

OPERATIONAL REVIEW

SUBJECT: Staff Assault

Date of Incident: November 10, 2010 - North Fraser Pre-trial Centre

On November 10, 2010, the Warden of North Fraser Pretrial Centre requested an operational review be conducted to investigate the circumstances surrounding the assault of a staff member that occurred in the Bravo West living unit at North Fraser Pre-trial Centre (NFPC) and to address the following:

- Compliance with Adult Custody Policy and Procedures and local Standard Operating Procedures
- The response to staff to the incident
- Any other factors that may be relevant to this incident.

In preparation of this report the following individuals were interviewed and/or submitted reports:

Mr. M. Monks, Correctional Supervisor, NFPC

Mr. J. Wheatcroft, Correctional Officer, NFPC

Mr. B. Penner, Assistant Deputy Warden, NFPC

Mr. G. Sandhu, Correctional Officer, NFPC

Mr. R. St. Godard, Correctional Supervisor, NFPC

Mr. M. Wallman, Correctional Supervisor, NFPC

Mr. S. Dickinson, Correctional Supervisor, NFPC

Mr. S. Kern, Correctional Officer, NFPC

Ms. C. Town, Correctional Officer, NFPC

Mr. J. Goheen, Manager-Calibre Health Services, NFPC

Mr. N. Risbey, Correctional Supervisor, NFPC

Mr. S. Meldrum, Correctional Officer, NFPC

All incident reports , medical reports and DVR evidence related to the incident were reviewed.

All members interviewed were offered the opportunity to have a Shop Steward present throughout the interview process.

Background

NFPC is a 660 bed secure facility that houses adult male inmates awaiting trial, inmates serving a short term provincial sentence, federal sentenced inmates awaiting transfer to a federal facility or individuals on immigration holds.

On s.22 was admitted to NFPC on remand status. Inmate s.22 was remanded for s.22 s.22 His criminal history in British Columbia dates back to s.22 and consists of s.22 He has an institutional history of non compliance and problematic behaviour including violence towards staff. During his last contact with corrections, inmate s.22 was on ESP and successfully completed all phases.

During the admissions process the inmate was interviewed by classification and his previous behaviours were noted. An inmate assessment was completed and he was rated as secure, general population. Mr.s.22 was placed on Bravo West. Movement and admission summary was not placed on the CLOG due to a system failure with ICON.

At approximately 16:31 hrs on November 10, 2010, a CLOG entry by officer s.22 reports that inmate s.22 has been "heavying" two inmates that were to be placed in s.22 , the same cell as inmate s.22 The inmates intended for s.22 were reassigned to an alternate cell placement. Officer s.22 noted that inmate s.22 would be receiving a third notification of a cellmate and if inmate s.22 continued to intimidate, inmate s.22 would be moved to segregation.

At approximately 16:40 hrs, correctional officer s.22 went over to inmate s.22 table and advised him that he would be receiving a cellmate. CO s.22 also advised s.22 that any further intimidation of cellmates would result in him being moved to segregation. The inmate became belligerent and argumentative with officer s.22 Officer s.22 returned to his workstation followed closely by inmate s.22 While at the workstation officer s.22 reiterated that inmate s.22 would be receiving a cellmate. The inmate continued to be argumentative and then returned to the table he had been sitting at. Officer s.22 left the workstation and went to where the inmate was sitting. At the table officer s.22 reiterated the need for s.22 to accept a cellmate. Officer s.22 started to walk away however s.22 made further comment and officer s.22 turned and returned to where the inmate was sitting, s.22 stood up and gave officer s.22 a push. After being pushed, officer s.22 moved back toward the inmate and a code yellow was called over the radio, stating "Code yellow, assault staff". He ended the transmission and then retransmitted "Bravo West". The

inmate then moved toward the officer and officer s.22 pushed the inmate back away from him. The inmate struck out at officer s.22 hitting him in the face, then grappled and threw the officer to the ground. While on the ground, the inmate kicked officer s.22 in the upper torso, grabbed a plastic juice container and struck the officer on the head. Officer s.22 stood up and the inmate moved away to the stair area of the living units. Officer s.22 followed him over and the inmate grabbed a kettle and threw it toward officer s.22 narrowly missing him. Officer s.22 called another "code yellow, Bravo West". The inmate moved toward his cell and went in and secured himself. Responding officers attended the unit almost immediately. Officer s.22 went back to his work station. Responding officers secured the unit, attended inmate s.22 and restrained him in handcuffs. Total elapsed response time from the initial code yellow was s.15 and s.15 after the second Code Yellow. The inmate was taken off the unit, taken to health care, assessed, and placed within segregation. The initial "Code Yellow, assault staff" was interpreted by central control as "Code Yellow, Alpha South". Any delay in responding to the original code was the result of responding staff first attending Alpha South as indicated by central control. Once the location had been clarified, responding staff responded quickly.

A correctional supervisor talked with officer s.22 and made arrangements for a member of CIRT to have a discussion with him. After talking with officer s.22, he was taken to healthcare for assessment. Healthcare describe injuries as "small 2cm abrasion at the back of the head, right hand unable to move thumb, sore middle finger, Left knee slightly swollen, hurts with range of motion, alert and oriented." Officer s.22 was provided Motrin and Tylenol, an icepack and advised to go home. It was recommended he follow up with his family doctor or attend a walk in clinic.

Once the healthcare assessment had been completed, officer s.22 reported to the correctional supervisor's office to complete an incident report and complete worksafe forms. Correctional supervisors described officer s.22 as being slightly confused, not having a full recall of the incident or basic information such as his full address. In response, correctional staff drove officer s.22 to his residence and stayed with him until a personal friend attended. The following day a member of CIRT called to offer additional assistance.

Affected staff were offered, and received, support from the centre's critical incident response team (CIRT).

Port Coquitlam RCMP was contacted and an investigation is under way with consideration of criminal code assault charges being laid against the inmate.

Findings:

- On s.22 the inmate was assigned after admission to Bravo West unit at NFPC. The classification admission summary cited several incidents of problematic behaviour while incarcerated including inmate and staff assaults. His last contact with corrections was Fraser Regional Correctional Centre and he successfully completed all phases of their ESP program without incidence. The admission summary was not placed onto cornet until November 19, 2010 due to CORNET system failure and as a result previous problematic behaviour information was not readily available to unit staff.
- While on the living unit, Bravo West, CLOG entry of November 06, 2010 indicate that the inmate may be intimidating cellmates and should be monitored.
- CLOG entry on November 10, 2010 noting continued intimidation of potential cellmates. Segregation outlined as consequence should this behaviour continues to a third potential cellmate.
- When a unit staff communicated to the inmate of the impending cellmate, an argument ensues. This communication occurred at the inmate's eating area.
- During the discussion about the inmate's requirement to have a cellmate, the inmate attacked the officer, first pushing the officer then striking him in the head area and wrestling him to the ground. When the officer was thrown to the ground, the inmate kicked the officer in the upper torso area and struck him in the head with a plastic juice container.
- The inmate moved away from the officer after the officer was able to stand up.
- Central control misinterpreted the location of the code yellow and staff were deployed to the wrong area.
- The response to the initial code yellow was delayed as a result of misinterpretation of the radio transmission. After a second code yellow identifying the location, central control redeployed the responders to Bravo West. This response was timely and effective.
- The PMT was not utilized as the correctional officer was not wearing a PMT as required in SOP 1.04.3 Communications Equipment Requirements.
- Appropriate use of force was employed to restrain the inmate who was combative and resistant to responding staff
- CIRT support and follow up was offered to affected staff.
- Appropriate medical assessment was provided to the officer who was assaulted and tended to the needs of the injured staff and to the inmate.
- Correctional supervisors provided further assessment and assigned staff to provide transportation for the officer assaulted.

- All responding/involved staff were assigned ICON reports to detail the incident and reported in a timely manner.
- The local RCMP detachment was notified and statements submitted in support of their assault investigation.
- An entry detailing the assault of staff was entered into the inmate's client log in a timely manner.
- The Warden or the provincial on call managers were not notified.
- Information detailed in the media was inaccurate in that the staff was not hospitalized, and did not suffer any concussion. The officer confirmed the information was not accurate.
- s.22

Recommendations:

1. NFPC management should review their standard operating procedures around communication of code yellows and ensure that their practices follow the described procedures; or, amend the SOPS.
2. NFPC management should review with staff the requirement to have and maintain safety equipment assigned to their post, i.e. PMT's.
3. NFPC management should review their standard operating procedures regarding communication for incidents involving assaults on staff to the provincial on call manager or the Warden of NFPC.
4. NFPC management should establish a training schedule for all staff regarding situational awareness.
5. NFPC staff should review its alternate practise/process of providing information to unit staff regarding problematic inmates.