



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

*Fatality Inquiries  
Act*

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

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

on the 7th, 8th and 9th day of January, 2019, (and by adjournment  
year

on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_),  
year

before The Honourable Judge Brandt, a Provincial Court Judge,

into the death of Ryan William Witvoet 31  
(Name in Full) (Age)

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

**Date and Time of Death:** August 20, 2015 at 22:30 hours

**Place:** Royal Alexandra Hospital

**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 – *Fatality Inquiries Act*, Section 1(d)).

Fentanyl and methamphetamine toxicity

**Manner of Death:**

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

Accidental

**Circumstances under which Death occurred:**

On January 7-9, 2019, a Fatality Inquire was held in Provincial Court in Edmonton, Alberta. The Inquiry examined the circumstances surrounding the death of Ryan William Witvoet on August 20, 2015 while he was in custody at the Edmonton Institution. Mr. Witvoet was discovered unresponsive in his cell at about 1:28 a.m. on that date. Mr. Witvoet was rushed to the Royal Alexandra Hospital and put on life support. Shortly before midnight he was declared dead from a narcotic overdose and taken off life support.

**Personal Circumstances**

Ryan Witvoet was born in Red Deer, Alberta on November 24, 1983. He and his twin brothers were raised by their parents in Red Deer.

His childhood and adolescence were normal and apparently happy.

Mr. Witvoet graduated from high school. Thereafter he attended college and obtained certification as a chef. He obtained employment in the oil field, bought a house and became engaged to his girlfriend.

In about 2007 Mr. Witvoet became involved with hard drugs. Almost immediately his life took a dark and tragic turn. He lost his job, his house and his fiancé and lost contact with his family. He got into trouble with the law and started a pattern of intermittent incarceration that only ended with his death.

Mr. Witvoet's final period of incarceration began on September 24, 2012. On that date he was sentenced to incarceration of 6 years and 4 months in federal prison.

In December 2012 while incarcerated at Drumheller, Mr. Witvoet was assessed has having a substance abuse treatment requirement of "Moderate".

In July 2013 Mr. Witvoet showed signs of morphine use while in custody. As a result, he was given notice of sanctions pursuant to the National Drug Strategy.

The National Drug Strategy (as outlined in Commissioner's Directive 585) was in this case used to impose punishments on Mr. Witvoet. These sanctions (reduction of pay, exclusion from certain jobs, loss of support for parole etc.) did not contain any element of treatment or rehabilitation.

Mr. Witvoet commenced the National Substance Abuse Program (NSAP) Maintenance Program. On October 4, 2013. Eventually he was suspended from that program for missing several sessions.

On October 17, 2013 Mr. Witvoet was found unresponsive due to an apparent drug overdose in his cell at Drumheller Institution. An ambulance was called and he was revived with the use of Narcan. He later admitted to having used heroin at that time.

As a result of this overdose, on November 15 2013 Mr. Witvoet was reclassified as a Medium Security inmate on the Custody Rating Scale.

These issues notwithstanding, on February 25 2014 Mr. Witvoet successfully completed the NSAP Maintenance Program on his second attempt. Pursuant to Correctional Service Canada (CSC) policy, offenders who successfully completed a correctional program could not repeat that program during the same sentence.

On April 3 2014 Mr. Witvoet was placed on administrative segregation due to his “ongoing involvement with violent acts and the institutional drug subculture”.

On September 8, 2014 while still at the Drumheller Institution Mr. Witvoet was again found unresponsive in his cell due to a suspected drug overdose. Again, he was taken to hospital by ambulance. Again, he advised that he had taken heroin.

As a result of this overdose, on September 16 2014 Mr. Witvoet was reclassified according to Correctional Services Canada from “Medium” to “Maximum” on the Security Reclassification Scale. This reclassification required that he be transferred from Drumheller, to the Edmonton Institution. On October 20, 2014 Mr. Witvoet was transferred from the Drumheller Institution to the Edmonton Institution, a Maximum-Security facility.

On August 17, 2015, an inmate arrived at the Edmonton Institution following a suspension of statutory release. It was suspected by the authorities that the inmate may have drugs concealed on his person. The inmate was interviewed by a Security Intelligence Officer. He was checked by a drug dog. He was kept separated from the general prison population. No drugs were detected. On August 18, 2015 the inmate was moved into the general population, in “F” Unit.

On August 19 at about 10:00 am, a correctional officer on patrol in “F” Unit noted Mr. Witvoet to be sleeping and snoring loudly. At 10:35 am, a Correctional Officer became concerned that Mr. Witvoet's condition may be “other than normal”. Officers gained entry to Mr. Witvoet's cell and attempted to rouse him, without success. A nurse was called 10 minutes later. Mr. Witvoet was found to be not responsive. At 10:46 am an ambulance was called. The ambulance arrived and attended to Mr. Witvoet at 11:05 am. He was immediately transported to the Royal Alexandra Hospital. Later that day at 23:10, Mr. Witvoet was declared deceased of a narcotic overdose and taken off life support.

During his time at the Edmonton Institution, Mr. Witvoet was not provided with any treatment for his drug addiction. Indeed, during his entire time at the Edmonton Institution there was no substance abuse program which Mr. Witvoet could have theoretically attended.

He was never offered substance abuse therapy or treatment because there was none available. It was simply not offered.

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

I have considered and dismissed a number of potential recommendations for prevention of deaths similar to that of Mr. Witvoet.

**Reclassification as a Response to Drumheller Overdoses**

The response of the Drumheller Institute to the second of Mr. Witvoet's two overdoses was to reclassify him from Medium to Maximum security classification. This in turn necessitated his transfer from Drumheller to the Edmonton Institution, as per CSC policy.

There was no treatment available for Mr. Witvoet's drug addiction at the Edmonton Institution.

That leaves the question of whether change in such a policy of changing security classification in response to drug abuse could prevent similar deaths.

I find that I am not able to answer such a question based on the evidence before me at the Inquiry.

I say so for 2 reasons:

- The reclassification and transfer took place some 10 months prior to Mr. Witvoet's final overdose and death. Thus it cannot be said that the reclassification and transfer was a proximate cause of Mr. Witvoet's death.
- I was not provided with adequate evidence of the circumstances surrounding Mr. Witvoet's transfer to make any finding based on it.

**Adequacy of Edmonton Institution Drug Interdiction Procedures**

I heard a great deal with respect to the drug interdiction procedures at the Edmonton Institution.

Despite the efforts of CSC authorities, contraband drugs were finding their way into the prison population.

Could an improvement in interdiction methods prevent similar deaths?

From all of the evidence before me, I find that CSC did all it could to prevent the flow of contraband drugs into the Edmonton Institution.

The attempts by prisoners to smuggle contraband, and the attempts by the authorities to interdict such smuggling had become a sort of arms race, with each party using increasingly sophisticated methods in an effort to get the upper hand. More extreme methods to interdict contraband had the effect to socially isolating prisoners. Such interdiction methods significantly interfered with the delivery of programming during Mr. Witvoet's time at the Edmonton Institution, but were not successful in stopping the inflow of contraband drugs.

Accordingly, I do not find that tightening interdiction procedures could prevent similar deaths in the future.

### **Adequacy of Edmonton Institution Response to Overdose**

Fentanyl use, and the risk of overdose associated with it was a new issue at the Edmonton Institution in August of 2015.

From the evidence that I heard, the Edmonton Institution has taken steps to have Narcan available since that time, and has ensured that staff are aware of it and of proper emergency treatment.

I also find that once Mr. Witvoet was found to be in distress, CSC personnel were quick to obtain proper medical assistance for Mr. Witvoet.

Accordingly, I cannot find that future deaths could have been prevented by improved or different responses to Mr. Witvoet's August 20, 2015 overdose.

### **Edmonton Institution Investigative Response to Mr. Witvoet's Death**

On October 8, 2015, Commissioner of Corrections, Don Head, convened an investigation into the series of drug overdoses on August 19 and 20, 2015. This included, but was not limited to, the overdose that led to the death of Mr. Witvoet.

A Board of Investigation was convened by CSC. The Board of Investigation response to the overdose of Mr. Witvoet was thorough. I find that I cannot say that any future deaths could be prevented by any change in the Board of Investigation procedures.

Mr. Witvoet was addicted to dangerous contraband drugs during all of the times when he was in contact with the justice system.

It was his addiction that led to the crimes that placed him in custody in the first place. It was also known to the authorities that Mr. Witvoet was not deterred from drug use by his life threatening overdoses on October 17, 2013 and September 8, 2014. It was well known to CSC that Mr. Witvoet would attempt to obtain and use contraband drugs while in custody.

Yet during his entire stay at the Edmonton Institution from October 20, 2014 until his death on August 20, 2015, Mr. Witvoet was not offered any form of treatment for his obvious and life-threatening addiction. Personnel at the Edmonton Institution did not offer Mr. Witvoet any treatment because CSC did not make it available. During his time there, Mr. Witvoet could not have taken any treatment regardless of his desire for it.

Evidence provided at this Inquiry was that the majority of prisoners at the Edmonton Institution including Mr. Witvoet, were abusers of one substance or another.

Incarceration was thus an opportunity to offer prevention and treatment to a captive population comprised largely of substance abusers. The liberal provision of such treatment would have the effect of preventing similar deaths in the future.

Accordingly, there is only one recommendation that I make:

1. That Correctional Service Canada make substance abuse treatment of prisoners a priority. This should include the provision of substance abuse treatment all inmates who desire it. Such treatment should include the provision of Methadone or other appropriate medications, and should also allow prisoners to repeat CSC substance abuse programs whenever they could benefit from such repetition.

DATED Mar 24, 2020 \_\_\_\_\_ ,

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

*Original signed*

\_\_\_\_\_  
The Honourable Judge Brandt  
A Judge of the Provincial Court of Alberta