



Royal Canadian Mounted Police  
Gendarmerie royale du Canada

Security Classification / Designation  
Classification / Désignation sécuritaire

Mail Stop #306  
14200 Green Timbers Way  
Surrey, BC  
V3T 6P3

March 12, 2014

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

Your file      Votre référence

2012-0376-0113

Our file      Notre référence

2012CP-0273

**RE: MITCHELL, Angus David - Coroner's Inquest into the death of**  
**BCCS Case File#: 2012-0376-0113**

**RECEIVED**

MAR 17 2014

Dear Ms. Lapointe:

MINISTRY OF SOLICITOR GENERAL  
OFFICE OF THE CHIEF CORONER

We would like to acknowledge receipt of your letter dated February 28, 2014. In order to properly respond to your letter on the Coroner's Inquest into the death of Mr. MITCHELL, we will be reviewing the recommendation(s) received and corresponding with various subject experts and officers within the RCMP.

We will provide follow up correspondence upon the completion of the review of the Jury's Findings and Recommendation(s).

Respectfully,

A/Commr. Norm Lipinski, MBA, LLB, OOM  
Criminal Operations Officer  
E Division Core Policing

April 1, 2014

Ms Lisa Lapointe, Chief Coroner  
Province of British Columbia  
BC Coroners Service  
Office of the Chief Coroner  
Metrotower II  
Suite 800 - 4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms Lapointe,

**RE: Coroner's Inquest into the death of:  
MITCHELL, Angus David  
BCCS Case File #2012-0376-0113**

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You have asked for our response to recommendations four and five of the Coroner's Inquest into the death of Mr. MITCHELL.

**Recommendation 4)**

"The PRIME system be unified to permit ready access for police officers in all areas of the province."

Coroner's Comments:

The jury indicated that timely access to PRIME files is necessary in order for investigating police officers to complete a thorough investigation.

PRIMECorp Response:

While it is true that PRIME-BC has three distinct servers, broken up by geographical areas, all police officers in the Province of BC have access to all the files (except for designated sensitive privatized files) on all three servers through an interface called the Police Information Portal (PIP). The information queried through PIP has to be complete in order to get the requisite results; i.e. an exact name and date of birth provides a more complete result to a query than a partial name. In addition, all police agencies have a number of designated individuals who have direct access (without going through PIP) into all three servers for queries that require a more thorough search with limited information.

In summary, we believe that PRIME-BC currently does provide the ability for all police officers to have timely information across the entire system.

**Recommendation 5)**

"That a process be developed to ensure the accuracy and consistency of the coding in PRIME."

Coroner's Comments:

The jury indicated that improper coding in PRIME can result in relevant information being missed in the course of an investigation.

PRIMECorp Response:

All police agencies who contribute records to the PRIME-BC system are the owners of their records and are responsible for the review and accuracy of those records including the accuracy of the coding.

The system is designed to automatically generate a Firearms Interest to Police (FIP) flag when correct and appropriate offence and subject role code (e.g. "subject of complaint", "suspect", "witness", etc.) is applied to an incident. Both criteria must be met (offence code and subject role code) for a system generated FIP to result. PRIME Policy requires all police agencies to have a review process in place to ensure that any automated FIP entries that are missed due to incorrect coding may be manually generated.

Police agencies and RCMP detachments in BC are responsible to ensure the accuracy and integrity of the information they contribute to the PRIME-BC system through data quality review processes that include review by a supervisor in accordance with PRIME-BC policies and procedures.

Sincerely,

A handwritten signature in black ink, appearing to read 'David W. Guscott', with a long horizontal flourish extending to the right.

David W. Guscott  
Chief Executive Officer

604-215-5002  
David.Guscott@primebc.ca



## WEST VANCOUVER POLICE DEPARTMENT

1330 Marine Drive, West Vancouver, British Columbia V7T 1B5 Telephone 604.925.7300 Fax 604.925.5938 wvpd.ca

Peter Lepine  
Chief Constable

Admin File #100-1

March 17, 2014

Office of the Chief Coroner  
Metrotown II  
Suite 800 – 4720 Kingsway  
Burnaby, BC  
V5H 4N2

**RECEIVED**

MAR 18 2014

MINISTRY OF SOLICITOR GENERAL  
OFFICE OF THE CHIEF CORONER

Dear Lisa Lapointe:

**Re: Coroner's Inquest into the Death of:  
MITCHELL, Angus David  
BCCS Case File #2012-0376-0113**

Thank you for your letter dated February 28, 2014 which includes a copy of the Verdict at Inquest into the death of Angus David Mitchell and your request for a response to the recommendation numbers four and five.

On reviewing the recommendations, West Vancouver Police Department (WVPD) will work with the PRIME Governing Council to consider consolidating PRIME databases.

WVPD is committed to ensuring accuracy and consistency in the coding of our files. Given the few number of files, we are confident that the accuracy of our PRIME files is, and remains high.

Please feel free to contact me at any time to discuss this matter further.

Yours truly,

Peter A. Lépine, MOM  
Chief Constable



**Stl'atl'imx Tribal Police Service**  
Box 488 Lillooet BC V0K 1V0  
(250) 256-7784 fax-(250) 256-4600 [www.stlatlimxpolice.ca](http://www.stlatlimxpolice.ca)

March 17, 2014

**RECEIVED**

APR 02 2014

Office of the Chief Coroner  
Metrotown II  
Suite 800 – 4720 Kingsway  
Burnaby, BC  
V5N 4N2

MINISTRY OF SOLICITOR GENERAL  
OFFICE OF THE CHIEF CORONER

Dear Lisa Lapointe:

Re: **Coroner's Inquest into the Death of:**  
**MITCHELL, Angus David**  
**BCCS Case File #2012-0376-0113**

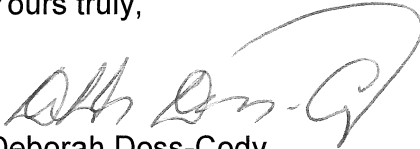
Thank you for your letter dated February 28, 2014 which includes a copy of the Verdict at Inquest into the death of Angus David Mitchell and your request for a response to the recommendation numbers four and five.

On reviewing the recommendations, Stl'atl'imx Tribal Police Service (STPS) will work with the PRIME Governing Council to consider consolidating PRIME database.

STPS is committed to ensuring accuracy and consistency in the coding of our files. Given the few number of files, we are confident that the accuracy of our PRIME files is, and remains high.

Please feel free to contact me at any time to discuss this matter further.

Yours truly,

  
Deborah Doss-Cody,  
Chief Officer



**RECEIVED**

APR 15 2014

MINISTRY OF SOLICITOR GENERAL  
OFFICE OF THE CHIEF CORONER

April 9, 2014

Ms. Lisa Lapointe, Chief Coroner  
Province of British Columbia  
BC Coroners Service  
Office of the Chief Coroner  
Metrotower II  
Suite 800 – 4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms. Lapointe,

Re: Coroner's Inquest into the death of  
MITCHELL, Angus David  
BCCS Case File: 2012-0376-0113

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In response to the Coroner's Inquest into the death of David Angus MITCHELL, you asked the Vancouver Police Department (VPD) to give consideration to jury recommendations four and five from the final report.

The VPD is compliant with PRIME -BC policy. We concur with the submission, as attached, made by PRIMECorp dated April 1, 2014, regarding both recommendations. For clarity, of our business processes, additional information specific to the VPD has been included in relation to recommendation five.

The VPD has incorporated several quality assurance processes to ensure that our reports are accurately scored and therefore compliant with PRIME-BC policies that address data quality and information integrity.

***PRIME BC Policy, Chapter 1.3, System Administration:***

*2.4 Individual users and supervisors are responsible for the quality of data entered on PRIME-BC. Data quality assurance will be maintained by Participating Agencies, and is subject to review by the PRIME-BC Audit and Compliance Unit.*

**PRIME BC Policy, Chapter 2.2 General Occurrence:**

*5.1 Participating Agencies must develop agency-specific policy that addresses protecting the integrity of information entered in a GO.*

*5.2. All text in a GO must be locked after appropriate approval. Agencies may choose to lock text before text approval as per their agency policy.*

*5.3 All deletions must be recorded in case notes where available and be able to withstand an audit or court challenge.*

*5.4 Agencies must limit the number of individuals authorized to delete records and strictly enforce policy as to what may be deleted.*

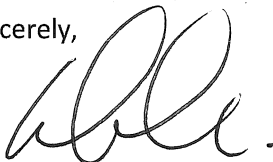
At the VPD, all Firearms Interest to Police (FIP) flagged records are managed in a dedicated queue and audited regularly to ensure accuracy. In addition, as a further quality assurance process, the VPD conducts monthly reviews of various system generated reports that may indicate that a FIP record was either not entered, or entered incorrectly.

The VPD holds a seat on the PRIME-BC Crime Stats Committee, and the Federal Data Manager's working group and has developed rigorous training curriculum for those responsible for reviewing General Occurrence reports. A new scoring guide that incorporates PRIME-BC policies on how police incidents are recorded will be adopted once the PRIME-BC Crime Stats Committee has approved it.

Further, all investigative reports submitted by patrol officers, where charges are recommended, are reviewed by our Information Management and Court and Detention Services Sections to ensure compliance with Departmental standards and PRIME-BC policy.

In summary, the VPD has many safe guards and processes in place to ensure the accuracy and integrity of the data we contribute to PRIME-BC. The VPD appreciates the opportunity to respond to the recommendations resulting from this Coroner's Inquest.

Sincerely,



Warren Lemcke  
Deputy Chief Constable  
Support Services Division

Encl.

April 1, 2014

Ms Lisa Lapointe, Chief Coroner  
Province of British Columbia  
BC Coroners Service  
Office of the Chief Coroner  
Metrotower II  
Suite 800 - 4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms Lapointe,

**RE: Coroner's Inquest into the death of:**  
**MITCHELL, Angus David**  
**BCCS Case File #2012-0376-0113**

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**Recommendation 4)**

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Police agencies and RCMP detachments in BC are responsible to ensure the accuracy and integrity of the information they contribute to the PRIME-BC system through data quality review processes that include review by a supervisor in accordance with PRIME-BC policies and procedures.

Sincerely,



David W. Guscott  
Chief Executive Officer

604-215-5002  
David.Guscott@primebc.ca



City of Port Moody  
Police Department

Chris J. H. Rattenbury  
Chief Constable

## OFFICE OF THE CHIEF CONSTABLE

3051 St. Johns Street, Port Moody, B.C. V3H 2C4 (604) 461-3456 Fax: (604) 937-1314

April 17, 2014

Lisa Lapointe  
Office of the Chief Coroner  
Metrotower II  
Suite 800-4720 Kingsway  
Burnaby, BC V5H 4N2

Dear Ms. Lapointe:

I write with respect to your letter dated February 28, 2014 in regards to the Coroner's Inquest into the death of Angus David Mitchell (BCCS File 2012-0376-0113). I have now reviewed the two recommendations provided to us by the jury.

The first recommendation was that "the PRIME system be unified to permit ready access for police officers in all areas of the province." While I am unable to unequivocally comment on the PRIME access available to police officers in other jurisdictions, I can say that our members have access to PRIME files that are generated anywhere in British Columbia. These can be searched from the computers in our police vehicles by using a function known as LEIP – the law enforcement information portal.

The second recommendation was "that a process be developed to ensure the accuracy and consistency of the coding in PRIME." Fortunately we already have this process in place. The file passes through three filters before it is finalized in PRIME. The initial report is created by the member, who has had PRIME training regarding properly coding files and assessing entities, and is then read by the officer's supervisor. Finally, it passes through our records section who read the file with an eye to ensuring that it is properly coded – in fact, that is the primary function of their every day job.

I hope that my responses have properly addressed the concerns raised by the jury. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Chris Rattenbury  
Chief Constable

**RECEIVED**

APR 25 2014

MINISTRY OF SOLICITOR GENERAL  
OFFICE OF THE CHIEF CORONER



# Abbotsford Police Department

2838 Justice Way, Abbotsford, BC V2T 3P5 Phone (604) 859-5225 Fax (604) 864-4809

*"Protecting with Pride"*

**Bob Rich**  
*Chief Constable*

May 1, 2014

**RECEIVED**

MAY 08 2014

Lisa Lapointe  
Chief Coroner  
Province of British Columbia  
Office of the Chief Coroner  
Metrotower II  
Suite 800 – 4720 Kingsway  
Burnaby, BC V5H 4N2

MINISTRY OF SOLICITOR GENERAL  
OFFICE OF THE CHIEF CORONER

Dear Ms. Lapointe:

**Re: Coroner's Inquest into the deaths of:**

**MITCHELL, Angus David**  
**BCCS Case File #2012-0376-0113**

**WILDER, Patrick Roy**  
**BCCS Case File # 2011-0448-0032**

In response to your letters dated February 28, 2014 and March 6, 2014 on the above referenced matters, respectively, this is to advise that these recommendations have been forwarded to the British Columbia Association of Chiefs of Police ("BCACP") for consideration and response. After review of the recommendations directed to the Abbotsford Police Department, these are matters that are provincially governed and as such require a response from the BCACP.

Sincerely,

Bob Rich  
Chief Constable

Cc: D/C/Cst. Len Goerke, President, BCACP

***Our Mission:***  
***To make Abbotsford the safest city in BC***



RECEIVED

MAY 23 2014

MINISTRY OF SOLICITOR GENERAL  
OFFICE OF THE CHIEF CORONER

MAY 21 2014

1005795

Ms. Lisa Lapointe  
Chief Coroner  
Ministry of Justice  
Metrotower II  
800 - 4720 Kingsway  
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

Thank you for your letter of February 28, 2014, regarding Recommendations 1, 2 and 3 made in the Coroner's Judgment of Inquiry into the death of Mr. Angus David Mitchell (Case File 2012-0376-0113). The Ministry of Health (the Ministry) has reviewed the recommendations and has the following response to each:

**Recommendation #1 (to the Minister of Health and the College of Physicians and Surgeons of British Columbia):**

*That the Mental Health Act (MHA) be amended to require physicians to report the outcome of assessments conducted on persons arrested by police under Section 28 of the MHA where a firearm is involved to the Chief Firearms Officer (CFO) and policy agency involved.*

**Recommendation Under Consideration**

Amendment of the MHA is under review and requires further research and stakeholder engagement before a decision can be made to amend this legislation. The Ministry is considering conducting further policy research; consulting with key stakeholders, experts and family representatives; and developing recommendations regarding the implications of amending the MHA. Policy research consultation would include physicians, psychiatrists, legal experts, family representatives, and other mental health stakeholders. A comprehensive analysis would be required in order to make an informed decision and address the legal considerations in amending the MHA.

**Recommendation #2 (to the Minister of Health and the College of Physicians and Surgeons of British Columbia):**

*That the psychiatrist assessing a person brought to them under Section 28 of the MHA make all effort to contact Next Of Kin or close friends to obtain collateral information of the patient's mental status.*

...2

**Recommendation Accepted**

The recommendation is congruent with Ministry policy that physicians obtain collateral information from family, friends and other service providers, when clinically appropriate, for assessing people for involuntary admission and treatment under the MHA into a designated mental health facility. There is consideration of the patient's ability to give consent for the family and others to be contacted. Ministry policy is outlined on page 8 of the Ministry's *Guide to the Mental Health Act*, available on the Ministry website at: <http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf>

**Recommendation #3 (to the Minister of Health and the College of Physicians and Surgeons of British Columbia):**

*That a study be conducted respecting the feasibility to allow a family to request a psychiatric assessment of a family member if they believe a mental illness exists, even though that family member may be resistive to voluntary assessment.*

**Recommendation Considered but deemed already met**

A study is unnecessary as the recommendation for a family to request a psychiatric assessment of a family member if they believe a mental illness exists, even though that family member may be resistant to voluntary assessment, is a standard of practice in BC and consistent with Ministry policy. The Ministry's *Guide to the Mental Act* provides specific guidance to family members in accessing a physician, mental health centre, police officer, or a judge to determine the need for examination and facility admission under the MHA. Mobile mental health crisis response services operated by regional health authorities conduct psychiatric assessments at the request of the family to deal with people in crisis. An example of a mobile crises response service is Car 87 operating in Vancouver.

The Ministry respects the recommendations proposed by the coroner and appreciates the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. Lake', with a stylized, flowing script.

Terry Lake  
Minister