CANADA
Province of Alberta

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Law Courts

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

on the 3rd day of June, 2011 (year), (and by adjournment

on the 12th day of October, 2011 (year)),

before J.T. Henderson, a Provincial Court Judge,

into the death of Matthew Wesley Veness (Name in Full) 25 (Age)

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

Date and Time of Death: November 19, 2008 at approximately 8:25 a.m.

Place: Royal Alexandra Hospital, Edmonton

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)).

Sequelae of incised wound of neck.

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)).

Suicidal

Circumstances under which Death occurred:

1. Introduction:

In the early morning hours of November 17, 2008, Matthew Veness, while alone in his cell at the Edmonton Institution, used a tool constructed of razor blades to inflict a 17 cm incision to the left side of his neck causing significant damage to the left carotid artery and the jugular vein. He was found unconscious and bleeding heavily, by staff conducting regular inspections of the cell block. Despite the efforts of correctional officers at the Edmonton Institution, as well as emergency medical responders and medical staff at the Royal Alexandra Hospital, Mr. Veness died in hospital on November 19, 2008 as a result of sequelae from the self inflicted injury.

This is my report to the Minister of Justice and Attorney General arising from a public fatality inquiry regarding the death of Mr. Veness, conducted pursuant to Part IV of the Fatality Inquiries Act R.S.A. c F-8 (the "Act"). In conducting this inquiry I am required to hear evidence and review relevant records for the purpose of making findings with respect to those issues identified in s. 53(1) of the Act which are: the identity of the deceased, the date, time and place of the death, the circumstances under which the death occurred, the cause of death and the manner of death. I am prohibited by s. 53(2) of the Act from assigning legal responsibility for the death or from coming to any conclusion of law. However, if I consider it appropriate to do so, I am authorized by s. 52(2) of the Act to make recommendations as to how similar deaths in the future may be avoided.

The inquiry received evidence and heard testimony over two days, led by inquiry counsel, Jennifer Stengel. The Edmonton Institution was granted status as an interested party in these proceedings and was represented by counsel, Kanchana Fernando. The father of the deceased, Kim Veness, did not attend at the inquiry but did indirectly participate by providing inquiry counsel with a list of his concerns and issues which he thought should be addressed in the inquiry. This was done so via an email dated April 27, 2011. Ms. Stengel has provided me with a copy of these concerns and issues and I will attempt to deal with each of them in this report.

The process of the inquiry was greatly aided by the comprehensive collection of records which were accumulated, organized and produced by inquiry counsel. Those records, amongst other things, included health care and psychology records, correctional service records relating to placement, incident reports and a detailed report dated February 11, 2009 from a Board of Inquiry Investigation. The records are a collection of relevant and material facts which provide much insight into the circumstances leading to the death. These records were collectively marked as an exhibit in the proceedings.

2. Background of Mr. Veness:

Mr. Veness was born in Regina, Saskatchewan and was the eldest of four children. When he was 2 years old, his family moved to Guatemala where his parents worked as missionaries for three years. On return to Canada, the family lived in Kamloops BC, Melfort Saskatchewan, and finally Okotoks Alberta where he graduated from high school.

While in high school Mr. Veness became involved in his first significant relationship with a young woman his own age. That relationship terminated when he discovered that the young woman had been unfaithful. Mr. Veness reported that he had a significant "emotional meltdown" as a result of the termination of this relationship.

Mr. Veness initially planned to attend Military College after high school. Instead, he enrolled in

the University of Lethbridge, majoring in Sociology where he completed two years of study.

During his time in Lethbridge, Mr. Veness became involved in a romantic relationship with a man. He reported that this relationship also broke down, following which he experienced a bout of extreme depression. He lost interest and motivation in his studies and failed to write exams. As a result he discontinued his studies and moved to Calgary to live with his mother who had just separated from his father. During his time in Calgary, Mr. Veness worked in a retail store and later as a creative director for a computer game development company.

While Mr. Veness lived in Calgary, he became involved in a romantic relationship with Scott Barr. This relationship became strained when Mr. Veness became aware that his partner was continuing to engage in relationships with other persons. Mr. Veness reported that the termination of this relationship resulted in feelings of depression and anger which he had been struggling with since his teenage years. Mr. Veness later reported to a psychologist that some of these issues originated from his conflict over how to deal with his sexual identity, and his belief that his family, and in particular his father, did not accept his homosexuality. It should be noted that after his incarceration Mr. Veness reported that he was receiving very strong family support and acceptance of his sexual orientation.

On April 3, 2005 police responded to a 911 call from the residence of Mr. Barr. Mr. Veness was present at the residence when police arrived and confessed that he had confronted Mr. Barr regarding his infidelity but got little more than an indifferent response. An argument ensued which escalated to a physical altercation during which Mr. Veness grabbed a knife and stabbed Mr. Barr. This resulted in the death of Mr. Barr.

Mr. Veness was convicted of 1st degree murder and on April 27, 2007 was sentenced to life in prison with no eligibility for parole for 25 years. At the time of his death he was in the process of appealing this decision.

3. Awareness and Response to History of Suicide Attempts:

Mr. Veness had spent 25 months at the Calgary Remand Centre awaiting trial. While in the Calgary Remand Centre Mr. Veness was reported to have made multiple attempts to take his own life. The last suicide attempt took place in November 2006.

After being sentenced on April 27, 2007, Mr. Veness was transferred to the Edmonton Institution, which is a maximum security facility. He arrived at this institution on May 4, 2007 and was initially housed in the Health Care Unit. An assessment of the overall health of Mr. Veness was conducted when he arrived at the institution. As part of the intake process Mr. Veness was seen by a Registered Nurse, M. Fitzpatrick who prepared a “Mens Health Status” report dated May 4, 2007. During this assessment Mr. Veness disclosed a history of depression and 4 suicide attempts during the period from 2002 to November 2006. Mr. Veness also disclosed that 2 of the suicide attempts were by “overdose” and 2 attempts were by “artery slash”. During this initial assessment Mr. Veness denied any suicidal ideation or plan.

The intake reports were reviewed by an assessment team which consisted of a number of professionals including a psychologist, Dr. Farzad Bawani who gave evidence before the inquiry. Dr. Bawani testified that when the assessment team became aware of the history of depression and suicide attempts, Mr. Veness was “flagged” for more intensive assessment and observation.

Dr. Bawani testified that, in his opinion, there are two periods during an inmate’s stay at a correctional institution when the risk of suicide is elevated. The time immediately after the arrival

of an inmate is particularly critical, as well as the period just prior to release.

Dr. Curtis Woods, a forensic psychiatrist who gave evidence before the inquiry also shared Dr. Bawani's opinion. He explained that the higher risk of suicide is associated with increased stress which is present at the time of entry into a correctional institution and at the time immediately prior to release. Based on these expert opinions, and also based on the disclosure of a prior history of suicide, I conclude that flagging Mr. Veness for more intensive assessment and observation on his arrival at the Edmonton Institution was completely appropriate.

Dr. Bawani further testified as to the availability of psychiatric and psychological services at the Edmonton Institution. He explained that in 2008 there were 4 to 5 psychologists working at the Edmonton Institution on a full time basis and that a psychiatrist was available at the institution for consultation 2 days per week. One clinical social worker, as well as several nurses and parole officers were also regularly working at the institution. Dr. Bawani explained that the resources available at the Edmonton Institution in 2008 resulted in much greater access to psychiatric and psychological services inside the institution than would be available to members of the public generally. Dr. Woods generally agreed with Dr. Bawani's assessment but noted that since that time the psychological and psychiatric care available to inmates at the Edmonton Institution has diminished.

Following the intake assessment, the Registered Nurse, M. Fitzpatrick, arranged for a Registered Psychologist, Dr. Greg D. Coftas, to conduct a psychological assessment of Mr. Veness. The assessment took place on May 7, 2007. During the assessment Mr. Veness was noted to have had a history of suicidal episodes both before his incarceration and also while he was at the Calgary Remand Centre. Mr. Veness reported that he tended to become despondent and suicidal when emotional difficulties arose, or when he failed to take the medication which had been prescribed to control his depression.

Dr. Coftas provided Mr. Veness with the option to be housed on the SLE (Structured Living Environment) unit where there would be a higher level of support and where there would be greater direct contact with a Psychologist or a Psychiatric Nurse. Mr. Veness responded that he was not interested in such a move to the SLE, preferring instead to be housed in the general population on the E-unit. Dr. Cotfas accepted this decision but encouraged Mr. Veness to talk to either a psychologist or a nurse in the event he experienced a depressive bout and/or self-harm ideation, or if the peer pressure or mistreatment became unbearable. Mr. Veness advised Dr. Cotfas that he was aware of the specialized support available and that he would request help if necessary.

Dr. Coftas noted that Mr. Veness' mood was positive and he was interacting in a clear and confident way. Mr. Veness denied that he was experiencing any suicidal or self-harm ideations. He claimed that after his latest suicidal attempt in the Calgary Remand Centre in November 2006, he was again put on antidepressant medication, which resulted in a significant improvement in his mental and emotional state.

Dr. Coftas recommended that Mr. Veness also have an assessment conducted by the attending psychiatrist, that he be flagged as a risk for suicide and monitored for depressive bouts or suicidal behavior such as "being despondent, withdrawn, anxious or agitated". These behaviours were noted to be indicators which might elevate Mr. Veness' risk for self harm from Low or Moderate to High.

Following the initial psychological assessment, Mr. Veness remained in the Health Care Unit at the Edmonton Institution for observation and integration into the general prison population. Mark Pelster is the Mental Health Coordinator in the Health Care Unit at the Edmonton Institution and is, by profession, a Registered Nurse. On May 8, 2007 he referred Mr. Veness to a psychiatrist,

Dr. Rai, for assessment. Dr. Rai saw Mr. Veness the very next day, on May 9, 2007 for assessment. Follow up assessments were conducted by Dr. Rai on May 16, 2007 and on May 23, 2007. Dr. Rai noted the prior history of suicide attempts and recommended that Mr. Veness be under observation and that he be double-bunked. These recommendations were made even though Dr. Rai observed that Mr. Veness was well composed, cognitively intact, calm, well-oriented and showed no pressure of speech or any other indication of anxiety or emotional distress. Dr. Rai noted that Mr. Veness was adjusting well to life in the Edmonton Institution, and was ready to move to the general population. Dr. Rai reported that Mr. Veness was unhappy about being double-bunked in the Health Care Unit (he was similarly double bunked in Calgary) though Dr. Rai believed that a double bunk would be appropriate for his initial move to the general population. The final Psychiatric assessment on the May 23, 2007 noted that:

> "Matthew has been adjusting to surroundings; psychology took him off of observation cell. He has been med compliant and has been communicative throughout stay."

Even after the assessment by Dr. Rai, Mr. Veness continued to be housed in the Health Care Unit for observation.

The records from Edmonton Institution and the testimony of Mark Pelster, the Mental Health Coordinator in the Health Care Unit, make it clear that throughout his 2 month stay in the Health Care Unit, Mr. Veness did not demonstrate any signs of suicidal intention nor had he caused any problems. He was a model inmate who was easy to get along with and expressed interest in pursuing continuing education and employment in the Library. Mr. Pelster testified that all the staff in the Health Care Unit knew of Mr. Veness' difficult past and were instructed to remain vigilant for signs of relapse or odd behaviors which might be suggestive of potential suicide. At that time it was common practice for the Health Care Unit staff to meet daily to discuss any issues or concerns regarding inmates on the Health Care Unit which may have arisen during the day.

Dr. Coftas conducted a more thorough psychological assessment of Mr. Veness on June 29, 2007. Mr. Veness reviewed a copy of the draft report arising from this assessment before it was put into final form. During the June 29, 2007 assessment Dr. Coftas observed that Mr. Veness appeared well kept and clean, was well oriented to time, place and person. He was pleasant and cooperative in the interview, exhibiting appropriate behavior. He had a good level of attention and his mood was euthymic (normal and moderate). His answers were coherent and relevant and he did not display any symptoms of formal thought disorder. With respect to a past history of suicide, Mr. Veness acknowledged that he had been diagnosed with Major Depression. Dr. Coftas reported that:

> "Before having been diagnosed and treated, Mr. Veness went through numerous periods of significant suicidality and has attempted to commit suicide in a variety of ways. He was well aware of his present situation and showed no obvious physical or mental impairment. His mental status is basically normal, and symptoms of a major mental illness or disorder were not present."

In his report arising from the June 29, 2007 assessment, Dr. Coftas recommended that Mr. Veness be considered for transfer to a medium security institution at the earliest opportunity. Additional recommendations included that he be under continuous psychiatric treatment, that he conform to the prescribed treatment and medication and that he should consider participation in anger management, emotional management and individual counseling programs.

After Mr. Veness was moved from the Health Care Unit he continued to be monitored by health care professionals. He was seen twice daily by a nurse to receive the medication which had

been prescribed to control his depression. One of the responsibilities which Mr. Pelster had as the Mental Health Coordinator was to administer prescribed medication. He testified that inmates such as Mr. Veness were monitored with respect to compliance with the medication regime. Inmates were not forced to take medication but if they did not do so then an entry would be made on the file to note this lack of compliance. Mr. Pelster testified that Mr. Veness was very compliant and the records do not disclose any failure to take his prescribed medication.

Mr. Veness was also seen by a psychiatrist, Dr. John Brooks on July 24, 2007 for a review. Nothing out of the ordinary was noted on this review. Dr. Brooks recommended continuation of the same medication regime which had been prescribed by Dr. Rai.

On March 7, 2008 Mr. Veness met with Mr. Pelster and requested a consultation with a psychiatrist. At that time Mr. Veness reported that he was tired and was concerned about his mood. He reported that the medication which he had been taking had not been as effective as it had been in the past and he wanted to discuss options with the psychiatrist. As a result Mr. Pelster made an appointment for Mr. Veness to be seen by the forensic psychiatrist, Dr. Woods, on March 14, 2008. However, on the date of the appointment Mr. Veness declined to see Dr. Woods.

During his testimony Dr. Woods advised that he had no independent memory of his interaction with Mr. Veness on March 14, 2008. However, his standard practice at that time was to personally attend at the cell of any inmate who had booked an appointment and speak to that inmate. Dr. Woods testified that inmates cannot be forced to see a psychiatrist and from time to time inmates refuse to be seen after having made an appointment. Dr. Woods advised that this type of behavior occurred only infrequently and, where it does occur, it can be a cause for concern.

Dr. Woods testified that all medical files relating to inmates who are taking medication are reviewed every 12 weeks for the purpose of assessing the medication regime. These reviews are done in consultation with the psychiatric nurse and are frequently conducted without actually seeing the inmate. This is a departure from the practice which he follows when treating patients who are not incarcerated. In those situations he regularly sees patients in person to review the medication regime. However, in those situations he generally does not have access to a psychiatric nurse who has daily contact with the patients, as is the case with his incarcerated patients.

On August 1, 2008 Mr. Veness was seen by Dr. Woods as part of a routine medication review. Dr. Woods testified that when he conducted the review on August 8, 2008 he was aware of Mr. Veness' history of suicide attempts and was also aware of the anti depressant medication which Mr. Veness had been taking. Dr. Woods was satisfied that the medications and the dosages were appropriate for Mr. Veness at that time. Dr. Woods testified that he specifically addressed his mind to the potential for suicide risk and concluded that Mr. Veness was not suicidal at that time. This was confirmed by the contemporaneous notes made by Dr. Woods at the time of the August 1, 2008 assessment.

The August 1, 2008 meeting with Dr. Woods was the last formal medical appointment which Mr. Veness had prior to his death in November 2008.

Medical personnel also conducted file reviews of inmates who were considered to be at higher risk. According to Mr. Pelster these file reviews took place every 3 to 4 months. Mr. Pelster testified that the medical staff never noticed any change in Mr. Veness' mood during the time that he was at the Edmonton Institution. He reported that Mr. Veness was calm, was functioning well and that he was talkative. Mr. Pelster noted no signs suggestive of depression.

Informal interaction between Mr. Veness and medical personnel also occurred on a regular basis. Members of the medical staff were aware that Mr. Veness was a model prisoner and had caused no problems within the institution. They were aware that Mr. Veness was taking positive steps to improve the quality of his time while incarcerated. He had arranged through his parole officer to be permitted to continue taking university courses by correspondence. He enjoyed working at the prison library. He acted as an advocate for other inmates in the prison system. He had good family support and had earned the privilege of extended private family visits in a stand alone house within the institution. Dr. Bawani explained that these visits are reserved for those inmates who have demonstrated an exemplary level of adjustment and adaption in the institution. The visits are arranged through the parole officer and require the approval of both security personnel at the institution as well as the mental health professionals. Any concerns regarding suicide risk would result in a denial of this privilege.

Dr. Bawani testified that he saw Mr. Veness a few weeks prior to his death and congratulated him on his success in being selected for a Christmas family visit. According to Dr. Bawani, Mr. Veness was very personable and could even be described as being in a happy and jovial mood. He exhibited no signs of depression or suicidal ideation.

Both Dr. Bawani and Dr. Woods described depression as an insidious illness which can give rise to a suicide risk. Dr. Woods explained success can be achieved in treating depression with medication and in many cases it is possible that the depression may go into remission, thus reducing the risk of suicide. However, for patients who suffer from depression and who have a history of suicide attempts, it is not possible to completely eliminate the risk of suicide. For these types of patients, the risk of suicide never fully disappears. What makes the disease even more difficult to treat is that patients who have depression with a history of suicide can repeat their suicidal behavior even when they do not display symptoms or warning signals.

Based on the professional evidence tendered at the inquiry, I conclude that in a correctional facility it is simply not possible to eliminate the risk of suicide. At most it is possible to monitor inmates with a past history of suicide with the goal of controlling their future risk. This can be done by ensuring compliance with the medication regime and by having properly trained medical and psychological personnel available to monitor at risk inmates, providing care and treatment where necessary.

It is theoretically possible to further reduce the risk of suicide by severely restricting the types of activities which these inmates might participate in. However each additional restriction imposed on an inmate is accompanied with a higher level of potential stress which could inadvertently create a higher suicide risk. Thus an appropriate balance must be achieved to create an environment that reduces the overall risk of suicide. This balance can only be achieved by the exercise of professional judgment by psychologists, psychiatrists and other medical staff working with inmates at a correctional facility.

Based on the evidence given and the documents marked as exhibits at the inquiry, I find that members of the medical staff at the Edmonton Institution were alerted to Mr. Veness' history of depression and suicide attempts immediately upon his arrival. He was promptly assessed by mental health professionals including the mental health coordinator, a psychologist and a psychiatrist. During the critical high risk period immediately following his arrival at the institution, Mr. Veness was housed in the Health Care Unit and thus was constantly in close proximity to medical staff. He was regularly seen by health care professionals and after 2 months in the Health Care Unit he was permitted to enter the general population in E-unit.

During the 18 months he was on the E-unit the medical staff continued to monitor Mr. Veness both formally and informally. His success in procuring a private family visit in December 2008 was merely one example of the ways in which he appeared to be adjusting to life at the

institution. I find that the medical staff's observations of Mr. Veness did not reveal any concerns that he was at an immediate risk for suicide in November 2008.

4. Correctional Services Response to Injury:

Donald Mumford is a correctional officer who began his employment at the Edmonton Institution 10 days prior to the death of Mr. Veness. His testimony at the inquiry and the records produced by the Edmonton Institution provide a chronology of the events that took place in the hours immediately before and after Mr. Veness was discovered in his cell.

Mr. Mumford was scheduled to work the evening shift starting at 2:45 p.m. on November 16, 2008. The regular shift was to end at 11:15 pm. Mr. Mumford completed his regular shift and then began an overtime shift that continued until 7:00 a.m. on November 17, 2008. One of his duties was to do range block checks every 60 minutes. His responsibility was to look in every cell to ensure that each of the inmates was present and safe. During these checks he also regularly checked to make sure each inmate was breathing.

While conducting the 4:00 a.m. range walk in E-Unit, Mr. Mumford was specifically drawn to the light that was on in cell 201. This cell was assigned to Mr. Veness. At this time Mr. Veness was observed to be sitting on his bed watching television. Subsequently, an hour later at 5:00 a.m., Mr. Mumford once again observed Mr. Veness to be sitting on his bed watching television with the light on.

At 06:04 a.m. Mr. Mumford conducted a further range walk in the E-Unit. Mr. Mumford observed that the light was still on in cell 201, but Mr. Veness could no longer be readily seen. In his statement prepared shortly after these events Mr. Mumford described his observations in the following way:

> "I looked down on the floor when I did not see him sitting on the bed watching his TV and saw Inmate Veness face down in a pool of his own blood. I observed blood on/in the sink and on the toilet. I also observed what appeared to be a tool made out of razor blades on the sink. I took another look at Veness to see if he was still breathing and his breathing was deep."

Mr. Mumford ran down the range and informed the Sub-Control officer of the circumstances. The Sub-Control officer notified the Correctional Manager and requested the help of additional corrections officers. The policy of Corrections Canada dictates that at least two officers must be present to enter an inmate's cell. The policy also dictates that the Sub-Control Officer is not able to leave his or her post.

At 6:05 a.m. the Sub-Control officer directed that Mr. Mumford return to Mr. Veness' cell. He did so and on arrival began to bang on the cell door while attempting to verbally attract the attention of Mr. Veness.

At 6:10 a.m. 4 additional corrections officers arrived and entered Mr. Veness' cell. They observed Mr. Veness to be lying in a large pool of blood with a gash on the left side of his throat. He was still breathing.

While two of the correctional officers rendered First Aid, the Correctional Manager radioed the Main Communications Control Post to call 911 and request an Ambulance.

At 6:18 a.m. Mr. Veness was placed on a stretcher and brought to the common area where there

would be more room to render first aid.

At 6:40 a.m. Emergency Medical Services arrived at the Edmonton Institution and took over responsibility for administering emergency medical care to Mr. Veness.

At 7:13 a.m. Mr. Veness was transported by ground ambulance to the Royal Alexandra Hospital where he was admitted as a patient. He remained at the hospital under the care of medical staff until he died at approximately 8:25 a.m. on November 19, 2008 due to "sequalae of incised wound of neck".

5. Placement in Maximum Security Institution:

When Mr. Veness was sentenced he was transferred to the Edmonton Institution, which is a maximum security facility. He had no prior criminal record and, except for the incident that gave rise to the conviction, had no history of violence.

Rick Dyhm is the Transfer Coordinator for Correctional Service Canada at the Edmonton Institution. He testified that Commissioner's Directive 705-7, *Security Classification and Penitentiary Placement,* mandates that all individuals serving a life sentence must spend the first two years of their sentence in a maximum security prison. Mr. Dyhm advised that the Directive does allow for "exceptions" but that there are no guidelines to explain when these "exceptions" are available. For any "exceptions" to be invoked, an initial review must be undertaken by the Warden to determine if the "exception" is warranted. The Warden's recommendation is then sent to the Regional Deputy Commissioner who assures quality control and compliance, and finally to the Assistant Commissioner for Correctional Operations and Programs.

Mr. Dyhm described some of the differences between a maximum security institution and a medium security institution. In the maximum security environment the movement of inmates is controlled to a much greater level. Constant checks and searches are undertaken, including pat down searches. Less programming is available to inmates and less volunteer opportunities exist. Further, in a maximum security institution, violence is a much greater problem both in terms of frequency and intensity.

Dr. Bawani explained that in a maximum security institution the rigidness and higher level of security can make it difficult for persons with mental health issues to cope and thus, where appropriate, a medium security institution is often a better option for these types of individuals.

In his detailed psychological assessment conducted in June 2007, Dr. Coftas recommended that Mr. Veness be a candidate for transfer to a medium security institution.

All of the evidence before this inquiry suggested that Mr. Veness would have been a much better candidate for a medium security institution than for a maximum security institution. His personality and demeanor, the absence of a longstanding criminal record, no history of violence except in connection with the offence for which he was incarcerated, his successes in the Edmonton institution including his interest in further education, his work at the library and as a advocate for other inmates and his reputation as a "model inmate" would have, on all accounts, made a medium security prison a much better option for Mr. Veness. The greater opportunity to participate in programs, undergo counseling, continue his education pursuits and spend less time in his cell would have greatly benefited his wellbeing.

On examination Mr. Dyhm described Mr. Veness as being a "perfect candidate" for transfer to the medium security institution at Bowden Alberta.

6. Availability of Razor Blades at Edmonton Institution:

The tool that Mr. Veness used to inflict the injury which resulted in his death was made out of razor blades. No evidence was presented at the inquiry with respect to the origin of the razor blades or who used the razor blades to create the tool.

Lori Smith, Correctional Manager of Operations at the Edmonton Institution, testified that the Edmonton Institution has a written policy with respect to razor blades. The policy is designed to control the presence of razor blades at the institution. The policy permits inmates to possess only disposable razor blades which are issued by the institution. Inmates are permitted to have possession of up to 10 razor blades in their cells at any one time. Any new razor blades are provided to the inmate on a 1 for 1 exchange basis so that correctional officers can control the number of razor blades in an inmate's cell. If a request is made for a new razor blade without presenting an old razor blade for exchange then the inmate's cell will automatically be searched.

The policy also provides that any razor blades which are tampered with will be considered to be "unauthorized". When correctional officers conduct cell checks they are instructed to look for and report any razor blades which are present in the cells. "Unauthorized" razor blades which are found, can depending upon the circumstances, result in the removal of the "Unauthorized" razor blade, or in appropriate cases, disciplinary action can be taken.

In segregation units at the Edmonton Institution the policy is substantially different. On those units a single razor blade is issued to each inmate at 10:00 a.m. each day and it must be returned to a correctional officer during the very next range walk. This much more restrictive policy reflects the higher risk associated with providing razor blades to these inmates.

In some situations where an inmate is considered to be "high risk", razor blades will be not permitted at all.

Corrections Canada has investigated possible alternatives to the use of razor blades. In particular they have considered the use of a hair removal cream but this proved to be unsatisfactory and thus razor blades continue to be in use.

In her 17 years with Corrections Canada, Ms. Smith has not become aware of any other instances where razor blades have been used to commit suicide or to attempt suicide. However there have been instances in which razor blades have been used as weapons against other inmates or staff. She estimated that in the last 16 years at the Edmonton Institution there have been approximately 10 instances in which razor blades have been used by inmates as weapons. Most of those situations occurred in the segregation units.

On the basis of the evidence presented at the inquiry I conclude that Mr. Veness used razor blades issued by the Edmonton Institution to create a tool which he used to inflict the injury which resulted in his death.

7. Specific Concerns Raised by Kim Veness:

In his email to inquiry counsel dated April 27, 2011, Kim Veness asked that I address four specific issues:

a.) Why did Corrections Canada not immediately contact the family?

This is an issue which is of great concern not only to the Veness family but also to other families

whose loved ones are incarcerated and whose health is gravely affected by suicide attempts or otherwise. It is an issue for Corrections Canada to deal with in a compassionate way. It is not something which is properly within the terms of reference of a Fatality Inquiry which can only investigate those issues that are specifically identified in s. 53 of the Act.

However, since Kim Veness raised the issue I will make some brief comments. The evidence is clear that the Veness family was not contacted for more than 6 hours after Mr. Veness was found in his cell in a very serious medical condition. The available evidence confirms that the family was contacted by the Roman Catholic Chaplain at approximately 12:15 p.m. on November 17, 2008.

However, I note that Corrections Canada did take steps to attempt to notify the family much earlier than this. In particular I note that almost 5 hours earlier, at 7:25 a.m., the Protestant Chaplin was asked by Corrections Canada to contact the family. This was very timely; approximately 12 minutes after Mr. Veness departed the Edmonton Institution by ambulance for the Royal Alexandra Hospital. It seems clear that Corrections Canada recognized its responsibility to contact the family in a timely way. It also seems clear that the first attempts were unsuccessful. I have no evidence available to me as to what steps the Protestant Chaplain took to make contact with the family or when those steps were taken. Nor do I have any evidence as to what steps, if any, Corrections Canada took to follow up on the attempts by the Protestant Chaplain to contact the family.

Since this is an issue which is outside the mandate of a Fatality Inquiry, I do not intend to make any recommendations regarding this issue.

b.) Why was a private Psychiatric assessment not permitted in Calgary Remand or at Edmonton Institution?

I did not require that inquiry counsel call any evidence with respect to the psychiatric or psychological care that was available at the Calgary Remand Centre or the care that was actually provided to Mr. Veness while in Calgary. I concluded that this evidence was not relevant and was not necessary to permit a full and proper understanding of the circumstances of the death of Mr. Veness. I came to this conclusion for two reasons. Firstly, 18 months passed between the date that Mr. Veness left the Calgary Remand Centre and the date of his death. I concluded that the passage of this length of time made the issues at the Calgary Remand Centre too remote to be relevant to the death of Mr. Veness. Secondly, and more importantly, on transfer to the Edmonton Institution in May 2007, the medical staff immediately became aware of the past history of depression and suicide and took prompt steps to assess the situation. Thus I conclude that what may or may not have happened at the Calgary Remand Centre is simply not relevant and is well outside the terms of reference of this inquiry.

I have dealt elsewhere in this report with the actual psychiatric and psychological care that was available to Mr. Veness at the Edmonton Institution. I am satisfied that Mr. Veness received prompt and appropriate psychological, psychiatric and medical care while at the Edmonton Institution. There was no evidence before me to suggest that any lack of psychological, psychiatric or medical care contributed to the death of Mr. Veness.

c.) How can an Inquiry which takes place almost 3 years after the death effectively determine the facts in a way to make the Inquiry meaningful?

It is very common for Inquiries of this nature to take place long after the events that give rise to the inquiry. This is no different from typical legal proceedings which can sometimes take years to proceed to the actual trial.

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Inquiry counsel is charged with the responsibility to gather the relevant documents and identify the witnesses who can give appropriate insight into the death. In this case counsel gathered documents which were prepared contemporaneous with the events both before and immediately after the death. The records include those of various professionals including the Medical Examiner who conducted the autopsy, the psychologists and psychiatrists who assessed Mr. Veness while in the Edmonton Institution and the emergency medical responders at the time of the incident. In addition, Inquiry counsel gathered the records from Corrections Canada relating to the time that Mr. Veness spent in the Edmonton Institution. Counsel also provided the results of an internal inquiry undertaken by Corrections Canada which resulted in the preparation of a detailed report less than 3 months after the death of Mr. Veness.

Counsel arranged to call a total of 7 witnesses, all of whom either had direct dealings with Mr. Veness in the months prior to his death, or were able to speak to policies in place at the institution at or before the time of death.

In all of the circumstances I am satisfied that the evidence made available at the inquiry was more than sufficient to permit a full understanding of the circumstances of Mr. Vaness' death. I do not feel constrained in any way because of the delay between the death and the hearing of the evidence.

d.) Will Kim Veness be provided with a list of the recommendations arising from this Inquiry?

This is a report to the Minister of Justice and Attorney General. It will become available to the public after it is reviewed by the Minister. The report itself will contain my recommendations.

I direct that inquiry counsel provide Kim Veness with a copy of the report, including the recommendations, as soon as it is available for release to the public.

Recommendations for the prevention of similar deaths:

All of the evidence heard in this inquiry has been assessed with the specific purpose of determining whether any recommendations can be made which might prevent similar deaths. It should be noted that any recommendation can only address the issues of how future deaths might be prevented, as opposed to how this death, with the benefit of hindsight, might have been prevented.

The primary issue in this inquiry related to the adequacy of the steps taken by the professional staff at the Edmonton Institution to assess and deal with Mr. Veness' history of depression and suicide attempts. The evidence was clear that the medical professionals at the Edmonton Institution were aware of this history immediately upon Mr. Veness' arrival. Steps were then taken to attempt to deal with Mr. Veness' personal circumstances. Tragically, the steps taken were not successful in preventing his death.

Any successful program at a correctional institution that is designed to reduce the risk of suicide is largely dependent upon the professional judgment of teams of medical professionals who have the training, skills and experience necessary to deal with these very complex issues. This is particularly so given the insidious nature of depression and the fact that suicide can, in some circumstances, occur where little or no perceptible signs are displayed.

Any recommendations which I could suggest may, inadvertently impose restrictions upon the

professional judgment of those who are best suited to make the difficult judgment calls which are necessary to reduce the risk that inmates may pose to themselves.

The evidence in the inquiry does not permit any conclusion or inference that the professional judgment of the medical staff, psychologists and psychiatrists was undertaken in anything other than an appropriate way.

For these reasons, and because I am satisfied that there is a program in place at the Edmonton Institution to identify and treat those inmates who suffer from depression and suicide ideations, I conclude that it would be counterproductive to recommend any specific changes to the manner in which medical professionals at the Edmonton Institution deal with these issues.

The recommendations which I make arising from the evidence in this inquiry are as follows:

1.) Policy regarding Razor Blades

I recommend that Corrections Canada undertake a review of its policy relating to razor blades which are permitted to be in the possession of inmates. Specifically I recommend that Corrections Canada:

(a) consider reducing the number of razor blades which an inmate may have possession of at any one time,
(b) consider whether razor blades should be distributed only for the limited time necessary to permit the inmate to shave and, finally,
(c) consider whether the use of razor blades by inmates with a history of suicide or depression should be closely supervised.

2.) Transfers to Minimum Security Institutions

I recommend that Corrections Canada undertake a review of its policy which requires that inmates who are sentenced to terms of life imprisonment serve the first two years of their sentence at a maximum security institution. Specifically, I recommend that

(a) the policy should have a much higher level of flexibility so that inmates who are better suited to an institution with a reduced level of security, particularly those suffering from mental health issues, be moved from the maximum security environment at the earliest opportunity, and,
(b) where psychologists, psychiatrists or other medical professionals recommend transfer from a maximum security institution to a medium security institution the assessment by Corrections Canada staff should be undertaken on a priority basis so that a decision on transfer can be made promptly.

DATED October 28, 2011 ,

At Edmonton , Alberta.

J. T. Henderson
A Judge of the Provincial Court of Alberta