REPORT TO THE ATTORNEY GENERAL

FOR THE PROVINCE OF ALBERTA

THE FATALITY INQUIRY OF LEO JOSEPH GRAVELLE

HELD IN PROVINCIAL COURT OF ALBERTA

AT HIGH RIVER, ALBERTA, MAY 22 A.D. 1992

AND BY ADJOURNMENT ON JUNE 19 A.D. 1992

BY HER HONOUR JUDGE S.L. VAN DE VEEN

Provincial Court of Alberta

High River, Alberta

July 3 A.D. 1992

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I am required to report to the Attorney General with respect to a number of matters. They are as follows:

1. The name of the deceased: The name of the deceased is Leo Joseph GRAVELLE.

2. The date, time & place of death: The death occurred on December 29, 1991 at the R.C.M.P. detachment cells in High River, Alberta. The time of death is not known to the minute but can be determined to have occurred between 11:52 p.m. December 28, 1991 and 12:33 a.m. December 29, 1991.

3. The cause of death: The death was caused by asphyxiation due to hanging.

4. The manner of death: The manner of death or mode of death was suicide.

5. The circumstances of death.

The deceased committed suicide by tying his socks together and then looping them through the bars of his cell and around his neck. He was found hanging from the bar of his cell at 00:33 a.m. on December 29, 1991.

The deceased had been taken into custody by R.C.M.P. in High River as a result of a domestic disturbance involving the deceased and a male house guest named Michael who was known to both the deceased and his wife. Michael, as a friend to the deceased and his wife, had been given permission to stay at the matrimonial home residence that night of December 28, 1991. The deceased himself was prohibited from staying in his home by reason of an Order from the child welfare authorities which required the deceased to live outside the matrimonial home because of the relationship he had with his son. The Order was not placed into evidence but the wife of the deceased, Kathryn Gravelle, testified that the deceased was not to live in the matrimonial home but could visit. He was to leave if any dispute arose between himself and his son.

The deceased was visiting the home on December 28, 1991. When R.C.M.P. were first called to the residence it was by the 10 year old son, Darren, who was frightened by a fight which had commenced between the deceased and the house guest, Michael. Some short time later Kathryn Gravelle also contacted the R.C.M.P. and they responded to her call. The deceased was removed from the matrimonial home by the R.C.M.P. when they were advised of the

existence of the Order from the child welfare authorities. The deceased made it known to the officers involved in the complaint that he intended to go back to the matrimonial home. He was extremely upset that the house guest, Michael, would be there in his absence and he was so concerned about this that Constable Schmidt assured the deceased he would return to the home and ensure that Kathryn Gravelle was safe.

The R.C.M.P., as a result of the deceased's intention to return to the matrimonial home, took the deceased into custody and because of the serious concerns expressed by the deceased they returned to the matrimonial home to inquire about the welfare of Kathryn Gravelle and her son. They were advised by Kathryn Gravelle that the house guest Michael was welcome in the home and that she felt no threat by his presence.

The deceased was taken into custody to prevent him from returning to the matrimonial home and was placed into a cell by himself, at his request, (he requested it to be alone) at 11:40 p.m., 20 minutes before the guard on duty would complete his shift. The deceased was intoxicated and laboratory tests conducted after his death show that the proportion of alcohol in his blood was 210 milligrams of alcohol in 100 millilitres of blood, approximately 2 1/2 times the legal limit for operating a motor vehicle.

Guards are required to check on prisoners every 15 minutes

under the Operational Duties & Responsibilities of the R.C.M.P. Detachment in High River. At 11:52 p.m. the guard noted the deceased sitting by his cell door and he thought he saw the deceased breathing. At 11:58 p.m. he just gave a cursory glance at the deceased and his evidence was he was not sure whether the deceased had changed position or not. He said he had not received any real instructions concerning how to conduct the 15 minute interval checks required by the regulations. He said he was to determine whether prisoners were alive, but he was not sure how he ought to go about this. He went off duty at 11:58 p.m. having given the deceased a "cursory glance" at that time.

The second guard who came on duty at midnight testified he relied upon the check conducted by the first guard at 11:58 p.m. along with comments made to the effect that everything was okay. He gave a "brief look" at the deceased and could not tell the inquiry whether he noticed the deceased was breathing or what his position was at the 11:58 p.m. check time. Therefore neither guard made a complete check of the prisoner at 11:58 p.m.

The check at 12:11 a.m. was such that the guard observed the deceased sitting with his back to the door. He did not notice the position of the hands or feet of the deceased and does not know whether the deceased was alive. He further said that if he had been concerned he would have shaken the prisoner, but because of the assumption he had made, he did not do so. He had assumed the

deceased was sleeping off the effects of excessive alcohol consumption.

At 12:24 a.m. the guard again checked the deceased and saw him sitting against the cell door. He once again assumed the deceased was sleeping.

By 12:33 a.m. the guard became concerned because the deceased did not seem to have moved. He went to Constables Thomas and Schmidt to advise them of the deceased's position. He said these constables also thought the deceased to be drunk and saw no cause for alarm initially, but when he returned to the deceased and poked him with a stick and got no response, he went back to Constable Thomas who came immediately. As Constable Thomas approached the cell he believed the accused was trying to hang himself. He could not see what was holding the deceased up at first but when he opened the door it would not slide open because the socks blocked the door. He then saw the socks and cut the deceased down. The deceased was in a kneeling position, his back to the cell door, and with his neck tied to the cell door with his socks at a position about 43" off the floor.

The deceased had no pulse, pale lips and was cool to touch on his head and chest when Constable Thomas arrived. Constable Thomas testified that he believed the deceased to already be dead and because of the absence of a mouthpiece along with his belief that

it would be pointless, he did not conduct C.P.R..

The lighting in the cell area was very dim. Only a 40 watt bulb together with a 15 watt bulb were used in two separate receptacles outside the cell itself. The cell itself had no lighting from within. The lack of lighting may have contributed to the fact that the deceased was not discovered at an earlier time. The deceased's cell was located directly around the corner from the door to the guard's office. The guards stood at or near the door when they observed the deceased according to the evidence given at the inquiry.

The medical evidence of Dr. R. Roy, of the Chief Medical Examiner's Office in Calgary was that it takes as little as 4 to 5 minutes for a body to become brain dead when oxygen is cut off by hanging. It takes as little as 10 minutes for the body itself to die in these circumstances.

The Operational Duties & Responsibilities of the R.C.M.P. at High River (Exhibit 16) require guards to check prisoners every 15 minutes. Clause 6 of that document provides as follows:

> "The safety of prisoners is of paramount importance and they shall not be left unguarded."

Section 12 provides that guards shall observe the condition of

all prisoners continuously and record same at intervals not exceeding 15 minutes, in the book provided, and examples are given of this check which includes sleeping, awake, reading, etc..

This policy would appear to be essential since a hanging can take place within the short time frame described by Dr. R. Roy, that being 10 minutes from the moment the hanging commences or the oxygen is cut off. The R.C.M.P. policy has been improved upon with respect to known suicide risks, and it is now a requirement that there be constant monitoring of such prisoners by a second guard hired for that purpose. However, there was a computer check done with respect to the deceased upon his being taken into custody, and there was no indication he was suicidal from any information available to the R.C.M.P. at that time.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

The Fatality Inquires Act provides that a Judge conducting a Fatality Inquiry may make recommendations to the Attorney General for the prevention of similar deaths. It is often the case that lessons are learned from experience and the purpose of this enactment is to ensure the knowledge learned from the death of Leo Joseph Gravelle is utilized to prevent similar occurrences. I wish to deal with the following recommendations:

1. My first recommendation would have been for improvement to the lighting at the R.C.M.P. facility in High River, Alberta. However, the R.C.M.P. themselves realized that the lighting ought to be improved, and this has now been done. Instead of the two lights containing 40 and 15 watt bulbs respectively, there now is a 4 foot neon light outside the cell which significantly improves the lighting in front of the cell area, where guards ought to be positioned when conducting their observations of prisoners. The R.C.M.P. are to be commended for having taken this action promptly prior to the Inquiry being conducted.

2. In circumstances where a prisoner is seated with his back to the cell door, it is recommended that special attention be paid to ensure his safety. This deceased was booked in at 11:40 p.m. and found somewhat cold to the touch about 53 minutes later, notwithstanding a number of visual observations having been conducted by guards on duty at the time, and notwithstanding that there were only 2 prisoners who were in custody and required such observation, the deceased and one other. Because this particular positioning is not unusual, according to the evidence before me, in order to prevent similar deaths it is recommended that personnel dealing with prisoners be alerted to the fact that they ought not to assume the deceased is sitting comfortably when they are unable to observe clearly whether he is breathing or in distress because of his positioning. Special care ought to be taken to ascertain the condition of the deceased's safety when he has positioned

himself in a manner which avoids a clear view by guards and other personnel entrusted with his care.

3. It is recommended that specific training and instructions or refresher training be provided to guards setting out the actions to be taken within the facilities at the R.C.M.P. at High River to ensure the safety of prisoners. The deceased was placed into his cell at 11:40 p.m., and found dead at 00:33 a.m., some 53 minutes later. The police required guards to check on the deceased every 15 minutes and of the five checks required within this time frame, only the first of these was such that the guard could tell the inquiry the deceased was alive because he had actually checked to see whether the deceased was in fact alive. The last of the five checks was when the deceased was found dead. It is therefore recommended that special attention by guards be given to ensure a prisoner is in fact breathing, is not in distress, and has not done anything harmful to himself particularly in circumstances where a prisoner partially shields himself from observation by sitting with his back to the cell door.

I do not mean to say that a prisoner ought to be poked or roused if it is clear to a guard that he is sleeping but I do mean to recommend that the condition of the prisoner ought to be in fact ascertained in order to ensure his safety when the visual checks that are required by the existing regulations are made by those entrusted with the care of prisoners at the R.C.M.P. Detachment.

It may be that it is appropriate to engage prisoners in conversation unless it is night time and they are breathing easily asleep in their bed, in which case it may not be appropriate to wake them every 15 minutes for obvious reasons.

4. It is recommended that as a part of the training for those entrusted with the care of prisoners emphasis be given to the avoidance of any preconceived ideas or stereo type behaviour. Assumptions such as the one made by personnel in the case of Mr. Gravelle may contribute to cursory glances or brief looks being substituted for the proper observations of prisoners anticipated by the existing regulations. Because of the assumption that Mr. Gravelle was sleeping off the effects of excessive /alcohol/ok consumption, it was not ascertained whether he was breathing or alive on a number of the required 15 minute interval checks which were conducted.

5. Due to the short time it takes for hanging to occur, it is recommended that the 15 minute time intervals referred to in the Operation Duties & Responsibilities of the R.C.M.P. at High River be reduced to intervals as brief as possible bearing in mind the practicality of existing manpower and resources available for this purpose. It would be desirable for the guards to have a clear view of the cells on an ongoing basis from the office they currently occupy, and it may be that this could partially be accomplished by having a window placed in the wall. However it is recognized that the security of the guards themselves must be considered as a part

of the matter I am suggesting, and I leave it to the R.C.M.P. themselves to determine how best to accomplish the objective of maximizing the observation of prisoners by those entrusted with their care.

In summary, I wish to indicate clearly that we are all geniuses in hindsight and the recommendations that I put forward become obvious when several witnesses are heard from in a court room setting. In this context what occurred can be analyzed, sifted, and the recommendations can fortunately be extracted. Those involved in the event as it occurs do not have this advantage in analysing their actions, and it is hoped that the lessons learned from the unfortunate death of Mr. Leo Joseph Gravelle will prevent similar deaths from occurring in such circumstances. All of which is respectfully submitted.

DATED THIS 3rd DAY OF JULY A.D. 1992 AT HIGH RIVER, ALBERTA.

S.L. VAN DE VEEN, PROVINCIAL JUDGE