Civil Litigation Team
9th Floor, Peace Hills Trust Tower
10011 – 109 Street
Edmonton AB T5J 3S8
Canada
Telephone: 780-427-1295
Abid.Mavani@gov.ab.ca
www.alberta.ca

BY E-MAIL

August 18, 2023

Shalee Kushnerick
Associate General Counsel, Litigation
Legal & Privacy, Alberta Health Services
Seventh Street Plaza, North Tower, Floor 5
10030 107 Street
Edmonton AB T5J 3E4

Dear Madam:

Subject: Joshua Lloyd Alston – Public Fatality Inquiry
Response to Recommendations

Please find enclosed a copy of the Honourable Justice P.G. Pharo's report to the Minister of Justice regarding the public fatality inquiry into the death of Joshua Lloyd Alston. This report will be publicly released on September 7, 2023. Please do not share the contents of the report in any manner that would cause it to become available publicly until after this date.

The following recommendations may impact Alberta Health Services ("AHS"):

> **Recommendation 1** – *Better Recording of Health Care Medication Requests and Follow-Up* – The evidence was that Mr. Alston had chronic severe migraine headaches from a young age. He treated them with Tylenol 4s, and other self-prescribed drugs. When he was admitted to LCC, Tylenol 4s were prohibited because they contain codeine, and standard Tylenols were substituted. Mr. Alston lost the ability to access the standard Tylenol after the diversion incident on February 23, 2019. There was evidence from a nurse at the Board of Inquiry that he subsequently asked for headache medication from AHS staff on rounds on February 25, 2019. This request does not seem to have been recorded anywhere, nor was there any evidence as to if or when it was followed up. The apparent suicide note mentions that his migraine headaches had become too much, suggesting that was a cause of the suicide. Therefore, it is recommended that all inmate requests for medication, and subsequent follow-ups be recorded by AHS staff.

Recommendation 6 – *Check Connectcare for Mental Health and Suicide Issues on Admission* – The evidence was that at the Admissions and Discharge Unit at LCC, an AHS nurse does a cursory medical checkup, which consists of going through a checklist with the inmate but does not include a medical examination. The evidence was that LCC now has, or will soon have, access to the new AHS Connectcare database, which is used by Alberta Hospitals. It is recommended that if an inmate reports any mental health concerns, or suicidal ideation on admission to LCC, Connectcare should be checked for hospital admission and discharge records, and pharmacy records with appropriate notes to be made on the inmate's records.

A request for a response to these recommendations has also been sent to counsel for Lethbridge Correctional Centre, Custody Operations Branch.

I ask that you please advise the following:

1. Whether AHS accepts in principle, does not accept, or has a different response to the recommendations;

2. A brief explanation of why that decision was made; and

3. If AHS intends to accept the recommendations, or to implement different measures, what steps will be taken in that regard.

A response to this enquiry is not mandatory. However, be advised that this letter and any response received will be publicly released and posted on the Open Government Portal:

https://open.alberta.ca/opendata/responses-to-public-fatality-inquiry-recommendations.

If a response has not been received by January 8, 2024 (four months after the public release date), that information will also be made publicly available.

Thank you for your cooperation in this matter.

Yours truly,

Abid Mavani

Abid Mavani
Fatality Inquiry Coordinator
Encl – Report of Justice P.G. Pharo