



October 2, 2014

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

Dear Ms. Lapointe,

**Re: Coroner's Inquest into the death of: BOURQUE, Roland Joseph
BCCS Case File #2012-0364-0085**

Further to your letter dated September 29, 2014, we have noted your request for action regarding the jury's number three recommendation. We will be reviewing the recommendation and will respond to you with our plans within the requested timeframe.

Sincerely,

A handwritten signature in black ink, appearing to read "Laureen Styles".

Dr. Laureen Styles
Vice President, Academic
Acting President



BRITISH
COLUMBIA

RECEIVED

NOV 13 2014

CHIEF CORONER

NOV 05 2014

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

Dear Ms. Lapointe:

Thank you for your letter of September 29, 2014, containing the Verdict at Inquest that includes recommendations resulting from the inquiry into the death of Roland Joseph Bourque.

The Assistant Deputy Minister of the Corrections Branch will provide you with responses to all five recommendations arising from this inquiry. While three of the recommendations are addressed to the Ministry of Justice, the other two recommendations involve organizations which have contracts with the Corrections Branch. The Corrections Branch is working with those organizations in the preparation of their responses. All responses detailing what action has been taken, or will be taken, regarding this matter will be provided to you within the specified 60 day timeframe.

Sincerely,

Suzanne Anton QC
Attorney General
Minister of Justice

pc: Mr. Brent Merchant
Ms. Liana Wright

Ministry of
Justice

Office of the
Minister of Justice
and Attorney General

Mailing Address:
PO Box 9044 Stn Prov Govt
Victoria BC V8W 9E2
e-mail: JAG.Minister@gov.bc.ca
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Telephone: 250 387-1866
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MAY 13 2015

MINISTRY OF JUSTICE
OFFICE OF THE CHIEF CORONER

C504823
59100-20/BOURQUE

May 8, 2015

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

Dear Ms. Lapointe:

Re: Coroner's inquest into the death of:
BOURQUE, Roland Joseph
BCCS Case File #2012-0364-0085

Further to my letter of November 19, 2014 regarding the referenced matter, I am writing to advise you of the final response to jury recommendation #3 arising from the Verdict at Inquest.

In consultation with a subject matter expert and a mental health professional, a review of suicide awareness training for correctional staff was undertaken by the program director of Adult Custody Training (Justice Institute of BC) and endorsed by the chair of the Strategic Training Committee (Adult Custody) in April 2015 with the following results:

1. Training provided during the first 33 days of employment was found to provide new correctional staff with a thorough overview of the issues related to suicide intervention and prevention.
2. The seven hour online course, currently offered during the 18 month advanced training program, has been determined to be a more beneficial resource for staff if it is provided within the first six months of employment. This change will come into effect on June 1, 2015.

A table outlining all recommendations with completed responses is attached.

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Protect Communities, Reduce Reoffending

Ministry of Justice

Corrections Branch
Office of the
Assistant Deputy Minister

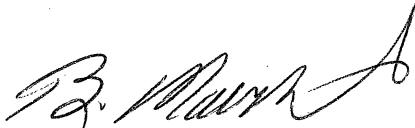
Mailing Address:
PO BOX 9278 STN PROV GOVT
Victoria BC V8W 9J7

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

Lisa Lapointe
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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,

A handwritten signature in black ink, appearing to read "Brent Merchant". The signature is fluid and cursive, with a large initial "B" and a long, sweeping tail.

Brent Merchant
Assistant Deputy Minister

Attachment

pc: Ms. Liana Wright, Presiding Coroner

**NORTH FRASER PRETRIAL CENTRE
INMATE DEATH – April 3, 2012**

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
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.	Corrections Branch Adult Custody Policy requires the warden to establish protocol for entry of inmate security alerts in CORNET (offender management system). Prior to transfer to another correctional centre, a review of alerts is undertaken and transporting officers are apprised of all CORNET alerts. The receiving centre reviews alerts during the admission process.		Completed	
2. That a legible copy of a booking report and initial health assessment should always be obtained and reviewed with each inmate upon admission.	All health care staff have been advised to ensure they receive relevant written documentation when accepting inmates from Vancouver Police or other agencies and to seek clarification where information is illegible, ambiguous, or unclear. A health assessment is completed with each inmate upon admission to a provincial correctional centre.		Completed	
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.	Correctional officers currently receive the following suicide awareness training: 1. Two educational training components provided to new correctional officers that address suicide risk factors and suicide prevention strategies. 2. A seven hour online course entitled Suicide Prevention and Intervention which addresses suicide risk factors and describes the requirement for correctional officers to identify, document and relay		Completed	

**NORTH FRASER PRETRIAL CENTRE
INMATE DEATH – April 3, 2012**

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
	<p>relevant information to health care professionals is offered during the 18 month advanced training program.</p> <p>In consultation with a subject matter expert and a mental health professional, a review of training was concluded by the program director of Adult Custody Training (Justice Institute of BC) and endorsed by the chair of the Strategic Training Committee (Adult Custody) in April 2015 with the following results:</p> <ol style="list-style-type: none"> 1. Training provided during the first 33 days of employment has been found to provide new correctional staff with a thorough overview of the issues related to suicide intervention and prevention. 2. The seven hour online course has been found to be a more beneficial resource for staff if it is provided within the first six months of employment. This change will come into effect on June 1, 2015. 			
4. That BC Corrections review older facilities to identify potential structural improvements which reasonably could mitigate the risk of suicide or violence.	Structural enhancements were put in place on the third tier at North Fraser Pretrial Centre to mitigate risk to inmates intent on harming themselves or who may be subject to violence. Other provincial correctional centres do not have third tier living units. Newly built correctional centres with third tiers will incorporate additional security features for inmates at risk.		Completed	

**NORTH FRASER PRETRIAL CENTRE
INMATE DEATH – April 3, 2012**

RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
	Every correctional centre has a union-management occupational health and safety committee which conducts monthly reviews focusing on safety concerns.			
5. That BC Corrections put forward a plan which implements a system which holds all information on an inmate in a central information system which will allow access to information to qualified individuals.	<p>All inmates are assessed upon admission to determined associated risks, identify security and safety alerts, and classify them to the appropriate placement within the correctional centre. This information is stored centrally in CORNET for the benefit of correctional staff.</p> <p>CORNET is an integrated and comprehensive operational application that supports management of offenders who are under custodial or community supervision, or assessment for court purposes. All branch staff have access to information in CORNET according to their need and access rating.</p> <p>The Corrections Branch maintains the Primary Assessment and Care (PAC) inmate health information system, a comprehensive health care application. All correctional health care personnel have access to PAC according to their need and access rating.</p>		Completed	