BRITISH COLUMBIA

Ministry of Justice

VERDICT AT INQUEST

File No.: 2012:0228:0091

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

in the Province of British Columbia, on the following dates May 12-14, 2014

before Isis van Loon, Presiding Coroner,

into the death of BERTRAND Darcy Richard 46 ☒ Male ☐ Female
(Last Name, First Name, Middle Name) (Age)

and the following findings were made:

Date and Time of Death: August 16, 2012 at 18:08

Place of Death: Abbotsford Regional Hospital Abbotsford, BC
(Location) (Municipality/Province)

Medical Cause of Death

(1) Immediate Cause of Death: a) Hypoxic Brain Injury

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Consequence of Hanging

DUE TO OR AS A CONSEQUENCE OF

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

(2) Other Significant Conditions Contributing to Death:

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

The above verdict certified by the Jury on the 14th day of May AD, 2014.

Isis van Loon
Presiding Coroner's Printed Name

Presiding Coroner's Signature

BRITISH COLUMBIA

VERDICT AT INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF DARCY RICHARD BERTRAND

FILE NO.: 2012:0228:0091

BERTRAND	Darcy Richard
Surname	Given Names

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Isis van Loon
Coroner Counsel:	Rodrick MacKenzie
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Correctional Services Canada/Paul Singh & Adam Taylor

The Sheriff took charge of the jury and recorded six exhibits. Sixteen witnesses were duly sworn and testified.

PRESIDING CORONER'S SUMMARY:

The following is a brief summary of the circumstances of the death as presented to the Jury at the Inquest. The summary and my comments respecting the Recommendations are only provided 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.

Mr. Darcy Richard Bertrand was in the custody of Correctional Service Canada (CSC) since 1996. In prison he openly identified as a gay man of aboriginal heritage. At the time of his death in August 2012 he had been applying for a transfer from Mission Institution, a medium security prison, to Kwìkwèxwelhp Healing Village, a minimum security institution which incorporates aboriginal traditions and beliefs. If he had survived he would have been eligible to apply for escorted day passes in October. Mr. Bertrand's family said that he was looking forward to his eventual release and that he had made contact with agencies on the outside in preparation. He did tell his Psychologist that he thought he would die in prison, but the context of this remark was not clear.

Six months before his death Mr. Bertrand filed a complaint against other inmates of his unit. He said that he was being bullied and harassed based on his sexual orientation. The institution accepted that he was being bullied on this basis but since he did not provide specific details he was advised that the complaint would not proceed. Two months before his death he was accused of a serious crime by an inmate in this unit. After investigation no charges were laid. According to two prisoners who knew Mr. Bertrand, the accusation itself may have been part of the harassment, and it in turn led to further harassment. When mediation between Mr. Bertrand and the inmate who was harassing him failed he opted to move to another unit at Mission Institution in July. One inmate, a friend, reported that this made the situation worse. Prison staff was not aware of any harassment issues after the move.

Four days before he hung himself Mr. Bertrand behaved inappropriately and was advised that as a result he would be receiving an institutional charge. He was upset about how the charge would affect his transfer application. After the outburst a staff member expressed concern about Mr. Bertrand's emotional well-being to the institution's Registered Psychiatric Nurse (RPN). The RPN met with him the day before he hung himself. Mr. Bertrand appeared emotional and expressed his distress about the

effect of the charge on his transfer. At the conclusion of the meeting he told the RPN that he was not suicidal and expressed his intention to continue to work towards being transferred.

Around 8:30 a.m. on August 14th Mr. Bertrand spoke with the prison librarian, a contract worker. He initially seemed to be very upset about the charge; by the end of the conversation he appeared to be feeling better. Later, in a brief conversation with his institutional parole officer Mr. Bertrand seemed somewhat upset about the charge and they agreed to talk again in the early afternoon. As well that morning, Mr. Bertrand went for a walk with another inmate and it was apparent that he was distressed. After the walk they agreed to meet again the next day. The charge was officially delivered by a corrections officer around 10:00 a.m. and he again expressed his concerns. They discussed it briefly and then Mr. Bertrand said he was fine. He went into his cell alone at 10:40 a.m. and his door was locked from the outside. During regularly scheduled rounds at 11:20 a.m. a corrections officer discovered him in his cell hanging, partially suspended by a piece of clothing around his neck which was tied to the railing of the upper bunk bed. The item of clothing had apparently been cut and fashioned into a ligature. Prison staff called 911 for assistance and started CPR because Mr. Bertrand was pulseless and unresponsive. Paramedics arrived and continued resuscitation while transporting him to Abbotsford Regional Hospital. By the time Mr. Bertrand arrived his heart had resumed beating; however, he had suffered a severe hypoxic brain injury due to hanging. He died in hospital at 6:08 p.m. on August 16, 2012.

The Royal Canadian Mounted Police (RCMP) investigated. They reviewed video which showed that Mr. Bertrand was alone in his cell and that no one else had access after he was locked in at 10:40 a.m. His cell was examined and a copy of the institutional charge was found on his table. No scissors or other tools were found that could have been used to cut the item of clothing he used to hang himself. Mr. Bertrand did not leave a suicide note. The RCMP concluded that there had been no foul play involved in Mr. Bertrand's death.

Following Mr. Bertrand's death Mission Institution has required all employees – including contract staff such as the prison librarian – to take a one hour online suicide prevention course. As well, all employees must attend a one day classroom based course on suicide prevention. Additionally, Mission Institution now provides practical training in emergencies including suicide, in the form of quarterly scenarios. Finally, all harassment and bullying complaints by inmates are now presented directly to the warden.

JURY RECOMMENDATIONS:

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:

To Correctional Service Canada:

1. Provide increased resources of psychological services for inmates with a particular focus on recruitment and retention of qualified clinicians.

Presiding Coroner's Comments: The Jury heard testimony that at Mission Institution there are over 350 inmates. The daily mental health care of this high needs population is performed by one Clinical Psychologist and one Registered Psychiatric Nurse. Evidence was provided that available resources were insufficient for a population of this size and complexity, and that there was difficulty with recruitment and retention of qualified mental health providers.

2. Review current practices and develop a national strategy to address the issue of bullying and harassment in prisons, with particular reference to sexual orientation and gender identity. Monitor and upgrade this strategy on a regular basis.

Presiding Coroner's Comments: The Jury heard testimony that Mr. Bertrand had been the victim of ongoing harassment and bullying based on his sexual orientation. The Jury stated that available avenues to get help and services could be improved.

3. Suicide is a crime of opportunity. Implement procedures that reduce inmate isolation, eliminate hanging points in cells, unsupervised access to potentially lethal tools and prevent placing one inmate in a double bunk cell.

Presiding Coroner's Comments: Suicide is not literally a crime. The Jury's use of this figure of speech emphasized that Mr. Bertrand had the opportunity and the means to hang himself while he was alone in his cell. The Jury was concerned over the availability of the means to harm himself - access to scissors in order to make the ligature, and a place to attach it in order to hang himself. Furthermore, they stated that he might have changed his mind that day if he had been sharing his cell and thus could have talked to another person.

4. Review current practices to improve the quality of suicide prevention training. All corrections staff should receive mandatory, one-day, in-class suicide prevention training. Monitor and upgrade this strategy on an annual basis.

Presiding Coroner's Comments: The Jury expressed the need not only for mandatory one day classroom based suicide prevention training for all staff, but for the yearly monitoring and upgrading of this training. The Jury heard testimony that a day long classroom based suicide prevention training had just been provided in addition to the previous one hour online training.