

March 25, 2022

BY E-MAIL

Christine Pratt
Field Law
2500, 10175 101 Street NW
Edmonton AB T5J 0H3

Dear Ms. Pratt:

**Subject: Timothy Driscoll – Public Fatality Inquiry
Response to Recommendations**

Please find enclosed a copy of the Honourable Judge J.L. Lester's report to the Minister of Justice and Solicitor General. This report will be publicly released on April 19, 2022.

The following recommendation made by Her Honour may impact the Custody Operations Branch / Edmonton Remand Centre:

1. Given the testimony of Ms. Butler, it is recommended that when the initial psychological/psychiatric contact is made with a newly admitted inmate on the Suicide Active/Mental Health Unit, there should be a file review prior to that initial contact. This is especially important where the newly admitted members to the Suicide Active unit have recent self-inflicted injuries.
2. The initial interview with a Suicide Active inmate, by any mental health professional, should be conducted in a secure and private area, regardless of the length of time it can entail in supervision and escorting of that inmate, in order to determine the appropriate next steps to ensure the health and safety of the inmate.
3. Testimony of CPO Zenowski spoke to the reduction of the team members, per shift, from four CPOs to three CPOs on the Male Mental Health Unit, over time. Firstly, it is recommended that there be four officers per shift, operating in teams of two at a time. To be clear, there should always be two officers in the pod, unless exceptional circumstances exist, to allow for the CPO

monitoring to request coverage if it appears an inmate may be in distress and a personal cell check is needed. If four CPOs is not feasible, then it is recommended that there should not be two CPOs on a break at the same time, when only three CPOs are working on shift.

4. The Board of Inquiry expressed concern, as does this Court, as to the effectiveness of camera checks. It was submitted that there are currently more in-person checks conducted on the Suicide Active area of the Unit, during each hour. However, it is a difficult process to enforce, on occasion. It is recommended that there be in-person checks of Suicide Active inmates, regardless of the difficulty of enforcement, but especially when the cell light is dimmed or whenever it is unclear as to the health status and safety of the inmate being observed. There is a call button in the cell for contact with the inmate so on those rare or exceptional occasions when an in-person check cannot be conducted, it is further recommended that there be voice-to-voice contact, at least, to ascertain if there are any concerns in need of attention.

I ask that you please advise the following:

1. Whether the Custody Operations Branch / Edmonton Remand Centre accepts, accepts in principle, does not accept, or has a different response to the recommendations;
2. A brief explanation of why that decision was made; and
3. If the Custody Operations Branch / Edmonton Remand Centre intends to accept the recommendations, or to implement different measures, what steps will be taken in that regard.

A response to this enquiry is not mandatory. However, be advised that any response received will be publicly released and posted on the Open Government Portal:

<https://open.alberta.ca/opendata/responses-to-public-fatality-inquiry-recommendations>.

If a response has not been received by August 19, 2022 (four months after the public release date), that information will also be made publicly available.

Thank you for your cooperation in this matter.

Yours truly,

Abid Mavani

Abid Mavani
Fatality Inquiry Coordinator