



**Report to the Minister of Justice  
and Attorney General  
Public Fatality Inquiry**

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Edmonton Law Courts  
in the City of Edmonton, in the Province of Alberta,  
(City, Town or Village) (Name of City, Town, Village)  
on the 24th day of April, 2006, (and by adjournment  
year  
on the 25th day of April, 2006),  
year  
before James K. Wheatley, a Provincial Court Judge,  
into the death of Christopher Robert Lapatak 31  
(Name in Full) (Age)  
of Edmonton, Alberta and the following findings were made:  
(Residence)

**Date and Time of Death:** November 12, 2004 at 7:50 A.M.

**Place:** Edmonton, Alberta

**Medical Cause of Death:**

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 Inquires Act, Section 1(d)).

Acute Heroin Toxicity

**Manner of Death:**

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

Undeterminable

**Circumstances under which Death occurred:**

The deceased Lapatak was an inmate at the Edmonton Remand Center at the time of his death. On the date of his death, the deceased Lapatak played cards with his cell mate until 2:30 a.m. When the cell mate awoke for breakfast at approximately 7:50 a.m., he attempted to get the deceased's attention and noticed no response and a pile of vomit beside his mouth. The cell mate alerted officials, emergency response teams were immediately called, to no avail and Mr. Lapatak was pronounced dead.

As a result of toxicology reports and the autopsy report it was determined that the cause of death was acute heroin toxicity.

Extensive in house investigations were undertaken by the Remand Center, and of their policies and despite rumors no determination was made as to how the inmate came into possession of the drugs required to cause this overdose.

Policies of the Remand Center require body counts and live body counts to be undertaken between midnight and 6:00 a.m. Despite these policies there is an uncertainty as to the precise time of death due to methodology of taking of live body counts.

**Recommendations for the prevention of similar deaths:**

1. Constant review and re-evaluation of security measures aimed at insuring that drugs do not make their way into the Edmonton Remand Center.
2. Increased level of training of guards and monitoring guard's procedures at the Edmonton Remand Centre.

(The inquiry determined that upon being hired potential guards receive a four day training program, and upon completion of that program there are a number of tests. Thereafter, they complete five shadow shifts where they shadow an existing guard and thereafter are assigned to duties in the Remand Centre. Initially they are not assigned to high profile areas but it is unclear as to what procedure is used to determine when an assignment to a higher profile area would be determined. As well it would appear that there exists a four week program that Correctional Officers or Guards are circulated through at the Alberta Solicitor General College and an attempt is made to get them into that four week program within the first year of their employment. It would appear at this point that this rarely happens and it is almost universally at least 18 months until that four week program of training is available due to staff shortages and availability of the program.)

3. It is recommended that guards at the Remand Centre complete more extensive formal training prior to taking up their duties.
4. Guards and the staff at the Remand Center are made very aware as to an appropriate procedure for determining a live body.

(The inquiry heard evidence that the requirement to do live body counts was perhaps abbreviated and "live" wasn't really determined due to complaints of defence counsel or inmates being disturbed from their sleep. Guards or Correctional Officers must, if their procedures require a live body, in fact confirm "live" as in physically breathing and adherence to that policy must be enforced by a monitoring and formal signoff on retained record and confirmation of obtaining a live result.)

DATED \_\_\_\_\_,

at \_\_\_\_\_, Alberta.

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James K. Wheatley  
A Judge of the Provincial Court of Alberta