



Report to the Minister of Justice

Fatality Inquiries Act

Public Fatality Inquiry

WHEREAS a Public Inquiry was held at the _____ the Courthouse

in the _____ Town _____ of _____ Stony Plain _____, in the Province of Alberta,
(City, Town or Village) (Name of City, Town, Village)

on the _____ 18th _____ day of _____ November _____, _____ 2019 _____, (and by adjournment
year

on the _____ 28th _____ day of _____ February _____, _____ 2020 _____),
year

before _____ Charles Gardner _____, A Justice of the Alberta Court of Justice,

into the death of _____ Trevor Clinton Eisel _____ 33 _____
(Name in Full) (Age)

of _____ Spruce Grove, Alberta _____ and the following findings were made:
(Residence)

Date and Time of Death: _____ December 28, 2017, at 2125 hrs _____

Place: _____ University of Alberta Hospital _____

Medical Cause of Death:

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

Gunshot wound of head, massive and untreatable brain injury

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)).

Suicide, Self-inflicted gunshot

Circumstances under which Death occurred:

1. The self-inflicted gunshot wound which resulted in the tragic death of Trevor Clinton Eisel, age 33, was inflicted by Mr. Eisel on December 25, 2017, in the home in Spruce Grove, Alberta which he shared with his spouse and their two small children.
2. Pursuant to s. 35.1 of the *Fatality Inquiries Act, RSA 2000 C.F-9* (the “Act”), an order was made by the Minister of Justice and Solicitor General for an Inquiry to be convened concerning Mr. Eisel’s death.
3. The Act establishes the parameters and scope of the Inquiry. Any person determined to have a direct and substantial interest in the inquiry subject matter may appear to present evidence and submissions at a formal Inquiry hearing. A record of the viva voce and documentary evidence heard and collected is to be preserved. At the conclusion of the hearing, the assigned, presiding Judge must submit a written report addressing certain factual findings to the Minister. These include the deceased’s identity, the date, time and place of death, and the circumstances, cause, and manner of death. Recommendations to prevent deaths in similar circumstances may also be made. Findings of legal responsibility or conclusions of law, however, are not permissible.
4. On December 25, 2017, Mr. Eisel, with his spouse and two small children barricaded, at least in a notional sense, himself in his home, and notwithstanding RCMP efforts to persuade him to do otherwise, he shot himself in the head with a firearm which he lawfully possessed. Prior to that happening, Mr. Eisel permitted his spouse and children to leave the home. He was transported to the University of Alberta Hospital where, on December 28, 2017, at 2125 hrs, he died from his injury.
5. As required by the Act, a pre-inquiry conference was conducted before myself, in Stony Plain, Alberta, on February 5, 2019.
6. At that conference, upon the application of Counsel for the RCMP, the RCMP were granted status for the Inquiry pursuant to s. 49 of the *Act*.
7. The mother of the deceased, Sherry Eisel, attended the pre-Inquiry conference by telephone conference and also attended a portion of the evidentiary component of the Inquiry itself. Mr. Eisel’s spouse chose not to participate in the Inquiry.
8. The following counsel appeared at the Inquiry:
 - Counsel to the Inquiry: Jennifer Stengel, Carla Cichowska
 - Counsel for the RCMP: Leona Tesar, Keelan Sinnott, Jennifer Lee
 - Counsel for the witness, Dr. Nicolaas Bothas: James Heland
9. The following exhibits were marked at the Inquiry:
 - Binder of Tabbed Exhibits 1-18
 - List of Acronyms and Abbreviations from RCMP Notes
 - List of RCMP acronyms
10. The following witnesses testified at the Inquiry:
 - RCMP Cst. Andrew Robinson
 - RCMP Superintendent Talbot
 - RCMP Staff Sergeant D. Brown
 - RCMP Corporal Sean Gordon

- Dr. Nicolaas J. Botha
11. RCMP witnesses were members of the Spruce Grove/Parkland detachment, who initially responded to the Eisel home, and members of the RCMP Emergency Response Team from Edmonton, who attended at the request of the local detachment.
 12. Events of December 25, 2017, which culminated in Mr. Eisel taking his own life, began at 1504 hrs with a telephone call to the Spruce Grove detachment from Kaila Eisel, the spouse of the deceased. She advised that Trevor Eisel was distraught about their relationship and was threatening to kill himself and possibly she and her two children if they attempted to leave the residence. She observed that he was in possession of a handgun and may be intoxicated. At the time of the call, she was in the garage, sitting in the vehicle with the children.
 13. Ms. Eisel also reported to police that day that her husband had been suicidal for about a month. She and the children were allowed by Mr. Eisel to leave the residence unharmed.
 14. RCMP conducted a risk assessment of the situation and responded to the residence, an assessment leading officers to deem the situation as one of very high risk. Circumstances leading to the conclusion that the situation was dynamic and demanding included:
 - Mr. Eisel's mental state: being distraught regarding his marital relationship, his possible intoxication, threats of suicide, and threats of violence to others
 - The presence of a firearm
 - The location of the residence in a populated area
 - The fact that it was Christmas Day when many nearby residences could be expected to be occupied
 - Extreme weather conditions, with temperatures at approximately -42 degrees Celsius-making the situation dangerous for responding members being exposed to those temperatures for extended periods of time
 15. The risk was somewhat deescalated when the spouse and children were permitted to leave but escalated when, subsequent to the arrival of RCMP officers, and based upon the sound of guns shots, it was determined that Mr. Eisel was discharging his firearm from within the home. This was verified by subsequent examination of the site and it was determined that bullets had in fact escaped the residence.
 16. Upon arrival, RCMP members contained the area around the Eisel home, to ensure nearby residences and guests were protected and established telephone communication with the deceased in an attempt to persuade him to surrender to police.
 17. Once the RCMP Emergency Response Team (ERT) was assembled in Edmonton and attended the scene, a command centre was established and telephone communications with Mr. Eisel continued.
 18. The communications were conducted by trained, skilled, and experienced ERT members and went on for several hours.

19. Ultimately, extensive attempts to persuade Mr. Eisel to surrender himself were unsuccessful, leading to him to fire the shot which led to the loss of his life. It is of note that a very experienced RCMP member of the ERT team, tasked with conducting negotiations with the deceased, testified that this was the first time that he had not been able to defuse such a situation and persuade the individual to surrender himself. That is to say, in his considerable experience in similar interventions, he had never encountered a situation in which a suicidal death had been the result.
20. Before dealing with the evidence of Dr. Botha and a proviso which arises from that evidence, there is nothing contained in the extensive RCMP occurrence reports contained in Exhibit 1, nor from what RCMP members disclosed in their testimony, which would lead me to conclude that anything else could have been done to prevent this tragic death.
21. Indeed, while not determinative, the deceased's mother, Sherry Eisel, after hearing the RCMP officer's testimony, commented that she was comforted that RCMP members had done everything they could to prevent the unfortunate outcome.
22. Dr. Botha was unavailable to testify when the Inquiry convened in November of 2019. The Inquiry reconvened to hear the Doctor's testimony on February 28, 2020.
23. Dr. Botha had recently, in September of 2017, become Trevor Eisel's physician and was treating him for concerns relating to his mental health. Mr. Eisel presented to the Doctor with a history which included a previous brain injury.
24. Dr. Botha is an experienced family physician, but also offered a unique and relevant perspective on circumstances leading to the December 25, 2017 death. Dr. Botha, as a military physician in a previous professional role, testified about extensive experience treating those suffering from traumatic stress.
25. While Mr. Eisel was clearly suffering from mental health issues, as displayed by his interactions with Dr. Botha throughout the fall and early winter of 2017, there was nothing about those issues which led Dr. Botha to conclude that suicide was a real likelihood during that time. Dr. Botha did acknowledge that family and relationship issues can become particularly acute during the Christmas season.
26. Of particular interest to the Inquiry was Dr. Botha's testimony that had he been contacted during the incident on December 25th and given the opportunity to speak with his patient, a different outcome might have resulted. The Doctor also testified that he would also have had available to him, on a 24 hr basis, the consulting expertise of a psychiatrist.
27. Dr. Botha also testified that systems were in place in his office through which he could have been contacted and that if he had been reached, he would have responded. Further, he told the Inquiry that on 3 previous occasions, when contacted regarding a suicidal patient, he had been able to prevent the patient from taking their life.
28. As counsel for the RCMP correctly points out, there is nothing in the evidence presented at the Inquiry to suggest that RCMP members were aware that Mr. Eisel was under a Doctor's care at the relevant time.
29. Nonetheless, RCMP members were aware of circumstances which would reasonably lead them to conclude that Mr. Eisel, on December 25, 2017, was suffering from a mental health episode. Nothing in the evidence suggests that any inquiry was made as to whether or not Mr. Eisel was under a physician's care.

30. A final issue bears comment and relates to Trevor Eisel's possession of firearms on the relevant date. As I have noted, his possession of firearms was not in any way unlawful at the time of his death. Nor do I find that there is any evidence to suggest that in the months or indeed years prior to December 25, 2017, that circumstances existed which would have justified the seizure of those firearms pursuant to the Canadian Firearms Program or the firearms seizure provisions of the *Criminal Code*.

Recommendations for the prevention of similar deaths:

As a result of these findings, this Inquiry recommends:

31. That RCMP policies and procedures relating to incidents in which there are mental health concerns involving a party to such an incident, that all reasonable steps be taken to ascertain whether or not that party is under a physician's care and if so, to attempt to contact that physician and seek medical advice regarding how best to deal with the situation.

DATED June 16, 2023,

"C.D. Gardner"

at Stony Plain, Alberta.

Charles Gardner
A Justice of the Alberta Court of Justice