FIELD LAW

2500-10175 101 ST NW
Edmonton, AB T5J 0H3
fieldlaw.com

CALGARY / EDMONTON /
YELLOWKNIFE

Christine Pratt, QC
Partner
T 780-423-7671
F 780-428-9329
cpratt@fieldlaw.com

Assistant: Debbie Thomson
T 780-429-7868
DThomson@fieldlaw.com

Our File: 37064-64

August 3, 2022

VIA EMAIL

Alberta Justice and Solicitor General
Legal Service Division
9th Floor, Peace Hills Trust Tower
10011 109 Street
Edmonton, AB T5J 3S8

Attn: Abid Mavani
Fatality Inquiry Coordinator
Dear Sir

Re: Fatality Inquiry of Timothy Driscoll
Response to Recommendations of Judge Joyce L. Lester

Thank you for your letter of March 25, 2022. I have reviewed the report and recommendations of Judge Lester dated February 23, 2022 with my client. Below please find the response of the Custody Operations Branch ("COB").

On December 2, 2016, Timothy Driscoll put a wad of toilet paper in his mouth and shortly after became unresponsive in his cell at the Edmonton Remand Centre (ERC). Resuscitation efforts were unsuccessful. The cause of death was choking, and the manner of death was suicide. Judge Lester noted that it appears Mr. Driscoll passed away before any intervention was undertaken, as explained in the evidence presented.

Judge Lester made four recommendations directed at both Alberta Health Services (AHS) and COB in the public fatality inquiry into the death of Timothy Driscoll.

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.**

We trust that AHS will review this recommendation and respond accordingly, as it does not pertain to COB operations.

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.**

The recommendation speaks to use of a secure and private area for the purpose of an initial interview between a mental health professional and an inmate on suicide active status. From an operational perspective, COB has no objection with the provision that available infrastructure allows this and there are no safety or security concerns that may jeopardize the health care professional.

COB accepts this recommendation in collaboration with AHS.

3. **Testimony of CPO (Corrections Peace Officer) 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.**

The ERC's Male Mental Health Unit is located in the Health Care Pod. There are three officers assigned to the Male Mental Health Unit. The officer station of the Male Mental Health Unit directly adjoins the officer station of the Female Mental Health Unit through a common area. The Female Mental Health Unit is also staffed with three officers. Between the two adjoined units, there are six staff members. Further, three and two officers respectively staff the Male Infirmary and Female Infirmary units, which are also part of the Health Care Pod. In total, there are 11 frontline officers assigned to regularly staff these four units.

During the two hour period for staff meal breaks, each unit has times in which only a single officer is assigned. However, even during staff meal break periods, a single floating officer is available on the Health Care Pod to support operational matters that may arise which require a second officer. Though Judge Lester alternatively recommends the Male Mental Health Unit is never staffed by less than two officers, it is impractical to guarantee this floating Health Care Pod officer remain on the Male Mental Health Unit during staff meal breaks. All officers at the ERC are additionally equipped with a portable radio to communicate with other staff on the Pod, or to initiate an emergency response when necessary. COB contends that there are adequate staff resources on the Pod at any given time to support any matter that may arise.

To underline this perspective, COB policy *6-1.3 SC - Inmate Counts*, procedure 4 states,

> 4. If a staff member is unable to complete the following tasks, the staff member shall immediately inform their immediate supervisor, or shift manager/designate who will promptly assign alternative staffing resources to complete the function(s).
>
> a) Formal count;
>
> b) Informal count;
>
> c) Security patrol;
>
> d) Security inspection;
>
> e) Inmate observation check;
>
> f) Any required security procedure.

This places onus on the Pod Supervisor to ensure adequate resources where an officer requires assistance to conduct a check that may be required on an urgent basis.

Given the staffing patterns outlined above and the policy in place to address resource issues, COB does not accept the recommendation to provide a continuous fourth officer for assignment to the ERC's Male Mental Health Unit, and cannot guarantee the unit can be staffed at all times by a minimum of two officers during day and afternoon shifts. However, support is available to staff members through the mechanisms outlined above.

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.**

The ERC had acted on the recommendation of the Board of Inquiry pursuant to the following response.

> "The Board had noted that observation checks relied disproportionately on camera checks as opposed to in person checks. The Board outlined that this practice inhibits ability to interact with the inmate and obtain up close assessments of the inmate. Although noted that at the time of the incident, there was no provincial policy requiring in person observations on a basis more frequent than hourly, the Board suggested that this practice be reviewed to determine whether more in person or verbal interactions with suicide active inmates be mandated.
>
> The ERC has accepted this recommendation in full and is currently in the practice of ensuring that all observation checks on inmates placed suicide active are conducted in person and through window to verify sign of life."

The provincial policy referenced in relation to the aforementioned remains COB policy *6-1.3 SC - Inmate Counts*. This policy reflected the Judge's recommendations, but will be amended to emphasize the requirement for checks on actively suicidal inmates to be done in-person. Procedures 8 and 9 state,

8.	Staff may also be required to conduct and record designated and prolonged observation checks for inmate safety, security, health care or mental health reasons (e.g., 15-minute observations of actively suicidal inmates).
9.	Staff conducting observation checks for inmate safety, security, health care or mental health reasons shall,
	a) Carefully observe the inmate in person at the required observation times;
	b) Not conduct observation checks by intercom or video camera surveillance;
	c) Ensure the inmate is breathing, alive, and is not in distress;
	d) Record their observations and findings at the required observation times in a separate log book, observation report, or in ORCA, in accordance with applicable policy requirements.

In accordance with COB policy *6-1.3 SC - Inmate Counts*, as cited in recommendation 3, officers are to advise the supervisor if they are unable to adequately conduct observation checks, in order for appropriate mitigation and support to be provided.

COB accepts this recommendation and will amend the applicable policy for clarity.

My client and I would like to thank Judge Lester and the participants in this inquiry for their work and diligence on this inquiry.

Regards,

FIELD LLP

Christine Pratt, QC
Partner
CJP:tg