RELEASE DATE: November 5, 2010

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***The Fatality Inquiries Act*** **C.C.S.M. c. F52**

AND IN THE MATTER OF: **An Inquest into the deaths of:**

Shawn JONES
(D.O.D. May 12, 2006)

Raynold GERLING
(D.O.D. December 11, 2006)

Brian PALMQUIST
(D.O.D. November 18, 2007)

Report on Inquest and Recommendations of
Judge R.L. Pollack
Issued this 29th day of October 2010

APPEARANCES:

Mr. Daniel Angus, Counsel to the Inquest
Mr. Scott Farlinger and Ms Kirstin Elgert, Counsel for Correctional Service of Canada
Mr. Jonathon Sinclair, Counsel for the family of Raynold Gerling
Mr. Tyler Kochanski, Counsel for Dr. Stanley Yaren

Manitoba

THE FATALITY INQUIRIES ACT, C.C.S.M. c. F52

REPORT BY PROVINCIAL JUDGE ON AN INQUEST INTO THE DEATHS OF:

SHAWN JONES
RAYNOLD GERLING
BRIAN PALMQUIST

Having heard evidence at the Law Courts in Winnipeg respecting these three deaths on January 11-15, 19-22 and 25-26, 2010, I heard summations on January 28, 2010. I also heard from counsel for the Gerling family and from Lucie Palmquist in writing. Having made a preliminary review of the evidence, I met in chambers with inquest counsel and Correctional Service of Canada counsel on February 12 and March 19, 2010. The purpose was to inquire whether useful evidence was available from the inmate population; I received the report that there was none.

The deceased, SHAWN JONES, 28 years of age, came to his death on May 12, 2006 at the Stony Mountain Institution, in Manitoba. This deceased came to his death upon ingesting a quantity of Amitriptyline and Methadone, the toxicity of which caused his death.

Seven months later, the deceased, RAYNOLD GERLING, 28 years of age, came to his death on December 11, 2006 at the Stony Mountain Institution, in Manitoba. This deceased came to his death by ingesting a quantity of Methadone, the toxicity of which caused his death.

Eleven months after that, the deceased, BRIAN PALMQUIST, 28 years of age, came to his death on November 18, 2007 at the Stony Mountain Institution, in Manitoba. This deceased came to his death by ingesting a quantity of Methadone and Fluvoxamine, the toxicity of which caused his death.

My recommendations are set out in this report which includes a list of witnesses and exhibits filed.

Pursuant to the provisions of subsection 33(3) of *The Fatality Inquiries Act*, I am ordering that all exhibits be returned to the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application with notice to any party with a privacy interest.

Dated at the City of Winnipeg, in Manitoba, this 29th day of October 2010.

"Original signed by:"

Judge Robert Pollack

Copies to: Chief Judge Ken Champagne, Provincial Court of Manitoba
The Honourable Andrew Swan, Minister of Justice
Dr. A. Thambirajah Balachandra, Chief Medical Examiner
Mr. Daniel Angus, Counsel to the Inquest
Mr. Scott Farlinger and Ms Kirstin Elgert, Counsel for *Correctional Service of Canada*
Mr. Jonathon Sinclair, Counsel for Mr. Rudy Gerling
Ms Lindsay Fushtey and Ms Lorraine Gerling
Mr. Tyler Kochanski, Counsel for Dr. Stanley Yaren
Ms Agnes Junk and Ms Jackie Watts
Mr. Larry Palmquist and Ms Lucie Palmquist
Native Clan Organization Inc., Mr. Robert W. Godin
John Howard Society of Manitoba, Mr. John Hutton

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I. BACKGROUND

(A) Introduction

[1] During an 18-month period, from mid-2006 to late 2007, three 28 year old inmates of the Stony Mountain Institution ("SMI") were found to have died in their cells after ingesting lethal amounts of drugs. The three had in common the post mortem finding of Methadone overdose.

[2] The provisions of subsection 19(3) of *The Fatality Inquiries Act* ("the *Act*") require the Chief Medical Examiner ("CME") to direct that an Inquest be held where there are reasonable grounds to believe:

> "that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause."

[3] On March 9, 2007, the CME wrote to the (then) Chief Provincial Court Judge directing an inquest into the May 12, 2006 death of Shawn Jones; on July 4, 2007 the CME wrote to the Chief Judge directing an inquest into the December 11, 2006 death of Raynold Gerling; on June 5, 2008, the CME wrote to the Chief Judge directing an inquest into the November 18, 2007 death of Brian Palmquist.

[4] Because of the already scheduled obligations of the Provincial Court and the limited availability of judges at the time, arrangements were being made for the Jones and Gerling inquests when the Palmquist referral arrived. At the first organizational meeting concerning the Palmquist matter, it became apparent that the deaths of these three men were closely related; each died in his Stony Mountain Institution cell, their cells were in the same unit, their deaths took place within a short period of time and each had ingested Methadone, a drug prescribed to none but, in a specialized institutional program, provided to others as treatment for addiction.

[5] In consultation with the Bench and counsel provided by Manitoba Justice, the Chief Judge recommended that one inquest be held and the CME directed that: "the provincial judge receiving the direction shall conduct one inquest with respect to the related deaths," pursuant to the provisions of subsection 26(2) of the *Act*.

[6] In each of his referrals, the CME cited these reasons for an inquest:

1. To fulfill the requirement for a mandatory inquest as defined in s. 19(3) of the legislation;

2. To determine the circumstances relating to the death;

3. To determine what, if anything can be done to prevent similar deaths from occurring in the future.

[7] My task is set out in clause 33(1)(a) of the *Act*:

> "make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death."

[8] I also have the authority to recommend changes in the "programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province" in addressing the third reason for holding an inquest. There is a limitation on me as well: I cannot express an opinion or make a finding concerning who may be culpable in the death that is the subject of my inquiry.

(B) Standing

[9] Parties interested in the inquest applied for standing and the following orders were made:

1. Correctional Service of Canada ("CSC") was granted standing as a party to the inquest;

2. Mr. Rudy Gerling, Ms. Lindsey Fushtey, Ms. Lorraine Gerling and Mr. Rudy Gerling Jr., were granted standing as parties to that portion of the inquest relating to Raynold Gerling

3. Dr. Stanley Yaren was granted standing as a party to that portion of the inquest relating to Raynold Gerling;

4. Ms. Agnes Junk and Ms Jackie Watts were granted standing as parties to that portion of the inquest relating to Shawn Jones;

5. Mr. Larry Palmquist and Ms Lucie Palmquist were granted standing as parties to that portion of the inquest relating to Brian Palmquist;

6. Native Clan Organization Inc. and John Howard Society of Manitoba were granted standing to conduct a watching brief and, with leave of the Court, to examine a witness and to make a submission at the conclusion of the evidence.

(C) Reporting Method

[10] In preparing this report I have the evidence along a timeline that begins prior to any of the deaths associated with Methadone and concludes in the spring of 2009. The timeline includes evidence of drug use in the institution prior to the deaths of each of the inmates, how they met their demise and what reaction there was to each of the deaths. As these events occurred I reviewed the timing of policies put in place by correctional authorities and steps taken to improve them with particular reference to the program of Methadone maintenance treatment.

[11] It is not my intention to give equal emphasis to each piece of testimony or exhibit material but to refer the reader to that evidence that I found essential to my recommendations that follow.

[12] Although some clinical language is used to describe some events, this report is prepared with respect for lives lost and profound condolences to those who mourn their passing.

[13] Having introduced the name of a deceased or a witness, I will refer to that person by surname. In doing so I mean disrespect neither to any person nor to a person's title, job description or profession.

II. METHADONE AND THE PENITENTIARY SETTING

(A) Security at SMI

[14] Christer McLauchlan is a security intelligence officer with 15 years experience at SMI. He explained that each deceased was housed in Unit 4. Without getting into criminological detail, the inmates in Unit 4 were there either because they caused problems when they were in general population or because the general population caused problems for them. In that latter regard, McLauchlan cited examples like the pressure of black market debt collectors and issues with gang members. A common theme in the inquest was that concerns about gangs prevail over every activity in the institution. He testified that at this time all major gangs are segregated and their members no longer in general population.

Clinton Mann, a correctional officer with 9 years of experience, stated that: "Stony Mountain Institution seems to evolve as the gang situation evolves." For Shawna Maruca-Unrau, his patrol partner the day Gerling died, it was noteworthy on a daily basis if someone known not to be a gang member was so much as seen talking with one of the higher-ups from one of the gangs.

[15] McLauchlan, psychiatrist Dr. Stanley Yaren and others testified that 80% of the inmates enter SMI with substance abuse issues. The demand for illegal drugs is, by definition, the same in SMI as it is on the street with an added component: inmate drug addicts have little else to think about in a prison environment then how to obtain drugs. They don't have the pressure of having to provide necessities for themselves and they certainly don't have much of a home life. Accordingly, McLauchlan has to run programs that respond.

[16] The first is detection. McLauchlan described how all mail is opened, vehicles that enter the Institution are searched and visitors are assessed as well as subjected to ion-scanning and dog patrols. Cells are searched regularly and intelligence is collected in a database to enable briefings on current institution events.

[17] The next program is deterrence. Whether by criminal prosecution, disciplinary action or administrative consequences such as cutting off visits, SMI relies upon these demonstrative steps to enforce safety and security.

[18] The third security response involves treatment including Alcoholics Anonymous or Narcotics Anonymous programming, education and – this is where Methadone maintenance comes in – synthetic opioids to wean inmates off their drug dependency. Inmate profiles, including those of the deceased, are replete with records of enrolment in and progress within such programs.

Not surprisingly, there is a supply side to analyzing illegal drugs at Stony Mountain Institution and indications are that it is mostly a function of gangs. Whether it is an individual desperate for his next dose or a supplier for profit, the evidence was that there appears to be no end to the ingenuity demonstrated in making drugs available in SMI:

1. Visitors have been known to conceal drugs in their mouths and other bodily cavities.

2. The same is true for some returning inmates who are returning deliberately, often under pressure from gang peers. An inmate on parole with a few weeks left in his sentence will arrange to be reported for domestic violence. While the criminal prosecution will later be dropped because of an uncooperative complainant, the inmate knows that he will be returned to SMI and has an opportunity to equip himself with drugs that can be smuggled in with him.

3. Drugs are thrown over a 10-foot barbed wire fence at a specific time when a particular gang is given an opportunity to exercise. The cache is then swarmed and inmates have been known to change clothing quickly in an effort to make themselves undetectable while the drugs disappear into hiding places.

4. Not all inmates are given drugs in daily doses and some have the opportunity to keep a supply in their cells. As will be demonstrated, there are opportunities to abuse those drugs or to sell them.

5. Those given daily doses find ways to divert the drugs. Some are not swallowed and stored in a sleeve while the nurse is distracted. There are documented cases of inmates manipulating a condom in their mouths to trap drugs before swallowing in order to have them for later abuse. In the case of Methadone, regurgitation may be prompted to obtain part of a dose for later consumption.

7. Some drugs, particularly LSD, can be secreted in mail in pages of a greeting card glued together.

[19] Although SMI is a penitentiary, it is also a community. Not unlike police in the general community, correctional officers receive bits and pieces of information all the time. Information that is relevant to security issues is required to be reported in a document called Officer's Statement/Observation Report ("OSOR"). These are forwarded to the Intelligence Office and collated in a database.

It must be kept in mind that there is little evidence that particular OSOR sources have proven reliable in the past or since becoming the subject of an OSOR. The collection of OSORs is nevertheless an important detection tool for SMI and, while their contents are not as reliable as evidence under oath, they are not to be ignored.

(B) Methadone Treatment

[20] Methadone is a synthetic opioid. It was a wartime invention in Germany, necessitated when morphine was not available. Its first use in treating drug addiction was in 1964. Researchers discovered that it was the speed at which heroin occupied certain receptors in the brain that produced the high sought by addicts. Methadone occupies those same receptors slowly and not only prevents the high but works for about a day. Accordingly, appropriate daily doses will result in a less difficult withdrawal

experience. With those receptors blocked, drugs like heroin no longer work for the addict.

[21] Dr. Leo Lanoie started a Methadone program at the Saskatchewan Penitentiary at Prince Albert in 1998. Through his experience since then he has become a national consultant to CSC on Methadone. He explained that treatment begins with a small dosage, perhaps 30 mg, and is increased every 5 to 7 days until the user becomes stable. Single doses are provided by prescription and only certain doctors have the exemption required to prescribe Methadone. It is dispensed mixed with Tang (the breakfast drink) in a small bottle. Tang is used because it cannot be boiled off to yield an injectable substance.

[22] Lanoie and other physicians explained that naïve users have a very low tolerance for Methadone, hence the small initial dosages. Therefore naïve abusers, using someone else's dose, inevitably and quickly put themselves in serious harm's way. Dr. Charles Littman described its potency vividly: breathing is depressed as the brain closes down until breathing stops.

[23] Methadone is not the only alternative for weaning addicts off opiates. For some, Suboxone is the preferred choice. It is said to provide an easier therapy for the addict with its fewer withdrawl effects. Lanoie indicated that some cannot tolerate Methadone and Suboxone is used in those cases. It comes at a price: $48.00 for 8 mg as opposed to $0.38 for 100 mg of Methadone. Program counsellor Gerald Pritchard, who works mainly on the Methadone team at SMI, said that "the sooner we move to Suboxone, the better".

(C) Methadone Treatment at SMI

[24] Janalee Bell-Boychuk has been a parole officer as well as a corrections officer since well before Methadone treatment began in 2002 at SMI. She is called the Officer of Principal Interest with respect to Methadone. She chairs its working group and serves as liaison with senior SMI management. The Methadone team consists of Pritchard, nurses and Dr. Jerry Martin Bergen, a family physician who prescribes Methadone for SMI inmates.

[25] The regional Methadone coordinator for SMI is Susan Urmson, a Registered Nurse with CSC for over 13 years. She audits the SMI Methadone program and programs in 14 different institutions annually and dialogues with each after receiving their action plans in response to her audit. Her first audit relevant to this inquest took place on April 13 and 14, 2005.

[26] Methadone is made available at SMI to inmates from the general population in the Visits And Correspondence ("V&C") area. Those segregated are given their doses in their unit, as was the case on Unit 4. The expectation is that a correctional officer will escort a nurse to the area for dispensing and will be the monitor for a 20-minute waiting period. Correctional Officer Brent Thornhill, with 12 years experience, observed that the administration of Methadone in the V&C area was "much more structured" than in Unit 4.

[27] The current procedure was summarized by Nurse Cora MacNeil. Administration of Methadone takes place in the V&C area or in a unit boardroom. Inmates cannot wear a jacket or a hood and are first frisked for containers. After they consume the Methadone they are required to say "Thank you," as a swallowing test. Then they must remain with an officer for 20 minutes.

Nurse Janice Beckles is the education coordinator for SMI's nursing standards and she offered an interesting observation about that 20-minute observation period during which the inmate ought to be made to speak. To her, it was a teachable moment offering an opportunity for some inmate education.

[28] The Methadone team at SMI has engaged in staff training and inmate education, whether through programming, literature or one-on-one contact. All personnel are aware of Methadone as a treatment drug and as a drug that carries with it security concerns. They are required to access online information and to sign off on some literature from time to time. A theme in the evidence was that there is clearly an institutional "buy-in" to the program.

(D) Diversion

[29] Lanoie is familiar with the diversion tactics of Methadone maintenance users. He emphasized how they must be checked to make sure they are carrying no containers and not wearing loose fitting clothes that could conceal such a device. Identification cards must be required before an individual dose will be given out. He is one of the witnesses who described how it is possible for a Methadone dose to be regurgitated by induced vomiting for later use (and relating how a patient of his once drank vomited Methadone and died). Twenty minutes after ingestion, enough Methadone has been absorbed into the system to make regurgitation useless for getting back a partial dose. For that reason, there must be a 20-minute period of observation following swallowing.

[30] Lanoie was one of the witnesses who commented on addiction generally and pointed out that, just as in the case of other drugs, some divert their Methadone in prison simply because they are "muscled" into diversion.

A recurring theme in the evidence, whether from prison staff or physicians, was that one ought never to underestimate the creativity of inmates to devise diversion tactics. In Urmson's opinion, the only opportunity now left for diversion of Methadone is regurgitation when the observation period is not properly monitored.

III. HISTORICAL CONTEXT

[31] When Methadone maintenance was introduced at Stony Mountain Institution in 2002, Palmquist was an inmate who had previously completed both a pre-release and relapse prevention substance abuse program. Gerling was there at the time as well, having been returned early in 2002 following a suspension of his full parole. Neither was involved with Methadone treatment.

[32] In 2004, Jones was serving a sentence for armed robbery. In April and May he completed his Offender Substance Abuse Pre-Release Program. On June 9, 2004, he entered the Methadone Maintenance Treatment program. Later that year he completed the National Substance Abuse Maintenance Program and, interestingly, Palmquist was in the same program.

(A) The 2005 Methadone Audit

[33] As the 2005 Methadone Audit Report was issued, Jones was still in the program. That audit itemized a series of concerns about SMI not complying with established policy:

> 1. A nurse carried Methadone in a locked tackle box unescorted through the hallways with inmates. At the V&C area the nurse sat alone with the unlocked box on her knee, although there was an officer inside the office. Something similar happened in one of the units when the nurse sat at a table with inmates. This offered inadequate theft protection.
>
> 2. Some identification cards were old and tattered and difficult to use for identifying the inmate producing it.
>
> 3. Part of the protocol involves asking the inmate to speak after swallowing the liquid Methadone. The nurse did not do so.
>
> 4. Inmates were allowed to bring their own cups of water and that is a diversion risk.
>
> 5. Inmates not on Methadone were allowed to approach and talk to the nurse, providing distraction.
>
> 6. Inmates were on a stairway near other inmates in one of the units during the 20-minute waiting period.
>
> 7. Officers required to monitor the 20-minute waiting period were also monitoring the unit at large.
>
> 8. Inmates were allowed to wear ball caps and jackets, increasing the risk of diversion.

[34] By the fall of 2005, Gerling was serving a 45-month armed robbery sentence and Palmquist was still in custody. And Jones was still on the SMI Methadone treatment program. Jones was to have continued his Methadone maintenance while on parole to

a half-way house in December but in January he withdrew. Shortly thereafter he violated his curfew and, in January, had no alternative but to turn himself in to resume his sentence.

[35] Both Palmquist and Gerling successfully completed the National Substance Abuse Maintenance Program in 2006 but Jones was not going in that direction. On April 27, 2006, two weeks before his demise, he was found to be intoxicated. Jones admitted taking pills obtained from someone else and drinking home-brewed alcohol; 10 litres were found in his cell.

[36] On May 8, 2006, four days before he died, Jones was found to be intoxicated again. He refused urinalysis and an institutional charge was laid.

(B) Jones Death

[37] On May 12, 2006, a patrol reported that Jones was asleep in his cell at 5:05 a.m. but snoring loudly. The next patrol, at 6:43 a.m., found him lying face down, apparently having vomited. The patrolling officer was not permitted, by established procedures, to enter Jones' cell until accompanied by a second officer who had to be summoned. Two minutes later two officers entered the cell and Jones presented without a pulse and not breathing. Cardiopulmonary resuscitation ("CPR") was initiated and continued while he was moved to the Health Care Unit and transferred to an ambulance. CPR continued in the ambulance without success and, a short time later, Jones was pronounced dead by a physician at the nearby Stonewall Hospital.

[38] An autopsy performed the same day showed no evidence of trauma and aspiration of gastric contents. Because overdoses affect the central nervous system, they affect the ordinary ability of a person to overcome choking by dulling what would ordinarily be a reflex action. A toxicology report delivered May 31, 2006 indicated elevated levels of Amitriptyline and Methadone as well as by-products consistent with those drugs. The Methadone result of 278 ng/ml is within the range for someone in a Methadone maintenance program but, by this time, Jones was what physicians call a naive user and would have to have begun Methadone treatment with a much smaller dose. This dose was lethal. The Amitriptyline, an anti-depressant, was elevated although not in itself lethal.

[39] On June 30, 2006, an OSOR described Palmquist as being in a condition of high anxiety. He wanted to know what CSC was doing about "bodies piling up", apparently referring to Jones' death and a recent suicide at SMI. There is no indication that Palmquist was intoxicated that day.

[40] The following week, on July 7, 2006, Gerling was returned to SMI after an unsuccessful day parole after just 10 days.

(C) 2006 Methadone Administration Rules

[41] On July 10, 2006, Littman completed the Autopsy Report form that included the immediate cause of death: "Amitriptyline and Methadone toxicity." The same week,

coincidentally, the warden issued a standing order concerning “Administration Of Methadone Treatment” which included the following:

> 1. A correctional officer will escort the nurse to Methadone administration locations.
>
> 2. General population inmates will have “Methadone administration and monitoring” in V&C.
>
> 3. The correctional officer will escort the nurse to closed population units where “the 20 minutes direct and continuous monitoring will be completed by correctional officers assigned to the unit”.
>
> 4. To receive Methadone, inmates must have an identification card, not wear winter parkas or headgear and not have any containers in their possession.
>
> 5. After verifying identification and dosage: “the nurse must monitor the inmate to ensure he takes the complete dose of Methadone. The inmate must return the empty bottle to the nurse, then drink a glass of water and finally he must speak with the nurse.” Following this: “after taking the Methadone, the inmate will be monitored for a minimum of twenty (20) minutes through direct and continuous observation from the time of administration. With approval from the monitoring staff, the inmate may leave.”

Pritchard, the correctional programs officer for Methadone, filed an OSOR on July 18, 2006 indicating information that the Methadone taken by Jones was from a cup that was used to divert a weekend dose of Methadone.

[42] On August 9, 2006, the Deputy Warden received a memorandum from Regional Headquarters about the July 31/August 1, 2006 Methadone audit at SMI. The memorandum stated that, during weekends and statutory holidays, inmates on the unit where Jones was found were not being observed for 20 minutes after Methadone was administered. They were allowed to stand on a stairway where they could interact with other inmates not in the program and the officer tasked with monitoring them had other activities in the unit also requiring monitoring. The memorandum stated:

> “when inmates are not directly observed, the risk of Methadone being diverted is increased to unacceptable levels. Diverted Methadone is extremely dangerous, when ingested by an opiate naive person can be fatal.”

(D) Jones Board of Investigation

[43] On June 14, 2006, a CSC Board of Investigation had been ordered to report on Jones’ death.

[44] On August 10, 2006, the day following the notice of non-compliance to SMI, the Jones Board of Investigation delivered its report. Included in that report are the toxicology results. The Board was of the opinion that the Methadone ingested by Jones was probably diverted Methadone and noted that Jones was one of the individuals who

would have been permitted to hang around the stairwell in Unit 4 on weekends. This Board made one recommendation:

> "The Board of Investigation recommends that Stony Mountain Institution, in consultation with the Regional and National Methadone Coordinators, reviews its procedures for the administration of Methadone on weekends."

[45] Dawn Hale was a Methadone nurse on the Methadone treatment team and, in an August 18, 2006 memorandum, she notified all correctional officers involved in units outside of the general population about the weekend Methadone concerns. She emphasized that inmates were not permitted to have containers and that there must be a 20-minute observation period. Her memorandum indicates that she has told inmates directly that they are not to mingle around non-Methadone inmates after receiving their dosage during the observation period.

[46] An August 21, 2006 directive from the Deputy Warden stated that, on weekends and holidays:

> "At 0800 to 0830, one officer will report to Unit 4 to assist with the Methadone program. The officer shall supervise inmates in the unit boardroom for a minimum of 20 minutes."

(E) Gerling death

[47] Gerling had been under Yaren's psychiatric care since his return to the institution. He was on prescribed anti-depressants and anti-anxiety medication. Although he came to the attention of officers once in October when he presented with slurred speech and unsteadiness, urinalysis indicated that he had only taken his prescribed medication. At his request he was enrolled in psychological counselling.

[48] On December 7, 2006, Yaren increased Gerling's anti-depressant medication after detecting experienced anxiety and depression as well as poor sleep. Gerling remained on his anti-anxiety medication that is taken in the morning and at suppertime.

[49] On Monday, December 11, 2006, Gerling failed to attend at the unit kiosk for his medication. The nurse and a correctional officer went to his cell to provide it. He was found unresponsive and, at 7:51 a.m., they entered and the officer shook his foot. There was no response and the nurse was unable to obtain a response to any stimuli. While the nurse left to alert the Health Care Centre physician, officers commenced CPR. Acting within the scope of her expertise and position, the nurse instructed them to cease CPR at 7:54 a.m. as Gerling presented with no pulse, no respiration, fixed pupils and mottling on his skin.

[50] On December 12, 2006, while an autopsy was being performed on Gerling in Winnipeg, an OSOR indicated that Gerling was able to obtain two points (*i.e.* doses) of Methadone the day before he died. The following day his unit manager wrote two OSORs reporting information he received that day. One indicated that Gerling had taken Methadone and four pills the day before his death. While there was a rumour that

the Methadone he took was ingested after regurgitation, the source found that unlikely. This source did say that inmates were able to divert simply by spitting into a cup or a bleach bottle that had been distributed to inmates. Some, the source claimed, actually filled their cheeks with cigarette filters that were used to absorb the dose during the 20 minute waiting period and enabling it later to be accessed. The same source said that he had cautioned Palmquist about purchasing and using Methadone. Apparently the price for a dose was one bale of tobacco. Another source said that Gerling had been smoking crack cocaine regularly for the past six weeks and that he was obtaining other medication in addition to his own. This source confirmed that drugs were easily available at SMI and stated that there was a quantity of powdered Methadone as well.

One OSOR source made the practical suggestion that inmates be made to open their mouths after ingesting Methadone and be subjected to pat-down searches to ensure that they do not have any bottles.

(F) 2007 Methadone Administration Rules

[51] On January 11, 2007, two documents were created. The first was the autopsy toxicology report confirming that “Methadone toxicity” was the immediate cause of death. (Gerling’s concentration of Methadone was 278 ng/ml, identical to that of Jones. That is nothing but coincidence because the reading at the time of the autopsy is not the same as it would have been at the time of death.)

[52] The other January 11, 2007 document was a new CSC “Administration of Methadone Treatment” standing order. It reiterated the previous requirements and stated that:

> “All inmates participating in the Methadone maintenance treatment program are subject to a routine frisk search immediately prior to or after the administration of Methadone. Searches will be performed by, and at the discretion of, the observing correctional officer.”

[53] The recommendations arising from the 2005 Methadone audit continued to be monitored by the CSC Executive Committee with which SMI corresponded. One issue, documented in a March, 2007 meeting minute, is the rejection by SMI of the conclusion that the Methadone ingested by Jones was probably diverted Methadone. SMI took the position that there was evidence of Methadone pills being in the institution (although none was confiscated) and therefore this conclusion of the Board of Investigation was not valid. The same minute also indicates a positive response to the weekend situation for administration of Methadone.

[54] On March 5, 2007, the autopsy report on Gerling was completed, specifying the cause of death as Methadone toxicity. No evidence of trauma was disclosed. Gerling suffered from coronary artery disease and, in Littman’s opinion, “was headed for a heart attack”.

(G) Gerling Board of Investigation

[55] The CSC Board of Investigation into Gerling's death was not ordered until May 3, 2007. At the same time, the National Drug Strategy of CSC was updated in a May 8, 2007 directive from the Commissioner. It specified the use of ion-scanners and drug-detecting dogs as "non-intrusive search tools" for detecting drugs on inmates, staff and visitors. Previous versions of the policy did not include specification of drug detection tools.

[56] The National Drug Strategy document begins with this statement:

> "POLICY OBJECTIVE
>
> The Correctional Service of Canada, in achieving its Mission, will not tolerate drug or alcohol use or the trafficking of drugs in federal institutions. A safe, drug-free institutional environment is a fundamental condition for the success of the reintegration of inmates into society as law-abiding citizens."

A bulletin accompanying the document states that these changes occurred following the outcome of a drug audit.

[57] That very week a distinguished member of this Court, the late Judge Ron Meyers, issued his report on the inquest into the death of Christopher John Holoka who had succumbed to an overdose of Methadone at the Winnipeg Remand Centre ("WRC") on April 15, 2005. It is clear from Judge Meyers' report that WRC had limited experience with Methadone at that time; its structure for administration of Methadone was thin compared to the emerging protocol at SMI. Also clear was that diversion was easily accomplished at WRC. An inmate testified that he watched it happen when a nurse was distracted, enabling part of the dose to be spit into a cup and secreted.

[58] The inquest judge also cited with approval the new WRC procedures:

> "1. When an inmate is admitted to custody and it has been verified by WRC Medical that he or she is on the MMT program, WRC Medical Staff will make the necessary arrangements to have Methadone supplied to the institution.
>
> 2. Methadone will be delivered to the recipient(s) in the 300 corridor Medical Holding Room or a Medical Observation Cell (if separation precludes holding all inmates in the Holding Room) and the recipient(s) will remain in the room for a period of 30 minutes following the ingestion of Methadone.
>
> 3. Level 300 staff will bring the inmates down from their living units at the request of Medical and will be held in the Medical Holding Room (or other area, as required).
>
> 4. Methadone will be dispensed by one of the WRC Nurses.

> 5. Inmates will drink at least 6 oz of water (Two Dixie cups) immediately following the ingestion of the Methadone and will remain in the holding area for a period of 30 minutes thereafter.
>
> 6. After 30 minutes, inmates will be subjected to a pat-down search and returned to their living unit."

Observing that these procedures follow an outline similar to that of CSC, Judge Meyers pointed out that CSC required monitoring for only 20 minutes.

[59] On May 22, 2007, the Deputy Warden was advised by CSC's regional office that

> "The steps taken by the institution to reduce the risk of diversion have been successful on most of the units, but there continues a risk on Unit Four during weekends and statutory holidays. Staff reports that during these time periods there have been occasions when correctional staff have not directly observed the inmates for a full 20 minute period after the Methadone has been administered."

[60] On June 8, 2007, Palmquist was found to be in a "condition other than normal". OCRs filed within a couple of days indicate that he obtained and hoarded drugs through deception of medical staff and was able to get himself intoxicated. He related his compulsion to do so to news of a death in his family.

[61] Later that month, on June 27, 2007, the Gerling Board of Investigation issued its report. That Board made no specific recommendations because its theme was obvious: weekend administration of Methadone on SMI Unit 4 required improvement. Taking full cognizance of the Jones Board of Investigation, and now reflecting upon the second Methadone overdose death in seven months, the Gerling Board called for "further revision of the weekend routing for Methadone distribution ... in order to reduce the risk of diversion."

[62] This Board knew that Hale had proposed that a correctional officer take Methadone inmates to the medical facility for Methadone administration. They also knew that "middle management" did not support her. In her evidence, Hale indicated that she voiced her concerns about the risk of diversion to Urmson, others on the medical staff and unit managers. In her opinion, concerns were always addressed slowly because changes were reactive rather than proactive.

[63] Perhaps because they were aware of the issue SMI took with the Jones Board of Investigation (*i.e.* their conclusion that diverted Methadone was responsible for Jones' demise), the Gerling Board noted that there was intelligence that Gerling had purchased Methadone in unit doses from an inmate.

Demonstrating diligence, the Gerling Board of Investigation consulted with the Winnipeg Police Service and was informed that Methadone was not readily available on the street. During its investigation something remarkable happened: an inmate being returned to SMI was found to be transporting Methadone.

[64] As noted earlier, Gerling's cause of death - Methadone toxicity - was noted on March 5, 2007 in official autopsy documentation. CSC delayed the Gerling Board of Investigation because it wanted to have information about the cause of death before the Board was convened. Although the Board was able to obtain the autopsy report upon request, it does seem odd that earlier inquiries, which included one from the Minister's office, went unsatisfied.

Staff from the Medical Examiner's Office agreed that, going forward, at least verbal information would be provided to CSC as soon as toxicology results were known unless a death was the subject of a murder investigation.

[65] SMI responded to the Gerling Board of Investigation and some of its responses were on the agenda of an Executive Committee conference call on September 5, 2007. The obvious concern about weekend Methadone administration on Unit 4 was discussed. SMI reported that:

> "A separate Methadone log book was placed on Unit 4 that requires the distributing nurse and supervising correctional officer to "sign-in" when they report to Unit 4 for Methadone supervision. The Unit 4 correctional supervisor and unit manager review the log book daily and either address or report any deficiencies to the coordinator, correctional operations, for follow-up. Consultation on 2007-05-09 between the institution's Methadone coordinator and both the Unit 4 correctional supervisor and unit manager revealed that the use of the log book has been effective in ensuring accountability and supervision. Stony Mountain Institution is confident that having this additional support measure in place has, and will continue to, alleviate any future concerns in this area. We will continue to monitor this area closely to ensure compliance with same. No further action required."

[66] The log book is set up for a health care officer to sign in as the Methadone distributer and a correctional officer as the Methadone supervisor. The log books for October and November, 2007, indicate almost perfect compliance with both health care and correctional officers signing in and signing out. On several occasions it is Pritchard, a member of the Methadone maintenance team, who takes the place of a correctional officer for the observation time.

Although it is unrelated to the event I am about to describe, it is remarkable that, on October 29, 2007, the day before Palmquist died, one of the entries in the log for the health care officer is incomplete.

(H) Palmquist overdose

[67] Palmquist was taking ibuprofen for pain after he injured himself during some horseplay in his unit. On August 22, 2007 he medicated himself with 15 ibuprofen pills, prompting staff to be concerned that he might be suicidal. He assured them that the overdose was for pain and nothing more. Palmquist had, by this time, completed substance abuse courses including a pre-release program.

[68] On October 30, 2007, Palmquist was found in a condition other than normal. At 10:25 a.m. he was unresponsive in his cell, medical staff were called and he was taken to hospital. In an OSOR that day, Gerald Pritchard reported that Palmquist admitted taking 160 mg of Oxycontin, obviously of black market origin.

[69] The following day, Palmquist told his parole officer, Margot Pitman, that he was just getting high and not attempting suicide. Pitman and Pritchard thought that Palmquist had taken Methadone and sought a urinalysis sample but Palmquist refused. That suspicion turned out to be clinically unfounded but their analysis was based on their clinic of experience with addicts.

Several OSORs at that time indicate that people were being pressured to provide diverted Methadone in the institution.

(I) Palmquist death

[70] On November 17, 2007, Palmquist presented as normal to a medical officer and gave no indication that he was suicidal. On Sunday morning, November 18, 2007, Palmquist was found unresponsive at 7:10 a.m. in his cell. Following protocol, CPR was applied until a nurse gave instructions that he was deceased. On November 19, 2007, an autopsy was conducted and no evidence of any trauma was disclosed.

OSORs indicated that Methadone was becoming available on weekends and that this third death left some inmates shaken. One source referred to the fact that Palmquist appeared not to get any help after his prior overdose.

[71] The toxicology report is dated December 4, 2007 and indicated an extremely high level of the anti-depressant Fluvoxamine and Methadone. Littman opined that the 3950 ng/ml of Fluvoxamine was enough to kill Palmquist. Bearing in mind that he was not on Methadone maintenance, his reading of 670 ng/ml is well in excess of what would be expected in a non-naive user.

(J) Palmquist Board of Investigation

[72] Three days later the Board of Investigation into the Palmquist death was ordered. The documentation of the autopsy, including toxicology, was signed January 11, 2008.

[73] This Board of Investigation had more information about the October 30, 2007 “overdose interrupted” incident than the cause of Palmquist’s of death. One would have expected that the phone calls would have been made to the Chief Medical Examiner’s office by CSC to enable it to determine cause of death before convening its Board of Investigation. When the Board of Investigation reported on February 28, 2008, however, its report was captioned “Death Of Unknown Causes” and stated:

> “The Board has not received any official information to indicate Palmquist’s cause of death. Therefore the Board is unwilling to identify Palmquist’s drug use and previous overdose on October 30, 2007 as a precipitating factor. In light of the preceding information the Board has

> determined that there were no precipitating factors to indicate that Palmquist was going to be found dead on November 18, 2007. There was no suicide note found."

[74] This void in the report is curious because Urmson - who had been performing Methadone audits at SMI, who knew that there were security problems at SMI, who was familiar with Unit 4 where Palmquist's cell was located - was one of the Palmquist Board of Investigation members. Board members knew that Pritchard and Pitman as well as a nurse suspected that Palmquist was involved with Methadone. It would appear that no inquiries were made regarding a possible link between Palmquist and Methadone.

Health care officer Calum Lunn testified that, as he entered the witness stand, he had still not heard it confirmed that Palmquist had ingested Methadone. Correctional Officer Richard Jongstra said that he had heard this but not from an "official source".

(K) The 2008 Methadone Audit

[75] SMI had been working on changes since October, 2007 specifically to address Methadone diversion and generally to address drug abuse. Urinalysis results have indicated that some progress is being made. Since April, 2008 all staff are receiving training with respect to Methadone treatment using mandatory on-line and written material. In that latter regard, the December, 2008 "Specific Guidelines for the Treatment of Opiate Dependence (Methadone/Suboxone)" is actually an electronic document. When printed, it contains a caution that users should consult the network version to verify that they have a current copy. This is important because the document circumscribes treatment in CSC institutions and community supervision programs.

Although I have not commented on this previously, the reader should know that audits of how SMI deals with Methadone have included references to the sincerity of SMI's commitment to safe Methadone maintenance and the dedication of its team members - Bell-Boychuk, MacEchern, Pritchard and their predecessors and co-workers.

[76] The April 2008 Methadone audit of SMI sought an action plan regarding two familiar issues. The first was that the correctional officer assigned to monitor the observation period after Methadone administration - a correctional officer who presumably signed in and signed out in the log book - sat in a boardroom reading a newspaper while the group of inmates sat out the waiting period. Elsewhere, in the intake unit, the sole officer in charge of controlling doors and monitoring movement of inmates was unable to monitor the single inmate who required 20 minutes of observation. A nurse was also observed to be carrying the locked box of Methadone bottles unescorted and inmates were about in an unlocked area. SMI responded quickly and appropriately to these specific concerns.

[77] The auditors noted that SMI was moving toward a weekend procedure for inmates in general population involving the use of the V&C area and stated that:

> "The change made to Methadone administration on Unit 4 appears to have been effect (sic) in resolving issues related to monitoring the inmates during weekends and statutory holidays."

[78] CSC followed up its 2008 audit with a visit on February 26, 2009. The report to the acting Deputy Warden stated that:

> ”Although attempts appear to have been made to improve the way inmates/patients are being observed by correctional officer from the kiosk there continues to be problems on units 1 and 4 where an inmate/patient was observed standing on the stairs not in direct view of the officer.
>
> “The situation on unit 5, where the inmate/patient is locked in the phone booth, although not ideal it is accept (sic) that the risk of diversion is low as long as the area (sic) continues to be frisked by the officer before the inmate/patient is put in.”

[79] An audit on July 21 and 22, 2009 found the SMI program running well and in compliance with the Guidelines. The memorandum from the auditors is the first one that does not mention any problem with Unit 4.

VII. DERIVING SOME RECOMMENDATIONS

[80] The words of a saddened mother to an inquest judge articulate the predicament of those who undertake the task of providing a "safe, drug-free institutional environment" in order to succeed in the "reintegration of inmates into society as law-abiding citizens" (National Drug Strategy Policy Objective):

> "I think there is a very powerful message being heard here and not just by me. The offender has been caught yet he continues to defy and outsmart the system right under its nose. They still have their gangs, their drugs, and their power. How much has really changed?"
>
> *Lucie Palmquist, March 2, 2010*

[81] At the hearing some counsel agreed that my task - to determine from the evidence if there are recommendations to prevent similar deaths - is not too different from what society has been trying to do to in addressing drug trafficking and drug consumption. But the deaths that were the subject of this inquiry require a more precise focus pursuant to the governing statute.

[82] There is no evidence of a counterpoint to Methadone treatment other than that Suboxone is an attractive alternative. I am not able to endorse Pritchard's complete endorsement of Suboxone as a replacement.

Recommendation #1

That the CSC continue its current Methadone audit of SMI by representatives from outside of SMI and that each audit include an analysis of whether substituting Suboxone for Methadone would address any issues raised by the auditors.

[83] There has always been a distinction between the administration of Methadone to inmates in general population and to those in a segregated unit. Regardless of an inmate's location, there has always been a distinction between the administration of Methadone on weekends and on weekdays. Removal of these distinctions would address many of the concerns expressed by SMI staff, Methadone auditors and, indeed, OSOR sources.

Recommendation #2:

That the CSC allocate the necessary resources to establish one protocol for the administration of Methadone, regardless of the day of the week or classification of an inmate who is the subject of Methadone maintenance treatment, the essential particulars of which should include:

1. **Methadone will be administered by a nurse and a correctional officer approved of by the Methadone Treatment Team.**

2. **Methadone will be moved in a locked box with the correctional officer as an escort.**

3. **Subjects attending for Methadone will wear a short-sleeved collarless t-shirt and no outerwear or headwear.**

4. **Methadone will be administered by the nurse to one subject at a time in the presence of the correctional officer.**

5. **Methadone will be administered in a closed treatment room equipped with a table and chairs.**

6. **The subject will be placed on continuous video recording while he is in the closed treatment room.**

7. **The subject will be seated at the table at all times and the correctional officer will watch the proceedings continuously.**

8. **A container holding the Methadone dose and a container holding a sufficient amount of water will be presented in a closed box on the table. A straw from each container will protrude through the top of the box.**

9. **The subject will not touch the box and keep his hands on the table while the box is on the table.**

10. **The subject will consume the Methadone and the water using each straw.**

11. **After consumption the subject will remain at the table and the nurse will remove the box. The nurse will leave the closed treatment room and inspect the containers in the box. The nurse will complete an entry in the subject's log recording the time, date, dosage and amount of water consumed.**

12. **For the next 30 minutes the correctional officer will engage the subject in an interactive education and counselling session in which the subject will be required to converse. The Methadone Treatment Team may replace the correctional officer with a counsellor, nurse, doctor or other therapeutic intervener for this session.**

13. **After 30 minutes the person conducting the interactive education and counselling session will permit the subject to leave and enter the time and date in the subject's log.**

[84] Manitoba law requires an autopsy and inquest for drug overdose deaths at SMI. Similarly the *Corrections and Conditional Release Act* requires CSC to investigate and report. These are not competing investigations and the utmost in cooperation is to be encouraged.

Recommendation #3:

That the Minister of Justice responsible for the administration of *The Fatality Inquiries Act* and the Minister of Public Safety and Emergency Preparedness responsible for the administration of the *Corrections and Conditional Release Act* take all necessary steps to secure a liaison between the office of the Chief Medical Officer and the Correctional Service of Canada, the essential particulars of which should include:

1. **The CME will notify the CSC as soon as practicable upon determining the cause of death of an inmate at SMI.**
2. **The CSC will notify the CME as soon as practicable upon convening a Board of Investigations into a death of an inmate at SMI.**
3. **The CSC and CME will disclose the results of its respective investigations into the death of an inmate at SMI.**

Dated at the City of Winnipeg, in Manitoba, this 29th day of October 2010.

"Original signed by:"

Judge R.L. Pollack

Appendix ‘A’ - WITNESS LIST

Ackerstream, Kenneth James	Correctional Officer
Baraniak, Dean	Correctional Officer
Beckles, Janice	Registered Nurse
Bell-Boychuk, Janalee	Methadone Officer of Principal Interest
Bergen, Dr. Jerry Martin	Family Physician, with methadone prescription exemption
Borrowman, John	Correctional Officer
Chevalier, Michel	Correctional Officer
Clark, Crystina	Correctional Officer, previously Parole Officer
Clark, Howie	Correctional Officer
Elez, Sinisa	Parole Officer
Hale, Dawn	Registered Nurse
Jongstra, Richard	Correctional Officer
Lanoie, Dr. Leo	Methadone Consultant to CSC
Laroche, Vincent	Correctional Officer
Littman, Dr. Charles David	Pathologist
Lunn, Calum	Health Care Officer
MacNeil, Cora	Registered Nurse

Mann, Clinton Paul	Correctional Officer
Maruca-Unrau, Shawna	Correctional Officer
McLaughlan, Christer David	Security Intelligence Officer
McMillan, Lisa	Unit Manager, previously Acting Assistant Warden
Pitman, Margot Rhea	Parole Officer, previous Correctional Officer
Pritchard, Gerald Fredrick	Correctional Programs Officer
Rebeck, Craig	Correctional Officer
Shaw, Kim	Registered Nurse
Thornhill, Brent	Correctional Officer
Urmson, Susan Margaret	Regional Methadone Coordinator
Yaren, Dr. Stanley	Psychiatrist

Appendix 'B' - EXHIBIT LIST

#	DESCRIPTION
1	1 page Stony Mountain institution map
2	4 pages of photos of metal staircase, security desk and gated entrances to cells
3	7 pages of photos of inmate Jones' cell, cell contents
4	12 pages of photos of inmate Gerling's cell (body), blister packs cell and cell contents
5	8 pages of photos of inmate Palmquist's cell (body), some photos with body covered and cell contents
6	Package of Board of Investigation into the death of Shawn Jones, an Inmate by possible suicide or overdose at stony mountain institution on May 12, 2006
7	Package of Board of Investigation into the death of Raynold Gerling, an Inmate by possible suicide or overdose at stony mountain institution on December 11, 2006
8	Package of Board of Investigation into the death of Brian Palmquist, an Inmate by possible suicide or overdose at stony mountain institution on November 18, 2007
9	3 pages – Standing order 585 Stony Mountain Institution Drug Strategy Dated March 27, 2007
10	9 pages – Commissioner's Directive 585 National Drug Strategy Dated May 8, 2007
11	1 page – Policy Bulletin
12	11 pages - Medical examiner's report, autopsy report toxicology report, Fatality Inquiries Act Autopsy Authority Form for Shawn Jones
13	11 pages - Medical examiner's report, autopsy report toxicology report, Fatality Inquiries Act Autopsy Authority Form for Raynold Gerling
14	8 pages - Medical examiner's report, autopsy report toxicology report, Fatality Inquiries Act Autopsy Authority Form for Brian Palmquist
15	10 pages – first 6 pages contains Methadone Audit Stony Mountain April 13-14 2005, and last 4 pages Follow up report by Susan Urmson
16	pages – Memorandum to Robert Bonnefoy, Deputy Warden Dated August 9, 2006, 1 page – Memorandum to Unit Managers Dated August 18, 2006, 2 page – Memorandum to Paul Urmson dated August 24, 2006, 2 pages – memorandum to R. Bonnefoy dated November 17, 2006

17	4 pages – 1 page memorandum to Robert Bonnefoy dated May 22, 2007, 2 pages email from Janalee Bell- Boychuk dated May 30, 2007, 1 page – memorandum to Robert Bonnefoy dated February 21, 2008
18	5 pages – 2 pages memorandum to Robert Bonnefoy dated April 03, 2008, 2 pages – Memorandum to Jan Nachtegaele dated April 22, 2008, 1 page – memorandum to Mike Pollman dated March 23, 2009
19	1 page Memorandum to Robert Bonnefoy dated July 27, 2009
20	3 pages - Standing Order dated July 10, 2006 Administration of Methadone Treatment
21	3 pages – Standing order dated January the 11, 2007 Administration of Methadone Treatment
22	3 pages – Standing order dated April 2, 2009 Administration of Substitution Treatment
23	143 pages entitled Specific Guidelines for the Treatment of Opiate Dependence (Methadone/Suboxone®)
24	2 pages –Physician's Order sheet – 1st date is November 10,06
25	7 pages of photos of blister pack pharmaceuticals front and back and one photo includes a photocopy of the methadone bottle 100 mg in tang
26	1 page – Physician's order Sheet for Shawn Jones
27	2 pages Physician Order Sheet for Brain Palmquist
28	3 pages computer generated Correctional Service of Canada/Assignment Summary sheet for Shawn Jones
29	1 page – officer's statement/observation report dated May 30 2006 at 1500
30	1 page – officer's statement/observation report dated May 30, 20056 at 0700 concerns of 7am incident report at 10 am
31	1 page – officer's statement/observation report dated May 30, 2006 at 0700 incident reported at 9 am
32	1 page – officer's statement/observation report dated July 18 2006 @ 15:30
33	1 page – officer's statement/observation report dated November 20, 2007 @ 1300
34	7 pages – Executive Committee Conference Call September 2, 2007
35	1 page – Officer's statement Observation Report Dated May 17, 2006 at 15:40 Written by Howie Clark regarding Shawn Jones

36	4 pages Emergency flow sheet dated May 12, 2006 for inmate Shawn Jones
37	1 page OSOR report from Howie Clark dated November 18, 2007 in regards to Brian Palmquist
38	2 pages computer generated Correctional Service of Canada/Assignment Summary sheet for Raynold Gerling Dated November 5, 2009
39	2 page OSOR report from Lisa McMillan dated December 13, 2006 at 13:45 in regards to Raynold Gerling
40	1 page OSOR report from Lisa McMillan dated December 13, 2006 at 17:30 in regards to Raynold Gerling
41	1 page OSOR From Dr. Jerry Pritchard, dated November 2, 2007 at 7 am - Statement starting with Methadone nurse Cherie MacEachern
42	1 page OSOR From Nurse Cherie MacEachern, dated November 2, 2007 at 1400 pm - Statement starting with As pat of our commitment to the methadone program
43	1 page OSOR From Dr. Jerry Pritchard, dated November 20, 2007 at 1300 pm - Statement starting with In a conversation with _____
44	1 page OSOR From Dr. Jerry Pritchard, dated November 2, 2007 at 1500 pm - Statement starting with I talk with _____ about Palmquist
45	1 page OSOR From Dr. Jerry Pritchard, dated November 2, 2007 at 7 am - Statement starting with I talk with Brain Palmquist about his overdose. There was a suspicion
46	1 page OSOR written by Richard Jongstra on November 18, 2007 at 8:56 am statement starting with During the course of conducting the 0700 count
47	1 page report Doctor's Orders and Progress Notes– hand written by Dr. Calum Lunn dated November 18
48	3 pages computer generated Correctional Service of Canada/Assignment Summary sheet for Brian Palmquist
49	2 pages Offender Management System Casework Record Log by Chronological order dated 2007-08-20 to 2007-10-31 written by Margot Pitman for offender Brian Palmquist
50	1 page OSOR written by Christine Neufeld RN on June 11, 2007 at 13:10 pm statement starting with I/M was asked to show proof of compliance
51	1 page OSOR written by Corinne Lindley on June 12, 2007 at 14:20 pm statement starting with On Thursday, June 7, 2007
52	1 page OSOR from Margot Rhea Pitman on November 19, 2007 at 13:30 pm statement starting with On the above stated date and time,

53	1 page OSOR written by Shortridge on June 30, 2006 at 15:15pm statement starting with Throughout afternoon
54	21 pages Contains Physician's order sheet for Brian Palmquist starting with date 7-10-30 Narcan 0.4 mg/ml, transfer
55	4 pages on legal paper named: Executive Committee Meeting – March 2007, Recommendation, Action Plan and Corrective measures – National Board of Investigation into the death Of an Inmate By Possible Suicide or Overdose at Stony Mountain Institution On May 12, 2006
56	4 photographs of a cell curtain with the cell door closed, open and from close up and farther away.
57	5 Pages Report dated 23-Feb-2009 end date 25-Feb-2009 Verdict Explanation Inquest Concerning the Death of Jacy Duncan Pierre Presiding Coroner Dr. Shelagh McRae
58	18 pages Methadone Effective yet Deadly power point presentation with Methadone log sheets beginning with October 4
59	5 pages Titled Checkpoint 2 first bullet is: Purpose
60	1 page – Memorandum dated August 18, 2006 addressed to Unit Managers, Unit CORRECTIONAL OFFICERIIIs, Unit Kiosks from Dawn Hale, RN RE: weekend methadone administration on the units
61	2 pages – Blank Inmate Needs Identification and Referral (completed upon admission to SMI
62	7 pages – Blank Intake Health Status Assessment form for Corrections Canada
63	19 pages – Fatality Inquest Act in the Death of Christopher John Holoka date of death April 15, 2005, report release date May 16, 2007 Report on Inquest and Recommendation of the Honorable Judge Ronald Meyers May 11, 2007