Ministry of Public Safety and Solicitor General
Coroners Service
Province of British Columbia

File Number: 2016-0381-0095

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

Tucker	**David Singh**
SURNAME	GIVEN NAMES

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

in the Province of British Columbia, on the following dates: December 10 - 13, 2018

before: Susan Barth, Presiding Coroner.

into the death of

Tucker	David	Singh	28	[X] Male [ ] Female
(Last Name)	(First Name)	(Middle Name)	(Age)	

The following findings were made:

Date and Time of Death: July 25th, 2016 (Date) between 00:00 and 01:00 hours. (time)

Place of Death: Cell SG111, Surrey Pretrial Services Centre at 14323 57 Avenue (Location) Surrey, British Columbia (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Acute methadone toxicity

Due to or as a consequence of

Antecedent Cause if any: b) Self-administered dose of unprescribed methadone acquired by unknown means

Due to or as a consequence of

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

(2) Other Significant Conditions Contributing to Death: Documented mental health issues

Classification of Death: [ ] Accidental [ ] Homicide [ ] Natural [X] Suicide [ ] Undetermined

The above verdict certified by the Jury on the 13th day of December AD, 2018

Susan Y. Barth
Presiding Coroner's Printed Name

S Barth
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Susan Barth
Inquest Counsel:	John McNamee
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Fernando de Lima and Rolf Warburton,counsel for BC Ministry of Public Safety and Solicitor General (Corrections Branch)

The Sheriff took charge of the jury and recorded 3 exhibits. 15 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. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

David Singh Tucker was described by family as a special human being, although flawed. He had a difficult childhood that involved significant contact with the Ministry for Children and Family Development (MCFD). As a teenager, he spent time in a youth detention centre and was incarcerated at age 18 for an eight-year sentence. Once released, he was optimistic about his future and working towards a different life.

Mr. Tucker was remanded to Surrey Pretrial Services Centre (SPSC) on May 2, 2016 for serious charges. He was assessed and put on suicide watch initially but was subsequently placed in a regular living unit on May 6, 2016.

Mr. Tucker was scheduled to appear in court on June 28, 2016. Prior to his attendance before the judge, he was found unresponsive in a holding cell in the Richmond Courthouse. He was taken to Richmond General Hospital (RGH) for treatment of a methadone overdose and was reported to be upset because his attempt at suicide had failed.

He was transferred to Forensic Psychiatric Hospital (FPH), also known as "Colony Farm" where he received further assessment. While at FPH, he expressed suicidal ideation and was disruptive and destructive to the physical space he lived in. He was diagnosed as having Antisocial Personality Disorder, deemed non-treatable and was released back to SPSC on July 14, 2018.

He was assessed on arrival at SPSC and assigned to a segregation cell where he was checked on every 15 minutes (Q15s) and given Special Handling Protocols (SHP) due to his suicidality and behaviour issues while at FPH. The SHP is implemented to manage risk for the inmate and staff and requires that two staff and a supervisor are present anytime the inmate is being moved or approached by staff. Conditions based on the assessment included the use of a suicide gown, rather than regular prison issued clothing, which agitated Mr. Tucker.

A prison psychologist caring for Mr. Tucker made a recommendation on July 18, 2016 to maintain the Q15 checks but allow regular prison issue clothing. This recommendation was not supported by the Corrections manager due to policy and structure around Q15 requirements. This information was relayed to Mr. Tucker which was followed by destructive behaviour. He pulled a sprinkler pipe out of the ceiling, scratched the protective covering on the camera lens and broke the glass in the window of his cell.

An email was sent to a manager regarding the camera lens, however the manager was on vacation, so this information was not acted on. The system for reporting damage to cameras has since been addressed by Corrections to ensure information regarding maintenance for safety issues is reported and acted on in a more reliable manner.

The broken window in Mr. Tucker's cell was replaced with Lexan as a temporary measure. The Lexan was subsequently scratched by Mr. Tucker and was noted to be difficult to see through, especially in dim lighting.

A family member had a telephone conversation with Mr. Tucker on July 19, 2016 where he expressed feeling suicidal and shared that he was planning another suicide attempt using methadone that he was storing. He indicated that he had approximately half of what he required and planned to ingest it in the evening in order to appear to be sleeping when Corrections officers checked on him. On July 20, 2016, the family member contacted SPCS to report that Mr. Tucker was suicidal and ask that SPCS listen to the recordings of their phone calls. The report was taken by a Mental Health Liaison Officer (MHLO) at SPCS; however, it was only documented in a summary form and not relayed verbally to other team members.

On July 22, 2016, the psychologist saw Mr. Tucker and recommended that checks be downgraded to every 30 minutes (Q30) and regular clothing be allowed to him, but still no cutlery or razors were to be allowed in the cell. The psychologist was concerned about Mr. Tucker's aggressive and destructive behaviours and felt this may mitigate them. The Corrections manager agreed with the recommendation; however, the negative behaviours continued.

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On July 24, 2016, nursing staff attempted to administer medications to Mr. Tucker at approximately 1944 hours. Mr. Tucker appeared to be sleeping and did not respond when the nurse and a Corrections officer who called out to him through the tray slot in his cell door. During the evening and into the night, further checks were conducted, and Corrections officers indicated that they noticed chest movement, so they left Mr. Tucker to sleep.

On July 25, 2016, at approximately 0125 hours, an officer noticed that Mr. Tucker had not changed positions while sleeping and called for other officers to attend to see if they could detect movement. After being unable to determine whether he was breathing, they called to him through the tray slot in his cell door and there was no response.

As a result of Mr. Tucker's SHP, a supervisor was called, and the officers entered the cell to perform a more in-depth check. Mr. Tucker was found unresponsive and BC Ambulance Service (BCAS) paramedics and RMCP attended. BCAS paramedics did not initiate resuscitation protocols as it was clear that Mr. Tucker was deceased. RCMP members investigated and determined that his death was not suspicious.

There was no anatomical cause of death found during autopsy; however, toxicology testing revealed a methadone level within a range considered therapeutic in patients on methadone maintenance therapy (MMT). Patients on MMT develop a tolerance to methadone, however Mr. Tucker was not on MMT and therefore his death could be attributed to the methadone level in his system. The pathologist therefore concluded that the cause of death was Acute Methadone Toxicity.

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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: Ministry of Public Safety & Solicitor General, Corrections Branch

1. Ensure that Corrections Officers include detailed documentation in the "C log" pertaining to body positions and unusual behaviours of Segregation inmates.

   Presiding Coroner Comment: *The jury heard evidence from Corrections Officers that they believed Mr. Tucker was breathing but it wasn't completely clear. Different officers checked Mr. Tucker and concern was raised once they identified that he hadn't changed positions while sleeping. It is not regular practice for Corrections Officers to document sleeping positions which may have triggered a wellness check sooner.*

2. Ensure that Corrections Officers have the ability to control lighting of individual Segregation cells housing high risk of suicide inmates.

   Presiding Coroner Comment: *The jury heard evidence that individual cells have lighting controls within the cell, but Corrections Officers only have the option of turning lights on for all cells, not individually. Evidence was given indicating a reluctance to turn the lights on at night to check on an inmate because it would disturb the entire pod, not just the inmate being checked on.*

3. Give consideration to future design of Segregation units whereby lighting; cameras; sprinklers cannot be compromised or defeated by inmates.

   Presiding Coroner Comment: *The jury heard evidence that damage and obstruction of these items is an ongoing issue in Corrections and are a safety issue for both staff and inmates.*

To: Provincial Health Services Authority (PHSA)

4. Change the Medical Administration database to require notations explaining why medications not given.

   Presiding Coroner Comment: *The jury heard evidence that the current database only allows "taken" or "refused" as options documenting medication administration. In Mr. Tucker's case, it was documented as "refused" with no explanation in the section for comments. This did not accurately depict what occurred.*

5. Investigate, by audit or other means, the diversion of methadone and other drugs not being taken by those prescribed them.

   Presiding Coroner Comment: *The jury heard evidence that diversion of medications is an ongoing concern which was demonstrated by Mr. Tucker's acquisition of methadone by unknown means while in segregation.*

To: Ministry of Public Safety & Solicitor General, Corrections Branch and Provincial Health Services Authority (PHSA)

6. Ensure that improved communication protocols are adhered to, and specific detailed information regarding high risk of suicide clients, from internal and external sources, is documented in the logs and reviewed and updated every shift.

   Presiding Coroner Comment: *The jury heard evidence that specific details of Mr. Tucker's intent, plan and possession of methadone conveyed to a family member during a telephone call was reported to SPSC but not passed to necessary staff.*

7. Require that inmates prescribed methadone be observed for 30 minutes, instead of 20 minutes, after administration.

   Presiding Coroner Comment: *The jury heard evidence that methadone can be diverted by regurgitation. Testimony was given that inmates are monitored for 20 minutes after administration to ensure absorption.*