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, Edmonton Alberta

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

on the 13 - 15 day of October, 2021 (year), (and by adjournment

on the 7 – 8 day of March, 2022 (year)),

before R.E. Tibbitt, a Provincial Court Judge,

into the death of Tyshawn Carl Murray Noering (Name in Full) 24 (Age)

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

Date and Time of Death: April 10, 2019, at 2:34 am

Place: Edmonton Remand Centre, Edmonton, 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)).

Intentional self-harm by hanging, strangulation and suffocation.

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:

Tyshawn Carl Murray Noering was an inmate at the Edmonton Remand Centre (ERC) from March 1, 2019, until his death on April 10, 2019. Mr. Noering died by suicide in his cell by asphyxiating himself with a bedsheet made into a ligature. He was 24-years old.

Upon admission to ERC, Mr. Noering was housed on the Mental Health Unit. As a result of violent behaviours, ERC staff determined that he had to be segregated from others. He was moved to the Maximum Security Pod, Unit D (Max D), which houses inmates who are held in segregation because they are a risk to themselves or others and who also have significant, acute, unmanaged mental health issues.

Routine inmate oversight in living areas at the ERC is conducted by Correctional Peace Officers. This includes making regular observations, delivering meals, transferring inmates for exercise, and responding to requests or incidents. While Correctional Peace Officers serve many functions, in this report "Correctional Peace Officer" (or CPO) refers to these front-line workers at the ERC.

On April 6, 2019, Correctional Peace Officers found Mr. Noering in his cell, suffocating himself with a ligature made from a bedsheet attached to the upper bunk mattress. Mr. Noering asked the Correctional Peace Officers not to cut him down. He told Correctional Peace Officers Seth Crowe, R Anstruther, Israel Barrow, and Cody McIvor that he wanted to die and would keep trying. After this incident, Mr Noering was placed on "suicide active" status and transferred to the Mental Health Unit, where he was subject to enhanced safety protocols. "Suicide active" protocols include removing inmate access to items that could be used to self-harm (including bedsheets) and observing inmates every 15 minutes.

On April 8, 2019, Dr. Curtis Woods, a psychiatrist, cleared Mr. Noering of "suicide active" status. Mr. Noering was moved back to Max D. On April 9, 2019, CPO Anderson and another CPO found a bedsheet that had been ripped and knotted to form a ligature in Mr. Noering's cell. Mr. Noering told the Correctional Peace Officers that this sheet had been left in his cell after his suicide attempt three days earlier. This was not possible or believable, since Mr. Noering was in a different cell, and mandatory cell inspections are conducted daily. CPO Anderson phoned the on-site Mental Health Team to tell them about the bedsheet, but no one answered, and he did not leave a message or page them. CPO Anderson made a note about the modified bedsheet in Mr. Noering's Inmate Case Notes portion of ERC's computer system. However, this was not accessible to Alberta Health Services (AHS), and no one drew the entry to the attention of other Correctional Peace Officers, so they were not aware of it.

A psychologist, Matthew Petrie, attended Max D on regular rounds later that morning. He spoke briefly with Mr. Noering. Although CPO Anderson (one of the Correctional Peace Officers who found the modified bedsheet) accompanied the psychologist, he did not tell the psychologist about the bedsheet.

On April 10, 2019, CPO Smart was the sole Correctional Peace Officer on night shift on Max D. He conducted a round and observed Mr. Noering in his cell at 1:05 am. Mr. Noering covered his cell camera with wetted paper at 1:06 am, but CPO Smart was not aware of this. CPO Smart next checked Mr. Noering's cell at 2:13 am. Mr. Noering had asphyxiated himself with a bedsheet looped around the upper bunk. He did not survive.

Recommendations for the prevention of similar deaths:

Recommendation 1: All Correctional Peace Officers who work on Maximum Security Unit D at the Edmonton Remand Centre should have mandatory, in-depth training on suicide risks in correctional facilities.

The Correctional Services Division provides Correctional Peace Officers with training about mental health and suicide, but it is limited. In particular,

- The five-day ERC new staff orientation includes a half-hour segment about suicide,
- One day of the nine-week Correctional Peace Officer recruit training is devoted to mental health, and suicide is mentioned, and
- The Correctional Peace Officer Recertification training, which must be done every three years, has two pages about suicide.

Occasionally, Correctional Peace Officers may be offered voluntary weekend training. ERC management located materials from one weekend training session on mental Illness. The sole slide about suicide noted that suicide is more common for people in correctional facilities than the general public. The weekend training sessions are not offered to all Correctional Peace Officers, are not mandatory, and are not tracked by ERC.

Max D is unit where all inmates are remanded, segregated, and have significant, acute, unmanaged mental health issues. It is well-established in the literature, and through Alberta Corrections' own analysis, that these three factors place these inmates at a heightened risk of suicide. Correctional Peace Officers who work on Max D receive no additional training about suicide risk, notwithstanding the high-risk population with whom they work.

By way of background, AHS delivers medical services to ERC inmates. While medical staff are employed by AHS, they are physically located within ERC. There is a Mental Health Team, which includes psychologists and specialized nurses.

Policies and procedures require Correctional Peace Officers to report observations to AHS in certain circumstances. In particular, they state:

- For segregated inmates, <u>unusual behaviours</u> are to be recorded in ORCA and flagged for follow up with an AHS staff member at the nearest opportunity, (Administrative Segregation Policy and Procedures)
- <u>Urgent concerns</u> by agency or centre staff about an inmate's mental health shall be conveyed verbally to AHS staff, and followed up with a memo or referral letter. (Mental Health Care in Correctional Facilities Policies and Procedures), and
- Agency and centre staff with <u>non-urgent concerns</u> about an inmate's mental health shall convey these to the AHS staff either verbally or in writing. (Mental Health Care in Correctional Facilities Policies and Procedures).

In order to effectively operationalize these policies and procedures, Correctional Peace Officers require training to identify what is "significant," "unusual" or "of concern" as it relates to suicide risk.

Correctional Peace Officers must follow Post Orders, which describe their duties. The Post Orders direct Correctional Peace Officers to communicate and record observations. Specifically, they say,

- Document unusual incidents or behaviour in the Daily ORCA Log and forward a written report,
- Keep close observation and report any unusual activity or abnormal behaviour to the Pod Supervisor as well as recording same on the Shift Occurrence Log, and
- Communicate all pertinent information to relevant staff during shift change.

Again, Correctional Peace Officers require training to identify "unusual incidents", "abnormal behaviour" or what is "pertinent" to suicide risk.

Correctional Peace Officers' present inability to effectively operationalize the policies, procedures and Post Orders as they relate to suicide risk is demonstrated by the fact that multiple Correctional Peace Officers failed to identify and communicate relevant information. This is not a situation where a single CPO made an error by failing to communicate information that he understood to be unusual, abnormal, pertinent, significant or of concern in the context of suicide risk.

On April 6, 2019, after Mr. Noering tried to take his life, at least four Correctional Peace Officers heard Mr. Noering say that he wanted to die and that he would keep trying. None of them communicated this to AHS. None of them passed this on to other Correctional Peace Officers. Similarly, two different Correctional Peace Officers located a bedsheet fashioned into a ligature in Mr. Noering's cell on April 9, 2019. They did not tell AHS, nor did they tell future shifts. Training would provide Correctional Peace Officers with the knowledge that behaviours of this nature are significant to suicide risk and should be communicated to others.

Training would also assist Correctional Peace Officers in understanding the complex and fluid nature of suicide risk, and the need to provide AHS with all information. For example, Correctional Peace Officers would learn that a negative response to a question about suicidal ideation does not conclusively establish that a person is not a suicide risk. Indeed, shortly before Mr. Noering took serious suicidal actions April 6, 2019, he denied suicidal ideation. On April 9, 2019, a CPO heard Mr. Noering say that he was not thinking about suicide. As a result, he personally concluded there was no risk and decided not to pass on information to the psychologist. This information would have changed the psychologist's approach to Mr. Noering.

Training would provide Correctional Peace Officers with knowledge of risks specific to correctional facilities. A 5-year review of suicides in Alberta correctional facilities showed that 100% were by inmates on remand status with a previous suicide attempt. This review also showed that suicides tended to occur in segregation and at low staff times (that is, night shift). However, no one conveyed Mr. Noering's recent attempt to the single CPO on night duty on April 10, 2019 .

In similar circumstances in the future, if Correctional Peace Officers identified and communicated all relevant information about suicide risk to AHS, AHS may place an inmate on "suicide active" status, direct more frequent inmate observations, or advise Correctional Peace Officers to remove bedsheets from a cell. Likewise, Correctional Peace Officers would be aware of the need for enhanced observations in certain situations. This could prevent future deaths.

Recommendation 2: A directive should be created that requires Correctional Peace Officers to communicate factors relevant to suicide risk to future shifts in writing through the Shift Occurrence Log in the Offender Records and Correctional Administration (ORCA) system.

ORCA is the computer system used by Alberta correctional facilities. It is a complex system with many functions. The relevant portions for this discussion are the Shift Occurrence Log (also called the Shift Log Report) and the Case Notes kept for each inmate.

Case Notes include details about a particular inmate. When making Case Note entries, Correctional Peace Officers know that other Correctional Peace Officers will not read them unless their attention is specifically drawn to them. The Post Orders do not require Correctional Peace Officers to review Case Notes. Indeed, it would impractical since there could be 72 inmates on a unit.

Mr. Noering's Case Notes in the days prior to his death included:

- he attempted to hang himself on April 6, 2019,
- he was cleared from "suicide active" status on April 8, 2019, and
- a bedsheet fashioned into a ligature was found in his cell on April 9, 2019.

However, as expected, other Correctional Peace Officers did not read this information because it was not flagged for them.

In contrast to Case Notes, Correctional Peace Officers coming on shift must review the Shift Occurrence Logs of prior shifts. As noted above, Correctional Peace Officers are required, through their Post Orders, to document any unusual incidents or abnormal behaviour in the Shift Occurrence Log. However, in practice at the ERC, concerns about inmates, including concerns relating to suicide risk, are not communicated through Shift Occurrence Logs.

A review of all of the Shift Occurrence Logs for all inmates on the units where Mr. Noering was housed from March 3, 2019 to April 8, 2019 shows that these logs list the rounds, meals, medication distributions, inspections, exercise periods, inmate transfers and similar events on the unit. An entry was made if an inmate refused medication or exercise. Other information can be conveyed through a "Log Note" or "Shift Summary."

In this period of more than 100 shifts, less than ten Shift Summaries were entered. In each case, the Shift Summary simply conveyed that there was nothing to report. There is only one Log Note about Mr. Noering. It identified Mr. Noering was in a conflict with Correctional Peace Officers on April 5, 2019. Again, this was not an error or oversight related only to Mr. Noering. There were no notations about any unusual incidents or abnormal behaviour about any other inmate. It is unfathomable that inmates on MAX D would have had zero relevant incidents or behaviours, because these inmates are placed on this unit because they are a danger to themselves or others, and they have serious unmanaged mental health issues.

Rather than use the written Shift Occurrence Logs to communicate in writing, ERC relies on information being communicated to Correctional Peace Officers verbally. Each shift commences with a Muster of 50 to 150 Correctional Peace Officers. Information conveyed in the Muster is not recorded. In any event, Muster communications would not include a suicide incident that occurred days before a shift, nor the finding of a ligature.

The Associate Director of the ERC said the expectation is that Correctional Peace Officers and supervisors would identify what is noteworthy and tell others. He explained that the Correctional Peace Officers who work on Max D typically work all their shifts there, so they may have familiarity with concerns about some inmates. Furthermore, of the three Correctional Peace Officers on duty during the morning and afternoon shifts, some will have worked recent shifts and be aware of events on the unit. However, no intentional scheduling practice is used to ensure there is always at least one Correctional Peace Officer on shift who typically works on Max D, nor to ensure that some Correctional Peace Officers on a shift have worked recent shifts.

Mr. Noering died during the night shift, when there was only one Correctional Peace Officer on Max D. This Correctional Peace Officer did not usually work on Max D. The only information he was told by the previous shift was that the afternoon had been quiet, and he should not have any problems that night. Thus, the informal conversations and staffing pattern were insufficient to ensure the night shift Correctional Peace Officer had important relevant information.

If Correctional Peace Officers communicated factors relevant to suicide risk in the Shift Occurrence Log, it would be viewed by subsequent shifts, who would then be aware of the need for enhanced observations. This could prevent future deaths by suicide.

Recommendation 3: The monitor view of cameras located within inmate cells should display an electronic stamp of the cell number and inmate's name.

Each of the 36 cells on Max D has a video camera. Correctional Peace Officers can view up to 12 cells at one time. They manually select the cells they would like to view on a touchscreen. Senior Management at ERC incorrectly believed that the video feed contained the cell number. In fact, the video feed does not identify the cell number or the inmate's name. For convenience, Correctional Peace Officers use a Sharpie marker and write the cell number and inmate name on the monitor.

On April 10, 2019, the Correctional Peace Officer on night shift noted that one of the monitors had "33 Noering" written on it with a Sharpie. He believed that he was watching Mr. Noering. While he was viewing cell 33, Mr. Noering had not been housed in that cell since April 6, 2019. The Sharpie notation had not been erased or updated with the new inmate's name, and Mr. Noering's actual cell was not displayed on a monitor at all. ERC's Associate Director told this Inquiry that Correctional Peace Officers would probably take the time to ensure the camera labels are correct. This did not happen for nine shifts.

An electronic stamp of the cell number and inmate name would ensure Correctional Peace Officers are watching the intended inmate. In the interim, a mandated procedure could be implemented to update the handwritten cell number and inmate names every shift. Had the Correctional Peace Officer been watching Mr. Noering's actual cell, he would have seen the covered camera and investigated further. Ensuring this does not happen in the future could prevent similar deaths.

DATED October 7, 2022,

at Edmonton, Alberta.

"R.E. Tibbitt"
Original Signed

A Judge of the Provincial Court of Alberta