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CHIEF CORONER

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June 6, 2019

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. In response to the recommendations from this inquest, BC Corrections provides the following:

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.

Current cell check training for new staff includes that the officer checks for any signs of concerns, including blood, unusual skin colour, lack of change in sleeping position, emotional stress or behavioural issues. Any concerns are investigated and reported as per local Standard Operating Procedures. All counts and visual cell checks are logged immediately upon completion in the unit log book. Through the formal correctional centre inspection process, correctional centres are inspected to ensure compliance with cell check protocols.

Recommendation 2 ***– Ensure that Corrections Officers have the ability to control lighting of individual Segregation cells housing high risk of suicide inmates.***

Presiding Coroner Comment: The jury heard evidence that individual cells have lighting on controls within the cell but Corrections Officers only have the option of

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turning lights on for all cells, not individually. Evidence was given indicating a reluctance to turn the lights on at night to check on an inmate because it would disturb the entire pod, not just the inmate being checked on.

BC Corrections has investigated the ability to control lighting of individual cells in segregation units. Future new segregation units will have the ability to individually control cell lighting, and upgrades will be considered during renovation of existing segregation units.

<u>Recommendation 3</u> – Give consideration to future design of Segregation units whereby lighting; cameras; sprinklers cannot be compromised or defeated by inmates.

Presiding Coroner Comment: The jury heard evidence that damage and obstruction of these items is an ongoing issue in Corrections and are a safety issue for both staff and inmates.

Mitigating the opportunity to compromise lighting, cameras and sprinklers is an existing key consideration in the design of segregation units. BC Corrections is committed to continued investigation of future design improvements which mitigate the ability for inmates to compromise or defeat these systems.

<u>Recommendation 6</u> – 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.

Information received from any source, either internal or external, is entered by corrections staff into the Client Log and is accessible to both health and corrections staff to assist with case management. Health care staff regularly collaborate with corrections case management and mental health staff to share information and coordinate interventions.

In collaboration with the Provincial Health Services Authority, the Adult Custody Division is conducting a full review of suicide and self-harm protocols which includes further consideration of communication regarding key information. The review is anticipated to produce policy changes for implementation by the fall of 2019.

<u>Recommendation 7</u> – Require that inmates prescribed methadone be observed for 30 minutes, instead of 20 minutes, after administration.

Presiding Coroner Comment: The jury heard evidence that methadone can be diverted by regurgitation. Testimony was given that inmates are monitored for 20 minutes after administration to ensure absorption.

BC Corrections and the Provincial Health Services Authority work collaboratively to ensure that best practices are adhered 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 maintains procedures that ensure compliance and consistency of practice with provincial policy regarding the distribution of methadone.

Thank you for the opportunity to respond to these recommendations. I will provide you with an update on our progress towards addressing these recommendations by September 30, 2019.

Sincerely,

Stephanie Macpherson
Provincial Director