BRITISH COLUMBIA

C553244

February 27, 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 at Inquest concerning the death of David Singh Tucker. Further to my response of June 6, 2019, BC Corrections provides the following for the two outstanding recommendations from this inquest:

Recommendation 1 – Ensure that Corrections Officers include detailed documentation in the "C log" pertaining to body positions and unusual behaviors of Segregation inmates.

Presiding Coroner Comment: The jury heard evidence from Corrections Officers that they believed Mr. Tucker was breathing but it wasn't completely clear. Different officers checked Mr. Tucker and concern was raised once they identified that he hadn't changed positions while sleeping. It is not regular practice for Corrections Officers to document sleeping positions which may have triggered a wellness check sooner.

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.

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.

Ministry of Public Safety and Solicitor General

Corrections Branch
Adult Custody Division

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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 Surrey Pretrial Services Centre but not passed to necessary staff.

Work continues with the Provincial Health Services Authority to develop relevant policy. The Adult Custody Division has conducted a full review of suicide and self-harm protocols which includes further consideration of communication regarding key information. Policy for both agencies have been drafted and is in the approval process. The policy is anticipated for completion and implementation by August 30, 2020.

I will provide you with an update on or before August 30, 2020.

Thank you for the opportunity to respond to these recommendations.

Sincerely,

Stephanie Macpherson
Provincial Director

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**	

JURY RECOMMENDATION	RESPONSE			
	ACTION TAKEN	**ACTION PLANNED**	**TIME FRAME**	**RESP.**
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.		Work continues with the Provincial Health Services Authority to develop relevant policy. The Adult Custody Division has conducted a full review of suicide and self-harm protocols which includes further consideration of communication regarding key information. Policy has been drafted and is in the approval process. The policy is anticipated for completion and implementation by August 30, 2020.	**August 30, 2020**	Provincial Director Provincial Health Services Authority
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			

CORONERS INQUEST
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INMATE DEATH – JULY 25, 2016

JURY RECOMMENDATION	RESPONSE			
	ACTION TAKEN	ACTION PLANNED	TIME FRAME	RESP.
	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.			