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 Building

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

on the 5th day of September, 2012 (year), (and by adjournment

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

before Darlene Wong, a Provincial Court Judge,

into the death of Raymond Charles Yellowknee (Name in Full) 37 (Age)

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

Date and Time of Death: Sometime before 0400 hours on August 27, 2009

Place: Edmonton Institution - 21611 Meridian Street, 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 – The 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 – The Fatality Inquiries Act, Section 1(h)).

Suicide

Circumstances under which Death occurred:

Mr. Yellowknee was incarcerated at the Edmonton Institution. On June 12, 2008, he commenced serving a sentence of 16 years to be followed by a 10 year Long Term Supervision Order after being convicted of four counts of impaired driving causing death, four counts of evading police in a vehicle causing death, theft over $5,000 and operating a motor vehicle while disqualified. Mr. Yellowknee was admitted to the Institution on July 4, 2008. His full parole eligibility date was October 11, 2013, and his statutory release date was February 11, 2019. The warrant expiry date was June 11, 2014 with 10 years Long Term Supervision Order to follow.

Mr. Yellowknee had a lengthy criminal history including at least fifty convictions prior to his convictions for which he was incarcerated at the Edmonton Institution. He had spent most of his adult life incarcerated with no significant continuous periods of time living in the community.

Mr. Yellowknee was classified as a maximum security inmate. In May, 2009, Mr. Yellowknee began the In Search of Your Warrior Program and he was regularly attending Aboriginal cultural ceremonies and activities.

On July 22, 2009, Mr. Yellowknee was assaulted by two inmates as another stands watch in the corridor. Later, Mr. Yellowknee refuses medical assistance. Several hours later, Mr. Yellowknee agrees to medical attention. An ambulance is called and he is transported to an outside hospital where he is diagnosed with a fractured jaw. He receives corrective surgery and he returns to the Edmonton Institution on July 27, 2009.

On August 4, 2009, a note surfaced threatening his safety. Mr. Yellowknee is placed in Dissociation and Segregation for his safety. On August 21, 2009, Mr. Yellowknee is seen by a psychologist after a referral from correctional officers heard him making comments that he might self-harm. Mr. Yellowknee denies making such statements and is assessed as not being in imminent danger.

On August 27, 2009, an officer on range patrol at about 03:58 hours observes Mr. Yellowknee hanging from a belt around his neck attached to the ceiling.

Mr. Yellowknee is cut down at about 04:01 hours by the correctional manager. According to the Board of Investigation Report :

> Page 11 - 04:02 hrs. The CM leaves the cell area to retrieve an Automated External Defibrillator (AED). Not recalling that an AED had recently been installed in the nearby unit office, the CM goes to retrieve one from the Correctional Managers' Office, some distance away.

At 04:17 hours the paramedics arrive and assess Mr. Yellowknee as deceased and direct cessation of CPR.

Mr. Yellowknee looped his belt around an exposed conduit. Mr. Donald MacDonald, a Correctional Officer who has been employed at the Edmonton Institution for 13 years, described a conduit which was exposed and permitted the belt to be looped around. Mr. Macdonald said there had been multiple attempts to try to stop inmates from altering what has been done by the engineering crew.

The Report was completed on November 20, 2009. The Board of Investigation made no recommendations.

Recommendations for the prevention of similar deaths:

The Office of the Correctional Investigator undertook quarterly assessments of Correctional Service of Canada Response to findings and recommendations "...of a series of internal and external (Office of the Correctional Investigator - OCI) reports, studies and investigations examining preventable deaths in federal custody." That Report is dated September 8, 2010, and is available on the website: http://www.oci-bec.gc.ca/rpt/oth-aut20100908-eng.aspx. That Report is helpful to me in considering recommendations for the prevention of similar deaths.

That Report identified concerns, including:

> Critical information sharing failures between clinical and front-line staff, improper or inadequate observation, surveillance and evaluation of suicide risk issues related to unprotected suspension points.

The Report notes:

> According to the Activity Report, "corrective measures had been taken to address all the issues identified above."

The Report further notes:

> I do not dispute the activity, efforts and commitment of CSC toward the 'preservation of life' principle. However, measurable progress, including a performance indicator framework to record improvement or deficits over time against well-defined criteria, is not yet where it should be. The latest numbers do not show a reduction in the rate of offender deaths by other than natural causes.

The Report commented on a Suicide by Hanging of a 54 year old Inmate where it was noted that "limited modifications of infrastructure to make it more difficult for inmate to commit suicide by hanging" and "...several projects undertaken to transform some cells in order to render them suicide-proof in the institution since 2006."

The Report further noted:

> In January of 2010, a Security Bulletin had been published by CSC, indicating:
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> It is critical that all potential points of suspension, both removable (i.e. furniture, shelving) and non-removable (i.e.) electrical outlets, air vents), and other cell vulnerabilities (i.e.) protective covers that have been tampered with or removed) are systematically and consistently identified, inspected, repaired, replaced, repositioned or removed.
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> In 2009, a business plan to remove suspension points from almost a hundred cells had been prepared by the institution where the inmate hanged himself. However, National Headquarters decided not to take action immediately on this business plan.

As I understand the Report, there remained concerns of removal of anchor/suspension points in cells and sustained application of lessons learned in some institutions.

The following recommendations were made by the authors of the Report:

- ....the Service develop a comprehensive public accountability and performance framework to ensure sustained progress in addressing factors related to preventing deaths in custody;

- ...that the Service provide 24 hour per day/7 days per week health care coverage at all maximum, medium and multi-level institutions;

- ...that basic information and instruction for managing offenders at risk or self-injury or suicide be shared with front-line staff so as to ensure effective monitoring, crisis response strategies and prevention protocols are easily and readily accessible;

- ...that the quality of security patrols be enhanced by introducing audit and accountability measures to ensure rounds and counts are conducted in a manner consistent with preservation of life principles;

- ...that the practice of placing mentally ill offenders at risk of suicide or serious self-injury in prolonged segregation be prohibited; and

- ...National Boards of Investigation involving suicide and serious self-injury should be chaired by an external health care professional and their reports be made public.

The evidence at this Inquiry confirms that staff at the Edmonton Institution is aware of the concerns and recommendations in the September 8, 2010 Report. The evidence at this Inquiry confirms that remedial steps have been undertaken at the Edmonton Institution to address some of the concerns and recommendations. Therefore, I recommend only that the administration at the Edmonton Institution continues efforts to implement and monitor the implementation of the recommendations made in the September 8, 2010 Report.

DATED December 5, 2012,

at Edmonton, Alberta.

Original signed by

Darlene Wong
A Judge of the Provincial Court of Alberta