Ministry of Justice

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File No.:2012-0378-0081

ALLEN	WARREN ROBERT
SURNAME	GIVEN NAMES

An Inquest was held at Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates March 10 – 13, 2014

before: Vincent M. Stancato, Presiding Coroner,

into the death of ALLEN (Last Name) Warren (First Name) Robert (Middle Name) 54 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: 20 July 2012 14:14 Hours

Place of Death: Chilliwack General Hospital (Location) Chilliwack, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Smothering by towel with plastic bag secured over head

Due to or as a consequence of

Antecedent Cause if any: b)

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☐ Accidental ☐ Homicide ☐ Natural ☒ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 13 day of March AD, 2014

Vincent M. Stancato
Presiding Coroner's Printed Name

PC

Presiding Coroner's Signature

ALLEN	WARREN ROBERT
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Mr. Vincent M. Stancato
Inquest Counsel:	Mr. Rodrick MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Counsel for the Correctional Services of Canada, Mr. Graham Stark Counsel for the Correctional Services of Canada, Ms. Judith Mules

The Sheriff took charge of the jury and recorded 10 exhibits. 12 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

At approximately 11:57 hours on July 20, 2012 a Correctional Officer was performing his regular 60 minute rounds in the Segregation Unit at Mountain Institution when he noticed Mr. Warren Robert Allen lying face down underneath his bed. He attempted to get Mr. Allen's attention by knocking loudly on the cell door, but after getting no response he immediately called out for assistance and was joined by another Correctional Officer. The two of them testified that they entered the cell and jointly pulled Mr. Allen, who was unresponsive, out from under the bed by his ankles. Both Correctional Officers observed that Mr. Allen's head was completely covered by a towel and a garbage bag which were secured around his neck by an electrical cord type ligature. The Correctional Officers could not remove the ligature immediately so one of them retrieved a knife and cut it. Once the towel and garbage bag were removed, one of the Correctional Officers testified that he noticed that Mr. Allen's head and upper body were covered in blood. He appeared to have a laceration, but the Correctional Officer could not determine its origin due to the amount of blood.

The Correctional Officers initiated resuscitation and were joined shortly thereafter by Health Care staff who continued resuscitation and ventilated Mr. Allen. While performing chest compressions they noticed a large laceration on the upper part of Mr. Allen's chest. An institutional nurse testified that they established an I.V. line and administered epinephrine, but there was no pulse and no sign of breathing. Multiple staff testified that they continued CPR, taking turns in performing chest compressions. Nursing staff employed the Automatic External Defibrillator (AED) which read no shock.

Paramedics attended at 12:31 hours and took over resuscitation efforts - they were able to establish a heart rhythm and airway and they transported Mr. Allen to Chilliwack General Hospital for immediate care. Dr. Kristopher Wiebe assessed and treated Mr. Allen upon his arrival. He testified that Mr. Allen had a low blood pressure and heart rate on arrival and was unresponsive with a Glasgow Coma Scale of 3/15. A chest x-ray revealed a bilateral pneumohemothorax which was treated, but there was very little improvement in his hemodynamic or neurological status. Dr. Weibe testified that Mr. Allen's condition continued to deteriorate and he passed away at 14:14 hours on July 20, 2012.

A post incident investigation of the cell was undertaken by police and the Coroner. A police officer testified that he viewed video footage taken from the segregation area which showed that the Correctional Officer conducted regular rounds at 11:00 hours and then again shortly before 12:00 hours and no one entered or exited the cell during this time. The Police officer also testified that they searched Mr. Allen's cell but were unable to locate the object that Mr. Allen had used to inflict the laceration to his chest. A suicide note was found by a Correctional Officer during the initial response – police took possession of the suicide note as per the Coroner's direction.

At the time of the incident, there was some debate about the cause of Mr. Allen's death as he had sustained a self-inflicted stab wound to the upper left chest as well as suffocating himself with a plastic bag. An autopsy was conducted by Dr. Craig Litwin who testified that the chest wound was superficial insofar as it passed through the skin and soft tissues of the chest wall but it did not enter into the chest cavity. He determined that the cause of death was due to smothering by a plastic bag placed over head.

Mr. Allen had been placed in segregation at Matsqui Institution on January 30, 2012 for his own personal safety due to the nature of his offences and the fact that he was previously employed as a police officer. He was later transferred to the segregation unit at Mountain Institution on March 27, 2012. According to his Institutional Parole Officer (IPO), Mr. Allen's criminal case received extensive media attention and his notoriety was heightened within the Pacific Region. His IPO testified that all options for his continued incarceration in the Pacific Region were reviewed, but none were feasible. His stay in the region would have required ongoing segregation for the duration of his sentence which would undoubtedly hinder the completion of his correctional plan. For this reason an involuntary transfer was completed to an institution in Ontario, but it was pending the outcome of ongoing court proceedings in the Pacific Region.

Mr. Allen's IPO was surprised by the circumstances of Mr. Allen's death as he was nearing parole eligibility. She described Mr. Allen as a very hardworking inmate that seemed level headed despite his history. She testified that the two sources of anxiety for him recently were related to an upcoming Court of Appeal decision regarding his offences and the impending transfer to Ontario.

According to Mr. Allen's Institutional Psychologist no major mental illness was identified upon intake aside from a self-reported history of anxiety and depression which was managed through medications. She noted that Mr. Allen had previous suicide attempts and passive suicidal thoughts due to ongoing anxiety related to the prospect of being harmed, shame regarding his offences, and difficulty associated with being housed in the segregation unit. It was noted that Mr. Allen wanted to be transferred to the Pacific Regional Treatment Centre, but this was not possible. Of note, Mr. Allen was seen by a psychiatric nurse two days prior to this incident for the purpose of having his medication reinstated. The psychiatric nurse testified that Mr. Allen was mentally stable at the time.

It is important to note that Mr. Allen's death was the first of three deaths (all ruled suicide by the Jury) that occurred within the Segregation Unit at Mountain Institution between July 20, 2012 and February 7, 2013. All three deaths were examined as part of this Inquest. The jury only made one set of recommendations which considered the circumstances of each death and the respective evidence elicited via witness testimony and review of the exhibits.

The Inquest focused greatly on policies and practices related to inmate segregation (voluntary and involuntary), intra/inter-institutional communication as well as critical decision making points related to transfer of inmates between institutions. Despite differing circumstances of death in each of the three cases that were the subject of this inquest they all, to some degree, shared these issues in common. The Acting Warden of Mountain Institution at the time (Mr. Terry Hackett) and the Assistant Warden Management Services (Ms. Brenda Lamm) both testified at the Inquest and provided insight to the jury about past and present practices regarding the key issues examined at this inquest.

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: Commissioner Don Head
Correctional Service Canada
National Headquarters
340 Laurier Avenue West
Ottawa ON K1A 0P9

The priority should be prevention of suicide and self-harm. To that end, we make the following recommendations:

1. Double the frequency of unscheduled cell-check rounds.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional staff and the Assistant Warden - Management Services at Mountain Institution (Ms. Brenda Lamm) that Segregation rounds switch from every 60 minutes to every 30 minutes at 18:00 hours. Several of the Jury's questions focused on whether the frequency of rounds was sufficient.*

2. Have two Correctional Officers performing the night shift rounds.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional Staff and Ms. Lamm that the staffing level in the segregation unit reduces to one console officer at 15:00 hours. The jury also heard that there were no operational adjustments to the staffing level since these three deaths have occurred.*

3. Require Correctional Officers' supervisors to obtain positive feedback that each Correctional Officer understands the parts of the normal daily briefings which apply to his/her shift at the beginning of each 4 hour posting.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional Officers that were working at the time of Mr. Tombaugh's death that they were not aware of Mr. Tombaugh's recent admission to hospital for self-inflicted cuts to his toes. The Correctional Officers that were on duty at the time of Mr. Cayer's death also testified that they did not recall receiving notice about the intervention with the psychologist that occurred earlier in the day. Ms. Lamm testified that, as a result of the three deaths examined at this Inquest, it is now a requirement that every officer review the unit logbook, which is a living document that contains information on all interactions within the segregation unit, at the start of and throughout their shift. In addition, she noted that the outgoing correctional officer completing their four hour rotation must provide a verbal shift takeover briefing to the incoming correctional officer as to anything significant that happened during the previous rotation. What was not covered in the testimony was a requirement for any communication of*

significant events between the supervisor and correctional officers to ensure they understood the status of inmates in the units prior to their rotation.

4. Install larger windows in the segregation cell doors for better observation of inmate status.

   Presiding Coroner Comment: *The Jury viewed photographs and heard testimony from a number of Correctional Officers throughout the Inquest regarding the small size of windows on the cell doors which limits visibility into the cell. Specifically, during the evidence into Mr. Tombaugh's death, the responding Correctional Officer testified that she initially could not make out why Mr. Tombaugh had not responded to her calls. He appeared to be sitting on the floor and it was only after closer inspection through the cell window that she observed a blue cloth ligature wrapped around his neck.*

5. Install sensors in the segregation cell floors to alert the console operators when an inmate gets up out of bed at night.

   Presiding Coroner Comment: *The jury heard testimony from Correctional Officers that Mr. Cayer had inflicted injuries on himself during the evening when inmates were thought to be sleeping. He was found thrashing around on the floor, but staff were unaware of his condition until he made a call to the console from his own cell.*

6. The Regional Director of Health Services establishes Memorandums of Understanding with the community hospitals which provide services to CSC inmates to ensure that Treatment/ Intervention summaries are provided to the Escort Officers for delivery to Health Services upon the inmate's return from the hospital emergency room.

   Presiding Coroner Comment: *The jury heard that Mr. Tombaugh was brought to a community hospital (Chilliwack General Hospital) the day prior to his death for treatment following self-inflicted cuts to his toes. The Correctional Officers that escorted Mr. Tombaugh to the hospital testified that they returned upon discharge without any hospital records/documentation regarding the treatment provided. As such, they were unable to pass any documentation along to Mountain Institution's Health Services Department or Correctional Supervisors. The jury also heard from Ms. Lamm who indicated that a similar recommendation had been made to the Correctional Services of Canada by the Board of Investigation that reviewed Mr. Tombaugh's death. Ms. Lamm noted that oftentimes paperwork/charting is not ready to be shared by the hospital physician upon discharge and it is usually multiple hours or the following day before the information is received at the Institution. Ms. Lamm testified that Mountain Institution has implemented a standing order requiring Correctional Staff to complete and share a "Suicide Risk Needs Assessment Checklist" when an inmate goes to an outside hospital for treatment.*

7. Establish Intermediate Mental Health Care Units (one in each region of CSC) to take care of the psychological needs of inmates where there is not sufficient justification respecting longer use of the Regional Treatment Centre's.

   Presiding Coroner Comment: *The jury heard testimony from two Institutional Parole Officer's that they were working on transfers in order to terminate segregation status for Mr. Tombaugh, Mr. Cayer and Mr. Allen. The Correctional Service of Canada, by law, must utilize the least restrictive measure when considering security classification and segregation. The Jury heard that in all three cases there were complicating factors (incompatibility, personality/mental health disorders, unwillingness on behalf of the inmate to go to a particular region) which made the transfers difficult. Specifically, the jury heard that Mr. Tombaugh and Mr. Allen wanted to be transferred to the Pacific Regional Treatment Centre, but the receiving institution was not supportive of the transfers. The theory behind the Intermediate Mental Health Care Unit (IMHCU) is that inmates who are not eligible for placement at the Pacific Regional Treatment Centre (where the intensive treatment programs exist), but still require a higher level of intervention than the institution can provide, would be placed into this unit. It would alleviate them from segregation status and allow them to participate in their correctional plan. Ms. Lamm testified that a similar recommendation was made by the Office of the Correctional Investigator (OCI) in 2011 which was accepted by senior executives at National Headquarters in 2013. It calls for the establishment of one IMHCU in each of the five regions. As of the Inquest date there had yet to be an IMHCU established.*

Ministry of Justice

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File No.:2013-0383-0008

CAYER	GERALD JOSEPH
SURNAME	GIVEN NAMES

An Inquest was held at Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates March 10 – 13, 2014

before: Vincent M. Stancato, Presiding Coroner,

into the death of CAYER (Last Name) Gerald (First Name) Joseph (Middle Name) 49 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: 07 February 2013 00:15 Hours

Place of Death: Mountain Institution (Location) Agassiz, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Exsanguination

Due to or as a consequence of

Antecedent Cause if any: b) Self-inflicted cut to carotid artery

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Razor blade retained from shaving

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☐ Accidental ☐ Homicide ☐ Natural ☒ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 13 day of March AD, 2014

Vincent M. Stancato
Presiding Coroner's Printed Name

Presiding Coroner's Signature

CAYER	GERALD JOSEPH
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Vincent M. Stancato
Inquest Counsel:	Rodrick MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Counsel for the Correctional Services of Canada, Mr. Graham Stark Counsel for the Correctional Services of Canada, Ms. Judith Mules

The Sheriff took charge of the jury and recorded 10 exhibits. 8 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

At approximately 23:27 hours on February 6, 2013 the on duty Correctional Officer in the Segregation Unit at Mountain Institution received a call from cell A-6. The Correctional Officer attended the cell and found Mr. Gerald Joseph Cayer in a prone position on the floor, crying out and bleeding profusely. The Correctional Officer testified that he immediately ran back to the console and called for assistance. Institutional Policy does not permit Correctional Officers to enter a cell alone. While waiting for sufficient support, the Correctional Officer called out to Mr. Cayer from outside the cell but Mr. Cayer didn't respond and continued to "thrash" around. At 23:30 hours, support arrived and multiple Correctional Officers entered the cell to aid Mr. Cayer.

The involved Correctional Officers testified that they removed Mr. Cayer from the cell due to excessive blood on the floor. They testified that Mr. Cayer was combative which made it difficult for them to render first aid. They were able to gain control by handcuffing Mr. Cayer which allowed them to assess the injury and assist. Both Correctional Officers testified that they observed a large cut to Mr. Cayer's neck which was bleeding profusely. Pressure was applied to the wound while the Correctional Officers and staff waited for medical assistance.

The Correctional Officers testified that while providing first aid to Mr. Cayer he lost consciousness and stopped breathing so they initiated Cardiopulmonary Resuscitation (CPR). During the resuscitation Mr. Cayer started breathing again and then suddenly stopped breathing. They had an Automated External Defibrillator, but it advised no shocks throughout. BC Ambulance Service paramedics arrived at approximately 23:50 hours and took over resuscitation. The attending paramedic testified that Mr. Cayer had sustained a large laceration to the neck (likely the carotid artery) with extensive bleeding. The paramedic testified that their resuscitation attempts were unsuccessful and he was advised by an Emergency Room Physician at Chilliwack General Hospital to stop the resuscitative attempt - Mr. Cayer died at 00:15 hours on February 7, 2013.

During the post incident examination of the cell a razor tied to a Popsicle stick and a suicide note were found. The note explicitly outlined Mr. Cayer's intent and also confirmed that he took the razor from a shaving blade provided to him during his morning shower. A Correctional Officer revealed that Mr. Cayer did have a shower at 09:25 hours on February 6, 2013 and testified that he provided a bic-style razor to Mr. Cayer in advance of the shower. Following the shower the Correctional Officer retrieved the razor from Mr. Cayer noting that it appeared to be intact. He was unaware that the razor portion could be removed without destroying the entire razor.

Evidence given at the inquest revealed that Mr. Cayer had an acute crisis episode in the afternoon hours of February 6, 2013. Dr. Sirkia, institutional psychologist, testified that she had a crisis intervention meeting with Mr. Cayer on February 6, 2013 at 15:00 hours. According to Dr. Sirkia, the session focused on Mr. Cayer's resentment about being "stuck" in segregation and his ongoing anger about his missing eye glasses and t-shirt, and what he perceived to be an inadequate response by the institution to locate these items. After their 45 minute session, Dr. Sirkia assessed Mr. Cayer as low risk for self-harm and he was returned to his cell. Dr. Sirkia testified that she made this determination only after Mr. Cayer agreed not to harm himself for the next 24 hours. Following the meeting, Dr. Sirkia emailed Correctional Managers advising them of the intervention and that Mr. Cayer was at low risk for self-harm. Of note, the Institutional Parole Officer (IPO) that testified at this Inquest did receive the email from Dr. Sirkia; however, the Correctional Officers that testified did not recall receiving any notice about the intervention with the psychologist earlier in the day.

According to his IPO, Mr. Cayer had a history of institutional adjustment difficulties which had not subsided since his incarceration. He was diagnosed with a personality disorder and at times he had been depressed and suicidal. The most recent suicide attempt was by medication overdose on December 30, 2012 following an altercation with another inmate. When questioned about the reason for the attempt he noted his ongoing frustration and anger regarding institutional staff who he perceived as not listening to him or doing anything to address his fears for personal safety. Following this incident he was voluntarily placed in segregation for his own personal safety.

The IPO testified that he met with Mr. Cayer quite often while in segregation. Mr. Cayer understood the reason for his segregation status, but wanted to be transferred to another institution so that he could carry on with his correctional plan in the general population. According to the IPO there were plans underway to transfer Mr. Cayer. Mission Institution was ruled out for transfer due to potential inmate incompatibles but in the days prior to his suicide, a management plan had been developed to transfer Mr. Cayer to the Pacific Regional Treatment Centre.

It is important to note that Mr. Cayer's death was the third of three deaths (all ruled suicide by the Jury) that occurred within the Segregation Unit at Mountain Institution between July 20, 2012 and February 7, 2013. All three deaths were examined as part of this Inquest. The jury only made one set of recommendations which considered the circumstances of each death and the respective evidence elicited via witness testimony and review of the exhibits.

The Inquest focused greatly on issues and policies related to inmate segregation (voluntary and involuntary), inter-institutional communication as well as critical decision making points related to transfer of inmates between institutions. Despite differing circumstances of death in each of the three

cases that were the subject of this inquest they all, to some degree, shared these issues in common. The Acting Warden of Mountain Institution at the time (Mr. Terry Hackett) and the Assistant Warden Management Services (Ms. Brenda Lamm) both testified at the Inquest and provided insight to the jury about past and present practices regarding the key issues examined at this inquest

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: Commissioner Don Head
Correctional Service Canada
National Headquarters
340 Laurier Avenue West
Ottawa ON K1A 0P9

The priority should be prevention of suicide and self-harm. To that end, we make the following recommendations:

1. Double the frequency of unscheduled cell-check rounds.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional staff and the Assistant Warden - Management Services at Mountain Institution (Ms. Brenda Lamm) that Segregation rounds switch from every 60 minutes to every 30 minutes at 18:00 hours. Several of the Jury's questions focused on whether the frequency of rounds was sufficient.*

2. Have two Correctional Officers performing the night shift rounds.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional Staff and Ms. Lamm that the staffing level in the segregation unit reduces to one console officer at 15:00 hours. The jury also heard that there were no operational adjustments to the staffing level since these three deaths have occurred.*

3. Require Correctional Officers' supervisors to obtain positive feedback that each Correctional Officer understands the parts of the normal daily briefings which apply to his/her shift at the beginning of each 4 hour posting.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional Officers that were working at the time of Mr. Tombaugh's death that they were not aware of Mr. Tombaugh's recent admission to hospital for self-inflicted cuts to his toes. The Correctional Officers that were on duty at the time of Mr. Cayer's death also testified that they did not recall receiving notice about the intervention with the psychologist that occurred earlier in the day. Ms. Lamm testified that, as a result of the three deaths examined at this Inquest, it is now a requirement that every officer review the unit logbook, which is a living document that contains information on all interactions within the segregation unit, at the start of and throughout their shift. In addition, she noted that the outgoing correctional officer completing their four hour rotation must provide a verbal shift takeover briefing to the incoming correctional officer as to anything significant that happened during the previous rotation. What was not covered in the testimony was a requirement for any communication of*

significant events between the supervisor and correctional officers to ensure they understood the status of inmates in the units prior to their rotation.

4. Install larger windows in the segregation cell doors for better observation of inmate status.

   Presiding Coroner Comment: *The Jury viewed photographs and heard testimony from a number of Correctional Officers throughout the Inquest regarding the small size of windows on the cell doors which limits visibility into the cell. Specifically, during the evidence into Mr. Tombaugh's death, the responding Correctional Officer testified that she initially could not make out why Mr. Tombaugh had not responded to her calls. He appeared to be sitting on the floor and it was only after closer inspection through the cell window that she observed a blue cloth ligature wrapped around his neck.*

5. Install sensors in the segregation cell floors to alert the console operators when an inmate gets up out of bed at night.

   Presiding Coroner Comment: *The jury heard testimony from Correctional Officers that Mr. Cayer had inflicted injuries on himself during the evening when inmates were thought to be sleeping. He was found thrashing around on the floor, but staff were unaware of his condition until he made a call to the console from his own cell.*

6. The Regional Director of Health Services establishes Memorandums of Understanding with the community hospitals which provide services to CSC inmates to ensure that Treatment/ Intervention summaries are provided to the Escort Officers for delivery to Health Services upon the inmate's return from the hospital emergency room.

   Presiding Coroner Comment: *The jury heard that Mr. Tombaugh was brought to a community hospital (Chilliwack General Hospital) the day prior to his death for treatment following self-inflicted cuts to his toes. The Correctional Officers that escorted Mr. Tombaugh to the hospital testified that they returned upon discharge without any hospital records/documentation regarding the treatment provided. As such, they were unable to pass any documentation along to Mountain Institution's Health Services Department or Correctional Supervisors. The jury also heard from Ms. Lamm who indicated that a similar recommendation had been made to the Correctional Services of Canada by the Board of Investigation that reviewed Mr. Tombaugh's death. Ms. Lamm noted that oftentimes paperwork/charting is not ready to be shared by the hospital physician upon discharge and it is usually multiple hours or the following day before the information is received at the Institution. Ms. Lamm testified that Mountain Institution has implemented a standing order requiring Correctional Staff to complete and share a "Suicide Risk Needs Assessment Checklist" when an inmate goes to an outside hospital for treatment.*

7. Establish Intermediate Mental Health Care Units (one in each region of CSC) to take care of the psychological needs of inmates where there is not sufficient justification respecting longer use of the Regional Treatment Centre's.

Presiding Coroner Comment: *The jury heard testimony from two Institutional Parole Officer's that they were working on transfers in order to terminate segregation status for Mr. Tombaugh, Mr. Cayer and Mr. Allen. The Correctional Service of Canada, by law, must utilize the least restrictive measure when considering security classification and segregation. The Jury heard that in all three cases there were complicating factors (incompatibility, personality/mental health disorders, unwillingness on behalf of the inmate to go to a particular region) which made the transfers difficult. Specifically, the jury heard that Mr. Tombaugh and Mr. Allen wanted to be transferred to the Pacific Regional Treatment Centre, but the receiving institution was not supportive of the transfers. The theory behind the Intermediate Mental Health Care Unit (IMHCU) is that inmates who are not eligible for placement at the Pacific Regional Treatment Centre (where the intensive treatment programs exist), but still require a higher level of intervention than the institution can provide, would be placed into this unit. It would alleviate them from segregation status and allow them to participate in their correctional plan. Ms. Lamm testified that a similar recommendation was made by the Office of the Correctional Investigator (OCI) in 2011 which was accepted by senior executives at National Headquarters in 2013. It calls for the establishment of one IMHCU in each of the five regions. As of the Inquest date there had yet to be an IMHCU established.*

Ministry of Justice

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST INTO THE DEATH OF

File No.:2012-0200-0086

TOMBAUGH	KYLE DARREN
SURNAME	GIVEN NAMES

An Inquest was held at Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates March 10 – 13, 2014

before: Vincent M. Stancato, Presiding Coroner,

into the death of TOMBAUGH (Last Name) Kyle (First Name) Darren (Middle Name) 35 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: 24 AUGUST 2012 09:34 Hours

Place of Death: Ridge Meadows Hospital (Location) Maple Ridge, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Anoxic Brain Injury

Due to or as a consequence of

Antecedent Cause if any: b) Self inflicted hanging

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☐ Accidental ☐ Homicide ☐ Natural ☒ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 13 day of March AD, 2014

Vincent M. Stancato
Presiding Coroner's Printed Name

Presiding Coroner's Signature

TOMBAUGH	KYLE DARREN
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Vincent M. Stancato
Inquest Counsel:	Rodrick MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Counsel for the Correctional Services of Canada, Mr. Graham Stark Counsel for the Correctional Services of Canada, Ms. Judith Mules

The Sheriff took charge of the jury and recorded 10 exhibits. 14 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

On August 21, 2012 at approximately 19:30 hours, a Correctional Officer was performing her regular 30 minute rounds in the Segregation Unit at Mountain Institution. She was the only Correctional Officer assigned to the Segregation Unit at the time. As part of the Correctional Officer's rounds she attended to a cell occupied by Mr. Kyle Darren Tombaugh who appeared to be sitting on the floor and leaning up against the wall. The Correctional Officer testified that she called out to Mr. Tombaugh a few times in an increasingly louder tone, but received no response. Upon closer inspection, through the cell door window, she observed a blue cloth ligature wrapped around Mr. Tombaugh's neck. It was affixed to a metal grate at the top of a cell window. She immediately called for assistance.

At 19:33 hours, multiple Correctional Officers arrived to the cell; they removed the blue cloth ligature, pulled Mr. Tombaugh out of the cell and rendered assistance. One of the attending Correctional Officer's testified that upon arrival, Mr. Tombaugh presented as pulseless with no airway obstruction. They initiated cardiopulmonary resuscitation (chest compressions and bagging for ventilation); however, the Automated External Defibrillator reported no shocks throughout the resuscitative attempt. Health care nurses arrived at 19:52 hours and paramedics arrived shortly thereafter – they continued resuscitative attempts and gained a pulse at approximately 20:16 hours. Mr. Tombaugh was intubated and immediately transported to Chilliwack General Hospital (CGH).

At CGH a CT scan of the brain and neck were unremarkable. He had a Glasgow Coma Scale (GCS) of 5/15 and was assessed as having sustained a hypoxic brain injury. He was transferred to Ridge Meadows Hospital (RMH) at approximately 02:00 hours on August 22, 2012. Dr. Deepu George testified that he saw Mr. Tombaugh upon arrival and continued with the hypothermic protocol in an attempt to cool the body to reduce injury to the brain. Dr. George testified that Mr. Tombaugh's condition continued to deteriorate and repeat CT scans of the brain revealed a diffuse hypoxic brain injury that was irreversible. Dr. George testified that Mr. Tombaugh succumbed to the brain injury on August 24, 2012 at 09:24 hours.

At the time of the incident police attended Mountain Institution and initiated an investigation which included an examination of the Mr. Tombaugh's cell. The investigating officer testified that he examined the scene and noted that the ligature appeared to be a blue cloth pillow case. He testified that part of it was affixed to a window grate and that there was no indication of struggle and no suicide note.

Further investigation revealed that on the day prior (August 20, 2012 @ 08:37 hours), Mr. Tombaugh was brought to Chilliwack General Hospital for treatment of self-inflicted cuts that he had made between his toes with a razor. The treating physician, Dr. Damien, testified that he stitched up the cuts, but was unaware of Mr. Tombaugh's history and did not believe there was any suicide risk at the time. He did not consider involving the on-call psychiatrist and did not recall advising the two attending Correctional officers of any suicide concerns. At 12:57 hours, following treatment, Mr. Tombaugh was returned to Mountain Institution and lodged back into his cell in the segregation unit.

Upon return to the Institution, the Health Care Unit was advised of Mr. Tombaugh's visit to hospital. The incident report and testimony from the Assistant Warden - Management Services indicate that a morning briefing was held on August 21, 2012 regarding Mr. Tombaugh's recent self-cutting incident. Nursing staff testified that Mr. Tombaugh reported that he had only cut himself out of boredom. Based on this information and the lack of past referrals from Health Care staff indicating any concerns about self-harm or suicide, it was determined that no follow up was necessary by psychology at the time. Of note, there was also an issue regarding lack of communication to correctional staff about the previous incident. The Correctional Officer on shift when Mr. Tombaugh was found hanging in his cell indicated that she was unaware of the incident the previous day.

Much of the testimony dealt with Mr. Tombaugh's incarceration history. On December 9, 2011 (commencement of his current term) Mr. Tombaugh was assessed at the Pacific Regional Assessment Centre and deemed to be at high risk for self-harm. He was placed in the Pacific Regional Treatment Centre's Psychiatric Hospital where he remained until his transfer to Mountain Institution. There was a documented history of self-harming behavior while at the Regional Treatment Centre as well as threats of self-harm and prior self-harming behavior at Mountain Institution.

Mr. Tombaugh's Institutional Parole Officer (IPO) provided the jury with a snapshot of his time at Mountain Institution since his transfer on July 3, 2012. The IPO testified that he and a psychologist met with Mr. Tombaugh on July 4, 2012. He described Mr. Tombaugh as upset and frustrated about his transfer, noting that he would not last more than two hours in general population due to unpaid debts during his last stay at Mountain Institution. The psychologist assessed him as high risk for self-harm and low risk for suicide. He was placed in the observation cell pending an assessment of his vulnerability in the general population. On July 9, 2012 it was determined that inmates had not forgiven Mr. Tombaugh for his past debts and that his safety in the general population could not be guaranteed – as such, he was involuntarily segregated on this date. While in segregation, the IPO and Mr. Tombaugh met weekly and part of their discussions revolved around transfer possibilities to the general population of a medium security institution where Mr. Tombaugh could participate safely in his Correctional Plan. According to the IPO, Mr. Tombaugh wanted to go back to the Pacific Regional Treatment Centre but that institution was not supportive of his transfer. The IPO testified that all options within the province were exhausted and his opinion was that Mr. Tombaugh would do best in another province. He suggested the other

options to Mr. Tombaugh who was in the process of considering them when the hanging incident occurred.

It is important to note that Mr. Tombaugh's death was the second of three deaths (all ruled suicide by the Jury) that occurred within the Segregation Unit at Mountain Institution between July 20, 2012 and February 7, 2013. All three deaths were examined as part of this Inquest. The jury only made one set of recommendations which considered the circumstances of each death and the respective evidence elicited via witness testimony and review of the exhibits.

The Inquest focused greatly on policies and practices related to inmate segregation (voluntary and involuntary), intra-institutional communication as well as critical decision making points related to transfer of inmates between institutions. Despite differing circumstances of death in each of the three cases that were the subject of this inquest they all, to some degree, shared these issues in common. The Acting Warden of Mountain Institution at the time (Mr. Terry Hackett) and the Assistant Warden Management Services (Ms. Brenda Lamm) both testified at the Inquest and provided insight to the jury about past and present practices regarding the key issues examined at this inquest.

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: Commissioner Don Head
Correctional Service Canada
National Headquarters
340 Laurier Avenue West
Ottawa ON K1A 0P9

The priority should be prevention of suicide and self-harm. To that end, we make the following recommendations:

1. Double the frequency of unscheduled cell-check rounds.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional staff and the Assistant Warden - Management Services at Mountain Institution (Ms. Brenda Lamm) that Segregation rounds switch from every 60 minutes to every 30 minutes at 18:00 hours. Several of the Jury's questions focused on whether the frequency of rounds was sufficient.*

2. Have two Correctional Officers performing the night shift rounds.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional Staff and Ms. Lamm that the staffing level in the segregation unit reduces to one console officer at 15:00 hours. The jury also heard that there were no operational adjustments to the staffing level since these three deaths have occurred.*

3. Require Correctional Officers' supervisors to obtain positive feedback that each Correctional Officer understands the parts of the normal daily briefings which apply to his/her shift at the beginning of each 4 hour posting.

   Presiding Coroner Comment: *The Jury heard testimony from Correctional Officers that were working at the time of Mr. Tombaugh's death that they were not aware of Mr. Tombaugh's recent admission to hospital for self-inflicted cuts to his toes. The Correctional Officers that were on duty at the time of Mr. Cayer's death also testified that they did not recall receiving notice about the intervention with the psychologist that occurred earlier in the day. Ms. Lamm testified that, as a result of the three deaths examined at this Inquest, it is now a requirement that every officer review the unit logbook, which is a living document that contains information on all interactions within the segregation unit, at the start of and throughout their shift. In addition, she noted that the outgoing correctional officer completing their four hour rotation must provide a verbal shift takeover briefing to the incoming correctional officer as to anything significant that happened during the previous rotation. What was not covered in the testimony was a requirement for any communication of*

significant events between the supervisor and correctional officers to ensure they understood the status of inmates in the units prior to their rotation.

4. Install larger windows in the segregation cell doors for better observation of inmate status.

   Presiding Coroner Comment: *The Jury viewed photographs and heard testimony from a number of Correctional Officers throughout the Inquest regarding the small size of windows on the cell doors which limits visibility into the cell. Specifically, during the evidence into Mr. Tombaugh's death, the responding Correctional Officer testified that she initially could not make out why Mr. Tombaugh had not responded to her calls. He appeared to be sitting on the floor and it was only after closer inspection through the cell window that she observed a blue cloth ligature wrapped around his neck.*

5. Install sensors in the segregation cell floors to alert the console operators when an inmate gets up out of bed at night.

   Presiding Coroner Comment: *The jury heard testimony from Correctional Officers that Mr. Cayer had inflicted injuries on himself during the evening when inmates were thought to be sleeping. He was found thrashing around on the floor, but staff were unaware of his condition until he made a call to the console from his own cell.*

6. The Regional Director of Health Services establishes Memorandums of Understanding with the community hospitals which provide services to CSC inmates to ensure that Treatment/ Intervention summaries are provided to the Escort Officers for delivery to Health Services upon the inmate's return from the hospital emergency room.

   Presiding Coroner Comment: *The jury heard that Mr. Tombaugh was brought to a community hospital (Chilliwack General Hospital) the day prior to his death for treatment following self-inflicted cuts to his toes. The Correctional Officers that escorted Mr. Tombaugh to the hospital testified that they returned upon discharge without any hospital records/documentation regarding the treatment provided. As such, they were unable to pass any documentation along to Mountain Institution's Health Services Department or Correctional Supervisors. The jury also heard from Ms. Lamm who indicated that a similar recommendation had been made to the Correctional Services of Canada by the Board of Investigation that reviewed Mr. Tombaugh's death. Ms. Lamm noted that oftentimes paperwork/charting is not ready to be shared by the hospital physician upon discharge and it is usually multiple hours or the following day before the information is received at the Institution. Ms. Lamm testified that Mountain Institution has implemented a standing order requiring Correctional Staff to complete and share a "Suicide Risk Needs Assessment Checklist" when an inmate goes to an outside hospital for treatment.*

7. Establish Intermediate Mental Health Care Units (one in each region of CSC) to take care of the psychological needs of inmates where there is not sufficient justification respecting longer use of the Regional Treatment Centre's.

Presiding Coroner Comment: *The jury heard testimony from two Institutional Parole Officer's that they were working on transfers in order to terminate segregation status for Mr. Tombaugh, Mr. Cayer and Mr. Allen. The Correctional Service of Canada, by law, must utilize the least restrictive measure when considering security classification and segregation. The Jury heard that in all three cases there were complicating factors (incompatibility, personality/mental health disorders, unwillingness on behalf of the inmate to go to a particular region) which made the transfers difficult. Specifically, the jury heard that Mr. Tombaugh and Mr. Allen wanted to be transferred to the Pacific Regional Treatment Centre, but the receiving institution was not supportive of the transfers. The theory behind the Intermediate Mental Health Care Unit (IMHCU) is that inmates who are not eligible for placement at the Pacific Regional Treatment Centre (where the intensive treatment programs exist), but still require a higher level of intervention than the institution can provide, would be placed into this unit. It would alleviate them from segregation status and allow them to participate in their correctional plan. Ms. Lamm testified that a similar recommendation was made by the Office of the Correctional Investigator (OCI) in 2011 which was accepted by senior executives at National Headquarters in 2013. It calls for the establishment of one IMHCU in each of the five regions. As of the Inquest date there had yet to be an IMHCU established.*