ALBERTA

Report to the Minister of Justice and Solicitor General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the The Provincial Court of Alberta

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

on the third to fifth day of December, 2018 (year), (and by adjournment

on the _____ day of _____, _____ (year)),

before T. W. Achtymichuk, a Provincial Court Judge,

into the death of Shane Andrew Matthon (Name in Full) 31 (Age)

of Edmonton, Alberta (Residence) and the following findings were made:

Date and Time of Death: 9:44 a.m. on March 7, 2015

Place: Fort Saskatchewan Correctional Centre

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)).

Adverse effects of heroin, codeine and oxycodone misuse

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)).

Unclassifiable

Circumstances under which Death occurred:

Mr. Matthon was an inmate at the Fort Saskatchewan Correctional Centre (FSCC) on March 6 and 7, 2015. He was serving weekends on the Intermittent Sentence Unit (ISU). At about 9:04 am on March 7, a drug dog handler was doing searches and found Mr. Matthon lying unresponsive on a bunk. A nurse started CPR. Staff attended to Mr. Matthon until an ambulance arrived at 9:22 a.m. RCMP arrived shortly after. However, at 9:44 a.m. Mr. Matthon was pronounced dead.

The Issues for this Inquiry

The Chief Medical Examiner notified the Fatality Review Board (Board) of Mr. Matthon's death, because he died while an inmate in a correctional institution. The Board recommended that this public fatality inquiry be held. In doing so, the Board was required to consider whether or not there was a meaningful connection between Mr. Matthon's death, and the nature or quality of care or supervision provided to him at FSCC (*Fatality Inquiries Act* (*FIA)*, s.33(3)(b)).

In this report, my findings are to include the circumstances under which Mr. Matthon died, the cause of death, and the manner of his death. My report may contain recommendations to prevent similar deaths. But my report cannot contain findings of legal responsibility (*FIA,* s.53).

Two conferences were held before the Inquiry. At the first, the primary issues were identified as:

1. How Mr. Matthon came to be in the possession of drugs;
2. How staff could identify that Mr. Matthon was under the influence of drugs;
3. The nature and quality of care that Mr. Matthon received while in custody;
4. The nature of patrols completed on the unit;
5. The ability of FSCC staff to determine when inmates are in medical distress; and
6. The ability of staff to identify inmates on the unit in an emergency situation.

I will deal with each of these issues in turn.

A binder of documents was admitted into evidence as Exhibit 1. The binder includes Medical Examiner documents, such as autopsy and toxicology reports. It also includes the almost 600 page Board of Inquiry Report from Alberta Correctional Services. I will refer to documents in Exhibit 1 by their page numbers.

The primary issues which have been identified for this Inquiry relate to the use of drugs by Mr. Matthon. I will review the evidence about that, before turning to those primary issues.

I find that Mr. Matthon died from the adverse effects of heroin, codeine and oxycodone misuse. This finding is based on the following.

The evidence is that Mr. Matthon died from drug misuse. The immediate cause of death listed in the Medical Examiner's Medical Certificate of Death is "adverse effects of heroin, codeine and oxycodone misuse" (00002).

That is confirmed in the autopsy report. That report notes a recent single needle puncture mark in Mr. Matthon's left inner elbow. The toxicology report showed heroin, codeine and oxycodone present in Mr. Matthon's system. Toxicology analysis also showed that the injection was shortly before death. There were no other marks, injuries, disease or trauma to account for Mr. Matthon's death (00003-00007).

This was also confirmed by Assistant Chief Medical Examiner Dr. Balachandra's testimony. He says it is not known whether Mr. Matthon died from an overdose, collateral side effects not related to the dose, or idiosyncratic hypersensitivity type reactions. The cause of death being described as the "adverse effects" of the drugs, includes all three possibilities.

Based on Dr. Balachandra's evidence, the levels of heroin seen in the toxicology report make it likely that it was injected rather than ingested. The codeine could be from the breakdown of heroin in the system, or being taken separately. It is possible that death can occur within 15 to 30 minutes after such an injection of heroin. Based on the information available to him, Dr. Balachandra's evidence is that Mr. Matthon may have died about 6 to 8 hours before he was first found unresponsive. That would be between 1 am and 3 am. He also says that it is hard to identify the time of Mr. Matthon's death with any certainty, because there are so many variables.

In summary, I find that Mr. Matthon injected heroin and died from the adverse effects of heroin, codeine and oxycodone.

I now turn to the primary issues.

1. How Mr. Matthon came to be in possession of the drugs.

The evidence shows that another inmate likely provided the drugs to Mr. Matthon that night in the ISU.

> A. Mr. Matthon likely did not take drugs before being admitted into the ISU that night.

Mr. Matthon likely did not take drugs before being admitted into the ISU that night. That is because he did not show signs of drug use when he was assessed by a nurse on his intake. Also, other evidence from video and from a guard, is that Mr. Matthon was not showing signs of intoxication or impairment for some time after his admission.

The ISU is located outside the main walls of FSCC. Most intakes of inmates into the ISU were between 7 pm and 9:00 to 9:30 pm. There were 2 nurses doing intake assessments in the same room.

Alberta Health Services (AHS) set the protocols for these assessments. There was a standardized list of questions for the initial intake assessments, and for later intake assessments after the first one. The initial intake assessment for an inmate was thorough. It involved a head to toe physical exam, full medical history, a review of psycho-social, mental health and addictions issues, vitals, and a review of any medical conditions or concerns.

For intakes on later dates as the inmate continued to serve the intermittent sentence, the intakes were not as thorough. The intake nurse had the intake file for the inmate, showing the initial assessment and any concerns noted along the way with later intakes. Although less thorough, there was still a conversation to assess manner, gait, speech, pupils, excitability, dry mouth, nodding off, perspiring and other signs of drug use. Licensed Practical Nurse (LPN) Pamela (Deanne) Thomas testified that she detected these signs all the time on intakes. She says that everyone denies addictions and using drugs. But she says 90% of inmates admit to drug use before intake when confronted with the signs. LPN Thomas was chosen to be an intake nurse because of her extensive experience with addictions and assessments, including identifying the signs and symptoms of drug use.

The usual intake process inmates go through before seeing the intake nurse, takes about 20 minutes. Ms. Thomas' evidence is that anyone who has taken drugs before starting the intake process, would be showing signs of drug use by the time they see the nurse.

Mr. Matthon was the last person to be assessed for admission on March 6, 2015. This was not his first intake to serve his intermittent sentence. Ms. Thomas did not do the initial intake for Mr. Matthon. But his March 6 admission was her third intake for him. She had his intake records. She found him to be articulate, with no medical history. He was forthright and quiet. He denied use of drugs that night. She had no concerns with him on any intakes, including this final one. She did not see any signs of impairment by drugs or alcohol.

On that night, video showed that it was about 10 minutes between the time Mr. Matthon was first admitted into the booking area, and when he was assessed by LPN Thomas (00023). That is less than the usual 20 minutes for signs of drug use to appear, before being assessed. However, the evidence still supports a finding that Mr. Matthon likely did not take drugs before his intake into ISU. Mr. Matthon was not showing any visible signs of intoxication or impairment on the CCTV video of his admission. That is consistent with LPN Thomas' assessment. Also, Correctional Peace Officer (CPO) Sylvain Daraiche had a conversation with Mr. Matthon after his admission. CPO Daraiche got to know him from past interactions in the ISU. The guard did not notice anything unusual about Mr. Matthon at that time.

Another inmate in the ISU that night told the Board that although Mr. Matthon had said he had taken drugs before being admitted into the ISU before, he had not taken any that night. The Board found that information to be credible.

Chad Pilgrim was an inmate in the ISU that night. He knew Mr. Matthon through work, and also from them being in the ISU together on some weekends before this. When Mr. Matthon was found unresponsive the next morning, Mr. Pilgrim talked to one of the guards. He said to the guard that Mr. Matthon had told him that he had taken drugs, including heroin, before being admitted into the ISU the night before, and that he took Fentanyl, Tylenol 3's and sleeping pills after he arrived.

I do not accept that Mr. Pilgrim was told this, nor that Mr. Matthon actually did what he says. That is because it is inconsistent with other credible evidence. It is inconsistent with the medical evidence that did not find Fentanyl in Mr. Matthon's system. It is also inconsistent with Mr. Matthon not showing signs of intoxication or impairment on intake, and for a significant time after his admission. Finally, I am satisfied that Mr. Pilgrim saying these things was at least in part designed to deflect from his own actions with Mr. Matthon that night, which I will discuss in more detail below.

Based on this evidence, I find that Mr. Matthon likely did not take drugs before his admission into the ISU that night.

B. Mr. Matthon likely got the drugs from another inmate in the ISU.

I find that Mr. Matthon likely got the drugs from another inmate in the ISU, for the following reasons.

First, drugs are brought into the ISU by inmates, despite procedures that are in place to prevent that. During intake into the ISU, inmates' clothes are removed and stored. They are given clothes to wear in the ISU. There is a thorough strip search. They sit in a Body Orifice Security Scanner (BOSS) chair used to detect whether they have any metal inside their bodies. At the time of this Inquiry, there was no machine available at FSCC to detect whether non-metal items were inside a person's body.

Despite these measures, inmates brought drugs into the ISU. That was the evidence of CPO's Matthew Loewen and Steven Marsden. Drugs are often hidden inside the body. That was the evidence of Mr. Pilgrim. Putting them in a non-metal container like a Kinder-Surprise Egg or something similar, which is then inserted in the anus, is a common method. That was information before the Board.

Second, video reviewed by the Board indicated that other inmates in bunks around Mr. Matthon were passing things to him. Just after 11:30 pm, video showed another inmate from a bunk next to Mr. Matthon's appear to hand something to Mr. Matthon. Mr. Matthon was propped up on his left elbow with his back to the CCTV camera, and with his bedding blocking the view of the camera. He appeared to be handling something under the blanket. He seemed to be concentrating on an area of his left arm. It appeared to the Board that he was injecting himself with an unknown substance. Shortly after that, Mr. Pilgrim was seen on video reaching in and out of another inmates' bunk, as if getting and returning things. Mr. Pilgrim then sat on Mr. Matthon's bunk with him.

Just after midnight, video shows several inmates, including Mr. Matthon and Mr. Pilgrim, going in and out of the bathroom. During this time, the guards left the unit to go to the front lobby to release two inmates to go "inside the wall", as confirmed in the log book. The guards returned at 12:08 am. Mr. Matthon returned from the bathroom about a minute later, after being in there for about 4 minutes. During that time, Mr. Pilgrim was moving between the bathroom, kitchen area, the common area, and once again to the bathroom. Mr. Pilgrim then returned to the bunk area with Mr. Matthon. An empty Kinder Surprise Egg was found on an upper shelf above the sink in the kitchen the next morning.

At 12:20 am, video shows Mr. Matthon walking to the kitchen. To the Board, his gait appeared looser, his arms were swinging casually and he touched a window frame which looked like an effort to steady himself. He walked back less than a minute later, and appeared steady. At 12:29 am, Mr. Matthon appeared to steady himself on other bunks as he stood up from his. At about 2:00 am, Mr. Matthon walked to the kitchen area. He touched the panes of glass in the kitchen area as if to steady himself. As he walked back within a minute, he staggered slightly and bumped a table with his hip. He appeared to the Board to be noticeably unsteady when compared to his earlier movements. That's the last recording of his movement on video.

Third, Mr. Pilgrim says that Mr. Matthon took drugs while in the ISU. That is consistent with what another inmate told the Board. That is consistent with the video evidence. Yet Mr. Matthon likely did not take drugs before his admission. Based on all of the evidence, I find that it is likely that he got the drugs from another inmate in the ISU.

2. How staff could identify that Mr. Matthon was under the influence of drugs.

Based on the Inquiry evidence, I find that staff likely could identify that Mr. Matthon was under the influence of drugs by 1) guards observing Mr. Matthon on camera and 2), guards observing Mr. Matthon in person, either while he was moving around, or during rounds by guards on patrol.

I have not mentioned here, the assessment by a nurse on intake looking for signs of being under the influence of drugs. That is because Mr. Matthon was not showing signs of that on his intake that night. I have found that he likely was not under the influence of drugs at that time.

However, there was evidence that Mr. Matthon had been under the influence of drugs when he was admitted into the ISU on other occasions. One way for inmates to try to avoid detection of drug use by a nurse was to show up late for intake into the ISU. The two nurses were in the ISU for the bulk of intakes during regular admission times. After that, they went back inside the walls of FSCC. If someone came late for admission after the nurses left, a guard could request that a nurse be brought back out for an assessment if the guard thought it was needed. The evidence is that this was not done very often. Mr. Matthon showed up late for at least some of his intakes. Records show he was only assessed by a nurse on four out of his nine admissions. But this was not a contributing factor to what happened to Mr. Matthon that night.

I will mention here the issue of security checks. That issue was addressed by the Board, and was the subject of evidence on this Inquiry. The Board found that s. 4(1) of Standing Operating Procedure (SOP) 14.45.23 ISU – Daily Procedures (00245) required that a security check of the ISU, including a search of all bunks, bedding and mattresses, be done and documented within one hour of the start of each shift. CPO's Daraiche and Loewen were on duty that night. They did not do a security check within one hour of the start of their 11 pm shift, nor during their shift at all.

Cameron Phillips was then Acting Director of Operations. His evidence at the Inquiry is that in March 2015, the existing policy required one security check when the ISU opened on Friday before inmates started arriving, and one on Sunday after the inmates were released. He says the policy changed in 2016, to require a security check within one hour of the start of each shift. He also says that security checks are of the physical plant – windows, doors, locks and the like. He did not mention searches of bunks, bedding and mattresses as part of security checks. It was said during submissions that security checks do not include searches of bunks.

The FSCC policies about this were not clear. Section 4(c) of that SOP says a "search and Security Inspection" was to be done when the ISU opened before inmates arrived. That seems to be what Mr. Phillips is talking about. Section 4(i) says "complete security checks and document within one hour of shift". That is what the Board is talking about. Different words being used – Security Inspection vs security check – suggest that these are different things. Other policies suggest "security checks" are of the physical plant rather than bunks, bedding and mattresses (s. 1, 2 SOP 10.00.04 – Inspection of Security Safeguards (00222)). But CPO Daraiche told the Board and this Inquiry that one reason they didn't do a security check that night, is that they would have to wake up inmates and search under bunks and mattresses, which puts guards in an unsafe position. Apparently, they understood a security check to include searches of bunks.

The Board noted the video showing that the night guards moved all the inmates into the kitchen area for the body count at the start of their shift. That was an opportunity to search bunks within the first hour of their shift.

It is unlikely that a search of bunks, bedding and mattresses before 12:00 midnight would have identified that Mr. Matthon was under the influence of drugs. It appears from video that he was taking drugs by about 11:30 pm. But the video did not reveal noticeable signs of impairment until well after midnight.

On the one hand, a search of bunks being done before midnight may have uncovered the drugs that Mr. Matthon appeared to be taking at 11:30 pm. It may have uncovered the items being taken out of bedding and passed to Mr. Matthon. It may have deterred the exchanging and taking of drugs that night. On the other hand, it is also possible that inmates knowing a search of bunks was being done, would have done things to still avoid drugs being found. However, even if a search of bunks at the beginning of a shift does not eliminate the use of drugs in the ISU, it is at least designed to reduce the risk of it. FSCC policies were unclear about whether a search of bunks was required. In any event, that was not done here.

I now turn to the ways staff could identify that Mr. Matthon was under the influence of drugs that night.

A. Guards observing Mr. Matthon on camera.

The evidence from guards is that there are at least two areas in the ISU where inmates want to be, if they want to avoid detection. The first is the bathroom. The second is an area of four bunks that is mostly or entirely out of site from the "bubble" where the guards sit. When Mr. Matthon was admitted, he chose a bunk in that area. He put shoes on the other bunks around him, appearing to save them for people he knew.

A new camera system had been installed in the ISU several days before March 6. They operated continuously. However, the one camera pointing to the trouble area of four bunks was mistakenly set up to begin recording only when there was motion, rather than continuously. The cameras were fed to screens in the bubble, for monitoring by guards.

Even though the camera pointing to the trouble area was not set up properly, the video still showed inmates taking things out of bedding, putting them back in, and exchanging them. It showed items apparently being passed to Mr. Matthon during these exchanges. It showed what appeared to be Mr. Matthon injecting something into his left arm. This camera, and others in the kitchen area, showed Mr. Matthon exhibiting increasing signs of physical impairment.

These videos are now being viewed with the benefit of hindsight, knowing what happened to Mr. Matthon. However, one might expect that guards would pay particular attention to a camera that is pointing at the area guards know that inmates want to bunk if they are going to get into trouble, when that area is not really visible from the bubble. One might also expect that guards would pay particular attention to video of Mr. Matthon walking to the kitchen at 2:00 am, appearing to be noticeably unsteady.

CPO's Daraiche and Loewen say they didn't notice anything wrong with the way the cameras were operating that night. They didn't notice that the camera for the trouble area only operated when there was motion. Granted, knowing the camera has stopped recording when there is no motion to record, might be hard to detect. But they both say that they didn't notice anything unusual in the behavior of Mr. Matthon or the other inmates that night. CPO Daraiche describes Mr. Matthon as someone who walked slowly. But that doesn't explain the video of Mr. Matthon being noticeably unsteady around his bunk and in the kitchen.

The two guards had already completed a shift elsewhere in FSCC from 3:00 pm to 11:00 pm. They were scheduled to work an overtime shift in the ISU from 11:00 pm to 7:00 am. They admitted that they were using the computer in the bubble for personal reasons that night, to watch You Tube and the like. They say this didn't divert their attention from their duties, but instead helped to keep them awake. However, they both acknowledge that their computer use was against FSCC policy.

There are other reasons to question how they were fulfilling their duty to monitor the screens in the bubble. They did not do a security check at the beginning of their shift, as they understood policy required them to, even if the policies were unclear. They did not do their rounds in the ISU that night as often or as thoroughly, nor record them properly, all as is required by policy, which I will detail below. Other ISU policies about lights out, turning off the TV, and allowing inmates to visit in bunks and to sit in the kitchen after bedtime, were not strictly followed. The cameras showed a lot of visiting in the trouble area after lights out, but guards didn't try to disperse the group (00039).

These other instances of how duties were carried out, may not have changed what happened to Mr. Matthon that night. Instead, I take them into account in assessing whether guards could have identified that Mr. Matthon was under the influence of drugs that night from the video of Mr. Matthon appearing to take drugs, being unsteady around his bunk after that, and while walking to the kitchen at 2:00 am. I find that the cameras could have identified that to guards.

I now turn to the second way that staff could identify that Mr. Matthon was under the influence of drugs.

> B. Guards observing Mr. Matthon in person, either while he was moving around, or during rounds by guards on patrol.

Some of Mr. Matthon's behaviours that were seen on camera, could have been seen by staff in person.

Mr. Matthon walking to and from the kitchen at 2:00 am and being noticeably unsteady, was an opportunity for guards to talk to him. He would have had to walk in view of the guards in the bubble to go to the kitchen. A light was left on in the kitchen area at night, so that it was not completely dark in the ISU. Mr. Matthon was awake and walking around the ISU at an unusual hour. Doing a check in with him then could have identified that he was under the influence of drugs.

Mr. Matthon's behaviours could have been discovered on rounds by guards in the early part of the night shift. FSCC policy required rounds by guards at least every 30 minutes. That policy also applied to the ISU. There should have been 4 rounds by 1:00 am. By then, the evidence is that Mr. Matthon had taken drugs, was very drowsy and unsteady around his bunk, and was showing some apparent unsteadiness while walking to the kitchen at around 12:30 am.

Video shows that by 1:00 am, the guards completed two rounds instead of four, at 12:00 and 12:31 am. They did not walk between all the bunks. They did not walk in the trouble area where Mr. Matthon was bunking. Instead, they walked around the perimeter of the bunks in a horseshoe. That was the practice they followed. An opportunity for guards to interact with Mr. Matthon on rounds before 1:00 am did not arise, because of the way the guards did their rounds.

Four rounds that included walking by Mr. Matthon's bunk could have identified that he was under the influence of drugs. That does not mean that it necessarily would have. It is unlikely it would have uncovered actual drug use. That could be quickly and easily hidden. Also, behaviours by Mr. Matthon and those bunked around him could quickly change to hide intoxication by, for example, faking sleep, knowing that guards are approaching the trouble area where they were. But it *could* have identified that he was under the influence, which can reduce the risk of it.

I now turn to the third issue.

3. The nature and quality of care that Mr. Matthon received while in custody.

There are two aspects to the nature and quality of Mr. Matthon's care. The first relates to the nature and quality of his supervision before he was found unresponsive. The second relates to the medical care he received after he was found unresponsive.

The first aspect - the nature and quality of his supervision before he was found unresponsive – I will deal with when I address the next issue about the nature of patrols on the unit. In this section, I will focus on the second aspect – Mr. Matthon's medical care.

I find that Mr. Matthon's medical care was very competent, and commendable.

By shortly after 9:00 am on Saturday, March 7, most of the inmates had arisen from their beds. CPO Shaun McCoy was a drug dog handler. He arrived at the ISU with the drug dog around that time. The dog took an interest in a bunk near Mr. Matthon's. CPO McCoy noticed that Mr. Matthon had not gotten up. His upper bunk was about 5 feet off the ground. He was laying on his right side. His head was facing the wall, with his back facing the aisle. He was in a semi fetal position. CPO McCoy shook Mr. Matthon's leg, which was stiff. There was no response.

By then, CPO's Korey Cleland and Steve Marsden were on their dayshift at the ISU, which started at 7:00 am. LPN Kennedy Ennis also was there to administer medications. CPO McCoy notified CPO Marsden that Mr. Matthon was unresponsive. CPO Marsden climbed up to Mr. Matthon's upper bunk. He saw that Mr. Matthon's face was blue, saliva had dried around his mouth, and his arm was stiff. An emergency code 99 was called. This was about 3 minutes after Mr. Matthon was first discovered unresponsive.

CPO Marsden went to the common area where LPN Ennis was. CPO's Marsden and Cleland went back to Mr. Matthon's bunk with LPN Ennis. She told them to bring Mr. Matthon down to the floor for CPR. His arm was bent in a 90 degree position, stiff in rigor. That told her that Mr. Matthon had been in that condition for some time. She told another CPO to call 911, which was done. She and CPO Marsden started chest compressions immediately, alternating to avoid fatigue.

The first members of Emergency Response Team arrived right away. Nurses Catherine Bache and Jessica Lowe brought the code bag, medical bag and oxygen tank. They started oxygen with a mask and bag. Another nurse Leah Warawa, arrived a few minutes later and helped with chest compressions.

During this time, other inmates were being interviewed. Chad Pilgrim told CPO McCoy that Mr. Matthon told him that he had taken drugs, and mentioned Fentanyl. This was relayed to nurse Bache. She immediately administered Narcan by injection. That can quickly reverse the effects of a narcotic if given in time.

The chest compressions, oxygen and Narcan, had no effect. Within 11 minutes of Mr. Matthon first being found unresponsive, Nurse Bache then applied the portable automated external defibrillator (AED), following the AED protocols. She applied it several times to see if there was a heart rhythm to shock. Each time, the AED indicated "no shock advised". That means there was no heart rhythm to shock, and the AED won't work.

The first team of Emergency Medical Services workers from Strathcona County arrived six minutes after that, which was 17 minutes after Mr. Matthon was first found unresponsive. A second team from Fort Saskatchewan EMS arrived, and assumed treatment. Their treatment included machine chest compressions, an intraosseous intravenous, and intubation. None of the steps they took revived Mr. Matthon. He was declared dead at 9:44 am by Strathcona EMS by teleconference with the attending physician Dr. Lee.

The evidence shows that the appropriate medical staff and equipment were properly available and used in providing medical care to Mr. Matthon after he was found unresponsive. The evidence is that the medical care Mr. Matthon received complied with FSCC policies for such situations. There was no evidence that the FSCC policies and procedures for this were inadequate. There was no evidence to indicate that this medical care was anything other than very competent and commendable.

I now turn to the other aspect of the care Mr. Matthon received - the nature and quality of his supervision before he was found unresponsive. This includes the nature of patrols completed on the unit.

4. The nature of patrols completed on the unit.

I will deal with three aspects of the patrols on the unit: 1) patrols by the night shift guards; 2) patrols by the shift manager that night; and 3) patrols by the day shift guards the next morning.

The Inquiry evidence shows that only the patrols by the day shift guards the next morning were done according to FSCC policies.

A. Patrols by the night shift guards.

The Inquiry evidence shows that when and how rounds were done and recorded by the night shift guards in the ISU that night, did not comply with FSCC policies for doing rounds.

FSCC policies for the ISU required the following:

1. Guards make routine rounds of the unit every 30 minutes at minimum, to monitor behavior and activity of offenders (s. 4(i) of SOP 14.45.23 and 14.45.06) (00043, 00245);

2. Guards do formal body counts at specified times, and informal body counts periodically to be satisfied all inmates are accounted for. Live body counts mean actual sight of the inmate's head, hand, foot or other part, and signs of life like, for example, breathing (ss. 1, 2 of Policy 10.00.03, Security Procedures – Security and Control, Counts of Offenders) (00220); and

3. Guards keep accurate records in the unit log book and ORCA (s. 4(g) SOP 14.45.23) (00245).

First, CPO's Daraiche and Loewen only did about half the rounds they should have that night, with no reasonable excuse. They were on the night shift from 11:00 pm to 7:00 am. The CCTV video shows that they did rounds at 12:00, 12:31, 1:35, 2:38, 2:56, 3:46, 4:36 and 6:30 am (00039). They only did 8 rounds instead of the required 15 on that night shift.

They say that unlike the rest of FSCC where rounds are required every 30 minutes, they thought that didn't apply to the ISU. They thought that a provincial requirement of rounds every hour applied in the ISU. Even that requirement was not met in the rounds they did. No reason was given for thinking that the FSCC policy did not apply to the intermittent sentence unit at FSCC.

Second, the guards did not complete any live body counts on that night shift after the formal count at the start of the shift, with no reasonable excuse. They did not go down each aisle between all the bunks. They did not walk down the aisle of the trouble area where Mr. Matthon was bunking. Instead, they only walked around the perimeter of the unit. The Board described their rounds as superficial glances around the unit. CPO Daraiche testified that in doing so, he was looking for breathing and any signs of movement. But in the darkness, it would be unlikely that he could have actually seen body parts and signs of life for every inmate.

CPO Daraiche says he did not feel safe walking down all the aisles in the dark, especially with bunks on both sides. However, guards have flashlights, and one can watch from the bubble either visually or by cameras, while the other guard does the count. That is how the day shift guards did rounds the next morning, when it was still dim.

Third, the night shift guards did not keep accurate records of the rounds they did that night, with no reasonable excuse. At that time, FSCC was moving from handwritten notes in a log book, to the ORCA computer system, to record notes. During the transition, guards were required to keep notes in both systems. The round times that the guards put into the ORCA system did not correspond to the round times that were recorded in the log book, or that were seen on video (00039). The ORCA entries recorded one less round than the log book and video (00025). Also, the times of the rounds recorded were inconsistent between all three of the logbook, ORCA and the video, sometimes significantly. The guards say that their recording of rounds was not intentionally falsified, but was simply mistaken.

These three policy requirements for rounds and live body counts were not met by the night shift guards.

B. Patrols by the shift manager that night.

The Inquiry evidence shows that the supervising shift manager did not complete his rounds of the ISU that night, as required by FSCC policy.

FSCC policy says that the shift manager shall complete daily rounds of all units, control posts and physical plant (s. 10 SOP 14.00.01 Operational Procedures – Shift Manager Duties and Responsibilities – General) (00237).

Mr. Phillips was the shift manager that night. The list of administrative duties for that position in FSCC policy is long. He says that on that night, he was not able to complete his rounds in the ISU and some other units, because he was occupied by those other administrative duties. That night, he was processing 8 unlawfully at large files including a temporary absence suspension. He was completing his other regular routine duties such as rounds of some units, scheduling and filling the roster, holding muster before the shift, assigning locations and duties for staff, completing OT records, hiring OT staff for the next morning, supervising staff, and making sure incidences were being properly reported. He had operational duties, like completing reports and time served file reviews. Also that night, he was dealing with 8 offenders in admissions and discharge due to medical and intoxication issues, with one or more on suicide watch (00078). There was no one else to whom he could delegate those tasks. For the most part, his duties were carried out inside the walls of FSCC.

This provides some justification for DDO Phillips not completing his rounds in the ISU that night. However, it did mean that the two night shift guards in the ISU that night were left unobserved for their entire shift. The cameras in ISU only send video in real time to the screens in the guard bubble in ISU. It is not sent to Central Control inside FSCC or to any other area. Apart from these two guards inputting their formal body counts into the FSCC system twice during their shift, they were unsupervised.

C. Patrols by the day shift guards the next morning.

The patrols completed by the day shift guards the next morning complied with FSCC policies, with one possible exception.

The possible exception was this. CPO Cleland and Marsden's day shift started at 7:00 am the next morning. FSCC policy stated that a security check be done within one hour of the shift starting. These guards say that it was not done by 8:00 am, because the drug dog handler was coming that morning, arriving at about 9:00 am. Doing a security check before that would eliminate the element of surprise for the drug dog search, and defeat its purpose. There was a rational justification for delaying the security check for an hour.

I have earlier referred to FSCC policies being unclear about security checks. Mr. Phillips did not mention bunk searches being part of security checks. The night shift guards thought security checks involved bunk searches. That also seems to be the case with the morning shift guards after. If they thought security checks included bunk searches, that could explain why they postponed the security check to avoid rousing inmates before the drug dog arrived.

CPO's Cleland and Marsden did a formal count at the start of the shift, looking at every inmate for signs of life and breath. They did their rounds at 7:30, 8:04, 8:30 and 9:04 am. The lights were still out except the one in the kitchen. It was a little bit dim, rather than completely dark. They went down the aisles between the bunks. On the first round, a chair was removed from the aisle between the bunks near Mr. Matthon. The guards appeared on video to be conscientiously looking at inmates in their beds during their rounds. CPO Marsden says Mr. Matthon was on the upper bunk, his back facing him. He only saw the back of his head, but thought he was breathing. The lights were turned on at 9:04 am, when the dog handler arrived. The inmates were directed to get up and go into the kitchen area.

The day shift guards appeared to do their rounds properly, carefully and according to policy. Yet their formal count and three rounds over two hours failed to discover that Mr. Matthon was unresponsive.

That leads to the next issue.

5. The ability of FSCC staff to determine when inmates are in medical distress.

The Inquiry evidence suggests that even if all the patrols that night had been done according to FSCC policies, that doesn't necessarily mean that Mr. Matthon's condition would have been discovered earlier. Rounds by the shift manager presumably would have been more supervisory, rather than him doing rounds in the ISU himself. But a discussion with the night shift guards about how they were doing them, could have led to more and better rounds by them that night. It is possible that more and better patrols by the night shift guards could have discovered Mr. Matthon's condition earlier. But apparently proper patrols by the day shift guards did not. So proper patrols that night would not have eliminated the risk of Mr. Matthon's medical distress going undetected. But they could have reduced the risk.

The Inquiry evidence does not suggest that inadequacies in the policies for the ISU requiring rounds and live body counts at least every 30 minutes, had a meaningful connection to Mr. Matthon's medical distress going undetected. For example, policies requiring that inmates be woken up on every round to confirm signs of life would eliminate the risk of undetected medical distress during rounds, and at least reduce that risk between rounds. But that, of course, would be unworkable for staff and inmates. The policies must strike an appropriate balance between reducing that risk, and allowing inmates to sleep and the ISU to function. These policies did that by requiring staff to implement the policies, involving the exercise of some judgment.

The Inquiry evidence shows that the night shift guards did not implement the policies in the ISU for rounds and live body counts. This was not a situation of staff making reasonable efforts to implement policies, but making errors of judgment or human mistakes in doing so. Instead, it was a failure to understand and fulfill their duties under these policies. Their evidence did little to acknowledge that they did not do their jobs properly. Instead, their evidence was more about rationalizing and justifying. Had they done their jobs properly, it could have increased the likelihood of determining that Mr. Matthon was in medical distress.

The shift manager did not implement the policy that he go to the ISU as part of his rounds of all units. The Inquiry evidence is that this was an error in judgment in implementing the policy. That is because the shift manager decided to not complete all of his rounds in the units, due to the other administrative duties he had that could not be delegated. Had he done his rounds to supervise the ISU night shift guards, it could have increased the likelihood of better patrols, and determining that Mr. Matthon was in medical distress.

The Inquiry evidence shows that the day shift guards made reasonable efforts to implement the policies for rounds and live body counts, but failed to determine that Mr. Matthon was in medical distress. This was due to human error in implementing the policies. Having said that, however, three rounds were done that morning before Mr. Matthon was determined to be unresponsive. On each, staff thought Mr. Matthon was breathing, when he was not. That indicates a degree of complacency about checking for signs of life. There can be many reasons for that. One possible reason for complacency is that doing a routine task many times over many shifts with the same outcome – in this case, no one being in medical distress – can lead to a belief that all the sleeping inmates you are looking at are breathing. Staff training is one measure to guard against such human error in implementing policies.

I now turn to the last primary issue.

6. The ability of staff to identify inmates on the unit in an emergency situation.

This was raised as an issue for this Inquiry, because after Mr. Matthon was found unresponsive, some time went by before staff could confirm his identity. This was not a contributing factor to the outcome in Mr. Matthon's case. But it could be in other medical emergencies.

The policy in the ISU was that each inmate was to be assigned a specific bed (s. 4(e)(iv) SOP 14.45.23 – Operational Procedures ISU – Daily Procedures) (00245). If that was followed, staff would know the identity of every inmate in every bed.

That policy was not followed in the ISU generally, nor that night. Several reasons were given. Sometimes the ISU housed many more inmates than there were beds, and inmates slept on the floor. There were 58 inmates in the ISU that night, which was at about capacity. Sometimes inmates chose to sleep on the floor instead of a bed. Even if beds were assigned at the start of a shift, it was hard to enforce rules against inmates switching later, leaving staff not really knowing who was in which bed. Another reason for not assigning beds was to avoid conflict with inmates. Information before the Board was that although some other intermittent server units in other Alberta facilities did assign beds, there were problems with enforcement and monitoring (00033).

Knowing the inmate's identity as soon as possible can be important in a medical emergency. That gives access to the inmate's medical history. That may indicate a health issue that is causing the medical distress. Any health issues or allergies can affect medications being given or other treatment being provided.

By the time Mr. Matthon was brought down to the floor for chest compressions and masking, they had still not identified him because beds were not assigned. After that, the oxygen mask covering his face prevented them from using his wallet id to conclusively identify him. That, and his skin discolouration, made it hard to identify him. The inmate Chad Pilgrim told a guard that it was Mr. Matthon, but there was no other confirmation of that. It was only when they compared records with all the other inmates, that by process of elimination they identified Mr. Matthon, which then confirmed Mr. Pilgrim's information.

Once Mr. Matthon was identified, nurse Warawa went to the health care unit to review his file and medical history, showing no previous health concerns or allergies. She checked Netcare, the Alberta Health Services medical information system, which corroborated the information on the FSCC file. That information was given to the ISU nurses and EMS staff. But again, this delay in identifying Mr. Matthon did not affect the outcome.

Based on the Inquiry evidence, it is likely that there was no "bed board" that morning. A bed board identifies which inmate is in which bed in the ISU. The evidence is conflicting about whether one was created that night. CPO's Cleland and Marsden testified that there was a bed board, saying that is always done. However, other witnesses told the Board that a bed board was not created that night, because beds were not assigned (00049). The information given to the Board about this was detailed and closer in time to the actual events. The absence of a bed board explains why Mr. Matthon's identity had to be confirmed by process of elimination. Therefore, it is unlikely that there was a bed board that morning. I note that a bed board would not be conclusive in any event, if inmates switch beds after they are assigned.

Not knowing for certain which inmate is in which bed is a troubling issue in the ISU. Unlike inside the walls of FSCC, the ISU is an open setting where there is less control of the movement of inmates. There are some practical difficulties in monitoring and enforcing any policies for assigned beds. This is not unique to the ISU at FSCC. The same problems exist in intermittent sentence units in other correctional facilities.

Again, however, this was not a contributing factor to the outcome in Mr. Matthon's case.

Summary of Findings

1. Mr. Matthon died from drug misuse, including a heroin injection, while a serving inmate in the ISU at FSCC.

2. Mr. Matthon likely was given the drugs by another inmate in the ISU that night.

3. The night shift guards did not fulfill their duties in watching the camera screens in the ISU, or monitoring Mr. Matthon either on their rounds or when Mr. Matthon was walking around. Doing so could have increased the likelihood of identifying that Mr. Matthon was under the influence of drugs, but would not necessarily have identified that.

4. The night shift guards did not fulfill their duties in completing and recording their rounds the way they were required to by policy, without reasonable excuse. Doing so could have increased the likelihood of identifying that Mr. Matthon was under the influence of drugs or unresponsive, but would not necessarily have identified that.

5. The shift manager did not include the ISU in his rounds of the units at FSCC that night, as required by policy. The shift manager's other duties were given priority. That was an error of judgment in implementing the policy. Doing so could have increased the likelihood of identifying that the night shift guards were not fulfilling their duties.

6. A search of the inmates' bunks within one hour of the start of the night shift was not done. Policies were not clear about whether bunk searches were included with security checks. The night shift guards thought they were included, but did not do them. Doing so could have increased the likelihood of identifying the presence or use of drugs, but would not necessarily have identified that.

7. The medical care that Mr. Matthon received after he was found unresponsive was very competent and commendable.

8. Issues about policies and procedures relating to the assessment of inmates by nurses on intakes to detect drug use, and assigning bunks to inmates to more quickly identify them in a medical emergency, did not play a role in Mr. Matthon's death.

Recommendations for the prevention of similar deaths

After Mr. Matthon's death, the Board made a number of recommendations (00069). Also, FSCC set up a temporary ISU Committee to review policies and procedures in the ISU. A number of things were done as a result. Some of those things relate to issues that did not play a role in Mr. Matthon's death. They include:

- Every ISU inmate is assessed by a nurse on intake, no matter how late they arrive. They are segregated until assessed.
- Inmates choose their bunks, and a bed board is made associating bunk numbers with inmates' photos, to help identify inmates quickly in medical emergencies.

Other things that were done after, relate to matters that could have reduced the risk of Mr. Matthon's death. Those matters are reducing the risk of inmates bringing drugs into the ISU, and ensuring policies and procedures for the ISU are being followed by staff. Things that were done after include:

1. Reducing the risk of inmates bringing drugs in the ISU.

    - Screening all new admissions for prior institutional behavior or drug convictions, to identify and assess the risk of them bringing in drugs;
    - Increasing communication between staff and shifts by email and whiteboard, to track inmates with behavior problems, including the risk of contraband;
    - Using a "contraband tracker" form for inmates who are caught with contraband to increase communication between staff and shifts about who is more likely to bring in drugs. Inmates with contraband are brought inside the walls, separated, dry celled, and monitored;
    - Using drug dogs more regularly as a deterrent (every weekend when available), on either Friday or Saturday to keep an element of surprise;
    - Having two staff at the gate to monitor and deter drugs coming in;
    - Increased RCMP presence during Friday night admissions, as a deterrent;
    - Reinforcing to staff to slow down the intake process, to prioritize detection over speed;
    - Using internal institutional charges for contraband more often, as a deterrent;
    - Having a dedicated DDO to communicate issues to inmates' probation officers. It can be a deterrent if inmates know that bringing drugs into the ISU can result in criminal charges outside FSCC for breaching their probation orders. Also, information from probation officers can identify high risk inmates.

2. Ensuring policies and procedures for the ISU are being followed by staff.

    - Identifying and assigning to the ISU a regular group of staff who are interested in working there, are prepared to enforce policies and procedures consistently, and have the interpersonal skills (de-escalation) and other competencies to be effective in an open setting like the ISU. Rookie guards are not assigned. All of this should increase the consistency with which policies for supervision, patrols and searches are enforced. Inmates then know what to expect, including rules to detect drugs. Inmates told the Board that rounds had improved in the ISU after, including guards walking down each aisle between bunks;
    - Where possible, not using overtime staff for the ISU. That is to keep staff more alert. Before, the ISU was not part of the regular shift schedule at FSCC. That is because it is only open from Friday afternoon to Sunday night. ISU positions were filled in addition to the regular staffing at FSCC, usually with overtime. There was no evidence about how much the use of overtime staff in the ISU has been reduced;
    - Mr. Phillips says there is more staff training and debriefing. There were no details of that;
    - A memo is sent to staff once a year about the prohibition against engaging in attention diverting activities while on duty, such as personal internet use;

- Extra staff who helped with Friday night intake before, now stay in the ISU to help with patrols, until everyone is settled and asleep. If the drug dog is not available on a weekend, extra staff is also assigned to ISU later Saturday, to help with patrols. These are the higher risk times for drug use. Extra staff make it more likely that policies for rounds are followed, and complacency avoided;
- CPO's Daraiche and Loewen were subject to disciplinary measures for not doing their jobs properly. There was no evidence about what those measures were. If those measures properly reflected the degree with which they did not fulfill their duties, that could send a message to other staff about the importance of following policies;
- The ISU Committee could not find a way to re-configure the bunks to eliminate any being in blind spots from the guard bubble in the ISU. Mr. Phillips says that with a given number of bunks for that space, eliminating a blind spot for some just created a blind spot for others. There have not been any changes to the bunks;
- There have been no changes to the camera system, other than the setting on the camera facing Mr. Matthon's bunk being switched to continual recording. Mr. Phillps says there is no infrastructure to run the video feed from the ISU cameras to inside FSCC, such as Central Control, for monitoring by others;
- The ISU is now included with the other FSCC living units, for the quarterly audit process. That does not mean every unit is audited quarterly. The audit is quarterly, for units on a rotation. There had been two audits of the ISU at the time of the Inquiry. That should increase supervision to help ensure ISU policies and procedures are adequate and followed;
- Shift managers have been directed to complete their rounds of all the units, including the ISU, before they start processing files for those unlawfully at large for not showing up for their intermittent sentence.

Recommendations

1. Body Scanner. At the time of this Inquiry, the Edmonton Remand Centre (ERC) was using a body scanner as a pilot project. It was described as similar to a full body scanner used at airports, to detect objects inside the body, including non-metal ones. At the time of the Inquiry, there was no information available about the effectiveness of the ERC scanner. There was some information to suggest that it was quite dependent on the operator, and proper training. There was some information that it had not resolved the issue of drug use at ERC. Without more information about the effectiveness of the ERC scanner and its applicability to FSCC, I am not in a position to recommend one for FSCC.

However, an effective way to detect non-metal items inside the body would be a useful tool in the range of measures taken to reduce drug use in correctional facilities, to reduce the risk of similar deaths. It is recognized that such scanners represent a large capital cost.

It is recommended that FSCC assess the effectiveness of a full body scanner such as the one used at ERC, and consider its use for FSCC.

2. Security Checks. If the amended policy requiring security checks within the first hour of every shift does not include bunk searches, it is recommended that FCSS consider a policy requiring that, at least for the ISU. That could increase the likelihood of identifying the presence or use of drugs. The recommendation is not to do this, but to consider it. That is because there may be issues to consider about implementing this, that were not fully canvassed at the Inquiry. One possible issue is the feasibility of searching bunks between 11 pm and midnight.

3. Reinforcement of Policies to Staff. After Mr. Matthon's death, an ISU Committee was formed to discuss policies and procedures. That led to some positive changes being made which could reduce the risk of similar deaths, outlined above. The ISU Committee was not continued after that.

Like any large organization, complacency can set in about staff implementing new (and old) policies and procedures. As staff move in and out of positions, steps to ensure policies and procedures are consistently implemented in the ISU can erode over time. Doing rounds properly in the ISU is a critical component of that, and of reducing the risk of similar deaths.

It is recommended that FSCC consider institutionalizing a periodic assessment of the ISU by those working there regularly. That could take the form of an ISU Committee meeting once a year, for example. Something like that could be a means to ensure that the measures taken after Mr. Matthon's death, particularly with staff enforcing policies and procedures consistently, are revisited and reinforced periodically.

Finally, I wish to acknowledge the participation in this Inquiry of Shane Matthon's parents. They were effective advocates for their son, and for Mr. Matthon's own two young children.

DATED August 26, 2020,

at Fort Saskatchewan, Alberta.

"T.W. Achtymichuk"

T. W. Achtymichuk
A Judge of the Provincial Court of Alberta