Release Date: May 16, 2007

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: THE FATALITY INQUIRIES ACT

AND IN THE MATTER OF: CHRISTOPHER JOHN HOLOKA
(Deceased)
(DOD: April 15, 2005)

Report on Inquest and Recommendations of
The Honourable Judge Ronald Meyers
Issued this 11th day of May 2007

APPEARANCES:

Issie Frost and Sean Boyd – Counsel for Manitoba Corrections
Elizabeth Pats – Inquest Counsel

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INTRODUCTION

[1] On the morning of April 15, 2005, fellow inmates of at the Winnipeg Remand Centre alerted Corrections Staff to the fact that Christopher John Holoka, who was still on the upper bunk in his cell appeared to be dead.

[2] He was, and the death of the inmate necessitated the calling of this inquest under Section 19(3) of The Fatality Inquiries Act, which provides as follows:

> Where, as a result of an investigation, there are reasonable grounds to believe
>
> (a) that a person, while a resident in a correctional institution or while an involuntary resident in an institution as defined in The Mental Health Act, dies as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
>
> (b) that a person died as a result of an act or omission of a peace officer in the course of duty;
>
> the chief medical examiner shall direct a provincial court judge to hold an inquest with respect to the death.

[3] As provided for in s 33 (1) of the Act, I have been charged with the task of making this written report and if of the view that there be recommended changes to programs, polices or practices of the institution to so recommend. However, in so reporting, I am not as provided in s 33(2) (b) of the Act to express an opinion or make a determination on the culpability of any party in respect of the death of the subject of this inquest.

[4] The inquiry into the death of Christopher John Holoka was held at the City of Winnipeg in Manitoba from January 15 to January 19, 2007, and heard from 17 witnesses. It concluded with submissions made by Mr. Issie Frost and Mr. Sean Boyd, Counsel for the Winnipeg Remand Centre, and Ms. Elizabeth Pats, Crown for the Inquiry. Standing at the inquiry was given to Dr. John Peterson, represented by Mr. Tyler Kochanski, and to Mrs. Louise Holoka and Mr. Morris Holoka, mother and father of the deceased.

[5] The questions to be answered by me are twofold, namely: (a) Could anything have been done to prevent the tragic death of Christopher John Holoka (hereinafter referred to as Chris Holoka and (b) Are there any steps that might be taken to avert future tragedies of this nature.

THE DEATH OF CHRISTOPHER JOHN HOLOKA

[6] At approximately 7:05 a.m. on the morning of April 15, 2005, inmates Brad Fright, Christopher Knight and Adam Curwin advised staff at the Winnipeg Remand

Centre that Chris Holoka was unresponsive to their efforts to waken him, bringing Corrections Officer Lisa Sicotte, Lucie Beaudry to his cell and prompting the initiation of a Code Red medical emergency alert and a lockdown of the facility. Attending nurse Donna Lee Peters after calling for Holoka to be removed from his bunk determined that his color was poor and his chest was not moving. She ordered that an ambulance be called to the institution and with assistance from other staff members attempted to resuscitate the inmate but to no avail.

[7] Medical emergency staff concluded that he was dead, and an autopsy of the body by Dr. Charles Littman a Pathologist established that the cause of death was a mixed drug overdose. Dr. Littman later concluded that the cause of death was methadone poisoning—and only methadone poisoning.

[8] That conclusion and the fact that methadone was not prescribed for Chris Holoka raised a number of questions for this inquiry including (a) How did methadone get into his system? (b) Were there any outward signs to indicate that Chris Holoka ingested methadone? (c) If there were any outward signs what steps were taken or could have been taken to prevent his death?

[9] To attempt to find answers to these questions it is necessary to first learn about Christopher John Holoka.

A PORTRAIT OF CHRISTOPHER JOHN HOLOKA

[10] Chris Holoka was a devoted son to his parents and a university graduate whose life in the last few years had spiraled out of control. Suicidal and addicted to drugs, he suffered through one failed marriage that saw him lose custody of his young son and another relationship that resulted in criminal charges for assaultive behavior against a female companion.

[11] Granted interim release on two occasions in late 2004 and January 2005, he was taken into custody days after his release on numerous criminal charges domestic in nature, and was an inmate at the Winnipeg Remand Centre, where he was detained until his death on April 15th, 2005. With a history of both suicide ideation and at least one serious suicide attempt which required his being hospitalized he was classified first as a high suicide risk(SUH), which was later lowered to his being a medium suicide risk (SUM).

[12] Dr. Jerrold Wilfred Brolund, a clinical psychologist, whose contact with Chris Holoka began in 2003, continued to see him during his incarceration and found him struggling to cope with his detention. And while finding his subject looking well when they last met on April 13th, 2005, , he continued to be concerned about Holoka's variability of moods and his taking of vast amounts of medication.

[13] However, Holoka never confided in Dr. Brolund as to his issue with methadone. Nor would this "naïve user" ever divulge to anyone in authority his consumption of

methadone. That secret remained with certain fellow inmates, who had come to befriend Chris Holoka in the months prior to his death.

[14] To staff members at the Winnipeg Remand Centre he was talkative and likeable but somewhat needy. As stated by Nurse Nancy Lynne Clarke, who had come to know him from an earlier admission to the WRC, he was "a little more of a needy individual, who liked the attention or seemed to seek out a fair bit of attention. Always had an ache or pain."

[15] There were aches and pains, both "real" and "phantom" that added to the stressors in the life of Chris Holoka and necessitated the prescribing of certain medications.

[16] In July 2002, at his employment he sustained an industrial accident when he caught his hand in a crusher, resulting in the amputation of his right index finger. To relieve the "phantom" pain still besetting him, he was prescribed a gel named Ketamine for topical application to his hand. It was later divulged that Holoka was ingesting Ketamine during his tenure at the Winnipeg Remand Centre.

[17] Other medications prescribed and taken by him were Celebrex, a painkiller, Paxil, an anti depressant, and Clonazepam, a tranquilizer. As an asthmatic he required the use of an inhaler and Ventolin.

[18] The stressors brought about by his detention, his deteriorating relationship with his estranged girlfriend, his concern over his father's health, the imminent departure of his young son to another country and the body pain both real and imagined had him seek out another means of coping.

METHADONE AND CHRISTOPHER JOHN HOLOKA

[19] Chris Holoka died as a result of methadone poisoning, and even though Ketamine and Paroxetine were during the autopsy, found to be in his system, it was an overdose of methadone, a synthetic narcotic drug often prescribed as a substitute for drugs such as heroin and morphine in the treatment of addiction that caused his death.

[20] How then, could an inmate for whom methadone was not prescribed manage to secure this drug in an institution where it was believed that safeguards were in place to ensure that its only delivery was to those for whom it was prescribed?

[21] And, despite the statement of testimony of veteran Corrections Officer Terry Webb that diversion of methadone from a recipient of the drug to another inmate was not possible, the only conclusion one can reach from the testimony of inmates Larry Curtis and Adam Curwin as well as the testimony of nurse Clarke, is that there was diversion.

[22] Curtis, a trustee at the Winnipeg Remand Centre during Holoka's detention told the inquiry that on more than one occasion the latter traded with inmate Brad Fright for

methadone. He would provide Fright a known drug addict with Ketamine gel, which when taken orally provided a change in one's state of mind.

[23] Curtis himself was provided methadone by Fright, and learned of those steps taken by him to secure enough methadone to effect trades. In fact, on occasion Curtis was witness to Fright's sleight of hand method in concealing his contraband from the eyes of unsuspecting nurses and corrections officers.

[24] During the period in question, Fright would attend with his own cup of juice or water to receive what the attending nurse believed to be his prescribed dosage of methadone. In fact, Fright knew exactly how much methadone was needed by him to absent his craving for heroin. He would then distract the attention of the attending nurse and pour part of his supply of methadone into his juice cup. Later he would transfer and store the mixture into an empty milk carton. Fright would then distribute the methadone. One of these recipients was Chris Holoka.

[25] Both Fright and Holoka confided in Curtis on several occasions of their method of exchange and the fact that Holoka ingested the methadone provided him.

[26] Curwin for his part stated that he was aware that Chris Holoka and other inmates were taking methadone although he never witnessed same. He based his opinion in part on Holoka's physical appearance the day prior to his death.

[27] Nurse Clarke gave support to Curtis' views on Brad Fright by stating

> "I think it could have happened, because it's obvious it did happen, because when you have somebody not on the methadone program having methadone in their system, it happened. How it happened? I think probably they, they try to distract you. They ask you for, you know, a Band-Aid at the same time. Maybe you bend down to get a Band-Aid for them, and they slip it back into their cup. Somehow they're doing it. I guess they were good at it."

[28] That there was evidence of a marked change in the physical appearance of Chris Holoka in the days prior to his death cannot be denied. And while officials of the Winnipeg Remand Centre either did not notice these changes or were oblivious to same, the testimony of both inmates Curtis and Curwin satisfied me that the effects of the methadone clearly had taken a toll on his body. According to Curtis, "the pupils of Holoka's eyes were almost invisible and appeared pinned. He had the appearance of being wired, that is extremely high and walked like a zombie."

[29] Curwin, who was with Chris Holoka on April 14th said that he looked shaky, had a red nose and kept scratching hive like red blotches on his skin. His description of Brad Fright, namely that "he looked like a pale zombie," compares with the description of Holoka as offered by inmate Curtis.

[30] This then is the picture one would draw of Chris Holoka on the day or days preceding his demise.

THE LAST DAY IN THE LIFE OF CHRISTOPHER JOHN HOLOKA

[31] No fewer than nine persons, eight of whom knew him to be a medium suicide risk (SUM) saw or had contact with Chris Holoka between the hours of seven o'clock in the morning and the institutional lockdown at 11 o'clock in the evening on April 14, 2005. His cellmate Curwin, who went to bed between one and two o'clock in the morning of April 15, 2005, recalls Holoka's raspy asthmatic breathing before he fell asleep.

[32] The widely divergent testimony of those witnesses is cause for concern since witnesses Curtis, Curwin, Sicotte and Susan Maureen Elson stand in stark contrast to the testimony of witnesses Clarke, Hazel Perrie, Webb and McFall.

[33] Curtis recounts his conversation with Chris Holoka between 5:30 and six o'clock in the evening, and describes him as "being quite out of it—a zombie." Holoka asked that Curtis wake him when the guards came around, and told the trustee that he would sleep well that night. He asked Curtis to wake him before nine o'clock in the evening.

[34] In his testimony Curtis stated as follows:

> "I went into his cell. I yelled his name. I shook him. In fact, he was wearing his radio and it was still blaring, so I took his radio off and turned it off. I slammed the door a couple times. I went back in there five minutes later. The nurse hadn't gotten there yet, though. He told me to wake him up at 20 to 9:00 and I tried continuously to wake him up for about 10 minutes. He wouldn't wake up. But he was alive. He was snoring, very loudly actually."
>
> And again:
>
> "Nothing was waking him up. So I assumed that, well, he had been taking the methadone so he was pretty tired and he was just not sleeping but passed out, I suppose.
>
> I know from experience, when somebody's been drinking all night—now, this is a completely different ball game, but when somebody's drinking heavily the night before, you can't wake them up. When somebody's passed out, they're out. You're not waking them up."

[35] Curtis did not tell anyone that he could not wake up Holoka, as he thought when it was time for medication he would try again. He did and still could not wake him up.

[36] Curtis admitted that he should have alerted people to the fact and did not, especially in light of the fact that Holoka for at least a week had been "wired,"-- that is

high on methadone. Curtis described Holoka's appearance over the five days preceding the day before his death as "walking like a zombie, walking like on an angle, walking like he was drunk, not in control of his movements. He attributed this to his ingestion of methadone.

[37] When Holoka was paged for his medications over the intercom system, Curtis told Corrections officials that he was sleeping and that he was not waking up. At no time was there any personal cell check by Corrections officials or medical staff to enquire from Holoka as to why he did not attend for his medication.

[38] Curwin's testimony of a shaky, slow walking Holoka covered with red blotches has earlier been described.

[39] Corrections Officer Sicotte, who was on duty during that day stated that Holoka looked tired and had bags under his eyes. While he did not complain, he did tell her that he was not feeling well.

[40] The testimony of Corrections Officer Elson who worked from 11 o'clock in the morning to 11 o'clock in the evening on April 14th went even further as she told of Holoka being in distress.

[41] In answer to the question of what impression she had of Holoka after seeing him emerge from the Counselor's office at around seven o'clock in the evening, she stated:

> "Physically, he seemed like he was having a lot of difficulty walking. His arms and legs were shaking. And he just seemed to be holding on to—like, when he came close to the pod, he was holding on to that wall. He was waiting for the door to the range to be opened. I had asked him if he was okay, if he was doing okay, or he needed help, or anything like that. And he said "No. No." He was fine. I don't remember the exact wording, but I remember it was something along that line."

[42] Elson stated that she brought her concerns to Counselor Hazel Perrie in the following words,

> "I had asked the counselor Hazel, who had just been in the room with him, if he was okay, or if there was anything, that, you know, we needed to watch for, or whatever. And she had—I don't remember exact words, but it had been in the positive, that no, he was going to be okay, type of thing."

[43] She noticed that Holoka didn't attend when called for medicine rounds at about nine o'clock, and inmates commented that he was sleeping. While positive of her voicing her concerns to Counselor Perrie, Elson could not be sure if she relayed the same information to nurse Clarke. However, her concerns did later lead her to

his cell where, without entering the cell noticed that he was sleeping and saw his chest rise and fall. To her he seemed very relaxed and not in distress.

[44] Elson commented to a fellow co-worker that she had earlier seen Holoka walking with great difficulty but that he appeared to be sleeping when she checked on him.

[45] Nurse Clarke, like Counselor Perrie and Corrections Officers Webb and McFall painted a different picture of Chris Holoka on April 14, 2005. Corrections Officer Webb, did see Holoka limp, but viewed it not as uncommon as Holoka being a former football player did suffer leg injuries and had earlier made Webb known of that fact. He did not see Holoka to be "wired" as described by Curtis and Curwin, nor did he see him in any distress or his eyes pin-like. McFall as well did not notice anything unusual about Holoka in any dealings he had with him that day.

[46] Nurse Clarke averred to having provided Holoka at the suppertime rounds with an antihistamine as a medication when he complained of being itchy and prone to scratching. However, she states that he never appeared to be high, strung out or disoriented. To her "he seemed talkative and chipper when he came out for his evening meds."

[47] Counselor Perrie met with Chris Holoka in the early evening of April 14th, and while he told her that he was not feeling well, and complained about flu like symptoms, sore knees and showed her what appeared to be hives for which he had received medication earlier from nurse Clarke he did not appear to be disoriented, confused or intoxicated.

[48] The meeting between Perrie and Holoka lasted some 45 minutes, and even though she had concerns about his not feeling well, she at no time redirected him to the nurse for the addressing of his complaints. She also did not recall Elson voicing concern over Holoka's distress and telling the Corrections Officer that he was going to be okay.

[49] However, it is clear from a totality of the evidence presented that there was every reason to be concerned about the well-being of Chris Holoka when he went to bed the night of April 14, 2005.

METHADONE GOVERNANCE AT THE WINNIPEG REMAND CENTRE

[50] Evidence as to methadone policies in place at the Winnipeg Remand Centre both at the time of death of Chris Holoka and following the tragedy was provided by nursing manager Chris Ainley and nurse Nancy Lynne Clarke.

[51] For the purposes of this report, it is my intention to describe both the policy as it existed prior to April 15, 2005 and the changes effected by the institution, which for the most part came into being in December of that year.

[52] As described by Mr. Ainley, the methadone program came into being "some four or five years ago," making it a relatively new program. According to Ainley, Manitoba was at first reluctant to implement a program. In his testimony he stated as follows:

> "I think the problems are self-evident, just from this, from the hearing. I mean, this type of thing that we're scared of. We're scared of the, the dosing, we're scared—we don't necessarily—let me give you a bit of history. Up until about four or five years ago, we never allowed methadone into the, the provincial jails. Were there problems? No. The inmates that were on methadone, which wasn't as big a problem back then. They tended to withdraw fairly rapidly. We treated their symptoms. We moved on. There was none of this narcotic coming into the institution.
>
> I guess across Canada it has become a treatment of choice for harm reduction. In the past it used to be to get people off narcotics. Now it's a treatment of choice for harm reduction. Corrections has taken the standpoint that the, the statistics warrant us giving this medication in our facilities in Manitoba, so that three of the facilities in Manitoba do give it.
>
> I guess our objection, as individual practitioners of nursing and medicine stem from the fact that we see the same guys coming on methadone all the time so the harm reduction part really isn't working for them. They are still continuing to do criminal activities and still coming to jail, so that, the public safety section is not working for them.
>
> We also note that a lot of them are taking other drugs, besides the methadone, often illicitly acquired. And so that, that health and safety aspect isn't there with some of these guys as well. I don't think that anybody will ever be able to say we can take methadone out of the institutions. Now that it's there, I think it's there to stay."
>
> And further:
>
> "I'm just talking from experience in terms of public pressure to do things. I mean, all of Canada is giving the stuff in correctional facilities. I don't think Manitoba is about to step up and be a leader and say, we don't need this in our facilities. I think that would be a bit harsh. Anyway, we get a number of people that come in, you know, for two days. They may never have been in custody before. They are on methadone and I don't have an issue with continuing with that at all."

[53] It would appear from the aforesaid exchange that it was inevitable that the introduction of a methadone policy at the Winnipeg Remand Centre would be minimal at best. And, in hindsight with there being no history of drug overdose deaths at the Centre it is easy to understand why the dispensing of methadone to inmate users would not be given preferred attention.

[54] The early practice with respect to inmates who advised that they were on methadone would be to contact the pharmacy with which that person dealt and have the methadone sent to the Centre. There was no indication of the dosage on the bottles delivered and no way of knowing what dosage was required by the inmate.

[55] Centre nurses would not know whether or not before the inmate's arrival he or she would be taking the required dosage under the eyes of a responsible dispenser of same or whether or not some or all of the methadone could be sold or traded on the street.

[56] There was no formalized training for officials and unawareness by both officials and inmates on the risks posed by methadone.

[57] Nurse Clarke in answer to how methadone was administered to qualifying inmates prior to April 15, 2005, stated,

> "At that time, we used to—the bottles—the program is outside of the jail. We don't run the program ourselves. Each of the people that are on the program contact—they all have workers. There's—there are a few different programs in the city. They contact their case worker, and let them know where they are.
>
> The methadone would be pre-mixed, and come into the institution in bottle form, and we would administer it to them. Sometimes they send in one day, or two days, if they don't think they're going to be there very long. They might send, maximum, a week's supply at a time. It's locked up in our pharmacy. And then we would take a bottle, and take it on our round. We give it out at the supper round. And they would come to the door with a glass of water, drink the methadone, drink a glass of water, and they will just sit in the common area, where the tables are, for 20 minutes to half an hour, and be observed by one of the officers in the pod."

[58] Nurse Clarke went on to add:

> "You know, how they get on the program, I'm not really sure. I can't really say whether they have to be referred by their doctor, or whether they can go directly to the program. There's the MINE program and the CARI program. And there was a third program running by a Dr. Wilson that I don't believe is any longer running.
>
> And I guess once they're established on the program, there's different—some go to these clinics every day, and pick up their methadone. Some are allowed to carry, it's called, and maybe they give them a week's worth or three days worth or five days. I don't know exactly.
>
> And because we don't, per se, run the methadone program at all out of the institution, when somebody comes in, and says, "I'm on the methadone

> program," then we tell them it's their responsibility to contact their worker, and let them know where they are, and potentially how long they might be there, and discuss it with them. And until it is delivered, you know, we don't give them anything, because it's not something we keep or stock. It comes in labeled for that individual."
>
> She added,
>
> "We don't have anything to do with the dosages, increasing, decreasing, anything like that. That's not ours. We just administer what the program sends to us."

[59] Clarke admitted that the nursing staff would not track the amount of methadone that came into the Centre but left that task to the methadone programs. Without a standing order staff would not even be required to acknowledge receipt of the methadone or keep an inventory of same. One of the few safeguards would be the locking up of the methadone in the pharmacy room.

[60] The inquiry learned that prior to April 15, 2005, that an inmate on the program would attend with their own cup of water or juice allowing for the opportunity to divert methadone not required for their own need. The inmate would then be allowed to sit in the range area as a member of the general population. It was the responsibility of the pod officer to observe them for some 20 minutes so that there would be no regurgitation allowing for methadone to again be diverted. Corrections officers admitted that not at all times were the observations intense.

[61] The Winnipeg Remand Centre has since taken positive steps towards the redressing of flaws in the aforesaid policy. New procedures were introduced shortly after the death of Chris Holoka and were formalized on December 1, 2005.

[62] The new procedures for the Methadone Maintenance Program of the Winnipeg Remand Centre and relevant to this inquiry provide as follows:

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 separations preclude holding all inmates in the Holding Room) and the recipient(s) will remain in the room for a period of 30 minutes following ingestion of the 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 (2 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.

[63] No longer do inmates bring their own cup of water or juice to the Medical Holding Room. The cups of water are provided by the Nurse who, after consumption by the inmate, discards the Dixie cups.

[64] And more recently the Winnipeg Remand Centre introduced further procedural changes to caution inmates on facts surrounding methadone, including the dangers of the medication and the fact that the sharing of methadone can have deadly consequences.

[65] These recent changes in procedure mirror in many respects Table 7 of the specific guidelines for methadone maintenance treatment of the Correctional Service of Canada and standards for the provision of methadone treatment for inmates at Pine Grove Correctional Centre at Prince Albert, Saskatchewan—procedures not in effect prior to the death of Chris Holoka.

[66] While the Correctional Service of Canada guideline prescribes the monitoring of inmates for a minimum of 20 minutes after their having ingested methadone, the Winnipeg Remand Centre now prescribes monitoring for 30 minutes. As at least half of the methadone dose is absorbed from the gastrointestinal tract within 20 minutes and is detectable in the bloodstream after 30 minutes, any diverted doses will, according to publications of the Canadian Correctional Service have a lesser concentration.

[67] As expressed by Mr. Ainley, inmates are no longer able to bring anything with them into the methadone administration area, which could assist them in diverting the drug. There is also a willingness to adopt such other safeguards such as the introduction of photo identification that inmates would produce prior to the taking of doses of methadone.

DISPENSING OF MEDICATION AT THE REMAND CENTRE

[68] In describing the procedure employed by the Winnipeg Remand Centre in the distribution of medication, Nurse Nancy Lynne Clarke stated as follows:

> "We go to each of the different floors. And they're divided into A side and B side. And we would, they would announce that medication rounds were beginning, and typically, the inmate—or sorry—the person receiving medication would come down and pick up their medication at the door. Each floor also has a list that if somebody wants to request something, like

> Tylenol, or Motrin for a headache, or ache and pain, whatever, they will put their name down, and when we're there, we'll dispense that to them as well. So, it's their responsibility to come to the door to receive their medication. We'll usually call a couple of times in, and if they don't come, a lot of them will miss their meds at times.

[69] And while certain Corrections Officers such as Edward Yendres, Webb and McFall made it their practice to personally attend to enquire why an inmate would not respond to both the general page for medication or to the Dukane page into that person's cell, it would appear that there was and still is no policy or standing order in place which would enquire of an inmate as to why he or she did not attend for their medication.

[70] Chris Holoka did not answer either page on April 14, 2005, and it remained for inmate Curtis to answer the Dukane page and to advise that he was sleeping. Other than a concerned Corrections Officer Elson looking into his cell once during the evening, there were no other efforts made to check on his well-being.

[71] Dr. Charles Littman confirmed that the life of Chris Holoka could have been saved had there been intervention when Elson looked into his cell and saw him breathing.

[72] According to Dr. Littman,

> "The manner or the mechanism of death with narcotic overdose, such as methadone, is respiratory depression. It's not sudden death in that it doesn't suddenly cause a cardiac arrest. The breathing is gradually depressed, in other words, the breathing becomes shallower and the respiration rate will fall.
>
> There are treatments, specific treatments, and non-specific treatments for such cases, specific treatments would be a drug such as nalorphine or naloxone which would diminish the effects of a narcotic or the breathing centre. And non-specific treatments would be simply supportive treatments, establishing an airway and ventilating the individual. Treatment could have been administered during the night to avoid the outcome."

[73] Dr. Littman pointed out that the only way to establish or recognize that Chris Holoka was having difficulties would be in an attempt to rouse him or awaken him.

CONCLUSIONS REACHED AT THE INQUEST

[74] Christopher John Holoka died as a result of an overdose of methadone—a drug which was not prescribed for him. And while he may or may not have been aware of the disastrous effects of methadone when he accepted same from inmate Bradley Fright, his willingness to ingest the drug must be described as misadventure on his part. We will never know whether or not Holoka ingested the methadone for the sole purpose of getting

high or as a painkiller in the same way as was his ingestion of Ketamine, which was originally designed to relieve him of his phantom pain problems.

[75] However, the tragedy exposed failings both in the methadone programming which was then in existence at the Winnipeg Remand Centre, and the practice employed at that institution in ensuring the attendance of inmates to medicine calls.

[76] Credit must be given to the Winnipeg Remand Centre for changes in policy as respects the manner in which inmates for whom methadone is prescribed, are now segregated and observed while ingesting methadone. The practice employed at the time of Chris Holoka's death was a direct result of a lack of knowledge by staff of the dangers of the drug and the increased abuse of same by inmates.

[77] So too, must credit be given to the institution for now informing inmates of the dangers of methadone. There will always be addicts such as Brad Fright, who could manipulate their dosage no matter what policy is instituted. However, a procedure to alert users and in particular a procedure which would spell out the dangers of diverting the drug to naïve users is a welcome addition to the Centre's evolving policy.

[78] However, shortcomings still remain. The lack of a formal education program for staff at the Winnipeg Remand Centre not only allowed for a fractured method of methadone distribution and oversight of inmates in their ingestion of the drug, but kept nursing and counseling staff from appreciating the destructive effect that the drug was having on Chris Holoka.

[79] What fellow inmates Curtis and Curwin noticed about Holoka in the days prior to his death was not recognized by a professional staff. And even when alerted by Corrections Officer Elson that Holoka was experiencing difficulties, the less than concerned reaction of both Nurse Clarke and Counselor Pirrie left him without the much needed treatment deserved by him. Staff, educated in the lethal effects associated with methadone would not so easily have brushed away those voiced concerns.

[80] The absence of a defined policy to ensure that inmates for whom medication has been prescribed attend when called on medicine rounds, resulted in Chris Holoka's remaining unattended in his bunk in the hours prior to his death. Had there been intervention when he failed to answer both the general page and the paging over his cell's intercom system his death could very well have been avoided. Corrections staff was aware that Holoka was a medium suicide risk and if for no other reason than that should there have been concerns over his not attending to receive his prescribed medication.

RECOMMENDATIONS

[81] At the conclusion of the hearing, I invited counsel to offer suggested recommendations which if accepted would form part of this report. The recommendations from both Mr. Frost and Ms. Pats reflect not only positive steps that if

instituted could help to prevent further tragedies, but are recommendations which in my opinion could be implemented without a heavy expenditure of monies.

[82] In its taking of the initial steps heretofore described, the Winnipeg Remand Centre has shown a willingness to address those institutional problems of its methadone policy, and has through Mr. Ainley agreed to give consideration to adopting most of the guidelines set out in Table Seven (7) of the Corrections Services of Canada, Specific Guidelines for Methadone Maintenance Treatment. With that assurance being given, it will not be necessary for me to specify same as a recommendation.

[83] If I am to accept the initial comments made by Mr. Frost, namely:

> "….Ms. Pats and I are pretty much on the same page in terms of the recommendations. She did, she did kindly give me a peek at them earlier, so I'm going to let her speak to the ones that she has and, in that regard, I am pretty much nodding my head…"

then I am confident that a major effort will have been made by the Winnipeg Remand Centre towards ensuring that needed steps will have been taken towards averting similar tragedies in the future. Recognize that there is no foolproof system and that the best that can be done is for the Winnipeg Remand Centre to eliminate those obvious weaknesses that existed prior to April 15, 2005 and still remain today.

[84] It is therefore recommended as follows:

(1) That the Winnipeg Remand Centre implement a meaningful staff education drug program in concert with the Addictions Foundation of Manitoba, and that this program be ongoing for all staff. That this program highlight addictions and the use of illicit drugs including methadone.

(2) That staff at the Winnipeg Remand Centre be adequately trained for the handling of emergencies in drug related cases.

(3) That dangers surrounding methadone be communicated both in writing and verbally to incoming methadone inmates on their signing of the requisite waiver, with particular emphasis on the dangers of diverting methadone to naïve users.

(4) That management at the Winnipeg Remand Centre continue to stress the importance of complete and accurate medication charting, and demand in writing an accounting from staff members who fail in this duty.

(5) That the Winnipeg Remand Centre establish a protocol with existent methadone treatment programs as to dosage requirements for incoming inmates who are registered with their programs. Such information would

be vital in ensuring that the inmate's dosage is used only for the well-being of that individual.

(6) That consideration be given to the implementation of a standing order which would dictate that where an inmate does not respond in person at scheduled medicine rounds to a page for attendance for essential medicines or medications that it be incumbent on staff to personally enquire of the inmate as to the reason for his or her non attendance. At the very least such an order should be mandatory as it applies to those inmates classed as being suicide risks.

It is with respect that I submit this report and my recommendations this 11thday of May, 2007, at the City of Winnipeg, in Manitoba.

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RONALD MEYERS, P.J.

EXHIBIT LIST

Exhibit	Description
1	Letter from the Chief Medical Examiner
2	Two (2) binders, Section I and Section II, containing court documents (medical reports, autopsy reports, remand reports and statements regarding death of Christopher Holoka
3	Curriculum Vitae of Dr. Charles Littman
4	Floor plan from the cell numbered 469 at Winnipeg Remand Centre (Christopher Holoka's cell at the time of his death)
5	Coroner's Jury report from the Sonia Keepness Inquest from the Pine Grove Corrections Facility in Prince Albert, Saskatchewan
6	Current Methadone Procedure from the Pine Grove Corrections Facility in Prince Albert, Saskatchewan
7	Transcript from phone calls intercepted at Winnipeg Remand Centre
8	Manitoba Civil Service Commission Position Description for Correctional Officer I position - dated July 29, 1998
9	Manitoba Remand Centre Methadone Administration Policy
10	Manitoba Corrections Division – Policy on Self-Administered Medications
11	Manitoba Civil Service Commission Position Description for Nurse I position – dated May 19, 1998
12	Manitoba Civil Service Commission Position Description for Shift Operations Manager position - dated July 2002
13	Manitoba Civil Service Commission Position for Counselor position – dated April 10, 2003

Exhibit	**Description**
14	Correctional Service Canada Publication – Specific Guidelines for Methadone Maintenance Treatment Dated January 17, 2007 (14 pages)