RELEASE DATE: September 6, 2018

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: Devon Sampson, Deceased
(D.O.D: November 23, 2013)

Dwayne Mervin Flett, Deceased
(D.O.D: April 15, 2015)

Report on Inquest and Recommendations of
The Honourable Judge Brian Corrin
Issued this 31st day of August, 2018

VOLUME 1 of 2

APPEARANCES:

Ms. Stephanie Harland and Ms. Catherine Bator, Inquest Counsel
Mr. Alexander Menticoglou and Ms. M. Beth Tait, Counsel for Correctional Services of Canada (CSC)
Mr. Andrew W. Boumford, Counsel for Dr. Stanley Yaren and Dr. Daniel Globerman
Ms. Allison Fenske, Counsel for the John Howard Society of Canada (Manitoba Branch) and the Canadian Mental Health Association (assisted by Mr. K. Chadwick-Garrett)

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATHS OF:
DEVON SAMPSON and DWAYNE MERVIN FLETT

Having held an inquest respecting the said deaths on September 5th, 6th, 7th, 11th, 12th, 13th, 14th, 18th and 19th and on November 6th, 7th, 8th and 9th, 2017 and February 8th, 2018, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased are: Devon Sampson and Dwayne Mervin Flett.

The deceased Devon Sampson came to his death on the 23rd day of November 2013 at Stony Mountain Institution, in the Province of Manitoba.

The deceased Dwayne Mervin Flett came to his death on the 15th day of April 2015 at Stony Mountain Institution, in the Province of Manitoba.

The deceased both came to their deaths by the following means: suicide by hanging in their cells at the Stony Mountain Institution.

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 31st day of August, 2018.

"Original signed by:"
Judge Brian Corrin

Copies to:

1. Dr. John Younes, Chief Medical Examiner (2 copies)
2. Chief Judge Margaret Wiebe, Provincial Court of Manitoba
3. Honourable Cliff Cullen, Minister Responsible for *The Fatality Inquiries Act.*
4. Mr. David Wright, Deputy Minister of Justice & Deputy Attorney General
5. Mr. Michael Mahon, Assistant Deputy Attorney General
6. Ms. Stephanie Harland and Ms. Catherine Bator, Counsel to the Inquest
7. Ms. M. Beth Tait and Mr. Alexander Menticoglou for Correctional Service of Canada
8. Exhibit Coordinator, Provincial Court
9. Ms. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court
10. Mr. Andrew W. Boumford for Dr. Stanley Yaren and Dr. Daniel Globerman
11. Ms. Allison Fenske for the John Howard Society of Manitoba and the Canadian Mental Health Association, Manitoba and Winnipeg Branch

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I. MANDATE OF THIS INQUEST:

[1] By letters dated August 8th, 2014 and December 30th, 2015, the Chief Medical Examiner for the Province of Manitoba (as he then was), Dr. T. Balachandra, and Acting Chief Medical Examiner Dr. J.K. Younes, directed that a Provincial Court Judge conduct an inquest into the deaths of Devon Sampson and Dwayne Mervin Flett 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. Sampson's and Mr. Flett's deaths; 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] Standing in this inquest was granted to the Correctional Service of Canada, the John Howard Society of Manitoba, the Canadian Mental Health Association and Doctors Stanley Yaren and Daniel Globerman. The inquest heard evidence and brief submissions on September 5th, 6th, 7th, 11th, 12th, 13th, 14th, 18th and 19th as well as November 6th, 7th, 8th and 9th, 2017 and February 8th, 2018. Mr. Flett's family expressed interest in the inquest but were not able to actively participate. Records filed suggest that his family stood behind him for many years and made exceptional efforts to assist him with his mental health and cognitive issues. His prior lack of involvement with the criminal justice system bespeak their efforts. The family deserves our deepest sympathy.

II. THE CSC BOARD OF INVESTIGATION

[4] Sections 19 and 20 of the *Corrections and Conditional Release Act* (CCRA), S.C. 1992, c. 20 provides that the Commissioner of the Correctional Service of Canada may appoint a person or persons to investigate and report when a federal inmate dies or suffers serious injury. Section 21 stipulates that, for investigations convened under section 20, sections 7 to 13 of the *Inquiries Act* apply i.e. the members of the Board of Investigation (BOI) appointed possess the special powers of "commissioners" under the federal *Inquiries Act*. Such incorporated legislation gives investigating appointees broad authority to compel the testimony of any person whose evidence is sought by the BOI. Copies of the two Convening Orders issued by the Commissioner in reference to Mr. Sampson and Mr. Flett are attached hereto as Appendices A and B to this report. The terms of reference include investigation of issues respecting compliance to the law, as well as policies and procedures of the CSC. The BOI in both cases was also authorized to make findings and recommendations which it considered appropriate "and which may contribute to the effective resolution and/or prevention of similar situations or occurrences in the future."

[5] Both BOI Reports were filed as exhibits at the proceedings. They document a fairly extensive investigation into both deaths based on personal interviews with many Stony Mountain Institution (SMI) staffers. The investigation findings were of great interest to the Inquiry.

[6] CSC counsel called an SMI staff person to testify respecting the oversight process employed by the BOI in relation to matters referred for investigation. This individual told the inquest that after receiving formal notice of a BOI investigation it was his duty to post such notice in "conspicuous areas" around the institution to ensure that staff were aware of the upcoming investigation. The inquest learned that the next step was the posting of a second notice advising the dates when the BOI would actually be attending at the institution. The staff member related that a typical inquiry usually entails the BOI being on site for a period of about two weeks. This witness related that his job required that he assist the BOI members by organizing provision of work facilities and pre-arranging and scheduling requested staff interview appointments as well as facilitating BOI requests for SMI file information access. In this respect the staff member informed the inquest that he would also often

be tasked to send a "significant amount" of such information to the BOI in order to assist their preparation for the investigation.

[7] The inquest learned that the members of the BOI, most often senior CSC staff from other regions, "will always book a meeting or a debriefing" with the Warden and relevant institutional senior management at the conclusion of their on-site investigative visit.

[8] At such meetings the BOI makes a preliminary "local" report outlining what it determined to have factually occurred both prior to and immediately after the incident in question i.e. the nature of and institutional response to the occurrence. After the findings of fact have been related, the BOI will then, if pertinent, discuss policy compliance issues and sometimes possible recommendations or areas for improvement based on their findings. The inquest was told that the meeting also "offers the institution an opportunity to…respond to…compliance issues or respond to any questions the board might have before finalizing" its Report.

[9] The inquest learned that the next step involved the witness staffer doing "research" in relation to SMI's "pre-emptively" addressing the known BOI findings prior to the release of the "next level" of report. The next level being a BOI/Regional debriefing meeting which was described as being "very similar" to the local report meeting, but now involving "regional sector heads." The inquest was advised that "further recommendations might come from that."

[10] The witness then described a third and final step in the post-investigative process; a national meeting where the BOI members meet with national sector heads. The witness related that it was after this meeting that a final BOI Report is circulated to designated senior administrative personnel within CSC. At SMI, the staff witness and the Warden receive such document. After the Report's distribution the CSC creates what was described as a "grid of compliance and findings", basically a chronical of the items that the BOI "would like to see us (CSC and SMI) address." These grids track CSC's response to issues and recommendations made by the BOI investigators.

III. PREAMBLE

[11] Information contained in the published 2009 and 2010 CSC Institutional Mental Health Guidelines, both of which were filed at the inquest, reveal an awareness of the complex issues associated with providing services suitable to the needs of incarcerated individuals. The relevant passage, found at page 4 of the Guidelines under the title Background and Overview of Services, is as follows:

> **Background and Overview of Services**
>
> The prevalence of mental disorders among incarcerated individuals is higher than the rates in the general Canadian population (Canadian Public Health Association, 2004). In a 2001 study on Canadian federal offenders, Brink, Doherty, and Boer found that 84% of 267 newly sentenced male offenders had at least one, 1-month or lifetime DSM-IV Axis I diagnosis, and 31.7% had a current mental health disorder. When the authors excluded substance use disorders the total prevalence was 43.1%. Furthermore, data collected by the Correctional Service of Canada (CSC) has demonstrated that the proportion of offenders entering the federal correctional system with mental health disorders is increasing. Specifically, in 1997, seven percent of male offenders coming in to CSC were diagnosed as having a mental health disorder. By 2008, the proportion had increased to 13%; an increase of 86%. Similarly, 1 in 4 women offenders present at intake with mental health issues.
>
> In addition to an increased prevalence of mental disorders, co-morbidity rates increase the complexity of responding to the needs of an incarcerated population with mental health disorders. Brink et al. (2001) found that 90% of the participants in their study diagnosed with either a mood, psychotic, or anxiety disorder, also had at least one other diagnosis, and about half of the participants with a substance use disorder had a mental health disorder as well. Furthermore, the rates of suicide in CSC's prisons exceed those of the general population in Canada. For example, an assessment of the health needs of federal inmates completed in partnership with Health Canada, found that the rate of suicide in CSC prisons was 3.7 times higher than the rate of suicide in the general public (Canadian Public Health Association, 2004). CSC's Annual Inmate Suicide Report (2007/2008) notes that a total of 182 federal inmates committed suicide over the 15-year period from April, 1993 to March, 2008. In the 2007/2008 fiscal year, there were 5 inmate deaths by suicide. When compared to other similar correctional systems between 2003 and 2006, Canada's rate is marginally lower (at 0.9) than the international average (at 1.0).

[12] Suicide is the leading cause of unnatural death in federal prisons. The rate of prison suicide, according to the 2004-15 Annual Report of the Office of the Correctional Investigator is several times higher than in the general population. This

Report documents that most of those who commit suicide in prisons have a history of mental health issues or a history of attempted suicide, suicidal ideation or self-harming behaviour. Just under half of the inmates who commit or attempt suicide were prescribed psychotropic medications at the time of their deaths. A Correctional Service of Canada (CSC) study released in September 2014 found that twenty-two percent of such suicides occurred in segregation or segregation-like conditions of confinement and another eleven percent occurred in a treatment centre (psychiatric hospital). Put another way, to quote from page 7 of the 2014 Office of the Correctional Investigator Report, one-third of all prison suicides took place in segregated incarcetory circumstances where there was actually "an enhanced level of observation and monitoring." According to a 2007 United States Department of Justice Report on Suicide Prevention in Prisons, having a mental health diagnosis or mental health issue appears to be a significant risk factor for suicide. The Prisons and Probation Ombudsman for England and Wales has found fairly recently (April 2014) that three-quarters of prisoners who committed suicide had mental health issues.

[13] Data from ninety-eight suicides, as recorded in the CSC study aforementioned, occurring between 2000 and 2010 in CSC facilities indicated that fifty-eight percent had a history of psychological problems, sixty percent had made a previous attempt and that eighty-five percent had been identified as having past difficulties with substance abuse (such 'self-medication' is often associated with mental health issues). A total of one hundred and twenty-eight such inmate suicides are chronicled between 2000 and 2014. In a study of all suicides occurring between April 2011 and March 2014 it was found that nearly all the deceased inmates (twenty-seven of thirty) had died by asphyxiation (twenty-five by hanging).

[14] Suicide deaths in prison are higher than rates in the general population. As a result there have been a significant number of inquests into similar events occurring both in Manitoba and elsewhere in Canada. A review of these reports makes clear that prison authorities and others involved with inmate mental health issues are very aware of the elevated risk of suicide in prisons. It is no wonder that CSC has created many policy guidelines designed to screen inmates for potential suicide indicators, guidelines that will be discussed hereafter in the context of the two deaths that are the subject matter of this report.

IV. PROCESS

[15] In this case it was unnecessary for me to compel the attendance of federally employed Stony Mountain Institution (SMI) witnesses as CSC counsel volunteered to produce such personnel without need for issuance of subpoenas. Inasmuch as I concur with Federal and Provincial counsels' opinion that a Provincial Judge presiding at a provincial inquest is without jurisdiction to make recommendations to the federal government because of constitutional constraints, I will not be sending a copy of this report to the federal Minister of Public Safety. Of course, CSC is free to share this report with anyone of its choosing should it wish to do so. I acknowledge that it is solely within the purview of the CSC to determine what, if any, action it wishes to take as a result of the Inquiry findings and recommendations in this regard.

V. THE LEGAL CONTEXT APPLICABLE TO FEDERAL CORRECTIONAL SERVICES

Section 3 of the *Corrections and Conditional Release Act*, S.C. 1992, c. 20 states that the purpose of the Federal correctional system is to contribute to the maintenance of a just, peaceful and safe society by

(a) carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders; and

(b) assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community.

Section 4, which is entitled "Principles that guide Service" states that such principles are as follows:

(c) the Service uses measures that are consistent with the protection of society, staff members and offenders and that are limited to only what is necessary and proportionate to attain the purposes of this Act;

(g) correctional policies, programs and practices respect gender, ethnic, cultural and linguistic differences and are responsive to the special needs of women, aboriginal people, **persons requiring mental care** and other groups; (emphasis mine)

Section 23(1) states that "(W)hen a person is sentenced, committed or transferred to penitentiary, the Service shall take all reasonable steps to obtain, as soon as is practicable,

(b) **relevant information about the person's personal history**, including the person's social, economic, criminal and young-offender history; (emphasis mine)

VI. DEVON SAMPSON

[16] Extensive documentation from SMI files was tendered as evidence at the Inquiry. Federal Corrections made same available on the understanding that same would be sealed and not available to the general public.

General Background and History

[17] At six years of age Mr. Sampson immigrated to Canada from Guyana. He first became involved in the youth criminal justice system in 1995 when he was fifteen years old. His first adult sentence, a suspended sentence, was received in 2001. In 2003 and 2004 he served time in provincial institutions for offences related to theft, weapons and robbery. He first entered the federal correctional system in 2005, having been sentenced to three years for several robberies, escape lawful custody and theft.

[18] Mr. Sampson was first diagnosed with schizophrenia in 1999, at the age of nineteen. As will later be discussed, he was hospitalized with respect to such illness several times between his initial diagnosis and his first federal admission in 2005. Each of the hospital admissions entailed several months in care, one was for eight months. By 2003, Mr. Sampson's psychiatrist, Dr. Michael Eleff, records a history of medication non-compliance and resistance to treatment, observing in a Case Summary report that Mr. Sampson "has a long history of severe, psychotic illness and intermittent non-compliance with treatment" (see exhibit 4E, tab 51). Of equal concern, Mr. Sampson had also developed a co-occurring substance abuse problem, an addiction to crack cocaine, and was noted to have often traded compliance of his psychotropic medications for this and other illegal drugs (see exhibit 4D, tab 15 - an SMI Psychological Assessment dated October 25, 2005). Such report also observed that Mr. Sampson had "significant lack of insight into psychiatric issues", suggesting that he couldn't accept his psychotic disorder and therefore required special continuity of care from professionals who were assigned to work with him at SMI.

[19] Mr. Sampson was a third-time federally placed offender who was thirty-four years old at the time of his death on November 23rd, 2013. An SMI registered nurse who worked with Mr. Sampson just prior to his death described him as "always" being at some level of "mentally ill." It was her opinion that he was "never okay." She recollected that he was "always polite" to her and stated that she had enjoyed "good rapport" with him.

[20] At the time of his death Mr. Sampson was serving a five and one-half year sentence, having been admitted to SMI on December 16th, 2011. He was initially classified as maximum security, a rating which was revised to medium security when a security reclassification scale was completed after a transfer to Saskatchewan penitentiary in May 2012. Mr. Sampson was placed in involuntary administrative segregation i.e. solitary confinement, pending a security level Intake Assessment from the time he arrived at SMI in December 2011 until he was transferred to Saskatchewan Penitentiary in May 2012, where ironically he was immediately placed back into AS until June 20, 2012, when, as previously mentioned, he was admitted as a medium security prisoner. The cumulative time spent in intake segregation amounted to one hundred and eighty-seven consecutive days (see exhibit 4A, tab 6 and exhibit 4F, tab 2).

[21] An SMI self-reported Psychological/Psychiatric Assessment report completed on December 22nd, 2011, shortly after his admission to SMI, documented no mental health concerns notwithstanding that Mr. Sampson had stated that he had previously been diagnosed as schizophrenic and bi-polar in 1999 and been subsequently in need of prescription medication to alleviate the symptoms of such illness.

[22] Institutional reports necessitated by this lengthy segregation status disclose little information about Mr. Sampson's ability to withstand such a long period of segregated solitary confinement. For the most part the weekly segregation meeting reports simply disclose issues and concerns related to matters such as clothing and telephone privileges. There is no assessment of the nature of his subjective state of mind whatsoever until a previously uninvolved and different Parole Officer comments, on February 15th, 2012 that Mr. Sampson "presented as stable, but somewhat subdued", suggesting that she may have discerned a symptom of depression. The next such reference to his subjective state of mind is documented on April 12th, again by a Parole Officer not previously interacting with Sampson. This writer describes him as being "agitated" and upset that he is being sent to Saskatchewan Penitentiary as a maximum security prisoner. Although the Inquiry can only speculate, there is a possibility that Mr. Sampson's failure to self-report and express concern about his actual emotional state to the interviewing officers may have been a shadow of his resignation, frustration and growing rancour about his isolation and lack of human contact.

[23] Mr. Sampson subsequently applied for transfer back to SMI and in May of 2013, as he now qualified as a medium security inmate, was readmitted. Upon returning to SMI Mr. Sampson was noted as "reluctant to resume (his) psychiatric medication" and as being in danger of psychiatric relapse if he didn't become medication compliant (see exhibit 4E, tab 35). In July 2013 a C.O. reports Sampson's behaviour as "odd" but makes no mention of being aware that the prisoner is actually mentally ill and in need of medication. Indeed, Mr. Sampson's personal Institutional Parole Officer testified that he was unaware that Sampson was non-compliant with his medication regime at such time.

[24] On November 10th, 2013 after assaulting a male nurse (by punching the nurse's throat area) he was again placed back in segregation. Mr. Sampson was found hanging from the upper bunk in his segregation cell at approximately 8:06 a.m. on November 23rd. Subsequent efforts by Corrections and nursing staff as well as paramedics, failed to revive him.

Events Prior To Death

[25] Mr. Sampson had been documented as medication non-compliant on a number of occasions at SMI, including the late spring, summer and early autumn of 2013. On October 22nd he actually requested assistance in such respect and a day later permitted and received his first medication injection in almost six months.

[26] As previously mentioned, Mr. Sampson had been removed from general population and placed in administrative segregation shortly after he assaulted a male nurse on November 10th. Dr. Stanley Yaren, a psychiatrist who interviewed Mr. Sampson two days later, found that Mr. Sampson had suffered a psychotic break on the day of the assault and was agreeable to receiving extra anti-psychotic medications to control and ameliorate the symptoms. Dr. Yaren told the inquest that Mr. Sampson had a psychiatric history going back to his late teens and had been admitted to hospital on four separate occasions with respect to same. The Inquiry was informed by Dr. Yaren that the lengths of these hospital confinements, including one of eight months when he was nineteen years old and two more stays of three months each prior to the end of 2002, suggested that Mr. Sampson was very ill on these occasions. Dr. Yaren also testified that schizophrenia is a condition where psychotic relapses are quite typical and even more so in patients with a history of medication non-compliance. Dr. Yaren told the Inquiry that psychosis is a particular

risk factor for suicide, and that symptomatic individuals are at greater suicide risk when they are not taking their psychotropic medication. According to Dr. Yaren, because Mr. Sampson had experienced many previous psychotic relapses "the level of recovery tends to take longer and be less complete - people with multiple relapses get sicker and sicker, and take longer to go into remission." Yaren felt that it was a virtual certainty that Mr. Sampson's mental health had effectively deteriorated with each of his many relapses, concluding that the length of several hospital stays suggested a "severely ill" person.

[27] On October 23rd, 2013 a Mental Health Nurse, the same one who attended Sampson's psychiatric clinics with Dr. Yaren, the one who had just provided Mr. Sampson with this medication injection, emailed her Psychology Department colleagues (see exhibit 1, binder 4, tab I09) advising that Mr. Sampson was experiencing "psychotic symptoms" (mentioning paranoia as well as his being off his medication for six months). The nurse, who is no longer an SMI staff member, advises her health service associates that Mr. Sampson doesn't require "extra monitoring" although she does suggest that he "may need some reassurance from staff <u>if</u> he asks when he will be seeing Dr. Yaren" (underlining not in original). There is no evidence suggesting that this information was imparted to other non-health care staff responsible for Mr. Sampson's care even though provisions set out in the pertinent Commissioner's Directive in force in 2013 as set out in provisions 10, 11 and 12 of CSC Guidelines for Staff Sharing of Inmate Personal Health Information did permit the sharing of information with the Warden as well as Correctional Officers and Parole Officers (see exhibit 2, tab 7A) albeit that such sharing was framed reactively to inquiries and not actually mandated on a proactive basis. The mental health nurse in question told the inquest that she was "unsure" why she had failed to disclose the information. For this reason the Inquiry concurs with the BOI Report conclusion that an integrated and coordinated inter-disciplinary team approach would have constituted best practice in the circumstances even if it hadn't ultimately been able to prevent Mr. Sampson's suicide.

[28] As previously mentioned, when seen by Dr. Yaren, on November 12th, Mr. Sampson agreed to take an additional weekly dosage of medication to contend with his currently presenting psychotic symptoms. Although Dr. Yaren hadn't observed such symptoms at his previous clinic meeting with Mr. Sampson on October 29th, 2013, a week after the mental health nurse reported "psychotic symptoms" to her

colleagues, Dr. Yaren told the inquest that Mr. Sampson was definitely suffering paranoid delusions on the 12th. And, as also previously mentioned, he testified that schizophrenics often experience relapse into psychotic states when not taking their medication and that such regressions can take from a few weeks to a few months to become symptomatic and similar periods of time for the prescribed medications to effectively control the relapse symptomology. Dr. Yaren was of the opinion that administrative segregation was not the "ideal place" for a psychiatric patient like Mr. Sampson to recover as he needed more interaction with professional staff to facilitate appropriate interventions. Dr. Yaren told the inquest that he was not asked for any opinion or input respecting the advisability of Mr. Sampson's continued stay in AS. Indeed, the Inquiry was told that his involvement with Mr. Sampson was solely as a contract clinic psychiatrist and that he was not personally involved as a participant in SMI mental health team meetings. Dr. Yaren expressed surprise about Mr. Sampson's suicide. There was no indication that the mental health nurse who assisted Dr. Yaren at clinic meetings with Sampson had ever told him that her file records contained a self-reported 2000 suicide attempt by Sampson, something which she had been aware of since October 13th, 2010 (see exhibit 4E, tab D63 - email).

[29] Overall there was little evidence of effective communication between SMI staff with respect to Mr. Sampson's mental health status, issues and function in the months before the assault on the nurse. Indeed, virtually all the witnesses appearing at the inquest stated that information pertaining to Mr. Sampson's medication non-compliance and his compromised mental health situation would have been helpful and informed their professional approach towards Mr. Sampson.

[30] As has been previously mentioned, Mr. Sampson was no stranger to suicide attempts. A February 1997 Manitoba Youth Centre (MYC) report chronicled that the then seventeen-year-old Sampson was presenting with "depression and feelings of persecution" while in MYC and noted his having been put on suicide watch in a low to medium risk category since being admitted. On a previous SMI admission, on October 13th, 2010, he was noted to have expressed suicidal ideation and been placed on suicide observation from October 13th to 19th. And, as previously mentioned, Mr. Sampson also told members of the SMI Psychology unit that he had actually attempted suicide in 2000, something he had not disclosed when questioned in this respect again on the December 22nd, 2011 mental health intake screening

assessment. A similar assessment, called an Intake Health Status Assessment, completed when Mr. Sampson returned from a transfer placement at Saskatchewan Penitentiary on May 15th, 2013 also revealed no concerns regarding self-injury and/or suicidal ideation. The self-reporting question "have you ever been treated for emotional or mental health problems?" was also wrongly or incorrectly answered in the negative. The evidence suggests that Dr. Yaren was never informed of Sampson's suicidal history at SMI.

[31] On November 10th, when Mr. Sampson was initially moved to segregation, he was interviewed by two staff members in relation to two CSC required report questionnaires that had to be filled out and filed. These were an Observation Report prepared by a nurse and an Immediate Needs Suicide Risk Checklist Report which was administered by a senior Corrections Officer (C.O.). No mental health concerns or suicidal risks were noted therein. In fact, Mr. Sampson answered "No" to every question on the checklist including one that asked "Have you ever been treated for emotional or mental issues?" (see exhibit 4F, tab E37). Both staff members relied solely on Mr. Sampson's answers to the questionnaire format. Of course, had they reviewed SMI files they would have determined that Mr. Sampson had a prior history of suicide attempts and also that he had been treated for mental health problems in the past. Given Mr. Sampson's misleading responses and the staffers' failure to review SMI file materials, the assault on the nurse was not considered to be recent "bizarre behaviour" suggestive of a serious mental disorder, notwithstanding Mr. Sampson's previous non-violent history as an inmate. One report writer, the C.O., acknowledged that Mr. Sampson was acting "upset" at the time of their interview but in his view that situation was only because Mr. Sampson knew what he had done was going to result in placement in segregation, a situation Sampson found disconcerting. Both writers were completely unaware of the October 23rd, 2013 email that had been distributed to Psychology Department staff members respecting Mr. Sampson presenting psychiatric symptoms to the mental health psychiatric nurse. The nurse, probably because she was a clinical not a mental health nurse, didn't discern the symptoms that were mentioned in the mental health nurse's email and confirmed by Dr. Yaren a couple of weeks later.

[32] A Segregated Status Fifth Day Working Review dated November 18th, 2013, written just several days before Sampson's suicide, also mentioned that there weren't any known mental health concerns that would preclude Sampson's continued

segregation placement. Interestingly, a similar review of segregated status authored in February 2012, during Mr. Sampson's multi-month intake assessment, also stated that "the CMT have not been advised of any concerns that would preclude continued segregation and no concerns are noted by the Psychology Department in the most recent Psychological Review for segregation dated January 4th, 2012." The writer of this Review is seemingly completely unaware of a February 3rd report mentioning that Mr. Sampson has indicated that he is feeling ill and ascribing same to particles in his cell flooring. A witness at the inquest, Dr. Kent Somers, a former Department Head and Chief Psychologist at SMI, questioned why such an unusual disclosure didn't trigger immediate inquiries into the possibility of psychotic misperceptions or delusional beliefs given Mr. Sampson's known history of schizophrenia.

[33] Six days before the Fifth Day Working Review was published, on November 12th, 2013, Sampson's assigned Parole Officer also met with Mr. Sampson and recorded in his Casework Record that Mr. Sampson "was coherent during the interview." This seems somewhat unusual as the 12th was the same day Dr. Yaren met with Sampson and determined that he was manifesting psychotic symptoms, leading Yaren to increase Sampson's psychotropic medication dosage.

[34] A Clinical Social Worker who met with Sampson on November 15th, 2013, in response to his request to see someone from the Psychology Department, described Sampson quite differently in her clinical notes. She recorded that she found him "rambling with rapid change of topic and anger issues." The social worker also told the inquest that she had never dealt with Mr. Sampson before and nevertheless had not taken time to review his medical file before their meeting. As such, she was unaware that Dr. Yaren had recently found him to be presenting psychotic symptoms. This witness also testified that she had discussed anger management with Mr. Sampson in relation to the precipitating event that had caused him to be placed in segregation. She told the inquest that she had given him an anger management workbook to complete prior to her departure. She also stated that she would not have done anything different even if she had been aware of his recent psychotic break (see exhibit 4D, tab C13 for her clinical note respecting their meeting).

[35] A Chaplain, who met separately with Mr. Sampson on the same day, and who provided a bible pursuant to Mr. Sampson's request, told the BOI that Mr. Sampson had presented as angry during their time together, that he had stated that he was angry because he had not yet received his personal effects from his general

population cell, property which he was entitled to receive by requirement of institutional rules. The Inquiry determined that even Mr. Sampson's personal medications were delayed two days and not received until November 12th. The Chaplain informed the Board of Inquiry that he had passed on this information to a C.O. on the unit. Evidence received by the Inquiry in such respect also revealed an Inmate Request sent by Mr. Sampson to his Parole Officer on November 15th wherein Mr. Sampson again requests that the rest of his personal property be sent to the segregation unit. Such request was forwarded to the appropriate staff person, a Corrections Manager, on November 22nd, some six days afterwards, a day after another staff member, a Unit Manager, received a second such request which is dated November 21st. A Corrections Officer, who identified himself as a CX2 responsible for segregation unit five administration, disclosed that eight days were then allowed by SMI rules for transport of personal belongings to the segregation unit. The operative CSC Administrative Segregation directive, #709, then provided that an inmate became eligible to receive his "authorized personal effects" within three days after his first five day status review, if a decision to maintain AS status had been made.

[36] As mentioned earlier, apart from Dr. Yaren, and the mental health nurse who assisted him during his clinic meeting November 12th, very few staff members interacting with Mr. Sampson were aware of the psychiatric concerns and findings that caused Dr. Yaren to increase Sampson's recommended drug dosage. The only people who appear to have been made aware of Dr. Yaren's findings were Mr. Sampson's Parole Officer, who nevertheless advised the fifth day Review Board that he perceived AS placement as necessary and safe because he believed that weekly meetings with Dr. Yaren were all Mr. Sampson needed, and an Assessment and Intervention Manager. Neither his assigned COII, his Clinical Social Worker nor the general institutional mental health team members were in the informational loop. This situation concerned the Board of Inquiry. Indeed, its Report cited research that indicates a heightened potential for inmate suicide associated with placement in segregation and a consequent need to closely monitor such high-risk situations. The BOI Report also notes that the mental health team members interviewed had advised that it was highly likely that, had they known, they would have provided additional monitoring, care and/or put a special intervention plan in place to appropriately

gauge and assess Mr. Sampson's personal issues and special needs in relation to his confinement in segregation.

[37] The Inquiry concurs with the BOI Report finding that Mr. Sampson was only afforded a "routine" type of monitoring response while in segregation and not given the attention his special needs actually required. A further example of this can be found in the testimony received from a registered nurse who did some daily checks respecting Mr. Sampson's well-being while he was confined in segregation (something which was also required by way of Commissioner's Directive #709). The nurse in question told the inquest that her practise was to announce her presence through a food slot in the door and then ask inmates if they were "OK." If the answer was "yes", her practise was to move on in continuance of her rounds. The BOI Report found that although these checks constituted compliance with the Commissioner's Directive, they were not of sufficient duration or quality to satisfy the spirit of the policy guidelines as they only ranged in duration from seconds to minutes. The Board also determined that Mr. Sampson had expressed a desire to two 'rounds' nurses to write a letter of apology to their colleague, the nurse who had been assaulted.

[38] The only formally written SMI assessment report detailing Mr. Sampson's psychological status was, as previously mentioned herein, written in 2005 by Dr. A Barbopoulos, a Registered Psychologist on SMI staff. The report details not only his mental status but also his cognitive abilities and risk factors. The report demonstrates how unreliable Mr. Sampson's self-reporting could be. For example, Dr. Barbopoulos mentions that Mr. Sampson attributed his schizophrenic diagnosis at the age of nineteen "from ink poisoning due to tattooing." He also told Dr. Barbopoulos that the medication he had been prescribed by the SMI psychiatrist was for "sleep problems", not mentioning that it was really for treatment of his schizophrenia.

[39] Dr. Barbopoulos's report reveals numerous instances of Mr. Sampson's responses to questioning being reflective of little personal insight. Dr. Somers described Mr. Sampson's responses as being consistent with little insight and/or ability to effectively share his experiences with others. Somers observed that such reported responses were "extremely terse, grammatically limited and literal." In her report, Dr. Barbopoulos indicated that Mr. Sampson's "significant lack of insight into psychiatric issues" was a critical factor "to be considered when predicting (his)

risk to reoffend." She also presciently warned that Mr. Sampson needed to be prevented from self-medicating his psychotic symptoms with illegal and addictive drugs when he was released back into the community, something that would later prove to drive Mr. Sampson's recidivism. In such respect she makes specific reference to the need for "continuity of care and communication between the different professionals" working with Mr. Sampson.

[40] Dr. Somers, although acknowledging that Barbopoulos's report was an "in depth assessment", was nevertheless critical of the report with reference to its failure to endorse an institutional response and/or accommodation strategy to cope with Sampson's mental disorder. He cited a lack of discussion respecting the impact of schizophrenia on Mr. Sampson and its expected influence on his SMI stay as being a report shortcoming because Dr. Barbopoulos failed to mention behaviour abnormalities that were associated with schizophrenia; abnormalities such as hallucinations, bizarre behaviours and irrational, unfounded beliefs as well as social skill deficits, low motivation and depression. He also referred to the positive correlation between these various symptoms and the risk of suicide. It was Dr. Somers' opinion that the report should have alerted other staff responsible for Mr. Sampson's care with respect to these specified vulnerabilities. Dr. Somers, referencing other SMI reports pertinent to Mr. Sampson, also contended that staff had wrongly misperceived Sampson's lack of program interest as stemming from laziness and general lack of motivation rather than his mental health concerns, concerns that were exacerbated as a consequence of his repeated failures to comply with his psychotropic medication prescriptions.

[41] Dr. Somers also elaborated that SMI/CSC's response to Mr. Sampson's mental health concerns had missed the mark because staff had often concentrated on his behaviour per se, mostly conduct issues, and again neglected the bigger picture; that his impulsivity, lack of insight, prior self-medication history, anger as well as his criminal behaviour while out of custody was caused by his mental disorder and not related to flaws of character. According to Dr. Somers this situation shouldn't have happened because CSC Institutional Mental Health Guidelines (IMHI), adopted in late 2009, specifically noted major mental health disorders such as schizophrenia as a predominant service concern. He related that IMHI Guidelines emphasized the prioritization of inmates who have a history of difficulty following through with recommended mental health interventions and whose "anticipated

duration of mental health concern is chronic." As such, he expressed concern about Mr. Sampson's placement in segregation prior to his death as well as multiple other times over his three federal warrant admissions, albeit recognizing that some of these had been voluntary placements i.e. for purpose of his protection. In 2006 and 2007 alone, Mr. Sampson spent two hundred and ninety-four consecutive days in segregation. Indeed, at such time, Mr. Sampson was actually community released directly from segregation and was only in the community for three days before being sent back to SMI for failing to reside at his designated residential facility (see exhibit 4A, tab 6). Upon his return to SMI Sampson was immediately placed back in segregation for ten days and then community released again. Two days later he was returned to SMI yet again after another breach involvement and was placed in segregation for sixty-two more days. Somers held the opinion that IMHI Guidelines demanded that Mr. Sampson should have been designated as an individual/inmate with "intensive needs" and that as an inmate in crisis and with intensive needs he should not have been subjected to punitive segregation. Somers told the Inquiry that IMHI Guidelines demanded "a strongly integrated and coordinated approach linking all CSC staff involved" (referencing p. 6 of the 2009 Guidelines which is attached hereto as Appendix "D"). He took the view that although medication was both a "reasonable and prudent component of mental health treatment, that its repeated reference to and reliance by SMI staff on it was not the only thing that Mr. Sampson required." In this regard he expressed criticism related to SMI departments functioning as independent "silos" in their dealings with Mr. Sampson, something also mentioned by other SMI staff witnesses. It was Dr. Somer's opinion that Mr. Sampson, because he was an inmate, had not received necessary mental health treatment that was offered to the general community.

[42] As I have now mentioned a number of times, the Board of Investigation also found lack of interdepartmental and communication program coordination to be a significant contributing risk factor to Mr. Sampson's suicide. The Board's Report first observes that it was well documented from Sampson's previous and current sentences, that Sampson was diagnosed with schizophrenia and that he was often under psychiatric care and in receipt of medication. The Report then observes that there was limited understanding by his Case Management Team (CMT) of the consequences/impacts of this diagnosis, in general, and/or during an active or psychotic phase. The Report then concludes that this gave rise, as a consequence, to

minimal attention being provided and/or action being taken by either Sampson's CMT or the Institutional Mental Health Team (IMHT) with regard to his mental health diagnosis and current circumstance; the circumstance being the response afforded Sampson after his assault of the male nurse. The Report goes on to describe same as being a "routine" response toward that of an average (non-mental health affected) inmate that assaults a staff member, i.e. that person is segregated, reviewed for external charges, and reviewed for potential transfer to higher security.

[43] The Board critically found that even after the Psychiatrist assessed Sampson as having been in a psychotic state during the assault, on November 12th, 2013, the IMHI did not become formally involved in the management of Sampson's case. And as previously mentioned, that the attention of the CMT was focused on Sampson's behaviour, i.e. the staff assault, to the exclusion of any mental health-related concerns flowing from Dr. Yaren's assessment that Mr. Sampson was likely in a psychotic state at the time of the assault.

[44] The BOI Report critically concludes that "the determinants associated with Sampson's assault of the male nurse were not fully explored relative to his mental health diagnosis and mental state at the time of the assault" and, as a consequence, limited action was undertaken to assess his personal mental health situation at a critical time in his life. The Inquiry Board further found that the attention of the Case Management Team was more "misbehaviour" focussed than mental health focussed because of the lack of effective communication about his compromised mental health condition. The Board also concluded that the professionals who interacted with Sampson, including nurses who did daily observation rounds, were for the most part simply not equipped with the necessary information to appropriately engage their monitoring duties.

[45] Dr. Somers was particularly critical of the failure of staff to place Mr. Sampson in a camera cell after November 12th. Dr. Somers contended that a known actively psychotic inmate should not have been left alone in an unmonitored cell because the risk of suicide or self-harm should at that point simply have been presumed. The clinical nurse who interviewed Mr. Sampson on November 10th, shortly after his arrival in the segregation unit conceded that she would have placed Mr. Sampson in such an observation cell if she had been aware that he had been experiencing "psychotic symptoms," a diagnosis that she was not professionally capable of making as she was not a psychiatric specialist.

Circumstances of death

[46] A CCTV SMI security video was received as an exhibit at the inquest. At approximately 7:27 a.m. on November 23rd, 2013, two C.O.s are seen on the video doing rounds in Mr. Sampson's segregation range. The Inquiry was advised that segregated inmate counts were required by a CSC Directive and that same related to verification that inmates were 'alive and breathing'. One C.O., employing a flashlight, bends down to view Mr. Sampson through the food slot. This C.O. informed the Inquiry that he had to do his check through the food slot, and not the cell door's window, because the lower part of the window was covered from within, obstructing his view of the cell's interior. The second C.O. related that he was tall enough to see over the window obstruction and testified that he could see Sampson "sitting" on his bed staring at the wall, something that was confirmed by his rounds partner. This check took about six seconds, a period of time that the BOI found inadequate and not in compliance with the policy objective of the pertinent Commissioner's Directive. Also, notwithstanding that the window obstruction constituted a segregation unit policy breach, as detailed in the Inquiry Board's Report, the officers failed to remove the obstruction immediately, as per the directive. The officers involved acknowledged such non-compliance.

[47] At approximately 7:53 a.m., a CX2 is seen on CCTV footage, entering the range where Mr. Sampson is domiciled. He has a clipboard and goes to each cell, appearing to engage or try to engage each confined inmate. The Inquiry learned that this officer was conducting rounds in order to determine whether the inmates on the range wished to participate in yard exercise that day, segregation inmates being then allowed out of their cells for one hour daily for such purpose. The officer is seen to bend down at the food slot of Sampson's cell for a moment, presumably because the obstruction hadn't been removed earlier, and then proceed to the next cell. The Inquiry does not know if Sampson spoke with this officer or if the officer actually saw Sampson because the officer, one of the two who performed the 7:25 a.m. check, was unable to recollect anything about his last visit to Sampson's cell. The Inquiry was told that the officer was sure he wouldn't have left without receiving an answer from Sampson and that he assumed Sampson must have been awake because he had personally viewed him sitting on the bed approximately a half hour earlier.

[48] At approximately 7:57 a.m., an inmate food service worker comes into view serving breakfast to the cell occupants of the range. At approximately 8:06 a.m.,

presumably because Sampson had not taken his food tray through the door slot, the worker looks into his cell through the slot (assumably he isn't tall enough to look over the window obstruction). The inquest received no testimony from this person as he was not subpoenaed by Inquest Counsel. Almost immediately thereafter, the worker notifies command kiosk officers that he has discovered Sampson hanging in his cell. Within a minute four officers are seen to appear at Mr. Sampson's cell. The cell door is opened and the officers go inside. They are no longer visible on the video. The Inquiry heard testimony from an attending nurse that Sampson had been placed on the cell floor after being freed from the ligature, a shoelace suspended from the frame supporting the upper bunk of his bed. She elaborated that the responders had decided to keep Mr. Sampson in the narrow cell because they feared damaging his neck if they attempted to move him. She also confirmed that CPR was already ongoing when she arrived on scene. According to the BOI, the Board received disclosure that officers had immediately begun CPR in an effort to revive Mr. Sampson. The BOI Report also documented and verified that an ambulance was summoned to SMI at 8:08 a.m., some two or three minutes before the members of the nursing staff arrive at the cell. At 8:12 a.m. the Report confirms the arrival of an Automated External Defibrillator (AED) at the cell and shortly thereafter, within one minute, its attachment to Mr. Sampson and deployment. The Board of Investigation further determined that SMI was in full compliance with the pertinent CSC 2013/14 National Training Standards and that all the responding Correctional Officers were qualified in First Aid. It further determined that all health service nurses that attended in response to the incident were "current" in cardiopulmonary resuscitation and AED usage.

[49] According to the Board Report, at 8:27 a.m., medical care was taken over by unidentified arriving paramedics who ran through all medical protocols and also administered four rounds of epinephrine (adrenaline) in an effort to restart Mr. Sampson's heart. Resuscitation efforts were reportedly discontinued at approximately 8:42 a.m. and four minutes later Mr. Sampson was unofficially pronounced dead. Inquest evidence disclosed that subsequent to this, at 10:13 a.m. on November 23rd, a representative of the Chief Medical Examiner's Office (OCME) personally examined the body and officially pronounced Mr. Sampson 'dead'.

[50] On November 25th, 2013, after autopsy, Dr. S. Nelko and Dr. C. Littman, both physicians with the Office of the Chief Medical Examiner pronounced "hanging" as

the cause of death. The autopsy report disclosed a ligature mark which extended around the front and both sides of Mr. Sampson's neck. The presence of "abrasions and healing abrasions" around Mr. Sampson's wrists were noted to be "consistent with handcuff marks dating from November 10th, 2013 when he had been involved in an assault and taken to segregation unit."

VII. DWAYNE MERVIN FLETT

General Background and History

[51] Extensive documentation from SMI files was filed at the inquest. CSC made same available on the understanding that same would be sealed at the conclusion of the inquest. Numerous SMI staff members were witnesses in relation to this matter, including Mr. Flett's institutional parole officer who provided information on Mr. Flett's placement in the Supportive Living Range (SLR). The SLR, now called the Mental Health Range (MHR), was a placement designed to meet the needs of inmates with general health or mental health issues. The parole officer described Mr. Flett as possessing a "child-like mind set" with limited coping skills, an inmate who required a lot of staff interventions. Court was told that Mr. Flett, although in his early 30's, was cognitively akin to a five to ten-year-old child, an observation shared by other staff witnesses, many of whom had interacted extensively with the deceased since his admission to SMI in June of 2011when Mr. Flett began to serve a four year, ten and one-half month sentence. This was Mr. Flett's first and only criminal conviction. Court records show that the sentencing judge was completely unaware of Mr. Flett's significant cognitive limitations.

[52] Mr. Flett received a mental health screening assessment soon after his arrival at SMI. The assessment indicated diagnoses of schizophrenia and depressive disorder, as well as a history of suicidal ideation. Cognitive impairment was also noted. The inquest was told that cognitively challenged inmates aren't actually cognitively assessed on admission even though such inmates are often unable to do institutional programming. Such assessments are only done if such an inmate is later referred to RPC. In Mr. Flett's case such an assessment was first done in December 2011 on the first of three occasions he was referred to RPC.

[53] Initially, in recognition of his mental health issues and related needs he was determined to be a suitable candidate for the SLR, a place where inmates are supposed to be provided with more intensive attention in relation to such issues and needs. A registered nurse who worked with him told the inquest that "he was always in a state of illness." Dr. Daniel Globerman, an SMI clinic psychiatrist who saw Mr. Flett regularly in 2014 and 2015, reported that Mr. Flett, who he described as "mildly retarded", schizophrenic and sometimes clinically depressed, had disclosed hearing voices since he was six or seven years of age. Notwithstanding this, the Inquiry

learned that Mr. Flett's initial assessment had not identified him as meeting the threshold of the Institutional Mental Health Initiative (IMHI). As a result, he did not qualify for specialized IMHI services and consequently no individualized personal mental health plan was put in place. It was noted by the BOI that in response to a Parole Officer referral, Flett underwent a second IMHI service screening process on July 23rd, 2013 but was again found to not meet the criteria for IMHI services. Notwithstanding this seemingly remarkable decision, the Inquiry received considerable evidence that Correctional Officers, case management staff and mental health professionals usually paid what appeared to be sincere and professional attention to Mr. Flett's special needs. There certainly appears to have been general recognition that Mr. Flett was essentially a mentally handicapped and very vulnerable person who required special attention.

[54] As mentioned, Mr. Flett had been transferred to the Regional Psychiatric Centre (RPC) in Saskatoon three times. His first such transfer, on March 9th, 2012, was on an emergency involuntary basis because he had been experiencing visual hallucinations. He was discharged and returned to SMI on January 25th, 2013. Subsequent transfers occurred on March 27th, 2014 and August 27th, 2014. His second transfer was only for five weeks and related to a specialized offender rehabilitative program offered only at RPC. The last transfer, again, was on an emergency basis, on the advice of Dr. Globerman, and related to stabilization needs relative to serious suicidal ideation concerns. Flett was held at RPC for approximately three or four months on this occasion and was reported to have only expressed suicidal thoughts on one occasion when records indicate that he told staff he was "feeling sad" and tried to tie a ligature around his neck. The BOI determined that Mr. Flett had left RPC despite being encouraged to stay. As he was not deemed certifiable under Saskatchewan *Mental Health Act* criteria he was returned to SMI in early December 2014, some four and one-half months prior to his death. Inquest testimony indicated that SMI professional staff were of the view that RPC was the best placement for Mr. Flett but at such time CSC regulations did not permit some unless the inmate required involuntary treatment placement or had personally requested such a transfer.

Events Prior To Death

[55] There was evidence before the Inquiry that Mr. Flett was not taking his psychotropic medication regularly for several months prior to his suicide on April 15th, 2015, something that had been flagged by a mental health nurse in an email to another mental health nurse on December 2nd, 2014. For instance, on January 21st, 2015 a nurse sends an email to the Psychology Department advising that Mr. Flett had refused his antipsychotic medication. She warns that he experiences "visions" and "voices" and lists several other "symptoms of relapse" to watch for. She asks that Psychology report any such concerning observations to her so she can relay these to his psychiatrist and institutional mental health team. SMI documentation filed in Exhibit Book 1D [see D17, D18, D19, D20, D23, D24, D26, D33] document the difficulties various staff experienced in relation to encouraging medication compliance in the context of wide-ranging mood disorder afflicting Mr. Flett during this period.

[56] Mr. Flett had been placed on suicide watch a total of fifteen times between August 12th, 2011 and March 18th, 2015, approximately one month before his suicide. Ten of these watches related to suicidal ideation. It was reported that most often he attributed such thoughts to inner voices that suggested self-harming behaviour.

[57] In the three months preceding his suicide i.e. between January 31st, 2015 and March 18th, 2015, Mr. Flett was placed on "modified" suicide watch four times and "high" suicide watch three times. The Inquiry learned that "high" suicide watch involves inmate removal to a special suicide resistant observation cell with an officer posted outside the cell. "Modified" watch cells were equipped with 24/7 video surveillance. Both watches involve immediate or as soon as possible follow-up assessments by specialized mental health nurses. The high suicide watch special placements occurred on January 31st, February 7th and March 8th, 2015. Each was initiated by Correctional staff. The BOI found that Mr. Flett had pressed his cell call button to inform staff of his suicidal ideation on two of these occasions and had personally spoken to a patrolling Corrections Officer on the other occasion. All three disclosures indicated that he planned to employ a blanket or bed sheet in his cell to hang himself. "High" suicide watch cells are not equipped with blankets or sheets and their conduit piping is not accessible to inmates.

[58] Inquiry witnesses convincingly testified that assessing Mr. Flett's risk of suicide was a difficult matter because of his severe cognitive deficits and often unfocussed child-like behaviours which often gave rise to contradictory statements or suspicions that he was threatening suicide to remove himself from certain stressors, often threat related in reference to personal debts he owed other SLR inmates, a situation that appears to relate to the socioeconomics of inmate subculture, an economy where income and lifestyle enhancements can apparently be generated by predatory and exploitive loan sharking activities. The inquest was told that generally speaking, Flett was easily exploited and often taken advantage of by other inmates. However, based on the evidence, prior to the night of his death, staff would almost invariably err on the side of caution when he told someone that he was feeling suicidal.

[59] Often, soon after being placed on suicide watches, Mr. Flett would tell staff that he no longer felt suicidal. This made it difficult for some staff to take his "threats" seriously. Notwithstanding this, as mentioned before, staff appear to have always previously complied with a 2013 Commissioner's Directive, #843, which sets out guidelines for management of suicidal behaviour which include the need for suicide risk screening by a mental health professional and appropriate precautionary 'watch' procedures. Such directive is attached hereto as Appendix D to this report.

[60] On March 9th, 2015 the mental health nurse who performed Mr. Flett's last mandatory suicide assessment ordered his release. The Inquiry was told that he was now in a good mood and symptom free. That morning the nurse in question sent an email to the Psychology Department and a couple of staff Parole Officers suggesting that Mr. Flett would be better served if he resided in an observation cell in Health Care. She disclosed that because Mr. Flett was constantly in and out of observation situations which she elaborated were related not only to suicide watches but also medication compliance issues, she felt it would be preferable to remove him from SLR. She also expressed concern about the need to get Mr. Flett away from inmates who were "muscling" him in the SLR. Soon after, Mr. Flett was temporarily housed in a Health Services hospital cell. Another nurse on the email chain relates that this will be "a short term solution so that Flett can deal with his debt on SLR so that he can be moved back to SLR in the near future as that is the best place for him". The Inquiry was told that Flett was removed from his Health Services placement on March 26th on a voluntary discharge basis i.e. at his own request. The Inquiry was

informed that since there were no presenting health concerns that would prevent such a voluntary discharge he had to be sent back to SLR. The situation was described as "unfortunate" by his Parole Officer.

[61] The Inquiry examined a number of institutional documents that were generated during Mr. Flett's March stay in suicide watch. One of these was authored by the same nurse who authorized his removal from suicide watch. This document (exhibit 1C, tab 63), a Psychological Services Clinical Progress Note indicates that Mr. Flett was experiencing "'shadows' which are like 'stretchy hands' trying to push its way into the centre of certain points of his brain, which causes him distress and at this point in time he has thoughts of suicide." He is related to have asked for different medication "that will decrease the 'strain' on his brain." The mental health nurse relates that he tells her that "he believes that there are senseless beings out there that attack his brain." He questions whether he has been given the "right medication" to help with this problem. Four or five days later he is put on high suicide watch after he discloses suicide ideation. Another form, filled out the day before and signed by a different nurse discloses that Mr. Flett is feeling down and tired from hearing "constant voices."

[62] Mr. Flett's last meeting with his assigned staff psychologist was on February 24th, 2015. When asked at the inquest if he was aware of Mr. Flett's related psychotic symptoms, the psychologist disclosed that he was not. A review of the filed documentation supports that testimony. When asked what he might have done if he had been advised about Mr. Flett's delusional state, the psychologist told the Inquiry that he would most probably have once again referred him to Saskatoon Regional Psychiatric Centre as a prospective involuntary patient/inmate as verbal psychotherapy did not appear to present as a viable treatment option. The BOI, however, was critical of the psychologist but not in relation to lack of communication related to other members of the Psychology team. In this respect the BOI cited the psychologist's failure to comply with Chapter Four of the Psychological Services Manual which requires Progress Reports after twelve sessions while more or less commending the SLR interdisciplinary team members from Nursing, Psychiatry, Psychology, Case Management and Security for meeting "at least on a monthly basis." The Inquiry observes that the level of service to Mr. Flett would have been much higher if he had been identified as meeting the eligibility threshold for IMHI services and a formalized mental health management plan been

thus required. It also observes that SMI staff described changes which were made by SMI in May 2015 to improve communication processes on the SLR, when the name of the unit was changed to the Mental Health Range (MHR). These related changes will be discussed in more detail later in this report.

[63] At approximately 10:56 p.m. on April 14th, 2014 Mr. Flett activated his cell call button and upon staff arrival, informed two C.O.s that he was having negative thoughts in relation to suicide ideation. One of the C.O.s immediately contacted the Duty Corrections Manager (DCM), who responded by ordering an "upgrading" of security patrols, from once hourly to half-hour intervals in order to monitor Mr. Flett's well-being. The DCM did not place Mr. Flett in a special cell on either high or modified suicide watch.

[64] A C.O. on duty then informed Mr. Flett that half-hour "walks" would be carried out during the rest of the evening and throughout the morning shift. The Inquiry was advised that Mr. Flett was also informed that an officer would be available to speak to him if he felt the need to speak with someone during the night. The C.O. testified that he also reminded Mr. Flett of the availability of the cell call system if he wanted to see someone during the night. The C.O. informed the Inquiry that he had also asked Mr. Flett if he would be "OK" till the morning and that Mr. Flett had replied affirmatively. The C.O. filed an Observation Report the following day which somewhat cryptically stated that the deceased had "displayed that he was demonstrating future oriented thinking" during their last interaction and was "making plans for bettering himself in the future" (see exhibit 1, tab A65). When questioned on the witness stand this C.O. related that it was likely that any other inmate would have been treated differently by him in the circumstances, that Mr. Flett's history of repeated suicide threats had created a "crying wolf" type of situation.

[65] The Inquiry viewed closed circuit security video recordings which indicated full compliance with the DCM's order. Video footage and testimony confirmed an approximately four minute chat between Flett and a patrolling C.O. who did the third half-hour check at about 12:16 a.m. The C.O. in question testified that he had engaged Mr. Flett in conversation in order to try and gauge where he was at from an emotional and psychological viewpoint. The Inquiry was told that nothing in such conversation raised any "flags". This C.O. informed the Inquiry that no one had

instructed or ordered him to remove Mr. Flett's blankets or sheets from the cell. The other C.O. on cell rounds that morning provided the same testimony.

Circumstances of Death

[66] At approximately 1:14 a.m. a patrolling C.O. making the fifth half-hour check, found Mr. Flett hanging from a conduit pipe in his cell. This officer told the Inquiry that he initially thought Mr. Flett was playing "a joke" on him. The CCTV footage shows this officer speaking on his radio shortly after looking inside Mr. Flett's cell. At approximately 1:17 a.m. another officer arrives and both officers enter the cell. The Inquiry was told that employee safety rules require two officers be present when a C.O. has to enter an occupied cell. The Inquiry was also told that two people were best suited to the task at hand, i.e. cutting Mr. Flett down: one to hold his weight and take pressure off Mr. Flett's "airway" while the other cut the noose with a knife. Both C.O.s lowered Mr. Flett's body to the floor after the noose, actually found to be constructed from a cell bedsheet, was cut. CPR was begun immediately according to the second attending C.O. who went on to inform the Inquiry that he had first checked Flett's airway to ensure that it wasn't blocked before starting the CPR. The C.O. further advised that he had received and certified in CPR training from St. John's Ambulance and recertified every three years as well as taking an annual refresher course offered by SMI.

[67] A Stonewall ambulance paramedic, Chad Ferens, arrived on scene at approximately 1:30 a.m. Mr. Ferens recollected that Mr. Flett was on the floor with a C.O. performing CPR. An automated external defibrillator machine (AED) was also hooked up to Flett's body. He was unable to detect any vital signs. Mr. Ferens confirmed that the CPR administration he observed conformed with his personal training, advising the Inquiry that it seemed "properly performed." The BOI Report confirmed that SMI was in compliance with appropriate CSC National Training Standards and that all the responding Correctional Officers were qualified in First Aid. Mr. Ferens also testified that he had connected Mr. Flett's body to a heart monitor machine and was unable to detect any electrical activity in his heart, information which meant that Mr. Flett was beyond medical assistance i.e. his heart could no longer be shocked into activity by an AED.

[68] Mr. Ferens also recollected that a second paramedic unit from Selkirk arrived at 1:45 a.m. bringing an advanced care paramedic on scene. The newly arrived

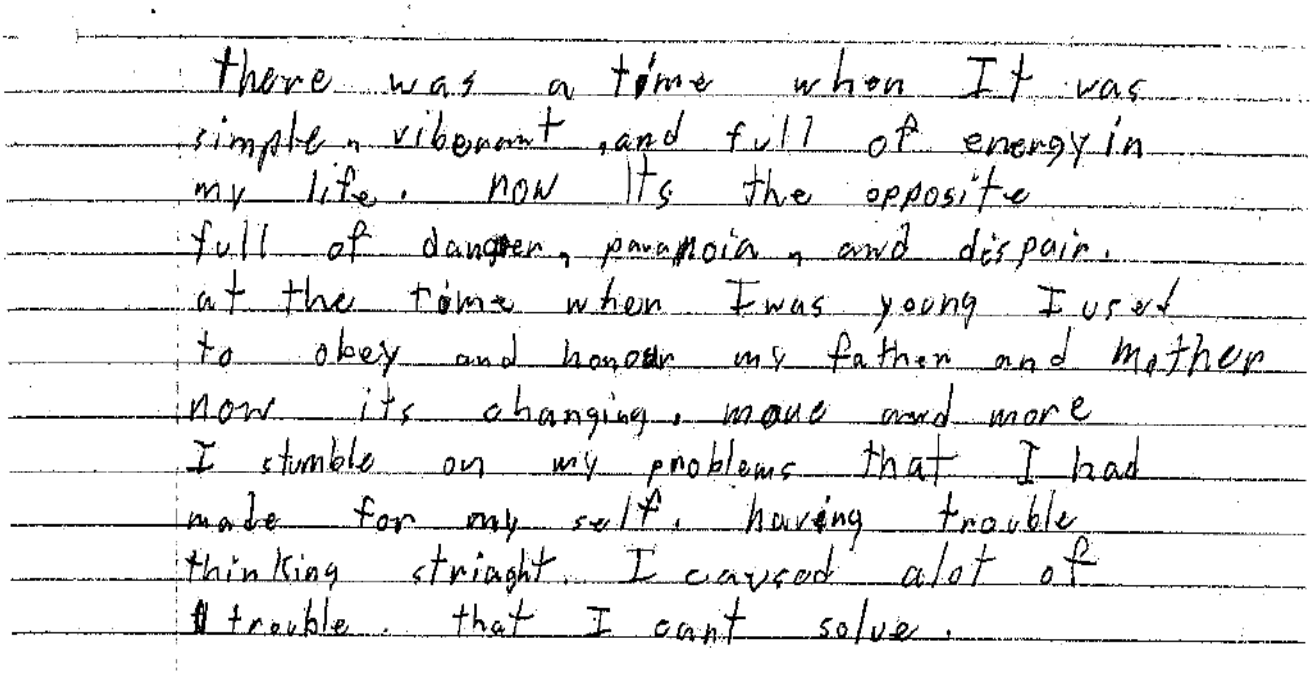
'specialist', Brian Collier, administered three "rounds" of epinephrine, commonly known as adrenalin, by injection, and also "inserted a tube in accordance with Advance Life Support cardiac arrest protocols." This was all to no avail and Mr. Collier finally pronounced Mr. Flett dead at 2:02 a.m. in his ambulance. The immediate cause of death was recorded as cardiac arrest caused by hanging.

[69] The Chief Medical Examiner authorized an autopsy, which was performed at the Health Sciences Centre in Winnipeg. The cause of death was determined to be "hanging". Another contributing cause of death, as noted by Dr. R. Rivera, the Medical Examiner who performed the autopsy, was sertraline toxicity caused by high levels of the depression drug detected in Mr. Flett's blood. Sertraline is used to treat major depressive disorders. An SMI Medication Administration Record entry on March 11th, 2015 indicates that Mr. Flett was receiving sertraline by way of two, 100mg capsules daily in April 2015. Dr. Globerman, the prescribing physician, told the Inquiry that he had "bumped up" Mr. Flett's anti-depressants in June 2014, after Flett had reported suicidal thoughts and told him that he would commit suicide the following year.

[70] Dr. Rivera, a pathologist, testified at the inquest. At such time he told the Inquiry that he no longer thought that Mr. Flett's high sertraline levels were a contributing factor with respect to death. He explained that his initial opinion had been premised on the possibility that Mr. Flett might have taken an acute overdose of the medication just prior to his death. Dr. Rivera told the Inquiry that he had subsequently sought the opinion of a specialist, a toxicology biochemist, Dr. C. Oleschuk, who had advised him by way of report (which is exhibit 17 in these proceedings) that therapeutic reference levels are of limited utility in autopsy cases for several reasons all of which were chronicled in Oleschuk's report. For this reason, Dr. Rivera no longer felt that the recorded drug levels were of concern notwithstanding that Mr. Flett was on a higher daily dosage that usual (200mg/day). He concluded that he now believed it "possible that the levels of sertraline that were measured could have represented a steady state (i.e. were a result of his prescribed ingestion) rather than an acute overdose."

[71] After death, a handwritten note was found in Mr. Flett's cell by Medical Examiner, Susan Hamilton. The note was undated so it is impossible to determine when it was written. The note's contents speak for themselves and clearly reflect Mr.

Flett's generally melancholic state of mind. A copy of the actual note, as written verbatim, is as follows:



there was a time when It was simple, vibrant, and full of energy in my life. now its the opposite full of danger, paranoia, and dispair. at the time when I was young I used to obey and honour my father and mother now its changing. more and more I stumble on my problems that I had made for my self. having trouble thinking striaght. I caused alot of trouble. that I cant solve.

VIII. THE BOARD OF INVESTIGATION'S RECOMMENDATIONS

Mr. Sampson

[72] The BOI filed its report on May 21st, 2014. It made three recommendations and a number of non-compliance findings which the Inquiry thought quite pertinent to the subject matter of this inquest:

Recommendations

1. That all inmates placed in AS have shoelaces and/or belts removed from their possession. The Inquiry was told that this recommendation was not supported by SMI's Warden as general CSC policy permits inmates to have all of their personal possessions transported to AS cells when they are relocated. The Inquiry was also advised that the Warden wasn't prepared to impose a restriction that would be generally perceived by inmates to remove an existing right; in this case the right to wear what they wished when ensconced in AS. The Inquiry was also told that since SMI's AS policy already prohibited the possession of belts (presumably for staff safety) there was no need to consider the recommended belt prohibition.

   The inquest was advised that in certain circumstances a local CSC institution like SMI can reject a BOI recommendation even if it is supported by regional or national CSC administration as was the case with this recommendation. Such circumstances arise when general national policy conflicts with a BOI recommendation as was the case with wearing shoe laces in AS. Therefore, since national policy had not been revised by CSC, the Warden of SMI retained authority to exercise personal discretion with respect to this recommendation. The SMI witness providing the aforementioned information also stated that regional CSC administration can, if it wishes, still trump local institutional decisions such as this in circumstances where national policy is inconsistent with change. The bottom line is that BOI recommendations aren't necessarily implemented and even if they are, are often only implemented as modified by the local institution or the regional or national office.

2. That the general policy requirement for a Psychology Department interview or review of all AS inmates be amended from once in the first twenty-five days of segregation to coincide with the existing requirement for the fifth day

working review of AS inmates. The Board's recommendation stipulated that this should minimally be done with respect to all inmates possessing a "known" mental health diagnosis. The Board submitted that earlier review based on actual interviews "would assist the Warden in their (sic) decision making and would also assist in formulating a 'baseline' of behaviour and/or evaluation of mental health which would aid in subsequent reviews if required (i.e. the twenty-five day and sixty day requirements by policy)". The Board also observed that earlier reviews would assist professionals "in establishing… therapeutic rapport."

This recommendation was not supported as the Offender Programs and Reintegration Branch (OPR) was of the view that several existing safeguards were already in place to ensure that inmates in segregation were adequately assessed with respect to their mental health needs, including the risk of suicide. The OPR Branch observed that the real concern in the Sampson suicide was "lack of information sharing and appropriate documentation" filing and not case management deficiencies. The Inquiry was informed that policy mandated first admission and subsequent daily nursing visits were thought to be an adequate precaution with respect to AS inmate suicide risk. A similar outlook pertained to the efficacy of the self-reporting suicide ideation Immediate Needs Checklist - Suicide Risk required to be completed upon inmate admission to AS. In Sampson's case he falsely denied any history of mental illness or prior suicide attempts when questioned respecting completion of this Checklist (see exhibit 1E, tab 37). The necessity of maintaining Segregation Log forms was also perceived by CSC as a further viable precaution.

3. The final recommendation made by the BOI was that **all** known mental health concerns and diagnoses be incorporated into the nationally mandated Institutional Mental Health Initiative Screening intake documentation. The BOI expressed concern that the current format only relied on inmate self-reporting and as such was an inherently unreliable tool in cases like Sampson's as his "long-standing mental health diagnosis and reliance on anti-psychotic medication was not considered or incorporated into in (sic) the Mental Health Initiative Screening Report/Note." (see exhibit 4D, tab 37). Presumably, the BOI was specifically referring to the self-reporting

information Mr. Sampson had provided to Dr. Barbopoulos, the SMI psychologist, several months after his first admission to SMI in October of 2005. (see exhibit 4D, tab C15, PSYCHOLOGICAL/PSYCHIATRIC ASSESSMENT REPORT) or the contents disclosed by his initial intake interview which was completed even earlier in time, on August 26th, 2005, approximately two months after such first SMI admission (see exhibit 4A, tab A55, CORRECTIONAL PLAN) or his disclosures made on December 19th, 2011 on the occasion of his initial interview after final re-admission to SMI (see exhibit 4C, tab I07, CASE WORK RECORD LOG). The BOI also emphasized the importance of providing staff responsible for the care and supervision of mental health inmates with "complete" and "integrated" representations of the inmates subject to their care, something which would facilitate "responsive and prompt access to mental health services under the collaborative care model" supported by national CSC Mental Health Service Guidelines.

National CSC Health Services expressed concern about this recommendation and did not support it as Health Services felt that it did "not comply with an offender's right for protection of personal health information and may also result in stigmatization of offenders who are currently functioning well" (pages 7 and 8 of Sampson BOI Recommendation Grid filed as exhibit 13 in these proceedings). Health Services also observed that the Computerized Mental Health Intake Screening System (COMHISS), another largely self-reporting screening mechanism employed by CSC, required follow up assessment by a mental health professional for "any offender who is flagged by COMHISS" including inmates expressing "current suicidal ideation." For unknown reasons, perhaps privacy related, Mr. Sampson had failed to self-report his prior mental health history and denied a history of depression notwithstanding that he was on medication for this condition at the time when questioned for self-reporting completion of his December 22nd, 2011 recent admission COMHISS rating form. The psychologist who performed this self-reported mental health screening in order to establish Mr. Sampson's needs scale for institutional follow up testified that referral to past file entries for prior-admission "new" inmates would be "a good idea" as he would then be able to determine that inmates like Mr. Sampson had failed to accurately self-

disclose their past history of mental health and suicide issues. The May 2014 Institutional Mental Health Services Guidelines contain a reference to COMHISS, describing effective screening and assessment as a "key element of best practice in the provision of mental health services" (see exhibit 2, tab 6, section 2.0 page 10). The referenced Guidelines section, entitled "Mental Health Screening at Intake" actually states that the "objectives of COMHISS are to provide early identification of offenders who are exhibiting signs or symptoms that may be associated with mental health problems and/or a mental disorder, in order to facilitate follow-up assessment and intervention; and the collection of **accurate** mental health data as a basis for the longer-term planning of CSC mental health care".

NON-COMPLIANCE FINDINGS

1. The Board of Investigation concluded that "the security patrols conducted by the Officer (sic) on the midnight shift were not of a quality to satisfy the policy objective of Commissioner's Directive 566-4, *Inmate Counts and Security Patrols and* Standing Order 566-4, *Inmate Counts and Security Patrols*, i.e. verify inmates are alive during counts and security patrols of accommodation areas." This was because the BOI had determined that the 0622 and 0642 hour rounds completed on the south side of E-range, where Sampson resided, "took only approximately twenty-one seconds and twenty-four seconds, respectively."

   The Board of Investigation also found that the security patrol/formal count, conducted by the two dayshift officers on the south side of E-range (where Mr. Sampson was being held) were not of a quality to satisfy the policy objective of Commissioner's Directive, 566-4, because the formal count of the south side of E-range had only been fifty-one seconds in duration. The BOI observed that during this count, one Correctional Officer had looked into the food slot of Sampson's cell and the second CO had "at best, gave (sic) only a cursory glance into the cell through the window that, as described to the Board, was fifty percent obscured from the bottom (to the upper) portion of the cell window". Presumably the BOI relied solely on the information imported by the two officers as the Report made no mention of interviewing the inmate food server in order to determine what degree of coverage he had perceived.

The inquiry was informed that SMI as a consequence of this compliance issue now requires Correctional Managers to perform a weekly "informal audit" of security video from each shift on the AS range.

2. The Board of Investigation found that Sampson obscured cell door window was in non-compliance with a Memo issued on March 2, 2009 on AS Unit Five which stated that "cell window coverings and obstructions on bed frames are not allowed. All window coverings and obstructions must be removed immediately. Staff must be able to have a clear visual… during all range patrols."

   SMI's Warden, in response to this finding, advised CSC's appropriate Assistant Commissioner that the memo referred to by the BOI had been distributed approximately four and one-half years before the incident and also that it was his/her opinion that the window obstruction "did not have impact on this incident." The basis for the latter conclusion is unknown to the inquest while the over four years time lapse reference seems to have been offered as an explanation respecting why the window covering had not been removed by staff as required. However, testimony received at the inquest confirmed that AS staff were aware of their obligation to remove window coverings notwithstanding the four and one-half year antiquity of the memo.

3. The Board of Investigation further found that the daily nursing checks completed in segregation, because they "were of 'seconds' in duration", did not meet the intent of Commissioner's Directive 709, *Administrative Segregation*, (November 9, 2007), paragraph 70(b). The Board noted that such directive required staff to "verbally interact with the inmate to determine if he or she has any health care needs". The BOI goes on to state that it was informed (presumably at the local report stage) that action has been taken to address this deficiency by SMI and that a unit meeting had been held where nursing staff was reminded that rounds must be of a duration to ensure that inmates are not suffering ill-effects from being in segregation and that follow up must occur if such ill-effects are suspected. The Inquiry also received evidence that SMI's Chief of Health Services circulated documentation, via electronic correspondence, to health care staff to remind them of their responsibilities with respect to Commissioner's Directive 709.

4. The Board of Investigation found that the Segregation Log (CSC-SCC 0218) pertaining to Sampson was not being maintained or fully filled out by staff in

accordance with Commissioner's Directive 709, *Administrative Segregation*, (November 9, 2007), paragraph 75. This CSC directive requires that all staff or persons seeing an AS inmate are required to sign a Segregation Log. The BOI determined that only the nurses completing the daily rounds had signed the Segregation Log, and that other staff that interacted with Sampson had not done so (i.e. his Parole Officer, a Clinical Social Worker and a Chaplain). In addition, the BOI expressed concern that the first Health Services Nurse to review Sampson, on November 11th, 2013, his admission date, had failed to complete the required "Health Concerns" section. The intake nurse's failure to fill in the Health Concerns section also appears to have been a breach of Commissioner's Directive 709, Administrative Segregation (November 9th, 2007) paragraph 70, which required that "the relevant section of the Segregation Log for each inmate be initialled by the Nurse".

The Inquiry learned that the purpose of the Segregation Log was to ensure sharing of vital inmate information amongst staff responsible for AS inmates' care while in segregation. The log is kept in the administrative area in order to ensure that it is always accessible to all staff for review. The Inquiry was informed that SMI's Warden, on November 14th, 2014, sent email direction to all staff reminding them of their obligation to comply with "paragraph 49" of Directive 709 (presumably paragraph 75 was repositioned to paragraph 49 after Mr. Sampson's death).

Mr. Flett

[73] The BOI filed its report on March 1st, 2016. The Report made no recommendations in reference to the subject matter of this Inquiry. It did, however, cite two "areas for improvement" which related to staff non-compliance issues and another area of improvement which was couched as a suggestion but almost verged on an overt recommendation:

1. The failure of appropriate mental health staff to file Treatment Progress Reports after twelve sessions as required by Chapter Four of the Psychological Services Manual. The inquest received testimony that subsequent to the issuance of the BOI Report, on April 15th, 2016, a memo was sent via email by the Chief of CSC Mental Health Services to all institutional mental health staff "as a reminder of the timeframe for the completion" of such reports.

2. The failure of staff to complete and file an Immediate Needs Checklist - Suicide Risk form and place Mr. Flett on High Suicide Watch as required by Commissioners Directive 843. Management of Inmate Self-Injuries and Suicidal Behaviour, paragraph 7(c) and 8 as they then were required that Mr. Flett be placed in a highly monitored special cell until a mental health professional was available to perform a proper assessment for suicide risk after Mr. Flett disclosed, several hours before his death, that he was thinking of killing himself. The Inquiry received testimony that the staff member, a Correctional Manager, was "spoken to" regarding this compliance issue in an effort to address this concern. The Inquiry also learned that this issue was also discussed at an Operations Meeting with other Correctional Managers present in order to provide them all with direction for possible similar future incidents situations.
3. The final area of improvement did not involve a rule or administrative policy non-compliance. It related to the Board's expression of opinion that both the cutting tool and the AED should have been retrieved simultaneously when "both are stored in close proximity to one another". This situation had presented in the Flett suicide scenario. The official Security Branch response to this possible improvement as filed by a CSC staffer at the Inquiry stated the following: "… even though the identified Area for Improvement might be best practise, its practicability may not be easily achieved given the uniqueness of all institutions across Correctional Service of Canada." It appears that the BOI suggestion for improvement did not provide any impetus for change of approach in this respect.

IX. ADMINISTRATIVE SEGREGATION CHANGES SINCE 2013

[74] Administrative segregation has changed since Mr. Sampson's death in November 2013. Many of these changes relate to CSC's Commissioner's Directive 709 ("CD 709") (see exhibit 2, tab 1). James Gonzo, a CSC Senior Project Officer for Segregation, in the Prairie Region, provided testimony with respect to the changes to administrative segregation policies and procedures CSC has implemented since November 2013.

[75] Mr. Gonzo described numerous changes that have been made with respect to the treatment of segregated inmates, the accountability with respect to inmates' admission into administrative segregation, and the periodic review of inmates' segregated status. The inquest learned that CSC has created the Segregation Assessment Tool ("SAT"), which is most often used by the Correctional Manager in charge of the Segregation Unit. The SAT is designed to help Correctional Managers determine if placement in segregation is recommended or not recommended for a given inmate. The SAT includes a review of case management, health, and mental health information and is to be completed prior to placement in segregation. The SAT also includes a risk assessment and requires the user to consider a variety of alternatives to administrative segregation to determine if any are reasonable under the circumstances (see exhibit 2, tab 2, Annex to Administration Segregation Guidelines).

[76] Upon placement in administrative segregation, a health professional, usually a nurse, still visits the inmate to discuss any health and mental health concerns the inmate may have. However, unlike in 2013, inmates with "serious mental illnesses with significant impairment," as assessed by a mental health professional, can no longer be placed in administrative segregation. Alternative placement for such inmates must be found. This policy applies equally to inmates at an elevated or imminent risk for suicide or inmates who are actively engaging in self-injury which is deemed likely to result in serious bodily harm (see exhibit 2, tab 1(b)).

[77] Inmates like Mr. Flett, who have been identified by the Institutional Head or a health care professional as requiring an enhanced level of observation due to a serious mental illness with significant impairment or a risk for suicide or self-injury, may now be placed on Mental Health Monitoring. The frequency of monitoring is determined by a health care professional (see exhibit 12(b), Interventions to Preserve

Life and Prevent Serious Bodily Harm). There is no longer a requirement that an inmate presenting a suicide risk be placed in a suicide observation cell. The action taken by the Duty Corrections Manager on the night of Mr. Flett's suicide would therefore now be compliant with CSC policy.

[78] For inmates with health or mental health concerns that do not preclude their placement in segregation, practices have purportedly now been implemented to ensure that CSC staff record and have access to the information they need to know in order to enable staff to manage an inmate's mental health concerns while in administrative segregation. Every day, anyone who comes in contact with a segregated inmate, including the Warden, Parole Officers, Correctional Managers, Correctional Officers, and physical/mental health professionals, must comment in the segregation log, as opposed to simply marking their signature as was previously the case. For physical and mental health professionals, this includes noting any concerns regarding an inmate's mental health. Correctional Managers and Correctional Officers on the Segregation Unit can, according to Mr. Gonzo, access the segregation log to check any concerns referenced to inmate's mental health.

[79] According to Mr. Gonzo, an Institutional Head, usually the Warden, is now required to personally visit every segregated inmate once daily, except weekends and holidays, to ensure that the conditions of their confinement are appropriate. On weekends and holidays, the officer in charge of the institution must also visit segregated inmates for this same purpose (see exhibit 2, tab 1(b), para. 8(g)).

[80] As well, upon entry into administrative segregation, all inmates are to be informed without delay of their right to counsel as well as their right to engage an advocate to assist with the segregation review process. They are also advised of their right to contact various organizations for assistance, including but not limited to the John Howard Society (see exhibit 2, tab 1(b), para. 33).

[81] As was the case in 2013, CD 709 still requires that a Segregation Review Board ("SRB") conduct a hearing within five working days after an inmate's admission into administrative segregation (the "fifth working day review"). However, unlike 2013, all fifth working day reviews now require the input of a mental health professional, even if the inmate refuses to participate in the fifth working day review process (see exhibit 2, tab 1(b), para. 44). After the hearing, the SRB must make its recommendation (see exhibit 2, tab 1(b), para. 9). The Deputy

Warden, is now the designated chairperson of fifth working day SRBs (see exhibit 2, tab 1(b), para. 9).

[82] If the decision is made to maintain an inmate's segregated status past the fifth day working review, a reintegration plan must now be created and implemented within ten days. The reintegration plan includes what CSC and the inmate plan to do in order to get the inmate out of segregation, and may include input from case management, healthcare, psychology, elders, chaplains, or anyone else who can assist (see exhibit 2, tab 1(b), para. 46).

[83] Regional Segregation Review Boards ("RSRB") must now review the case of every inmate who reaches thirty days of administrative segregation and must review each case once every thirty days thereafter. In 2013, the RSRB reviewed each case only every sixty days. Now, the Regional Deputy Commissioner must review the RSRB's recommendation within two days, but no later than forty calendar days after an inmate was placed in segregation (see exhibit 2, tab 1(b), para. 64 and 65).

[84] Since 2013, CSC has also created a national long-term Segregation Review Committee (the "National Committee"). The National Committee reviews all segregated inmates' files after the first sixty days, and every thirty days thereafter. The National Committee must determine whether an inmate should be released from or maintained in administrative segregation. The National Committee is empowered to create plans for cases that do not yet have a plan to resolve the segregation placement. It is also mandated to identify any roadblocks to implementing the plan, and ensure the mental health of an offender is being monitored and addressed when concerns are identified. The National Committee must also review the case of every inmate who has had four placements in administrative segregation in a calendar year or ninety cumulative days during such a time frame (see exhibit 2, tab 1(b), paras. 66-69).

[85] Both the RSRB and the National Committee are also now required to consider an inmate's Indigenous social history, gender, and mental and physical health in determining whether he or she should be released from or maintained in administrative segregation (see exhibit 2, tab 1(b), paras. 65(b) and 68(c)).

[86] The inquest also learned that CSC has mandated an increased focus on policy compliance with respect to the treatment of segregated inmates. For instance, CD 709 provides for immediate reporting of policy non-compliance, bi-weekly reporting

to CSC's Commissioner, and various other frequent and periodic reporting and tracking of non-compliance throughout the year (see exhibit 2, tab 1(b), paras. 12 to 18).

[87] Another CSC witness, Mr. Lee Vandenbrock further advised that the process for transferring inmates out of administrative segregation has also been streamlined since 2013, as has CSC's physical infrastructure in Manitoba. Inmates in administrative segregation who require mental health services may now be expeditiously transferred to the MHR or to other locations where moderate intensity intermediate mental health care is provided.

[88] Mr. Gonzo testified that although the process of physically transferring an inmate within the region still takes approximately thirty days, the transfer decision-making process has changed to speed-up those inmates in administrative segregation that require a transfer to alleviate segregation. Mr. Gonzo related that, for transfers within a region, it used to be the "receiving" institution that was the decision-maker, causing the consultation process to be sometimes lengthy. Mr. Gonzo related that for expedition purposes, it is now the Warden of the "sending" institution that is the decision maker for intra-regional transfers.

[89] Mr. Vandenbrock related that SMI now has a maximum-security unit and that movement from administrative segregation to such maximum-security unit usually takes no more than two or three days after security reclassification is completed.

[90] The inquest also learned that the conditions of confinement for segregated inmates have reportedly improved since 2013. In particular, segregated inmates are now provided with more time outside of their cell each day. Until August of 2017, segregated inmates were offered one hour of exercise each day and one shower every other day. Now, segregated inmates are offered two hours outside of their cell each day, which can include outdoor exercise activities, time on the range, and time participating in programming. Inmates are apparently also offered a shower every day in addition to the two hours they are permitted outside their cell (see exhibit 2, tab 1, para. 39).

[91] Segregated inmates must also now receive their personal property more quickly. In 2013, a segregated inmate's personal belongings were supposed to be moved from their normal cell to their segregated cell within three days of the fifth working day review. This meant that, accounting for weekends, it may have taken

up to ten days for a segregated inmate to receive their personal possessions. Now, CD 709 requires that immediately upon admission into administrative segregation, an inmate is given personal property items related to hygiene, religion, spirituality, medical care and non-electric personal items. All remaining personal items are to be provided to the inmate within twenty-four hours after admission into administrative segregation, subject to any specific safety and security concerns (see exhibit 2, tab 1, para. 39).

X. RECOMMENDATIONS

Mr. Sampson

[92] The John Howard Society is a non-profit organization with a long and reputable history of commitment to and involvement relating to issues of Canadian criminal justice. Their expertise is particularly recognized and respected with respect to matters pertaining to penal policy and convictions. This NGO also has a well deserved reputation for advocating evidence - based and humane approaches to incarceration, rehabilitation and crime reduction.

[93] The Canadian Mental Health Association is a venerable advocacy and education NGO that seeks to promote the mental health of all Canadians. It also supports the recovery of individuals who experience mental illnesses. CMHA is known to provide and support high quality services contending with these issues across our province as well as across our country.

[94] In order to assist me fully appreciate the scope of these parties' work and knowledge in their respective fields, I asked their mutual counsel to provide me with information about their governance, sources of financial and other supports as well as their spectrum of community programming and work. I was very impressed with the submissions provided on these various topics. So much so that I decided to share this information with the readers of this Inquest Report. As such, the materials in question have been attached as Appendix E hereto.

[95] The Inquiry is of the view that both of the aforementioned interveners are essentially fully qualified experts in their chosen fields of endeavour and as such their views should be accorded significant deference. For this reason I have decided to attach the entire forty-seven page brief submitted by John Howard and CMHA. Suffice it to say that the conclusions and recommendations outlined in this joint brief deserve serious consideration by CSC as same pertains to specialized knowledge and experience possessed by the interveners and their witnesses; specialized knowledge and experience which a person of my background as judge and lawyer, does not possess. Accordingly, I attach the entire written submission as Appendix F to this report and commend its contents to appropriate staff of CSC.

[96] The Inquiry also suggests that in the future CSC give consideration to providing full and timely published reasons with respect to any BOI

recommendation or general improvement suggestions that it has failed to fully implement.

Mr. Flett

[97] As previously mentioned, the CSC policy in place at the time of Mr. Flett's death required that he be immediately placed into high suicide watch i.e. visual observation, if no mental health professional was available to immediately assess him, something that did not happen. The non-compliance with CD 843 was communicated to staff involved as a corrective measure (exhibit 12, page 2).

[98] CSC issued a new version of CD 843 on August 1st, 2017. This new policy granted CSC staff a measure of discretion similar to what was non-compliantly exercised by employees at the time of Mr. Flett's death. High or Modified Watch, which entail constant observation are now only used as a "last resort", to adopt the phrase employed by CSC counsel in his final submissions. All reasonable efforts to use less restrictive measures and de-escalation strategies must first be considered and assessed as **not effective** (see exhibit 2, tab 12B, paras. 8-11) prior to High or Modified Watch implementation.

[99] CSC counsel argued that the conferral of such discretion to employees was in CSC's opinion "appropriate" and reminded the Inquiry that in May of 2015, the SLR range where Mr. Flett had been placed at the time of his death was "overhauled" to better care for inmates who require "moderate intensity intermediate" mental health care. Moderate intensity intermediate mental health care being meant for inmates with "serious mental illness" and "moderate impairment" that does not require twenty-four hour care (see exhibit 2, tab 6D, Integrated Mental Health Guidelines, June 26, 2017). Of course, inmates, notwithstanding their mental health issues, must fully consent to being placed on this range, now re-named the Mental Health Range (MHR).

[100] The Inquiry learned, from two employee witnesses, C.O.s Stott and Beatty, who had been present on the SLR the night of Mr. Flett's death, that notwithstanding the new policy sanctioning the less interventive approach taken by staff, that MHR inmates as well as other inmates in the institution, are now placed on full suicide observation immediately if they threaten self-harm, and are not released therefrom until they have been fully assessed by a mental health professional. This approach does not appear to be a ringing endorsement of CSC's new relaxed version of CD

843. Indeed, the new policy change, because it provides for lower levels of monitoring, would seemingly result in suicidal inmates being more likely to be able to commit suicide as its relaxed provisions authorize the very situation in which Mr. Flett's suicide occurred (see p. 3, line 15, March 8th, 2018). For this reason, the Inquiry is of the view that SMI correctional staff should be commended for their augmented vigilance in relation to CSC's most recent iteration of CD 843.

[101] The Inquiry also suggests that in the future CSC give consideration to providing full and timely published reasons with respect to any BOI recommendations or general improvement suggestions that it has failed to fully implement.

I respectfully conclude and submit this Report on this 31st day of August, 2018, at the City of Winnipeg, in the Province of Manitoba.

"Original signed by:"
Judge Brian Corrin