Release Date: April 1, 2009

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **GRANT RYAN ERMINE**
(DATE OF DEATH: June 27, 2006)

Report on Inquest and Recommendations of
The Honorable Judge Fred H. Sandhu
Issued this 27th day of March, 2009

APPEARANCES:

Mr. M. Sobering, Provincial Counsel to the Inquest
Mr. S. Restall, Federal Counsel to Inquest
Tyler Kochanski, Counsel for Dr. Stanley Yaren
Patricia Ermine (Mother)
Robert Daniels (Stepfather)

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I. INTRODUCTION

[1] An inquest respecting the said death having been held by me on October 27, 28 and 29, 2008 at Winnipeg, in Manitoba, I hereby report as follows.

[2] The name of the deceased is **Grant Ryan Ermine**.

[3] The deceased came to his death as a result of suicide by hanging at the age of 23 in his cell at Stony Mountain Institution in Stonewall, Manitoba, at approximately 02:41 hours on June 27, 2006. His suicide by hanging took place in his cell on Unit 4, at Stony Mountain Institution. While conducting a routine institutional hourly range patrol, a correctional officer observed what he believed to be Mr. Ermine standing in his cell with his back to the door. The officer asks if Ermine is alright and receives no reply. Using his flashlight the officer observes that Ermine is suspended from his neck by a ligature attached to the ceiling. The officer immediately proceeds to the control desk (kiosk) and asks the officer on the desk to call for assistance. Within a minute the correctional supervisor arrives on Unit 4, also radioing for further assistance. The supervisor receives the cut-down tool and a container of irritant spray and immediately proceeds to Ermine's cell with the other officer. The cell is remotely opened and the two officers enter the

cell. Ermine is cut down from the ligature, constructed of bed sheets. CPR is administered and an ambulance called by the kiosk officer. Ermine is placed on a gurney and taken to the front entrance of the institute. Ambulance personnel arrive at 02:44 and take charge of resuscitation. At 03:08 a senior ambulance attendant determines that Ermine is clearly deceased. A hospital physician is consulted via radio and orders termination of the resuscitation procedure and the ambulance proceeds to the hospital. Death was formally pronounced shortly thereafter. Mr. Ermine was a first time federal inmate at the age of 20. He was serving a 6 year and 2 month sentence. This sentence commenced on July 3, 2003. He had been convicted of a total of eleven offences, the most serious being sexual assault with a weapon and the robbery of the same victim. He as also convicted of 3 counts of break and enter, mischief and five breaches of Court orders. Mr. Ermine had a previous history of violence and property offences, dating back to the age of 13. Attached hereto and forming part of my report is a schedule of all exhibits required to be filed by me.

II. **HOLDING OF INQUEST**

[4] At approximately 02:41 a.m. on June 17, 2006, at Stony Mountain Institution, Stonewall, Manitoba, an inmate, Mr. Grant Ermine, was found hanging

in his cell from a ceiling metal conduit of his cell on Unit 4 The inmate involved in this suicide, Grant Ermine, was 23 years of age at the time of death and was serving a six year, 2 month sentence for various offences as above-noted which sentencing had occurred on June 3, 2003. He was admitted to Stony Mountain Institution on June 5, 2003. Mr. Ermine had a previous history of serious violent offences. He did not have a prior federal institutional history, this being his first federal admission. Upon discovering Mr. Ermine, correctional officers removed Mr. Ermine from the bed sheet restraint that he had placed around his neck and placed him on the floor just outside his cell. It was indicated by correctional staff that no vital signs were present; however, staff commenced resuscitation procedures and continued applying resuscitation procedures. These procedures were continued by ambulance paramedics until they were told to discontinue the procedures by a hospital physician. Mr. Ermine was declared deceased at approximately 0:310 a.m. by a hospital physician.

[5] All reporting requirements regarding the incident to the R.C.M.P., the coroner's office, regional and national headquarters was completed appropriately and in a timely manner. A Royal Canadian Mounted Police member was notified and notification of Mr. Ermine's next-of-kin in regards to his death was completed.

Stress management services were provided or offered to all staff involved in the incident in a timely manner according to institutional rules and follow-up support services to the inmates were provided on the day of the incident and in the days following. The Board of Investigation that was convened following the death identified no issues of non-compliance by members of the service with respect to this incident.

[6] As outlined in Exhibit 1 filed at this inquest, being a letter dated March 9, 2007, from the Chief Medical Examiner Dr. T. Balachandra, under s.19(3) of the Fatality Inquiries Act an inquest into the death of Grant Ermine is mandatory. The letter of the Chief Medical Examiner states that Mr. Ermine was a 23 year old man who had been admitted to the Stony Mountain Institution on June 22nd, 2003 to begin serving a six year, 2 month sentence for sexual assault with a weapon and other offences.. He was discovered by a Correctional Officer on June 27, 2006 at 02:41 hrs. hanging in his cell via an electrical conduit during a routine hourly unit patrol. Resuscitation attempts were discontinued at 03:10 hours. It was noted that Mr. Ermine had a past medical history, which included anxiety, depression, substance abuse and one previous suicide attempt in 2001 while in provincial custody in Prince Albert Saskatchewan. A medico-legal autopsy was performed,

confirming the cause of death was asphyxiation due to hanging. The manner of death was suicide.

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

(1) to fulfill the mandatory requirements of an inquest as defined under s.19(3);

(2) to determine the circumstances under which the death occurred; and,

(3) to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

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

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

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

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

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

[10] The fatal inquiry regarding the death of Grant Ermine was held from October 27-29, 2008, in Winnipeg, Manitoba.

III. REVIEW OF EVIDENCE

Psychological and psychiatric history and profile of Grant Ermine

[11] Grant Ermine entered the Stony Mountain Institution, this being his first entrance, on June 5, 2003, to begin serving a six year, 2 month sentence for sexual assault with a weapon and other offences. He was initially placed onto the intake assessment unit as are all inmates.

[12] Mr. Ermine, whose date of birth is March 15, 1983, had a lengthy history of criminal convictions, beginning at the age of 13. These are detailed in the Board of Investigation Report that was filed as an exhibit in this inquest (Exhibit #3).

[13] Due to the sexual and violent nature of the sexual assault with a weapon offence, a full psychological intake assessment was required by policy and was completed on October 21, 2003 (Exhibit #13). Ermine was seen to present no apparent mental disorder, to be of 'below average' intelligence and to possess a 'criminally entrenched' belief system. He was found to not present a significant risk of self-harm at that time. The report concluded that Ermine presented with a high risk of sexual recidivism and a high degree of risk for violent and non-violent offending. He was found to have current gang associations. Ermine was recommended for a High Intensity Sexual Offenders program available at the Regional Psychiatric Centre in Saskatchewan.

[14] Ermine was attendant at the Long Term Substance Abuse Program from December 29, 2003 to February 2, 2004. He was reported to have participated reasonably well during this short program and to have displayed some progress, attending all but four of the twenty-four sessions. It was clear that he still had issues to address in terms of substance abuse and life skills issues.

[15] Ermine was transferred to the Regional Psychiatric Centre in Saskatoon, Saskatchewan where he attended form November 25, 2004 to July 15, 2005. While there he was diagnosed with anxiety disorder and treated by medication, Seroquel,

until the time of his death. A therapeutic quantity of Seroquel was found in his system at the time of his death.

[16] The final report from the Psychiatric Centre indicated he had made some marginal progress and was assessed as low-risk to reoffend sexually, however it was noted that the risk would increase substantially should he abuse substances. Ermine was noted to display impulsivity and other characteristics consistent with Fetal Alcohol Spectrum Disorder; however a formal diagnosis was not made. Ermine was returned to the Stony Mountain Institute at the end of August, 2005 and remained there until his death.

[17] The life of Mr. Ermine was a difficult one from the time of his involvement with drugs at an early age. In addition to the reported suicide attempt at Prince Albert, there was also a self-report of a suicide attempt at age eleven while residing in a group home. As previously noted, the full psychological examination shortly after the time of his admission to Stony Mountain found him not to be in immediate danger of self-harm, but that this risk would increase if there were familial issues. A second psychological exam took place just one month prior to his death. Suicide did not present itself as an issue at that time.

[18] Ermine was seeing a contracted psychiatrist on a regular basis, but only with respect to prescribing and monitoring his dosage of the anti-anxiety drug Seroquel. The following is a summarization of Mr. Ermine's psychological and personal background as evidenced by testimony heard at the inquest and from documents filed at the inquest.

IV. WITNESSES CALLED AT THE INQUEST

[19] Three witnesses were called by agreement. A number of exhibits were tendered at the outset and consolidated in the tabbed Exhibit #1. As a result of this, the number of witnesses called was limited to the following:

Chris McLaughlin

[20] The witness is a Correction Officer Level II. His CV was filed as Exhibit #2. One of his responsibilities is to assist Boards of Investigation for Corrections Canada on a local level. He was qualified as an expert to give opinion evidence on matters of:

(1) institutional security;

(2) the nature of federal prison Boards of Investigation.

[21] He testified that he was requested by the warden to conduct a study of historical suicide incidents at Stony Mountain Institute in the recent past. He stated there have been 22 incidents in the past seven years. Seven of these suicide attempts were by hanging with two successful.

[22] In addition he was tasked to do a “points of ligature” study of private areas of Stony Mountain Institute. This was requested to identify places where inmates may be able to hang themselves without immediate detection. He identified areas and places using a weight system to determine the suitability of physical areas and spots where an inmate may be able to hang himself. He identified all cell bars on Units 1-5, being the only common areas. He further identified electric conduits (the same ones used by Ermine) in individual cells. He also identified book cases and bunk beds in unit 5 only as possible “points of ligature”.

[23] Mr. McLaughlin testified that he had reviewed the Board of Investigation Report and made some comments regarding same. He testified that it is “quite unusual” that no recommendations were made. He testified that given the nature of this suicide and the background of Ermine he concurred with the report. As a result of the “no recommendation” of the report, no action plan was done. He

testified as to the Intake Process generally and the Psychological Intake and Assessment.

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

[25] He further testified that with respect to the formal count system, there are four counts a day at 7:00 a.m., 11:30 a.m., 4:30 p.m., and 11:00 p.m. There are also informal counts which are done on occasion as required by each unit. With respect to Unit 4, the minimum there is to be a range walk every hour. He testified that the times they do a range walk varies according to each individual Unit but on average a range walk on Unit 4 takes approximately 1 to 2 minutes if there are no problems found. He testified that a manual system known as the "Dystar" was used until 2004.

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

testified that it was institutional policy at the time to do hourly walks on the range, but since this incident range walks are done on a half hour basis, randomized.

[27] Mr. McLaughlin commented on the implementation of past recommendations of previous inquests involving suicide deaths at the Stony Mountain Institute. He stated that a psychiatric nurse was hired in 2006 along with a mental health social worker. He stated that programming and research are being addressed and that a diagnostic tool has been developed for Fetal Alcohol Spectrum Disorder. All hired staff now has some training in suicide detection and prevention.

[28] He testified as to Ermine's parole eligibility dates and performance progress reports. He testified as to the nature of the work of the Board of Investigation in general and the nature of the makeup of the Board.

Dr. Stanley Yaren

[29] Dr. Yaren is a qualified expert in forensic psychiatry and was so permitted to give opinion evidence. Dr. Yaren testified that he has been the contract psychiatrist for Stony Mountain Institution since 1983 and has been attending Stony Mountain Institution for three half day clinics a week along with Dr. Globerman who is the

other contract psychiatrist and attends to one of these half day clinics per week. He testified that he receives referrals from Stony Mountain Institution as a result of:

- recidivism, that is from past history of psychiatric illness upon intake;
- screening by medical staff of new inmates where there are indications of anxiety, depression, psychosis, past history self harm ideation, or where the inmate is already on psychotropic prescription;
- by way of psychology department direct referral on intake;
- during family physician clinics at Stony Mountain Institution which are held several times a week;
- correctional staff will also initiate referrals which are filtered through the nursing staff;
- self referred mechanism by the inmate which is then proceeded through a screening process, eventually arriving to him.

[30] Dr. Yaren testified that he was somewhat familiar with Mr. Grant. He stated that nothing remarkable stands out in his mind. His filed notes (Exhibit#17) indicate that on August 30, 2005 there was no evidence of depression and there was a good response to Seroquel which Ermine wished to remain on as he had been since his stay at the Psychiatric institute in Saskatchewan. He described Seroquel as an anti-psychotic that is commonly used in prison as it has few side effects. The indication for Mr. Ermine was for insomnia.

[31] Dr. Yaren testified that there were no major issues identified and no psychotic symptoms noted. There had been no other referrals to him regarding any other issues with Ermine to the time of his death and none were noted on his medical records. He testified that there were to his knowledge no issues or indication of suicidal ideation with Ermine throughout. He saw Ermine every 4 to 6 weeks and appeared quite stable. Ermine was briefly taken off his medication in March, 2006 but this was restored as the issue of possible 'drug diversion' by Ermine was settled in his favor. Dr. Yaren's last contact with Ermine was April 13, 2006. Two subsequent appointments were missed, with no indication why, but nurse notes indicated no issues and Ermine was continuing to take the medication.

[32] With respect to the issue of self harm, he testified that Ermine seemed quite stable prior to his death. There was an absence of any sign of risk to self-harm. He is always alert to the signs of self-harm and saw nothing to raise such concern regarding Ermine. In cross-examination, he acknowledged he was unaware of Ermine's past suicide attempts. As there was no note left, the suicide is suggestive of a highly impulsive decision. He testified that with a combination of perplexion, planning and privacy, suicide risk increases. He further testified that with "readily available means' the likelihood of a suicide being attempted increases.

[33] With respect to Dr. Yaren's relationship with Stony Mountain Institution, he testified that he reports directly to the Chief of Health Care. He has a day-to-day relationship with the nursing staff that assists him with his clinics, including a newly hired mental health nurse.

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

[35] He testified that the intake psychological assessment is placed in the health care file and that he does have access to it. He does not use the self reporting suicide assessment scale, although he is aware that some psychiatrists do use it. He indicated that a high score on the BSS would be of interest to him combined with other knowledge of his patient, but that his other knowledge of his patient may override any score on a BSS self reporting.

[36] He testified that the majority of Stony Mountain inmates that he sees would be outpatients if they were not in gaol, but this is because there would be a lot more resources available outside of gaol. He testified that in terms of access to a psychiatrist, this is probably better for inmates then it is within the community, as

within the community it would take up to several months to see a psychiatrist, whereas in the institution the psychiatrists go there three times per week.

[37] He testified that he respects all the staff at Stony Mountain in terms of the medical staff and that they have varying degrees of experience and competence. He advises that he is informed by the nursing staff if an individual is placed on suicide watch and the inmate is either his patient or Dr. Globerman's patient, but is otherwise not advised.

Mary Kay Laing

[38] Ms. Laing was a parole officer at time of death in 2003. Her evidence was brief and involved a review of the Intake Assessment report, Exhibit #6. She essentially testified that no serious mental health issues were identified.

V. The Emergency Response to the Discovery of the body of Grant Ermine

[39] There was some focus on the initial response by staff at the SMI to the discovery of the body of Mr. Ermine. All staff involved in the discovery and follow-up acted promptly and efficiently. The failure to cut Mr. Ermine down immediately upon discovery is attributed to security concerns in that two officers are to be present before opening any cell door. The emergency measures that were

utilized involving the use of CPR and an airbag were performed with the requisite skills and timeliness.

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

VI. RECOMMENDATIONS

[41] I appreciate that anything that might be said in terms of detection of suicidal ideation and the prevention of a particular suicide by doing something different is somewhat speculative and based much on hindsight.

[42] I accept that the detection of suicidal ideation is difficult, particularly when one recognizes that it would be the desire of the suicidal person to conceal such.

[43] I appreciate that corrections officials and administration have a difficult job. I appreciate that there are limited financial resources. Inmates in penitentiaries are no doubt more difficult to deal with than the norm. They evoke less sympathy, perhaps rightly so, than law abiding citizens. Thus they are not high on the list of governmental priorities in the allocation of fiscal resources. Nevertheless they are human beings. They are still citizens. We, as a society have decided to punish them

by absolute confinement. They are our societal responsibility. As we must house and feed them, so too must we care for their medical needs. Defined psychiatric disabilities are a subset of general medical disabilities. Inmates should be treated for their mental health issues, and the resources made available for their treatment, in the same way as any other medical disability.

[44] Inquest counsel submitted that there were few recommendations that he could advise as the death of Mr. Ermine was likely not preventable based on the evidence presented at this inquest. The submission was that the death was not foreseeable and no action or inaction was a contributor to the death. He submitted that it was difficult to make any recommendations as to policy and procedure that may have prevented the death of Mr. Ermine, that is was a rare occasion where perhaps nothing could be done to prevent death. He did opine that based on the evidence and the opinion statements of Dr. Yaren in this regard; there may be some value to examining the possibility of reducing "points of ligature" in private areas.

RECOMMENDATIONS

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

[45] In previous inquests involving suicides at Stony Mountain Institute the writer of this inquest was able to personally examine all the cells in Unit 1 (Mental Health and Intake). The unit housing Mr. Ermine is said to be similar with respect to the electrical conduits. What was striking was the number of cells with very strong metal conduits running across the ceiling that were bent away from the ceiling, thus affording an easy access point for anyone contemplating suicide by hanging. The testimony of Mr. McLaughlin confirms the numerous points of ligature (hanging) that are available in the private area of inmate cells scattered throughout the Institute. The testimony of Dr. Yaren should make clear that the availability of such readily accessible points of ligature in inmate cells increases the risk of contemplation and successful suicide.

2. Consideration be given to permit patrolling correctional officers to open private cell doors and assist immediately any inmate clearly in distress where there is no clear and present danger to the correctional officer.

[46] It is well recognized that officer safety is of paramount consideration. There may be situations where safety of the officer is not in issue. The unassisted immediate response of a single correctional officer in the case of an obvious suicide attempt may result in the saving of a life. Consideration should be given to

amending range patrol procedural protocol to permit entry into a cell in such a circumstance.

I respectfully submit my recommendations and conclude this report this 27th day of March, 2009, at the City of Winnipeg, in Manitoba.

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Fred Sandhu, P.J.

EXHIBIT LIST

Exhibit No.	Description
1.	White binder of exhibits with tabs
2.	Curriculum Vitae of Correctional Officer Christer D. McLaughlan
3.	Report titled " Board of Investigation into the suicide of an Inmate at Stony Mountain Institution on June 27, 2006" with tabs
4.	Transfer (Pen Placement) Referral Decision Sheet
5.	Offender Security Level Referral Decision Sheet
6.	Initial Detention Review Assessment
7.	Primary Information Sharing checklist
8.	Procedural Safeguard Declaration
9.	Assessment for Decision required for Offender Security Level
10.	Referral Sheet Identification of Membership or Association with Criminal Organization
11.	Officer's Statement/Observation Report
12.	Memorandum – Psychological Intake Screening
13.	Psychological Psychiatric Assessment Report – Psychological Intake Assessment
14.	Psychological Psychiatric Assessment Report – Psychological Other Purpose

Exhibit No.	**Description**
15.	Officer's Statement/Observation Report dated 2006-06-27 by J. Roche A/SIO
16.	Curriculum Vitae for Dr. Stanley Yaren
17.	Doctor's Order's and Progress Notes re: Grant Ermine
18.	Assessment for Decision required for Day Parole – Pre Release
19.	Inmate Suspension from a Program Assignment sheet
20.	Response by Correctional Service Canada to the Richard Lagimodiere Inquest
21.	Response by Correctional Service Canada to the Alan Nicolson Inquest

DISTRIBUTION LIST

1. Dr. A. Thambirajah Balanchandra, Chief Medical Officer
2. Chief Judge Raymond E. Wyant, Provincial Court of Manitoba
3. The Honourable David Chomiak, Minister Responsible for *The Fatality Inquiry Act.*
4. Mr. Jeffrey Schnoor, Deputy Minister of Justice and Attorney General
5. Mr. Brian Kaplan, Director of Winnipeg Prosecutions
6. Mr. Steven Johnston, Counsel to the Inquest (Provincial Crown)
7. Mr. Sid Restall, Counsel to the Inquest (Federal Crown)
8. Mr. Tyler Kochanski, Counsel for Dr. Yaren
9. Mr. Mike Anthony, Exhibit Officer, Provincial Court
10. Ms. Aimee Fortier, Executive Assistant and Media Rep., Provincial Court
11. Ms Patricia Ermine, Mother
12. Mr. Robert Daniels, Stepfather