CANADA
Province of Alberta

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Edmonton Court House

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

on the 22 day of November, 2010 (year)

before The Honourable Judge E.J.M. Walter, a Provincial Court Judge,

into the death of Joseph Douglas Bellerose (Name in Full) 35 (Age)

of Edmonton (Residence) and the following findings were made:

Date and Time of Death: April 4, 2008 at 2306 hours

Place: Edmonton Institution, Edmonton, Alberta

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)).

Acute Desipramine Toxicity

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)).

Undeterminable

Circumstances under which Death occurred:

Introduction

On April 4, 2008, Joseph Douglas Bellerose ("Bellerose") died at the Edmonton Institution ("the Institution") as a result of Acute Desipramine Toxicity. The manner of death is undetermined.

The public fatality inquiry into this incident took place on November 22, 2010.

Brief Review of Bellerose's History at the Institution

On July 25, 2007, Bellerose was transferred to the Institution from the Regional Psychiatric Centre (RPC) in Saskatchewan. When discharged from RPC, Bellerose had been diagnosed with a variety of mental health issues including Psychotic Disorder, Attention Deficit Hyperactive Disorder (ADHD), Conduct Disorder, Borderline Personality Disorder, and Anti-social Personality Disorder. Bellerose also had a borderline IQ, a history of substance abuse, and suffered a head injury in a traffic accident in 2003. Bellerose had reported previous suicide attempts.

When Bellerose was admitted to the Institution he was assessed by the Psychology Department at the Institution. It was concluded that Bellerose was mentally unstable, but was not a suicide risk. As a result of the concerns regarding Bellerose's mental health, he was to be placed in the Structured Living Environment (SLE). The SLE is a unit at the Institution that houses inmates with mental health concerns and who require significant intervention. Although Bellerose was to be housed in the SLE, he initially spent a few days in the segregation unit until space became available in the SLE.

Bellerose was returned to the segregation unit in January 2008 for thirteen days. He was placed in segregation due to his non-compliance with taking his medications, which resulted in Bellerose having auditory hallucinations telling him to harm others. Once he was discharged from the segregation unit, Bellerose retuned to the SLE. On February 1, 2008, Bellerose was again deemed to be a risk to the Institution and was returned to the segregation unit. The risk resulted from allegations that Bellerose planned to take a nurse hostage. It was determined that he could no longer be safely managed on his cell block and was to be segregated pending review. He remained in segregation until the time of his death.

Due to the isolation experienced by inmates while in segregation, the Institution has a policy regarding the treatment of inmates in this unit. The institutional policy provides that a senior staff member must visit the segregation unit once per day; this is usually the correctional manager. The warden of the Institution also visits the unit once per week for a walk through the unit. Additionally, a member of the nursing staff visits the unit three times per day to provide medication. The policy further provides that the inmate is to be seen by a psychologist within twenty five days of being placed in segregation and at least once every sixty days thereafter.

The policy also demands that the inmate's placement in segregation be reviewed. The Segregation Review Board must hold a hearing within five working days of an inmate's confinement to segregation and must continue to hold hearings every thirty days thereafter. The information reviewed at the hearings would include details such as the inmate's mental health status and why the offender was originally segregated. The offender is always invited to be part of this process.

It appears that this policy was adhered to during Bellerose's last period of segregation. Bellerose attended his segregation reviews, which took place on February 8, 2008, February 27, 2008 and

March 25, 2008. It was determined that Bellerose remained appropriately placed in the segregation unit. Bellerose had not seen a psychiatrist since January 2008. Bellerose had a scheduled appointment on March 12, 2008, but refused to attend. The Manager Assessment and Intervention, Maria Popiwchak ("Popiwchak") and a psychiatrist, Dr. John Brooks, advised that meeting with the psychiatrist is voluntary and the inmates can refuse. However, the policy standards were met as Bellerose saw a psychologist on February 19, 2008 and last saw a psychologist on March 19, 2008. On March 19, 2008 the psychologist determined that Bellerose was not suicidal.

Although the policy standards were met, at the last segregation review Bellerose requested a change in medication. Notwithstanding this request, there was no psychiatric or psychological referral made. Popiwchak advised that, despite this error, Bellerose had a daily opportunity to speak to a nurse regarding his medication.

Medication

When Bellerose arrived at the Institution he was initially prescribed the same medications that he had been prescribed at RPC. His medications were adjusted as necessary while at the Institution.

Transfer to RPC

While at the Institution, a transfer request, which was supported by both the Psychology Department and Bellerose, was sent to RPC. RPC denied this request on March 26, 2008. The transfer request was denied as Bellerose was found to be incompatible with another inmate housed in the unit where Bellerose was to be placed. On April 1, 2008, Bellerose was informed that his transfer was denied. There is no record of how Bellerose responded to this information.

The Incident on April 4, 2008

On April 4, 2008, Margaret Kirsten Engelbert ("Engelbert"), a Registered Nurse, was responsible for administering medication to Bellerose at 5 p.m. Engelbert did not have an independent recollection of Bellerose at the time of this inquiry. Her report dated April 10, 2009 indicated that she observed Bellerose to be oriented, polite, cooperative and appeared to take his pills normally. The report further indicated that Bellerose was given an envelope containing medication to be taken at 11 p.m. The interaction between Engelbert and Bellerose was the last documented interaction Bellerose had with the staff at the Institution.

Engelbert advised that, with the exception of evening medications, the inmates were only given one dose at a time and the nurses would do their best to watch the inmates take the medication. Engelbert testified that if she became suspicious that an inmate was not taking his medication (i.e. if inmate appeared to be hiding medication in his cheek), she would ask the inmate to see inside their mouth or hands. If this happened Engelbert would make a note of it as the physician would have to be notified. Inmates were not observed when taking their evening medications. The evening medications were provided to the inmates in labeled envelopes. Each envelope contained one dose to be taken that evening. Engelbert testified that the only way a nurse would know if an inmate was not taking this medication was if the inmate disclosed it to a nurse.

At approximately 6 p.m., Bellerose was released from his cell to shower. While walking to the shower he spoke briefly with another inmate, who was locked in a cell. Following Bellerose's death, the inmate reported that Bellerose complained about a sore stomach and constipation. The inmate also advised that Bellerose did not want to tell the nurse. Aside from this complaint, which was not yet disclosed to the staff at the Institution, there was no indication at this time that Bellerose was in an abnormal condition.

At 9:00 p.m. Rory Munro ("Munro"), a correctional officer at the Institution, delivered the inmate mail while conducting the hourly watch. He did not recall if he interacted with Bellerose, but did not recall anything being "remiss". Munro indicated that if something was out of the ordinary he would have made a note of it.

At 10 p.m. there was a formal count of the inmates. This was done by Munro and his partner D. Quann. When they arrived at Bellerose's cell, he appeared to be sleeping in an awkward position. The officers attempted to get a response from Bellerose by knocking on the cell door and calling out to him. When there was no response the correctional officers determined that they needed to enter the cell. Quann went to notify the correctional officer in charge of the unit, Kimberly Muller ("Muller"). Muller relayed this information to Carmen Olson ("Olson"), the Correctional Manager. Muller and Quann immediately returned to the cell.

There is an institutional policy that prevents correctional officers from entering cells alone, so Munro waited for Quann and Muller to return before entering the cell. When they entered Bellerose's cell, Bellerose had no pulse and was not breathing. Cardiopulmonary resuscitation (CPR) was started. Munro preformed the artificial respiration, while Quann preformed the compressions. Muller, appreciating the gravity of the situation, called for an ambulance.
Upon being informed via telephone that there was an unresponsive inmate in the segregation unit, but prior to attending at Bellerose's cell, Olson contacted the main gate. Olson instructed them to advise the incoming Correctional Manager to report immediately to the segregation unit and to hold back staff in case additional staff was required. Olson then took an Automated External Defibrillator (AED) to Bellerose's cell. When she arrived Munro and Quann were properly performing CPR. Olson proceeded to use the AED on Bellerose. They continued to use the AED, perform CPR, and assist EMS as necessary until they were instructed by EMS to stop.

Bill Rawlings ("Rawlings") was one of the EMS members who responded. Upon their arrival, Rawlings and his partner moved Bellerose into a hallway and began treating for cardiac arrest. The treatment included tasks such as intubation, inserting an IV, and heart monitoring. These additional efforts were unsuccessful at resuscitating Bellerose. The treatment for cardiac arrest continued for approximately 25 minutes before a physician at the Royal Alexandra Hospital was contacted. The physician instructed the EMS team to stop treatment. Bellerose was pronounced deceased at 11:06 p.m.

Following this incident, the Institution staff did not immediately search the cell as this was not part of their procedure. The cell would generally be locked at this stage, although Olson does not recall if she did this. While the cell was not searched at this time, Muller observed approximately seven or eight medication envelopes while she was in the cell. Muller advised that inmates occasionally kept the medication envelopes to store other items in afterwards. She did not observe whether they were empty or full. The General Occurrence Report prepared by the Edmonton Police Service (EPS) indicated that a search of Bellerose's cell was conducted. EPS did not find anything out of the ordinary in the cell and determined that nothing in the cell contributed to Bellerose's death. On April 5, 2008, the Institution staff did a search and found three empty medication envelopes.

Toxicology Report

Graham Jones ("Jones") is, and was on April 4, 2008, the Chief Toxicologist for the Office of the Medical Examiner, Alberta. At this inquiry he was qualified as an expert capable of providing evidence regarding drugs, their interactions with each other and their effects on humans.

The toxicology testing of Bellerose was completed under Jones' direction. His analysis of the test results led him to conclude that the desipramine found in Bellerose reached a potentially toxic level. Since the amount of desipramine exceeded what would be expected following therapeutic

usage and that there was no indication that Bellerose consumed more than he should have, Jones considered the other drugs that Bellerose had been taking. Jones considered whether the use of those drugs could have accounted for the increased levels of desipramine. At least two of the other medications taken by Bellerose could have impaired the metabolism or the expulsion of the desipramine from Bellerose's body, leading to the potentially fatal concentration. In particular, Jones referred to chlorpromazine and methotrimeprazine, which are known to interact with tricyclic antidepressants such as desipramine. While the interaction of these drugs is known, Jones was clear that he was not criticizing the physician who prescribed them. The interaction varies from person to person and this could not have been predicted. Jones also advised that, while these results could have been the result of taking the drugs as prescribed, the toxic level of desipramine could have also been reached by Bellerose saving a number of doses and taking them all at once.

Recommendations for the prevention of similar deaths:

Following the death of Bellerose there was an Executive Committee meeting of the National Board of Investigation regarding any corrective measures that should be taken. The corrective measures outlined in the Committee's report will likely improve the operation of and safety in the Edmonton Institution. However, the evidence does not disclose that any of the deficiencies acknowledged by the National Board of Investigation could have prevented the death of Bellerose. While the death of Joseph Bellerose is undoubtedly tragic, after hearing all of the evidence no recommendations are necessary in the circumstances.

DATED _____,

at Edmonton, Alberta.

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The Honourable Judge E.J.M. Walter
A Judge of the Provincial Court of Alberta