C560531

September 11, 2020

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

Dear Lisa:

Thank you for your letter of August 4, 2020 in which you provided the Verdict of Inquest concerning the death of John Michael Murphy at Surrey Pretrial Services Centre (SPSC). This inquest resulted in five recommendations. Three recommendations were directed to SPSC, one was directed jointly to BC Corrections and BC Ambulance Service, and one was directed jointly to BC Corrections, Fraser Health Authority and Surrey Memorial Hospital. In response to these recommendations, BC Corrections provides the following:

Recommendations to BC Corrections

Recommendation 1: Reinforce, with additional and ongoing staff training, existing Standard Operating Procedures for Segregation Unit with respect to compliance regarding the safety and security for staff and inmates, specifically with reference to:

(a) Logbook documentation
(b) Visual unit cell checks
(c) Synchronization of video camera time displays
(d) Exchange of critical information between staff during shift changes

Presiding Coroner Comment: *The jury heard testimony and were provided documentary evidence that:*

(a) Entries in the segregation unit logbook were missing or incomplete as per standard operating procedures (e.g. Chapter 1 S.O.P. for Security and Control in Segregation: 1.21.2(3). The cellmate was removed and returned to Cell 209 with no log entry; 1.2.1.1(5) No logbook reference to the Code Blue for this incident was noted.

Ministry of Public Safety and Solicitor General
Corrections Branch Adult Custody Division
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(b) Visual unit checks were not always completed at irregular intervals, not greater that 30 minutes (Exhibit #6) and that the segregation unit was under-staffed at given times which restricted compliance with the standard operating procedures (e.g. one C.O. in the unit).

(c) The time displays for the computerized video surveillance systems were not synchronized (SOP Chapter 1 – Security and Control, Electronic Security and Communication System 1.12).

(d) Correctional officers changing shifts did not recall receiving significant unit information such as visual checks not being completed (Chapter 6: Administration and Regulatory Services, 6.9.1).

BC Corrections Response:

a) Logbook documentation:

SPSC management have reminded supervisory staff of their responsibility for accuracy of logbook entries and ongoing training and coaching of staff. The assistant deputy warden, regulations, conducts log-book checks while on rounds and addresses non-compliant entries with the segregation supervisor.

b) Visual unit cell checks:

A new provincial process is in place whereby the deputy warden, operations, prepares an annual schedule of units/times for visual unit cell checks to be reviewed via DVMS.

The assistant deputy warden, regulations, conducts the review and documents the results for DW review. Non-compliance is addressed with the staff and area supervisor.

c) Synchronization of video camera time displays:

Video cameras are synchronized every three months by the building facilities contractor.

d) Exchange of critical information between staff during shift changes:

SPSC staff were reminded of the requirement to ensure critical information is exchanged verbally, documented on the shift and segregation reports. The operations department has implemented supervisor meetings at 1430 and 1830 to improve information exchange during shift change.

Recommendation 2: Consider an expansion of the current use of the video monitoring system to supplement existing visual unit cell checks. Consider utilizing larger monitors and software that provides automated rotating cell views. Provide staff with training and guidance on the use of any new technology.

Presiding Coroner Comment: *The jury heard evidence that the video surveillance camera views at the monitoring station are limited in size and fixed in number*

when on multiple screen view. They also heard testimony that the monitor displays must be changed manually by a correctional officer.

BC Corrections Response: The segregation staff station had two additional monitors installed since this incident in 2016 to supplement visual unit check requirements. The monitor display includes the medical observation cells. The display does require staff to still manually cycle through the cells which is included in training.

A segregation renovation is planned with a scheduled start of fall 2020, which will reduce the number of cells in segregation from 36 to 31. More cameras will also be added to increase visual monitoring.

Recommendation 3: Consider changing policy to prevent inmates who are involved in the same incident of violence, and are sent to segregation pending a disciplinary hearing, from being placed together in the same cell.

Presiding Coroner Comment: *The jury was provided evidence during this inquest that indicated two inmates involve in the same violent incident in general population were placed together in segregation and a subsequent violent incident occurred between these individuals.*

BC Corrections Response: The Adult Custody Division is reviewing implications of eliminating double bunks in all segregation areas as part of the Segregation Infrastructure Project.

Adult Custody Policy does not support the placement of two inmates in the same cell after an altercation. SPSC Standard Operating Procedures were updated to reflect that inmates involved in the same incident of violence on a living unit are not placed together in a cell.

Recommendation to: BC Corrections and BC Ambulance Service

Recommendation 4: To collaborate to devise a plan to optimize speed of access for responding emergency personnel to all areas to the Surrey Pretrial Services Centre.

Presiding Coroner Comment: *The jury heard testimony from the responding paramedic that the access time to the segregation unit was unusually short on the day of this incident however access normally takes much longer.*

BC Corrections Response: SPSC management consulted with BC Emergency Health Services (representing BC Ambulance) and introduced new procedures in the Standard Operating Procedures to ensure that paramedics are met by a waiting officer and are escorted through the building as expeditiously as possible via the most direct route. Also included is that all other movement will be halted while the paramedics are moving through the building.

Recommendation to: BC Corrections, Fraser Health Authority, and Surrey Memorial Hospital

Recommendation 5: Collaborate to develop a mutually acceptable protocol for the handling and security of inmates in a hospital environment.

Presiding Coroner Comment: *The jury heard evidence that there was conflict between medical and corrections staff with respect to security of the inmate/patient and the family's ability to visit with the inmate/patient in a non-secure environment.*

BC Corrections Response: Adult Custody Policy has been updated to direct all staff to share next-of-kin information with offsite medical professionals when death of an individual is imminent.

SPSC management consulted with Fraser Health Authority (representing Surrey Memorial Hospital) and introduced new procedures in their Standard Operating Procedures to establish rules to expedite the processing of requests from incarcerated individuals to have immediate family/next-of-kin visit in hospital when the death of the individual is imminent.

Thank you for the opportunity to respond to these recommendations.

Sincerely,

Stephanie Macpherson
Provincial Director