Ministry of Justice
Coroners Service
Province of British Columbia

File No. 2014:0228:0094

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

SURNAME	GIVEN NAMES
LANGLET	**David Lawrence Robert**

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

in the Province of British Columbia, on the following dates May 4 and 5, 2015

before: Liana Wright, Presiding Coroner.

into the death of LANGLET (Last Name) David (First Name) Lawrence Robert (Middle Name) 40 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: May 9th, 2014 at 19:12 Hours

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

Medical Cause of Death:

(1) Immediate Cause of Death: a) Asphyxia

Due to or as a consequence of

Antecedent Cause if any: b) Cervical Ligature 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 5 day of May AD, 2015

Liana Wright
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Liana Wright

Inquest Counsel: Rodrick H. MacKenzie

Participants/Counsel: Correctional Services of Canada/Mr. Paul Singh

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded six exhibits. Fourteen 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 May 9, 2014, Mr. David Lawrence Robert Langlet, was discovered hanging in his cell at Kent Institution, a federal penitentiary, in Agassiz, BC. Mr. Langlet had been given a life sentence for First Degree Murder.

He arrived at Pacific Institution's Regional Reception Assessment Centre (RRAC) on December 27, 2013. Mr. Langlet was assessed by the psychologist on December 31, 2013, and the intake screening report that was completed indicated that he was not suicidal, had never attempted suicide and had no suicide plan. Mr. Langlet had made his wishes known in writing to the Warden of Pacific Institution that he was opposed to being incarcerated at Kent penitentiary and asked to be considered for placement at Pacific Institution instead. He had also communicated this wish to his parole officer. Following a review by the Warden, his request for penitentiary placement at Pacific Institution was denied and he was recommended for placement at Kent Institution, citing reasons as a rating of 'high' for Institutional Adjustment, 'moderate' for Escape Risk and 'high' for Public Safety Risk.

He was transferred to Kent Institution in late April 2014. He completed an inmate's request form to see a physician regarding anxiety and medication concerns and was seen by the prison physician last on April 28, 2014. On that visit, Mr. Langlet complained of feeling depressed, empty and told the physician he had stopped taking his anti-depressant Celexa one month ago. He complained that the Celexa made him feel 'brain dead'. The physician noted that Mr. Langlet had thoughts of suicide but had no plans. He asked to try the anti-depressant Effexor which the physician agreed to prescribe with a re-assessment to take place in one month's time.

On the morning of May 9th, a correctional officer (CO) was walking by Mr. Langlet's cell when he stopped to talk with him. Mr. Langlet was holding an Inmate's Request Form which he slid under the cell door to the CO. He told the officer he was having 'bad thoughts' and wanted to see the psychologist. The CO called the psychologist's office and received no answer. He left a voice mail indicating that Mr. Langlet was having some difficulty and wanted to see him. The CO spoke with Mr. Langlet later that day and told him he had left a voice mail for the psychologist. Mr. Langlet told the CO he was fine and had just been having a panic attack.

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The CO gave evidence that he had last seen Mr. Langlet alive in his locked cell shortly before 1730 hours, prior to the officer's dinner time which ran from 1730 – 1815 hours. All the inmates were locked in their cells during the officers' dinner break. The cell doors were unlocked upon their return. At 1820 hours, Mr. Langlet was discovered hanging in his cell when an inmate walking past his door noticed him. The inmate called other inmates who accompanied him to the cell door where they were all able to look into Mr. Langlet's cell from the hallway. The inmates then notified the CO's of Mr. Langlet's status which prompted an immediate response. The medical team was alerted and nurses attended to him. Mr. Langlet's body was taken down and cardiopulmonary resuscitation was administered. This continued until arrival of paramedics who then took over the rescue efforts. Vital signs remained absent and paramedics received a cease order via the telephone from an emergency room physician who had been consulted.

Agassiz RCMP attended the scene and an officer testified that she reviewed the CCTV footage. She reported that no one entered Mr. Langlet's cell from the last time he was seen alive to when he was discovered unresponsive. The RCMP closed their investigation into this death on the basis that no foul play was suspected.

The psychologist, who had been left a voice mail message on Friday, testified that he did not learn about Mr. Langlet's request to see him until he came into his office on Monday morning. He confirmed that there was no referral to their office following Mr. Langlet's initial assessment at the RRAC nor would they see the RRAC Psychology Intake Screening unless there was a concern. Following Mr. Langlet's death, there has been a change in practice with respect to referrals. If a CO is unable to contact the psychologist, they are to send a group email to the psychologists as well as informing the Correctional Manager. The Correctional Manager could contact the psychologist on-call if the need was deemed urgent.

The Coroner who had attended the scene gave evidence that she viewed Mr. Langlet's body and found no signs of external injury or trauma. She testified that the physical findings were consistent with death due to asphyxia from a cervical ligature hanging.

Evidence given by the Assistant Deputy Warden of Operations at Kent Institution, confirmed that the new practice with respect to notifying the psychologist was communicated to all staff after Mr. Langlet's death; however, it was not added to policy or standing orders. He further added that if this type of issue was to arise after 1800 hours, the inmate could be brought to the Observation cells where they would remove any items that could be used to self-harm and the inmate would be on a constant watch. The inmate would remain there until a mental health expert assessed him and gave permission for him to be discharged from the Observation cells.

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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:

JURY RECOMMENDATIONS:

TO: Correctional Service Canada

1) When a guard relays an inmate's request, there should be a mechanism to confirm the request has been received by the appropriate staff.

   The jury was concerned that no one from the psychology department had responded back to Mr. Langlet regarding his request to see the psychologist, and that this may have been a factor in his suicide.

2) We recommend that different care teams at the facility need access to inmates' files to better identify inmates' potential risk factors.

   The jury reported that the psychologist was not aware of the medical doctor's findings of suicidal ideation and did not know that Mr. Langlet was on medications for depression.

3) For these suggestions to be effective, they must be made policy.

   The jury noted that Kent Institution has taken steps to rectify the 'lack of response' Mr. Langlet received to his request; however, they felt concerned that this could become a temporary practice which could become lost if not written into policy.