Ministry of Public Safety
and Solicitor General

File No. 2015-0378-0097

Province of British Columbia

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

ROY	Christopher Robert
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates July 18 – 21, 2016

before: Mr. John Knox, Presiding Coroner.

into the death of Roy (Last Name) Christopher (First Name) Robert (Middle Name) 37 (Age) ☒ Male ☐ Female

The following findings were made:

Date and Time of Death: June 3, 2015 at 18:49

Place of Death: Abbotsford Regional Hospital 32900 Marshall Rd. (Location) Abbotsford, B.C. (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Anoxic brain injury

Due to or as a consequence of

Antecedent Cause if any: b) Asphyxia

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Hanging

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☐ Accidental ☐ Homicide ☐ Natural ☒ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 21st day of July AD, 2016

Mr. J. Knox
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:

JURY RECOMMENDATIONS:

Government of Canada:

1. To bring forward meaningful discussion and debate into the House of Commons with respect to legislated caps on the length of time inmates can be held in segregation, and prohibitions against placing inmates in segregated custody who are known to have mental health issues or histories of self-harming behaviours.
2. Immediately makes it policy to adopt the United Nations recommended guidelines on solitary confinement and segregation.

To Correctional Service Canada:

1. CSC implement the recommendations (that are not already implemented) from the Board of Investigation into the Death of an Inmate at Matsqui Institution June 3, 2015, within 90 days.
2. CSC revise policy to increase the frequency of unit cell checks and increase staffing as necessary to achieve this. Cell checks should be staggered at unpredictable intervals to minimize inmate self-harm opportunities.
3. CSC have a dedicated roster for segregation to facilitate more continuity and communication between inmate and staff. When a member of this roster is coming back from a leave, they must be given sufficient time to confer with their replacement, to review events that transpired during the leave.
4. Segregation roster should include a full time Registered Psychiatric Nurse.
5. Take the steps to improve the availability of on-site psychiatric service at all institutions.
6. Psychiatrists should be retained to conduct comprehensive mental health assessments of segregated inmates at regular interval, and should also participate in all segregation reviews board meetings pertaining to those inmates.
7. Revise policy to increase daily yard time offered to segregation inmates, and increase staffing as necessary to achieve this.
8. Focus mental health training to the dedicated staff working in segregation.
9. Regular scenario training to prepare for possible future events, with the view to improving response times.
10. Engineering solutions at national level to improve safety in all cells.
11. Inmates be allowed to have their segregation report reviewed by an entity independent of CSC and that inmates be given sufficient time and a private place to review and understand all documents related to their incarceration.
12. Ensure all temporary detainment inmates have the means to access trauma-informed mental health and abuse treatment programs on an interim basis prior to their eventual institution placements.
13. Ensure that all segregation inmates have the means to access specialized one on one, trauma-informed mental health and substance abuse treatment program.
14. Retain the expertise of external advisory panels to conduct regional assessments of the quality and availability of mental health services and programming. Specific focus should be given to identifying and eliminating barriers to treatment for inmates of all categories and security classifications. These advisory panels should be comprised of registered psychiatrists, psychologists, and other accredited mental health practitioners.

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15. The findings of these advisory panels should form the basis of future mental health strategic planning and policy.
16. Revise policy to ensure that any inmate held in segregation more than 4 days is provided TVs, books, or other safe and reasonable distractions, for the betterment of their mental health.
17. All control posts in every unit be equipped with an AED, a bag valve mask, and other items appropriate for an interim response to a potentially fatal self-harm incident. These items should be stored together in a bag or kit that can be brought to the scene.
18. Request the Commissioner of Corrections Canada and/or the Regional Manager of Tech services and Facilities in Ottawa that more power be given to Wardens to allocate budgets to where they are needed, pertaining to their particular institution's needs.
19. Review the funding formulas to allow hiring and maintaining mental health staff; especially psychiatric doctors.
20. The Offender Management System should be easily accessible by all authorized staff and should contain all inmates' files and paperwork.
21. Provide a unit within the institution to house inmates who have specific needs that cannot be met in general population, with the view to eliminating or reducing the need for administrative segregation.
22. That CSC create a role akin to a family liaison to assist with timely and meaningful communication at such time an inmate has been hospitalized with a serious injury or medical condition.
23. That all recommendations arising from this inquest and other processes which examine conditions and events at correctional institutions be taken seriously.