



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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Drumheller Provincial Court
in the Town of Drumheller, in the Province of Alberta,
(City, Town or Village) (Name of City, Town, Village)
on the 1st and 2nd day of May, 2018, (and by adjournment
year
on the _____ day of _____, _____),
year
before The Honourable E.J. Creighton, a Provincial Court Judge,
into the death of Earl William Davenport 56
(Name in Full) (Age)
of The Drumheller Institute, Drumheller, AB and the following findings were made:
(Residence)

Date and Time of Death: January 26, 2015

Place: Drumheller Institution

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 – *The Fatality Inquiries Act*, Section 1(d)).

Asphyxia by Hanging

Manner of Death:

("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *The Fatality Inquiries Act*, Section 1(h)).

Suicide

Circumstances under which Death occurred:

Circumstances

On January 26, 2015, the deceased, DAVENPORT, was found unresponsive in his jail cell suspended by a ligature formed from a shoelace that had been attached to a vent duct grill. After resuscitation efforts, he was pronounced dead at the Institution. The examination findings were consistent with hanging. There were no other injuries or suspicious findings. DAVENPORT was 56 years of age at the time of his death.

Summary

DAVENPORT was serving a life sentence for 1st and 2nd degree murder. His sentence commenced in November, 1987. As a result of DAVENPORT'S death a Board of Investigation was convened in April, 2015. The Board found the deceased had no documented history of mental health concerns or suicidal or self-injurious behavior. He was not known to be part of the drug subculture at the time of his death or an associate of a security threat group or gang.

The Board identified a precipitating event – fear of retribution for the appropriation of some drugs DAVENPORT reportedly found in December, 2014, belonging to a security threat group. He used the drugs to his own advantage. The drug cache consisted of 300 Hydromorphone tablets. From this activity, DAVENPORT owed the group a sizeable amount of cash and may have feared retribution from them. Other than this precipitating event, the Board found no evidence to suggest that staff were aware DAVENPORT was contemplating suicide.

Three year review of Federal Inmate Suicides: This review was conducted before DAVENPORT'S death and the relevant recommendation was: *A. Recommendation 1:* Remove all known suspension points in segregation cells. *Response:* This was reportedly implemented at the Drumheller Institution before DAVENPORT'S death. However, it does appear that this type of preventative step has been exhausted. Both the Warden and Correctional Services Canada (CSC) indicate that eliminating suspension points can only extend so far while providing for basic human needs.

Board of Investigation Report in response to DAVENPORT'S death: B. A National Cell Condition Checklist could not be located for DAVENPORT'S cell. *Response:* The Drumheller Institution committed to a process for executing a Cell Checklist and to briefing staff. C. Transporting DAVENPORT outside was unnecessary, extended the potential crime scene and deteriorated forensic evidence. (**NOTE:** DAVENPORT was removed from the cell by staff and eventually taken outside for EMS access in efforts to revive him.). *Response:* The Institution committed to briefing staff to not do so and to include the reminder in medical scenarios for Correctional Officers. D. The quality of CPR deteriorated once transported. *Response:* The Institution committed to briefing staff through medical scenarios carried out during shift changes. E. Health Care Nurses did not assert control. *Response:* The Institution indicated this was reviewed in a staff meeting and committed to reviewing in future staff meetings.

Beyond the above commitments, there is no documentation affirming the above actions were taken.

Recommendations for the prevention of similar deaths:

Although this is a Policy and a commitment by the Institution, it must always conduct Cell Condition Checklists each time an inmate is placed in segregation. Checklists also should be done as often as possible during an inmate's stay in segregation. These checks must be documented.

The Institution needs to consistently brief staff, especially at shift changes, of cell conditions. Inmate's remarkable conditions need to also be focal discussion points at meetings and shift changes. Again, documentation of such briefings must be made.

Health Care Nurses must assert control over a subject/patient upon arrival on scene.

Obvious suspension points that can be potential hazards should be addressed with safety in mind, but this must also be balanced with basic human needs. However, there are or will be suspension points that do not require a balancing of interests and these should be removed.

DATED July 17, 2019,

at Calgary, Alberta.

Original signed

A Judge of the Provincial Court of Alberta