Ministry of Justice
Coroners Service
Province of British Columbia

File No. :2013:0383:0047

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

LAHN	Jesse Marcel
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates April 13-15th 2015

before: Isis van Loon, Presiding Coroner.

into the death of LAHN (Last Name) Jesse (First Name) Marcel (Middle Name) 33 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: May 3rd 2013 6:44 AM - 7:10 AM

Place of Death: Kent Institution 4732 Cemetery Road (Location) Agassiz, British Columbia (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Anoxia

Due to or as a consequence of

Antecedent Cause if any: b) 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 15th day of April AD, 2015

Isis van Loon
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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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:

PARTIES INVOLVED IN THE INQUEST

Presiding Coroner:	Ms. I. van Loon
Inquest Counsel:	Mr. R. H. MacKenzie
Participants/Counsel:	Mr. C. Wurkin, Ms. Mules/Correctional Services Canada
Court Reporting/Recording Agency:	Verbatim Words

The Sheriff took charge of the Jury and recorded six exhibits as entered. Twenty three witnesses were duly sworn/affirmed and testified.

PRESIDING CORONER'S SUMMARY

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

Jesse Marcel Lahn was released from federal custody on mandatory supervision in March 2013. Upon his release he moved into Harbour Light, a Vancouver halfway house. He met regularly with his community Parole Officer to ensure that he was fulfilling the conditions under which he was released. On April 2 nd, 2013, Mr. Lahn told his Parole Officer he had been using illicit drugs – specifically crystal meth. He and his Parole Officer developed a plan to manage this problem. Two days later at a group counselling session Mr. Lahn admitted to having 'fleeting thoughts of self-harm". The group counsellor notified Harbour Light. When Mr. Lahn confirmed that he was continuing to have these thoughts Harbour Light staff notified the after-hours National Monitoring Centre. Mr. Lahn's release was suspended that evening. He had been in the community for a total of fourteen days. The community Parole Officer told the Jury that his report of his work with Mr. Lahn, including the recent use of crystal meth and voicing thoughts of self-harm, was available to other Parole Officers involved with Mr. Lahn.

The Vancouver Police took him into custody and transported him to the Vancouver Jail. A document relating to Mr. Lahn's incarceration at the Jail included concerns with respect to suicide and mental health. It was not clear if these concerns were recent or historical. Mr. Lahn was transferred briefly to North Fraser Pretrial where, without provocation, he attacked another prisoner. He was subsequently moved to the Temporary Detention Unit (TDU) at the Matsqui Complex in Abbotsford, British Columbia. The Matsqui Complex encompasses several prisons as well as a prison hospital with mental health facilities. Prisoners coming back into custody are

held for up to thirty days in the TDU for assessment pending a decision on whether to release them back into the community or maintain them in custody.

Mr. Lahn's Parole Officer at the TDU said they were aware that in 2008 he had had an episode of drug induced psychosis after using crystal meth. They conducted a risk assessment of Mr. Lahn and said there were no current concerns of self harm. He was classified as high risk because of the unprovoked assault at North Fraser Pretrial. The TDU Parol Officer recommended that Mr. Lahn be sent to Kent Institution, which is a maximum security prison located in Agassiz, British Columbia. According to the TDU Parole Officer there was no formal process of information sharing between the prison mental health department and Parole Officers, but informal communication was customary. The TDU Parole Officer also stated that the case management team at Kent would make their own assessment when Mr. Lahn arrived there.

On April 9th, 2013, the TDU Chief Psychologist saw Mr. Lahn briefly in passing. The next day Mr. Lahn told the Chief Psychologist that other prisoners were making assumptions about him that would put him at some risk in the population. Mr. Lahn said that he would feel safer in segregation, and his request was granted. The Chief Psychologist told the Jury that there was no evidence that Mr. Lahn's concerns were valid. Later, on April 16th, Mr. Lahn told her that he was 'fine'.

On April 17th, 2015 a guard had concerns about Mr. Lahn's mental health and asked a Social Worker to meet with Mr. Lahn when he was in segregation. These concerns were not related to potential self-harm but were more general in nature. The Social Worker was aware of Mr. Lahn's history of drug induced psychosis in 2008. They were not aware that he had expressed thoughts of self-harm during his recent release into the community, nor did they know the reason why Mr. Lahn was in segregation. Mr. Lahn refused to speak with the Social Worker on the 24th of April. He also declined to speak with a Psychiatric Nurse sent afterwards by the Social Worker in the hope that he might be more comfortable with a different clinician. When offered, Mr. Lahn declined further visits by family as well. Pending further assessment, the Social Worker placed him on thirty minute mental health monitoring. This meant that guards would check him at thirty minute intervals, instead of the usual sixty minute checks.

The Chief Psychologist attempted to meet with Mr. Lahn on the 29th of April. Mr. Lahn continued to refuse to consult a mental health clinician. The Chief Psychologist did note that he was coherent and future oriented on the 29th, and when questioned directly he denied that he was thinking of killing himself. She subsequently reduced the frequency of monitoring from thirty minutes to routine sixty minute checks. The Chief Psychologist was not aware that Mr. Lahn's release had been suspended after he had expressed thoughts of self-harm, but said that it would not have changed anything in the assessment. Although she did not believe there was a risk of

self-harm, the Chief Psychologist felt that something was not right with Mr. Lahn and made a referral to the TDU Psychiatrist. She also advised the Chief Psychologist at Kent Institution by email that Mr. Lahn would need further observation, and received a response that they would follow-up with him when he was transferred.

The TDU Psychiatrist attended Mr. Lahn on April 29th. The Jury heard that Mr. Lahn declined to leave his cell, and that the Psychiatrist observed him and spoke briefly through the meal slot on the cell door. Mr. Lahn told the Psychiatrist clearly that he did not want to talk to him. The Psychiatrist stated that Mr. Lahn knew by that time that he was going to be transferred to Kent Institution, and he was not happy about it. He also said there was no evidence of agitation or psychosis and that he had no basis to have Mr. Lahn involuntarily committed under the Mental Health Act.

Mr. Lahn's Health Care File and his Mental Health Records were sent to Kent around the time of his transfer on May 2nd, 2013. The Jury heard that these were two distinct records. A transfer summary accompanied these records, and it stated that he had "'thoughts of self-harm' and had recent drug-induced psychosis/psychotic periods" and also noted his recent crystal meth use. The Jury heard from the author of this summary, a Registered Nurse (RN) at the TDU, that she believed that his thoughts of self-harm had been in the past. This RN was unaware that his return to custody had been triggered, at least in part, when Mr. Lahn voiced thoughts of self-harm.

On May 2nd , 2013, Mr. Lahn was transferred to a transitional unit at Kent Institution. As a newly arrived inmate, he was to be kept in this transitional unit until he had been fully assessed and placed into an appropriate setting within the prison. On admission Mr. Lahn completed a checklist in which he indicated that he was not suicidal. An RN at Kent reviewed his Health Care File and completed a Health Intake form close to the time he arrived. This form did not note any mental health issues and specificallyindicated 'no' to mental health concerns including previous psychiatric admissions and current suicidal ideation or plan. Evidence was given by this RN that Mr. Lahn's Health Care File contained, at the front, an ongoing 'Major Problem List' which was intended to be updated as new major health issues occurred. Copies of the two 'Major Problem List' pages in Mr. Lahn's Health Care File reflected assessments from December 2011, and an apparently newer, undated entry noted substance abuse with crystal meth. There were no further entries.

The Deputy Warden of Operations at Kent told the Jury that an inmate would not be transferred from the TDU to another institution before being assessed and cleared for transfer. This would have included a mental health evaluation. If an indication of risk of harm to self arose after arrival, he confirmed that specialized cells and monitoring were immediately available at Kent. The transitional area where Mr. Lahn was brought was located in an older part of the institution.

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The Deputy Warden agreed that there may be obvious ligature points (places that a person so inclined could use to hang themselves) in the cells in this area.

In the Kent transitional unit guards performed routine checks, as per the rest of the prison, at approximately sixty minute intervals. While in this unit inmates had limited time outside of their cells, pending assessment and placement in the general population. Guards gave evidence that they had very limited information available to them in terms of inmate health and mental health history, and that it would have been helpful to have knowledge of relevant issues.

After the initial intake process on May 2nd , Mr. Lahn was given basic supplies – bedding and personal care items – which he took to his assigned cell at 11:50 AM. At 1:40 PM Mr. Lahn activated the emergency call button in his cell and told the responding guard that he wanted to know when the next meal was. The guard explained that the button was for emergency use only. Mr. Lahn had a conversation with a neighbouring inmate shortly before 5:00 PM. This neighbour gave evidence that Mr. Lahn said he was depressed and was contemplating suicide. This information was not reported to the guards.

Guards stated that Mr. Lahn entered his cell alone at 4:56 PM, and that afterwards the cell door was locked for the night. They saw Mr. Lahn standing by his cell window alive at 6:44 AM the next morning during a routine check. At 7:10 AM a guard, while opening the meal slot in preparation for breakfast, saw Mr. Lahn was hanging in his cell. The guard called for assistance, and shortly thereafter the door was unlocked and several guards entered. They found that Mr. Lahn had tied a sheet around his neck and fixed it to bars on his window. They moved him to the floor and initiated first aid. An RN arrived shortly thereafter and continued first aid. Basic Life Support Paramedics arrived at 7:35 AM, followed at 7:42 AM by Advanced Life Support (ALS) Paramedics. All in attendance gave evidence that at no time after Mr. Lahn was discovered hanging was he found to have a pulse or any other signs of life. Efforts to revive him were discontinued at 7:43 AM when an ALS Paramedic confirmed that Mr. Lahn was deceased.

The Royal Canadian Mounted Police (RCMP) were notified and attended. An RCMP Constable viewed video of the hall outside of Mr. Lahn's cell. The Constable confirmed that no one had exited or entered the cell between the time he was locked in alone the evening before and when he was discovered unresponsive the following morning. The Constable also verified that hourly checks had been conducted. The RCMP closed their file as a non-suspicious death.

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JURY RECOMMENDATIONS:

To Correctional Services Canada

1. Kent Institution should conduct a survey of ligature points in its cells. Based on this survey, develop a process to mitigate any issues identified. Correctional Services Canada is reminded that this survey may be of value at other institutions, particularly older facilities.

   Presiding Coroner's Comments: The Jury heard evidence that, particularly in older facilities such as the part of Kent Institution in which Mr. Lahn was placed, there were potential ligature points. This Recommendation is made to assist in reducing future suicides by hanging.

2. It is recommended that Correctional Services Canada revise the frequency of checks on new inmates during the transitional period, and that video surveillance should be installed for use during this period.

   Presiding Coroner's Comments: This Recommendation would permit prison staff to become familiar with new inmates and their issues, and would ensure a more rapid response when an emergency such as a suicide attempt occurred.

3. Correctional Services Canada is asked to review formal and informal information sharing processes with respect to inmate welfare, and to develop improvements to the system so that relevant information is made available to all staff that have contact with the inmate.

   Presiding Coroner's Comments: The Jury explained that having relevant information available to all staff will ensure a safer environment, and will enable staff to get to know the inmates more quickly. The Jury heard that certain information is privileged. This Recommendation would permit all staff to receive relevant, but not privileged information.

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4. Correctional Services Canada is recommended to audit medical files and implement changes as necessary based on this audit to ensure that the Major Problem List is current and complete. There should be one unified medical and mental health file accompanying an inmate through the correctional system.

   Presiding Coroner's Comments: This Recommendation is intended to allow quick and thorough review of an inmate's health history by all associated health workers, including mental health workers, and to ensure that relevant information is easily available and does not get overlooked.

To British Columbia Ministry of Health

1. Funds should be made available to create a facility where people with mental health and addiction problems can be intercepted before they get into the correctional system, such as the facilities that existed at Riverview.

   Presiding Coroner's Comments: This Recommendation is self-explanatory.