Report to the Minister of Justice and Solicitor General Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Edmonton Law Courts

in the City (City, Town or Village) of Edmonton (Name of City, Town, Village), in the Province of Alberta,

on the 2 - 4 day of November, 2020 (year), and

on the 22 day of December, 2020 (year),

before The Honourable Carole D. Godfrey, a Provincial Court Judge,

into the death of Darcy Whitehead (Name in Full) 47 (Age)

of Edmonton, AB (Residence) and the following findings were made:

Date and Time of Death: May 19, 2016 at 6:54 hours

Place: Royal Alexandra Hospital

Medical Cause of Death:

("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *Fatality Inquiries Act*, Section 1(d)).

Fentanyl and Alcohol Toxicity and contributing cause of emphysema

Manner of Death:

("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *Fatality Inquiries Act*, Section 1(h)).

Accidental

Circumstances Under which the Death Occurred:

Overview:

On November 2-4, 2020 and December 22, 2020, a Fatality Inquiry was held at the Provincial Court of Alberta, Edmonton, Alberta.

The Inquiry examined the circumstances surrounding the death of Mr. Darcy Whitehead on May 19, 2016 while he was in custody at the Detainee Management Unit (hereinafter DMU) at the downtown detachment of the Edmonton Police Service, Edmonton, Alberta. He was found unresponsive and not breathing in his cell at 3:02 am May 19, 2016. After futile attempts to resuscitate him, he was transferred to the Royal Alexandra Hospital and declared deceased at 6:54 am on May 19, 2016.

Parties Participating in the Inquiry

Inquiry Counsel: Alberta Justice and Solicitor General: Lesley Akst

Edmonton Police Service Counsel: Lorena Harris

Family of the Deceased were advised and served with notification of the Inquiry and choose not to attend.

Witnesses Called:

Correctional Peace Officers Dufva, Hawley and Mason-Baril, Constables Varty and Chernyk, Sergeant Alex Thomas and Staff Sergeant Farnell were called as witnesses and testified before this Inquiry.

Personal Circumstances:

Mr. Whitehead was a 47 year old indigenous male. He was born in the Northwest Territories and had no fixed address on the date of his death. At the time of his arrest, he was on release conditions to have no alcohol or other intoxicating substances. He was known to have alcohol issues.

On May18, 2016, Mr. Whitehead was arrested at the Kingsway Garden Mall by security personnel for alleged theft of liquor and recognizance breaches occurring at the Sobey's Liquor Store. He exhibited signs of intoxication upon arrest, but was arrested without incident and ultimately taken to the Downtown Division cells and booked in at 2345 hours. After an evaluation of his needs, which did not suggest to be out of the ordinary, he was later transferred from downtown cells to the Detainee Management Unit (DMU). He was signed into cell #115 at about 0033 hours.

Upon his arrival to the DMU, Correctional Peace Officer (CPO) Mason-Baril testified that Mr. Whitehead exhibited signs of intoxication, although he was able to understand the questions put to him. There was no unusual note of concern with respect to his actions and he was cooperative throughout the process.

Between 0050 and 0056 hours on May 19 he was taken for processing and then returned to his cell #115. At some point after he had been in his cell, Detainee B was placed in cell #115 with him. Between 0215 and 0230 hours, while CPO's were doing checks, they were called to Mr. Whitehead's cell. Mr. Whitehead stated that he was not feeling well and was detoxing after having been drinking for a long time. He was seen by CPO Hawley who stated that Mr. Whitehead was sitting on the ground with his back against the wall.

This information was passed to Constable Chernyk who was covering for Sergeant Thomas while on lunch break. Constable Chernyk testified that he observed Mr. Whitehead on monitor and then physically attended at his cell. Constable Chernyk testified that based on his observations of Mr. Whitehead, he did not think Mr. Whitehead required EMS attention.

Sometime after 3:00 am, one of the CPO's attended Mr. Whitehead's cell and found him unconscious on the cell floor. EMS was immediately requested while officers attempted to provide medical assistance to Mr. Whitehead. Mr. Whitehead was transported to the Royal Alexandra Hospital and despite medical intervention, he never regained consciousness. He passed away at 0654 May 19, 2016.

Constable Chernyk testified that during his shift, the situation in the DMU was Code Red. This meant that cells were full and they could not accept any further detainees. The evidence was clear that it was a busy and challenging night. There was a total of 26 prisoners in the DMU prior to Mr. Whitehead entering. Between 0030 – 0300 hours there was a total of 33 detainees in the DMU.

CPO Masin-Baril testified that his role that night was completing the 10 minute cell checks. Although they are required to conduct 15 minute cell checks, they have a light that illuminates at 10 minute intervals and an officer will walk about visually checking the detainees. The CPO will swipe their card at the various electronic card readers in carrying out the checks. With respect to Mr. Whitehead, there is video evidence that although most checks were done 10-12 minutes apart, there was a time from 02:12:30 to 02:30:28 where the video camera does not show a check done at cell #115.

Detainee B:

Detainee B was arrested on May 18, 2016 at approximately 12:13 hours during the execution of a search warrant for various offences including break and enter. At the time of his arrest, he was frisk searched by the arresting officer before being placed in the police vehicle. He was then frisk searched again once he reached the Edmonton Police Service Downtown Detachment.

At the time of his arrest, he had shown signs of drug consumption. He was sweating and seemed anxious, but the arresting officer felt these signs also seemed consistent with general anxiety and nervousness. Detainee B denied any drug consumption.

By the time Detainee B had reached the police detachment, his symptoms had seemed to improve and he stated that he did not wish medical attention. Both of his frisk searches had to that point revealed nothing. Upon arrival at the DMU he was frisked again, still revealing nothing. He was placed in cell #115 with Mr. Whitehead at 1:53:54 a.m. It was not believed at the time that grounds existed to strip search Detainee B.

Video surveillance shows that at 1:59:10 Detainee B seemed to retrieve something from his person which was later found to be fentanyl. Detainee B had hidden the drugs within his body. Between that time and 2:04:52, Detainee B provided fentanyl to Mr. Whitehead who then ingested the same.

An extensive ASIRT investigation was conducted into Mr. Whitehead's death with recommendations that the ASIRT report be submitted to the Director of Investigations and the Executive Director for their review. Detainee B was also subsequently investigated for possible criminal charges; however, this criminal investigation was ultimately abandoned and no criminal charges were laid.

CAUSE OF DEATH;

On May 19, 2016, an autopsy was conducted on Mr. Whitehead by Dr. Cecilia Wu, a Medical Examiner at the Medical Examiner's Office in Edmonton, Alberta. It was determined that the cause of death was Fentanyl and Alcohol Toxicity with a significant contributing cause of emphysema.

It was noted in the report that although the level of fentanyl in Mr. Whitehead's system was not tremendously elevated, it had a substantial depressive effect and was sufficient to cause his death. Likewise, he was more vulnerable to toxic drugs given his underlying condition of emphysema.

Staff Sergeant Mark Farnell

Staff Sergeant Mark Farnell is a 14 year member of the Edmonton Police Service and presently a Staff Sergeant in charge of the DMU. He was a long term acting Staff Sergeant in the DMU in 2013 – 2014 and moved back into that position in 2019. He provided testimony with respect to the policies and procedures in the DMU both at the time of Mr. Whitehead's death in 2016 and subsequent to his death which will be further outlined in this report.

Staff Sergeant Farnell testified that there is a difference between a temporary holding facility and the DMU. When an individual is arrested, an officer will decide in consultation with their superiors whether the suspect will be released or whether there will be further investigation. Usually the suspect is taken back to the officer's particular detachment and put in their temporary holding facility and that particular cell block. The officer will then continue with their investigation. The Correctional Peace Officer (CPO) will check on the suspect during that time pursuant to protocol.

If it is decided after consultation that the detainee cannot be released, they are transported to the DMU.

If it is determined they are to go to DMU and a Code Green exists – meaning DMU cells are available, they are then transported to the DMU. The DMU is in the basement of the Edmonton Police Service downtown Headquarters. (The Edmonton Police Service downtown division is also at Headquarters and they have their own cell block as do the outside divisions.)

When a detainee comes to the DMU, they are searched again by DMU staff before they are put into a cell. DMU searches presently involve metal detectors. Risk factors are considered before a strip search can be done on a detainee arriving at the DMU. These factors include a number of considerations including the suspect's behavior, the nature of the offence and whether the detainee will be going into a cell with another detainee.

POLICIES AND PROCEDURES IN PLACE PRIOR AND SUBSEQUENT TO MAY 18, 2016

Subsequent to 2016, the Edmonton Police Service initiated a review of policies and procedures with respect to the DMU facility. This review involved addressing issues such as strip searches within the DMU, medical assistance and how it is made available in the DMU and the monitoring of detainees while they remain in the DMU.

May 2016: Search and Seizure Policies in DMU

In 2016 and at the time of Mr. Whitehead's death, frisk and strip search procedures were carried out in conjunction with the Edmonton Police Service Search and Seizure Policy.

To conduct a frisk search, an officer needed neither reasonable grounds or suspicion before proceeding. A frisk search was allowed in a lawful arrest and done when someone would enter the DMU as a detainee.

A strip search generally required reasonable and probable grounds if certain conditions existed. However, strip searches could also occur on reasonable suspicion. In determining which standard applied, factors considered included the type of offence, the demeanor of the offender, circumstances of the arrest, personal history of the detainee, whether the detainee had any suicide history and whether the individual would be sharing a cell with another person. Before a strip search could occur on reasonable suspicion, the approval of a DMU Sergeant was required.

2017: Changes in Search Policy

In May of 2017 and pursuant to an Edmonton Police Service Directive, a new form entitled Service Search Authorization Record was implemented into strip search

procedure. This document must now be completed outlining the reasons for the strip search prior to the strip search occurring.

Sergeant Mark Farnell testified at the Inquiry that the principles governing the threshold of strip searches were relatively the same in both 2016 and 2017. In 2016 however, reasons for a strip search would have been documented in the notes of the officers only. Now these reasons must be outlined in the new Service Search Authorization Record including the specific grounds if the reasonable suspicion threshold was being sought. There must still be authority given from a superior officer. As well it is clear that the lower threshold of reasonable suspicion can allow for a strip search in certain situations such as if detainees will be sharing the same cell and will be in contact with another detainee for longer than a sort duration. This was confirmed in the May 2017 Edmonton Police Service Directive.

Body Scanners:

Staff Sergeant Farnell testified that presently body scanners are being considered for the new DMU at the Northwest Campus in Edmonton and the evaluation process will be underway to add body scanners to facilitate in searches. This measure would assist in locating drugs on detainees.

May 2016: Temporary Holding Facilities Procedure

In 2016 detainees being held in a temporary holding facility required monitoring to be done every 15 minutes by physical checks. There was also monitoring via closed-circuit television.

The DMU has an Edmonton Police Service Sergeant on duty with a team of peace officers from commissionaires under Edmonton Police Service contract. In the divisional stations, a CPO would do the 15 minute detainee checks. Staff Sergeant Mark Farnell stated that the province wide requirement was a 15 minute interval. Evidence given in the Inquiry however, confirmed that detainee interval checks in the DMU in Edmonton in 2016 were occurring approximately every 10 minutes.

In the DMU, the officers complete the walk around checks in a process called the blue light check. A blue light flashes at the requisite interval and the only way the light can be extinguished is when the officer swipes their personal card at the requisite key locations. During this check they will look in and note each of the cells. Any safety or security issues of a detainee are to be immediately reported.

The detainee in the cell would be medically screened and visually inspected for signs of injury or illness. EMS was to be called for medical emergencies and in non-medical emergencies the detainee could not be admitted to the DMU. The transporting officer would arrange for medical attention.

With respect to Mr. Whitehead, there is evidence that at one point, between 2:12 and 2:30 am, there was no check to Mr. Whitehead's #115 cell. The evidence showed that the drug had already been ingested by Mr. Whitehead sometime between 1:59-2:04.

October 2017 and October 2019: Changes in Temporary Holding Facility Procedure

Changes were implemented to the temporary holding facility procedures by the Edmonton Police Service in October 2017 and October 2019. One difference between these policies and the 2016 policy is that the updated policy defines an arousal check as a brief conversation with the detainee to determine if they are alert. This brief conversation must be done hourly to ensure that the detainee is responsive and not in need of medical assistance. In 2016, physical and visual requirements were discussed; however, now a check definition exists with respect to arousal requirements.

Additionally, the October 2019 update also provided more rigorous guidelines for checks and balances as they related to violent and combative detainees.

May 2016: Detainee Well-being Procedure

In a medical emergency, EMS would have to be requested from off site of the DMU. For non-emergent medical situations, the Supervisor was to be consulted. The Supervisor would document all reasons regarding the assessment if medical attention was delayed or not provided.

April 2018: Detainee Well-being Procedure

Paramedics:

Since April 2018, a Paramedic is now kept on duty in the DMU at all times. Although there have been some issues where a paramedic can be called elsewhere, the general proposition is that a paramedic is on site in the DMU at all times.

Presently whenever a detainee enters the DMU they are, after consent, assessed and medically screened by a paramedic. If the paramedics determine treatment is needed, EMS is called to facilitate transport to the appropriate medical facility. The paramedics can also assist with Downtown Divisional Cells, but the primary focus is to present for the DMU. They can also assist to some degree with mental health assessments.

The drug Narcan (Naloxone) that reverses the effects of an opioid overdose is now also available on site at the DMU to deal with these emergent drug situations.

May 2016 and Present: Relief of Supervisors by Constables:

In 2016, there was no formalized procedure for the role of the Constable at the DMU when the Supervisor went on a scheduled break as occurred in Mr. Whitehead's scenario.

Staff Sergeant Farnell testified that presently the duties and responsibilities of Supervisors, including in the DMU are outlined in the respective job postings. Some of those responsibilities include backing up temporary acting Superiors (T/A positions). Constables filling that T/A position will have fulfilled the examination

requirements to be a T/A and will have received mentorship from their Sergeant; therefore qualifying them to step in when the Supervisor is on a break or temporarily absent. This would apply to the T/A's in the DMU.

Training:

Staff Sergeant Farnell testified that in early 2021, CPO's would be given a refresher course on the issues and practices in the DMU. This training will be run by the Sergeants over a two day time frame.

CONCLUSION:

I find that the implementation of the above policy and practise revisions have addressed a number of issues in the DMU.

As to the question of strip searches and when are they available, there is now additional training and clarification of information made available to officers and DMU employees with respect to when strip searches can be done and upon which standard including the reasonable suspicion standard that determination can be made. This would include looking at a number of factors and includes when detainees are being placed together in one cell. Documentation of these reasons and requirements has become more structured.

The introduction of body scanners to facilitate in searches appears to be at its early stages of implementation and will provide assistance in determining what is being brought into detention facilities including hidden drugs and weapons.

With respect to medical assistance in the DMU, the Edmonton Police Service has now directed that paramedics be present within the DMU unit on a continual basis. This direction will provide a medical professional to directly assess a medical situation within moments of its occurrence. Additionally, the drug Narcan (Naloxone) that reverses the effects of an opioid overdose is now available for immediate use. Both of these medical interventions would undoubtedly result in the prevention of similar deaths to that of Mr. Whitehead.

Finally, with respect to monitoring the transfer of items between detainees, it is clear from the evidence before this Inquiry that several mechanisms exist to monitor detainees. There are visual physical cell checks every 10 minutes in the Edmonton DMU facilitated by the blue light electronic activation reminders. This 10 minute interval is more stringent that the provincial requirement of 15 minutes.

There are also additional cell checks by the DMU staff via the camera monitor. Although it would be impossible to maintain complete monitor observation of the cells at every second, this cell observation by monitor - in conjunction with the physical cell checks should better facilitate the officers to observe any exchange of materials between the detainees. Additionally, the CPO's are continually working throughout the cells and observing detainees even during that 10 minute period.

Finally, additional training is being given to DMU staff on policies and procedures in the DMU to deal with issues before they occur.

RECOMMENDATIONS:

I do not have further recommendations in this matter. The policy changes implemented by the Edmonton Police Service subsequent to 2016 will hopefully serve to prevent deaths similar to that of Mr. Whitehead. The death of Mr. Whitehead is a tragedy and all steps must be taken to ensure that similar events cannot happen again.

DATED May 31, 2021,

at Edmonton, Alberta.

Original Signed

The Honourable Carole D. Godfrey
A Judge of the Provincial Court of Alberta