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Manitoba Ombudsman

March 5, 2010

The Honourable Ken Champagne
Chief Judge
Provincial Court of Manitoba
5th Floor - 408 York Avenue
Winnipeg, MB R3C 0P9

INQUEST INTO THE DEATH OF CHRISTOPHER JOHN HOLOKA

Dear Chief Judge Champagne:

I am writing to advise of the results of the inquiries made by my office concerning the inquest report recommendations dated May 11, 2007 issued by the Honourable Judge Ronald Meyers into the death of Mr. Christopher John Holoka.

Mr. Holoka came to his death in Winnipeg, Manitoba on April 15, 2005 as a result of a methadone overdose at the Winnipeg Remand Centre (WRC).

The Chief Medical Examiner called for an inquest pursuant to subsection 19(3) of *The Fatality Inquiries Act*. The inquest report was released on May 16, 2007.

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a provincial department, agency or municipality. In this case, Judge Meyers made six recommendations which are directed to the Winnipeg Remand Centre. The following are the recommendations and the responses we received:

RECOMMENDATION ONE:

That the Winnipeg Remand Centre implement a meaningful staff education drug program in concert with the Addictions Foundation of Manitoba, and that this program be ongoing for all staff. That this program highlight addictions and the use of illicit drugs including methadone.

MANITOBA JUSTICE RESPONSE:

Manitoba Corrections has since developed staff training in concert with the Addictions Foundation of Manitoba. The training material includes information regarding Methadone and the use of illicit drugs.

This training is available online to all correctional staff and there is a requirement for staff to review this material and have a direct supervisor sign off when the training is completed. The training material will be available to staff on an ongoing basis thereafter.

The various adult correctional centres also have the autonomy to provide additional training for staff, who are regularly in contact with inmates participating in the Methadone Maintenance Treatment (MMT) program. Training initiatives are determined by assessing operational needs, budget and the availability of trained facilitators.

This training initiative will be implemented at all facilities with a methadone maintenance program, regardless of the format ultimately adopted. The self-directed training package can be accessed at http://www.jus.internal/Corrections/index.html .

RECOMMENDATION TWO:

That staff at the Winnipeg Remand Centre be adequately trained for the handling of emergencies in drug related cases.

MANITOBA JUSTICE RESPONSE:

> *There is no suggestion in the inquest report that there were any shortcomings in the emergency response of the medical staff in the case. All institutional staff, including correctional officers, are trained in emergency first aid, with refresher training. As well, we are currently in the process of specializing our first aid training – tailoring it to fit specific circumstances. In addition to the first aid, all staff receive annual CPR training, and this is particularly relevant to cases of drug overdose. As the medical examiner noted in the Holoka case, respiratory depression is the cause of death in cases of narcotic overdose (paragraph 72).*

Manitoba Corrections clarified that all correctional staff currently receive Workplace Emergency First Aid and CPR Level C training. The refresher training is provided to staff every three years.

Manitoba Corrections indicated that Automated External Defibrillation (AED) devices are anticipated to be available in all nine provincial correctional centres in 2010. Correctional staff responsible for using the AED devices will receive approved certification training.

RECOMMENDATION THREE:

That dangers surrounding methadone be communicated both in writing and verbally to incoming methadone inmates on their signing of the requisite waiver, with particular emphasis on the dangers of diverting methadone to naïve users.

MANITOBA JUSTICE RESPONSE:

Our office made inquiries with Manitoba Corrections and confirmed the Winnipeg Remand Centre, Headingley Correctional Centre, Portage Correctional Centre and Brandon Correctional Centre provide a "Methadone: Facts" sheet upon admission to all inmates who are enrolled in the

Methadone Maintenance Treatment (MMT) program. The fact sheet is also verbally communicated to inmates to ensure they understand the effects and dangers of using Methadone.

The Methadone Facts sheet states:

1. ***Methadone is a dangerous medication.***
2. ***Sharing your Methadone can have deadly consequences.*** *Even a portion of your dose could be lethal to someone not used to taking it.*

A form titled "Agreement to Participate in Long Acting Narcotics/Methadone Maintenance Program" is given to the inmates to sign when continuing a community MMT program. All four applicable correctional facilities have implemented the forms into their standing orders.

RECOMMENDATION FOUR

That management at the Winnipeg Remand Centre continue to stress the importance of complete and accurate medication charting, and demand in writing an accounting from staff members who fail in this duty.

MANITOBA JUSTICE RESPONSE:

> *Divisional policy has been developed and operationalized with respect to medical charting. The [policy] outlines detailed requirements in this regard. As well, the [policy] is in place to report all medication errors, and follow-up is required by the physician, Health Care supervisor, as well as the Director of Health Care Services for the Division.*

Manitoba Corrections further advised that this policy has been in place for several years and clarified that the medical charting requirements are outlined in the Custodial Policy titled, "Nursing Documentation". This policy establishes protocols for accurate medication charting.

When a medication error is made, the staff member is required to fill out a two page form. This form documents the incident and initiates an internal review for quality assurance purposes.

Additional information regarding policies and standards can be found on Manitoba Corrections' website at http://www.jus.internal/Corrections/index.html .

RECOMMENDATION FIVE:

That the Winnipeg Remand Centre establish a protocol with existent methadone treatment programs as to dosage requirements for incoming inmates who are registered with their programs. Such information would be vital in ensuring that the inmate's dosage is used only for the well-being of that individual.

MANITOBA JUSTICE RESPONSE:

> *The Divisional policy, "Methadone Maintenance Program" was [updated] on July 5, 2007. It contains clear direction with regard to the delivery, storage and handling of methadone prescriptions.*
>
> *Divisional policy speaks to the matter of verifying dosage requirements. However, establishing a specific protocol is difficult given the large number of physicians and pharmacies that are involved from time to time in supplying methadone to incarcerated prisoners. Pharmacies that fill the prescriptions and send them to the institutions all have different procedures. A copy of the prescription is, however, always provided to the institution and this serves as the written order for medical staff to follow.*

Manitoba Corrections further clarified that while the MMT program was implemented in provincial correctional centres several years ago, the Custodial Policy regarding this program was last updated on July 5, 2007 following the inquest. The policy currently states in part:

> *Prescriptions/Assessments*
>
> *4. The physician in the community responsible for prescribing methadone to the offender shall continue to be responsible for the prescriptions, and may attend the custodial facility, if required, to attend to the patient:*
>
> *4.1 a copy of the triplicate prescription shall be provided to the dispensing pharmacy, along with a copy to the custodial facility, and shall also serve as the written order for the nurses;*
>
> *4.2 the MMT program physician shall be responsible for any assessments of the offender and the prescription renewals;*
>
> *4.3 the custodial facility shall provide the necessary escorts for such assessments; and*
>
> *4.4 collaboration and communication between programs shall continue for continuity of care.*

The WRC has also developed a "Health Service Procedure - Methadone Maintenance Administration" protocol which outlines the procedures of the MMT program for healthcare staff.

RECOMMENDATION SIX:

That consideration be given to the implementation of a standing order which would dictate that where an inmate does not respond in person at scheduled medicine rounds to a page for attendance for essential medicines or medications that it be incumbent on staff to personally enquire of the inmate as to the reason for his or her non attendance. At the very least such an order should be mandatory as it applies to those inmates classed as being suicide risks.

MANITOBA JUSTICE RESPONSE:

> *In May 2007 the WRC instituted a post order that requires officers to visually check on inmates not responding to their medication round.*

Manitoba Corrections Custodial Policy titled, "Offender Health Services", has been amended to include a requirement that a correctional officer attend the cell of any inmate who fails to respond to calls for medication. Section 17.8 of the policy states:

> *17.8 in the event that an offender does not respond to the call for medication, the nurse will provide the offender's name(s) to the assisting officer, who* **will immediately ensure an officer will attend to the cell to determine why** *the offender is not responding.*

Manitoba Corrections advised our office that this assessment would involve verbally communicating with the offender to clarify the reason(s) why he/she failed to attend for their medication.

Although recommendations 1, 2, 4 and 5 are directed to the WRC, the inquest findings seemed relevant to the other three provincial correctional centres that are a part of the MMT program. We made inquiries with Manitoba Corrections and confirmed that in addition to the Winnipeg Remand Centre; Headingley Correctional Centre, Portage Correctional Centre and Brandon Correctional Centre adhere to Custodial Policy and will be notified of any future changes.

Based on our review of this matter, it would appear that Manitoba Justice has given reasonable consideration to the above noted recommendations. As such, our file concerning the Christopher Holoka inquest has been closed.

Yours truly,

Original Signed by

Irene A. Hamilton
Manitoba Ombudsman

cc: Mr. Jeffrey Schnoor, QC
Deputy Minister of Justice and Deputy Attorney General

Dr. Thambirajah Balachandra
Chief Medical Examiner