BRITISH COLUMBIA

Ministry of Justice
Coroners Service
Province of British Columbia

File No. :2014:0378:0055

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

REZANOWICZ	Roman William
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates December 7-8, 2015

before: Isis van Loon, Presiding Coroner.

into the death of

REZANOWICZ	ROMAN	WILLIAM	57
(Last Name)	(First Name)	(Middle Name)	(Age)

☒ Male ☐ Female

The following findings were made:

Date and Time of Death: April 30, 2014 1515hrs

Place of Death: Pacific Institution, 33344 King Road (Location) Abbotsford, British Columbia (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Exsanguination

Due to or as a consequence of

Antecedent Cause if any: b) Self-inflicted wound to the femoral artery

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 8 day of December AD, 2015

Isis van Loon
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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

REZANOWICZ	Roman William
SURNAME	GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Isis van Loon
Inquest Counsel:	Rodrick H. MacKenzie
Court Reporting/Recording Agency:	Verbatim Words
Participants/Counsel:	Correctional Service Canada/Paul Singh Drs. Iskander and Saine/David Pilley

The Sheriff took charge of the jury and recorded three exhibits. Seventeen 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.

Mr. Roman William Rezanowicz was serving a life sentence. He had been incarcerated for close to twenty years when he transferred to Mountain Institution, in British Columbia, from Ontario in the middle of 2013. Mountain Institution is a medium security facility. Mr. Rezanowicz had requested the transfer in order to get a 'fresh start' and was planning on living in B.C. after his release.

In the fall of 2013 Mr. Rezanowicz applied to have his security status changed to minimum security. Minimum security allows for more freedom, and is part of the transition of an inmate back into the community. His application was denied, which disappointed and frustrated him. Shortly after, around the 20th of November 2013, he reported feeling suicidal. He also reported symptoms related to psychosis; he had been diagnosed with schizophrenia many years before. He specifically stated that he was going to commit suicide by cutting a major artery. As a result he was transferred into the Regional Treatment Centre (RTC), a psychiatric hospital at Pacific Institution.

Mr. Rezanowicz was assessed under close supervision when he first arrived at the RTC. After the assessment period, his psychiatrist diagnosed him with possible anxiety and depression, and noted his previous diagnosis of schizophrenia. The psychiatrist determined that while Mr. Rezanowicz's mood was low, he was not a risk to himself or others. On the basis of the psychiatric assessment Mr. Rezanowicz was assigned to a lesser level of monitoring on the RTC and was allowed to move to a regular cell.

The psychiatrist testified that Mr. Rezanowicz's psychotic symptoms were not in the forefront, and that his anti-psychotic medications were discontinued with no recurrence of psychotic symptoms. Later, Mr. Rezanowicz told his psychiatric nurse that he had not been truthful about his symptoms in November

2013. He told her that he had reported having psychotic symptoms because he did not want to share a cell and he wanted to be transferred to the RTC.

Mr. Rezanowicz was well educated and articulate. He was described by several inmates as well as Correctional Service Canada (CSC) staff members as a loner. His psychiatrist characterized him as a proud person, who was frustrated with rules and limits to his autonomy. From time to time Mr. Rezanowicz expressed fears that other inmates wished him harm, and his psychiatrist said there may have been some basis for this, as he was a bit different from the rest of the population. He participated in some activities, including assisting another inmate with homework, and regular jogging. He did have work serving meals, but discontinued doing so shortly before his death, apparently after having difficulty with the staff.

Several inmates from Mr. Rezanowicz's range (a specific area in the RTC) gave evidence that they were familiar with suicide risk recognition and prevention, to varying degrees – CSC provides a voluntary training course for inmates in how to recognize risk factors and what to do. The inmates said that Mr. Rezanowicz had given them no indication that he was suicidal. One inmate did testify that the day before he died Mr. Rezanowicz told him "I have nothing, I have nobody" and walked away.

His last visit with the psychiatrist was April 23, 2014. During this visit Mr. Rezanowicz displayed some subtle differences associated with depression. While he denied any intention to harm himself, he was agitated and argumentative, and expressed the feeling that no one would miss him if he was gone. As well, Mr. Rezanowicz told the psychiatrist that a friend had died in April. (The institution's Warden later testified that this friend was believed to be more of an acquaintance than a close friend). Therefore, the psychiatrist placed him on the highest level of monitoring that would not also restrict him from his daily coping activities, such as jogging. This meant he was under closer observation and staff members were required to complete daily reports, but he was not placed in an observation cell or on constant watch.

Each inmate is assigned an institutional parole officer (IPO) to assist them with preparations for future parole, including the gradual downgrading in security levels over time. Mr. Rezanowicz met with his RTC IPO five times in the five months before his death. His IPO testified that they did not discuss downgrading his placement to a minimum security institution, nor his eventual release into the community. Mr. Rezanowicz did say he wanted a fresh start, and disclosed that he had no contact with his family. Less than a week before Mr. Rezanowicz's death, he was assigned a new IPO at the RTC. This new IPO did not meet with him before his death, and there was no formal handing over of information by the original IPO to the new IPO.

The jury viewed video from April 30, 2014, which showed the hall in front of Mr. Rezanowicz's cell door. In the video Mr. Rezanowicz is observed coming and going from his cell several times around 11:30 AM. The first time he spoke with another inmate. The second time he looked out the window briefly. The third time he carried a bundle of clothing downstairs, and came back to his cell without it. After this, pairs of Corrections Officers (COs) were seen at one hour intervals doing prisoner checks. The first check was a 'stand-up' check where COs were required to verify that the inmate was literally

standing up as evidence that he was alive and well. At the subsequent check the COs, observing Mr. Rezanowicz on his bed, believed him to be sleeping. On the next check, at about 2:50 PM, two COs came to Mr. Rezanowicz's cell. When they attempted to communicate with him he did not respond. One entered the cell and found him unresponsive under a blanket on his bed. The second CO went to get assistance and call 911 while the first stayed outside the door of the cell. The second officer gave evidence that he did not have a radio, as it was shift switchover and there were not enough radios for each CO during the time when shifts temporarily overlapped. Consequently he felt it was fastest to run to get assistance. The first officer testified that he had a radio; however, the second officer was unaware of this.

The COs did not administer first aid. First aid was initiated by the nursing staff when they arrived. The nurses moved Mr. Rezanowicz to the hallway and commenced CPR. They continued their efforts until paramedics arrived outside of his cell at 3:11 PM. The paramedics found no signs of life. One of the paramedics consulted with an Emergency Physician at Abbotsford Regional Hospital who confirmed death at 3:15 PM.

The British Columbia Coroners Service was notified. The attending coroner examined Mr. Rezanowicz's body at the RTC. Mr. Rezanowicz had a deep cut to his right femoral (groin) area. There was a large amount of blood in his bed and pooling on the floor. The coroner found a number of sharp objects near his bed – one, a blade from a disposable plastic razor, was covered in blood and appeared to be the item used to inflict the injury. The coroner testified that the cause of death was exsanguination (bleeding out) from the wound in his groin.

Mr. Rezanowicz had a calendar on his cell wall. The coroner testified that the days prior to April 30th were crossed off, and a star with "The End" was written on the 30th of April. A handwritten note on his wall, dated April 30, 2014, stated "The battle is over, Today is a good day to die" and was signed "Roman". A second note on the wall stated "it's just not worth it!"

Members of the Abbotsford Police Department attended and conducted an investigation. Police noted a total of four razor blades in Mr. Rezanowicz's room. They reviewed video showing the door to his cell and concluded that he had been in the cell alone. Police found no evidence of criminality.

After Mr. Rezanowicz's death, an inmate received a letter addressed to "Guys". In it Mr. Rezanowicz stated that he wanted to explain to his fellow inmates why he committed suicide. He expressed frustration with the prison system, and wrote that he had been deceived with respect to having his security clearance decreased to minimum. He explained that he had considered his options and had made a decision to take his own life. He detailed how he had planned to do so – by cutting a large artery in his groin. A second letter, addressed to his primary nurse, similarly detailed his frustrations and loss of hope, the method he intended to use, and directed the disposal of his money to support mental health.

The Warden of Pacific Institution/RTC testified at the Inquest. He reviewed training requirements for staff with respect to suicide prevention and emergency first aid. He testified that it is institution policy that staff members give first aid immediately, including CPR, when appropriate. In light of this death, the

Warden has raised this issue with the specific staff involved. With respect to emergency response and training in general, he said that there are regular training sessions in emergency medical issues which occur quarterly. Staff members who happen to be on shift at the time participate in these tabletop sessions. The Warden testified that frontline staff such as the COs would have attended an average of one per year. Annual attendance is not mandatory.

The jury asked the Warden about the availability of sharp objects such as razor blades. He stated that the policy across CSC is that inmates are allowed, if medically cleared, to have one disposable razor at a time. They must turn it in for disposal to staff in order to receive a new one. Staff members are required to check that the blade is still in the razor when it is returned. The Warden could not explain how Mr. Rezanowicz obtained four razor blades.

According to the Warden's testimony, policy requires the timing of prisoner checks to be random and unpredictable. He has reviewed this issue with the COs who were performing checks regularly at sixty minute intervals. He also testified that policy requires that during shift overlap COs must work in pairs and one of each pair must have a radio.

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
REZANOWICZ	**Roman William**

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. Research appropriate technology that can be provided to all Corrections Officers on duty to enable them to request immediate assistance, including during overlapping staff changeover times. (One radio per staff member, but not limited to just this. Consider the possibility of microphones or audio available to complement the video in the hallways.)

Presiding Coroner Comment: *The jury expressed concern for staff on duty. Staff can become separated and should each have a radio for their safety. In future, this could prevent a delay in response for medical treatment as well.*

2. Provide regular (at least once a year) practical, scenario based training in first aid including CPR to all frontline prison staff. This would be a mandatory requirement, and not just if the staff member happened to be on shift.

Presiding Coroner Comment: *The jury stated that the frontline staff are the first responders, and starting CPR quickly is critical - seconds can make a difference.*

3. Inmate checks should be conducted at random intervals, not on a completely predictable basis.

Presiding Coroner Comment: *If someone is determined to take their life, if the checks are random they won't know when staff will be looking in on them. The jury believes that this might help prevent future similar deaths.*

4. Information sharing – all departments should have access to relevant information, and possibly medical records when it could pose a risk to other inmates or staff. This information sharing should be mandatory for frontline staff to be aware of, rather than just optional. Frontline staff should have as much information as possible to provide the best treatment and safety to all staff and inmates.

Presiding Coroner Comment: *The jury heard that information is available but felt that there is no requirement for staff members who may benefit from this information to access it.*

5. Transition between institutions should be improved. Proper documentation of inmate profiles from previous institutions should be read and considered by new staff at the receiving institution. Parole officers should add proper notes and documentation to the system, especially the staff that

interact with the inmate the most, or have the best knowledge. Parole applications should be evaluated by someone with all of the information, including the history.

Presiding Coroner Comment: *There is information available, but the jury expressed the need to ensure that everyone who may need to see it is able to access it.*

6. Ensure that Critical Incident Stress Management is available to staff after a stressful incident. Follow-up should be done with staff. (Staff is clearly still affected by this incident and perhaps follow-up needs to occur).

Presiding Coroner Comment: *This recommendation is self-explanatory.*

7. Regular meetings, proper documentation, and information sharing between departments needs to occur so no one falls through the cracks.

Presiding Coroner Comment: *This recommendation is self-explanatory.*