REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at Courtroom 604, Courthouse, 611 - 4th St.S.W.

in the City (City, Town, etc.) of Calgary (Name of City, Town, etc.)

on the 5th day of August, 1993 (and by adjournment

on the 6th day of August, 1993), before

John Harvie, a Provincial Court Judge.

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

Twila May ALSTON (Name in Full) 30 Years (Age)

of Bow River Correctional Institute (Residence) and the following findings were made:

Date and Time of Death March 22, 1993 - between 2:30 a.m. and 7:20 a.m.

Place Bow River Correctional Institute

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))

Respiratory Failure - (combined drug overdose)

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))

undeterminable

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CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

See attached pages (1 - 17)

No. of additional pages attached _____

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

See attached pages (18 - 20)

No. of additional pages attached _____

DATED this 14th day of December, 1993.

A Judge of the Provincial Court of Alberta

REPORT TO THE DEPARTMENT OF JUSTICE

PUBLIC INQUIRY - FATALITY

CIRCUMSTANCES OF DEATH:

1. Twila May Alston died on the morning of March 22, 1993. The cause of death was respiratory failure caused by a concoction of drugs. She was then an inmate confined in the Bow River Correctional Institute (Bow River) at Calgary, serving sentences aggregating 13 months imprisonment imposed on January 27, 1993 for cocaine and soliciting offences.

2. Ms. Alston's body was discovered lying on her bed, apparently dead, by another inmate at 7:20 a.m. who opened the door and went into Room F88 in Spruce Unit which Ms. Alston occupied alone.

3. The inmate called for help. It came in seconds. There was no indication of continued life during attempted resuscitation. Jaw rigor mortise impeded ventilation. The ventilation equipment had a failed battery. The nurse and another staff member who attempted resuscitation were overdue for their annual C.P.R. refresher courses. Calgary paramedics came quickly but went first to the wrong buildings and had to be redirected. These slips made no difference. I find Twila Alston was dead before 7:20 a.m.. The body had passed vomit, urine and faeces. Odour was noticeable. Approximate time of death is addressed later. It goes to staff watching inmates and possible recommendations.

It seems she told a staff member that the man accused in the forthcoming trial had repeatedly raped her, and threatened her with a knife, in 1990. There is no evidence that allegation was reported or prosecuted.

6. No autopsy was preformed. There is no explanation why not. Specimens from the body were examined for the presence of alcohol and drugs. No alcohol was found. Various drugs (and their metabolites) were found. Some could be quantified. The drugs are:

- Cocaine
- Morphine
- Diazepam - sedative and muscle relaxant - an ingredient of Valium
- Diphenymdramine - anti-histamine
- Canabinoids - (which may have been in her system for a number of days)

The medical opinion is that no specific drug is shown to be present in sufficient quantity to cause respiratory failure and death. But in aggregate there is sufficient which did. I so find.

7. A lethal concoction of drugs got into the prison and prisoner. The evidence is consistent with voluntary taking and accidental overdose. It does not support or rule out more sinister variants of acts and intents.

8. There is medical evidence about the time span required for the drugs to act. It is that injected drugs "rises to its peaks in a few seconds, then levels drop quite quickly as there is no continuous supply in the stomach". There is no evidence about the possibility of medical intervention saving

4. Spruce Unit was immediately cleared of inmates and searched. Two used syringes and a spoon, bearing traces of cocaine, morphine and diazepam were found in a nearby washroom. There were both old and fresh marks on Ms. Alston's arms. The marks are consistent with intravenous drug use. Ms. Alston was known to staff and inmates as an intravenous drug user. She was disciplined for drug involvement in Bow River on February 18, 1993. The penalty was extra kitchen duty. Other illicit drugs were found in Ms. Alston's room but not in specimens from her body.

5. Ms. Alston was a 30 year old woman in general good health and spirits. She is described as a pleasant person, social, kind and happy who got along well with other inmates. She had a back problem. It was being treated by physiotherapy and Motrin, a prescription anti-inflammatory, which she was permitted to posses and self-medicate. Except for escorted absences to the nearly Calgary Correctional Institution for physiotherapy, there is no evidence she had been absent from Bow river between her admission on January 28th and her death. She had been assessed as not suicidal. She was of native origin. She had little or no interest in native culture. Before her imprisonment she had been leading an urban street life involving prostitution, alcohol and drugs. She had expressed desire to leave that on her release and to be reunited with her children. There is evidence that she was apprehensive about having to give evidence in a trial in May about communication for prostitution. It is hazy and unsatisfactory.

her life if Ms. Alston had been discovered still alive. There is no explanation why not.

9. There is no medical evidence attempting to proximate the time of death by working backwards in time from its symptoms and progression on discovery of the body. There is no explanation why not.

10. The evidence about events concerning Ms. Alston before her body was discovered is from Bow River staff and inmates. It has two aspects which are interrelated: evidence about the nature of the Institution and how affairs there are conducted; evidence about specific events. There are difficulties about existence and weight of evidence as to both aspects. A rather lengthy digression is now required in order to explain the difficulties and to put events before the discovery of the body into context and focus.

11. About 5 months elapsed between Ms. Alston's death and the Fatality Inquiry commencing to hear evidence. Inmates with relevant evidence to give were released over that period. Only one was located and brought before the Fatality Inquiry. Another was served with a summons but failed to attend. The Inquiry was told others could not be located. There is no evidence about effort to locate and serve.

12. However in a sense the evidence of the missing inmates is before the Fatality Inquiry. They were interviewed by a Corrections Service Board of Inquiry (the Board) held the day after the death. The interviews were recorded, transcribed and exhibited at the Fatality Inquiry along with other

evidence and proceedings of the Board. The answers to questions at the interviews were not made under oath or affirmation. That raises concern about the weight to be given to the interviewees evidence as does the fact the Fatality Inquiry has not seen and heard these people. Less obvious, but relevant to the Fatality Inquiry, is the non-existence of "missing inmate evidence" on a number of matters of interest to the Fatality Inquiry because the Board did not ask questions that might have been asked.

13. This may appear to be critical of the Board but it is not so intended. The nature and function of the Board is different from that of a Fatality Inquiry, although both cover some of the same ground. The Board conducted an internal inquiry into tragic misworkings in a bureaucracy. It was convened with laudable promptitude. All Board members have expertise about Corrections. The chairperson was from another institution. There was one member from Bow River management and one from the Bargaining Unit.

14. The Board expressed its mandate in broad terms:

> "...to examine the circumstances and determine findings and make recommendations regarding the death...".

15. That expression of mandate encompasses taking evidence on topics such as open prison philosophy; granting a majority of inmates daily unescorted absences; facilities: staffing; budgets; and a large variety of related subjects which have either been imposed on the Corrections system by legislation or decision at a political level, or developed within it by its most

senior decision makers. The Board was composed of people who know about such matters. It is entitled to notice what it knows without taking evidence. It obviously did that. A Fatality Inquiry is not so equipped. It cannot notice what it does not know. From the point of view of the Fatality Inquiry the Board exercised its mandate narrowly in taking evidence. It touched on some topics set on high. It did not pursue any. It did not ask inmates about their perception of availability and use of drugs in Bow River - the adequacy of surveillance to prevent drug entry and use, and related matters. The reality is that mid-level enquirers conducting any internal inquiry are likely to err on the side of inhibition when it comes to asking heavy questions going to philosophy, policies, facilities, etc. they are fixed with and without power to change. So here. It is understandable. Furthermore, expertise about corrections is different from the expertise developed by experienced litigation counsel in formulating questions and following up on hazy or evasive answers. Taken altogether, such considerations are limiting to both the value of the evidence and proceedings of the Board to the Fatality Inquiry and from the point of view of this Fatality Inquiry the Board's recommendations for measures to prevent future like deaths. More later as to this.

16. There is now some description of the nature of some of the evidence before the Fatality Inquiry and some reasons why some it poses concern. The question arises whether or not the Fatality Inquiry should have been

adjourned to hear more evidence? Decision is not to do that. Reasons include; but are not limited to:

- no reasonable assurance that ex-inmates will be found and got before the Fatality Inquiry within a reasonable time, and that their evidence would be much different from what they told the Board.
- the risk of legitimate perception that a Fatality Inquiry into a specific death was being turned into a Public Inquiry into Alberta's Prison system.
- the unavailability of a courtroom in the Calgary area with a number of months for the week or ten days of evidence taking that is my estimate of the minimum time likely required.
- expense to the state and inconvenience to people in circumstances where it is not assured that much that is useful will be added.

17. It is now necessary to describe Bow River in general terms as revealed by the evidence there is.

18. Bow River is a minimum security prison operated by the Government of Alberta. A sketch map shows a cluster of joined together buildings set in

park like grounds. No fencing is shown to exist. Anyone may go onto the grounds and meet with inmates who stroll there, or to cache contraband for recovery. The overnight inmate population on March 21 - 22 was about 111 of which about 22 were female. 'About' is the correct word. Inmates come and go. It depends when the count is made. Each day about three quarters of the inmate population are granted unescorted temporary absences from Bow River to go to work, look for work, go to places in Calgary for lifeskills, school and so forth. They are to return for the night. The evidence is that inmates granted unescorted absences will 'ordinarily have served at least one-sixth of their sentence'. Ms. Alston had not achieved that before she died. However, according to the Director of Bow River, an inmate may be granted unescorted absences anytime after admission! Ms. Alston was admitted the day after she was sentenced. It therefore seems she might have been, but was not, released the day after she received a 13 month sentence for a cocaine offence. There is no evidence about criteria for release including whether possible factors such as overcrowding, budgets and the like enter into release decision. Or qualification of those who decide. All this goes to public confidence in the justice system generally, and in particular to getting further and better information abut what actually goes on in prisons in order that similar deaths may be prevented. (There is a recommendation about this.)

19. Bow River is not served by the Calgary Transit system. Starting very early in the morning(5:15 a.m.), a series of prison bus runs are made, taking inmates to a city transit stop. Each round trip from Bow River to the stop takes about half an hour. At the end of the working day, and in the evening, another series of runs are made bringing inmates back. The bus driver on the morning runs has given up what the general public would call "guard duties" at the prison to be a bus driver. Between 5:15 a.m. and 6:45 a.m. the morning time staff of three at Bow River is reduced to two. One is off driving the bus. Close observance of inmates is suspended. No one to do it. The two remaining staff people are busy getting the prison day started.

20. The doors leading to the outside of the buildings are unlocked during the day. Inmates can walk out and away. The doors are locked at night. At night, the buildings are floodlit by lamps on the grounds. There is no curtaining on inmates' windows. Floodlight glare disturbs rest and sleep. Inmates are permitted to hang makeshift curtaining. Ms. Alston did that in her room. This goes to the visibility of inmates to staff who look in on them by opening the opaque doors to their rooms during the night time. More later about this.

21. The evidence is that "a majority" or "many" of the inmates have alcohol/drug abuse problems. I regard this as important.

22. Inmates are permitted to possess and self medicate prescription drugs. There is no evidence about possession, and quantities permitted, of sold over the counter non-prescription medications. The relevance is that some of the drugs found in Ms. Alston's body are in both prescription and non-prescription medications. Others found are not.

23. On admission to Bow River, an inmate names two persons who may visit them. Visiting is only permitted at certain hours in the common dining area. There is no evidence that visitors are searched - or of capability to search them - or of the quality of surveillance during visiting to prevent the passing of contraband. There is no evidence of capability to search the large number of inmates who return to Bow River each day. The evidence is that if carrying in contraband is suspected, then the inmate is searched. There is nothing about criteria for suspicion; the sufficiency and capability of staffing for surveillance as to contraband coming in; returning inmates being under the influence of alcohol or drugs and numerous like topics, going to contraband generally and drugs in particular getting into the Institution. There is evidence of spot searching of premises (but apparently not persons), for contraband including drugs. "Second offence" in the Bow River for drug involvement there is said to cause automatic transfer to a more secure institution. Staff say the police have not been co-operative in investigating drug possession complaints made to them by staff, and in laying charges.

24. When interviewed, inmates told of stories circulating among inmates that female inmates out on the grounds had been picked up - taken off for sexual purposes - and returned, all without the staff being aware. In its recommendations the Board referred to absences without leave and recommended inmates only be permitted on some of the grounds. This is the only 'evidence' about unauthorized absences. There is no way of knowing whether the Board was giving credence to such inmates stories, or referring to something different which it noticed pursuant to its expertise. In any event, the 'evidence' is there for whatever it may be worth, if anything. The sketch map of the grounds suggests that in March 1993 a number of watchers would be required to see what goes on out on the grounds. There is no evidence of video equipment to help in surveillance. There is no evidence of fencing being erected to keep inmates "in bounds", and outsiders away, pursuant to the Board's recommendation which the Fatality Inquiry was told had been implemented. The Board did not recommend fencing. It recommended division of the grounds into "in" and "out of bounds" for inmates.

25. The foregoing shows a facility and arrangements that make it difficult for front line staff to keep drugs out. Bow River is a porous place respecting drugs and other small sized contraband.

26. Turning now to use of drugs by inmates in Bow River, and surveillance and measures to prevent that, and to care generally for the health and safety

of the inmate population, particularly during the night time, the evidence is to the following effect:

27. The night time staff of three come on duty at 10:45 p.m. and work until 6:45 a.m. when the next shift change is made. A count of inmates is made at each shift change. The Policy Procedure Rules say that "living flesh" be seen on every inmate counted. The evidence is that it takes about half an hour for a counter to count all inmates. The counter has to open the opaque doors to washrooms and bedrooms and either enter or look in sufficiently using available lighting, or a flashlight (the use of which appears to be discretionary) to count the number of person inside a room and to see living or moving flesh on each. There is no requirement that the counter be of the same sex as those being counted. In ordinary language there is peeping in on persons of the other sex at night time who may be and often are in a state of undress. There is a recommendation by the Board that "Correctional Service Division continue its initiatives to provide gender and aboriginal sensitivity training to staff on issues of relevance to female offenders". There is no evidence of the curricula of that or what it involves. The Board has taken notice of something within its expertise. The Fatality Inquiry has seen and heard from male staff members who had the counting and nighttime watching duties overnight before and during the time of death. As a trial judge accustomed to assessing witnesses, I find them to be decent men respectful of the privacy of undressed females and

not comfortable with their close observance duty respecting females especially at nighttime. There is no evidence about the attitude of female inmates to intrusions on privacy by male staff. Or whether race or cultural background has anything to do with it except as may be inferred from the Board's recommendation which imply it may.

28. Policy and Procedures also require periodic identical observance of "moving flesh" on all inmates at irregular intervals occurring at least once an hour (but without counting) between midnight and 6:00 a.m. Both the formal counts and periodic hourly observations are to be logged in writing with the person or persons making them. Staffing at Bow River is not sufficient for required observance.

29. There were shortcomings in some of the logging done overnight March 21 - 22. The Board made a recommendation about that. There is no need to go into detail. It is the observance of person that matters. Observance goes specifically to drugs being taken (or administered?); the time span required for the drugs to act during which discovery and medical intervention might have saved life; and the proximate time of death. All are pertinent to the quality of care by the state of confined citizens and possible recommendations aimed at the prevention of like deaths in future.

30. The Board concluded that the proximate time of death might have been up to two hours before the body was discovered at 7:20 a.m. It appears to base this conclusion on the condition of the body on discovery. I regard

that as a medical matter. The Board seems to be stepping outside its expertise.

31. The more detailed evidence of events concerning Ms. Alston on the evening before the death is now addressed.

32. Two inmates told the Board, and one them told the Fatality Inquiry, that Ms. Alston walked the grounds on the evening of March 21 in their company. All were expecting drugs to be dropped off. None say they saw drugs received, although a fourth inmate told the Board that Ms. Alston told her they had been received. The drugs expected are variously named as liquid morphine, cocaine and 'peelers'; ('peelers' are morphine in capsule form). The evidence is that a user breaks open the peeler capsule, dissolves the drug in spoon, draws the solution into a syringe and injects. Inmates hide 'peelers' before use by secreting them where they are not likely to be found, perhaps by disguising them as some other medication according to labelling and packaging. Cocaine is normally a white powder. There is some evidence of a white powder being on the sink.

33. Several inmates say that Ms. Alston was under the influence of drugs during the evening of March 21 and that her speech was slurred and she was "dopey". A staff member says he told Ms. Alston to go back to her room at 12:30 a.m. and he noticed nothing unusual about her. Another staff member said he saw Ms. Alston 3/4 of an hour earlier at 11:45 p.m. and she appeared normal to him. Several inmates told the Board that Ms.

Alston had 100 Valium pills. Several inmates who did not give evidence at the Fatality Inquiry gave contradictory evidence about seeing Ms. Alston before 3:30 a.m., and her being or not being, under the apparent influence of drugs.

34. The weight of evidence is to the effect that Ms. Alston was alive at 2:30 a.m. That evidence comes from the inmate who gave evidence before the Fatality Inquiry, and a staff member who also testified. The inmate says she was under the influence of drugs. The staff member did not notice that. She seemed normal to him.

35. At 4:15 a.m. a staff member testified he opened the door to Ms. Alston's room and saw her lying on her bed covered to the waist. He initially said he was not sure if she was breathing. Later he said she was breathing. I find he is simply not sure either way.

36. The next observation visit by a staff member was during the shift change body count at approximately 6:45 a.m. That officer did not notice living or moving flesh. He says he noticed the odour of perfume but no other odour. He admits he did not make the "living or moving flesh observation" he was required to make. The Board recommended disciplinary action.

37. No other staff member saw Ms. Alston until the alarm was raised at 7:20 a.m. and she was dead. More accurately, there is no evidence of any staff member seeing her. The door to her room was closed.

38. An inmate who did not give evidence at the Fatality Inquiry told the Board she returned a blanket to Ms. Alston's room at about 6:50 a.m. She says M. Alston appeared to be asleep - she touched her leg and thanked her - she did not notice if Ms. Alston was breathing - there was no reply. No odour was noticed.

39. On the evidence, I find Ms. Alston was alive at 2:30 a.m. (although possibly under the influence of drugs) and died before 7:20 a.m. The evidence is not sufficient for confidence in proximation closer than that.

40. In making this report it is thought that nothing useful would be added by identifying staff persons by name or job title. To that there have been two exceptions thought justifiable. One of the staff persons, who attempted resuscitation is a nurse and I have said so. Bow River had a person with recognized medical certification at the body within seconds of its discovery. That is good. The other staff member identified is the Director - (see paragraph 18). A copy of the Board's conclusions and recommendations is attached, but with identity of persons and job titles deleted. The deletions are for purposes of consistency.

41. Mr. Whittaker was counsel to the Fatality Inquiry. He is able and experienced. His help is appreciated. There is much in this report that may be seen as critical. There is no criticism of Mr. Whittaker. He had the same material to work with as I have. The Fatality Inquiry got what he had.

CONCLUSIONS:

1. Drugs are easily got into Bow River.
2. The design of the place especially the opaque doors to rooms, gives inmates much opportunity to use drugs without staff being able to notice.
3. Both the above arise out of a particular penal philosophy carried into action. A drug overdose death such as Ms. Alston's is a cost against whatever virtues a liberal prison scheme may have.
4. The staff at Bow River do the best they can considering the facility and in circumstances in which they have to work.
5. Future like deaths will probably occur unless major changes are made. Similar deaths probably cannot be prevented entirely. They occur from time to time in the most secure prisons.
6. Staffing at Bow River appears inadequate.
7. Bow River is a pretence of a prison. The recommendations of the Board of Inquiry seems to this Fatality Inquiry to be variously either 'housekeeping' or 'motherhood' assertions which fall way short of addressing real problems which must be identified and dealt with if future like deaths are to be prevented as much as possible.
8. This Fatality Inquiry has been handicapped by persons with relevant evidence to give not being brought before it.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS:

1. That the Government of Alberta decide whether it is operating a prison or a drug use facility.
2. That to decide that it first be recognized that the prison system operates outside public scrutiny, except for such rare and limited glimpse as are provided by Fatality Inquiries into prison deaths and when prison incidents get into civil or criminal courts.
3. Recognizing that, and to inform the public who pay, about what actually occurs, and to get advice about what to do, there be a broader Inquiry into the philosophy and operation of Alberta's prison system - either a Public Inquiry or a Royal Commission. In particular, such a tribunal, acting in public would look into the whole matter of substance abuse by those ordered imprisoned; the various release and absence schemes as they actually operate and contribute to substance abuse; and measures existing to deter the entry of drugs into prisons and use there by inmates.
4. The foregoing is the credible way to go about prevention of similar deaths. (A similar recommendation by me a few years ago conducting a Fatality Inquiry into another prison death was not acted on). If this one is also rejected, or if it is accepted, there are interim measures to be taken at the Bow River Institution to deter drug entry and use:
    a) fencing to keep inmates in and others out.

b) searching all inmates returning from unescorted temporary absences.

c) barriers and surveillance to prevent visitors from passing or caching contraband including drugs.

d) door replacement or alterations so that staff can see into rooms occupied by inmates and what inmates are doing.

e) banning or severely limiting possession by inmates of both prescription and non-prescription medications. The advice of qualified persons should be obtained. One should be a toxicologist. Another should have expertise about the behaviour of people with substance abuse problems. Advice should address both quality and quantity.

f) requirement that staff involved with counting and seeing "moving flesh" duties be of the same sex as those observed.

g) requirement that Fatality Inquiry evidence taking into apparently unnatural prison deaths start at most a few days from death occurring before inmates with relevant evidence to give are released; so that their evidence is taken under oath or affirmation; and while events are fresh in mind. And so the questioning is done by experienced litigation counsel. This may require adjournment for medical and other evidence not then available to be taken later when it is available. So be it.

h) taking and giving weight to the advice of front line staff who actually have to deal with inmates about other and related measures to deter drug entry and use. Such advice would be expected to address, among other things, staffing requirements and video surveillance.

All of which is respectfully submitted.

John Harvie
Provincial Court Judge

RECOMMENDATIONS

1. THAT, the Bow River Centre Director undertake a review to enhance procedures to control the introduction and use of drugs in the centre and the unlawful leave of offenders from centre property.

2. THAT, the Director of Bow River Correctional Centre ensure that a live body count is taken between the hours of 0500 and 0645, possibly in conjunction with the earliest morning wake up call, and that Standing Operating Procedures are amended accordingly.

3. THAT, the Director of Bow River Correctional Centre ensure that each live body count is documented in the log book by time and unit and signed.

4. THAT, the Bow River Correctional Centre Director re-inforce that in the case of every Code 99, all emergency equipment, including the suction, is taken immediately to the scene of the incident.

5. THAT, ***** *****, *** **, be considered for disciplinary action for failing to conduct a live body check in accordance with Department Policy and Procedures 10.00.03. While ***** described the correct procedure for conducting a live body count, he admitted that he did not see Alston move nor was he sure that he saw her breathing. Given the degree of rigor mortis, it would appear that the offender may have been dead for up to two hours at the time of the Code 99.

6. THAT, *.*. ** ******** and ***** ********* update their annual proficiency training in C.P.R.

7. THAT, the Bow River Correctional Centre Director ensure that in the case of a major incident, Managers ensure that reports are obtained from all staff directly involved in the incident. In this case, a staff report was not submitted by Correctional Officers ********, ******** or ***** ********.

8. THAT, the Correctional Services Division continue its initiatives to provide gender and Aboriginal sensitive training to staff on issues of relevance to female offenders.