



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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Provincial Court of Alberta
in the City of Calgary, in the Province of Alberta,
(City, Town or Village) (Name of City, Town, Village)
on the 4, 5 & 6th day of June, 2008, (and by adjournment
year
on the _____ day of _____, _____),
year
before The Honourable Barbara Lea Veldhuis, a Provincial Court Judge,
into the death of Eric Encontre 55
(Name in Full) (Age)
of Holden, Alberta and the following findings were made:
(Residence)

Date and Time of Death: October 3, 2006

Place: Calgary Correctional 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 – The Fatality Inquiries Act, Section 1(d)).

Coronary thrombosis arising as a complication of atherosclerotic coronary artery disease.

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)).

Natural.

INTRODUCTION

On April 19, 2006, Eric Encontre received a global sentence of one year of incarceration on conviction for two counts of Assault Peace Officer and one count of Assault Causing Bodily Harm (to an Alberta Family and Social Services worker). His anticipated release date was to be December 12, 2006. There were no previous convictions on his record. A Stay of Proceedings was entered for an Assault originating in Winnipeg, Manitoba in 1999. Further, a charge of Assault arising in Holden, Alberta was withdrawn in 2003. On October 3, 2006, while serving the April 2006 custodial term, Mr. Encontre suffered a coronary thrombosis and died.

NARRATIVE

At approximately 4:45 p.m. on October 3, 2006, C.O. Amanda Smith responded to an offender reporting “a man is down” in the East Wing of the Calgary Correctional Centre. C.O. Smith undertook a preliminary assessment, initiated “Code 99”, ordered offenders back to their bed spaces, and then returned to the staff station. She let the initial response team into the secured area and CPR was initiated by two staff nurses. Mr. Encontre was unresponsive, was not breathing and had no pulse. Additional life saving measures were taken including inserting an intravenous line into the left forearm to administer saline as well as inserting an airway device.

Following the initial assessment and intervention, Pamela Rivoire, a nurse, directed that a 911 call for an ambulance be made. At about 5:00 p.m. EMS arrived and paramedics took over and continued to perform life saving measures until 5:25 p.m. At that time, attempts to resuscitate Mr. Encontre were terminated and he was pronounced dead.

A Board of Inquiry was convened on October 5, 2006. An investigation was conducted and a report was produced. Reference to that investigation will be highlighted in this Report.

The Medical Examiner's Certificate and Autopsy Report was filed on January 11, 2007, indicating Mr. Encontre's death was due to Coronary Thrombosis and the antecedent cause was Atherosclerotic Coronary Artery Disease. No internal injuries were present to account for death. A small scrape or abrasion was noted on the left lower eyelid, and there were some tiny pinpoint bleeding sites on the eyelids. Postmortem toxicology was negative for the presence of alcohol and other intoxicating drugs in the blood.

WITNESSES TESTIFYING AT THE INQUIRY

The following witnesses testified:

1. Dr. Graeme Dowling – Chief Medical Examiner for the Province of Alberta
2. Martin Laslo – offender housed at Calgary Correctional Centre (CCC)
3. Elmer Jacobson – offender housed at CCC
4. Oscar Mendoza – offender housed at CCC
5. Cesar Guzman – offender housed at CCC
6. Randolph Taylor – Deputy Director Operations, CCC
7. Amanda Joyce Smith – Correctional Officer I, CCC
8. Frank Wilkins – Acting Case Worker, CCC
9. Karen Lawlor – Control Room, CCC
10. Dr. Abdul Majid Fahoum – Royal Alex Hospital, Edmonton, Alberta
11. Dr. Ian Hanish Bailes – on contract to Fort Saskatchewan Correctional Facility (FSCF), Fort Saskatchewan, Alberta
12. Dr. Dennis Yinjip Wong – on contract to Edmonton Remand Centre (ERC), Edmonton, Alberta
13. Blaine Vandekerkhove – Acting Correctional Officer III, CCC
14. Brenda Middleton – Registered Nurse, CCC
15. Lesley Bells – Correctional Service Worker, CCC
16. Pamela Rivoire – Registered Nurse, CCC
17. Michael Anthony Dewilde – Corrections Officer, CCC
18. Robert Jones – Deputy Director of Programs, CCC
19. Dr. John Gillespie – on contract to CCC
20. Elaine Kwan – Registered Nurse, FSCF
21. Linda Whitley – Health Care Manager, FSCF

22. Ethyl Lynn Mark – Secretary, Health Care Unit, FSCF

23. Tiffany Murray – Health Care Manager, CCC

Ms. Caroline Gordon, mother-in-law of the deceased and Ms. Aileen Brandon, step-daughter of the deceased and granddaughter of Ms. Gordon, both appeared as interested persons on behalf of the family for the entirety of the Inquiry. At the conclusion of the evidence, Ms. Gordon made a number of submissions and recommendations.

CIRCUMSTANCES LEADING UP TO DEATH

The evidence before this Inquiry, as well as before the Board of Inquiry, disclosed that Mr. Encontre's death occurred immediately following a verbal altercation with one or more offenders in the Protective Custody unit where he was housed at CCC. There was an issue among several members on the unit about Mr. Encontre's hygiene, as well as the belief by some of his peers that he was a sex offender. Verbal altercations had occurred between Mr. Encontre and his peers on a number of occasions prior to his death. He was described as being "low on the pecking order" on the unit. On October 3, 2006, a number of offenders were observed following Mr. Encontre back to his bed space (a small cubicle with half walls, assigned to each offender), taunting and verbally harassing him. Mr. Encontre was observed to back into his bed space and as he appeared to sit down, he collapsed onto the floor.

The lone, female Correctional Officer, Amanda Smith, who was in the guards' office, referred to as "the bubble", was notified that there was "a man is down". The offenders who testified said she entered the area cautiously, made observations, and then directed the offenders to return to their respective bed spaces. The evidence, from the perspective of the offenders, suggests that there was a casual air about the guard's response.

Ms. Smith had been a Correctional Officer I for about nine months and this was her first medical emergency. At the time of the incident she was in ‘the bubble’ on her own as her colleague, Frank Wilkins, was taking the meal carts away. Ms. Smith said that she had been helping clear up the meal trays with her partner and she had not noticed anything taking place on the unit. Her initial assessment was that the commotion might be a set-up. However, she quickly determined that it “felt like something was wrong”.

Ms. Smith testified as follows: “I walked fast. I was kind of cautious. I was watching the other offenders and what – what their movements were.” She walked about 85 feet from her station to the area where Mr. Encontre was observed to be laying on the floor face down. She immediately initiated a medical emergency by calling “Code 99” via her hand held radio. Ms. Smith had to return to ‘the bubble’ to control the opening of doors to let the initial response team into the unit to attend to Mr. Encontre. The initial response team responded quickly and CCC nurses Pam Rivoire and Brenda Middleton performed life-saving measures. It was quickly determined that an ambulance would be required and 911 was called.

Ms. Rivoire testified that “we cannot give medication without direction and this man definitely needed to go to the hospital. There was no question that 911 needed to be called and they needed to respond quickly.” There is no defibrillator on site at CCC and when asked why, Ms. Rivoire said “It is not for lack of wanting one. I do not know what the actual reason is.” **[While policy decisions are not usually the purview of frontline staff, Ms. Rivoire’s comment about the reason for no defibrillator being available was as candid and complete as any provided by a witness in these proceedings.]**

Ms. Bells, a nurse, responding as part of the on site initial response team, also testified that she did not understand why there was not a defibrillator on site at CCC. The paramedics who responded to the 911 call used a defibrillator which they brought with them.

Dr. Gillespie, when asked whether it would be appropriate to have a defibrillator at CCC, said:

Well, certainly, AED's, automatic external defibrillators are now available in many parts of the community. We see them in airports, in malls, on airplanes. Certainly I think it would be reasonable to have an AED in the CCC, probably shouldn't be hanging on the wall in one of the units but in the health care area.

The 911 call was made at 4:48 p.m. CPR was continued by on site responders until the arrival of the EMS, when paramedics took over the responsibility for Mr. Encontre's care. Paramedics continued to perform life saving measures until 5:25 p.m. when attempts to resuscitate Mr. Encontre were terminated and he was pronounced dead.

At the time of his admission to the ERC on April 19, 2006, Mr. Encontre underwent a cursory medical examination. He advised the admitting nurse that as well as having angina intermittently since 1996, he suffered from chronic atrial fibrillation (irregular contractions of the heart that throw off the rhythm of the heart and pulse). As well, he suffered a brain injury from a motor vehicle accident in 1994 and had experienced seizures as a result, although not recently. Nitroglycerine spray was given to Mr. Encontre as self-medication.

One day after being sentenced, that is on April 20, 2006, Mr. Encontre was taken from ERC to the Royal Alex Hospital in Edmonton, Alberta suffering from chest pain and pale, clammy skin. Medication was commenced for atrial fibrillation with follow-up recommended following his return to ERC. On April 21, 2006, Mr. Encontre was medically cleared by Dr. Wong and he was transferred to FSCF on that date to serve as a sentenced offender.

Between April 21, 2006 and August 15, 2006 Mr. Encontre experienced several medical events. He was taken to a hospital on at least 6 occasions and in addition, seen by on site correctional centre physicians who assessed and treated him for various matters. On August 15, 2006, a request was made to transfer Mr. Encontre from the Assessment and Treatment Unit to general population following an evaluation of suitability by the FSCF psychologist who determined that Mr. Encontre had developed contentious

relationships with some other offenders. This required him to be kept separate from several of them and the psychologist recommended a transfer to another centre. CCC was considered to be an appropriate placement and on August 16, 2006 he was transferred to CCC.

Upon arrival at CCC on August 16, the admitting nurse referred Mr. Encontre to the CCC doctor, psychologist and psychiatrist. He was provided with medical care for a number of medical issues and procedures at that time, of a minor or routine nature.

On September 15, 2006, Mr. Encontre was returned to FSCF. He attended the Royal Alex Hospital for heart monitoring testing which had been scheduled prior to his placement at CCC. On September 22, 2006, Ms. Kwan, a nurse, contacted the lab regarding the heart monitoring report and the lab advised that the report would be ready the following week. Testing was completed and he was transferred back to CCC, arriving on September 27, 2006.

On September 27, 2006, the lab sent the report by fax to FSCF after Mr. Encontre had already left for CCC. The same day, September 27, 2006, health care staff at CCC realized they had not yet received the test results. On September 29, 2006, staff at CCC faxed a Medical Information Request to the Holter Monitor Lab requesting the results. CCC received the results on October 5, 2006, two days after Mr. Encontre's death.

The earlier copy of the lab results which had been requested by FSCF on September 22, 2006, arrived at CCC on October 17, 2006. None of the medical staff who testified at the Inquiry could recall seeing the report at FSCF. It is inconclusive as to what happened to the report between its arrival at FSCF on September 27 and its arrival at CCC on October 17, 2006.

On both admissions to the CCC, Mr. Encontre was housed in Protective Custody. This unit afforded Mr. Encontre access to staff if he required assistance. The evidence suggested that while some of his peers were aware that Mr. Encontre was being harassed by other offenders respecting hygiene issues as well as the perception that he was a sex offender, the CCC staff who testified said they were not aware of the

harassment nor did Mr. Encontre express any concerns about his health to those staff members.

The oral evidence from CCC staff was contrary to the notes on the Unit Record (Exhibit #9) pertaining to Mr. Encontre which reflected concern about hygiene issues and that other offenders were afraid that he was contagious. Mr. Encontre was also noted to be “needy”. On September 27, 2006, staff noted that Mr. Encontre was being threatened by offenders and that was brought to the attention of the acting CO III. The next notation was October 3, 2006, indicating “Code 99 – cardiac arrest.”

The Board of Investigation found the following:

1. There are divisional policies and procedures as well as centre standing operational procedures in place for an incident such as this.
2. Centre staff adhered to all established procedures and conducted themselves accordingly.

Recommendations of this Inquiry:

1. The CCC should have an AED, automatic external defibrillator, on site in an area convenient to health care and emergency personnel and the appropriate staff should be trained to use it.
2. There was evidence of precipitating factors available to staff that could have led to a reasonable inference that a potentially volatile situation existed. Given the diverse range of offenders in Protective Custody, some consideration should be given to non-violent crisis intervention where unusual issues arise, where communication might alleviate escalation of issues, and where offenders have special needs or health issues.
3. Inmate movement for medical purposes and the corresponding tracking of medical reports and personal files should be reviewed to ensure the information accompanies the inmate in a timely manner.