



C553244

March 3, 2023

Lisa Lapointe
Chief Coroner

Email: Lisa.Lapointe@gov.bc.ca

Dear Lisa 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 previous responses, 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.

BC Corrections has over the past year developed an Intensive Case Plan that is developed for all individuals displaying self harm or suicidal behaviours. This case plan includes involving health care and mental health resources at the onset with direction to document the information. Several other initiatives have been put in place including meaningful human contact, robust mental health training for correctional officers at all levels, and edits to adult custody policy that outlines options for individuals demonstrating self harm and suicidal behaviours. This policy also strengthens the direction to communicate all identified risks and needs with health care staff to better support these individuals. This policy is in its final approval stages and will be aligned with PHSA-CHS health care policy.

Thank you for the opportunity to respond to this recommendation.

Sincerely,

Matt Lang
A/Provincial Director

Protect communities, reduce reoffending

Ministry of
Public Safety and
Solicitor General

BC Corrections
Adult Custody Division

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