Ministry of Justice
Coroners Service
Province of British Columbia

File No. :2013:0380:0004

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
VEGA JIMENEZ	Lucia Dominga

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

in the Province of British Columbia, on the following dates September 29, 2014 to October 7, 2014

before: Margaret Janzen, Presiding Coroner.

into the death of VEGA JIMENEZ (Last Name) Lucia (First Name) Dominga (Middle Name) 42 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: December 24, 2013 1341 Hours

Place of Death: Mount Saint Joseph Hospital (Location) Vancouver, 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) Prolonged cardiac arrest

Due to or as a consequence of

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

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 7th day of October AD, 2014

Margaret Janzen
Presiding Coroner's Printed Name

M. Janzen
Presiding Coroner's Signature

This document has been prepared pursuant to the authority of the Chief Coroner as provided in Section 53 (2) (e) of the Coroners Act, [SBC 2007] C 15.

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	Rodrick H. MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Canada Border Services Agency/Graham Stark, R. Keith Reimer Public Service Alliance of Canada/Chris Buchanan British Columbia Corrections/Pamela Manhas Canadian Council for Refugees/Phil Rankin, Tien Tran British Columbia Civil Liberties Association/Jason Gratl, Neil Chantler, Josh Paterson British Columbia Nurses' Association/Heather Cane

The Sheriff took charge of the jury and recorded 17 exhibits. Twenty nine witnesses were duly sworn and testified.

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 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 December 1, 2013 at approximately 1000 hours, Lucia Dominga Vega Jimenez was detained by transit police conducting fare enforcement at the Main Street SkyTrain station in Vancouver. She could not produce proof of payment of her fare and offered identification in two different names. As part of their investigation the transit police contacted the Canada Border Services Agency (CBSA) who advised them that if she was the person identified on one of the pieces of ID, she had been deported previously and was in Canada illegally. A CBSA agent attended to the station and Ms. Vega Jimenez admitted that she had come across the border illegally. She explained that she was working in BC for cash and was afraid to return to Mexico because of a violent boyfriend. She had 540 dollars in her possession and said that it was for rent. She was arrested under the Immigration and Refugee Protection Act (IRPA) and transported to the Immigration Holding Centre (IHC) at the Vancouver International Airport.

On December 2, 2013 Ms. Vega Jimenez was seen by a CBSA agent who advised her that she was subject to immediate removal and provided her with an application for a Pre-Removal Risk Assessment (PRRA). A PRRA is a process that gives the applicant two weeks to apply, and when completed, a further two weeks in which to provide evidence that they would be at risk if they were returned to their country of origin. During this time the detainee is not subject to removal, but may be detained. On December 3, 2013 Ms. Vega Jimenez was taken to the CBSA office in downtown Vancouver where she was interviewed by another CBSA officer and confirmed her intention to apply for a PRRA. Since the IHC was a short-term holding facility designated for detentions not exceeding 72 hours, Ms. Vega Jimenez was transported to the Alouette Correctional Centre for Women (ACCW).
Ms. Vega Jimenez was booked into the ACCW and issued prison clothes. She was held in the high-risk portion of the jail. She underwent a mandatory health assessment including a mental health screening.

She appeared to be in good health and self-reported that she was a little bit sad, anxious, depressed and afraid; given her situation this was not wholly unexpected and she denied suicidality.

Ms. Vega Jimenez was a quiet detainee who mostly kept to herself. She did not eat much and told inmates that she was afraid to return to Mexico for fear of torture and murder. She was transported to the CBSA office in downtown Vancouver again on December 9 and 11, 2013, for further interviews with CBSA officers, a meeting with duty counsel and another detention hearing. On December 12, 2013, she asked to see a doctor at ACCW saying that she had chest pain. She was seen by a licenced practical nurse (LPN) who did not feel that her cardiac status was a concern, but did recommend that she be seen by the mental health coordinator for support. Ms. Vega Jimenez was not seen by the mental health coordinator as there were inmates needing to be seen on an urgent basis and she was taken back to the IHC before she could be seen.

Ms. Vega Jimenez spoke to legal counsel while she was in ACCW and withdrew her PRRA application on the day it was due, December 17, 2013. On December 18, 2013, she contacted a CBSA agent and stated that she did indeed want to file the PRRA and was advised that she had missed the deadline and would be deported. Also on that day she again requested to see the doctor for neck and face pain. The form states that she self-referred and checked the box marked 'urgent'. Before she could be seen she was transferred back to the IHC on December 19, 2013.

There were three other women at the IHC when Ms. Vega Jimenez arrived. All of them spoke Spanish and attempted to talk to her, but she was very withdrawn and uncommunicative apart from saying that she had been in jail for 19 days and was being deported the next morning at 0900 hours.

The cell doors were opened on the morning of December 20, 2013, at approximately 0600 hours and Ms. Vega Jimenez went into the shower area carrying a towel over her arm. When she had not reappeared after approximately 40 minutes, the other detainees knocked on the guards' window and stated that she had been in there a long time and something might be wrong. The guard asked the female detainees to check on Ms. Vega Jimenez, but they refused. He came into the detainee unit and could hear the shower running. He knocked on the door, but got no response. He opened the door and saw that she was hanging by the neck from the shower rod. He immediately held her up and yelled for help. Another guard assisted him to get her down. She had no vital signs so they started CPR and called 9-1-1. BC Ambulance Service paramedics attended and were able to resuscitate her at approximately 0718 hours.

Ms. Vega Jimenez was transferred to the nearby Richmond General Hospital emergency department for assessment and stabilization. Due to bed availability she was then sent to Mount Saint Joseph Hospital for further care. She never regained consciousness and was diagnosed with an anoxic brain injury following her prolonged cardiac arrest. On December 24, 2013, at 1341 hours she was declared brain dead.

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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: **Canada Border Services Agency (CBSA)**

1. Create a dedicated Holding Centre for immigration detainees:

- Centre should be located within 30 minutes driving of YVR.
- Centre should be staffed by CBSA employees.
- Detainees must have access to legal counsel, medical services, NGO's, spiritual & family visits.
- Detainees should have monitored internet access.
- Telephones should be readily available and capable of free local calls & the use of international calling cards.
- Centre should be above ground allowing natural light, ventilation & outside access.
- Detainees should be allowed to wear civilian clothing.
- Centre should have an onsite courtroom for immigration hearings.

Presiding Coroner Comment: *The jury heard evidence that detainees were regularly transferred between the IHC, the CBSA offices in downtown Vancouver, and Provincial Corrections facilities if their stay was longer than 72 hours. Female detainees were held at the ACCW and males were held at the Fraser Correctional Institute. The logistics meant that detainees in a BC Corrections facility who had appointments with CBSA officers often had to get up early and came back to the facility late in the day. Distance from Vancouver meant that it was more difficult for legal counsel, family and others to meet with detainees. The evidence showed that the private security guards contracted to staff the IHC were not trained to the level of the CBSA employees and there was a high staff turnover, possibly due to low wages. Prior to the incident supervision of the facility by the security company consisted of reviewing the daily log sheets weekly. CBSA supervision appeared to be sporadic. There was significant disparity between what the guards were contracted to do and what actually was being done. IHC Standing Order number thirteen stated that "Detainees shall not be permitted to receive visitors at the BCHC (IHC). If visits by counsel or consular officials are to occur...CBSA shall arrange for suitable space elsewhere...". Legal counsel were refused contact with detainees at the IHC. Evidence showed that while there was a chaplaincy service at the airport offering multi-faith and secular spiritual support services, they were unaware of the existence of the IHC and had not attended there until a spokesman was invited about two months before the inquest took place. A women's support worker testified that her organization had expertise in assisting women who were victims of violence and would welcome the opportunity to counsel and assist immigrant women in detention. The worker testified that violence against women took a number of forms in Mexico and that the words "tortured and killed" suggested that a group, possibly a*

cartel, was involved. There was evidence led which showed that internet access for detainees would greatly improve their ability to communicate with outsiders and to acquire supporting documents for hearings such as the PRRA. The evidence also showed that international telephone calls were made with $5.00 calling cards and at restricted hours. All phone calls from the ACCW were prefaced with a recorded message in English instructing the recipient how to accept or decline the call, regardless of whether the recipient understood English. If they did not follow the instructions correctly then the caller might be blocked from calling that number again. The IHC was below ground level with no natural light or ventilation. No outside access was possible. Even though detainees were detained for administrative reasons they were treated exactly the same as convicted and remanded inmates at the Provincial Correctional facilities, including the use of restraints and wearing of prison uniforms.

2. At a minimum the following changes should be made at the Vancouver International Airport (YVR) Holding Centre:

- Legal counsel & Non-Governmental Organizations (NGOs) must be allowed access to the YVR holding centre.
- Self-harm proofing of bathrooms & sleeping rooms should be completed immediately.
- Call buttons need to be added to each sleeping room and to the bathroom, toilet, and shower area.
- Holding area should become staffed solely by CBSA.
- Telephones should be readily available and capable of free local calls & the use of international calling cards.
- An AED should be placed in the control room with the first aid kit.

Presiding Coroner Comment: *Regardless of where detainees are held, the jury felt they should have access to legal counsel and representatives from non-governmental organizations (NGOs). The evidence revealed that Ms. Vega Jimenez had hanged herself with strips of her bedding tied to the shower curtain rod, which was bolted into the wall and capable of supporting the weight of a person. A witness with expertise in prison design testified that simple changes were available to remove some ligature points and that many products were available to replace unsuitable furniture and fittings. While the shower curtain rod had been removed by the time of the inquest, several clear ligature points remained at the IHC including disability bars, taps and furniture. He also testified that call buttons were present in the cells at correctional facilities so that communication was possible with the guards in the event of an emergency. The detainees at the the IHS had no way to communicate with the guards except by knocking or banging on the window. When the security guards were trying to resuscitate Ms. Vega Jimenez they required the use of an Automatic External Defibrillator(AED), but did not have one in the facility. They were able to access one from the hallway outside, but the jury appear to have felt that a dedicated AED was required inside the facility.*

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3. While the YVR Holding Centre is staffed by sub-contractors, the following recommendations are made:

- CBSA will access the video monitoring system at random times to ensure the staffing levels and contract commitments are being made.
- Any violations of staffing levels and procedures should be dealt with according to the provisions of the contract.

Presiding Coroner Comment: *Evidence was led which showed that the contract between CBSA and the private security company set out numerous requirements including Standing Orders that were not being met. After the incident CBSA had an agent in the IHC two days per week who reviewed the video footage in the centre at random intervals to see if guards were conducting their duties as required. The jury felt that this practise should be continued. The contract had penalties associated with non-performance which were not used.*

4. Day one of processing immigration detainees:

- If there is any doubt about a detainee's abilty to understand English a translator must be obtained immediately.
- An orientation kit in the correct language must be issued immediately. The kit should include:
  - Instructions on how to access a lawyer
  - Instructions on how to contact NGO groups
  - Any approved pamphlets supplied by NGO groups
  - Contact for a Detention Liaison Officer (DLO) and a brief description of his or her duties
  - International calling card (not limited to one) and instructions on how to call different countries
  - Notebook & Pencil
- The orientation kit should remain with the detainee throughout their detention.

Presiding Coroner Comment: *Some of the evidence suggested that the detainees were not able to work on their paperwork at times because it did not travel with them everywhere. This reduced the time available for completion of the already complex PRRAs. Evidence was adduced that Ms. Vega Jimenez was asking for her lawyer, was questioned in her lawyer's absence, and seemed confused about her rights in this regard. The jury appears to have felt that NGOs could provide valuable advice and assistance to detainees, part of which might be contained in pamphlets to be handed out to them as soon as possible. The Detention Liaison Officer for BC (DLO) testified that he was available to the detainees and tried to*

assist them in any reasonable way. This recommendation recognizes the value of early contact with the DLO.

5. Pre-Removal Risk Assessment (PRRA) should be issued no sooner than 24 hours AFTER a detainee's initial Detention Hearing.

Presiding Coroner Comment: *The PRRA application was provided to Ms. Vega Jimenez the day after her detention. Time started to run for the deadline at that time. Evidence led suggested that she had no opportunity to act on it at that time and therefore lost opportunity to complete it in a timely manner.*

6. Make the Detention Liaison Office (DLO) a sole job function and increase the job function to a minimum of two officers. This position should be staffed as equally as possible by both male & female employees.

Presiding Coroner Comment: *Evidence showed that the DLO also had other job duties in addition to his DLO duties. This recommendation confirms the value of the position and suggests that another such position be created, preferably to be staffed by a female.*

7. The following training should be madatory for all CBSA and subcontracted security companies having contact with detainees:

- Suicide prevention
- Courses relating to the mental health of others
- Courses on handling detainees in a respectful manner
- Diversity training

Presiding Coroner Comment: *The jury heard evidence that the private security guards did not have any training beyond shackling, handcuffing and basic first aid. After this incident the DLO officer from CBSA had undergone extended suicide prevention training and the other CBSA agents had taken a half-day course. This recommendation confirms the value of such training and recommends expanding it to include mental health, sensitivity and diversity training and making it mandatory for all CBSA and guard employees.*

8. CBSA should offer seminars by the DLOs to NGO representatives to help them understand their roles and resources when helping detainees.

Presiding Coroner Comment: *Evidence was adduced that showed that the DLO position was the most suited to connecting the detainees with services. The jury appear to have envisioned that this role be expanded to be the liaison for NGOs seeking access to the detainees.*

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9. CBSA should aid NGOs in obtaining any security clearances needed to gain access to detainees in CBSA care or Corrections care.

Presiding Coroner Comment: *Evidence from the private security company was that security clearance for guards took up to nine months to be granted. This recommendation suggests that there is a role for CBSA in assisting NGOs with security requirements.*

10. An improvement committee consisting of NGOs & DLOs to discuss current concerns and recommendations should be created. This committee should meet quarterly.

Presiding Coroner Comment: *Evidence was led that showed that the Toronto Holding Centre had a committee comprised of CBSA employees and NGO representatives that met regularly to discuss detainee concerns and that the committee had a beneficial effect for everyone concerned. This recommendation is for the creation of such a committee in BC as well.*

11. Detainees should have their first mental and physical health assessment within 72 hours. A mental health asessment must be done just prior to deportation.

Presiding Coroner Comment: *This recommendation priorizes mental health assessment for detainees in recognition that detention and deportation are stressful and tend to become more so as the detainee nears deportation.*

12. Any visible signs of physical abuse must be brought to the attention of medical authorities.

Presiding Coroner Comment: *Ms. Vega Jimenez asked a nurse at ACCW to document a number of scars which she stated she suffered as a result of abuse. This could have evidentiary value in a PRRA application and may also signal a need for physician follow-up.*

13. CBSA should establish and be responsible for the appointment calender of each detainee. Any other interested parties must notify the CBSA of any detainee appointments. This will ensure that the CBSA has control over any scheduling conflicts.

Presiding Coroner Comment: *The jury heard evidence that each facility tracked the detainees' appointments separately, which may have resulted in communuication errors in this respect.*

14. CBSA needs to reassess their use of restraints. Handcuffing & shackling should only be used when absolutely necessary. Visible signs of physical abuse must be brought to the attention of medical authorities.

Presiding Coroner Comment: *Evidence was led that while the use of shackling (leg irons) had been discontinued by CBSA since the incident, detainees who appeared to pose no risk were still being*

handcuffed regularly. Other evidence was led which suggested that this treatment of detainees had negative mental health consequences for them.

15. Detainees in the Correction system must have access to their own money.

Presiding Coroner Comment: *Ms. Vega Jimenez had $540 in her possession when she was apprehended, but did not have access to it. This money appeared to have been given to another person without her express permission.*

16. That reference be made to the Canadian Red Cross Society Report for CBSA Pacific Region after-incident working group and every effort made to follow through with the recommendations.

Presiding Coroner Comment: *The Canadian Red Cross Society reviewed this incident and recommended that approximately 30 changes be made by CBSA in order to conform with national and international standards for refugees. This recommendation adopts those recommendations.*

17. A mental health care professional should be present when a detainee is given notice of deportation.

Presiding Coroner Comment: *A number of witnesses testified that detainees' anxiety and stress increased as the time for their deportation drew closer. This recommendation is aimed at monitoring of that anxiety and stress by a trained mental health professional.*

To: **Government of Canada**

18. Pre-Removal Risk Assessment (PRRA) Legislation be changed to empower the CBSA to extend the PRRA deadline.

Presiding Coroner Comment: *Evidence was heard that the 14-day deadline for submission of the PRRA application was problematic for detainees, particularly where they did not have simple access to legal counsel, had language barriers, could not locate supporting documents, or were moved frequently.*

19. PRRAs should also be accepted in languages other than English & French.

Presiding Coroner Comment: *The jury heard that the PRRA application had to be completed in one of the official languages of Canada. This created difficulties for immigrant detainees, especially those without easy access to legal counsel and an interpreter.*

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20. To appoint an independent Ombudsperson to mediate any concerns or complaints put forward.

Presiding Coroner Comment: *The evidence showed that there was no independent, realistic method for immigrants to bring forward concerns or complaints. This recommendation addresses that issue.*

21. To create a civilian organization to investigate critical incidents in CBSA custody.

Presiding Coroner Comment: *Evidence was led which showed that there was no independent organization to review critical incidents in CBSA custody. The BC Coroners Service independently reviews all sudden and unexpected deaths which occur in the Province, including suicides, accidents and homicides. The BC Coroners Service does not review non-fatal critical incidents. The jury appeared to feel that this level of oversight was required.*

To: **British Columbia Corrections**

22. Immigration detainees need to be given access to regular non-inmate phones and/or internet to facilitate international communication. Timing of such communication should take into consideration the time zone of the country being called.

Presiding Coroner Comment: *Refer to recommendation number 18, above. The jury appeared to feel that where time zones were an issue, detainees would face further barriers to contacting persons or organizations, particularly as they were locked down during the night at the ACCW. Where at the time of this incident the detainees at the IHC were locked down between 2300 and 0600 hours, evidence was led that that practise had been discontinued.*

23. To work with the CBSA to share access to computer systems regarding immigration detainee schedules. A process needs to be in place to immediately notify CBSA of any appointments scheduled within Corrections and of any changes to a detainee's appointments.

Presiding Coroner Comment: *Ms. Vega Jimenez had made two requests for medical appointments while she was at the ACCW, but did not see a medical professional. Because of how appointments were scheduled within the Correctional system, CBSA agents did not have access to detainees entire appointment calendars. While other evidence was led that critical information was conveyed verbally between CBSA and Corrections, this recommendation would ensure more seamless access.*