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 The Law Courts

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

on the 5th day of September, 2008 and on the 1st, 2nd, 3rd, and 4th day of June, 2009, (and by adjournment

on the 23rd day of February, 2011 and the 1st day of September, 2010),

before P.G. Sully , a Provincial Court Judge,

into the death of Vincent Patrick Beaudry (Name in Full) 32 (Age)

of no fixed address (Residence) and the following findings were made:

Date and Time of Death: June 29, 2006 between 6:04 p.m. and 9:30 p.m.

Place: Edmonton Police Service Holding Cells in Arrest Processing Unit

Like so many people who live in Edmonton's inner city, Vincent Beaudry was aboriginal, homeless, addicted and mentally ill. He had numerous previous interactions with police. Vincent Beaudry died in a police cell while in custody. This Inquiry called into question the care provided to Vincent Beaudry by police during his time in custody.

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)).

On June 30, 2006, an autopsy was performed on the body of Vincent Beaudry by Dr. Graeme Dowling, the Medical Examiner. In his autopsy report dated October 12, 2006, Dr. Dowling stated that during the autopsy, he found extensive fat deposition in the liver (i.e. diffuse fatty change of liver) in keeping with the history of alcohol abuse.

Dr. Dowling stated that the postmortem toxicology revealed the presence of a high intoxicating level of alcohol in the blood. Dr. Dowling stated that cocaine, benzoylecgonine, methadone, amitriptyline and nortriptyline were detected in the blood in insufficient levels to account for death in and of themselves although it would be reasonable to assume that the alcohol, methadone and amitriptyline (all of which are depressant medications) would have a combined toxic effect.

Dr. Dowling concluded that the cause of death has been attributed to long-standing drug and alcohol abuse (i.e. chronic ethanol and drug abuse). Dr. Dowling stated that chronic alcoholics can die suddenly and unexpectedly. He further stated that the actual reason why chronic alcoholics die in this circumstance is not currently understood. Dr. Dowling stated that this may explain the death of Vincent Beaudry, although, there is a distinct possibility that the combined toxic effects of alcohol and other drugs found in the blood would have been a factor in his death.

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)).

Unclassifiable

Circumstances under which Death occurred:

As a result of a complaint, at 3:48 p.m. on June 29, 2006, Vincent Beaudry was arrested for aggressive panhandling by Edmonton City Police at the corner of 108th Street and Jasper Avenue, Edmonton, Alberta. At the time of his arrest, Mr. Beaudry was intoxicated. He was wearing heavy clothes that were inappropriate for the existing weather conditions and he was sweating. At the scene of the arrest, police officers were advised by witnesses who were familiar with Mr. Beaudry that he was behaving strangely, in a manner out of character for himself. They were concerned about his mental condition. In addition, the police officers were advised by Mr. Beaudry that he was on medication. None of this information was documented. The arresting officer judged Mr. Beaudry as being capable of understanding his circumstances and capable of looking after himself. He stated that he did not observe any signs or symptoms in terms of medical distress.

At the time of the arrest of Mr. Beaudry, he was searched by the police officers. In Mr. Beaudry's possession was a letter dated the 6th of February, 2006 from Dr. Curtis Wood stating that Mr. Beaudry suffers from schizophrenia. None of the police officers responsible for the custody of Mr. Beaudry familiarized themselves with the contents of this letter.

Mr. Beaudry was transported to the downtown police station where he was strip searched by one of the arresting officers and lodged in a temporary holding cell at 4:17 p.m. Mr. Beaudry remained in the temporary holding cell for one hour and 13 minutes while the arresting officer completed his reports. One of the reports was the Arrest Booking Report (R9 Report) which indicated that Mr. Beaudry was not on any medication. This report was prepared by one of the arresting officers and signed off by another arresting police officer who testified that the report was in error with respect to Mr. Beaudry's medication.

At 5:35 p.m., the arresting officer turned over custody of Mr. Beaudry to officers in the Arrest Processing Unit ("A.P.U."). Accompanying Mr. Beaudry was the Arrest Booking Report (R9 Report), In addition, the A.P.U. officers received the Prisoner Property Report along with Mr. Beaudry's property which included the letter of Dr. Curtis Wood.

At the A.P.U., Mr. Beaudry was searched by A.P.U. officers. All of the previous information as to the medical condition of Mr. Beaudry was not communicated to the A.P.U. officers. Instead, it was alleged that Mr. Beaudry was asked a series of questions by an A.P.U. officer in the presence of a Temporary Acting Sergeant. Normally, the arresting officer would be present during these questions. The questions to Mr. Beaudry were as to whether he had any injuries; whether he was on any medication and whether he was infected with any diseases. Mr. Beaudry was not asked by the A.P.U. officer whether he had any medical condition as required by the policy manual of the Edmonton Police Service (Exhibit 1; Tab-19; Part 2; Chapter C-4). The A.P.U. officer could not recall asking Mr. Beaudry the above described questions but testified that it was standard practice. The A.P.U. officer stated that if he received a positive response to any of these questions, he would record that response in the remarks section of the Lock-Up Record of the detainee. The remark section of Mr. Beaudry's Lock-Up Record contained no notation of a response. The Temporary Acting Sergeant did not have a good recollection of the events while Mr. Beaudry was in custody in the A.P.U. However, he testified that had he been informed that Mr. Beaudry was suffering from schizophrenia, he would have considered ordering a medical examination of him. During the autopsy, it was noted that there was a number of minor bruises and abrasions on the body of Mr. Beaudry.

At 5:39 p.m., the A.P.U. officers placed Mr. Beaudry in a holding cell. While in the cell, Mr. Beaudry was monitored by A.P.U. officers by both a television within the cell (CCTV) and visual checks (the visual checks were conducted by the A.P.U. officers walking to the occupied cells and making a visual check on the physical well-being of the detainee). A detainee monitoring log was maintained which contained the times of the checks, the nature of the checks and the initials of the A.P.U. officer who conducted the check. Based on the contents of the detainee monitoring log, between 5:35 p.m. and 9:30 p.m., Mr. Beaudry

received eight checks by CCTV and seven physical checks. At 6:00 p.m., Mr. Beaudry was taken out of his cell by the Identification officers when he went for his fingerprints. He was brought back to his cell at 6:04 p.m.

There was evidence that during the period between 6:04 p.m. and 9:30 p.m., Mr. Beaudry was asleep quite a bit of the time. One of the policies for the A.P.U. stated the following:

> Detainees who are asleep or apparently asleep must be roused at least once per hour and, if the detainee cannot be roused, they should be taken for immediate medical assessment.

There was evidence that the practice of A.P.U. officers was not to rouse detainees where there were visual signs that the detainee was alive such as breathing, snoring or moving during their sleep. During the period between 6:04 p.m. and 9:30 p.m., the A.P.U. officers did not enter Mr. Beaudry's cell. All physical checks were made from viewing Mr. Beaudry from outside the cell through the opening of the cell door. The video tapes of the television in the cell of Mr. Beaudry indicates that there was no movement of Mr. Beaudry from 7:09 p.m. to 9:31 p.m.

At 9:30 p.m., Mr. Beaudry was scheduled for his bail hearing. In attempts to wake him for his bail hearing, Mr. Beaudry was found by A.P.U. officers to be unresponsive in his holding cell. The attempts by A.P.U. officers to resuscitate Mr. Beaudry through CPR and by the use of a defibrillator were unsuccessful. Furthermore, the efforts of the fire department and EMS to revive Mr. Beaudry were also unsuccessful.

Had the information available at the scene of the arrest, as to the medical condition of Mr. Beaudry, been documented and passed on to the officers in A.P.U., it is possible that a medical examination may have been ordered for Mr. Beaudry. A medical examination may have resulted in the officers in A.P.U. providing closer attention to Mr. Beaudry. In turn, the closer attention may have prevented the death of Mr. Beaudry.

Recommendations for the prevention of similar deaths:

The following is a list of my recommendations following the Fatality Inquiry into the death of Vincent Beaudry held in June, 2009 and September, 2010. The purpose of these recommendations are for the prevention of deaths in similar circumstances. There was evidence that many of these recommendations have already been implemented. Accordingly, I have indicated those recommendations which have been implemented.

1. Public Fatality Inquiry Reports involving the death of a detainee while in police custody should be distributed within a reasonable time to every police facility involved in lock-up of detainees with a request for comments.

2. For police officers involved in dealing with detainees prior to arrival at police lock-up facilities and for all officers responsible for the custody of detainees in the Arrest Processing Unit ("A.P.U."), implement the following policies:

a) Where there is evidence that the detainee is ill, or is suspected of suffering from alcohol poisoning or a drug overdose, or has ingested a combination of alcohol and drugs or has sustained a recent injury, seek immediate medical assistance: **already implemented**.

b) At the scene or as soon as practicable, record in your notebook any observations and medical concerns and any pertinent information from detainee/witnesses: **already implemented**.

c) Assess responsiveness regularly: **already implemented**.

d) Record evidence of alcohol/drug consumption including evidence of the quantity consumed where available.

e) Relay this information and the results of the responsiveness assessment to all officers responsible for the custody of the detainee. It is recommended that the A.P.U. be staffed with a Paramedic. The information and the results of the responsiveness assessment

should also be relayed to the Paramedic.

f) Ensure the information and the results of the responsiveness assessment are relayed to all relief officers responsible for the custody of the detainee. Relief officers should regularly assess the detainee and relay their findings to all officers responsible for the custody of the detainee: **already implemented**.

g) All officers that are responsible for the custody of the detainee should record the results of the responsiveness assessment of the detainee in the Detainee Screening Form prior to lodging the detainee in a cell. The results of all subsequent assessments of the responsiveness of the detainee should be recorded in the Detainee Monitoring Form by the officers responsible for the custody of the detainee: **already implemented**.

h) In relation to assessing the responsiveness of a detainee in custody in the A.P.U., incorporate the following:

> **(i)** The officers on duty are responsible for determining the responsiveness of each detainee in cells and must be familiar with the requirement to assess the responsiveness of each detainee and conduct assessments as required: **already implemented**.
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> **(ii)** The officers on duty must assess the responsiveness of each detainee and record the results on the Detainee Screening Form prior to lodging the detainee in a cell. Once the detainee is lodged in the cell, thereafter, the officers on duty should conduct assessments of the responsiveness of each detainee regularly and record the results of all subsequent assessments in the Detainee Monitoring Form: **already implemented**.
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> **(iii)** The officers on duty should not attempt to determine the degree of responsiveness of a detainee who appears to be less than fully conscious. The officers on duty should understand that if that officer is not satisfied as to the responsiveness of the detainee, that officer should ask another officer to assist in assessing the responsiveness of the detainee. Officers in charge should not assume that the detainee is "sleeping it off": **already implemented**.
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> **(iv)** Officers on duty should record any unusual behavior exhibited by the detainee, e.g. suicidal tendencies, violence, real or feigned illness or conditions verified by a medically trained person. Officers on duty should record any unusual behavior of the detainee in the Detainee Monitoring Form. The first officer at the scene should undertake an assessment of the responsiveness of the detainee. If there is an indication that the detainee is ill, suspected of having alcohol poisoning, a drug overdose, or ingested a combination of alcohol and drugs, concealed drugs internally, or sustained an injury, that officer should seek immediate medical assistance: Exhibits 13 & 17 - 2006 Annual Report of RCMP In-Custody Deaths (Operational Manual - See App. 19-2-1 Amended 2007-07-31).

i) Officers on duty should record all assessments of the responsiveness of each detainee in the Detainee Monitoring Form. The record should detail the activities of the detainee, the type of assessment undertaken, and the results of the assessment. The officer making the entry should ensure that the entry can be read and understood if reviewed at a later date.

j) If the officer undertaking the assessment is unable to establish responsiveness, he should immediately request medical assistance and call for backup: **already implemented**.

3. All officers responsible for the custody of detainees in the A.P.U., in addition to the present standard first aid training, re-certification training and suicide awareness training, should be required to take the course offered by the Solicitor General Staff College's Nurse on observation

and care of detainees.

4. The Government of Alberta should implement for the A.P.U., by way of policy and training, the Card Access Reader system and the in-person cell assessments for responsiveness every 15 minutes described in Exhibit 14: **already implemented**.

5. The Government of Alberta should implement for the A.P.U., by way of policy and training, the Detainee Monitoring Form attached to Exhibit 14: **already implemented**.

6. The Government of Alberta should implement for the A.P.U., by way of policy and training, the Detainee Screening Form attached to Exhibit 14 together with the addition of the following words to the form, "notation required if detainee refuses to answer": **already implemented**.

7. Implement into policy and training that the detainee's history and, where practical, the police service's data base be reviewed for any information which may assist in the determination of the detainee's illnesses, mental disorders, drug addictions, suicide tendencies and, where practical, require such information be documented in the records accompanying the detainee while in custody and, where practical, that it be reviewed by all officers responsible for the custody of the detainee.

8. Implement into policy, random audits of CCTV video records to determine whether officers on duty are actually conducting assessments of responsiveness of detainees and that the detainees are being roused when sleeping

9. In the event of a death of a detainee while in police custody, all CCTV videos relating to the detainee and evidence of assessments of responsiveness of the detainee should be preserved: **already implemented**.

DATED July 27, 2011,

at Edmonton, Alberta.

P.G. Sully
A Judge of the Provincial Court of Alberta