BRITISH COLUMBIA

C491034
59100-20/SLATTEN

March 28, 2013

Ms. Lisa Lapointe
Chief Coroner
Office of the Chief Coroner
BC Coroners Service
Metrotower II
Suite 800 – 4720 Kingsway
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

I am responding to your March 11, 2013 letter in which you request to know what action the Corrections Branch will take regarding jury recommendations arising from the Verdict at Inquest concerning the death of Robert Wayne Slatten. Mr. Slatten died while in custody at Fraser Regional Correctional Centre.

Of the seven recommendations directed to the attention of the Corrections Branch, five have been addressed as follows and as detailed in the attached response table:

1. Inmates are assigned to a living unit following a classification process that accounts for alerts. Living unit officers are advised of alerts pertaining to each inmate assigned to their unit.

2. BC Corrections will maintain a single category of importance for all alerts. Correctional staff are expected to review all alerts for each inmate.

3. Correctional staff will meet the requirements of current Adult Custody policy regarding the conduct of visual checks. The recommendation that all inmates' body movements are recorded is not something that can be met. To do so would require accessing cells which could disrupt inmates and compromise safety and security of inmates and staff.

4. Adult Custody Division's health care personnel meet or exceed community prescribing practices with respect to the provision of direct-observed narcotics therapy. Due to medical confidentiality, correctional staff are not privy to inmates' prescribed medications. Correctional staff are trained and expected to be vigilant in their supervision of all inmates, including during the conduct of inmate checks.

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Ministry of Justice
Corrections Branch
Office of the
Assistant Deputy Minister

Mailing Address:
PO BOX 9278 STN PROV GOVT
Victoria BC V8W 9J7

Location Address:
7th Floor, 1001 Douglas Street
Telephone: 250 387-5363
Facsimile: 250 387-5698

7. Adult Custody policy has been amended to require the correctional centre chaplain to follow up in a timely manner with the local police or RCMP to ensure notice to next of kin about the death of an inmate has occurred.

I appreciate having the opportunity to respond to these recommendations. I shall apprise you of the status of the two outstanding recommendations by May 3, 2013.

Yours sincerely,

Brent Merchant
Assistant Deputy Minister

Attachment

pc: Mr. Pete Coulson, Provincial Director (w/a
Mr. Steve DiCastri, Warden (w/a)
Ms. Marnie Mayhew, Director (w/a)
Mr. Vincent Stancato, Regional Director (w/a)

BRITISH COLUMBIA

C491034
59100-20/SLATTEN

May 13, 2013

Ms. Lisa Lapointe
Chief Coroner
Province of British Columbia
Metrotower II
Suite 800 – 4720 Kingsway
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

Further to my letter of March 28, 2013, please find attached the response table that details action taken to address recommendations arising from the Verdict at Inquest concerning the death of Robert Wayne Slatten. Mr. Slatten died while in custody at Fraser Regional Correctional Centre.

In addition to the five recommendations already resolved, recommendation #5 has been addressed as follows:

5. Policy has been established that requires Corrections staff and health care staff to independently verify the inmate's identity prior to the distribution of medication to that inmate. Staff have been advised of this policy requirement.

I shall apprise you of the status of the one outstanding recommendation by May 31, 2013.

Yours sincerely,

B. Merchant

Brent Merchant
Assistant Deputy Minister

Attachment

pc: Mr. Pete Coulson (w/a)
Mr. Steve DiCastri (w/a)
Ms. Marnie Mayhew (w/a)
Mr. Vincent Stancato (w/a)

Protect Communities, Reduce Reoffending

Ministry of Justice
Corrections Branch
Office of the
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FRASER REGIONAL CORRECTIONAL CENTRE
DEATH OF INMATE – OCTOBER 19, 2010

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
1. It is recommended that the Correctional Officer responsible for the cell assignments must review all prior ALERTS on CORNET prior to confirming any cell assignment.	Classification officers are responsible for ensuring that an inmate is properly assigned to a living unit having taken into consideration all alerts. Living unit officers are advised of alerts pertaining to each inmate assigned to their unit.		**Completed**	
2. It is recommended that BC Corrections adopt the practice of treating critical ALERTS in a SEPARATE CATEGORY from routine ALERTS.	B.C. Corrections regards all assigned inmate alerts as important. There is an expectation that correctional staff review all alerts in practice when a requirement to do so exists in policy. Creating two categories of alerts based on relative degrees of criticality could lead to the neglect of those alerts deemed to be of lesser importance. Consequently, B.C. Corrections will maintain a single category of importance for all alerts.		**Completed**	
3. It is recommended that the Log Book entries regarding inmate checks include descriptive language including inmate position and chest or breathing movements rather than the entry 'visual check'.	Adult Custody Policy requires correctional staff to conduct a visual check of all inmate areas that identifies activities or conditions that may compromise the safety of inmates and staff or the security of the centre. Correctional staff are trained to meet this policy requirement. The recommendation that the position and movements of every single inmate are accounted for by correctional staff when conducting visual checks is not something that can be met. The proper implementation of such a practice would require opening the		**Completed**	

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
	cell door to interact with the inmate(s) to confirm chest or breathing movements. This could disrupt the inmate(s) and compromise unnecessarily the safety and security of inmates and staff. Consequently, correctional staff will continue to meet the requirements of Adult Custody Policy as currently written. They have been reminded of the need for diligence in conducting visual checks of all inmate areas.			
4. It is recommended that with respect to inmate checks, that more vigilance be paid to their well-being and level of consciousness in the hours following the administration of methadone and/or narcotics.	Adult Custody Division health care personnel meet or exceed community prescribing practices with respect to narcotics. All narcotics are direct-observed therapy. Inmates do not remain in health care after receiving narcotics, and correctional officers are not privy to the inmates' prescribed medications, as this would breach medical confidentiality. Furthermore, due to a multitude of factors, each individual metabolizes methadone and/or narcotics differently. Consequently, it is not possible to provide effective extraordinary supervision of an inmate who has been prescribed a narcotic. Correctional staff are trained and expected to be vigilant in their supervision of all inmates, including during the conduct of inmate checks.		**Completed**	

FRASER REGIONAL CORRECTIONAL CENTRE
DEATH OF INMATE – OCTOBER 19, 2010

RECOMMENDATION	RESPONSE		
	ACTION TAKEN	ACTION PLANNED	TIME FRAME
5. It is recommended that Correctional Officers be jointly responsible for identifying inmates along with Health Care staff prior to the administration of medications.	Policy has been established that requires corrections staff and health care staff to independently verify the inmate's identity prior to the distribution of medication to that inmate. Staff have been advised of this policy requirement.		**Completed**
6. It is recommended that BC Corrections implement training to front line staff to reinforce the existing policy and standard operating procedures with respect to Methadone, and that it be followed up by careful onsite monitoring, even by a third party.	The health care contractor's pharmacy lead, in line with the Corrections Branch Medication & Therapeutic Committee, has implemented a bi-annual audit process to monitor all pharmacy-related procedures and practices within all centres. The Product Distribution Centre pharmacy manager attends centres on an annual basis to conduct procedural audits related to methadone use within B.C. Corrections.	Standing operating procedures in all provincial correctional centres will be updated to reflect current principles and practice with respect to methadone. Correctional staff and health care staff will be reminded of Adult Custody Policy, Health Care Services Manual policy, and local standing operating procedures regarding methadone, including requirements for monitoring following distribution.	May 31, 2013

FRASER REGIONAL CORRECTIONAL CENTRE
DEATH OF INMATE – OCTOBER 19, 2010

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
7. It is recommended that BC Corrections discontinue the practice of assigning responsibility of notifying next of kin upon an unexpected inmate death to RCMP and implement a policy of delegating a specific staff member to perform this function in an expeditious and compassionate manner.	Adult Custody Policy has been amended as follows: • The chaplain asks the local police or RCMP to notify next of kin about the death of the inmate. • The chaplain confirms within 12 hours that local police or RCMP have notified next of kin. • The chaplain then contacts the next of kin to offer condolences and assistance as necessary. • In cases when the chaplain has developed a prior relationship wit , the inmate's next of kin, the chaplain consults with local police or RCMP to det rmine the most appropriate course of tion for notifying next of kin in an expe ent and compassionate manner.		**Completed**	

BRITISH COLUMBIA

C491034
59100-20/SLATTEN

May 30, 2013

Lisa Lapointe
Chief Coroner
Office of the Chief Coroner
BC Coroners Service
Metrotower II
Suite 800 – 4720 Kingsway
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

Further to my letter of May 13, 2013, please find attached the completed response table that details action taken to address recommendations arising from the Verdict at Inquest concerning the death of Robert Wayne Slatten. Mr. Slatten died while in custody at Fraser Regional Correctional Centre.

The one remaining recommendation has been addressed as follows:

6. Correctional staff and health care staff in all provincial correctional centres have been reminded of updated policy with respect to methadone. Regular audit processes regarding methadone procedures and practices are conducted by the health care contactor's pharmacy lead and the Product Distribution Centre's pharmacy manager.

The BC Corrections Branch strives to provide a safe and secure environment for incarcerated offenders. When tragedies such as this occur, the branch endeavours to modify and improve procedures to prevent similar occurrences.

Yours sincerely,

Brent Merchant
Assistant Deputy Minister

Attachment

pc: Pete Coulson, Provincial Director (w/a)
Steve DiCastri, Warden (w/a)
Vincent Stancato, Regional Director (w/a)

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FRASER REGIONAL CORRECTIONAL CENTRE
DEATH OF INMATE – OCTOBER 19, 2010

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
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2. It is recommended that BC Corrections adopt the practice of treating critical ALERTS in a SEPARATE CATEGORY from routine ALERTS.	B.C. Corrections regards all assigned inmate alerts as important. There is an expectation that correctional staff review all alerts in practice when a requirement to do so exists in policy. Creating two categories of alerts based on relative degrees of criticality could lead to the neglect of those alerts deemed to be of lesser importance. Consequently, B.C. Corrections will maintain a single category of importance for all alerts.		**Completed**	
3. It is recommended that the Log Book entries regarding inmate checks include descriptive language including inmate position and chest or breathing movements rather than the entry 'visual check'.	Adult Custody Policy requires correctional staff to conduct a visual check of all inmate areas that identifies activities or conditions that may compromise the safety of inmates and staff or the security of the centre. Correctional staff are trained to meet this policy requirement. The recommendation that the position and movements of every single inmate are accounted for by correctional staff when conducting visual checks is not something that can be met. The proper implementation of such a practice would require opening the		**Completed**	

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
	cell door to interact with the inmate(s) to confirm chest or breathing movements. This could disrupt the inmate(s) and compromise unnecessarily the safety and security of inmates and staff. Consequently, correctional staff will continue to meet the requirements of Adult Custody Policy as currently written. They have been reminded of the need for diligence in conducting visual checks of all inmate areas.			
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RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
5. It is recommended that Correctional Officers be jointly responsible for identifying inmates along with Health Care staff prior to the administration of medications.	Policy has been established that requires corrections staff and health care staff to independently verify the inmate's identity prior to the distribution of medication to that inmate. Staff have been advised of this policy requirement.		**Completed**	
6. It is recommended that BC Corrections implement training to front line staff to reinforce the existing policy and standard operating procedures with respect to Methadone, and that it be followed up by careful onsite monitoring, even by a third party.	Standard operating procedures in all provincial correctional centres have been updated to reflect current principles and practice with respect to methadone. Correctional staff and health care staff have been reminded of Adult Custody Policy, Health Care Services Manual policy, and local standard operating procedures regarding methadone, including requirements for monitoring following distribution. The health care contractor's pharmacy lead, in line with the Corrections Branch Medication & Therapeutic Committee, has implemented a bi-annual audit process to monitor all pharmacy-related procedures and practices within all centres. The Product Distribution Centre pharmacy manager attends centres on an annual basis to conduct procedural audits related to methadone use within B.C. Corrections.		**Completed**	

FRASER REGIONAL CORRECTIONAL CENTRE
DEATH OF INMATE – OCTOBER 19, 2010

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
7. It is recommended that BC Corrections discontinue the practice of assigning responsibility of notifying next of kin upon an unexpected inmate death to RCMP and implement a policy of delegating a specific staff member to perform this function in an expeditious and compassionate manner.	Adult Custody Policy has been amended as follows: • The chaplain asks the local police or RCMP to notify next of kin about the death of the inmate. • The chaplain confirms within 12 hours that local police or RCMP have notified next of kin. • The chaplain then contacts the next of kin to offer condolences and assistance as necessary. • In cases when the chaplain has developed a prior relationship with the inmate's next of kin, the chaplain consults with local police or RCMP to determine the most appropriate course of action for notifying next of kin in an expedient and compassionate manner.		**Completed**	

Royal Canadian Mounted Police / Gendarmerie royale du Canada

Security Classification / Designation
Classification / Désignation sécuritaire

Mail Stop #105
14200 Green Timbers Way
Surrey, BC
V3T 6P3

Your file / Votre référence

March 21, 2013

2010:0354:0314

Our file / Notre référence

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

2013CP-0026

Re: Coroner's Inquest Recommendations
In Custody Death of,
Slatten, Robert Wayne (B: 1978-12-27)
Fraser Regional Correctional Centre (FRCC) - 2010-08-06

Dear Ms. Lapointe:

We acknowledge receipt of the BC Coroners Service, Verdict at Inquest report dated January 18, 2013 in relation to the death of Mr. Robert Slatten. We have now had an opportunity to review the recommendation directed to the Commanding Officer, "E" Division RCMP, and I wish to provide the following response.

Recommendation #8:

1) It is recommended that the RCMP be required to conduct a thorough and comprehensive investigation including interviewing all individuals directly involved in any unexpected death of a BC Corrections inmate.

Upon receipt of this Verdict at Inquest, I directed the Ridge Meadows OIC to personally review and comment on the investigation.

This investigation garnered numerous investigative avenues which included the taking of statements from inmates and FRCC staff members who were directly and indirectly involved.

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Exhibits were seized which included Mr. Slatten's clothing and bedding. There was nothing present to show an indirect or direct consumption of methadone. Photographs of the scene were taken by the attending general duty members.

Upon completion of this investigation, a fulsome review was completed by the Operations Officer of the Ridge Meadows, whereby he consulted with the Ridge Meadows Serious Crime Unit. It was collectively determined that based on the known facts there was nothing pointing to a "criminal act."

It should be further noted that since this incident took place another level of supervision has been added to Ridge Meadows Detachment. The respective general duty watches have now embedded Investigational Support and General Investigation members. These additional resources will enhance the existing level of expertise and supervision.

I have further conducted a review of existing RCMP policy which articulates clear investigative processes. This included our RCMP Operational Policy located within Chapter 41.3 "Human Deaths." I am confident this policy addresses and provides accepted investigative principals when dealing with unexpected deaths of BC Corrections inmates.

Yours truly,

R.J. (Randy) Beck
Assistant Commissioner
OIC Criminal Operations - Core Policing
RCMP, "E" Division

encl. Verdict At Inquest