ALBERTA

Report to the Minister of Justice

Fatality Inquiries Act

Public Fatality Inquiry

WHEREAS a Public Inquiry was held at the Lethbridge Court House

in the City (City, Town or Village) of Lethbridge (Name of City, Town, Village), in the Province of Alberta,

on the 16th – 18th day of January, 2023 (year), (and by adjournment

on the _____ day of _____, _____ (year)

before The Honourable Justice P.G. Pharo, of the Alberta Court of Justice,

into the death of Joshua Lloyd Alston (Name in Full) 38 (Age)

of 180 N 2 Street, Magrath, Alberta (Residence) and the following findings were made:

Date and Time of Death: 10:15 pm March 1, 2019

Place: Chinook Regional Hospital, Lethbridge, 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 – *Fatality Inquiries Act*, Section 1(d)).

Sequelae of hanging

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)).

Suicidal

Circumstances under which Death occurred:

Introduction

This Fatality Inquiry (the "Hearing") concerned the death of Joshua Lloyd Alston (Mr. Alston), who at the time of his death was an inmate at the Lethbridge Correction Centre (LCC), which is a provincial correctional and remand center, usually containing between 200 and 300 inmates.

On February 27, 2019, at about 8:08 p.m. Mr. Alston was being held in a segregation unit at LCC, in a cell by himself, when a correction officer stopped by his cell doing a routine check. She saw that Mr. Alston had made a ligature from a security blanket from his cell, tied it to an overhead vent, and had hung himself. She called for assistance, and as a result Mr. Alston was revived to the extent he had a pulse. He was taken by ambulance to the Chinook Regional Hospital (CRH). He died several days later, on March 1, 2019.

Preliminary Matters

Ms. Andrea Simmonds represented the Attorney General and was counsel for conducting the Public Fatality Inquiry.

Ms. Louw appeared as counsel for Alberta Health Services (AHS), and Ms. Freeman appeared as counsel for Alberta Corrections.

Bill Alston and Sue Alston, who are Mr. Alston's parents also appeared. Mr. Tom Alston, Mr. Alston's brother, appeared and participated as the primary family representative, however Bill Alston and Sue Alston also took part.

Six witnesses appeared at the Hearing, as follows:

1. Brooke Grayston – Registered Nurse at LCC
2. Dr. Marc Ascione – Medical Doctor at LCC
3. Larry McGale – Registered Psychologist at LCC
4. Kristine Knoll – Health Services Manager at LCC
5. Kevynn Wiebe – Correctional Peace Officer 2 (CPO-2) at LCC
6. Doug Whillans – Deputy Director of Administration at LCC

Approximately 500 pages of documents were entered as exhibits during this Hearing.

The day after this incident, on February 28, 2019, a Board of Inquiry (the "Inquiry") was ordered. The Board carried out the Inquiry by interviewing the various witnesses, and a report was submitted in due course. This report included a number of recommendations, which were included in the exhibit at the Hearing.

Background of Mr. Alston

In submissions at the Hearing, Mr. Alston's family advised that Mr. Alston had a long history of severe migraine headaches. They said that the headaches were so severe that there were days and weeks where he could not function, even as a child. They said he often had to go to the hospital, where he received such high doses of medication that he was rendered comatose for days afterwards. The family said that by age 18, he was taking morphine, and soon was on a cycle of dependency and drug abuse, which escalated to more potent and dangerous drugs, including illicit street drugs. They said it got to the point where he was hallucinating, and barely recognizable to his family.

The evidence was that on June 3, 2018, Mr. Alston was taken by the RCMP to the CRH emergency room, because of a disturbance that occurred at his house (page 340). He is described as a single father of three, and a carpenter. The RCMP found his house completely in chaos. At the hospital, Mr. Alston received a psychiatric consultation with a psychiatrist, Dr. Gonsalvez. Mr. Alston reported ongoing erratic behavior, but described various periods when he was doing "ok". Collateral reports were of a long history of polysubstance abuse, and recent legal issues with court coming up soon. Mr. Alston said he missed his three children, who lived with his ex-wife in Coaldale. He denied any thoughts of harm to himself or to others. He was discharged to the care of his parents.

On June 21, 2018, the evidence was that Mr. Alston appeared in Provincial Court in Lethbridge to enter a plea to his criminal charges. The court transcript was in evidence at the Hearing, and it showed that his lawyer felt that Mr. Alston was not in a position to give proper instructions. After some discussions, the result was that the pleas were not entered, and Mr. Alston was remanded into custody at LCC on that day. The admission documents to LCC on that day (pages 269-271) disclose that Mr. Alston said that he used marijuana, cocaine, crack and meth, and that his drug use was causing him problems. He said he had seen a psychiatrist or psychologist about a month before that. He denied that he had ever attempted suicide before. He said his current medical problems were hypertension, restless legs, migraines and chronic pain.

On June 26, 2018, Mr. Alston was released from LCC after signing a release document, promising to appear at the next court date.

Circumstances Leading Up to the Incident

The next important court date for Mr. Alston was February 20, 2019, where he appeared in Lethbridge Provincial Court and was convicted of two counts of robbery and sentenced to two years in penitentiary. He was admitted to LCC on February 20, 2019 at approximately 4:26 p.m. The standard operating procedure when inmates were admitted to LCC was that AHS would interview the inmate in the cursory medical room located in the Admitting and Discharge (A&D) area. The AHS staff would assess the inmate visually and ask a number of questions while completing an intake questionnaire. Mr. Alston told the nurse that his current medical concerns were migraines, depression, hypertension and nerve pain to his neck. He identified his current medications to be Gabapentin, Propranolol, Tylenol and Cipralex, and that he smoked cannabis daily. He reported having seen a psychiatrist or psychologist in the community after his divorce but could not recall when or who he saw. He denied ever attempting suicide in the past and denied current suicidal ideation.

A further part of the standard admission procedure for inmates is a medication reconciliation.

Mr. Alston identified the following medications which he had been prescribed in the community:

1. Gabapentin – for nerve pain
2. Propranolol – for hypertension
3. Cipralex – for depression and anxiety
4. Tylenol #4 with codeine – for pain management
5. Maxeran – for nausea and the treatment of migraines
6. Ondansetron – for nausea

The doctor on call at LCC reviewed the medication list and approved the following medications for Mr. Alston:

1. Gabapentin
2. Propranolol
3. Cipralex
4. Tylenol without codeine

5. Maxeran

Because Mr. Alston was not authorized to receive the Tylenol 4 with codeine, the LCC doctor noted that Mr. Alston was authorized to start on the drug withdrawal program if he showed signs of withdrawals.

While at the A&D area at that time, he was approached by the drug dog, who alerted on him. The drug dog was trained to check the inmates and the physical areas in LCC for any evidence of illicit drugs. Because the drug dog alerted on him, LCC staff asked if he had any contraband concealed on him. Mr. Alston denied it. As a result of the dog alerting on him, Mr. Alston was placed on LCC's dry cell protocol at approximately 4:30 p.m.

The dry cell protocol is a standard procedure at LCC by which efforts are made to discover, obtain and eliminate contraband on an inmate's person, which are considered to be detrimental to the general safety and welfare of the inmates and staff of LCC. Inmates are placed in a cell where the water source to the toilet is shut off. The dry cell protocol outlines a systemic process initiated whenever the inmate needs to have a bowel movement. The inmate notifies staff that he needs to use a toilet for a bowel movement and the inmate is escorted to a washroom to use the toilet. The correctional staff inspects the fecal matter for contraband, and then searches the inmate and the cell before the inmate returns to the dry cell. Bowel movements, inmate searches and cell searches are documented on the dry cell report. LCC policy was that inmates are to be placed in dry cell for a minimum of 72 hours to ensure that ingested contraband has been surrendered or passed via three bowel movements.

On February 21, 2019, several LCC staff members interviewed Mr. Alston about his dry cell placement. During this interview MR. Alston admitted to having a container in his rectum containing Tylenol 4. LCC staff escorted Mr. Alston to holding cell in the A&D unit, where he removed a Tylenol travel container and small clear bag from his rectum. The contents of the container and bag revealed Tylenol 4 and orange pills that were unable to be identified by AHS.

Mr. Alston was immediately placed on institutional charges for having an unauthorized drug. He appeared before the hearing adjudicator the next day on February 22, 2019. He admitted to a charge and was given a disciplinary segregation sentence of six days segregation to serve, with another six days to serve, which was suspended for sixty days. Mr. Alston was then placed back in the dry cell. At 11:00 a.m. he passed a large bowel movement which was clear of contraband. It was decided that he should be released from the dry cell, although the full 72 hours in accordance with the standard protocol were not up.

At approximately 11:30 a.m. on February 22, 2019, Mr. Alston was moved from A&D to Unit 2, a unit utilized for administrative and disciplinary segregation inmates. He received a mattress, security bedding and orange coveralls, in compliance with standard operating policy. Although initially he was housed with other inmates, at around 8:25 a.m. on February 27, 2019, he became the sole occupant of Cell 2, which did not have a camera which showed the inside of the cell.

Inmates housed in Unit 2 are checked twice per hour, along with a unit security inspection conducted on day shift and afternoon shift. When unit security inspections are conducted in Unit 2, three Correctional Peace Officers (CPOs) are normally present. Two CPOs enter the cell to search and inspect the area, and the third COP conducts a pat down search of the inmate out in the common area. During these unit security inspections, the CPOs check to ensure security clothing and blankets are free of any flaws and tears and if any damage is found, they ensure that these security times are replaced.

During evening medication rounds on February 23, 2019, the nurse observed Mr. Alston diverting his Gabapentin and Tylenol, meaning he did not take it as prescribed, and tried to keep it in his hand. In accordance with standard operating procedures, the nurse placed the administration of these two medications on hold until reviewed by the LCC physician. On February 26, 2019, the LCC doctor reviewed Mr. Alston's medication and ordered the Gabapentin and Tylenol to be discontinued.

There was evidence given at the Inquiry that on February 25, 2019, Mr. Alston asked a nurse for Tylenol for a headache, but she told him that she could not give him the medication because of his recent diversion of medication but that she would check with a doctor. Mr. Alston seemed okay with that response. However, there was no notation of this request in the multi-disciplinary notes, nor was there any indication of any kind of follow-up on this request by the nurse.

The LCC standard operating procedure was that a nurse shall attend at the disciplinary segregation unit once every 24 hours and the psychologist was to attend once every workday to check on the wellbeing of the inmates. On the date of this incident, being February 27, 2019, the evidence was that there was compliance with this procedure, and there were no concerns noted on the records that were kept.

The evidence of Psychologist McGale was that he had interaction with Mr. Alston on that afternoon, and nothing was remarkable. The psychologist said Mr. Alston made good eye contact with him and said he was OK. However, the log sheet evidence showed that the psychologist was on the unit for a total of 22 seconds during that visit.

The standard procedure was that the CPO on the unit was to do rounds, and check on the inmates twice every hour, at irregular times.

The evidence of CPO Wiebe was that her practice is to engage and chat with the inmates when she does her rounds, and she tried to do that with Mr. Alston on that day, but he did not seem willing to chat. She did say that his behavior seemed a little odd and he had a weird look on his face, however he said he was fine and did not need anything.

There was no evidence that Mr. Alston had told correctional or AHS staff that he had been experiencing withdrawal symptoms while in custody.

The Incident – February 27, 2019

On the date of the Incident, February 27, 2019, the unit security inspection occurred at 3:08 p.m. Since one of Mr. Alston's cellmate had moved out, CPO Wiebe removed the extra mattress, and Mr. Alston was fine with that decision. At 4:26 p.m. the nurse entered the unit to conduct medication rounds, and dispensed Propranolol to Mr. Alston. At 7:27 p.m. CPO Wiebe conducted a round of the unit and then left for her break. Mr. Alston was alone in the cell at that point. She conducted another round of the unit at 8:08:05 p.m., whereupon she observed Mr. Alston in his cell and it appeared to her that he had something around his neck which was attached to the vent above the cell toilet. CPO Wiebe called out to Mr. Alston and approximately 10 seconds later initiated a code 99, which is an emergency medical code, from her radio. In addition, CPO Wiebe also relayed over her portable radio "cell 2 and the inmate is hanging". Central Control officers remotely opened the cell door and CPO Wiebe called out to Mr. Alston. She observed Mr. Alston's feet dangling off the floor and that he appeared blue. CPO Wiebe observed a torn portion of the security blanket had been used as a ligature, with one end around Mr. Alston's neck and the other end attached to the vent above the cell toilet. She entered the cell and wrapped her arms around Mr. Aston's waist and lifted him up to relieve the pressure of the ligature around his neck.

At 8:08:56 p.m. three other CPOs, along with two nurses responded to the scene. Two of the CPOs took over from CPO Wiebe holding up Mr. Alston. At 8:09:24 p.m. another CPO brought the code bag to the unit door, and one of the nurses took it. The CPO asked that nurse for scissors to cut the ligature, however the nurse had difficulty locating them in the code bag. While the nurses were searching the code bag for scissors, CPO Wiebe climbed onto the top bunk and untied the ligature from around Mr. Alston's neck. At 8:09:59 p.m. another CPO brought some scissors to the unit. At 8:10:04 p.m. four CPOs carried Mr. Alston out of the cell into the common area and placed him on his back on the floor. An ambulance was called. A nurse determined at that point that Mr. Alston had no pulse and was not breathing. At 8:10:15 p.m. one of the CPOs started doing CPR by doing chest compressions. At this time, a nurse used a bag valve mask to assist with breathing. The nurses also had an AED device which was deployed. An oropharyngeal device was also inserted to maintain an airway. A nurse also stared an IV line.

The CPOs continued to do CPR, and two EMS personnel arrived at 8:20:30 p.m. At 8:21:59 p.m. three more EMS personnel arrived. At 8:31:12 p.m. the CPOs stopped doing CPR because the EMS personnel advised that there was a pulse. EMS personnel then took Mr. Alston to CRH. He was placed on life support. He passed away on March 1, 2019 at CRH.

A member of the corrections staff was assigned to make notes of what was happening during the incident, which was done, but the notes were passed on to AHS staff in due course and were apparently then destroyed.

Subsequent investigations showed that the ligature was made from a torn security blanket. The reinforced seam edging had been separated from the rest of the blanket. A note was also found written in pencil on an open page of the Bible in the cell, which said:

> The Migraines R Too much to deal with alone.
> Bye my loved ones.
> Sorry

There was also a plastic knife found on the floor near the desk in the cell.

Board of Inquiry Recommendations and Responses

A Board of Inquiry (the "Board") was struck, which was composed of Patty Kohl, Director of the Professional Standards Unit, and Dawn McMaster, Deputy Director Operations, Medicine Hat Remand Centre, for the purpose of investigating this incident. The Board was convened and sat on March 7, 8 and April 1, 2019 at LCC. The Board interviewed a number of correctional services staff, AHS staff and an inmate. The Board evidence was that the inmate they interviewed, who was Mr. Alston's last cellmate on the morning of the incident, told them that Mr. Alston was sad and said he was going to kill himself, but the inmate did not take him seriously, so did not tell anyone about it.

The Board made a number of findings, and the following recommendations.

Recommendation 1 – That the various AHS and correctional staff who responded should get some recognition.

Response - The evidence was that this has been done.

Recommendation 2 – The Health Services Manager of LCC considers reviewing placement of inventory within the emergency code bags (in this case, the emergency scissors) to ensure consistent location of items. This may simply take the form of reminding AHS personnel of the importance of consistent location of inventory.

Response – The evidence was that this has been done.

Recommendation 3 – The Director of LCC reviews with the correctional personnel the importance of strictly following the dry cell protocol as outlined in branch policy. Specifically, ensuring inmates remain on the dry cell protocol for the required minimum 72-hour period and ensuring rounds are documented.

Response – The evidence was that this has been done.

Recommendation 4 – That the Director of LCC reminds all staff to ensure they maintain continuity of their original notes when documenting event, as they are not transitory and are considered evidence.

Response – The evidence was that this has been done.

Recommendation 5 – That the Director of LCC reviews alternative types of ventilation covers to minimize the ability of inmates to affix anything to the vent slats.

Response – The Director of LCC contacted Alberta Infrastructure, but no changes have been made to date.

Recommendation 6 – That the Director of LCC, in consultation with the Executive Director, Adult Centre Operations Branch, consider adding additional camera infrastructure in Unit 2 (and other areas with similar limitations) to ensure full CCTV coverage of the area, including right outside the cells.

Response – The evidence was that this is being done and is about half completed.

Recommendation 7 – That until new SOPs are officially in place to replace SOP 16.05.02, the Director of LCC considers issuing a directive or memorandum to clarify approved practice in Unit 2; specifically, practice with regard to what inmates in segregation are permitted to have in their cells, and what type of cutlery they are authorized to use.

Response – The new policy is that inmates not on suicide watch but who are in segregation are entitled to have plastic cutlery, including knives. However, the intent of the policy is that what goes into the cell comes out of the cell. By the next security inspection, any extra food or the extra cutlery is to be removed.

Recommendation 8 – That upon approval and direction of the Assistant Deputy Minister, Correctional Services Division and the Executive Director of Adult Centre Operations Branch, an investigative debriefing is held with LCC personnel involved in the Board of Inquiry.

Response – The evidence was that this has been done.

Recommendations for the prevention of similar deaths:

Recommendations of this Fatality Inquiry

I wish to express sincere thanks to counsel, Ms. Simmonds, Ms. Freeman and Ms. Louw for their very able assistance in this Fatality Inquiry. I also want to express appreciation and thanks to the Alston family who attended and participated throughout, especially Mr. Tom Alston, who represented the Alston family in an extremely well prepared and professional manner. Tom Alston made a number of very helpful suggestions for recommendations. Although I have not been able to adopt all of Tom Alston's suggestions, I can assure him that they were all seriously considered.

Section 53(2) of the *Fatality Inquiries Act* allows me to make recommendations to prevent similar deaths in the future. It does not allow me to assess blame or fault. To that end, I have seriously considered the submissions as to recommendations from all the parties.

In considering what recommendations should be made in this Fatality Inquiry, I believe it is important to recall that this situation occurred while Mr. Alston was in the segregation unit, but he was there for disciplinary purposes, and not because he was considered to be a suicide risk. The evidence throughout was that he had been asked if he had any suicidal ideations on admission a few days before, and he had denied them. There was no reasonable evidence that any staff felt or had reason to believe that he was suicidal.

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 2 – *The Vents* – The evidence was clear that Mr. Alston managed to make a ligature from his security blanket, which he tied to the overhead vent in his cell, so he could hang himself. The evidence was that LCC, and Alberta Infrastructure has made inquiries about replacing these vents with something safer, but no progress has been made. It was submitted by Tom Alston that there are tamperproof anti-ligature vents available on the market. This was also the subject of Recommendation 5 from the Board of Inquiry. It is recommended that the overhead vents be replaced by tamperproof anti-ligature vents.

Recommendation 3 – *Security Blankets* – The evidence was that the ligature in this case had been fashioned by taking apart the security blanket, but it was not clear exactly how this was done. It was suggested that it was either done by the plastic knife found in the cell, or alternatively Mr. Alston did it with his teeth. These security blankets are made by inmates at the Calgary Correctional Centre. It was suggested that there may be other and better options on the market. 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.

Recommendation 4 – *Plastic Knives* – There was evidence that a plastic knife was found in Mr. Alston's cell. There was evidence that it was possible that a plastic knife could be used to make the ligature from the security blanket, although there was no evidence that actually happened, in that Mr. Alston could have done so with his teeth as well. It is acknowledged that current corrections policy is not to deny inmates any privileges, unless there is a good reason to do so. It is also acknowledged that Mr. Alston was not on suicide watch, he was on the segregation unit for disciplinary reasons. Nonetheless, there was also evidence that inmates can pass items back and forth between cells using various illicit means, including fishing lines. 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.

Recommendation 5 – *Compliance with Internal Policies* – In cross-examination, Mr. Tom Alston pointed to a number of LCC policies which were not complied with by LCC staff in this incident. First of all, Mr. Alston was supposed to be kept in the dry cell for 72 hours, but he was released to the segregation unit to begin his sentence there earlier. Secondly there was a plastic knife in his cell which was contrary to LCC policy. It should be said that there is no evidence that these non-compliances contributed directly to Mr. Alston's death. It also must be said, as was pointed out by LCC staff, that it was to Mr. Alston's benefit that he was released from dry cell early so he could start serving his disciplinary sentence, which would then get him into the general LCC population sooner. Tom Alston also pointed out other apparent areas of non-compliance, such as the lack of reporting records for the dry cell, the pencil found in Mr. Alston's cell, timing of the rounds in the unit, and the fact that there may not have been two guards with Mr. Alston at the hospital. It should be stated that, with the possible exception of the plastic knife in the cell, it is not clear that any of these non-compliances contributed to the death of Mr. Alston. LCC staff testified that in a complex and constantly changing human environment such as LCC, some flexibility in policy must be allowed in the context of every situation. Having said all that, there is still a concern that the CPO in Mr. Alston's unit was not aware that the policy said plastic knives were not permitted. This speaks to a possibility that either the policy was out of date, or the CPO had not been sufficiently trained on the policy. 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.

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.

Recommendation 7 – *Annual Audit of the Code Bags* – In this case, the evidence was that while the code bag was brought to the scene in a fairly timely fashion, AHS staff could not locate the scissors in the bag needed to cut down Mr. Alston. In the meantime, the CPO was physically holding him up to try to relieve the pressure on his neck. It is clear that every second counts in a situation like that, and it is easy to imagine a situation where a CPO is unable to hold up a hanging inmate. 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.

Recommendation 8 – *Drug Withdrawal and Suicide Training* – 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.

In closing, I wish to again express my thanks to counsel for their able assistance and representations. To Tom Alston, your hard work has been appreciated, and your contributions have been helpful and substantial. To the Alston family, deep condolences for your loss. Losing a son and brother like this must be a very difficult path to walk.

DATED June 30, 2023,

Original Signed

at Lethbridge, Alberta.

P.G. Pharo
Justice of the Alberta Court of Justice