"E" DIVISION CRIMINAL OPERATIONS
CORE POLICING

NOV 22 2018

CHIEF CORONER

November 7, 2018

Ms. Lisa Lapointe, Chief Coroner
Chief Coroner's Office
Metrotower II
Suite 800 - 4720 Kingsway
Burnaby, BC
V5H 4N2

RE: Rhett Patrick Victor MUTCH
Coroner's Inquest into the Death of
BCCS Case File: 2014:0380:0006

Dear Ms. Lapointe:

As a result of the tragic death of Mr. Mutch, we undertook a review of related RCMP policy and training, and wish to respond to the following Coroner's Jury police-related recommendations:

To South Island Police Departments:

Recommendation 7

"All members to be made aware of and encouraged to participate in care services after a critical incident."

Response:

In addition to the services and supports enumerated in the responses provided to the Chief Coroner by the Acting OIC West Shore Detachment, S/Sgt. Raj Sandhu, on 2018-07-11 and by the NCO i/c Sidney Detachment, S/Sgt. Wayne Conley, on 2018-07-26, I would add the following:

Per E Division Operational Manual 54.3.4.3.3.4., a detachment commander must ensure that "a trauma debriefing is made available for the involved officers, employees and, where necessary, their family members." "E" Division Administrative Manual (E AM) Bulletin 758—Trauma Debriefing Program provides the comprehensive outline for this process. It is a lengthy protocol and includes, in part, the following directives:

"In the course of their duties, RCMP employees may be exposed to traumatic incidents, which can cause acute emotional distress. When this occurs, it is important for the person to immediately access peer and professional support." (E AM 758 2.3.)

"A group trauma debriefing will ideally be held 72 hours following a traumatic incident, but an individual trauma debriefing may occur at any time." (E AM 758 2.6.)

"The trauma debriefing provides an opportunity for those involved to share their experiences in a non-judgmental setting where people can speak about their own reactions to an extraordinary event; and gain a better understanding of their responses." (E AM 758 2.8.)

The above is reinforced in the RCMP's *Critical Incident Stress Management Aftercare Guide*, itself a product of the Force's Mental Health Strategy.

To the Police Chiefs of Southern Vancouver Island and the Vancouver Island Health Authority:

Recommendation 9

"To require that after a defined number of multiple crises calls to police from a single source are received, the following [will] occur a) an early intervention from appropriate Ministries is initiated and b) a collaborative safety plan is created."

Response:

Each police call for service must be examined on a case-by-case basis and with its own unique safety risk assessment; those principles alone make establishing a fixed number of repeat calls to a single complainant as a trigger for a specialized response an elusive process. There will be times when a *single* crisis call from a complainant leads the police to work with other agencies on a collaborative solution to the client's needs. And there will be instances in which multiple crisis calls (later determined by investigation to be of an innocuous nature) from a complainant will not lead the police to work with other agencies.

After examining an individual's PRIME history, the police will determine whether or not previous calls for service and police response have been effective in a given situation and whether or not a more robust response, including a safety plan, may be required. As above, this stronger response may be triggered by few or many calls for service depending on a totality of circumstances. PRIME is a common Records Management System among BC policing agencies, and would therefore provide South Island investigators, for example, the ability to assess the responses to repeat clients among *all* South Island policing agencies. The RCMP has the authority at *any* time to share relevant information with provincial and municipal agencies to ensure that a common client receives the best care possible and public safety is preserved; the Force need not wait until a

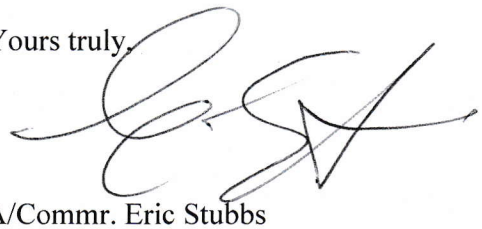
certain number of calls for service have occurred.

The most basic safety plans begin when the RCMP works with the courts and Crown Counsel to ensure that any related release conditions for an offender protect the victims. Further, per E Division Operational Manual 37.6.3.2., RCMP Victim Services may work with investigators, even in small detachments, to establish safety plans for victims, especially in the case of domestic violence. Those safety plans may be further enhanced by the RCMP's collaboration with provincial and municipal agencies. The RCMP course "Assessing Risk and Safety Planning in Domestic Violence Investigations" is mandatory for all operational front line members.

In summary, for the police to assign a fixed or set number of calls for service in order to initiate police contact with relevant provincial agencies for the purposes of initial investigation or safety planning may, in certain incidents, cause a delay in assisting the person in crisis.

Thank you for bringing these recommendations to my attention. The RCMP is committed to learning from tragic incidents such as these and to developing policies and procedures that will help prevent their recurrence.

Yours truly,



A/Commr. Eric Stubbs
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"E" Division RCMP