ALBERTA

Report to the Minister of Justice
Public Fatality Inquiry

Fatality Inquiries Act

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

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

on the 26th day of September, 2022 (year), (until

on the 29th day of September, 2022 (year)),

before Olugbenga Shoyele, a Provincial Court Judge,

into the death of Tyrone Blue BLIND (Name in Full) 31 years (DOB - July 8, 1986) (Age)

of 9516 101 Avenue NW, Edmonton AB T5H 0B3 Canada (Residence) and the following findings were made:

Date and Time of Death: February 1, 2018 (at approximately 3:27 p.m. after his family elected to withdraw care, following which he died upon extubation).

Place: Royal Alexandra Hospital, 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)).

Sequelae of Hanging (January 31, 2018)

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

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Introduction

1. The events regarding the death of Mr. Blind [Mr. Blind or the Deceased] occurred while he was in the Upper "A" Unit at Edmonton Institution [EI] – a maximum security penitentiary – located in Edmonton, Alberta.

2. On December 18, 2017, when Mr. Blind arrived at EI – following his suspension for breach of condition of his Long-Term Supervision Order [LTSO] – he had an Intake Assessment, which involved a telephone consult with the Institutional General Practitioner [GP or Doctor] as well as an assessment by a Nurse from Physical Health Services. The Nurse completed an Immediate Needs Identification and Referral Form for mental health attention.

3. A Mental Health Nurse attended to Mr. Blind on the same day (December 18, 2017). She noted that Mr. Blind indicated he had attempted suicide a month and a half prior while he was at a halfway house but denied any current thoughts or intentions of suicide or self-harm. Both Mr. Blind and the Mental Health Nurse discussed his medications; and his request for a medication change was forwarded to the psychiatrist, Dr. Woods.

4. A few weeks later, on January 21, 2018, at approximately 17:15 hrs., Mr. Blind gave an Inmate Request Form to a Nurse during the medication line indicating he was feeling suicidal due to his gastrointestinal problem. The Nurse submitted an "Urgent" referral to mental health services, which was actioned the next day, January 22, 2018.

5. On January 24, 2018, Dr. Woods had a session with Mr. Blind, where his gastrointestinal problem was discussed, and a note was made that Mr. Blind was "50/50." He adjusted Mr. Blind's medication, increased his Ativan dosage, and prescribed Epival on a trial basis.

6. On January 28, 2018, Mr. Blind was moved into a structured intervention unit based on safety and security concerns. He was released the following day.

7. On January 31, 2018, at approximately 18:25 hrs., a Correctional Officer [CO or CX], who was conducting a security patrol, walked past Mr. Blind's cell and noticed that there was a towel covering his cell window. While returning, the officer tapped on Mr. Blind's cell door twice with a data wand, walked past the cell again without pausing. The Officer informed the Board of Investigation, which convened earlier in relation to this incident – and discussed below – that Mr. Blind responded to the tap and said he was "on the toilet," although there was no independent confirmation of this evidence.

8. At approximately 18:40 hrs., an inmate opened Mr. Blind's food slot, looked into his cell, and observed that he was likely hanging. The observing inmate, along with five other inmates, started scrambling around and subsequently alerted the authority about their discovery regarding Mr. Blind.

9. The cell door was unlocked, and two inmates went inside. Mr. Blind was observed to be hanging by the neck from ligature made out of bedsheets that was tied around the frame of the top bunk bed in the cell. He was freed from the ligature and laid on the floor of his cell. Correctional Officers arrived at the scene and one of the officers initiated the First Aid procedure as well as commenced Cardio Pulmonary Resuscitation [CPR]. The first officer to enter the cell was later joined by other officers in providing CPR to Mr. Blind.

10. The Warden, Deputy Warden, Assistant Warden Operations, and the Security Intelligence Officers were notified of the incident at 18:46 hrs.; the Emergency Medical Services [EMS] arrived on scene at 19:00 hrs.; and the EPS was informed of the incident at 19:07 hrs.

11. At 19:21 hrs., Mr. Blind was placed on a stretcher, put on life-support, and the EMS crew departed the EI, *en route* to the Royal Alexandra Hospital in Edmonton, Alberta, escorted by two armed Correctional Officers and the EMS crew on board the ambulance.

12. On February 1, 2018, at 15:30 hrs., a Correctional Officer, who was posted at the Royal Alexandra Hospital informed the EI that Mr. Blind was pronounced deceased.

Board of Investigation's Report

13. On May 3, 2018, the Board of Investigation [BOI or Board] into the death of Tyrone Blue Blind was constituted by the Interim Commissioner of Correctional Service Canada [CSC]. She appointed three individuals as members of the BOI, pursuant to ss 19 and 20 of the *Corrections and Conditional Release Act*, SC 1992, c 20.

14. During its investigation, the Board interviewed and consulted with approximately 28 individuals who were involved with Mr. Blind's care management while he was in custody at the EI or serving his sentence in the community. Subsequently, the Board provided its Report [BOI Report or Report].

Board of Investigation's Findings

15. The Board made the following findings in its Report:

> *Finding A*: *A coordinated effort, in the form of an inter/intra multi-disciplinary team meeting amongst all of [Mr. Blind's] care providers, including persons with case management and/or custodial duties, was not undertaken*. Hence, the management of the pre-incident indicators, precipitating events, contributing risk factors and the security intelligence information pertinent to [Mr. Blind's] risk for suicide and management thereof was, at best, fractured. While [those] individuals […] operated to the best of their individual abilities/capacities, the fractures (in the comprehensive sharing of information) left care providers […] at a disadvantage in providing optimal care/intervention for [Mr. Blind].
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> *Finding B*: The security classification of [Mr. Blind] as a Maximum Security inmate, was consistent with policy. [His] Aboriginal Social History was documented within his most recent Assessment for Decision report and considered; however, culturally appropriate alternatives and/or restorative options to placement at EI were not documented as having been considered.
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> *Finding C*: [Mr. Blind's] physical and psychiatric care was managed in a timely and appropriate fashion. [He] was not assigned to a Mental Health Service provider for therapeutic/counseling intervention in spite of the mental health distress that was noted, hence, a mental health management plan was not in place at the time of [his] death. [He] was not referred to the CSC's National Dietician for review of potential dietary concerns and/or potential implementation of a diet that could have assisted in ameliorating gastrointestinal issues he was experiencing. At the time of his death, [Mr. Blind] was on the waitlist for an appointment to see a Gastroenterologist (specialist) in Edmonton, Alberta, for assessment/diagnostic purposes.
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> *Finding D*: The staff presence on Alpha "A" Unit where the incident occurred was consistent with deployment standards: no operational adjustments were made. All formal counts were conducted as per policy and *security patrols were consistent with ensuring living breathing bodies, with one exception, that being the security patrol that was completed at approximately 1827:51 hours. This security patrol, which included [Mr. Blind's] cell, was*

> *assessed as cursory in nature and inconsistent with policy standards to ensure a live breathing body*. The Board of Investigation noted an underlying issue with respect to food slots of cells being left unlocked and the cell windows, as well as night lights, being covered for extended periods. Post incident corrective measures were taken at the local level to address the unlocked food slots.
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> *Finding E*: After the A/B Unit sub-control Correctional Officer was informed by inmates on the Range that [Mr. Blind] was in distress (hanging in his cell), the staff response was immediate and proficient.
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> [*Emphasis added*]

Board of Investigation's Recommendations

16. The Board, at the conclusion of its investigations and in light of the findings enumerated above, made the following recommendations:

    (a) *Recommendation 1*: The Board of Investigation recommends that the Assistant Commissioner, Correctional Operations and Programs in consultation with the Assistant Commissioner, Health Services consider, that in cases wherein the risk for an individual to commit suicide and/or engage in self-injurious behaviour is believed to be elevated to a high level of risk and/or imminent risk, that an inter/intra multi-disciplinary meeting, with Institutional/contract staff assigned to manage a specific case and available/on site at the time be mandated to occur immediately.

    (b) *Recommendation 2*: The Board of Investigation recommends that the Chief of Mental Health Services, at EI: 1) review and delineate the processes for referral, triage and therapeutic intervention of high and/or imminent risk suicidal inmates; 2) clarify roles and responsibilities amongst the contingent of mental health professionals in EI with deference to limitations, based on scope of practice; and, 3) consult with the Chief of Health Services in order to ensure continuity of care within the realm of Mental and Physical Health Care at EI.

Provincial Activities and the Inquiry

17. For context, at the provincial level, the examination of Mr. Blind's body was performed at the Office of the Chief Medical Examiner in Edmonton on February 2, 2018, commencing at 11:08 hrs.; and formally, the Certificate of Medical Examiner was issued by Dr. Bernard Bannach on April 9, 2018.
18. Pursuant to s 33 of the *Fatality Inquiries Act*, RSA 2000, c F-9 [*Fatality Inquiries Act* or *FIA*] the Fatality Review Board by its Decision, dated May 18, 2018, recommended – after its review of the relevant medical examiner's case file – that a public fatality inquiry be held in relation to Mr. Blind's death for the purpose of restoring public confidence and preventing similar deaths.
19. On October 18, 2021, a Pre-Inquiry Conference [PIC] was held at the Provincial Court of Alberta in Edmonton, Alberta (*FIA*, s 37.1). Present at the PIC were Ms. Hillary Flaherty, the Inquiry Counsel; Ms. Leona Tesar, Counsel for the Attorney General of Canada; Mr. Tom Engel, Counsel for the Blind Family [including Daniel and Blanche Blind (parents of Tyrone Blue Blind); Sherese Blind and Violet Munteen (sisters of Tyrone Blue Blind)]; as well as Dr. George Pugh (Psychologist, supporting the Blind Family).
20. The PIC continued on March 11, 2022, to crystallize the relevant issue(s) for consideration by this Public Fatality Inquiry [or "the/this Inquiry"].

21. Significantly, on June 29, 2022, the Inquiry ruled that the issue of "standard of care" or calling a "community health standard witness" engaged determination of legal liability or responsibility and constituted a finding or conclusion of law that is prohibited by s 53(3) of the *Fatality Inquiries Act* (Exhibit 4).

22. In the context of the Fatality Review Board's Decision and its recommendations, as referenced earlier, this Inquiry determined that the central issue for exploration relates to "the sharing of information between multidisciplinary care providers, case management, and custodians at the [EI] when an inmate is believed to be at high or imminent risk for suicide or self-injury." (Inquiry Counsel Letter, dated October 13, 2021). A considerable number of other issues suggested for this Inquiry's consideration by Counsel for the Blind Family, both at the PIC and in his written submissions, are efficiently subsumed into this fundamental issue.

23. The Inquiry was conducted between September 26-29, 2022. In attendance at the commencement of, and at various times during, the Inquiry were: Ms. Hillary Flaherty, the Inquiry Counsel; Ms. Jennifer Lee (appearing with Lauren Sapic (Student), Counsel for the Attorney General of Canada; Mr. Tom Engel, Counsel for the Blind Family; Daniel Blind, Blanche Blind, Karen Blind, Varina Munteen, Violet Munteen and Dr. George Pugh.

24. The following witnesses testified before me at the Inquiry: (a) Ms. Shereen Ram; (b) Dr. Curtis Woods; (c) CX Pavel Moskwa; (d) Inmate Caleb Costello; (e) Inmate TK Assoun; (f) Ms. Bernadette Boers; and (g) Ms. Danielle Segall.

25. During the conduct of the Inquiry, the exhibits admitted were marked as follows:

    (a) Exhibit F1 – 3 Binders of Exhibits collectively marked as one exhibit: (a) (i) Binder with 36 Tabs, 537 pages; (ii) Second Binder (Supplemental Exhibits) with 23 Tabs, 514 pages; (b) Supplemental Exhibit Binder, (c) a USB with four videos.
    (b) Exhibit F2 – Observation Report.
    (c) Exhibit F3 – Referral for Health Services.
    (d) Exhibit F4 – "Community Health Standard Witness" Decision Letter of Judge O. Shoyele.
    (e) Exhibit F5 – Email exchange between Thibault Sarah and Segall Danielle (2 pages); and
    (f) Exhibit F6 – CSC Records (staff logbook entries, and Institutional morning meeting minutes made between December 17, 2017 and January 31, 2018, mentioning Tyrone Blue Blind)

26. At the conclusion of *viva voce* evidence at the Inquiry, on September 29, 2022, Counsel were required to provide written submissions with the following timelines: (a) the Blind Family may file written submissions by October 27, 2022; (b) the Attorney General of Canada may file written submissions by November 17, 2022; and (c) the Inquiry Counsel may file written submissions by November 24, 2022.

27. The written submissions were made in compliance with those timelines; and a tentative reconvening date of January 12, 2023 was released by this Inquiry on November 30, 2023 having found Counsel's submissions and comments comprehensive and satisfactory.

Summary of Evidence at the Inquiry

28. At the Inquiry, the relevant evidence adduced through *viva voce* and documentary evidence are summarized below.

Ms. Shereen Ram

29. Ms. Ram indicated that she had approximately 17 years of experience as Parole Officer at the time of the Inquiry. She was assigned to Mr. Blind and trained to ask questions as well as check for specific things where there are concerns about an inmate who is at risk of committing suicide. She had extensive and comprehensive discussions with the Deceased on several occasions before his death. Based on the materials before this Inquiry, Ms. Shereen Ram met with Mr. Blind on December 20, 2017, and discussed wide arranging issues, including his gastrointestinal challenges. She also met with him on January 29, 2018, while in the structured interventions unit; and on January 30, 2018, in order to share with him the Assessment for Decision regarding his LTSO suspension as well as on all other relevant issues (including his prior suicide attempts and his gastrointestinal problems). At the point of these conversations, Ms. Ram was of the opinion that Mr. Blind was always "forward-thinking" in terms of his future looking plans.
30. She completed a "Referral Form" for him to see EI health services, given the ongoing nature of his health concerns. While she did not mark the "Referral Form" as "Urgent," she flagged the related email as one of "High Importance."
31. She testified that the Deceased never criticized the EI for lack of attention. She agreed with the Blind Family's Counsel that Parole Officers are not qualified to assess mental health. Ms. Ram also completed a statement/observation report on Mr. Blind's health concerns, which was reviewed and discussed with her immediate Manager (Ms. Susan Letendre) before passing it on to the Correctional Manager. She was unable to recall whether the comment made by the Deceased in the Referral Form to the effect that, "if he were to die today, it would not matter to him" was specifically discussed with her immediate manager, Ms. Susan Letendre.

Dr. Curtis Woods

32. Dr. Curtis Woods testified that he specializes in the prevention of suicide. He is not an employee of CSC but gets paid for his services through Alberta Health Services [AHS]. He was unable to specifically recall providing mental health services to the Deceased. However, based on his professional medical notes, he could confirm that Mr. Blind was prioritized to be seen by him, albeit in the context of the limited time space he had to consult with multiple patients at the EI.
33. On January 24, 2018, Dr. Woods assessed Mr. Blind and specifically wrote in his notes:

> [D]owncast, preoccupied with declining physical health and weight loss (narcissistic injury and vanity), negativistic cognitions, not psychotic, not thought disordered, not actively S/H (i.e., suicidal/homicidal), future–oriented, sensorium intact, chronic lack of insight and judgement.
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> [Supplementary Binder, at 990]

He then proceeded to recommend trial of Epival and optimization of Lorazepam dosage. Notably, in an earlier assessment conducted on December 19, 2016, Dr. Woods similarly indicated that Mr. Blind was: "generally settled during interview, not particularly guarded or on edge, not psychotic, not actively S/H, future oriented, sensorium intact." [Supplementary Binder, at 1011].

34. It is unclear from the evidence, whether the disturbing comments by Mr. Blind in the Referral Form, completed by Ms. Ram, was brought to Dr. Wood's attention.
35. Regarding the challenges around prediction of suicide, Dr. Woods, among other things, agreed with the statement in the CSC's *Clinical Framework for Identification, Management, and Intervention for Individuals with Suicide and Self-Injury Vulnerabilities* (September 2018)

[*Clinical Framework*] that, "[it] is widely accepted that suicide is the result of a complicated, nonlinear, and time-varying interaction among many factors."

36. In response to questions from Counsel to the Blind Family, he did not recall being interviewed by the Board of Investigation and had not reviewed the Report submitted by the Board. Dr. Woods reiterated that at the point he assessed Mr. Blind, he had no active suicidal or homicidal thoughts; and his presentation was not as severe for placement on the Unit designated for patients with, for example, schizophrenia, bipolar, etc., where 24/7 hours of monitoring was mandatory.

CX Pavel Moskwa

37. CX Pavel Moskwa indicated in his testimony that he was employed as a Correctional Officer at the EI for approximately seven years, prior to his transfer to the province of Ontario. He was at the scene of the event, along with other EI staff members, where Mr. Blind was provided CPR following the discovery of his hanging inside his cell. CX Moskwa confirmed that at EI, patrol walks are performed on an hourly basis to ensure that inmates are alive, breathing and moving. He testified that an inmate staying back from attending gym with other inmates is not unusual; because some inmates regularly stay back to do laundry, catch up on sleep, or "hang out" with other inmates. Ordinarily, in such circumstances, Correctional Officers would ask the affected inmate questions whether they are doing fine, from a welfare perspective.
38. CX Moskwa confirmed that he had First Aid Training certificate and completed recertification trainings every three years. Prior to Mr. Blind's incident, he has had the benefit of performing CPR as well as using an Automated External Defibrillator [AED] in live situations; and as such, was familiar with the instrument and its practical use. He testified that an AED's failure to pick up rhythm in a particular situation does not equate to its defect as a device.
39. On the issue of coverage of cell windows by inmates, CX Moskwa testified that some of the inmates cover their windows for privacy reasons; and if that happens, the patrolling Correctional Officer would typically knock on the window to ensure safety of the inmate inside the cell. He stated that there are also "Health Check Rounds," which involve Correctional Officers and nurses going around to individual cells – without entering the cell – to ask inmates questions, subject to inmates' privacy rights.
40. He confirmed that Correctional Officers have access to the Offender Management System [OMS] database and the Reports of Automated Data Applied to Reintegration [RADAR] program available on the institutional computer system. The RADAR program and OMS database contain information on offenders' past history – including past suicide attempts, case notes by Parole Officers or Correctional Officers, and dietary information (such as the one concerning Mr. Blind's gastrointestinal issues).

Mr. Caleb Costello

41. Mr. Caleb Costello was one of the inmates on Unit A with Mr. Blind. He testified that while cleaning Mr. Blind's cell – and within approximately a week of Mr. Blind's arrival at the EI – he observed strips of torn bedsheet (ligature/rope) in his cell. He took the strips, put them away in the garbage, and told a Unit Representative about the incident.
42. Mr. Costello was one of the inmates who went inside Mr. Blind's cell on the day he was found hanging in his cell to provide assistance.

Mr. TK Assoun

43. Mr. TK Assoun who was an inmate with Mr. Blind on Unit A of the EI testified that the Deceased was a quiet individual who had discussed his bowels trouble with him. On January 31, 2018, Mr. Blind appeared normal to the witness, prior to his departure for gym / recreation at approximately 17:30 hrs. to 18:30 hrs.
44. After gym, Mr. Assoun stopped to chat with the Deceased, and that was when he observed him hanging. He alerted the guards. And when the cell door was opened, Mr. Assoun was one of the first inmates to go inside Mr. Blind's cell. He observed that bedsheet strips were braided together into a rope/ligature and used by Mr. Blind to hang, and thereafter started CPR immediately before a Correction Officer came in to take over.

Mr. Bernadette Boers

45. Ms. Bernadette Boers was the former Chief of Mental Health Services at the EI (currently works with the National Health Services). Ms. Boers testified that suicide awareness programs are available at the CSC. She referred to a number of training programs and general tools (including specialty tool for indigenous individuals) that are now specifically available at the EI for the mental health care team. She confirmed that a few of the tools were not available at the time of the incident that is the subject of this Inquiry – apparently introduced in response to the event. Ms. Boers mentioned the 2019 CSC's *Clinical Framework*, as well as associated tools, such as the *Suicide Vulnerability and Needs Classification Tool* that are currently being used at the EI at different stages – including intake assessment, referral and post self-injury incidents.
46. Ms. Boers described the nature of the working relationship between Dr. Woods, AHS, and the EI, working alongside institutional Mental Health Nurses, who have access to the Offender Health Information System-Electronic Medical Record [OHIS-EMR] that houses individual records of all offenders in a comprehensive manner. She identified Mr. Blind's specific record on OHIS-EMR (Exhibit F1, Tab 57). She also referred to the availability of – and testified that all of the health-care practitioners at EI conduct their charting in – the Open Source Clinical Application Resource [OSCAR], which gives all health services staff access to all inmate patient records from the perspective of information sharing at the Institution.
47. In her view, the EI staff operated efficiently regarding Mr. Blind's gastrointestinal issues because, fundamentally, he met with medical personnel on January 2 and 16, 2018 and was referred to a gastroenterologist in Edmonton for consultation and evaluation. Ms. Boers stated that the absence of formal diagnosis of the Deceased regarding his gastrointestinal problem would explain his being on the waitlist for referral to a dietitian at the time he died. Nevertheless, she dispositively confirmed that the EI had Mr. Blind's medical records – which included his gastrointestinal complaint – from the Edmonton Remand Centre where he was previously for approximately 14 months. Ms. Boers indicated that to the best of her knowledge, a "Working Team" was constituted to address the BOI recommendations.

Ms. Danielle Segall

48. Ms. Danielle Segall is the Manager of Integrated Health at the EI. Her position was created in 2019 to integrate mental and physical health services at the Institution. In this role, she participates in daily morning meetings to discuss developments within the last 24 hours in her department. Ms. Segall similarly attends: (a) the institution-wide meeting on a daily basis; (b) the biweekly meetings with all EI executives; (c) the biweekly population management meetings, where individual inmates' situations are discussed; (d) the monthly meetings with the Chiefs of Mental and Physical Health; and (e) the bimonthly meetings with all of mental and

physical health services for the purpose of reviewing new policies, procedures, and all other concerns.

49. Ms. Segall testified that following the release of the BOI Report, a considerable number of changes and improvements have been made at the EI. In her evidence, she listed multiple examples of such improvements, which include:

    (a) the Chief of Mental Health operates in compliance with the current Integrated Mental Health Guidelines to triage, assign, and follow up on cases of inmates at high risk for suicide;

    (b) where referrals are marked "Urgent" for self-injury and suicide, a call must be made directly to the Chief of Mental Health's number;

    (c) there is now a "tickler" system that provides reminders regarding non-urgent referrals for discussion during the daily morning meetings;

    (d) there are now three Mental Health Nurses and 10 physical health nurses at the EI;

    (e) nursing staff shifts have been adjusted to start from 7:00 a.m. to 7:00 p.m. (instead of 4:00 p.m.);

    (f) there are now two psychiatrists per week assigned to the EI, who attend to inmate patients at the Health Services Department instead of the Units;

    (g) access to dieticians at the EI has been improved, and in particular, there is now a CSC Prairie Region Dietician;

    (h) all health services and nursing staff as well as intervention staff at the EI receive *Clinical Framework* trainings administered by a psychologist, with biennial training refreshers; and

    (i) the requirement for all CSC staff, including Correctional Officers, to take a mandatory Suicide and Self-Injury Training at the commencement of their employment with the organization.

50. Ms. Segall was appointed as CSC "authorizer" for the provincial Alberta Netcare system [Netcare]. As an "authorizer," she gives access to other CSC healthcare staff into the provincial Netcare system – at the CSC because of the confidential and private information contained in the system. Netcare has its limitations in the sense that some of the community doctors in the province do not put their medical information in Netcare.

51. According to Ms. Segall, AHS is now moving to Connect Care – a clinical information system – which would encompass all of the doctors' offices in the province. However, CSC is not included as a partner because it's a federal agency. Ms. Segall's preference would be for CSC to have access to Connect Care because of its potential to encapsulate a broader scope of health information to share with its recognized partners.

Submissions of Counsel

52. In addition to endorsing the recommendations in the BOI Report, Counsel for the Blind Family submits, among others, that:

    (a) "[the] Warden, Chief of Mental Health Services, Chief of Physical Health Services, Manager of Integrated Health Services, and their successors at EI be required to read […] the *Third Independent Review of Deaths in Custody* [published by CSC …]";

(b) "[the] Government of Alberta, Alberta Health and Alberta Health Services implement a system whereby health records from Alberta Correctional Centres are made available online to CSC healthcare when they receive prisoners from those Centres and that [Alberta Health Services] at the Correctional Centres prepare a summary of what health issues the offender has, which will accompany the offender on transfer."

53. Counsel for Attorney General of Canada contends that no recommendations are appropriate for making by this Inquiry, given that the BOI "did a thorough review of the incident, made pertinent and focused recommendations, and then [CSC] made the requisite changes."

54. The Inquiry Counsel points to her neutral position and comments that "the sharing of private health information from provincial correctional institutions to federal correctional institutions was *not* an issue in this Fatality Inquiry."

Issues

55. The primary issue identified by the Inquiry is whether there is room for improvement in "the sharing of information between multidisciplinary care providers, case management, and custodians at the [EI] when an inmate is believed to be at high or imminent risk for suicide or self-injury."?

56. The Inquiry acknowledges its Counsel's neutrality but believes the issue of sharing inmates' health records between provincial and federal correctional centres / institutions is an integral part of this identified primary issue from a fundamental perspective.

57. In the context of the foregoing primary issue, and in order to proffer recommendations for prevention of future deaths by suicide, this Inquiry has been guided by the following analytical questions:

    1. Can the risks of suicide be timely diagnosed?
    2. Can future suicides be prevented by a better integration of physical health and mental health?
    3. How could suicide committed by the use of hole(s) in bunk beds be prevented in the future?
    4. Can security patrol by Correctional Officers be done differently?

Inquiry Findings

Sub-issue 1: Can the risks of suicide be timely diagnosed?

58. Counsel for the Attorney General of Canada submits that based on multiple statements from CSC's *Clinical Framework* and the evidence of Dr. Woods, suicide is difficult to predict.

59. Counsel for the Blind Family submits that Mr. Blind's death was "preventable" but occurred because of "egregious failures" within the EI. He proceeds to suggest a litany of additional findings and recommendations for this Inquiry's consideration.

60. This Inquiry is alive to its jurisdictional limitation. Section 53(3) of the *Fatality Inquiries Act* provides "The findings of the judge shall not contain any findings of legal responsibility or any conclusion of law." That statute prescribes that a public fatality inquiry is not a fault finding or assigning endeavour. Neither should the Inquiry make conclusions of law.

61. In the result, I conclude that a few of the findings and recommendations suggested by the Blind Family to the Inquiry for its consideration appear to be either inapt (in the context of the Inquiry's statutory mandate) or subsumable within the BOI recommendations.
62. That said, the Inquiry considered germane the Blind Family's recommendation that, the Warden, Chief of Mental Health Services, Chief of Physical Health Services, Manager of Integrated Health Services, and their successors at EI should be required – from functional and operational perspectives – to review and familiarize themselves with the *Third Independent Review of Deaths in Custody*, published by CSC.
63. Further, although contemporary studies and literature by leading suicidologists and scholars offer a level of fresh optimism, the challenges around the predictability of risks of suicide remain valid at this point.
64. This Inquiry particularly notes the inherent challenges with diagnosing mental health problem among inmates. And in this regard, I find the evidence of Dr. Woods helpful that, "[it] is widely accepted that suicide is the result of a complicated, nonlinear, and time-varying interaction among many factors."

Sub-issue 2: Can future suicides be prevented by a better integration of physical health and mental health?

65. Both *viva voce* evidence as well as the materials before the Inquiry demonstrate that: (i) the EI staff were aware of Mr. Blind's gastrointestinal problem as well as his mental health situation, including his suicidal propensity; and (ii) Mr. Blind was provided with the medical and mental health services that were available within the system at the EI; albeit with some "fractures," identified in the endorsed BOI Report.
66. In that vein, this Inquiry finds that the fundamental problem with Mr. Blind's death at the EI inheres with his mental health – in the context of his gastrointestinal issues – and the challenges around the predictability of risks of suicide coupled with the availability of an enabling environment for committing it.
67. Further, the evidence before the Inquiry reveals, *inter alia*, that following the release of the BOI Report, the health services sector – in response to Recommendation 1 – started on finalizing associated staff trainings based on the *Clinical Framework*.
68. Similarly, in response to Recommendation 2, the roles and responsibilities of various professional designations have been clarified through discussions at monthly mental health meetings, as well as email communications; there is no longer separation of treatment of inmates, based on medical or mental health concerns; such that, for example, all discharges now follow the same process for a more effective standardized continuity of care; and there are ongoing initiatives being explored in order to increase collaboration between the Clinical Services and Mental Health Departments at the EI to ensure continuity of care between the two departments. (Exhibit F1, at 488).
69. The Inquiry notes that all referrals are now directly assigned to individual mental health professionals by the Chief of Mental Health; and that email referrals to the "539 – Mental Health Distribution List" are now accessible to the entire department. (Exhibit F1, at 491).
70. The Warden has issued direction to the Assessment and Interventions Group that all information contained in Statement/Observation Report (SOR) submitted by Parole Officers must be properly documented, recorded, and broadly shared to ensure immediate action for imminent risk of self-injury. (Exhibit F1, at 495).

71. On the gastrointestinal problem and waitlist, the material before the Inquiry reveals that since the completion of the BOI investigation regarding Mr. Blind's death, a Regional Dietician – a position that was not available at the time of his death – has been created and assigned to the Prairie Region. The Regional Dietician would conduct a clinic once a month for half a day via video conference. Also, OSCAR "ticklers" can now be sent to the Regional Dietitian where required; and further all healthcare staff now have the dieticians contact information to facilitate effective communication. (Exhibit F1, at 496).

72. It is apparent, from the foregoing, that the EI has either commenced or had already implemented a significant number of recommendations made by the BOI in relation to the integration of physical health and mental health services.

Sub-issue 3: How could suicide committed by the use of hole(s) in bunk beds be prevented in the future?

73. This matter is considered by the Inquiry to be a substantively significant collateral sub-issue.

74. On availability of enabling environment, the evidence is clear that Mr. Blind used ligature – made from torn bedsheets – that was tied around the frame of the top bunk bed in his cell to commit suicide by hanging.

75. The use of double bunk beds with suspension points was effectively addressed by the BOI Report and recommendations.

76. Regarding this point, the Board noted:

> Post incident action was taken to eliminate the point of suspension in [Mr. Blind's] cell; however, identical points of suspension, on the steel frames of the upper bunks located in cells, on the same Range of A Unit where the incident occurred, were not addressed. The point of suspension was not previously identified in any reviews.
>
> [BOI Report, at 41]

77. The Inquiry notes, however, that an Update (dated June 30, 2020) in the evidence before the Inquiry satisfactorily indicates that the Works and Engineering Department at the EI has *completed* the sealing with epoxy caulking – which takes approximately three days to completely crystallize – of all holes/suspension points of all upper, double bunks for Units A-H at the EI. (Exhibit F1, at 504).

Sub-issue 4: Can security patrol by Correctional Officers be done differently?

78. The evidence before this Inquiry squarely put in focus the issue of cell window coverage by inmates for extended time period *vis-à-vis* the effectiveness of security patrol by Correctional Officers.

79. More specifically, regarding Mr. Blind's case, the evidence confirms that at approximately 18:25 hrs., on January 31, 2018, the patrolling Correctional Officer observed that there was a towel covering Mr. Blind's cell window.

80. The Inquiry notes that in relation to cell windows that were covered for extended periods between one or more security patrols, the materials evidentially demonstrate that:

> (a) the *EI Inmate Handbook* was updated to include a requirement keeping cell door windows unobstructed; and

(b) Standing Order 566–4 – dealing with *Standards for Counts and Security Patrols at Edmonton Institution*, was revised "to clarify that an unobstructed view of the inmate is required to ensure not only a live, breathing body, but to confirm the wellbeing of the inmate." (Exhibit F1, at 499, 502 – July 17 and 23, 2019 Updates).

These actions that have already been taken by the EI are both commendable and satisfactory from the Inquiry's perspective.

81. On this issue, therefore, the Inquiry *additionally* recommends that a monitoring system should be designed specifically to track the activities of those who desire to opt out of gym, whether doing so is usual, understandable, or suspicious. In this regard, the Inquiry notes that in the circumstances of Mr. Blind's case, it was not the lack of sufficient recreation time or opportunity that was the issue; rather, it was his deliberate choice not to attend the gym that partially facilitated his suicide on January 31, 2018.

Recommendations for the prevention of similar deaths:

82. Based on the foregoing, the qualitative recommendations proposed by this Inquiry are as follows:

(a) In agreement with both the Blind Family as well as the Attorney General of Canada, *all* of the BOI recommendations are hereby endorsed by this Inquiry.

That said, the Inquiry *additionally* recommends – on the issue of security patrol – that a monitoring system should be designed specifically to track the activities of those inmates who desire to opt out of gym, whether the particular Inmate's decision to do so is usual, understandable, or suspicious.

(b) While it appeared that Mr. Blind's health information got transferred from provincial Edmonton Remand Centre to the EI, it is unclear from the evidence before the Inquiry whether there is an established, formal system in place to make this happen from the perspective of information sharing, which is the primary issue in this Inquiry.

In that context, this Inquiry recommends that – alongside the current system – a *formal* arrangement for information transfer system be implemented between the Government of Alberta (Alberta Health), AHS and CSC, *subject to the relevant privacy law regimes governing sensitive medical information in Canada*, whereby health records from provincial correctional institutions / remand centres are made available online to CSC healthcare when they receive prisoners from those provincial centres.

Partnering with the CSC within the province of Alberta's Netcare and Connect Care Systems are examples that some witnesses who appeared before the Inquiry mentioned. There may be other similar systems developed in the future or presently existing outside the evidence provided at the Inquiry. These should all be explored comprehensively to optimize information sharing in the interest of safety and security of inmates at the EI.

(c) This Inquiry recommends an obligatory review of CSC's *The Third Independent Review of Deaths in Custody* (October 2015), as an operational and functional requirement, by the Warden, Chief of Mental Health Services, Chief of Physical Health Services, Manager of Integrated Health Services, and their successors at EI – with particular attention being paid to the best practice guidelines advanced therein.

That document, *inter alia*, provides a synthesis of best practice guidelines to be followed for the successful implementation of suicide prevention programs in correctional settings as follows:

- Intake and on-going screening at critical points (e.g., transfers)
- Comprehensive assessment and on-going re-assessment for those at risk
- Monitoring
- Meaningful Communication between all parties
- Meaningful Suicide Prevention Training (provided annually)
- Treatment without barriers
- Non-punitive suicide interventions
- Housing - avoid isolation unless constant observation is possible, house with other inmates in safe environment, increase interaction between inmates and correctional, medical and mental health staff, require regular follow-ups of inmates released from mental health monitoring
- Suicide-resistant housing (clothing, showers) commensurate with risk level
- Post suicide procedures (procedures for notification, reporting and reviewing).

DATED March 23, 2023,

at Edmonton, Alberta.

O. Shoyele
Original Signed

A Judge of the Provincial Court of Alberta