Correctional Service Canada | Service correctionnel Canada

Ottawa, Canada
K1A 0P9

Your file | Votre référence

2015-07-27

Our file | Notre référence
279849 / 279984

Lisa Lapointe
Chief Coroner
Metrotower II, Suite 800
4720 Kingsway
Burnaby, BC
V5H 4N2

Re: Coroner's Inquests into the Deaths of Jesse Marcel LAHN on May 3, 2013 and David Lawrence Robert LANGLET on May 9, 2014 at Kent Institution

Dear Ms. Lapointe,

I would like to confirm that the Correctional Service of Canada (CSC) has received the British Columbia Coroners Service Inquests into the deaths of David Lawrence Robert LANGLET (dated May 28, 2015) and Jesse Marcel Lahn (dated June 2, 2015). On behalf of the Commissioner of CSC, I would like to thank you for providing us with these Coroner's Inquests.

I note that each of the Inquests requested CSC to respond to the recommendations put forward by the Jury within 60 calendar days. Please be advised that CSC takes these recommendations very seriously and is currently coordinating a response which will be forwarded to your office by the end of September 2015. We hope that this timeframe is reasonable for you.

Should you have any questions please do not hesitate to contact me at the coordinates listed below.

Yours truly,

Original signed by:
Julie Blasko
A/Director General, Incident Investigations Branch, National Headquarters
Julie.Blasko@csc-scc.gc.ca
613-947-3922

c.c.: Anne Kelly, Senior Deputy Commissioner

Correctional Service Canada | Service correctionnel Canada

Commissioner | Commissaire
Ottawa, Canada
K1A 0P9

Your file | Votre référence

SEP 17 2015

Our file | Notre reference

Lisa Lapointe
Chief Coroner
Province of British Columbia
Metrotower II, Suite 800
4720 Kingsway
Burnaby, B.C.
V5H 4N2

Re: Verdict at Coroner's Inquest into the Death of Jesse Marcel LAHN at Kent Institution on May 3, 2013

Dear Ms. Lapointe:

Thank you for your report dated April 15, 2015 stemming from the Inquest held April 13 to 15, 2015 into the tragic death of Jesse LAHN at Kent Institution. As a voluntary participant in the inquest, the Correctional Service of Canada (CSC) thanks you for your Verdict. While we recognize that the recommendations are not binding on CSC as a federal organization, we have nevertheless taken them under consideration and provide you with the following responses.

Recommendation #1:

Kent Institution should conduct a survey of ligature points in its cells. Based on this survey, develop a process to mitigate any issues identified. Correctional Services Canada is reminded that this survey may be of value at other institutions, particularly older facilities.

An evaluation was completed at Kent Institution which reviewed cell windows in the older units of the institution in order to identify whether the cell windows could be used as a suspension point and whether the cell occupant could kick the glass out of the window. New cell window design was also reviewed for possible suspension points and it was determined that the new design mitigates the greater risks and reduces potential issues. The institution has begun a project to replace any windows identified during the review as requiring updates, with a projected installation completion date of summer 2016.

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In August 2014, CSC completed a survey (across all institutions) of coat hooks which could possibly be used as suspension points. Following the survey, Kent Institution reviewed the location of these hooks within the institution, specifically with respect to segregation cells. Any coat hooks identified as possible suspension points were subsequently removed from segregation cells.

In addition, the Pacific Region has undertaken a review of Cell Suspension Points. These findings will be shared with the Regional and National Offices of Technical Services and Facilities. Any findings of risk within the Cell Suspension Point Review have an identified mitigating strategy.

Recommendation #2:

It is recommended that Correctional Services Canada revise the frequency of checks on new inmates during the transitional period, and that video surveillance should be installed for use during this period.

During the intake process, CSC's policy framework requires that newly admitted offenders undergo screening and assessment to ensure timely identification of mental health needs, including risk of suicide and self-injury. This includes a nursing mental health screening within 24 hours of admission, a further evaluation of the offender's mental health status within two weeks, as well as a computerized mental health intake screening system completed by the offender within three days to two weeks of admission. Additionally, policy mandates that offenders be screened using the *Immediate Needs Checklist – Suicide Risk* form within 24 hours of arrival to a new institution; upon admission to Administrative Segregation; upon return from outside court; and, by any non-health care staff interacting with the offender where there is reason to believe that the offender may be at risk for suicide (when a mental health professional is not immediately available).

Specifically, Commissioner's Directive (CD) 560, *Dynamic Security and Supervision*, clearly outlines that the Institutional Head… will ensure:

> *a) managers and supervisors actively practice dynamic security and supervision; b) operating procedures facilitate staff visibility and constructive interaction with offenders in a manner that is consistent with the safety of staff and offenders; and, c) staff interact with offenders in institutions ... and document information as soon as possible.*

As well, CD 566-4, *Inmate Counts and Security Patrols*, states that *"At maximum, medium and multi-level institutions, and the Secure Units at women's institutions, the security patrols in inmate accommodation areas will be as frequent as possible, but must be once every 60 minutes from the beginning of the last patrol"*. The frequency of checks on offenders is governed by this policy and any deviation from the CD requires approval from CSC's Executive Committee.

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To enhance the ability of CSC staff to identify offenders who may be at an increased risk for suicide and self-injury, implementation of the revised *Suicide and Self-Injury Intervention* refresher training began in April 2014. This training requires staff to complete the 1-hour computer-based module annually, as well as to attend a 2-hour in-class session every two years. The in-class component of the training is facilitated by health care professionals.

Currently, video surveillance is already in place where the need exists. Ranges and subsequent activities are monitored and recorded, and in the event of an emergency situation, handheld cameras are deployed to record the events. All offender living units/ranges are equipped with closed-circuit television (CCTV) camera coverage and institutions also have observation cells with CCTV camera coverage. In the event that an offender exhibits suicidal or self-injurious behaviours, he or she would be placed in an observation cell equipped with appropriate CCTV coverage.

It should be noted that offenders maintain a right to privacy and dignity, especially in situations where no security threat (to themselves or others) has been identified. Therefore, cameras may not be warranted in situations where offenders do not exhibit harmful or at-risk behaviours.

Recommendation #3:

Correctional Services Canada is asked to review formal and informal information sharing processes with respect to inmate welfare, and to develop improvements to the system so that relevant information is made available to all staff who have contact with the inmate.

CSC guidelines regarding the sharing of personal health information are currently in place. The *Guidelines for Sharing Personal Health Information* (updated in October 2013) "*provide clarification regarding what offender personal mental and physical health information (verbal, hard copy or electronic files) may be shared by health care professionals, when it can be shared and with whom*". In addition, the *Fundamentals of Mental Health* Training provided to front-line staff includes a participant learning activity specific to the use of these and reinforces the importance of staff sharing offender information within the interdisciplinary mental health team. These guidelines are currently under review and are expected to be promulgated by Fall 2015. CSC will develop a plan to ensure the guidelines are broadly communicated, for example, through webinars, publication on CSC's internal website and direction will be provided to senior management to disseminate to staff and to ensure they are made aware of any changes.

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Interdisciplinary mental health teams are established in all CSC institutions to coordinate the provision of mental health services to offenders. In addition to mental health staff, team members may include clinical services staff, Parole Officers, Correctional Managers, Elders, and ad hoc members as required. The team discusses current clinical, operational and case management issues/concerns, short-term/long-term goals, and the roles and responsibilities of all staff intervening with the offender in order to respond effectively, and provide advice and support as required.

The sharing of information and working as part of a multi-disciplinary team are critical components of effective case management. CSC's policy framework supports this mandate under Section 87 of the *Corrections and Conditional Release Act* which requires that CSC take into consideration an offender's state of health and health care needs in all decisions affecting the offender, and in the preparation of the offender for release and the supervision of the offender. Specifically, for example, CD 843, *Management of Inmate Self-Injurious and Suicidal Behaviour*, directs that "*the Institutional Head will ensure that ... a communication process is in place so that staff who have regular interaction with the inmate are informed, in a timely fashion, when an inmate has been placed in the Pinel Restraint System, on High Suicide Watch, Modified Suicide Watch, Mental Health Monitoring or when the observation level has been changed*". CD 705-3, *Immediate Needs Identification and Admission Interviews*, requires that "*within 24 hours of the inmate's arrival at a new institution and prior to cell assignment, staff responsible for the immediate needs identification will conduct an interview with him/her to:*

a) *review the immediate needs identification contained in the Preliminary Assessment for security and critical concerns;*
b) *document, in the Offender Management System, the additional security immediate needs ...and complete the Immediate Needs Checklist – Suicide Risk; ...and,*
c) *review the alerts, flags and needs and update as required.*"

Additionally, as per CD 710-6, *Review of Inmate Security Classification*, in their overall analysis, Parole Officers are required "*to identify whether the inmate has a history of mental health issues, suicidal ideation, self-injury*" to consider any "*psychological concerns based on the results of psychological or psychiatric assessments or other information, including the existence of mental health concerns/disorders*; and to analyze the offender's "*emotional stability/instability, self-injury and suicide history*".

As well, the Service has taken steps to strengthen the sharing of information with respect to offender welfare since the tragic death of Mr. Lahn. The *Discharge Planning & Transfer Guidelines* revised in May 2014, for example, outline comprehensive discharge planning processes to ensure continuity of care. These Guidelines highlight the requirement for Parole Officers to liaise with institutional Health Services and to consider an offender's health care needs prior to all release and/or transfer decisions. CSC provided direction to staff regarding the importance of utilizing the *Health Status*

at Discharge - GIST Report form in establishing consistent communication between Case Management and Health Services staff as part of the discharge planning and transfer processes. Also, following this incident CSC published a Discharge Planning Matrix Tool which highlights the functions, roles and responsibilities for staff involved in the discharge planning process.

Further, in the 2014/2015 Fiscal Year, CSC's *Parole Officer Continuous Development* training included an *Effective Discharge Planning* component designed to enhance the flow, documentation and sharing of pertinent offender health care information between Case Management staff and Health Services staff.

With respect to transfers, CSC's *Health Care Requirements on Reception and Transfer* Guidelines as well as the *Discharge Planning and Transfer* Guidelines outline the requirement that prior to any transfer, an offender's Health Services file shall be reviewed to identify any health-related problems in order to ensure continuity of care and fitness for program placement at the receiving institution and to ensure that no medical complications are likely to arise during transfer. It is also the responsibility of the sending institution's Health Services staff to complete and send to the receiving institution a *Transfer Summary* form, which outlines critical medical information, including suicide attempts and self-injury status, and major mental health and physical health problems, no more than 48 hours prior to the offender's transfer.

Recommendation #4:

Correctional Services Canada is recommended to audit medical files and implement changes as necessary based on this audit to ensure that the Major Problem List is current and complete. There should be one unified medical and mental health file accompanying an inmate through the correctional system.

CSC's *Documentation for Health Services Professionals* Guidelines were revised in March 2014 and currently include information on how to manage the documentation of health services provided to offenders admitted to a Regional Treatment or Psychiatric Centre. An information memo was also distributed to all regional staff explaining the revisions made within the Guidelines with respect to the enhancement of communication between physical health care and mental health care staff. The memo stated that the revised procedure would enhance the communication between health services professionals which would contribute to patient safety through the consistent management of health information. Finally, in March 2014, CSC revised the Service's Health Care Record Audit Tool used for monthly audits of Health Care Records. The tool was changed in order to incorporate a Doctor's Orders section, to correct the previously auto-generated statistics to avoid false entry and properly reflect the data, to make the tool more user-friendly and to streamline the tool overall.

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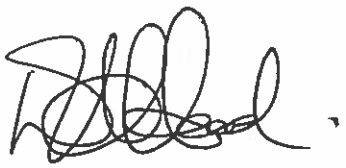
On behalf of CSC, I thank you for your contribution as we improve our efforts to protect the safety of those under our charge.

Yours sincerely,



Don Head

c.c.: Regional Deputy Commissioner, Pacific Region
Executive Director and General Counsel, Legal Services, National Headquarters (NHQ)
Assistant Commissioner, Correctional Operations and Programs, NHQ
Assistant Commissioner, Corporate Services, NHQ
Assistant Commissioner, Health Services, NHQ
A/Director General, Incident Investigations Branch, NHQ
Office of the Correctional Investigator

The second project, Interfaces between Mental Health and Substance Use Services and Police Services, is a joint project with the health authorities and MoJ, Policing and Security Branch to create provincial guidelines to facilitate the development of local protocols between police agencies and MHSU services on their respective roles and responsibilities for providing an effective, efficient and integrated response to people with MHSU problems who come into contact with police.

Thank you again for bringing these matters to my attention. The Ministry with its partners is committed to taking actions to improve outcomes for people with severe mental illness and substance use disorders and prevent deaths of a similar nature. I believe the work outlined above will lead to improvements, and we are committed to further enhancements as we measure and assess progress.

Sincerely,

Terry Lake
Minister of Health

pc: Mr. Doug Hughes, Assistant Deputy Minister, Health Services Policy
and Quality Assurance Division, Ministry of Health
Ms. Isis van Loon, Presiding Coroner