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 Law Courts Building

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

on the 20 and 21st days of July, 2010 (year), (and by adjournment

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

before T.J. Matchett, a Provincial Court Judge,

into the death of Trevor Jeffrey McKort (Name in Full) 37 (Age)

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

Date and Time of Death: August 1, 2008 at 12:12 p.m.

Place: Edmonton 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)).

acute morphine toxicity (i.e. an overdose of morphine)

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)).

Unclassifiable

Circumstances under which Death occurred:

Please see Attached CIRCUMSTANCES

Recommendations for the prevention of similar deaths:

Please see Attached RECOMMENDATIONS

DATED January 28, 2011 ,

at Edmonton , Alberta.

"Original signed by"
T.J. Matchett
A Judge of the Provincial Court of Alberta

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED:

1) On August 1, 2008, Trevor Jeffrey McKort (McKort) was a 37 year old Remand inmate on the segregation unit 5D at the Edmonton Remand Centre (ERC). Unit 5D consists of 12 separate cells. McKort was the sole occupant of cell #5.

2) McKort was admitted to ERC on January 11, 2008, having been remanded on several charges, including serious motor vehicle offences, obstructing a peace officer and escaping lawful custody. At the time of his admission to the facility, he had an extensive criminal record dating back to 1989 and had served time in federal institutions.

3) For much of the period between January 11, 2008 and his death on August 1, 2008, McKort was confined in the segregation unit, Unit 5D, because of his involvement with drugs within the institution and also because of his assaultive and aggressive behaviour towards staff.

4) On February 12, 2008, McKort was designated a "high profile" inmate because of his attempt to assault a corrections officer who had entered his cell to interview him. The high profile designation resulted in McKort being placed on administrative segregation in unit 5D where there are fewer cells than in other units and where prisoners are locked up 23 hours a day and only permitted out of their cell twice a day for half hour exercise periods. Designating McKort high profile also resulted in increased security precautions being taken by staff whenever he was being escorted either within or outside of the ERC.

5) Over the ensuing months, McKort was involved in several incidents where he caused damage to his cell and was found to be in possession of or using non-prescribed drugs.

6) On May 15th Remand Centre staff discovered that a window to McKort's cell had been compromised. Subsequent investigation revealed that the window had been removed and that tobacco, marijuana, alcohol and lighters had been raised from the ground level by a string.

7) On May 23rd, McKort was observed passing what was later determined to be marijuana from his cell to an inmate in another cell. While being escorted from his cell to be strip searched, he became defiant and aggressive which resulted in him having to be restrained. He advised the correctional officers involved that they would never find all of his contraband. As a result of this incident, on May 28th, McKort was sentenced to 14 days disciplinary segregation. On the same date, a urinalysis sample taken from him tested positive for opiates and cannabenoids.

8) As a result, McKort was "dry celled" which means he was placed in a cell without running water until he passed the solid waste in his system. Marijuana was later found in his stool.

9) It is clear from the psychological reports prepared by ERC psychologist and filed at the inquiry, that McKort's emotional state fluctuated over time while in the institution. He was at times quite calm and cooperative while at other times he was very agitated. When Theresa Vandomselaar, a psychologist at ERC, met with McKort on February 29, 2008, he indicated that he was close to a mental breakdown, having been in jail much of the last 20 years, almost 4 of which he had spent in segregation. He claimed to be experiencing rapid mood shifts and while admitting that he had fleeting thoughts of self-harm, he denied having any intent on acting on these thoughts. Ms. Vandomselaar concluded that McKort was not an immediate risk to harm himself and he was referred to a psychiatrist for follow up.

10) Ms. Vandomselaar testified that she saw McKort regularly throughout his time at the ERC including on the day of his death, but that February 29th was the only time that he appeared upset or spoke of suicide. The psychological reports prepared after February 29th indicate that McKort was not depressed or suffering from any thought disorder or mental illness. He had, however, been prescribed Neuron, which is a sedative, and had on one occasion been caught by a nurse "cheeking" his medication. Cheeking refers to an inmate placing the pill under the tongue or the upper lip, not swallowing it and saving it for use later or for sale within the institution.

11) At no time during her interactions with McKort between February and August 2008 did Ms. Vandomselaar ever come to the opinion that he was suicidal. She did conclude that he was drug-seeking and often asked for sedative or sleeping medication. Throughout the month of July 2008, McKort was receiving a daily prescription of Surmonotil, a sedative and antidepressant.

12) In terms of the events immediately preceding McKort's death on August 1, 2008, 5 witnesses gave evidence: William Peeke, Guillaume Petit and Brian Harrison, (correctional peace officers on duty that day); Theresa Vandomselaar (the psychiatrist on duty) and Helen Thompson (a registered nurse working at ERC who responded to the Code 99 emergency call).

13) William Peeke, a level 2 Correctional Peace Officer (CPO) at ERC was assigned to units 5C and 5D on August 1, 2008. Unit 5C is a mental health unit, while 5D is a segregation unit where inmates confined to administrative or disciplinary segregation are held. McKort was in Cell No. 5 on Unit 5D. Officer Peeke described inmate McKort as volatile and unpredictable, aggressive one moment and passive the next. On August 1, 2008, CPO Peeke worked the day shift from 7:00 a.m. to 3:00 p.m. He first saw McKort that day just after 7:00 a.m. when he came out of his cell for exercise. He served a meal to McKort through a portal in his cell door at approximately 7:35 a.m. and observed that he appeared normal and that he ate some of the food from the tray. He does not recall any conversation with McKort at that time.

14) CPO Peeke did not see McKort again until 11:55 a.m. when he began delivering lunch to the cells in 5D with the assistance of another inmate on the unit. The inmate called out twice for McKort, advising that his meal was there but received no response from the cell. CPO Peeke looked through the cell portal and yelled "McKort" a few times but received no response. Inmate McKort was lying on top of his bed on his back with a blanket pulled up over his face, a position he often assumed during the day so that he could black out the light and sleep. Because Peeke could not tell whether McKort was breathing or not, he locked up the prisoner who was assisting him and entered McKort's cell. He shook him by the left foot but received no response. CPO Peeke thereafter pulled the covers down and found that McKort was very ashen, his eyes were closed and there was no movement whatsoever. Given his many years experience as a police officer, CPO Peeke concluded that McKort was dead. He immediately called in a Code 99 medical emergency and within a minute four members of the ERC nursing team were on scene along with two ERC First Aid responders.

15) The Code 99 team assessed McKort to be unresponsive to pain stimuli, his eyes were unresponsive to light stimuli, he was blue in color and he was not breathing. The team initiated CPR and made a call at approximately 12:00 p.m. for Emergency Medical Services (EMS) to respond. They continued CPR until EMS arrived approximately 10 minutes later. After assessing Mr. McKort, EMS pronounced him dead at 12:12 p.m.

16) CPO Petit, also a Level 2 CPO, was working the day shift at ERC, specifically assigned to Unit 5D. He conducted a "formal count" of all the prisoners on 5D at 6:58 a.m. and recorded it in the unit logbook. By reference to a video log of Unit 5D on August 1, 2008, he recalled Mr. McKort coming out of his cell at 7:10 a.m. and making several phone calls. McKort did not appear to be under the influence of any drugs at that point and returned to his cell at 7:19 a.m.

17) The policy at ERC requires that CPOs conduct "informal" rounds of each cell on an hourly basis during the day shift. CPO Petit admitted that, while he recorded a 9:00 a.m. round in the logbook, the video camera on the unit confirmed that he had not actually checked Cell No. 5, the cell occupied by McKort, or 6 of the other cells. His explanation for this oversight was that his attention must have been drawn elsewhere.

18) At 11:01 a.m. CPO Petit did another formal count as a "formal" count requires CPOs to look for signs of life from each inmate, he recalled looking into McKort's cell and seeing his chest rising and falling under the blankets.

19) CPO Petit admitted that some of the security checks he was required to do on August 1st had not been done even though records he completed indicated that they had been completed. ERC policy requires that on a daily basis, all cells are searched to ensure that physical plant (i.e. doors, windows, fixtures, etc.) are intact. Results are to be recorded in the Daily Occurrence Log. The log for August 1, 2008 contains no entry indicating such a search was conducted. However, a Weekly Unit Security Inspection Record filled out by CPO Petit indicated that a security search had in fact been conducted on Unit 5D on August 1, 2008.

20) ERC policy also requires that on each day, some of the offenders on each unit are targeted for a personal search of their cells and their person for contraband (drugs, weapons or other prohibited items). These searches are to be documented on a Monthly Offender Search Record filled out by unit CPOs. CPO Petit admitted that he recorded on this document that two Unit 5D inmates had been searched when in fact that had not occurred. He explained this as having recorded something he intended to do but had not been able to complete on that date.

21) The significance of these sloppy practices will be discussed later in the report in dealing with the issue of illicit drugs within the ERC and the response of management in addressing the issue. I will simply note at this point that CPO Petit was disciplined for his neglect of duty by the Correctional Services Division.

22) Brian Harrison, was the Acting level 3 Correctional Officer on Unit 5D on August 1, 2008 responsible for Units 5A, B, C and D. At 9:14 a.m. he joined the staff psychologist, Ms. Vandomselaar, during her rounds of the unit and observed her have some interaction with McKort in Cell No. 5 even though he did not look into the cell or recall seeing him at that time.

23) Theresa Vandomselaar testified that she saw inmate McKort at approximately 9:20 a.m. while on her daily psychology rounds. She asked him if he was okay and he responded by moving the blanket down from over his eyes, nodding, and returning the blanket over his eyes. She indicated that this was typical behaviour for him.

24) Dr. Bernard Bannach, a forensic pathologist, provided evidence at the inquiry as to the cause and manner of death of the deceased, Mr. McKort. Having performed the autopsy and received the results of requested toxicology test, Dr. Bannach concluded that the immediate cause of death was acute morphine toxicity. He found no natural disease

which could have caused death, nor were there any external signs of traumatic injuries on the body.

25) The toxicology report indicated the presence of a number of drugs: morphine, clonazepam (a mild sedative) and trimipramine (an antidepressant medication). Dr. Bannach said that the morphine concentration found in the deceased's blood was .66 gm/litre which was far in excess of what was required to produce death given that people have died from morphine concentrations as low as .05. He said that the other central nervous system depressants found in the deceased's system, clonazepam and trimipramine, would have a potent additive toxic effect. Dr. Bannach indicated that the presence of morphine in the blood would mean that McKort ingested morphine or heroin, because heroin metabolizes to morphine rapidly in the blood. He went on to say that morphine could be ingested in a number of different ways: swallowed, injected, snorted or smoked. Dr. Bannach found no evidence of needle punctures that would indicate that particular route of injection. He testified that even with the slowest route to a peak blood level of morphine, which is swallowing it, it would still only take only 20 to 30 minutes to achieve the peak. Therefore, in his opinion, it was quite possible that Mr. McKort was alive at 11:00 a.m. but unable to be revived at 12:00 noon.

26) In terms of manner of death, Dr. Bannach said that there were 6 classifications used in Alberta by the Medical Examiner: natural causes, homicide, suicide, accident, undetermined and unclassified. Unclassified is used when a death is due to substance abuse, whether alcohol or drugs, because it is very difficult to know whether a substance abuser had any intention of causing their death. In this case, given that there were no indications in the weeks preceding his death that he was suicidal, the drug overdose taken by McKort on August 1, 2008 was probably not intended by him to cause his death but rather was the result of an accidental overdose of either morphine or heroin. It is also likely that he ingested those drugs after he was last seen alive at 11:00 a.m. on August 1, 2008.

Drugs in the Edmonton Remand Centre

27) The death of inmate McKort involved the ingestion of drugs not prescribed at the ERC and, therefore, drugs which must have been secreted into the facility. Some of the evidence at the inquiry touched generally upon the issue of illicit drugs within the ERC, the extent to which it is a problem, what steps have been taken by Correctional Services Division to address the issue and what, if any, further action might be recommended at this time. Two witnesses provided very candid and helpful evidence to assist in this endeavour.

28) Terrence Garnett is currently the Director of the Correctional Services Intelligence Unit as well as the Director of Security Standards Audits and Investigation Unit. He has been with Correctional Services since 1981 and was a Manager at the ERC between 1991 and 2004 prior to his current appointment. The duties of his position include investigations of security breaches at correctional centres throughout the province, audits to ensure compliance with policy and procedures, and intelligence gathering to enhance security within and outside correctional environments. A key area of his responsibility is to determine how drugs and other contraband are entering correctional facilities and being passed within those facilities. Mr. Garnett has attended both Correctional Service of Canada and Police Service Training to stay current with the latest developments around reducing the amounts of illegal drugs within prison populations.

29) In giving his testimony, Mr. Garnett referred to several provincial offender search and cell search policies which are applicable to the ERC. One of the clearly stated purposes of these policies is the prevention and discovery of drug trafficking within provincial institutions. In terms of offender searches, policies require regular, routine pat down of offenders; strip searches when there are reasons to believe an offender is concealing contraband (including drugs); internal body cavity searches which, because of s. 8 Charter concerns, can only be done for compelling medical reasons unless the inmate consents; drug dog searches; random urinalysis checks and the use of x-ray equipment such as the Boss Chair which can detect drugs hidden in a body cavity if they are wrapped in a metal-based product.

30) Mr. Garnett indicated that the use of drug dogs had been particularly successful in detecting drugs within the institutions. Prior to 2005, the Correctional Service had a contract with the RCMP to have their drug dogs do some searches for them. In 2005 the Province started their own drug dog program consisting of one dog and one handler. However, given the number of institutions, a unit like 5D would, according to Mr. Garnett, only be searched by a drug dog one or two times per year. The Correctional Service Division is seeking additional funding from the Government to add another drug dog and handler for the province.

31) Mr. Garnett went on to outline the building, unit and cell search policies currently in place to detect (a) tampering with the physical plant and (b) the presence of contraband within the facility. Once a year a facility is searched from top to bottom. Every unit is searched by a team of 5-10 CPOs on a monthly basis and each day both the day and the evening shifts on each unit are to search all cells to ensure the integrity of the physical plant (doors, windows, grills, mattresses) has not been compromised. Records of these searches is recorded on the Weekly Security Inspection Record. In addition, the CO-3 on each unit is to pick two cells on a daily basis to be searched for contraband and to record who was searched, who conducted the search and what, if anything, was found in a Monthly Offender Search Record.

32) In conducting his review of the circumstances surrounding the death of inmate McKort, Mr. Garnett became aware of some instances where the policies outlined above were not executed fully by staff and other incidences where the documents executed by staff falsely claimed to have conducted searches or rounds which had in fact had not been done. In response to this problem, the Correctional Services Division has intensified their efforts to educate staff on the importance of rounds, security checks and searches to both inmate and staff security. Once per year staff are now required to review all policies and sign off on their review. Since January 2010 the security manager at ERC has been conducting audits of compliance with these requirements as well as requirements to keep accurate records of security checks and searches. Once per week he randomly picks a living unit and monitors the CCTV coverage to ensure compliance with all security policies. When staff are found to be non-compliant with procedures, disciplinary action is taken. In addition, the Weekly Cell Check Record has now been changed to a Daily Cell Check Record so that the importance of this process would be heightened with staff and to enable issues identified to be brought to the attention of senior management in a more timely fashion.

33) Mr. Garnett expressed the opinion that the security measures in place at the ERC have been relatively successful in detecting drugs. In 2008 there were 102 incidences where drugs were found, with the largest seizure being 14 pills. Rendered in the context of a centre admitting 15,000 to 20,000 people per year, he did not believe that this was a high number. Mr. Garnett has visited approximately 25 correctional institutions throughout North America, all of which have a problem with drugs to a lesser or greater extent. He

said that while the Correctional Services Division has a zero tolerance policy with respect to drugs, they can never be completely eliminated because most of the drugs are "suitcased" into the facility in body cavities and the ability of Corrections staff to conduct cavity searches is severely limited, as it should be, by Charter protections guaranteeing the bodily integrity of every human being.

34) The last witness at the inquiry was Wayne Reddon, Director of the ERC for the past three years. Mr. Reddon testified that the current ERC was designed to accommodate 335 prisoners but now houses an average of 800 inmates per day. This results in triple bunking of inmates which obviously increases stress levels and opportunities to exchange contraband. Sixty to 64 CPOs work the day shift within this extremely busy environment. Mr. Reddon went on to say that the new ERC opening in the fall of 2012 will not only deal with the overcrowding issue, but will implement a new system called direct supervision where staff and inmates interaction is greatly increased over the current static security model where most staff are located behind a pod. This will enable staff to be more attuned to inmate issues and increase the capacity to gather intelligence and to reduce security and safety risk to both inmates and staff. Four units at the current facility have already been converted to this model.

35) The staffing plan for the new facility calls for extra staff in the administrative-disciplinary segregation pod because inmates are locked up most of the time in their cells. This requires more movement by CPOs to attend to their needs and to ensure that all security procedures are fully executed by staff. The new centre will also have a dedicated search team whose only job will be to conduct daily searches. This will be a significant improvement over the current practice of pulling already busy staff from different areas to conduct these searches.

36) Mr. Reddon also confirmed that Correctional Services Division has requested another sniffer dog and handler for the province and as well requested a dog and handler dedicated solely to the new Edmonton Remand Centre.

37) In terms of steps which could be taken to reduce the misuse of prescribed drugs within the facility, Mr. Reddon stated that while it was the practice of nursing staff to watch inmates ingest their daily prescribed medication, there may not be a specific policy requiring that to be done and he felt that there should be such a policy.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS:

1) Given the significant overcrowding in the ERC, it is recommended that funding be provided to establish a dedicated search team within the current facility rather than waiting until the new ERC is operational in the fall of 2012.

2) The search dog program initiated in 2005 by the Correctional Services Division has proven its value. It should be expanded to include another dog and handler for the Province as well as a dedicated dog and handler for the new ERC.

3) The audit process initiated at ERC early in 2010 to ensure staff compliance with policy in relation to rounds, personal searches, cell searches and record keeping should be formalized and expanded throughout all Provincial Correctional Institutions within Alberta.

4) Given the unique circumstances of segregated inmates and the prevalence of drug usage on such units, it is recommended that cell checks take place once every half hour during morning and afternoon shifts and that all such rounds include sufficient personal interaction with the inmate to ensure that the inmate is alive and well.

5) With respect to drugs prescribed and administered to inmates, if there is no written policy requiring staff to actually observe the inmate swallow their drugs, such a policy should be put in place.