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 29, 30 and 31st days of January, 2014 (year), (and by adjournment

on the 21st day of May, 2014 (year)),

before The Honourable James K. Wheatley, a Provincial Court Judge,

into the death of Edward Christopher Snowshoe (Name in Full) 24 (Age)

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

Date and Time of Death: August 13, 2010 at 21:15 hrs

Place: Edmonton Institution

Medical Cause of Death:
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 Inquires Act, Section 1(d)).

Hanging

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Suicide

Circumstances under which Death occurred:

The Deceased

Edward Snowshoe, born on the 11th of November 1985 is of aboriginal descent with his family remaining in Fort McPherson, Northwest Territories. His father was killed in an accident at an early age and Mr. Snowshoe was raised, together with three brothers, by his mother. On May 8, 2007 he received a sentence of five years, five months and twelve days in his first federal sentence and had a statutory release date of December 26, 2010, and a warrant expiry date of October 19, 2012. His sentence was served at various federal facilities but for the purposes of this report, most notably at Stony Mountain, a medium security institution, and latterly at the Edmonton Institution, a maximum security institution. While in custody at Stony Mountain Institution he attempted suicide on three occasions in November 2007, September 2008 and February 2009. Following a major depressive episode in August 2009 there was a self harm incident in 2010 which resulted in him being placed in observation on a suicide watch. On March 1, 2010 he is involved in an incident where he brandished what appeared to be a jail-made weapon which later was found to be a stabbing weapon made out of a juice box turned inside out and, as a result of this incident, he was placed in segregation on March 2, 2010. A decision is made to transfer him to Edmonton Institution, a maximum security institution as a result of this incident. On July 15th he is transferred from Stony Mountain to Edmonton Institution arriving on July 16th. He is once again placed into segregation and remained in segregation until his death. In total he was in segregation in Stony Mountain for 134 days and Edmonton Institution for 28 days for a total of 162 days consecutive with the exception of the one day out when he was being transported from Stony Mountain to Edmonton Institution.

Offender Management System (OMS)

This is an electronic log which is compiled and contains all matters material to a prisoner within the federal penitentiary system. Virtually everything done in relation to them or done to them is placed into this log including medical, psychological and prison records of every type. The senior administrative personnel who gave evidence at the Inquiry told the Inquiry that virtually everyone within the penitentiary system with the possible exception of outside third parties teaching courses within institutions has access to the OMS. That evidence was contradicted by correctional officers and other penitentiary personnel whose view is that only senior management within their divisions had access to OMS. Correctional officers who were in direct supervision of Mr. Snowshoe gave evidence that they were not in access to OMS and were never advised of his three previous attempted suicides before coming to the Edmonton Institution. The Inquiry heard evidence that three suicides attempts and the self harm incident were all in the OMS and were flagged, and in fact the Inquiry received evidence that the nurse who did the initial interview with Mr. Snowshoe knew of those incidents and had afforded the appropriate document to the psychology department of Edmonton Institution for follow-up. That follow-up was never done adequately.

Segregation

Holding a prisoner in an individual cell by themselves with no access to a general population. The Inquiry heard that this is done basically for two reasons: (1) to protect an individual from self harm or harming others, and (2) to protect them from harm from others in the general population. Mr. Snowshoe went into segregation at Stony Mountain because of the juice box knife incident as he was perceived to be a threat to others or prison personnel.

Segregation Reviews

The present regulations mandate that when a person is placed in segregation they are to be subject to reviews on a fixed timed basis.

On admission to an institution the corrections manager must complete a casework record. That casework record had immediate needs checklists – one for suicide and one for security and the same were not completed in respect of Mr. Snowshoe. The corrections manager made a decision at that time to place him into segregation and on handcuff status. Thereafter, compulsory reviews must take place. These

reviews could be summarized as follows:

1. **Five-day review**: An internal review conducted by a review board of internal officials including the corrections manager, parole officer and other officials required by law. The report is compiled by the parole officer. In Mr. Snowshoe's case it was compiled by a parole officer who was assigned to Mr. Snowshoe but in fact never interviewed him or spoke to him and who immediately after the five-day review left on holidays with no back-up system in place.
2. **Thirty-day review**: A similar internal segregation review board. Thereafter, it would appear that thirty-day review boards would be done with regards to someone in segregation but that any segregation review completed thereafter must be chaired by an assistant warden intervention or a level of no less than an assistant warden as per various directives. Many times after 60 days of segregation a regional segregation oversight manager review must take place for anyone held in segregation more than 60 days.
3. Thereafter every 30 days by Regional Segregation Review Board

The Inquiry heard no evidence of regional segregation review boards being established or segregation review committees on a regular thirty-day basis being chaired by at least assistant wardens. Indeed, it would appear that when Mr. Snowshoe was transferred from Stony Mountain Institution to Edmonton Institution a new segregation system was commenced starting with a new five-day review, five days after his transfer rather than a continuation of the clock so that when his five-day review was committed at Edmonton he in fact had been in segregation for something like 139 days. It should have been before the Regional Segregation Oversight Committee and should have been in segregation hearings chaired by at least an assistant warden from his sixtieth day onward. Those to be held after 60 days in segregation and each 60 days thereafter.

The report for the five-day segregation review at Edmonton Institution was completed by the assigned parole officer who had never met with him. Mr. Snowshoe was given notice of it and did not attend. Although a statement of the juice box knife incident is recorded in that report there is no mention in that report to the first segregation board of any of the three suicide attempts or the self harm attempt and that report notes that there was one prior segregation placement at Stony Mountain with no note as to the fact that that placement was for 134 days. The report also states under *Health Care, Mental Health and Access to Psychological Counselling* that he was not seen by a staff psychologist but would be seen in the future and that "there are no concerns that would preclude his continued placement in administrative segregation at this time".

It is clear that a case of anyone in segregation over thirty days must be reviewed by a Regional Segregation Oversight Manager within 60 days. That Regional Segregation Review Board must be chaired by an assistant deputy commissioner and must be reviewed within 120 days of segregation and every sixty days following that. This was never done.

It must also be noted that his initial segregation was confirmed by an assistant warden on her last day of work before leaving on a one-year absence.

It is also noted that the Inquiry heard evidence that Mr. Snowshoe immediately upon his arrival at Edmonton Institution on July 16, 2010 made a request to be moved to general population. This request, although moved up the line, appears to have gone missing and was not found until November 10, 2010 when it turned up in some miscellaneous documents with no particular significance to the Snowshoe incident.

Mental Health Processes

The Inquiry heard evidence that a nurse had done a health evaluation of Mr. Snowshoe and had sent that document on to the psychology department for follow-up. No follow-up was done although one initial attempt was made to interview Mr. Snowshoe which he had refused. Nothing was done to attempt to set up psychological communication with him even though the psychology department had been advised by the admitting nurse of the prior suicides and self harm incidents.

The correctional manager doing the initial recommendations for segregation made no reports to others including correctional officers under his administration of the prior suicide attempts or self harm incidents although he did make a point in all of his reports to advise of the prior incident with the juice box knife.

The cell Mr. Snowshoe was held in had a single observation through a mail slot. Within that segregation unit there were two full observation cells available and one was fully available during the period that Mr. Snowshoe was there. Only cursory attempts to try to establish a mental health or psychological process with Mr. Snowshoe were made during his 28 days at Edmonton Institution.

Parole Officer

The Inquiry heard evidence that within an institution there is an internal parole officer assigned to every prisoner. It is that person's responsibility to provide the liaison and reporting function in respect of each prisoner. It would appear that each parole officer within an institution has a caseload of about 25 inmates and they should see them each once a month. It does not appear that this is an overburdening responsibility.

The Inquiry heard evidence that the parole officer assigned to Mr. Snowshoe did not in fact meet with him any time during the five days before his five-day review but did attend the five-day review and it would appear that nothing in respect of his mental health history was brought to the attention of the five-day review even though it would appear that everyone sitting on the five-day review board had full access to the OMS which flagged those incidents. The parole officer in question left on vacation at the conclusion of the five-day review and there was not a formal process for someone picking up his caseload. The Inquiry heard evidence that this is done on an informal basis of a sort of a buddy system where another parole officer would be available only if there was an emergency situation. It would appear that the original parole officer's buddy name appears on the segregation log book once during the period of time that Mr. Snowshoe was in custody at the Edmonton Institution but that officer could not state with any certainty as to whether or not he had ever met with Mr. Snowshoe.

The parole officers stated that in their evidence that it was not their policy to have any liaison with a parole officer at a former institution such as Stony Mountain in this case but to rely totally on OMS.

Communication and Confusion

Given the evidence received there would appear to be no formal process for a transfer of records other than through the OMS in a manner that would allow alerts to be given to a new institution in respect of psychological or mental health issues that were evident in this case.

It would appear that despite the OMS having flags of suicide and self harm incidents of Mr. Snowshoe that these flags were not observed or dealt with any degree of care or alertness by numerous people involved with Mr. Snowshoe while at the Edmonton Institution even though the existence of his conditions were flagged at the first incident by the admitting nurse. Ordinary correction officers on the block were not aware of his suicides and felt that they were not entitled to access the OMS which would have certainly alerted them to this situation. Despite the alert as to the suicide condition efforts to set up any kind of psychological communication with him were of a cursory and practically non-existent nature. Just asking someone if they need help doesn't cut it when there is a clear history of psychological need. The lines of communication between Stony Mountain and Edmonton Institution are garbled, contradictory and totally reliant upon a use of the OMS in a competent manner.

Conclusion

Edward Christopher Snowshoe fell through the cracks of a system and no one was aware of how long he had been in segregation even though that information was readily available.

Recommendations for the prevention of similar deaths:

1. When a transfer of a prisoner within institutions takes place, that a formalized system of providing a written transfer report detailing health or mental health issues involving that person be established to ensure that that communication takes place.
2. That immediate clarification to all staff be made of their ability to access the OMS and that all staff sign off on having received that advice and having received appropriate technical training in how to use it.
3. That a system be established whereby staff leaving on holidays who have responsibility for particular prisoners be required to brief and hand off loads to a person to exercise their responsibilities in their absence at both a parole officer, corrections manager and senior administrative level.
4. That clarified guidelines be established in respect of segregation clocks and segregation reviews and put in place with a mechanism perhaps by a third party to ensure that these reviews take place. (It would appear that new policy directives in respect of this are partially in place in respect of preventing a new segregation clock to commence running upon a transfer thus preventing the regional segregation reviews from taking place as required).
5. That procedures within the psychology departments relating to prisons be reviewed carefully to ensure that when a serious mental health issue exists that processes are put in place to ensure that those individuals receive help with efforts to properly set up communication even when the psychological nature of the problem may in fact lead the prisoner not to think that they have a need of that service. These people can't accept an easy "no, I don't need help" when there is a clear flag that help is required.
6. That psychologists and parole officers attending upon prisoners, especially prisoners in segregation keep a proper file complete with detailed notes of their interactions with recommendations to follow-up.
7. That security classification procedures be reviewed in prisons (how does a juice box knife end up with162 days in segregation?).
8. That full observation cells be used where there is a suicide history.
9. That all staff visiting segregation units be required to complete the segregation unit log with a notation as to what person on the segregation unit they in fact visited and that policy be enforced.
10. That a better system set up upon prisoner transfers to allow family access to prisoners during and after a transfer process and that communications with family be formalized and allowed.
11. That the aboriginal status of a prisoner and the cultural issues involved in their aboriginal status be recognized within the prison system and that compulsory system of access by elders be set up especially where there are mental health or other cultural concerns.
12. That a review of all persons placed in segregation be put in place to ensure that, when appropriate, the person in segregation is transferred to a special handling unit commensurate with their mental health or medical needs.

DATED June 4, 2014,

at Edmonton, Alberta.

Original signed by

James K. Wheatley
A Judge of the Provincial Court of Alberta