C553244

517059

December 9, 2020

Ms. Lisa Lapointe
Chief Coroner
PO Box 9259 Stn Prov Govt
Victoria BC V8W 9J4

Dear Ms. Lapointe:

Thank you for your letter of March 22, 2019, in which you provided Verdict of Inquest concerning the death of David Singh Tucker. Further to my response September 15, 2020, BC Corrections provides the following for the outstanding recommendation from this inquest:

> ***Recommendation 6 – Ensure that improved communication protocols are adhered to, and specific detailed information regarding high risk of suicide clients, from internal and external sources, is documented in the logs and reviewed and updated every shift.***
>
> ***Presiding Coroner Comment: The jury heard evidence that specific details of Mr. Tucker's intent, plan and possession of methadone conveyed to a family member during a telephone call was reported to SPSC but not passed to necessary staff.***

Adult Custody Policy has been drafted and work continues with the Provincial Health Services Authority as they develop parallel relevant policy. The draft policy continues to move through the approval process with Adult Custody Division.

I will provide you with an update on or before February 26, 2021.

Thank you for the opportunity to respond to this recommendation.

Sincerely,

Stephanie Macpherson
Provincial Director

Ministry of Public Safety and Solicitor General
BC Corrections Adult Custody Division
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CORONERS INQUEST
SURREY PRETRIAL SERVICES CENTRE
INMATE DEATH – JULY 25, 2016

JURY RECOMMENDATION	RESPONSE			
	ACTION TAKEN	**ACTION PLANNED**	**TIME FRAME**	**RESP.**
1. Ensure that correctional officers include detailed documentation in the "C log" pertaining to body positions and unusual behaviours of Segregation inmates.	A review of training and policy concluded that detailed descriptions of body positions are not recorded in the CORNET Client Log. Any concerns regarding lack of change in sleeping position, emotional distress or behavioural issues are immediately investigated. Unusual behaviours of all inmates that present a concern during cell checks are responded to immediately and recorded in the CORNET Client Log.		**Completed**	
2. Ensure that correctional officers have the ability to control lighting of individual Segregation cells housing high risk of suicide inmates.	BC Corrections will investigate the ability to control lighting of individuals cells in segregation units, as part of future segregation unit upgrades.		**Complete**	
3. Give consideration to future design of Segregation units whereby lighting, cameras, sprinklers cannot be compromised or defeated by inmates.	BC Corrections will ensure consideration is given in the design of future segregation units is to change utilities such as lighting, cameras and sprinklers to mitigate the ability for inmates to compromise or defeat these systems.		**Complete**	
6. Ensure that improved communication protocols are adhered to, and specific detailed information regarding high risk of suicide clients, from internal and external sources, is documented in the logs and reviewed and updated every shift.		Adult Custody Policy has been drafted and work continues with the Provincial Health Services Authority as they develop parallel relevant policy. The draft policy continues to move through the approval process with Adult Custody Division.	**February 26, 2021**	Provincial Director Provincial Health Services Authority

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7. Require that inmates prescribed methadone be observed for 30 minutes, instead of 20 minutes, after administration.	BC Corrections and PHSA work collaboratively to ensure that best practices are adhere to for methadone distribution. Current evidence-based guidelines recommend 20 minutes of observation to ensure adequate medication absorption to lessen the likelihood of diversion. To further reduce opportunities for diversion, individuals receiving methadone are frisk searched by corrections staff prior to the distribution of methadone for items that may be used to receive and contain regurgitated methadone. Each correctional centre maintain procedures that ensure compliance and consistency of practice with provincial policy regarding the distribution of methadone. A review of Adult Custody Policy will be conducted with PHSA to change the observed time after administration of methadone.			