BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

File No.: 2012:0364:0085

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

in the Province of British Columbia, on the following dates September 16th, 2014`

before Liana Wright, Presiding Coroner,

into the death of BOURQUE Roland Joseph 69 ☒ Male ☐ Female
(Last Name, First Name, Middle Name) (Age)

and the following findings were made:

Date and Time of Death: April 3, 2012 @ 0806 hours

Place of Death: North Fraser Pretrial Centre Port Coquitlam, BC
(Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Severe head trauma

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) A fall from a height

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 16th day of September AD, 2014.

Liana Wright
Presiding Coroner's Printed Name

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

FILE NO.: 2012:0364:0085

BOURQUE	**Roland Joseph**
Surname	**Given Names**

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Liana Wright

Inquest Counsel: Rodrick H. MacKenzie

Participants/Counsel: BC Corrections/Pamela Manhas

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded two exhibits. Nine witnesses were duly sworn in 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 purpose of the summary 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 March 12, 2012, Mr. Roland Joseph Bourque was arrested by police on a Canada-wide warrant as he arrived at Vancouver International Airport from a flight abroad. Mr. Bourque had been charged with two counts of sexual interference of a person under the age of 16 and two counts of sexual assault. He was taken to the Vancouver Police Department lock-up and housed in a cell. His booking report included an entry that 'he had contemplated suicide'. He was seen on rounds by the doctor on duty who reported that she had given him medications for heartburn and he reportedly told the nurse that he did not have any previous psychiatric history. He was transferred to the North Fraser Pretrial Centre (NFPC) the following day on March 13, 2012.

The nurse and mental health screener who assessed Mr. Bourque at NFPC reported that he denied any suicidal ideation or history of violence. He was reportedly future-oriented and informed the screener that he was looking forward to being discharged from jail the next day on bail. Both the nurse and mental health screener gave evidence that they had not seen the Vancouver Police Department Booking Report which contained the notation that Mr. Bourque had contemplated suicide. Their evidence was that it was 'hit or miss' whether or not they saw this document when an inmate was transferred to their facility and that sometimes the document did not accompany the inmate at all.

BOURQUE	**Roland Joseph**
Surname	**Given Names**

Mr. Bourque was housed in the Alpha North Unit which was explained as a unit where inmates were kept that needed to be separated from the general population for their own safety. On April 3, 2012, shortly after the cells doors were unlocked at 0800 hours, Mr. Bourque was captured on CCTV exiting his cell on the second tier and walking up the stairs to the third tier to where chairs and telephones were located for inmate use. He moved a chair against the railing and after a very brief hesitation, climbed up on the chair and jumped over the railing to the floor below.

A Security Officer heard one of the inmates yell 'Oh my God' and turned to see Mr. Bourque as he was falling to the floor below. He instantly called a Code Blue and help arrived in seconds from the nearby health care unit. The doctor who responded to the Code Blue gave evidence that Mr. Bourque had sustained severe head trauma and showed no signs of life. Resuscitation was not attempted. The scene was attended and investigated by the on-duty coroner and members of the Coquitlam RCMP.

The jury heard that since Mr. Bourque's death, changes have been made to the third tier at the North Fraser Pretrial Centre and now floor to ceiling bars are in place that would prevent an inmate from jumping to the floor below.

At the conclusion of the evidence, the jury deliberated and made five recommendations.

BOURQUE — Surname

Roland Joseph — Given Names

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: Ministry of Justice/Police Services

AND

Ministry of Justice/BC Corrections

1. All Policing and Correctional Agencies develop a plan to implement a policy that all alert information should be included when any inmate is transferred to a new facility. This alert information should be always reviewed by the new facility for history or relevant information.

   Coroner's Comments: *The jury indicated that the fact that the Vancouver Police Booking Report had the entry 'he had contemplated suicide 2013/03/12' and that it appeared several tick boxes had been marked under 'Alerts', that it would be useful for this information to be communicated to the intake nurse at the receiving facility when an inmate is transferred.*

To: Sentry Health Correctional Services

2. That a legible copy of a booking report and initial health assesement should always be obtained and reviewed with each inmate upon admission.

   Coroner's Comments: *The copy of the Vancouver Police Booking Report provided was difficult to discern in some parts and that this information was important to pass on and to be reviewed.*

BOURQUE	**Roland Joseph**
Surname	**Given Names**

To: The Justice Institute of British Columbia

3. That a review occur of the Correctional Officer training program to assess the adequacy of its suicide risk awareness component. If there is no such component then an update to the program should be implemented.

Coroner's Comments: *During the interview of Mr. Bourque's cell mate, inmate P. Duncan told police that Mr. Bourque was in his room all the time and ate all of his meals in there. The jury suggested that self-isolating changes in behaviour could be noted and logged and therefore could trigger another mental health assessment.*

To: Ministry of Justice/BC Corrections

4. That BC Corrections review older facilities to identify potential structural improvements which reasonably could mitigate the risk of suicide or violence.

Coroner's Comments: *Evidence given by the Deputy Warden was that all facilities are different and that the bars were rasied on the third tier of the NFPC only. The jury would like to see a review of older facilities to bring them up to date.*

5. That BC Corrections put forward a plan to implement a system which holds all information on an inmate in a central information system which will allow access to information to qualified individuals.

Coroner's Comments: *Staff require all the information they can obtain when assessing an inmate.*