ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Law Courts

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

on the 1st to 3rd day of May, 2019 (year), (and by adjournment

on the 27th day of June, 2019 and

on the 11th day of September, 2019 (year)).

before Janet L. Dixon, a Provincial Court Judge,

into the death of Curtis Hill (Name in Full) 34 (Age)

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

Date and Time of Death: December 24, 2013 at 2132h

Place: Edmonton Remand Centre

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)).

Blunt head and neck injuries

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)).

Homicidal

Overview:

1. The purpose of a fatality inquiry is set out in section 53 of the *Fatality Inquiries Act* (*Act*). A judge is appointed to conduct the inquiry in public and must make the following findings:

    a. Identity of the deceased;

    b. The date, time and place of death;

    c. The circumstances under which the death occurred;

    d. The cause of death; and

    e. The manner of death.

2. The *Act* permits the judge conducting an inquiry to make recommendations as to the prevention of similar deaths, subject to the following limitations:

    a. No finding may be made regarding legal responsibility;

    b. No conclusions in law may be reached; and

    c. Any recommendations must be related to the death.

3. The design of the *Act* is to undertake the inquiry after all other processes arising from the death, other than civil matters, are complete.

4. The *Act* provides standing to the next of kin and the personal representative of the deceased to cross-examine witnesses and present arguments and submissions. Section 49(2)(d) of the *Act* permits other parties who claim to have a direct and substantial interest in the subject matter of the inquiry to appear with leave of the judge. The mother of Mr. Hill, participated in the inquiry as a matter of right. She was assisted by her partner. In addition, the following parties were granted leave to participate, having established they had a direct and substantial interest in the subject matter:

    a. Alberta Health Services (AHS)
    b. Alberta Corrections

Inquiry Process:

5. The Ministry of Justice and Solicitor General, Correctional Services Division conducted a Board of Inquiry (Internal Inquiry) into the circumstances surrounding the death of Mr. Hill. The Internal Inquiry commenced December 31, 2013, reviewed documentary records and conducted interviews of ten Correctional Service Division staff, two AHS staff and three inmates. Based on its review, the Internal Inquiry made the following recommendation for improved procedures:

    That the adult centre operations branch discusses with all centre directors the requirement to have cell doors shut at all times, and determine what course of action should be undertaken on a provincial level. Once a determination is made, ACOB policy should be created to reflect this issue and provide staff the procedures to accomplish this goal.

6. The directed completion date for the Board of Inquiry was February 11, 2014. The Internal Inquiry Report, including documentation, witness statements and recommendations, was tendered as an Exhibit in this Inquiry.

7. The Edmonton Police Service investigated the death of Mr. Hill. Three fellow inmates were charged. In May 2016 one of the three individuals charged pleaded guilty to the offence of manslaughter and was sentenced to a period of five years imprisonment. Charges against the remaining accused were stayed.

8. The Fatality Review Board reviewed the Medical Examiner's Case file in this matter and on March 31, 2016 recommended that a public fatality inquiry be held to clarify the circumstances of the death of Mr. Hill and consider recommendations to prevent similar deaths in the future.

9. Pre-inquiry steps commenced in the fall of 2018, including preliminary identification of exhibit materials and witnesses, notice to interested parties and scheduling discussions.

10. This Fatality Inquiry commenced hearing evidence May 1, 2019. There were four days of evidence concluding June 27, 2019. The following witnesses gave evidence:

    Correctional Peace Officer 2 – unit officer at time of death (CPO2)

    Correctional Peace Officer 1 – unit officer at time of death (CPO1)

    Director of Programs – ERC – at time of death (DP)

    Director of Security – ERC – at time of testimony

    Manager, Addiction and Mental Health Services, Correctional Health Services, AHS - at time of testimony

    Dr. Keith Courtney – Facilities Medical Director for Corrections Health Services, AHS

    Dr. Alberto Choy – Section Chief Forensic Psychiatry, Northern Zone, AHS – at time of testimony

11. This Inquiry reconvened September 11, 2019 resulting in further directions for exhibits to be provided by Alberta Health Services prior to any further in person proceedings. After the material was provided, but prior to any further direction for in person proceedings, the courts were closed due to the State of Public Health Emergency.

12. Inquiry counsel assisted in canvassing all interested parties regarding options for continuing with the Inquiry. A consensus was reached by all interested parties: given all witnesses had been heard in person and all requested materials had been submitted to the Inquiry, further in person or video proceedings were not required. With the consent of all parties, final submissions were tendered in writing. The mother of Mr. Hill was offered the opportunity to make final submissions in writing or orally through a virtually convened hearing. She ultimately declined the opportunity to make final submissions, relying or her questions and submissions throughout the public portions of the Inquiry, prior to the disruption of proceedings due to the State of Public Health Emergency. The Inquiry formally concluded in November 2020, after all submissions were received.

13. In assessing the proper breadth of the inquiry to be undertaken, this Inquiry has considered the guidance provided by Justice Kent in *Silverberg v Landerkin,* 1998 ABQB 1105. *Silverberg v Landerkin* was a judicial review of a Fatality Inquiry Report regarding the death of a young person who tragically hung himself while in police custody. Justice Kent found the Judge in that case infringed the jurisdiction of a fatality inquiry. The errors under review related to findings of law associated with the propriety of the arrest in the first instance and findings of liability. Justice Kent also noted some recommendations lacked fairness as a potential interested party was not present, having not been provided notice of the concern of the judge. She summarized the focus of effective recommendations as follows:

> "However, the most effective recommendations that an inquiry judge can make are those that deal with the specific facts surrounding the death. If the death is a youth who committed suicide while in the custody of the police, effective recommendations about how to deal with youths during their time in the custody of the police should be emphasized, not how he got there, whether it be in terms of the offence which he was accused of or the more metaphysical question of whether he had a caring upbringing." (emphasis added)

14. In analyzing the proper role of a fatality inquiry, Justice Kent considered the comments of Justice Cory in *Canada (Attorney General) v Canada (Commission of Inquiry on the Blood System in Canada - Krever Commission)*, [1997] 3 SCR 440, and extracted the following principles relevant to fatality inquiries (*Silverberg v Landerkind,* p 8):

1. The terms of reference or the statutory basis for any inquiry must be the basis for any decision about the extent to which the inquirer may find fault or lay blame. Some inquiries are set up by the government outside of the bounds of the specific statute other than the Public Inquires Act. The Krever Inquiry is an example. One must look to the terms of reference to decide the extent to which the inquirer is expected to find legal responsibility. A fatality inquiry in Alberta does not have any terms of reference such as those found in Krever or Nelles but rather is conducted pursuant to the provisions of section 47 of the Fatality Inquiries Act.

2. A public inquiry into a death is important because of the public airing of evidence and findings of fact that are made therefrom. Inquiries have frequently played an important role in investigating tragedies and making helpful recommendations aimed at rectifying dangerous situations. Cory, J. says at page 14:

> A public inquiry before an impartial and independent commissioner which investigates the cause of tragedy and makes recommendations for change can help to prevent a recurrence of such tragedies in the future, and to restore public confidence in the industry or process being reviewed.

3. Fact finding is the primary role of the inquirer.

4. From the findings of fact made by the inquirer, the inquirer may draw certain conclusions. Indeed, most inquiries are held before a judge who is accustomed to making findings of facts, synthesizing them and drawing conclusions. A fact finding expedition without any resulting conclusions or recommendations would be barren and in some cases meaningless.

15. This Inquiry has carefully considered the helpful guidance provided by Justice Kent in defining the scope of the review appropriate to the circumstances of Mr. Hill's death and in arriving at the findings of facts and resulting conclusions and recommendations contained in this Report.

Circumstances under which Death occurred:

16. At the time of his death, Mr. Hill was an inmate at the Edmonton Remand Centre (ERC) placed on Unit 2D in cell 4. On December 24, 2013 at approximately 2029h Mr. Hill entered cell 7, that of another inmate (the offender). At approximately 2049h the offender approached CPO2 and advised him Mr. Hill had been in a fight in cell 7 and was not moving. Upon responding to the information, CPO2 found Mr. Hill badly beaten. Emergency medical care was provided by trained Corrections staff and by AHS Emergency Medical Services on scene but was discontinued at 2132h, prior to transport of Mr. Hill to a hospital. The Medical Examiner subsequently concluded Mr. Hill died at 2050h of blunt force head and neck injuries consistent with considerable force being applied to the face and neck area of Mr. Hill while he was lying face up with his head on the floor.

17. This Inquiry heard comprehensive evidence related to the incarceration history of Mr. Hill and the circumstances of his confinement at the time of his death. The circumstances will be described in the following categories:

a. Transfer to Edmonton Remand Centre (ERC);
b. Transfer from Segregation to Unit 2D within ERC;
c. Supervision of Inmates in Unit 2D;
d. Circumstances Leading to the Death of Mr. Hill on December 24, 2013; and
e. AHS Management of Corrections Health Services.

<u>Transfer to Edmonton Remand Centre</u>

18. Mr. Hill was remanded to the Calgary Remand Centre (CRC), having been convicted in the fall of 2013 of aggravated assault and other matters arising from the circumstances of the offence. The Crown applied to have Mr. Hill found to be a dangerous offender. As one of the first stages of the determination of the dangerous offender application, the court granted an Order for Assessment October 29, 2013. The Assessment was to be conducted within 60 days. Due to resource issues, AHS could not comply with the Order in southern Alberta. AHS decided to have the Assessment conducted at Alberta Hospital Edmonton. Mr. Hill was transferred from the CRC to ERC for the purposes of the Assessment at Alberta Hospital Edmonton.

19. Prior to his transfer from CRC, Mr. Hill was under the care of Dr. Keith Courtney, a psychiatrist who provided direct patient care to inmates in CRC. Dr. Courtney was also the Facilities Medical Director for Corrections Health Services, AHS, a role which included overseeing the provision of medical, mental health and substance abuse services in all Alberta Corrections facilities.

20. Dr. Courtney provided care for Mr. Hill from at least July 2013 in CRC and prescribed medications in response to his diagnosis of Mr. Hill which included issues related to impulsivity. In a September 2013 follow up, Dr. Courtney noted Mr. Hill was having additional symptoms arising from anxiety associated with his upcoming Assessment, including panic attacks. In response, Dr. Courtney continued the medications. Dr. Courtney last saw Mr. Hill on November 7, 2013. At that time Mr. Hill indicated he was doing well and compliant with medication and felt it was helping him so Dr. Courtney continued the prescription.

21. Mr. Hill was transferred to ERC on November 25, 2013. The prescription ordered by Dr. Courtney was not continued. Dr. Courtney reviewed the Medication Administration Record tendered as an Exhibit. It indicated the substitute prescription was not administered until December 6, 2013, 12 days after the transfer. Dr. Courtney testified if that was the case, the prior symptoms for which the medication was prescribed may have returned.

22. Inmates are required to fill out a Health Services Request form for any health concern they have. The form does not include a field for the date of completion by the inmate. The "Office Use" portion of the form includes a field for the date of receipt to be completed by the AHS staff member initially processing the form.

23. The evidence discloses Mr. Hill filled out a Health Services Request received by AHS November 27, 2013 confirming that he was not receiving his prescription medication and asking for the medication to be resumed. The indicated response on the form was dated November 27, 2013 and stated as follows: "Curtis, Our pharmacists cannot start this medication as we do not carry it at ERC, I have referred you to our psychiatrist to determine which medication will be appropriate." The ERC psychiatrist reviewed Mr. Hill's chart on November 29, 2013 and ordered a substitute medication at a reduced dosage.

24. Mr. Hill filled out another Health Services Request. The receipt date is not filled out by AHS. He acknowledged he was started on a substitute medication but expressed concern the dosage was too low and asked for the dose to be adjusted. The response to the request was dated December 11, 2013 and was stamped "AHS – your request will be forwarded to psychiatry for review".

25. Dr. Courtney was asked about the differences in medication between his prescription and the substitute. He testified the two medications were technical equivalents, however he noted the dosage he prescribed was the equivalent of 40 to 50 mg, compared to the substitute dosage of 30 mg of the substitute medication. Dr. Courtney gave evidence that the medication he prescribed resulted in a higher level of compliance due its manner of effectiveness upon being digested. He saw this as an advantage over the substitute medication.

26. Mr. Hill filled out another Health Services Request in which he included the date December 9, 2013. The Request was noted received December 11, 2013. Mr. Hill made the following request: "I would like to see a doctor. Please can you put me on the list to see Doctor Stewart. Thank you." The response to this request is dated December 12, 2013 as follows: "We need to know specifically what you want to see a doctor about so we can make the right assessment and procede (sic) from there."

27. The Medication Administration Record indicated Mr. Hill was a "no show" to receive his medications on December 15, 16, 17, 21, 22 and 23, 2013. The AHS practice at the time was to take no further action if an inmate did not show to receive his medication. This practice has since changed as a result of a recommendation made in a Fatality Inquiry Report regarding a death in custody at the Ft. Saskatchewan Correctional Facility. The current practice requires the dispensing AHS staff to speak to the inmate to better understand the reason for non-attendance, to address the concern if possible and to encourage the inmate to take his medications.

28. Mr. Hill was seen by a psychiatrist at the ERC on December 20, 2013. The psychiatrist maintained the substitute drug and dosage initially prescribed upon Mr. Hill's transfer from CRC.

Transfer from Segregation to Unit 2D

29. The Inquiry heard evidence from former Director of Programs (DP) at ERC at the time of Mr. Hill's death. The DP explained ERC generally houses inmates who are remanded prior to trial or sentencing. There are exceptions including incarceration for non-payment of fines or immigration detention. Mr. Hill was in custody after conviction but prior to sentencing while awaiting a court ordered Assessment.

30. ERC has seven areas in which inmates may be housed: five pods with four units each, the segregation area or the health unit. Some pods are designated for specific populations including maximum security, female inmates or older inmates. Other pods are designated as general population, but may have defined populations known to the classification team and considered as part of the placement process.

31. The intake process for ERC is the same whether an individual is transferred from another Provincial or Federal facility or newly arrested. The newly arrived inmate goes through an intake and classification process. Standard Operating Procedure (SOP) 8.00.21 details the Standard and Procedures related to Admission. ERC does not rely on the classification made by other facilities as each facility has a unique structure and operational program which affects the risk assessment associated with inmate placement.

32. The classification unit of ERC was aware of the planned transfer of Mr. Hill in advance of his arrival and expected it to be a short stay for the purpose of the Assessment only. Once the Assessment was complete Mr. Hill was to be transferred back to CRC. Mr. Hill had previous stays at ERC, was well known to them and considered hard to place. Given the circumstances, the plan was made in advance to initially place Mr. Hill in a segregation unit and discuss his transfer to another unit after further information was gathered.

33. The decision regarding classification is made by a classification officer. In coming to a decision, the classification officer relies on the record of the inmate possessed by ERC through ORCA (Offender Records and Correctional Administration), the information provided by the inmate and other sources.

34. The DP outlined the many sources of information considered prior to selecting a unit for placement of an inmate, including: case workers on all of the pods, security intelligence officers who work with the police, health care staff who may offer input on the mental health impact of a placement like segregation, case worker supervisors who float between pods and Corrections staff members who can comment on internal facility dynamics. ORCA records are also reviewed. Mr. Hill was also interviewed and advised the classification he had no new "incompatibles" and no gang involvement. The DP explained inmates were relied upon to identify other individuals who may be in custody with whom they anticipated conflict or for other reasons required separation. ORCA contained a list of prior "incompatibles" identified both inside and outside the ERC, either due to Crown or police request, prior street issues, prior administrative decisions or prior altercations.

35. Once a classification is made, the placement on a unit will depend on many factors. The Inquiry heard evidence that placement will consider the volatility on a unit; for example, if a current inmate is "vying for top dog" on a unit, a new inmate who may be seen a competitor would not be placed on that unit.

36. The DP noted Mr. Hill had been anxious to get moved from the segregation unit. He signed his request for placement in general population the day he arrived at ERC. His request was approved on November 27, 2013 based on the written promise of Mr. Hill he would behave on a regular unit. In the experience of the DP, these types of written promises were generally successful. Mr. Hill was moved to Unit 2D, a regular unit, from segregation.

37. The Request for Placement in General Population is framed as a waiver of liability, requiring the inmate to acknowledge he is fully aware of the possible consequences of not being segregated from the inmates on a general population unit. At the time Mr. Hill signed this document, he had just arrived at ERC from CRC and no decision had yet been made where he would be placed. He was not aware his medication would be suspended until December 6, 2013, nor the dosage reduced.

38. While on the segregation unit Mr. Hill was confined to his cell 23 hours a day. There was a recognition by the classification team that segregation posed potential health and mental health risks to any inmate. The DP explained the SOP addressing segregation requires inmates to have their physical and mental health needs closely monitored by a multi-disciplinary team of correctional staff and AHS staff through live contact while in segregation. Overall the classification team concluded the risks of transferring Mr. Hill to Unit 2D were warranted given the potential risks to Mr. Hill if he were to be kept in segregation.

39. The DP was specifically asked to comment on the risk of conflicts she anticipated moving Mr. Hill to Unit 2D. She responded "we knew there would probably be trouble" but elaborated that conflict was to be anticipated in a correctional setting. The classification team anticipated issues around rudeness to staff. The team considered the inmate population of Unit 2D at the time and anticipated the transfer would change the dynamics on the unit. The unit had some "heavies" on it and Mr. Hill was also seen to be a "heavy". This term described an inmate who was experienced in custody and could exercise some influence with other inmates on a unit. The team recognized there were dynamics amongst the population of which they were not aware but assessed the risk of conflict. They considered Mr. Hill did not generally lash out at other inmates, but rather told them he did not like them and encouraged them to ask for a transfer from the unit.

Supervision of inmates in Unit 2D

40. The Inquiry was provided with the SOPs relevant to the management and supervision of inmates on Unit 2D. SOP 14.20.00 states the following Standard: "Staff shall ensure that inmates adhere to the Edmonton Remand Centre rules and regulations in order to maintain an orderly and effective management of the centre." Specific rules enumerated in SOP 14.20.00 include the following:

    a. Inmates are not permitted to enter another inmate's cell.
    b. Cell doors are to be kept closed at all times.

41. SOP 14.20.03 sets out the Procedures for Supervision of the Unit during the afternoon shift (1500 - 2300). The requirements for staff assignments, briefings, conducting inmate counts, exercise time, medication issuance time, and final lock up are clearly set out.

42. In addition to SOPs, staff are provided further detailed directions through Post Orders. Post Order No. 6 detailed the duties of all Correctional Peace Officers. Post Order No. 13 detailed the scheduled and non-scheduled duties to be discharged by a Unit Officer during the shift. Included in the directions was the following:

    9. Maintain a continuous presence on the living unit. Staff should interact directly with inmates on the living unit and not remain at the staff station.

    10. Supervise inmate movements and unit activities including movement to program rooms, video court and professional visits on the second level. Ensure conformance of inmate's movement as closely as possible with routine schedules.

43. The list of duties detailed in the two Post Orders is extensive, including 10 pages of text. Post Order No. 13 lists a total of 58 duties, scheduled and non-scheduled, to be performed managing a unit with 72 inmates in 36 cells located over 3 levels with 12 units per level. The security station is located on the main level at the back of the unit facing the cells. The security station is "u-shaped" and is equipped with desk space, one computer terminal, a monitor and a phone. The ERC has installed an Electronic Detention Monitoring and Control System (EDMCS). CPOs lock and unlock cell doors from a touch screen monitor at the security station. A key feature in EDMCS is the PASS mode which locks a cell door from the outside, while leaving it unlocked from the inside which permits inmates to leave the cell.

44. A unit is staffed by two CPOs and one float during the afternoon shift. The float is responsible for moving carts and meal trays, covering breaks and assisting with the nursing clinic which occurs in the evening.

45. The Inquiry heard evidence from CPO2 on duty the evening of December 24, 2013 which provided a "real time" description of the operation of Unit 2D. From 1800h on a typical day on the Unit the inmates have recreation time which is unstructured. Options include watching television, exercising, going into the yard, submitting requests, getting library books, using the telephone or other programming which may be available in the program room on the unit.

46. One of the CPOs' primary duties at the security station is to manage the EDMCS system. When a cell door is in the PASS mode, the CPO must touch a button on the computer screen to permit an inmate to re-enter his cell if he wishes re-entry. Cell doors are always set in either locked mode or PASS mode so an inmate cannot enter his cell without CPO action at the monitor on the security station. An inmate may wish to re-enter his cell for many reasons during free time, including having privacy, using the toilet or before and after a shower. The showers are common showers, located in the central area of each level. There are no toilet facilities in the common area of the Unit.

47. The functioning of the PASS mode was explained by CPO1, CPO2 and the Director of Security. The cell door locks may only be managed from the security station. The status of the cell door lock and whether the door is open or closed is shown on a computer monitor. If the cell door is programmed to be locked and properly closed, it will show on screen as a green square which indicates the cell is secure. If the cell door is programmed to be locked but is not closed it shows as a red square which means the cell is not secure. There are other modes in EDMCS which are not relevant to this Inquiry.

48. When an inmate is permitted to be out of his cell, his cell door is placed in the PASS mode. This allows the inmate to leave his cell, but leaves it locked from the outside. A CPO can permit an inmate to access his cell when the door is in PASS mode, by touching a box on the touch screen monitor that unlocks the door for a few seconds to permit an inmate to access the cell and then automatically relocks the door.

49. The cell door is not spring loaded, and does not close automatically. If an inmate leaves his cell and does not close the door behind him, while his cell door is in the PASS mode the monitor will show a red square.

50. CPO2 gave evidence that an inmate would seek permission to be allowed back into his cell by asking at the security station, standing at his door, raising his hand at his door or yelling from his door.

51. Both CPO1 and CPO2 noted it was an ongoing issue that inmates left their doors ajar rather than waiting to be let back into their cell. This resulted in several red squares on the monitor. The CPOs were responsible for ensuring all the cell doors were properly secured, which is indicated by a green square. The CPOs were constantly yelling out to inmates to close their doors. CPO2 described it as an ongoing battle to get the inmates to close their doors because the inmates wanted the freedom to come and go without CPO approval.

52. Given the distance from the security station to some cell doors, CPO2 gave evidence it was sometimes difficult to see if the cell door was open so the CPOs relied on the monitor to assess the status of the cell door.

53. CPO2 gave evidence that inmates were well aware of the rule they were not permitted to enter each other's cells because the CPOs were continually yelling at them for breaching the rule. CPO1 gave evidence CPOs were constantly "harping" at inmates not to visit in cells, however some inmates continued to do so and the PASS mode enabled visiting as the inmate could open his door from the inside to let someone in.

54. The Inquiry was provided documentary evidence from counsel for Corrections that since October 16, 2013 Unit 2D had been on an 18-cell rotation, meaning only the inmates in 18 cells at a time were permitted to leave their cells. This was based on a report by CPO2 which noted the following: "Recent behavior on the unit has degraded. Excessive cell visiting leading to a code 66 (inmate on inmate assault) and possible assault. Poor attitude on part of most in not locking up when told to and interfering with code team during response. Recommend moving unit to an 18-cell rotation."

55. With the 18-cell rotation, cell doors were only in PASS mode when inmates in the 18 cells were permitted to be out of their cells. CPO2 gave evidence that at the start of those hour-long sessions he extended additional liberty to allow inmates to leave their doors ajar as they may forget to take an item out of the cell or need re-entry for some other reason.

56. In addition to being attentive to requests from inmates on the three levels for entry to a cell, other CPO duties can only be done from the security station, including managing lighting and water, entering required log information and external telephone communications. Supplies are also issued from the security unit including things like razors, soap and toothpaste. Inmate written requests are submitted for processing to the CPO at the security station. CPO duties also include varying levels of data entry, which may only occur from the security station. During a busy time when there activities including video court, clinics or visitors to delivery programming, the CPO documentation must be maintained current to record the inmate movement on and off the unit. CPOs are also required to assist with inmate movement during the administration of medications or when the canteen is open. One of the two CPOs on duty was required to walk through the entire unit once an hour while the other stayed at the security station.

57. While a CPO is supposed to have a continuous presence on the whole unit and not stay at the security unit, the evidence before the Inquiry leads to the conclusion there would be few practical opportunities to fulfill that obligation. Not all the Unit areas are visible from the security station; those areas must be monitored by security cameras which are only visible from the security station. The evidence before the Inquiry supports the conclusion the CPOs are virtually tethered to the security station for the majority of their prescribed duties for a shift other than the designated hourly rounds and have little or any meaningful opportunities to be "continuously present" on the unit. It appears from the evidence before this Inquiry the requirement for hourly rounds is considered as fulfilling the continuous presence requirement by the CPOs on duty. CPO2 described continuous presence as face to face encounters. CPO1 explained that given one CPO must be at the security station at all times the other CPO is engaged in duties including rounds, processing inmate requests, accompanying Unit visitors and cell searches, so what duties can be completed depends on the time available.

58. CPO2 testified that once an inmate is assigned to a unit the inmate is assigned to a cell within that unit by the CPO on duty. There is no SOP or other direction regarding cell assignment within a unit. CPO2 was on duty when Mr. Hill arrived on Unit 2D and assigned him to cell 4 on the top level of the Unit. CPO2 testified there was a gravitation of "heavies" to the top level of the unit. This was because the inmate population on Unit 2D tended to be serving longer periods of remand and the inmates sought permission to be moved to the top level. CPO2 indicated these "heavies" were more savvy about the unit and preferred the top level, as there was less ability for the CPOs to supervise and it took longer for CPOs to respond if there was an incident. In addition, when the Unit was on a rotation, the gravitation of "heavies" to one area resulted in the heavies all being on liberty in the same rotation, which they preferred. CPO2 confirmed it was his understanding this gravitation of "heavies" occurred on all units. While CPO2 acknowledged it was not desirable to have all the "heavies" located in one area, he indicated there was nothing he could do about it because each shift made independent decisions about where an inmate was placed and whether a request for a change in placement would be made. Each of these decisions was made in the sole discretion of the CPO on duty. There is no policy guiding decisions by CPOs regarding the placement of inmates within cells or levels on a unit.

59. This Inquiry was provided with the Internal Inquiry Report inquiring into the death of Mr. Hill. The Internal Inquiry interviewed 15 individuals including Corrections staff, AHS staff and inmates. In its final Report Internal Inquiry made the following comments

> "Unit 2D is a 36 cell unit spread over three levels, with 12 cells on each level. At the time of the incident, the unit was on a cell rotation, where only 18 cells at a time are allowed out to the common area on the unit. This approach is often utilized at ERC when significant behavioural issues are occurring. In doing so, and by only allowing approximately one half of the inmates out at a time, it is less likely for incidents to occur. This practice does result in increased lock ups for the other inmates on the unit, as they are confined to their cells until their rotation is allowed out for exercise.
>
> Another procedure that CPOs utilize to monitor these units other than direct supervision is to conduct hourly rounds and keep cell doors locked, thus preventing inmates from entering each other's cells. The policy that specifies cell door locking is identified in ERC SOP 14.20,03 procedure 6: *"During program hours when the unit is not on lock-up, cell doors shall be placed on the "PASS" function This is to allow inmates access to exit their own cell but will require the living unit officer to unlock the cell for re-admittance".* This policy has been appended for reference in tab 19. The "PASS" feature refers to the electronic control at the officer's staff station. The CPOs can electronically lock and unlock cell doors from their panel. In addition, they can also place it on PASS mode. This would enable an inmate to open the cell door from inside the cell, but not able to access the door from the outside, without the officer's assistance."

60. The Internal Inquiry made the following recommendation for policy review:

> That the adult centre operations branch discusses with all centre directors the requirement to have cell doors shut at all times, and determine what course of action should be undertaken on a provincial level. Once a determination is made, ACOB policy should be created to reflect this issue and provide staff the procedures to accomplish this goal.

61. The Director of Security and CPO2 described one change arising from this recommendation: the opportunity for an inmate to return to his cell was limited to 5 minutes every 30 minutes. Cell doors are now completely locked from 0 to 25 minutes of every hour and put in PASS mode from 25 to 30 minutes, then completely locked from 30 to 55 minutes and put in PASS mode from 55 to 00 minutes. This was a change implemented at the ERC. Each facility was provided the opportunity to design changes appropriate to their facility security structure. CPO2 advised the problem with cell doors being left open persists, even with the new process.

Circumstances Leading to the Death of Mr. Hill on December 24, 2013

62. CPO2 described the events leading to the death of Mr. Hill while observing the CCTV recording of the Unit from December 24, 2013. His evidence and this Report relies on the times disclosed in the CCTV video.

63. Mr. Hill was assigned to cell 4 on the top level of the Unit, the third cell left of the showers. On December 24, 2013 Mr. Hill did not have a cell mate. Mr. Hill was killed in cell 7, occupied by the offender, the first cell right of the showers. CPO2 confirmed the inmates in the 18 cells including cell 4 were entitled to be out of their cells commencing 2000h, once the inmates from cells 19 to 36 had returned to their cells.

64. At 2002h CPO2 testified the cell doors for cells 1 to 18 were either unlocked or put into PASS mode.

65. The video shows numerous occasions, between 2002h and 2050h of inmates moving freely from one cell to the other on the upper level and of cell doors being left ajar or wide open for over 1 minute.

66. At 2029h the offender left the main level and entered his cell (7). Mr. Hill followed the offender and entered his cell (4). At 2030h Mr. Hill left his cell, walked directly to cell 7, opened the door and entered the cell. At 2031h another inmate walked up the stairs and entered cell 7 through the door which was ajar. At 2032h an inmate left cell 7 and walked directly into cell 9, through the door which appeared to be left ajar. A fourth inmate then climbed the stairs and directly entered cell 7 without seeking assistance from the security station. The fourth inmate left cell 7 almost immediately and walked into cell 8 with no apparent assistance from the security station. Ultimately CPO2 was called to investigate the situation at 2050h. The cell doors of cells 8 and 9 are visibly open or ajar for the period from 2032h to 2050h.

67. CPO2 testified no round was done between 2000h and 2100h as a count had been completed at 1930h and a final lock up for the day with the count was planned for 2100h. CPO2 acknowledged that from 1950h to the time he was called to cell 7 neither CPO on duty had remained within steps of the security station.

68. Upon arriving at cell 7, CPO2 immediately called a code. There was a prompt and thorough response from both Corrections and AHS. External Emergency Medical Services, AHS (EMS) also responded. Care continued until 2132h when EMS was given the order to discontinue CPR by the physician with whom they were consulting.

AHS Management of Corrections Health Services

69. This Inquiry heard evidence from Dr. Keith Courtney who took on the role of Facilities Medical Director for Corrections Health Services in September 2012. (Dr. Courtney also provided direct care to Mr. Hill while he was at CRC, as discussed earlier in this Report). Prior to his appointment to that role Dr. Courtney had extensive experience in overseeing the provision of mental health care in correction facilities. He maintained his Certified Correctional Health Care Professional status through the National Commission on Correctional Health Care (US) since June of 2002.

70. The process of transitioning the responsibility for Corrections Health Services from Corrections to AHS took place over four years. AHS commenced a process in 2012 to review Corrections health policies and develop AHS policies which aligned with the Corrections policies and met the AHS objectives during the transition process.

71. Given the diagnosis and treatment of Mr. Hill while at CRC and ERC, this Inquiry focused on the area of mental health services provided in ERC. Dr. Courtney testified that upon his commencement in the role as Facilities Medical Director the mental health screening policy for inmates was vague. He testified the policies subsequently developed by AHS were consistent with the practices in place in 2013, but noted some new procedures were introduced in the AHS policies. The evidence disclosed AHS adopted the *Addiction & Mental Health Services Provided to Patients in a Provincial Correctional Facility Policy* as part of the four year process described by Dr. Courtney. The *Addiction & Mental Health Services Provided to Patients Procedure* was developed in accordance with the policy and took initial effect January 2, 2016.

72. Dr. Courtney testified that some of the refinements in the AHS policy from the prior Corrections policy included refining the questions asked when inmates were admitted, follow up guidelines, time frames for mental health interventions when concerns were identified and clearer delineation of responsibility for follow up with an inmate.

73. Dr. Courtney testified AHS had no role in inmate placement to a unit or within a unit. If an inmate was seen and diagnosed with a health issue, AHS staff would follow up as medically appropriate. Other than follow up, AHS would only become involved with an inmate if the inmate made a request for consultation or if a Corrections staff member raised a concern.

74. Dr. Courtney testified the diagnosis and treatment of an inmate followed the inmate when transferred through the transfer summary. Ordinarily this would include continuation of prescriptions, however he observed that the prescription drugs available at Correction facilities vary from facility to facility. This may result in the medication of an inmate being suspended until the inmate is seen by AHS staff and a new medication prescribed. He also noted the medical file, consisting of Physician Orders & Progress Notes and other material, did not follow the inmate from facility to facility upon transfer. He likened this to a patient moving from clinic to clinic in the community and noted the file would only be transferred upon special request.

75. Dr. Courtney noted the average time he spends with a patient on a consult is 5 to 45 minutes. He indicated his assessment relies heavily on observations made by the health care team providing support to a Unit and on Unit CPOs. This Inquiry was directed to a "Mental Health Alert Assessment" form to be completed by CPOs in specified circumstances. No Mental Health Alert Assessment was completed in relation to Mr. Hill during his period of remand at ERC prior to his death.

76. This Inquiry heard evidence from the AHS Manager, Addiction and Mental Health Services, Correctional Health Services. Since she had only occupied the position from September 2016, the Manager had informed herself on the policies and practices she expected would be in place in December 2013.

77. The Manager testified the standard of care intended to be achieved in a Correction Facility is similar to accessing care in the community. The patient may file a form to self-refer or may be referred by a member of the health care team. In cases where an inmate has a diagnosed mental health condition but is not appropriate to be placed on the mental health unit, appropriate information would be provided to Corrections to be considered as part of placement on a unit. Corrections staff may share information with AHS as concerns arise. AHS is under significant privacy restrictions and will only share information where permissible under the legislation. Meetings occur daily between AHS and Corrections to discuss events of the day within these parameters.

78. SOPs entered as Exhibits in the Inquiry also referenced the sharing of concerns related to mental health. For example SOP 8.00.21 related to Admission and Discharge includes this direction under the heading "Mental Health":

> "Operational staff shall pass on any concerns provided by police or escort staff or external sources to Health Care and Placement staff. The Placement Officer will consult with Health Care staff on placement of inmates who have serious mental health issues."

79. Dr. Courtney testified he has been asked to review training for corrections officers and referenced national and international guidelines in existence to set standards for the training.

80. This Inquiry sought additional detail regarding the existence of national and international guidelines regarding standards for training of Correction staff. The response to this request, provided through letters and documents, and shared with all parties, is summarized below:

    a. The National Commission on Correctional Health Care (NCCHC) has created standards for "Health Services in Jails (2018)" and "Mental Health Services in Correctional Facilities (2015)". These documents were shared with the Inquiry.

    b. Corrections was asked to comment on the NCCHC Standards and provided the following response through Inquiry counsel:

        "Corrections advises that the National Commission on Correctional Health Care is a heath care focused body, so Corrections would not be involved with this type of accreditation body. Corrections is aware of one standards and audit body, the American Correctional Association/Global Correctional Association, and it appears that Canadian institutions are eligible for membership. ERC is not a member of this association, and is not aware of any Canadian institutions that are members."

    c. AHS was asked to comment on standards and provided the following response through Inquiry counsel:

        Alberta Health Services advises that healthcare services provided in Alberta correctional institutions go through an accreditation process provided by Accreditation Canada. The last accreditation cycle was in 2014, and Correctional Healthcare

received a 98% compliance rating. The next accreditation cycle is commencing now and the assessment will take place next spring.

d. The NCCHC document regarding Mental Health Services in Correction Facilities directly identifies training of correction officers as essential in MH-C-04 which states as follows:

"A training program, established or approved by the responsible mental health authority in cooperation with the facility administrator, guides the mental health-related training of all correctional officers who work with inmates."

Recommendations for the prevention of similar deaths:

Recommendation 1:

The Edmonton Remand Centre management staff develop Standard Operating Policies for inmate cell and level assignment and re-assignment within a Unit incorporating similar risk management and inmate management considerations as are applied to Unit classification.

81. This Inquiry concludes on the evidence that the Edmonton Remand Centre applies scrutiny and care in assessing the risk to an inmate, and the risks an inmate may cause to others, prior to the inmate being moved from segregation to another unit. The assignment of an inmate to a cell or level within a unit is not subject to any oversight or policy and was at the discretion of the CPO on duty at the time of arrival.

82. The Inquiry concludes on the evidence before it that due to a lack of policy on cell and level placement there is a gravitation of inmates within a Unit to the most remote cells where supervision was the most difficult. The death of Mr. Hill occurred in the cell furthest from the security station and amongst the most difficult to supervise.

83. This Inquiry also concludes that a further incentive for inmates to gravitate to a cluster of cells on the highest level is the opportunity to share recreation time, even when a unit is in a form of security lock-down.

84. This Inquiry was advised there is no current policy for considering overall unit risk management in assigning inmates to cells within a unit. This appears to be a gap in risk management, particularly given the high level of care and supervision applied before an inmate is permitted to move out of segregation.

Recommendation 2:

The Edmonton Remand Centre management undertake a comprehensive review of the risks associated with the PASS mode of the Electronic Detention Monitoring and Control System to enhance the safety of inmates including consideration of the following risk management strategies:

a) providing additional staff to monitor the EDMCS when in PASS mode;

b) making changes to the physical structure of the units to enable inmates to access toilet facilities without returning to their cell; and, or

c) providing additional staff to ensure the capacity for a continuous presence on the Unit as required by current policy.

85. The SOPs and Post Orders guiding the duties of CPOs include an expectation the CPO can have a continuous presence on a unit as part of the security plan. The monitoring requirements of the PASS mode coupled with other duties effectively tethers at least one of the CPOs to the security station at all times during a shift. The second CPO has little time to be present on the Unit as he/she is left to attend to all the other shift duties detailed in the Post Orders.

86. Cell doors on Unit 2D were regularly left open despite direction from CPOs. CPOs were aware cell visits were occurring in violation of the inmate rules; these visits were enabled by the inability of CPOs to properly supervise cells, especially those located on the top level, furthest away from the security station.

87. The evidence before this Inquiry indicates changes implemented in response to the Internal Inquiry recommendation arising from this death have not materially changed the conduct of inmates. Doors continue to remain open and visiting continues to occur.

88. A logical motivator for leaving the cell doors open was identified by a CPO: inmates may be going for a shower or simply want to enter their cells to use the toilet facilities. The long waits to get a cell door re-opened, due to the congestion at the security station, motivated the inmate to simply leave his door open when he left his cell.

89. Once an inmate learns that PASS mode cannot be meaningfully supervised, the cell becomes a location for unsupervised contact between inmates, as there are no security cameras within cells. This is especially true on the third level where direct supervision is extremely difficult. Inmates, especially “heavies”, are known to seek re-assignment of their cell to the area of most difficult supervision.

90. The evidence in this Inquiry supports the conclusion that, in the absence of sufficient staff to have a continuous presence on the Unit, the physical configuration of the Units at ERC make meaningful supervision, especially of the top level of a unit, extremely difficult with only two CPOs on duty.

Recommendation 3:

Corrections management ensure that Correctional Peace Officers receive mental health-related education and training to understand signs and symptoms of mental illness; to be better equipped to share relevant observations with the AHS health team; to be prepared to make referrals of inmates for mental health and other services; and to consider the potential impact of mental health related behaviours on inmate placement within a Unit.

91. Dr. Courtney gave evidence he was asked to review training for correctional officers in this area and referred to recognized standards, subsequently identified as the NCCHC Standards. This testimony alerted the Inquiry to both the requirement and existence of standards for correctional officer training. NCCHC Standard MH-C-04 confirms the importance of Correctional Officer training in this area.

92. Corrections advised this Inquiry it did not consider the NCCHC Standard for Mental Health Services in Correctional Facilities to be relevant to its policies or programming as it viewed it to be an area of responsibility of AHS.

93. This Inquiry heard evidence that the process of assessing mental health issues by health professionals in a correctional setting relies on the observations from all of those who interact with an inmate, including CPOs and other Corrections staff.

94. This Inquiry concludes this recommendation is relevant to the circumstances of this Inquiry, particularly given the evidence before this Inquiry that this standard is seen by Corrections to be the responsibility of AHS, notwithstanding the staff to be trained are employees of Corrections. There appears to be a gap in responsibility for training and education of correctional officers at ERC.

Recommendation 4:

Alberta Health Services management develop a standard list of medications to be available at all Corrections facilities to be dispensed to an inmate to avoid any interruption in the treatment of a diagnosed health condition without an updated assessment.

95. The medication prescribed to Mr. Hill was suspended for 12 days upon his transfer to ERC due to a lack of availability of the medication. When a substitute medication was resumed on December 6th, 2013 it was at a reduced dosage from the CRC prescription.

96. Mr. Hill actively advocated to have his prescription restored, submitting Health Service Requests specifying his concern. He was not seen by psychiatry at ERC until December 20th, 2013.

97. AHS is responsible for the provision of health services throughout all provincial Correctional Facilities. While there may be differences in medication preferences from physician to physician for similar diagnoses, care should be taken to avoid any potential adverse impact on a inmate due to these medication preferences.

98. An inmate is not the equivalent of a community patient. He is not able to seek a second opinion in the community or check with other pharmacies to fill a prescription. An inmate has no control over the timing or location of his transfer and no ability to take steps to ensure a continuous supply of medication until a new physician can be consulted.

99. The creation of a standard list of available medications will ensure seamless continuation of medications upon transfer between correctional facilities and avoid unpredictable consequences to an inmate arising from a change in medication or dosage which is not easily monitored in the environment of a corrections facility.

Recommendation 5:

Alberta Health Services management disclose all Fatality Inquiry Reports which include a discussion of AHS policies or practices to all future accreditation processes conducted by Accreditation Canada.

100. The evidence before this Inquiry identified that existing standards for Health Services in Jails and for Mental Health Services in Correctional Facilities, articulated by the NCCHC are not expressly being audited by Accreditation Canada.

101. AHS participates in a sanctioned accreditation process involving peer review and assessing compliance with articulated standards. Incidents leading to Fatality Inquiries are exceptional events and include a full review of the policies, procedures and circumstances leading to the death. This information may meaningfully inform the assessment of compliance with standards set by Accreditation Canada.

102. The disclosure of Fatality Inquiry Reports in which AHS has applied for the right to call evidence and make submissions will foreseeably enhance public trust in the provision of health services to those in correctional facilities.

Conclusion

103. An inquiry should identify the relevant policies connected to the death of the individual and analyze the relationship of the policy to procedures and to practices. It is paths of analysis like this which best inform recommendations which address systemic concerns in the operation of a facility. The objective of this Inquiry is to prevent similar deaths in the future; that is a broader mandate than analyzing the few minutes preceding the death under review.

104. Key to some recommendations is the need to restore public confidence in public institutions. All recommendations are directed to parties who have self-identified as interested parties and fully participated in the Inquiry. The foregoing recommendations are offered after a thorough investigation into the tragedy in this case; the death of Mr. Hill. The recommendations are made mindful of the clear and principled purpose of an inquiry of this nature as expressed by Cory, J (*Canada (Attorney General) v Canada (Commission of Inquiry on the Blood System in Canada - Krever Commission*), [1997] 3 SCR 440):

> A public inquiry before an impartial and independent commissioner which investigates the cause of tragedy and makes recommendations for change can help to prevent a recurrence of such tragedies in the future, and to restore public confidence in the industry or process being reviewed.

DATED August 31, 2021,

at Edmonton, Alberta.

Original Signed

Janet L. Dixon
A Judge of the Provincial Court of Alberta