Provincial Health Services Authority
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May 20, 2019

Lisa Lapointe
Chief Coroner
Office of the Chief Coroner
PO Box 9259
Stn Prov Govt
Victoria, BC V8W 9J4

Dear Ms. Lapointe:

Re: Inquest recommendations arising from the death of Tucker, David Singh
BCCS Case File# 2016-0381-0095

Thank you for your letter dated March 22, 2019, in which you outlined four recommendations for the Provincial Health Services Authority (PHSA) to consider.

Mr. Tucker passed away on July 25, 2016, over one year before PHSA assumed responsibility for delivering health care in BC's correctional facilities on October 1, 2017. Since we assumed responsibility for care, we have made a number of improvements that will reduce the likelihood that an incident such as the one involving Mr. Tucker will occur again.

Below, I've outlined your recommendations and corresponding comments, as well as my responses, which describe actions PHSA has taken.

1. Change the medical administration database to require notations explaining why medications are not given.

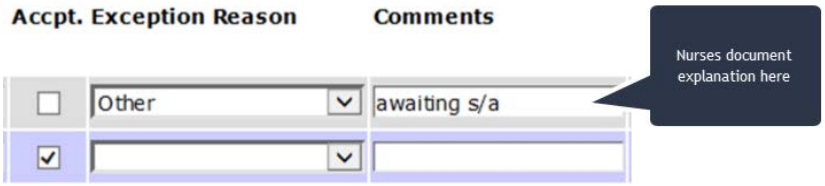
   Presiding coroner comment: The jury heard evidence that the current database only allows "taken" or "refused" as options documenting medication administration. In Mr. Tucker's case, it was documented as "refused" with no explanation in the section for comments. This did not accurately depict what occurred.

   PHSA response: We expect all nursing staff to ensure that the appropriate medication administration information is entered in the electronic medical record by choosing one of the following 15 options from a drop-down menu:

1	At court	6	No show	11	Refused
2	At hospital	7	Non-compliance	12	Released
3	Back data entry	8	Other	13	Security not available
4	Blood work	9	Out on escort	14	Transferred
5	Meds not available	10	PRN not required	15	Meds withheld

When nursing staff select #8 "Other," they are required to provide further explanation.

Figure 1.0



Since PHSA assumed responsibility for care, we have taken a number of steps to ensure nurses appropriately follow this process. Training for new staff includes the appropriate use of the electronic medical record, as well as nurse roles and expectations when administering medication. We also reinforce these processes during orientation and by assigning new staff to "buddy" shifts with more experienced staff.

2. Investigate, by audit or other means, the diversion of methadone and other drugs not being taken by those who are prescribed them.

Presiding coroner comment: The jury heard evidence that diversion of medications is an ongoing concern, which was demonstrated by Mr. Tucker's acquisition of methadone by unknown means while in segregation.

PHSA response: When PHSA assumed responsibility for care, we implemented a medication diversion policy: If health care staff identify a patient who is diverting drugs to others or consuming diverted drugs, the health care professional will educate the patient about the health care consequences up to and including the possibility of death. If health care staff discover that a patient on opioid agonist treatment (OAT) has been diverting prescribed medication, the staff member notifies the attending physician, who may change the treatment plan. This may affect the patient's access to medication.

Correctional Health Services' (CHS) standard operating procedure is to report to BC Corrections when a divertible drug is identified during a urine drug screen and indicate the unit on which the patient resides. BC Corrections can then decide what investigation is required.

Since the investigation, CHS and BC Corrections have discussed further process improvements, and together they will ensure the following:

- All protocols are adhered to.
- Clients are observed and frisked before and after OAT medication delivery.
- Clients present themselves wearing a single layer of clothing.
- The observation period after medication administration is applied consistently.
- The appropriate level of monitoring is applied.
- A corrections supervisor attends morning medication/OAT delivery to enforce the rules.

3. Ensure that improved communications protocols are adhered to, and specific detailed information regarding clients at high risk of suicide, 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, were reported to Surrey Pretrial Services Centre, but not passed on to necessary staff.*

   ***PHSA Response**:*

   We have communicated with BC Corrections' leadership about ensuring that correctional officers record all relevant client information in the client log. Both health care staff and BC Corrections staff review client logs regularly to determine whether clients are showing any concerning behaviours that require further assessment. Clients who are deemed to be at risk of self-harm are seen at least once a day by either the nurse or mental health coordinator – sometimes both. These clients are discussed by the clinical services manager, mental health coordinator and nursing staff during rounds. Relevant information is then shared with the BC Corrections' mental health liaison officer and other corrections staff to enable the development of a joint and comprehensive care plan for the client.

4. Require that an inmate who is prescribed methadone be observed for 30 minutes, instead 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*.

   ***PHSA Response**:* PHSA clinical professionals follow evidence-based guidelines which recommend a 20-minute observation period for medication absorption. This is reflected in our communications with BC Corrections. BC Corrections currently determines the length of the observation period, and may decide to increase it to 30 minutes.

Thank you for the opportunity to respond.

Sincerely,

Carl Roy
President & CEO
Provincial Health Services Authority

cc: Lynn Pelletier, VP, BC Mental Health and Substance Use Services