CANADA
Province of Alberta

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Calgary Courts Centre

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

on the 29th and 30th day of October, 2007 year, (and by adjournment

on the 11th day of April, 2008 year),

Before Judge P.M. McIlhargey, a Provincial Court Judge,

into the death of Eva Marion Farnel (Name in Full) 53 (Age)

Of Suite 201, 707 – 57th Avenue SW, Calgary, Alberta, (Residence) and the following findings were made:

Date and Time of Death: May 12, 2006 at approximately 4:35 a.m.

Place: Rockyview General Hospital, Calgary, Alberta

Medical Cause of Death:
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 – The Fatality Inquires Act, Section 1(d)).

Sequelae of hanging.

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

Suicide.

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED:

INTRODUCTION

At approximately 4:26 a.m. on May 8, 2006, following a noise complaint, four Calgary Police Service (CPS) Officers attended the residence of Eva Marion Farnel, unit 201, 707 - 57th Avenue S.W., Calgary, Alberta, a building containing 28 to 30 apartments. This was the second time that morning the police had attended the residence in response to a noise complaint. Two officers had previously attended at 2:22 a.m. At 4:26 a.m. the officers found Ms. Farnel to be extremely intoxicated and were concerned about leaving her at the residence. Calgary Emergency Medical Services (EMS) was called and two paramedics attended. After assessing Ms. Farnel they determined that she was not in need of medical attention.

Ms. Farnel was arrested to prevent further breaches of the peace and for her own safety. She was transported to the City of Calgary Police Arrest Processing Unit (APU) arriving at 5:12 a.m. Ms. Farnel was booked in at 5:19 a.m. on a charge of being intoxicated in a public place. Her personal property, a necklace, was removed. She was then re-examined by an EMS paramedic and lodged in a cell. At approximately *9:15a.m. she removed a long sleeve shirt she was wearing and used it as a ligature to hang herself from a pole supporting a privacy partition for a toilet located in the cell.

A guard observed her hanging at approximately *9:24 a.m. Efforts were made to resuscitate her. These efforts met with limited success. Ms. Farnel was initially transported to the Foothills Hospital and later that day she was transferred to the Rockyview General Hospital.

On May 12, 2006, after life support was terminated at the request of her family, she succumbed to her injuries and passed away.

* *Note: The times referred to are those recorded and displayed on the APU Video Surveillance tapes for May 8, 2006.*

EVA MARION FARNEL

The APU, its procedures and physical attributes, cells, bars, buzzers, the Fatality Inquiry process, the issues and the nature of the evidence heard, and this Report, all tend to dehumanize and even stigmatize an individual who is the subject of the Inquiry. That is not the intent. The purpose of this Inquiry was not to assess Ms. Farnel as an individual and very little evidence was heard with respect to her values, family relationships or community involvement. The focus of the Inquiry is the events of May 8, 2006 and the short period following. The purpose of this Inquiry being to examine the circumstances of Ms. Farnel's death and if possible, to make recommendations that might assist in preventing similar deaths.

Eva Marion Farnel was the youngest of five children. She had one sister and three brothers. In May of 2006 Ms. Farnel was 53 years of age and resided at 201, 707 - 57 Avenue S.W., Calgary, Alberta, in an apartment that she shared with Dennis Morgan, her common law spouse of 11 to 12 years. The relationship was described by Joyce Stevens, Ms. Farnel's sister, as being very stressful.

Ms. Farnel had been unemployed since September of 2005. She was described as having an "*alcohol problem*", stemming back possibly as far as 1987. She was not known to use non-prescribed drugs. She had never attempted to commit suicide and there was no family history of suicide.

COMPLAINT AND POLICE ATTENDANCE

In a statement provided to the police at 6:03 p.m. on May 8, 2006, Dennis Morgan (who did not testify), advised that he and Ms. Farnel had started drinking at 2:00 p.m. to 3:00 p.m. the preceding afternoon and that they drank too much, resulting in a disagreement. He had very little recollection of the police attending their residence on either of the two occasions that morning.

It was clear on the evidence of the attending officers, the attending EMS technicians and the Building Manager that Ms. Farnel was intoxicated on both occasions that the police attended. A Toxicology Report respecting post mortem blood samples taken at 10:20 a.m. on May 8, 2006, disclosed *ante mortem* blood and plasma ethanol readings of 240 and 260 milligrams of alcohol per 100 milliliters of blood.

First Complaint and Attendance

Constable Patrick J. Kiez testified that at 2:16 a.m. on May 8, 2006, he and his partner, Constable McGregor, both City of Calgary Police Service (CPS) Officers, were dispatched to 707 - 57 Ave. S.W., Calgary, Alberta, in response to a noise complaint stated as coming from "*below 301*". They arrived at 2:22 a.m. and exited their police car. As they moved toward the building they observed the lights on in a single unit in the complex. They saw a male and a female in that unit, both seated on the couch and through an open balcony door they could hear loud music, lots of loud talking and the television. The officers tried unsuccessfully to buzz the complainant in apartment 301. Believing the music to be coming from 201 they then tried that apartment. While buzzing that apartment a female, later identified as Eva Marion Farnel, came out onto the balcony of the apartment they had previously observed and yelled that they had the wrong "*fucking number*". After buzzing apartment 201 several more times they gained admittance to the building.

At 2:27 a.m. the officers dealt with Ms. Farnel at the door of her apartment, apartment 201. Constable Kiez described her as obviously intoxicated, unable to stand correctly, slurred speech and the facial appearance of a person who is intoxicated. While speaking to her the man who was on the couch, later identified as Dennis Morgan, was yelling profanities at the officers and Ms. Farnel. Ms. Farnel was also yelling at the officers, but settled down once they told her why they were there. She was told that she would be issued a citation if they had to come back. She said she was going to bed. The officers left at 2:31 a.m.

Second Complaint and Attendance

Building Manager, Tom Crawford, testified that at about 4:00 a.m. May 8, 2006, he received a noise complaint from the occupant of apartment 301. Mr. Crawford testified that he knew both Ms. Farnel and Mr. Morgan as he had dealt with them on a casual basis and that there were times "*that I had to deal with the two of them…..they were both drinkers and they were both loud and they both needed to be told to shut up on occasion*", these "occasions" being mostly late at night.

In response to the complaint Mr. Crawford went to Ms. Farnel's balcony window and spoke directly to her. Mr. Morgan was lying on the couch. Mr. Crawford described Ms. Farnel as "*extremely drunk.*" After several minutes they had still not shut it down so he went to the door. He described the noise coming from the apartment as a "*drunken rant, screaming*," which continued until after the police arrived. He pounded on the door, received a rude response and then he called the police who arrived about 10 minutes later.

Constable David Bailey and his partner, **Constable Matt Binda**, in one police car, and **Constable Troy Leckie** and his partner Peterson, in another car, responding to "*a second noise complaint … a complaint of people arguing in an apartment*", arrived at the building at 4:26 a.m.

On exiting their vehicles they heard what was described by Constable Leckie as an "*indiscernible loud noise*" from what appeared to be a second floor apartment. The balcony door of the apartment was open. Admitted to the building by Tom Crawford, Constable Bailey went to the door of the apartment the noise was coming from, apartment 201. He knocked repeatedly at the door, announcing while doing so that the police were at the door. After receiving no response the Building Manager was asked to and did use his keys to open the door to the apartment.

I make no finding regarding the lawfulness of the entry into the premise or Ms. Farnel's subsequent arrest. I accept Constable Bailey's evidence that after knocking on the door and announcing that they were police officers there was "*no discernible difference in the noise level"*

and that *"as the noise was still continuing...we made the decision to enter and find out exactly what was going on*". I accept that they entered, as stated by Constable Leckie:

> "… *due to the nature of the call and the potential that it was possibly related to a domestic…. certainly there's some unusual noises that I heard myself upon attending that caused me some concern. And we entered the apartment to check on the welfare of the people within*".

On entering, the police found Ms. Farnel, who they described variously as "*unable to hold her head up … a total lack of muscle control … incoherent … seemingly unable to comprehend or respond to questions … could not walk or stand without assistance*". Attempts were made to put Ms. Farnel to bed and the officers observed that she could not support herself in bed. Constable Bailey testified that it was during this period that he determined that Ms. Farnel needed to be taken to a place of safety. EMS were called so that Ms. Farnel could be examined to determine if there were any medical concerns and to make certain that Ms. Farnel did not require medical treatment.

EMS paramedics **Wayne Anderson** and Alfred Klein attended apartment 201 and at 4:50 a.m. Ms. Farnel was examined by Mr. Anderson, who at that time had 27 years experience as a paramedic.

Mr. Anderson described Ms. Farnel variously as "… *appearing intoxicated … seemed quite upset … shouting profanities*". He stated that her responses, although slightly slurred, were coherent and intelligible, and further testified that when she stood she needed assistance, and was staggering. In a statement provided to the police immediately following the incident he wrote that Ms. Farnel *"appeared intoxicated, shouting, belligerent and argumentative*".

After the examination Mr. Anderson determined that Ms. Farnel was not in need of medical attention and did not need to be transported to the hospital. With respect to this last determination. I note that when Mr. Anderson arrived he had understood that Ms. Farnel was to be transported by the police to APU and "*that she would be seen there again and reassessed again with an ongoing official check on her*". He completed a Patient Care Record (Exhibit 14).

Of note, Mr. Anderson estimated that he spent 30 to 45 minutes with Ms. Farnel. Constable Bailey had testified that he thought it was about five to ten minutes.

<u>DECISION TO ARREST AND TRANSPORT</u>

Following a brief discussion the officers determined that Ms. Farnel should be arrested, for the following reasons:

- for her own safety, as she was incapable of caring for herself and there was no individual present who was capable of caring for her,
- following arrest she would be transported to APU, where she would be subject to a further medical examination and would be regularly monitored, and
- unless she was removed the breach of the peace would continue.

Constable Bailey arrested Ms. Farnel for breaching the peace. In accordance with CPS policy, prior to Ms. Farnel being transported, Constable Bailey contacted the Staff Sergeant at the APU and the circumstances of the arrest and other possible options were discussed.

Constable Bailey testified that although he had no recollection or note of advising Ms. Farnel of her right to counsel, he believed he should have, and would have done so, as department policy requires that a person be given their rights whether they seem to understand or not.
Mr. Anderson testified that Ms. Farnel appeared upset by the decision to take her from her apartment, that she did not go voluntarily and that she was assisted to her feet and escorted to the door. He observed that she required the assistance of at least two police officers. He stated that when it became apparent to her that she was being taken to a police car and not an ambulance she collapsed and "*started screaming"* following which she had to be physically carried. Once in the rear of the police car Ms. Farnel was verbally combative. She continued to shout, scream and bang on the Plexiglas divider which was in place between the front and rear seats of the vehicle.

Although not asked, Mr. Crawford did not mention any improper conduct by the police officers.

I note that while all of the witnesses who testified as to Ms. Farnel's condition described varying degrees of sobriety, all agreed that she was intoxicated.

Ms. Farnel was transported to the APU by Constables Bailey and Binda with Constables Leckie and Peterson following in a separate car in the event further assistance was required. Constable Bailey testified that during transport to the APU Ms. Farnel quit banging on the Plexiglas divider and that she seemed to settle down. Her appearance was described by the officer as "*typical intoxicated*".

During transport a record check was conducted. On learning that Ms. Farnel had no prior record of offences it was decided to change the reason for arrest to a charge of being intoxicated in a public place, a provincial rather than a federal *Criminal Code* offence.

The officers arrived at the APU with Ms. Farnel at 5:12 a.m. and a "booking-in sheet" (Exhibit 13) was completed at 5:19 a.m. She was then "processed" according to standard procedure, Constable Bailey stating that "*once property and any laces, belts, anything that could be used as a ligature is taken --- taken from the individual, they're taken to EMS technicians who work full time at APU just to be re-examined medically*…". During this procedure a necklace was removed. After medical examination Ms. Farnel was lodged in cell 12.

Officers booking persons in to the APU provide a written synopsis. It is intended that this synopsis be reviewed by the Staff Sergeant or Custody Sergeant to assist the jailors in dealing with detained persons. Such a synopsis was provided in the case of Ms. Farnel and appended as a separate page to the booking-in sheet. Believed to have been written by Constable Binda, it was read over and signed by Constable Bailey. The synopsis stated:

> Acc was located at 707 57 Ave. EXTREMLY Drunk, Acc was causing Excessive Noise Admitted to drinking alcohol, strong smell of alcohol from her breath. Acc had no other place to go or stay.

There was no evidence that any other information was given to or accessed by the APU staff whose duty it was to monitor Ms. Farnel (see "Calgary Arrest Processing Unit", below).

<u>Alternatives to APU</u>

Both Constables Kiez and Bailey were asked about alternatives to removing intoxicated persons to the APU, specifically, Alpha House. Constable Kiez, who responded to the first noise complaint at 2:22 a.m. (and had indicated in his testimony that he would not have considered arresting Ms. Farnel at that time) commented that:

> *"It is a place that where persons that I have found myself generally that live on the street have been transported to so they can sleep off…if they're impaired and more so for their own safety too. If they're walking the street and all of a sudden some people take offence to the fact that they are intoxicated they…they could possibly be assaulted …*"

He further testified that as a condition of admission persons have to be able to walk on their own, they cannot be carried in and they cannot be violent at the time. "*We have many assaults at Alpha House*".

Constable Bailey felt that neither Alpha House nor the Calgary Drop-In and Rehabilitation Centre were options, as he considered those facilities were for homeless persons. In his opinion, persons taken to Alpha House generally have other addictions and substance abuse problems and/or mental health issues. He testified that if Ms. Farnel were taken to one of these places she would be like "*a fish out of water*".

No other evidence was adduced as to the availability or appropriateness of Alpha House, the Calgary Drop-In and Rehabilitation Centre or the Salvation Army.

CALGARY POLICE SERVICE ARREST PROCESSING UNIT

Physical Layout

The APU is located at 316 – 7th Avenue, S. E., Calgary. The prisoner and holding cell area occupy the west side of the third floor. It is designed as a short term holding facility pending prisoner release or transfer to the remand centre. The east side of the floor contains administration offices, staff lunch room, etc.

I have attached a diagram of the floor plan for the APU as Appendix A. The diagram shows only those areas that are relevant to this report and is not to scale.

Ms. Farnel was lodged in cell 12. As can be seen in Appendix A, cell 12, the "Female Tank", is at some distance from the Arrest Processing Counter while the "Male Observation Cells" or "Male Tanks" are across the hall, so to speak, and visible from the counter as the two areas are separated by a clear Plexiglas divider. The cell doors and the west walls for each of cells 4 to 13 consist of vertical bars. As depicted in the floor plan, there is a breezeway at the west end of the cells. This area is not generally used or accessed.

On May 8, 2006, cell 12 was, and continues to be, used for intoxicated female persons. The east end of the cell consists of an open area, bare walls, bare ceiling and floor, without benches or fixtures of any kind. A one piece washstand and toilet unit is installed adjacent to the west end of the cell. This unit is mounted on the north wall. The washstand and toilet are made of brushed chrome steel with no toilet seat or other fixtures such as a towel or toilet paper rack. In fact there are no towels, paper or otherwise, and no toilet paper in the cell. Hot and cold water for the sink and the flushing mechanism for the toilet consist of push buttons mounted flush to the wall.

A privacy partition is mounted on the north wall adjacent to and on the cell side of toilet. It consists of a flat piece of sheet metal that appears to be approximately two feet in height by three feet in width. The partition is supported by the north wall at one end and by a pole at the other. The bottom of the partition is two feet from the floor such that if a person were seated on the toilet then the only part of that person that would be visible from the cell door would be their head, their shoulders, and their legs, from the knees down.

It was the privacy partition support pole that Ms. Farnel used to hang herself.

No changes have been made to the physical layout of cell 12 or its use.

Video Surveillance

All cells and hallways on the prisoner side of the APU were on May 8, 2006, and continue to be, subject to video surveillance. Twelve video display monitors are mounted on the wall in the administration area at the Arrest Processing Counter of the APU. These consist of single cell monitors and four-plexes, capable of monitoring and displaying four areas simultaneously. The only cells not monitored in this manner are cells 1, 2 and 3, or the "Male Drunk Tanks". These cells may be viewed directly from the Arrest Processing Counter through the clear Plexiglass wall referred to above.

Card Access Readers

Card Access Readers are located in the cell block area at the Staff Sergeant's Desk and at cells 4, 13, 18 and 20. When swiped with a magnetic identification card, the Readers record the time and identity of the user. Every ten minutes a light flashes in the administration area and on the Card Access Readers as a reminder to conduct rounds. The lights on the Readers continue to flash until swiped with an ID card. Prior to Ms. Farnel's death, buzzers would sound as an ID card was being swiped. **The Readers now operate in 'silent mode'** as it was felt that the buzzers enabled the prisoners to predict the Commissionaire's movements.

The Access Granted Events printout (Exhibit 9) provides a written record of all card swipes for the period from 5:00:06 a.m. to 9:51:09 a.m. on May 8, 2006, in the following format: Date/Time, Device (location), Badge Number and Cardholder Name.

Prisoner Care and Monitoring

The Arrest Processing Unit is staffed 24 hours a day, seven days a week, by four shifts consisting of four teams. Staffing for each team is comprised as follows: One Staff Sergeant, one sergeant, three sworn Constables and four Commissionaires, a total of nine persons per team. The Staff Sergeant is and has always been responsible for reviewing the reasons for arrest of each new person brought into the APU. The sworn Constables generally act as "presenters" and are involved in prisoner release while the Commissionaires, under a Corporal, deal primarily with the monitoring and movement of prisoners and their property. Teams are generally at full strength. In October of 2007, on the date that Staff Sergeant Kotowski first testified, there were 22 to 23 people working at the APU.

On May 8, 2006, prisoner care and monitoring was, and continues to be, the responsibility of Commissionaires, who work in two 12 hour shifts per day (6:00 a.m. to 6:00 p.m.) with four Commissionaires per shift. Commissionaire duties included booking prisoners in and entering their information on the computer, removing and securing their property, lodging them into cells, moving them from cell to cell when required, or to the front counter or hearing office, to be fingerprinted or for hearings, or to the telephone to talk to a lawyer or a family member.

The Commissionaires are also responsible for making rounds of the cell block area every ten minutes to personally view the prisoners. They also monitor the video displays in the administration area.

In May of 2006, prior to Ms. Farnel's death, the ten minute rounds were done by whichever Commissionaire was free and the video displays in the administration area of the arrest processing office viewed randomly by Commissionaires in the office when not occupied with other duties.

Following Ms. Farnel's death a formal policy has been implemented and is now in place. Specific Commissionaires are assigned on one hour rotations to conduct rounds of the cells every ten minutes. The same Commissionaire, when not conducting rounds, then being responsible to monitor the video display monitors.

Suicide Awareness, Detection and Training

In their testimony, **Commissionaires Dan Colesnick** and **Gerald Spencer**, who had six and eleven years experience, respectively, at the APU, acknowledged that they had received no formal training for their position and duties at the APU, relying rather on "on the job training" and their past experience as police officers. Specifically, they had not received any suicide awareness training.

PROCEDURES ON ARRIVAL AND DETENTION AT APU

In May of 2006 information flow regarding each prisoner was conducted on an informal basis. Any notes or memos made or left by an arresting officer would not necessarily be brought to the attention of the Commissionaires and there was no official shift change or transfer of information. At shift change Commissionaires would generally talk to each other, but only about problem prisoners. A prisoner log and computer entries were available, but only for the purpose of indicating who was there. There was no formal prisoner log or procedure in place to record and transfer or pass on specific prisoner information.

As part of the booking-in procedure, individuals were usually asked by the Commissionaires if they were suicidal. If there was an affirmative indication that they were, then the practice was to report the matter to the Staff Sergeant for further follow-up.

Commissionaire Dan Colesnick recalled asking Ms. Farnel about suicidal tendencies but did not recall her response, assuming therefore that it must have been negative, or he would have spoken to the Staff Sergeant. He dealt with Ms. Farnel for only a brief period of time, a "*couple of minutes*". He described her as extremely intoxicated but calm and able to stand without assistance while her booking-in photograph was taken. Commissionaire Colesnick completed his shift at 6:00 a.m.

EMS Examination and Assessment

Following the initial completion of the Booking-In Sheet at the APU but prior to being lodged in cells, Ms. Farnel was examined at 5:23 a.m. by Calgary EMS **Paramedic Wally Mah**. Mr. Mah was an employee of Calgary EMS, on assignment to the Calgary Police Service to provide medical services at the APU. By contract paramedics were provided for two 12 hour shifts per day (6:00 a.m. and 6:00 p.m.), on a four day rotation, once every 12 weeks.

APU policy required that every person in custody be medically assessed by a paramedic, whose duties included an initial examination of the detained person's physical and mental health prior to their being lodged in cells and the further monitoring of a detained person when there were concerns. The Medical Office was equipped with a video monitor, a four-plex, such that four cells could be monitored simultaneously.

Mr. Mah was unable to specify which cells were or could be monitored by video. He advised that in May of 2006 there was no formal policy regarding monitoring, it was a matter left to the discretion of the individual paramedic. He had no recollection of monitoring Ms. Farnel in her cell following the completion of his assessment of her. Although not specifically asked, his answer suggests that no formal record was kept of subsequent monitoring of detained persons by paramedics.

Mr. Mah testified that his schooling as a paramedic included suicide awareness training involving text material to be read. There was no indication of any follow-up training or re-certification being required.

The mental health assessment conducted as part of the medical examination at the APU was described by Mr. Mah as basic and subject to a paramedic's discretion. It was generally limited to the standard questions as set out on the EMS APU Patient Care Record (Exhibit 16), including, where necessary, a brief explanation of the questions asked. For example, the following questions are set out in Part B of the Patient Care Record:

- Previous/current mental health treatment?
- Previous/current psychiatric medications?
- Previous mental health hospitalizations?
- History of violence?
- History of drug/substance abuse?

The mental health assessment for risk of suicide was also basic. Further questions set out in Part B were:

- Have you ever heard voices?
- Have you ever seen things that weren't really there?
- History of suicidal thoughts?
- History of attempted suicides? Date of last attempt?
- Current suicidal thoughts?

Other questions addressing known stress factors were not required to be asked, relating to matters such as:

- Relationship breakups
- Loss of employment
- Death of a parent or family member

Mr. Mah stated that as a matter of policy, if there were suicide concerns, such as family history or current suicidal thoughts, then the detainee would be lodged in a cell in a different area where they could be more closely monitored and put in "baby dolls", a garment that is more difficult to tear or rip.

Mr. Mah was not provided with a copy of EMS paramedic Anderson's Patient Care Record of the examination conducted at Ms. Farnel's residence prior to her being transported.

Relying on his recollection and records, Mr. Mah testified that Ms. Farnel's examination took seven to eight minutes following which he had no concerns for her physical or mental health.

Mr. Mah described Ms. Farnel as "moderately" intoxicated, as opposed to "mildly" or "severely". He noted the following:

- admission of consumption of alcohol, specifically wine, "lots of wine"
- able to answer questions appropriately, and
- walked, slightly unsteady gait but on her own.

At 5:27 a.m. a Commissionaire escorted Ms. Farnel to, and placed her in, cell 12. There was one other person, a female, Brittany Nelson, lying on the floor in that cell. Ms. Nelson was removed at 7:13 a.m. to be fingerprinted and released on bail.

COMMISSIONAIRE'S OBSERVATIONS

Commissionaire Gerald Spencer came on shift at 5:30 a.m. To his recollection he received no specific information regarding the prisoner in cell 12 and in fact it was Commissionaire Spencer who at just after 9:21 a.m. (as per the Card Access Reader printout) or at 9:24:14 a.m. (as per the video record), entered Ms. Farnel's cell 12 after observing her suspended by her shirt form the privacy partition in her cell.

In his testimony he estimated that he had made rounds past cell 12 five or six times. The Access Granted Events printout records only three rounds by Commissionaire Spencer prior to finding Ms. Farnel that morning, at 6:11 a.m., at 6:40 a.m. and at 8:40 a.m.

Commissionaire Spencer described Ms. Farnel as appearing intoxicated, this being based on his observations of her sitting on the floor and some yelling. He never saw her asleep. He was not asked if he had observed her on the video monitor. Based on his experience with intoxicated persons, he did not find her actions alarming.

On conducting a round at 9:21 a.m., Commissionaire Spencer found Ms. Farnel suspended in her cell. In his own words:

> "*when I got to cell 12, which is the female drunk tank I …I saw a lady in a seated position with her back up against the shield that covers the …that … that protects the washroom, and she was …she had…she was hanging from a cloth around her neck, tied to the pole, which, …which goes up to the ceiling and holds the vanity thing.*"

Commissionaire Spencer called for help, opened the door, entered the cell and used his knife to cut the cloth off the pole. In fact, the cloth was her shirt. He believed that he then untied, rather than cut, the cloth from around Ms. Farnel's neck and flung it into the hallway. She was unconscious. He had no idea for how long. In response to his calls "*everyone came running*", a paramedic, another Commissionaire and a police sergeant. As they began first aid he returned to the main office.

Commissionaires **Sherri Hulburd**, **James DeFillipo** and G. Powis were also on duty on the 6:00 a.m. to 6:00 p.m. shift, May 8, 2006.

Commissionaire Sherri Hulburd, who had seven years experience with the CPS testified that she (generally) arrived at 5:30 a.m. to 5:40 a.m. for her shift. She stated that any information from the previous shift would have been given to Commissionaire Spencer and that she did not receive any specific information with respect to Ms. Farnel.

Although she conducted cell checks at 6:30 a.m. and again at 6:50 a.m., she believed that she had no personal dealings with Ms. Farnel and had no recollection of seeing Ms. Farnel in her cell. Based on this she assumed that at the times she passed Ms. Farnel's cell she would not have noted anything untoward. She had some recollection of hearing Ms. Farnel talking to herself in her cell, something about a "*TV changer in her purse*". This occurred as she was placing another prisoner in cell 11, adjacent to cell 12. She stated that Ms. Farnel was not yelling, just "*speaking to herself*". She did not see Ms. Farnel at this time and based in part on the fact that Ms. Farnel was in the "tank", believed her to be intoxicated. Refreshing her memory from a statement that she had provided to the police at 11:00 a.m. on May 8, 2006, she believed that this incident took place about five minutes before Ms. Farnel was found hanging in her cell.

On hearing Commissionaire Spencer's call for help, Commissionaire Hulburd immediately attended cell 12 with the paramedic on duty at that time, Steven Grant, and on his direction

commenced and continued CPR on Ms. Farnel until the arrival of the transport medics. She testified that during this period Ms. Farnel never regained consciousness.

Commissionaire Hulburd's testimony confirmed:

- the lack of any formal policy regarding the recording or transfer of information between shifts as of May 8, 2006, and
- that following Ms. Farnel's death, policy changes were implemented with respect to the monitoring of video display and cell checks.

Commissionaire James DiFilippo started working at the APU in November of 2005, six months prior to Ms. Farnel's death. He had First Aid training but no prior experience or training in dealing with prisoners. His training, prior to commencing his duties at the APU, consisted of shadowing other officers for ten to 14 days and on the job training as required. He could not recall any such on the job training and he received no training for suicide awareness.

Commissionaire DiFilippo, whose duties included booking in prisoners, moving and monitoring prisoners, was on duty on May 8, 2006, on the day shift, starting at 5:30 a.m. At the commencement of his shift he had been verbally advised by Commissionaires Dan and Ken, who were just ending their shift (and whose surnames he could not recall), that they had just placed a female in cell 12 and that she would be "high maintenance" due to her inebriation. The term 'high maintenance" was not explained. In context it seemed to mean 'was likely to cause problems, another drunk'.

Initially there was another prisoner, Ms. Nelson, in the cell with Ms. Farnel. Ms. Nelson asked to be moved, complaining that Ms. Farnel kept hugging her, seeking compassion. Shortly later, after being fingerprinted Ms. Nelson was moved from cell 12 and lodged in cell 11. Commissionaire DiFilippo could not recall either the time of the complaint or the time that Ms. Nelson was relocated.

Ms. Farnel was upset by this and other issues, complaining often. Commissionaire DiFilippo did not find her conduct unusual. He described her speech as being coherent but not entirely logical. He found her actions to be consistent with a person who was intoxicated.

Commissionaire DiFilippo testified and had noted, in his handwritten notes, that on conducting a cell check at 9:10 a.m. he had found Ms. Farnel on all fours (hands and knees) in her cell, stating that initially she *"wanted her lawyer there, now"*, and then, after being asked if she thought she was in a good enough condition to speak to her lawyer, she stated that "s*he wanted her lawyer to bring her cigarettes, now"*.

On the evidence of Staff Sergeant Kotowski (see below) and Commissionaire DiFilippo, I am satisfied that as a matter of unwritten policy, with one exception, if a prisoner asks to speak to counsel, then that request will be granted. The exception being that if a request is made by a prisoner being held in the male or female tanks or the observation cells, then that request will be assessed by a higher ranking officer, being the Staff Sergeant or Corporal, on duty.

Commissionaire DiFilippo's evidence was that at 9:21 a.m., by his watch, set according to the control room clock, he was in the control room when he heard Commissionaire Spencer call from Ms. Farnel's cell.

I have some difficulty in reconciling Commissionaire DiFilippo's recollection and his notes.

As recorded on the Access Granted Events printout, Commissionaire DiFilippo conducted cell checks 11 times prior to Ms. Farnel being found at 9:21 a.m., the last of these beginning at

8:50:03 a.m. and ending at 8:51:00 a.m. This was approximately 20 minutes before Ms. Farnel was found by Commissionaire Spencer. The printout recorded that the cell checks at 9:00 a.m. and 9:10 a.m. had been conducted by Commissionaire Powis. Commissionaire Powis did not testify.

When asked about the discrepancy between the Access Granted Events printout and his notes, he had no explanation but that his notes would have been based on his watch.

Asked further about his observations, regardless of the recorded time, he stated that it was his recollection that Spencer called not more than 11 minutes after he had last observed and spoken to Ms. Farnel.

His recollection was that Ms. Farnel had not asked to speak to her lawyer, only that she wanted him there. His notes, however, made at the time of the incident, indicated only that she asked to speak to her lawyer.

VIDEO RECORDING - CELL 12

I viewed the video tape (Exhibit 11) which recorded Ms. Farnel's movements at the APU from the time she was brought in at 5:12 a.m. on May 8, 2006, and continuing until after incident. The video record includes a time read-out and consists of still pictures, displayed with an eight second to 15 second interval. I specifically noted the events in cell 12 during the period 08:49 a.m. to shortly after 09:25 a.m.

Observations

The times referred to in this section are as per the **video record** and are subject to my comments below concerning the discrepancy between the time shown and recorded on the video tape and the times recorded by the electronic card swipes (Card Access Readers) as shown on the Access Granted Events printout.

Ms Farnel, from 8:46 a.m. to 9:14 a.m., was up and moving freely about the cell, sitting or squatting near the walls and corners, at times looking out through the bars at the back of the cell and occasionally looking out the cell door. In this period the Commissionaires would not have noticed anything untoward. When the Commissionaires made their rounds Ms. Farnel was generally inactive, sitting or standing. This was consistent with her movements during this entire period.

From 9:10 a.m. to 9:14 a.m., Ms. Farnel stood more or less motionless and leaning against the north wall of her cell near the privacy partition. At 9:14 a.m., after standing motionless for approximately four minutes near the partition, she moved to the cell door to look out, then moved into the corner adjacent to and to the left of the door at the front of the cell, first sitting with her back to the wall and legs extended in front of her, then slumping down, prone on floor, with her legs extended in front of her. She then crossed the cell to stand at the rear of the cell in the far left hand corner and from 9:14:45 a.m. to 9:15:02 a.m. stood looking out into the breezeway.

Without detailing her exact movements, between 9:15:19 a.m. and 9:16:20 a.m., Ms. Farnel removed her shirt and fastened it behind her back to the pole supporting the privacy partition, sliding to her knees thereby using her shirt as a ligature. With the exception of a very slight movement at 9:16: 56 a.m., there was no movement in the cell until Commissionaire Spencer entered at 9:24:14 a.m., followed by other personnel at 9:25:32 a.m.

The video overwhelmingly suggests that between 09:10 and 09:14 a.m. she was contemplating her move with the final decision made at about 09:14:34 a.m. when she was slumped in the

corner. She had not sat or slumped this way previously. **The video is evidence of how quickly this event transpired. Once Ms. Farnel made her decision it took her approximately one minute to effect her purpose.**

Continuous video monitoring may have resulted in a much shorter detection and response time.

TIME

I have the following comments regarding the various estimates and declarations of the time.

Time of Occurrence of Events

Several individuals were asked and gave estimates of the time they began or took to complete certain tasks. Based on the times actually recorded it appears that most tended to overestimate the time involved, for example:

- Mr. Anderson, recalled that his examination of Ms. Farnel at her residence took 30 to 45 minutes. I note however that on his Patient Care Record (Exhibit 14) he recorded a start time of 4:50 a.m. The evidence was that Ms. Farnel arrived at the APU at 5:12 a.m. and was booked in at 5:19 a.m., respectively, 22 and 29 minutes later. There was no evidence of the synchronization of watches. However, assuming some minor discrepancies in the times displayed on different peoples watches, I am satisfied that he did not spend 30 to 45 minutes with Ms. Farnel.

- Mr. Mah, testified that he spent seven to eight minutes with Ms. Farnel. The time display of the video recording entered as Exhibit 11 had Ms. Farnel's book-in photo taken at 5:22:23 a.m. and shows her being escorted to the paramedic's office at 5:23 a.m., in that office at 5:23:40, and back on the bench at the arrest processing counter at 5:26:53 a.m. (presumably her examination having been completed), this being approximately four and not seven or eight minutes as initially estimated by Mr. Mah. Asked about this, Mr. Mah testified that:

  > "*The time indicated in my documentation is actually entered through the computer. We simply click on that space and hit the tab and the time automatically comes up. As far as whether it is three minutes or seven or eight it's a possibility, I really couldn't say.*"

Other estimates of time given in testimony should also be considered, in the absence of more detailed evidence, as just that, estimates only which may be subject to a significant error.

Discrepancy In Time of Occurrence – Video vs. Card Access Readers

The **Video** and the **Card Access Readers** each recorded and displayed a time of the occurrence. There is an approximate three minute discrepancy between the time recorded and shown as part of the video display, and the time recorded by the Card Access Readers (card swipes) at the APU on the Access Granted Events printout. Specifically, the times displayed on the video display are equal to the times displayed on Access Granted Events printout plus three minutes. I base this finding on the following evidence.

There was a Card Access Reader at cell 13 adjacent to Ms. Farnel's cell 12. The Access Granted Events printout of Commissionaire Spencer's regular ten minute rounds shows that it was his practice to make his rounds in the following sequence: Staff Sergeant's Desk, cell 18, cell 20, cell 13 and then cell 4. As such he would pass Ms. Farnel's cell in a matter of seconds after swiping the Card Access Reader at cell 13.

The Access Granted Events printout has Commissionaire Spencer at cell 13 at **9:21:11 a.m.** and on his evidence, on discovering Ms. Farnel, he immediately entered her cell and cut her down. On the video printout Commissioner Spencer is shown entering cell 12 at **9:24:14 a.m.**, a discrepancy of "plus three" minutes.

This fact is significant.

The Access Granted Events Printout of the Commissionaires' prior round has Commissioner Powis at cell 13 at 9:10:50 a.m. and at cell 4 at 9:11:06 a.m. As with Commissionaire Spencer, in travelling from cell 13 to cell 4, Commissioner Powis would pass directly in front of (Ms. Farmel's) cell 12.

The video recording of Ms. Farnel in her cell during this period shows her moving to the cell door to look out at 9:14:01 a.m., then sitting and slumping down in the corner adjacent to the door with legs extended, then crossing the cell, apparently walking, to stand at the rear of the cell, looking out into the breezeway.

Adjusting the times recorded in the Access Granted Events printout by adding three minutes, such that they are in sequence with the times displayed in the video display, then as per the video display **Commissionaire Powis passed Ms. Farnel's cell on his round between 9:13:50 a.m. and 9:14:06 a.m., at the same time that Ms. Farnel was at her cell door and within two minutes, Ms. Farnel was lying motionless in her cell, suspended by ligature around her neck. Eight minutes later she was found by Commissionaire Spencer**

Ms. Farnel was timing her actions to the Commissionaire's rounds.

MEDICAL TREATMENT AT APU AND TRANSPORT TO THE FOOTHILLS HOSPITAL

Paramedic Steven Grant was on duty at the APU on the 6:00 a.m. to 6:00 p.m. shift, May 8, 2006. He had been a paramedic for four years, with two years experience prior to that as an Emergency Medical Technician.

When Mr. Grant started his shift he had received no report from Mr. Mah of any concerns with respect to Ms. Farnel, in fact he received no information at all with respect to her. At that time information would only be recorded and passed on if there was a medical concern. On May 8, 2006, the only information passed on was with respect to a diabetic inmate with seizure concerns.

The Medical Office was equipped with a video monitor on which four cells could be displayed at one time. Mr. Grant did not recall viewing Ms. Farnel's cell on the video display and he stated that although he did not specifically recall Ms. Farnel, he did recall doing at least two rounds of the cells before the incident and not having any concerns.

In May of 2006 paramedics were not required to regularly monitor detainees either on the video monitor in the Medical Office or by making rounds of the cells, and only one paramedic was on duty at a time, regardless of the number of detainees in cells.

Mr. Grant testified that on hearing the call for a medic (help) he ran out of his office. Initially concerned that it may be a seizure, he was advised that it was a hanging. He went to Ms. Farnel's cell where he found her laying on the floor "*obviously not breathing, blue in color*". In his PRU Response (Exhibit 19), completed later that morning, he recorded the time as 9:22 a.m. Mr. Grant went back to the Medical Office for his medical equipment and on returning to the cell began the process of trying to resuscitate Ms. Farnel. As she had no pulse and was not breathing, he instructed one of the guards to begin CPR and provided the other guard, whom he

believed to be a sergeant, with a bag valve mask (a manual breathing apparatus) and assisted him in starting its application on Ms. Farenl. He stated that the primary objective at this juncture was to get the heart started.

He next started an IV and attached a cardiac monitor which would detect any electrical activity in the heart. His evidence was that he injected, in order, through the IV, two drugs, Epinephrine and Atropine and that he obtained a pulse about four to five minutes after CPR had been started.

On realizing that Ms. Farnel was in "cardiac arrest" he had called for an ambulance and as it was a "cardiac arrest" the Fire Department also respond by sending out a one man emergency unit referred to as a JEEP. The JEEP was manned by Steve Winter, a Medic 3, and arrived about the time that Ms. Farnel was noted to have a pulse. Folowing two unsuccessful attempts by the fire department medic, Ms. Farnel was intubated by Mr. Grant, the purpose being to secure an airway and provide proper ventilation.

Mr. Grant estimated that the ambulance arrived about eight or nine minutes after CPR had been commenced, just about the time that they had intubated Ms. Farnel. She was then made ready to be transported by the ambulance crew, and she was transported to the Foothills Hospital.

Mr. Grant noted that at 9:35 a.m. Ms. Farnel had a pulse of 118 beats per minute. She never did start breathing spontaneously.

Asked about his prognosis for her at this time, he stated:

> "*Well, pretty much anyone who's in cardiac arrest has a very poor prognosis. So knowing that we got a pulse back doesn't affect, you know, organ damage and, obviously, brain injury due to lack of oxygenation….the outcome is still very grim."*

<u>Transport to the Foothills Hospital</u>

On May 8, 2006, **Paramedic Paul Sunderland**, who had been with Calgary EMS for nine years, was one the ambulance crew responding to the call for emergency assistance from APU. He was stationed at 2 Station, Fire and EMS, located at 10th Avenue and 9th Street S. W., Calgary. Emergency calls result in an alarm bell being sounded in the fire hall, followed by a page, followed by specific instructions over the radio in the ambulance, in this case, to go to the APU for a "cardiac arrest".

Mr. Sunderland and his partner transported Ms. Farnel to the Foothills Hospital. There was no evidence of the criteria used, of why or who made the determination of which hospital Ms. Farnel would be taken to. While enroute, the hospital was called and advised that they were coming and "*so they usually get the trauma room ready*". On arrival at the hospital they stopped briefly at the triage desk to provide the patient's name and then took her directly to the trauma room.

A Patient Care Record is completed for each patient treated. In this case, due to the nature of the emergency, it (Exhibit 20) was not completed until following treatment. The PCR provides details of the readings taken of Ms. Farnel's vital signs at 9:41 a.m., 9:49 a.m., 9:56 a.m. and 10:04 a.m. and the treatment received by her from the ambulance crew. Of note:

- although Ms. Farnel's breathing was assisted, Mr. Sunderland noted spontaneous respirations at 6 to 10 a minute, and

- Ms. Farnel was transported on a stretcher rather than a spinal board, which would normally be used, as a "spinal board" would not fit into the APU elevator. There was no evidence that this had any impact on Ms. Farnel's condition or injuries.

PATIENT TRANSFER FROM FOOTHILLS TO ROCKYVIEW GENERAL HOSPITAL

At about 4:00 p.m., May 8, 2006, approximately six hours after arriving at the Foothills Hospital, Ms. Farnel was transferred from that hospital to the Rockyview General Hospital.

Decision to Transfer

Dr. Christopher James Doig, who for four years had held the position of Medical Director of the Foothills Multi-System Intensive Care Unit, testified with respect to the initial assessment and treatment received by Ms. Farnel at the Foothills Hospital and the basis for the decision to transfer her to the Intensive Care Unit (ICU) at the Rockyview General Hospital. As Medical Director he was in essence the supervisor in ICU and in his own words:

> "*… apart from providing primary care responsibilities in the Intensive Care Unit, I provide a leadership role for the other physicians in the health region with respect to the Foothills Multi-System ICU."*

Dr. Doig, graduated in 1988, obtained his qualifications and was licenced as a specialist in Internal Medicine in 1993, and as a specialist in Critical Care Medicine in 1995. I do not intend to recite here the detailed testimony which he provided with respect to the treatments and basis for his diagnosis and prognosis for Ms. Farnel. These are recorded in the transcript of his evidence.

In summary, on admission to the Emergency Department Ms. Farnel was first assessed by one of the emergency physicians, Dr. Nesdoly. While Ms. Farnel remained in the Emergency Department Dr. Nesdoly was responsible for her primary care. When Dr. Nesdoly assessed her he found her 'deeply unconscious', the usual cause being that the brain has been injured both by a lack of oxygen and a lack of blood flow as a consequence of a cardiac arrest. The treatment required for an injury of this nature could only be provided in an ICU.

Dr. Nesdoly asked Dr. Doig to assess Ms. Farnel, first, to determine whether it would be appropriate to admit her to the ICU and second, to address other factors that may have caused her cardiac arrest or arisen as a consequence.

Dr. Doig initially had one of his residents, Dr. Peter Laconia (phonetic), assess Ms. Farnel. He then assessed her himself concluding: that apart from injury due to hanging, there was no other obvious precipitating factor for the cardiac arrest, that she had suffered a severe brain injury and that she did require admission to an ICU where she could be continuously cared for.

As there are three adult ICUs in the Calgary Health Region, at the Foothills, the Rockyview and Peter Lougheed Hospitals, a decision then had to be made regarding which ICU Ms. Farnel should be transferred to. Dr. Doig explained that while each ICU can "*manage a wide range of complex problems*", each is designed to handle certain types of cases. For example, the Foothills deals with regional trauma cases or victims of motor vehicle collisions and the Peter Lougheed Centre with individuals who have peripheral vascular surgery problems. He stated that there was no reason that Ms. Farnel be admitted to the Foothills ICU, she did not have traumatic injury.

Dr. Doig had discussed Ms. Farnel's condition by telephone with Dr. Kirby, the attending physician at the Rockyview General Hospital and arranged her transport to the Rockyview. This was at 2:30 p.m., May 8, 2006.

When asked specifically, Dr. Doig was not certain whether the Foothills ICU was at capacity at the time. He indicated that the decision to transfer a patient is based not only on the occupancy and the workload of each of the ICUs, but also **the patient's specific needs**.

At the time of transfer, Ms. Farnel:

- was intubated and on ventilation,
- had various monitors affixed, comprised of a standard five lead cardiac monitor, to continuously monitor her heart rate, a blood pressure cuff and an oxygen saturation monitor, and
- was receiving medications through an IV.

Except for ventilation, which had to be done manually during transport, none of the treatments she was receiving had to be discontinued or otherwise varied to facilitate her transfer.

Ms. Farnel's Foothills Hospital medical file was entered as Exhibit 6, and after the confirmation by Dr. Doig of the their contents and accuracy, copies of the Calgary Health Region Statement of Principles and Policies regarding firstly, ICU Admission During High Occupancy, and secondly, Administrative Admission, Transfer and Discharge, were also entered (Exhibit 22). Dr. Doig testified that he was comfortable that Ms. Farnel's transfer had met these standards.

Transfer by Ambulance

Ms. Farnel was transferred from the Foothills to Rockyview in an ambulance driven by **Paramedic Cameron Brander**, who had seven years experience with Calgary EMS, three plus as a paramedic and prior to that three plus as an EMT.

When he and his partner arrived at the Foothills Hospital Emergency they were directed to Ms. Farnel. Mr. Brander described her as being ventilated, non-responsive. He described her as having a "decreased level on consciousness" as there was some tearing that he observed and which he attributed as being to a reflex to the tube in her throat. But for the tearing, he would have described her as "unconscious". Mr. Brander testified that he understood that Ms. Farnel was transferred as there were no ICU beds available at the Foothills Hospital.

Due to rush hour and one lane traffic on the Glenmore Causeway the trip took approximately 30 minutes. On arrival, the staff at the Rockyview were ready. Within five minutes Ms. Farnel was placed in a bed and her care transferred over to a Registered Nurse at ICU. As a matter of policy, ambulance staff on transfers are instructed that care may only be turned over to someone with equal or greater qualifications. Without recalling specifically what occurred in Ms. Farnel's case, his evidence was that as a matter practice the RN would be given a verbal report of the reasons for transfer and a copy of the Paramedics Patient Care Record. Ms. Farnel's medical records would then be accessed by computer. Mr. Brander's evidence was that transportation did not seem to have any effect at all on Ms. Farnel's condition.

A Paramedics Patient Care Record was completed by Mr. Brander's partner (who did not testify) and after being acknowledged by Mr. Brander as accurate was entered (Exhibit 21).

CHANGES AT APU, COMPLETED AND PENDING

CPS Staff Sergeant David Kotowski testified regarding the inquiries undertaken and changes recommended and completed at the APU following the death of Ms. Farnel. Staff Sergeant Kotowski's responsibilities and duties include the administration of the Arrest Processing Unit, the Crown Liaison Unit and the Court Unit.

Following Ms. Farnel's death three independent inquiries were commenced and completed, as follows:

- An investigation by CPS homicide Detective Christopher Matthews into possible criminal activity associated with the hanging. At 9:47 a.m. May 8, 2006, Detective Matthews was called to the APU and assigned as lead investigator to determine whether or not there had been any criminal activity involved with a possible death in police custody. Although the APU was not provided with a copy of Detective Matthew's report, it was understood that he had determined that there had been no signs of criminal activity. A copy of his report was not placed before the Inquiry.

- An administrative review by Professional Standards. A copy of the report compiled by Professional Standards, although not prepared specifically for the APU, was made available to the administration at APU. The report was not placed before the Inquiry.

- An informal assessment conducted Staff Sergeant Kotowski, during which he and Detective Matthews debriefed those present at the time of Ms. Farnel's death. The review was not required by policy but conducted in response to the incident. The recommendations arising from this investigation were summarized in a letter from Staff Sergeant Kotowski to Blair White, Commander Investigative Support Section, dated October 20, 2007 (Exhibit 23).

Following, and in some instances prior to Staff Sergeant Kotowski's correspondence of October 20, 2007, the following recommendations and changes, which are relevant to Ms. Farnel's arrest and detention, have been implemented:

1. Responsibility for Prisoner Monitoring is now assigned. Individual Commissionaires, in one hour shifts, are specifically assigned to conduct cell checks once each ten minutes and when not so occupied are dedicated and required to monitor the video displays. Commissionaires monitor prisoners for among other things, self-harm behavior, fights and prolonged periods of inactivity. Although Commissionaires are required to log in as they assume responsibility for monitoring the cells and videos, no other information is recorded. After review it has been deemed impractical to include prisoner information due to the number of prisoners passing through the APU, being approximately 23,000 to 24,000 per year, 60 to 80 a day.

2. Signage in the APU has been added to or increased, clearly directing arresting officers to notify the Staff Sergeant on duty at the APU prior to booking in a prisoner and reminding APU staff and Commissionaires not to accept anyone unless they have first seen the Staff Sergeant. These changes are not to policy but to signage. The Staff Sergeant is and has always been responsible for reviewing the reasons for arrest of each new person brought into the APU.

3. Standard Operating Procedure respecting the reporting processes following a suicide were reviewed. Changes, if any, that have been made were not specified. **There was no indication that recommendations have resulted in regularly a scheduled review of Standards.**

4. Record keeping was reviewed and tightened to ensure that incidents were recorded, including additional information such as the arresting officer's regimental number and the date of occurrence, such that:

   A record is kept on CPIC of persons who actually attempt suicide while in

custody. That record is available to police across the country who may deal with that person.

A record is kept at the APU, by means of alert tabs (Mug Shot Alert) on the book-in computer, of persons who are booked in with, for example, a particular medical problem, a communicable disease, or who by their actual conduct or a statement made by them indicate an intention or a desire to harm themselves. The record is kept for future reference, specifically in the event that a person returns to APU. Although the information is accessed when a prisoner is booked in, there is no requirement that it be viewed on a shift change - information with respect to problem prisoners being conveyed at that time informally, by word of mouth.

5. A "Jailor's Course", relating to the care and custody of prisoners, was offered to and attended by sworn police officers and Commissionaires in APU in October of 2006. The course syllabus, outlining objectives and topics and titled "Continuing Education Training, Course Training Standard, Jailers Course" was entered as Exhibit 29. The course dealt with numerous matters in relation to the APU. Of relevance to this Inquiry it dealt with: diversion of low risk non-violent adult offenders; suicide indicators; care and responsibility for prisoners, including medical attention, cell extraction, violent inmates, suicidal inmates and clothing. Presenters for the Course included representatives from Calgary EMS, the Calgary Diversion Service, the Calgary Remand Centre, a Calgary Police Service attorney, and a CPS representative with respect to the *Freedom of Information and Protection of Privacy Act*. As of April, 2008, the course has not been repeated and no repeats were scheduled.

6. A "Presenting Officer's Course" which dealt with the processing and the release of prisoners, in particular with the decision to detain or release, was offered to sworn officers and completed in September of 2006.

7. A "Cell Extraction Course", for sworn officers and Commissionaires was offered and completed in June of 2007.

8. Arrest Approval by a Sergeant or Staff Sergeant has been changed from a "swipe card" approval, to a "book-in signature" approval, to ensure that information regarding a prisoner's arrest is properly reviewed and assessed. Previously, in the event of a backlog of prisoners, the swipe card could be used by persons other then the proper reviewing officer to expedite prisoner bookings.

9. Card Access Readers have been changed from audible to silent mode to deter prisoners from accurately patterning the Commissionaire's movements.

10. The procedures for tracking prescription medications that come in with prisoners has been reviewed and tightened so that these medications are not misplaced and are seen by the medic and dispensed as may be required.

As of April of 2008, the following improvements and reviews were pending:

- A new digital camera system with a reduced number of larger plasma screen monitors, to enhance not only picture quality, but recording retrieval and the ability to enlarge the video display from any given camera.

- The cost of installing Lexan, a clear high tech Plexiglas, as a covering for the inside of the bars in the cells and to be used in altering the privacy partitions in the female cells

(thereby removing anything from which a ligature could be suspended), is being investigated. NOTE: The cost, estimated at $300,000.00 and problems that arise with respect to proper ventilating the cells, made this option appear to be impractical.

Other changes have as well been made. Calgary EMS previously provided paramedics to the APU. Aaron Paramedical, a private corporation, now provides paramedics, two 12 hour shifts per day, seven days a week.

Debra Carrit, a paramedic of eight years experience and an employee of Aaron Paramedical testified in April of 2008. At that that time she was on assignment to the APU. On her evidence:

- To become a paramedic, an individual must move through a progression of levels of employment and training, first, as an Emergency Medical Responder, which requires two weeks training, then as an Emergency Medical Technician, which requires six to 12 months training and finally as a Paramedic, requiring two years training.

- There is little training on suicide risk assessment.

- Paramedics assigned to the APU receive an orientation but no specific training related to working with the prisoner population.

In addition to the EMS APU Patient Care Record, which is still in use, a schedule of Expanded Assessment Parameters are now included as part of the standard assessment. These contain more detailed questions as part of a “Suicidal Suggested Checklist and Protocol”.

Prisoner cells may still be monitored from the Medical Office and Ms. Carrit identified the cells that could be monitored in this way, being: cell 12, the centre male tank, the medical observation cell and the male juvenile holding cell. She stated that while it is “*nice to have them*” there was no official policy with respect to monitoring, as that is the responsibility of the Commissionaires, and further, that if there were someone who required constant monitoring then that person would be transferred to hospital.

<u>IN SUMMARY</u>

While there have been no changes to the physical layout of cell 12 (such that a person intent on self-harm, if similarly dressed, could attempt suicide in the same manner as Ms. Farnel), the changes which have been implemented clearly increase the likelihood of early detection of an inmate in such a circumstance.

Improvements to video surveillance, through the introduction of a new digital camera system with enhanced picture quality and a continuous feed, would just as clearly improve prisoner monitoring and early detection of problems.

Subject to these preliminary comments, on the evidence of Staff Sergeant Kotowski, the information and resources necessary to deal with persons at risk of suicide or significant self-harm are, in most cases, already in place:

- Two manuals, The Calgary Police Service Care In Custody (22 pages), and In Police Custody Investigations (4 pages), were identified and marked as Exhibit 30. The first of these manuals is comprehensive to say the least and deals with issues of prisoner suicide and self-harm, generally, as well as specifically and in more detail in a section dedicated to “Prisoners at Risk for Suicide or Significant Self-Harm”.

A Statement of Principle at page one provides in part as follows:

> "Studies have shown that for some individuals, being in custody can lead to a suicidal state, particularly during the first three (3) hours of confinement. The Calgary Police Service is committed to the goal of maintaining facilities that reasonably limit the means by which prisoners might inflict self-harm…Officers should be aware that prisoners present a higher risk for suicide than the general population."

- Also set out on the first page in Section 2, Arrest, Item 2(3) and (4), provide as follows:

  > Police officers will continually assess the mental health of prisoners throughout their detention, and
  >
  > Prisoners believed to be at risk of suicide or significant self-harm will be handled in accordance with section 9 of this policy.

- Facilities at APU include observation cells.

- A change of prisoner clothing may be made in circumstances where it is deemed necessary. A paper suit and booties can be used where a prisoner's own clothes have been removed to be retained as evidence or where soiled and unsanitary, "baby dolls", being a heavy canvas type of robe that cannot be torn, are available to be used when there are concerns that a prisoner may attempt self-harm. As previously noted Ms. Farnel was not required to remove her clothing, only her necklace was taken.

What seems lacking is any policy regarding ongoing education and upgrading, or any requirement for the periodic review of policies, procedures and standards, all of which were prompted by and done as a result of Ms. Farnel's death.

<u>SUICIDE ATTEMPTS IN ARREST PROCESSING</u>

Since May of 2006 there have been three attempts at suicide, one by hanging, none of which were successful. In the year prior to Ms. Farnel's death, there had been six attempts, all by hanging, all averted (by increased vigilance?).

As stated by Counsel during the Inquiry, suicide is "one of the great mysteries of human existence". It remains thus.

Recommendations for the prevention of similar deaths:

I make the following recommendations:

1. A policy for ongoing education and upgrading, including a requirement for a periodic review of policies and procedures, should be implemented.

2. All new recruits to the Arrest Processing Unit should be required to take a [or "the"] Jailers Course. To be feasible, such a course could be offered as part of a Province wide initiative and made available to police forces and APU personnel throughout Alberta.

3. Comprehensive suicide risk assessment and awareness training should be part of initial training and annual refreshers.

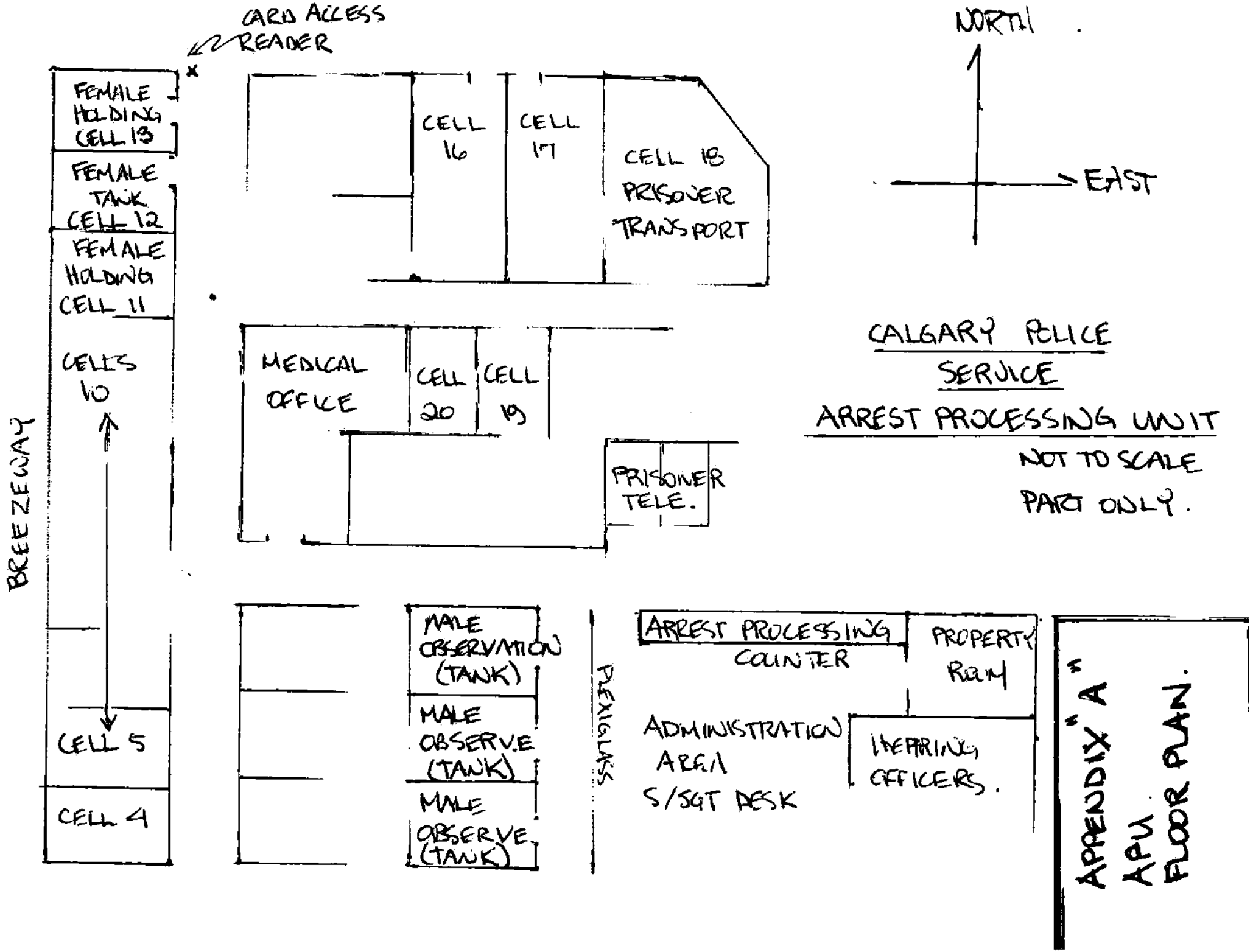
4. There should be a formal policy regarding the transfer of prisoner information on shift changes. The current informal policy may lead to the assumption that as no concerns were received then there are no concerns, when in fact the information may simply have been misplaced.

5. Clocks and times in security devices, that is, video surveillance and cards readers and any other technology employing a continuous time record or display, should be synchronized.

DATED October 29, 2008,

at Calgary, Alberta.

The Honourable Judge P.M. McIlhargey
A Judge of the Provincial Court of
Alberta


CARD ACCESS READER
FEMALE HOLDING CELL 13
FEMALE TANK CELL 12
FEMALE HOLDING CELL 11
CELLS 10
CELL 5
CELL 4
BREEZEWAY
CELL 16
CELL 17
CELL 18 PRISONER TRANSPORT
MEDICAL OFFICE
CELL 20
CELL 19
PRISONER TELE.
MALE OBSERVATION (TANK)
MALE OBSERVE (TANK)
MALE OBSERVE (TANK)
PLEXIGLASS
ARREST PROCESSING COUNTER
PROPERTY ROOM
ADMINISTRATION AREA
S/SGT DESK
INTERVIEWING OFFICERS.
NORTH
EAST
CALGARY POLICE SERVICE
ARREST PROCESSING UNIT
NOT TO SCALE
PART ONLY.
APPENDIX "A"
APU
FLOOR PLAN.

Fatality Inquiry
Eva Marion Farnel
Docket No. 070274642I1

Appendix B
Witnesses Appearing

Appeared October 29, 2007

Christopher James Matthews, Detective, Calgary Police Service, primary investigator in the death of Ms. Farnel
Joyce Yvonne Stevens, Sister of the Deceased
Tom Crawford, Building Manager, 707 – 57th Avenue S.W. Calgary, Alberta
Patrick John Kiez, Constable, Calgary Police Service
David Howard Bailey, Constable, Calgary Police Service
Troy Michael Leckie, Constable, Calgary Police Service

Appeared October 30, 2007

Wayne Larry Anderson, Paramedic, Calgary Emergency Medical Services, attended Ms. Farnel's apartment on request of police and examined her.
Wally Mah, Paramedic, Calgary Emergency Medical Services, conducted initial examination of Ms. Farnel on arrival at the APU.
Dan Colesnik, Commissionaire, Calgary Police Service, Arrest Processing Unit
Gerald William Spencer, Commissionaire, Calgary Police Service, Arrest Processing Unit
Sherri Hulburd, Commissionaire, Calgary Police Service, Arrest Processing Unit
Steven Grant, Paramedic, Calgary Emergency Medical Services, attended and treated Ms. Farnel when found in her cell.
Paul Sunderland, Paramedic, Calgary Emergency Medical Services, transported Ms. Farnel to the Foothills Hospital.
Cameron Brander, Paramedic, Calgary Emergency Medical Services, transported Ms. Farnel to Rockyview General Hospital.
Dr. Christopher James Doig, Medical Director, Foothills Multi System Intensive Care Unit
David Heinz Mark Kotowski, Staff Sergeant, Calgary Police Service

Appeared April 11, 2008

James Eugene DiFilippo, Commissionaire, Calgary Police Service, Arrest Processing Unit
Debra Suzette Carritt, Paramedic, Aaron Paramedical
David Heinz Mark Kotowski, Staff Sergeant, Calgary Police Service

Fatality Inquiry
Eva Marion Farnel
Docket No. 07027464211

Appendix C
Exhibits

Entered October 29, 2007

Exhibit 'A' – For Identification – Exhibit Book
Exhibit 1 – Certificate of Medical Examiner
Exhibit 2 – Medical Examiner's Certificate of Death
Exhibit 3 – Xternal Examination Form, Office of the Medical Examiner
Exhibit 4 – Toxicology Report (*ante mortem* blood and plazma readings)
Exhibit 5 – Rockyview Hospital Death Summary, Ann S. Kirby, MD, FRCPC, Critical Care and Internal Medicine
Exhibit 6 – Foothills Hospital Medical File
Exhibit 7 – Detailed Floor Plan of Arrest Processing Unit
Exhibit 8 – Photographs of Arrest Processing Unit Cell 12
Exhibit 9 – Access Granted Events Printout
Exhibit 10 – Video of Ms. Farnel in the cell
Exhibit 11 – Video covering the time from 5:12 to 9:15
Exhibit 12 – Summary of interview with Dennis Morgan, conducted by detective Matthews
Exhibit 13 – Calgary Police Service, Arresting Processing, Booking in Sheet

Entered October 30, 2007

Exhibit 14 – Paramedics Patient Care Record PCR-7044090, W. Anderson
Exhibit 15 – Statement of Wayne Anderson, June 13, 2006
Exhibit 16 – EMS Arrest Processing Unit Patient Care Record, W. Mah
Exhibit 17 – Statement of Sherri Hulburd, May 8, 2006
Exhibit 18 – Two pages of Detective Matthew's Notes and Email from Peter Heyman
Exhibit 19 – Two pages of Paramedic Response Unit Response Form, S. Grant
Exhibit 20 – Patient Care Record, P. Sunderland
Exhibit 21 – Paramedic Patient Care Record, Brander and Rosic
Exhibit 22 – Two documents entitled: ICU Admission During High Occupancy
Exhibit 23 – Memorandum dated October 20, 2007, S/Sgt. Kotowski to Blair White, re: Changes to APU

Entered April 11, 2008

Exhibit 24 – Typewritten Will-State of James DiFilippo
Exhibit 25 – Handwritten Statement of James DiFilippo
Exhibit 26 – Photocopy of handwritten notes from notebook of James DiFilippo
Exhibit 27 – Two page Standard Assessment Form and Expanded Assessment Parameters, Aaron Paramedical
Exhibit 28 – Memorandum dated April 11, 2007, S/Sgt. Kotowski to Inspector Luch Berti
Exhibit 29 – Document titled: Continuing Education Training Course Training Standard Jailers Course
Exhibit 30 – Document titled: Calgary police Service, Authority and Responsibility, Care in Custody
Exhibit 31 – One white paper suit and two paper booties
Exhibit 32 – APU Standard Operating Procedures document regarding prisoner phone calls

Exhibit 'B' – For Identification – Case Summary Dated May 8, 2006