ALBERTA

Report to the Minister of Justice and Solicitor General Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the The Provincial Court of Alberta

in the City (City, Town or Village) of Red Deer (Name of City, Town, Village), in the Province of Alberta,

on the fourteenth day of June, 2021 (year), (and by adjournment

on the ______ day of ______, ______ (year)),

before James A. Glass, a Provincial Court Judge,

into the death of William Aage Wilkie (Name in Full) 46 (Age)

of 5107 40 Street, Innisfail, AB (Residence) and the following findings were made:

Date and Time of Death: April 22, 2017 at 7:15 p.m.

Place: Red Deer Remand Centre

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *The Fatality Inquiries Act*, Section 1(d)).

Asphyxia by Hanging

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *The Fatality Inquiries Act*, Section 1(h)).

Suicidal

Circumstances under which Death occurred:

See attached report.

Recommendations for the prevention of similar deaths:

See attached report.

DATED July ~~28~~ 30, 2021,

at Red Deer, Alberta.

Original Signed

James A. Glass
A Judge of the Provincial Court of Alberta

WILLIAM AAGE WILKIE
FATALITY INQUIRY CIRCUMSTANCES AND RECOMMENDATIONS

Circumstances under which Death occurred:

[1] On April 22, 2017, William Aage Wilkie, aged 46 years, died of asphyxia by hanging while incarcerated at the Red Deer Remand Centre. Mr. Wilkie occupied cell #70 on the east wing of the Remand Centre and did not have any roommates. Mr. Wilkie indicated to the intake nurse that he was not actively suicidal upon his admission. Personnel at the Remand Centre did not notice any significant change in his behavior or mental state that would have raised concern regarding any suicidal ideations on his behalf. Remand records indicate that Mr. Wilkie was prescribed to receive depression medication daily and that he had missed or was late to receive his medication on a number of occasions. Mr. Wilkie requested and met with the psychologist who was on staff at the Remand Centre and he did not have any concerns regarding Mr. Wilkie's presentation, at least as it related to suicidal ideation. Mr. Wilkie had been placed on a suicide watch and had other mental health alerts on previous admissions to the Remand Centre, however this information was not readily available to Remand Centre personnel. Mr. Wilkie tore some of his bedding to form a ligature that he was able to secure between the cell door and frame. Mr. Wilkie did leave a suicide note. After resuscitation efforts, Mr. Wilkie was pronounced dead at the Remand Centre.

Circumstances:

[2] Mr. Wilkie was admitted to the Remand Centre on March 18, 2017 as a result of numerous outstanding criminal charges. He was remanded in custody until his next court appearance on May 5, 2017 at the Provincial Court in Ponoka. As a result of Mr. Wilkie's death, a Board of Investigation was convened in April 2017. The Board found that at the time of Mr. Wilkie's admittance to the Remand Centre he denied any active suicidal ideation, but did advise that he suffered from depression. The Board found that there were no recorded concerns by staff of concerns regarding suicidal ideations by Mr. Wilkie and that he specifically denied having any such thoughts when he met with the Remand Centre's psychologist on April 12, 2017. The Board also found that there was information on Mr. Wilkie's archived file concerning suicide, however, neither the archived file nor the ORCA system was accessed by staff, including the psychologist. The psychologist testified that he does not have access to the ORCA system.

[3] Mr. Wilkie's archived file revealed the following mental health concerns:

- July 31, 2013 – actively suicidal at the Remand Centre;
- April 7, 2015 – CSC Notification to Detention Centre form indicating past or current mental health concerns;
- May 11, 2015 – CSC Receipt of Inmate form – Flag-suicide/self-injury history – Needs – mental health concerns;
- June 25, 2015 – Unit 11;
- December 31, 2015 – CSC Receipt of Inmate form – Unit 31, suicide/self-injury history;

- August 23, 2016 – actively suicidal at the Remand Centre;
    - CSC Notification to Detention Centre form – indicating past or current evidence of suicide concerns;
    - CSC Standard Profile form – indicating suicide history;
- September 16, 2016 – CSC Receipt of Inmate form – Unit 31, Suicide self-injury history;
- March 24, 2017 – Mr. Wilkie submitted a Request for Interview form at the Remand Centre indicating "I need help" and "help me" recognizing his drug use and criminal behavior. The response provided directed him to complete a residential treatment application;
- April 17, 2017 – Mr. Wilkie applied for residential treatment at the Remand Centre where he indicates "...the depression is borderline suicidal" and that he has "fleeting" thoughts of suicide or self-harm. It is unclear what was done with this form or whether it was reviewed by staff at the Remand Centre.

[4] While it is unclear what impact this information may have had in respect to dealing with Mr. Wilkie at his latest period of incarceration, the psychologist advised the Board that he would have found it to be important. In addition, Ms. Poshtar who testified on behalf of AHS at the Fatality Inquiry when presented with some of this information indicated that "I think it is fair to say that there would have been at a minimum another assessment of this patient."

[5] Mr. Wilkie did not take his medication nine times between March 18, 2017 and April 22, 2017. This prompted an informal referral to the psychologist by the Remand Centre's Nurse. The psychologist met with Mr. Wilkie on April 12, 2017 and noted that Mr. Wilkie displayed flat affect, slowed psychomotor behavior, teariness, poor hygiene and an unkempt appearance. Following this meeting, the psychologist did not see a need to place any mental health alerts on Mr. Wilkie's file. Corrections officers and health care staff did not note any other concerns with respect to Mr. Wilkie and noted that he was a quiet and well-mannered inmate.

[6] A unit round and formal count was conducted on the unit that Mr. Wilkie was housed on at 5:57 pm on April 22, 2017 and he was observed alive in his cell. The next hourly check was conducted at 6:57 pm and it was at that time that Mr. Wilkie was seen to be in distress. These rounds and checks were done in compliance with security and prisoner protocols at the Remand Centre. Upon noticing Mr. Wilkie's distress, the officer immediately called an emergency medical code 99. Other inmates were locked into their cells and the officer was able to gain access to Mr. Wilkie's cell. The emergency response team attended shortly thereafter and all medical efforts were undertaken to revive Mr. Wilkie. Unfortunately, these efforts were not successful and a medical doctor declared Mr. Wilkie deceased at 7:15 pm.

[7] At the Fatality Inquiry, the correctional officers testified that they do not receive much in the way of ongoing training for assessment of and prevention of suicides, apart from that received in their initial training. Inmates status are reviewed at shift changes including any mental health concerns. None were noted for Mr. Wilkie.

[8] The ORCA system does not contain readily accessible alerts about prior mental health concerns for inmates. If an inmate's mental health concerns were not currently active or of concern, an officer would have to read through notes on the inmates file to find any indications

of previous concerns. This could take hours and would be difficult to fit into all of their other duties while on shift.

[9] There were concerns about the cell that Mr. Wilkie was occupying and obstructed sight lines for officers to that cell. It was well documented that there are certain cells within the Remand Centre that have obstructed sightlines given the very nature of the construction and layout of the building. Cameras alleviate some of these sightline concerns but not completely. The use and placement of cameras has to be balanced with the inmates right of privacy and safety within the Remand Centre. The Remand Centre is slated to receive 127 new cameras this year that will provide enhanced views for correctional officers.

[10] The Medical Examiners reports are found at Tabs 2- 6 of Exhibit 1. The report confirms that Mr. Wilkie died from asphyxiation by hanging. The toxicology report concluded that there was evidence of citalopram in Mr. Wilkie's blood which is consistent with his use of same for his depression.

[11] This Fatality Inquiry was conducted in one day. There were 4 witnesses and one binder of Exhibits, including the Certificate of the Medical examiner and the Autopsy Report.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS:

[12] This report under the *Fatality Inquiries Act* contains findings of facts relating to the identity of the deceased; the date, time and place of death; the circumstances under which death occurred; the cause of death; and the manner of death. The *Fatality Inquiries Act* specifically provides that the findings of the judge in the Inquiry shall not contain any findings of legal responsibility or any conclusions of law. The Report, however, may contain recommendations for the prevention of similar deaths. As a result of the evidence received and reviewed by me at the Inquiry, I make the following recommendations:

1. All staff, correctional and health care, should be required to document recurring absences from the medication line, changes in the demeanor and presentation of inmates in the ORCA system.
2. All staff should be briefed on any remarkable changes in the presentation of inmates at all shift changes and document those briefings in the ORCA system or readily accessible note book at the guard station.
3. All correctional staff, including AHS staff, should be required to complete annual training sessions that specifically address inmate suicide signs and suicide prevention techniques.
4. AHS should develop a checklist for new admissions to a correctional facility to include specific reference to determining whether an inmate had prior admissions on ORCA and when readily available, to review patient records from the prior admission.
5. The ORCA system be revised to indicate on an inmate's opening screen whether there had been prior mental health or suicidal concerns, watches or attempts. These warnings should not be subject to expiry and removed from the screen, rather an indication that they are either active or inactive be noted.

6. Any inmate files that are stored offsite be provided as quickly as possible when the inmates mental health is noted by staff as a concern or there are prior mental health or suicide alerts noted on the ORCA system.
7. Corrections and AHS management review and update their file management practices at the Remand Centre, specifically with respect to file archiving/merging and patient notations to ensure that staff at the facility is fully aware of inmate backgrounds. This would include information received from third parties such as Corrections Services Canada (CSC).
8. Corrections and AHS management review and make clear to staff at the Remand Centre who has the responsibility for uploading and updating AHS information into the ORCA system. In addition, all Health Care team members should have access to ORCA.
9. Corrections and AHS staff should be educated annually as to the type of medical information that can be shared and disclosed in regards to an inmate. These guidelines must be followed by all corrections and AHS staff.

CONCLUSION

[13] It is acknowledged that even with the above recommendations in place, Mr. Wilkie's death may not have been prevented.

Dated July 30, 2021,

at Red Deer, Alberta.

Original Signed

James A. Glass

A Judge of the Provincial Court of Alberta