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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Courthouse

in the City (City, Town or Village) of St. Albert (Name of City, Town, Village), in the Province of Alberta,

on the 5th and 6th days of May, 2021 (year), (and by adjournment

on the ______ day of ______, ______ (year)),

before The Honourable Vaughn H. Myers, a Provincial Court Judge,

into the death of Bradley Raymond Perrott (Name in Full) 47 (Age)

of 55512 Range Road 263 Sturgeon County, Alberta (Residence) and the following findings were made:

Date and Time of Death: May 22, 2015 at approximately 22:32 to 22:54

Place: 55512 Range Road 263 Sturgeon County, Alberta

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)).

Gunshot wound of abdomen

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)).

Homicidal

Circumstances under which Death occurred:

Introduction

In setting out the circumstance of Perrott's death, I will deal with the following topics:
Preliminary Matters
Exhibits
Events Leading up to the Shooting – General
The Events of May 22, 2015 up to and including the shooting of B. Perrott
The Events following the shooting of B. Perrott to the time he was declared deceased
Recommendation for the Prevention of Similar Deaths

Throughout this Report:

a) All dates are in 2015 unless otherwise indicated;
b) All events and locations are in Sturgeon County, Alberta, unless otherwise indicated;
c) All times are on the 24-hour clock;
d) "ASIRT" means Alberta Serious Incident Response Team;
e) "ASIRT Final Report" means that report of the ASIRT dated January 17, 2020;
f) "CNT" means the RCMP Crisis Negotiation Team;
g) "EMRT" means Emergency Medical Response Team;
h) "ERT" means the RCMP Emergency Response Team;
i) "Inquiry" means this Fatality Inquiry;
j) "Probation" means the Alberta Correctional Services Division;
k) "Probation Order" means an order of the court enforced by Alberta Correctional Services Division;
l) "FACS" is the Provincial Forensic Assessment and Community Serves, a service dealing and treating patients with mental health issues involved in criminal behaviour;
m) "RCMP" means the Royal Canadian Mounted Police;
n) "RMI" means the remote mechanical investigator (a robot);
o) "TAV" means tactical armored vehicle;
p) Residence means the residence of Perrott's Father (comprising buildings and lands) at 55514 Range Road 263, Sturgeon County, Alberta; and
q) Reference may be made to the following person:
    i. Dr. Mitchell Weinberg ("Dr. Weinberg"), Assistant Chief Medical Examiner for the Province of Alberta
    ii. Dr. Vijay Singh ("Dr. Singh") Treating Psychiatrist
    iii. Tyson Sergent ("Sergent"), RCMP Constable
    iv. James Elford ("Elford"), Justice Canada Counsel to the RCMP
    v. Luc Rogers ("Rogers"), RCMP Constable
    vi. Justin St. Onge ("St. Onge"), RCMP Constable
    vii. Bradley Raymond Perrott ("B. Perrott")
    viii. Gord Corbett ("Corbett") RCMP Sergeant, ERT Team Leader
    ix. Jennifer Stengel ("Stengel"), Inquiry Counsel
    x. Ashley Emerson ("Emerson"), ASIRT Investigator
    xi. Shalee Kushnerick ("Kushnerick") Counsel for Alberta Health Services
    xii. Claudine Perrott ("C. Perrott") sister of Bradley Raymond Perrott
    xiii. Nicole Perrott ("N. Perrott") sister of Bradley Raymond Perrott
    xiv. Raymond Perrott (R. Perrott) Father of Bradley Raymond Perrott
    xv. Judith Thompson-Legare (Thompson-Legare) Probation Officer
    xvi. Deanna Frey (Frey) Edmonton Director of Community Corrections

Preliminary Matters

A Pre-Inquiry Conference was held before me on February 8, 2021 at the Provincial Court of Alberta, #3 St. Anne Street, St. Albert, Alberta. In attendance were Stengel, Elford, Kushnerick, C. Perrott and N. Perrott. The following preliminary issues were addressed:

It was decided that the Inquiry would commence at 0930 hours and continue for the three scheduled days, May 5, 6 and 7, 2021, at the Provincial Court of Alberta, St. Albert, Alberta, in Courtroom #2;

C. Perrott and N. Perrott were provided with a copy of the Exhibit Binder (Items 1-42) pursuant to my Order that they be bound by section 37.2 of the *Fatality Inquires Act* with respect to the contents of the Exhibit Binder;

The Fatality Inquiry Coordinator for Alberta Justice was to prepare the summonses which would be sent to me for signature and then provided to the RCMP for service on the witnesses; and

The RCMP and Alberta Health Services were granted standing at the inquiry pursuant to s. 49(2)(d) of the *Fatality Inquiries Act*.

At the commencement of the Inquiry, and before evidence was heard, I advised those present of the provisions of section 49 of the *Fatality Inquires Act* and the right of interested persons to apply for standing at the Inquiry. No one indicated a desire to apply for such a standing.

Exhibits

Exhibit #1 – Black Binder containing tabs 1 to 42
Exhibit #2 – Black Binder containing tabs 43 to 80

Events Leading up to the Shooting – General

1) B. Perrott, the deceased and the subject of this fatality inquiry, was the son of R. Perrott and brother of N. Perrott and C. Perrott. R. Perrott resided at 55512 RR263 Sturgeon County, Alberta, the scene of the confrontation and the proximate area of the shooting.

2) B. Perrott had first come to the attention of the staff at the Forensic Assessment and Community Services (FACS), a service dealing with and treating patients with mental health issues involved in criminal behaviour. A treating forensic psychiatrist, Dr. Singh first met B. Perrott in mid June 2011, to conduct a court ordered in-house forensics evaluation. He remained under his care until July 28, 2011 when he was discharged. He was diagnosed at that time with "Bipolar Mood Disorder and Poly substance Abuse including Cocaine Crystal Meth, Cannabis & Alcohol. He was treated with all medications which primarily consisted of Anti-Psychotic medications, mood stabilizing agent and ... was given anti-arthritic medication for chronic arthritic pain. He was released on probation which was 12 months in duration... At the time he was taking those oral medications and seemed to be doing mentally reasonably well."

3) Dr. Singh later saw B. Perrott in 2014 when he understood B. Perrott was under Probation with a term compelling him to comply with treatment conditions. Dr. Singh also noted B. Perrott had been diagnosed with substance induced psychosis as well as antisocial personality disorder. Dr. Singh described substance abuse psychosis, and indicated it can induce schizophrenia-like symptoms, such a as hearing voices, confusion, altering

mood and affecting cognition behaviour and judgment.

4) It was on August 8, 2014 that B. Perrott was prescribed Risperidone Constra, an injectable medication administered every second week. The advantage of this injectable treatment is that it remains in the system longer than daily oral medications. This is important when treating patients who may have difficulties following daily regimen. This drug dissipates all unusual experiences (imagination and irrational beliefs) and induces internal relaxation. Dr. Singh opined that Risperidone Constra is “The main Forte for combating Psychosis”. Dr. Singh indicated B. Perrott was prescribed Risperidone injectables every two weeks commencing August 8, 2014 and continuing on until March 19, 2015 with what was described as a “few misses here and there”. Dr. Singh testified that while on the drug, he found B. Perrott “Quite stable”, “co-operative” and “very much grounded in reality”.

5) Dr. Singh acknowledged that B. Perrott had not received any shots between January 26, 2015 until March 19, 2015, and thereafter no further shots leading up to his death on May 22, 2015. The only notes from the March 19, 2015 visit were that he was “polite and pleasant” and that his “appearance and speech were appropriate”. This indicated to Dr. Singh that B. Perrott was “relatively stable”.

6) The next time B. Perrott showed up for his shot was April 23, 2015, some 25 days after his last shot. This would be almost four weeks after his last shot. It is unclear whether an intervening appointment had been missed or whether this was an unscheduled appointment. In any event, B. Perrott was impatient and had been told to wait (it appears so that a Dr. Alock could see him) to which B. Perrott became “angry, abusive and left”. He did not receive his shot on April 23, 2015.

7) The question of whether the staff at FACS informed Probation of the missed appointments and the manner and timing of when they notify Probation when a patient misses his appointments was unclear. Further, the circumstances under which a Probation Officer would instigate a Breach of Probation allegation for a client failing to take their treatments was also unclear.

8) With respect to FACS, there appeared to be a discretion within the treating professional, to forego reporting any missed appointments based on the history of the patient’s compliance or lack thereof. The Probation Officer, Thompson-Legare, once informed of such a breach, appears to have a similar discretion as to whether to lay a breach of probation charge.

9) With respect to whether or not Probation was informed of B. Perrott’s missed appointments, and in particular which ones and when, was also somewhat unclear. Dr. Singh was asked the following:

   > “Was it your understanding in 2014 that Mr. Perrott had been court-ordered to receive the Risperidone Consta injection?”

   To which he replied

   > “I knew that he was under Probation, he had to comply with, you know, treatment conditions.”

   Dr. Singh was further asked the following question

   > “And as a result, was there a reporting requirement on you as a physician if he failed to receive his injections on any occasion?”

   To which he replied:

> "There is no written rule for that but as a clinical, you know practice, I always ensure that Probation is duly informed and I remember I had. I did send a letter – of course that was based on Mr. Perrott to let his (sic) Probation of the progress he was making and if I am not greatly mistaken that letter also contained that he failed to show up on a particular date."

10) Unfortunately, it was never clarified which "date" was that "particular date". Dr. Singh described what would be the "general" practice as to inform Probation when injections were missed; whether it be by letter or phone, but again, he couldn't specify the practice of what would happen "a few days" after a missed appointment.

11) Dr. Singh did testify however, that on Mr. Perrott's chart was a notation that on April 23, 2015, the date Mr. Perrott attended FACS but failed to remain to receive his shot, that someone "left voicemail with P.O., client is still on Probation. We also discussed treatment plan with Dr. Singh to await development." Dr. Singh assumed that said call was made by a nurse, but no name was recorded of said nurse.

12) While the said note Dr. Singh referred to (made on April 23, 2015) does not specifically refer to the fact contents of the message left by the suspected nurse, it is inconceivable the fact that Mr. Perrott missed his appointment, and therefore his shot, would <u>not</u> have been discussed. Whether that message was left on a general or specific phone line was unclear; just a voicemail was left "with P.O".

13) Dr. Singh testified that said note was the last note in Mr. Perrott's file. In answer to the question "and if the Probation Office had contacted FASC would there be a note to that effect?", the answer was "Generally, you know, it is documented."

14) J. Thompson-Legare was B. Perrott's Probation Officer. She acknowledged that under the terms of the Probation Order, she had the ability to "breach him for failing to take his medications under the terms of this Order." She further acknowledged that she was informed that B. Perrott had missed his injection. The Court makes the inference that this missed injection was on April 23, 2015, in light of all of the circumstances.

15) Indecision arose between FACS and the Probation Office with respect to what to do with B. Perrott's failure to take his injection. It appeared FACS did not want B. Perrott arrested as they originally believed he was a "formal" patient (apparently a "certified patient) as opposed to what they later determined and described as a "voluntary patient" (i.e. a "non-certified" patient) presumably under the *Alberta Mental Health Act*.

16) When asked the question after referring to the police, "You as Probation Officer, you have the power to say 'please go get, take him and him his shot'?", J. Thompson-Legare responded as follows:

> "I think at the time, reviewing the case notes, when he was leaving Alberta Hospital yes, initially they thought he didn't get his shot and the person that had initially called thought that he was certified to be there and later they did say he was there as a voluntary client. I think that if he hadn't stayed as a voluntary client and in consultation with Alberta Hospital or FACS if, you know, his assigned psychiatrist felt that he should be there, then I think he could have be obliged to – to be there, and if he had left Alberta Hospital, you could – breach for a violation report for – for not complying with his counseling condition. I think that we had been in contact – had been in contact with the police at that time, and without a formal breach, they were ready to – if-if he was – if he had been (indiscernible) they were ready that they were to locate him to take him back to Alberta Hospital to get the shot but that didn't – didn't' end up being the case."

17) J. Thompson-Legar conceded that after an in-person office visit on March 26, 2015, a missed April 9, 2015 phone check-in report (car troubles), a phone contact on April 22, 2015 and an in person visit April 23, 2015 (the same date as the missed injection) the latter was the last contact she had with B. Perrott. She noted he had failed to make his May 7, 2015 phone call and did not answer her May 14, 2015 phone call. She did leave a message. She indicated she was out of the office part of the next week and had received a call from B. Perrott's sister inquiring as to his reporting as she had not heard from him. She indicated she would have been reviewing the file to consider a violation for both not reporting and leaving the April 23, 2015 FACS appointment without receiving his injection. She felt he had been doing quite well up until then, and during his last contact with her, was very invested in changing the conditions to attend his father's residence (which he was prohibited from doing) and appeared willing to continue to work with Dr. Singh. She was very surprised at his passing.

18) The last witness was Frey, the director of community corrections of the Edmonton District. She indicates when Probation refers a client to FACS, Probation sends FACS a synopsis of the offence, the client's criminal history as well as the client's background and conduct concerns. She could not comment on whether FACS had a reporting requirement to Probation if a client's prescribed injections have been missed.

The events of May 22, 2015 up to and including the shooting of B. Perrott.

19) On May 22, 2015, a call was received by the Morinville RCMP at approximately 6:40-6:50 pm, believed to have been made by C. Perrott. The call indicated that her brother, B. Perrott, was at their father's home (R. Perrott) and was destroying contents. The complainant indicated B. Perrott was not allowed to be there and C. Perrott was unaware as to whether B. Perrott was off his medications or was under the influence of drugs. She believed there may be firearms in the residence but was unsure.

20) RCMP T. Sergent was the initial officer in charge of the response. Upon receiving the complaint, he sought information at the Morinville RCMP detachment. Sergent then made independent inquires in police data banks and satisfied himself of the following:

    1) B. Perrott was under a Probation Order prohibiting his attendance at his father R. Perrott's home;

2) He was not to consume or be under the influence of alcohol or drug;
3) B. Perrott had a criminal past along with an association with other criminal groups (i.e. The Hells Angels);
4) The risk of firearms being present was high;
5) He had overheard actual recorded conversations from the Edmonton Remand Centre where B. Perrott, in his opinion, was intimidating a witness (R. Perrott) and;
6) He had heard allegations of B. Perrott's drug use.

21) Sergent decided to respond to the home and to have the attending officers dress in body armour. Sergent, along with Rogers and St. Onge all attended to the residence of R. Perrott. A Cst. Holly Muller was also in attendance. Sergent approached the home of B. Perrott to clear the house when the police heard a man yelling 100's of metres to the South. St. Onge and Muller drove to the area wherein they attempted to converse with B. Perrott. B. Perrott was yelling and angry and after Sergent and Rogers were informed that the other officers had located B. Perrott, they too attended the location. One of the officers then noted that B. Perrott had a rifle in his hands. At that point, the RCMP officers looked for cover, drew weapons and attempted to contact RCMP dispatch with limited success.

22) B. Perrott began walking away from the RCMP into the field. He was very agitated, making statements like "Whatcha gonna do, come get me" and waving the police towards him. It was during this conversation that Sergent realized B. Perrott had two long items, which he later determined to be rifles.

23) Sergent followed B. Perrott at a distance, seeking shelter from trees while continuing to maintain visual contact. At one point, Sergent feared B. Perrott was aiming at him (later to discover he was) but Sergent did not discharge his weapon because he was unsure as a result of the sun in Sergent's eyes. Sergent continued walking and found limited shelter behind a low clay berm with a body of water behind it. While the clay berm offered limited and imperfect protection, the body of water, with an unknown depth and known deleterious effects on his weapons, was an option of last resort. Sergent sought protection behind the berm with his rifle shouldered. It was at this point that he saw B. Perrott aim his rifle at Sergent in a shooting stance (rifle to shoulder). Believing he was in a position of limited protection from the clay berm and with B. Perrott pointing his rifle at him in a shooting stance (rifle to shoulder), Sergent aimed at B. Perrott's centre of mass and shot. B. Perrott fell down with his rifle, falling to his right side.

The Events Following the Shooting of B. Perrott to the Time he was Declared Deceased

24) After B. Perrott fell, his body and position were partially concealed by tall grass, such that the officers involved could not see him. They did observe some leg and arm movements, and in fact saw B. Perrott move to sit up, only to lie back down in the grass. The RCMP had further help from Air Services which observed B Perrott lying on the ground with a weapon within 10 – 15 FT away from his feet; and movement consistent with being wounded, struggling to move or get up, but with no success. The officers shouted to B. Perrott to move away from his guns, but B. Perrott did not or could not comply. While the police believed they may have hit B. Perrott, they were still uncertain as he had previously attempted to lead or wave on the police to the confrontation that had eventually transpired. The police had a concern B. Perrott could also have been lying in wait for the police to approach to see if he was alright before reengaging them. The senior officer at this point had changed to a corporal, the highest-ranking member at the scene at that time, who was also a dog handler. That officer made the decision to call in the ERT for assistance. This team has superior training and self protection equipment to deal with firearm confrontations among other events. It was of note that the corporal did not send the canine unit (i.e. police dog) into the situation, for what can reasonably be inferred was a situation that was too uncertain and dangerous.

25) The ERT is a unit with specialized training and equipment to deal with high risk interactions. Unfortunately, due to the specialized equipment training involved, only 2 such RCMP units operate in Alberta; one each in Edmonton and Calgary. The resources are only available for two RCMP units in Alberta, and only for all unit members to be on shift half time and on call the other half. In this situation, the ERT members were on call. It was clear however, that their attendance in this situation was the only way treatment and medical aid could be administered to B. Perrott. Even though air footage prior to the ERT arrival showed limited movement by B. Perrott, the weapons were clearly in his vicinity, and his failure or inability to distance himself from those weapons required an armed escort for the EMRT to attend to his location. They could not and would not have attended to treatment without that level of safety. Unfortunately, by the time they had arrived at the scene of where B. Perrott was lying, B. Perrott was pronounced deceased. B. Perrott was shot at approximately 20:24 on the evening of May 22, 2015. From the time a critical incident program deployment was initiated (including a call to ERT) at 20:56, to the time the tactical armoured vehicle (TAV) arrived at 22:20, to the approach of B. Perrott's body 22:39 and the commencement of lifesaving procedures by EMRT at 22:50, B. Perrott had been lying for some 2 hours and 26 minutes.

Recommendations for the prevention of similar deaths:

With respect to the events leading up to May 22, 2015 and in particular, the relationship and communications between FACS and Alberta Probation, the following is noted. When FACS alerted Probation of B. Perrott's failure to receive his injection, they did so because they believed he was a "certified" patient. They resiled from that position once they realized he was "not" a "certified" patient. Because he was not a "certified" patient, in their lexicon, they believed and treated him as a "voluntary patient." While that is how FACS viewed this situation, *vis a vis* their definitions and description, it does not incorporate the larger view of B. Perrott's responsibilities to conform with the conditions of his Probation Order. Under those conditions, B. Perrott is mandated to comply with medical treatment; if injections are part of those conditions, he must comply as such. His treatment is <u>not</u> voluntary as it is compelled by the Probation Order. Indeed, the standard Probation Orders with treatment terms have the client consent, on the record, to agree to sign consents to release information to the Probation Officer from medical health providers to ensure compliance with medical assessment treatment and counselling.

Further, both FACS and Probation have a tolerance level of when to report a patient who has missed certain terms of their treatment regimes. A level of discretion is natural in any human relationship process (indeed, to build a relationship with a patient/client, it may well be counter productive to report every breach, no matter how small). FACS may not wish to imperil their relationship with a patient and treatment program by contacting Probation over the slightest treatment breach. The problem is that it is Probation that has the responsibility of monitoring the client, and therefore the duty to breach or not breach the client for missed appointments. The fact that FACS may inform Probation of even a slight breach does not compel Probation to breach the accused; it gives them information in their broader mandate to protect the client and society by ensuring the client is following his Court ordered terms. In short, it puts the discretion in the hands of those who have the responsibility of ensuring compliance: Probation. It is this Court's recommendation that in a situation where an offender is under a Court ordered Probation Order to comply and follow his physician's treatments and prescriptions administered through FACS and/or AHS, that a process be established to inform Probation of:

1) What prescriptions/treatments/assessments and/or counselling have been prescribed to the patient/client and;
2) In what form (email/letter/phone etc.) FACS would use to inform Probation of non-compliance and;
3) At what point in time after the non-compliance FACS would inform Probation.

With respect to the events of May 22, 2015 up to and including the shooting of B. Perrott, the tragic loss of the life of B. Perrott was a culmination of mental health issues and non-treatment. This Court offers no recommendations in the handling of the events leading up to the shooting of B. Perrott on the date of May 22, 2015.

With respect to the events following the shooting of B. Perrott to the time he was declared deceased; no recommendations are offered. Help could not be provided safely until the ERT arrived with protective equipment for the EMRT. This specialized unit came as quickly as it could. The best efforts were made to ensure the safety of the EMRT while still attempting to provide medical assistance to B. Perrott.

DATED October 4, 2021,

at St. Albert, Alberta.

"V.H. Myers"

Vaughn H. Myers
A Judge of the Provincial Court of Alberta

Classification: Public