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VIA EMAIL

Abid Mavani

Fatality Inquiry Coordinator Civil Litigation Team Legal Services Division Alberta Justice 9 Floor Peace Hills Trust Tower 10011-109 Street NW Edmonton AB T5J 3S8

Re: Joshua Lloyd Alston - Fatality Inquiry

A Public Fatality Inquiry was recently completed that reviewed the circumstances surrounding the death of Joshua Lloyd Alston, at the Lethbridge Correctional Centre (LCC). The Honourable Justice P.G. Pharo chaired the inquiry and provided six recommendations to the Custody Operations Branch (COB) of the Correctional Services Division (CSD).

Recommendation 1:

It is recommended that all inmate requests for medication and subsequent follow-ups be recorded by AHS staff.

This recommendation has been provided to Alberta Health Services for their consideration and response. COB is not involved with requests for medication other than to refer inmates to AHS staff.

Recommendation 2:

It is recommended that the overhead vents be replaced by tamperproof anti-ligature vents.

COB accepts this recommendation and has engaged in the process to replace the vents as recommended.

Recommendation 3:

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It is recommended that a market survey be done by Adult Centre Operations Branch, to see if there are better options available on the market, and if so, the existing security blankets be replaced.

COB has engaged in this recommendation.

The sewing program at the Calgary Correctional Centre (CCC) currently produces the security blankets. Samples and designs from other manufacturers and jurisdictions have been reviewed and tested. Other products and materials will be assessed on an ongoing basis, as well as consultation with jurisdictional partners. At present, the current security blanket is consistent with other materials available. In addition to assessing the quality of products, the replacement of worn materials will be assessed, to ensure blankets showing wear are circulated out of use.

Recommendation 4:

It is recommended that a policy be put in place that where there are inmates on suicide watch on a unit, then if plastic knives are provided to other prisoners on that segregated unit with a meal tray, then such knife must be returned at the end of the meal.

COB accepts this recommendation. The policy affirms that any incarcerated individual have all unauthorized articles removed and controlled by unit staff. Any utensils received at mealtime, would be retrieved by staff after each use, and not permitted to remain in the cell.

Recommendation 5:

It is recommended that LCC management should review all policies and procedures that are not compliant with what actual current practices and should ensure that all LCC staff are trained so they are up to date with current policies.

COB accepts this recommendation and confirms this is current policy and practice. COB policies and procedures are available to all staff via hard copy and on-line and affirmed annually. Any revisions to policy are communicated to all staff through the following avenues: memo, email, verbal communication in pre-shift meetings, bulletin board postings and individual communication between supervisors and front-line staff. COB managers and supervisors are to ensure that staff assigned to their area, comply with all provisions of the policy manual.

Recommendation 6:

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.

This recommendation has been provided to Alberta Health Services for their consideration and response. COB does not have access to inmate's health records or Connectcare.

Recommendation 7:

It is recommended that an annual audit be made of the emergency code bags to ensure first of all that they are in the right place, secondly everything in the code bag is where it is supposed to be, and thirdly that staff are familiar with them and trained to use them.



This recommendation has been provided to Alberta Health Services for their consideration and response. Contents of the code bag are managed by AHS. Correctional staff do receive training for awareness of the code bag contents at induction training. Staff, however, are not trained to use the equipment, as it requires medical training, and should be used only by a trained medical professional.

With respect to security equipment referenced such as security scissors, they are located and accessible at all provincial centres, on all units, where individuals are housed. Staff must account for and ensure that the scissors are in good working order at each shift change.

Recommendation 8:

It is recommended that LCC staff be given further and regular training on signs any symptoms of drug withdrawal, as well as the signs and symptoms of suicide risk.

COB accepts this recommendation and is currently reviewing the re-certification curriculum, which historically includes suicide awareness training. Consideration for regular training on signs and symptoms of drug withdrawal is also underway.

Sincerely,

FIFIDIIP Original Signed

Jane Freeman

Partner JHF/as