BCEHS | BC Emergency Health Services

March 8, 2016

Cliff: 1023016
File: 51020-50

Lisa Lapointe
Chief Coroner
Metro Tower II
Suite 800 - 4720 Kingsway
Burnaby BC V5H 4N2

Dear Ms. Lapointe:

Re: Coroner's Inquest into the Death of GEORGE, Alyssa Josephine Talina
BCCS Case File #2013-0380-0003

Thank you for your letter of February 10, 2016, regarding the Coroner's Inquest into the death of Alyssa Josephine Talina George. BC Emergency Health Services (BCEHS) has reviewed the verdict and the jury recommendation regarding the BC Ambulance Service (BCAS). As a result of this review, we are pleased to provide the following response.

Recommendation #16 (to Ministry of Health, Northern Health, RCMP, Mills Memorial Hospital and BC Ambulance Service): Investigate having a better and more accurate means of transmitting urgent/non-confidential medical information from one agency to another.

It is BCEHS policy and practice that all relevant information is provided to our healthcare partners in order to ensure continuity of care. For each patient transported, paramedics complete a written record detailing the patient's condition and treatment provided, and then we give this to the receiving facility, along with a verbal report. When picking up a patient for an interfacility transfer, the paramedics are required to obtain a report of the patient's condition from the sending facility, along with all relevant records, and then provide this information to the receiving facility.

We would be pleased to participate in any initiative brought forward by the Ministry of Health to improve communication between agencies. Again, thank you for bringing this matter to our attention.

Yours truly,

Jodi Jensen
Chief Operating Officer

Royal Canadian Mounted Police
Commissioner

Gendarmerie royale du Canada
Commissaire

Ms. Lisa Lapointe
Chief Coroner
Province of British Columbia
Office of the Chief Coroner
Metrotower II
800-4720 Kingsway
Burnaby, British Columba
V5H 4N2

Dear Ms. Lapointe:

On February 10, 2016, I received the Verdict at Inquest Report from your office concerning the tragic death of Alyssa George. There were a total of 16 recommendations, four of which were directed specifically at the Royal Canadian Mounted Police (RCMP) for consideration at the national level. Another was directed toward multiple agencies operating in the Province of British Columbia, including the RCMP.

The RCMP recognizes and commends the extensive work and effort that the jury put into formulating its recommendations. A thorough review of the recommendations directed at the RCMP was conducted at the national level. Our response is outlined below.

In terms of records management (Recommendation #1), the coroner's jury recommended that Form C-13, RCMP Prisoner Report, be amended to include information such as last intake of drug/alcohol, dosage of any medication, pre-existing medical conditions and allergies. The RCMP is currently in the process of amending Form C-13 to include all of the information suggested by the jury.

With respect to policies and procedures (Recommendation #2), the coroner's jury recommended that all RCMP policies, procedures, and standards be considered mandatory, not best practices. This is the case at present; all RCMP policies and procedures are written directives that must be adhered to.

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K1A 0R2

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With respect to timely assessment (Recommendation #8), the coroner's jury recommended that the time for seeking a medical assessment of an individual suspected of having a drug or alcohol addiction be reduced from 12 hours to eight hours. The RCMP is currently in the process of amending its policy to reduce the time for seeking medical assessment for persons with suspected substance addictions, as suggested by the jury. Furthermore, the RCMP policy on incarceration of intoxicated persons is also in the process of being amended to clearly outline policies and procedures specifically related to the arrest, detention and subsequent medical care of intoxicated persons.

With reference to training (Recommendation #13), the coroner's jury recommended that first aid training be enhanced to include medical information and scenario training more conducive to alcohol and drug addiction, as well as community-level training such as the intergenerational effects of residential schools on First Nations, and the cultural sensitivities of other minorities. First aid training for members of the RCMP is under the jurisdiction of the provinces. However, national RCMP policy does exist for assessing responsiveness prior to taking persons into custody. RCMP policy mandates that RCMP members must complete an assessment of responsiveness before taking a person into custody, and provides a visual aid to assist members in correctly completing this process. This process, combined with the aforementioned policy amendment to reduce the time for seeking medical assessment for persons with suspected substance addictions, will serve to bolster the first aid training that RCMP members receive.

Training on the effects of residential schools exists as part of the RCMP's online Aboriginal and First Nations Awareness course. This course covers topics relating to the historical social injustice towards Aboriginal people and includes (a) the history of why residential schools were implemented, (b) the purpose or design of the residential school system, (c) life in the residential school for the children, (d) what went wrong with residential schools, (e) reconciliation and government apology for residential schools, and (f) the legacy of the assimilation policy on Aboriginal communities. All regular members working in First Nations communities are required to complete this course, as are all RCMP cadets. Furthermore, this training is made available to all regular members of the RCMP and is mandatory in a number of RCMP divisions.

With respect to information sharing (Recommendation #16), the coroner's jury recommended that a number of agencies operating in British Columbia, including the RCMP, investigate having a better and more accurate means of transmitting urgent or non-confidential medical information from one agency to another. There are no restrictions on RCMP members that would hinder the sharing of such information.

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Finally, in addition to the previously noted measures, the RCMP's Contract and Aboriginal Policing section is committed to conducting a thorough review of all of the policies and procedures related to the care of persons in RCMP custody to assist in efforts to avoid deaths in the future.

I understand that this response will form part of the official public record and that it will be available on the Coroners Service website, along with the jury verdict.

Yours sincerely,

Bob Paulson
Commissioner

THE CITY OF TERRACE

CITY HALL
3215 EBY STREET
TERRACE, B.C. V8G 2X8
250-635-6311 PH.
250-638-4777 FAX
www.terrace.ca

March 31, 2016

Ministry of Public Safety & Solicitor General
BC Coroners Service
Metrotower II, Suite 800 – 4720 Kingsway Drive
Burnaby, BC V5H 4N2

Attention: Lisa Lapointe, Chief Coroner

Dear Ms. Lapointe:

Re: Coroner's Inquest into the death of Alyssa Josephine Talina GEORGE
BCCS Case File #2013-0380-0003

On behalf of City of Terrace Council the following are the City's responses to recommendations 4 to 13 and 15 from the Verdict at Inquest concerning the death of Ms. George.

As the RCMP Guards are under the direction of the RCMP and follow RCMP policy I have consulted with the RCMP on some of the following responses to the recommendations, where applicable.

Jury Recommendations:

4. *To: RCMP (Terrace Detachment) and* ***City of Terrace***

   Guards must follow/adhere to existing policies/procedure (operation manual Part 19) concentrating on: 4 R's (Rousability), watch command 4 hour prisoner check, guard physical check every 15 mins.

   City of Terrace response:

   As per RCMP policy the RCMP Guards will conduct physical checks every 15 minutes and have received refresher training on this policy requirement.

5. *To: RCMP (Terrace Detachment) and* ***City of Terrace***

   Use of CCTV should be used as a secondary backup to physical checks.

   City of Terrace response:

   As per 4 above.

6. *To: RCMP (Terrace Detachment) and* ***City of Terrace***

RCMP/Guards should use the cell check log appropriately (follow all blocks of the form and fill out completely).

City of Terrace response:

As per RCMP policy the RCMP Guards will fully complete the cell check log and have received refresher training on this policy requirement.

7. *To: RCMP (Terrace Detachment) and* ***City of Terrace***

To assist the guards doing the physical cell checks, the hall lighting could be reduced or matte coating on the cell door window to reduce the glare from the above lights.

City of Terrace response:

The current lighting is consistent with RCMP standards for the safe handling of prisoners. As the landlord of the building the City of Terrace would make adjustments to the building as requested by the RCMP.

8. *To: RCMP (the Commissioner) and* ***City of Terrace***

Consider reducing OM 19.2, section 2.1.2.6 to reduce medical assessment time to 8 hours.

City of Terrace response:

This refers to national RCMP policy. The City will rely on the RCMP to respond to this recommendation.

9. *To: RCMP (Terrace Detachment) and* ***City of Terrace***

A committee should be established to discuss the possibility and funding a second guard on duty at all times.

City of Terrace response:

The current policy of the Terrace RCMP Detachment is one guard on duty per shift. An additional guard is brought in when there are 12 prisoners in cells or based on a risk assessment conducted by the RCMP Supervisor on shift if there is a higher risk prisoner. This is standard RCMP practice for similar-sized detachments and is an efficient and effective method of managing prisoners.

On September 3 and 4, 2013 there was a manageable number of prisoners in cells at the Terrace RCMP Detachment and well below the 12 prisoner threshold for calling in a second guard. Having a second guard on duty at all times would be cost prohibitive for the municipality. The 2015 cost of salaries and benefits for the four full-time RCMP Guards we have on staff was $326,000.

10. *To: RCMP (Terrace Detachment) and* ***City of Terrace***

Investigate upgrading the existing CCTV system to include larger monitors, with the ability to select the video feed to focus on one cell, ability to zoom and pan video feed while maintaining the source feed for the recording, audio mics at each end of the hallways free of background noise.

City of Terrace response:

The existing CCTV system meets acceptable RCMP standards and was installed in 2011 based on national RCMP specifications. Any changes would be at the direction of the RCMP.

11. *To: RCMP (Terrace Detachment) and* ***City of Terrace***

Install a 2 way non-recording intercom system into all cells, other than 1 & 7, for rousability checks, a loud buzzer noise in cell to precede actual 2 way communication for prisoner privacy.

City of Terrace response:

Any changes to the audio system in the cell block would be based on RCMP policy and would be at the direction of the RCMP.

12. *To: RCMP (Terrace Detachment) and* ***City of Terrace***

Ensure that all guards and RCMP members take the existing training as required and investigate increasing some training cycles to ensure retention of information/policies/procedures.

City of Terrace response:

Training of RCMP Guards is identified and required as per national RCMP policies.

13. *To: RCMP (the Commissioner) and* ***City of Terrace***

First aid training should be enhanced to include medical information and scenario training more conducive to alcohol and drug addiction, and community level

training such as the intergenerational effects of residential school on First Nations, as well as the cultural sensitivities of other minorities.

City of Terrace response:

Training of RCMP Guards is identified and required as per national RCMP policies.

15. *To: Northern Health, First Nations Health Authority, Ministry of Health, and* ***City of Terrace***

A committee/focus group should be established to investigate the construction of a proper medically staffed substance abuse/detox centre in the City of Terrace to service all outlying areas. This should include one or more substance abuse doctor and counsellor.

City of Terrace response:

The City of Terrace has been participating in a dialogue initiated by Northern Health involving all stakeholders named in this recommendation along with others. The City is now co-leading this initiative with the purpose of these discussions being to develop a process for the stakeholders to work together to create a shared care plan that allows for a coordinated, collaborative approach to managing the needs of at risk individuals.

If you have any questions please contact me at 250-638-4722 or by email at havison@terrace.ca.

Sincerely,

H. Avison

Heather Avison,
Chief Administrative Officer

pc: Acting Inspector Syd Lecky, RCMP Terrace Detachment
Donita Kuzma, Regional Coroner, Northern Region

First Nations Health Authority
Health through wellness

501 — 100 Park Royal South
Coast Salish Territory
West Vancouver, BC
Canada V7T 1A2
T 604.693.6500
F 604.913.2081
www.fnha.ca

April 5, 2016

Lisa Lapointe
Chief Coroner, British Columbia Coroners Service
Ministry of Public Safety and Solicitor General
5th floor, 910 Government Street
Victoria, BC V8V 1X4

Re: Response to BC Coroner Service Inquest into the death of Alyssa Josephine Talina GEORGE (BCCS Case File #2013-0380-003)

Dear Ms. Lapointe:

Thank you for the opportunity to provide a response to the recommendations made during the recent Coroners Inquest regarding the tragic death of Alyssa Josephine Talina George (a.k.a. Oleksiuk). Alyssa was a young First Nations woman who struggled with alcohol use, and ultimately died as a result of multiple organ failure from the physical effects of long-term alcohol use. While the accompanying background report doesn't give details of Alyssa's personal history or attempts to obtain assistance in the form of treatment for substance use, it is well-known that accessing culturally safe treatment facilities is challenging in the North. As such, the First Nations Health Authority welcomes and supports the jury's recommendation (no. 15) that:

> *A committee/focus group should be established to investigate the construction of a proper medically staffed substance abuse/detox centre in the City of Terrace to service all outlying areas. This should include one or more substance abuse doctor and counsellor.*

This recommendation was made to FNHA, Northern Health, the Ministry of Health, and the City of Terrace. We are committed to working with these partners to offer culturally safe and holistic detox services, substance abuse treatment and counselling, and medical care that could prevent future substance abuse-related deaths among First Nations peoples and other citizens in the North. This response is intended to provide an overview of the services FNHA is currently providing and the work we are undertaking towards transforming current service provision. These items align with the recommendations outlined in your Coroner's report.

The FNHA provides funding for treatment programs from the National Native Alcohol and Drug Abuse Program (NNADAP), mental health supports for one-on-one counselling and group therapy. When required the FNHA also supports First Nations to attend non-NNADAP funded treatment facilities. The current rate of access to non-NNADAP funded facilities will not be sustainable in years

to come and current NNADAP treatment facilities are well utilized. The FNHA and partners, such as the Ministry of Health and all the health authorities, are working towards solutions.

Current detox plans for Northwest BC: FNHA has identified several goals with respect to increasing detox services in the North:

- Improve accessibility and eligibility to Northern Health detox centers
- Increase the number of beds available to Northern residents
- Provide resources and physician support (via telehealth or otherwise) for those who are detoxing at home
- Expand detox access to those living with concurrent disorders
- Clarify policy around emergency room provision of detox services
- Provide 'daytox' services closer to home

A key part of moving towards these goals is the current review of NNADAP by an external consultant team. This review will identify priorities that will help to re-envision treatment and detox centers that align more closely with best practices in addictions treatment. Of particular note is that this realignment will add additional beds to help close the gap on the Northern Region's allocated spaces as part of the BC Ministry of Health's plan to increase the number of substance use beds by 500 on a provincial level. Revised NNADAP treatment centers and services will also increase worker capacity to treat clients with complex needs and those underserved by the current system (e.g. youth, women, LGBTQ, court/criminal justice referrals, people in active addiction or utilizing a harm reduction program, and those with concurrent disorders or chronic diseases).

An additional detox and treatment project underway through the Joint Project Board is the "Mobile Support Team" initiative which establishes regional Mental Wellness and Substance Use teams (MST) that offer 'wrap-around' services consisting of community detox and treatment initiatives. This approach reflects the First Nations perspective on wellness in that these services treat not only the physical effects of substance use, they also address mental, emotional, and spiritual issues that facilitate the healing process. The team includes Registered Clinical Counsellors, Psychiatric Nurses, and MSWs that work to provide ongoing support, education, and crisis response in surrounding First Nations communities. They also work to build sustainable community capacity in crisis response by providing training opportunities to community members in the areas of Core Addiction Practice, Trauma-Informed Practice, and Applied Suicide Intervention Training.

The creation and formation of the MSTs is being done in conjunction and partnership with FNHA and Project Advisory Committees (PACs) which are made up of community members and health workers from each community that receives service. This model of utilizing community-based Advisory Committees has been adopted by Mental Health and Addiction services, particularly with some services established in the Northwest. Additionally, the MSTs will be integrated with the Aboriginal Health Improvement Committees already active in each of the three HSDAs. Teams will

be phased in between 2014/15 and 2015/16 in concert with local planning within each sub-region and various communities.

The provision of culturally safe, holistic detox services in the North for First Nations people will only be accomplished through a collaborative and sustained effort. The FNHA has several initiatives underway that could be resources to a larger partnership between our organization, Northern Health, the Ministry of Health, and the City of Terrace. We respectfully put forward this response with the sincere hope that it may contribute to the prevention of tragic substance use-related deaths in the future, such as that of Alyssa George.

In health and wellness,

Joe Gallagher,
Chief Executive Officer, FNHA

cc: Arlene Paton, ADM, MoH
Doug Hughes, ADM, MoH

BRITISH
COLUMBIA

JUL 0 5 2016

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

Dear Ms. Lapointe:

Re: Coroner's Inquest into the death of:
Alyssa Josephine Talina GEORGE
BCCS Case File #2013-0380-0003

Thank you for your letter of February 10, 2016, regarding Recommendation numbers 14 to 16 made as a result of the Coroner's Inquest into the death of Ms. Alyssa Josephine Talina George aka Oleksiuk. My apologies for the delay in responding.

The Ministry of Health (the Ministry) has carefully reviewed the recommendations from a provincial perspective and has the following response:

Recommendation #14: We recommend to the Provincial Ministry of Health that [it] "must keep blood samples taken from patients who are gravely ill for 14 days and follow patient if transporting to alternative medical facilities."

The Ministry of Health respects the recommendations proposed by the Coroner and conducted a review of the proposed changes to laboratory procedures with its health authority partners and the Diagnostic Accreditation Program (DAP), the diagnostic medicine accreditation body for British Columbia. Concerns were raised regarding the feasibility of the recommendations respecting sample retention time and sending blood samples with patients being transferred to an alternative level of care.

The Ministry's review concluded that due to a number of significant concerns identified below, this recommendation cannot be reasonably implemented.

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Ministry of Health
Office of the Minister
Mailing Address:
PO Box 9050 Stn Prov Govt
Victoria V8W 9E2
Location:
Parliament Buildings
Victoria

Specimen Retention

- The DAP does not specify a standard length of time for sample retention, rather it specifies that procedures must be in place regarding patient sample retention.
- The DAP's Accreditation Standards 2015 Laboratory Medicine, PRE5.0 Sample Storage and Discard, section PRE5.1.4 accredits that "there are procedures for identification, retention, indexing, access, storage, maintenance and safe disposal of samples."
- Health authority laboratories have laboratory service policies in place regarding retention of patient samples based on sample type and testing methodology.
- Blood samples are typically retained in a health authority laboratory for one week. Retaining samples for 14 days would lead to storage capacity issues.
- Exceptions are made if the RCMP request a specimen be held until it obtains a warrant; in which case the specimen will be kept for up to 6 months or until a warrant is issued.

Specimen Movement with Patient

- When a patient moves to an alternate level of care, best practice is for the new facility to draw and test a new sample. A patient's condition is dynamic, as is their sample, and the original sample may no longer reflect the current health status of the patient.
- The laboratory results from the patient's initial blood sample are entered into the Provincial Laboratory Information Solution (PLIS), a clinical results repository, which can be accessed by clinicians anywhere in the province. A clinician at the alternate level of care facility can review a patient's full laboratory results history on PLIS.

Recommendation #15: A committee/focus group should be established to investigate the construction of a proper medically staffed substance abuse/detox centre in the City of Terrace to service all outlying areas. This should include one or more substance abuse doctor and counsellor.

The Ministry is responsible for providing broad provincial policy direction regarding substance use services to health authorities which includes the expectation that there is a continuum of substance use services available within communities. The health authorities, including Northern Health Authority (NHA), are responsible for the direct delivery of those substance use services within their geographic region. Given this, NHA is the primary respondent to this recommendation.

Both the Ministry and NHA agree that this unfortunate death highlights the need for the health and social systems to do better within the current resources to provide care and support for individuals struggling with problematic substance use. NHA has considered the recommendation to construct a `properly medically staffed substance abuse/detox centre` and is working with service providers to explore ways of delivering appropriate withdrawal management services and other therapeutic supports to meet service need for communities surrounding the City of Terrace. To respond to the issues identified by the Coroner's Inquest, NHA has been holding facilitated dialogues in Terrace with stakeholders from the City of Terrace, First Nations Health Authority, Royal Canadian Mounted Police, BC Ambulance Services, community agencies, and First Nations organizations, on how to better serve people in need of withdrawal management and other community supportive services. This group of stakeholders meets monthly and has committed to moving forward with ongoing work to identify barriers to information sharing. This group will continue to work on creating processes to improve communication between service providers to better serve and support at risk individuals. In addition, NHA is carrying on complementary work to make supportive recovery services available whether in acute, residential or community-based programs. This work will include pathways to transition from withdrawal management to community programs.

Recommendation #16: Investigate having a better and more accurate means of transporting urgent/non-confidential medical information from one agency to another.

Ministry IMIT is working with health authorities to develop provincial standards to improve information sharing, however Ministry IMIT does not direct agencies on when to share information.

Thank you again for bringing these matters to my attention. The Ministry respects the recommendations proposed by the coroner and appreciates the opportunity to respond.

Sincerely,

Terry Lake
Minister

pc: Mr. Doug Hughes, Assistant Deputy Minister, Health Services Policy Division, Ministry of Health
Ms. Donita Kuzma, Regional Coroner, Northern Region Donita.Kuzma@gov.bc.ca

3205 Eby St
Terrace, BC
V8G 2X7

March 08, 2017

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

RE: Alyssa GEORGE
Coroner's Inquest into the Death of
BCCS Case File: 2013:0380:0003

Dear Ms. Lapointe:

As a result of the tragic death of Ms. George, we undertook a review of related RCMP Policy, including local detachment directives, and wish to respond to the following Coroner's Jury recommendations directed to "Terrace Detachment":

Recommendation 3

Ensure RCMP watch commander performs and is accountable for physical (in cell) checks every 4 hours of all prisoners in cells.

Response:

Terrace detachment, like any other detachment, is subject to RCMP National HQ Policy, and to Division and District Supplements to that policy. Related National policies are the following:

Detachment/Unit Commanders are responsible for their cells and cellblock operations, unless specifically delegated to another member/position and documented in Unit Supplements. / Ensure Unit Supplements are in place which stipulate how prisoners are to be handled, searched and monitored while in detachment cells. [E Div OM 19.1.3.5.1.]

Check prisoners frequently and at irregular intervals to ensure their security and well-being. The intervals are to be no more than 15 minutes apart. These checks must be physical checks, not a check of the CCVE. The use of CCVE may augment, but not replace physical checks. [This is the guard's responsibility per NHQ OM 19.3.4.5.1.]

An intoxicated prisoner must be awake or awakened and responsive a minimum of once every four hours. [This is the guard's responsibility under NHQ OM 19.3.4.5.2., although a member must accompany a guard *into* cells if a physical waking is required per 19.3.4.5.3.]

Conduct physical checks of prisoners at every guard and member shift change. If guards are switching shifts and a member is not present, both guards will conduct physical checks of all prisoners and document observations in the prisoner log record book. If guards are switching shifts and it is practicable for a member to be present, the senior member will conduct physical checks of all prisoners and document observations in the prisoner log record book. [Except where a "member" is mentioned, this is the guard's responsibility per NHQ OM 19.3.4.5.7.]

Conduct checks of the cell block at the beginning of each shift, and periodically during and at the end of the shift. [This is the Supervisor/Shift Supervisor's responsibility per NHQ OM 19.3.5.1.]

Ensure all members and personnel under your command who are responsible for prisoner care read and initial the applicable national directives, divisional, detachment, and unit supplements...Repeat this process every six months and retain the initial records. [This is the Commander's responsibility per NHQ OM 19.3.6.1.4.]

The NHQ OM's standards exceed this recommendation, that while intoxicated prisoners must be roused once every four hours, *all* prisoners must be physically checked at least once every fifteen minutes. The NHQ OM does not demand that a member (be she watch commander or not) conduct these checks (unless of course, the guard must enter the cell itself to rouse the prisoner). In general, the Commander is responsible (and ultimately accountable) for the actions of all employees in the detachment and in specific, according to NHQ OM 19.3.6.1.4. and E Div OM 19.1.3.5.1, is responsible for ensuring that all employees, be they guard or police officer, who take care of prisoners must be aware of all prevailing prisoner care directives.

As part of our own comprehensive detachment debrief/review of the incident, we impressed upon our guard staff the imperative of following all related RCMP directives.

Recommendation 4

Guards must follow/adhere to existing policies/procedure (operation manual part 19) concentrating on: 4 R's (Rousability), watch command 4 hour prisoner check, guard physical check every 15 min.

Response:

The detachment agrees. The guards must follow all applicable RCMP directives, including rousability checks of intoxicated prisoners every four hours and random physical checks of all prisoners every fifteen minutes.

As part of our own comprehensive detachment debrief/review of the incident, we impressed upon our guard staff the imperative of following all related RCMP directives.

Recommendation 5

Use of CCTV should be used as a secondary backup to physical checks.

Response:

The detachment agrees. The guards must follow all applicable RCMP directives, including conduction physical checks of prisoners every fifteen minutes, and only using CCTV as a supplementary checking system per NHQ OM 19.3.4.5.1.

As part of our own comprehensive detachment debrief/review of the incident, we impressed upon our guard staff the imperative of following all related RCMP directives.

Recommendation 6

RCMP/Guards should use the cell check log appropriately (follow all blocks of the form and fill out completely).

Response:

The detachment agrees. The members and guards must follow all applicable RCMP directives, including completion of the log book per the following directives:

If there is any concern about a prisoner's medical or mental condition, a guard must immediately alert a member on duty and note in the Prisoner Log. [E Div OM 19.1.3.3.]

Instruct the guard on duty to assess responsiveness as required and to document the results of the assessment in the prisoner log record book. [NHQ OM 19.3.3.1.1.]

All checks of a prisoner will be recorded in the prisoner log record book. [NHQ OM 19.3.4.4.1]

The entries in the prisoner log record book must be clearly documented such that they can be easily read and understood when reviewed at a later date. [NHQ OM 19.3.4.4.4]

If guards are switching shifts and a member is not present, both guards will conduct physical checks of all prisoners and document observations in the prisoner log record book. If guards are switching shifts and it is practicable for a member to be present, the senior member will conduct physical checks of all prisoners and document observations in the prisoner log record book. [NHQ OM 19.3.4.5.7.]

Record on form C-13-1 and the prisoner log record book [all related medical information]. [NHQ OM 19.3.4.7.1.]

Initial the prisoner log record book during inspections. Take corrective measures necessary to rectify shortcomings. [NHQ OM 19.3.5.2.]

Ensure that quality checks are completed on the original Prisoner Reports and Prisoner Log Record Book for accuracy and completion. [This is the responsibility of the Detachment Commander per E Div OM 19.3.8.1.7.1.]

As part of our own comprehensive detachment debrief/review of the incident, we impressed upon our guard staff the imperative of following all related RCMP directives.

Recommendation 7

To assist the guards doing the physical cell checks, the hall lighting could be reduced or a matte coating on cell door window to reduce the glare from the above lights.

Response:

The detachment has examined the glare issue and concluded that the current lighting is *not* an impediment to the guard's physical checking of prisoners.

Recommendation 9

A committee should be established to discuss the possibility and funding a second guard on duty at all times.

Response:

The cost of a full time second guard is significant and not financially feasible for a community of this size. However to deal with high risk prisoners or events which may yield a larger than normal number of incarcerated persons, the detachment will call in a second guard. This call-in will also occur when the detachment's prisoner count reaches 12 clients at any one time, and the guard will remain until such time as the clients are released and the prisoner count returns to a manageable level.

This is a standard practice for similar sized detachments and has been effectively used at the Terrace Detachment for some time.

Recommendation 10

Investigate upgrading the existing CCTV system to include larger monitors, with the ability to select the video feed to focus on one cell, ability to zoom and pan video feed while maintaining the source feed for the recording, audio mics at each end of the hallways free of background noise.

Response:

The detachment's CCTV system adheres to the Standard Video Surveillance Recordings in Police Buildings policy (Sec. 4.1) of the BC Provincial Policing Standards. In any case, as the Coroner's Jury reiterated in Recommendation 5 (above), the CCTV system is merely a supplementary system to the physical and rousability checks per NHQ OM 19.3.4.5.1 and 2., which are far more effectual.

Recommendation 11

Install a 2 way non-recording intercom system into all cells, other than 1 & 7, for rousability checks, a loud buzzer noise in cell to precede actual 2 way communication for prisoner privacy.

Response:

As above, the detachment's CCTV system adheres to the Standard Video Surveillance Recordings in Police Buildings policy (Sec. 4.1) of the BC Provincial Policing Standards. In any case, the *physical* rousability checks conducted per NHQ OM 19.3.4.5.2. are far more effectual than any CCTV system, even if it had an operating audio system.

Recommendation 12

Ensure that all guards and RCMP members take the existing training as required and investigate increasing some training cycles to ensure retention of information/policies/procedures.

Response:

The detachment will ensure that all guards meet the training standard per NHQ OM 19.3.4.2., and that all related directives are reviewed every six months per NHQ OM 19.3.6.1.4. The detachment has no plan to decrease that interval at this time.

Terrace Detachment is committed to improving its prisoner care, and indeed all of its operations, and the findings of Courts, Inquiries and Inquests contribute significantly to that improvement. Thank you for bringing these recommendations to my attention.

Respectfully,

Insp. Sydney Lecky
Officer in Charge
Terrace Detachment