CORRECTIONS BRANCH
Critical Incident Review

Subject:

Inmate Death

Date of Incident:

December s.22 and s.22 2015 at Surrey Pretrial Services Centre

Review Team:

Teri DuTemple	Chair	Warden, Nanaimo Correctional Centre
Dr. Diane Rothon	Member	Medical Director, Corrections Branch
Coy Meyers	Member	ADW SPSC
Bonnie Moriarty	Member	Community Advisory Board
Niru Turko	Member	Community Advisory Board
Connie Dykstra	Member	Chiron Health Services
Marcia Marchenski	Participant/ Observer	Investigation and Standards Office
Donna Ward	Participant/ Observer	Investigation and Standards Office

Review Dates:

December s.22 and s.22 2015.

Mandate and Scope of Review:

The mandate of this review was to investigate the death of an inmate at Surrey Pretrial Services Centre on December s.22 2015, as well as the circumstances surrounding two additional near-death overdoses on December s.22 and s.22, 2015 and to determine compliance with:

- Adult Custody policies and procedures;
- 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 Surrey Pretrial Services Centre.

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

Background:

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On the evening of December s.22 2015 as per digital video records, subjects #1 and #2 are seen entering cell s.22 for lock up. s.15
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At 1735 hours the unit officer approaches cell s.22 to unlock the cell. Upon arriving at cell s.22 , the officer appeared pre-occupied with something to his left and is not observed looking into the cell to note the location or appearance of the inmates within.

At 1750 hours another inmate entered cell s.22 and upon observing subject #1, alerted subject #2 and together they make efforts to revive subject #1. At 1754 hours an inmate alerted the unit officer to a medical concern in cell s.22 . The unit officer attended the cell and upon seeing subject #1 called a Code Blue for medical assistance. A responding correctional supervisor arrived at 1756 hours and began cardiopulmonary resuscitation (CPR). Health care nursing staff arrived at 1756 hours and took over CPR of subject #1 at 1758 hours. Subject #1 was dosed with naloxone (Narcan) at 1803, 1806 and 1808 hours.

Shortly after health care assumed CPR, a nurse can be seen searching through the contents of the emergency cart and appeared to have difficulty locating a piece of equipment.

The supervisor ordered the unit to be locked down and later requested two officers to go cell to cell to ask inmates if they knew what substance the subjects had consumed. No useful information was provided.

During the lock down of the unit, subject #2 was secured in a cell with two other inmates. When checked, he was observed to be behaving erratically and was moved to a single cell for closer observation. At 1805 hours, subject #2 was brought out of his cell and into the common area for closer observation and evaluation by health care. Subject #2 was placed on a mattress on the floor and was observed lying back and moving his legs rapidly as if riding a bicycle. He was checked by health care staff at 1807 hours. Although subject #2 was behaving erratically, nursing staff elected not to administer naloxone as he did not appear to be in respiratory distress and remained conscious.

Members of the Surrey Fire Department arrived at 1811 hours and at 1815 hours, the first of two paramedics arrived on the unit. The second ambulance arrived at 1820 hours.

As nursing staff attempted to utilize the vital signs monitor on subject #2, the monitor did not show any readings and a second monitor was requested. Although this monitor had been previously utilized on subject #1, its lack of functionality was not detected as there were likely no vital signs to detect.

Subject #2 remained conscious, was loaded onto a stretcher at 1828 hours, and was provided naloxone by paramedics at 1829 hours. The ambulance left at 1842 hours with subject #2.

Subject #1 was pronounced deceased by the Paramedic at 1854 hours following consultation with a physician. RCMP and coroner arrived at 1950 hours.

First responders were offered Critical Incident Response Team (CIRT) debriefing and provided contact information for Employee and Family Assistance Program (EFAP) counselling services.

Living unit s remained locked down pending an investigation, during which all inmates from the unit were interviewed. No useful information was acquired from the inmates during these interviews.

A third incident of inmate overdose occurred on December s.2 2015. At 1830 hours living unit s was unlocked. The unit officer, who is the same officer as the previous evening, reported that inmates from the top tier came down to the lower level and that approximately 15 inmates attended the yard area and dispersed as the officer approached. It is noteworthy that it is uncommon for inmates from the second and third tier to congregate on the first tier.

At 1958 hours, four inmates entered cell s.22 on the lower tier. Subject #3 was among this group. At 2003 hours subject #3 was carried out of cell s.22 by two inmates. Upon seeing subject #3 in distress, the unit officer attended to the inmate immediately, called a code blue, and began CPR. The correctional supervisor, who is the same supervisor as the previous evening, arrived on the unit and took over CPR. The inmates were instructed to lock down in their cells. Health care staff arrived on scene at 2004 hours. The subject was nonresponsive with no detectable pulse, breathing or signs of life. Naloxone was administered at 2011 and 2013 hours while CPR continued. Officers reported subject #3 regained consciousness at approximately 2016 hours.

Nursing staff informed that they had to request a second oxygen bottle during this code as the one on the emergency cart was getting low. Paramedics and fire department arrived at 2020 hours; subject #3 was loaded onto a stretcher and taken to hospital at 2035 hours. He was conscious and responsive upon leaving the centre.

Health care staff interviewed reported that the emergency carts are reviewed every Sunday and that it is standard practice to replenish the carts following a code blue.

Health care staff reported that they felt delayed in getting to the codes on both December s.2 and s.2 2015, as they had to wait for doors to be opened. Although video was not viewed to determine if a delay was in fact an issue, the response of health care on both occasions was within two minutes.

It is noted that neither health care nor correctional staff who were involved in CPR wore protective glasses.

During the resuscitation efforts for subject #1 and #3 it was observed that nursing staff waited approximately four minutes after applying the oxygen rebreather mask with oxygen flow until they attached the manual resuscitator and gave positive pressure 'breaths' with the bag. Prior to attaching the manual resuscitator, the officer and nurse held the rebreather mask on the subject's face while compressions were performed.

Findings:

From a careful review of the evidence provided, it does not appear the unit officer conducted a proper and thorough observation of the inmates in cell 112 during the 1730 hours unlock on December s.2 , 2015, as per adult custody policy.

The response to the code blue on December s.22 2015, was timely and both health care and correctional staff acted professionally in their efforts to address the medical issues being presented by subjects #1 and #2. Although subject #1 could not be revived, the quick actions of staff in recognizing that subject #2 was at risk prompted proactive action to support a positive outcome.

Nursing staff had some difficulty locating a piece of equipment on the emergency cart during their response to subject #1.

Contrary to naloxone protocols, health care staff elected not to administer naloxone to subject #2, as he remained conscious and was not showing signs of respiratory distress.

A unit lock down and investigation was conducted following the death of subject #1, however it was not determined how the drugs entered the unit. It is suspected that subject #2 brought them in with him on intake, however when questioned subject #2 claimed to have found the contraband on the floor and denied knowledge of how the contraband got there.

The video recordings of December s.2 and s.2 , 2015, revealed that inmates frequently entered cells that were not their own and the unit officer did not appear to recognize this was occurring.

Information provided through interviewing staff revealed that the assistant deputy warden on shift December s.2 , 2015, showed the health care staff video footage of subject #1 and #2, including the activities in the cell prior to the code blue. The video was shown to them following code blue and prior to them leaving that evening, contrary to adult custody policy.

During the resuscitation efforts for subject #1 and #3, it was observed that nursing staff waited approximately four minutes after applying the oxygen rebreather mask with oxygen flow until they attached the manual resuscitator and gave positive pressure breaths with the bag. Prior to attaching the manual resuscitator, the officer and nurse held the rebreather mask on the subject's face while compressions were performed. Best practice is to apply the manual resuscitator at the same time as the rebreather mask.

The oxygen bottle on the emergency cart utilized for the code blue on December s.22 2015 was low as it had not been replenished from the previous evening. As such, a second bottle had to be requested during the code blue.

The vital signs monitor utilized on subjects #1 and #2 was not functioning as required. A second monitor had to be obtained from the health care department.

It is noted there was no standardized form to record notes of the treatment delivered during the code blue and prior to being entered as formal notes into PAC. Notes that were during this event made were destroyed after being entered into PAC.

Neither health care nor correctional staff who were involved in CPR wore protective glasses contrary to good practice.

Recommendations:

1. SPSC management should ensure staff are reminded that units are to be locked immediately upon calling a code.

2. SPSC management should ensure that staff are reminded of cell check policy requirements and the potential consequences for discipline if not followed.

3. The provincial director should conduct a review of random audits to ensure cell check policy is being adhered to.

4. SPSC management should ensure that staff are reminded of policy requirements concerning inmate's entering other inmate's cells.

5. SPSC management should ensure staff are reminded that viewing recorded video evidence is done in a controlled manner according with ACP 7.9.5.1.

6. SPSC management should review the efficiency of movement through the building for code responders to ensure minimal delay in attendance.

7. The provincial director should consider creating current policy for staff involved in providing emergency first aid including CPR to wear protective safety goggles.

8. The health care contractor should ensure health care personnel wear protective eyewear when providing emergency care where there is risk of exposure to body fluids.

9. The health care contractor should ensure health care staff are reminded of naloxone administration protocols, including protocols for conscious patients.

10. The health care contractor should ensure that emergency carts and equipment are organized in a consistent manner which ensures optimum access to equipment, contains the required supplies for responding to a medical emergency, that health care staff are aware of the content and location of equipment on the cart, and that emergency carts are reviewed and restocked following each use.

11. The health care contractor ensures that the health care department at designated high risk facilities have a secondary emergency cart available to respond to concurrent medical emergencies.

12. The health care contractor ensures that all health care personnel are trained in the deployment of the manual resuscitator and oxygen rebreather.

13. The health care contractor provides a current policy and procedure document for all staff for the provision of CPR and provides code blue charting forms for ease of charting during a medical emergency.