

Ministry of Public Safety & Solicitor General Coroners Service Province of British Columbia

VERDICT AT CORONERS INQUEST

Findings and Recommendations as a Result of the Coroner's Inquest Pursuant to Section 38 of the Coroners Act, [sbc 2007] c 15, Into the Death of

ROY Surname			Chri	Stopher GIVEN NAMES	r Robert	
An Inquest was held at	Burnaby Coroners Cou	urt, in th	e municipality o	f	Burnaby	
in the Province of British Co	lumbia, on the following	dates	Jul	ly 18 – 21, 20)16	
before: John Knox		, Presi	iding Coroner.			
into the death of	ROY (Last Name)	Christopher (First Name)			7 🛛 Male 🔲 Fen	nale
The following findings were	made:					
Date and Time of Death:	June 3, 2015			18:49		
Place of Death:	Abbotsford Regional H (Location)	Hospital, 3290	0 Marshall Rd	Abbotsfo	ord, BC	
Medical Cause of Death:						
(1) Immediate Cause of De	ath: a) Anoxic bra	ain injury				
	Due to or as a c	consequence of	ŕ			
Antecedent Cause if any:	b) Asphyxia					
	Due to or as a c	consequence of	e I			
Giving rise to the immediat cause (a) above, <u>stating</u> <u>underlying cause last.</u>	e c) Hanging					
(2) Other Significant Condit Contributing to Death:	ions					
Classification of Death:	Accidental	Homicide	🗌 Natural	Suicide	Undetermined	
The above verdict certified	by the Jury on the 2	tay c	of	July	AD,201	6
John Kn	OX			- (mANA)	(June)	
Presiding Coroner		-	K		- NY X	



FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO SECTION 38 OF THE CORONERS ACT, [SBC 2007] C 15, INTO THE DEATH OF

ROY	Christopher Robert
SURNAME	Given Names
PARTIES INVOLVED IN THE	INQUEST:
Presiding Coroner:	Mr. John Knox
Inquest Counsel:	Mr. Rodrick MacKenzie
Participants/Counsel:	Mr. David Kwan, counsel for Correctional Services Canada Mr. Bibhas Vaze, counsel for Robert and Brenda Roy
Court Reporting/Recording Agency:	Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded seven exhibits. Fifteen 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 Findings 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 Findings and Recommendations.

Christopher Robert Roy, 37, was a federal inmate who came to his death after hanging himself in his cell at Matsqui Institution, a medium security prison operated by Correctional Service Canada (CSC). At the time of the incident he had been held in administrative segregation for 60 days.

The jury heard from Mr. Roy's Community Parole Officer (CPO), who explained that her role is to monitor paroled offenders, assist them with managing their risk factors, and to work with them towards reintegrating into the community. She provided an overview of Mr. Roy's parole from Mission Institution, his time at a halfway house in Victoria, and the events that brought him into custody at Matsqui Institution.

Mr. Roy had been sentenced to two years in federal custody for breaking and entering with intent to commit theft, as well as various breaches of undertaking and probation conditions. He commenced his sentence at Mission Institution in November 2013. In February 2015, he was granted "day parole," which meant he was to be supervised in the community by a CPO with a condition to reside in a halfway house. Mr. Roy requested a halfway house in Victoria as he had previously lived there for a short time, and had ties to a local church organization.

Mr. Roy was just a few weeks short of completing two-thirds of his sentence, after which point he would have been eligible for statutory release with "full parole," meaning he could leave the halfway house and reside wherever he wanted, subject to any conditions placed upon him. He was required to participate in ongoing mandatory drug testing in either case.



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The CPO testified that she met Mr. Roy three times in the first two and a half weeks following his release from Mission Institution. He indicated to her that he was experiencing stress and anxiety. He registered with an 8-week skills and recovery program offered by the Salvation Army, and was regularly attending the Men's Trauma Centre to address some childhood issues. When Mr. Roy qualified for full parole, he requested that he be permitted to stay at the halfway house so that he could continue with his Salvation Army recovery program. His request was approved.

On March 31, 2015, Mr. Roy asked to be excused from his recovery program to attend a doctor's appointment the following day. On April 1, 2015, he left the halfway house and did not return. He did not respond to phone messages inquiring as to his whereabouts. The following day the halfway house notified the National Monitoring Centre (NMC) that Mr. Roy was unlawfully at large and not reporting as required. The NMC issued a Warrant of Suspension – this meant that he was to be arrested and detained until such time that his CPO determined whether it was appropriate to continue with supervised parole in the community, or if he should complete the remainder of his sentence at a correctional institution.

Mr. Roy turned himself in to Mission RCMP on April 5, 2015. He was briefly transferred to the custody of Abbotsford Police, and was lodged in the segregation unit at Matsqui Institution shortly thereafter.

The CPO explained that offenders with suspended paroles are usually sent to Matsqui Institution's temporary detainment unit until decisions are made with respect to their immediate futures. Mr. Roy, however, reported safety concerns about "incompatible inmates" at Matsqui, and as such he was lodged in the segregation unit instead. She testified that she had not been notified that Mr. Roy had been placed in segregation, but said it was not unusual for this to happen.

She said that some offenders with suspended paroles might be returned to community supervision after a week or two. Those who are not suitable for a return to the community have their paroles revoked, at which point they would be moved from temporary detainment to other units or other institutions.

The CPO conducted a post suspension interview with Mr. Roy during which he disclosed that he had relapsed with alcohol, crystal methamphetamine and heroin. He reported that he subsequently travelled to the Lower Mainland and continued to use drugs, before deciding to turn himself in. She told the jury that Mr. Roy's criminality was linked to his drug and alcohol use; specifically that he committed crimes to support his habits. She said he also claimed to struggle with Post Traumatic Stress Disorder and Obsessive Compulsive Disorder, though she could not verify this. In any case, she stated it was very clear he was a troubled man who was struggling with childhood issues.

The jury heard that the CPO had the authority to reinstate an offender's parole within 30 days of a Warrant of Suspension if she concluded the offender's risk factors could be safely managed in the community. She testified that she did not believe this was possible in Mr. Roy's case given his recent history of drug use and being unlawfully at large after spending just very short time in the community. She said she also had the option of deferring the decision to the Parole Board of Canada after 30 days, but explained that this process could take an additional 90 days for a decision to be rendered.



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The jury also heard evidence from an Institutional Parole Officer (IPO) who came to know Mr. Roy over the 60 days he spent in the segregation unit. His description of his duties was similar in many respects to that of the CPO, the key difference being that an IPO works with offenders who are still in prison. He said it was his job to assist inmates with recommendations for programming and release planning, and to provide them with documents from CSC and the Parole Board of Canada.

The IPO met with Mr. Roy at least twice per week, sometimes more. He described Mr. Roy as "a friendly guy" and "personable," and recalled that they seemed to have a good rapport. He said Mr. Roy did not disclose any mental health concerns to him, nor did he initially appear to be struggling. There was nothing about Mr. Roy which caused him to consider the possibility he was using drugs while in custody.

On April 29, 2015, Mr. Roy's parole was officially revoked by the Parole Board of Canada. The first IPO explained that the next step for Mr. Roy was "pen placement," which meant he would remain in segregation until CSC decided what institution he should be sent to.

On May 19, 2015, Mr. Roy was served a notice of an "Assessment for Decision" that he was to be sent to Mission Institution. He filed a handwritten rebuttal indicating he had concerns for his safety there due to the presence of a particular inmate who he did not name.

On the morning of May 29, 2015, a Correctional Officer noticed that Mr. Roy had covered his cell window with his mattress. Attempts to communicate with Mr. Roy were unsuccessful. When Correctional Officers attempted to open the meal tray slot on his door, Mr. Roy allegedly tried to deter them using a broom handle. A half hour later, Correctional Officers successfully opened the meal tray slot. Mr. Roy's institutional parole officer (IPO) observed Mr. Roy sitting on his bed and engaged him in a brief discussion. Mr. Roy reportedly yelled "*I want to go to Kent*!" - a reference to Kent Institution, a maximum security prison. Mr. Roy said he had something he wished to discuss with a Security Intelligence Officer (SIO), and the IPO agreed to facilitate a meeting.

Later that morning, Mr. Roy was removed from his cell by a Correctional Officer and was brought to an office to meet privately with a SIO and his IPO. During the 30 minute meeting, Mr. Roy relayed concerns that other inmates in the segregation unit had the ability to open their cell doors, and that he was afraid they would come into his cell to harm him.

Mr. Roy then told the SIO that he had been recruited by a gang to obtain drugs while on parole, and his instructions were to smuggle the drugs back into Mission Institution. He was concerned that since he had not delivered the drugs, other inmates would suspect he had stolen them.

Mr. Roy also expressed some concerns to the first IPO about being sent to Mission Institution – he felt he would be at risk there from other inmates. He later changed his mind and told the first IPO that he did want to go there after all. Mission Institution, however, was unwilling to take Mr. Roy as per concerns he had allegedly been involved in a conspiracy to import drugs there.



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On the afternoon of June 1, 2015, Mr. Roy was served with notice by another IPO that he had been reclassified as a maximum security inmate and was going to be transferred to Kent Institution.

A few hours later, Matsqui personnel brought medications to the inmates housed in the segregation unit. At 1732 hours, it was discovered that the window to Mr. Roy's cell had been covered. A CO called out to Mr. Roy but heard no response. The CO opened the food tray slot in the door, and determined Mr. Roy was suspended from the ceiling by a ligature around his neck. The ligature had been anchored to a metal covering that had been installed to prevent inmates from accessing a ceiling-mounted heat sensor. The CO summoned staff to the unit, and they entered the cell at 1740 hours. The ligature was cut with a "911 tool," and Mr. Roy was brought to the floor, pulseless and unresponsive.

Staff commenced cardiopulmonary resuscitation immediately until paramedics assumed responsibility for his care. Mr. Roy's pulse was restored after several minutes, and he was transported by ambulance to Abbotsford Regional Hospital. Medical imaging identified damage to Mr. Roy's brain caused by a lack of oxygenated blood supply for an extended period of time. He was placed on life support, but over time his neurological condition deteriorated to the extent that it met the criteria for brain death. Mr. Roy was declared deceased on June 3, 2015 at 1849 hours.

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: Government of Canada

1. To bring forward meaningful discussion and debate into the House of Commons with respect to legislated caps on the length of time inmates can be held in segregation, and prohibitions against placing inmates in segregated custody who are known to have mental health issues or histories of self-harming behaviours.

Presiding Coroner's Comment: The jury heard from various witnesses there are no legislated limits nor any external oversight with respect to the duration a person can be held in segregation by Correctional Service Canada (CSC). The jury heard further evidence that the Office of the Correctional Investigator has significant concerns with respect to the mental health impacts that may result from placing certain types of vulnerable inmates in segregation.

Mr. Roy was held in administrative segregation for 60 days. An Institutional Parole Officer (IPO) testified that in his experience, this was "...a long time" to be held on that unit, and Mr. Roy had "...reached his breaking point" to the extent that his mental health was deteriorating. A Correctional Manager testified that he was aware of at least one inmate previously being held in segregation for 120 days. He also said that in the course of his 10 year career at Matsqui Institution, he was personally aware of at least 10 suicide attempts, about half of which involved inmates in the segregation unit.



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The jury also heard that the Office of the Correctional Investigator has specifically identified the use of segregation as a risk factor in inmate suicides, and has made numerous recommendations to CSC to address this issue.

2. Immediately make it policy to adopt the United Nations (UN) recommended guidelines on solitary confinement and segregation.

Presiding Coroner's Comment: The jury heard that the UN's guidelines concerning appropriate use and duration of segregation are much more restrictive than CSC's current policies and practices. Similar recommendations have been submitted to CSC in recent years by various agencies and inquest juries.

To: Correctional Service Canada

3. CSC implement the recommendations (that are not already implemented) from the Board of Investigation into the Death of an Inmate at Matsqui Institution June 3, 2015, within 90 days.

Presiding Coroner's Comment: CSC conducted an internal review of the circumstances of Mr. Roy's death, resulting in numerous recommendations to improve safety and prevent similar deaths. The jury heard that some of these recommendations had not been implemented at the time of the inquest.

4. CSC revise policy to increase the frequency of unit cell checks and increase staffing as necessary to achieve this. Cell checks should be staggered at unpredictable intervals to minimize inmate self-harm opportunities.

Presiding Coroner's Comment: A Correctional Officer employed at Matsqui Institution testified that cell checks in the segregation unit are conducted once per hour between 0600 and 1700 hours, and once every 30 minutes thereafter. She stated that the timing of range walks to check the segregation cells is occasionally impacted by other job duties.

5. CSC have a dedicated roster for segregation to facilitate more continuity and communication between inmate and staff. When a member of this roster is coming back from a leave, they must be given sufficient time to confer with their replacement, to review events that transpired during the leave.

Presiding Coroner's Comment: A Correctional Officer testified that a typical 12-hour shift at Matsqui Institution was comprised of three four-hour postings to various units or locations within the prison, one of which may happen to be the segregation unit. The jury also heard from a registered nurse and two

This document has been prepared pursuant to the authority of the Chief Coroner as provided in Section 53 (2) (e) of the Coroners Act, [SBC 2007] C 15.



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institutional parole officers (IPOs) employed at Matsqui Institution that their responsibilities were not specific to segregation unit inmates.

An IPO testified that she returned to work from maternity leave on the morning of June 1, 2015. Approximately 28 inmates were immediately placed on her caseload, including Mr. Roy. She participated in Mr. Roy's 60-day segregation review board meeting within a few hours of arriving on site. She testified she had no time to obtain a history from Mr. Roy's previous IPO, and was not aware of his recent concerns that Mr. Roy's mental health was deteriorating. She testified that she introduced herself to Mr. Roy for the first time about one hour prior to the discovery of his hanging by Correctional Officers.

6. Segregation roster should include a full time Registered Psychiatric Nurse.

Presiding Coroner's Comment: The jury heard that registered psychiatric nurses (RPNs) have specialized mental health training above and beyond that of registered nurses. They also heard that while some RPNs did work at Matsqui Institution, none were specifically assigned to the segregation unit.

7. Take the steps to improve the availability of on-site psychiatric service at all institutions.

Presiding Coroner's Comment: The jury heard that Matsqui Institution has an inmate population that typically fluctuates between 275 – 325, but has at times peaked at more than 400. At the time of Mr. Roy's incarceration there, a psychiatrist was under contract to attend the prison once per month for half a business day. Various witnesses employed at Matsqui Institution confirmed this level of service remains in effect today.

8. Psychiatrists should be retained to conduct comprehensive mental health assessments of segregated inmates at regular intervals, and should also participate in all segregation reviews board meetings pertaining to those inmates.

Presiding Coroner's Comment: The jury heard that Mr. Roy was not formally evaluated by a registered psychologist or psychiatrist at any point during his 60 days in administrative segregation. The jury also heard that key participants in his segregation review board meetings had limited interactions with him, or in some cases none at all, prior to making decisions about extending his placement in the segregation unit.



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9. Revise policy to increase daily yard time offered to segregation inmates, and increase staffing as necessary to achieve this.

Presiding Coroner's Comment: The jury heard that segregation inmates are limited to one hour of outdoor yard time per day. Unlike other inmate populations, segregation inmates generally "yard" alone or with one other compatible inmate, and they do not have access to exercise equipment other than a pull-up bar.

10. Focus mental health training to the dedicated staff working in segregation.

Presiding Coroner's Comment: Various witnesses employed at Matsqui Institution testified that they received some training with respect to recognizing suicide risk factors and warning signs, however, they said they had not received any specialized mental health training specific to their work with segregation inmates. The reference to "dedicated staff" arises from issues raised in jury recommendations #5 and #6.

11. Regular scenario training to prepare for possible future events, with the view to improving response times.

Presiding Coroner's Comment: Various witnesses employed at Matsqui Institution testified that they had not previously participated in any scenario-based training to prepare them for responding to a hanging incident. An Assistant Warden testified that since Mr. Roy's death, some Correctional Officers have participated in a hanging response exercise from which lessons learned shall be integrated into future training.

12. Engineering solutions at national level to improve safety in all cells.

Presiding Coroner's Comment: An Assistant Warden testified that prior to Mr. Roy's death, CSC took steps to eliminate potential suspension points in cells that inmates could anchor ligatures to. Changes at Matsqui Institution included the installation of metal covers around ceiling-mounted heat sensors. He stated that it was not thought possible to utilize the metal covers as an anchor point until Mr. Roy's death proved otherwise. The Assistant Warden reported that since then, the metal covers and their fastener bolts have been removed from cells at Matsqui Institution, and the heat sensors have been relocated within the ceiling. He said was not aware if these same measures had been undertaken at other federal corrections facilities.



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13. Inmates be allowed to have their segregation report reviewed by an entity independent of CSC and that inmates be given sufficient time and a private place to review and understand all documents related to their incarceration.

Presiding Coroner's Comment: The jury heard that there is no external oversight of the segregation review board process. The jury also heard that while inmates are permitted to attend their segregation review board meetings, they do not always exercise that option, and often learn of the board's decisions after the fact from their IPO.

The jury also saw video of Mr. Roy receiving three documents from his IPO on the afternoon of June 1, 2015. The IPO testified these documents related to his 60-day segregation review board meeting held earlier in the day; his newly applied classification as a maximum security inmate; and a final decision by the Warden to transfer him to Kent Institution, a maximum security prison.

The video showed the IPO handing the documents to Mr. Roy through the meal tray slot on his cell door. He signed and returned them to the IPO, who then left the unit. The timestamp displayed on the video showed that the duration of their interaction was one minute and six seconds.

14. Ensure all temporary detainment inmates have the means to access trauma-informed mental health and substance abuse treatment programs on an interim basis prior to their eventual institutional placements.

Presiding Coroner's Comment: The jury heard that temporary detainment inmates at Matsqui Institution were not eligible to participate in substance abuse treatment and counselling programs.

15. Ensure that all segregation inmates have the means to access specialized one on one, traumainformed mental health and substance abuse treatment programs.

Presiding Coroner's Comment: The jury heard that substance abuse treatment and recovery programs offered at Matsqui Institution are conducted in group settings with general population inmates. Segregation inmates are not eligible to participate due to safety concerns.



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16. Retain the expertise of external advisory panels to conduct regional assessments of the quality and availability of mental health services and programming. Specific focus should be given to identifying and eliminating barriers to treatment for inmates of all categories and security classifications. These advisory panels should be comprised of registered psychiatrists, psychologists, and other accredited mental health practitioners.

Presiding Coroner's Comment: The jury heard that Mr. Roy's initial risk of suicide and self-harm was assessed by way of self-reported responses to a questionnaire that he completed upon arrival at Matsqui Institution in the presence of a Correctional Officer. The jury also heard that Mr. Roy was never assessed by a psychiatrist or psychologist during his time at Matsqui Institution, and had very limited, non-clinical contact with mental health clinicians. One mental health clinician testified that at the time of Mr. Roy's death, her CSC job title was "assistant psychologist" even though she was not actually registered with the BC College of Psychologists. She confirmed this job title appeared adjacent to her name and signature on reports contained within Mr. Roy's mental health records.

17. The findings of these advisory panels should form the basis of future mental health strategic planning and policy.

Presiding Coroner's Comment: Supplementary to jury recommendation #16.

18. Revise policy to ensure that any inmate held in segregation more than 4 days is provided TVs, books, or other safe and reasonable distractions, for the betterment of their mental health.

Presiding Coroner's Comment: Various witnesses employed at Matsqui Institution testified to their belief that the mental health of inmates in segregation would benefit from stimulating distractions such as television sets and reading materials.

19. All control posts in every unit be equipped with an AED, a bag valve mask, and other items appropriate for an interim response to a potentially fatal self-harm incident. These items should be stored together in a bag or kit that can be brought to the scene.

Presiding Coroner's Comment: A BC Ambulance Service paramedic testified that automated external defibrillators (AEDs) and bag valve masks are important tools that can assist with the resuscitation of a patient following a cardiac arrest. The jury heard that when Mr. Roy was discovered unresponsive in the segregation unit, the nearest available AED was one floor below in the temporary detainment unit. The jury also heard that Matsqui Institution is not equipped with bag valve masks.



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20. Request the Commissioner of Corrections Canada and/or the Regional Manager of Tech Services and Facilities in Ottawa that more power be given to Wardens to allocate budgets to where they are needed, pertaining to their particular institution's needs.

Presiding Coroner's Comment: The jury heard that Wardens face some limitations with respect to their authority to re-allocate financial resources from one aspect of an institution's budget to another for the purpose of addressing site-specific issues such as increasing staff, implementing new programs or improving infrastructure.

21. Review the funding formulas to allow hiring and maintaining mental health staff; especially psychiatric doctors.

Presiding Coroner's Comment: Supplementary to jury recommendation #20. The jury heard that Matsui Institution has excess Correctional Officers, whereas some witnesses indicated that inmates would benefit from additional mental health personnel.

22. The Offender Management System should be easily accessible by all authorized staff and should contain all inmates' files and paperwork.

Presiding Coroner's Comment: The jury heard that the Offender Management System (OMS) is case management computer software used by CSC and the Parole Board of Canada. One mental health clinician testified that at one point she did not have access to Mr. Roy's complete psychological records, as the paper file had not yet been transferred to Matsqui Institution. She explained that it was her understanding that not all records were accessible via OMS.

23. Provide a unit within the institution to house inmates who have specific needs that cannot be met in general population, with the view to eliminating or reducing the need for administrative segregation.

Presiding Coroner's Comment: The Assistant Warden testified that he had submitted a proposal to CSC upper management to build a living unit similar to what is described in the jury's recommendation. At the time of the inquest, he had no timeline for when a decision might be rendered.



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24. That CSC create a role akin to a family liaison to assist with timely and meaningful communication at such time an inmate has been hospitalized with a serious injury or medical condition.

Presiding Coroner's Comment: The jury heard from Mr. Roy's father, who testified that he and his wife experienced some challenges in their dealings with CSC personnel while attempting to visit their son in the hospital.

25. That all recommendations arising from this inquest and other processes which examine conditions and events at correctional institutions be taken seriously.

Presiding Coroner's Comment: A retired employee from the Office of the Correctional Investigator testified that the agency has made repeated recommendations to CSC with respect to inmate segregation, mental health issues and suicide prevention over the past 20 years, but many of their concerns have not been addressed.