Release Date: November 9, 2016

Manitoba

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: Gilbert Moise, Deceased

Report on Inquest of Judge K. Dale Harvey
Issued this 4th day of November, 2016

APPEARANCES:

D. Ireland, Inquest Counsel
M. Mason and A. Menticoglou, Counsel for Correctional Service of Canada
J. Moise, mother of Gilbert Moise

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF GILBERT MOISE

Having held an Inquest respecting the said death on the 4th and 5th days of May, 2016, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: Gilbert Moise.

The deceased came to his death on the 7th day of April, 2013, at the age of twenty-one years.

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

I hereby make no recommendations for the reasons set out in the attached report.

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

Dated at the City of Winnipeg, in Manitoba, this 4th day of November, 2016.

"Original signed by:"

K. Dale Harvey, Judge
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, A/Chief Medical Examiner (2 copies)
2. Chief Judge Margaret Wiebe, Provincial Court of Manitoba
3. The Honourable Heather Stefanson, Minister Responsible for *The Fatality Inquiries Act.*
4. Ms. Julie Frederickson, Deputy Minister of Justice & Deputy Attorney General
5. Mr. Michael Mahon, Assistant Deputy Attorney General
6. Mr. David Ireland, Counsel to the Inquest
7. Mr. Mark Mason and Mr. Alexander Menticoglou, counsel for Correctional Service of Canada
8. Ms. Josephine Moise, mother of Gilbert Moise
9. Exhibit Coordinator, Provincial Court
10. Ms. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: GILBERT MOISE

TABLE OF CONTENTS

I. MANDATE OF THIS INQUEST

[1] By letter dated December 13, 2013, the Chief Medical Examiner for the Province of Manitoba (as he then was), Dr. T. Balachandra, MBBS, FRCPC, FCAP, directed that a Provincial Judge conduct an Inquest into the death of Gilbert Moise for the following reasons:

1. To fulfill the requirement for an Inquest as defined in section 19(3)(b) of *The Fatality Inquiries Act*;

> **Inquest Mandatory**
>
> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe:
>
> (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
>
> (b) that a person died as a result of an act or omission of a peace officer in the course of duty;
>
> the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.

2. To determine the circumstances relating to Mr. Moise's death; and

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

[2] By virtue of section 33(1), *The Fatality Inquiries Act* requires that the presiding provincial judge:

> (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;
>
> (b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and
> (c) send a copy of the report to the medical examiner who examined the body of the deceased person;
>
> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

[3] The Inquest commenced with notice to the public that a Standing Hearing would be held on June 1, 2015. Standing in this Inquest was granted to the Correctional Service of Canada and Josephine Moise, mother of Gilbert Moise. The Inquest heard evidence and brief submissions on May 4 and 5, 2016.

II. SUMMARY AND REVIEW OF THE EVIDENCE

[4] On February 23, 2013, Mr. Moise was sentenced to the equivalent of five years incarceration, with 888 days recognized as having been served in pre-sentence custody and 937 days remaining to be served. He was admitted to the federal penitentiary at Stony Mountain Institution on February 28, 2013.

[5] On April 7, 2013, he was being held on D range in Unit 5. During the second of two late evening range walks to ensure the safety of the inmates, a correctional officer discovered the window of Mr. Moise's cell blocked by a towel. After following appropriate procedures for removal of the blockage, the officer discovered Mr. Moise hanging by his neck from the bars of the cell window. Resuscitation efforts by correctional officers and emergency services personnel were unsuccessful. Mr. Moise was pronounced dead at 12:22 in the morning of April 8, 2013. A "suicide note" was found within the cell.

[6] Sadly, events such as this are not uncommon, and many Inquests into similar situations have been held.

[7] I make no recommendations for changes in policy or procedure that have not previously been considered, recommended, or made that would be likely to prevent similar deaths from occurring in the future.

III. THE EVIDENCE

[8] Jim Wheeler was one of two correctional officers (CO's) on the midnight shift on Unit 5 on the evening of April 7, 2013. He had previously worked at Grand Cache Institution in Alberta for one year before moving to Stony Mountain Institution in October of 2012.

[9] He testified that the midnight shift ran from 6:30 p.m. to 7:15 a.m. His partner that night was David Olmstead.

[10] Unit 5 was a segregation unit and consisted of four ranges of cells, identified as C, D, E, and F, emanating outward like spokes from the central control room or 'bubble'. The officers' responsibilities included doing counts four times per day, to ensure that no one had escaped, and range walks, basically walking each of the four ranges, usually once an hour, confirming that the inmates were there, alive and safe. After the prisoners were locked in their cells for bed time at 10:30 p.m., and after the evening count, there were two walks between 11:00 p.m. and midnight.

[11] Olmstead did the second walk of D range at 11:36 p.m. on April 7, 2013. When he got to Mr. Moise's cell, Officer Wheeler noted a "kind of puzzled look" on Olmstead's face. Olmstead returned to the bubble and asked for "the food slot keys and his shield" and told Wheeler that the cell window was covered. A key is required to open the food slot. The shield is a piece of curved Plexiglass with two handles that is placed in front of the food slot to protect officers from anything that may be thrown at them when they open the food slot to remove the item covering the window.

[12] Olmstead unlocked and opened the food slot, and reached in and removed what turned out to be a towel covering the window. He then used his flashlight to

illuminate the cell, looked in, stepped back and told Wheeler that "someone was hanging".

[13] Wheeler too looked in and saw Mr. Moise "basically on the ground with a ligature around his neck and he was not moving", hanging from the bars of the exterior window.

[14] Olmstead called a medical emergency over the radio to Timothy Stott, a correctional officer level 2 (Wheeler and Olmstead were correctional officers level 1) and the on-duty correctional manager, Craig Gunter.

[15] Wheeler ran to the control desk in the bubble to "evacuate the doors to the Unit", effectively unlocking the three doors into the Unit to allow access by responding officers, standard procedure in the event of any type of emergency. He then grabbed a "911 knife", a curved knife sharpened on the inside edge and designed for cutting through things like ropes, towels and bed sheets, and ran back to Mr. Moise's cell.

[16] When he arrived at the cell, Stott had arrived. Per safety protocol, with three correctional officers on scene, they were permitted to enter the cell and did so. Stott entered the cell, turned on the light, and cut the towel that was around the neck of Mr. Moise. Wheeler too entered the cell and began CPR "right away". Other officers soon arrived and assisted with CPR. Paramedics arrived and moved Mr. Moise out into the hallway, where there was more room to work. They employed an Automated External Defibrillator (AED), ultimately without success.

[17] Olmstead testified that it was his understanding that there were to be two range walks per hour.

[18] He began the first walk after 11:00 p.m. at approximately 11:05 p.m. His recollection of looking into cell 9 was of seeing Mr. Moise sitting on his bed. The television was not on. Olmstead described having a feeling that something was out of the ordinary, such that he asked Mr. Moise if everything was okay, to which Mr. Moise replied, "Yes." Olmstead then told him to press his cell call button if he needed "any help or anything" or that he could tell him on the next walk.

[19] When Olmstead returned to cell 9 at 11:36:27 on the second walk, there was a towel over the window. He said that although it was not unusual for the window to be covered on occasion, perhaps for privacy, it was not allowed. He could not recall whether he yelled or knocked on the door in the hope of generating a response from within, but he can be seen on the range video to have kicked at the cell door.

[20] Olmstead testified to the subsequent events in accord with the description by Wheeler, and he too performed CPR on Mr. Moise.

[21] Stott testified and explained that while CO1's do more security-type work at posts and checkpoints, in towers and on mobile patrols, CO2's are assigned to a Unit, and are more involved in case management with up to 15 inmates.

[22] On April 7, 2013, he was on the morning shift, from 10:45 p.m. to 7:15 a.m., some of which involved roving from Unit to Unit assisting with range walks, and some of which involved monitoring cameras and radios in the Perimeter Intrusion Detection System (PIDS) room.

[23] When the call came of a medical emergency in Unit 5, he ran there, learned what was happening and instructed another officer to run to the bubble to retrieve a camera to record the event, there being no cameras in the cells (but for cells for those new to the institution who may be bringing in contraband and those on suicide watch).

[24] He then assessed the situation to determine whether it was safe to enter the cell, being aware of previous instances where inmates had pretended medical emergencies for the purpose of assaulting an unsuspecting guard or guards.

[25] Once he had determined that it was safe to enter, they did so. His description of the attempts at resuscitation thereafter accords with those of Wheeler and Olmstead.

[26] Stott also made arrangements to have a Peer Offender Prevention Service (POPS) inmate attend to talk to other inmates to check on their wellbeing, and moved the body back into cell 9 so that other inmates could not see it and officers could conduct rounds.

[27] Stott explained that officers had authority to immediately move any inmate showing any sign of suicidal ideation to a monitored suicide cell, and that Mr. Moise had not been on suicide watch in such a cell.

[28] The Inquest heard also from Laura Kirby, a 14 year veteran of the Stony Mountain Institution. She worked for 4 years as a correctional officer, 6 years as a parole officer, and since 2011, as manager of Assessment and Intervention.

[29] As such, she was assigned to the Administrative Segregation Unit, Unit 5, the only segregation unit in Stony Mountain Institution. The position involved case management of inmates assigned to segregation, including reviews, placement reports, ensuring entitlement format in segregation, ensuring legislated timeframes were met and direct supervision of a group of parole officers.

[30] Kirby explained how inmates could come to be in the segregation unit, how long they might stay and the amenities offered, including access to the exercise yard, to showers every second day, to a chaplain or other spiritual support such as the aboriginal liaison officer or elder and family visitation. She advised that they would have regular visits with their case management teams, either in cell or in a meeting room. Psychological services were available at the request of the inmate or the case management team and on a daily basis if warranted.

[31] Kirby testified that in 2013, there were 600 inmates in general population and 80 beds for segregation, including maximum security designated inmates who were kept in segregation until they could be transferred to another institution. In 2014 a Maximum Security Unit was opened in Stony Mountain Institution, so that as of May 2016 there were 60 beds available for inmates in segregation.

[32] Kirby was clear that an inmate would not be placed in segregation as a punishment for misbehaviour, but likely would be for threatening or being

physically assaultive toward another inmate or staff. She said segregation is used as a last resort when it is required for the security of the offender or the institution. But she made it clear that placement in segregation is not a final placement, as transfers between units are common and placement in segregation negatively impacts an inmate's access to programs and their mental health.

[33] She advised that every inmate coming into the institution undergoes an intake period of up to 70 days for the purpose of assessment. Ultimately, recommendations are made for which penitentiary would be best suited for the inmate, their security level, their placement within the penitentiary and what programming would be most appropriate for their rehabilitation. The first option with new inmates is to place them in general population. The inmate also may request segregation.

[34] One of the assessment tools employed is a custody rating scale which considers factors such as the severity of the index offence, overall street stability, incidents while on remand and any outstanding charges.

[35] In the case of Mr. Moise, Kirby informed the Inquest that his custody rating was for maximum security, based in large part upon his having been involved in several fights with other inmates while on remand pending sentencing. Accordingly, he was placed into segregation upon arrival. That placement, as with every initial placement, was constantly under review, based upon behaviour and any request by the inmate for transfer to general population.

[36] It became apparent through meetings with Mr. Moise that he was somewhat unhappy with his placement in segregation. Despite that, Kirby confirmed that Mr. Moise twice was offered the option of a move out of segregation but declined. However, he had indicated a desire to be transferred to an institution in British Columbia as he had family supports there, something that was being considered as a part of the 70 day intake process.

[37] One of the moves offered was to C range in Unit 5, an open unit comprised mainly of offenders with some security concerns that precluded their placement within the main general population. Another option would have been a move to the

General Intake Assessment Unit, one within the General Population Unit but closed to only those in their intake period. Those inmates associate only with others in the unit. New inmates are encouraged to go into the General Intake Unit upon arrival.

[38] Mr. Moise actually was moved once within D range from one cell to another because he was being verbally harassed by another inmate.

[39] Upon admission to Stony Mountain Institution on February 28, 2013, Mr. Moise met as required with Kelly Campbell, R.N., who completed a form entitled "Intake Health Status Assessment", a relatively comprehensive review of the inmate's physical and mental health. The notes indicated that Mr. Moise denied any "current suicidal ideation or plan" and "having ever attempted suicide". In response to the question, "Are you feeling depressed, helpless, hopeless or have you experienced a significant loss recently?" the handwritten noted reply is "split with girlfriend; lost cousin in 2012; will consult elder to talk to him". The summary of the review showed that the inmate reported being sad but denied any suicidal ideation.

[40] On March 13, 2013, Mr. Moise met with another registered nurse, who noted that Mr. Moise reported his mood as sad, because he "misses his family", but again denied any suicidal thoughts. The notes also indicated that he reported "feeling better lately, exercising in his cell, eating and sleeping better".

[41] On March 28, 2013, Mr. Moise met with Dr. Anna Bergen of the Psychology Unit for the first (and routine) psychological segregation review. Dr. Bergen noted that he was "tearful, spoke quietly and was in distress about his placement in segregation rather than open range. Is anxious due to nature of his offence also". Dr. Bergen referred him to the Unit 5 elder and made a referral to Psychiatry "for evaluation of mood/anxiety/rumination".

[42] The Psychiatrist, Dr. Yaren, saw him on April 5, 2013, two days before he took his life. Dr. Yaren noted. "Referral by Psychology. No evidence of clinical depression. No self harm ideation/intent. No signs of neurovegetative signs of

mood disorder. O/E articulate spontaneous. Future oriented situational issues. Med seeking but none indicated."

[43] Those observations were the result of questions put to Mr. Moise, and the answers given and interpreted by Dr. Yaren. Clearly the results suggested that Dr. Yaren had no cause to suspect an imminent suicide; in fact, they suggested Mr. Moise had plans for the future, consistent with his request for a transfer to the Pacific Region to be closer to family supports.

[44] While at Stony Mountain Institution, Mr. Moise also had a brief meeting with an aboriginal liaison officer. In the materials forming part of Exhibit 1, there are notes regarding meetings where Mr. Moise's segregation status was reviewed and confirmation of two instances where he declined to attend. There also is a document entitled "Segregation Log March 2013", being a summary of the daily activities, including whether or not Mr. Moise showered, took exercise and how he behaved. Mr. Moise's behaviour was listed as good. The Inquest heard that a healthcare professional visited every day to speak to each inmate in segregation to inquire as to any medical or mental health concerns that needed to be addressed.

IV. CONCLUSION

[45] In his closing submission, Inquest Counsel advised that Ms. Moise was shocked to learn that her son had taken his life, in that she had been aware that he wanted to serve his sentence in British Columbia to be closer to family. I suspect that everyone involved with Mr. Moise during his brief time in Stony Mountain Institution may have had the same reaction. He had been offered and declined transfers when he had expressed unhappiness with his placement in segregation. His behaviour was monitored daily and noted as good. He was approached daily by a healthcare professional and asked if he had any medical or mental health concerns. He was seen by a psychiatrist two days before he took his life, and denied any thoughts of self harm or suicidal ideation. And he was asked during the first range walk at 11:05 p.m. if everything was okay, and was reminded that all he needed to do to get assistance was to press his cell call button or mention it on the next range walk.

[46] Clearly, no one saw this coming. The fact that Mr. Moise blocked the window of the cell after the first range walk demonstrated that he fully intended to take his own life. Short of stripping a cell down to the bare walls, and creating inhumane living conditions, I do not know what else could be done to prevent someone bent on taking their own life from doing just that.

[47] Regarding the note found in the cell, while Ms. Moise expressed some concerns about the handwriting being her son's, it is obvious from where the note was found and the contents of the note that it was his. It confirmed beyond doubt that he intended to take his own life.

[48] I note that during submissions, Inquest Counsel suggested that there was a delay of approximately two minutes awaiting the arrival of the necessary number of officers required by protocol before entering a cell, when Wheeler ran back to the bubble to unlock the access doors to the range. By the time he returned to cell 9, Stott had arrived. If counsel meant to suggest that Olmstead ought to have entered the cell alone, then on the possibility of the situation actually having been a ruse to entice an officer to enter the cell (something known to have happened previously), given what I see as justifiable safety concerns, I would not suggest any changes to require the officers to break from established policy in these circumstances.

V. RECOMMENDATIONS

[49] Accordingly, I have no recommendations for changes that might prevent similar deaths from occurring in the future.

I respectfully conclude and submit this Report on this 4th day of November 2016, at the City of Winnipeg, in the Province of Manitoba.

"Original signed by:"

K. Dale Harvey, Judge
Provincial Court of Manitoba

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: GILBERT MOISE

APPENDIX A - EXHIBIT LIST

Exhibit No.	Description
1	Binder of Materials from Correctional Services of Canada
2A	Video Disc of Range Footage of D Range
2B	Video Disc of Handheld Camera
3	Schematic of Stony Mountain Unit
4	Image of Jail Cell Door
5	Case Work Record Log
6	Inmate Request, Note from Inmate and Note from Parole Officer
7	Photographs of Mr. Moise's Cell
8	Translation of Notes of Dr. Yaren