

**REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY**

THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at PROVINCIAL COURT

in the CITY of DRUMHELLER
(City, Town, etc.) (Name of City, Town, etc.)

on the 24th day of MAY, 1991 (and by adjournment

on the _____ day of _____, 19____), before

HIS HONOUR JUDGE G. W. CLOZZA, a Provincial Court Judge.

A jury was was not summoned and an Inquiry was held into the death of

SHAWN VERNON MCEWAN 24 years
(Name in Full) (Age)

of DRUMHELLER, ALBERTA and the following findings were made:
(Residence)

Date and Time of Death DECEMBER 6, 1990 (1:20 a.m. - 3:20 a.m.)

Place DRUMHELLER INSTITUTION DRUMHELLER, 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))

ASPHYXIA - DUE TO HANGING

Manner of Death ("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable - The Fatality Inquiries Act, Section 1(g))

SUICIDAL

REPORT TO AG 338 - PAGE 2

CIRCUMSTANCES UNDER WHICH DEATH OCCURED

During the early hours of December 6, 1990, the deceased hung himself in his cell by means of a shoelace attached to a screw inserted into the cell wall. The deceased was found in this position at approximately 7:03 a.m. Death was estimated to have occurred between 1:20 a.m. and 3:20 a.m. on that date.

The Institution had no prior information or notice suggesting the deceased might be suicidal.

No. of additional pages attached _____

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

Obviously, suicide cannot be totally prevented in a normal institutional setting.


The Institution provides for hourly cell checks to determine the presence of a "live breathing body" by the Corrections Officer on duty. That morning seven hourly checks were apparently made of the deceased's cell and nothing unusual was noted. For whatever reason the deceased was not seen in the position where he was found on the eighth cell check at 7:03 a.m. Dr. Julson noted that finding the deceased earlier would probably not have made any difference.

I am satisfied that the "cell check" procedure is adequate provided that it is properly and carefully carried out. In itself, it will not prevent suicides.

I have no specific recommendations in this case.

No. of additional pages attached _____

DATED this 24th day of MAY, 19 91 .


A Judge of the Provincial Court of Alberta