ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Provincial Court of Alberta

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

on the 10 day of September, 2018 (year), (and by adjournment

on the n/a day of n/a, n/a (year)),

before M.V. De Souza, a Provincial Court Judge,

into the death of Kenneth William Schaer (Name in Full) 25 (Age)

of Drumheller Institution (Residence) and the following findings were made:

Date and Time of Death: February 15, 2014 at 7:20 am

Place: Drumheller Institution

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *The Fatality Inquiries Act*, Section 1(d)).

Hanging

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *The Fatality Inquiries Act*, Section 1(h)).

Suicide

Circumstances under which Death occurred:

Introduction

Following s. 53(1) of the *Fatality Inquiries Act*, R.S.A. 2000, Ch. F-9, I have made the following findings and recommendations to help prevent similar deaths.

Circumstances under which Death occurred

On February 15, 2014, at the Drumheller Institution (the "Institution"), Mr. Kenneth William Schaer died by suicide, as a result of asphyxiation.

At approximately 06:51 hours, a security officer completed a routine patrol in Unit 8 and found Mr. Schaer in Cell F-07 hanging by a bed sheet and sock, knotted around his neck, attached to a metal clothes rod in an open closet. His feet were restrained to a desk using a pair of thermal pants and a wool sock.

Mr. Schaer was unresponsive to an Automated External Defibrillator and cardiopulmonary resuscitation, and Alberta Emergency Medical Services pronounced Mr. Schaer deceased at 7:20 am. The Alberta Medical Examiner's Officer determined cause of death was hanging.

Mr. Schaer was last seen alive and without incident during a security patrol at approximately 22:28 hours. He left a note stating his adoptive Mother as next of kin.

Personal Antecedents

At the time of death, Mr. Schaer was 25 years old. He was born in Hinton, Alberta, the only male child of four children. In 1991 Alberta Child and Family Services (ACFS) removed him and his sisters from the family home, due to dysfunction and neglect. His father committed suicide in 1993.

Mr. Schaer's adoptive life was reportedly stable until his adoptive father died in 1998. After this time, when Mr. Schaer was about 12 years old, he became angry, rebellious and difficult to manage; he returned to ACFS, and lived in foster care and group homes.

By age 14, Mr. Schaer used substances, initially marijuana and alcohol, and later heroin and crack cocaine. Mr. Schaer did not complete grade 12 and had limited employment history. He had one common law relationship that produced one child, who was one year old. The relationship ended when the child was born.

Mr. Schaer was suspected of suffering Fetal Alcohol Effects, and had a history of mental health concerns, including bipolar disorder, and suicidal ideation.

Criminal History

Mr. Schaer's documented offences began as a youth in 2007; they were drug and alcohol related, and involved violence.

Mr. Schaer was serving three years at the Institution for aggravated assault; this was his first federal incarceration. His was remanded to provincial custody on November 30, 2013 and his sentence began on January 2, 2014.

Identifying Mr. Schaer as a suicide risk.

Mr. Schaer had been in federal custody for twenty-four days. He was in the early stages of the intake process at the Institution and none of the assessment documents such as Correctional Plan, Criminal Profile, Penitentiary Placement, Aboriginal social history had been completed, and the information retrieval process was still in progress. Furthermore, no decisions that required consideration of Mr. Schaer's Aboriginal social history had occurred or were due at the time of his death.

Reports of Automated Data Applied to Reintegration indicated Mr. Schaer had no institutional charges or security incidents. He was placed on general population range following the admission process.

Upon intake, Immediate Needs Checklists for Security and Suicide and Intake Health Status Assessments, Parts I and II were completed by correctional officers and healthcare nurses, respectively, as required by Commissioner's Directives 705-3, Immediate needs Identification and Admission Interviews (June 13, 2012); and 800, Health Services (April 18, 2011).

The Immediate Needs Assessment for Suicide revealed negative responses to both a history of suicide and current suicidal ideation. Mr. Schaer underwent six specific suicide screenings or interviews, health assessments and psychological/mental health assessments addressing the risk of suicide. On each occasion he denied past and present suicidal behavior, ideation or intent. Nevertheless, due to Mr. Schaer's mental health history, including bipolar disorder, and prescription for psychotropic medication, Mr. Schaer was referred to Institutional Mental Health Services.

On January 22, 2014, a mental health nurse interviewed Mr. Schaer. During the interview no suicidal concerns were disclosed. However the nurse noted a history of bipolar disorder and psychotropic medications and made a non-urgent referral to the Institutional Mental Health Initiative, and Institutional Psychiatrist for medication review.

On January 23, 2014, a psychiatrist assessed and evaluated Mr. Schaer and determined Mr. Schaer's history of manic episodes were caused by cocaine and methamphetamine consumption. The psychiatrist acknowledged Mr. Schaer's previous suicidal thoughts; however, Mr. Schaer did not acknowledge symptoms of previous major depressive episodes. Mr. Schaer denied suicidal ideation, suicidal behavior, and self-injury.

The psychiatrist prescribed Mr. Schaer anti-convulsant medication to control manic episodes, and discontinued anti-psychotic medication due to no psychotic symptomology. Mr. Schaer was scheduled for psychiatric follow-up on February 21, 2014.

Mr. Schaer completed the Computerized Mental Health Intake Screening System assessment on January 24, 2014. He was identified as "high need" for mental health

services and was referred for additional mental health assessment. This was pending at the time of his death.

On February 5, 2014, Mr. Schaer was identified as “moderate need” for mental health services and was accepted for psychiatric services. He was not accepted for psychological services, pending outcome of the mental health assessment initiated following the Computerized Mental Health Intake Screening.

On February 10-12, 2014, Mr. Schaer participated in the Orientation Program; this included a Suicide Awareness Workshop. Following the Orientation Program, a shadow parole officer interviewed Mr. Schaer, who presented as agitated, however claimed to be “keeping it together”. The parole officer referred him to an Aboriginal Elder who saw him immediately. Mr. Schaer again interacted with Aboriginal staff and was seen by an Elder on February 10, 2014 with respect to adjustment to the institutional environment.

Mr. Schaer was seen daily during routine patrols; and was described as a quiet inmate who generally kept to himself and caused no problems. Initially, he was also seen, daily, by nurses during the evening medication line; however, he did not attend the line four days prior to his death. No referral to Mental Health Services or follow-up was provided with respect to his absence; his failure to attend was documented on his healthcare file.

In conclusion, no pre-incident indicators to Mr. Schaer’s suicide were identified. There was no information known to correctional officers, psychologists, health care staff or other members of the Case Management Team, prior to the incident, which indicated Mr. Schaer was at imminent risk for suicide.

Precipitating factors included stress of incarceration; loneliness and isolation; and mental health concerns, specifically thought-disturbance and changes to psychotropic medications, voluntary and involuntary.

Correctional Service of Canada staff were aware of the identified precipitating factors and provided interventions, which included referrals to institutional mental health and Aboriginal services.

Contributing factors included a dysfunctional childhood; familial separation; cultural isolation; a history of substance abuse; a history of desensitization to violence; a history of suicidal ideation; and a history of cognitive deficits, which impacted executive functioning.

As Mr. Schaer was a new inmate to the Correctional Service of Canada, in the early stages of the intake process, little social history or background information was available to inform staff’s understanding of Mr. Schaer, or dynamics of his case; consequently the contributing factors had not been specifically addressed.

Proper Patrols

The Institution was resourced according to required staffing levels, and security patrols were completed in accordance to frequency and on schedule on February 15, 2014.

Drumheller Institution Post Order 27, Unit Supervision COI Day, Evening and Morning Shift (December 3, 2012) specifically required " a total of at least 9 security patrols…between 23:00 hours and 6:30 hours". Security rounds were completed within sixty minutes of the commencement of the preceding round and varied to be unpredictable.

However, the security rounds were not of the appropriate duration and quality. The Digital Video Recordings revealed that from commencement of the morning shift security patrols were conducted at 23:10:54 until 6:00:06. The Correctional Officer conducted the rounds in a brisk manner, shining his flashlight randomly at the cell doors as he walked down the range. He was not observed taking sufficient time to look into each cell window to confirm "the inmates are alive and not in distress" as required in Commissioner's Directive 566-4, Inmate Counts and Security Patrols (April 5, 2013).

The security round did not allow for the identification of a "living breathing body" or an inmate in "distress". This failure resulted in Mr. Schaer not being consistently monitored and potentially discovered in time for successful life-saving intervention.

Institutional Management identified this issue during their review of the incident and corrective measures were instituted. The Correctioal Officer in question no longer works at the institution.

Based on the condition of Mr. Schaer's body when he was discovered hanging in his cell (i.e. large muscle rigor mortis and dependant lividity), it was determined he had been deceased for a number of hours, conceivably having hanged himself close to the beginning of the morning shift, most likely shortly after the 22:28 hours count.

Despite the inadequate security patrols, it cannot be said proper security patrols would have prevented Mr. Schaer's death. It is possible Mr. Schaer had died by asphyxiation during the interval between security checks.

Clothes Rod

The suspension point from which Mr. Schaer hung himself was the clothes rod in the cell closet/wardrobe. The clothes rod was six to eight inches long and attached securely to the rear wall and front frame of the closet. The design of the closet and the rod was such that the clothes rod did not breakaway under stress. Whereas another coat hook mounted on the cell wall was made of plastic and designed to break away when under sixty pounds of stress.

As required by Commissioner's Directive 550, Inmate Accommodation (February 5, 2013) a National Cell Condition Checklist (CSC/SCC 1448) was completed when Mr. Schaer was placed in cell F-07. The completed checklist did not "identify all potential points of suspension, non-removable and removable, and other cell vulnerabilities as required.

In addition, during the National physical infrastructure vulnerability study, conducted by Technical Services in 2010, the Institution had not identified the closet rod as a vulnerable piece of infrastructure.

Recommendations for the prevention of similar deaths:

Findings and Recommendations

The following findings and recommendations are made to mitigate risk an inmate could die in a similar way: -

1. It is impossible to remove all infrastructure vulnerability from the Institution; however, it is recommended that the closet/wardrobe clothes rods in cells at the Institution be identified as infrastructure vulnerabilities that require mitigation and a new design.

   There was evidence replacing the rod in all cells is cost-prohibitive, and is being done on a staggered basis. New inmates, not having completed the intake and assessment process, should be held in cells that do not contain vulnerable infrastructure.

2. The routine patrols did not comply with policy and were inadequate. The employee conducting the patrols was terminated before this Inquiry, and procedures were implemented to prevent inadequate checks in future. In addition, the direction of the rounds have been varied to add greater unpredictability.

3. Ensure timely follow up with inmates after recurring absences from the medication line, even in the case of low-dosage, voluntary medication.

It is acknowledged that Mr. Schaer's death may not have been prevented with any or all of these measures in place.

DATED February 19, 2019,

at Calgary, Alberta.

Original signed

A Judge of the Provincial Court of Alberta