Release Date: August 25, 2005

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **ALAN NICOLSON**
(DATE OF DEATH: August 28, 2003)

Report on Inquest and Recommendations of
The Honourable Judge Fred H. Sandhu
Issued this 22nd day of August 2005

APPEARANCES:

Mr. S. Johnston, Provincial Counsel to the Inquest
Mr. S. Restall, Federal Counsel to Inquest
Ms. C. Cheater, Federal Counsel to Inquest
Mr. Tyler Kochanski, counsel for Dr. Stanley Yaren
Mr. Raymond Nicolson, father of Mr. Alan Nicolson

RELEASE DATE: August 25, 2005

M A N I T O B A

The Fatality Inquiries Act

Report by Provincial Judge on Inquest

Respecting the death of: Alan Nicolson

An inquest respecting the said death having been held by me on February 11th through February 22nd, 2005 at Winnipeg, in Manitoba, I hereby report as follows.

The name of the deceased is **Alan Nicolson.**

The deceased came to his death as a result of suicide by hanging at the age of 34 in his cell at Stony Mountain Institution in Stonewall, Manitoba. His suicide by hanging took place in his cell, A6-18 of Unit 1, Intake and Admission/Reception Range, at Stony Mountain Institution at approximately 0:57 a.m. on August 28, 2003. While conducting an institutional 'take-over' count, a correctional officer found Mr. Nicolson hanging from a metal ceiling conduit in his cell. The correctional officer immediately called for assistance, retrieved an emergency knife and an Ambubag, and commenced resuscitation procedures. Other correctional officers responded to the area. The cell was opened and Mr. Nicolson was found to have used a bed sheet to wrap around his neck with the other end attached to the metal conduit. He was cut down with a rescue knife and placed on his on the floor. Resuscitation attempts were made utilizing CPR and a ventilator bag, without success.

Mr. Nicolson was a first time federal inmate. He was serving a 4 year and 2 month sentence for one count of robbery. The sentence commenced on

July 15, 2003. He was admitted to Stony Mountain institution on July 22nd, 2003. Mr. Nicolson had a previous history of robbery and property offences, dating back to 1990. Convictions included property offences, drugs possession, assaults, impaired driving, armed robbery, unlawfully at large and one escape conviction. Evidence adduced indicated a long history of drug addiction with the majority of crimes being related to this addiction.

Despite the efforts made by correctional officers to resuscitate Mr. Nicolson upon discovery of his body in his cell, the efforts were unsuccessful.

The current crime involved the hold up of a convenience store on June 5, 2003, while armed and masked with a t-shirt. He was apprehended shortly thereafter and pled guilty to the crime at a very early date, being July 15.

He was seen by an institutional psychiatrist on August 27, the day before his death. A suicide note was found in his cell, apparently written shortly after his meeting with the psychiatrist.

With regard to the date of his death, after his body was discovered and CPR administered by correctional staff, an ambulance arrived at the institution at approximately 00:45 a.m. and the attendants were escorted to Mr. Nicolson's cell by correctional officers to assist with CPR. R.C.M.P. officers were also called and arrived at the institution at approximately 01:10 a.m. CPR and resuscitation efforts were halted at approximately 00:57 a.m. and the medical examiner was called. The medical examiner arrived at the institution at approximately 02:00 a.m. A suicide note was discovered in a Bible in the cell shortly thereafter, Mr. Nicolson was pronounced dead at 02:20 a.m. The body was removed to the health care department at approximately 03:30 a.m.

Attached hereto and forming part of my report is a schedule of all exhibits required to be filed by me.

DATED at the City of Winnipeg in Manitoba this 22nd day of August, 2005.

Fred Sandhu, P.J.

Copies to: Chief Medical Examiner (2)
Deputy Attorney General
Chief Judge, Provincial Court of Manitoba

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I. HOLDING OF INQUEST

[1] At approximately 0:35 a.m. on August 28, 2003, at Stony Mountain Institution, Stonewall, Manitoba, an inmate, Mr. Alan Nicolson, was found hanging in his cell from a ceiling metal conduit of his cell on Unit I (the mental health unit) cell A6-18. That cell block range was part of a “specialized” unit commonly called at the time the “mental health range” and was subject to regular range checks by correctional officers performed in the usual and ordinary course of their duties. The inmate involved in this suicide, Alan Nicolson, was 34 years of age at the time of death and was serving a four year, 2 month sentence for robbery which sentencing had occurred on July 15, 2003. He was admitted to Stony Mountain Institution on July 22nd, 2003. Mr. Nicolson had a previous history of robbery, drug and property offences. He did not have a prior federal institutional history, this being his first federal admission. Upon discovering Mr. Nicolson, correctional officers removed Mr. Nicolson from the bed sheet restraint that he had placed around his neck and placed him on the floor just outside his cell. It was indicated by correctional staff that no vital signs were present; however, staff commenced resuscitation procedures and continued applying resuscitation procedures until they were told to discontinue the procedures by members of the

Stonewall Ambulance Service. Mr. Nicolson was declared deceased at 0:220 a.m. by medical personnel at the scene.

[2] All reporting requirements regarding the incident to the R.C.M.P., the coroner's office, regional and national headquarters was completed appropriately and in a timely manner. A Royal Canadian Mounted Police member was notified and notification of Mr. Nicolson's next-of-kin in regards to his death was completed. Stress management services were provided or offered to all staff involved in the incident in a timely manner according to institutional rules and follow-up support services to the inmates were provided on the day of the incident and in the days following. The Board of Investigation that was convened following the death identified no issues of non-compliance by members of the service with respect to this incident.

[3] As outlined in Exhibit 1 filed at this inquest, being a letter dated December 23rd, 2003, from the Chief Medical Examiner Dr. T. Balachandra, under s.19(3) of the Fatality Inquiries Act an inquest into the death of Alan Nicolson is mandatory. The letter of the Chief Medical Examiner states that Mr. Nicolson was a 34 year old man who had been admitted to the Stony Mountain Institution on June 22nd, 2003 to begin serving a four year, 2 month sentence for

robbery. He was discovered by a Correctional Officer on August 28th, 2003 hanging by in his cell during a "takeover count". Resuscitation attempts were discontinued at 00:57 hours. It was noted that Mr. Nicolson had a past medical history, which included anxiety, depression, and previous suicide attempts. A medico-legal autopsy was performed, confirming the cause of death was asphyxiation due to hanging. The manner of death was suicide.

[4] In accordance with s.19 of the Fatality Inquiries Act a Provincial Court Judge was directed to hold an inquest into the death of Alan Nicolson for the following reasons:

> (1) to fulfill the mandatory requirements of an inquest as defined under s.19(3);
>
> (2) to determine the circumstances under which the death occurred; and,
>
> (3) to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[5] Under s.33(1) of the Fatality Inquiries Act a presiding judge on an inquest has a responsibility to:

> (a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
>
> …..

> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

[6] In addressing those responsibilities, the presiding provincial judge must also be reminded of s.33(2)(b) of that same Act which states that a provincial judge:

> …shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest.

[7] The fatal inquiry regarding the death of Alan Nicolson was held from February 11th to February 22nd, 2005, in Winnipeg, Manitoba.

II. REVIEW OF EVIDENCE

A. Psychological and psychiatric history and profile of Alan Nicolson

[8] Alan Nicolson entered the Stony Mountain Institution, this being his first entrance, on July 22nd, 2003, to begin serving a four year, 2 month sentence for robbery. He was initially placed onto the intake assessment unit as are all inmates.

[9] Mr. Nicolson, whose date of birth is December 15, 1968, had a lengthy history of criminal convictions, beginning in 1990 at the age of 21. From 1990 to 1994 he was involved in numerous property crimes, all of which were dealt with by fines and probation, or very short periods of incarceration. Also, and most telling, he began to accumulate convictions for drug possession. In 1995 he was convicted of forcible entry and served his first substantial prison term of 3 months.

[10] An escalation occurred with respect to Mr. Nicolson's criminal conduct in 1996 with crimes involving violence. In 1996 he was convicted of armed robbery and other charges resulting in imprisonment for 2 years less a day. After his release to year 2000 he continued with criminal activity involving thefts, unlawfully at large, possess stolen property, drive impaired, resulting in prison terms ranging from 3 months to one year.

[11] In year 2000, he was convicted of assault cause bodily harm, mischief (x4), fail to comply with recognizance (x5), possess goods obtained by crime, theft under $5000, uttering threats (x2), and escape lawful custody. He was sentenced to 11 months of jail and twelve months probation. In December of 2000 he was again convicted of uttering threats and received a conditional sentence of 6 months and probation for 13 months.

[12] On July 15, 2003 Mr. Nicolson was convicted of robbery and sentenced to a term of 50 months imprisonment. Particulars of the offence indicate that on June 15 shortly after midnight he ran into a 7-11 store with a white t-shirt over his face and an 8 inch knife in his hand. He demanded cash from the female clerk. He became upset as the register only contained twenty-three (23) dollars. He snatched the money and ran around the counter, waving the knife at the clerk and grabbed a quantity of cigarettes. As he fled from the store was seen by a passing police patrol car with the white shirt still on his face and the knife in his hand. He was chased and apprehended shortly thereafter. He was taken into custody and remained in custody until July 11, 2003 when he pled guilty to robbery. He was sentenced on July 15, 2003. He was also ordered to provide a DNA sample and was placed on a 10 year weapons prohibition. He was transferred to Stony Mountain Penitentiary on July 22, 2003.

[13] The life of Mr. Nicolson was a difficult one from the time of his involvement with drugs at the age of 19, to the time of his first crimes at the age of 21, and thereafter to the time of his untimely death. It is important to understand this life in the context of a developing addiction to narcotics and a life long struggle with this addiction. Mr. Nicolson was not found to be an aggressive or assaultive person unless under the influence of, or in the pursuit of drugs. He has

been described by his family as being a normal, kind and compassionate person while not under the influence of drugs. His father, Alan Nicolson Senior, a party to these proceedings, and a witness at the inquest, has clearly and compassionately outlined the struggle of the Mr. Nicolson to free himself of the addiction. The struggle included eight prior attempts at suicide. The consequences of the failure to secure a positive resolution to this addiction have been devastating both to Mr. Nicolson and to his family.

[14] The following is a summarization of Mr. Nicolson's psychological and personal background as evidenced by testimony heard at the inquest and from documents filed at the inquest.

[15] Mr. Nicolson was the middle son of three boys born during the marriage of their parents. He was raised in a middle-class area of Winnipeg. He reportedly had a normal and average upbringing. His parents separated at the age of 15. Reconciliation occurred, but there was another separation in 1999 and then a divorce. His parents are described by case reports as good providers, affectionate, supportive and positive. Certainly having heard from and observed his father, Alan Senior, a party to these proceedings, the compassion and caring of the family and extended to the son is without question.

[16] At the age of 15, the normal life of Mr. Nicolson began to change, coinciding with the breakup of his parents. The break up was taken hard by him. He began to experiment with marijuana. He progressed to taking cocaine and heroin into his late teen years. As his addiction increased, his life fell apart. His parents, particularly his father, did all they could but were helpless in the face of this terrible addiction. Alan ended up living on the streets He ended up living with a woman who was also an addict. He fathered fraternal twins, a boy and a girl. Alan broke up with this woman in 1996 and has not had contact with his children. His father describes a pattern of recovery and failure throughout this period of time. The impression one is left with is of a man with a deep addiction, but with an almost equally deep desire to recover. There were periods of recovery, but in the end the addiction was too strong. According to his father the addiction to drugs “took over his life”. Almost all his criminal activity can be tied directly to his addiction.

[17] Mr. Nicolson’s younger brother committed suicide by hanging on July 22, 2000. He also was involved with drugs. It should be noted that 2 months prior to Mr. Nicolson’s suicide, another inmate at the institution, Richard Lagimodiere, committed suicide in the same Unit. This death is the subject of

another inquest reported, dated August 10, 2005. It is unknown if this suicide had any influence on Mr. Nicolson. The inmates were not known to each other.

[18] At the time of his death, Alan had not received any institutional visits. His father did keep in contact with him on a regular, almost daily basis, except for those periods when he was in suicide watch, and he also had contact with a Pastor.

[19] Mr. Nicolson had a history of suicide ideation during his brief stay an inmate at Stony Mountain Institute. He was placed on suicide observation range on two occasions, August 7th and August 14th, which will be detailed further in this report.

[20] At the time of his death, Mr. Nicolson was in his cell in the Intake Assessment Unit, having been removed from the "mental health range" on August 20th. He had been seen on the morning of August 27th by the institutional psychiatrist. No changes were made to his placement. He wrote a suicide note apparently on the afternoon of August 27th. He was found dead in his cell shortly after midnight on August 28th.

III. WITNESSES CALLED AT THE INQUEST

THIS SUMMARIZATION WILL BE OUT OF ORDER IN TERMS OF ACTUAL TESTIMONAL EVIDENCE CALLED AT THE INQUEST FOR THE SAKE OF CLARITY AND IS GENERALLY SUMMARIZED TO OBTAIN CHRONOLOGICAL ORDER. SOME EVIDENCE AT THE *LAGIMODIERE* INQUEST, COMPLETED THE WEEK BEFORE THIS INQUEST, WAS APPLIED MUTATIS MUTANDIS TO THIS INQUEST WHICH PORTIONS FROM THE *LAGIMODIERE* INQUEST REPORT BEING SET OUT IN FULL IN THIS REPORT

Correctional Officer Sheldon Derksen (CO1)

[21] The witness is a Correction Officer I, and has been employed as such for 5 years. On August 28, 2003 he was conducting a take-over count, done when there is a staff changeover. He testified that he commenced the count at around 00:30, with a walk down range A 6 which is at the bottom of a two tiered block known as the Intake Unit. As he looked in Mr. Nicolson's cell he observed him hanging from the overhead electrical conduit with a blue bed sheet in cell A6-18. At approximately 00:35 hrs he immediately informed his supervisor, CO2 Saggar for assistance. He retrieved a 911 emergency knife and an Ambubag. Correctional Officers Sloane and Richardson arrived at 00:38 hrs and the cell was opened. Mr. Nicolson was cut down and placed on the floor. The bed sheet was removed. No pulse was detected. CPR was performed. He was relieved after about 10

minutes by Correctional Officer Sloane and returned to the lower kiosk of Unit 1 to monitor.

[22] He testified that he has received core training in suicide prevention and response prior to him being hired as a correctional officer. He has not received any mental health training. He received counseling and follow-up to deal with the stress of the incident.

Correctional Officer Doug Sloane (CO1)

[23] The witness testified that he responded to a call from Unit 1 at 00:35 hrs. He ran from Unit 5 to Unit 1, about 10 to 15 seconds away. He noted the presence at the time or shortly thereafter of Officers Roberston, Saggar and Derksen. He unlocked and entered the cell of Mr. Nicolson. He noted no signs of life. He called for further assistance. He switches CPR operations with Officer Derksen. He further testified as to the chronology of the arrival of paramedics, RCMP, the institutional nurse, other correctional officers and the medical examiner as previously indicated.

Correctional Officer Jeff Foreman (CO2)

[24] The witness testified to being stationed at the communications center. He received the radio transmission to call '911' from Unit 1 staff, as there was a hanging and an ambulance was required. He did so. He also contacted RCMP and the institutional nurse. All of this was done in a timely manner.

Correctional Officer Johnathon Gunter (CO2)

[25] The witness testified that he was not at the institute that day. He received a call at 00:35 hrs on August 28, 2003 requesting he return as there was an incident requiring extra staff. He testified as to speaking with the next door inmate of Mr. Nicolson. Nothing untoward had been noted by this inmate.

[26] The witness testified that his primary involvement was as counsel to the correctional officers responding to the suicide, to discuss the incident verbally with the officers, to assist and remind officers of the requirement to write a report and anything else they required.

Correctional Officer W.S. Robertson (CO3)

[27] The witness testified that at approximately 00:35 hrs on August 28, 2003, he was contacted by radio communication and requested to attend to Unit 1

immediately. The witness is a correctional supervisor and is in charge of the institute during evening and night shifts. He is the security supervisor during the day shift. He has been employed with the Stony Mountain Correctional Institute for 10 years. He testified that upon receiving the request, he proceeded to Unit 1 and was met there by Correctional Officers Derksen, Sloane and Saggar. He was informed that during the take-over count it was discovered that the inmate was hanging in his cell. Upon arrival at the cell, he saw the inmate Nicolson hanging by the neck from the ceiling of his cell. The inmate had apparently used a ripped bed sheet and tied it to the electrical fixture on the ceiling of his cell. He indicated that at approximately 00:38 hrs the cell was opened and the inmate was cut down. Correctional Officers Derksen, Saggar and himself supported the inmate and he was placed on the floor just outside of his cell and the rest of the bed sheet was cut off of his neck. Officer Derksen checked Nicolson for vital signs and none were found. CPR was administered by Officers Derkson and Saggar. The witness instructed the officers to continue with CPR and he went out to meet the ambulance and make other necessary phone calls. Stonewall Ambulance Service arrived at approximately 00:50 hrs. Inmate Nicolson was pronounced deceased by the ambulance attendants. Later institutional investigative security officers, the RCMP, and the medical examiner also attended.

[28] The witness testified that it is within the officer's discretion to open the cells while alone but this is very rare and only during the day. Institutional policy is that at least two officers be present for security reasons before a cell is opened.

[29] He further testified that with respect to the formal count system, there are four counts a day at 7 a.m., 11:30 a.m., 4:30 p.m., and 11 p.m. There are also informal counts which are done on occasion as required by each unit. With respect to Unit 1, the Intake Unit, at a minimum there is to be a range walk every hour. He testified that the times they do a range walk varies according to each individual Unit but on average a range walk on Unit 1 takes approximately 1 to 2 minutes if there are no problems found. He testified that a manual system known as the "Duistar" was used in August 2003.

[30] He testified that an automated system known as the "Silvergard" is now used which involves a guard punching a Silvergard disk at each end of the Unit which then records the time automatically. He further testified that there are two cameras on each range which are fixed and capable of taping. He was unable to testify as to whether or not the cameras were in use on the date in question.

Correctional Officer Jeet Saggar (CO2)

[31] The witness testified that he arrived at Unit 1 at approximately 00:30 hours for the formal take-over count. Officer Derksen was working the Unit. Officer Derksen proceeded to the upper ranges to begin the count. At approximately 00:35 hours, Officer Derksen came running down the stairs and informed him that there was an inmate hanging on Unit A6. The witness called for assistance. He also called the communicate centre and informed the officer that an ambulance was required immediately.

[32] Prior to all of this, he testified that he being responsible for bringing the Duistar check system to the Unit did so at approximately 00:30 hrs and handed the Duistar to Officer Derksen. He testified that Officer Derksen was observed to start his count on the upper unit tier and it was shortly thereafter that Officer Derksen came running down and informed him of Mr. Nicolson being found hanging in his cell. He also testified that he began recording the unit via the cameras. He testified he waited for back up and then noted Officer Derksen to enter the cell first and the officer then used the 911 emergency knife to cut the sheet around the neck of Mr. Nicolson. He testified that no vital signs were present. He testified that Officers Saggar and Derksen began to administer CPR. Officer Saggar was

administering chest compressions and was later relieved by Officer Sheasgreen. Paramedics arrived that took over the situation.

[33] The witness testified that he never knew the inmate Nicolson or had dealt with him before. He testified that he was given counseling after the incident. He testified that the counseling was of assistance to him. He testified that he drew double shift that day having commenced worked at 3:30 p.m. He testified that it was institutional policy at the time to do hourly walks on the range, but since this incident range walks are done on a half hour basis, randomized.

Correctional Officer Kenneth Staub (CO3)

[34] The witness testified that he is the correctional supervisor and has worked for 30 years with Corrections Canada both at Stony Mountain Institute and Rockwood Institute. He testified that there are two supervisors in charge (CO3) during the evening shift.

[35] He testified with respect to an incident that occurred on August 6, 2003. He testified that on that date, officers on Unit 1 alerted him that Mr. Nicolson had attempted to commit suicide and was taken to health care. He attended to the health care unit where Nurse Coates was administering first aid to the inmate. He noted cuts to the left wrist of Mr. Nicolson which appeared to be minor. He asked

Mr. Nicolson if he would be willing to be placed on the suicide observation unit and he explained the procedures to Mr. Nicolson. He testified that Mr. Nicolson was fully compliant and was willing to go to suicide observation. He testified that both Nurse Coates and Correctional Officer Melnyk (C02) witnessed a conversation between himself and the inmate. He testified the inmate was placed in Unit 5 under suicide observation.

Correctional Officer Harold Clark (C02)

[36] The witness testified that he was an acting correctional officer 2 on August 14, 2003 and at the time had been working with Corrections Canada for 2½ years. He testified that on August 14, 2003 Alan Nicolson approached him at Unit 1 upper kiosk and asked to speak to him. He testified that when questioned, Nicolson stated: “I feel highly suicidal and I want to kill myself. If I go back down range I’m going to slash up and hang myself.”

[37] Mr. Nicolson was asked if he had any materials in his cell to carry out his suicide threat to which Mr. Nicolson stated: “No, but I will just make something to use.” Mr. Nicolson also said to him that he lied to get out of suicide observation the previous day, being August 13, 2003, because he just wanted to go back to the mental health range to kill himself. The witness testified that he

escorted Mr. Nicolson to health care where he was seen by Nurse Cora Macneil. He then escorted Mr. Nicolson to the suicide observation cell E2.

[38] He testified that Mr. Nicolson was very compliant while being returned to the suicide watch unit.

Anne Coates

[39] The witness is a nurse at Stony Mountain Correctional Institute and has been for 11 years. She testified that she has a diploma as a registered nurse (1970) and as a mid-wife (1994). The registered nurse designation was at the Moncton Hospital School of Nursing. She has worked 30 years total as a nurse. She has no specific psychiatric training and has learned about psychiatric and psychological matters on the job.

[40] She testified that her first dealing with Alan Nicolson was on August 6, 2003 when Mr. Nicolson presented with what she termed as a scratched arm and suicidal ideation. She testified that on the date in question Mr. Nicolson appeared agitated and was threatening suicide. She testified that Mr. Nicolson said that his range was haunted and that he was hearing whispering noises. She testified that Mr. Nicolson informed her that he was diagnosed with Hepatitis C in 1998 or 1999 and was using injectable medication, but was currently asystematic. Mr. Nicolson

was asked if he was receiving any follow-up in the community. She testified that Mr. Nicolson appeared to her to be uncooperative and refused any follow-up in terms of blood work. She testified that Mr. Nicolson was fearful of needles. She testified that Mr. Nicolson was requesting Ritalin and Aspirin to manage his Hepatitis C. All these requests were denied. Mr. Nicolson then requested to see a doctor regarding a knee problem and this request was booked. She testified that the Hepatitis C concern would only be followed up at the inmate's initiation.

[41] She testified that she was aware that Mr. Nicolson had made a reference to "1984". The "1984" reference was with respect to a prison riot in 1984 in which a guard had been killed at the Stony Mountain Institute. The witness testified that she had become aware that Mr. Nicolson had previously made such a reference in a joking manner. She testified she did not take Mr. Nicolson's 1984 reference as a threat to anyone. She testified that she felt that Mr. Nicolson was not coming across as being totally honest. She testified that Mr. Nicolson would not do a "contract for safety". She testified that she was aware that a psychiatrist was coming to the Institute the next date, being August 7, 2003. She testified that at the time psychiatrists came to the Institute only on Tuesdays, Wednesdays and Thursdays.

[42] She testified that she had no other meetings with Mr. Nicolson. She indicated that she was never really concerned that Mr. Nicolson would actually commit suicide.

[43] She further testified that on August 27, 2003, she had a clinical meeting with Dr. Yaren who was the contract psychiatrist who had been and was to see Mr. Nicolson. She testified she stood by the door and listened in on the conversation between Mr. Nicolson and Dr. Yaren. She overhead Mr. Nicolson requesting an increase or a change in his medications including the desire to obtain Ritalin. Dr. Yaren had denied this request. She testified that Mr. Nicolson appeared "a little bit hostile verbally". On August 27, 2003, Mr. Nicolson was no longer in suicide observation and was in his cell on the intake range. She testified that she was unaware that Mr. Nicolson had banged his head on his cell wall and testified that if she was aware of this she would have examined him.

[44] She further testified that there is a "critical suicide intervention team" at Stony Mountain Institute consisting of the chief psychologist (Dr. Somers), a case psychologist, the chief of health care (a nurse manager), a nurse educator, a parole officer and a correctional officer 2 who would be on shift at the time of the meeting of the team.

[45] She testified that since August 2003, the mental health range has had a change in name from “mental health range” to “assisted living unit”. She testified that the change in name was only that, that there are no other changes made to the former “mental health unit”. She testified that she is the only nurse on the evening shift from 3 p.m. to 11 p.m. and that there is no nurse on the night shift. She is however on call as would be any other nurse from the prior shift.

[46] She testified that any clinician can place an inmate on suicide watch. As well, any clinician can take an inmate out of suicide watch.

[47] She testified as to her opinion of the character of another inmate Jon Nemeth, a witness at this inquest. She testified that in her opinion Mr. Nemeth was selfish and “gets what he wants”. She testified that she dealt with this inmate Nemeth approximately three times a week while Mr. Nemeth was there.

[48] She further testified that in her opinion Mr. Nicolson was also manipulative. She testified, under cross examination, that with respect to the August 6 scratches to Mr. Nicolson’s arm, she considered this manipulation and not a true suicide attempt. She further testified under cross examination that with respect to her over hearing of the conversation between Mr. Nicolson and the institutional psychiatrist, Dr. Yaren, on August 27, 2003, in part of the

conversation Mr. Nicolson stated that his anxiety was under control and that he had wanted Ritalin prescribed to him as he had attention deficit disorder. This was the Ritalin requested that had previously been indicated as denied by Dr. Yaren.

Cora Macneil

[49] The witness has been a nurse for 40 years receiving her registered nurse degree in the Philippines. She has been working for Corrections Canada at Stony Mountain Institute for 30 years. She testified that she had no independent recollection that Mr. Nicolson and relied upon notes that she had made of her interaction.

[50] She testified that she made a note in Mr. Nicolson's medical log about him refusing medication on August 7, 2003. She testified that on August 14, 2003 Mr. Nicolson showed no signs of depression or panic. She testified that to her knowledge Mr. Nicolson was not seen by a psychiatrist until August 20, 2003, though this is incorrect. She testified that policy has now been changed at the Institute whereby a psychiatrist makes rounds for all inmates at suicide watch every day that the psychiatrist is present.

Dr. Stanley Yaren

[51] It should be noted that the evidence of Dr. Yaren which was tendered at the Inquest of another inmate *Richard Franklin Lagimodiere* with regards to which a inquest report was submitted on August 10, 2005, was applied "mutatis mutandis" to this inquest. In that regard, Dr. Yaren's testimony at the Lagimodiere inquest is hereafter set forth in full as it appeared in that inquest.

[52] Dr. Yaren is a qualified expert in forensic psychiatry and was so permitted to give opinion evidence. Dr. Yaren testified that he has been the contract psychiatrist for Stony Mountain Institution since 1983 and has been attending Stony Mountain Institution for three half day clinics a week along with Dr. Globerman who is the other contract psychiatrist and attends to one of these half day clinics per week. He testified that he receives referrals from Stony Mountain Institution as a result of:

- *recidivism, that is from past history of psychiatric illness upon intake;*
- *screening by medical staff of new inmates where there are indications of anxiety, depression, psychosis, past history self harm ideation, or where the inmate is already on psychotropic prescription;*
- *by way of psychology department direct referral on intake;*

- *during family physician clinics at Stony Mountain Institution which are held several times a week;*
- *correctional staff will also initiate referrals which are filtered through the nursing staff;*
- *self referred mechanism by the inmate which is then proceeded through a screening process, eventually arriving to him.*

[53] Dr. Yaren testified that he was very familiar with Mr. Lagimodiere prior to Mr. Lagimodiere's last entrance to incarceration at Stony Mountain Institution. He cared for Mr. Lagimodiere for almost ten years, including past times that Mr. Lagimodiere was in gaol and in the community between times when Mr. Lagimodiere was in gaol.

[54] Dr. Yaren testified that Mr. Lagimodiere was diagnosed with schizophrenia and that his treatment for the past ten years was directed towards this disease. Dr. Yaren had known Mr. Lagimodiere for three years as an outpatient prior to the year 2000 which included meeting Mr. Lagimodiere regularly for clinical interviews, usually during the time when Mr. Lagimodiere would attend for his four week interval injection of Haldol, which is a psychotropic medication.

[55] Dr. Yaren testified that Mr. Lagimodiere was receiving a high dose of Haldol being 180 milligrams injectible to which he was showing a good response. Mr. Lagimodiere's response to the medication was effective, there had been no

reoccurrence of symptoms for several years and Mr. Lagimodiere was quite motivated to take the medication.

[56] He testified that Mr. Lagimodiere had a good degree of insight into his disease although he rejected new drugs as he was content with the Haldol treatment and was anxious regarding any change in his medication. Dr. Yaren testified that Haldol, was a drug that was first administered starting in 1970 and has shown to be effective in treatment of forms of schizophrenia. He indicated that Haldol has been implicated in psychosis and can result in a disphoric which can contribute to self harm. However, he had not seen this as a side effect in Mr. Lagimodiere. Dr. Yaren referred to his clinical notes of June 11th, 2003, which was the last time he saw Mr. Lagimodiere. Dr. Yaren attended Stony Mountain Institution on June 11th as a result of a prearranged appointment at a scheduled clinic. His notes indicate that Mr. Lagimodiere had no relapse for four years and that there had been no cognitive decline in Mr. Lagimodiere during that period of time.

[57] His notes indicated that Mr. Lagimodiere admitted to starting using crack cocaine approximately three years ago, which had led to further criminal activity. Mr. Lagimodiere was encouraged to try new medications. Mr. Lagimodiere

apparently indicated that he would consider the new medication when he was transferred to the mental health range. Dr. Yaren renewed Mr. Lagimodiere's prescription and scheduled Mr. Lagimodiere to be seen on his next regular visit to Stony Mountain Institution.

[58] Dr. Yaren testified that he was "very surprised" to hear of Mr. Lagimodiere's suicide. He testified that there is no such thing as a zero risk of suicide in any of his patients with mental illness. He testified that the risk for self harm is greater for individuals with schizophrenia and it is greater during the acute phases of schizophrenia.

[59] He testified the risk for self harm also increases with past history of self harm, history of substance abuse, being younger, social alienation and the presence of stressors. He testified that Mr. Lagimodiere's desire to possibly confess to a serious past crime, possibly homicide, was a clear stressor. However, Mr. Lagimodiere had tolerated other stressors quite well in the past during his treatment of him and as well Mr. Lagimodiere had been in prison for lengthy periods of time previously and had handled those periods well.

[60] With respect to Dr. Yaren's relationship with Stony Mountain Institution, he testified that he reports directly to the Chief of Health Care, being Dr. Kim

Shaw. He has a day-to-day relationship with the nursing staff that assists him with his clinics.

[61] He testified that he has occasional discussions with the psychology department on a case-by-case basis. He shares his psychiatric file on an inmate on a request basis. He testified that the health care file is subject to privacy regulations but is shared on a request basis.

[62] He testified that the intake psychological assessment is placed in the health care file and that he does have access to it. He does not use the self reporting suicide assessment scale, although he is aware that some psychiatrists do use it. He indicated that a high score on the BSS would be of interest to him combined with other knowledge of his patient, but that his other knowledge of his patient may override any score on a BSS self reporting. He testified that there is no psychiatric nurse position currently at Stony Mountain Institution. He testified that it would be highly desirable to have a registered psychiatric nurse (R.P.N.) which is a specialized stream separate from the registered nurse stream.

[63] He testified that a registered nurse who is not a registered psychiatric nurse could be trained in the area, or a registered nurse with experience or training in the psychiatric area would be of assistance. However, ideally he would

like to see a registered psychiatric nurse at Stony Mountain Institution. He testified that the absence of a nurse very much affects his ability to assist inmates.

[64] He testified that the function of a registered psychiatric nurse would be:

- *to make him and the psychiatry department more familiar with the inmate;*
- *to provide ongoing care;*
- *to assist in communication with psychiatrists and the psychology department;*
- *there would be much better continuing of care between his visits;*
- *to assist with clinics and provide quick updates on inmates;*
- *liaison with staff, administration and the psychology department;*
- *would allow psychiatry to focus on treatment and free time for others in the psychology department of Stony Mountain Institution.*

[65] He testified that a registered psychiatric nurse would be very desirable and valuable in the Stony Mountain Institutional setting and would increase the overall functioning of psychiatric aid to inmates. He testified that his ongoing caseload at Stony Mountain is 50 inmates with Dr. Globerman having an ongoing caseload of 25 inmates.

[66] He testified that the majority of Stony Mountain inmates that he sees would be outpatients if they were not in gaol, but this is because there would be a lot more resources available outside of gaol. He testified that in terms of access to a psychiatrist, this is probably better for inmates then it is within the community, as within the community it would take up to several months to see a psychiatrist, whereas in the institution the psychiatrists go there three times per week.

[67] He testified that the ability of himself and Dr. Globerman to see an inmate as needed compensates for the lack of community resources. He testified that treatment of individuals in an institutional setting is more than just housing them in the same area and that there is no point to housing individuals in the same area if resources are not provided for their treatment.

[68] He testified that there needs to be more up front investment in health issues, including addictions issues and "classic" mental health treatment. He testified that both of these are lacking at the Stony Mountain Institution. Dr. Yaren testified that it is his own perception that he is very experienced in the treatment of schizophrenia.

[69] He testified that he respects all the staff at Stony Mountain in terms of the medical staff and that they have varying degrees of experience and competence. He

testified that he was not involved in setting up of the mental health range at Stony Mountain Institution or of any other facility like Stony Mountain Institution. There is no formal notification to him or his department when an inmate is placed on the mental health range. He advises that he is informed by the nursing staff if an individual is placed on suicide watch and the inmate is either his patient or Dr. Globerman's patient, but is otherwise not advised.

[70] He further testified generally about the progression of schizophrenia which he described as being a progressive disease, going through certain phases. He testified that even upon treatment of individuals who have gone through the phases that relapses are common.

[71] He testified that many patients are fully treated or "cured", but this is only in the minority of cases. He testified that before Mr. Lagimodiere went to gaol in 2003 he was "quite stable", "very cooperative", "insightful", "very compliant", and "never missed his Haldol injection". Mr. Lagimodiere was described as someone with a pleasant demeanor who continued to be quite stable and seemed in particularly good spirits for someone in gaol.

[72] Dr. Yaren further testified and concluded his testimony by stating that he was confident Mr. Lagimodiere was stable at the time of his admission to Stony

Mountain Institution and that he saw no signs of concern to him with respect to suicidal ideation when he last met with Mr. Lagimodiere on June 11th, 2003.

[73] Dr. Yaren further testified that Mr. Nicolson was a patient under his care during his incarceration at Stony Mountain Institute. He testified that on July 24th, Mr. Nicolson was identified by the intake nurse as someone with a psychological history and therefore Mr. Nicolson was referred to him. He testified that he first saw Mr. Nicolson on July 24th but at that time had no documentation on him. This was a preliminary meeting. He was aware that Mr. Nicolson has been at the Winnipeg Remand Centre for about one month but that he did not have any records from the Winnipeg Remand Centre. He was aware that a Dr. Khamanda was Mr. Nicolson's family physician but he never obtained any records from Dr. Khamanda. He testified that he was aware that Mr. Nicolson was on a regime of medicine which included the following:

1. Effexor - This is an anti-depressant used for general anxiety disorder and panic disorder. Mr. Nicolson was taking 300mg, one time a day in the morning.

2. Rispradol(sic) – This is a second general anti-psychotic used for persons with schizophrenia of a bi-polar type, and for depression with psychotic features. Mr. Nicolson was to take 2mg at bedtime.

3. Alprazolam(sic) – Dr. Yaren testified that this drug was discontinued at the Winnipeg Remand Centre. It is used as an anti-anxiety drug for short term usage as it is possibly addictive.

[74] Dr. Yaren testified that from the medications that Mr. Nicolson was on, he was generally aware of Mr. Nicolson's medical requirements from a psychiatric stand point. He was aware that Mr. Nicolson had a substance abuse history and had previous suicide attempts. He testified that it is not uncommon for inmates to present with a history of mixed substance abuse and psychosis. He was unable to determine if the substance abuse was as a result of an underlying psychosis or if the substance abuse induced the psychotic symptoms that Mr. Nicolson had presented with in the past.

[75] Dr. Yaren testified that he wanted to wait for a psychological assessment for more information. In that regard he indicates that a nurse practitioner would be very helpful to him in doing his job as there would be from a nurse psychiatrist the ability to contact family members, contact with the Winnipeg

Remand Centre, observations of an inmate and contact with correctional officers who would know the inmate better.

[76] Dr. Yaren testified that he again met with Mr. Nicolson on July 30th. Mr. Nicolson complained of anxiety attacks and wanted an increase in a drug that had been substituted for Alprazolam, being the drug Chlonazapam. Mr. Nicolson was very insistent that he wanted this new drug.

[77] Dr. Yaren indicated that he agreed to increase the drug, giving Mr. Nicolson the benefit of the doubt but that he was cautious that he was perhaps being conned. Dr. Yaren indicated that the drug can be used for sale or trade, that it has an institutional value. He testified that the effects of Chlonazapam are similar to alcohol in that it induces euphoria and can enhance the effects of alcohol. A change was made in Mr. Nicolson's medicine regime to provide the medicine two times daily in the morning and afternoon at 2mg each.

[78] Dr. Yaren testified that he next met with Mr. Nicolson on August 7, 2003. He was aware that Mr. Nicolson had attempted suicide on August 6 and was aware of Nurse Coates' notes. At the meeting Mr. Nicolson demanded an increase in his medication. Dr. Yaren agreed only to increase the Rispradol and not the Chlonazapam as demanded by Mr. Nicolson. Dr. Yaren stated that Mr. Nicolson

continued to express concerns for self harm if he continued anxiety attacks. Dr. Yaren wanted the suicide watch to continue. Mr. Nicolson appeared quite assertive and aggressive in his requests. Dr. Yaren testified that Mr. Nicolson was never overtly aggressive but was hostile at times. The Rispradol medication was now increased to 2mg, two times a day.

[79] Dr. Yaren testified that it would be highly desirable if the Stony Mountain Institute had a psychiatric nurse for various reasons. He testified that having a psychiatric nurse would be of great assistance in identifying and assisting with inmates who are suicidal or who are indicating suicidal ideation. He testified that he left Mr. Nicolson on suicide watch as he felt that Mr. Nicolson remained as a moderate risk for real self harm. He testified that he did not feel that Mr. Nicolson would actually commit suicide or do a real attempt at suicide. He believed that Mr. Nicolson's attempt to date were "para-suicide" which are self harm actions motivated by other reasons that actual attempts at suicide. He testified that he was still acquiring ongoing knowledge of Mr. Nicolson and his background as he still had no file except for the history that had been self reported by Mr. Nicolson.

[80] Dr. Yaren testified that he next saw Mr. Nicolson on August 13th, 2003. At the time, Mr. Nicolson denied any hallucinations. He claimed that the Rispradol was making him anxious and he wanted to go off of it. Mr. Nicolson claimed he was no longer suicidal and wanted out of suicide watch. He again demanded an increase in his Chlonazapam which was denied. Dr. Yaren's assessment of the risk of Mr. Nicolson doing self harm was minimal. Dr. Yaren testified that if an inmate presents with any indication of a possibility of self harm or talk of self harm, he should be placed in suicide watch. In his words "if someone is threatening to commit suicide, they will likely do it" in terms of self harm. Dr. Yaren discontinued suicide observation at this time.

[81] Dr. Yaren testified that he was having trouble with Mr. Nicolson's agenda as being genuine. He felt that Mr. Nicolson was possibly being manipulative and that Mr. Nicolson's self reporting of his mental condition did not make clinical sense. Dr. Yaren testified that he was subsequently made aware that Mr. Nicolson was placed back in suicide watch on August 14, 2003. It was his conclusion that Mr. Nicolson was deceiving him or attempting to deceive him in order to change his medications but he was not a hundred percent sure. He had to use his best judgment and in that regard can never say that a suicide risk is zero percent. Dr. Yaren testified that he always has the option to transfer an inmate to

the Saskatchewan penitentiary which has a mental health ward. He testified that the system works well in that upon his request, an inmate will be transferred to Saskatchewan without question. He testified that in his judgment, Mr. Nicolson's suicide risk was manageable and that he ought not to be transferred to any specialized mental health institute.

[82] Dr. Yaren testified that he again met with Mr. Nicolson on August 20, 2003. At the time Mr. Nicolson did not present to him as being in danger of committing suicide. Having been aware of the "head banging" incident, he did not perceive this as a real self harm attempt and was more indicative of mental distress. Mr. Nicolson reported hearing voices again but Dr. Yaren testified that this was to him unconvincing. His self reporting did not match well with his overall symptoms. Mr. Nicolson appeared very calm and in Dr. Yaren's opinion some of his reported episodes were clearly manipulative and exaggerated. Dr. Yaren increased the dosage of Effexor for Mr. Nicolson and he was removed from suicide watch on his order.

[83] Dr. Yaren testified that he last met with Mr. Nicolson on August 27, 2003. At the time Mr. Nicolson wanted an increase to his Ritalin and advised Dr. Yaren of his attention deficit disorder history. Dr. Yaren indicated he was puzzled

and suspicious as to how Mr. Nicolson could have forgotten this and not told him earlier. Dr. Yaren testified that Ritalin has a high potential for abuse and is highly sought after in the prison environment. The request for Ritalin was denied.

[84] Dr. Yaren testified that according to the observation notes, in fact no observations notes were made in his medical file up to his death August 28, 2003. From that Dr. Yaren was able to deduce that Mr. Nicolson was doing well and adjusting to his return to the intake assessment unit.

[85] Dr. Yaren testified that Mr. Nicolson was settled and cooperative and although he was disappointed in not getting the Ritalin, he was not hostile. This seems to accord fairly well with the testimony of Nurse Coates.

[86] Dr. Yaren testified that because of Mr. Nicolson's history, there is always some risk in terms of suicide. He testified that he must make a judgment call in that regard. He testified he was very surprised when notified of Mr. Nicolson's death; indeed he was "shocked".

[87] Dr. Yaren testified that in his opinion, on August 27th, 2003, Mr. Nicolson presented as a long term suicide risk but not immediate. He testified that between August 20th and August 27th, 2003, Mr. Nicolson's health record

indicates that he did not involve health care staff although he had further dealings with correctional officers in that week which were problematic.

[88] Dr. Yaren was cross examined by Raymond Nicolson, father of Alan Nicolson, with respect to why his son was not kept in suicide watch after August 20th, 2003. Dr. Yaren testified that it would be inhumane for Mr. Nicolson to remain there indefinitely as it was in his opinion no longer necessary for him to remain there. Dr. Yaren was asked why Mr. Nicolson or any inmate for that matter in suicide watch is not given books, magazines, games etc. to occupy them while in the suicide watch cell. To this Dr. Yaren responded that those people who are supervising the suicide watch cells are there for security purposes and not for therapy and they are simply following a strict protocol which emphasizes security over therapy.

Rose Lionetti

[89] The witness is the aboriginal liaison officer at the Stony Mountain Institute. Her job is to facilitate communication between inmates, staff and aboriginal elders. She has been trained as a suicide prevention trainer and has been trained in several prevention and detection programs for inmates. She has conducted several full day courses in 2002 and 2003 in which many correctional

staff have been trained. She testified that in 2002, she had three full day sessions and in 2003, she had three sessions in which 36 correctional officers and other staff were trained in suicide prevention, intervention, and post event conduct. She testified that in 2004, there was no training as a result of work load issues and lack of funding. She testified that another session was to be done in February or March of 2005.

[90] She testified she does training with respect to suicide prevention and intervention along with a Greg Hart in a shared capacity. She feels that the program that she has been trained on and that she is using is an excellent program. She is required to maintain a certificate by doing three sessions a year and is concerned about her losing her certificate as she has done no training in 2004.

[91] She testified that there are up to 500 staff at the Stony Mountain Institute so that there is a good deal more training needed with respect to the issue of suicide.

[92] She testified she has a Bachelor of Science, Social Work from the University of Manitoba in 1994 and has worked for Corrections Canada now for four years. Previously she had worked for Child and Family Services at various aboriginal agencies.

[93] She testified under cross examination that she is satisfied with the level of training that she has received in order for herself to become a trainer in the area of suicide prevention and detection. She testified that she has an ongoing case load and that if somebody is on suicide watch and on her case load, she would see that person but if that person is not on her case load, she would not see them.

[94] She testified that she never met Mr. Nicolson. She testified she was on holidays from the end of July to the beginning of September. She testified that she went through the basic correctional officer training program but that she felt that the suicide training of correctional officers in terms of prevention and detection was very basic.

Rosemary Paley

[95] The witness is a parole officer with seven years experience. She testified that there is a case management system with respect to each inmate and that every contact by staff is to be recorded in this case management system.

[96] She testified that in the summer of 2003 she was assigned to the Intake Assessment Unit at the Stony Mountain Institute. She testified that she was on the Intake Unit on July 22, 2003 and was assigned to a Intake Parole Officer. She testified that during the intake process, numerous tests and reports are collected

with respect to an inmate including court records, history of substance abuse, educational background, and a health assessment and in selected cases a psychological intake assessment. She testified that an inmate is normally not seen by herself as a parole officer but she did see Mr. Nicolson. She met Mr. Nicolson early regarding a money issue and then met with him on August 7, 2003. At the time, Mr. Nicolson was in segregation (suicide watch) and was on her case load. It was her responsibility to see anyone on her case load once per week while the person was in segregation.

[97] She testified that on August 7 she noted self harm marks on Mr. Nicolson's wrists which were inflicted the day before. Mr. Nicolson agreed with her this was not appropriate. Mr. Nicolson indicated he was not sleeping well. Ms. Paley encouraged Mr. Nicolson to continue to speak to staff regarding any issues that he may have.

[98] Ms. Paley next met with Mr. Nicolson on August 14 at 10:30 a.m. in the dome area of Unit 1. At the time Mr. Nicolson appeared calm and was polite. She testified that Mr. Nicolson had a fixation to go to the regional psychiatric centre in Saskatchewan. She indicated that she reminded Mr. Nicolson that he was still on

the intake process, that he would be assessed psychologically at the appropriate time and that he was encouraged to speak to staff if he had any ongoing problems.

[99] Ms. Paley testified that there are approximately 300 new intake inmates per year. She testified her only recollection of Mr. Nicolson was from her notes.

[100] She testified that she again met with Mr. Nicolson in Unit 5, in suicide watch on August 15. Mr. Nicolson refused to come out from his cell. However, shortly thereafter he did agree to come out and they met in the interview room in the hallway near the suicide watch cell. There was a brief discussion. Mr. Nicolson was not rude or yelling.

[101] The witness testified that she met with Mr. Nicolson on August 21st, and recalled from her notes that Mr. Nicolson was calm and polite. Mr. Nicolson was now in intake as he was not following instructions from his psychologist. Mr. Nicolson denied any manipulation of his symptoms. He provided several reasons why he should not be in intake, but rather should be in the mental health ward. He seemed not to understand why he was removed from the mental health ward and blamed correctional officers Cole and Blaine for being removed from the mental health range and being placed on the intake range. Mr. Nicolson was advised that he no longer met the criteria for being on the mental health range. He

was advised that intake will review his needs shortly. Mr. Nicolson was advised that if he was not going to be in mental health range or in Saskatchewan Regional Mental Centre, he wanted to be in segregation. The witness testified that at the end of the interview, Mr. Nicolson became red in the face, angry and terminated the interview.

[102] The witness testified that criteria for the mental health range includes the following:

1) suicide history;

2) whether on medications;

3) whether low functioning; and

4) the overall mental health history.

[103] The witness testified that she felt that Mr. Nicolson was stable, that his medications were appropriate, and that he was not at risk of self harm or that his risk of self harm was low.

[104] She testified that on average there are 17 to 18 admissions to the Stony Mountain Institute per month. Her duty is to review the inmate file just before the inmate is released from intake which is a process that takes about 8 to 10 weeks.

The inmate file is then given to the case management team for a final assignment into the Institute from the Intake Unit. She testified that on the case management team is herself, the unit managers, the mental health parole officer, the intake correctional officer, the chief of programs, a representative of health care, the inmate's parole officer (in Mr. Nicolson's case being Charmaine Nickels).

Greg Hart

[105] Mr. Hart has been with Corrections Canada since 1997 and with Stony Mountain Institute since early 2003. He is currently assigned to the Rockwood Institution and was so assigned in 2003. He has been trained on the "Living Works Program" and has been trained in Suicide Recognition Prevention and Dealing With Suicide.

[106] He testified that he has completed a three day course in the Living Works program which includes a suicide recognition and prevention module, in order for himself to be trained to give the course.

[107] He testified that in his career he has given the course four times, only once to guards, the rest being to program personnel.

[108] He testified he did not teach any of the course in 2004, being decertified to do so in 2003. He testified he was told by the Stony Mountain Institute management to teach the program anyway although he had been decertified. He testified that Corrections Canada has three modules and testified generally as to the suicide prevention and detection training given by Corrections Canada. He testified that the overall program is excellent and felt that it needed to be given to all staff. He testified that training for correctional officer and front line staff is minimal and that the training in the area is "glossed over". He testified that suicide prevention and detection can be and should be done as part of the core training for newly hired correctional officers.

[109] He testified that in his opinion, placing an inmate on suicide watch was basically a "rest area" and that little was done to assist the inmate while the inmate was in the suicide watch area.

Sandy Woytowich

[110] The witness was the acting unit manager at Unit 1 in 2003. She has worked for Corrections Canada at Stony Mountain Institute for 11 years and use to be a parole officer. As unit manager, she is in charge of the overall management of

the unit in an overseer role. She never met Mr. Nicolson and was involved in one decision regarding him.

[111] She testified that she was involved in the placement of Mr. Nicolson back to intake from the mental health unit. She testified that his parole officer Charmaine Nickels came to her regarding Mr. Nicolson's behaviour being disruptive. Ms. Nickels had recommended that Mr. Nicolson be taken off of the mental health unit and placed on the intake unit which to her recollection occurred on August 21st, 2003.

[112] She testified the decision to transfer an inmate from mental health unit to any other unit is made by several people although the ultimate decision is hers. She testified that she was told that Mr. Nicolson was being disruptive, manipulative and was inciting other inmates to demand things. She testified that she accepted Charmaine Nickels' recommendation and as well she had collateral information from other staff. She testified that even if an individual meets all the criteria to remain or be on the mental health range, if the inmate's behaviour cannot be managed, the inmate can be removed from the mental health range. She testified that the mental health range and the intake range are basically the same in terms of physical layout and in terms of supervision and programming available.

She testified that in effect the “mental health range” is a mental health range in name only.

Charmaine Nickels

[113] Ms. Nickels was Mr. Nicolson’s parole officer. She has a Bachelor of Arts and Criminology/Sociology from the University of Manitoba and had been a parole officer for 4 years. She was on the mental health range for five months before August 2003. She testified that in the summer of 2003, she was assigned to the mental health range with an assigned case load. She testified that there is no written criteria for transfer to the mental health range other than issues of “vulnerability”, “mental health issues”, and that the placement is to be voluntary. She was not aware of any other specific criteria to be placed on the mental health range. She testified that if any inmate is placed on the mental health range she is assigned as that inmate’s parole officer as an adjunct. She testified that if Mr. Nicolson was physically on the mental health range that she would have contact with him. She testified that Ms. Paley is Mr. Nicolson’s parole officer, not her.

[114] She testified that in terms of mental health issues, she receives no training. She testified that when she was shifted from Unit 5 to Unit 1, five months

before, August 2003, she received no training with respect to the issues that she would now probably have to deal with. She testified that her first involvement with Mr. Nicolson was when he was first at the Institute on July 22, 2003. She testified generally as to the expectations of Mr. Nicolson while in the Institute. She was asked by Mr. Nicolson at the time if it was appropriate for him to go to the mental health range. She explained the procedures in that regard to him. In her opinion, Mr. Nicolson met the criteria to go to the mental health range although there is no formal process in that regard. He was subsequently so placed.

[115] The witness then met with Mr. Nicolson again on August 6, 2003 which was a routine meeting between Mr. Nicolson and a correctional officer Blaine. She testified that during the meeting Mr. Nicolson stated: “it sounded like staff here want another 1984”. He said so loudly. The reference to 1984 was in their opinion a reference to a riot in 1984 in which a correctional guards had been killed. Apparently there is still a great deal of sensitivity among correctional staff regarding that incident. She testified that correctional officer Blaine and her indicated that Mr. Nicolson’s outburst was inappropriate, that the comments were not to be repeated.

[116] She testified that she was aware that Mr. Nicolson was taken into suicide observation shortly after this incident as a result of wrist slashing.

[117] She testified that she next met with Mr. Nicolson on August 20, 2003 regarding the transfer of money. She testified that she was not aware of any money issues but when told that there appeared to be no money in his account, he became belligerent and upset. He asked the witness to call finance. She told him she could not do anything about it at the moment. She testified that Mr. Nicolson was reminded that he was placed on the mental health range as a favour to the intake assessment unit as he reported anxiety and history of mental illness upon arrival. When she advised Mr. Nicolson that she was considering placing him back to the intake assessment range in light of his commitment to change his behaviour, he stated: “I don’t care what you do.” She testified that Mr. Nicolson became belligerent and when he reached the door, he turned around and stuck his middle finger in her face and stated: “You’re a fucking bitch.” She testified this his aggressive and abusive behaviour continued while the correctional staff returned him to his cell and upon arrival to his cell he slammed his door and started to bang on the door. The witness testified that there were a number of factors for placing Mr. Nicolson into intake including what happened at this meeting, his history of

behaviour, the possible effect of his disruptive behaviour to the rest of the mental health range and this suicide attempts appear to be manipulative.

[118] She testified that Mr. Nicolson met the criteria for the mental health range but his behaviour was simply too disruptive for him to remain there.

[119] Under cross examination, the witness testified that she was not aware that Mr. Nicolson had schizophrenia or had been previously so diagnosed.

Wayne Siemens

[120] It was agreed at the outset of this inquest that Mr. Siemens' testimony from the Lagimodiere Inquest, be applied mutatis mutandis to this inquest and therefore the contents of his summarization of facts from that inquest are set forth as follows:

[121] This witness is a psychological associate at Stony Mountain Institution. He holds a Master of Arts Degree in Marriage and Family Counseling and was a practicing family therapist in British Columbia for a number of years. He first began employment with Stony Mountain Institution (Corrections Canada) in 1996. He indicates that he received no formal training prior to his employment but did attend two or three orientation sessions. He had previous training in suicide and

suicide prevention as part of his Master of Arts Education. He had also attended a one day seminar "Assessing Suicide Risk" put on by the Manitoba Psychological Society which is the educational wing of the Manitoba Society of Psychologists. In his current job he is a clinician with the Sex Offender Program at Stony Mountain Institution. He commenced this job in the spring of 2003, having received two weeks training in sex offender therapy. He returned to Stony Mountain shortly after his training. Prior to being a sexual offender program clinician he did do psychological intake assessments and was involved in crisis intervention for inmates. His job in that regard was taken over by Theresa Houston.

[122] He testified that the Department of Psychology's role at Stony Mountain Institution was multi-faceted. The role of the department included he being notified of new offenders, and receiving a printed copy of the inmate's preliminary assessment. After reading the report if there was any mental health concerns then he himself would proceed to the intake unit and interview that inmate in an interview that would take up to one hour. He would take notes during the interview with the inmate. His final assessment of the intake in terms of mental health would take from one day to eight weeks to complete. If there are no mental health concerns then his assessment would take one day, but if there were mental health concerns of a major nature then a full assessment was required, which would take

up to eight weeks. His report would be submitted to a case management team that would meet to consider the inmate's placement within the institution, including security placement and general health/mental health follow-up.

[123] He indicates that prior to 2000 he was part of a mental health team as the primary clinician and did so from the fall of 1997 to 1999. He testified that there are currently no clinicians as part of the mental health team. He indicates that there are currently no program officers to provide programming to inmates with mental health needs.

[124] He testified that prior to 1997 there was a psychiatric nurse on staff but this is no longer the case. He testified that the contract psychiatrists to the Stony Mountain Institution, being Dr. Stanley Yaren and Dr. Daniel Globerman, do not regularly attend mental health team meetings, although that has happened infrequently in the past. As to why he became involved with Mr. Lagimodiere in June of 2003, he testified this was a result of Theresa Houston advising him that Mr. Lagimodiere had an elevated suicide risk.

[125] He testified that it was not his position to do a suicide assessment but he did so because he was available. He testified that he reviewed Mr. Lagimodiere's two page suicide self report which he uses as an aid in assessment of

Mr. Lagimodiere's or any inmates overall psychological profile. He indicates that the self report form (BSS) is routinely administered to new inmates. He then meets with inmates and he did meet with Mr. Lagimodiere as a result of the self report form and a review of Mr. Lagimodiere's "psychology file". He was not sure if he had seen all of Mr. Lagimodiere's intake materials before meeting with him, but he did see Mr. Lagimodiere's psychological intake screening interview. He says he was not aware of any particular protocol if an inmate had a high BSS score.

[126] He testified he met Mr. Lagimodiere on June 19th and assessed Mr. Lagimodiere in terms of Mr. Lagimodiere's current state of mental fitness, current stressors, current mood, any suicidal ideations and as a result of his interview and his overall knowledge of Mr. Lagimodiere's file, he did not place Mr. Lagimodiere in suicide watch, but felt that further assessment was indicated and that a full assessment in terms of a psychological profile needed to be done. This was a process that was still ongoing prior to Mr. Lagimodiere committing suicide on June 29th.

[127] The witness testified that psychological screening intakes are done by him and that he is responsible for they psychological screening intake of Mr. Nicolson. The witness simply testified as to the preparation of his

psychological intake screening memorandum dated July 23rd, 2003, which was filed as Exhibit 24 at the inquest.

[128] In summary, upon initial psychological screening of Mr. Nicolson he was assessed as moderate risk for engaging in self harm. The witness testified that the initial intake assessment was only done the day after Mr. Nicolson arrived at the Stony Mountain Institute and therefore should be considered only as a historical summary. The report concludes with the recommendation that there be close monitoring of Mr. Nicolson's mental health state and behaviour and that Mr. Nicolson met the criteria for a psychological intake assessment.

Dr. Kent Somers

[129] Dr. Somers is a registered psychologist, having obtained his Doctorate in Psychology at the University of Manitoba in 1998 and has been a registered psychologist in Manitoba since 2000. He worked nine years for the Child Guidance Clinic and also in private practice up to the year 2000. He has been employed by Corrections Canada since the spring of 2000 as the Chief Psychologist on the psychology unit at Stony Mountain Institution. The psychology unit consists of himself as the Chief Psychologist, an administrative clerk, apparently borrowed from another department, contract psychologists who are

hired on an occasional basis and two psychological associates, one of which is currently doing sexual offender treatment.

[130] He indicates that in the past the department has been much larger, including a Chief Psychologist, two registered PHD Psychologists inside Manitoba, two registered PHD Psychologists outside Manitoba, a psychological assistant, two clerks and contract psychologists who would be responsible for psychological assessments on intake or for the parole board and a contract psychologist from the Manitoba Schizophrenic Society.

[131] Dr. Somers testified that through the years the number of personnel in the psychological unit has been considerably reduced as indicated. He testified that the mental health services are available to all inmates and that the mental health team is available to anyone for consultation. Specific services are provided to vulnerable persons, inmates with documented mental illness and inmates with assessments of suicidal problems.

[132] He testified that it is desirable to have a psychiatric nurse, a program officer with an assistant nurse and a parole officer, all of whom would be assigned directly to the mental health unit. As already indicated he testified that the resources have eroded over time due to restraints of budget and shifting demands

on the mental health unit's time. Why this has occurred according to him is because or the shift of emphasis to intake assessments being done and parole assessments being done on a timely basis and further resources being taken up by sexual offender treatment. As a result there is less time for interventions for programming and absolutely no time for research.

[133] With respect to research psychological intervention in an incarceratory setting is an area of research that appears to be quite lacking. He testified that he never met Mr. Nicolson. He testified that a recent change from the mental health unit range now being called the "supportive living range" is really only a matter of semantics.

[134] He testified that the range is not truly a mental health range and that there is no true orientation towards mental health. There is a lack of true mental health services and that this is a matter of money. He felt that his unit is not responsible for the mental health range in any way. The responsibility of the unit is that of the unit manager, and not of psychological services. Psychological services at the Stony Mountain Institution is a consultative service, where as the running of the range is by the unit manager. Psychological services may be called to the unit on a consultative basis, but they are not involved in treatment or programming of

anyone on the mental health range or as it is now called, "the supportive living range".

[135] He views the mental health range as being like any other range with some extra limited resources. He testified that prior to 2003 and the deaths of Mr. Lagimodiere and Alan Nicolson by suicide, the psychiatric and psychological resources available to inmates functioned somewhat separately. For instance if psychiatry admits someone to the suicide observation then only psychiatry can remove the inmate. If psychology admits someone to the suicide watch or suicide range, then only psychology could remove the inmate. This was the case in 2003. He testified the situation now is that anyone can admit an inmate to suicide watch or observation. The psychology department or health care staff will do the observation of the inmate. An assessment is done by a nurse on weekends or by the psychology department. There is a meeting by the mental health team to plan further action with respect to an inmate on suicide observation. Upon recommendation by the psychology department or the psychiatry department, the department being under contract, an inmate can be removed after recommendation to the warden.

[136] He testified that since 2003 there is better communication between the two disciplines of psychiatry and psychology and that this was in direct response to the recommendations of the commission investigating the death of an inmate, Alan Hansen, who was the subject of a prior inquest and report. He testified that as a result of a new directive, being directive 843, there is now more suicide awareness training and prevention for new employees and refresher training for current employees. However, he testified that there is really nothing with respect to providing resources for research or for programming.

[137] He testified that training is now required for all CO I and CO II Correctional Officers, which are provided by Corrections Canada on hiring and on demand from correctional program officers and that there is one correctional officer, Greg Hart, CO II classification, designated for training on suicide prevention and detection.

[138] He testified that the contract psychiatrists, Dr. Yaren and Dr. Globerman are attached to the health care unit which is separate from the institutional psychology unit.

[139] He testified that Mr. Nicolson was undergoing a psychological intake assessment at the time of his death which was more intensive than the routine intake assessment.

[140] *He testified that there are new standing orders from Corrections Canada with respect to suicide and suicide prevention being standing orders #843 and #850, which have been filed as exhibits in this inquest.*

[141] In essence, Dr. Somers has testified that it was institutional policy which made the psychology department not very much involved in the mental health range or with respect to inmates in suicide watch. He testified that the time psychology and psychiatry were not well coordinated. He testified that he is constantly petitioning senior management for more resources and staffing. He testified that since the summer of 2003 some positive changes have been made. In particular:

1) a case suicide intervention team has been set up and is created to deal with any high risk inmate

2) the suicide watch cell protocol has been changed to ensure that all people in suicide watch are cared for and are seen by someone from psychology or psychiatry on a daily basis from Monday to Friday.

[142] He testified that with respect to the critical decision to move Mr. Nicolson directly from suicide watch to intake and assessment range on August 21, 2003, that this was done without any input from a psychiatrist or a psychologist. In effect, there is a lack of inter-disciplinary communication and planning of the care for mental health inmates with such communication and planning being unstructured and very difficult to structure given the resources and competency of the staff available.

[143] Under cross examination, Dr. Somers testified and agreed that placement in suicide watch can be a sanctuary for some people in that they are not genuinely suicidal but need to be there for some other reason including protection from other people. He could not say if that was the case for Mr. Nicolson.

Jon Nemeth

[144] The witness is an inmate at Stony Mountain Institute. At the time of his testifying at the inquest, he had been at Headingley Correctional Institute for one year, but previous to that had been an inmate at Stony Mountain for about six or seven years. He has a lengthy property record.

[145] In the summer of 2003, Mr. Nemeth testified that he was on the mental health unit due to eating problems and an anxiety disorder. He met Mr. Nicolson at Stony Mountain Institute and knew him only from that time period.

[146] He testified that he met Mr. Nicolson while both of them were in suicide observation in August 2003. He testified that he had been in a suicide watch cell for about 2½ to 3 weeks. He testified that he met Mr. Nicolson in the court yard while both were briefly released from their cells for exercise. He testified that while in suicide watch, an inmate is observed every half hour to one hour. He testified he also spoke to Mr. Nicolson on several occasions through the ceiling vents in their cells while in the suicide watch area.

[147] He testified about an incident one morning before Mr. Nicolson left the suicide watch area. He overheard a conversation between Mr. Nicolson and a case worker. He says that Mr. Nicolson was clearly upset when the case worker said to him: “You’re not going back to the mental health range.”

[148] He testified that Mr. Nicolson lashed back at the case worker verbally. He testified the next day correctional officer M. Mcintosh (CO1) told Mr. Nicolson that it a decision had been made that Mr. Nicolson was not going back to the mental health range because “you are a pain in the ass here” and also said “instead

of banging your head, why don't you just hang yourself." He testified that he heard other inmates laughing about this. He testified that in his opinion Mr. Mcintosh was insensitive to self harm issues. He testified that Mr. Mcintosh also said to Mr. Nicolson "you must not want to die that bad since you are still here." He testified that he had no further contact with Mr. Nicolson and was advised a few days later that Mr. Nicolson was deceased.

[149] He testified that he made a statement to the police regarding all of this in April of 2004. He testified that he didn't tell anyone about this incident with correctional officer Mcintosh until some time later when he asked to see the Chief Psychologist Dr. Somers when he mentioned this incident to him. He testified that he spoke to a Chaplin about his time at suicide watch and his concerns regarding the behaviour of guards in general but was not sure if he told the Chaplin regarding the incident with correctional officer Mcintosh. He testified that while at the Winnipeg Remand Centre, while he was at the mental health range there, he spoke with a Chaplin about the incident between Mr. Nicolson and officer Mcintosh and that he also spoke with Dr. Globerman. He testified that he spoke with all these people in an effort to really assist himself as he was concerned about how this incident between Mr. Nicolson and Mr. Mcintosh affected him.

Correctional Officer Mcintosh

[150] The witness testified that he was a correctional officer (CO1) in the summer of 2003. He testified that he has no recall of Mr. Nicolson and no recall of inmate Nemeth. He testified with regard to the allegations that he had made inappropriate comments towards Mr. Nicolson while Mr. Nicolson was in suicide watch and denied the allegations. He testified that correctional officers do not make those types of comments alleged especially in suicide watch. He testified he has no idea why inmate Nemeth would say this about him.

Raymond Nicolson

[151] The witness is the father of the deceased, Alan Nicolson. Mr. Nicolson testified as to the background of his son and his relationship with him. Mr. Nicolson testified that his son was first diagnosed with schizophrenia at the age of approximately 22 or 23 years old while living in Saskatchewan. Mr. Nicolson in general testified to a history of self abuse by his son beginning at the age of 15 and deteriorating thereafter with respect to his son's progressive addiction to various illicit drugs.

[152] He testified that his son had an admitted problem particularly with cocaine and was on a methadone program for a total of two years. He testified that his son

tried sincerely to get off of his addiction and did get off of it for periods of time. He testified that for instance at the low point of his son's addiction, he weighed close to a 150 lbs, was constantly ill, had lesions on his face and was perhaps close to death. He testified that during his time on the methadone program he was mentally, physically and socially much better and that he gained weight back to 200 lbs. This was during the timeframe 2001 to 2003. Raymond Nicolson testified that during the time his son was attempting to get off of narcotics, he was assisted in doing so by his family physician Dr. Khamenda, and by his psychiatrist, Dr. Fait. He testified that his son went regularly to clinics to see his psychiatrist, for his methadone and also for treatment for Hepatitis C that he had contracted.

[153] Mr. Nicolson testified that he controlled his son's finances while he was on the methadone program and although his son got into some minor crimes, he was doing relatively well.

[154] He testified that in June 2003, he went to Calgary for a few days. He testified that while he was away his son cashed his welfare checks and got back onto the drugs. When he returned from Calgary, he learnt that his son had been arrested and was in prison. Mr. Raymond Nicolson kept extensive notes from June 1st, 2003 to October of 2003 with regards to his involvement with his son.

[155] Mr. Nicolson testified that although he never met personally with his son while he was in prison, he spoke with him on an almost daily basis, except times his son was in suicide watch. He testified that on July 25, 2003, his son called him from Stony Mountain. His son did not want him to see him at Stony Mountain. He testified that he was surprised that his son got such a long sentence and that he was going to a federal institute. Sometimes his son would call him four or five times per day. He was aware that his son was on the medical unit and that he seemed to feel better upon his transfer to the mental health unit. He seemed on an "even keel".

[156] The witness testified that he brought a TV and some money to Stony Mountain Institute for his son. He was told that his son would get the TV within 10 days and the money within 2 to 3 days. He testified that the telephone calls suddenly stopped and he was made aware that his son had been placed on suicide watch. He was only advised of this after his son had been out of suicide watch.

[157] He testified that after his son was out of suicide watch for the first time, they spoke by telephone and that he always spoke about the TV and the fact that he didn't have it and that he was looking forward to receiving the TV and the money. His son told him that suicide watch was absolute hell and he did not wish to return.

He testified that his son told him that he accepted being in the suicide unit and on suicide watch but the conditions were so horrible that he felt that he was being punished and that he was not being treated for his condition. He testified that his son told him that the treatment consisted of being out of the cell for 15 minutes to ½ hour each day and that no one including correctional officers refused to help him in any way, and that he had no one to talk to.

[158] He testified regarding his son saying something about "1984" and that he "really blew it". His son only realized later that this was a bad thing to mention but he thought that the issue was resolved. He said to his father: "They are all over me and won't give me a break." "The guard told me go ahead and do it, it will solve all our problems" in response to the guard saying "go ahead and kill yourself".

[159] The witness testified that on August 13 he spoke to his son and his son will still waiting for his money and his TV. He described voices and hearing things from former staff from 1984. His son was speaking in a monotone voice, but the voice was strong, confident and even. He admitted that he had lost it with a female guard regarding the money and the TV issue. The witness testified that he received no further phone calls from his son until August 20th.

[160] The witness testified that on August 20th his son told him that he had been in suicide watch again for a second time. He testified that this was over an incident with a female guard by the name of Nickels. The witness testified that his son appeared calmer and said “I’ve got to get out of here”. The witness testified that he suspected his son may do self harm but that he would not commit suicide. He testified that his son never did get his TV and he is unsure if he got his money.

[161] The witness testified that on August 27, 2003, he spoke to his son and tried to encourage him with respect to seeing Dr. Yaren. The witness testified that his son told him: “I saw Dr. Yaren but Dr. Yaren did not want to help me, that Dr. Yaren lectured me and completely disregarded what I had to say.” “It’s my fault, I have no control over my body.” “How could I change, I don’t feel I can change.” “No one will give me a break.”

[162] The witness testified that his son again raised the issue of not having the TV or any money in his account. The witness testified that his son tried to convince him that he had settled down but that he thought it was unfair that he was now in intake and not in the mental health unit. The witness testified that his son would not tell him why he was kick out of the mental health unit, just that there

was no good reason. He testified that his son abruptly hung up. He testified there is no indication given to him that his son was going to commit suicide.

[163] The witness testified he found out August 28th by Winnipeg Police Service coming to his door that his son had committed suicide. He testified he was surprised that his son had committed suicide, that he could not understand how someone could kill himself in jail. He testified that the Correctional Services Chaplin came to see him at his residence later that same day.

[164] The witness testified under cross examination that his son appeared to be doing fine while he was at the Winnipeg Remand Centre pending his sentence and that no complaints of his psychiatric care at the Winnipeg Remand Centre. The witness testified that his son did have attention deficit disorder and was on Ritalin before.

[165] The overall impression of Mr. Raymond Nicolson is of a caring and compassionate father who did all he could to assist his son to overcome what was a horrible addiction. During the two years prior to his son being incarcerated for the last time it would appear that Mr. Raymond Nicolson devoted his life to try and get his son away from narcotics. It appeared to be working all the way up until the time he left for Calgary, leaving his son alone who then got reinvolved with his

addiction. The inquest is grateful for Mr. Raymond Nicolson's input into this inquest.

Len Horyski

[166] The witness is the coordinator of Correctional Operations for Corrections Canada and has been with Corrections Canada for 27 years. The witness testified generally with respect to Corrections Canada policy and procedure and how such policy and procedures are derived. He explained the differences between post orders, standing orders and correctional directives which are essentially a hierarchal regime. For example, there are approximately 100 post orders at any given time which are the responsibility of correctional supervisors (CO3) to enforce. It is Mr. Horyski's job in part to periodically review these orders for compliance. If there are any discrepancies, then he is to advise the correctional supervisors to comply. For instance, if there is a order for a half-hour patrol on a particular range and compliance appears to be at one hour intervals, then he will bring this to the attention of the correctional supervisor so that the situation can be remedied.

[167] The witness also testified regarding the placement of cameras on the ranges and their taping policy. He testified that the cameras on the mental health range

and on the intake range are capable of taping but they need to be activated which is at the discretion of the officer at each post.

Rick Reiman

[168] The witness is the deputy warden of the Stony Mountain Institute and has been so for 3 ½ years. He has been with Corrections Canada for a total of 21 years. The witness testified that he is in charge of all operational aspects of Stony Mountain Institute including:

1) Correctional Officers Supervision through Correctional Officer 3

2) Administration and discharge of inmates;

3) All correspondence to the institute;

4) Health care, psychiatric care and psychological care of inmates;

5) Case management of all inmates;

6) In total, 16 managers from various departments report directly to him.

[169] The witness was asked regarding why the television brought by Mr. Nicolson's father was not given to him. He testified that the procedure can take up to 30 days for security reasons. He testified that large volume items

constantly come into the institute and each must be secured, stored, itemized and cleared for delivery. He testified that no items are given to an inmate during the time that they are in suicide watch and that Mr. Nicolson's request to have a TV may have been delayed by the times that he was in suicide watch. He also testified that things can back up if there are a large number of inmates in intake.

[170] The witness testified that the Chief of Psychology reports directly to him. He testified and confirmed that the Chief of Psychology has requested more resources for his department and that the Chief of Psychology is of the opinion that there are not enough resources.

[171] The witness further testified generally with respect to the new National Directive issued in November 2004 regarding training and refresher courses for correctional officers regarding suicide prevention and procedure and testified that each correctional officer level has different training requirements. He testified that there is a total of 4 to 8 days of training per year for correctional officers per the national training standard.

[172] He testified that with respect to the National Board of Investigation recommendations into the death of Alan Nicolson, that there is now a clear protocol with respect to individuals with suicide ideation and potential and that

there is a clear chain of accountability, the most important of which is the involvement of mental health staff on any decisions with respect to inmates in suicide watch.

[173] The witness was asked to comment upon the recommendations made by the Board of Investigation review into the death of Alan Nicolson which contained the following recommendations:

1) *Stony Mountain Institute needs to establish a clear protocol of how inmates are assessed for and placed on "suicide watch".*

Inmates are reassessed on a daily basis with a view to gradual reintroduction/release from suicide watch. This process must be managed by mental health professionals who are part of the mental health team at Stony Mountain Institute.

With respect to this recommendation, the witness testified that the protocol in this regard has been revised and that there is now clear accountability with respect to placement and removal of inmates from suicide watch and that mental health professionals are involved in any decision making.

2) *If Stony Mountain is to maintain the operation of a mental health unit range, it must provide clinical interventions and programming delivered by staff who are trained in mental health.*

With respect to this recommendation, the witness testified that this has not been accepted. He testified that there is no policy that directs the institute in that regard. He testified that the institute was already in compliance with the current directive.

3) Placement into and release from the mental health unit must be based on a review of the mental health needs of inmates and progress made through the interventions provided. The decision making must include qualified mental health professionals.

The witness testified that the mental health team is now part of the decision making replacement but that there is no intervention so that there is no analysis based on “intervention progress”.

Bo Gadja

[174] The witness is a Chaplin at Stony Mountain Institute. He had no contact with Mr. Nicolson directly.

[175] Mr. Gadja testified that he goes to suicide watch unit at Stony Mountain Institute in response to any inmate's requests. He testified that he had dealings with Mr. Nicolson's father after notification of death to his father which is part of his job. He testified that he met with Mr. Nicolson's father to provide comfort counseling and general support. He testified he spent some time with Mr. Nicolson's father and received various concerns from Mr. Nicolson's father. He testified that as a result of his meeting with Mr. Nicolson's father, he reflected upon the concerns and composed an e-mail to the warden dated August 30, 2003 which has been filed in this inquest. The e-mail deals mainly with practical matters such as transfers of money and items to inmates.

Bruce Cameron

[176] The witness is a Chief of Works and Engineering at Stony Mountain Institute and is the manager of all maintenance and repair including electrical, mechanical and structural. He has been with the Federal Government for 34 years,

previously being a supervisor at the Winnipeg Airport. He holds diplomas from the Alberta Southern Institution of Technology and is a certified engineer technologist.

[177] The witness was asked questions regarding the physical structure of the cell in which Mr. Nicolson was found deceased. He testified that the cell was constructed in the 1920s and conduits for electrical were placed in the cells some time later. He testified that the electrical conduit is placed on the ceiling in the manner that it is as a junction box is live and must be accessible. This was simply the way the fixtures were placed at the time of construction. He testified that all electrical “runs” are behind the cells and in order to have a light fixture in the ceiling, a conduit is required which cannot be run through the concrete. He testified that the exception to this is the lower tier of Unit 1 where a light can be placed on the back wall as there is access to the electrical “run” from the back mechanical chase but on the upper tiers the conduit must be on the roof.

[178] He testified the cell walls are concrete so an electrical conduit must be on the walls or on the ceiling. He testified that it would be very difficult to change things without considerable expense.

[179] The witness was asked about the fact that the pipe conduit for the electrical run in Mr. Nicolson’s cell was bent. Thus it made an easy attachment point for

anyone who wishes to commit suicide. The witness testified that the pipe was bent due to previous entries to the junction box which was in the middle of the ceiling. He testified that it would be possible to recess the conduit and then put a barrier over the recessed conduit and the junction box.

Doug Zawada

[180] The witness is a correctional officer 2. The witness has been with Stony Mountain Institute for 32 years and in 2003 was assigned to the intake assessment unit. He testified that he started the assessment on Mr. Nicolson although he was never able to complete it. He testified that his first contact with Mr. Nicolson was on July 22, 2003. He testified that he received an e-mail from parole officer Penner to watch for Mr. Nicolson's mental health issues and he did so.

[181] He testified that he notified parole officers Nickels of concerns regarding Mr. Nicolson's mental health history and that he met with Ms. Nickel's regarding same. He testified that they decided to place Mr. Nicolson on the mental health range immediately.

[182] The witness testified generally about the intake procedure which is common to all inmates which includes processing by an admissions' officer, fingerprints, pictures, issuing of inmate cards, being taken to hospital for a medical

background and then to intake unit where they are physically placed for further processing. This would include whether or not a full blown mental health assessment or psychological assessment needs to be taken as well as a security classification. The entire process of the intake assessment unit can take 30 days or longer.

[183] The witness testified that in fact Mr. Nicolson spent his first night at Stony Mountain Institute on the mental health range and not in the intake assessment unit.

[184] The witness testified that on July 23rd, he did an educational assessment on Mr. Nicolson. Mr. Nicolson was classified as low functioning and "needy". The witness testified that he did an initial interview with Mr. Nicolson which utilizes a standard questionnaire. The witness knew of Mr. Nicolson's prior suicide attempt history and was concerned for his well being. He testified that he contacted the psychology department and a referral was made to Mr. Siemens.

[185] The witness testified that the inmate indicated ongoing concerns with the Indian Posse and the Manitoba Warriors Gang. This information was given to the preventive security officer.

[186] The witness testified that his conclusion was that Mr. Nicolson was "vulnerable" as a result of mental health issues and the gang related concerns.

[187] He testified that he did not feel that Mr. Nicolson was suicidal at the time and was surprised to hear that Mr. Nicolson had committed suicide.

IV. ISSUES ADDRESSED AT THE INQUEST

[188] Some context should be referenced in terms of the physical layout of the "mental health range", and the Intake Assessment Unit. The inquest had the opportunity to attend to Stony Mountain Institute (hereinafter referred to as "SMI") and view the mental health range. We also viewed the suicide watch cells. A video was taken of our visit and is filed as an exhibit. The video best depicts the areas. The following is a partial summary.

[189] The mental health unit consists of a long rectangular area with a total of 40 cells on two levels, one above the other. As you enter the unit area, there is located a rather spacious control area separate from the inmate area. At this control area a correctional officer will be on duty monitoring the mental health range immediately in front of his "pod" and to his left. To the right is an identical area of 40 cells on two levels that are a mirror the mental health range. This is the Intake Unit range.

[190] Both units are accessed by a hallway and the upper levels further accessed by stairways at each end of the rectangular block. As you enter the mental health range, all the cells are to the right, on the main level. The second level above is identical.

[191] Each cell is for a single inmate and is rather Spartan, consisting of a bed, a toilet/sink area and a chair/table. The cells were built in a long ago era. The light and plumbing are contained in metal conduits that are exposed. The cell door consists of many vertical and horizontal steel bars. The height of the highest bar is perhaps 6 feet. It was one of these horizontal bars from which Mr. Nicolson was able to hang himself, despite his feet still being able to touch the ground. The cell door has a small window and a privacy curtain. The window can be looked into by staff while conducting range counts and monitoring.

[192] The suicide watch cells consist of 3 cells. Suicide watch is essentially the placement of an inmate in a camera monitored cell in a tear-proof smock with a blanket. The cells are similar to the cells in the Unit 1. There are no regular human contacts with staff from psychology, health care, etc. to address the mental health concerns. There is no programming or treatment. It is merely a placement to

prevent suicide in situations of acute concern of suicide. The issues leading up to the suicide concern are not addressed in any meaningful way.

[193] There was some discussion and evidence at the inquest as to how modifications could be made to the cells so as to prevent persons from physically being able to hang themselves. This suicide was the third that had occurred in the mental health and intake units in 5 years, all by hanging.

1. Non-Medical and Non-Administrative Institutional Contacts and Response While in Custody from July 22, 2003 to date of death August 28, 2003.

[194] A summarized chronology some of the major events, outside of contacts with Intake, Administrative and the Mental Health departments of SMI on and after Mr. Nicolson's admission to SMI is contained in an excerpt from The National Board of Investigation report from pages 8 to 12 and which I accept as accurate in that regard and which is in accordance with the evidence adduced at this inquest.

[195] Mr. Nicolson was a first time federal inmate. As such a Preliminary Assessment Report was prepared before he arrived at Stony Mountain Institute.

The report clearly outlined his history of drug abuse, emotional instability, familial discord and previous suicide attempts, the last of which was some 8 years prior.

[196] Upon entry to the institute, Mr. Nicolson, like all inmates, was placed on the Intake Assessment Range. A process of assessment then begins, culminating in a placement within the institute. The process can take several weeks. Stony Mountain has a block of cells (‘range’) dedicated to inmates with mental health concerns. This range has had its resources severally curtailed over the years prior to 2003. The psychologist, Mr. Greg Hart, was previously assigned half-time to work with inmate assessment a mental health capacity. He as transferred in early 2003 to deliver family violence programs. He was not replaced. A nurse assigned to the range was on educational leave and was not replaced. Two program officers delivering programs to the range were reassigned to other areas. A prior psychiatric nurse was terminated and not replaced. The range was left with a parole office, two correctional officers and a nursing assistant and a contractor 2 half days per week. The ‘mental health range’ had become that in name only. All these staff had no training whatsoever in mental health issues.

[197] At the time, any correctional staff could place an inmate on suicide watch, but if placed by a psychologist or psychiatrist only they could remove them.

The psychiatrist treatment Mr. Nicolson attended the institute only on a weekly basis.

[198] Furthermore, placement or removal of an inmate from the mental health range is an operational decision without input from anyone trained in mental health issues. The removal of Mr. Nicolson from the mental health range to the Intake Unit made on August 20, 2003 was so made.

2. Intake Process and Involvement of Health Professionals

[199] Mr. Nicolson was initially interviewed by Correctional Officer Zawada (CO2) on July 22, 2003. Among other matters, his mental health issues were noted. His parole officer was notified regarding these concerns and he was immediately placed on the mental health range, where the intake process was to continue. This was all done by staff without any mental health training.

[200] Mr. Nicolson was extensively interviewed by a psychologist the next day who noted in his report that he appeared “distracted at times, stating he was experiencing auditory hallucinations during the interviews.” He was reported as at moderate risk for self-harm. Close monitoring of his mental health was advised and this information relayed to his parole officer.

[201] Mr. Nicolson had met with his psychiatrist, Dr. Stanley Yaren, as has already been related, on July 24. There was limited documentation on his mental history, but Dr. Yaren was aware from his medicinal regime of the general nature of the issues. Dr. Yaren expressed some trepidation about the genuineness of his hallucination complaints.

[202] On August 6, 2003 an incident occurred that set the tone for remainder of Mr. Nicolson's life at the institute. During a meeting with other inmates and with the range parole officer and the mental health range correctional officer, Mr. Nicolson made comments to the effect of "do you want another 1984". This was in reference to an incident at the institute in which correction officers had been killed. Apparently Mr. Nicolson had raised this as an attempted catalyst for him obtaining better mental health care and perhaps as a perceived way to change or increase his medication, or to be transferred to the psychiatric facility in Saskatoon. This comment upset everyone present. There was a great deal of discord and Mr. Nicolson was chastised. Later that day he slashed his wrists superficially. He was placed in suicide watch. Staff apparently did not see this as a real suicide attempt, but merely a continuation of his behavior from earlier in the day.

[203] Mr. Nicolson was not seen by anyone with mental health training until August 13 when Dr. Yaren interviewed him and released him from suicide watch back to the mental health range. He received no programming or treatment, He was essentially warehoused.

[204] The following day, August 14, Mr. Nicolson was again placed in suicide watch by a nurse after he said he felt like killing himself. Again this placement was made without consultation with psychological or psychiatric staff. In making this decision, no medical reason was adduced other than the verbal threat. No evidence was led as to why mental health professionals where not consulted before another placement so shortly after the first placement into suicide watch.

[205] On August 20, Mr. Nicolson was again seen by Dr. Yaren, who again removed him from suicide watch. Dr. Yaren was unconvinced about his self reports of hallucinations and other symptoms that seemed inconsistent with his history and medications. He was “clearly a person in distress”, but at great risk of suicide.

[206] After being released from suicide watch, Mr. Nicolson was, in my opinion, inexplicably not returned to the mental health range. As indicated in testimony from his Institutional Parole Officer and the Acting Unit Manager an

operative decision was made to have him transferred back to the Intake Assessment Unit, where he had last been on the first day of his arrival at the institute. He met all the informal criteria for admission to the mental health range it was decided that his “disruptive behavior” made him ineligible to return. After this decision, as reported by Raymond Nicolson, his son’s attitude changed and he perceived being “kicked out” of the mental health range as a death sentence. The decision to do this had no input from a mental health professional. In retrospect this was a very poor decision indeed, especially in light of the recent history of Mr. Nicolson’s confinement in suicide watch. He clearly perceived this decision as a punishment, institutionally made without regard to his mental well-being.

[207] While at Intake from August 20 to August 28, there appears to be little to indicate what would happen next. Mr. Nicolson appeared to be adjusting well. As noted by Dr. Yaren there were no entries in the medical log. However, Mr. Nicolson continued to complain about the lack of his obtaining his television and monies given by his father and a correctional officer (CO2) noted that the day before his suicide, he continued to talk about his removal from the mental health range.

[208] Mr. Nicolson was last seen by Dr. Yaren on August 27, 2003. Dr. Yaren saw the risk of suicide as low though risk of self harm as highly probable. He was seen as being manipulative, particularly in view of his continued desire to obtain Ritalin.

3. Institutional Resources Related to Psychiatric and Psychological Care

[209] With respect to psychiatric care, a psychiatrist attends to SMI on 3 days per week for a half-day. This is premised upon a contractual relationship with Dr. Stan Yaren and Dr. Daniel Globerman. This is an arrangement that has been in existence for almost 10 year. Referrals to the psychiatrists can be made from a variety of sources, including self-referral, intake referral, and referral from the psychology department or from another inmate, subject to approval. Regarding the last, there is a "Samaritan program", whereby designated inmates, trained in suicide counseling, can make a referral. The evidence adduced at the inquest satisfies me that the psychiatric services offered are adequate. Indeed, as noted by Dr. Yaren, access to his services in SMI is considerable easier than if one were in the community. The quality of these services is not an issue.

[210] There was more evidence adduced at the inquest about the availability and quality of resources available from the psychology department at SMI. There appears to be a lack of resources provided for inmates in the specific areas of

treatment, programming and research. The head of the department expressed clear concerns about the utilization of his limited staff. The current utilization is primarily, if not exclusively to the areas of intake assessments and assessment required by the Parole Board. There is in fact no treatment of mental health concerns of inmates at SMI. There is no research, an important area where the professionals are dealing with a rather unique situation – convicts with mental health issues.

[211] The "mental health range" as it was then known is really only a name. No more mental health services are provided than might be available to other inmates in other areas of the prison. It appears that there are more frequent walks by institutional correction staff, so that inmates are kept a better eye on, but other than that, I have no evidence that being placed in the mental health range means anything. There is no programming. There is no treatment. The mental health staff in the psychology department has no special duties or responsibilities to those inmates housed in this ward.

[212] There appears to now be adequate communication between the psychiatric and psychological staff. This was not the case before the ***Alan Hansen***

inquest report of Judge Joyal of January 18, 2001, but this did not arise as an issue before me.

[213] It is to be noted that Commissioner's Directive 843 requires ongoing care in terms of planning for all suicidal inmates. This includes risk assessments by qualified people. This was not done. There was no planning for Mr. Nicolson. There was a risk assessment done, but not by qualified people, through no fault of their own. Resources were simply lacking. The Commissioner's Directive requires there be ongoing interventions with a view to a progressive return to the inmate of responsibility for his own behavior as well as activities/ stimulation/ exercise to constructively occupy time until a return to the inmates own cell. This was requested by Mr. Nicolson and his father. It was not done. It only makes sense. Anyone with an elevated risk of suicide has a medical issue that needs to be addressed with compassion and planning by qualified personnel. Such qualified personnel, so assigned, simply do not exist in Stony Mountain Penitentiary for those with Mr. Nicolson's needs.

4. Supervision and Monitoring of Mental Health Range During Early Morning Shifts

[214] SMI has written policies pertaining to the monitoring of the whereabouts of all inmates at specified times and intervals. Inmate counts are

either formal or informal. Formal counts are to be done four times per day at set hours. Informal counts are to be done as directed by the Correctional Supervisor in charge of the institution. On the "mental health range", in addition to the formal counts, there was to be an hourly count. This count was done manually at the time of Mr. Nicolson's death. There is also an electronic system, known as "Silvergard".

[215] The National Board of Investigation identified a concern regarding these systems, as contained in the aforementioned *Lagimodiere* death investigational report at page 25:

> "The Post Order specifies that informal range patrols will be completed by two (2) officers proceeding down the range. This is not possible on the morning shift, as only one (1) officer is available to complete the informal range patrol, while one (1) officer remains at the kiosk to monitor the officer conducting the range patrol. Stony Mountain Institution Post Order #07, entitled Range Patrols, should be updated to reflect the current practice on the morning shift.
>
> It was noted that Stony Mountain Institution utilizes only one (1) Silvergard wand for the purpose of completing the informal range patrols on the morning shift. A CO II attends each unit and provides the Silvergard wand to the officer, who then performs and registers the informal range patrol. This practice would unfortunately limit the unit officer's ability to perform and register timely informal range patrols, should the CO II become occupied in another area of the institution. It also limits the flexibility to stager informal range patrols and to register additional patrols or checks if deemed necessary. In the absence of the CO II, other staff could assist the unit officer in that regard, however in the absence of the Silvergard wand to register the informal range patrol, there would be no documented proof that

the action occurred. It is felt that Stony Mountain Institution should explore the option of assigning and placing Silvergard wands to each of the units.

It was determined by the Board of Investigation that the current placement of the Silvergard discs are inadequate to ensure that informal range patrols are completed according to the policy requirement. Security Bulletin 00-14, Security Patrols and Inmate Counts, outlines the importance of ensuring the well being of any inmate observed during counts and patrols with an onus on the institution to establish mechanisms to ensure that these requirements are met. i.e. complete rounds. The Silvergard Data Collector scanned disc report for the period leading up to the incident identifies that on 2003-06-29 informal range patrols occurred on A7 range at 0101:25 hours, 0159:54 hours and 0315:47 hours. On those specific occasions, it would appear that the officer entered the front of A5 Range, proceeded down the range and performed a cursory check of the inmates located there. He then proceeded to the disk, which is mounted on the outer range wall midway down range, and registered the wand on the disk. The officer then proceeded to the stairs, located at the end of A5 Range and, proceeded up the stairs to the backend of A7 Range. He then proceeded to conduct the cursory check of the inmates on that specific range, finally arriving at the front-end of A7 Range, and registering the wand on the disk located at the front of A7 Range.

Because of the current location of the Silvergard disks, it is not possible to determine the exact time spent on each specific range. It is verified that the length of time that elapsed between the time that A5 and A7 disks were punched, as indicated in the timeframes specified above, is forty-two (42) seconds on the first occasion, fifty-six (56) seconds on the second occasion and fifty-three (53) seconds on the third occasion. Upon initial review, these do not appear to be reasonable lengths of time to conduct proper an informal range patrol, to ensure the presence of live, breathing bodies as required by Commissioner’s Directive 566-4, Inmate Counts, however as stated previously the current location of the disks do not cover the ranges in their entirety. It was also determined that although there are a total forty (40) cells located on A5 and A7 Ranges, only twenty five (25) of the cells were occupied on the date of the incident. Further complicating the issue is that the time needed to proceed between the ranges also needs to be factored into those specific timeframes. As well, some disks are located on the outside wall, which means staff could conduct their walks without necessarily

> walking close to the cells, and if they did walk adjacent to the cells, they would then need to proceed to the outer wall to register the wand on the disk. As such it is difficult to determine the actual amount of time spent on the individual ranges, for the actual patrol. When Correctional Officers were questioned about the thoroughness of the informal range patrols in relation to scanned disk report, all staff indicated that they checked each inmate according to policy. This being Stony Mountain Post Order 561.45, entitled Conducting Inmate Counts, which specifies; 'To ensure by personal observation, that each inmate on the Register is alive and in the cell assigned to him, or is in a place where he is authorized to be.' In addition to this, the CO II, whose duty was to monitor the officer conducting the informal range patrol from the kiosk, advised the board that her personal observation of the officers conducting their informal range patrols on the night of the incident, was according to that policy."

[216] The inquest was told that the Silvergard system is now in place. The adequacy of the monitoring was an issue at the inquest in that there was speculation that more frequent monitoring may have detected Mr. Nicolson earlier and saved his life.

[217] I have concluded that more frequent monitoring would not have made any difference. It would be an easy matter for an inmate in his cell to note the passing of a guard by his cell for a count and to time the suicide attempt accordingly. The issues raised at the inquest regarding the monitoring do not impact the mandate of this inquest.

5. The Emergency Response to the discovery of the body of Alan Nicolson

[218] The initial part of this inquest focused on the initial response by staff at the SMI to the discovery of the body of Mr. Nicolson. All staff that were involved in the discovery and follow-up acted promptly and efficiently. The emergency measures that were utilized involving the use of CPR and an airbag were performed with the requisite skills and timeliness.

[219] On the totality of the evidence and circumstances, I am satisfied as to the manner of response by correctional and other emergency personnel after the discovery of the body of Alan Nicolson.

V. RECOMMENDATIONS

RECOMMENDATION NO. 1

The immediate hiring of a registered psychiatric nurse, to be assigned to the institution's psychology department and made available for consultation with the contract psychiatrists.

[220] As indicated by both Dr. Yaren and Dr. Siemens, there is an acute need for a psychiatric nurse. The duties of the nurse would be to assist in the intake process; to monitor, observe and take notes of inmates assessed with mental health issues; to act as liaison between psychiatry and psychology; to be a contact person

for relaying of familial information or outside institution concerns; and to help create and administer treatment and therapeutic programs.

[221] I appreciate that anything that might be said in terms of detection of suicidal ideation by doing something different is speculative and based much on hindsight. I accept that the detection of suicidal ideation is difficult, particularly when one recognizes that it would be the desire of the suicidal person to conceal such ideation. In the case of Alan Nicolson, the ability of a psychiatric nurse to be in day to day contact with him, to have responsibility for his day to day general psychiatric well-being and to be the contact person for concerned family - this may have been able to prevent suicidal ideation from then taking such a tragic outcome. Alternatively the ideation may have been detected and dealt with by intervention and therapy.

RECOMMENDATON NO. 2.

Consultation by Stony Mountain administration with the psychology department with the goal to creating programming and to promote research with regards to mental health issues in an institutional setting; at a minimum to bring staffing levels back to pre-1997 levels.

[222] The creation of an ‘Integrated Mental Health Unit’, as it was referred to during the inquest would attach itself directly to a true mental health unit where

treatment and programming would be provided to identified inmates. Such a unit would consist of a registered psychiatric nurse, a program manager, a dedicated parole officer and an assistant nurse.

[223] I appreciate that corrections officials and administration have a difficult job. I appreciate that there are limited financial resources. Inmates in penitentiaries are no doubt more difficult to deal with than the norm. They evoke less sympathy, perhaps rightly so, than law abiding citizens. Thus they are not high on the list of governmental priorities in the allocation of fiscal resources. Nevertheless they are human beings. They are still citizens. We, as a society have decided to punish them by absolute confinement. They are our societal responsibility. As we must house and feed them, so too must we care for their medical needs. Defined psychiatric disabilities are a subset of general medical disabilities. Inmates should be treated for their mental health issues, and the resources made available for their treatment, in the same way as any other medical disability.

RECOMMENDATION NO. 3

Specialized training in suicide presentation and recognition as a mandatory component of all new hires for Correctional Officers.

[224] There appears to be some progress in this regard as evidenced by Commissioner's Directive 843, dated November 24, 2004 and Commissioner's Directive 850, dated May 2, 2002. This recommendation is an endorsement of that progress and those directives. Could this tragedy have been avoided? I do not know. Even a trained, competent and involved psychiatrist, Dr. Yaren was surprised by the death of Mr. Nicolson, having seen him in person mere hours before his death.

Recommendation No. 4

Placement of an inmate into and out of the Mental Health Unit shall be based upon a full mental health review conducted by a qualified psychologist or psychiatric nurse. The reasons for the placement shall be documented.

[225] The placement of inmates into the mental health unit at Stony Mountain Institute is so informal as to be arbitrary. The effect on the mental well being of an inmate in being removed from such a placement if well demonstrated in this inquest.

Recommendation No. 5

Medical Records from Winnipeg Remand Center or other Correctional Facility should be remitted immediately upon the physical transfer of the inmate.

[226] The reason for this should be self-evident. One's health is of paramount importance. As the state is responsible for the mental and physical well being of those it chooses to incarcerate, so then is the state responsible for the timely transfer of medical information as and when the inmate is physically transferred.

Recommendation No. 6

While in suicide watch inmates must have a 'healthier' environment. At a minimum they must be given something to do, in terms of recreational material, such as books, magazines, access to games, radio, stereo or television.

[227] How are those placed in suicide watch able to occupy their time? They are watched constantly. Lights are on. There is no treatment or programming. In this environment, to be deprived of positive distractions amounts to cruelty.

Recommendation No. 7

All ceiling fixed metal electrical conduits be recessed and covered with a barrier to prevent use as a fixed point for hanging any material.

[228] The inquest was able to examine all the cells in Unit 1 (Mental Health and Intake). What was striking was the number of cells with very strong metal

conduits running across the ceiling that were bent away from the ceiling, thus affording an easy access point for anyone contemplating suicide by hanging. This seemed incongruous in areas that house such at risk inmates such as Mr. Nicolson.

[229] I respectfully submit my recommendations and conclude this report this 22nd day of August 2005, at the City of Winnipeg, in Manitoba.

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Judge Fred Sandhu

EXHIBIT LIST

Exhibit No.	Description
1.	Videotape – February 4, 2005 -Inquest Tour of Stony Mountain Institution: Units 1 & 5
A.	Witness Statement: John Nemeth
2.	Preliminary Assessment Report – John Nemeth
3.	Criminal Record of John Nemeth
4.	Booklet of photos (10 pictures)
B	Binder of Inquest documents
5.	Officer Statement, Observation Report – S. Derksen (Located in Exhibit B at B43)
6.	Officer Statement, Observation Report – J. Saggar (Located in Exhibit B at B41)
7.	Officer Statement, Observation Report – C. Gunter (Located in Exhibit B at B38)
8.	Officer Statement, Observation Report – J. Foreman (Located in Exhibit B at B4)
9.	Officer Statement, Observation Report – B. Robertson (Located in Exhibit B at B40)
10.	Observation Report – A. Coates, R.N. (Located in Exhibit B at B66)
11.	Health Care Centre Suicide Observation – Stony Mountain (Located in Exhibit B at B56)

Exhibit No.	Description
12.	Patient Medication Record, 2 pages (Located in Exhibit B at B69)
13.	Health Services Admissions Record (Located in Exhibit B at B79)
14.	Health Services Admissions Record (Located in Exhibit B at B79.1)
15.	Health Care Centre Suicide Observation – Stony Mountain
16.	Progress Notes, 4 pages (Located in Exhibit B at B71)
17.	Inmate Request: Dated August 22, 2003 (Located in Exhibit B at B12)
18.	Inmate Request: Dated August 20, 2003 (Located in Exhibit B at B13)
19.	Memo of Don Kynoch: Dated August 27, 2003
20.	Officer Statement – W. Melnyk (Located in Exhibit B at B6)
21.	Officer Statement – B. Pfirmmer (Located in Exhibit B at B7)
22.	Officer Statement – K. Staub (Located in Exhibit B at B8)
23.	Suicide Observation Form (similar Ex. 15)
E	Officer Statement, Observation Report – C. Nickels (Located in Exhibit B at B6)
24.	Psychological Intake Screening Form
25.	Organization & Areas Responsible Manual Stony Mountain Institution
26.	Offender Management System Printout – Alan Nicolson

Exhibit No.	Description
27.	Autobiography – Alan Nicolson
28.	Documents found in A. Nicolson's cell (Located in Exhibit B at B47, B48, B48.1)
29.	Community Assessment Report (Located in Exhibit B at B27)
30.	Suicide Statistics for 1990-2005, Corrections Canada
31.	Officer Statement, Observation Report – B. Sheasgreen (Located in Exhibit B at B39 & B39.1)
32.	Post Orders
33.	Copy of E-mail from J. Cardey – Dated: February 9, 2005 re: August 29, 2003 – Post Order Revisions
34.	Standing Order #843
35.	Commissioner's Directive #843
36.	Commissioner's Directive #850
37.	Letter to Chief Judge Wyant – Dated: January 9, 2004 directing inquest into the death of A. Nicolson (Located in Exhibit B at A1)
38.	Autopsy Report for A. Nicolson – Dated: October 21, 2003 (Located in Exhibit B at A2)
39.	Board of Investigation Report into death of inmate at Stony Mountain Institution August 28, 2003 (Located in Exhibit B at B1)
40.	Letter to Saskatoon Police – Dated: July 28, 2003, Request report on A. Nicolson's offences (Located in Exhibit B at B17)

Exhibit No.	Description
41.	Saskatoon Police Service, Disclosure Report, Case Number: 1999-40154 (Located in Exhibit B at B18)
42.	Saskatoon Police Service, Disclosure Report, Case Number: 1999-36552 (Located in Exhibit B at B19)
43.	Letter to Bureau of Police Records, Request Report on A. Nicolson's offence (Located in Exhibit B at B20)
44.	Court Assistance Report – Dated: 2003 06 05 (Located in Exhibit B at B21)
45.	R.C.M.P. Criminal Record (Located in Exhibit B at B22)
46.	Reasons for Sentence – The Honourable Judge Curtis: Dated July 15, 2003 (Located in Exhibit B at B29)
47.	Disposition Sheet of Alan Nicolson, Information 006-24348 Dated: July 15, 2003 (Located in Exhibit B at B30)
48.	Copy of Information PR#03-115846 Dated: June 5, 2003 (Located in Exhibit B at B31)
49.	Transcript excerpt from proceedings – Dated: July 11, 2003 (Located in Exhibit B at B32)
50.	Empty prescription drug bottle – A. Nicolson, Pharm@zeem 201 Edmonton St. Wpg, MB C16031 – Ritalin

DISTRIBUTION LIST

1. Dr. A. Thambirajah Balanchandra, Chief Medical Officer
2. Chief Judge Raymond E. Wyant, Provincial Court of Manitoba
3. The Honourable Gord Mackintosh, Minister Responsible for *The Fatality Inquiries Act.*
4. Mr. Bruce MacFarlane, Deputy Minister of Justice & Attorney General
5. Mr. Brian Kaplan, Director Regional Prosecutions and Education
6. Mr. Steven Johnston, Counsel to the Inquest (Provincial Crown)
7. Mr. Sid Restall, Counsel to the Inquest (Federal Crown)
8. Mr. Tyler Kochanski, Counsel for Dr. Yaren
9. Mr. Mike Anthony, Exhibit Officer, Provincial Court
10. Ms. Karen Fulham, Executive Assistant and Media Rep., Provincial Court
11. Mr. Raymond Nicolson, party to inquest and father of Mr. Alan Nicolson