ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Drumheller Provincial Court

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

on the 1st to 2nd day of May, 2018 (year), (and by adjournment

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

before The Honourable E.J. Creighton, a Provincial Court Judge,

into the death of Martin Nathan Pinkus (Name in Full) 47 (Age)

of The Drumheller Penitentiary, Drumheller, AB (Residence) and the following findings were made:

Date and Time of Death: January 28, 2015

Place: Drumheller District Health Services

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)).

Asphyxia by 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:

Circumstances

On January 28, 2015, the deceased ("PINKUS") was found hanging from a TV stand via Bed Sheet in his cell at the Drumheller Penitentiary and was pronounced dead at the hospital. No suicide note and no medications were found in the cell. He had a history of impulse and anger control issues. There was no suspicious trauma or concern. PINKUS was 47 years of age at the time of his death.

Summary

PINKUS was serving a life sentence at the Drumheller Penitentiary having been convicted of Second Degree Murder and Aggravated Assault in December 1999. He was transferred to Drumheller from the Edmonton Penitentiary in April 2007. It is to be noted that the Edmonton Institution is a Maximum Security Institution and Drumheller is Medium Security.

PINKUS was twice transferred to the Regional Psychiatric Centre (Prairies) for mental health stabilization and each time was returned to Drumheller. The first time was in May 2009, and he was returned to Drumheller in October 2009, a stay of approximately 5 months. The second transfer to the Psychiatric Centre was in September 2013, for an approximate stay of 4 months before he was returned to Drumheller in January of 2014.

On January 21, 2015, PINKUS was placed in segregation due to his deteriorating behavior. There were indications of possible threats he may have been making to harm other inmates and staff. PINKUS was agitated because of the possibility he may be transferred to a Maximum Security Institution. He had indicated he could not handle going back to a Maximum Institution – that if 'the guys' do not hurt him 'he will probably do something to hurt himself.' On this same date, a psychologist interviewed him and deemed him <u>not</u> to be 'currently suicidal or self-injurious.' (Emphasis mine).

According to the investigative report into PINKUS' suicide by Correctional Services Canada (CSC), four precipitating events indicating suicide was a risk were identified: placement in segregation; the recommendation for transfer to a Maximum Security Institution; the inability to call his mother due to a phone card problem; and an untreated impulse control disorder.

There was also an indicator passed on to staff by an informant that PINKUS was giving away his property. Whether this was an indication PINKUS was preparing to end his life was not interpreted as such by staff or the psychologist.

Recommendations for the prevention of similar deaths:

Four recommendations were provided by the Correctional Investigator on September 10, 2014, relevant to PINKUS' death: (1) Remove all known suspension points in segregation cells; (2) Prohibit long-term segregation of seriously mentally ill, self-injurious or suicidal inmates; (6) Identify inmates at elevated risk of suicide in long-term segregation or have history of repeated placements and develop appropriate mitigation measures; and (11) Staff training to contain more practical focus on mental health issues.

Correctional Services Canada (CSC) provided its response to these recommendations: (1) The Warden indicated this has been completed before PINKUS' death. He went further and testified that suspension points cannot be totally eliminated while still providing basic human needs; (2) The Warden testified that the Drumheller Institution now does not segregate the mentally ill even for short periods of time; (6) It is uncertain if this recommendation was implemented; (11) This recommendation has been implemented. The Warden testified that the Drumheller Institution mandates suicide awareness training.

The Board of Investigation Report commenced after PINKUS' death identified two compliance issues regarding the policy and procedures during the deceased's stay: (1) A National Checklist was not completed for PINKUS' move to segregation; and (2) Self-injurious behavior was not reported. In response the Institution (1) instituted a process for completion of Cell Condition checklist and committed to briefing staff; and (2) Corrective measures were taken by the Institution to ensure all staff complete such reports when unusual behavior is noted. The Institution is committed to regular briefings to ensure required information is gathered and shared for Incident Reports.

Inquiry Recommendations

It is to be noted that efforts are being made by the Drumheller Institution to monitor and do all to mitigate suicides of inmates at the Institution. A balance must be met between inmate safety and security with basic human needs of inmates.

I conclude that the Drumheller Institution policies and procedures relative to inmate self-injurious situations exist but the enforcement of same must be consistently enforced and carried out by staff.

DATED July 17, 2019,

at Calgary, Alberta.

Original signed

A Judge of the Provincial Court of Alberta