ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Law Courts Building

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

on the 9th day of May, 2017 (year), (and by adjournment

on the 10th day of May, 2017 (year)),

before MC Doyle, a Provincial Court Judge,

into the death of Jessie McAdam (Name in Full) 22 (Age)

of Victoire, SK (Residence) and the following findings were made:

Date and Time of Death: July 16, 2013; 4:56 pm

Place: Edmonton 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 – *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 – *Fatality Inquiries Act*, Section 1(h)).

Suicidal

Circumstances under which Death occurred:

On July 16, 2013, Mr. McAdam was found hanging in Cell 147 in the segregation unit of the Edmonton Institution by a prison guard during a routine check at 4:06 pm. This check is an Institutional "stand to count" which requires the inmate to stand so that Correctional officers can confirm their status. Mr. McAdam did not respond to Correctional Officer French. Correctional Officer French then realized that Mr. McAdam was hanging and unresponsive. A ligature in the form of a torn bedding sheet was attached to an overhead knob that was used to open the window. Correctional Officers responded to assist within seconds. Mr. McAdam was lowered to the cell floor and the Automated External Defibrillator ("AED") was applied. An institutional nurse also entered Mr. McAdam's cell and assumed control of medical intervention. Institutional medical staff used the AED, CPR and airway support with the delivery of oxygen through a bagged mask. Emergency Medical Services were dispatched and arrived on scene at 4:14 pm, and began medical interventions at 4:18 pm. This intervention included the establishment of an intravenous line, and administration of medication. Resuscitation attempts were unsuccessful. Mr. McAdam did not recover consciousness, or a pulse or spontaneous breathing. The AED reported no shockable rhythm. Mr. McAdam was pronounced dead in his cell by Emergency Medical staff at 4:56 pm.

Mr. McAdam's cell had last been checked at 2:58 pm. A review of video in the Institution confirmed that no one entered Mr. McAdam's cell between 2:58 pm and 4:06 pm. No suicide note was located in Mr. McAdam's cell; however, located within Mr. McAdam's cell was an Application for Transfer dated July 16, 2013 requesting a transfer to Saskatchewan Penitentiary "because I can't integrate in general population because of the STG ["Security Threat Group"] I was hanging out with on G Unit. I also just lost my Mother just recently and I could not attend the funeral because I was not in the same province as my family where her funeral was. I also don't have any family in Alberta, my family lives in Saskatchewan where they can support me. I also have a Grandfather that works at Saskatchewan penitentiary that can help me stay strong for my loss. His name is [undecipherable]. So if I can get a transfer back to Saskatchewan Penitentiary I would appreciate it very much." It was confirmed that Mr. McAdam's mother died on July 10, 2013.

Toxicological results indicate that Mr. McAdam had an elevated concentration of amphetamine in his blood. There was, however, no evidence of amphetamine overdose, thus the presence of the elevated concentration of amphetamine was not of significance in evaluating the cause of death.

The Deceased

1. Personal Antecedents

Mr. McAdam was a 22 year old Aboriginal male. He was born in Prince Albert, Saskatchewan to Evelyn Sanderson (of James Smith First Nation) and Wilfred McAdam (of Big River First Nation). He was one of six siblings, and he and his parents were part of the Big River First Nation community. Mr. McAdam was raised on the Big River First Nation until he was approximately 8 years old, when he was apprehended by Children's Services as a result of substance abuse, neglect and violence in his home. He was placed initially in foster care, but he persistently ran away. He was then placed in the Prince Albert Residential School for approximately 3 years. While there, Mr. McAdam reported that he was physically abused because of his aboriginal heritage. He reported that he was physically and sexually abused by other children at the residential school. He also reported that he was forced to take medication at the residential school. Mr. McAdam received a Common Experience Payment as a result of his experience in this residential school. At the age of 12, Mr. McAdam was placed in Ranch Ehrlo, a group home in Saskatchewan. While there, he was diagnosed with Conduct Disorder, and he was reported to exhibit aggressive and combative behavior. Mr. McAdam remained at Ranch Ehrlo until he was

16 years of age, having run away many times in those years. Mr. McAdam returned to his family, but reported that he felt "lost" among his biological family, having been separated from them more than half of his life. After some time "couch-surfing", Mr. McAdam moved to Prince Albert to live with a maternal aunt. He was incarcerated for the first time shortly thereafter. After his first incarceration, Mr. McAdam was in the community for short stints between periods of incarceration. Mr. McAdam had a family history of substance abuse, and he abused substances himself. He reported that he began using marijuana at the age of 9, and inhaled propane to get high. He began using alcohol heavily at the age of 16. In the community, he achieved Grade 10. Mr. McAdam had limited employment, and relied upon Social Services for financial support. When not in custody, Mr. McAdam had considerable residential instability. At some time, he had been diagnosed with Attention Deficit Hyperactivity Disorder, for which he had been prescribed medication. Mr. McAdam's grandmother opined that Mr. McAdam might have suffered from FASD. At his August 2012 sentencing hearing, it was represented that Mr. McAdam was the father of a 2 year old child. As part of a Mental Health Initiative pilot project, Mr. McAdam participated in a series of assessments at the Saskatchewan Penitentiary on October 15, 2012. These assessments suggested elevations of clinical levels of anxiety and psychosis. Mr. McAdam reported that he had engaged in self-injurious conduct by slashing his forearm with a plastic knife while in provincial custody in approximately October 2011. Mr. McAdam denied suicidal ideation, and denied that this was a previous suicide attempt. Mr. McAdam requested ongoing counselling, reporting that depression was interfering with his sleep. At the time of his assessment in October 2012, Mr. McAdam expressed an intention to return to Big River First Nation, where he had support from his grandmother. He said that he intended to learn dancing and drumming and other indigenous cultural and ceremonial traditions.

2. Criminal History

At the time of his death, Mr. McAdam was serving his first federal term of incarceration. Mr. McAdam had a history of convictions as a youth, commencing in July 2009. His convictions revolved primarily around property offences, and included various breach related convictions. Mr. McAdam was identified by authorities as a member of the West Side street gang in August 2010. Mr. McAdam advised correctional authorities that he had dropped out of this gang in November 2010. Mr. McAdam was first remanded in a provincial correctional centre in January 2010. Mr. McAdam's longest previous sentence was imposed on May 10, 2011 when he received a 15 month gaol sentence followed by 12 months probation for break and enter charges and probation/release order breaches. He was released from custody on March 20, 2012. On August 9, 2012, Mr. McAdam was sentenced for a robbery that took place on July 6, 2012 in Prince Albert, Saskatchewan. This was Mr. McAdam's first adult conviction, and involved the serious robbery of an 11 year old child. Mr. McAdam's co-Accused was his uncle. Mr. McAdam was sentenced to 2 years less 1 day, to be followed by 2 years probation. On October 10, 2012, Mr. McAdam was sentenced to 4 months consecutive to his robbery sentence after pleading guilty to assaulting a Correctional Officer in the Prince Albert Correctional Centre. This assault occurred on September 27, 2012, and involved Mr. McAdam slamming a cell door on the officer's hand when the officer was providing Mr. McAdam with medication. This sentence placed Mr. McAdam into the federal correctional system. It appears that at this sentencing hearing, Mr. McAdam asked the Court for a sentence that would provide an aggregate federal term, in order that he might have access to better rehabilitative programs.

3. Custodial Adjustment

While he was in provincial custody, Mr. McAdam incurred several institutional charges for various negative behaviors. Some of this behavior included fights as a result of incompatibility with gang affiliated inmates. Mr. McAdam's motivation for programming was reported to be low. His behavior in custody was generally non-compliant and disruptive. Mr. McAdam was classified as a maximum security inmate on October 12, 2012 by Janice Gerstner, apparently because of his

conduct while incarcerated and the seriousness of the robbery offence that had generated the sentence. Mr. McAdam was then transferred to the Saskatchewan Penitentiary Maximum Security Unit. A Casework Record Log was filed in the Inquiry as Exhibit 3, and it details Mr. McAdam's incarceration at the Saskatchewan Penitentiary. On October 11, 2012, Mr. McAdam was assessed upon admission by Officer Tillmanns. Once he was classified as a maximum security inmate, Mr. McAdam was segregated for approximately 1 week pending his transfer to the Saskatchewan Penitentiary Maximum Security Unit. On October 30, 2012, Mr. McAdam's placement into the Saskatchewan Penitentiary Max Unit was approved by the warden, Jason Hope. On November 26, 2012, Mr. McAdam was involuntarily placed in administrative segregation. This arose as a result of an alleged threat that he made to a Correctional Officer. He was released from segregation by the Segregation Review Board on November 29, 2012. In December 2012, Mr. McAdam participated with a Case Management Team at the Saskatchewan Penitentiary to devise a programming plan. This plan included a referral to a program called "In Search of Your Warrior", intended to assist with his impulse control and aggression, an Aboriginal Basic Healing Program where he was to work on life goals with elders in a culturally relevant context, institutional work placement and basic education. On February 24, 2013, Mr. McAdam was voluntarily placed in segregation after he identified threats posed to him by other inmates. A review of his segregation status was conducted on March 26, 2013, and Mr. McAdam remained in segregation. On April 11, 2013, Mr. McAdam requested a transfer application to apply for transfer to another federal institution. He was still in segregation at the time of that request. On April 14, 2013, Mr. McAdam requested a transfer to "Edmonton Max". On April 18, 2013, the transfer was to be processed to "relieve seg. Status" per Officer Tanya Kohle. On April 23, 2013, placement in a unit was deemed appropriate, but no housing was available in that unit. Accordingly, Mr. McAdam remained in segregation. In a segregation review report dated April 25, 2013, the transfer was reported to be an involuntary transfer, and an involuntary transfer recommendation was provided to Mr. McAdam on May 2, 2013. A report dated May 2, 2013 described this transfer as voluntary, so this aspect of the transfer is somewhat unclear. Apparently, an involuntary transfer was approved as an alternative in the event that Mr. McAdam changed his mind about the transfer to Edmonton Institution. It is clear that Mr. McAdam was in segregation from February 24, 2013 until his transfer to Edmonton Institution on May 17, 2013, a period of approximately 83 days. Upon his transfer to Edmonton Institution, Mr. McAdam had participated in none of the programming that was recommended in December 2012 by the Case Management Team.

Upon arriving at Edmonton Institution, Mr. McAdam was assigned a parole officer named Kevin Kindrachuk. Mr. Kindrachuk was a very experienced parole officer, who had between 25 and 30 offenders on his caseload including Mr. McAdam. Upon his arrival at the Edmonton Institution, Mr. Kindrachuk testified that Mr. McAdam would go through an immediate intake process that is completed by a correctional officer or manager, as well as an attending nurse. This process would involve several questions posed to the offender in order to determine their placement. The process was described as less in-depth for transferred inmates than for new inmates, as some of the work would have been completed on initial intake. The policy for Admission Interviews is contained at Exhibit 1, TAB 21. Mr. Kindrachuk testified that placement in segregation is initially completed by a correctional manager. This placement must be approved by the warden within the same day as placement. Mr. Kindrachuk met with Mr. McAdam on one occasion only. That meeting was on May 30, 2013. Following placement in segregation, there is a 5 day review, followed by reviews every 30 days. Informal reviews could occur at any point, however it is unclear what factors would motivate an informal review. Mr. Kindrachuk identified concerns with segregation as non-access to programming, less freedom, less access to recreation, and increased isolation. Mr. McAdam's affiliation with a security threat group was said to compromise his ability to integrate into open population and Mr. McAdam was again placed in segregation on June 27, 2013. The affiliation appeared to involve a group called the "Posse Killer Mobsters". Mr. McAdam was housed with a member of that STG while in an Intake cell at the Edmonton Institution. Pursuant to his request, Mr. McAdam was housed in a unit with other members of the

STG on May 21, 2013. Mr. McAdam's request is dated May 20, 2013. His request is to stay in G-Block with his brother-in-law. The unit that Mr. McAdam occupied was "re-profiled" by correctional authorities and Mr. McAdam and other members of the unit were placed in segregation on June 27, 2013. Mr. McAdam remained in segregation until July 11, 2013, when he was placed in an open unit. At that point, Mr. McAdam had been in segregation for an additional 14 days. Later this same day, Mr. McAdam told Acting Correctional Manager Burke that his mother had passed away and he wanted to go to segregation for quiet time. Mr. McAdam's mother had, in fact, died the previous day. Mr. Burke advised Mr. McAdam that he could not be placed in segregation for that reason. Mr. McAdam then indicated that he had been threatened by another inmate. Mr. Burke approved his placement in segregation. Mr. Burke did not conduct further inquiries about the death of Mr. McAdam's mother. An Immediate Needs Identification and Referral document, screening for suicide before placement into segregation, indicates referral to a health care professional if an inmate answers "yes" to the receipt of recent bad news. There is no mention on this document of the death of Mr. McAdam's mother. As of the date of his suicide, Mr. McAdam had been in segregation for approximately 113 days, nearly 1/2 of the sentence that he had been serving since August 9, 2012.

4. Administrative Segregation

James Gonzo testified in the Fatality Inquiry. He is a senior project officer with Corrections Canada, and is responsible to ensure that correctional institutions in the Prairie Region are adhering to legal requirements and policy when placing an inmate in administrative segregation. In this capacity he conducts reviews of segregation of inmates at 45 and 60 days, and every 30 days thereafter. Mr. Gonzo testified that an inmate is eligible for segregation for any of the 3 reasons outlined in section 31(3) of the *Corrections and Conditional Release Act*. Mr. Gonzo testified that he does not generally meet with inmates, but reviews placement reports filed in the Offender Management System. Mr. Gonzo's responsibility includes working with institutions to alleviate an offender's segregation, either to ask about placing an inmate on a range or transferring the inmate if replacement in the institution is not feasible. Mr. Gonzo did not conduct a review of Mr. McAdam's segregation. He testified that there are now improved measures in place to track an inmate's segregation. When Mr. McAdam was serving, the system of reporting accumulated segregation time to Mr. Gonzo was essentially by email. Mr. Gonzo testified that it was difficult, structurally and operationally, to offer mainstream inmate programming to offenders in administrative segregation. He testified that the inmate is able to participate in segregation interventions – but it is unclear whether these interventions are offered at the discretion of institutional administration. There is no evidence that Mr. McAdam was offered segregation intervention. Mr. Gonzo testified that inmates in segregation are offered "cell study", but there is no evidence that this was offered to Mr. McAdam, although Mr. Gonzo testified that "we do encourage it". It is unclear, given the visitors that Mr. McAdam had, who would be offering these programs to Mr. McAdam. Although Mr. Gonzo testified that "we want elders going to the range, the segregation units, on a daily basis…" these visits did not happen during Mr. McAdam's segregation. Given Mr. Gonzo's testimony about the expectations that are to be met by an institution housing an inmate in segregation, many of the theoretical best practices are not achieved in practice – or, at least, were not achieved in Mr. McAdam's case. When these obligations are not met, there does not appear to be meaningful redress for institutional failings or even meaningful challenges to institutional decision making.

5. Institutional Resources and Training

The Court heard evidence from Vanessa Hutchinson, who is the chief of the institutional mental health team at the Edmonton Institution. She was largely removed from much of the day to day involvement with inmates, and occupied a management role within the institution – a role that she occupied at the time of Mr. McAdam's suicide.

She testified that all correctional staff were provided with an annual online course in the area of suicide assessment and training. Every other year, correctional staff are provided with a 2 hour in-class course. Ms. Hutchinson testified that the mental health department receives training over and above that provided to correctional staff, which is largely provided upon staff request to attend at conferences that might be available.

Ms. Hutchinson testified that she had no contact with Mr. McAdam while he was an inmate at Edmonton Institution. Ms. Hutchinson testified that inmates receive mental health services from an interdisciplinary team of psychologists, mental health nurses and social workers. Since Mr. McAdam's suicide, an occupational therapist has been added to that team. At the time of Mr. McAdam's suicide, correctional policy dictated that an inmate in segregation receive a "psychological for segregation" interview and report at their 25th day of segregation and every 60 days thereafter. Additional services were provided if requested by the inmate. Physical health nurses were required to attend to each segregated offender on a daily basis, in order to monitor the inmate's physical health. Physical health nurses are not mental health nurses. Ms. Hutchinson testified that "not all physical health nurses feel competent in the assessment of suicide risk".

Visits to segregated inmates are logged on a monthly segregation log. The segregation logs for Mr. McAdam are contained as part of Exhibit 1. June 2013 is located at pgs 321-3, July 2013 is contained at pgs 324-6, the re-entry log in July 2013 is contained at pgs 327-329. Visits are recorded in the log by initials. The logs show that Mr. McAdam was visited by the warden on June 27, July 5 and 12. It appears that he was visited by "health care" daily. He did not receive a visit from any other person, including a parole officer, a chaplain, an elder, an aboriginal liaison officer, or a psychologist. Although the logs provide sections for comments, none are made aside from the comment "no health concerns" made by a nurse on July 12. Mr. McAdam is routinely graded as "fair" with regard to his daily behavior. The logs show a dramatic decrease in Mr. McAdam's participation in daily exercise.

In addition to the segregation logs, Ms. Hutchinson testified that each inmate has a "health care file" where heath care information was recorded, but not shared with other staff in the institution out of concerns for preserving the confidentiality of the information. The information is shared on a "need to know" basis, and it is not clear that the information is audited or reviewed by anyone unless the person noting a health care concern made a referral. By way of example of "need to know", Ms. Hutchinson cited the existence of an infectious disease as something that would be shared. An identified concern about suicidal ideation would result in a referral to the mental health department. It is unclear who would make this referral. It does not appear that anyone made a referral in Mr. McAdam's case, since such a referral would place an inmate into a camera cell with an officer posted outside. This did not happen with Mr. McAdam. Since Mr. McAdam was visited by a physical health nurse and the warden, the referral would presumably depend on either these persons or a Correctional Officer to identify a suicide risk. It is unclear whether any of these individuals would be properly qualified or motivated to identify a suicide risk. When Ms. Hutchinson described the sort of conduct that might identify a pre-indicator for suicide risk, she focused on identifying "deviations from what is typical for that individual". It is difficult to contemplate how the warden, the physical health nurse, or Correctional Officers would have been familiar enough with Mr. McAdam to somehow identify a deviation from typical behavior. Not one person had sufficient contact with Mr. McAdam to have been capable of identifying the sort of deviations that the mental health team is relying on to inform a referral. It is fair to say that if the inmate does not directly articulate suicidal thoughts, there is no one that is properly placed to attempt to discern a heightened suicide risk.

Ms. Hutchinson testified that since 2013, mental health has been more involved in the placement of offenders in segregation. They are notified when an inmate is placed in segregation and conduct a file review which they then provide to correctional managers and the inmate's parole

officer. The file review is based on a review of the inmate's "file". A representative from the mental health department attends to segregation review hearings on the 5th working day review, and on the 25th day review, and every 60 days thereafter. The mental health department does not meet with the inmate unless some concern has been identified. Similarly, the mental health team will not meet with the inmate before the 25th day review unless there is a referral, or the inmate requests a meeting. A mental status examination of the inmate is completed, but it was not entirely clear who completes the examination, or whether a meeting with the inmate is part of the examination. In 2013, a mental health unit was instituted in the Edmonton Institution, which receives additional mental health resources – but inmates in segregation would not have access to this unit. A mental health representative would meet with the inmate at the review hearings only if an inmate were to choose to attend the segregation review hearings.

Ms. Hutchinson testified that mental health services would meet with an inmate and have a clinical interview if there was a reason to believe that the inmate had an elevated suicide risk or was experiencing suicidal ideation. Ms. Hutchinson identified static factors that informed an assessment of suicide risk, including a history of suicide attempts or self-harm, a history of psychiatric diagnosis or mental health treatment, a negative family history, gender and cultural background. All of these static factors identified Mr. McAdam as at increased risk for suicide. Dynamic factors that increased risk were identified by Ms. Hutchinson as current stressors, such as a recent loss. Ms. Hutchinson declined to identify placement in segregation as a "current stressor". This conclusion is somewhat at odds with the current correctional policy which requires that mental health services be notified upon placement of an inmate in segregation. If this is not a stressor, it begs the question of what the object of such a notification might be. Mr. McAdam had experienced a recent loss (the death of his mother), he had recently transferred from another Institution, and he had been moved from a jurisdiction where he had outside familial support. Mr. McAdam had none of the protective factors identified by Ms. Hutchinson; he had no support group, he was not visited by an elder, he had no community support in Edmonton. All of these static and dynamic factors were within the knowledge of staff at the Edmonton Institution. No one identified Mr. McAdam as being at risk of suicide. Not one staff member made a referral, and not one member of the mental health team met with Mr. McAdam. Ms. Hutchinson noted in her evidence that these factors exist with the vast majority of the prison population, and conflated that reality with the conclusion that the indicators were not significant in Mr. McAdam's case. The fact is that clear suicide indicators resulted in no attempt at remedial action. The fact that other inmates receive a similar lack of care does not ameliorate the circumstance with regard to Mr. McAdam's death.

6. Institutional Culture

Correctional Officer (Acting Correctional Manager) Darrel Burke met with Mr. McAdam for the first time on July 11, 2013. His purpose for meeting with Mr. McAdam was to evaluate Mr. McAdam's request to be placed in administrative segregation. Mr. Burke testified that Mr. McAdam told him that he wanted to be placed in segregation for quiet time as his mother had passed away. Mr. Burke described Mr. McAdam as quite insistent, while he indicated to Mr. McAdam that he could not be placed in segregation for that reason. After a "continuing conversation" where Mr. Burke "began with other questions to try and determine why he had to go", Mr. McAdam told Mr. Burke that he had been threatened by another inmate and had to leave the unit. This physical threat was described by Mr. Burke in the Segregation review form at pg 351 of Exhibit 1 as an "admission" by Mr. McAdam. As part of the segregation placement, Mr. McAdam was asked by Mr. Burke in the course of routine questions if he had suffered a recent loss. When Mr. McAdam said no, Mr. Burke "understood that to mean that his mother had not died" or "that he had come to deal with it in some manner". There is a correctional policy that governs an inmate request for a funeral absence, but Mr. McAdam did not request that and "didn't mention it [his mother's death] again". The policy involves confirmation of death by the chaplain; however, this policy was not followed because Mr. McAdam did not ask to attend his mother's funeral. With regard to the

immediate needs questionnaire at pg 416 of Exhibit 1, Mr. Burke testified that he asked the questions listed of Mr. McAdam, but not necessarily by directly quoting all of the questions. Mr. Burke testified that he received "on the job" training on the completion of this important form. Mr. Burke had received the online suicide risk training and the 2 ½ hour in-class training (which may have occurred after Mr. McAdam's suicide). When asked by Mr. McAdam's family members at the Fatality Inquiry why he did not take steps to confirm the death of Mr. McAdam's mother, CO Burke said "well, without intending to put too fine a point on it, he didn't demonstrate that much interest in it, Mr. McAdam, I mean. He – when he found out I wouldn't put him in segregation for his mother having died he simply stopped talking about it". Later in his evidence, knowing that Mr. McAdam had in fact learned of his mother's death on July 11, and knowing that Mr. McAdam had committed suicide 5 days later while in the segregation that he placed him in, and knowing that he had taken no steps to ascertain whether Mr. McAdam had in fact suffered a recent loss which might have increased his risk for suicide, and having made no referral for any services to Mr. McAdam, CO Burke made the stunning announcement that "whether it's the loss of a mother or a father or a sibling or a significant other, without putting too fine a point on it, people die every day and people have to deal with it every day." CO Burke advised the Inquiry that, even with the benefit of hindsight, he would not have changed any of the decisions that he made in this case.

The Warden's Situation Report on the suicide of Mr. McAdam is found at pg 537 of Exhibit 1. This document is again demonstrative of the institutional culture in the Edmonton Institution. When identifying the precipitating factors to Mr. McAdam's suicide, the warden notes that "McAdam had initially stated to Correctional Manager that he wanted to go to segregation due to a death in the family, however during the interview McAdam did not provide any details that could confirm the death in the family and then changed his reason for wanting to go to segregation to indicate that he did not feel safe on the unit and had been threatened in the gym". It is quite unclear what details the warden thought ought to have been provided by Mr. McAdam. The Edmonton Institution had immediate access to contact information for Mr. McAdam's next of kin and could immediately have confirmed or refuted this information in the interest of securing the stability of their inmate. It seems unlikely that Mr. McAdam would be in a position to provide the "details" that the warden was seeking, whatever these were. The warden goes further in the report at pg 539 and notes that none of Mr. McAdam's "community members" contacted the Edmonton Institution to report his mother's death. It is unclear why other community members were thought to be responsible to advise the Edmonton Institution of a death that they had already been made aware of. This report also ignores the fact that Correctional Manager Burke advised Mr. McAdam that he was not entitled to enter segregation because of a death in his family. The warden's report notes that Mr. McAdam did not respond that he suffered a recent loss in his Immediate Needs Assessment, found at pg 416. Why would Mr. McAdam report his mother's death again when he was ignored when he did so the first time? The warden's report is a study in blaming Mr. McAdam for the failure of the Institution to respond to indications of elevated suicidal risk factors. In other words, Mr. McAdam was responsible because he: (1) did not ask for help; (2) did not disclose suicidal ideations; and (3) did not make himself heard. This report is illustrative of an institutional culture that echoes the evidence of Correctional Manager Burke. The inmate did not ask for help, therefore it was his fault that he did not receive help.

Recommendations for the prevention of similar deaths:

1. CREATION OF AN INMATE ADVOCACY AGENCY

Like many institutional bureaucracies, most of the resources that are available to inmates at Edmonton Institution are available "upon inmate request". Often, these resources are dependent on the completion of the appropriate form. There are numerous processes that are in place to ensure consistency and uniformity. Inmates become anonymous and, in Mr. McAdam's case, they retreat to segregation. The process appears to be intensely overwhelming. At the Inquiry,

there was evidence about such processes to request for compassionate escorted temporary absence, for access to elder or spiritual guidance and access to mental health services. Found in Mr. McAdam's cell after his death was a form requesting a transfer to attend his mother's funeral – which was pointed out to be the "wrong form". Inmates are expected to learn the processes by asking staff members or other inmates. They are expected, for the most part, to advocate for themselves – apparently after a careful self-inventory of their needs. It appears that there is almost no recognition that, relative to the general population, inmates are often less educated, younger, and compromised by a history of trauma, violence and substance abuse. Inmates often have little to no job skills, and have a poor history of demonstrated life skills. In that context, waiting for an inmate to request mental health care seems intensely naïve and perhaps deluded. There does not appear to be anyone or any agency whose task it is to advocate for an inmate, to ensure their needs are met, to evaluate their time in segregation, their access to programming, and generally to ensure that an inmate is not alone in a morass of bureaucracy and officials. I recommend that this deficiency be corrected.

Every prison institution, including Edmonton Institution, should have an embedded agency whose exclusive task is to advocate on behalf of its inmates. This body should be modelled as an ombudsman type agency. It should be comprised of legal professionals, medical professionals, members of the public, and a meaningful proportion of indigenous people, and, ideally, inmate representatives. This body must be independent of institutional leadership in order to operate effectively and in order to avoid adopting the institutional culture that was observed during the evidence in this Fatality Inquiry**.** In the case of Mr. McAdam, this institutional culture exhibited itself as a callous disregard of the loss that he had experienced, as an adherence to forms, as a model of warehousing without evidence of recognition that it is human beings that are being housed. This advocacy body would relieve correctional officers from the task of identifying inmates at risk when they are ill-placed and ill-trained to discharge this responsibility. Correctional officers are, and should be, primarily tasked to maintain order and institutional security. The advocates contemplated by this agency would be tasked with advocating on a personal level for individual inmates. It will be the task of these advocates to gain the trust of inmates, to advocate for inmates, to ensure that inmates are aware of available resources and how to ask for them, and to ask for these services on their behalf if they consider them advisable. It is important to recall that most inmates will be released. Mr. McAdam was eligible for release in early 2014. Preparing an inmate for release should be a priority goal for this agency.

2. DECONSTRUCTION OF ADMINISTRATIVE SEGREGATION

Correctional resistance to the reality of administrative segregation and its indisputable impact on the physical and psychological well-being of inmates was evident throughout this Inquiry. There is an obvious complacency within institutional personnel about administrative segregation. There is a perception about administrative segregation that is not founded in reality. For instance, Mr. Kindrachuk testified that inmates in segregation have access to native elders and chaplains. There is no evidence that Mr. McAdam visited with native elders or chaplains while in segregation. Mr. Kindrachuk opined that staff often ensures that segregation inmates shower daily. Mr. McAdam did not shower daily. Mr. Kindrachuk made reference to daily exercise entitlements, but no one became concerned when Mr. McAdam declined his recreational time. Ms. Hutchinson opined that segregation might be a relief for some inmates, given that prison is a "scary place" and some inmates might find segregation to be something of a refuge. Ms. Hutchinson adhered to this view, even though it was utterly contradicted by the report of Dr. Knoll – filed as Exhibit 4 in this Inquiry – which evidences a direct connection between segregation and elevated suicide risk. Ms. Hutchinson adhered to this view, even though she was unfamiliar with the scientific research that refuted her position. Her position may have been anecdotal – at best – but it is unclear which inmates formed the basis for her anecdotally informed perceptions that some inmates prefer segregation. It is beyond the purview of this Inquiry report to engage in the

sort of comprehensive assessment of the reality of administrative segregation as was undertaken in *British Columbia Civil Liberties Association* v *Canada (Attorney General)*, 2018 BCSC 62. Suffice to say that there was no recognition by institutional staff that testified at this Inquiry that administrative segregation itself causes harm. Administrative segregation is spoken of as a placement amongst a host of placement options. Placing an inmate in segregation is not, however, a placement. The description of administrative segregation as a brief emergency placement is imperative in every relevant policy and training session undertaken by correctional staff. The process of withholding intervention until psychological distress is identified is intensely unsatisfactory. Distress should be presumed. The task of institutional staff is to minimize harm on those occasions when an emergency placement in administrative segregation is mandated by an extraordinary event. Commissioner's Directive 209, which existed at the time of Mr. McAdam's placement, was extremely vague and left considerable discretion for defining key terms in the hands of institutional personnel. Mr. McAdam's placement in administrative segregation was based primarily on vague, unsupported, and unproven associations with Security Threat Groups. If the institution is incapable of managing threats of violence that might be visited upon inmates, the placement of the threatened inmate in segregation is not a satisfactory solution to institutional defects. Placement of inmates in segregation must be identified as extraordinary, a decision informed and motivated by pressing and urgent concerns. It is not sufficient to simply opine that an inmate cannot be integrated. From the perspective of institutional culture, an inmate in administrative segregation should represent a pressing problem in need of immediate correction – not as the norm.

In October 2015, Correctional Services Canada issued an amended Commissioner's Directive for Administrative Segregation. This directive was amended again in August 2017. These directives do not contemplate external inmate advocacy. They are dependent for their effectiveness upon a corporate culture that does not appear to exist within the Edmonton Institution. This is a culture of passivity, a culture that normalizes the exceptional, a culture of adversarial containment rather than a culture focused on rehabilitation and preparation for release. This culture hearkens again for the need of an independent inmate agency. One of the significant tasks of the professional members of an Inmate Advocacy Agency should be to conduct daily visits of inmates in segregation and to attend all segregation review board hearings. Members of the agency should be tasked with advocating for the inmate's wellness, either for relief of the inmate's segregation or improvement of segregation conditions, or for access to resourcing for inmates while segregated. It is presumed, for instance, that inmates in administrative segregation do not receive the benefit of programming. The reason for that is unclear. Perhaps inmates in administrative segregation are in the greatest need of programming, through cultural initiatives, or educational opportunities, or other programming options. It is unacceptable to simply assume that all is well because an inmate in not asking for anything.

A sea change to the perception of the impact of administrative segregation is recommended. Such a sea change contemplates independently verifiable and articulable reasons for a placement in administrative segregation. Such a placement should result in the immediate assignment of state-funded legal counsel to the inmate, to ensure that the placement is lawful, and to ensure that the inmate is represented at review hearings. When an inmate is placed in administrative segregation, it is recommended that mental health services be engaged immediately and personally. An inmate in distress may not disclose their distress on the first visit or the second visit. A willingness to provide services and an evident motivation to engage and provide relief would go a long way to fostering an environment where an inmate in need of services could access those services.

3. TRAINING OF CORRECTIONAL STAFF

Mr. Kindrachuk testified that he received yearly training on suicide and self-harm risks – normally completed on-line. Mr. Burke, a correctional officer with more than 21 years of experience,

testified that he received online training in suicide prevention and awareness. He testified that this training was approximately 2 ½ hours long. He testified that he had also attended in-class training, but could not recall if that was before or after Mr. McAdam's suicide.

On-line annual training on the issue of suicide prevention does not appear adequate. Of course, correctional staff are not experts in psychology and this training will not make them experts. The training that they receive should include mock-scenarios, because the training is hands-on and practical rather than theoretical. This training should take place in person, rather than on-line. It should involve correctional staff from other institutions to encourage the development of networks and best practices. More than anything else, the training should be memorable. It should be goal-focused on the obvious imperative of identifying risk and acting immediately. It did not appear that the training efforts that had been undertaken by Mr. Kindrachuk or CO Burke were impactful or meaningful. I recommend that correctional staff participate in annual, in-person training sessions that are specifically directed at inmate suicide and self-harm risk prevention. These sessions should be led by external professionals, so that the training does not simply reinforce existing corporate assumptions, but challenges pre-existing assumptions and corporate complacency.

Given the evidence that there is no specific training to correctional staff that work in segregation units, it is recommended that these staff receive regular additional and specific training about the psychological effects of segregation and isolation and the recognition of mental distress that is occasioned by segregation. These correctional officers should have specific classifications that recognize the need for increased and ongoing training in this field. It is clear that many of the professionals in the Edmonton Institution rely on these staff to make referrals or identify concerns with segregated inmates. They should be trained in a fashion that is commensurate with the expectations that are placed on them.

DATED March 15, 2018 ,2018

at the City of Edmonton , Alberta.

Original signed by

MC Doyle
A Judge of the Provincial Court of Alberta