CANADA
Province of
Alberta

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Courthouse

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

on the 5th and 6th day of February, 2009 (year), (and by adjournment

on the _____ day of _____, _____ (year)),

before Leo J. Wenden, a Provincial Court Judge,

into the death of Todd STEVENSON (Name in Full) 40 (Age)

of _____ (Residence) and the following findings were made:

Date and Time of Death: September 10, 2005 at approximately 14:20 hours

Place: Edmonton Remand Centre, Edmonton, Alberta

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)).

Hemoperitoneum due to lacerated spleen, due to blunt trauma.

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)).

Not reported on – probably accidental / homicidal

Circumstances under which Death occurred:

The deceased Todd Stevenson was an inmate at the Edmonton Remand Centre, Edmonton, Alberta. He was housed in Unit 4B which is made up of 24 cells, 12 up and 12 down. He was housed in the upper tier. At 14:00 hours Stevenson's tier was on its recreation break. This meant that inmates were allowed out in the general area; or if they wanted they could remain in their cells. Stevenson chose to remain in his cell. At approximately 14:20 hours, the Correctional Officers were advised that Stevenson was in physical distress. They went to the cell and saw Stevenson on the floor of his cell.

Immediate medial intervention by staff on duty at the time was not sufficient to revive him.

An extensive investigation by the Edmonton Police Service was inconclusive.

The Fatality Inquiry

Medical Evidence:
Dr. Bannach was qualified as a forensic pathologist. He is the Assistant Chief Medical Examiner for the Province of Alberta. His *curriculum vitae* was filed with the Court as Item 3 of Exhibit 1. He has testified as a forensic pathologist on numerous occasions. On 12 September, 2005 in Edmonton, he preformed an autopsy on the deceased, Todd Stevenson. He observed external injuries to the head, neck, torso and upper extremities.

There were injuries present on:

(a) Both sides of the neck;
(b) Top of the left shoulder;
(c) The outer bicep areas on the right arm and back of the right shoulder; and
(d) Elbow region and back of the left forearm.

Internally there was evidence of injury to the strap muscles on the side of the neck.

The major internal injury was a ruptured spleen, which resulted in a large volume of blood being present in the abdominal cavity. Approximately one half of the volume of blood was in the abdominal cavity. The injury to the spleen was as a result of a blunt injury. Dr. Bannach had noted two broken ribs which were indicative of blunt force being applied. It was his opinion that the cause of death of Todd Stevenson was the result of bleeding into the abdomen which was due to a lacerated spleen which in turn was due to blunt trauma.

Evidence of Correctional Officers:
Shanon Kelly:
This witness is a Corrections Officer who on the 10 September, 2005 was working on Unit 4B. He said that in that unit there were 24 cells, 12 on the upper tier, and 12 on the lower tier. Recreation for the inmates was regulated using the following procedure. A 12 cell tier was released for one hour. During this time the inmates can do whatever they want, eg. recreate, shower or stay in their cells. The door remains unlocked for only five minutes. Only one tier is allowed out at one time. At the end of the hour inmates must return to their cells. There are two cleaners who are permitted to be out of their cells for the entire day. Their duties encompass cleaning, laundry and helping with the meals. On 10 September the doors to the upper tiers were unlocked, and the inmates were free to leave their cells.

Corrections officers can see what is happening in the common area, they cannot see what is happening in the cells. Thus the corrections officer was not able to see what was happening in Cell 4, the cell where the deceased was housed. All he could see was the door to Cell 4.

At about 2:20 p.m., an inmate told Mr. Kelly that there was an inmate inside Cell 4 who appeared unwell. This witness, accompanied by another correctional officer went in to the 4B area and to Cell 4. He saw that the inmate Stevenson was in some physical distress. He moaned and waived his arms about. A miniscule amount of blood was noted on the cell wall. He had seen Stevenson at 13:45 that day when the latter went to the bubble to obtain his daily medications, at that time Stevenson appeared normal.

A code 99, signalling a medical emergency was broadcast throughout the Edmonton Remand Centre. When a code 99 is broadcast, inmates are required to return to their cells. This took a few minutes to accomplish, but the witness did not view this as unusual. During the code 99 lockdown, Stevenson's cell mate was relocated to another secure area.

William Muazcsuk:
This witness a Corrections Officer, was assisting meeting the inmates' needs. He recalled that Stevenson's cellmate asked permission to return to his cell to get a coffee. He was given permission to do this and it was observed that he did not spend too much time in his cell. The witness also noted that another inmate, whose identity was not determined, entered Cell 4. The witness could not say whether or not Stevenson's cellmate was in Cell 4 when this visit took place. The visit was contrary to Edmonton Remand Centre regulations. It was around this time that the code 99 was broadcast. He went in to Cell 4 and saw Stevenson lying on the floor. He observed that Stevenson's injuries appeared to be from a kicking or stamping and saw a bruise the same shape as a foot print. He carried out a "knuckle check" of the inmates to find out it any of them had scraped or scuffed knuckles, blood on their shoes, or any other indicia that would support the inference of a physical altercation. He found nothing. It was his opinion that Stevenson got along well with the other inmates. The last time he saw the deceased was when the latter was issued his medications. At that time the deceased appeared normal and there was nothing to suggest that there were any problems.

Philip Landry:
The Corrections Officer who instituted the code 99, and was responsible for ordering inmates back to their cells. It was his opinion that the inmates took their time returning to their cells and medical staff had to wait an extra 30 seconds before everyone was in their cells and locked up.

Dwight Buchanan and Kevin Duchnyz:
Correctional Officers who responded to the code 99 call. They went to Unit 4B with the required medical equipment. They observed the nursing staff assist Stevenson. They accompanied him to the Royal Alexandria Hospital.

Sandra Wells:
A psychiatric nurse answered the code 99 emergency and went to Cell 4 on Unit 4B. Upon entering the cell she made the following observations:

(1) Stevenson was on his left side;
(2) She had difficulty assessing him as he insisted upon sitting up;
(3) He kept wanting to go to the bathroom; and
(4) She noted that he was breathing on his own.

Deborah Ryan:
The registered nurse who answered the code 99 call. She went to Cell 4 and observed that the deceased was suffering from a serious injury. He was breathing on his own, and CPR was not needed. The only thing that the deceased kept saying was that he wanted to go to the bathroom. Stevenson was turned over to Emergency Medical Services.

Wesley Manchester:
Was the Correctional Officer in charge of the fourth floor of the Remand Centre on 10 September, 2005. He heard the page for the code 99. He observed that the prisoners were slow in returning to their cells, looking over railing, filling cups with hot water, etc. It was his opinion that it took a minute and one half to clear the area. This was necessary to ensure safety for the response team. He did not enter Cell 4. He set about trying to obtain information. There was no information to suggest that Stevenson had been in any danger and the atmosphere in the unit was relaxed.

Unit 4B is a maximum security floor and housed inmates who were charged with serious offences. He said that the cleaners had the status of trustees. They were allowed to be outside their cells all day and free to go where their duties directed them. They cleaned up, did laundry and other chores.

Mr. Rosack:
Was the Deputy Director of Operations, which meant that he administered the shift. At around 2:00 p.m. on 10 September, 2005 he heard the Code 99. He went to Cell 4 and spoke with the nurses. He ordered his staff to call for an ambulance that was equipped with advance life support equipment, as in his opinion the inmate's injuries dictated such a response. He observed the inmate sitting up and semi-coherent. He cautioned his people to disturb the scene as little as possible in the event a crime had been committed. He contacted the Edmonton Police Service.

Aaron Box:
Was the Emergency Medical Services technician that assessed the inmate. His assessment was that:

(1) The inmate had no femoral or carotid pulse;
(2) The monitor showed pulseless electrical activity which meant the heart was not pumping blood;
(3) CPR was started in an effort to resuscitate the inmate. This was not successful;
(4) A series of other life restoring activities were started, all unsuccessful.

Detective Anstey, Edmonton Police Service:
He attended at the ERC. He noted that the Unit 4A and 4B was where the serious criminals were housed. He was able to determine that although Stevenson had a long record, he was not regarded as a problem inmate. He understanding of the procedure on Unit 4A and 4B was that the upper and lower tiers were not released from their cells at the same time. The cleaners were the only ones who could be out of their cells the entire day, with access to both tiers.

His investigation was hampered by the fact that inadvertently the guards placed Stevenson's cellmate with the cleaning staff who were the main suspects. Thus any blood or DNA evidence found in this cell could be attributed to the cellmate's clothing. The collection of any DNA evidence was also hampered by the fact that access to the laundry room was still available during the investigation and the investigators did indeed find a fresh load of laundry being done that consisted of two full sets of clothing. The smell of ammonia and bleach was present in the wash.

The forensic staff examined every inmate's hands, clothing, shoes, and anything that appeared to have blood on it. Any clothing that had blood on it was seized and examined in an effort to identify any DNA. Results were negative. In an effort to match the pattern bruising on the deceased with a pattern on shoes, 720 pairs of shoes were seized. The forensic team was unable to get a positive match. Lastly, efforts to speak to Stevenson's cellmate were scotched by the fact that the cellmate was placed in the infirmary and one of the suspects using the subterfuge of a hunger strike was placed in the infirmary with him. Any conversations with Stevenson's cellmate thereafter were of no use.

Based upon their interviews with the inmates (and the police interviewed every inmate) the police theorized that the assault upon the deceased was not meant to kill him, rather to teach him a lesson. It was a debt collection of approximately $40 - $80, either for drugs or a tattoo that the deceased had failed to finish.

The police sent their investigation to the Department of the Attorney General. Their decision was that there was not enough evidence to prosecute anyone.

Recommendations for the prevention of similar deaths:

There is not enough evidence upon which to make any recommendations

DATED August 28, 2009,

at Edmonton, Alberta.

Original signed by

Honourable L.J. Wenden
A Judge of the Provincial Court of Alberta