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BY E-MAIL

August 18, 2023

Jane Freeman
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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 Lethbridge Correctional Centre, Custody Operations Branch:

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.

A request for a response to Recommendation Numbers 1 and 6 has also been sent to Alberta Health Services.

I ask that you please advise the following:

1. Whether Lethbridge Correctional Centre, Custody Operations Branch, 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 Lethbridge Correctional Centre, Custody Operations Branch, 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