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 Law Courts

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

on the 5th and 6th days of September, 2018 (year), (and by adjournment

on the 6th day of November, 2020 (year)),

before The Honourable R.K. Bodnarek, a Provincial Court Judge,

into the death of Ryan Holteen (Name in Full) 32 (Age)

of Edmonton Institution, 21611 Meridian Street, Edmonton, Alberta (Residence) and the following findings were made:

Date and Time of Death: September 26, 2013 at approximately 9:00 p.m.

Place: Edmonton Institution, 21611 Meridian Street, Edmonton, 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)).

Multiple Injuries.

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)).

Homicidal.

Circumstances under which Death occurred:

1. Introduction

This report relates to the death of Ryan Holteen (Holteen) at the age of 32. Tragically, Holteen died in his cell from multiple injuries inflicted by a fellow inmate in the Edmonton Institution on September 26, 2013.

I'll start by providing an overview of what happened in this case.

I'll then review four specific issues respecting Holteen's death, with a view to assessing whether this death was preventable. My assessment will not and cannot contain any findings of legal responsibility, nor any conclusions of law in accordance with s. 53(3) of the *Fatality Inquiries Act*, RSA 2000 Chapter F-9.

Finally, I'll discuss whether or not I have any recommendations that may assist in avoiding similar deaths in the future.

2. Overview of circumstances

Holteen was convicted of a charge of break and enter to commit a robbery with a firearm and related offences and was sentenced to 4 years and 2 months of imprisonment. Although Holteen had a prior criminal record, this was his first criminal conviction to attract a federal penitentiary sentence. His sentence commenced on August 28, 2013. On September 6, 2013, Holteen was transferred from Provincial custody into a general population unit at the Edmonton Institution. This transfer was for his initial intake assessment into the Federal correctional system to determine where he would ultimately serve his jail sentence. The Edmonton Institution is a maximum security facility under the administration of Correctional Service of Canada (CSC).

Holteen died before this intake assessment was completed. His death was a result of injuries inflicted by another inmate, Roderick McNeil (McNeil) on September 26, 2013, a little less than three weeks following Holteen's admission to the Edmonton Institution.

More specifically, McNeil and another inmate, Kimani Crawford (Crawford), entered Holteen's cell. McNeil beat Holteen, while Crawford stood watch. This was preceded by Crawford's prohibited entry into McNeil's cell upon their return from the gym. A short while later both McNeil and Holteen's cell doors were opened at the same time to permit them to access the showers. It was at this point that McNeil and Crawford entered Holteen's cell and the fatal beating was inflicted.

Although it's not entirely clear as to the motivation for this beating, it's possible that it may have related to Holteen's refusal to bunk with a roommate and the impact this may have had on the lack of sharing of a loaner television.

Ultimately, McNeil was convicted of manslaughter in relation to this incident and received a 13-year jail sentence. Given Crawford's lesser role in this attack, he was convicted of assault causing bodily harm and received a 20.25-month jail sentence.

In February of 2014, the Acting Commissioner of CSC established a Board of Investigation ("Board") under the authority of the Federal *Corrections and Conditional Release Act,* S.C. 1992, c. 20. The Board was tasked with, among other things, providing "... recommendations it considers appropriate and which may contribute to the effective resolution and/or prevention of similar situations or occurrences in the future."

The Board conducted an extensive investigation into this incident. The Board completed its report on May 6, 2014 and did not make any recommendations.

3. Issues to be addressed

The scope of this Inquiry, as determined at the Pre-Inquiry conference, relates to the following four issues:

- Holteen's placement at the Edmonton Institution for the completion of his initial intake assessment;
- options open to inmates who have safety concerns;

- the role of inmates in operational matters, such as the allocation of televisions and the creation of the shower schedule; and,
- the observation of inmates by CSC staff.

The information used to analyze these four issues comes from the numerous documents marked collectively as exhibit one to these proceedings.

In addition, I heard verbal testimony of the following CSC employees who were working in various capacities at the Edmonton Institution in the month of September 2013, as follows:

- Kelly Hartle (warden — who spoke to issues surrounding Holteen's placement at the Edmonton Institution for intake and assessment purposes);
- Chris Dunn (correctional officer — who found Holteen in his cell after the attack);
- Carmen Ings (correctional manager — who spoke to operational practices at the Edmonton Institution at the time); and,
- Wayne Villeneuve (correctional officer — who communicated with Holteen on the day of the attack regarding double bunking and a loaner television).

Finally, at the conclusion of the Inquiry on September 6, 2018, CSC legal counsel agreed to provide some additional information. This information was provided through Inquiry counsel by way of letter dated September 26, 2018. This letter attached Standing Order 566-3 titled "Inmate Movement at Edmonton Institution" which was due to be implemented by mid-October 2018. An update on the implementation of this Standing Order by CSC legal counsel was communicated through Inquiry counsel by way of letter dated March 20, 2019. This update indicated that the portion of the Standing Order relating to the number of cell doors open on each range at one time was implemented on December 11, 2018. The Inquiry was continued on November 6, 2020 for the sole purpose of marking these additional documents as an exhibit in the proceedings.

I now turn to my analysis of the four issues.

A) Holteen's placement at the Edmonton Institution for the completion of his initial intake assessment

Holteen was a first time Federal inmate. I have considered whether to make any recommendations relating to the placement of federal inmates for the initial assessment phase and have determined that no recommendations are required.

In coming to this conclusion, I have carefully considered both the documentary evidence and the oral testimony of Kelly Hartle (Hartle).

Hartle testified that following the imposition of Holteen's Federal penitentiary sentence, a community parole officer, Bill Keith (Keith), interviewed Holteen while still in provincial custody. Keith's job was to make an initial recommendation as to where Holteen would be sent for his initial 90-day intake assessment in the Federal correctional system. She noted that Keith completed a two-page form on September 4, 2013. On this form, Keith rated Holteen on two scales. She advised that these scales are still in use today with no change to the matrix of factors used for these scales.

The first is referred to as an "institutional adjustment" scale. This scale considers, among other things, prior incidents that a person may have been involved in while in custody and a person's alcohol and drug use history. These factors have a bearing on the level of supervision required during the initial intake assessment. Holteen was given a score of 94 on this scale. This score is on the top end of the scale for medium security supervision. A score between 95 to 99 would suggest that maximum security level supervision is required.

The second is referred to as a "security risk" scale. This scale considers, among other things, the number of prior convictions, the severity of the current offence, the length of the person's sentence, and the person's

street stability. On this scale, Holteen received a score of 84, which would suggest medium security supervision. A score between 134 to 207 would suggest that maximum security level supervision is required.

Despite both scores being suggestive of medium security supervision, Keith completed another document titled "preliminary assessment report". This report recommended that Holteen be placed in a maximum security environment for his initial intake assessment. Hartle advised that this was not abnormal given that Holteen's institutional adjustment score was at the very top of the scale for medium security supervision and having regard to the fact that Holteen was involved in three institutional incidents of violence prior to his sentencing. Keith's report also refers to concerns that Holteen was caught "cheeking" his medications, which is indicative of him abusing his medications.

Given the recommendation that Holteen be placed in a maximum security setting for his intake assessment phase, Hartle went on to explain that the initial placement typically is into the Federal institution that is closest to the place of sentencing. In this case, Holteen was sentenced in Grande Prairie and was then moved to the Edmonton Remand Centre (ERC) for his preliminary assessment by Keith. In these circumstances, the Edmonton Institution was the closest maximum institution available.

Hartle also advised that Holteen had the right to stay at the ERC for 15 days before moving to a Federal Institution, but noted that Holteen signed a waiver allowing him to be moved to the Edmonton Institution earlier. Not signing the waiver would have temporarily delayed his placement for intake assessment at Edmonton Institution. If he was unhappy with this placement for intake assessment, he could have initiated a redress procedure — which was not done in this case.

Hartle then outlined the process for Holteen's placement in a general population unit. She noted that Holteen requested to be placed in a general population unit and that, realistically, this was the best option available to him and she agreed with his placement. More specifically, Holteen did not match the profile for inmates incarcerated outside of general population, such as in the mental health unit, protective custody unit, or, sexual offenders unit. She also noted that there was no identified incompatibility with his assailant, McNeil. She further confirmed that McNeil was appropriately placed in a general population unit at the Edmonton Institution, based upon his security classification that was consistent with a maximum security institution.

Finally, Hartle noted that the Board's findings support her assessment. In particular, the Board concluded that:

> *... Holteen's violent behaviour in provincial custody, coupled with his misuse/abuse of medications, was sufficient justification to house him at the Edmonton Institution for the completion of his intake assessment. This ensured that his institutional adjustment, escape risk, and risk to the safety of all persons would be accurately assessed prior to a transfer to a facility of lower security.*
>
> *McNeil's most recent Security Reclassification Scale, prior to the incident under investigation, was completed on February 1, 2013 and was consistent with maximum security.*

Based upon my review of the evidence, I agree with the Board's conclusion that Holteen was appropriately placed in a general population unit at the Edmonton Institution for the purpose of completing his initial intake assessment and to determine his ultimate placement into the Federal correctional system.

B) <u>The options open to inmates who have safety concerns</u>

I have considered whether to make any recommendations relating to the options open to inmates who have safety concerns and have determined that no recommendations are required.

In coming to this conclusion, I have carefully considered both the documentary evidence and the oral testimony of the witnesses who provided testimony on this issue.

By way of background, Wayne Villeneuve (Villeneuve) testified that on the afternoon of September 26, 2013, the day Holteen was killed, a loaner television was brought to Holteen's general population unit. An inmate acting in the role of unit representative spoke to him about a plan to have Holteen double bunk with another inmate so that both inmates would have access to a television. Villeneuve spoke with Holteen about the proposed plan and he rejected it on the basis that he could not climb to the top bunk because of his bad knees.

Holteen's refusal was overheard by the unit representative who proposed the plan and he did not appear impressed with this refusal. Ultimately, Holteen remained in a cell by himself and ended up with the loaner television that day. Villeneuve did not assess this issue as a security threat to Holteen.

Nonetheless, according to the Board report, that same evening Holteen called his mother and informed her that he had messed up and that other inmates on the range were angry at him about the bunking issue. The Board report indicates that it's unclear whether Holteen shared with his mother whether or not he feared for his safety or his life.

Further, the Board reported that they could not come to a definitive conclusion as to the motive for the attack on Holteen, but commented that the double bunking and loaner television was a potentially continuous issue with other inmates. Based upon the information before me, I agree with the Board's assessment on this point.

The final piece of background information is that just minutes before the attack, Chris Dunn (Dunn) observed Holteen while handing out mail to the inmates. He appeared to be fine and there was nothing unusual about his behaviour. Similarly, Holteen did not ask for help nor did he express any concerns to Dunn.

Turning now to options available to inmates who have safety concerns.

Carmen Ings (Ings) testified that all inmates are provided with a general orientation from CSC staff. As a part of their orientation, new inmates are advised about the emergency call button that is located in every cell that can be used for medical or other emergencies. They are also encouraged to verbalize any safety or medical concerns they may have. They're also advised that they can raise concerns not only with correctional officers, but others working at the institution such as chaplains, psychologists, health care workers, and parole officers.

Ings further testified that given the dynamics with other inmates, someone with a safety concern would have been advised of other ways to get a staff member's attention without drawing attention to themselves. Examples provided were putting a note on the cell window that can be seen by an officer walking on the unit, or a quiet gesture to an officer indicating that they need to speak privately with them. This information was confirmed by Villeneuve. Ings indicated that new inmates also learn about these safety tips from other inmates.

Ings further advised that all new inmates are provided with an inmate handbook, although she could not recall whether the handbook provides safety related information.

Lastly, Villeneuve testified that when safety concerns are raised by an inmate, they have the option of being moved to protective custody or to another unit.

On the basis of this testimony, it's apparent that Holteen would have been aware of what to do to raise a safety concern. There is no evidence to suggest that he did raise any safety issues with any staff at the Edmonton Institution. In addition, there is no evidence that any staff member flagged any safety concern that was unique to Holteen.

As Holteen was beaten to death in his own cell, it is notable that he did not press his emergency call button in his cell. For privacy reasons, there are no closed-circuit television (CCTV) views inside individual cells (aside from inmates on suicide watch or for other health reasons). Therefore, I can't determine whether he had attempted to press the call button and was prevented from doing so by McNeil or Crawford.

At the conclusion of this Inquiry, I requested further information as to whether CSC ever considered equipping inmates with a portable personal alarm (PPA). Counsel agreed to make this inquiry of CSC officials. The CSC response was communicated through Inquiry counsel.

CSC indicated that although staff are issued PPAs, they are not aware of whether PPAs have ever been considered for inmates. They go on to describe a number of operational and security related concerns that would be raised. These are summarized, below:

- The current fixed alarms in each cell are superior to PPAs in that they are tied to a specific location, so that staff know the precise location where the distress call emanates.

- Rather than increasing inmate safety, there is a concern that issuing PPAs to inmates could in fact have the opposite effect. In particular, because PPAs are not tied to a specific location, PPAs could be used by inmates to create a diversion for various nefarious purposes. CSC notes that PPAs work for staff because they are assigned to persons at specific locations, such that an alarm will trigger a response to that location — similar to the fixed alarms in cells. In addition, it's apparent that CSC would also not have to worry about staff members using PPAs for nefarious purposes.

- Inmates could use the parts from their PPAs (battery, electronics, antenna) for unintended purposes that could create increased risk to inmate and staff safety.

- Logistically, issuing PPAs to all inmates would put a significant strain on the Technical Services branch, which would include ongoing maintenance, repair, calibration, testing, and battery replacement.

- Finally, there is the issue of cost. CSC indicates that the PPAs used by their staff members cost about $500 each.

The operational and security concerns raised by CSC appear to be valid and would mitigate against a recommendation to equip all federal inmates with PPAs.

The cost concern, although a factor to be considered, is the weakest argument against issuing all inmates PPAs. Hartle estimated that there are approximately 14,000 inmates incarcerated in federal institutions in the country. If all federal inmates were to be equipped with PPAs, this would require about a $7,000,000 million initial purchase cost, exclusive of ongoing maintenance and repair costs.

C) <u>The role of inmates in operational matters, in particular, the allocation of televisions and the creation of the shower schedule</u>

I have considered whether to make any recommendations relating to the role of inmates in operational matters and have determined that no recommendations are required.

i) Loaner televisions

Ings testified that televisions in the general population unit were considered a privilege. They could be purchased by family members or at the canteen. There was also a loaner television program offered at the time of this incident.

As mentioned in my earlier review of the circumstances, the fact that Holteen received a loaner television in his single occupancy cell was a potentially contentious issue that may have created discord on his unit. Although the motive of his assailants can't be definitely determined, the loaner television he received may have played a role.

Ings confirmed that the loaner television program has been disbanded at the Edmonton Institution, thus eliminating a potential source of discord among inmates.

ii) Shower schedule

At the time in question, once the range had been secured, 2 cells were opened at any given time to give inmates access to showers and telephones. Chris Dunn (Dunn) testified that, at the time of this incident, inmates created the shower schedule and this was routinely done by an inmate that was the designated unit representative. Of concern was his testimony that there have been occasions where this privilege has been manipulated to assault another inmate. Similarly, Ings also acknowledged that the setting of the shower schedule could be used for ulterior motives. I have conflicting evidence as to whether this occurred in this case, although McNeil admits, in his related criminal proceedings, that he in fact created the shower schedule on the day in question.

In any event, any concerns relating to the inmates' role in the creation of shower schedules for nefarious purposes has been all but eliminated by the CSC Standing Order 566-3 titled "Inmate Movement at Edmonton Institution". This Standing Order was implemented on December 11, 2018. In particular, this Standing Order provides that:

"Once the range is secured, **one cell per range may remain open** (to allow for cleaning, showers, phone calls, etc.) and only if there are no other inmates on the range." (Emphasis added.)

D) The observation of inmates by CSC staff

As identified in the pre-inquiry conference, I will review the circumstances relating to how Crawford was able to enter and remain in McNeil's cell unnoticed by CSC staff, and how McNeil and Crawford were able to enter Holteen's cell and remain undetected for the duration of the fatal assault lasting approximately 4 minutes.

A detailed chronology of events that occurred on September 26, 2013 is outlined in the Board report and reproduced below.

- 9:02:35 p.m. - A security patrol commences on E-unit and Holteen is observed by correctional officers during this patrol and no concerns are noted. This was confirmed by the testimony of Dunn.
- 9:05:09 p.m. - Cells E-010 (McNeil's cell) and E-011 (Holteen's cell) are opened remotely by the sub-control officer for showers and phone calls. McNeil exits cell E-010 and stands in the hallway looking toward the sub-control area.
- 9:05:20 p.m. - McNeil enters E-011 which is occupied by Holteen.
- 9:05:21 p.m. - Crawford exits cell E-010 and also enters cell E-011.
- 9:09:42 p.m. - McNeil and Crawford exit cell E-011 and return to cell E-010.
- 9:56:44 p.m. - Correctional Officers enter the range to conduct a count and security patrol.
- 9:57:40 p.m. - Holteen is discovered lying on the floor of his cell unresponsive.

The evidence establishes that there was a full staffing complement on duty on E-Unit on the evening of September 26, 2013. These staff were charged with monitoring inmate activities.

Ings testified that inmates are required to be in their own cells and are not permitted to visit other cells. The methods of monitoring inmate activities are through inmate counts (4 per day), security patrols (hourly), and range camera observation/direct observation of inmate movement by the Officer assigned to the sub-control post.

These monitoring activities failed to detect Crawford entering McNeil's cell following their return to E-Unit after their recreational time in the exercise yard, and McNeil and Crawford's entry into Holteen's cell and exit from his cell some four minutes later.

Ings advised that she's aware that inmates go into other inmates' cells and that this was a problem in 2013 and continues to be a problem. She testified that it's incumbent on staff to know who's on their ranges and to which cell each inmate belongs.

There was no CCTV video footage available from cells E-010 or E-011 because cells are not monitored by CCTV for privacy reasons. As mentioned previously, the only exception to cell video monitoring is for inmates on suicide watch or other medical purposes.

There was CCTV video footage of the range ("range video") that was reviewed following this incident. The range video would have been displayed in real time in the sub-control unit that was staffed by a single correctional officer on the evening in question. The range video was provided to the Board to assist in their review. Unfortunately, it was destroyed prior to this inquiry. As such, I've had to rely upon the description of the range video contained in the Board report.

The Board provided the following description of the range video:

i) Regarding Crawford (who normally resided in cell E-009) sneaking into McNeil's cell (E-010):

"... [Crawford and McNeil] walked down the range toward McNeil's cell, with a group of other inmates behind them, thereby obliterating the line of vision for the Correctional Officer in the sub-control post.

> No staff member observed this; however, upon close perusal of range video footage following the incident, it was discerned by security intelligence staff after a number of viewings. Given the grouping of inmates near the end of the range at the time Crawford entered McNeil's cell, the Correctional Officer could not have observed this unless he/she was looking directly at the area, at that exact time, due to how quickly it occurred."

ii) Regarding McNeil and Crawford exiting McNeil's cell/entering Holteen's cell/returning to McNeil's cell.

As mentioned earlier, the last hourly security patrol occurred at 9:02:35 p.m., less than 3 minutes prior to McNeil and Crawford entering Holteen's cell. Dunn testified that, as a part of these security patrols, "... we check every cell for the live, breathing bodies." This patrol failed to identify that Crawford's cell was empty and there is no explanation for this.

The range video description by the Board states:

> "Within three minutes of the completion of the 21:02:35 hour security patrol, McNeil and Crawford entered Holteen's cell, and remained there for approximately four minutes and twenty seconds during which the incident was perpetrated."

There is no indication that the view of McNeil and Crawford entering Holteen's cell was blocked or obscured by anyone. This is not surprising given that the range had already been secured and only cell doors opened at that time were E-010 and E-011 for the use of the showers and telephones. The only apparent explanation as to how the officer in sub-control would have missed this observation relates to the numerous tasks and responsibilities of a single officer in sub-control at any given time.

In particular, the Board report outlined these responsibilities as follows:

> "Upon touring the incident site, the Board found that each sub-control post, which controlled two units, was operated by one Correctional Officer. This officer was tasked with the observation of all four ranges in each of the two units; all range movement, all movement into and out of the unit via the front entrances into the units, as well as range camera observation. In addition to this, the Correctional Officer in the sub-control must observe Officers while conducting security patrols. During these patrols, the sub-control Officer must focus all attention on that particular task to ensure the safety of Correctional Officers and inmates alike. This could delay movement into, out of, or within the other unit, which may include security patrols in the opposite unit. This was not construed as justification, though the **Board recognized and acknowledged the difficult position that the Correctional Officer posted in the sub-control must fulfil.**" (emphasis added).

Dunn and Ings confirmed the demanding nature of the duties in the sub-control.

More specifically, Ings elaborated on the many duties of the officer assigned to the sub-control as follows:

> "As a subcontrol officer you're going to spend a portion of your shift in there, usually no more than three to four hours, and it's one of the points in the day when I say you need to be hypervigilant of what's going on. There's one officer controlling essentially two units and each unit has four ranges so he's responsible for eight ranges. Behind him he has unit offices as well is responsible for operating the doors coming in and out of the two units. So he will be responsible for manning all of the door functions. There will be inmate workers coming and going, any inmates in programs, responsible to watch his officers when they are walking on [the] other side. We have mini yards at the end of those units, that's where if the gym is shut down or if it's not an inmate's day for gym we still need to offer fresh air. He'll be watching his partners while they let inmates out for fresh air. Inmates have phones, washers, dryers, refrigerators, toasters, on the ranges. He's constantly letting different inmates from different ranges in and out of the doors so that they can access. They require access officers, parole officers, it's endless essentially."

In light of these many responsibilities assigned to a single individual, she acknowledged that it's not surprising that an inmate can slip into the wrong cell unnoticed by the officer in the sub-control unit. This was also confirmed by Dunn.

Ings further advised that the staffing requirements for the sub-control units are prescribed by CSC national directives, which at the time of this inquiry was one Correctional Officer per sub-control unit.

Since this incident, both Dunn and Ings testified that the CCTV camera system has been improved with better and more cameras which translates to better viewing of the activities on the ranges by those working in the sub-control post. Further, Dunn advised that for ranges E and F, as at the time of this Inquiry, there were two officers assigned to staff the sub-control unit. He explained that this is due to the fact that F unit, at that moment in time, is classified as a split unit — meaning that the upper and lower ranges can't mix and this additional operational consideration required an extra officer in sub-control. Ings confirmed that this is a temporary arrangement that will only last for the duration of time that there is a split unit.

Based upon my review of all the circumstances, Holteen's death may have been prevented had the sub-control officer observed McNeil and Crawford entering Holteen's cell and immediately advised officers to respond to this breach of CRC rules prohibiting inmates from entering other inmate cells. It was no surprise to the CSC witnesses that an officer in the sub-control post could miss this type of transgression. This is due to the myriad of responsibilities required of a single correctional officer. Although the improvements to the number and quality of cameras will likely be of some assistance to the sub-control officer, this does not fully address the challenge of divided attention.

4. Recommendations for the prevention of similar deaths:

Holteen received a fatal beating in his cell by McNeil, a violent federal offender who'd previously killed another inmate in custody. McNeil had previously spent nearly three years in the most secure federal institution, the Special Handling unit, in the Province of Quebec. Following Holteen's death, McNeil was transported back to the Special Handling unit and will remain there until such time as he's considered suitable for re-integration into the general maximum security population.

McNeil was able to slip into Holteen's cell undetected by the sub-control officer. Based upon the testimony of the CSC witnesses and the commentary I've referred to in the Board report, it's apparent that it's extremely challenging for a single officer posted to the sub-control unit to manage all the competing demands placed on them.

I recommend that CSC reconsider its current national directive mandating a single correctional officer to staff the sub-control post. In particular, CSC should carefully assess whether two correctional officers, with split responsibilities, could better handle volume and variety of tasks required of them.

DATED November 10 ,2020

at The City of Edmonton , Alberta.

Original Signed

The Honourable R.K. Bodnarek
A Judge of the Provincial Court of Alberta