IN THE PROVINCIAL COURT OF ALBERTA
CRIMINAL DIVISION - CALGARY

IN THE MATTER OF A FATALITY INQUIRY INTO THE DEATH OF RODNEY DREYSKO HELD PURSUANT TO THE PROVISIONS THE FATALITY INQUIRIES ACT OF ALBERTA

REPORT OF THE HONOURABLE JUDGE H. A. LAMOUREUX

SEPTEMBER 5th, 1996

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LEGISLATIVE CONTEXT - FATALITY INQUIRY ACT

The Provincial Court of Alberta was ordered to conduct an Inquiry into the death of Rodney Dreysko in accordance with s.36 of the Fatality Inquiries Act of Alberta. The Court heard evidence in accordance with this Act on October 23, 1995, January 15, 1996 and June 10, 1996. In addition to the hearing of evidence the Court attended at the Calgary Remand Centre, the situs of the death of Rodney Dreysko. The Court is now required, pursuant to s.47 of the Act, to report to the Minister of Justice and the Attorney General in connection with the medical cause of death, the manner of death, the circumstances under which death occurred and if necessary and advisable to provide recommendations for the prevention of similar deaths.

For the purpose of all who may review this report the Act prohibits this Court from making findings of legal responsibility. The Act prohibits the Court from drawing any conclusion of law. Therefore, this report will not assign any blame for the death of Mr. Rodney Dreysko.

It is also to be made clear that in connection with recommendations which may be made the Court has adopted a retrospective analysis for the purpose of allowing others to learn from the experience at the Calgary Remand Centre.

CAUSE OF DEATH

Rodney Dreysko was an inmate at the Calgary Remand Centre, Calgary, Alberta on the day of his death. On the 15th day of July, 1995 at 1755 hours, Mr. Dreysko was found hanging, fully extended, from a sheet which had been secured to metal grillwork by Mr. Dreysko's shoelaces in his cell in Unit 1 of the Calgary Remand Centre. Officer Downey of the Remand Centre was the first individual to find Mr. Dreysko in this circumstance. The Remand Centre had a special code for emergencies such as this - Code 99.

Exhibit 1, the Certificate of Medical Examiner, exhibit 2, the Examination Form of the body completed by Office of the Chief Medical Examiner and exhibit 3, the Toxicology Report, together establish that the medical cause of death was as a consequence of acute cerebral hypoxia followed by anoxia of both the brain and heart. These events were precipitated by the act of hanging by the neck.

MANNER OF DEATH

The method of death as required to be determined under s.1(g) of the Fatality Inquiries Act was by suicide. The circumstances surrounding the death of Mr. Dreysko are summarized through the evidence of the witnesses. For the purpose of review of their testimony the Court proposes to provide a summary of the testimony of each of the witnesses as it pertains to the circumstances leading up and surrounding the death of Mr. Dreysko by suicide.

EVIDENCE OF ELLA ROBERTA SMITH

Ms. Smith was a registered nurse employed by the Calgary Remand Centre for the past thirteen years. She was the individual who was on duty at the Calgary Remand Centre on July 15th, 1995, for the purpose of the initial "screening" of Mr. Dreysko on admission to the Centre. It was Ms. Smith who completed exhibit 4 at approximately 1250 hours. Exhibit 4 consists of a series of forms which are completed for all inmates admitted to the Remand Centre. The forms require a registered nurse to conduct a cursory medical examination. A cursory medical examination involves the posing of a series of questions to allow the nursing staff to arrive at a suicide assessment for each inmate. Ms. Smith posed the following questions to Mr. Dreysko:

1. Question: Have you ever attempted suicide in the past?
   Answer: Yes
   Question: When?
   Answer: As a child.
   Question: Have you attempted suicide while incarcerated?
   Answer: No.

Question: Are you considering suicide now?
Answer: No.
Question: Do you have thoughts about dying?
Answer: No.
Question: Do you have feelings of hopelessness?
Answer: No.
Question: Do you feel that you have friends, family in the community who care about you?
Answer: Yes.
Question: Do you feel depressed, sad, upset, disoriented, confused?
Answer: No.
Question: Has anyone in your family committed or tried to commit suicide?
Answer: No.
Question: Have you seen a psychiatrist, psychologist?
Answer: Yes.
Question: Why?
Answer: As a child re: suicide attempt

As a result of this cursory medical examination Nurse Smith did not make any recommendations as to where Mr. Dreysko was to be housed in the Remand Centre and did not require that he undergo any further medical examination by the attending psychiatrist, Dr. Weston or one of his designates.

EVIDENCE OF LLOYD WINSLOW DOWNEY

Mr. Downey is an employee of the Calgary Remand Centre as a Correctional Officer II. On July 15th, 1995, Mr. Downey was on duty in Unit 1 of the Remand Centre which is a closed medium security unit housing 48 inmates. Mr. Downey spoke with Mr. Dreysko via intercom at 1630 hours and again at 1700 hours on the day in question. These intercom telephone communications with Mr. Dreysko were in connection with the

inquiry as to whether Mr. Dreysko wished to access his food tray or to have coffee off his food tray. Mr. Dreysko responded in the negative to both inquiries.

At 1755 hours Mr. Downey was required to do a formal count of all inmates in his unit by going to each door to check for their presence and to determine if they were breathing. He approached Mr. Dreysko's cell, No. 145, and observed Mr. Dreysko hanging from the air vent in a position where he was kneeling by the toilet area. Mr. Downey called a Code 99, which is a medical emergency code, opened the door to the cell and tried to pick Mr. Dreysko up to relieve the pressure of the bedsheet on his head. But he was unable to lift Mr. Dreysko. Mr. Downey observed that the ligature was a bedsheet wrapped about Mr. Dreysko's neck; the bedsheet in turn being secured to a couple of shoelaces which were in turn secured to an air vent from the ceiling. Mr. Downey was finally able to get Mr. Dreysko's body into a prone position by ripping the sheets. He laid Mr. Dreysko's body down on the floor. Mr. Downey testified that the particular physical configuration of the unit, as documented in exhibit 5, prohibits Mr. Downey from observing the interior of all cells from his central unit control location. In particular, because unit 1 is a location involving units with solid walls, solid doors and a small window in each door, the correctional officers cannot observe the activities within their individual cells.

EVIDENCE OF DOUGLAS KENNETH LOWDEN

Mr. Douglas Lowden is a Correction Officer II at the Calgary Remand Centre. He was on duty on the afternoon of July 15th, 1995 and as part of his duties he had been

assigned to the institutional response team which consists of four staff members assigned to specifically deal with emergencies which arise during every shift. Mr. Lowden was trained in CPR and he responded to the Code 99 forthwith. Mr. Lowden testified that there was no definite protocol in place which decided who would be in charge of the four member response team known as the Institutional Response Team. Accordingly, when he came into the room, he did not know specifically who would be responsible for checking the inmate's breathing pattern nor did he know who would be responsible for checking vital signs and other critical information. I shall deal with this later in my recommendations however the evidence of Mr. Lowden appears to be best summarized by the evidence that he gave under oath at page at page 35 and 36 of the transcript (October 23, 1995 transcript) starting at line 27:

"Q So, you didn't have any assigned duties when you went into the cell. In other words, you didn't know which officer was going to check breath and which officer was going to check vitals, et cetera?
A No.
Q How many officers went into the cell?
A I honestly don't know.
Q Well, did all four members of the institution response team respond?
A I'm not even sure of that.

and continuing on page 37 at line 5:

" Q But was there any definite protocol in place for deciding who was in charge of the team when you arrived to resuscitate an inmate?
A No, not to the best of my knowledge."

EVIDENCE OF WILLIAM OWEN DARBISON

Mr. William Darbison is also a Correction Officer II at the Calgary Remand Centre. Mr. Darbison confirmed that the Institutional Response Team, which responded to the Code 99 for Mr. Dreysko, has a different makeup of individuals on each and every occasion, depending on the allocation of staff decided by the duty officer who prepares the staff roster. Mr. Darbison confirmed that an Institutional Response Team can consist of any one of a number of different types of people from Health care, Admission and Discharge (A & D), Maximum security, Medium security and Central security. The Institutional Response Team is also responsible for performing relief services during lunch breaks and coffee breaks. According to Mr. Darbison, when a Code 99 is called, it is only necessary that the people who are available respond. (page 43, line 13 - 16)

Mr. Darbison also confirmed that the medical bags containing important equipment required for resuscitation are not located on each unit. The medical bags are located in the medium supervisor's office, in central control, in health care and in units "A" and "D". Medical bags are centrally located so that every unit does not have a medical bag. When asked by the Court who was responsible for getting the medical bag in the event of a Code 99, Mr. Darbison answered (at page 44 of the transcript):

"Q My question is though how do you know which person will get the medical bag in advance? A Code 99 is called. How do you know which person is to get the bag?

A The people who respond to the code know that they must bring a medical bag. There have been cases where more than one medical bag have shown up.

Q All right. So, everyone knows they must go and find a bag?

A Yes.

Q And how many medical bags are there located in Unit 1 at that time?

A In unit 1 there was none. The -- the medical bag was located in the medium supervisor's office. There's one located in central control. There's one located in "A" and "D". There's one located in health care."

EVIDENCE OF MAUREEN ANN FITZPATRICK

Ms. Fitzpatrick is a registered nurse having qualified in 1977. Ms. Fitzpatrick has been employed at the Calgary Remand Centre since 1981. Ms. Fitzpatrick saw Mr. Dreysko for a cursory medical examination on July 8th, 1995. In her view Mr. Dreysko presented as upset. He had apparently been living at the Bedford House and working during the evenings. He was apparently late from reporting back from his place of employment to Bedford House. The curfew rule had apparently been violated and Bedford House has Mr. Dreysko arrested and brought to the Remand Centre. Ms. Fitzpatrick did not fill out a complete cursory medical form on this occasion. She simply updated the previous record on file at the Remand Centre. Ms. Fitzpatrick noted beside the question "Have you ever attempted suicide in the past" that in response Mr. Dreysko answered "yes - and that in 1974 he drank poison". Ms. Fitzpatrick asked Mr. Dreysko if he felt suicidal at present. In response he said no. However, because Mr. Dreysko had a mental health history and because he was on psychotropic medication, Ms. Fitzpatrick did refer Mr. Dreysko to see the Remand Centre psychiatrist Dr. Weston. Dr. Weston apparently attended at the Remand Centre " two to three times a week." Ms. Fitzpatrick was on duty on the afternoon of July 15th, 1995. She was the only nurse on

duty that day. When Ms. Fitzpatrick heard the Code 99 being called over the Remand Centre loudspeaker she took the emergency medical cart and proceeded to Cell 145 in unit 1. As Ms. Fitzpatrick entered the cell she observed Mr. Dreysko lying on his back. He had no pulse and was not breathing. Ms. Fitzpatrick opened his airway, commenced ventilation and started CPR. Ms. Fitzpatrick instructed the centre to call for paramedics who arrived 7 - 10 minutes after the call. The psychotropic medication that Mr. Dreysko had been on at the time of death was Prozac.

EVIDENCE OF DR. WILLIAM ALAN WESTON

Dr. Weston is a qualified specialist in the field of psychiatric medicine. He has practiced as a psychiatrist for thirty-six years. Dr. Weston is the medical director of the forensic assessment and out-patient program at the Calgary General Hospital. He is an associate professor at the University of Calgary and he visits the Calgary Remand Centre three occasions per week. He has done so for the past thirteen years. Dr. Weston was qualified as a psychiatrist entitled to give opinion evidence in connection with issues concerning the assessment and treatment of a psychiatric patient.

Dr. Weston saw Mr. Dreysko on July 11th, 1995. He continued the medication Prozac which Mr. Dreysko had been on at the time of his admission to the Remand Centre. Mr. Dreysko informed Dr. Weston that he had been late to report back to Bedford House. Mr. Dreysko indicated to Dr. Weston that he was upset about the charge of parole violation which followed as a consequence of the missed curfew. Dr. Weston observed the past suicidal ideation and was aware of the past medication of

Prozac but did not asses the patient as having present suicidal thoughts. He did not provide any recommendations for the Remand Centre in terms of a special watch to be placed upon Mr. Dreysko.

EVIDENCE OF HERBERT MONTGOMERY PIERCE

Mr. Pierce was a Correctional Officer III on duty at the Calgary Remand Centre on July 15th, 1995. When Mr. Pierce heard the Code 99 being called on that day he responded. He was not a member of the response team but he felt that it was appropriate that he respond as a consequence of his perception that the response team members are not always available. (page 64, line 5)

When Mr. Pierce arrived at Cell 145 Mr. Dreysko was on the floor. Both he and Mr. Paschke attempted to check for a pulse by holding Mr. Dreysko's wrist. He was unable to find a pulse. At this point Nurse Fitzpatrick arrived and Mr. Pierce stepped out of the way.

EVIDENCE OF FREDERICK CALVIN PASCHKE

Mr. Paschke is a Correctional Officer II at the Calgary Remand Centre. He was on duty on July 15th, 1995. When the Code 99 was called, he together with Mr. Elder and Mr. Pierce, proceeded to respond. He arrived at Cell 145 and observed Mr. Dreysko on the floor. He endeavoured to obtain a pulse and was unable to do so. He asked Mr. Pierce to obtain a pulse and again Mr. Pierce was unable to do so. It was Mr. Paschke who removed the bedsheet from around the neck of Mr. Dreysko.

EVIDENCE OF LARRY JAMES ELDER

Prior to the calling of this witness counsel for the Attorney General entered exhibit 6 at the Fatality Inquiry. Exhibit 6 indicates that members of the emergency response team for the afternoon of July 15th, 1995 were one Kok, Elias, Caton and Lowden.

Larry James Elder is a Correctional Officer III. He was on duty on July 15th, 1995. When Mr. Elder heard the Code 99 being called at 17:55 hours he was aware that two of the individuals who might be responding to the code had the key for the medium supervisor's office which contained the medical bag. Mr. Elder stopped at the medium supervisor's office, a key was pushed under the door by Ms. Caton to Mr. Pierce. Mr. Pierce threw the key 15 - 20 yards towards Mr. Elder who was standing at the medium supervisor's doorway. Mr. Elder took the key, grabbed the medical bag and responded to the code. The medical bag arrived at the unit at 17:57 hours. The paramedics arrived at the scene at 18:03 hours and worked on Mr. Dreysko in his cell until 18:37 hours and then left with him. In response to a question from the Court Mr. Elder advised that the aspect of throwing the keys was in violation of protocol. He advised that an exception was made on this day to speed up the process of obtaining a medical bag. Mr. Elder advised that there are four medical bag rooms, the closest one to cell 145 being that one contained in the medium supervisor's office. Mr. Elder advised that there are four keys to the medium supervisor's office containing the medical bag: an emergency key located in central control, and three keys held by the emergency response team, the maximum security supervisor and the medium security supervisor, respectively.

EVIDENCE OF JANEEN LOUISE CATON

Ms. Caton was a Correction Officer I at the Calgary Remand Centre and a member of the emergency response team on July 15th, 1995. On hearing the Code 99 call Ms. Caton proceeded to the medium supervisor's office, passed keys underneath the door to Mr. Pierce, a C.O.III, and proceeded up to cell 145. Ms. Caton testified that her purpose in slipping keys under the door to Mr. Pierce was to facilitate the process of accessing the medical bag. When Ms. Caton subsequently arrived at cell 145 and observed the sheeting about the neck of Mr. Dreysko she obtained scissors located in a locked box in the office. She then reported to down to "A and D" (admission and discharge) to wait for the ambulance attendants.

EVIDENCE OF RAYMOND LAVERNE ELIAS

Mr. Elias is a Correction Officer II at the Calgary Remand Centre and he was on duty July 15th, 1995 as a member of the emergency response team. When Mr. Elias arrived at cell 145 he observed Mr. Dreysko on the floor on his back. Mr. Elias checked for a pulse and was unable to discern one. As soon as Ms. Fitzpatrick, the nurse, arrived into the unit Mr. Elias stepped aside. Mr. Elias enquired of Mr. Parkin as to whether anyone had been assigned to accompany the paramedics. When he received a negative response, Mr. Elias proceeded to central location and thereafter to "A and D" to await the arrival of the paramedics.

EVIDENCE OF BRUCE VINCENT HRNCIRIK

Mr. Hrncirik is a paramedic who responded from the City of Calgary Emergency Medical Services Department to Mr. Dreysko. He advised that upon arrival and checking of Mr. Dreysko there was some electrical activity in the heart rhythm but no pulse. He initiated advanced life support procedures which included inserting a tube into the trachea, ventilation of the patient, intravenous access and medication access.

Mr. Hrncirik radioed to Dr. Kureishi at the Foothills Hospital who prescribed sodium bicarb, epinephrine and heart ventilation. On route to the hospital there was a change in the electrical activity with Mr. Dreysko heart causing the paramedics to believe that for a temporary period of time there was a pulse. The ambulance arrived at Foothills hospital at 18:51:41 hours.

EVIDENCE OF DR. DARLEENA ELIZABETH KUREISHI - MANNER OF DEATH

Dr. Kureishi is a medical specialist in the field of emergency medicine practicing at the Foothills Hospital. She was qualified for the purpose of the Fatality Inquiry as a specialist in the field of emergency medicine and a general medical practitioner entitled to give opinion testimony in connection with the manner of death of Mr. Dreysko. Upon arrival of Mr. Dreysko at the hospital Dr. Kureishi ascertain that he had no vital signs, no spontaneous respiration, no palpable pulse and no blood pressure. Dr. Kureishi ordered continuation of CPR, cardiac monitoring and appropriate medication. None of this treatment was successful. Dr. Kureishi opines that the cause of death was acute cerebral anoxia and hypoxia.

EVIDENCE OF DONNA ANN CHEYNE

Ms. Donna Cheyne was an investigator at the Medical Examiner's Office. It was she who located the final writing of Mr. Dreysko entered as exhibit 9. This was located in Mr. Dreysko's cell.

EVIDENCE OF DALE DANIEL TRENTON

Mr. Trenton was an inmate at the Calgary Remand Centre on July 15th, 1995, housed in Unit 1 in a cell proximate to that of Mr. Dreysko. Mr. Trenton testified that he overheard a telephone conversation between Mr. Dreysko and an unknown person on July 15th, 1995, in which he heard Mr. Dreysko state: "I'll kill myself".

EVIDENCE OF LLOYD PETER ERICKSON

Mr. Lloyd Erickson is the director of the Calgary Remand Centre. Mr. Erickson has been employed in the corrections field since 1970 and has been employed as the director of the Calgary Remand Centre since February 1988. Mr. Erickson testified that since 1993 there have been two suicides at the Remand Centre. The suicide of Mr. Dreysko was approximately one month after the suicide of another inmate, Gerry Ryder. A Fatality Inquiry was also held into the death of Mr. Ryder. Mr. Erickson testified that within the Calgary Remand Centre there are certain protocols for the classification of inmates. The designation "Suicidal - R" means that the inmate has a designation of having attempted suicide in the past. The designation "Suicidal - R" is part of the bundle

of information that the admitting staff obtain, however no special precautions are taken for individuals who are designated "Suicidal - R".

The next designation which an inmate may receive is "Suicidal - A". If an inmate is designated "Suicidal - A" then special precautions are taken to house the inmate under constant 24 hour observation.

In the case of individual who is designated 'Suicidal - R", this person receives ordinary housing according to his security risk. If he is housed in the medium security unit he is checked once per hour by the attending corrections officer. This hourly checking requires the officer to identify each individual in the unit to determine if that individual is in fact present and alive.

There are no special clothing requirements for inmates who are designated "Suicidal - R" as opposed to those who are designated "Suicidal - A". "Suicidal -A" patients receive protective clothing which is tear proof and all items are taken away from the inmate which could assist him to commit suicide. "Suicidal -A" inmates unlike "Suicidal -R" inmates are seen regularly by a psychologist or psychiatrist. The designation of "Suicidal - A" versus "Suicidal - R" is made on admission by an admitting nurse after a cursory medical examination. Mr. Erickson testified that once an inmate is designated as "Suicide - R" there is no set protocol for re-assessing the inmate within a set period of time to determine if the "Suicide - R" rating should be changed to a "Suicide - A" designation. The reason for this is that approximately 90% of the Calgary Remand Centre is "Suicidal - R". This is the opinion of Mr. Erickson as quoted at p.127, line 4:

"A Because about 90 percent of our population , I think would be "Suicidal - R".
Q 90 percent?
A Yes.
Q Is that because it is such an awful place to be, or what?
A It's just -- I couldn't tell you why. A lot of the people who come into gaol have a history of suicide some place in their history, and the designation is very broad because it covers from the time, you know, as a young child right through till today. "

Mr. Erickson testified that following the two suicides at the Calgary Remand Centre the Remand Centre under took a major change to all of the grills on the air ducts processing air into the individual cells. The grills are modified to provide a much finer mesh making it far more difficult for the individual grill to be used for the purpose of hanging ligature such as was used in the Dreysko suicide. All of the grills in all four of the medium security units have been changed as of the date of this Fatality Inquiry. Mr. Erickson was of the opinion that additional steps should be taken to secure a better flow of medical information and personal information concerning inmates who are being transferred from Bedford House and other halfway houses to the Calgary Remand Centre. Bedford House is a halfway house where individual inmates stay while on parole. Mr. Erickson was of the opinion that all of the halfway houses who transmit inmates to and from the Calgary Remand Centre should have more expeditious means of channelling information concerning inmates between their facilities and the Remand Centre. (pp. 130-133)

Mr. Erickson was also the opinion that the protocol with respect to the shoes issued to inmates who are not in constant observation should be changed. He indicated that the Remand Centre was in the process of developing a velcro runner to replace shoes with shoe laces. (p.139)

EVIDENCE OF SHIRLEY ROBERTA HINDS

Ms. Hinds is the Health Care Manager at the Calgary Remand Centre. She graduated as a registered nurse from St. Michael's Hospital in 1960 and received a degree from the University of Calgary in 1991. Ms. Hinds has 7 full time nurses, 1 psychologist, a case worker and contract staff from the educational consortium, contract physicians, a psychiatrist, a dentist and physiotherapist all working under her purview in the health centre in the Remand Centre.

At the conclusion the preliminary testimony of the above witnesses the Court recalled Dr. Alan Weston and the director, Mr. Lloyd Erickson. After the recall and further evidence of these individuals the Court ordered a personal viewing of the Remand Centre to be conducted in conjunction with the solicitor from the Justice Department, Mr. Meikle and with the director Mr. Erickson. The finding of this personal review of the Centre will dealt with at the conclusion of this report.

RECALL OF DR. WILLIAM ALAN WESTON

Dr. Weston testified on recall that he was satisfied with the assessment procedures utilized by the nursing staff on admission of inmates into the Calgary Remand Centre.

He testified that the standard for assessment procedures utilized at the Remand Centre is equal to that of any other institution of its type in North America. Dr. Weston was also of the opinion that the standing operating procedures for the Calgary Remand Centre and the Provincial policy and standards for the handling of suicidal and/or mentally unstable offenders (entered as exhibits 12 and 13 of the Fatality Inquiry) were indicative of one of the highest standards in Canada. Dr. Weston was of the view in accordance with the medical literature that there are 3 potential risks for inmates in situations such as the Remand Centre. The first and highest risk of suicide is at the time of sentencing and initial admission to the Remand Centre. The second highest risk of suicide is when an event occurs in the institution which alters the status of the inmate within the institution. The third highest risk of suicide is when the inmate receives a "Dear John letter" or the "Dear John telephone call". The words 'dear john' of course refer to a personal event which causes the inmate to lose access or contact with an important individual in that inmate's life. It was Dr. Weston's view that the third instance was precisely the event which occurred that caused Mr. Dreysko to hang himself.

In connection with the conditions at the Calgary Remand Centre Dr. Weston offered the following opinions:

(a) It was Dr. Weston's view that conditions might be improved for the men at the Remand Centre in terms of allowing them to participate in activities to allow them to occupy their time in more useful ways. Dr. Weston testified that the overriding theme that he hears from inmates

is one of boredom as a consequence of the lack of anything to occupy their time. (p.181-182 of the Fatality Inquiry transcript)

(b) Dr. Weston was also of the view that the number of nursing staff allocated to admission at the Remand Centre was insufficient. Dr. Weston indicated that the shortage of nursing staff caused the unit to be unduly stressed for the purpose of permitting the nurses to make a detailed assessment of the psychological status of all inmates on admission. (p. 185 - 186 of the Fatality Inquiry transcript) Dr. Weston was of the view that if a further 4 - 5 nursing staff were hired that this would "very, very useful".

(c) The final and perhaps strongest recommendation of Dr. Weston was in connection with the allocation of medical time to the Remand Centre. In other jurisdictions, according to Dr. Weston, a full time medical officer is employed at institutions. This is not the situation at the Calgary Remand Centre. Dr. Weston is of the view that the services provided for a psychiatric assessment were insufficient in terms of the number of permitted hours at the Remand Centre. Dr. Weston was of the view that psychiatric medical services should be allocated every morning at the Remand Centre 5 days per week. In terms of exact time he would be of the opinion that a psychiatrist should be on duty at the Calgary Remand Centre 5 days per week

from 8:00 am until 12:00 noon for a total of 20 medical billable hours per week. The current levels permitted by the budget is 6 hours per week. The difference in terms of actual dollars would be from $2,000.00 per month to slightly over $8,000.00 per month. Dr. Weston was of the view that this would result in a great increase in the quality of psychiatric service provided to the Remand Centre with respect to the assessment of the psychological stability of the inmates. The director of the Remand Centre agrees with this proposition. (p.201)

ATTENDANCE OF THE COURT AT THE CALGARY REMAND CENTRE

In July 1996, the Court attended at the Calgary Remand Centre in the company of Mr. Alan Meikle, Department of Justice and Mr. Lloyd Erickson, Director of the Calgary Remand Centre. During the course of the tour it was noted by the director that the Remand Centre is often in the position of providing a defacto housing facility for mentally incapacitated individuals who had previously been handled by other institutions such as psychiatric hospitals. These individuals who now find themselves in the Calgary Remand are clearly men who have "fallen through the cracks" of the psychiatric system in the Province of Alberta. These individuals lack basic life skills such as cooking, cleaning, home care, paying bills and other simple day to day tasks. This observation of the director was personally viewed by the Court when the Court observed a home economics class at the Remand Centre being conducted for the benefit of certain inmates by a home economist. These individual inmates were observed by the Court to

be learning the basic skills of salad preparation, the setting of a table and the washing of clothes. It was clear upon observing these individuals that they required basic training on the simplest tasks of daily living. Clearly, the Remand Centre, was never intended to function as an institution for the handling of mentally challenged individuals. These individuals may, in the opinion of Mr. Erickson, have ended up at the Remand Centre as there was simply no other appropriate place for them be adequately housed.

In all other respects, the Calgary Remand Centre is a well organized, clean, well functioning institution. The Court was particularly impressed with the knowledge, compassion and extensive understanding exhibited by the director, Mr. Erickson, not only during his testimony in court but during the course of the tour that he conducted. Mr. Erickson is to be commended for operating a facility which appears to function for the most part in an very efficient and appropriate manner. Having said this the Court is concerned about the evident and apparent shortage of psychiatric medical and nursing care at the Remand Centre which may be compromising the overall effective functioning of the Centre.

RECOMMENDATIONS

Arising from the Fatality Inquiry and the evidence heard by this Court, it is the purpose of this Inquiry to reassure the community and the members of the public that an appropriate investigation has been conducted into the death of Mr. Rodney Dreysko.

The following recommendations arise from the exhaustive evidence and review of

the facilities of the Calgary Remand Centre and may assist the director Mr. Erickson in the implementation of his duties and responsibilities in the future.

1. It is recommended that psychiatric medical attendance at admissions at the Calgary Remand Centre be increased from the present level of 6 billable hours per week to 20 billable hours per week such that Dr. Weston or his designate may be appropriately funded to attend every morning Monday through Friday from 8:00 am to 12:00 noon for the purpose of providing medical care and attention to the inmates at the Remand Centre from a psychiatric perspective.

2. It is recommended at the ratio of nursing staff working at the admissions and discharge unit of the Calgary Remand Centre be increased and that in addition 4 - 5 registered nurses with psychiatric nursing experience be hired immediately to attend at the Admissions and Discharge Unit.

3. It is recommended that the members of the emergency response team have pre-designated functions to be performed in the event of a Code 99, such that at the beginning of each shift each individual member of the team is made aware of the specific duty each is to perform in the event a Code 99 is called. Regular drills to assess the performance of the team on a Code 99 call should be called by the Centre during the course of each week.

4. It is recommended that a procedure be developed to facilitate and require the flow of information concerning inmates and in particular their psychiatric history, this information to be transmitted by a protocol to be developed by appropriate authorities, for the purposing of ensuring more accurate communication between the various halfway houses and the Remand Centre in connection with inmates which transport between these facilities.

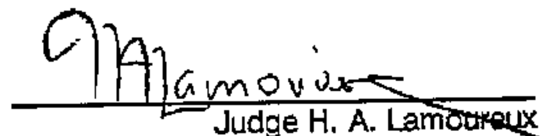
5. It is recommended that all grills located in all cells in all units at the Calgary Remand Centre be replaced with the smallest possible meshing that may facilitate adequate air flow and at the same time prevent the passage of ligature such as bedsheets, shoe laces or other hanging materials through the grill located in each unit.

6. It is recommended that fully stocked medical bags be located in each unit of the Remand Centre and not just in medical supervisors' offices. A protocol should be developed whereby these bags may be readily accessed by the emergency response team.

7. It is recommended that all inmates be issued on admission special velcro shoes which do not have any shoe laces or any other tying devices.

All of which are respectfully submitted.

DATED 5th day of September A. D. 1996 at the City of Calgary in the Province of Alberta.



Judge H. A. Lamoureux