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 (Criminal Division)

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

on the 28th, 29th & 30th day of November, 2016 (year), (and by adjournment

on the _____ day of _____, _____ (year)),

before The Honourable Judge Peter Barley, a Provincial Court Judge,

into the death of Dang Akays Dang (Name in Full) 27 yrs (Age)

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

Date and Time of Death: December 12, 2011 – 20:01 Hours

Place: Drumheller District Hospital

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:

Summary:

[1] The deceased, Dang Akays Dang, was a serving inmate at Drumheller Institution. He had been transferred there from Ontario on December 7th, 2011, and put into segregation at his request. On December 12, 2011 he was found unresponsive in his cell. A strip of bedding was tied around his neck and to a grate. He never regained consciousness and was pronounced dead shortly thereafter.

Circumstances

[2] At the time of his death, Mr. Dang was a 27 year old male serving a sentence at the Drumheller Institution.

[3] The deceased was born in the Sudan, but his family went to Italy in 1989 and then came to Canada as refugees in 1993. The family lived in Ontario initially, but eventually the parents separated with the father living in Calgary and the mother moving to Edmonton with his siblings. The deceased remained in Ontario.

[4] He was serving a two year sentence for possession of a controlled substance for the purpose of trafficking and two counts of breaching a probation order at the time of his death.

[5] He was eligible for release on this sentence on December 22, 2011. It was unclear if he would actually be released then, because he was under an order of deportation back to the Sudan based upon that sentence. He was sent to Drumheller to be close to his mother in Edmonton. She was expected to be of assistance to him in his appeal of the deportation order and to provide support if he was released pending the appeal.

[6] The deceased had previous convictions as follows:

02/10/08	Possess Schedule 2 Substance Theft Under $5000, Possess Property Obtained by Crime Under $5000	4 months conditional sentence ordered on each charge concurrently
02/10/08	Fail to Attend Court Possession of Schedule 2 Substance	Probation 1 year on each charge.

03/01/15
1) Breach Conditional Sentence
2) Possess Prohibited or Restricted Weapon and Ammunition
3) Possession of Property Obtained by Crime Over $5000
4) Possession of Break in Instruments
5) Fail to Comply with Disposition
6) Obstruct Peace Officer
7) Occupant of a Vehicle Without Consent
   1) Order terminated
   (2-7) 4 months on each charge concurrent and prohibition order Section 110 CC for 5 years.

[7] The deceased also had a history of mental illness and psychiatric intervention. He had been apprehended by the police for exhibiting bizarre behavior as early as 2004. He had multiple admissions to a psychiatric hospital in London, Ontario. In 2005 he was found to be unfit to stand trial on some minor matters.

[8] More significantly, Mr. Dang had a history of self harm. A diagnosis of schizophrenia was made in 2000. He attempted suicide by hanging in 2009 while in a medical facility. He slashed himself in 2008 and was banging his head in 2011.

[9] Mr. Dang was transferred to the Regional Treatment Centre as an inmate in April 2011. This transfer was originally under the *Mental Health Act,* but he was remanded there voluntarily until his transfer to Drumheller on December 7, 2011.

[10] A 19 page report on Mr. Dang was sent from the Regional Treatment Centre to Drumheller Institution on December 1, 2011. It noted the diagnosis of schizophrenia, listed the history of self harm and set out the medications that Mr. Dang was being provided.

[11] It also included a copy of a letter sent to Border Services from a doctor, arguing against deportation. It was also noted that Mr. Dang had requested the transfer to Edmonton to get help from his mother to fight the deportation order and to access community support.

[12] The transfer to Drumheller Institution was originally scheduled for October, 2011. At that time there were messages sent by the clinical social worker at the Regional Treatment Centre to others outlining steps that needed to be taken in connection with the transfer. This included the need to ensure that the medications prescribed for Mr. Dang were given to him during the transfer.

[13] The worker was unaware who would be accompanying Mr. Dang. There seems to have been no written policy about who would have the responsibility for providing these medications to the inmate and it is clear that they never were during the flight made on December 7, 2011.

[14] Mr. Dang was seen on December 8, 2011 by a nurse at Drumheller, who did the Intake Health Assessment. She noted that he was severely anxious with rapid thoughts and a feeling that his heart would not stop. He admitted his previous suicide attempt but denied current suicidal ideation.

[15] The mental health triage was done at 8:30 a.m. on December 8th. Mr. Dang was very anxious about missing his medications the day before, saying that he did not do well without them.

[16] Mr. Dang was then taken to see Candace Wylie-Toews, a nurse who was receiving training as a psychiatric mental health nurse. Mr. Dang also expressed a concern about being in the general population, disliking being around so many people. He expressed a desire to go to segregation, which would be quieter. This request was granted. He again denied suicidal ideation.

[17] Before going to segregation, Mr. Dang was taken to see a psychologist, James Marland. He again denied suicidal thoughts, but did complain that the missed medication was making it more difficult to function.

[18] Ms. Wylie-Toews had a concern about a proposed change in the medication that Mr. Dang would be receiving at Drumheller. Dr. Darlington, the psychiatrist on contract to the institution had a standing order that benzodiazepines, known as Ativan, should not be used in the institution. His concern was apparently that these drugs could be misused by other inmates. The standing order was that this drug would be gradually tapered off, but that Seroquel, an anti-psychotic medication would be given in greater doses to compensate.

[19] Ms. Wylie-Toews was able to speak to Dr. Darlington early that afternoon and he confirmed his order. The changes were then made.

[20] In segregation, every inmate was seen daily by a nurse to monitor their condition. However, Mr. Dang was also being seen three times daily by the nurses who would provide him the required medication.

[21] Notes show that Mr. Dang was reassured at 4:00 p.m. on December 8th that he would be receiving medication soon. He had been fixated on that issue.

[22] On December 9th, at 3:45 p.m. Mr. Dang expressed concerns about the change in his medications, but was reassured on this point. The next morning he was able to calmly repeat the changes.

[23] At 5:00 p.m. on December 10 he denied thoughts of self harm to the nurse who saw him but said that he had some suicidal thoughts since arrival. He was told that a note about these thoughts would be left for the mental health nurse, and that he should use his in-cell link to the guard bubble if things got worse.

[24] This conversation took place on Saturday, December 10th. Unfortunately, the only mental health nurse at the institute was Ms. Wylie-Toews and she was off work until the following Tuesday, December 13th. By the time she got this note Mr. Dang was dead.

[25] Ms. Wylie-Toews testified that the nurses who saw Mr. Dang would know that she was not working on the 11th. If they wanted someone to see Mr. Dang before she came back to work, they could have telephoned the psychology department and told them of the concern.

[26] However, the psychologist did not work on the weekend either.

[27] The note left on the 10th referred to Mr. Dang complaining of continued racing and disorganized thoughts, but denying any thoughts of suicide or other self-harm.

[28] Ms. Wylie-Toews testified that the nurses that were on duty on the weekend have the ability to do a risk assessment for suicide. If there was a high risk, they could put the inmate on suicide watch where he is under continuous video surveillance. If the risk continued, the inmate might be transferred to the Regional Centre in Saskatoon.

[29] Ms. Wylie-Toews testified that it would have been better for Mr. Dang to have been in a Regional Treatment Centre, as he had been in Ontario. However, the closest one was in Saskatoon, and it would seem that a transfer there would contradict the reason for leaving Ontario, which was to put him close to his family in Edmonton.

[30] Dr. Darlington was now resident out of the country and was not available to testify at the Inquiry. Dr. Linda Healy, the senior psychiatrist at Correctional Services of Canada, testified after reviewing Mr. Dang's Correctional Services file. He never was under her care.

[31] She testified that Mr. Dang was receiving five medications when he was in the Regional Centre in Ontario. Only two of them were for mental health issues. One was Seroquel, an anti-psychotic drug. The other was Lorazepam, also known as Ativan, a short acting anti-anxiety medication.

[32] She opined that the lack of the anti-psychotic medication for the day of travel would not likely cause the emergence of symptoms of psychosis. After that travel day, the level of this medication was steady.

[33] There was a standing order from Dr. Darlington that all inmates were to have their Ativan

reduced quite drastically. Dr. Healy opined that she did not approve of a standing order that applied even when the inmate had not yet been seen by the institution's psychiatrist. Standing orders are no longer allowed by Correctional Services. Changes in medication are not made until the inmate has been seen by the prescribing doctor. That may be the psychiatrist or another doctor after consulting with the psychiatrist.

[34] Dr. Healy also opined that Mr. Dang's anxiety medication dose should not have been changed since he was in new surroundings and due for release soon. The lack of anti-anxiety medication on the transfer day and subsequent reduction in dosage might lead to an increase in anxiety because of the awareness of a change in treatment and a lessened ability to deal with it. This would be an uncomfortable feeling but there would not be a causal link to suicide.

[35] No witness was able to explain why Mr. Dang took his own life. He had attempted suicide before, but nothing suggested that he was about to at the Drumheller Institution. In fact, he specifically denied any such ideation repeatedly in his dealings with various staff. He left no note.

[36] Three obvious concerns to be addressed were the failure to provide Mr. Dang with his medication on the day of transfer, the use of a standing order to change medication for all inmates being transferred in, and the existence of a grate in segregation cells that could anchor a ligature.

[37] The existence of a standing order to change medication was not significant, because Dr. Darlington confirmed that change on the day after Mr. Dang's arrival. In any event, the use of standing orders regarding medication has now been stopped within the federal corrections services.

[38] The failure to provide Mr. Dang with his medication during the transfer resulted from a lack of clear policy about the procedure to be followed. In his case an envelope with the medications was given to an escorting officer to pass on to the nurse. The envelope was not labelled and no one could remember who got it. Specifically, the nurse on the transfer flight did not remember getting the envelope, and the flight log did not record that the medications were ever administered to Mr. Dang.

[39] Documents were presented to the Inquiry to show that by May 17, 2013, procedures were put in place to establish the responsibilities of various staff members to administer medication during a transfer, and to record that those steps were followed.

[40] It provides that the sending institution will prepare a package for transfer that contains the inmate's name and number, the medication needed for transfer and a tracking form.

[41] The package is to be given to the escorting corrections officer, who is to give it to the accompanying nurse. These transfers are recorded on the accompanying form, and the nurse then has the responsibility for the proper administration of the medications.

Night of Death

[42] Evidence was given by Johanna Devries, the guard who found Mr. Dang hanging in his cell. She was not expecting to be working then, but had been asked to work overtime.

[43] She testified that the segregation unit had been searched earlier that day to look for missing fence pieces that could be used as weapons. Mr. Dang was noted by another officer to be very polite and friendly during the search, as he was when she later brought him his meal. However, the search had upset the inmates in segregation so that they were heckling her and causing her to go from end of the unit to the other to see what the inmates were complaining about.

[44] When she first found no sign of Mr. Dang being visible in his cell, she assumed that he was taking part in the harassment of her. She was the only guard on duty in segregation by then, so she finished the check of the other inmates. This took less than three minutes, and then she used the intercom to call Mr. Dang's cell. When there was no reply, she radioed for help. Policy directed that she call immediately upon finding an inmate to be unresponsive.

[45] When help arrived she let the other staff into the segregation unit. They then opened the cell doors and found that Mr. Dang was hanging by a cloth to a vent. He was cut down and CPR was given to him. He was breathing but unresponsive.

[46] Ms. Devries was not aware that Mr. Dang had mental health issues. There was a log in the control area, when concerns with inmates are noted. This would list any significant issues, but there were none for Mr. Dang. She was aware that he had been seen that day by a nurse.

[47] Carl Campbel, the assistant warden at Drumheller Institution also testified. He advised that the grates in cells have been changed. The new grates are shaped differently so that it is more difficult to tie objects to them.

[48] He testified that there was no need for Mr. Devries to wait to open the door for other staff, since they would have keys. However, there should be two staff present before a cell door is opened.

Parties

[49] Inquiry counsel was Jennifer Stengel. Rolinda Mack appeared as counsel for Correction Services Canada, an interested party. The mother of Mr. Dang, Ms. Awatif Cama Maluok, took part in the Inquiry by video link from Edmonton. She was assisted by an interpreter. She asked questions and made recommendations.

Conclusions and Recommendations for the prevention of similar deaths:

[50] Even in hindsight it is difficult to see how Mr. Dang's suicide could have been anticipated. In 2009 and April 2011, he advised medical professionals that he was feeling suicidal and he received help. At Drumheller Institution he specifically denied suicidal thoughts. There seems to have been no advanced warning.

[51] I am tasked to make recommendations to help prevent similar deaths. The three obvious concerns that arose during the inquiry are set out in paragraph 36 of this report.

Issue 1: The lack of clear policy at the time ensuring that inmates receive their prescribed medication during transfer.

This had been changed in 2013, as set out in paragraph 39.

Issue 2: The use of standing orders to change medication for transferred inmates.

This policy has been changed. Medications are not now changed without the inmate being seen by a medical professional.

Issue 3: It seems obvious that steps should have been taken to lessen, if not eliminate, the possibility that a suicidal inmate has anything to attach a ligature to. The grates have now been altered as explained in paragraph 47.

[52] It is not known if these changes were made as a result of Mr. Dang's death. If so, it is tragic that they were not made earlier. However, since they have been made already. I do not see a need to make further recommendations.

DATED March 22, 2017,

at Calgary, Alberta.

Original signed by

Judge Peter Barley
A Judge of the Provincial Court of Alberta