REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at the Provincial Court of Alberta

in the City (City, Town, etc.) of Calgary (Name of City, Town, etc.)

on the 5th day of October, 1992 (and by adjournment

on the 18th day of November, 1992), before

G. G. Cioni, a Provincial Court Judge.

A jury ☐ was ☑ was not summoned and an Inquiry was held into the death of

Tyler Thompson (Name in Full) 18yrs (Age)

of Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death June 25, 1992 8:50 A.M.

Place Calgary General Hospital, 841 Centre Avenue East, Calgary, 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 — The Fatality Inquiries Act, Section 1(d))

Hanged

Manner of Death ("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable — The Fatality Inquiries Act, Section 1(g))

Suicidal

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CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

(See attached page)

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RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

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DATED this 16th day of December, 1992.

A Judge of the Provincial Court of Alberta

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

The deceased Tyler Thompson was a sadly troubled, 18 year old young man who had experienced difficulties and was not able to live with his parents. While he is said to have been generally quite happy, without suicidal tendencies, he may have had concerns for his personal security and, specifically, a fear of imprisonment.

On June 22, 1992 at Calgary, at around 4:30 - 4:45 p.m. he attracted the attention of the police resulting in a high speed car chase, a minor collision with a police vehicle and his arrest and detention around 5:00 p.m. He initially declined to give his age and name but shortly thereafter changed his mind. He was not rude. A District Sergeant arrived at 5:20 p.m. and Mr. Thompson was transported to Police District Office #4 at 5:42 p.m. in the custody of Constables Munnikhuis and Bullock.

Shaun Elson who was with the deceased during the chase says, in his witness statement that Tyler "was crying and saying he didn't want to go to gaol. He may have 'felt bad' and that 'he let people down'" (Exhibit 7).

Constable Bullock found the deceased very quiet. Mr. Thompson did, however, ask whether or not he was going to gaol but Constable Bullock told him that he did not know that was going to happen.

At the District Office, the deceased was given access to a telephone and the Legal Aid list. One request to call was not allowed, to an uncle, due to a suspicion of stolen property and a potential Search Warrant. Mr. Thompson asked for and was given a drink of water.

Constable Munnikhuis recalls the Legal Aid list, the request for a drink of water and that Mr. Thompson wished to call an aunt, Eileen, which was denied on suspicion of stolen property. He gave a number for his parents, which the constable called and reached an answering machine.

The deceased was put into an interview room about 6:00 p.m. His belt, shoes and handcuffs were removed; he was searched and his personal belongings were taken. They were stored in a locker outside the door. He was dressed in jeans, socks, a baseball shirt and a T-shirt. The two constables then went to the computer room to do paperwork and to pursue inquiries about the vehicle and licence plate.

Such interview rooms are present at all District Offices. They are used to conduct investigations, interviews and interrogations and are considered to be holding cells. There are no other holding facilities there. They are said to be covered by written policy but it is probable that instruction about their use, based on the policy, is given orally and by way of operating procedure at each District Office. It is well known and, I perceive, well followed that upon arrival at a District Office a detainee is logged by name, time, charge or reason and arresting officer(s). The Duty Sergeant is told and has the duty to monitor such custody. The Log Sheets are maintained at each office. Thereafter, matters and conduct, are left up to the discretion of the arresting officer(s). As soon as a door opens lights flash at the sergeant's desk.

The rooms are not meant for indefinite custody, nor for holding people overnight. Inspector Kavanaugh described the "logging-in" procedure through the Duty Sergeant. When the detainee is secured in the room, the arresting officer(s) proceed with their investigation. They are charged with the custody of the individual. Observation, comings and goings, breaks for relief and convenience are in their hands. Detective Kyska confirms that there is no formal process. It would be highly improper to leave a person for a lengthy time without making clear arrangements. His experience notes custody in a room for up to 11 - 12 hours. Inspector Kavanaugh confirms lengthy custody although his basic scenaraio is to have officers leave a suspect 15 - 30 minutes to regain his/their composure and to do paperwork or computer search, usually within the area. There is no immediate communication available to lone occupants other than by knocking on the door.

Each room is approximately 9 meters by 6 meters, containing a table and chair (See Exhibit 5, 4, 3). There is a single, solid wooden door, which opens inward, and cannot be opened from the inside. An outside red light indicates the room is in use. There are no windows or glass panels but there is a fish-eye peephole in the door that allows a view of about three-quarters of the room. This set-up allows of blind spots, lower down and in corners. There are no mirrors that would pick up that slack.

I return to the events of Mr. Thompson in this setting.

Constable Jeffrey Farmer estimates that at 6:05 p.m. he heard a knocking at the room's door. He asked what Mr. Thompson wanted and was told he wanted to talk. He looked in the peephole and saw a male, in his 20's or so who was calm and using a normal voice. There seemed to be no urgency. He did not wish to compromise any confession so he said that he would tell Constable Bullock. He went down the hallway in about 10 seconds.

Constable Munnikhuis recalls he was just leaving the computer room after up to 20 to 25 minutes when he was approached by a traffic constable about a driver's licence and the deceased. It was about 6:20 to 6:25 p.m. He tried to open the door but it wouldn't "shove". He saw a T-shirt hanging from the door knob. The deceased was sitting with his hands in front of him with his back to the door, his feet on the ground, his neck bound by the T-shirt on the doorknob. He grabbed the knotted shirt off and lowered Mr. Thompson. There was no pulse. There were cries for help. Munnikhuis began C.P.R. within 15 seconds. Sergeant McEvoy took over mouth to mouth resuscitation. Neither used pocket masks. Another policeman guided and took over. He estimates it was five to six mintues until the paramedics arrived.

Constable Bullock recalls Constable Farmer coming at 6:10 to 6:15 p.m. and Constables Munnikhuis and Howell conversing about the driver's licence perhaps 10 to 15 minutes after Farmer came. He ran to look for an airway kit occupying 30 seconds. The time that pops into his mind is 6:20 to 6:25 p.m. A call for paramedics and an ambulance was made, presumably by a dispatcher,

not, I believe, by direct contact. There seems to be no time recorded.

The medical dispatch records and Mr. Brakke show that a call was received at 18:41, with C.P.R. in progress. An ambulance was dispatched at 18:44 and arrived at 18:46 (Exhibit 6). Mr. Thompson was pulseless and breathless. The paramedics' efforts to restart heart/pulse action was not successful. Mr. Brakke felt he was dead from the time they started and dead on arrival at the hospital at 7:12 p.m.

The family was called to the hospital by 8:30 p.m. and given crisis counselling by Ms. Brenda Duncan. Dr. Sidney Viner attended Mr. Thompson. He noted no inconsistent signs or bruising outside of the T-shirt mark, or bruise. He diagnosed severe brain injury due to being without oxygen for a lengthy time. Life support was withdrawn on June 25, 1992 at 8:50 a.m.

I am informed by Inspector Kavanaugh that, subsequent to the death, silent video cameras have been installed in District #3 with very good results. The "feedback" is good for all purposes and the cameras allow for full surveillance of each room, with no "shortfall". Mr. Lloyd Erickson, as Director of the Calgary Remand Centre for the Department of the Solicitor General of Alberta, has told me that his institution is subject to three binders of provincial policy on custodial matters, setting standard operating procedures. They have no rooms without surveillance. The standard is a 7 inch by 14 inch glass panel as well as video cameras and a policy which regulates intermittent observation based on classification, history and warnings.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

Tyler's sad death underlines the fragility of people who find themselves under the stress of custody. Some may face dealings with the police with real or feigned bravado. Most, I suspect, are nervous.

The holding of people in custody, on a short and long-term basis, is a necessary part of policing. It should be done on a fair, open basis that balances the needs of the police to do their job and the basic rights and security of the detainee. The police, as custodians, must ensure those rights and security.

Tyler Thompson's brief period of custody for valid reasons of arrest, identification, verification of age, charge, basic investigation and release was practical and warranted.

Notwithstanding his concern about going to gaol which may have suggested a "risk" factor, Tyler's desperate act could not be reasonably foreseen in such a short period of time. Assistance was given to him swiftly. I was impressed to hear that Sergeant McEvoy and Constable Munnikhuis immediately began C.P.R. and resuscitation without safety precautions. There is some concern about the time taken to obtain the ambulance.

The basic policy of the City of Calgary Police Service regarding custody i.e. logging, identification, is sufficient.

I am concerned, however, that the policy becomes more vague and less controlled when transferred to the discretion of arresting officers, who are left on their own.

The use of locked, solid-door, limited-observation interview rooms, with some restrictions on communicating, as holding cells, stresses the isolation of the detainee.

Accordingly, I would make the following recommendations:

1. That the City of Calgary Police Service review fully all policy and practices respecting the detention of accused and suspects at District Offices.

2. That such reviewed policy be implemented directly and formally into all Calgary Police District Offices, not only as an operating procedure.

3. That the role and purpose of interview rooms and of holding cells be considered carefully.

4. That interview rooms be less isolated and open to view, either by permanent adoption of the pilot project of video cameras, glass panels or other devices.

5. That clear guidelines on "risk" cases be adopted and "risk" accused be subject to same.

6. That the Provincial Government (Solicitor General's Department) policy guidelines on holding facilities be generously consulted.

7. That the policy or practice regarding the obtaining of emergency medical assistance to any police station stress direct and immediate contact.

The aim of these recommendations is to reduce the wide responsibility placed on busy police personnel in favour of clear practices that will help and protect.

All of which is respectfully submitted.