ALBERTA

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

Fatality Inquiries Act

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

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

on the 30-31 day of October, 2017 (year), and

on the 1 day of November, 2017 (year),

before S. L. Oishi, a Provincial Court Judge,

into the death of Travis Lee Halmrast (Name in Full) 28 (Age)

of Warner, Alberta (Residence) and the following findings were made:

Date and Time of Death: November 25, 2013 at 1330 hours

Place: Lethbridge, Alberta

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)).

Asphyxia by 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:

September 11, 2013 Mr. Halmrast was arrested and charged with criminal offences relating to violence and use of a weapon against his girlfriend. As the police moved to arrest him, Mr. Halmrast ingested several tablets of Ibuprofen. He was taken to the Milk River Hospital Emergency and while there, tried to wrap a cord around his neck. He was certified under the Mental Health Act and transported to the Chinook Regional Hospital in Lethbridge for further psychiatric evaluation.

Mr. Halmrast was released from hospital on September 12 and transported to the Lethbridge Correctional Centre (LCC) where he remained in custody in relation to his outstanding charges. At the time of admission he was examined by a nurse to whom he denied being suicidal but due to his recent acts of self-harm the nurse referred him to the LCC psychologist for assessment.

Mr. Halmrast saw the LCC psychologist that same day. The psychologist noted that Mr. Halmrast was somewhat vague and dismissive with regard to whether he had any intent to kill himself. The psychologist consulted with a psychiatrist before designating Mr. Halmrast as “suicidal active”. As a result of this, Mr. Halmrast was moved to a cell where he could be monitored by camera and where regular observation checks could be done.

September 13, Mr. Halmrast was again interviewed by a psychiatrist who determined that Mr. Halmrast would remain “suicidal active” but he indicated that the designation could be modified by the LCC psychologist. September 16, the psychologist assessed Mr. Halmrast and cleared him from camera observation, allowing him to be placed in a regular cell.

Upon subsequent psychiatric review of Mr. Halmrast’s file, it was determined that there was no need for follow-up unless Mr. Halmrast requested it.

September 24, Mr. Halmrast was ordered transferred to the Calgary Remand Centre (CRC) to await assessment at the Southern Alberta Forensic Psychiatric Centre (SAFPC). While at CRC and at his request, he was seen by psychologists multiple times. He denied suicidal ideation but wanted to discuss stressors he was experiencing. October 4 he was transferred to SAFPC where he remained under psychiatric care until November 14. He was thereafter transferred back to CRC where nurses examined him and noted no major concerns.

November 19, he was then transferred back to LCC and examined upon arrival by a nurse. She received no information from either Mr. Halmrast or the transfer summary from CRC that there were any concerns or immediate mental health issues that needed to be addressed. Mr. Halmrast was placed in a regular remand unit for prisoners in custody awaiting disposition of charges.

November 19 or 20, Mr. Halmrast submitted a written request to see the LCC psychologist about the results of his assessment at SAFPC. Ordinarily, such requests were addressed within 24 hours but the psychologist states that this request never came to his attention. Requests such as this might be placed in any one of multiple locations to be noticed or retrieved by the psychologist. It was unknown where this particular request had been placed, when, or by which correctional staff member.

Of relevance however, on November 20 a nurse saw Mr. Halmrast in response to a separate written healthcare request he had made. He discussed with her only the refill of a prescription for eczema cream and the need for an extra mattress. He was “polite and pleasant” and voiced no other concerns.

November 22, Mr. Halmrast made a court appearance via video from the LCC. He had

communication with his lawyer prior to this bail hearing and he was represented during the hearing. The court denied his release. Mr. Halmrast was escorted back to his living unit.

The correctional officers who were present with Mr. Halmrast in and around the time of his bail hearing stated that his demeanor was nothing more than might be expected from someone who had just been ordered detained in custody. He seemed a little agitated, but he said nothing and demonstrated no unusual or concerning behavior. Immediately upon his return to his assigned living unit, Mr. Halmrast was seen to be making a telephone call within the common area.

Mr. Heselhurst was the roommate of Mr. Halmrast and the two shared a friendly relationship. At approximately 1:30 pm when Mr. Halmrast returned from his court appearance he told Mr. Heselhurst that his bail had been denied. He uttered a single angry obscenity and Mr. Heselhurst concluded that Mr. Halmrast simply needed some time to himself so he left the area.

A correctional officer conducted a unit check at 1:42 pm that included Mr. Halmrast's cell. Mr. Halmrast was noted to be in a common area at this time. Mr. Halmrast entered and exited his cell several times after this, the last entry being at 2:12 pm.

Mr. Heselhurst returned to the cell at 2:30 pm and met resistance as he tried to push the door open. With further effort he was able to enter and he saw Mr. Halmrast, a bed sheet wrapped around his neck, hanging from the C-shaped handle on the interior side of the cell door. He immediately called for help and correctional officers and nurses were on scene without delay attempting to resuscitate Mr. Halmrast who remained unresponsive from beginning to end.

They continued their efforts until the timely arrival of Emergency Services at which time a pulse was detected just prior to transport of Mr. Halmrast to the hospital. In the days that followed, he remained neurologically unresponsive and on November 25 he was taken off life support and declared deceased.

Suicide notes written to family members were found in Mr. Halmrast's cell.

Recommendations for the prevention of similar deaths:

1. There should not be structures within a correctional facility cell that would support the weight of a human body such that hanging might occur. This would include "C" shaped handles on the interior side of cell doors. This is particularly the case where the cell is used to house inmates who are suicidal; who have any other serious mental health issues; or those in remand awaiting case outcomes including bail hearings. The latter group may tend to be more emotionally unsettled about their legal status than those who are serving a sentence.

2. Written requests by inmates to speak to health care workers, particularly the psychologist, should be deposited in a single location at the correctional facility where it is certain to be received and addressed in a prompt manner.

DATED December 20, 2017,

at Lethbridge, Alberta.

Original signed by

The Honourable S. L. Oishi
A Judge of the Provincial Court of Alberta