject had no contact concerns and considered him to be .

On the date of intake, at NFPC, the subject was identified as having The subject was described a d individual. This was the subject's . The subject was seen by the intake nurse and it was noted that the subject . On the recommendation of the intake nurse the subject was to

be single-bunk status

He was referred to for an appointment the next day.

The mental health screener saw the subject on and reported that the subject

The mental health screener identified that the subject was the officers. The subject initially

The mental health screener referred him to

While the subject was in he had interactions with , the chaplain and there were numerous entries in his file indicating calls to his lawyer. The subject had visitors, made phone calls to his parents, and had sent in from the publisher. He had mail come in but there is no record of him sending any mail out. It is noted that on several days there are no daily client log entries, as per NFPC standards operating procedures (SOP) regarding the subject's behaviour.

had attempted to see the subject on however the subject was at court.

On saw the subject in the Records area after he had a visit with another individual from outside the jail. stated the subject seemed The subject was reported as saying

The subject was described as at the end of his visit with was delivered to the living unit shortly thereafter for the subject. was concerned

On during a subsequent visit, said the subject wa

never received a request from the subject to meet again.

said the subject seemed . said they had short conversations with the subject but described the subject as fitting in well and having On one occasion, he expressed a concern about

saw the subject on and ordered the

On the subject was seen by who noted the subject was referred the subject to the also set an appointment for follow up with

A fax date-stamped was sent from the subject's lawyer stating the subject was . On saw the subject and noted he continued to

On saw the subject. She confirmed an and set an appointment for reassessment in one week. She recommended he be The subject was also seen by that day.

On based on a review of recommendation, the subject was started on

On both confirmed the subject was to remain .

and he had a scheduled visit so he did not see as planned.

On the subject declined to see He did see who found the subject to be at that time. and a follow-up with

On an indicated a fax addressed to a "Corrections supervisor on duty" and dated had been received from the in Vancouver. The fax mentioned that the client was The was aware that the subject was and further indicated he shared this fax with a correctional supervisor.

On t saw the subject in and requested that a longer interview take place on .

On the subject saw and requested to described the subject as He also felt that the subject was settling, . noted tha was due to follow-up with the subject on .

On , found the subject to be . She recommended the subject be but to remain in .

On , saw the subject about and also recommended he be gave the subject found the subject to be noted the subject had seen the day before and agreed with the recommendation that

On recommended that the subject be The subject was subsequently from .

The subject was double-bunked on the second tier with contrary to the classification to be single-bunked.

At s.15 hours on , the subject was observed by the living unit staff appearing to use the phone on s.15 after being unlocked approximately ten minutes earlier. The subject hung up the phone and s.15 The subject came down the steps to the living unit officer's desk to receive a letter the living unit officer placed out for him. The subject returned to s.15 phone area but then went back to his cell. Upon re-emerging he did not have any papers in his hand. The subject returned again t s.15 phone area. During this time, the living unit officer observed the subject and asked, by words and gestures, if there was a problem or if his phone card was working. The subject indicated he was fine and again appeared to be using the phone.

At , the living unit officer observed the subject The living unit officer immediately called a medical emergency code (code blue) on the radio.

The first responder and the living unit officer began to lock up the unit and evidence was secured. The first supervisor on the scene attended at approximately . At approximately , three nurses were in attendance. By the physician was at the scene, after being called by one of the nurses. At this point the subject was s.15 floor being attended to by staff and appeared The subject was attended to by firefighters and paramedics and taken off the unit at and escorted to the emergency department.

Findings:

- As per NFPC SOP, the internal classification officer (ICO) conducted an interview with the subject and classified him correctly as

- The subject was interviewed by the intake nurse as per NFPC SOP, ACP and HCSM policy.

- The subject was interviewed by a mental health screener as per NFPC SOP, Adult Custody Policy (ACP) and Health Care Services Manual (HCSM) policy. The Jail Screening Assessment Tool (JSAT) was completed within the required timelines.

- The ICO placed the subject correctly in

- CORNET alerts were entered by staff to indicate the inmate's risk as well as recommendations to manage that risk. These alerts were not expired once the risk was reduced.

- The living unit officer initiated a code blue immediately. All responders attended the scene as per NFPC SOP. Inmates were directed to lock up, the windows were covered, and 911 was called.

- The health care response was prompt and efficient.

- The protection of evidence SOP was followed.

- Not all required reports were completed prior to the investigation.

- As per ACP, post-emergency measures were taken to care for staff, including support from the Critical Incident Response Team (CIRT). CIRT was also offered to health care staff.

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

- There was a notation in CORNET (Alerts and Client Log screens) that the subject should be single-bunked. This notation was not updated in the file and the subject was bunked with another inmate on living unit CN.

- The subject had considerable contact with professionals while in custody at NFPC. agreed on the management plan for this inmate.

- Contrary to NFPC SOP, there were s.15 client log entries regarding issues during the subject's stay

- All NFPC staff, except one, who were interviewed by the critical incident review team, had reviewed the DVR after the incident. This is contrary to ACP authorization for DVR viewing.

- The health care contractor's refused to attend the review.

- Two of the health care contractor's refused to attend the review.

- Faxes and conversations with lawyers and the were not recorded in CORNET. Some documents containing potentially relevant collateral information were not shared with NFPC health care professionals or management.

- Health care staff did not make a request for collateral information regarding the subject's

- There was confusion as to what records could be released to the subject's lawyer.

Recommendations:

1. NFPC management should ensure that staff review digital video recording policy so that recordings are not viewed without authorization.

2. NFPC management should ensure that staff review NFPC SOPs regarding daily comments being entered in CORNET for all inmates

3. NFPC management should consider what measures can be put in place to prevent inmate

4. The health care contractor should ensure health care staff have a process for monitoring alerts in CORNET, including expiry dates when the alert is no longer in effect.

5. NFPC management should ensure that all incoming documentation or notes concerning discussions (e.g. from lawyers family) related to inmates are scanned and attached or noted in CORNET.

6. The health care contractor should remind health care staff that all collateral information from outside agencies should be brought to the attention of the appropriate health care professional and recorded in the Primary Assessment and Care (PAC) inmate health information system.

7. The provincial director should ensure the authority and procedures for sharing inmates' information with outside agencies is clarified for all staff.

CORRECTIONS BRANCH
Critical Incident Review

Subject: Inmate Death

Date of Incident: at Prince George Regional Correctional Centre

Review Team:

Evan Vike	Chair	Warden Kamloops Regional Correctional Centre
Joe Peters	Member	Assistant Deputy Warden Prince George Regional Correctional Centre
Diane Shepherd	Member	Director of Health Services Adult Custody Division
s.22	Member	Community Advisory Board Prince George Regional Correctional Centre
Lynette Pineau	Participant/ Observer	Inspector Investigation and Standards Office

Review Dates:

January 2 to 4, 2013 at Prince George Regional Correctional Centre

Mandate and Scope of Review:

On the acting assistant deputy minister, Corrections Branch, requested that a critical incident review be conducted to investigate the circumstances surrounding by an inmate at the Prince George Regional Correctional Centre, 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 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.

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

Background:

On s.22 (the subject) was admitted to the Prince George Regional Correctional Centre (PGRCC) at approximately on a

the subject had come into contact with B.C. Corrections and he

When the subject arrived from court at the centre's admission and discharge area he was frisked by the receiving correctional officer. The officer recalled that the subject

, When the officer asked the subject if (a routine question) he replied A short time later the officer asked the subject how he was doing; the subject replied by telling the officer the story . The officer asked the subject if he had any intentions and advised the subject that if he did he should tell the officer so he could ensure he received the necessary help The subject

While being held in the admission and discharge area the officer asked the subject how he was doing several times, each time the subject The officer recalled the subject saying The officer did not observe any indications to suggest the subject was The officer informed the classification officer that the subject

The review team interviewed the health intake nurse of She reported that the subject was but she observed him as being . When the intake nurse asked the subject about any history of . The intake nurse observed him as being The intake nurse identified that the subject had been she subsequently called the health care on-call physician, who directed the subject be assessed The intake nurse recalled that she made an appointment for the subject to be assessed at the next clinic, which was scheduled for . She also recalled that she or the mental health screener made an urgent appointment for the subject to be assessed by

The intake nurse discussed her assessment of the subject with the mental health screener in regards to the subject's unit placement. They agreed that the subject should be placed in a correctional centre. The intake nurse assessed that the subject was The intake nurse did not recall conferring with any correctional staff regarding the subject.

The mental health screener (the screener) responsible for assessing the subject during intake was interviewed by the review team. The screener recalled the subject answering all required screening questions. The screener assessed that the subjec . The screener further recalled that the subject He told the screener he was r. The screener noted that the subject seemed .

During the admission process the subject was interviewed by the classification officer (CO). The CO advised the review team that this was the subject' and he had Before the CO interviewed the subject he conferred with the intake nurse and screener, both of whom described the subject a The CO recalled that the subject The subject presented as He answered all questions clearly and concisely and volunteered the story behind his charges. Based on his experience with other inmates, the CO assessed that the subject's mood As the subject , the CO arranged for the subject's placement in The CO recalled making a note

in the subject's CORNET Client Log summarizing the classification information. The CO completed the required Inmate Assessment (IA) form.

The following morning, , the mental health coordinator (MHC) interviewed the subject. The MHC told the review team that he recalled reviewing the screener's report prior to interviewing the subject. He also reviewed the subject's Client Log, which indicated the subject was

The MHC informed the review team that his session with the subject lasted approximately one hour, during which the subject disclosed he had bee

prior to his admission. The MHC relayed that the subject disclosed he had
The subject presented as bein
The subject requested a t
however, when the MHC provided information about the subject did not pursue the matter further. When the subject was queried by the MHC he
The MHC informed the review team that he determined the subject
The MHC also recalled making a note in the subject's electronic health care file that the subject should be monitored and any concerns brought to the MHC's attention; however, the MHC could not remember if he made a note in the subject's Client Log for corrections staff. This was the extent of the MHC's contact with the subject.

The review team interviewed the unit officer of . The unit officer, in the job, informed the review team that he did not know the subject prior to coming on shift on nor was any information available or provided indicating the subject The unit was unlocked at s.15 hours. The unit officer recalled that he reviewed the subject's Client Log entries, had two brief conversations with the subject at the staff station, that the subject made brief eye contact, used the phone a couple of times, was quiet, kept to himself, mainly remained in his cell, and , all of which did not indicate to him that the subject The unit officer also recalled that other inmates in the unit were not acting oddly so as to suggest that something was happening.

At approximately 0900 hours the unit was locked and was to remain so until noon due to staff training. Unit cell checks were conducted every s.15 as per PGRCC Standard Operating Procedures (SOP). The unit officer recalled he conducted a cell check at approximately 1035 hours and had no concerns; however, at the 1100 hours cell check the unit officer observed a in the subject's cell and the subject on the floor, The unit officer immediately radioed a code blue and waited for responders (corrections staff and nurse) to arrive.
The unit officer recalled that the first officer responder (the responder) arrived s.15 s.15 after the code blue; the unit officer immediately advised the responder of the situation. Upon looking into the cell, the responder radioed control that an ambulance was required. Subsequently, a second responder arrived. The unit officer recalls the responders' decision to keep the cell door closed until first aid or medical staff arrived, as they determined there was nothing they could do until that time. The unit officer informed the review team that responders continued to arrive at the scene, in total. The cell door was opened when the nurse arrived and she immediately attended to the subject. The unit officer recalled that he . He confirmed that he had a current basic level first aid certificate.

During his interview with the review team, the responder recalled arriving at the scene of the code blue quickly, having coincidently just entered the unit. The unit officer informed the responder that the subject had and he had no idea of the severity. The responder recalled that when he looked through the cell window he immediately radioed control to call for an ambulance. He also recalled a second responding officer arriving and the officers staying by the closed cell door until health care arrived. According to the responder, the inmate wa The responder related that he asked the subject if he was okay, but . He also observed there was on the partition by the toilet and the When the nurse arrived the subject's cell door was opened and the responder and nurse entered together. The responder recalled and the nurse attending to the subject immediately. When the ambulance paramedics (the paramedics) arrived they . The only prior information the responder had regarding the subject was . He was not aware of an

The responder informed the review team that he did not enter the cell immediately for several reasons: policy requiring that a nurse be present; concerns for officer safety – the possibility that the subject had a weapon; and, health and safety concerns given the

The review team interviewed the control officer on duty the day of the event. She was one of two control officers on shift but was the most involved during the incident. She recalled responding to the unit officer's code blue, radioing the code to all officers and moving a CCTV camera to view the situation. The control officer responded to a

subsequent radio transmission from the responder, and called for an ambulance. The control officer recalled the unit officer informing her that the subject's cell was he was the sole occupant of the cell, and that The control officer advised that the ambulance arrived at the centre at approximately hours and the paramedics were escorted to the scene. At approximately hours the shift assistant deputy warden (ADW) of regulations, at the request of the paramedics, directed the control officer to call 911 and request an unit. The 911 operator informed the control officer that the unit was attending another accident and unavailable. The paramedics left the centre with the subject at 1145 hours.

The review team interviewed the primary correctional supervisor (CS) who was the first CS on the scene; she recalled entering the unit with another responder. The CS informed the team that she did not know the subject, observed officers by the cell and that the cell door was closed as was appropriate. The CS advised that she assessed the situation, saw , on the partition by the toilet, and the subject in front of the cell door. She reported that she tried to communicate with the subject but could not see his face. The CS recalled informing the ADW of the situation when she arrived at the scene. The CS further recalled gloving up, with other responders, in preparation for entering the cell. About into the situation, the nurse arrived along with other responders.

The CS recalled that prior to opening the cell door she asked the unit officer if the subject was alone. The CS confirmed that the subject was alone in the cell, By the time the nurse arrived the CS had determined it was safe to enter the cell. The door was opened and an officer stepped or reached in and removed before or about the same time as the nurse entered. The nurse attended the When the paramedics arrived they took charge of the subject's immediate needs and The CS relayed it would be normal for staff not to enter a cell prior to a CS's arrival, before sufficient staff were present and proper precautions were in place for safe entry. Due to the CS was concerned about staff The CS also informed the review team that once she had completed her assessment a cell entry would have occurred without medical staff (the nurse) if necessary.

The review team interviewed the ADW. She recalled that she did not know the subject or have any information about him other than that furthermore, the subject had not been identified as In response to the code blue the ADW entered the unit and observed what was occurring. She recalled that the subject's cell door was closed. The CS in charge of the situation informed her that she thought the subject . The ADW recalled observing a few staff in the unit, and that the nurse arrived shortly after she did, at which

time the cell door was opened and the nurse attended to the subject. The ADW recalled that the CS was handling the situation. The ADW informed the review team that she is the critical incident response team (CIRT) coordinator for the centre and had ensured all involved staff attended a CIRT debriefing meeting. According to the ADW, the CIRT also followed up with staff involved in the situation.

The ADW also informed the review team that staff would not enter a cell in response to a code until sufficient responders arrived and assessed the scene. In a situation such as this, the person with first aid training would address an inmate's immediate needs; staff without first aid training would not deal with the situation. When asked how many staff are required to deal with a code response situation, the ADW replied from staff, depending on the situation.

During the attending nurse's interview with the review team, she advised that prior to the incident she had not known the subject or had any information about him. She recalled entering the unit, observing a few staff around the closed cell door and gloving up. The cell door was opened upon her arrival, although it was difficult to enter because the . The nurse recalled that the subject was talking and that he complied with her request to move . The nurse recalled entering the cell with an officer and being the first to reach the subject. At first the subject was very responsive to the nurse's questions; he made statements to the nurse

The nurse recalled assessing the cell to ensure it was safe. She reported that this was The nurse advised that the subjec The nurse was the only responder with CPR training of those who were with the paramedics moving the subject from the unit to ambulance, and the only RN on shift at the time. The unit officer who also had CPR training had already been excused from the situation by the ADW as the officer was The nurse departed in the ambulance and one LPN was left at the centre. The health care manager was called in and the nurse returned to the centre following the ambulance's arrival at the hospital.

The subject's first and second cellmates were interviewed. The inmate who shared the subject's cell in unit – from the evening of until the morning of informed the review team that the subject was

on the subject's comments, the cellmate observed he was The cellmate did not pursue further conversation with the subject and the subject went to bed early. The following morning, the cellmate observed the subject reading the newspaper prior to going to healthcare. That was the last time the cellmate saw the subject. The cellmate did not convey any information to the unit officer.

The inmate who shared the subject's cell in unit – from the afternoon of until the morning of when the cellmate left for court – recalled that the subject The cellmate learned after the fact that the subject told other inmates he was The subject did not want to engage with the cellmate; however, any comments the subject made were The cellmate recalled the subject having The cellmate did not think the subject He was very surprised to hear of the incident when he returned The cellmate informed the review team that when he returned from court other inmates on the unit told him that the subject had In the cellmate's opinion . The cellmate did not convey any information to the unit officer.

A Prince George police report to the Crown counsel stated that the subject sai numerous times during the police interview; furthermore, the police report recommended An attempt to contact the author of the police report was unsuccessful; however, the police provided the booking information form (C13-1), which described while being booked into police lockup. The screening portion of the form indicated the subject's state of mind were identified.

Further follow-up included interviews with the deputy sheriff who escorted the subject from police lockup to court and the deputy sheriff who escorted the subject from court to the centre for admission. Neither deputy recalled receiving information from the police lockup guard or the court regarding concerns about the subject, nor did the deputies recall the subject that would cause concern. The deputy who escorted the subject to court recalled receiving the police booking information form (C13-1) from the guard and completing the booking out portion. The deputy provided a copy of the form during the interview; the review team had previously received a copy.

Findings:

- The subject was assessed by the mental health screener as per the Adult Custody Division (ACD) Health Care Services Manual (HCSM) policy. The mental health screener completed the Jail Screening Assessment Tool.

- The subject was assessed by the intake nurse as per the ACD HCSM policy. The Initial Health Information form was completed.

- As per PGRCC SOP and Adult Custody Policy (ACP), the classification officer on intake interviewed the subject and completed the Intake Assessment (IA). No

placement risks were identified and the classification officer appropriately assigned the subject to

- The subject was reclassified from at the request of the subject. . As per ACP, an Inmate Re-assessment was completed by the classification officer, and a Client Log entry made.

- The interviews and assessments conducted by the intake nurse and mental health screener They agreed that a placement in unit with a cellmate,

- The mental health coordinator's assessment of the subject revealed he wa

- The mental health coordinator made an entry in the Primary Assessment and Care inmate health information system indicating that the subjec however, he did not define Although this information was also intended for corrections staff, an entry was not made in the subject's CORNET Client Log or communicated to corrections staff.

- An appointment was made for assessment of the subject's ; however, the incident occurred prior to the appointment.

- An appointment was made for the subject to be assessed by

  The subject did not have an opportunity to be assessed by

- The event occurred while the inmate population was locked down due to staff training.

- At approximately 1100 hours, the unit officer discovered the injured subject while conducting a living unit count (cell check) as per ACP and PGRCC SOP. The previous living unit count (cell check) occurred at approximately 1035 hours; no concerns were noted. Seconds after discovering the injured subject, the unit officer radioed a code blue call to control.

- The control log indicates the code blue was announced to all staff at approximately 1100 hours.

- The control log indicates that at approximately 1100 hours, a call was made to 911 and an ambulance requested.

- The different sources of clock time associated with this event from the Electronic Security Communication System, Digital Video Management System (DVMS) and actual time were not compatible. As a result, all responder times noted below were taken from the DVMS in reference from when the code blue was logged by the control officer at 1100 hours.

- Approximately s.15 after the code blue announcement, the primary CS and responders had arrived at the subject's cell door. The CS conducted a risk assessment. Other responders followed shortly thereafter, seven in all.

- The unit officer was certified in Occupational First Aid level 1.

- The nurse arrived approximately s.15 after the code blue announcement. The cell door was opened and the nurse attended to the subject's

- As per ACP and PGRCC SOP are provided to inmates as part of their toiletries. ACD has approved the .

- PGRCC's code blue SOP lists a nurse as a responder and indicates that at least staff responders must be present before a cell door is opened. The initial responders were of the understanding that the nurse had to be present before the cell door could be opened .

- Some responders made comments of concerns they had of entering the cell due to lack of training and knowledge of how to protect themselves

- The ambulance paramedics arrived at the cell door approximately s.15 after the code blue announcement.

- An Inmate Assessment (IA) was completed pertaining to escort security during the subject's transport and admission to the hospital. officers were assigned to escort duty.

- All staff directly involved in the incident submitted the required reports. The shift ADW coordinated a CIRT debriefing on the day of the incident for all involved staff.

- As per interviews of the subject's cellmates, in neither case while sharing a cell did the subject
  however, both cellmates observed that the subject was

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- The last CORNET Client Log entry on the subject was made on
  no further entries were made between . This does not comply with ACP and PGRCC SOP requirements that Client Log entries be made every four days.

Recommendations:

1. The provincial director should review requirements for staff responding to code blue situations to determine if Adult Custody Policy needs to be enhanced.

2. PGRCC management should review and clarify their code blue response SOP, specifically pertaining to staff with first aid training assisting those in medical need while awaiting health care response, and deliver training as required.

3. The director, Health Services should review the need for education and training to raise correctional staff's awareness regarding .

4. The director, Mental Health Services should review PGRCC's services arrangement with the health care contractor.

5. The director, Mental Health Services and the director, Health Services should consider the need for a standardized assessment tool and provide training to all health care staff.

6. The health care contractor should ensure all new and existing health care staff are made aware of the requirement to provide corrections staff with information pertaining to the safe housing of inmates at the centre.

7. PGRCC management should review the practice of CORNET Client Log entries to ensure policy requirements are met, and ensure that staff are reminded of the policy and/or any changes resulting from the review.

CORRECTIONS BRANCH
Critical Incident Review

Subject: Inmate-on-Inmate Assault

Date of Incident: at North Fraser Pretrial Centre

Review Team:

Kary Steele	Chair	Deputy Warden Surrey Pretrial Services 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
Lynette Pineau	Participant/ Observer	Inspector Investigation and Standards Office
Diane Shepherd	Member	Director, Health Services Adult Custody Division
Maureen Olley	Member	Director, Mental Health Services Adult Custody Division

Review Dates:

at North Fraser Pretrial Centre

Mandate and Scope of Review:

On the a/assistant deputy minister, Corrections Branch, requested a critical incident review be conducted to investigate the circumstances surrounding the assault of an inmate that occurred in the at North Fraser Pretrial Centre 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 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 were contacted to ensure the review would not compromise any investigation that the department may have been conducting. Clearance was granted and the review proceeded.

Background:

On , at approximately 1903 hours, a correctional officer initiated a code blue in the unit at North Fraser Pretrial Centre (NFPC). The officer reported that he had been sitting at the unit desk and observed on a digital video monitor inmate hereafter "the victim", who appeared to be unconscious on the floor of

Health care and correctional staff responded to the cell. The victim's roommate, inmate hereafter "the subject", was removed from the cell and put in an adjacent yard. The victim was assessed by the centre health care staff and emergency health services were contacted via 911.

The health care staff leaving the inmate in the same position as he was found in. It has been documented that health care staff suspected, based on information provided by the subject, that the victim

Shortly after the victim was sent off the grounds via ambulance, the correctional supervisor (CS) reviewed the cell digital video recording (DVR) and realized that the victim had been

The victim was remanded to custody at NFPC on charged with . His Inmate Assessment (IA) was completed and noted and he was found suitable for double-bunking by the initial intake classification officer. He was placed in a general population unit at NFPC.

On the subject was remanded in custody at NFPC, charged with His Inmate Assessment (IA) was completed and it was noted that the subject . He was found suitable for double-bunking by the initial intake classification officer. s.15 with other suitable inmates. He was placed in at NFPC.

On , the subject was suspected of on and was transferred to for further investigation. s.15 He was charged with

On the subject was transferred to Surrey Pretrial Services Centre (SPSC) to await a transfer to Upon arrival at SPSC, his inmate assessment was updated by the initial intake classification officer and he noted

at this time. His CORNET alerts were not updated to reflect the change, contrary to Adult Custody Policy. The initial intake classification officer at SPSC reported that the decision to make the subject

The initial intake classification officer at SPSC recommended that the inmate be placed

On the subject was transferred on

On he was re-admitted to SPSC and transferred the same day back to NFPC. The classification officer on shift at SPSC who arranged the subject's transfer to NFPC noted that he was and this officer updated the inmate's client log to reflect that the subject was The classification officer made an entry in the subject's client log but did not update the subject's Inmate Assessment to reflect the change.

Upon receipt at NFPC, the acting initial intake officer at NFPC reported interviewing the subject and determined that he
He recommended that . In addition, he recommended in the subject's client log that the subject be .

The subject's updated IA was reviewed and approved but the changes making the subject were not reflected in this updated document.

The mental health screener did not interview the subject upon his return to NFPC. It is not a requirement for an inmate on a to be re-assessed by a mental health screener.

The subject was placed in from with another inmate with no reported issues.

On at NFPC, the assistant deputy warden reviewed the subject's placement and placed him The rational for the continued placement was noted as:

It is unclear as to where the initial intake classification officer or the assistant deputy warden who reviewed the subject' received the information that as the MHS did not formally interview the inmate upon intake.

On inmates on living unit began complaining about the victim's and, as a result, the victim reported to staff that he was He was moved to on and subsequently to on due to continued issues.

On at approximately 1045 hours, the victim wa

. . At approximately 1217 hours, the segregation unit officers placed the victim in with the subject.

As part of the critical incident review, the following facts surfaced after a review of the DVR footage and staff reports from :

- Based on a review of the DVR footage of the cell, the inmates appear to have a brief verbal exchange and are let out of their cell at 1230 hours for their exercise period. A unit officer reported that the inmates elected to terminate their exercise period early and were secured back in the cell at approximately 1301 hours. The inmates were re-secured in the cell until dinner was served at approximately 1650 hours. From the DVR footage there are no noted behavioural issues. The inmates appear to continue to talk, move around the cell, or sleep.

- At approximately 1733 hours, the subject is seen offering the victim some food, which he accepts. The inmates are seen shaking hands. The victim then appears to lie face down on the upper bunk and go to sleep.

- The subject moves around the cell, lies on the lower bunk, drinks water, and uses the toilet several times throughout the next hour.

- At approximately 1836 hours, the subject appears to be stretching his arms and legs while sitting on the lower bunk.

- At approximately 1844 hours, the subject appears and shows someone on the other side of the cell door

- At approximately 1846 hours, the subject sits back down on the lower bunk and appears to stretch some more.

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- At approximately 1903 hours, the unit officer reported he viewed on the desk monitor an inmate lying on the floor and initiated a code blue over his portable radio. The last documented check prior to the announcement of the code blue was at 1750 hours.

- At approximately 1904 hours, he appears to be speaking to someone and sits on the lower bunk.

- At approximately 1905 hours, the subject is removed from the cell and placed in The health care staff then enters the cell.

- Health care staff are observed checking the victim's .

- At hours, correctional staff then enter the cell and placed their hands on the victim's legs and torso. The responding staff stated that the inmate appeared

- At approximately hours, paramedics enter the cell, stand back and appear to speak with a nurse. The health care staff are observed continuing to provide first aid to the victim.

- At approximately hours, the paramedics leave the cell, followed by the health care staff and the victim is carried by correctional staff to the paramedic's stretcher.

The paramedics transported the inmate to the hospital.

The subject was removed from the yard and placed i .

The RCMP were contacted and as a result of their investigation they have recommended against the subject.

The subject was charged under the *Correction Act Regulation* During his disciplinary hearing, the subject stated that he assaulted the inmate because he thought he wa

The victim returned from the hospital on and placed on Based on evidence provided by the medical director, the victim did not
On he was sentenced and on was transferred to Fraser Regional Correctional District.

Findings:

- The code blue response was prompt and effective.

- During the course of this review, non-compliance with Adult Custody policy and local policy and procedures was noted, specifically:

    - Visual cell checks were not conducted in accordance with Adult Custody policy – specifically, frequency and requirement to document.

    - Living unit logs entries were not conducted in accordance with local policy – specifically, the officers assigned to maintain and update the segregation unit log book did not document the date at the commencement of their shift, length of shift hours, visual checks, visitors to the unit, and unusual occurrences.

    - The victim's cell placement was not authorized by a supervisor as required in local policy.

  - The subject's electronic Inmate Assessment was reviewed and approved but not updated on .

  - The forms referenced an opinion made by the mental health screener (MHS) even though the MHS did not assess the inmate. The unconfirmed opinion was part of the rational for placing and keeping the subject

- The subject was on a temporary absence from The subject was not assessed by mental health staff when he returned to a provincial correctional centre. A summary of his was sent to SPSC and forwarded to NFPC. It was placed in the subject's file without a date stamp and was not reviewed by a centre physician.

- The subject provided misleading information to correctional and health care staff regarding what occurred to the victim. Prior to treatment or movement of the victim, health care staff did not seek further clarification to how the inmate got on the floor. As such, health care staff could not confirm that the victim did not have a C-spine injury. Trained medical staff should have provided further care and direction to correctional staff when they moved the victim without C-spine considerations due to potential unknown injuries.

- When the paramedics arrived in the cell, they did not take an active role in assisting the health care staff or moving the victim to the stretcher. The CIR team was unclear as to when the inmate's medical care should be transferred from correctional staff to paramedics. The paramedics transported the inmate to the hospital.

- The warden or designate is responsible to establish protocol for entry of alerts in CORNET. The subject's over a period while at two separate centres and it was not recorded on the subject's alerts.

- Only DVR footage of the unit for the duration of the response was saved by NFPC. This made it challenging to review staff check times leading up to the incident.

Recommendations:

1) NFPC management should ensure staff are aware and are reminded of the importance of relevant policies and procedures regarding visual checks, documentation requirements, policy, inmate assessments, and placement.

2) The director of health services should review and clarify the process as to when an inmate should be assessed by centre medical staff when

3) The director of health services should review and clarify the process for moving an inmate with possible C-spine injuries.

4) The director of health services should review and clarify as to when an inmate's medical care is to be transferred from health care staff to attending paramedics.

5) NFPC and SPSC management should review policy specific to alerts and provide direction to staff.

6) NFPC management should review current practice regarding the collection of evidence after an incident and include all DVR of the area leading up to and including the time of the incident.

CORRECTIONS BRANCH
Critical Incident Review

Subject: Inmate Death

Date of Incident: at Nanaimo Correctional Centre

Review Team:

Shauna Morgan	Chair	Warden Vancouver Island Regional Correctional Centre
Marlene McKay	Member	Assistant Deputy Warder Nanaimo Correctional Centre
Diane Shepherd	Member	Director of Health Services Adult Custody Division
	Member	Community Advisory Board Nanaimo Correctional Centre
Lynette Pineau	Participant/ Observer	Inspector Investigation and Standards Office

Review Dates:

at Nanaimo Correctional Centre

Mandate and Scope of Review:

On the acting assistant deputy minister, Corrections Branch, requested that a critical incident review be conducted to examine the circumstances surrounding an inmate death at Nanaimo Correctional Centre and to specifically 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 Nanaimo 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.

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

Background:

, inmate (the 'subject") reported to the Nanaimo Correctional Center (NCC) at to comply with his sentence. The subject was for charges of . He commenced his at NCC.

The subject :

The subject self-reported to the classification officer that he and his offences were

Upon initial intake on , the subject was seen by the intake nurse and an initial health assessment was completed. He reported a past history of but there were no presenting health issues. In accordance with policy he was screened as a new intake by the mental health screener and reported

The subject reported to Records at approximately and the records officer did not note any unusual behaviour. The subject was changed out of his civilian clothes by a correctional officer who was familiar with the subjec He did not observe any unusual or suspicious behaviour with the subject or . It is noted that the subject had

On 1825 hours, the subject and other were moved to unit In transit to the unit, other inmates, who had commenced their were collected from and added to this group. A review of digital video recording (DVR) for the previous evening showed .
This same inmate later became the subject's roommate in .

that has recently been renovated and is used when th s.15 t. The subject had in this unit; however, he had been housed in living area is composed of three rooms: common area, sleeping area, and a washroom. The sleeping area has six bunks, for a maximum capacity of twelve. The adjoining common area has a kitchenette, tables with seating, and a television. There are three other rooms in the trailer that are not accessible to inmates.

On at 1900 hours, a review of the DVR showed the subject and the roommate repeatedly going in and out of the washroom area and into their bunk space. . At 1915 hours another inmate was brought into the unit. The subject and roommate quickly connected with this inmate and the three engaged in similar activity; hovering near the washroom door and taking turns in the bunk space s.15 The other inmates in the unit stayed in the common area and it appears that, while aware of the activity, they did not participate or engage with the subject.

Following the aforementioned suspicious behaviour, the subject moving from sitting to standing and then lying on the floor. He can also be seen

(Such behaviours are consistent) During the interview with the roommate, he described the subject's behaviour as and states he was The roommate denied on the unit.

At s.15 hours, a correctional officer entered the unit and proceeded to move through the unit. The log book describes this visit as a "tour" and a count of inmates is documented.

At s.15 hours, a correctional officer and a nurse attended the unit, but no entry is made in the log book. The correctional officer told the committee that he forgot to log the count and that he asked another officer to write in the formal count for him.

At 2116 hours, the subject is viewed slowly climbing up onto his bunk. He lay on his stomach with his face on a pillow and his arms up by his head. Soon after he laid down,

camera coverage shows the subject's

A count is conducted at s.15 hours, and no unusual behaviour in the unit is observed. At 2159 hours, the roommate and the other inmate approached the subject in his bed and attempted to wake him up. The roommate turned the subject's head from face down to the side. When interviewed, the roommate stated he was concerned about

At 2201 hours, the roommate turned off the night light in the bunk space and moved his mattress into the common area where he spent the night.

At s.15 hours, a correctional officer entered the unit to conduct a count. The overhead lights in the unit are off and the officer did not use a flashlight. The officer indicated his flashlight was out of batteries and he did not feel it was required. He did not note anything unusual in the unit.

As per NCC standard operating procedure (SOP), the 2230 hours count is to be an identification count which requires inmates to present their phone card to the officer to confirm identity. A correctional officer attended the unit at s.15 hours and conducted a count but this count did not comply with the NCC SOP.

At s.15 hours, and at s.15 hours, , counts were conducted. The officer did not use a flashlight and recalls seeing an inmate on a mattress in the common room. This officer reported that all the inmates were alive during both his counts and he saw the subject lying face down in his bed. It is noted that this officer informed the review team that he reviewed the DVR footage of the incident prior to completing his report.

On at s.15 hours, counts were conducted. The officer used his flashlight and looked into each bunk space. He stated that he is familiar with the unit, and noted that there was one inmate snoring, but it was not the subject. He did not see or hear anything unusual.

The day shift correctional officer conducted counts at s.15 hours with the count at s.15 hours being a formal count called into Control. This officer used her flashlight for the s.15 hours count and she reported there was enough daylight for the remaining counts.

At 0819 hours, inmates started getting up and approached the subject's bunk to get a closer look at him. It appeared that they were trying to wake him up; and, after no success, they gathered in the common area and the roommate pushed the call button at 0835 hours. He stated to the control officer that "we have a dead guy down here". The control officer activated a code blue and called 911.

First responders arrived at the unit at and were directed by the inmates to the subject's bed.

The nurse arrived with the emergency bag at hours and immediately commenced her initial assessment. She but continued to with the assistance of a corrections first responder while the other officer commenced .

BC Ambulance Service arrived on site at hours and assumed care of the subject. The subject was pronounced dead at 0902 hours by paramedics. The coroner was then notified.

The assistant deputy warden (ADW) was reached at her home just after 0900 hours and arrived at NCC at 0930 hours. The warden was contacted and arrived at NCC at 0945 hours and was briefed by the ADW. The acting provincial director was contacted as per ACP.

An RCMP member was on site in at 0930 hours and the coroner at 1003 hours. Both concluded their review of the scene and the funeral home recovery team was contacted. The body was supervised at all times until removed at 1130 hours.

was then secured and, at a later time upon direction of the ADW, a search was conducted. found t Nothing else of consequence was found. given to the coroner.

The coroner and RCMP interviewed the inmates. An acting correctional supervisor was present and recorded the interviews. The inmates denied that there were unusual activity on the unit. A few relayed that they heard weird breathing sounds in the night, and found the subject dead in the morning.

All inmates were and seen by the mental health co-ordinator. All the tests

The critical incident response team (CIRT) members and shop stewards were contacted by an unauthorized correctional officer. After they were contacted, they attended the site and assisted staff with reports and debriefing. Staff were relieved of duty and backfill provided. Some staff were

The primary incident reports were completed in a timely fashion.

Findings:

- On , as per NCC SOP, the classification officer conducted an intake interview with the subject

- The subject was assessed by the intake nurse and an IHA was completed as per Adult Custody Policy (ACP) and Health Care Services Manual (HCSM) policy. No health issues were identified.

- The subject was assessed by a mental health screener upon intake as per ACD and HCSM policy and no concerns were identified.

- On the weekend of , the subject reported to NCC as required and participated in the intake process as per NCC SOP. No unusual behaviours were observed by staff.

- It is noted that the only CORNET Client Log entry made was for . This is contrary to ACP and NCC SOP that require CORNET Client Log entries to be made once every four days.

- The counts at s.15 hours were logged as a "tour". These checks should have been logged as a "visual check" as per NCC SOPs. Staff indicated that they do "tours"; however are confined to their unit and therefore visual checks at intervals not to exceed s.15 must be conducted. Staff do not sign their name in the log book.

- The formal count at s.15 hours was conducted as per NCC SOP; however, the correctional officer did not document the count in the unit log book. He asked another correctional officer to write the count in the unit log book, but that officer forgot to log the count.

- At s.15 hours, a correctional officer attended the unit, walked through and logged a count. According to NCC SOP, a formal identification count should have been conducted at s.15 hours. The count was not conducted in accordance with policy.

- Beginning on the remaining counts from s.15 hours on did occur. Some staff used flashlights during the night time hours; other staff did not. Staff did not approach each bed and watch for signs of life; however, they did look into the sleeping area and count bodies. When interviewed, staff stated they believe that they were in compliance with the NCC SOP which requires them to note the inmates "presence and condition" when doing the visual check.

- At 2201 hours on the roommate turned off the night light in the bunk space and moved his mattress into the common area where he spent the night.

- When the code blue was called, correctional staff and the nurse responded and their life saving measures were commendable.

- As per ACP, critical incident notification requirements were made to the warden and then to the acting provincial director.

- As per NCC SOP, the protection of scene and notifications were made appropriately.

- As per ACP, post-emergency measures were taken to care for inmates by health care and the mental health co-ordinator.

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

- As per ACP, post-emergency measures were taken to care for staff.

- Of note is that the CIRT staff and union stewards were contacted during the incident (0915 hours) by an unauthorized correctional officer.

- Several staff involved in the incident stated they had observed the DVR coverage of the incident and were not aware of Adult Custody Policy which directs that video is to be viewed on a "need to know" basis and only as authorized by the warden.

Recommendations:

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

2. NCC management should review their process for formal identification counts and ensure these counts are conducted according to policy.

3. NCC management should review their SOP for visual checks with the intent to provide further clarification as to what "presence and condition" means or to educate staff as to how to conduct these checks.

4. NCC management should review Unit Rules for inmates with all staff working in the unit to ensure the rules are enforced and that staff are familiar with the layout of the unit and the location of log books and flashlights.

5. NCC management should ensure that a bed placement sheet is implemented and maintained by staff supervising inmates in the unit.

6. NCC management should restrict access to digital video recordings as per Adult Custody policy and establish a standard operating procedure that addresses this.