REPORT TO THE ATTORNEY GENERAL

PUBLIC INQUIRY

THE FATALITY INQUIRIES ACT

DESTA BAHLIBI (Deceased)

October 18, 1991
Calgary, Alberta

B. N. Laven
Provincial Court Judge

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 28th day of June, 19 91 (and by adjournment to completion

on the 27th day of September, 19 91), before

B. N. Laven, a Provincial Court Judge.

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

DESTA BAHLIBI (Name in Full) 25 (Age)

of No Fixed Address Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death December 9th, 1990 at approximately 10:10 hours

Place Holy Cross Hospital, 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))

Asphyxiation - as a consequence of self hanging

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

AG 338 (REV. JUNE 86)

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

See attached appendix

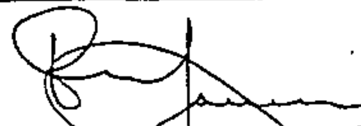
No. of additional pages attached 4 pages

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

See attached appendix

No. of additional pages attached 1 page

DATED this 18th day of October 19 91.



A Judge of the Provincial Court of Alberta
B. N. LAVEN

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

The relevant evidence is as follows:

1. On November 20, 1990, the deceased Desta Bahlibi, a 25 year old, single, male Ethiopian (a refugee with some immigrant status) was admitted to the McNab Wing of the Holy Cross Hospital, Calgary, Alberta, after apparently attempting suicide by jumping off a fourth floor balcony of an apartment block in Calgary aforesaid.

2. Prior to November 20, 1990 the deceased did have a history of alcohol abuse; paranoia and wandering in the streets without the seeking of shelter or accommodation - all coupled with other indicia of his inability to cope with his thoughts or his surroundings. When admitted he was in a "bad mood", and dishevelled, and disorganized in thought process. He was hearing voices -- and in fine - suffering from an "apparent schizophrenia form" disorder.

3. During his medical (mental) assessment in general and his stay in hospital total and meaningful communication with the deceased was at a premium due to cultural/social reasons and perhaps due to a language barrier. The language barrier was more as a result of mistrust by the deceased of his friends, employers, doctors and other hospital staff rather than a barrier of misunderstood language or communication. By way of repetition and for purpose of clarity I found that the language bar was not per se a barrier to assessment, treatment or therapy.

5. As a result of thorough analysis by way of conference meetings and active assessments the deceased, as late as two days before his death, was rated as a low suicide risk and accordingly was to be discharged pending settlement of a place to stay and the resolution of other relocation problems.

6. On December 9, 1990 at or about 10:10 a.m. the deceased was found suspended by an electrical cord from the bars between the stairs on the second and third floor of the McNab Building, a wing of the said Holy Cross Hospital. The deceased was cut down from his suspension and found to be without pulse or respiration and was, in fact, found to be dead.

7. Under all known circumstances of the death and as there was no known next-of-kin an autopsy was not requested. However careful examinations of the body and some toxicological testing was done.

8. David Kinloch appeared on the Fatality Inquiry as counsel for the Attorney General of Alberta.

9. Mr. G. C. Hawco, Q.C., represented the Calgary District Hospital Group and a number of the nurses appearing as witnesses. Mr. Hawco was declared to be "an interested party" and was given the right to examine witnesses.

10. In all, six (6) exhibits were entered in this Fatality Inquiry, namely:

<u>Exhibit 1</u> - Photocopy of Certificate of Dr. R. P. Roy (Medical Examiner) - all as to death of Desta Bahlibi

<u>Exhibit 2</u> - Photocopy of completed examinations

for by Dr. R. P. Roy

Exhibit 3 - Photocopy of Toxicology Report re:

blood and urine by Peter P. Singer PhD.

Exhibit 4 - Photocopy of Medical Examiner's

Certificate of Death - (Dr. R. P. Roy)

Exhibit 5 - Photocopy of Medical Records of

the deceased

Exhibit 6 - Photograph of portion of relevant

stairwell in McNab Wing, Holy Cross

all of which I have critically examined.

11. The Fatality Inquiry heard sworn or affirmed evidence from the folowing witnesses namely:

Marjorie Hazel Wallace (Manager of Health Records Holy Cross Hospital)

Keith Gerald Reimer (Constable, Calgary Police Service)

Donna Ann Cheyne (Investigator with office of the Chief Medical Examiner's Office)

Wesley Blaine Steed (Medical Doctor - I.C.U. resident doctor)

Norman Ronald Aldous (Medical Doctor - psychiatrist)

Johannes Dirk de Vries (Medical Doctor - psychiatrist)

Myrna Lenore Bowman (Registered Nurse)

Dorothy Ranks (Registered Nurse)

Jasbir Gill (Registered Nurse)

Headly Campbell (Registered Nurse)

I was impressed with the evidence of all witnesses both as to clarity, credibility and demeanour. I found all witneses

be forthright and direct in the giving of their evidence.

12. Any thought, doubts or misgivings I did have during the course of the Inquiry relative to - language bar or barrier;

- assessments;
- treatments;
- prognosis;
- locus
- surrounding circumstances
- staff and qualifications

were in the main allayed and satisfied by the evidence given by the witnesses on the Inquiry.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

1. It is recommended that more staff persons be on the floor at all times. Also a "recreation" person may be hired to monitor the lounge and its occupants, trips to the tuck shop and hospital grounds.

2. It is recommended that a ready listing of available interpreters and alternates (in all languages and dialects) be accessible for initial assessments and admissions in particular and for follow ups and patient conferences in general.