Action No. 017342270I101001

REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Fatality Inquiry was held at the Courthouse in the City of Red Deer, in the Province of Alberta on January 23 and 24, 2002 before The Honourable E. D. Riemer, Judge of the Provincial Court.

A jury was not summoned and an inquiry was held into the death of

of no fixed address, Alberta, and the following findings were made:

Identity of the deceased:

Male person

Date and time of death: May 30, 2001 at 8:50 p.m.

Place of death: Red Deer Remand Centre

Red Deer, Alberta

Medical cause of death: Arterial compression caused by hanging by the neck from a bed sheet tied to the ceiling of the cell occupied by the deceased.

Manner of death: Suicide.

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED:

was admitted in custody into the premises of the Red Deer Remand Centre in Red Deer, Alberta at 10:30 p.m. on May 24, 2001. According to the Prisoner Report which is Exhibit 11 in this inquiry, had been arrested and detained in custody earlier in the day by a peace officer at Lacombe, Alberta after being found in possession of one or more items alleged to be stolen. At this time, was in the company of another youth, who is a female person and who was also arrested and detained. stated that she had known for the previous 6 months as a friend in Edmonton, Alberta and that they had hitchhiked together from Edmonton to Lacombe. She stated that while in Edmonton, she knew regularly used drugs which she described as "crystal meth and marijuana." She stated that was "fun to be with" and "really nice," and got along well with others most of the time. She stated that he had never said anything to her that suggested he was unhappy or caused her concern that he may take his life.

The Prisoner Report of earlier referred to contained a notation "Diagnosed with several behavioural disorders. Handle with care." The source of the information and the specifics of the information prompting this notation are not clear from the evidence led at the inquiry.

At the time of the initial admission of into the Red Deer Remand Centre on the evening of May 24, 2001, he was observed and addressed by Ms. Lynn MacDonald, a registered psychiatric nurse, who at that time was being trained or oriented by Ms. Pamela McPherson who is also a registered psychiatric nurse. Both of them made notations on Exhibit 12 which is titled Young Offender Intake + COMIS Admission Record. The notation includes an acknowledgment from that he had attempted suicide once earlier in his life in

Grade 5 by ingesting an overdose of the prescription drug Ritalin. He denied any present suicide ideation. He admitted to being sexually abused at some unspecified time in the past by a person known to his family. He presented to the nurses as cooperative and alert, although somewhat "hyper" which I infer to mean hyperactive. Because of the reference to previous sexual abuse and the reference to a suicide attempt although apparently some years previous, Ms. MacDonald referred to Dr. Handley.

Dr. Handley, who has been a clinical psychologist since 1968 and who has had a contract as a psychologist with the Red Deer Remand Centre for the past 12 years, attended in his professional capacity upon at the Remand Centre at 7:30 a.m., May 25, 2001 as a result of the referral by Ms. MacDonald. appeared angry and curt with Dr. Handley apparently because he had not been wakened by Remand Centre staff that morning and had missed breakfast. He declined to discuss the issue of sexual abuse with Dr. Handley, and when asked if he was thinking of killing himself, he replied, "No, never. I'm not that stupid." Dr. Handley who has had extensive experience in suicide assessment, stated in respect of his observations and assessment of that depression was not an issue, his self-esteem was up, and he displayed a sense of hopefulness. He further noted that thinking was clear and his thought process and content were well within normal limits. He observed that was angry at an emotional level about not getting breakfast that morning, but did not appear emotionally upset in a psychological or psychiatric sense. He formed the impression that was going to have difficulties in adjusting to the unit in the Remand Centre since he did not like being in gaol in Alberta compared to the custodial facilities he had experienced in B.C. Dr. Handley stated that he had not held any concern or suspicion that might commit suicide.

During the morning of May 25, 2001, was supervised by Mr. Otto, a youth worker employed at the Remand Centre and who had received training on suicide intervention and recognition of suicide risks. He described as very confrontational and as displaying a negative attitude towards himself (Mr. Otto) and other staff members. Mr. Otto contacted the Child Welfare authority in B.C. where had previously resided and was informed that was the subject of what was described as Continual Custody Order which he described as being similar to a Permanent Guardianship Order in the jurisdiction of Alberta. He was further informed that had served 2 or more short times in custody for minor offences and that he displayed difficulty in staying at the residential placements arranged for him. Mr. Otto stated that he questioned whether there were any mental concerns or other matters with respect to that he should be informed of and that no reply was given to the inquiry.

Mr. Otto took steps to arrange a process whereby could be released from custody on his upcoming initial Youth Court appearance date which was to be May 31, 2001. During his observation of on May 25, 2001, he observed him to continue to be confrontational with Mr. Otto and other staff members.

On Sunday, May 27, 2001, Ms. Herzog, a youth worker, observed during her shift which was from 3:00 p.m. to 11:00 p.m. During the morning of May 27, 2001, in the dining area of the Young Offender Unit, engaged in a dispute with another female youth also in custody that involved throwing juice or milk at each other. As a result, both were confined to their rooms to await a disciplinary hearing which proceeded in the early afternoon of May 28. As a result of the hearing, was placed on a phase program or behavioural management program in which discipline is administered by the removal of privileges and the gradual restoration of them provided there was compliance with the rules of the Young Offender Unit.

As a youth worker, Ms. Herzog interacted with during her daily shifts from May 27 to May 30, 2001. During a portion of this time, she described him as loud, threatening, demanding and swearing at herself and other staff members. She stated that throughout her dealings with she did not have concern that he was suicidal. She observed him to be generally noncompliant, and formed the impression that he was playing the role of being a "tough guy."

On May 30, she arrived on shift at 3:00 p.m. and commenced her duties. At this time, was confined to his room being no. 3015Y88 on the 3rd floor of the Young Offender Unit of the Red Deer Remand Centre. Ms. Herzog conducted a "take over count" at the beginning of her shift which confirmed that the number of youths in custody in the Unit at that time was 10, including Shortly after 4:00 p.m., a cart with meals on individual trays was supplied, and exited his room to obtain his meal and returned to his room to consume it. Ms. Herzog noted that his demeanour was moderate compared to her previous encounters with him, and that he "seemed to be settling down a bit." At 5:00 p.m., all rooms on the Unit were locked including Y88 while the staff members, including Ms. Herzog, took their supper break. Thereafter, at 6:00 p.m., a further formal count of the youths on the Unit was conducted by Ms. Herzog as indicated in the extract of the Young Offender Unit Log Book which is Exhibit 17. At 6:35 p.m., Ms. Herzog proceeded to the gymnasium on the 2nd floor of the Remand Centre with 7 of the 10 youths on the Unit, leaving 3 youths, including in their respective rooms which were locked. Ms. Herzog returned to the Unit from the gymnasium at 7:35 p.m. with the 7 youths and at 8:00 p.m. or 20:00 hours, a snack was made available to the youths. at this time did not respond to the invitation issued over the intercom system to his room to retrieve or obtain his snack. Also, at this time, Ms. Herzog conducted what she referred to as an "informal count" depicted in the Log Book entry (Exhibit 17) as "20:00 Round and Snack." At this time, Ms. Herzog looked into Room Y88 and saw laying on the bed in the room with his eyes open. She did not unlock the doors to the room at this time, and continued with other duties. At 8:45 p.m., a nurse attended at the Unit to dispense medications to youths who had been prescribed medication. The nurse departed, and at 8:50 p.m., Ms. Herzog directed the youths on the Unit who were outside their rooms to go to their rooms, and she proceeded to take a "formal count" of the youths on the Unit. As she began this process, one of the youths that was

proceeding to his room which was adjacent to Room Y88 indicated that she should check the occupant of Room Y88, and in doing so, she observed hanging by the neck from a sheet in his room. The photographs which comprise Exhibit 6 disclose that a bed sheet was tied to a metal support on the ceiling adjacent to a wall of the cell. The lower portion of the sheet was tied or knotted around the neck of and he was suspended from it.

At 8:53 p.m., Ms. Herzog, through the intercom system, placed an "all call" or Code 99 signalling a medical emergency on the Young Offender Unit. Mr. Patterson, a correctional officer, and Ms. Fulton, a registered nurse, who were both on duty at the Remand Centre that evening responded to the Code 99 call and arrived at Room Y88 at or shortly after 8:53 p.m. where they saw hanging by his neck in the room. The sheet was cut and he was lowered to the floor at which time Ms. Fulton checked for a carotid pulse. There was no pulse and was not breathing. Ms. Fulton commenced CPR on by way of chest compression and ventilation. Shortly thereafter, as a result of an earlier call from the Remand Centre, Mr. Lefebvre who is an Emergency Medical Service attendant, arrived at Room Y88 and observed staff of the Remand Centre including Ms. Fulton conducting CPR on He checked for a pulse and respiration and applied the heart monitor to determine if there was any electrical activity. There were no signs of life. He offered the opinion that could have been dead for up to an hour.

The time of death of has been determined to be 8:50 p.m. May 30, 2001 based upon the evidence of Dr. Denmark, the medical examiner, as disclosed in the Autopsy Report Form which is Exhibit 2. This is consistent with the time that Ms. Herzog discovered hanging in his room. From the evidence of Mr. Lefebvre, the Emergency Medical Attendant, who examined shortly after 8:50 p.m., it appears that may have expired at some indeterminate time prior to 8:50 p.m., but certainly after 8:00 p.m. when Ms. Herzog observed alive on his bed in Room Y88.

Mr. Tholenaer, who has been the Director of the Red Deer Remand Centre for seven years, gave evidence and reviewed his responsibilities as Director that included the care, custody and control of persons detained in the Remand Centre. He recalled meeting once briefly on May 25, 2001 on the Young Offender Unit while he (Mr. Tholenaer) was conducting his weekly personal inspection tour of the Remand Centre. He recounted that he had discussed the status of with Dr. Handley after the latter's mental health assessment of and was informed that there was no indication of suicide risk. He confirmed that he had been kept informed by other staff members of misbehaviour and the phase program or behavioural management program that had been applied to him following his disciplinary hearing. He further confirmed that he reviewed and approved the decision to have placed on the phase program, and stated that based on the whole of the information he received about and his own experience, there were no concerns raised or presented that may be a suicide risk. He reviewed in detail the standard practices, policies and procedures to be followed at the Remand Centre with

respect to the admission and care of persons detained there. Relevant portions of these procedures are set out in the document extracts comprising Exhibits 18-27 of the inquiry. In reviewing the whole of the evidence, I conclude that the staff members of the Remand Centre substantively complied with the policies and procedures in effect on May 24, 2001 when was admitted to the Remand Centre.

As a result of the death of an internal inquiry by the Justice Department was conducted and seven recommendations were made that are comprised in Exhibit 30. The recommendations are as follows:

1. That nursing staff at the Red Deer Remand Centre be reminded of their responsibility to enter young offender suicide status on admission on the YoMIS/CoMIS.

2. That the Red Deer Remand Centre develop a more formalized process to ensure each young offender is assigned a "key worker" on admission.

3. That whenever a young offender is considered for placement on the Behaviour Management Phase Program, that the young offender be referred to the centre psychologist for assessment and screening to determine the young offender's suitability for the program prior to being placed on the program.

4. That whenever a young offender is placed on a Behaviour Management Phase Program at the Red Deer Remand Centre, that the young offender be seen in person and assessed by the psychologist daily with respect to progress on the program and/or any changes required in the program to facilitate the young offender's progress.

5. That whenever a young offender is confined to their room on the Young Offender Unit that an observation report (SG264-CS) be used to record observations of the young offender's attitude and behaviour every half hour.

6. That the Red Deer Remand Centre examine the feasibility of modifying the ceilings in all the young offender rooms in the Young Offender Unit to prevent young offenders from having access to the ceilings.

7. That young offender staff at the Red Deer Remand Centre be reminded of the Centre Standing Operating Procedure requirements to conduct informal counts of young offenders every thirty minutes and

record the informal counts in their unit log book.

The evidence of Mr. Tholenaer is that as of January, 2002, the above recommendations have been accepted and implemented at the Red Deer Remand Centre.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

After reviewing the evidence and the now-implemented recommendations resulting from the internal inquiry earlier held and as previously set out in the Report, I adopt the enumerated recommendations without exemption or addition as being a reasonable and comprehensive response for the prevention of similar deaths.

DATED this 18th day of November, 2002, at the City of Red Deer, in the Province of Alberta.

E. DARRELL RIEMER
Judge of the Provincial Court of Alberta