**Release Date: December 21, 2009**

# THE PROVINCIAL COURT OF MANITOBA

**IN THE MATTER OF:** ***The Fatality Inquiries Act*** **C.C.S.M. c. F52**

**AND IN THE MATTER OF:** **DEVON CHESTER NEWSON**
(DOD: JULY 23, 2006)

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**Report on Inquest and Recommendations of**
**The Honourable Judge Marva J. Smith**
**Issued this 16th day of December 2009**

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**APPEARANCES:**

**MS. V. CORNICK, inquest counsel**
**MR. S. RESTALL & MR. K. STASKA, for Correctional Services of Canada**
**MR. T. KOCHANSKI, for Dr. Stanley Yaren**

**THE FATALITY INQUIRIES ACT**
**REPORT BY PROVINCIAL JUDGE ON INQUEST**

**RESPECTING THE DEATH OF: DEVON CHESTER NEWSON**

Having held an inquest respecting the said death on November 24, 25, 26, 27, 28, 2008 and April 28, 2009 at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: DEVON CHESTER NEWSON

The deceased came to his death on the 23rd day of July 2006 at the City of Winnipeg in the Province of Manitoba.

The deceased came to his death as a result of suicide by hanging at the age of 18 in his cell at Stony Mountain Institution in Stonewall, Manitoba.

I hereby make the recommendations as set out in the attached report.

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

Dated at the City of Winnipeg, in Manitoba this 16th day of December 2009.

*"Original signed by:"*

Marva J. Smith
Provincial Judge

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## INTRODUCTION

[1] Devon Chester Newson died while incarcerated at Stony Mountain Institution (SMI), a Federal Penitentiary located in Manitoba. At the time he was serving a six year sentence for aggravated assault. The Chief Medical Examiner directed an inquest into Mr. Newson's death pursuant to *The Fatality Inquiries Act* C.C.S.M. c. F52. The inquest is required to fulfill the requirements in s.19(3) (as Mr. Newson was imprisoned at the time of his death), to determine the circumstances under which the death occurred, and to determine what, if anything, can be done to prevent similar deaths occurring in the future.

[2] What makes Mr. Newson's death particularly tragic is his young age. He was born on October 20, 1987 and was only 18 years of age when he committed suicide by hanging himself in his cell on July 23, 2006.

[3] Suicide rates in prison are higher than in the general population, for a variety of reasons. As a result there have been a number of inquests into similar events in this jurisdiction and elsewhere. Prison authorities and those in health care delivery in institutions in all jurisdictions are aware of the elevated risk of suicide in prison, and are trained to screen for indicators of potential suicide risks so that appropriate referrals and preventative action can be taken. Among prison suicides, hanging is not uncommon. SMI is an old institution and there are many potential points of suspension. In this case Mr. Newson hung himself by wrapping bed sheets to an electrical conduit in his cell.

[4] As will be seen below, all of the available information points to Mr. Newson's suicide as being an impulsive, unplanned act. The action he took followed a minor beating he received from gang involved inmates the night before his death apparently because he looked at one of them the wrong way. Staff, the prison psychologist, the consulting psychiatrist, and some inmates who had tried to befriend him were surprised and shocked at his suicide.

[5] Are deaths such as Mr. Newson's just a tragic part of the statistical reality of a prison system? The challenge of this inquest is to consider what if anything can be done to prevent a suicide that seems to have been, by all established suicide risk factors, impulsive and unpredictable.

[6] The evidence included a comprehensive report into Mr. Newson's death by a Board of Investigation (BOI), appointed under sections 19 and 20 of the *Corrections and Conditional Release Act*, S.C. 1992 c. 20. The Report was filed as a key exhibit at the proceedings and documents a careful and full investigation into Mr. Newson's suicide, with personal interviews with all staff and some inmates

who had direct contact with Mr. Newson, as well as a thorough analysis of the steps taken to respond to the medical emergency by staff and ambulance personnel. The BOI makes a number of findings and some recommendations. The BOI was chaired by a deputy warden, and included a psychologist and a citizen representative.

[7] Counsel representing the Correctional Service of Canada at the inquest took no issue with the report, save for disputing one of the findings and a related recommendation. The BOI found "that SMI may not have been the best environment to send a first time 18 year old federal offender", a situation the BOI also found "was exacerbated when he was placed in SMI, Unit 2 . . . because this range is considered a tough inmate gang environment". Related to this finding, the BOI made a recommendation that "SMI must put in place internal procedures and guidelines for staff to facilitate inmate placement to select the best unit and range possible to ensure security."

[8] Extensive documentation from the Corrections file on Mr. Newson was filed at the inquest. I also heard oral testimony from Dr. Stanley Yaren, a consulting psychiatrist who was treating Mr. Newson and saw him only a few days before his death, SMI psychologist Dr. Richard John Howes, and Mr. Scott Skene, the first parole officer (PO) who dealt with Mr. Newson at SMI. Christer McLauchlan was called as the main witness from the institution. He is a level two correctional officer who has a very varied background within the institution including being the media spokesperson, project officer, acting security intelligence officer, member of emergency response team, dog detector handler and search specialist. He testified about the corrections file and procedures generally within Corrections Canada and at SMI. He also described a report and study he authored on "Points of Suspension" concerning points within the institution that could be utilized to commit suicide by hanging. SMI Nurse Charmaine Shaw also testified. Finally, inquest counsel called psychologist Dr. Kent Somers, the former chief of psychology at SMI. We also took a tour of SMI so that I could have a better sense of the physical environment where Mr. Newson was housed.

[9] According to the evidence I heard, discussed below, there is a chronic shortage of programming staff in SMI such that rehabilitative programs largely "work to deadline" – they are priorized largely based on when an inmate is about to be released. Mr. Newson was "wait listed" for all the programming and counselling he so evidently needed with no start dates on the immediate horizon.

[10] Was any of this a factor in his suicide? It is impossible to say for certain. But suicide is an act of despair and hopelessness. In many cases – and almost certainly

in this case (given the absence of classic warning signs) – it is also an impulsive act. If Mr. Newson had access to programming or counselling to help him deal with his issues, if he knew about the peer support program at SMI, if he had been placed in a different range or unit, or if he had developed a relationship with his new parole officer (or even met him in the month before his death) would he have been able to delay his impulsive and final solution to the situation that he found himself in? The answers to these questions are impossible to know. However, it seems to me that these issues are worthy of some consideration in this inquest.

[11] The other noteworthy evidence I heard was that youthful age or the fact that an individual is serving a first federal sentence are not factors given any special consideration in correctional planning. An offender's individual background and record and circumstances dictate the correctional plan.

[12] Devon Newson's family expressed interest in the inquest but was not able to actively participate. The file record shows that his family stood by him for many years, making exceptional efforts to help their son deal with his problems. He had long standing problems with drugs, alcohol and criminal involvement as a youth. The file shows that Mr. Newson acknowledged to officials that his "family had done everything for him". The fact that he was sentenced for a vicious attack on a family member produced an understandable period of estrangement between Mr. Newson and his family. The hope that was no doubt shared by all including his family was that Mr. Newson would, with the help of prison programming, decide to make the necessary changes to live a decent life.

[13] Devon Newson's impulsive choice to commit suicide has surely caused more pain for his family. I do not think this fact was something present to his mind in the circumstances. The family deserves our deepest sympathies.

## SENTENCING HEARING – NOVEMBER 30, 2005

[14] On November 30, 2005, ten days after his 18th birthday, Mr. Newson was found liable to an adult sentence under the *Youth Criminal Justice Act.* (YCJA) He was sentenced to six years for an aggravated assault committed on a family member on August 12, 2005, when he was 17 years of age. The offence was fuelled by a week long binge of crack cocaine, alcohol and other drugs and was a vicious, unprovoked attack on a defenceless victim. Devon Newson had a long history with the youth justice system, mainly for property offences. He had served time in youth facilities, his longest prior sentence being nine months - that is six months in custody and three months under community supervision. In addition, he

had spent considerable time in a youth residential substance abuse program in Alberta.

[15] A psychiatric report was ordered pursuant to s. 34 of the YCJA, and was filed as an exhibit in the sentencing hearing. The Report is an extremely comprehensive twelve page report by Dr. John Naylor, consulting psychiatrist to the forensic adolescent program of the Calgary Health Region. In reading the reasons for sentence, it was quite apparent that this important report was considered by the judge. The report was not transmitted to Corrections Canada and no one from Corrections Canada ordered a copy of that report, which was readily available as an exhibit in the proceedings, or from the Crown Attorney.

[16] In his comprehensive report provided at the sentencing hearing, Dr. Naylor provided his DSM IV Diagnosis, identifying, under Axis I that Mr. Newson fit the criteria for "Conduct Disorder; Attention Deficit Hyperactivity Disorder; Substance abuse – cocaine, ecstasy, marijuana and alcohol; Substance induced Mood Disorder and Insomnia; and Learning Disability – NOS." Axis II was noted as "Deferred"; Axis III had no diagnosis; Axis IV indicated "Moderate psychosocial stressors." According to Dr. Naylor his Global Assessment of Functioning was 40 at present; the same as the best in the past year. He indicated that:

> Devon has asked that he be restarted on his medications prescribed after our previous report, namely Wellbutrin and Risperidone, which helped him to control symptoms of Attention Deficit Hyperactivity Disorder, his mood instability and insomnia as well as his reactive anger. Unfortunately, he has not been well enough invested in the treatment to continue with the medications after release from the Calgary Young Offender Centre.
>
> Devon has proven that he is not able to control his impulsive criminal behaviours and substance abuse in spite of intensive residential substance abuse treatment. His substance abuse and criminal behaviours have also continued in spite of strong parental support and involvement in the AARC program as well as a high level of accountability to his probation officer. Given the relative certainty of his return to substance abuse and the subsequent return to criminal and possibly violent behaviour, the patient should be asked to undertake a period of abstinence of greater than eighteen months before a gradual and closely monitored reintegration to the community can be approached with any safety. Continuous substance abuse treatment during this time is strongly recommended. The patient should also be given the opportunity to involve himself in any available therapeutic groups while at the Calgary Young Offender Centre. (Emphasis added.)

> The prognosis for Devon remains guarded as he continues to relapse in the face of negative consequences for himself and his family. He has responded to medication in the past with an improvement in mood, temper control and academic functioning. A sustained period of treatment with medication may also help him to invest in prosocial strategies to maintain his self esteem in the future. (Emphasis added.)

[17] The doctor also observed that "Devon has a limited ability to follow through with . . . medical instructions without containment, structure, support, guidance and supervision." The doctor also observed that "Devon has been treated with Risperidone and Wellbutrin during past admissions to Calgary Young Offender Centre. The medication was effective in helping him sleep, control his anger, reduce impulsivity and remain focused." It seems regrettable that medical authorities at Drumheller and SMI did not have this report, and the information that the described medication regime had been of benefit in the past, along with the observation that to continue a regime, Devon Newson required structure, support and supervision. When at the Calgary Young Offender Centre, as with all youth facilities, the taking of medication was monitored and supervised. As we will see below, the situation is quite different in a penitentiary.

[18] That failing to obtain this report by Dr. Naylor was an oversight by Corrections Canada was denied by Mr. McLauchlan initially, but later in the proceedings he produced a Commissioner's Directive (CD) dated 2006-04-10 which specifically indicates in paragraph 13(d) that there is now a duty on corrections officials to obtain such reports.

[19] It was obvious to the health care professionals who testified that a 12 page detailed psychiatric report prepared at the time of sentencing would be valuable to both psychiatric and psychological service providers. An undue amount of time was taken up at the inquest attempting to deny the obvious oversight, and to prevent that report from forming part of the record. As it turned out, there were no revelations in that report that would have materially changed the treatment Mr. Newson received, save perhaps that a different medication regime may have been initiated by Dr. Darlington at Drumheller had he been provided with Dr. Naylor's report. Perhaps the psychiatrists may have also given greater consideration to the method of delivery of his medication, given the difficulties Dr. Naylor referenced with compliance absent support, guidance and supervision.

[20] In any event, Inquest counsel obtained the report and it was filed as an exhibit in the proceedings. Inquest counsel also tried on several occasions by telephone and letter to contact Dr. Naylor to ascertain any opinions or views he might have that could be of use to the inquest. Dr. Naylor simply did not respond.

[21] **I recommend that any psychiatric report and pre-sentence report referred to in a sentencing hearing not only be obtained in compliance with CD dated 2006-04-10, but that copies when obtained be provided to both the psychology and health (psychiatric services) departments of SMI.**

[22] As noted above, at his sentencing hearing, Devon Newson was found liable to an adult sentence. Section 76 of the YCJA requires a placement hearing be held to determine where a youth will serve an adult sentence, with a mandatory placement report required under s. 76(4). The Act contemplates that age twenty is the maximum age that a youth sentenced to an adult sentence can remain in a youth facility. Mr. Newson may have been eligible to serve a portion of his sentence in a youth facility.

[23] It appears that no such placement hearing was held, counsel acting on Mr. Newson's behalf apparently waiving such a hearing, and the judge making no mention of the requirement for it in his decision on sentence. In my opinion it is doubtful if such a hearing can be waived. If the theory of transfer to a penitentiary is that intensive rehabilitative programming will begin shortly after admission, there needs to be an evidentiary examination of any such assumption. Indeed the Crown submissions made at the sentencing hearing were that "the federal system has a lot more to offer in terms of programs. This is really a situation of Mr. Newson's best hope at a possible rehabilitation." Crown counsel continued: "He ought to have hope but also have enough time to be able to partake in programs."

[24] **I recommend that a s. 76(4) placement hearing ought to be held in every case where an adult sentence is imposed under the YCJA, and is particularly important where a penitentiary sentence is imposed.**

[25] It is also noteworthy that Mr. Newson's prior record consisted mainly of property offences, with no prior entries for violence. A summary of charges and convictions are as follows:

| DATE | CHARGE | SENTENCE |
|---|---|---|
| 2001-03-19<br>(Youth Court) | Theft Under $5000, Mischief and BE & Commit | Probation 12 months on each charge |
| 2002-10-21<br>(Youth Court) | Break & Enter, Break Enter & Commit, Theft Under $5000 and Fail to Comply with Recognizance | 18 month probation |
| 2003-07-03 | Theft Under $5000, Break Enter & | 52 days pre-sentence |

| | | |
|---|---|---|
| (Youth Court) | Commit | custody on each charge |
| 2003-07-18 (Youth Court) | Theft Over $5000 and take Motor Vehicle | Nine days and five days under supervision |
| 2003-11-27 (Youth Court) | Break Enter & Commit | 180 days and 90 days under supervision in the community |
| 2004-03-17 (Youth Court) | Break Enter & Commit and Unlawfully at Large | Two months plus one month under supervision in the community |
| 2004-08-10 (Youth Court) | Unlawfully at Large | 30 days and 15 days under supervision in the community |

[26] The offence for which he was sentenced, however, was an extremely violent act committed on a person he loved in the course of a cocaine binge, and prior history contained in the psychiatric assessment filed in youth court suggests prior acts of violence were reported by collateral contacts. Ironically, this lack of a formal prior record for violence worked against Mr. Newson in at least two respects.

[27] First, he was not eligible for a sentence of Intensive Rehabilitation and Custody (IRCS) under the *Youth Criminal Justice Act*, a sentence that might better have addressed his needs. Such an option was not available to the sentencing judge, because of s. 42(7) of the YCJA. Under that section, aggravated assault is not one of the triggering offences which in itself makes that sanction available under clause 7(a)(i); and he did not qualify under clause (ii) below because of the concluding words of 42(7)(a)(ii) underlined below for emphasis. The section states:

> (7) A youth justice court may make an intensive rehabilitative custody and supervision order under paragraph (2)(r) in respect of a young person only if
> (a) either
>
> > (i) the young person has been found guilty of an offence under one of the following provisions of the Criminal Code, namely, section 231 or 235 (first degree murder or second degree murder within the meaning of section 231), section 239 (attempt to commit murder), section 232, 234 or 236 (manslaughter) or section 273 (aggravated sexual assault), or

> (ii) the young person has been found guilty of a serious violent offence for which an adult is liable to imprisonment for a term of more than two years, and the young person had previously been found guilty at least twice of a serious violent offence;
>
> (b) the young person is suffering from a mental illness or disorder, a psychological disorder or an emotional disturbance;
>
> (c) a plan of treatment and intensive supervision has been developed for the young person, and there are reasonable grounds to believe that the plan might reduce the risk of the young person repeating the offence or committing a serious violent offence; and
>
> (d) the provincial director has determined that an intensive rehabilitative custody and supervision program is available and that the young person's participation in the program is appropriate.

[28] **I recommend that the Federal Department of Justice give consideration to adding aggravated assault to s.7(a)(i) of the YCJA, so that in appropriate cases, an IRCS sentence could be imposed on a young person found guilty of that offence under the YCJA.**

## TRANSFER TO DRUMHELLER FEDERAL PENITENTIARY

[29] On December 9, 2005, Devon Newson was transferred to the Drumheller Federal Penitentiary (Drumheller) in Alberta, his home province. On December 12, 2005, Debbie Anderson, Manager of Assessment and Intervention, met with him noting that "this is a very young 18 year old who claims to be associated with another young and immature inmate on his range." She indicates she cautioned him "about getting in over his head as would relate to debts, drug involvement or just simple unacceptable/ defiant behaviour." As will be seen Mr. Newson was either too immature or too irresponsible to put her caution in play.

[30] On December 12, 2005, he was screened for mental health purposes, including suicide risk factors by social worker Lesa Toffan. None were noted. There was no history of suicide/ or self-injurious behaviour nor any current suicidal or self harm behaviour. It was noted that "inmate is young … yet seems to have adjusted well to the institution and has no concerns in this regard." As will be seen that assessment proved to be short-lived.

[31] On December 14, 2005, he was seen by psychologist Dr. Robert Smith, chief of psychological services at Drumheller. He too screened him for self-harm issues and found no concerns, nor any documented history of mental health issues. He found that there was "No history of persistent or gratuitous violence or sexual

offending." This finding was significant as it made Newson ineligible for intensive psychological screening. In coming to this conclusion, Dr. Smith relied on the past criminal record which did not contain prior findings of guilt for violence. As will be seen later in this Report, it appears that this restrictive approach to eligibility for a psychological assessment may be changing.

[32] On January 5, 2006, the correctional record shows that Mr. Newson made the following request: "I have problems with school. I am ADD and need you to see me so that I can be set for school. Please and thank-you." He also noted: "I need your help with my sleep. I don't get to sleep until 4 o'clock every night because my mind does not stop and I sleep all day and sometimes miss meals. Please help, thank you." On January 10, 2006 Social Worker Toffan noted she would see inmate on January 16, 2006 to assess needs. Follow up notations on his file from her on January 25, 2006 indicate that he signed a consent form for one on one counselling forms and she made a request to Dr. Darlington, Drumheller consulting psychiatrist that he see Mr. Newson. She wrote:

> Inmate was referred to this writer for an initial assessment as he requested to see the institutional psychiatrist. Newson was sentenced in December 2005 to his first federal term of incarceration, and therefore the information is sparse. He has made arrangements to start school next week and is concerned with regard to his behaviour in relation to a prior diagnosis of ADD. He described a history of difficulties in school and with school work due to an inability to concentrate and focus on the task at hand. He stated he is able to read but has difficulties comprehending the information. He struggles when he tries to maintain his attention on anything for very long. He noted school had always been frustrating for him, and he was eventually sent to a doctor who diagnosed him with ADD. He was first placed on Dexedrine, however he suffered a number of side effects including loss of appetite, inability to sleep, mood swings and depression. His doctor discontinued the Dexedrine and prescribed him Wellbutrin, however he did not find this helped him. Newson was eventually prescribed Ritalin, which he found had a beneficial effect, however he worried that Ritalin may not be good for him as he heard that it has negative effects on the nervous system. He is requesting to see Dr. Darlington to discuss these matters and is thereby being referred.

[33] Psychiatrist Dr. Darlington did respond to the referral made by Ms Toffan. He interviewed Mr. Newson on February 9, 2006 and prepared a one and one-half page psychiatric report based on his interview. Again he did not have access to Dr. Naylor's comprehensive report. However based on his interview his Axis I diagnosis was "Substance dependence (cocaine, alcohol), Provisional ADHD – Adult type, mild." As to Axis II he noted "Antisocial personality traits". On Axis IV he noted "Moderate Stressors" and found as to Axis V – Current level of

functioning – some difficulty (GAF=70). He prescribed Prozac 20 mg because of the ADHD diagnosis. In his report I note that he accepted Mr. Newson's erroneous self- report that he had spent five years behind bars.

[34] On February 23, 2006, Mr. Newson did not attend for his follow up appointment with Dr. Darlington. By March 9, 2006 Mr. Newson was in segregation for his safety as is explained below. The doctor attended to his cell that afternoon and found him sleeping, with no other complaints, so that the medication was re-ordered.

[35] Meanwhile, on January 26, 2006, John Gavin, Mr. Newson's parole officer in Drumheller, made the following referral to Psychological Services.

> Newson is an 18 year old first time federal offender serving six years for robbery. He asked his [family member] for money for drugs and when ... refused he assaulted his [family member]. This is his first conviction involving violence and it demonstrates an escalation in his offending behaviour. The CLAI test indicates that he would benefit from participation in a high intensity substance abuse program and he will be referred to this program in the institution. I am requesting a psychological assessment for Newson to determine the reason for his violent behaviour and to determine his risk for future violent behaviour.

[36] Dr. Smith quickly responded that "this case does not meet the policy driven criteria for an Intake Psychological Assessment. No further action will be taken on this case." I understand that these polices may be changing, from the evidence I heard from Dr. Richard Howes *infra*.

[37] In any event, **I recommend that a detailed psychological assessment be conducted as part of an initial assessment in every case where an offender age 25 or under is serving a first federal sentence.**

[38] In many, if not all federal institutions including Drumheller and SMI, psychiatric services are delivered through a chief health of care, and psychological services are separated and run through a chief of psychology. I will refer to whether there could be improved information sharing later in this report.

## PROBLEMS OF ADJUSTMENT IN DRUMHELLER

[39] Within a very short time after his arrival in Drumheller, Devon Newson ran into difficulties. He feared gang members as he had left the gang with which he was formerly but briefly affiliated. He had incurred an $800 drug debt by consuming drugs (cocaine) while in Drumheller, drugs he held for another inmate while that inmate was on a family visit while in the institution. He had previously

"ratted" out another inmate, giving a statement to police which had become known, and (unfairly he claimed) had also been labelled a cell thief concerning some missing tobacco. He began attending the institutional school at Drumheller on February 2, 2006 but did not return after being threatened by other inmates at the school. He claimed that he had received "shots" in the school and was called names. He was suspended on February 20, 2006 for non attendance.

[40] That same day, February 20, 2006, as a result of these difficulties with other inmates, authorities at Drumheller placed him in administrative segregation for his own safety and requested a transfer. Authorities and Mr. Newson concluded that it was not safe for him to be in general population in Drumheller.

[41] Although it appears that SMI had been identified by early March as the institution to which Newson would be sent, he remained in segregation at Drumheller from February 20, 2006, until his transfer out of the institution on May 18, 2006 to SMI. He was classified as a medium security and SMI was the only institution in the region that responded affirmatively to the transfer request.

[42] Staff members at Drumheller noted that while there he was co-operative, quiet and there were no incidents of him being disrespectful to authorities.

[43] By May 2, 2006, he was aware of the pending transfer to SMI but stated a preference to remain incarcerated in Alberta so he could be closer to family. A few days later, May 6, 2006, he stated he was not having problems coping with segregation and the Prozac was helping. He enquired about a transfer to Bowden and was told he could look at transferring from SMI to there if necessary.

[44] The picture that emerges from Drumheller Institution is of a young first time federal inmate experiencing significant difficulties in adapting to life in general population in a federal adult institution.

[45] Meanwhile, on March 3, 2006, while Newson was in Drumheller segregation awaiting his transfer to SMI, Newson's PO John Gavin made a request for programming to be scheduled for Newson while in SMI. The requests were based on a comprehensive correctional plan for Mr. Newson that was developed in Drumheller.

[46] Mr. Gavin identified three programs: "Reasoning and Rehabilitation," noting that Mr. Newson "makes poor decisions in regard to his lifestyle, behaviour, associates and substance abuse. He has no appreciable life skills and he has no family or community support at this time." Similarly he made a recommendation for "Anger and Emotions Management" programming referencing the level of

violence involved in the offence, and a recommendation for the "Substance Abuse Program – High Intensity," observing that "Newson has been involved in drugs and alcohol from an early age and his offences are directly related to his abuse of drugs and alcohol."

[47] All three programs were requested as HIGH priority by the Drumheller PO and were discussed at a Program Board meeting. All were referred to in Newson's correctional plan. Prior to leaving Drumheller segregation Mr. Newson asked to review parts of his correctional plan.

## ARRIVAL AT SMI

[48] Upon admission to SMI, on May 18, 2006, a nurse performed a health status assessment and noted that, on transfer from Drumheller, Devon Newson's medication regime was Seroquel and Prozac, and checked "yes" to current mental health problems noting "depression/ anxiety." The records from Drumheller filed do not show when or if Seroquel was prescribed. In any event, during the health status assessment a checklist was completed by the nurse indicating no need for immediate intervention regarding mental health issues; and answers were in the negative to suicide assessment with the exception of an affirmative response to "recent loss of relationship, death of a close friend or relative." The checklist also answered "no" to "inmate showing signs of depression or hopelessness."

[49] As was noted above, Mr. Newson had been assessed by psychiatrist Dr. Darlington at Drumheller, and because he was receiving medication at the time of transfer he was referred to and continued under the care of consulting psychiatrist Dr. Yaren at SMI. In fact on May 18, 2006, the day of his arrival at SMI, the record shows Dr. Yaren gave a verbal authorization to continue the 20 mg of Prozac he had been receiving at Drumheller and as is standard practice, an appointment was arranged for Mr. Newson to meet with Dr. Yaren in person.

[50] On May 19, 2006, PO Darrin Boch spoke with Mr. Newson and reported that Newson had no concerns with going to general population at SMI and that he had no incompatibles at the institution. It should be noted that residing in general population is considered far superior (compared with segregation) in terms of access to recreation time, to outside exercise, to movement within the prison and other programming and activities, as well as socializing and some freedom within a range.

[51] Mr. Newson told Mr. Boch he was willing to work closely with his case management team.

## ASSIGNMENT TO UNIT 4

[52] Mr. Newson was initially assigned to Unit 4 which was a temporary intake unit pending assessment of an appropriate longer term housing unit. He was also assigned to PO Scott Skene who testified at the inquest. Mr. Skene impressed me as a thoughtful PO who had a good approach to the inmates on his caseload, while being quite aware of the varied and difficult issues for inmates and management at SMI.

[53] Mr. Skene stated that one of their practices at SMI is within the first two working days of being assigned an inmate, "you should go and meet with the inmate." He met with him on May 19, 2006 – two days after Mr. Newson's arrival. He had an introductory meeting with him, as he said, so "the offender knows how to ask for me, who I am" – it was a "meet and greet". He did recall meeting with Mr. Newson. They talked about the brutal nature of his crime and also about why he was transferred and his fear that the drug debt from Drumheller might follow him.

[54] Mr. Skene felt that unlike some inmates, Mr. Newson was not afraid to do his time. He wanted to go to general population. He was embarrassed to discuss his crime and the hold that drugs had taken on him, in Mr. Skene's opinion.

[55] Mr. Skene also described the physical location of his office in relation to where the inmates are housed. At one point during the inquest proceedings we went to SMI and viewed the range (Unit 2) where Mr. Newson was housed when he died. The physical setup was very similar to Unit 4. In Unit 2 there are four ranges, an upper and lower range on each side of a common area. There is a kiosk, located on the main floor, where the correctional officers (CO's) that control the movement of the offenders are seated. Behind the kiosk, a floor above it is a hallway of offices where the PO's are located. It is an open floor with a railing so that the kiosk and the floor below are visible. When inmates are out of their cells, not locked down, activity can easily be seen. Inmates are free to approach the kiosk at these times, and collect their meals there. The PO's area is only about 50 yards from the barrier behind which the inmates are contained. Mr. Newson's final PO was located within a minute's walk of the unit where he was housed.

[56] Mr. Skene described his frequent pattern of going out to where the inmates are eating their lunches or gathered to say "hello, how's it going." Mr. Skene testified that if an inmate had a problem and wanted to speak to him, it would be no problem unless he was tied up in a meeting. The inmate could go to the kiosk or flag down a CO and ask to speak to Mr. Skene. That would be quite normal. He

had an open door policy. He stated he tries to see all 25 inmates on his caseload at least once a week. But if there are problems he has seen offenders three or four times a day. He related that not all PO's operate the way he does. He thought that he would have made Mr. Newson aware that he would have a new parole officer when he moved to the new unit.

[57] The second meeting Mr. Skene had with Mr. Newson was on May 30, 2006. He was still housed in Unit 4. At that meeting Mr. Newson stated his wish to go to general population. His safety concerns were related to a gang at Drumheller (RA) none of whom he believed were in SMI. He did not feel his safety was in jeopardy. Mr. Skene told him that he would talk to those in charge about a move. He specifically noted "I informed him . . . should he be moved, I advised him to approach staff if he has any concerns and he indicated he would."

**JUNE 19, 2006 – TRANSFER TO UNIT 2**

[58] Mr. Newson was transferred to Unit 2 on June 19, 2006. He was assigned to a different parole officer. But it was only one hour after his placement on the new unit that Mr. Newson was having a problem on his range. He approached the kiosk and asked to be moved off the range, stating, (according to a note placed on the offender management file by a CO), that there were three inmates from Drumheller that wanted to assault him. He stated he would not be safe in any unit in population now that they knew he was here. He agreed to be locked up in his cell until the matter could be addressed. He also asked for Mr. Skene.

[59] Mr. Skene came to the range to meet with Mr. Newson, even though he was no longer responsible for Mr. Newson's case, to try to help him resolve the problem he was having. Newson told Skene he had not been directly threatened but an inmate from Drumheller who had been in the hole when Newson was in administrative segregation there stopped by his cell and was asking him a question. He thought the person was a friend of the inmate from whom he had stolen the $800 worth of drugs. He feared for his safety. Mr. Skene got a member of the Inmate Affairs Committee (IAC) involved. I was told that every range (or unit) has a representative of the Inmate Affairs Committee. This is different than the Peer Support Committee, which will be discussed below.

[60] Mr. Skene testified that the most important concern for him and fellow staffers is the safety of the inmate. He investigated the concern, spoke to Newson and called an inmate in from the IAC, someone with whom Mr. Skene had a good rapport. The concern was discussed and addressed. Mr. Skene checked with

Mr. Newson and learned that he was satisfied with the resolution and chose to stay in general population at that time.

[61] Mr. Skene stated that he advises every offender that "this is the plan now. If it's working, it's working. If it's not working you go to the officers, you go to –if, if it's eight to four and I'm here, you come to me or you come to a parole officer, anybody –any employee that, that can get the information that you're not safe and why you're not safe, and we do what we have to do to make them safe." He told Newson to seek out anyone if he gets a threat or perceives one.

[62] Mr. Skene testified that inmates on a range generally have an interest in solving problems also, in that if there are problems, they get locked down and rights get taken away. He had a rapport with the particular inmate from the inmate committee that he asked to solve the problem. Mr. Skene documented the fact that he advised Newson should he see any signs of a problem he is to approach staff. Mr. Newson stated that he understood this and returned to his range.

[63] Mr. Skene indicated that he takes a required online two hour course on suicide awareness and prevention every two years. He is familiar with the tools for suicide risk assessment. He did not believe that conflict with other inmates was an identified risk factor. In fact studies have shown that conflict with other inmates has been identified as an occurrence that has preceded some prison suicides. However, the reality is that these kinds of conflicts are also fairly common in prison settings.

[64] Mr. Skene recalled that Mr. Newson did have fear related to his drug debt from Drumheller following him to SMI, but in the three meetings with him he saw no red flags concerning suicide. In reality, he testified, drug debts are not all that uncommon in SMI and sometimes with the help of the IAC, inmates make arrangements to gradually pay them off. Mr. Skene testified that inmates can ask any staff member to arrange for them to talk to an Inmate Peer from the Peer Support Program as well. I will say more about this program later.

[65] I asked Mr. Skene if he had any suggestions for improvements that could minimize the chance that a similar suicide would occur in the future. His impression was that there was little that could be done. He felt that Mr. Newson had nothing and did not want to reach out to what the correctional service had to offer to him. He felt he had a lot of time to think about things and at some point realized it was too much for him. He was young. In his view, he was coming to terms with what he had done. He noted that "we have gang members – we have a lot of unsavory people behind bars." He speculated that maybe it was the

additional stress of incarceration that led him to make the decision he did. He did not feel the system or service had failed him. He felt Mr. Newson knew he could have reached out for help and chose not to do so.

[66] When I look at the various requests made by Devon Newson for help, I formed a different picture. He was asking for help in a number of areas. He was largely placed in a holding or waiting pattern to receive the help he requested, and that his correctional plan recommended as priorities.

## LACK OF ACTION BY NEWLY ASSIGNED PO

[67] As noted, Mr. Skene went to Mr. Newson's new range and assisted with the problem that had arisen the day of his transfer June 19, 2006. He then took the responsible step of emailing the new PO, on June 23, 2006 to alert him to the issue so that he could follow up. Inexplicably, there was no follow up by the new PO.

[68] The unfortunate reality is that the new PO, despite having been alerted to a situation that bore watching and follow up, never spoke to or even introduced himself to Mr. Newson from the time Mr. Newson arrived on Unit 2 June 19, 2006 and was assigned to him until his death on July 23, 2006. There was no "meet and greet" or any other contact whatsoever.

[69] Similarly disappointing is that fact that he never had any interaction with his newly assigned CO on Unit 2, even though his CO was on duty in that unit and on the range where Mr. Newson was housed. It is surely up to the PO and the CO to institute contact and develop some kind of relationship with those on their caseload. The record shows that the CO called for Mr. Newson once or twice over the intercom during the 5 week period but when he did not respond, took no action to initiate contact.

[70] There was no evidence led that convinces me that Mr. Newson even knew the names of his PO or CO at the time of his death. It is admittedly speculative to suggest that had an appropriate relationship with these individuals been developed, he may have felt he could turn to them for help with his apparent despair, or that they may have detected signs of a potential suicide with greater interaction.

[71] The fact remains that staff need to be proactive, in my view, in monitoring the well being and adjustment of any inmate new to a range, particularly one with a history of adjustment difficulties. Although it was indicated that inmates "know" that they can ask to speak to a CO, PO, an inmate peer counsellor or a nurse if needed, I am not convinced that there are adequate procedures in place for newly transferred inmates to understand that inmate peer support or help is available, and

how and when it can be accessed. I was told that CO's have the authority to summon an inmate peer counsellor at any time of the day or night if an inmate is in distress and needs someone to talk to. On the evidence I heard I am not convinced that Mr. Newson in fact grasped or understood this option. I will have more to say about the Peer Support Program later in this report.

[72] I acknowledge that based on what Mr. Skene told Mr. Newson he should have known to contact "staff" if he had safety concerns. However, it is self evidently easier to confide your fears to someone you have met and know and with whom you have some sense of trust. Mr. Skene understood that well and did what was necessary to establish a relationship with those on his caseload. So too did the CO on Unit 4.

[73] Proactive efforts by the assigned PO and CO are particularly important for young, first time federal offenders, or indeed any first time federal offenders. No explanation was provided for the lack of follow through by the CO or PO involved, and they were not called to testify. It does not matter how well trained in suicide risk factors staff may be if they have no contact with offenders on their caseload. We will simply never know if there were any warning signs either may have been able to discern, or if there had been a relationship at all, whether Mr. Newson may have thought to postpone his last act until he had a chance to talk to either.

[74] The failure of both the newly assigned PO and CO to ensure that contact was made and to take an active approach to this young inmate was the subject of concern and criticism by both the BOI and officials at SMI. SMI has now established a guideline – which would seem only sound practice – that a PO must meet a newly assigned inmate within 48 hours. Nationally Corrections Canada is apparently reviewing PO standards and job descriptions. Should a further recommendation be made that with young or new federal inmates, there should be face to face meetings not less than once a week for at least a set period?

[75] Mr. McLauchlan, although he has never been a PO, cautioned against any rigid number of times that should be set. We did not question Mr. Skene in detail on this but his own practice was that he tries to see all offenders on his case load at least once a week. One would hope that frequent contact would be the norm. In the case of younger inmates who are first time federal offenders, I have concluded that there should be a guideline requiring frequent follow-up contact to recognize the additional potential vulnerability of these youthful offenders.

[76] Therefore, **I recommend that the PO's should meet with first time federal inmates age 25 or under within 48 hours of their assignment, and not**

**less than once per week for at least the first four months after an inmate is placed on any new unit or range, to ensure the PO's are aware of and can assist with any adjustment difficulties. If inmate conflict is flagged as a potential problem, meetings should be more frequent, not less than twice a week. All these meetings should be entered on the Offender Management System (OMS).**

[77] Currently the practice direction for CO's is that they should meet inmates on their caseload "regularly". That term is vague but it has been communicated that it means more than once a month. CO's have a much smaller caseload of 10 inmates but obviously have other duties to perform.

[78] **I recommend that the CO's should meet with first time federal inmates age 25 or under within the first two daytime shifts of their assignment, and not less than once per week for at least the first four months after an inmate is placed on any new unit or range, to ensure they are aware of and can take appropriate action concerning any adjustment difficulties. If inmate conflict is flagged as a potential problem, meetings should be more frequent, not less than twice a week. All these meetings should be entered on the OMS.**

## CONTACT WITH SMI PSYCHIATRIST DR. YAREN

[79] As noted above, on the day of his arrival at SMI, Dr. Yaren verbally authorized continuation of Mr. Newson's medication. Mr. Newson was booked to see Dr. Yaren at the psychiatric clinic on May 24, 2006. Dr. Yaren could not see Mr. Newson that day, according to the records, because there was no escort available to bring the patient to the clinic. He was rebooked for June 1, 2006.

[80] Dr. Yaren saw Mr. Newson on June 1, 2006. He had Dr. Darlington's psychiatric report on file and reviewed it at that time. His notes state that on examination, he found Mr. Newson to be "mildly depressed but not suicidal, complaining of poor sleep and decreased concentration. Plan, try increased Prozac first. If no improvement try Strattera next." He explained that SSRI drugs, of which Prozac is one, have a wide range of applicability for depression, anxiety and in some cases for adult ADHD.

[81] He explained that at the severe end of the depression spectrum individuals will have persistent difficulties with sleep, appetite, energy, and concentration. This can be a serious illness, so that feelings of despondency to the extent, on occasion, of suicidal thinking can occur. Mild depression on the other hand is not greatly distinguishable from situational sadness, or mood fluctuations within the

norm. Mild depression (which he noted concerning Devon Newson) bears watching but does not generally call for antidepressant therapy.

[82] In Mr. Newson's case Dr. Yaren indicated he reported feeling sad, and he looked sad, "but he didn't endorse the full constellation of depressive symptoms and certainly didn't, didn't (sic.) express any suicidal or self-harm intention and, and did have future oriented thinking, for example, was obviously interested in, in, in (sic.) improving his performance in school which is, . . . an encouraging sign so as that he's sort of motivated, he hasn't given up hope, all of those sorts of things."

[83] Dr. Yaren decided just to keep an eye on the depression, and since he was increasing the Prozac to improve the response in terms of the ADHD, it wouldn't hurt in terms of any emerging depression as well to increase the Prozac. He testified that Mr. Newson did impress him as being young, but to counterbalance that he noted that he was not inexperienced in the criminal justice system and therefore had some past involvement with an antisocial peer group similar to that which he might find in a prison. He impressed Dr. Yaren as someone who was reasonably forthright and focusing on relating his difficulties with attention and sleep. He did not strike him as deceptive. He did not identify him as someone with any severe mental disorder and "certainly did not identify him as someone who was in any way at high risk of self-harm and engaging in self-harm behaviour. That wasn't his style up to that point in time of coping with, with (sic) issues in his life."

[84] Concerning Dr. Naylor's report, Dr. Yaren agreed it was a highly relevant document and generally would be helpful. In this case, however, especially given that Dr. Darlington had prescribed Prozac, he did not believe that his approach to prescribing medication for Mr. Newson would have been different had he been in possession of the report.

[85] Dr. Yaren is an experienced psychiatrist well versed in detecting the signs and symptoms of suicide risk and experienced in dealing with inmates who do show signs of suicide risk, such as ideation, past self harm, lack of future oriented thinking, suicide planning etc. He described the approach he takes in interviewing and screening for suicide risk as kind of a branching process. Different answers to questions may lead to further probing questions. But he did screen Mr. Newson, and detected no signs of a risk of suicide so he did not go into the more detailed steps he would have otherwise engaged in had the presentation been different. He routinely screens for this type of risk when he interacts with patients, and is quite aware of the elevated risk of suicide in prison settings.

[86] Dr. Yaren observed that there is no objective test to determine whether or not someone is intending to commit suicide or is at an elevated risk of suicide. Self-harm is a complex behavioural phenomena and there is no accurate way of predicting it, just tools that have been developed to assist in risk assessment. But "[a risk assessment] is no crystal ball." As to Mr. Newson, applying risk assessment tools, Dr. Yaren considered his risk quite low, and he did not in any way cause concern that he was someone having difficulties adjusting to a new or intimidating environment. " . . . [H]e didn't state any of that and he didn't respond to any questions to affirm that and there wasn't anything in his record that would suggest that."

[87] Although Dr. Yaren has access to the health care record, he does not have access to his case management file, correctional record, or correctional file.

[88] He was asked to comment on Mr. Newson's sleep difficulties. He acknowledged that sleep difficulties can be a symptom of depression, but that sleep difficulties are very common generally and even more common among the prison population. He did acknowledge that Prozac can sometimes interfere with sleep.

[89] Dr. Yaren observed that patients see him on a voluntary basis, and the ultimate decision about participating in treatment or taking medication rests with the patient, and that he would always discuss risks and potential side effects with the patient. He testified that when patients in SMI see him, it is up to them to decide whether or not they want to carry through with the recommendations for treatment, and that they have the same rights of refusal and consent to treatment as any other citizen.

[90] Dr. Yaren explained that there are two ways that medication is dispensed at SMI. Medication can be unit dosed, where each dose is administered by a nurse who comes to the unit where the inmate is housed and observes the inmate take the medication, perhaps even doing a mouth check to see if it is swallowed. The second way is by providing the inmate with a blister pack (usually with seven days worth of medications) to self administer. Certain types of medication, subject to abuse or misuse, are not suitable for self administration. After seeing Mr. Newson on June 1, 2006, he determined that the blister pack approach was appropriate for Mr. Newson.

[91] The second appointment with Dr. Yaren was scheduled for July 13, 2006. The records indicate that although Mr. Newson had been given a pass for that appointment, so that he could attend without an escort, he did not show for that appointment. Although there are occasions when Dr. Yaren will investigate why a

patient has not attended, on this occasion he had no reason to be concerned. Instead he rebooked Mr. Newson for July 19, 2006. He did see Mr. Newson that day for the second and last time, as it was only four days later that his patient committed suicide.

[92] On July 19, 2006, he recorded that Mr. Newson was "much improved in terms of mood and ADHD since increased Prozac to 40 milligrams. Side-effect – insomnia. Plan – short-term Imovane." Dr. Yaren testified that Mr. Newson appeared to be having more difficulty with sleep, so that perhaps he was having the side effect of increased insomnia. He thought that Imovane would be helpful as it is a sleeping medication that could normalize his sleep cycle and then be gradually withdrawn. This meeting would have been a brief assessment because he was not presenting with problems but rather with significant improvement. He testified that at the earlier interview Mr. Newson's risk of self harm would have been assessed at very low and at this interview even lower.

[93] Mr. Newson was not forthcoming about his difficulties with other inmates to Dr. Yaren. Dr. Yaren believed he would as a matter of common practice discuss with his patient that there is a mental health nurse he could have talked to if he needed to do so. Dr. Yaren also testified he thought that inmates were made aware of the fact that they can call the desk on their range at any time if in distress.

[94] Nurse Charmaine Shaw, Chief of Health Services at SMI explained the responsibilities of the nurses in activating prescriptions. They review the doctor's orders and advise the pharmacy. They then dispense the medication in one of two ways.

[95] Nurse Shaw elaborated on the method of dispensing medication and interpreted Mr. Newson's chart. For certain medications it is "observed dosing" – the nurse hands the medication to the inmate and watches him take it. The nurse attends to the unit and the inmate is paged to attend to the kiosk in the range. If the inmate doesn't attend, absent exceptional circumstances or special instructions from the psychiatrist, the nurse leaves without dispensing the medication.

[96] The other way of dispensing medication is through blister pack. If authorized by the doctor the medication is dispensed in a blister pack and the patient is given the responsibility to take his daily dose. Dispensing blister packs is done similarly to dispensing doses. The Nurse's chart shows that from the 19th to the 22nd of May, Mr. Newson did not respond to the page to the kiosk and take his verbally authorized daily doses of Prozac. After that he appears to have taken his medication daily from May 23 to May31.

[97] As of June 1, 2006, the day he saw Dr. Yaren, as noted above, his Prozac medication was changed to a seven day blister pack. Nurse Shaw testified that the record shows that he picked up his blister packs for Prozac on June 2, 9, 17, 23, and 30, and July 7 and 14.

[98] At the time of his death, however, no Prozac was found in his system and had he been taking the medication as prescribed, according to Dr. Yaren, it should have been detected. The same can be said of the Imovane for sleep difficulties – no trace was found. In fact the record shows that he only picked up the Imovane once on July 21, 2006.

[99] It seems despite Mr. Newson's consent to treatment, he was not taking his medication at the time of his death. I do not take this to mean that Mr. Newson had withdrawn his consent to treatment, but rather that due to his immaturity and lack of responsibility, and perhaps disorganization, his follow through was lacking. I also refer back to Dr. Naylor's report concerning Mr. Newson's need for structure, support and supervision for compliance with medication regimes, a report that Dr. Yaren did not have access to at the time he was treating Mr. Newson.

[100] With great respect to Dr. Yaren, I believe an approach to medication management that involves more coaching, support and supervision is necessary and advisable for individuals with Mr. Newson's profile. He was only 18. Had he been in the community with family members, he would no doubt have been reminded and coached to take his medication. Similarly in youth facilities, there would be greater supervision. As noted above at paragraph [17], Dr. Naylor had observed that "Devon has been treated with Risperidone and Wellbutrin during past admissions to Calgary Young Offender Centre. The medication was effective in helping him sleep, control his anger, reduce impulsivity and remain focused." At the same time, Dr. Naylor noted the need for "containment, structure, support, guidance and suspension" concerning follow through with medical instructions.

[101] So we have the evidence that supervised medication regimes did work well for Devon Newson in youth facilities where he had previously been in custody. Specifically, under those regimes, the symptoms Devon Newson had - many of them the same symptoms he complained of in the penitentiary - were significantly ameliorated.

[102] Many offenders in penitentiaries such as SMI have disabilities such as ADHD (as Devon Newson did) or a Foetal Alcohol Spectrum Disorder (FASD). It is unrealistic to assume that young inmates with these disabilities will be mature, responsible and organized enough to follow a medication regime, even one they

consent to follow and indeed wish to follow. Even absent such disabilities, psycho-social maturity of young adults lags significantly behind cognitive maturity. So although cognitively patients are capable of determining whether they wish to consent to treatment, follow through may be lacking due to delayed psycho-social maturity.

[103] Because of these factors, I think greater supervision of medication regimes in federal institutions is highly desirable for young federal inmates, in particular. I emphasize that this is not about forcing treatment or medication, but encouraging and assisting, much as would be done by a concerned parent or relative with a young adult needing psychiatric medication.

[104] Therefore, **I recommend that nurses should meet face to face with inmates 25 and under and inmates of any age with a confirmed or suspected FASD diagnosis, who have been prescribed medication for psychiatric conditions, daily, if medication is prescribed on that basis. If these individuals do not respond to a page to their kiosk, the nurse should obtain the assistance of CO's on duty to locate the individual and bring him to the kiosk, along with any blister pack medication. The purpose of the face to face encounter is to remind, encourage, and support the inmate to take his medication as prescribed, to maintain a record as to whether the inmate is observed to take the medication and to hear any concerns that need to be reported to the doctor. Similar approaches should be taken with daily dose medication. At some point, if it is established that the inmate is both committed to and able to follow the medication regime, such intensive supervision may be diminished.**

[105] I recognize that this will put an additional burden on the nursing staff, and for this reason I have given it very careful consideration. Particularly concerning medications for inmates with neurologically driven impulse control problems, and with sleep problems serious enough to warrant medication, implementation of this should be given a high priority. Again, it is impossible to say that such a regime would have made a difference with Devon Newson. But logic suggests that if he had been taking his medication he may have had greater impulse control, and possibly been assisted with sleep.

[106] Dr. Yaren agreed with the suggestion that there are two types of suicides – those that are planned and those that are impulsive. "I think that's a fair statement that . . . there are suicide behaviours that do occur on impulse spur of the moment without any previous warning or forethought of signs, and then there are those where there are all kinds of signals that one can identify in retrospect."

[107] Dr. Yaren testified he thought inmates are made aware of their options through the intake process about what resources are available to them. He was unsure how frequently they need reminders, but he indicated it would vary. Beyond this observation about ensuring inmates know how they can address acute stressors he did not have any specific recommendation to make. I will come back to this later.

## MR. NEWSON'S REQUEST TO SEE PSYCHOLOGIST AND FOLLOW UP – EVIDENCE OF DR. HOWES

[108] Meanwhile, on June 27, 2006, Mr. Newson's correctional file shows that he made a request to see a psychologist. He wrote: "I would like to talk to you if that is OK. I think talking to you would help me out. I need a good plan for my time here. Please and thank-you."

[109] Dr. R. Howes, who testified at the inquest, saw him the same day. At the time of the inquest Dr. Howes was the acting chief of the psychology department and had been employed as a psychologist at SMI for 25 years. Unfortunately by the time of the inquest, Dr. Howes stated he had no specific recollection of his meeting with Mr. Newson, but relied on his notes, which gave this account:

> A Okay. My note says: He appears so remorseful. Understandable inasmuch as his offence involved an assault and robbery of his [family member] while he was high. That his motivation to change may be sincere in spite of his relapse at Drumheller. He is eager for programs, AA and upgrading, and he avows an intention of leaving behind his impulsiveness, irresponsibility, recklessness, selfishness, et cetera. He is, he is only 18 and there is potential here. I am placing him on our treatment waiting list as a moderate priority and he understands it may be many months before he is called up. And I added a postscript: At that time he may have demonstrated how committed he really is to change.

[110] Dr. Howes also testified that as part of his routine interaction with any inmate, he always screens for signs of suicide risk, and had there been any indication of hopelessness or despair, he would have made a note and followed up. He was therefore confident that Mr. Newson never displayed any suicide risk markers in his encounter with him on June 27, 2006.

[111] He was asked to explain his reference to Mr. Newson's young age. He testified:

> A I guess more than anything it was obviously his first time in jail and we know that that's one of the factors associated with lower risk of re-offending.

> People if they are into their second sentence almost invariably re-offend, but a number of people come to jail once and learn from the experience and never return. (Emphasis added.)

[112] He was asked if he could elaborate on his particular concerns about young first time federal offenders. He stated:

> A I have a couple of comments to make about that, as reflected in my comment there that, you know, he's only 18 and there's, there's still hope, I guess that's sort of an affirmation of my sense that, you know, before a person is too contaminated by a prison experience, you know, there's still hope. A person coming back multiple times, you know, incarceration has lost any effect and they'll just continue. So if you can catch them when you're -- they're young and in for the first time and being held seriously accountable for the first time in, in their lives, I know that's associated with lower risk of re-offending. But I also anticipated the concern about the fact that he's 18 in, in a prison of adults where he would be the youngest age. (Emphasis added.)

[113] He testified that currently there were only 23 inmates who were 20 years of age or under out of a population of 570. But he testified that there are many inmates – nearly 50% - who are still relatively young – that is, under 30 years of age. Unfortunately, no greater breakdown of inmates by age was provided.

[114] Concerning Dr. Howes' note that "it may be many months before he is called up" he stated that because of "a lack of resources", and "our inability to hire psychologists, we had an extensive waiting list at the time and still do." Thus the counselling Mr. Newson wanted and needed was not available to him in a timely way. It should have been.

[115] Dr. Howes did describe a new corrections initiative "The Institutional and Mental Health Initiative" that he hoped would be underway in early 2009. Under this initiative, all new inmates would receive more comprehensive screening and assessment for mental health issues than had been the case when Mr. Newson entered the system.

[116] It was not clear if the additional resources and new program would also have more capacity for delivering psychotherapy or psychological counselling services in a more timely way, as opposed to screening, or if, given Mr. Newson's profile described in the assessments by Drs. Naylor and Darlington, - including the absence of a major mental disorder diagnosis such as schizophrenia or bipolar disorder - he would be considered a priority under that initiative.

[117] Dr. Howes estimated that in excess of 85% of inmates would have a diagnosis of anti social personality traits, and over 50% would have an axis I serious substance abuse disorder. (While as Dr. Yaren explained there is no treatment *per se* for anti social personality disorder, there are definitely programs that can assist persons with that diagnosis in many of their behaviours.)

[118] Dr. Howes stated that when Mr. Newson would have been called up for psychological services, the process of psychotherapy would be initially to develop a relationship. He testified:

> A I suppose a starting point would be to develop a, a relationship of, of trust and probably the first step is to inspire him with some belief that change is possible and that the profound errors of judgment he had shown in his life don't need to characterize him forever. And at 18 that's a more manageable task than someone who's 45, say. (Emphasis added.)

[119] **I recommend that all young first time federal offenders age 25 and under have high priority access to psychological counselling if such counselling is recommended in their correctional plan.**

[120] Dr. Howes testified that he did have a copy of Dr. Darlington's psychiatric report on Mr. Newson's psychology file that had been transferred to him from Drumheller. He expressed the view that a protocol of sharing psychiatric or psychological assessments between the health unit (where psychiatry is housed) at SMI and the psychology department would be welcomed. He testified that it appeared there was such a protocol at Drumheller, but he did not believe one exists at SMI. He added that any serious concerns were shared between psychology and psychiatry on an *ad hoc* and as needed basis. He also testified that Dr. Naylor's report (the comprehensive report prepared for Mr. Newson's sentencing hearing that never found its way to corrections files) contained the kind of information that would be "enormously helpful" to the psychotherapy process.

[121] In fact when I asked Dr. Howes if he had any thoughts on what could be recommended in this inquest, he indicated that he wished that every psychiatric entry and every psychological entry were shared between the departments. He stated that his handwritten observations might benefit psychiatry and *vice versa*, for in effect a more holistic approach to the mental health needs of the inmates. It seems to me as well that psychology should be aware in particular if psychiatry has prescribed medication to an inmate. It appears that at least at Drumheller there is a closer relationship and greater sharing of information between the two departments. Of course, there are issues of patient confidentiality that need to be addressed in any information sharing regime.

[122] In this case, if anything, the individual observations of Dr. Yaren and those of Dr. Howes – that neither saw until the inquest hearing - were quite consistent in pointing away from any risk of self harm. However, individuals may present differently on different days and with both departments having the shared goal of supporting the mental health of inmates, it is hard to see any reason why the records should not be shared. I am mindful of Dr. Yaren's comment that there is a limit to how many reams of paper are actually useful to read as compared with detracting from valuable patient contact time. I am sure that the two departments could come to some understanding on sharing the appropriate amount of information, particularly notes of patient requests and contact.

[123] **I recommend that the Chief of Health Care at SMI arrange a meeting to include herself, Dr. Yaren and the Chief of Psychology to discuss a protocol for the sharing of patient notes and other information between the two areas. In particular, I recommend that (a) inmate requests either to psychology or to psychiatry be provided to both departments; (b) psychiatric or psychological assessments created or obtained by either department be shared with the other; (c) where psychiatrists prescribe medication or discontinue same, the psychology department be informed of the type of medication and dosing; (d) if inmate psychological counselling has been commenced or proposed or scheduled, psychiatry be informed and be kept informed of any progress or significant issues that arise.**

## THE EVENTS OF JULY 22, 2006 AND PRE-INCIDENT STRESSORS

[124] As noted, the evening prior to his suicide the BOI found (and I have no reason to doubt their finding) that Mr. Newson was beaten by some gang involved inmates reportedly simply because he looked at one of them "the wrong way". This was not a severe beating, and no one reported it to the authorities until the next day, after Mr. Newson was found hanging in his cell.

[125] The BOI found that Mr. Newson had talked to his friend in the cell next door at 10:30 p.m. the evening prior to hanging himself and had complained that his jaw hurt (from the assault that had occurred hours before). His cell neighbour suggested that they go to Health Care the next day to have it looked at. Devon Newson did not indicate to him thoughts of suicide ideation.

[126] The BOI's analysis of pre-incident stressors that may have been factors in the suicide is as follows:

> Newson had not disclosed the nature of his offence . . . to his two inmate friends. They knew he was estranged from his family but during the interviews it became

> clear that they did not know why Newson had no contact with them. It can be speculated that Newson struggled with what he had done to his [victim] and family and did not tell other inmates of his offence.
>
> Newson had not had a visit since incarceration and had his relationship with a girlfriend terminated early in his custody.
>
> Newson had been segregated at Drumheller and was in fear for his safety there and this continued while he was at SMI. Newson was a small 18 year old white male placed on a gang range in Unit 2. Inmates interviewed stated Newson was labelled a "rat", "goof", "piece of shit". Newson was worried about his safety. One inmate . . . looked out for him, giving him [some items]. Newson was described as not being a fighter, and easy target to be bullied. Newson was very much alone in life. The assault [the night before his suicide] and fear for his safety may have been determining factors that his life was not worth living.

[127] Because Mr. Newson never left a suicide note, or discussed plans or reasons for suicide with anyone, the BOI's analysis is obviously speculative. But based on the available information, that analysis seems logical and quite plausible.

## WAS SMI AND UNIT 2 APPROPRIATE FOR DEVON NEWSON?

[128] In the third paragraph of the quotation from the BOI's report referenced above at paragraph 123, the BOI referenced concerns it had about Mr. Newson's placement on Unit 2 at SMI. As noted, in the course of its investigation the BOI interviewed a number of inmates as well as staff who had contact with Mr. Newson. They had concerns both about SMI and Unit 2 and found as follows:

> B5. The BOI found, however, that Stony Mountain Institution may not have been the best environment to send a first time 18 year old federal offender.
>
> B6. The BOI also finds the situation was exacerbated when he was placed in Stony Mountain Institution, Unit 2, after he was processed in the Pre-Population range in U nit 4, because this range is considered a tough inmate gang environment.
>
> B7. The BOI found that there was a need for staff to have internal procedures and guidelines to facilitate inmate placement in the units because of the complexity of managing all these different populations within the same Institution.

[129] The officials from SMI called at the inquest took issue with these findings. First, it was noted that Newson was properly classified as a medium security inmate. Because of the difficulties he got himself into at Drumheller, a transfer was required. The programs available at SMI fit the correctional plan for the inmate. Further SMI was the only institution in Western Canada that agreed to take him.

[130] I did not read the BOI's finding as a criticism of SMI's willingness to accept Newson as a transferred inmate. And I note that the BOI - with presumably a greater access to federal institution profiles - did not suggest what institution would have been more suitable for Mr. Newson. Should a separate institution be created or set aside only for young inmates? I doubt if such a course of action would be practical or feasible. I heard no evidence on this point, and delving into such a broad question seems beyond the scope of this Inquest. Certainly within Manitoba SMI is the only institution that exists for medium security male inmates.

[131] The BOI's second concern was about the suitability of the placement of Mr. Newson on Unit 2 which it characterized as "a tough inmate gang environment"

[132] Mr. McLauchlan took issue with the BOI's characterization of the unit being "a tough gang range" stating "it's no more a, a (sic.) tough gang range than any other range . . ."

[133] Mr. McLauchlan testified that approximately 40% of SMI inmates are affiliates of gangs and that there are gang members on every range in the institution. There are a multitude of gangs at SMI, a number of whom cannot peacefully co-exist, so there are many challenges for staff in housing the inmate population safely and appropriately.

[134] The testimony of PO Mr. Skene provides a further glimpse of the problems of managing gangs at SMI. He commented:

> A There's two ways I see it. If we mix all the gang members together, like of certain specific gangs such as Manitoba Warriors referred to there, they're easier to monitor. If we break them up, which, which I've seen happen, you place some to one unit, some to another, then what happens is they recruit from -- it's basically a power struggle. Street gangs, prison gangs -- numbers mean power. I've seen if we, if we split the gangs, then they recruit others 'cause they're looking for numbers to be more powerful. My personal school of thought is keep them together where we can keep an eye on them, who they're interacting with, who they are.
>
> Q So, when you say "keep them together," you mean -- do you mean keep the gang members together with other gang members or what do you mean?
>
> A I personally like to see all the Manitoba Warriors live together, all the Native Syndicate live together. That said, you know what I mean? We don't have -- you know, if we have 35 Manitoba Warriors, we don't have a 35 bed unit where we can place them all. We have to, we have to mix. It's a constant struggle. Population management at Stony Mountain is, is an ongoing struggle. When

> gangs get along, they can, they can live on the same units well. If a problem happens in the prison or a problem happens on the street that comes into the prison, you know, these are street gangs. The Warriors don't always get along with the Native Syndicate and the Indian Posse and the new gangs that are -- there's new gangs emerging constantly, constantly so we're struggling to -- these people need to be incarcerated and we can't isolate every single individual. That said, the Manitoba Warriors also have problems with -- within their own organization. So, it's a constant battle to keep on top of where we're placing offenders and our primary concern is their safety.

[135] Mr. McLauchlan testified that although there were gang members on Unit 2, they did not predominate in numbers. Due to the profile and number of inmates at SMI, the number of gang affiliated inmates and the number of different gangs, every unit would have to include some gang members. I am not certain why it is not possible to have any "gang-free" units in SMI, given that only 40% are described as gang affiliates.

[136] In any event, Mr. McLauchlan testified that Unit 2 housed the Intensive Supervision Unit (ISU) otherwise known as the "drug-free unit". Not all inmates in Unit 2 are part of this regime, but some are. The inmates who are part of that regime agree to extra drug tests and to co-operate with their case management team, and to remain free of institutional charges. He felt because of those factors it may have been significantly less "tough" than other ranges within the institution. Failure to comply meant an inmate would be "booted out" of the range. He acknowledged that there were, and still are, gang members housed on the range, and as mentioned, not every inmate housed in the area would be part of the ISU regime.

[137] The evidence was that in reality all that was offered to those who wished to be part of this regime is more frequent drug-testing. The idea of the drug free range is that proof of abstention garnered from participation in voluntary frequent drug testing could go a long way towards hope of early release on parole.

[138] Little if anything in the way of enhanced programming or increased supervision was available in this range merely because of its designation as the drug free range. (I recognize the irony of only a particular unit in SMI being designated as "drug-free".)

[139] There is nothing in any of the files to suggest that Newson was aware of the option to participate in this program or that he was actually part of it. The testimony was that inmates who are part of this regime would meet with an official (likely their PO) so that the rules would be explained and they would then sign a

document attesting that they were aware of the program, agreed to be in it, and accepted the rules. There was no evidence that this was ever done by anyone with Mr. Newson. Despite this, Mr. McLauchlan thought Devon Newson was part of the ISU. He may have been, but it is unusual that there was no documentation or any witness to say the program was explained and accepted by Mr. Newson.

[140] The BOI heard evidence that this was indeed a tough gang range. They spoke directly to both inmates and officials on that range. While how "tough" is "tough" may be a matter of opinion, I am not prepared to dispute their finding that this was a tough gang range. I did not hear from as many witnesses directly as they did. None of the inmates they interviewed were called to testify at this Inquest, for example. Gang inmates were housed on that range, and there was intimidation of Mr. Newson, such that he was fearful. I accept their finding that the day or night before his death he was given a minor beating (a punch in the jaw) by gang involved inmates, based on simply looking at a gang member "the wrong way".

[141] I do not think it is appropriate that non gang affiliated first time federal offenders age 25 or under be placed on units where there are gang members who may be expected to recruit and or intimidate such first time federal offenders. Where first time federal offenders age 25 or under who have been or are gang affiliates are judged sincere in a wish to leave gang affiliation, they should also be housed on a range where this goal can realistically be met. SMI officials indicate that there now exist policies for inmate placement, but I do not believe as currently constituted they answer the issues raised by the BOI in connection with Devon Newson's experience at SMI.

[142] **I endorse the BOI's recommendation that SMI must put in place internal procedures and guidelines for staff to facilitate inmate placement. The purpose would be to select the best unit and range possible to ensure each inmate's security. Consideration would be given to the complexity of managing different populations especially gang members and organized crime.**

[143] **I also recommend that when determining which unit or range an inmate is assigned to, every effort should be made to house first time federal offenders 25 years or under - who are not active gang members or associates or have a genuine desire to dissociate themselves from past gang involvement - in units and ranges where there are no gang members. For all first time federal inmates under age 25, every unit assignment ought to contain written documentation on the OMS noting why the unit has been selected and why it**

**is suitable for a youthful first time federal offender and what the gang realities are on the unit.**

**EVENTS OF JULY 23, 2006**

[144] On July 23, 2006, at approximately 6:10 in the morning, a correctional officer conducting a routine patrol discovered Mr. Newson hanging from a bed sheet tied to an electrical conduit attached to the ceiling of his concrete cell. The officials took prompt action to call an ambulance, to cut him down and to perform CPR until the ambulance and paramedics arrived 15 minutes later. They immediately transported Mr. Newson to Stonewall Hospital. Although efforts to revive Mr. Newson at hospital produced a pulse for a time, he was later transferred to the Health Sciences Centre in Winnipeg where he was pronounced deceased later that afternoon. By the time the pulse was revived, damage to Mr. Newman's brain would have been profound and irreversible.

[145] Thus, the immediate cause of death of Mr. Newson is no mystery, and the care he received upon discovery was appropriate but insufficient to save him. The BOI looked at this issue in detail and observed:

> Cardiopulmonary Resuscitation (CPR) procedures were performed by Correctional Staff on duty in the unit as soon as the inmate was found and cut down from his hanging position. The Officers used the Ambu-bag they brought with them from the kiosk to the scene. Correctional Staff were trained in using the Ambu-bag and the continued CPR procedures until they were released by the paramedics.
>
> All observations were completed by Correctional Staff before they left at the end of their shift. The CS in charge informed the Correctional Officer at the Main Communication and Control Post to call the ambulance immediately when he got the alarm and it took only 15 minutes between the time the alarm was given and the arrival of the ambulance at the institution.
>
> The Medical Emergency Checklist was not completed by the correctional staff on the shift where the incident occurred, although it was completed the next day. The BOI found that all actions listed in the Checklist were performed by all concerned staff in full compliance with policies and procedures.
>
> The BOI was impressed by the quickness, timeliness and professionalism demonstrated by all staff during the intervention in order to save the inmate's life.

[146] There was no nurse on duty at the time of Mr. Newson's suicide. The Chief of Health Services at SMI, Nurse Charmaine Shaw testified that this is not unusual; there are no resources to fund a shift from 11:00 p.m. until 7:00 a.m. She has 12

nurses who report to her, and she engages seven or eight contractors for various health services, including contracting with Dr. Yaren for psychiatric services. She is not responsible for training correctional officers in first aid.

[147] In view of these findings by the BOI which I accept, there is little comment to make concerning medical intervention save one. At the hearing, I was told that SMI had acquired one AED (automated external defibrillator) which was still in storage pending training. These machines are reportedly extremely simple to operate and are increasingly placed in public spaces because they can be operated by untrained individuals.

[148] Where medical emergencies are involved, seconds count. It is not merely a question of having such machines available to restart a heart, but having them available to do so before significant brain damage occurs. It is especially important to have these available as there is no nurse on duty at night, a time when most suicide attempts occur.

[149] **I recommend that a sufficient number of Automated External Defibrillators (AED's) be acquired by SMI so that there will be one available at each kiosk.**

## LACK OF ORIENTATION FOR TRANSFERRED INMATES

[150] Nurse Charmaine Shaw testified that as part of Correctional Services' mandate all inmates get suicide awareness training. In the case of Mr. Newson, she stated, that it "was probably done at Drumheller as part of the intake reception process." In SMI her department co-ordinates it and it is led by a nurse. It is called the "RAP" - Reception and Awareness Program. The session talks about "some of the symptoms, some of the signs [of suicide]. It talks about . . . what some of the people are they can go to. We have inmate peers who are trained supports, nursing, psychology, their parole officer . . . And they are also given the signs and symptoms so they can watch out for their fellow inmates."

[151] **I recommend that the suicide awareness program that is part of Reception and Awareness Program should have a component dealing with impulsive suicides and acute stressors that may be at play and how an inmate can deal with these stressors himself or concerning a fellow inmate.**

[152] This suicide awareness programming is given once upon admission for every new sentence at the orientation program. It includes other topics such as substance abuse and infectious diseases and takes a half day of training. Nurse

Shaw testified that Mr. Newson did not get this training at SMI because he was not a new admission but a transferred inmate.

[153] There is no orientation program for inmates who are transferred to SMI. There are doubtless some institutional differences. Peer support programs do not exist in every institution. As stated below, I am not at all confident that Devon Newson knew about the valuable Peer Support Program, or how it operated.

[154] **I recommend every inmate transferred to SMI should be required to attend a "transferred inmate reception and awareness" orientation program.**

## ONGOING SUICIDE AWARENESS FOR INMATES

[155] I also do not accept that only one program on suicide awareness given at the initial orientation is sufficient for inmates. If staff must be trained every two years, why is only once per sentence sufficient for inmates?

[156] Inmates are probably the individuals closest to other inmates and more likely to detect acute stressors that can lead to impulsive suicides. If they are better informed they are more likely to either access help for a fellow inmate or themselves in appropriate circumstances.

[157] I asked Dr. Yaren if there were any suggestions he had that could be considered in relation to Mr. Newson's death that might assist in the future. He indicated that after the fact he learned that Mr. Newson had some acute stressors at the time, a breakup with a girlfriend and conflict with other inmates. He suggested that if those factors were or could have been identified at the time there could have been some intervention around that:

> . . . if it in fact was even known, I don't know - - by either peers or other staff, just to direct him towards, you know, you're having a tough time with this, you know, here is some options, you can talk to this person, that person. Those are the –you know, those, those would –that—if there would have been an opportunity to intervene it would have been around that – those, those acute stressors that he was facing.

[158] Perhaps with such greater awareness, Devon Newson's inmate friend may have told staff about the beating Newson received the night before he died and staff could have intervened.

[159] **I recommend that a short brochure concerning suicide risks and stressors, peer and other supports be made available for use at the initial meeting between a parole officer and inmate. The brochure should be developed by those with training and expertise in the field and knowledge of**

**inmate profiles. I recommend that there be a structured requirement that the topic of suicide prevention and peer support be discussed – only briefly if that seems appropriate - periodically between parole officer and inmate, perhaps once every six months. In addition or as an alternative, SMI should consider periodic group training for inmates.**

## INMATE PEER SUPPORT PROGRAM

[160] SMI must be commended for having an Inmate Peer Support Program. Mr. McLauchlan described the existing Inmate Peer Support Program and how it could be accessed as follows:

> A Each of the cells is equipped with a cell call button. When they hit that button, it sends an electronic signal to the kiosk which is manned by the officers. The officers will then get officers to respond to inquire as to what the, what the nature of the emergency is and then, depending on the nature of the emergency, they would, would respond. So, in particular, if the, the inmate stated he was, he was not necessarily in crisis, but that he was feeling down and he wanted somebody to talk to, we would give him access to our, our SAMS (phonetic) or Peers (phonetic) inmates. If he stated that he was actually feeling suicidal, then we would intervene and place him under a suicide watch in our suicide prevention cell until such time as he could be seen by psychology in the morning.

[161] He went on to describe the program as follows:

> SAMS or, you, you made reference to, on a previous document to the SAMS programs. It's been renamed the, the Peer, Inmate Peer Program. But basically the, the concept of the program is to have a number of inmates receive several hours of training in basically, in counselling in regards to suicide prevention awareness, body language, et cetera. And their role is to basically serve as a peer counsellor to inmates, which, (sic.) and any inmate can request their presence at any time to talk to them. We use them on midnight shifts in particular, knowing that, you know, that an individual may be a little despondent, just wants somebody to talk to. Obviously we can't spare an officers to sit with them the entire time, so we'll actually go and get an inmate peer, place him into the cell with the, with the inmate and they can talk as long as they want. When they're, when they're done, he'll hit the cell call again and, and we'll come and get them. But, so they get, have that access at any time, not just on midnight shift, but at any time.

[162] The ability to access the Peer Support Program at any time as described by Mr. McLauchlan may have been of assistance to Mr. Newson had he known about it. According to the evidence, such a program may or may not have been in existence at Drumheller and discussed there – and Mr. Newson “would have” received a lengthy SMI handbook where there is reference to a Peer Support

Program "committed to assisting other offenders". The further details of how to access it are not contained in the handbook.

[163] Mr. McLauchlan's evidence was that at the time he last checked, there were eight inmate peers for 550 inmates. This translates into about one peer for every 70 inmates. These are the individuals that can be accessed at any time. Although an inmate can request to speak to an inmate peer at anytime, according to Mr. McLauchlan this is not very common, so that the eight members seem sufficient. I have doubts about how well known the program is, given its infrequent use, juxtaposed against the many challenges inmates must face living in a penitentiary setting.

[164] It was stated that there is some ongoing training for the peer counsellors, but the particulars or frequency of that training were not detailed.

[165] In response to questioning by me, Dr. Yaren indicated that there is a peer support system among inmates and added that:

> "I would be in favour of a higher level of training . . . within the peer support process. Obviously it's inmates that are closest to the ground in terms of observing issues that, that their fellow inmates may exhibit that they may not want to disclose to other correctional staff or even to mental health personnel, and I think that, that that would be a benefit, just as it would be a benefit in the general community for as many people as possible to have some awareness of interventions and, and risk factors to look at in terms of risk factors for self-harm".

[166] As suggested by Dr. Yaren, focusing efforts on better training and awareness among inmates generally, and peer counsellors in particular about the need to notify staff or get peer counsellors involved in a given situation, may help to reduce the risks of impulsive suicides like Mr. Newson's.

[167] The concept of Peer Suicide Prevention has also been discussed in some of the academic literature. For example, in an article entitled "Inmate Suicide: Prevalence, Assessment and Protocols" found in *Brief Treatment and Crisis Intervention* 2007 7 (1); 40-54, published by the Oxford University Press, the authors Tripodi and Bender of the School of Social Work, University of Texas at Austin discuss issues related to inmate suicide and review extensive literature in the field. Of interest is their reference to what they describe as an "innovative suicide prevention program" in Alberta Canada described by Hall and Gabor (2004) "Peer suicide prevention in prison" *Journal of Crisis Intervention and Suicide Prevention* 25: 19-26. They describe a program based on the idea that

inmates are more likely to confide in one another than in staff members. The program, which was called "SAMS in the Pen" involved volunteers meeting with distressed inmates through self-referral or request from another inmate or staff. Tripodi and Bender noted:

> The top three reasons that inmates self-referred themselves, or were referred by staff or another inmate, were emotional problems, incarceration-related problems, or family and relationship problems. In a review of documentation, Hall and Gobor (2004) found that the percentage of inmates that sought services at risk for suicide ranged from 21% to 28%. Between 0.6% and 2.1% was assessed as being acutely suicidal.

[168] The authors state that the results from the program were encouraging, but it was cancelled for unknown reasons. As to one measure of its success they noted:

> In the 5 years prior to implementation, there were four completed suicides, equaling a suicide rate of 131 suicides for every 100,000 prisoners. During the 5-year period the program operated, there were two completed suicides, equaling a rate of 65.5 suicides for every 100,000 prisoners. In the 2 years following the cancellation of the program, there were two successful suicides, equaling a rate of 165 suicides per 100,000 prisoners.

[169] Tripodi and Bender also indicated that over the past two decades several important risk factors for suicide have been identified. Interestingly they observed that in one study 23% of suicides were precipitated by inmate-related conflicts – in common it seems with this case. At my invitation Dr. Yaren commented that this factor in isolation would not be particularly meaningful, given that inmate related conflicts probably occur in 95% of the inmates in an institution. As he put it "[t]his is not a group of individuals who as a rule work and play well with others."

[170] After the hearing, I located the Alberta study referred to in Tripodi & Bender's article. See: Hall B and Gabor P. (2004) Peer suicide prevention in a prison. *Journal of Crisis Intervention and Suicide Prevention* **25: 19-26.** Of interest are perceptions of various stakeholders noted about the program. Some of the comments include:

> Active SAMS in the Pen Volunteers:
>
> Overall, the SAM volunteers expressed considerable confidence in the service. As one said, "if I can prevent one person from suicide, then it works." One comment such as this does not empirically demonstrate solid results, but it does show that inmates believe the suicide prevention program has a degree of utility. They were virtually unanimous in stating that, in their view, the program is helpful and beneficial, and their work did not focus exclusively on suicide prevention. They

> saw their services as dealing with grief, depression, and self-harm. Many SAM volunteers raised the theme of prevention, indicating that their service often helps to stop emotions from snowballing.
>
> General Inmate Population:
>
> A typical comment was, "I feel it is a decent service in regards to people who feel that they have no one to talk to ... and feel lonely and out of place to discuss their problems," while another stated, "I believe it is a good service for people who are having a hard time." A few inmates responded that they found the service quite useful and one offered a very powerful comment, "if it wasn't for SAMS, I probably wouldn't be alive today.".
>
> Professional Staff:
>
> One parole officer illustrated the power of peer help with the following story. A SAM showed up to talk to an inmate who had been "cutting up." This SAM was a lifer and told the inmate, "We need to talk." As he did this he pulled his own sleeves to show scars. The inmate agreed to see him.
>
> If you empower inmates, they can do wonderful things. They have done some good work. I have been very impressed with them. Over time I am sure, the program saved an inmate's life. One inmate was in a very high-risk situation and the SAM resolved it; it may have saved a life.

[171] It seems that SMI is on the right track with its Inmate Peer Support Program which offers promise in helping to prevent suicides such as Devon Newson's. Efforts to build upon and improve the existing program and training, and increase awareness of it, as suggested by Dr. Yaren, are warranted. Perhaps SMI staff could consult with the authors of the study in the Alberta program.

[172] **I recommend that SMI should make efforts to increase the number of peer counsellors in the Inmate Peer Support Program so they have a greater presence, and more obvious accessibility within the institution. A goal of one peer counsellor for every 35 inmates would seem reasonable.**

[173] **I recommend that all young first time federal inmates who are age 25 or under - including transferred inmates - should meet a peer counsellor as part of their orientation.**

[174] **I recommend that SMI and the Inmate Peer Support Program members should meet and consider whether such young inmates should actually have a specific peer counsellor assigned to them; and further what type of regular contact should be encouraged.**

**[175] I recommend that there should be periodic training of the peer counsellors – not less than once every two years – of suicide signs and risks, and this should include material on acute stressors and impulsive suicides, not simply the better known signs.**

## THE SIGNIFICANCE OF AGE

[176] I pressed the various witnesses to comment on the need for special treatment for those inmates who are quite young. I was told that in developing a correctional plan, the focus is on the offence itself, criminogenic risk factors and the prior record. Age alone is largely irrelevant. In Mr. Newson's case it was pointed out by Mr. McLauchlan that he had a lengthy prior youth record, and could be considered criminally entrenched, and experienced in dealing with incarceratory settings.

[177] This was not universal. Dr. Somers, former Chief of psychology at SMI, stated:

> I, I would hesitate to describe him as entrenched, in, in part because of his age, in part because at 18 I think there's still a developmental progression that, that could see him making significant changes.
>
> In terms of risk prediction, the ages between 18 and 25 are, are often an area of significant risk, which connotes that there's development that happens such that after 25 there's a degree of stability that many individuals will present.

[178] Dr. Howes also commented specifically on youthfulness and the link to greater potential for success in rehabilitation. (See paragraph [109].) So too did Dr. Yaren. (See *infra* paragraph [211].)

[179] I cannot accept that youthful age should receive no special consideration relative to the handling of inmates in a federal institution. My conclusion was apparently shared by the three members of the BOI, which had the benefit of direct evidence from more of the staff and inmates involved with Mr. Newson.

[180] There are several reasons for this. First, an offender such as Mr. Newson whose prior sentences had all been served in youth facilities should not be considered prepared for life in an adult federal penitentiary. The youth facilities are less prison like in design and programming. It is well known that the staff ratios are higher than in prison. There is more supervision. There is less violence. There are fewer drugs and drug disputes.

[181] In this case, file materials erroneously suggest (largely through self-report) that Mr. Newson had spent five years in youth facilities in the past. That is not correct. According to his record he had spent a total of 301 days in custody as a youth, with an additional 125 days spent serving a custodial sentence in the community. In addition, he spent some time in a youth residential facility for substance abuse. Even though he had previously spent approximately a year of his life in youth custody, I reject the notion that such an experience could prepare this youth to face a six year sentence in a medium security federal prison.

[182] Second, young persons generally lack the maturity and common sense that potentially come with age and experience. This is something that every parent and community member has seen and experienced in life outside the criminal justice system. There is no magic transformation on the eighteenth birthday.

[183] Those young adults who find themselves involved with the criminal justice system are generally even more immature than their non criminally involved cohorts.

[184] In addition, like Mr. Newson, a very significant proportion of those young adults sentenced to federal terms of imprisonment are impulsive, many with a diagnosis such as ADHD (as was the case with Mr. Newson) or FASD, or suspected diagnosis, which explains the clinical basis for the impulsivity. It is easy to see how these qualities can get an inmate in trouble with other inmates in pretty short order. They are also placed in a facility with other adults who are difficult to deal with having anti-social personality disorders. The problems are complicated by the presence of multiple gangs, with both intimidation and recruitment on their agendas.

[185] Moreover, particularly when an offender is sentenced to an adult sentence under the *Youth Criminal Justice Act*, case law establishes that the principles that underlie this legislation with its focus on the special needs of young persons remain relevant in fashioning the sentence itself. It seems that the considerations underlying that legislation and its heightened focus on rehabilitation and treatment of youthful offenders should not entirely disappear the moment an adult sentence is pronounced and the prisoner is led out of the courtroom. Similarly, courts in sentencing young adult offenders expect that rehabilitation will be a significant goal of correctional authorities.

[186] Finally, a greater investment in early rehabilitation programming for all young federal offenders is necessary, whether sentenced under the YCJA or the Criminal Code. Why wait until the inmate becomes more criminally entrenched

through association with more hardened and older criminals? The cost of programming is not greater when it is afforded at the outset of a sentence. I will return to this theme below.

[187] Although the legal age of adulthood is 18, at that age young people for the most part are still malleable, and still growing up. Social science evidence backs up the notion that brain development and significant psych-social maturation is at play until age 25.

[188] **I recommend that SMI and Corrections Canada put in place enhanced guidelines and clearly delineated responsibilities respecting inmates 25 or under who are sentenced to a first time federal sentence, to protect their safety, and to facilitate their adjustment and placement within the institution.**

## VISITING PROGRAMS

[189] As noted, the BOI concluded that, at the time of his death, Mr. Newson was estranged from his family. The file materials also show that his family was very involved and caring during his contact with the youth justice system. Given that his offence was committed on a family member, a period of estrangement would be completely appropriate and expected.

[190] The BOI noted that a girlfriend had discontinued a relationship early in his sentence and Mr. Newson had no visitors in the nearly seven months he was incarcerated. It is fair to assume that Newson may have felt very much alone and without community supports, albeit as a result of his own actions.

[191] The evidence was that Mr. Newson would not be at all unique in this profile, as many inmates have either victimized family members, or, by their offending behaviour alienated family supports such that they are on their own in a prison setting. It would be impractical to suggest greater supports for this reason alone, given the large majority of inmates who share family alienation.

[192] However, consistent with my view that society owes a special duty to the youngest of those incarcerated, as they lack maturity and life experience, **I recommend that SMI give consideration to the creation of a structured volunteer visitor program, specifically aimed at young first time federal inmates age 25 or less, transferred from other institutions or not, and consult with the John Howard Society or other volunteer organizations concerning such an initiative. Part of orientation for all such inmates should include inquiring whether the inmate wishes to participate in such a program.**

## WAITING FOR PROGRAMMING

[193] The other concerning aspect is the fact that at the time of his death, Mr. Newson - despite apparently being sincere in wanting to change and rehabilitate himself - was offered nothing in the way of programming. He was on a wait list for psychological counselling. None of the rehabilitation programs identified as high priority had started or were on the immediate horizon.

[194] Mr. McLauchlan testified about the programming the Mr. Newson took or was awaiting. At Drumheller he started the Reception and Orientation program on December 12, 2005 and completed it on January 18, 2006. As discussed above, he started Adult Basic Education – Level 1 on February 6, 2006 in Drumheller but only attended for a few days until he stopped due to fear of reprisals from inmates at the school. By February 20, 2006 he was suspended from the ABE program due to non-attendance. He was placed in administrative segregation at Drumheller for his own safety from February 27 to May 18, 2006 when he was transferred to SMI.

[195] In March of 2006, while awaiting transfer, his correctional plan was completed and based on it as noted above, his Drumheller PO applied for the programming he was required to take as part of his correctional plan.

[196] He is shown as "unemployed" from his arrival at SMI on May 18, 2006 until June 27, 2006. On that date he was shown as registered to attend school. It appears from the records produced by Mr. McLauchlan that he actually commenced school on July 7, 2006 and attended until the day before his death – July 22, 2006. Mr. McLauchlan was uncertain whether it was a full or half day program.

[197] There are a number of performance indicators upon which students are judged and Mr. Newson scored "good" on all of them. This leaves me with the impression that Devon Newson was accessing the limited programming available to him at the time, and making genuine efforts. It was noted that there was one unauthorized absence/late arrival/or early departure during this period. In comments which were entered on the Offender Management System by his teacher Marianne Brittain on July 26, 2006, she remarked:

> Devon attended school for two weeks. He was well mannered and polite. He worked well and did not present behaviour problems in class.

[198] Ms Brittain was not interviewed by the BOI or called to testify at the Inquest. Mr. McLauchlan explained that Ms Brittain, in common with all SMI

staff, is trained in assessing any warning signs of suicide and had there been anything out of the ordinary it would have been noted by her and action taken.

[199] Very detailed and impressive correctional plans are developed for every federal inmate, as was the case for Mr. Newson. His was developed at Drumheller, and based on the correctional plan his Drumheller PO John Gavin requested that Mr. Newson be enrolled in the programs that had been identified.

[200] Mr. McLauchlan advised that at the time of his death Mr. Newson was wait listed for the High Intensity National Substance Abuse Program, as well as being wait listed for the Anger and Emotions Management Program, both high priority programs according to Mr. Newson's Correctional Plan. It may be recalled that Dr. Naylor had written in his psychiatric report that Devon Newson needed "continuous" in custody substance abuse rehabilitation. In fact the projected start date of one of those programs was set out in Mr. Newson's Correctional Plan to commence prior to his death. It did not.

[201] Mr. McLauchlan testified that little weight should be put on the start dates referred to in Correctional Plans, noting "the correctional plan gives us an idea of when we'd like something to happen."

[202] He continued:

> Individuals get put onto wait lists in and around these dates to try and hit around these dates, but I, (sic.) it would be very rare, I'd say its unusual if I saw an individual actually taking these classes on the dates that appear in their correctional plan.

[203] Mr. McLauchlan indicated that a person could be on a wait list for over a year. He explained:

> We don't have substance abuse going on ever (sic.) single day. There's only so many facilitators that can give that program and those facilitators may be giving other programs as well.

[204] Mr. McLauchlan indicated that there was nothing unusual about the fact that Mr. Newson was wait listed for programming. Wait lists are an expectation, as he put it "it's business as usual at SMI and I would say with the Correctional Service of Canada period."

[205] The third high priority program identified in Mr. Newson's correctional plan was the "Reasoning and Rehabilitation Program, (sometimes called the Cognitive Living Skills Program.") He was not yet even on a wait list for that program.

Mr. McLauchlan said this was not unusual given the length of Mr. Newson's sentence.

[206] He testified that priority for programming is largely based on parole eligibility dates.

> So obviously a guy who is going to be getting out in three months is going to be a higher priority than a guy who is getting out in three years.

[207] I am satisfied that in so candidly describing the reality of these wait lists for programs, Mr. McLauchlan was not endorsing that approach. He was merely demonstrating that Devon Newson was treated in a fair and consistent manner as compared to the treatment of other inmates.

[208] In my opinion, the situation described by Mr. McLauchlan is undesirable, particularly for offenders such as Mr. Newson. He was only 18. Despite a very troublesome youth record, and some longstanding problems, and perhaps because of these features it is hard to see how warehousing this young man in a tough prison environment and making him wait – possibly years – for meaningful programming would be in his best interest or society's best interest.

[209] It has been noted that there is a strong gang presence in SMI, and the experience of the court is that young non-affiliated inmates are often recruited to gang membership while incarcerated. Having young inmates languishing while awaiting necessary programming may increase their susceptibility to such efforts, making rehabilitation more difficult. And for society's sake as well as the offender's, the success of rehabilitation is important.

[210] As indicated earlier in paragraph [177], Dr. Somers referenced the importance of the period 25 and under. Both young inmates like Mr. Newson and society need to have something to hope for when a six year sentence is imposed. And with the kinds of long standing issues he brought with him, rehabilitation was a tall, but not impossible order. Being on that road may have given Mr. Newson the kind of hope for the future he needed to resist the impulse to end it all over conflict with some other inmates.

[211] When asked about the effect of delays on programming for rehabilitation, Dr. Yaren said that "sooner is better than later. More is better than less." Concerning special considerations for early or more intensive programming for young people, particularly those serving a first federal incarceration he stated:

> --interventions with that group would have perhaps greater opportunity for success than, than with an older recidivist population. So if I had to put my resources in the most – in the areas where one could do the most good in terms of intervention, as a general rule I would, I would direct that towards younger and first time offenders. (66-67)

[212] It is hard to see how the same programming delivered at the front end of a long sentence is any more expensive than programming delivered on the eve of reintegration on mandatory parole. Logic would suggest that programming delivered early would have a better chance of success, thus providing more value for the taxpayer dollar. Both Dr. Howes and Dr. Yaren favoured programming "sooner" rather than "later". Part of the rationale for Mr. Newson's adult lengthy sentence was that he needed intensive rehabilitation over a considerable period of time.

[213] Perhaps a short term infusion of funds is necessary to end chronic wait lists. Program start dates are currently based largely on parole eligibility dates. This is misconceived.

[214] Obviously it is highly speculative to suggest that had Mr. Newson been engaged in therapeutic programming, or had he had access to a psychologist for counselling and therapy – instead of being wait listed for that as well – the outcome would have been any different. But suicide is certainly an act of despair and hopelessness. Rehabilitation programming and psychological counselling are intended to give an inmate the tools to change, and the belief that change is possible, and that life can get better – a sense of hope for the future.

[215] **I recommend that programming should begin – especially for young first time federal offenders age 25 and under – as soon as the intake and orientation period is over.**

## POINTS OF SUSPENSION

[216] Mr. McLauchlan noted that he had recently done a project on points of suspension. Within a typical SMI cell he identified the front bars, each of two bookcases affixed to the walls, and the electrical conduit that runs across the top of the cells as points where an inmate could hang himself. Mr. Newson used the electrical conduit. Mr. McLauchlan felt that it would not be practical to refit the 400 plus cells in SMI to deal with those points of suspension. He pointed out that there are other methods of suicide as well and a person who is determined to end his life has a variety of ways that can be accomplished.

[217] My colleague Judge Sandhu recommended in an inquest report dated August 25, 2005 following the death of Alan Nicholson, that "All fixed metal electrical conduits be recessed and covered with a barrier to prevent use as a fixed point for hanging any material." While it appears true that eliminating that one point of suspension would leave other points as possibilities, where one is dealing with impulsive acts as opposed to predetermined plans, there may be some benefit to removal of the electrical conduit option, the one that would seem on observation the simplest to use.

[218] I did not hear any evidence on the costs involved, but **I recommend that SMI investigate the costs of cell modifications to recess and cover all electrical conduits to prevent use as a fixed point for hanging, and that an evaluation of the costs and benefits be made, with a view to first eliminating those conduits in cells where inmates under treatment by psychiatry are residing.**

## CONCLUSION

[219] Devon Newson suffered from frequent insomnia. He was beaten by gang involved inmates the day before his death, unknown to authorities until after his death. He was led to believe they would be back. He had no visitors or contact with the outside world. He had not seen a PO in over a month, and never had a face to face conversation with his currently assigned PO or his assigned CO. Other than two weeks in a school program at SMI, he was not engaged in anything productive during the days as he was "wait listed" for all programming and psychological counselling. For a young person of 18, he was at the beginning of what must have seemed to him a very long sentence of six years. Although prescribed some medication to deal with his ADHD – which may have also assisted with his mild depression and impulsivity – he was left on his own to take the medication, and apparently was not taking it or the prescribed sleeping medication at the time of his death.

[220] In another study referred to by Tripodi and Bender, *supra* the authors found that newly sentenced inmates and those with longer imposed sentences are of greater risk for suicide. Other studies suggest younger inmates are at higher risk. Transferred inmates have also been noted to be at higher risk. Yet Devon Newson was assessed by skilled professionals and some staff and I was convinced that he presented as low or very low for risk of suicide to them. It was an impulsive act.

[221] In a report dated February 28, 2007, entitled "Deaths in Custody - Final Report" submitted to the Office of the Correctional Investigator (Corrections Canada), Dr. Thomas Gabor found that "There is no evidence that Correctional

Services Canada has improved its overall capacity to prevent or respond to deaths in custody during the five-year study period."

[222] In the same Report the author acknowledges that it is always difficult to say with any certainty that any particular suicide could have been prevented. However, he also points out that some have a history of attempts and eventually desist from self harm. In addition, referring to impulsive suicides, he notes:

> Also, the fatalistic notion that nothing can be done to prevent suicides . . . ignores the impulsive nature of many of these acts. There is much evidence in the behavioural sciences that rage and despair leading to these extreme acts are often transient and may dissipate following unsuccessful suicide or homicide attempts.

[223] That author notes (p. 20) that without a comprehensive mental health assessment at intake, followed by significant investments in the care, treatment and support of offenders in custody, some offenders will fall through the cracks.

[224] This was a challenging Inquest, because of the apparently impulsive nature of Devon Newson's suicide. I have made a number of recommendations throughout this report which are collected and set out in Appendix A.

[225] As a society, we owe special duties to youth and young adults, including those who violate society's norms as did Devon Newson. Clearly the loss of liberty imposed on Devon Newson was justified. But prison is not intended as a death sentence. I am convinced that staff and professionals at SMI are dedicated to the safety of the inmates housed there. These recommendations may assist authorities in preventing the loss of another young life to suicide. I hope they will be given serious consideration by these authorities.

[226] All of which is respectfully submitted.

*"Original signed by:"*

**MARVA J. SMITH, P.J.**

# APPENDIX A

# RECOMMENDATIONS

See paragraph #

## SENTENCING HEARING – NOVEMBER 30, 2005

[1] I recommend that any psychiatric report and pre-sentence report referred to in a sentencing hearing not only be obtained in compliance with CD dated 2006-04-10, but that copies when obtained be provided to both the psychology and health (psychiatric services) departments of SMI. [21]

[2] I recommend that a s. 76(4) placement hearing ought to be held in every case where an adult sentence is imposed under the YCJA, and is particularly important where a penitentiary sentence is imposed. [24]

[3] I recommend that the Federal Department of Justice give consideration to adding aggravated assault to s.7(a)(i) of the YCJA, so that in appropriate cases, an IRCS sentence could be imposed on a young person found guilty of that offence under the YCJA. [28]

## TRANSFER TO DRUMHELLER FEDERAL PENITENTIARY

[4] I recommend that a detailed psychological assessment be conducted as part of an initial assessment in every case where an offender age 25 or under is serving a first federal sentence. [37]

## LACK OF ACTION BY NEWLY ASSIGNED PO

[5] I recommend that the PO's should meet with first time federal inmates age 25 or under within 48 hours of their assignment, and not less than once per week for at least the first four months after an inmate is placed on any new unit or range, to ensure the PO's are aware of and can assist with any adjustment difficulties. If inmate [76]

See paragraph #

conflict is flagged as a potential problem, meetings should be more frequent, not less than twice a week. All these meetings should be entered on the Offender Management System (OMS).

[6] I recommend that the CO's should meet with first time federal inmates age 25 or under within the first two daytime shifts of their assignment, and not less than once per week for at least the first four months after an inmate is placed on any new unit or range, to ensure they are aware of and can take appropriate action concerning any adjustment difficulties. If inmate conflict is flagged as a potential problem, meetings should be more frequent, not less than twice a week. All these meetings should be entered on the OMS. [78]

## CONTACT WITH SMI PSYCHIATRIST DR. YAREN

[7] I recommend that nurses should meet face to face with inmates 25 and under and inmates of any age with a confirmed or suspected FASD diagnosis, who have been prescribed medication for psychiatric conditions, daily, if medication is prescribed on that basis. If these individuals do not respond to a page to their kiosk, the nurse should obtain the assistance of CO's on duty to locate the individual and bring him to the kiosk, along with any blister pack medication. The purpose of the face to face encounter is to remind, encourage, and support the inmate to take his medication as prescribed, to maintain a record as to whether the inmate is observed to take the medication and to hear any concerns that need to be reported to the doctor. Similar approaches should be taken with daily dose medication. At some point, if it is established that the inmate is both committed to and able to follow the medication regime, such intensive supervision may be diminished. [104]

See paragraph #

## MR. NEWSON'S REQUEST TO SEE PSYCHOLOGIST AND FOLLOW UP – EVIDENCE OF DR. HOWES

[8] I recommend that all young first time federal offenders age 25 and under have high priority access to psychological counselling if such counselling is recommended in their correctional plan. [119]

[9] I recommend that the Chief of Health Care at SMI arrange a meeting to include herself, Dr. Yaren and the Chief of Psychology to discuss a protocol for the sharing of patient notes and other information between the two areas. In particular, I recommend that (a) inmate requests either to psychology or to psychiatry be provided to both departments; (b) psychiatric or psychological assessments created or obtained by either department be shared with the other; (c) where psychiatrists prescribe medication or discontinue same, the psychology department be informed of the type of medication and dosing; (d) if inmate psychological counselling has been commenced or proposed or scheduled, psychiatry be informed and be kept informed of any progress or significant issues that arise. [123]

## WAS SMI AND UNIT 2 APPROPRIATE FOR DEVON NEWSON?

[10] I endorse the BOI's recommendation that SMI must put in place internal procedures and guidelines for staff to facilitate inmate placement. The purpose would be to select the best unit and range possible to ensure each inmate's security. Consideration would be given to the complexity of managing different populations especially gang members and organized crime. [142]

[11] I also recommend that when determining which unit or range an inmate is assigned to, every effort should be made to house first time federal offenders 25 years or under – who are not active gang members or associates or have a genuine desire to dissociate [143]

See paragraph #

themselves from past gang involvement – in units and ranges where there are no gang members. For all first time federal inmates under age 25, every unit assignment ought to contain written documentation on the OMS noting why the unit has been selected and why it is suitable for a youthful first time federal offender and what the gang realities are on the unit.

## EVENTS OF JULY 23, 2006

[12] I recommend that a sufficient number of Automated External Defibrillators (AED's) be acquired by SMI so that there will be one available at each kiosk. [149]

## LACK OF ORIENTATION FOR TRANSFERRED INMATES

[13] I recommend that the suicide awareness program that is part of Reception and Awareness Program should have a component dealing with impulsive suicides and acute stressors that may be at play and how an inmate can deal with these stressors himself or concerning a fellow inmate. [151]

[14] I recommend every inmate transferred to SMI should be required to attend a "transferred inmate reception and awareness" orientation program. [154]

## ONGOING SUICIDE AWARENESS FOR INMATES

[15] I recommend that a short brochure concerning suicide risks and stressors, peer and other supports be made available for use at the initial meeting between a parole officer and inmate. The brochure should be developed by those with training and expertise in the field and knowledge of inmate profiles. I recommend that there be a structured requirement that the topic of suicide prevention and peer [159]

See paragraph #

support be discussed – only briefly if that seems appropriate – periodically between parole officer and inmate, perhaps once every six months. In addition or as an alternative, SMI should consider periodic group training for inmates.

## INMATE PEER SUPPORT PROGRAM

[16] I recommend that SMI should make efforts to increase the number of peer counsellors in the Inmate Peer Support Program so they have a greater presence, and more obvious accessibility within the institution. A goal of one peer counsellor for every 35 inmates would seem reasonable. [172]

[17] I recommend that all young first time federal inmates who are age 25 or under – including transferred inmates – should meet a peer counsellor as part of their orientation. [173]

[18] I recommend that SMI and the Inmate Peer Support Program members should meet and consider whether such young inmates should actually have a specific peer counsellor assigned to them; and further what type of regular contact should be encouraged. [174]

[19] I recommend that there should be periodic training of the peer counsellors – not less than once every two years – of suicide signs and risks, and this should include material on acute stressors and impulsive suicides, not simply the better known signs. [175]

## THE SIGNIFICANCE OF AGE

[20] I recommend that SMI and Corrections Canada put in place enhanced guidelines and clearly delineated responsibilities respecting inmates 25 or under who are sentenced to a first time federal sentence, to protect their safety, and to facilitate their adjustment and placement within the institution. [188]

See paragraph #

## VISITING PROGRAMS

[21] I recommend that SMI give consideration to the creation of a structured volunteer visitor program, specifically aimed at young first time federal inmates age 25 or less, transferred from other institutions or not, and consult with the John Howard Society or other volunteer organizations concerning such an initiative. Part of orientation for all such inmates should include inquiring whether the inmate wishes to participate in such a program. [192]

## WAITING FOR PROGRAMMING

[22] I recommend that programming should begin – especially for young first time federal offenders age 25 and under – as soon as the intake and orientation period is over. [215]

## POINTS OF SUSPENSION

[23] I recommend that SMI investigate the costs of cell modifications to recess and cover all electrical conduits to prevent use as a fixed point for hanging, and that an evaluation of the costs and benefits be made, with a view to first eliminating those conduits in cells where inmates under treatment by psychiatry are residing. [218]

# EXHIBIT LIST

| Exhibit No. | Description |
|---|---|
| 1. | Curriculum vitae of Christer David McLauchlan |
| 2. | Copies of photographs |
| 3. | Board of Investigation Report (E1) |
| 4. | Information Showing Checklist Update (F3) |
| 5. | Procedural Safeguard Declaration (F4, F4.1) |
| 6. | Primary Information Sharing Checklist (F5 to F5.2) |
| 7. | Procedural Safeguard Declaration (F6 to F6.1) |
| 8. | Intake Assessment (F7) (sealed exhibit) |
| 9. | Correctional Plan (F8) |
| 10. | Criminal Profile Report (F9) |
| 11. | Transfer (Per Placement) Referral Decision Sheet (F10) |
| 12. | Offender Security Level Referral Decision Sheet (F11) |
| 13. | Program Application/Referral (F12) |
| 14. | Family Violence Risk Assessment (F13) |
| 15. | Assessment for Decision (F14) |
| 16. | Casework Record Log by Chronological Order |

| Exhibit No. | Description |
|---|---|
| 17. | Response to Incidents Involving a Medical Emergency (H3) |
| 18. | Quality Improvement Review of Health Emergency Response Form (H4) |
| 19. | Emergency Flow Sheet (H5) |
| 20. | Men's Health Status, Admission Assessment (H12) |
| 21. | Doctor's Orders and Progress Notes (H15) |
| 22. | Men's Health Status, Admission Assessment (H9) |
| 23. | Health Services Transfer Summary Report (H29) |
| 24. | OMS Preliminary Assessment – Immediate Needs Indicators (H8) |
| 25. | Patient Medication Record (H17) |
| 26. | Physician's Order Sheet (H7) |
| 27. | Reception and Orientation Program (F25) |
| 28. | Psychiatric Report (H19, H20, H21) |
| 29. | Inmate's Request (H36) |
| 30. | Referral for Consultation and Report (H22) |
| 31. | Letter dated July 4, 2007 from the CME Balachandra to the Chief Judge, PC (A4) and autopsy report form (A10) |
| 32. | Curriculum vitae of Stanley Yaren |

| Exhibit No. | Description |
|---|---|
| 33. | Toxicology Report (A11) |
| 34. | Inmate's Request (G3) |
| 35. | Numbers of Inmates prepared by Dr. Howes |
| 36. | Youth Criminal Justice Act, Section 34, Psychiatric Report dated October 3, 2005, by Dr. John Naylor re: Devon Newson (sealed exhibit) |
| 37. | Curriculum Vitae of Dr. Kent Somers |
| 38. | Stony Mountain Institution Inmate Handbook, Revised Version March 1, 2008 |
| 39. | Admission & Discharge Briefing |
| 40. | Commissioner's Directive 705-2 |
| 41. | Printed e-mail dated November 27, 2008 from Skene Scott to Vandenbroeck Lee |
| 42. | Preliminary Report of Death |
| 43. | Copies of photographs, enlarged |
| 44. | Officer's Statement/Observation Report (sealed exhibit) |