ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Edmonton Law Courts

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

on the 22/23/24/25 days of March, 2021 (year),

before The Honourable Joyce L. Lester, a Provincial Court Judge,

into the death of Timothy Michael Driscoll (Name in Full) 34 (Age)

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

Date and Time of Death: 02 December 2016 at 6:40pm

Place: Cell FM05, Edmonton Remand Centre 18415 - 127 Street

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)).

Choking as stated in the Amended Medical Examiner's Medical Certificate of Death, dated August 16, 2017 and signed by Dr. Mitchell Weinberg.

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)).

Suicidal death as stated in the Amended Medical Examiner's Medical Certificate of Death. Dr. Mitchell Weinberg noted in the description of circumstances that Timothy Driscoll had placed what appeared to be an unrolled wad of toilet paper into his mouth, resulting in a loss of consciousness, within minutes.

Circumstances under which Death occurred:

To begin, some information as to how Timothy Driscoll came to be in the Edmonton Remand Centre (ERC) will be presented. On November 29, 2016, Mr. Driscoll was arrested by the Royal Canadian Mounted Police (RCMP), Stony Plain Detachment, due to a robbery investigation. Mr. Driscoll had received a head injury during the alleged robbery and was taken to Westview Health Centre, Stony Plain, for medical attention. Upon medical clearance from the Health Centre, he was then transported to the Royal Alexandra Hospital in Edmonton, to obtain a CT scan of his head. Once this was completed and it was determined that he did not have a skull fracture, Mr. Driscoll was discharged from the hospital and then transported to ERC.

When Mr. Driscoll was in the Admission and Discharge area of ERC, he was assessed for proper placement within the facility by Paramedic Joanne Britton. This occurred at 4:00pm on November 30, 2016. Based upon her observations and the conversation with Mr. Driscoll, it was determined that he could be placed in the general population. Ms. Britton learned during her interview with him that he was bipolar and had attempted suicide in September, 2016. Later, in the Inquiry, there was evidence from Ms. Hargrove-Driscoll that the attempt was actually in August, 2016.

Mr. Driscoll presented as alert, during this admission process, and Ms. Britton found him to be oriented. He self-reported that he was not suicidal nor depressed despite his flat affect. Ms. Britton filled in the required Mental Health Alert and Mr. Driscoll was assigned a lower bunk in a cell within the general population, in the event he underwent any withdrawal symptoms from nonprescribed medication he had ingested before arriving. Being closer to the ground in the event of any seizures would be safer for him.

Later that evening, Mr. Driscoll signed out a tempered razor believed to be for shaving use. This took place at 7:09pm and by 7:45pm, Mr. Driscoll had activated a cell call button, to get attention from the staff. Upon arrival at his cell, Mr. Driscoll was observed with a large wound to right wrist and a cut to his neck. He was bleeding profusely, from self-inflicted injuries. Ultimately, he required 40 sutures to mend the laceration to his wrist and the wound to his neck was treated with medical glue.

Ms. Britton attended to Mr. Driscoll's injuries and indicated that, although he was not crying when she saw him, this second time, he was quiet and disappointed that he did not hit the appropriate veins to end his life. She described him as now appearing depressed and he expressed that he just wanted to go home to New Brunswick.

On November 30, 2016 at 8:30pm, Nurse Guo Hong Lin completed another Mental Health Alert, after the suicide attempt by Mr. Driscoll. She indicated in her notes that, although Mr. Driscoll was cooperative while being sutured, he stated "I want to die."

He was again described as having an emotionally flat affect.

Post-treatment, Mr. Driscoll was taken back to an isolation cell in the Admissions area where he was under 15-minute observations. His mental health status would be assessed further, on the morning of December 1, 2016.

Once Mr. Driscoll was further assessed on the morning of December 1, 2016, he was then assigned and placed in his own cell on the Male Mental Health Unit, Suicide Active/Tier Three. When placed onto the Suicide Active Unit, Mr. Driscoll remained in what was described as protective clothing. It is sleepwear that is difficult to damage or to tear such that it could be used to self-harm. The blanket provided is of the similar material.

Throughout the day of December 1, 2016, Mr. Driscoll had several interactions with medical personnel. He was assigned to his cell around 8:00am and sometime before 11:00am, he was seen by Jennifer Kruger, a registered psychologist who was conducting rounds on the unit to see if there were any requests to address or any referrals needed for other therapeutic appointments. Mr. Driscoll was described by Ms. Kruger as settled and oriented. He indicated to her that he was upset the previous day due to frustration at not being able to contact his family in Eastern Canada, by telephone. However, on this day, he said he was no longer having thoughts of self-harm. Mr. Driscoll also mentioned that he had not received his medications yet. Ms. Kruger formed the opinion that, due to the serious nature of the injuries from his suicide attempt and due to not yet being fully assessed as to his medications, Mr. Driscoll should remain on the Suicide Active list. She made a referral for him to see a psychiatrist, Dr. Gordon Kelly, for this same day. Ms. Kruger considered Mr. Driscoll to be in a “moderate” ranking for Suicide Active inmates, when asked in the Inquiry.

Dr. Gordon Kelly, a qualified expert in adult psychiatry, met with Mr. Driscoll during the day of December 1, 2016. Dr. Kelly had worked at ERC for approximately 10 years, at this point. During his onsite, in-person interview with Mr. Driscoll, he learned that Mr. Driscoll was bipolar and had attempted suicide the previous evening and earlier that August, 2016. Mr. Driscoll stated he was no longer suicidal and that he was upset due to missing his family. He was tearful at times but denied being depressed. Dr. Kelly found him to be future-oriented and organized in his thoughts. Mr. Driscoll’s medications were discussed, considered and he was then prescribed Abilify and Olanzapine, until a more complete assessment would be conducted and to observe his behaviours while on these medications.

Throughout the rest of the day and evening of December 1, 2016, there was nothing particularly remarkable to report. Mr. Driscoll was quiet, as described by some of the Correctional Officers, and seemed settled. He spoke with a registered nurse, M. Chora, around 7:00pm that evening and denied any further suicidal thoughts. At approximately 10:00pm, Mr. Driscoll received his medication, Olanzapine, as directed by Dr. Kelly and he was described as sleeping throughout the night.

Mr. Driscoll was checked at 1:30am, December 2, 2016, according to the Corrections Suicide Checklist and observed asleep on the floor, regular breathing and no distress was noted. He was observed also at 5:00am and registered nurse, Tammy Tibault, noted he was sleeping with no visible signs of distress and his breathing was regular. At 8:00am, Mr. Driscoll received his prescribed dose of Abilify.

The next medical visit occurred on December 2, 2016 by the psychologist, Kelly Butler. She met Mr. Driscoll in his cell at approximately 9:30am. She described her interaction as brief, lasting about four to five minutes. Although she had been aware that Mr. Driscoll had attempted suicide, when medical rounds were made, information was only exchanged, orally, about each inmate. There was no file review beforehand. She further stated that it would be inconvenient and a challenge to do a complete file review of the chart and it would take time away from other tasks. It is incomprehensible to the Court that such a review would be described as taking time away from other tasks, when understanding the inmate's mental health status is, in fact, a serious and material task.

Further to this, when addressing actual initial discussions with new admissions on the Unit, Ms. Butler stated that when it came to privacy and interviewing, it was not logistically possible to maintain confidentiality due to the physical setup, with these meetings being conducted in an area whether others could listen. She indicated that more extensive interviews could be scheduled and those would occur in a private area.
Ms. Butler noted that Mr. Driscoll was frustrated when she advised he would not be cleared from the Suicide Active unit. There was some confusing testimony from this witness, where she stated that Mr. Driscoll was not considered to be showing any acute mental health issues yet self-harming is considered as a significant risk factor.

The next timeframe to be considered is from the point where Mr. Driscoll was served his evening meal up to the attendance of the emergency response team, being the medically trained onsite staff of ERC.

At approximately 4:37pm on December 2, 2016, Mr. Driscoll was served his evening meal by Correctional Peace Officer (CPO) Opdendries. There was no actual interaction between these two people. It should be stated that much of this material now presented is from the video reviewed and entered into the proceedings, in conjunction with testimony of the witnesses. The meal was placed in the food slot as is the usual practice. Mr. Driscoll took his meal from the meal slot and then sat at his side table and ate his meal. Approximately five minutes later, he placed his dinner container near the cell door and then turned off the light in his cell. Then, near 5:26pm, he took the toilet paper roll from the side table and laid down on his bed, covering himself with the blanket. Mr. Driscoll proceeded to remove an undetermined amount of toilet paper from the roll and then placed this wad of paper into his mouth. Within two to four minutes, approximately, he became visibly agitated and got up from his bunk. He paced for a few steps and then appeared to be trying to vomit in the toilet bowl. Mr. Driscoll got down on his hands and knees and then laid flat on the floor, on his stomach. Aside from a small amount of movement, for a very brief interval, he stopped moving altogether at approximately 5:30pm.

At approximately 6:08pm, CPO Opdendries attended the cell to collect the food tray. He saw Mr. Driscoll motionless on the floor and kicked at the cell door, in an effort to arouse him. When there was no response, he radioed the main pod area to get the cell door unlocked. Mr. Driscoll did not regain consciousness, despite all efforts taken by the medical staff, who came to his aid, immediately upon being notified.

From the evidence and materials, then, it is noted that between dropping off the meal by CPO Opdendries and the return to retrieve the empty container, by this same CPO, there were notations entered, as required, by CPO Zenowski, monitoring the cells by way of camera checks, down on the main floor pod. These notes at 5:15pm state that Mr. Driscoll is laying on his back but no details as to whether it is on the bunk or the floor. The video shows him in his bunk, at this time. Then, at 5:30pm the entry notes that Mr. Driscoll is on his stomach. This is when he is now on the floor, as shown in the video. At 5:45pm, it is again noted that Mr. Driscoll is still on his stomach. Again, the video shows him on the floor, not moving, at this time. These notes in the log which were entered by CPO Zenowski were stated to reflect what he was observing at those times. The images were on a monitor located in the main floor pod where CPO Zenowski was working, alone, at these times. He further indicated that when the cell light is turned off and because the images are quite minimal in size, it is difficult to see clearly what is happening in the cell, when conducting camera checks. Mr. Driscoll, at 5:15pm, at 5:30pm and at 5:45pm was only required to be viewed by camera checks on the monitor. CPO Zenowski testified that he thought that Mr. Driscoll may have been speaking to another inmate in a nearby cell, as this type of activity does occur in the institution, between inmates. The result of the misinterpretation as to what was occurring in Mr. Driscoll's cell during these checks can only be described as devastating.

It is important to recognize the submissions made to the Inquiry Court by the widow of Mr. Driscoll, Ms. Kelly Hargrove-Driscoll. She expressed her personal belief that Mr. Driscoll's actions were a cry for help and that, as on a prior occasion when he attempted suicide, his behaviour was due to frustration and poor impulse control. No one would challenge this belief, but it is not possible for anyone to accurately and without hesitation, confirm the state of mind of another individual at any given time, no matter the connection. There is no way to know Mr. Driscoll's intention concerning his self-destructive actions, on this occasion, but the result is undisputed.

Ms. Hargrove-Driscoll asked many questions as to what the possible outcome could have been if many aspects of Mr. Driscoll's life were handled differently. The metaphor, the butterfly effect, comes to mind in that it encompasses how the smallest of changes in initial conditions will result in very different end results. It is important to consider the evidence of two of the medical experts presented to the Inquiry, given some concerns expressed in Ms. Hargrove-Driscoll's submissions.

Firstly, Dr. Gordon Kelly, the psychiatrist who assessed and prescribed medications for Mr. Driscoll gave evidence. His opinion was that the timing of the medications given was appropriate and necessary. The timing would allow observation of Mr. Driscoll's behaviour once his system was cleared of any effects due to non-prescribed drugs he ingested before admission to ERC. This was the best practice at that time. However, Dr. Kelly acknowledged that, currently, the medication process has improved at ERC and it would now be unusual for any newly admitted inmate to wait more than 24 hours for a medication assessment.

Secondly, Dr. Mitchell Weinberg, the Medical Examiner at the time, also testified in the Inquiry. He stated that he had conducted the autopsy. Based upon all of the information provided to him, initially, and his own medical expertise, he completed the first Certificate of Death, dated 19 July 2017, indicating complications of hepatic cirrhosis as the cause of death and the manner of death as being natural. It was some months later when Dr. Weinberg was provided with the video of Mr. Driscoll's actions during the minutes before he passed away. Dr. Weinberg followed proper medical protocol required to invalidate the initial Certificate of Death and issue the final Certificate of Death, dated 16 August, 2017. This document states that the cause of death was choking, and the manner of death was suicide.

Before presenting the recommendations of this Inquiry, this portion of the Report cannot appropriately be framed as part of the recommendations as it does not fall within the parameters of the duties and obligations of the Court, in this forum. Regardless, it is important to consider whether or not immediate access to video footage, when available, should become part of the protocol when providing file information to the Medical Examiner's Office. It may only be useful when, in cases similar to this one, there is what is initially an unexplainable loss of consciousness leading to the death of an inmate. The cause of death of Mr. Driscoll is exceptionally rare, although the manner of death is not, sadly. Most often, it is readily apparent to those supervising the health and safety of people as to the cause of one's death. To conclude this consideration, it may be that if the next of kin, in these special circumstances, had been aware of the manner and cause of death, at the earliest occasion, there may have been less bewilderment and mistrust throughout the course of events that led up to this Inquiry. Given the immense confusion and emotional impact on Ms. Hargrove-Driscoll at the loss of Mr. Driscoll, one desirable outcome of this Report is that it offers some solace to and acceptance by Ms. Hargrove-Driscoll and that the final recommendations will be thoughtfully considered, by all participants.

Recommendations for the prevention of similar deaths:

Before outlining the basis upon which the Court will make the following recommendations, it is necessary to reinforce the findings that were made by the Board of Inquiry in relation to the Emergency Response Team onsite at ERC who attended, shortly after the call was made. It is evident that Mr. Driscoll was not responding to any interventions employed by these medical officers despite their immediate attendance when notified and the methods utilized were efficient, appropriate but, sadly, ineffective in this situation. It is beyond the Court's expertise to comment any further, given the parameters of this Inquiry. From both the materials entered and the testimony of the witnesses regarding the resuscitation efforts, all that could have been done, medically, was performed and to a high standard. To suggest that, were the procedures undertaken by the medical personnel altered, any future incidents, similar in nature, would not result in death is inapplicable in this case. Given the noted absence of a pulse and no visible breathing except when air was forced into Mr. Driscoll, upon immediate attendance at his cell, Mr. Driscoll appeared to have passed away before any intervention was undertaken, as explained in the evidence presented.

To conclude, appreciating that the Board of Inquiry has expressed some concerns that will also be referenced in the Report, there are some other elements for consideration:

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.

DATED February 23, 2022, ***Original Signed***

at Edmonton, Alberta.

The Honourable Joyce L. Lester
A Judge of the Provincial Court of Alberta