CORRECTIONS BRANCH
Critical Incident Review

Subject: Inmate Death

Date of Incident: January s. 2016 at North Fraser Pretrial Centre

Review Team:

Phil Chafe	Chair	Warden Prince George Regional Correctional Centre
Raj Bahia	Member	Assistant Deputy Warden North Fraser Pretrial Centre
Dr. Maureen Olley	Member	Director, Mental Health Services
Shannon Dalzell	Member	Community Advisory Board North Fraser Pretrial Centre
Joan Parkin	Participant/ Observer	Inspector, Investigations and Standards Office
Dr. Scott Bezeau	Participant/ Observer	Chief Mental Health Officer Chiron Health Services Inc.

Review Dates:

January s.22 and s. 2016

Mandate and Scope:

On January s. 2016, the assistant deputy minister, Corrections Branch directed that a critical incident review be conducted to investigate the circumstances surrounding the death of an inmate at the North Fraser Pretrial Centre. Specifically, to investigate the following:

- 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 the North Fraser Pretrial Centre.

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

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

Background:

s.22

On s.22 2015, the subject returned to NFPC as a new intake charged with s.22 s.22 At the time of intake, no concerns of self-harm or suicide ideation were noted by the classification officer. The assistant deputy warden (ADW) placed the subject on short term separate confinement in unit Alpha West (AW) for a period of assessment due to s.22 demeanor that the intake officer described as *"odd"* s.22 s.22 The ADW had reasonable grounds to believe that the subject would likely be at risk of serious harm from others if not confined separately.

s.22

Page 03

Withheld pursuant to/removed as

s.22

The subject resided on unit CN for over four months until the incident on January s 2016. Client log entries during this time do not indicate any concerns with behavior, staff/peer interactions or mental health. The drug and alcohol counsellor provided the subject with self-directed workbooks; s.22 s.22 . Due to the lack of any behavioral concerns and positive interactions with others in the months before the January s 2016 incident, the subject was not actively monitored by the mental health team. Client log entries between s.22 , 2015 and January s 2016 from various staff suggest that the subject was doing well in unit CN.

At approximately 1045 hours on January s 2016, the MHLO and the mental health coordinator (MHC) attended unit CN to conduct interviews. At this time the subject was observed sitting by the phones s.22 The MHC observed that the subject was pale in color and appeared "off" and asked him how he was doing. The subject stated that he was feeling sick to his stomach. From this interaction, the MHC attributed the subject's appearance and demeanor to a physical illness and referred the subject to the centre physician for follow up.

At approximately 1115 hours, video recordings show the subject s.22 s.22 s.22 . This action was not observed by the unit officer at the time.

At approximately 1234 hours the CN unit officer was conducting a unit check and observed the subject sitting on the s.22 stairs. The unit officer asked the subject if everything was ok to which the subject replied *"Yes, everything is ok"*. The unit officer reminded the subject that loitering on the stairs was not permitted and continued with his unit check. The subject remained sitting on the stairs for approximately one minute, proceeded briefly to the phone area on the third tier then went into his cell located on the second level. The subject remained in his cell for approximately thirty seconds. Upon exiting his cell, the subject s.22 s.22 s.22 At that time, no other persons were in the immediate vicinity of the s.15

At the time of the incident, the unit officer was located at the staff station attending to the needs of other inmates. The unit officer did not observe the subject s.22 s.22 and immediately called a code blue. There is no evidence to suggest that any other inmates had fore knowledge or involvement in this incident.

The first correctional staff member to respond was in the area, s.15 and immediately attended the unit. A second correctional staff member arrived on the unit approximately fifteen seconds later. Additional correctional staff and one nurse arrived on the unit approximately at approximately 1237 hours. Two more nurses arrived with the medical "crash cart" seconds later and attended to the subject.

At approximately 1238 hours, the physician arrived on the unit and attended to the subject. After a period of assessment of approximately five minutes, the physician declared the subject deceased. At approximately 1248 hours, ambulance paramedics arrived on the unit and departed shortly thereafter. The coroner attended NFPC at approximately 1430 hours and departed with the subject at approximately 1520 hours.

Post-incident measures were taken to care for the well-being of corrections and health care staff including support from the Critical Incident Response Team (CIRT). Post-incident support was provided to the inmates on unit CN by the chaplain, MHC, and MHLO.

s.22

s.22 An autopsy was not performed.

s.15

The unit officer assigned to unit CN on the day of the incident was not a regular unit officer and had not received any formal training for dealing with inmates with mental health needs.

Although health information in the incident was documented by a designated recorder, some health care staff were unsure of the process and provided additional documentation in Primary Assessment and Care System (PAC) as a precautionary measure. Most of the health care staff did not chart information in the PAC system as they were relying on the previous health care provider's process.

Findings:

On initial intake, the classification officer appropriately recommended classifying the subject to short-term separate confinement for a period of assessment. The ADW placed the subject on separate confinement in unit AW due to the s.22 s.22 belief that the subject would likely be at risk of serious harm if not confined separately.

s.22

In accordance with NFPC's standard operating procedures, daily client log entries were made while the subject was housed in unit AW.

s.22

The subject resided on unit CN for over four months. Client log entries do not indicate any concerns with behavior, staff/peer interactions or mental health. s.22 s.22

On January s 2016 the subject s.22 s.22 The unit officer observed the subject as s.22 and immediately radioed a code blue. There is no evidence to suggest that any other inmates had fore knowledge or involvement in this incident.

Response to the code blue by corrections and health care staff was very prompt and efficient. Appropriate measures were taken to secure the unit and protect the scene in accordance with Adult Custody Policy.

s.22

The unit officer assigned to unit CN on the day of the incident was not a regular unit officer and had not received any formal training for dealing with inmates with mental health needs.

The health care contractor's code blue policy does not adequately identify documentation responsibilities. Several health care staff relied on the policy from the previous health care contractor that identifies a designated recorder as responsible for documentation in an emergency situation.

Recommendations:

1. NFPC management should consider measures to prevent the ability of inmates to s.15 of units CN and AW.

2. NFPC management should ensure that all staff assigned to work in mental health designated units receive training in working with inmates with mental health needs.

3. The health care contractor should ensure their code blue policy is updated to clarify responsibilities for charting and documentation in emergency situations.

4. The health care contractor should ensure staff and contracted personnel are aware of the requirement to participate in critical incident reviews.

5. The director, mental health services and the chief mental health officer should consider best practices for ongoing long-term follow up with inmates s.15
s.15

6. The director, mental health services and the chief mental health officer should review the expectations for processing psychiatrists' consultation notes, including determining follow-up needs.

7. The director, mental health services and the chief mental health officer should review how the addiction counsellor at NFPC provides services to inmates.

Ministry of Justice
Corrections Branch
Adult Custody Incident - Primary

Master Incident Number: INC-0187513-01

Current State: Complete

Incident Date & Time: 2016.01.22 12:37

Code: ☐ Red ☒ Blue ☐ Yellow

Primary Incident Type: Injury/Illness/Birth

Incident Location

Reporting Centre: North Fraser Pretrial Centre

Location: C-N

Clients Involved

CS Number	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.22			Victim	☒	☒	☐	☐

Staff Involved

User Id	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.15,s.22			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐

Other Involved Participants

Type	Last Name	First Name	DOB	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
					☐	☐	☐	☐

Incident Details

On Friday s.22 2016, I was assigned to CN unit. At 1235 hours Inmate s.22 was sitting on the s.15 stairs as I was doing my unit check. This writer asked Inmate s.22 if he was okay which he replied "yes everything is ok". I then reminded s.22 that he was not allowed to loiter on the stairs and continued my check. As I came to the staff desk and started helping other inmates with their requests, I saw Inmate s.22 s.22 . I then called code blue on the radio and instructed the unit to lock up. I started to lock up the unit with the responding staff. Health care staff and supervisors responded and I was advised to get off the unit by CS s.15,s.22 . This concludes my involvement with this incident.

BRITISH COLUMBIA

Ministry of Justice
Corrections Branch
Adult Custody Incident - Primary

Master Incident Number: INC-0187513-01 **Current State: Complete**

Client Log Entry

Incident Report Created By: s.15

Reviewer/Correctional Supervisor

Incident Type	Incident Details Classifications			
Violence	☐ Assault	☐ Attempted Assault	☐ Threat	☐ Fight
Critical Event	☐ Riot	☐ Hostage	☐ Disturbance	☐ Fire
	☐ Escape	☐ Attempted Escape	☐ Extraction	☐ Natural Disaster
	☐ Inadvertant Release	☐ Inadvertant Hold	☐ Unlawfully At Large	☐ TAC
Contraband	☐ Marijuana	☐ Heroin	☐ Cocaine	☐ Methamphetamine
	☐ Brew	☐ Pharmaceuticals	☐ Tobacco	☐ Weapons
	☐ Electronics	☐ Tattoo Equipment	☐ Needles	☐ Others
Injury/Illness /Birth	☐ Self-Harm	☐ Accident	☐ Serious Illness	☐ Overdose
	☐ Birth	☒ Death COD: Suicide		
Behaviour	☐ Sexual	☐ Suspicious	☐ Inappropriate	☒ Mental Health
	☐ Predatory	☐ Horseplay	☐ Abusive	☐ Inciting
	☐ Theft	☐ Peer Problem	☐ Hunger Strike	☐ Non-compliance
Security	☐ BSCS	☐ Missing Items	☐ Unauthorized Access	☐ Maintenance
	☐ Inmate Communication	☐ Damage To Property	☐ Search	☐ Effects
	☐ Ion	☐ Intelligence	☐ False Code	☐ Money $
	☐ Information Incident			

At approximately 12:37 on s.15 2016, a Code Blue was called by Officer s.15,s. who was assigned to work CN. Along with other responders, I arrived on CN to find an inmate, later identified as Inmate s.22 s.22 . We were advised that this inmate s.22 . CS s.15, identified SO s.15,s. as the unit staff, and once the unit was locked he was s.15,s.22

Master Incident Number: INC-0187513-01 **Current State: Complete**

Reviewer Details

s.15,s.22 The responding nurses immediately attended to the inmate, s.22
s.15,s.22 which we provided. CS s.15,s.22 called Central Control via radio to have them send an ambulance s.15 . Nurse s.15 asked for the on site Dr. to attend, and I made the radio call to the Healthcare Officer to escort the doctor immediately to CN. At approximately 12:40 Dr Schlagintweit attended CN to assess the medical emergency. He and the nurses continued to treat and assess the situation, and at approximately 12:45 the doctor stated " He's gone". At approximately 12:46 the ambulance team arrived at NFPC and were informed of the death. Appropriate notifications were made, and the Coquitlam RCMP attended NFPC for investigation purposes. A debriefing for all available staff was completed at 13:20 in the s.15,s.22
s.15,s.22
Photos of the scene were taken and forwarded to Operations Manager. DVMS was saved. The coroner attended the center and left with the deceased at approximately. The times of arrival and departure for the coroner were scribed, and the notes forwarded to Management. Grief counselling was arranged with the Chaplain for inmates on CN.

s.15

Ministry of Justice
Corrections Branch
Adult Custody Incident - Primary

Master Incident Number: INC-0187513-01 **Current State: Complete**

Charges

External	☐ **External Charges**
Internal	☐ 21(1)A ☐ 21(1)B ☐ 21(1)C ☐ 21(1)D ☐ 21(1)E ☐ 21(1)F ☐ 21(1)G ☐ 21(1)H ☐ 21(1)I ☐ 21(1)J ☐ 21(1)K ☐ 21(1)L ☐ 21(1)M ☐ 21(1)N ☐ 21(1)O ☐ 21(1)P ☐ 21(1)Q ☐ 21(1)R ☐ 21(1)S ☐ 21(1)T ☐ 21(1)U ☐ 21(1)V ☐ 21(1)W ☐ 21(1)X ☐ 21(1)Y ☐ 21(1)Z ☐ 21(1)Z.1 ☐ 21(1)Z.2 ☐ 21(1)Z.2i ☐ 21(1)Z.2ii ☐ 21(2)A ☐ 21(2)B ☐ 21(2)C ☐ 21(2)D ☐ 21(2)E ☐ 21(2)F ☐ 21(2)G ☐ 21(2)H ☐ 21(2)I ☐ 21(2)J ☐ 21(2)K ☐ 21(2)L ☐ 21(2)M ☐ 21(2)N ☐ 21(2)O ☐ 21(2)P ☐ 21(2)Q ☐ 21(2)R ☐ 21(2)S ☐ 21(2)T ☐ 21(2)U ☐ 21(2)V ☐ 21(2)W ☐ 21(2)X ☐ 21(2)Y ☐ 21(2)Z ☐ 21(2)Z.1 ☐ 21(2)Z.2 ☐ 21(2)Z.2i ☐ 21(2)Z.2ii

Incident Report Last Reviewed By: s.15

Approver Comments

s.15 counselling made available by Chaplain s.15 s.15
s.15
s.15 after the RCMP and coroner had released the scene. DVMS was saved of the incident and for a period of time preceding. Photos were taken and forwarded to the DW Operations. Notification of the incident was made by the Warden to the Provincial Director. Restricted access only to the unit for persons authorized to be there.

☐ **Apply Confidentiality** ☐ **Attachments**

Incident Report Last Approved By: s.15

Requested by: s.15 Melaina Clarke Printed on: 2016.09.12 11:50

Ministry of Justice
Corrections Branch
Adult Custody Incident - Supplementary

Master Incident Number: INC-0187513-02

Current State: Complete

Incident Date & Time: 2016.01. 2 12:35

Code: ☐ Red ☒ Blue ☐ Yellow

Primary Incident Type:

Incident Location

Reporting Centre: North Fraser Pretrial Centre

Location: C-N

Clients Involved

CS Number	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.22			Instigator	☒	☒	☐	☐

Staff Involved

User Id	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.15,s.22			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Witness	☐	☐	☐	☐
			Responder	☐	☐	☐	☐

Other Involved Participants

Type	Last Name	First Name	DOB	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
					☐	☐	☐	☐

Incident Details

I responded to a called code blue on living unit Charlie North at approx. 12:35 hours. As I entered the living unit I saw CO s.15,s. at cells 4 and 5 securing doors with an inmate still in the shower area. I thought the incident was secured in the shower area so I made my way up to the second tier to secure the remaining cells so healthcare staff could access the unit. As I made my way up to the second tier s.15,s.22 s.15,s.22 I continued to lock up the second and third tiers and then I exited the unit to the lobby s.15,s.22 . This concluded my involvement.

Ministry of Justice
Corrections Branch
Adult Custody Incident - Supplementary

Master Incident Number: INC-0187513-02 **Current State: Complete**

Incident Report Created By: s.15

Reviewer Details

Incident report of Officer s.15 appears to be accurate and complete. Inmate s.22 had s.15,s.22 and was subsequently declared deceased. Report forwarded for approval.

Incident Report Last Reviewed By: s.15

Approver Comments

DVMS reviewed. This report appears complete and accurately captures this officers limited involvement in the incident. Please refer to the Primary report and other Supplementary reports for more information.

☐ **Attachments**

Incident Report Last Approved By: s.15

Ministry of Justice
Corrections Branch
Adult Custody Incident - Supplementary

Master Incident Number: INC-0187513-03

Current State: Complete

Incident Date & Time: 2016.01.s.22 12:37

Code: ☐ Red ☒ Blue ☐ Yellow

Primary Incident Type:

Incident Location

Reporting Centre: North Fraser Pretrial Centre

Location: C-N

Clients Involved

CS Number	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.22			Instigator	☒	☒	☐	☐

Staff Involved

User Id	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.15,s.22			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐

Other Involved Participants

Type	Last Name	First Name	DOB	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
					☐	☐	☐	☐

Incident Details

At approximately 1237 hours, a "Code Blue, Charlie North" was announced by Central Control and I, (Alpha 1), immediately responded by assisting Nurse s.15,s.22 with the Health Care "crash cart" on route to Charlie North. I entered Charlie North and noticed Inmate s.22 There was a

Master Incident Number: INC-0187513-03 **Current State: Complete**

Health Care staff tending to Inmate s.22 along with previous responders. Charlie North had already been secured. More responders arrived along with other Health Care professionals. That was the end of my involvement in this incident.

Incident Report Created By: s.15

Reviewer Details

At approximately 12:37 on s.22 , 2016, a Code Blue was called by Officer s.15,s. who was assigned to work CN. Along with other responders, I arrived on CN to find an inmate, later identified as Inmate s.22 s.22 . We were advised that this inmate s.22 CS s.15, identified SO s.15,s. as the unit staff, and once the unit was locked he was removed from the scene s.15,s.22 s.15,s.22 The responding nurses immediately attended to the inmate, s.15,s.22 s.15,s.22 CS s.15,s.22 called Central Control via radio to have them send an ambulance Code 3. The rest of the responding nurses arrived and assisted with treatment. Nurse s.15 asked for the on site Dr. to attend, and I made the radio call to the Healthcare Officer to escort the doctor immediately to CN. At approximately 12:40 Dr s.15,s.22 attended CN to assess the medical emergency. He and the nurses continued to treat and assess the situation, s.15,s.22 At approximately 12:46 the ambulance team arrived at NFPC s.15,s.22 . Appropriate notifications were made, and the Coquitlam RCMP attended NFPC for investigation purposes. A debriefing for all available staff was completed at 13:20 s.15,s.22 s.15,s.22 . Photos of the scene were taken and forwarded to Operations Manager. DVMS was saved. The coroner attended the center and left with the deceased at approximately. The times of arrival and departure for the coroner were scribed, and the notes forwarded to Management. Grief counselling was arranged with the Chaplain for inmates on CN.
CO s.15,s. account of his involvement and actions during this Code Blue incident appear to be accurate as they are written.

Incident Report Last Reviewed By: s.15

Approver Comments

DVMS supports the written report. The creator was in a role as escort to emergency medical personnel only and had no further involvement.

☐ **Attachments**

Incident Report Last Approved By: s.15

Ministry of Justice
Corrections Branch
Adult Custody Incident - Supplementary

Master Incident Number: INC-0187513-04

Current State: Complete

Incident Date & Time: 2016.01.s.2 12:35

Code: ☐ Red ☒ Blue ☐ Yellow

Primary Incident Type:

Incident Location

Reporting Centre: North Fraser Pretrial Centre

Location: C-N

Clients Involved

CS Number	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.22			Participant	☒	☒	☐	☐

Staff Involved

User Id	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.15,s.22			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐

Other Involved Participants

Type	Last Name	First Name	DOB	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
					☐	☐	☐	☐

Incident Details

At approximately 12:35hrs on January s. 2016 I was posted as Charlie one and standing in the Charlie Pod lobby. I s.15,s.22 that originated from Charlie North. I entered the unit immediately and a Code blue was initiated by the unit staff SO s.15,s. SO s.15,s. informed me upon entry that an inmate s.22 . I looked towards the unit telephones and saw an injured inmate s.22 , later identified as Inmate s.22 s.22 . I gave direction for the unit to return to their cells and lock up. I approached the injured inmate and s.15,s.22 The

Master Incident Number: INC-0187513-04 **Current State: Complete**

injured inmate s.22 I secured the first tier and headed up to the third tier to secure it as; responding staff were already on the second tier. Window coverings were placed over cell door windows. CO s.15,s and I were tasked to wait out front of the building and wait for the responding paramedics. Ambulance and fire arrived at approximately 12:45hrs and CO s.15,s escorted the first arrivals into the jail and I waited out front for a second ambulance we were informed was arriving shortly. The second ambulance arrived at approximately 12:50hrs s.15,s.22 s.15,s.22 s.15,s I escorted the paramedic out of the Sally Port. This ends my involvement in this incident.

Incident Report Created By: s.15

Reviewer Details

At approximately 12:37 on December 8, 2016, a Code Blue was called by Officer s.15,s. who was assigned to work CN. Along with other responders, I arrived on CN to find an inmate, later identified as Inmate s.22 s.22 . We were advised that this inmate had s.15,s.22 . CS s.15, identified SO s.15,s. as the unit staff, and once the unit was locked he was removed from the scene s.15,s.22 s.15,s.22 . The responding nurses immediately attended to the inmate, s.15,s.22 s.15,s.22 CS s.15,s.22 called Central Control via radio to have them send an ambulance s.15 . Nurse s.15 asked for the on site Dr. to attend, and I made the radio call to the Healthcare Officer to escort the doctor immediately to CN. At approximately 13:40 Dr s.15,s.22 attended CN to assess the medical emergency. He and the nurses continued to treat and assess the situation, s.15,s.2 s.15,s.22 . At approximately 13:46 the ambulance team arrived at NFPC and were informed of the death. Appropriate notifications were made, and the Coquitlam RCMP attended NFPC for investigation purposes. A debriefing for all available staff was completed at 13:20 s.15,s.22 s.15,s.22 CS s.15, took photos of the scene. DVMS was saved. The coroner attended the center at approximately 14:30 and left with the deceased at approximately 15:20. Grief counselling was arranged with the Chaplain for inmates on CN. CO s.15, report appears to accurately reflect his role and actions during this incident.

Incident Report Last Reviewed By: s.15

Approver Comments

DVMS supports the written report. All aspects of protocol were followed. Refer Primary Report for further details.

☐ **Attachments**

Incident Report Last Approved By: s.15

Requested by: s.15 Melaina Clarke Printed on: 2016.09.12 11:51

Ministry of Justice
Corrections Branch
Adult Custody Incident - Supplementary

Master Incident Number: INC-0187513-05

Current State: Complete

Incident Date & Time: 2016.01.s.22 12:35

Code: ☐ Red ☒ Blue ☐ Yellow

Primary Incident Type:

Incident Location

Reporting Centre: North Fraser Pretrial Centre

Location: C-N

Clients Involved

CS Number	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.22			Participant	☒	☒	☐	☐

Staff Involved

User Id	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.15,s.22			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Witness	☐	☐	☐	☐
			Responder	☐	☐	☐	☐

Other Involved Participants

Type	Last Name	First Name	DOB	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
					☐	☐	☐	☐

Incident Details

At approximately 12:35 a code blue was called for CN. I was in centre hall when this occurred and saw CO s.15 leaving CPod s.15,s.22 I assisted CO s.15,s.22 . As I arrived on the unit I saw the medical staff trying to help inmate s.22 . I left the unit to attend the sally port so that I could escort external professional responders to the scene. The paramedics and firefighters arrived on the scene at approximately 12:45 and were escorted to CN by this officer. CO s.15, waited in the sally port for the responding advance life support team. As I returned to the unit with the external responders s.15,s.22

Master Incident Number: INC-0187513-05 **Current State: Complete**

s.15,s.22 The firefighters then left the unit and were escorted by A/CS s.1 back to records as I waited on the unit for the paramedics to leave. The paramedics left the unit at approximately 13:00 and were escorted back to the sally port by this officer. This ends my involvement.

Incident Report Created By: s.15

Reviewer Details

At approximately 12:37 on s.22, 2016, a Code Blue was called by Officer s.15,s. who was assigned to work CN. Along with other responders, I arrived on CN to find an inmate, later identified as Inmate s.22 s.22 . We were advised that this inmate had s.22 CS s.15, identified SO s.15,s. as the unit staff, and once the unit was locked he was removed from the scene s.15,s.22 s.15,s.22 The responding nurses immediately attended to the inmate, and requested s.15,s.22 CS s.15,s.22 called Central Control via radio to have them send an ambulance s.15 . Nurse s.15 asked for the on site Dr. to attend, and I made the radio call to the Healthcare Officer to escort the doctor immediately to CN. At approximately 13:40 Dr s.15,s.22 attended CN to assess the medical emergency. He and the nurses continued to treat and assess the situation, s.15,s. s.15,s.22 At approximately 13:46 the ambulance team arrived at NFPC and were informed of the death. Appropriate notifications were made, and the Coquitlam RCMP attended NFPC for investigation purposes. A debriefing for all available staff was completed at 13:20 s.15,s.22 s.15,s.22

CS s.15 took photos of the scene. DVMS was saved. The coroner attended the center at approximately 14:30 and left with the deceased at approximately 15:20. Grief counselling was arranged with the Chaplain for inmates on CN. CO s.15 s account of his role and actions in this report appear to be accurate as they are written.

Incident Report Last Reviewed By: s.15

Ministry of Justice
Corrections Branch
Adult Custody Incident - Supplementary

Master Incident Number: INC-0187513-05 **Current State: Complete**

Approver Comments

Report appears to be accurate as written.
I was the ADW responsible for the afternoon shift, and I arrived at work at approximately 1250hrs. I was informed by ADW s.15,s.22 s.15,s.22 . ADW s.15 who was in charge of the day shift, was not in the office to touch base with at the time, and so I chatted with a few staff that were in the area to see where they were with regards to the incident and what I could assist with. s.15,s.22 s.15,s.22

s.15,s.22 Throughout the management of incident and the hours that followed, I performed various duties. I assisted in the completion of a unit check on Charlie North to ensure everyone was doing okay. I continued to delegate all unnecessary staff away from the incident, utilizing only those that had already been exposed to the incident and were seemingly coping well given the seriousness of the events. As the Correctional Supervisor assigned to C pod was busy with other tasks, I spent a lot of time on Charlie North unit myself to provide ongoing support to CO s.15, who had been assigned to do checks on the unit and to be a scribe, as well as to assist and respond immediately to requests by the RCMP as they came up. I gathered next of kin information and other relevant documents as part of the investigation, and retrieving DVMS for the members to view during their initial investigation. Once the Coroner had attended the scene s.22 s.22 and the scene was released back to us, I instructed CO s.15,s.22 s.15,s.22 I then liaised with DW s.15 to bring him up to speed where we were at. Afterwards I attended the Chaplains office and spoke with Chaplain s.1 about how to approach returning the unit back to regular programming, as I wanted to plan a method that would be most helpful to her as well as to the inmates s.15,s.22 s.15,s.22 , and I assisted her with this process. An s.15,s.22 s.15,s.22 . Chaplain s.1 remained on the unit for the evening, offering grief assistance to everyone that wanted to talk with her.

Please refer to the Primary Report and other Supplementary Reports for more information

☐ **Attachments**

Incident Report Last Approved By: s.15

Ministry of Justice
Corrections Branch
Adult Custody Incident - Supplementary

Master Incident Number: INC-0187513-06

Current State: Complete

Incident Date & Time: 2016.01.s.2 12:37

Code: ☐ Red ☒ Blue ☐ Yellow

Primary Incident Type:

Incident Location

Reporting Centre: North Fraser Pretrial Centre

Location: C-N

Clients Involved

CS Number	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.22			Victim	☒	☒	☐	☐

Staff Involved

User Id	Last Name	First Name	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
s.15,s.22			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐
			Responder	☐	☐	☐	☐

Other Involved Participants

Type	Last Name	First Name	DOB	Role	Injured	Treatment Onsite	Treatment Offsite	Treatment Hospital
					☐	☐	☐	☐

Incident Details

At approximately 12:37 hours, a code blue was called for CN. The writer (located in Alpha Pod) held the Health Care door open for crash cart responders. At 12:39, a request was made from responders on CN to have a Doctor attend. The writer provided an escort to CN for DR. s.15,s.22 Upon arrival the writer observed several nurses and Corrections Staff s.22) of CN. It was further observed that the unit was being locked up and that window covers were being placed. The writer assisted Officer s.15,s. on the third tier in placing window covers. After the covers were placed, the writer was posted at the CN Officers desk by CS s.15,s. to continue with logbook activity and manage phone communication to and from the unit. The writer was relieved from this post at 13:00 hours. Nothing further to report.

Requested by: s.15 Melaina Clarke

Printed on: 2016.09.12 11:49

Ministry of Justice
Corrections Branch
Adult Custody Incident - Supplementary

Master Incident Number: INC-0187513-06 **Current State: Complete**

Incident Report Created By: s.15

Reviewer Details

At approximately 12:37 on s.22 2016, a Code Blue was called by Officer s.15,s. who was assigned to work CN. Along with other responders, I arrived on CN to find an inmate, later identified as Inmate s.22 s.22 . We were advised that this inmate s.22 The responding nurses immediately attended to the inmate, s.15,s.22 s.15,s.22 CS s.15,s.22 called Central Control via radio to have them send an ambulance s.15 Nurse s.15 asked for the on site Dr. to attend, and I made the radio call to the Healthcare Officer to escort doctor s.15,s.22 immediately to CN. At approximately 12:40 Dr s.15,s.22 attended CN to assess the medical emergency. He and the nurses continued to treat and assess the situation, s.15,s.22 s.15,s.22 At approximately 12:46 the ambulance team arrived at NFPC and were informed of the death. Appropriate notifications were made, and the Coquitlam RCMP attended NFPC for investigation purposes. A debriefing for all available staff was completed at 13:20 s.15,s.22 s.15,s.22 Photos were taken of the scene and forwarded to Management. DVMS was saved. The coroner attended the center and removed the deceased. A scribe has noted the times that the coroner arrived and left and forwarded that information to managemen. Grief counselling was arranged with the Chaplain for inmates on CN.

Incident Report Last Reviewed By: s.15

Approver Comments

Reviewer comments captures the event. DVMS supports the written report. The is an error in the name of the staff in the creation report. The staff has mistakenly used the wrong name of the staff he was assisting in covering the window, writing s.15,s. when it was actually s.15,s. the unit officer that he assisted. s.15,s.22 s.15,s.22 Due to the seriousness of the incident, the report is submitted with the correction noted here by the Approver. Otherwise, complete and accurate report.

☐ **Attachments**

Incident Report Last Approved By: s.15

Requested by: s.15 Melaina Clarke Printed on: 2016.09.12 11:49