# OCME Investigation Report

into the

# OCME Body Storage Capacity Incident and Decedent Transfer Incident

by

Don Smallwood, Investigator

October 25, 2019

# Table of Contents

*Executive Summary*

On September 5, 2019, the Edmonton Office of the Chief Medical Examiner (OCME) reached its body storage capacity for decedents (Incident #1). Dr. Elizabeth Brooks-Lim, the Chief Medical Examiner (CME), had a refrigerated trailer placed near the OCME office on September 6, 2019 and 17 decedents were moved into the trailer. On September 9, 2019 a CBC film crew recorded a decedent being removed from the trailer in an inappropriate and disrespectful manner, as the decedent was slid across the floor of the trailer on his back and onto a raised gurney, while open to public view (Incident #2).

At the request of the Assistant Deputy Minister of Justice Services Division, I have conducted an operational review of these incidents, to determine what happened, and why. During my investigation, I reviewed numerous background materials and documents and I interviewed several people for their perspectives. I also analyzed data from OCME's information database regarding the admission and release of decedents.

A summary of my findings for each of the five questions asked in my mandate follows.

1. What is government's version of what transpired during the incident in question?

   Regarding OCME reaching its body storage capacity on September 5, 2019, information from the information database showed that this arose primarily from a surge in incoming decedents. For the week starting September 2, 2019 (Week 36) there were 55 new decedents received; the highest number of any week in 2019. The incoming number of decedents was especially high on Wednesday and Thursday of Week 36, when OCME received 12 and 15 decedents respectively.

   Contributing factors to the body storage capacity being reached may have included understaffing in the Edmonton Investigation Unit, ongoing delays in hiring new Investigators, fatigue within the Unit, a consolidation of operational processes and leadership that had not yet been fully optimized, and several OCME staff were in Acting roles at the time of the incidents.

   When body storage capacity was reached, a refrigerated trailer was obtained to provide additional storage space for decedents until room could be made in the morgue. In effect, the trailer was setup as one continuous gurney/body storage rack and a diagram was created showing the placement and identify of each decedent. Decedents were in a clean, secured and 24/7 monitored space, maintained at proper temperature. Decedents were separated from each other, each was properly identified, and room was left for attendants to manoeuvre in the middle portion of the trailer. However, the positioning of the trailer, coupled with the initial lack of privacy screening, left the back end of the trailer exposed to passers-by on Belgravia Road and beyond.

   Use of a refrigerated trailer was in accordance with the Mass Fatality Plan and was previously identified as the default (albeit imperfect) option for additional body storage, as bodies cannot be put on the floor or ground, nor can they be turned

away by OCME. OCME is currently acquiring additional body storage racks for its Edmonton and Calgary morgues, to reduce the likelihood of requiring a trailer for operational needs in the future.

As this is the first time OCME acquired a refrigerated trailer, several improvements are being made to plans, policies and procedures. OCME should also consider leaving permanent privacy screening in place, so a decedent's privacy is better protected when being placed into or removed from the trailer, should one be required again in the future.

Regarding the disrespectful removal of a decedent from the trailer on September 9, 2019, the CBC video clearly showed a decedent being moved by a Calgary funeral home employee in a manner that was unprofessional and contrary to standard operating procedures of the OCME and the Alberta Funeral Services Association (AFSA). My investigation found that the decedent shown in the CBC video was the only decedent in the trailer that was moved in an unprofessional or inappropriate manner.

Following this incident, both the CME and the funeral home operator in Calgary promptly undertook steps to ensure it did not happen again. My investigation found that sliding a decedent on his back was a one-time incident by someone outside of OCME. The CME, who had conducted the initial examination of the decedent, re-examined the decedent on Friday, September 13, 2019. After this re-examination, the CME stated she did not see any damage to the decedent, due to sliding the decedent across the trailer floor.

On Saturday, September 14, 2019, the CME and the Operations Manager of the Calgary funeral home met with the decedent's brother in Calgary. They both apologized for the manner in which the decedent was removed from the trailer and answered several questions from his brother, none of which related to his brother's removal from the trailer. The CME also provided the decedent's brother with her contact information, should he have any further questions. As of October 9, 2019, the CME had received no further questions from the decedent's brother.

In her communications and instructions to others, the CME consistently directed that decedents be treated and handled in a professional and respectful manner. OCME's policies, practices, communications, and culture regarding the professional and respectful treatment of decedents has been, and remains, of foremost importance to OCME management and staff.

2. What relevant policies or instructions were in place at the time of the incident?

At the time of the incidents on September 5, 2019 (reaching its body storage capacity) and September 9, 2019 (the disrespectful removal of a decedent from the trailer), there were numerous plans, policies or instructions in place, as referenced in the Investigation Approach section of this document. These included standard operating procedures on the release of a decedent and specific

instructions provided to funeral homes regarding the removal of a decedent from the refrigerated trailer at OCME. I have reviewed each of these, and information was consistent within and between them.

3. Do the existing policies or instructions address the present situation so that any reoccurrence is unlikely?

   Existing policies, procedures and plans covered the body storage capacity issue, and they were followed by OCME during the incidents on September 5, 2019 and September 9, 2019.

   While improvements to each of these policies, procedures and plans are being made, they will not guarantee that another body storage capacity event will not happen again, or that a refrigerated trailer will not be required again for operational purposes, as OCME has no control over how many decedents it may receive in any given period. However, acquiring additional body storage racks should greatly diminish the likelihood of requiring a trailer in the future.

   As for the funeral home employee sliding a decedent on his back in the trailer, my investigation found that this was a one-time incident by someone outside of OCME. It would be useful for OCME to develop an additional standard operating procedure and/or expand existing standard operating procedures regarding the "do's and don'ts" of professional and respectful handing of a decedent, as formalizing these practices in writing would better codify the professional practices already followed at OCME.

4. What was the OCME contingency plan for excess storage capacity in place at the time of this incident?

   The Mass Fatality Plan dated November 4, 2016 was the plan referenced by the CME at the time of the body storage capacity incident on September 5, 2019. This plan states in point 11 on page 5 of the plan, as well as in point 5b on page 7 of the plan, that OCME is responsible for the establishment of temporary morgue/cold storage facilities if required, and it specifically notes the use of refrigeration trucks [trailers].

5. Does the contingency plan address the present situation so that any reoccurrence is unlikely?

   The Mass Fatality Plan addressed OCME's situation of reaching its body storage capacity generally, but further details should be added to this plan and/or standard operating procedures to clarify the use of refrigerated trailers and how they should be equipped, setup, and protected from public view. As was requested by the CME, a ramp and interior lighting should have been provided when the trailer was setup on Friday, September 6, 2019. Privacy screening should also have been in place, to better protect the dignity of decedents as they were placed into or removed from the trailer.

Regarding any reoccurrence of a decedent being handled disrespectfully, policies, procedures and directions to funeral homes in the future should be more explicit that funeral home staff will not be permitted access to the trailer if they do not arrive with the proper number of employees. It should also be made clearer to OCME staff that if a funeral home only sends one employee when two are required, OCME employees are empowered, and obligated, to refuse access to the trailer for removal of a decedent.

I received a prompt and thorough response from all OCME management and staff that I spoke to during this investigation, as well as from the Operations Manager of the Calgary funeral home. I thanked all of those I spoke with for their willingness to cooperate and to promptly provide all requested information for my investigation.

## ***Context of OCME Body Storage Capacity (Incident #1)***

On Thursday, September 5, 2019, the Edmonton Office of the Chief Medical Examiner (OCME) reached its capacity for the storage of decedents. OCME management was made aware of this at approximately 8:00 a.m. on that date and Dr. Elizabeth Brooks-Lim, the Chief Medical Examiner (CME), had a refrigerated trailer placed near the OCME office on Friday, September 6, 2019. Seventeen decedents were moved into the trailer the same day, to provide temporary body storage capacity and allow for continued OCME operations.

## ***Context of Decedent Transfer (Incident #2)***

On Monday, September 9, 2019 at approximately 10:40 a.m., a CBC film crew recorded a decedent being removed from the trailer in an inappropriate and disrespectful manner, as the decedent was slid across the floor of the trailer on his back and onto a raised gurney, while open to public view. CBC released that video in a news story on or about September 10, 2019.

## ***Mandate for Investigation***

I was provided with a mandate for my investigation on Wednesday, September 11, 2019 by David Peace, the Assistant Deputy Minister (ADM) of Justice Services Division (JSD), Justice and Solicitor General (JSG). In this mandate, the scope of my investigation was limited to an operational review, based on the following questions:

1. What is government's version of what transpired during the incident in question?

2. What relevant policies or instructions were in place at the time of the incident?

3. Do the existing policies or instructions address the present situation so that any reoccurrence is unlikely?

4. What was the OCME contingency plan for excess storage capacity in place at the time of this incident?

5. Does the contingency plan address the present situation so that any reoccurrence is unlikely?

## ***Declaration of Perceived Conflict of Interest***

I declare that the CME and I both report to the same person.

I also declare that I do not have a personal or professional conflict of interest in investigating this matter, or any personal or professional gain in any way from its findings. I have been given free reign to review whatever material I wish, interview whomever I wish, and write whatever I wish in my investigation report, and I have done so to the best of my ability, without any interference or influence by others.

## ***Investigation Approach***

In undertaking my investigation, I reviewed numerous background materials, such as the *Fatality Inquiries Act* (*FIA*) dated February 1, 2019; Mass Fatality Plans dated November 4, 2016 and September 1, 2019; OCME Body Release Protocols and standard operating procedures; OCME organization charts, and several OCME position descriptions.

I also reviewed data from OCME's information database showing admissions and releases for each day in 2019; an email alerting the CME that OCME had reached its body storage capacity; the CME's email response to OCME staff; and a layout diagram of how decedents were placed in the refrigerated trailer. In addition, I reviewed the CBC video of the incident on September 9, 2019 and CCTV recordings of the same incident, from different cameras.

Finally, I interviewed several people, to discuss what had happened (who, what, when, where, and why), from their perspectives. Interviews included the CME (Dr. Elizabeth Brooks-Lim); the Deputy CME (Dr. Enrico Risso); the Director, Operational Services; the Acting Team Lead of Morgue Technicians shown in the CBC video; and the Operations Manager of the Calgary funeral home.

## ***Investigation Findings***

1. What is government's version of what transpired during the incident in question?

    *Background Information*

    Deaths in Alberta can occur anywhere, including at home, in a hospital or nursing home, at an accident scene, at a crime scene, etc.. In some cases, a residing Physician can sign the death certificate and release the decedent to a funeral home, while in many cases, only OCME has that authority, under the *Fatality Inquiries Act* (FIA) and only an OCME medical examiner can certify an unnatural death in Alberta.

    Part 2 of the FIA identifies a wide range of deaths which OCME must investigate, including deaths that occur unexplainedly; deaths that occur unexpectedly when the decedent was in apparent good health; deaths occurring as a result of violence, accident or suicide, etc. For deaths under Part 2 of the FIA, OCME must accept the decedent and carry out examinations and responsibilities described in the FIA.

    The Edmonton OCME office has 32 gurneys used for body storage within its main coolers, as well as two storage body racks in a separate cooler that have four body trays each, thereby allowing for a maximum body capacity of 40 decedents, with one decedent on each gurney/body storage tray. Using the same calculation approach, the Calgary OCME office has capacity for 37 decedents. My investigation found that OCME is seldom, if ever, asked by next-of-kin where a decedent is stored while at OCME, only where a decedent can be viewed.

Based on OCME's responsibilities under the *Fatality Inquiries Act* (FIA), the CME's position is that OCME cannot refuse to accept a body, and that OCME is obligated to take custody of a decedent at the time they arrive. Under the FIA, OCME is obligated to secure the decedents as well as any possessions on them, in order to preserve the chain of evidence and the forensic integrity of its operations. The CME also stated that examinations need to be done on-site at OCME due to the infrastructure in place, it's secured premises, body cooling facilities, specialized testing equipment, and OCME's information database. In short, OCME must always find a place to store decedents until examinations can be completed and decedents are released and picked up.

OCME's policies and practices are that a decedent should never be placed on the ground or floor during operations, but rather, on a gurney or body tray, in order to respect the dignity of the decedent and to ensure the forensic integrity of its operations. OCME staff are also directed not to place a decedent on the floor or ground, or to lift a decedent from the floor or ground, for Occupational Health and Safety (OH&S) reasons. In the case of a Mass Fatality Incident (MFI), which may involve the deaths of dozens or evens hundreds of people at once, this would not be possible or realistic, but there was no MFI in this instance.

In her communications and instructions to others, the CME consistently directed that decedents be treated and handled in a professional and respectful manner. All materials I reviewed and interviews I conducted reflected that OCME treats decedents in their care with the utmost dignity and that this has been, and remains, a core part of OCME's policies, practices and culture.

*Decedent Volumes*

OCME undertakes approximately 4,000 post mortem examinations a year between both offices, with a slightly higher percentage occurring in Edmonton, so on average, Edmonton OCME receives 7-8 new decedents per work day. However, OCME has no control over when decedents may arrive and the actual number received each day can vary widely, from zero to over 20.

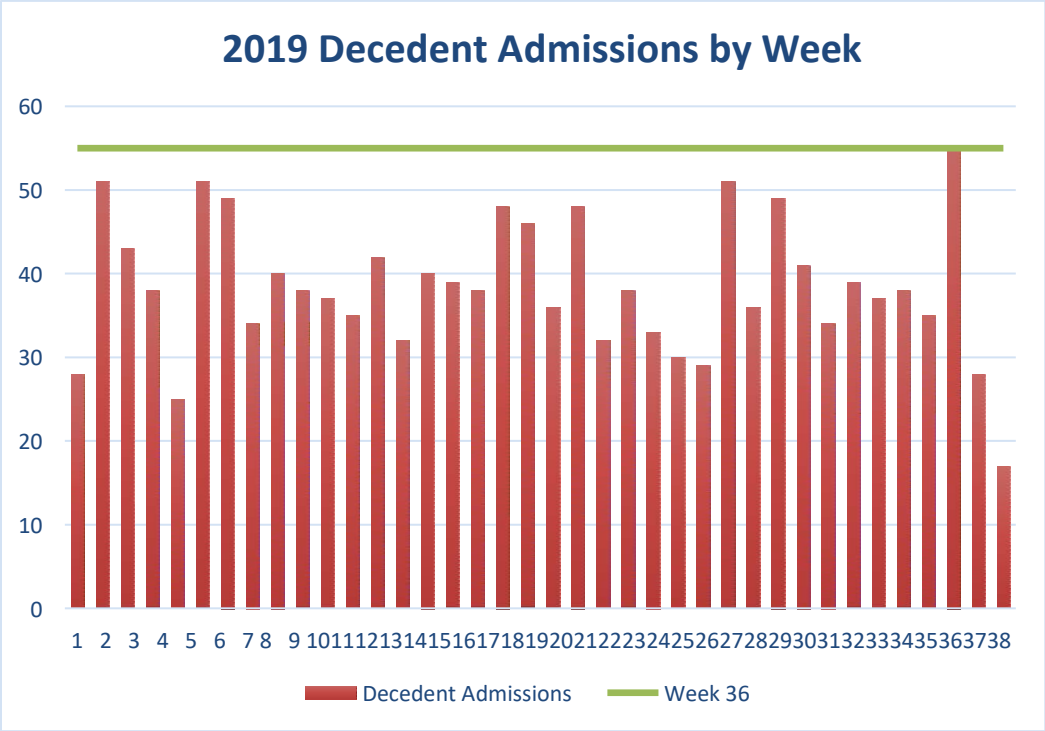
When received, decedents are examined promptly (between .2 and 1.0 days, on average), to maximize the integrity of examinations (autopsies). Once examinations are completed, a body release protocol is followed (requiring 1.7 to 3.4 days, on average) to release the decedent for pick up. Once notified, most funeral homes pick up decedents the same day.

I have examined data from OCME's information database, which records the number of decedents received and released by OCME daily, covering the period of January 1, 2019 (start of Week 1) through September 20, 2019 (end of Week 38).

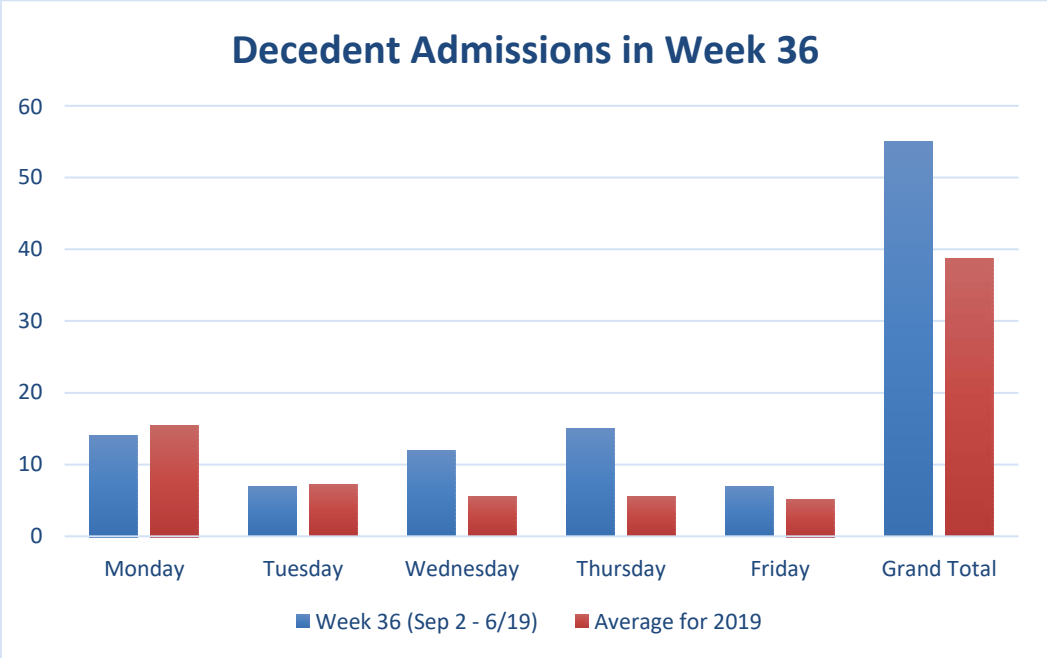
My observations on this data are:

- As shown in the graph below, a significantly higher than average number of

decedents were received in Week 36, which ran from Monday, September 2 through Friday, September 6, 2019 inclusive. In Week 36, 55 decedents were admitted, which was the highest number for any week in 2019 and 43 per cent over the average number of 38.4 decedents received per week in 2019, through the end of Week 38.




- The following graph shows additional detail on when decedents were admitted in Week 36, leading up to reaching body storage capacity on Thursday, September 5, 2019:



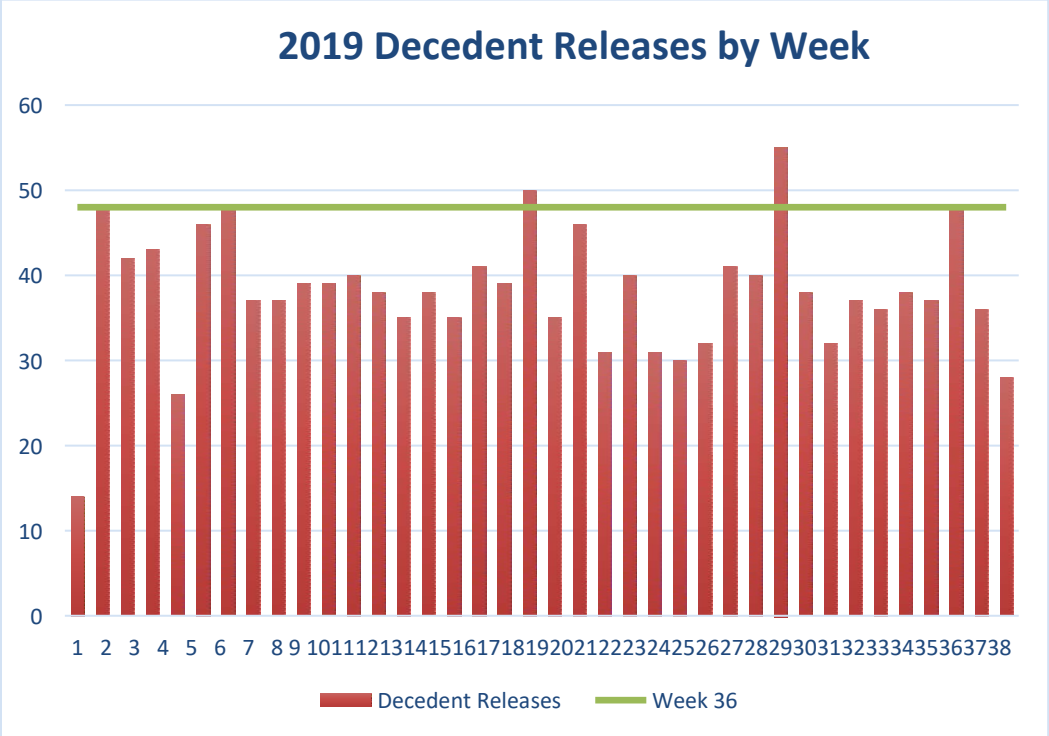
- Of the 55 decedents received in Week 36, 48 of them were received on Monday through Thursday – the day body storage capacity at OCME was reached. Fourteen decedents were received on Monday, which is slightly lower than the average of 15.5 decedents admitted on a Monday, and seven decedents were received on Tuesday, compared to the average of 7.2 for a Tuesday.

- On Wednesday, 12 decedents were received, which was 2.1 times the normal number of decedents (5.7) for a Wednesday, and on Thursday, 15 decedents were admitted, which was 2.8 times the normal number of decedents (5.4) for a Thursday.

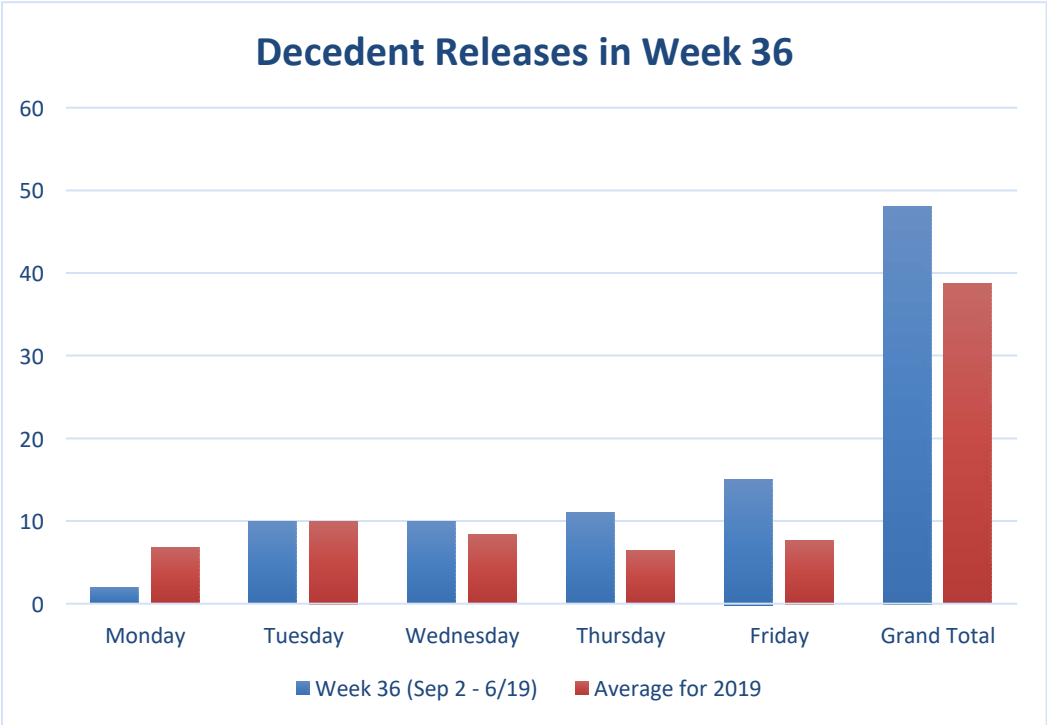
- On Monday, September 2, there were two decedents released (picked up), which is below the average of 6.8, but normal for a statutory holiday Monday.

- In Week 36, there were 10, 10, 11 and 15 decedents released on Tuesday through Friday respectively, compared to averages of 9.9, 8.2, 6.5 and 7.7 respectively for those days of the week in 2019.

- As shown in the graph below, in spite of Monday, September 2, 2019 being a statutory holiday, the total number of decedents released in Week 36 was 48. This was tied for the third highest number of decedents released in a week in 2019, and 26 per cent higher over the average of 38.1 decedents released per week in 2019, through the end of Week 38.



- The following graph shows additional detail on when decedents were released in Week 36, leading up to reaching body storage capacity on Thursday, September 5, 2019:




In summary, there were 48 decedents admitted from Monday, September 2, 2019 through Thursday, September 5, 2019; well above the average of 33.8. However, there were also 33 decedents released over those same four days, also above the average of 31.4.

Promptly notifying funeral homes and/or next-of-kin that a decedent is ready for pick up is a critical step in freeing up body storage space for incoming operational requirements. Given there were a higher number of decedents released on Tuesday and Wednesday of Week 36 than normal, statistical data from the OCME's information database for releases shows that a higher than average number of funeral homes and next-of-kin were being called to pick up decedents, prior to OCME reaching its body storage capacity on Thursday, September 5, 2019.

*Body Storage Capacity Reached*

On Thursday, September 5, 2019 at approximately 8:00 a.m., staff notified the CME that the body storage capacity of Edmonton OCME had been reached. OCME had never before encountered a situation in routine operations where it would have no place to put additional decedents, if they arrived.

Efforts were expedited to have those decedents ready for release picked up as-soon-as-possible, to free up body storage space, but some time was required to make those calls and for the already-examined decedents to be removed from OCME's premises. A refrigerated trailer was therefore obtained, as per the Mass

Fatality Plan, to provide additional storage space for decedents until room could be made in the morgue.

While not all funeral homes and/or next of kin had been notified prior to September 5, 2019 that decedents were ready for pick up, several operational factors may have contributed to this:

- The Edmonton Investigation Unit was understaffed in 2019 compared to their counterparts in the Calgary OCME office and were providing 24/7 services with only four staff for an extended period of time, which led to fatigue within the Unit.

- There were ongoing delays in hiring new Edmonton Investigators, due to budget constraints, a hiring pause, and new recruitment rules imposed by the Deputy Ministers' Human Resource Integration Committee (DMHRIC) formed in the Spring of 2019.

- While a decision was made on August 29, 2019 to consolidate the processes and leadership of Edmonton and Calgary Investigation Units, the operational implications of these changes had not yet been fully optimized.

- During 2019, there were numerous OCME staff in Acting roles, including during the week starting September 2, 2019, so there may have been some confusion as to who was monitoring the body storage capacity.

- Dr. Enrico Risso, the Deputy CME in Edmonton, was on vacation from August 27, 2019 through September 14, 2019 inclusive and was not available to help with the operational incidents that arose. The Director of Operations in Edmonton, was also on vacation from September 5, 2019 through September 11, 2019 inclusive and was not available to help with the operational incidents that arose.

*Response/Trailer Setup*

The CME made the decision to execute the most recently approved Mass Fatality Plan of November 4, 2016 and ordered that a refrigerated trailer be moved to the parking lot adjacent to the OCME building. My investigation showed that this was the first time the Mass Fatality Plan had been executed for these purposes.

The CME sent an email to OCME staff on Thursday, September 5, 2019 at 16:57 hours, in which she stated that OCME had reached its body storage capacity, and why. The CME stated that bodies cannot be put on the ground, nor can they be turned away. She went on to state that an emergency plan had been put into place, and described the elements of that plan, including that funeral homes were to send two staff to remove a decedent from the trailer and that OCME would not be able to move a body from the floor [of the trailer] for them. The CME described steps underway to obtain additional body storage racks in order to expand OCME's body storage capacity, and ended her email with a reminder of the importance of OCME's care for decedents and their families.

JSG arranged for the refrigerated trailer to be setup at the OCME site on the afternoon of Friday, September 6 and OCME used its contracted body transport vendor to move 17 decedents from the OCME morgue into the trailer. The CME stated the vendor followed its standard operating procedures for placing the decedents into the trailer, using their own equipment and a body lift, as a ramp was not yet in place.

In effect, the trailer was setup as one continuous gurney/body storage rack elevated four feet off the ground and a diagram was created showing the placement and identity of each decedent in the trailer. Decedents were placed around the interior perimeter (sides and front), such that each decedent was separated from the others, each was labelled on the outside of the body bag to identify the decedent, and the middle portion of the interior space was left open, for navigation purposes.

When the trailer arrived on September 6, the trailer was properly cooled to the required temperature, it was secured, a vehicle was parked at the front of the trailer to prevent an unauthorized move of the trailer, and security personnel were contracted to monitor the trailer 24/7.

When delivered on Friday, September 6, 2019, there were no interior lights in the trailer, no ramp to the rear of the trailer, and no privacy screening to protect the rear of the trailer from public view and help preserve the dignity of the decedents. The CME raised these concerns on September 6, 2019 and was informed that her requests would be looked after, but no work was completed over the weekend and these requests were not resolved prior to the CBC video on the morning of Monday, September 9, 2019.

The placement of the trailer allowed the truck hauling the trailer to back in, it left room for an approximately 30 foot long ramp at the rear of the trailer, and it allowed continued access to loading bay doors at OCME. Unfortunately, it also left the back end of the trailer exposed to passers-by on Belgravia Road and beyond.

Several debriefs occurred between OCME management and its morgue staff on September 9, 2019 to identify and implement immediate process improvements, which addressed the absence of a ramp and interior lighting, the need for privacy screening around the trailer, and dealing with the incident where only one funeral home employee was dispatched, when two were requested. The ramp and privacy screening was installed on September 10, 2019, and additional lighting was provided on September 11, 2019. The CME also distributed a letter on September 10, 2019 to the Alberta Funeral Services Association (AFSA) and contracted body transport companies confirming in writing that two people were to be sent to remove a decedent from the trailer.

Subsequent to September 6, 2019 there were no further decedents added to the trailer, and those in the trailer were released for pick up as-soon-as-possible. All decedents in the trailer were picked up and both the trailer and the privacy screening around the trailer were removed from OCME's site on September 18,

2019.

As this is the first time the Mass Fatality Plan has been executed by OCME and the first time a refrigerated trailer was acquired for its use, there are certainly operational improvements that can be made, and which should be reflected in updated plans, policies and procedures.

If a refrigerated trailer is required in the future, lighting and ramps should come with the trailer, but privacy screening may be more difficult to put into place quickly, due to the size of the structure. OCME should consider leaving permanent privacy screening in place, so a decedent's privacy is better protected in the future if a trailer is acquired, including when initially placing decedents into the trailer.

*CBC Video and Media*

On Monday, September 9, 2019 at approximately 10:40 a.m. the first decedent was removed from the trailer and a CBC film crew recorded that event, which was later released on CBC News. The CBC video was taken from the north side of Belgravia Road, looking directly in the rear of the trailer, at which time both doors to the trailer were open. The video ran for one minute and consisted of several, separate segments of video, so it did not display a continuous image of events in the trailer.

The CBC video showed a segment several seconds long of someone (a Calgary funeral home employee) holding onto the bottom end of a body bag and sliding a decedent on his back in the trailer, and another segment several seconds long of the funeral home employee and OCME employee jointly lifting and sliding the decedent onto a raised gurney at the rear of the trailer. The video, which can be viewed at CBC Video of OCME shows cars driving by in the foreground, as the rear of the trailer was exposed to the nearby street, Belgravia Road.

I viewed the CBC video several times, to discern who was present and what happened. I also reviewed numerous media comments regarding the video, in which most commentators objected to the manner in which the funeral home employee was sliding the decedent on the floor of the trailer, and that contents and events in the trailer were visible to the public.

There were CCTV video cameras in the vicinity and I reviewed video from each of these, to assist with my understanding of what happened. The CCTV cameras showed views which included an angle of events at the rear of the trailer. I confirmed that all CCTV cameras were working properly and that they were properly synchronized with each other. There were no CCTV cameras that gave a direct view into the rear of the trailer, but I have no reason to believe that events recorded on the CBC video inside the trailer did not happen, as shown on the CBC video.

CCTV cameras showed that the funeral home employee arrived at approximately

10:20 a.m. on Monday, September 9, 2019 and that he left OCME premises approximately 34 minutes later, at 10:54 a.m.. He backed his van into the first loading bay and the decedent was loaded into his van at approximately 10:45 a.m., after all loading bay doors were closed. To put context to the CBC video, the funeral home employee and OCME employee can be seen sliding the decedent onto the raised gurney at the rear of the trailer at 10:42:30 a.m. in the CCTV video.

The decedent pick up recorded by CBC was unique, in that it was the first pick up ever conducted from a trailer at OCME. Further, it entailed a different pick up procedure, as a decedent would normally be brought out to the funeral home employee for loading in OCME's loading bay, rather than having the funeral home employee have to locate and then pick up a decedent, as happened in this case.

The Morgue Technician shown in the CBC video had approximately four years of experience with OCME and was Acting Team Lead of the Morgue Unit at the time of the incident on September 9, 2019. He was the right person to oversee the pick up, and he followed standard operating procedures for his part in the pick up, which was to oversee the pick up and help transfer the decedent onto the gurney, but not help lift the decedent. In this case, he also helped identify the decedent for pick up, as there were numerous other decedents in the trailer.

The Morgue Technician brought a hydraulic-lift gurney to the rear of the trailer, which he raised to the same level as the floor of the trailer. His part in helping slide the decedent onto the raised gurney was similar to the process followed for decedents in the morgue and compliant with standard operating procedures; the only difference being it was an end-slide rather than a side-slide, due to the logistics of the trailer.

The Morgue Technician also brought a metal tray for moving the decedent within the trailer. The Morgue Technician stated that he offered the funeral home employee the metal tray for use inside the trailer to lift the decedent onto, but that the funeral home employee refused this offer.

The Morgue Technician also stated that he directed the funeral home employee not to move the decedent by himself but the funeral home employee refused this instruction and proceeded to move the decedent by himself. The challenge the Morgue Technician had in the moment was understanding his authority to stop the funeral home employee from proceeding with the pick up, as he was in a unique situation he had never encountered before and it transpired within a few seconds.

The Operations Manager of the Calgary funeral home confirmed that they had received direction from OCME to send two employees to pick up the decedent, but had not done so due to the distance and cost. The Operations Manager also stated that their employee should not have moved the decedent on his own, as he had been instructed to have a colleague from an Edmonton funeral home help him.

I note that there is no audio recording of what was actually said by the parties at the time the decedent was moved in the trailer. Regardless of who said what, the CBC video clearly showed the decedent being moved by the funeral home employee in a manner that was unprofessional, inappropriate, and contrary to standard operating procedures of the OCME and the AFSA. My investigation found that the decedent shown in the CBC video was the only decedent that was moved in an unprofessional or inappropriate manner.

The OCME Morgue Technician promptly reported his concerns to the CME about how the decedent was removed from the trailer. However, this did not occur until the following day, as the CME was in court for part of September 9, 2019 and was not available until then.

*Response Following the CBC Video Release*

Following release of the CBC video, both the CME and the Operations Manager in the Calgary funeral home commenced internal investigations as to what had happened and why, and both promptly undertook steps to ensure that disrespectful treatment of a decedent did not happen again. These steps included the CME sending a letter to the AFSA and body transport companies on Tuesday, September 10, 2019 that bringing two staff was a requirement for removal of decedents from the trailer, and directing OCME staff to refuse access to the trailer if funeral homes did not do so.

On Friday, September 13, 2019 the CME met with the Operations Manager of the funeral home in Calgary, who confirmed that they had received instructions from OCME to send two employees for the pick up, but had decided to send only one. The funeral home employee was directed by funeral home management to assess the situation once he got to the trailer, and to seek the assistance of another Edmonton-based funeral home employee to move the decedent. For reasons unknown, the funeral home employee elected to ignore this direction from his employer and move the decedent on his own.

In her email of September 5, 2019 to staff, the CME noted that 18 new decedents had arrived overnight, while the information database indicated that 15 new decedents had arrived overnight. Regardless of the actual number, the CME stated that in her capacity as a Forensic Pathologist on service, she personally examined nine of the decedents that had arrived overnight, including the decedent removed from the trailer in the CBC video. At the request of the Calgary funeral home, the CME re- examined the decedent on Friday, September 13, 2019. After this re-examination, the CME stated she did not see any damage to the decedent, due to sliding the decedent across the trailer floor.

On Saturday, September 14, 2019, the CME and the Operations Manager of the Calgary funeral home met with the decedent's brother in Calgary. The CME and Operations Manager from the Calgary funeral home both stated that they apologized for the manner in which the decedent was removed from the trailer and answered several questions from his brother, none of which related to the

manner in which his brother was removed from the trailer. The CME provided the decedent's brother with her contact information, should he have any further questions. As of October 9, 2019, the CME had received no further questions from the decedent's brother.

A request to acquire additional body storage racks has been on the OCME capital- planning list for the last two fiscal years. Six additional body storage racks (each holding four decedents) are currently being acquired for the Edmonton OCME office and two more body storage racks (each holding four decedents) are currently being acquired for the Calgary OCME office.

2. What relevant policies or instructions were in place at the time of the incident?

   At the time of the incidents on September 5, 2019 (reaching its body storage capacity) and September 9, 2019 (the disrespectful removal of a decedent from the trailer), there were numerous plans, policies or instructions in place, as referenced in the Investigation Approach section of this document. These included standard operating procedures on the release of a decedent and specific instructions provided to funeral homes regarding the removal of a decedent from the refrigerated trailer at OCME. I have reviewed each of these, and information was consistent within and between them.

3. Do the existing policies or instructions address the present situation so that any reoccurrence is unlikely?

   Existing policies, procedures and plans covered the body storage capacity issue, and they were followed by OCME during the incidents on September 5, 2019 and September 9, 2019.

   While improvements to each of these policies, procedures and plans are being made, they will not guarantee that another body storage capacity event will not happen again, or that a refrigerated trailer will not be required again for operational purposes, as OCME has no control over how many decedents it may receive in any given period. However, acquiring additional body storage racks should greatly diminish the likelihood of requiring a trailer in the future.

   As for the funeral home employee sliding a decedent on his back in the trailer, my investigation found that this was a one-time incident by someone outside of OCME.

   It would be useful for OCME to develop an additional standard operating procedure and/or expand existing standard operating procedures regarding the "do's and don'ts" of professional and respectful handing of a decedent, as formalizing these practices in writing would better codify the professional practices already followed at OCME.

4. What was the OCME contingency plan for excess storage capacity in place at the time of this incident?

   The Mass Fatality Plan dated November 4, 2016 was the plan referenced by the CME at the time of the body storage capacity incident on September 5, 2019. This plan states in point 11 on page 5 of the plan, as well as in point 5b on page 7 of the plan, that OCME is responsible for the establishment of temporary morgue/cold storage facilities if required, and it specifically notes the use of refrigeration trucks [trailers].

   The Mass Fatality Plan dated September 1, 2019 (which was not yet approved on September 5, 2019) also states in section 4.3 that that OCME continues to be responsible for the establishment of temporary morgue/cold storage facilities if required, and it specifically notes the use of refrigeration trucks [trailers].

5. Does the contingency plan address the present situation so that any reoccurrence is unlikely?

   The Mass Fatality Plan addressed OCME's situation of reaching its body storage capacity generally, but further details should be added to this plan and/or standard operating procedures to clarify the use of refrigerated trailers and how they should be equipped, setup, and protected from public view. As was requested by the CME, a ramp and interior lighting should have been provided when the trailer was setup on Friday, September 6, 2019. Privacy screening should also have been in place, to better protect the dignity of decedents as they were placed into or removed from the trailer.

   Regarding any reoccurrence of a decedent being handled disrespectfully, policies, procedures and directions to funeral homes in the future should be more explicit that funeral home staff will not be permitted access to the trailer if they do not arrive with the proper number of employees. It should also be made clearer to OCME staff that if a funeral home only sends one employee when two are required, OCME employees are empowered, and obligated, to refuse access to the trailer for removal of a decedent.

***Conclusions***

- The CME's position that a body can not be refused when it arrives at OCME is a reasonable interpretation of the FIA and consistent with the need to preserve evidence, protect the forensic integrity of operations, and utilize OCME's facilities, equipment and supporting infrastructure and systems to properly conduct their duties under the FIA.

- OCME had to find the best possible alternative body storage space after its body storage capacities were reached, and the alternative body storage space had already been identified in the Mass Fatality Plan as a refrigerated trailer.

- When placed into the refrigerated trailer, decedents were in a clean, secured and 24/7 monitored space, four feet off the ground and maintained at proper temperature. They were not placed on the ground, and others were not required to raise the decedents from a ground or floor position. Decedents were separated from each other in the trailer, each was properly identified on body bag labels, and room was left for attendants to manoeuvre in the middle portion of the trailer.

- Placing decedents into a refrigerated trailer could be deemed disrespectful to a decedent (or not) depending on the context and circumstances, and whether it was an operational necessity at the time. If there were empty gurneys or body storage racks in the morgue available, it could be disrespectful to place a decedent in a trailer, rather than use a vacant gurney or body storage rack. However, if all gurneys and body storage racks were already occupied and the only other option would be to place a decedent on the floor of the morgue or the ground, it would not be disrespectful to place a decedent in the trailer, as it would be the best previously identified (albeit imperfect) option available in the moment.

- OCME's policies, practices, communications, and culture regarding the professional and respectful treatment of decedents has been, and remains, of foremost importance to all OCME management and staff.

- Despite the lessons learned from these incidents, the improvements already in place or underway, and the acquisition of additional body storage racks, it is possible that OCME's body storage capacity could be exceeded again in the future. Contributing factors that could lead to such an event include Alberta's growing population, the timing at which decedents arrive at OCME, limitations on the number of staff OCME can employ, delays in filling vacant positions, or other unforeseen events outside the control of OCME.