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 Law Courts

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

on the 10th – 21st day of January, 2005 (Year), (and by adjournment

on the 13th – 28th day of June, 2005, and by adjournment

on the 12th – 13th day of September, 2005 (Year)),

before Jerry N. LeGrandeur, a Provincial Court Judge,

into the death of Kyle James Young (Name in Full) 16 (Age)

of 31 Oake Ridge Drive, Edmonton, Alberta (Residence) and the following findings were made:

Date and Time of Death: January 22nd, 2004 between 11:15 a.m. and 11:35 a.m.

Place: Edmonton Law Courts building, 1-A Sir Winston Churchill Square, elevator #4 hoistway

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)).

Hanging (neck suspension)
(See report at page 78)

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)).

Accidental

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PART I

Circumstances under which Death occurred:

A. Inquiry Process

1. Establishment of Inquiry

Pursuant to s.35(1) of the Fatality Inquiries Act RSA 2000 c.F-9 as amended, the Attorney General in and for the Province of Alberta ordered that a public fatality inquiry into the death of Kyle James Young, which occurred on the 22nd day of January, 2004 in the Law Courts Building in the City of Edmonton, be conducted by a Provincial Court judge without a jury.

I was designated to conduct this Inquiry by the Chief Judge of the Provincial Court of Alberta and thereby charged pursuant to the subject Act and specifically pursuant to s.53(1) and (2) of the Act with determining:

- the identity of the deceased
- the circumstances under which death occurred
- the cause of death
- the manner of death (which means the method of death, whether natural, homicidal, suicidal, accidental or undeterminable)

and the making of recommendations (if any), for the prevention of similar deaths.

Given that this youth plunged to his ultimate death down an elevator shaft in the Law Courts building in Edmonton while shackled and in the physical control of Provincial Protection Officers, the need for an investigation as to how this could occur is clear. The family, the public, and the administration of justice not only need to know how this happened, but indeed, demand to know.

2. Overriding Purpose of Fatality Inquiry

I have outlined aforesaid the specific issues I am to report to the Attorney General upon; through the process of answering those questions, the overall purpose of the fatality inquiry is fulfilled. The often cited case of ***R.v.Faber*** [1976] 2 S.C.R. 9 (S.C.C.), describes that purpose as follows:

> [Fatality inquiries are] to assist and reassure the public by exposing the circumstances of a death. An inquiry dulls speculation, makes us aware of the circumstances which puts human life at risk and reassures all of us that public authorities are taking appropriate measures to protect human life. The Inquiry also has an important role in ensuring that the justice system operates properly because it will investigate and review the work of the medical examiner and scrutinize the role that other parts of the justice system may have played.

Mr. Justice Kirby, in his report in the Administration of Justice in Provincial Courts of Alberta, stated that the purpose of a public inquiry into fatalities is:

> As a means for public ascertainment of facts relating to deaths, as a means for formally focusing community attention on an initiating community response to preventable deaths and as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed or ignored.

A full and open hearing by an independent finder of fact who investigates the cause and

circumstances of death and makes recommendations so as to prevent the reoccurrence of such a tragedy, hopefully serves to restore public confidence in the system under scrutiny.
My primary role is one of fact finder so as to lay open before the public all the circumstances surrounding and leading to the death of Kyle James Young. The facts I find may lead to recommendations which will hopefully serve to prevent the reoccurrence of similar tragedies.

It is critical in this process to remember that this inquiry is neither a criminal nor civil trial designed to determine legal liability. Indeed s.53(3) precludes me from making a finding of legal responsibility or coming to any conclusion of law. Section 53(3) states:

> 53(3) The findings of the judge or jury shall not contain any findings of legal responsibility or any conclusion of law.

Mr. Justice Cory's comments in the case ***Re: Krever et al***, (1997) 151 D.L.R. (4th) p.1, although spoken in the context of a Federal Commission of Inquiry are nonetheless, in my view, apropos to the Alberta fatality inquiry process. At paragraph 34 of the case report, Justice Cory states:

> The Commission of Inquiry is neither a criminal trial, nor a civil action for the determination of liability. It cannot establish either criminal culpability or civil responsibility for damages, rather, an inquiry is an investigation into an issue, event or series of events. The findings of a Commission relating to that investigation are simply findings of fact and statements of opinion reached by the Commissioner at the end of the inquiry. They are unconnected to normal legal criteria. They are based upon and flow from a procedure which is not bound by the evidentiary or procedure rules of a courtroom. There are no legal consequences attached to the determination of a Commissioner. They are not enforceable and do not bind Courts considering the same subject matter.

Likewise, the fatality inquiry process is not an adversarial process and accordingly does not provide all the safeguards available when issues of criminal or civil culpability are the focus of the proceedings. It is, as I have said, a fact gathering and finding process, designed to publicly air all the circumstances leading up to and surrounding the death of a member of our society. This process cannot provide the evidentiary and procedural safeguards which exist at a criminal and civil trial and this relaxation of evidentiary and procedural safeguards make it apparent that findings of criminal or civil liability cannot be made. (See: ***Re: Krever et al***, supra, para.53)

It is in principle, wrong for a public body, other than a Court to make formal pronouncements respecting the legal responsibility of any person, whether it be in a criminal or civil matter. If a Fatality Inquiry were to conclude that an unlawful homicide or negligent act caused or contributed to a death that had occurred, without a trial having been conducted and without the benefit and protection of due process of law, this could lead to the wrongful and irreversible condemnation of an individual by the community at large. Hence the legislative prohibition against expressions of legal responsibility or conclusions of law relative to circumstances of death.

It is to be noted however, that although this Inquiry is prohibited from issuing expressions of legal responsibility or rendering legal conclusions with respect to the death of Kyle James Young, it nonetheless is required to ascertain the facts and circumstances relating to his death. It is axiomatic that the facts found and the recommendations arising from those facts, may be interpreted as findings of misconduct. The potential that inferences of misconduct may arise from facts found by the Inquiry, however, does not mean that the Inquiry for that reason, is precluded from expressing its findings of fact. The findings of fact that may reflect adversely on an individual do not in and of themselves offend the prohibition set out in s.53(3), supra, provided that the factual findings themselves are not couched in terms of legal or civil culpability or as conclusions of law. (See: ***Re: Krever et al***, supra, para.39)

3. Fact Finding Process

Pursuant to s.49(1) of the Act, the Minister of Justice appointed counsel to appear on his behalf at the inquiry and examine and cross-examine witnesses and present argument and submissions. Appointed counsel's role was in fact much more encompassing than the aforementioned, in that counsel for the Minister also arranged for the hearing dates, vetted government documentation and materials that were considered relevant to the Inquiry, and arranged for the disclosure and distribution of those materials and other materials requested by other interested parties, or as directed by myself. He summoned witnesses on his own initiative and/or as requested by other counsel or myself, he coordinated and arranged for all pre and mid inquiry conferences involving counsel for all interested parties and myself and led the examination of almost all witnesses called. Although appointed by the Minister of Justice, he is in fact independent counsel whose position is not to advocate a position for or against government or any other entity or person, but rather to help facilitate the fact finding process of the Inquiry.

The inquiry hearing was fixed to commence on January 10th, 2005 in the Law Courts Building in the City of Edmonton, Alberta. With my concurrence, counsel for the Minister arranged a pre-inquiry conference by telephone which was conducted on the 13th day of December, 2004 in preparation for the January hearing. Present at that pre-inquiry conference were counsel for all parties who either had statutory standing or were by my allowing them to participate in the conference given standing to participate in the inquiry process by virtue of the provisions of s.49 of the Act. The parties in standing to participate in the hearing process at the time of the first pre-inquiry conference of December 13th were:

- The Minister of Justice for the Province of Alberta
- The Young Estate and Young next of kin
- Lerch Bates Inc.
- Thyssen Krupp Elevator (Canada) Ltd.
- Court Security Personnel
- Constables Fayad, Chambers and Tomaino
- Edmonton Youth Criminal Defence Bar Office
- Alberta Infrastructure, Municipal Affairs

Further pre-inquiry conferences were held on December 21st, 2004 and January 4th, 2005. The purpose of these pre-hearing conferences was to hear from all parties with standing at that time and discuss the matter of what witnesses should be called, the production and exchange of documents and potential exhibits and to deal generally with matters of procedure that could further the inquiry process thereby making it more thorough and efficient.

4. The Hearings

The first portion of the inquiry hearings commenced on January 10th, 2005 at the Law Courts in Edmonton and continued through the 21st day of January. At the commencement of the inquiry I granted standing to one further entity, that being AEDARSA – Alberta Elevating Devices and Amusement Rides Safety Association, which is a body that has a mandate from the Government of the Province of Alberta to investigate any accident involving an elevating device. In this case they did do such an investigation (the report of which may be found at Tab 64 of Exhibit 1 in these proceedings).

During the course of the first ten days of testimony, it became clear that given the number of witnesses that were to be called and the breadth of the inquiry, the ten days initially scheduled for

completion of the inquiry was inadequate. After consulting counsel, I directed that the inquiry reconvene on the 13th day of June, 2005 for the completion of the evidentiary portion of the inquiry. The viva voce evidence of all witnesses, including all experts, was completed in the late afternoon of June 28th, 2005. No further time for the presentation of submissions was available, so I directed that any counsel who wished to present written submissions do so on or before the 15th day of August, 2005. The inquiry received written submissions from counsel for security personnel, Tomaino, Chambers, and Fayad, Thyssen Krupp Elevator (Canada) Ltd., the Estate of Kyle James Young (Young family), the Solicitor General and Public Security Department, Infrastructure and Transportation Department and Municipal Affairs Department, and the Youth Criminal Defence Office.

Final oral submissions were presented before the Inquiry by all interested parties in the Edmonton Law Courts on September 12th and 13th, 2005, at which time the Inquiry was adjourned for the preparation of this report.

5. Witnesses and Documentation

Over the course of the 23 hearing days, the Inquiry heard testimony from 29 witnesses and marked 67 exhibits which cumulatively filled 7 two inch binders. The Inquiry proceedings yielded in excess of 4,100 pages of transcript. The testimony presented and the documents filed as exhibits, broadly speaking, included testimony and documents relative to the statutory requirements relative to the operation and maintenance of elevators; testimony as to the actual operation of and maintenance of the subject elevator; testimony of the security personnel in whose custody Kyle James Young was at the time he fell to his death; the physical set up of the youth holding cells on the 4th floor of the Law Courts building, Provincial Court side; policy and practice with respect to use of force by Court Security personnel, testimony from one youth present in the youth holding cells on the 4th floor at the time Kyle James Young fell to his death; policy, procedure and practice of security personnel re the transfer of young persons from Edmonton Young Offenders Center to the Court and on return to Edmonton Young Offenders Center; procedures for admission of young persons to EYOC including policy and procedure in dealing with young persons on medication when admitted to EYOC; testimony as to the personal background and circumstances of Kyle James Young and the circumstances and events that occurred over the days leading up to his death; testimony and documentation relating to the actual maintenance of the subject elevator; testimony and documentation as to what steps were taken post incident to investigate and determine what happened; expert testimony from engineers and other persons expert in the operation of elevators as to the condition of the elevator hall door at the time of the incident and the quantum of force or energy necessary to cause the hall elevator door to open. The Inquiry also heard testimony and received documentation relating to the Provincial code requirements for elevator hall doors. Testimony was also tendered through some of the experts called and other witnesses involved in the construction, design or maintenance of elevators, as to what could be done to prevent such incidents in the future.

At the conclusion of the evidentiary portion of the hearings on the 29th day of June, 2005, I inquired in open proceedings whether there was any other person or persons who could give evidence touching the matters in question in this Inquiry, and invited such person or persons to come forward. No other person sought to present any further evidence in this proceeding.

6. Ban on Publication of Names of Young Persons

Section 110 of the Youth Criminal Justice Act provides that subject to the exceptions provided in

s.110 itself, no person shall publish the name of any young person or any other information related to a young person if it would identify the young person as a young person dealt with under the Young Offenders Act. Kyle James Young was such a young person at the time of his death. Given his death and the purpose behind s.110, it is arguable that s.110 would not apply insofar as it relates to publication of his name in these proceedings or through press coverage of this Inquiry. Counsel for the Young estate and family made application pursuant to s.110(6) for leave to allow the publication of Kyle Young's name during the course of this inquiry. Kyle Young's mother, who counsel described as his personal representative, sought such leave. I concluded that publication of his name would not be contrary to the public interest or his best interests and granted leave as sought.

Given that other witnesses anticipated to testify before this Inquiry were young persons within the meaning of s.110 of the Youth Criminal Justice Act, I reiterated on the record that there could not be publication of their names or any information that might identify them. Any reference herein to such youths will be by initial identification I have assigned the respective youth witnesses for purposes of these proceedings.

7. Open Hearings

The evidentiary parts of the subject inquiry were in their entirety open to the public as required by the provisions of the Fatality Inquiries Act. There were two aspects of the proceedings that were not open to the public. These instances were not evidentiary or fact gathering in nature. On the first day of the hearings, January 10th, 2005, I allowed counsel and members of the press to view the youth holding cell and elevator area on the 4th floor of the Edmonton Law Courts, Provincial Court side, where the circumstances leading to the fatality occurred. This was not an evidentiary gathering process, rather it was intended to give counsel a better understanding of the physical layout of the area in which the incident that led to Kyle James Young's death occurred. This viewing was not on the record and I directed that no photographs of the viewed area were to be taken.

The second instance occurred during the June hearings when myself and most counsel took the opportunity again for purposes of context, to ride up on the top of the subject elevator as it rose to the 4th floor. This was again, not a fact gathering process, but only for purposes of allowing counsel and myself to better understand the testimony given on the record as it related to elevator operation and maintenance procedures.

B. Factual findings and Conclusions with Respect to the Death of Kyle James Young, January 22nd, 2004

It is my intention in this portion of this report to review and summarize the testimony of the Provincial Protection Officers who were directly involved with Kyle James Young on January 22nd, 2004, the youth prisoners, the evidence presented relative to the failure of the elevator hallway door, its condition at the time of the incident and the expert testing undertaken with respect to that door and the evidence as to its ongoing maintenance and to make findings as to how and why the subject elevator door failed and how Kyle James Young came to fall to his death.

I will also discuss and reach conclusions as to whether the pre-January 22nd, 2004 treatment of Kyle Young by Provincial Protection Officers and EYOC personnel and the fact that he was not provided with his prescribed medication upon admission to EYOC on January 19th, 2004, contributed in any way, to the circumstances that led to his death.

1. Background of Kyle Young and Chronological Summary of Events to January 22nd, 2004

Kyle Young was a troubled 16 year old at the time of his passing. In January of 2004, he already had an extensive history with foster care, and the justice and mental heath systems.

Lorraine Young, Kyle Young's mother, testified at the Inquiry. She stated that she had first noticed problems in controlling Mr. Young's behavior around the age of six or seven. This was at approximately the same time that he had been diagnosed with Attention Deficit Disorder. Ms. Young testified that he had been on medications for this illness since he had been first diagnosed. In addition, she believes that he had also been diagnosed with Oppositional Defiance Disorder. Ms. Young agreed with the evidence of others given at the Inquiry – he would often flip out over nothing, was unpredictable and had an explosive temper.

Mr. Young's behavioral issues became too much to handle, and Mr. Young was placed in a group home. This occurred around the age of nine, ten or eleven. Mr. Young did not do well in this setting. From the time of his first placement until the time of his death, Ms. Young believed that Mr. Young had been in as many as 30 group homes.

Prior to his death, Mr. Young had contact with the Youth Criminal Justice System on a number of occasions, including incarceration in the Edmonton Young Offenders Centre. After his last incarceration in EYOC expired on the Fall of 2003, Mr. Young returned home to reside with his mother once again.

From an early age, Mr. Young had been prescribed many medications with the hope that they would improve his behavior. The medications prescribed to Mr. Young over the years included Citalopram, Quatiapine, Resperdal, Ritalin, Dexedrine, Risperidone, Prozac, and Lorazepam. While housed at the Edmonton Young Offenders' Centre in November of 2002, Mr. Young was seen by a psychiatrist, Dr. Sarah Matthews. She had Mr. Young admitted to the Alberta Hospital so that he could receive some assistance with his behavioral issues. He was an inpatient at the hospital from November 19, 2002 until December 4, 2002 when he returned to the Edmonton Young Offenders' Centre. Dr. Matthews then saw Mr. Young in March, April, and September of 2003. All of Dr. Matthews' visits with Mr. Young occurred while he was either in custody at the Edmonton Young Offenders' Centre or an inpatient at the Alberta Hospital. Mr. Young was also seen by psychiatrists Dr. Mejia and Dr. Lai.

Dr. Matthews testified at the Inquiry. She stated that, in her opinion, Mr. Young's main problem was a conduct disorder. She stated that Mr. Young had behavioral problems and his choices of behavior caused conflict between himself and society. She also found that he had anti-social personality traits. Dr. Matthews agreed that Mr. Young had characteristics of Attention Deficit Disorder and Oppositional Defiance Disorder, however she did not think these were his primary problems. Dr. Matthews thought that medications initially helped Mr. Young calm down but, after one to two weeks of taking the medications, she did not think that they had a significant impact on his functioning.

When Mr. Young was released from the Edmonton Young Offenders' Centre in September of 2003, he was taking Tetracycline, Resperdal, and Clonidine. Ms. Young testified that she obtained refills of the medications for Mr. Young and had him see a General Practitioner as necessary. She also testified that she believed Mr. Young was relatively consistent in taking his medications and, that if he forgot, he was compliant in taking them when she reminded him. She could not, however, remember the dosages of the medications that Mr. Young was taking.

In addition to the medications prescribed during his incarceration in 2003, Mr. Young had also

been seeing a counselor named, Terry Bailey. These visits continued once or twice a week while Mr. Young was living with Ms. Young. Ms. Young testified that she would usually take Mr. Young to the counseling sessions and then at the end, she would go in and all three of them would talk. In the months leading up to January 19, 2004, Ms. Bailey had expressed no concern to Ms. Young about Mr. Young's behavior.

Ms. Young testified that, in December of 2003, Mr. Young dropped out of correspondence school and said that he was going to try and find a job. He was not successful in doing so. Ms. Young did not find this surprising, given that he had no education and no experience.

On January 19th, 2004, Mr. Young was arrested and brought to the Edmonton Young Offenders Centre.

The notes from the Edmonton Young Offenders' Centre indicate that Mr. Young was brought to the Admissions and Discharge unit at 22:10 hours. There, he was assessed by Don Livingstone, the acting senior unit officer. Mr. Livingstone recalled nothing out of the ordinary in completing Mr. Young's admission, and testified that he was calm and cooperative. After Mr. Livingstone had completed his admission requirements, Mr. Young was referred to nurse Sherri Roles. Ms. Roles was required to see Mr. Young because when Mr. Livingstone completed his assessment, Mr. Young indicated that he had problems with hyperactivity, had problems controlling his temper at times, had previously been a ward of the government, and had changed homes and schools several times in the last year. This combination of answers mandated that the admissions officer refer Mr. Young for a mental health assessment at the time of the admission.

Ms. Roles testified that she was somewhat familiar with Mr. Young from prior admissions and that she recognized his name before she actually went down to conduct the interview. While familiar with Mr. Young, she recalled no previous problems with him. Like the interview with Mr. Livingstone, Mr. Young was very cooperative, calm and participated in the interview. Based upon her interaction with him, Ms. Roles had no medical concerns. She did, however, schedule Mr. Young to see the psychiatrist on the next scheduled clinic day. The reason that she did this was because Mr. Young disclosed that he had previously been taking Prozac and Resperdal. Upon being advised that Mr. Young was taking medication, Ms. Roles asked him if he had it with him. Mr. Young responded that he did not and that he had not been taking the medication for about two to three weeks. Ms. Roles stated that, generally speaking, youths were quite truthful about whether or not they were taking their medications and she therefore took Mr. Young for his word. Because he indicated that he had not taken his medications for two to three weeks, she did not feel that there was any urgency for him to see a psychiatrist, and that the next available clinic date would be soon enough. Ms. Roles testified that if Mr. Young had told her that he had not taken his medication for two days, as opposed to two weeks, her response would have been different. In that case, she would have contacted his group home or his guardian and asked that the medications be confirmed and then brought in so that the Edmonton Young Offenders' Centre could continue dispensing them.

There were no further notes on any of the medical files at the Edmonton Young Offenders' Centre from January 19 to January 22, and Ms. Roles believes that no medical concerns were raised after Mr. Young's mental health assessment.

Mr. Young's interviews with Mr. Livingstone and Ms. Roles appear to have taken approximately half an hour, as the log for Admissions and Discharge notes that Mr. Young was moved to the Athabasca unit at 22:40 hours. The logs also indicate that Mr. Young was dorm confined upon his admission into the Athabasca unit. No one who testified could explain why Mr. Young would have been dorm confined at this time.

The Athabasca unit is the general population unit at the Edmonton Young Offenders' Centre.

When housed in this Unit, the young offenders have some freedom of movement and privileges that they do not have in any of the other units.

At 7:05 hours on the morning of January 20, 2004, Mr. Young was moved from the Athabasca unit back to Admissions and Discharge for his transfer to the Edmonton Law Courts. At 8:20 hours, the security officers with the security operations branch of the Solicitor General's Department of Alberta arrived to transport the youth that had court appearances that day. The transfer of the young offenders to the Law Courts, which included Mr. Young, occurred without incident.

While at the Law Courts that morning, Mr. Young was involved in an altercation with the security officers. Mr. Young and some other young offenders were causing a disturbance in the cells and were told to be quiet. When Mr. Young did not comply, he was told that he was going to be moved to a separate cell and was asked to come out of the group cell. Mr. Young came out of the cell, but refused to go any further. Constable Simmons then went to grab his arm in order to guide him into the other cell, and the altercation ensued. Two additional security officers were engaged in bringing the matter under control. Mr. Young was eventually handcuffed and taken to the cells in the basement of the Law Courts until he was transported back to EYOC. The logbook for the Admissions and Discharge unit notes that Mr. Young was returned to the Edmonton Young Offenders' Centre at 17:30 hours.

As a result of this incident, Mr. Young was not placed back in the Athabasca unit. Instead, he was held in the Admissions and Discharge unit from 17:30 hours until 21:50 hours when a cell was available in the Zama unit. Mr. Young was then moved there. The director's logbook notes that Mr. Young was to be placed in the Zama unit until a further placement decision was made on January 21st, 2004.

The Zama unit is the isolation unit at the Young Offenders Centre. It contains four cells. The young offenders housed there are usually under suicide watch or are there for discipline reasons. In January of 2004, when young offenders entered this unit, they were strip searched and then given baby doll clothing to wear. Baby doll clothing is a one-piece garment which has two straps over the shoulders and hangs like a dress. No shoes, undergarments, or any other form of clothing were permitted. This practice has now apparently changed and only those young offenders on suicide watch are required to wear the baby dolls.

In addition to the restrictions on clothing, youths in the Zama unit are not given cutlery to use. There is no light switch in their rooms and the lighting is controlled by the staff. The rooms themselves contain only a desk, a chair, and a bed frame. Mattresses are removed at approximately 7:00 a.m. and returned to the cells at approximately 9:00 p.m. The youths are given one blanket.

The youths in the Zama unit are locked in the cells for the majority of the day, sometimes as much as 23 and a half hours per day. There are no radios or televisions in the cells, although the youths can have books.

During his incarceration in 2003, Mr. Young was involved in two altercations at the Law Courts which, each time, resulted in Mr. Young being immediately housed in the Zama unit upon his return to the Edmonton Young Offenders Centre. One of those incidents occurred in April of 2003. Mr. Young was spitting in his cell and the security officers were attempting to put a spit mask on him when he bit Constable Lamer.

On January 21, 2004, the director's loge indicates that a Disciplinary Review Board was to be held with respect to Mr. Young's incident at the Law Courts. A Disciplinary Review Board was held when an incarcerated youth was involved in an incident. Generally speaking, the deputy

director and team leader would meet with the young offender and discuss the incident with him or her in order to get their side of the story. The deputy director and team leader would then determine the appropriate consequence. Kevin Kieser, the program director of the Edmonton Young Offenders Centre, spoke with the staff who had conducted the Disciplinary Review Board with Mr. Young on January 21st, 2004. They stated that Mr. Young was open and calm in the hearing, and that he had admitted to assaulting Constable Simmons. They found that he had accepted responsibility for the assault. After the hearing, the staff decided that Mr. Young should be housed in the Wabasca unit and double-staffed, meaning that he had to have two people handling him at all times when he was out of his room. At the daily staff meeting earlier that day, the director had recommended that Mr. Young be placed in the Wabasca unit and double-staffed. The Disciplinary Review Board therefore confirmed the director's earlier decision.

The Zama unit is the most secure confinement unit at the Edmonton Young Offenders Centre. The Wabasca unit is the second most secure confinement unit. It is a behavior management unit. It has a highly structured and educational environment to assist offenders who have mental health issues that hinder their ability to function, or to assist those young offenders whose behavior is a threat or is highly disruptive. The youths in this unit are given minimal unstructured free time, but have more privileges (for example, they receive cutlery and have more gym time) and more opportunity to interact with others than those housed in the Zama unit.

The logbooks from the Edmonton Young Offenders Centre indicate that at 12:50 on January 21st, 2004, Mr. Young was moved from the Zama to the Wabasca unit. Mr. Young was kept there until he was moved to Admissions and Discharge at 7:28 hours on January 22nd, 2004 in preparation for his transfer to the Edmonton Law Courts. In general, the logbooks and notations from the Edmonton Young Offenders Centre for January 19th to January 22nd, 2004 indicate that Mr. Young had no behavioral issues and was involved in no altercations at the Edmonton Young Offenders Centre during this brief period of incarceration.

2. Physical layout of Level 4 Youth Holdings cells

The Youth Justice court holding cells at the Edmonton Law Courts are located on the 4th floor of the Provincial Court side of the Law Courts building. A floor plan of the building may be found at Tab 78 of Exhibit 1 in the Inquiry proceedings and for ease of reference, a copy of the same is attached hereto as **Appendix 1**. The constituent parts of the holding area are identified individually by numbers. Throughout this report I shall describe the area which I am referring to by reference to the individual numbers as set out on the floor plan, **Appendix 1**.

3. Events of January 22nd, 2004

On the morning of January 22nd, 2004, at approximately 7:30 a.m., Mr. Young was brought from the Wabasca unit at the Edmonton Young Offenders Center to the Admissions and Discharge unit in preparation for his attendance at the Law Courts that day. Mr. Don Livingstone, acting senior unit officer, was working in Admissions and Discharge that morning. He was advised that Mr. Young was designated as double staff, meaning that two staff members had to be with him at all times. Mr. Livingstone was also advised that Mr. Young had received this designation because of his altercation with the Constable Simmons, two days prior. Because there were only two staff members in the unit at the time and one of them had to go and get breakfast for the young offenders in the unit, Mr. Livingstone put Mr. Young in one of the cells. Mr. Young was not in high profile restraints at this time.

Mr. Young received his breakfast, consisting of cereal, a sandwich, a piece of fruit, and juice. He ate, but Mr. Livingstone does not recall whether or not Mr. Young complained about being still

hungry. Mr. Young did ask for a new T-shirt, and Mr. Livingstone provided him with one. Mr. Young was in the cell for about 40 minutes. Provincial Protection Officers then arrived, and Mr. Young was placed in high profile restraints and taken to the Law Courts, with other young offenders, at approximately 8:10 a.m.

On January 22nd, 2004, Constables Enio Perrizzolo and Karin Simmons, both of whom are Protection Officers with the Security Operations Branch of the Solicitor General's Department of Alberta, were assigned to work the early shift of the Young Offenders holding area at the Law Courts building. They had been assigned to that shift for that entire week, Monday through Friday. Their morning would start at 7:30 a.m. Once on duty they would obtain a print-off from the Dispatch Office of which young offenders were being transported from Edmonton Young Offenders Center to the Law Courts for appearance that date. They would normally pick up the keys for the van, move to the Young Offenders cell area on the 4th floor of the Law Courts Provincial Side West, do security checks and then head down to the sally port where they would pick up their van and drive to the Edmonton Young Offender Center for pick up of youth prisoners for transport to the Law Courts for court appearance.

The routine to be followed by the early shift workers is found in Exhibit 1, Tab 78, pp.0487-0488, attached as **Appendix 2** to this report. The process described therein represents the standard practice in this regard, followed by Provincial Protection Officers.

Officers on duty would normally leave the Law Courts at approximately 7:30, arriving at EYOC at approximately 8:00 a.m. When they arrive, the transportation van is parked in the admissions and discharge area which is a separate housed unit at EYOC. Once parked they exit the van, secure their sidearms and ammunition, open up all the cages in the van and move to the admissions and discharge area with their restraints in hand. Restraints consist generally of handcuffs and leg irons (shackles).

The first thing done upon confronting the youth prisoners at EYOC, is to do a pat down search of the youths to be transported who are then restrained with security personnel equipment. Every youth prisoner in the van has handcuffs and leg irons on, unless there is some requirement for a higher grade restraint which will, if required, be implemented. The higher grade restraint used could be a belly chain that's wrapped around an individual's waist, to which the handcuffs are attached, or high profile restraints which are a set of cuffs and a set of leg irons and a chain that connects the cuffs to the leg irons in front of the prisoner. Under this system of restraint, the prisoner's hands would not be capable of being raised past the level of his or her waist. EYOC is to advise the officers whether or not any youth requires high profile restraints or double staffing. This information is to be provided by the admissions and discharge staff at EYOC.

Upon return to the Law Courts the transportation van is parked in the sally port and the youth prisoners are unloaded. Once again, the security officers will exit the van, secure their pistols and ammunition, unload the occupants of the van, remove the handcuffs from the prisoners and transport the prisoners in leg shackles up to the 4th floor of the west side of the Law Courts where they are housed, males and females separately. Any prisoner in high profile restraints remains in those restraints and is placed in a separate cell from the general male or female population on the 4th floor.

Cameras monitor all the cells except one which is encased in glass. The activities of the cell inmates are video recorded. Once the youth prisoners are brought to the cell block area and placed in cell blocks, a video recording of the cell blocks is undertaken. The cells would be monitored by the early morning crew, that week being Constables Simmons and Perrizzolo

On January 22nd, Kyle Young was placed in high profile restraints as a consequence of the previous incident occurring at the Law Courts on January 20th as described aforesaid. Neither

Simmons nor Perrizzolo, so far as I can determine, were provided with a copy of the Offender Profile with respect to Mr. Young or any medical or mental history concerning him. As far as Constable Perrizzolo knew, no one at EYOC told either Simmons or he that there were any special behaviour problems or mental health issues with respect to Mr. Young. Certainly both Simmons and Perrizzolo were aware of the incident of January 20th because they were both personally involved in that incident. The movement sheet for Mr. Young picked up by Simmons and Perrizzolo from EYOC the morning of January 22nd, 2004, Exhibit 2, attached hereto as **Appendix 3**, simply indicates with respect to Mr. Young that he had a suicide record and was a high profile transportee. When asked, Constable Perrizzolo was unable to determine what the letters "SAC" stood for as set out on the movement sheet. Constable Perrizzolo testified that Mr. Young was placed in the female holding cell (Cell 17791, **Appendix 1**) by himself, given his high profile restraint circumstance, although he could not remember whether it was he or Constable Simmons who actually placed him in the cell. His recollection is that Mr. Young showed no resistance or objection to being placed in the holding cell by himself, as opposed to being with the other youth prisoners.

At approximately 9:40 a.m. that morning, Constable Wadden, a member of the Edmonton Police Service (EPS), was dispatched to the Law Courts 4th floor youth holding cells area to investigate the complaint of Constable Simmons alleging assault by Kyle Young against her on the 20th of January, 2004, as described aforesaid. Constable Wadden spoke with Officers Perrizzolo and Simmons and then met and spoke with Kyle Young. The interview with Mr. Young was outside his cell and although Constables Simmons and Perrizzolo were not present at that interview, Constable Perrizzolo testified that he could hear some of the discussion as they were not able to remove themselves totally from earshot during Mr. Young's meeting with Constable Wadden.

Mr. Young advised Officer Wadden that he knew that he was there to investigate the alleged assault by himself on Constable Simmons. Constable Wadden advised Mr. Young of his Charter rights and cautioned him, noting in his testimony that Mr. Young did not appear to be very interested in that process. He advised Mr. Young that he may be looking at an assault charge as a result of the incident, to which Mr. Young stated "Fuck you, add it to the list". This comment, according to the testimony of Constable Wadden, occurred before the constable had even discussed the details of the incident with Mr. Young.

Mr. Young advised that he had punched Constable Simmons in the stomach several times and indicated to the effect that he wanted to "fuck her up". Constable Wadden noted that Mr. Young seemed agitated, angry and disinterested with the whole interview process. After he had finished discussing the matter with him, Constable Wadden indicated in his testimony that he did not recall Mr. Young acting in any unusual or extraordinary way, nor did he recall any dialogue between Mr. Young and protection officers, Perrizzolo or Simmons, when they returned him to his cell. Constable Wadden agreed in cross-examination that Mr. Young seemed to have a strong dislike of authority figures. This conclusion of course was reached simply on the basis of this one meeting with Mr. Young on the 22nd of January, 2004.

Constable Wadden testified that he had no personal knowledge of whether Mr. Young apologized to Constable Simmons for his assault upon her. Constable Perrizzolo in his testimony indicated that he understood that Mr. Young had apologized on January 22nd to Constable Simmons for his actions on January 20th.

Once the discussions between Constable Wadden and Mr. Young had finished, he was escorted back to his cell by Constable Simmons and/or Perrizzolo. Constable Perrizzolo testified that he noticed nothing unusual or out of the ordinary about Mr. Young's demeanor at that time, and he seemed fine. At approximately 10:45 a.m. Constables Perrizzolo and Simmons were given their lunch break with their duties being taken over by other protection officers. While on that lunch break the incident which is the subject of this Fatality Inquiry occurred.

Constable Simmons did not testify at the public Fatality Inquiry in this matter as she was serving with the Armed Forces in Afghanistan. Her statement given on September 2nd, 2004 to an Internal Review Board established by the Director of the Solicitor General was filed as part of Exhibit 1 at Tab 78, pp.0643-0653. Her recollection of the events of the morning of January 22nd as set out in her statement, is consistent with the testimony of protection officer Perrizzolo and Constable Wadden of the Edmonton Police Service. Her statement indicates that Mr. Young presented no observable problem to her during the period of her contact with him the morning of January 22nd and it also indicates that after Mr. Young's interview with Constable Wadden, he offered an apology to her for his assaultive behavior on January 20th.

4. Events Immediately Preceding the Death of Kyle James Young

Any findings of fact with respect to the events that occurred on the 4th floor youth holding area leading up to the death of Kyle Young and that occurred after Constables Perrizzolo and Simmons were relieved of their duties for their lunch break at approximately 10:45 a.m., to the extent that such findings can be made, must be based on the following evidentiary material before the Inquiry:

1. The direct testimony of protection officers Chambers, Tomaino and Fayad, the officers in charge of the youth holding cells and prisoners located therein at the time Kyle Young fell to his death.
2. The testimony of the youth, L.J. who was present in the holding cells at the time of the incident.
3. The video recording of the holding cells on the 4th Floor, Provincial Court West on the morning of January 22nd, 2004.
4. Evidence as to the condition of the hallway door of elevator #4 as at the time of the incident and expert testimony as to how the elevator hallway door opened, the force necessary to cause it to open as described by the viva voce testimony and the maintenance history relative to the #4 elevator.

The testimony of these witnesses, the video tape recording of the youths present in the cells, the physical evidence related to the elevator door failure as viewed after the incident, and the opinion of various experts as to how the door failed and the amount of force necessary to cause the failure of the door, plus the maintenance regiment and procedures relative to the door are the primary sources of evidence available to this Inquiry as to the circumstances and events that immediately precede the falling of Kyle James Young to his death.

A finding of fact as to the condition of the elevator hallway door at the time of its failure is fundamental to the determination as to how it failed and the determination as to the quantity and kind of force necessary to cause such a failure. These facts are also crucial in assessing the credibility of the testimony of the three protection officers and the youth prisoner, L.J.

5. Video Recording of Cell Area

Each of the cells in the youth holding area on the 4th Floor, Provincial Court West with the exception of the glassed-in cell (45798, **Appendix 1**) is monitored by a camera for security purposes.

The cells monitored are usually video recorded as well. Exhibit 5 is a video recording of the youth holding cells on January 22nd, 2004. This video does not record sound and does not record anything outside the actual cell so it offers no direct assistance as to how Kyle James

Young fell down the hoistway of elevator #4. There is no hallway video recording, nor any recording of the area around the entrance of elevator #4 - 27231, **Appendix 1**.

There is a monitoring device that shows the entrance area to elevator #4, on the 4th Floor, however that only allows the elevator dispatcher located on the lower floor of the Law Courts building to view prisoners getting on and off the elevator. It is not a monitor that is video recorded, so it offers no assistance with respect to the happenings in this matter at the elevator entrance. There is no video evidence relating to the actions of the protection personnel or Kyle Young after he was removed from the cell he was being held in – cell 17791, **Appendix 1**.

6. Testimonial, Expert and Physical Evidence

a. Testimony of Provincial Protection Personnel

Provincial Protection Officers Tomaino, Chambers and Fayad, who were all present and interacting with Mr. Young to varying degrees at the time of his death, all testified at the Fatality Inquiry. Each had prepared his own notes contemporaneous with the incident on January 22nd, 2004. Together they had also given their summary of events to a stenographer on the instruction of their superior for briefing purposes. Each officer was interviewed and gave a statement to a member of the Edmonton Police Service. They had each also prepared an incident report and participated in a risk management assessment interview (February/March 2004). They were each also interviewed by the Review Board convened to investigate Mr. Young's death in September of 2004. All of their statements, notes and prior testimonies were exhibits in this Inquiry and available to all counsel for purposes of cross-examination of the officers during their viva voce testimonies before this Inquiry.

The examination and cross-examination of each of these protection officers was lengthy, extensive and detailed, touching upon their personal background; their training and experience with adult and youth prisoners; their day to day duties as protection officers in the Law Courts building; specifically the events of January 22nd and their post-incident actions and conduct. They were also questioned extensively by counsel concerning other statements and testimony that they had provided in other investigations with respect to this incident. It would serve no purpose to repeat in detail their testimony as part of this Inquiry. Rather, I will summarize each officer's testimony as to what happened to Kyle James Young and then later in this report, after other sources of information have been considered, I will make my findings as to the credibility of the testimony of the three protection officers.

- **Testimony of Christopher Chambers**

The examination and cross-examination of Officer Chambers occupied 174 pages of transcript during the course of the Inquiry. At the time of the Inquiry his occupation was a Court Constable with the Solicitor General's Department of the Alberta Government. He had commenced that position in the early part of October, 2003. Prior to moving to Edmonton, he had worked as a Provincial Corrections Officer for 12 years in Victoria, British Columbia. His position there was in a maximum security jail where he had acted in command or as a shift supervisor. He had worked the segregation unit, the handling unit and 11 of 12 years on the tactical team unit. His position in British Columbia involved the handling of adult male prisoners. He did not perform any Court House duties in that position.

His first month of employment with the Solicitor General's Department consisted of shadowing his field training officer or shadowing other constables in the performance of their duties. After the first month of training Chambers was not assigned to a particular area at the Court House and his

duties varied daily. Generally he worked 8:30 to 4:30 and was considered to be on wage probation. Probation lasts as long as the officer is wage personnel as opposed to holding a permanent position. For the most part, despite being wage personnel, he has worked, as of the date of this hearing, on virtually a full-time basis. The only difference between wage and permanent positions is the benefits package; wage employees are also on call, and their duties are the same as permanent employees.

Chambers testified that prior to January 22nd, 2004, he estimated he had worked the youth holding cells about 8 to 10 days as part of his training, during which time he would work with the protection officers that were normally assigned there. The morning of January 22nd, Constable Simmons and Perrizzolo were the morning shift and Chambers indicated that he had worked with these two officers previously. The other team that would normally rotate the morning shift, Chambers believed, was that of Fayad and Tomaino. He had also worked with these officers prior to January 22nd, 2004. Chambers had prior experience transporting youth prisoners up and down elevator #4 to different levels of the Court House and had never encountered any problems, either with the elevator or with respect to the transport of youth prisoners from the 4th floor holding cells to the lower cells. He was aware of no incidents occurring or difficulties with respect to elevator #4 prior to January 22nd, 2004. Officer Chambers did not have any previous experience with Mr. Young.

On January 22nd, Officer Chambers was assigned to work the door to the holding cell area from Courtroom 444. The young offenders would be brought into the docket, Chambers would supervise them while they were there, recording the disposition of the Court, informing the staff in the cell area of the disposition when they were done and then return them to the holding cells through the courtroom door. Courtroom 444 finished at approximately 11:00 a.m. on that date. Officer Chambers does not recall specifically Mr. Young having been brought into Courtroom 444 to be dealt with by the Court, but it is clear that at some point in time in the morning, Mr. Young did appear.

Officer Chambers was informed at the beginning of his shift at approximately 8:45 a.m. that an Edmonton Police Services officer would be attending to interview one of the youth prisoners concerning a prior incident involving a young offender and a protection officer. Chambers noted that there were no disturbances within the courtroom on the morning of January 22nd, and nothing unusual or out of the ordinary. Officer Chambers had no discussion with the EPS officer when he did arrive and doesn't even recall the time the officer attended. The incident that was being investigated by the police officer was a matter that Chambers had learned of from general information from other protection officers.

When Chambers entered the youth holding cell area after the conclusion of court in 444, he assumed he was going to be relieving Officer Perrizzolo and that Officer Fayad would relieve Officer Simmons. When he entered the holding cell area, Fayad and Tomaino were already there. Almost immediately he was told about the young offender in the female holding tank and that he was high profile; although he cannot recall if it was Tomaino or Fayad or both who informed him of that situation.

Chambers testified that Mr. Young was pointed out to him as the individual in the female holding tank and that this was the individual who had assaulted Officer Simmons at a prior date. He testified that he was advised that Mr. Young had a history of acting out and had a history of trying to spit on staff. These were not matters of personal knowledge for Chambers, as he had no knowledge or history of Mr. Young prior to that date. Officer Chambers testified that normally upon entering the holding cells it would be his practice to review the paper work that was there for his own information to see what status the prisoners were at before they were transported. On January 22nd, he did not do this because shortly after he entered the area, Mr. Young started to act out in his cell. Officer Tomaino's testimony was, to the effect that Mr. Young had started

acting up before Officer Chambers had entered the holding cell area. Indeed Officer Chambers testified that there was no activity to suggest any ongoing confrontation with any youth at the time he entered the cell area, or any indication of a problem.

According to Officer Chambers, shortly after his entrance into the holding cell area, Young began to act out, that is he started yelling, making demands, swearing, indicating that he wanted things to happen, he wanted to know when he was going to eat. Tomaino or Fayad responded to the effect that things "would happen when they happen". Young appeared to become more agitated, more demanding. Tomaino approached the cell that Mr. Young was in, instructing him to knock it off, which seemed, according to Chambers, to escalate things even more.

Tomaino and Fayad decided to speak to Mr. Young privately, out of the earshot of the other youth prisoners, but this was not discussed with the sergeant in charge, or the supervisor. Chambers proceeded to the control bubble to open the cell doors and Tomaino and Fayad went to the cell area where they went through the first door and stood by the cell door. Mr. Young was told to come out and he did so. Chambers can't recall whether Mr. Young was told why they were moving him from the cell or that they were going to take him around the corner and speak with him one on one. Officer Chambers believes Officer Tomaino took one arm of Mr. Young by the bicep or tricep area and walked past Officer Chambers in the bubble, Tomaino and Fayad were on each side of Mr. Young. Mr. Young was still yelling and was threatening to kill Tomaino and Fayad and their families. Chambers then secured the cell doors and when he observed Young, Fayad and Tomaino again, Mr. Young was struggling and resisting. At this time they were near the bench in the corridor leading to the area in front of the elevator door adjacent to the protection officers' desk, - See: Photo 7, Exhibit 1, Tab 5 attached hereto as **Appendix 4**.

Officer Chambers heard what he thought was Mr. Young making a "hocking" sound and observed him turning his head as if he was going to spit at Fayad. At that time Constable Fayad was behind Young and to his right. According to Chambers, both officers then had control of him and someone said, "Don't even think about it." Chambers was now following the three and observed that Fayad and Tomaino appeared to have Young under control. He was taken into the corner by the exit door across from the elevator #4 door, then put face first towards the wall with both officers on either side of him, holding an arm. Officer Fayad stepped back. Tomaino was left controlling Young with his hand on the back of his neck or his shoulders. Chambers doesn't know how much pressure was being exerted in that regard. Mr. Young was swearing and threatening and he started uttering "Bruise me, bruise me, I don't care". Tomaino continued to restrain Young and attempt to calm him down. He was told that if he didn't calm down they would charge him, and that he would be moved downstairs.

Chambers said Mr. Young was not pushed or jammed against the wall. Officer Fayad went back to the desk area while Tomaino kept trying to talk to Young. Mr. Young started to squirm again, so Officer Chambers stepped forward and put a restraining hand on his back. Officer Tomaino had not called for Officer Chamber's assistance. Chambers testified that he decided to put Young on his knees, so he took the chain from between his ankles, pulled it back and he and Tomaino lowered Young to his knees. They were still on both sides of Young with their hands on him and they were holding him against the wall so he couldn't resist. Officer Chambers believes he told Mr. Young that he was going to put him down on his knees and after he was put on his knees he started to say things like "hit me, bruise me".

Chambers testified that he suggested that Young be charged with uttering threats and indeed said "Let's give him more of a history." Mr. Young, according to Chambers, didn't care, he was still continuing to threaten the officers and their families. Tomaino then went to the desk area to look up in the Criminal Code the charge they would be laying against Young. It was also decided that Young would be taken to a holding area downstairs and Chambers heard Tomaino, using the whisper phone, ask if the female holding cell was open and ask that the elevator be sent up.

Chambers recalls hearing something that would indicate that the elevator was coming up. At this time, Mr. Young was still in the corner by the stairwell and on his knees. Officer Chambers testified he was having no problem controlling him.

With the understanding that the elevator was on its way up, Chambers lifted Mr. Young to his feet, took control of him by putting his right hand on the back of his neck, then he turned him and took him to the elevator entrance area just across the corridor. Young was still acting out when he placed him face first into the corner being the right angle of the left side of the elevator door as it intersected with the elevator door frame or jamb. Chambers testified that he did not have Kyle Young pressed up against the elevator and that he was not using his body weight against him. He stated that his right arm, which was the hand and arm holding Young by the back of the neck was almost straight and that he was not applying any real force against him. Mr. Young's left shoulder would be up against the elevator door frame; the right shoulder would have been up against the elevator door. Officer Chambers thought that his right shoulder would have been in contact with the elevator door throughout the whole episode.

Mr. Young continued to squirm and attempt to twist out of his grasp, however, Officer Chambers testified that he felt that he had full control over Mr. Young. Officer Fayad then came in to the picture to assist Chambers, although Chambers testified that he did not call for assistance. Officer Fayad moved from the desk area on Chambers left, came to almost a stop and then put his forearm across the middle of Young's back, Chambers assumed to help hold him in position to stop his resistance. Chambers testified that Fayad was not running when he put his arm across his back and that he was either stopped or almost stopped. He testified initially that Fayad used his right arm, but thinks as he reconstructs it in his mind that it was his left arm. (Officer Fayad, as you will note in his testimony, says it was his right arm.)

Chambers testified that there was no thrusting or smacking of Young against the elevator door. Officer Fayad put his arm in the middle of the back below Young's shoulder blades and did not appear to be using a lot of force. Upon Fayad putting his arm across his shoulder and pressing against Mr. Young to control him, the door gave away the moment that occurred. Chambers testified that the left side of the elevator hall door swung into the shaft, with the bottom of the door moving inward first. When the door swung open, Officer Chambers lost his grasp of Young immediately and Young fell into the shaft, turned 180 degrees and initially was facing Chambers as he fell.

Chambers testified that Young's right shoulder went forward and his left shoulder was turning back towards him. Young was spinning counter-clockwise according to Chambers.

Officer Chambers testified that when Mr. Young fell into the shaft he struck something on the left side of the shaft, although he doesn't know what part of Young's body was contacted.

Chambers and Fayad then faced each other in disbelief and told Tomaino that Young had fallen. Chambers said to call downstairs and tell them not to move the elevator. Chambers testified that Tomaino went to the whisper phone and Fayad went to the hard line. Chambers watched them both. He told them he was going downstairs to make sure they didn't move the elevator and he then left the area. Chambers stated that he had never placed a youth prisoner in the location of a hallway elevator door jam before, although he had done it with adults. He testified that it is common to put someone in that position so they can't resist or fight with you. He thought the elevator was on its way up and he wanted Young near to it so that as soon as the elevator got there, Young could be put in and taken down to the holding cell in the lower area.

Chambers testified that he felt that he had full control over Young while pressed into the elevator jam area and that he was able to control Young with one hand on the back of the neck. He said he was not shoving forward and he wasn't letting Young push back against him either. When

Young escalated his resistance to this, Fayad stepped in and put his forearm across the middle of Young's back. Chambers stated that he didn't think he leaned into Mr. Young very much, however it seemed the moment that Fayad put his arm on his back, the elevator door swung open. He testified as well, that there was no smacking of Young or shoving of him against the elevator door. Officer Chambers does not recall any noise associated with the elevator door opening. He, as stated aforesaid, believes that the bottom of the door swung open first and the door went into the shaft. There was nothing to warn anyone prior to it happening that the door was going to open as it did. Chambers doesn't recall what he did to prevent himself from falling into the shaft, indeed he understands that he may have stopped Fayad from falling, but he doesn't remember doing that.

A short time thereafter, Chambers was relieved and taken to a boardroom with Officers Tomaino and Fayad, where they remained until approximately 7:00 p.m. They were directed to separately prepare their notes and Chambers testified that he only conferred with the other officers while making his notes as to what time the alarm was pulled. He testified that there were no discussions involving actual details as to what happened with other personnel during the time he and the other officers made their notes. At approximately 7:00 p.m., each of the officers went over to the Edmonton Police Service and gave individual statements. Those interviews were conducted separately, video taped and transcribed.

In cross-examination, Constable Chambers acknowledge that he had no information concerning Mr. Young's offender profile at the time he was dealing with Mr. Young. He also acknowledged that Mr. Young appeared to have some difficulty dealing with authority figures. When he was told to be quiet, this seemed to cause him to escalate his conduct; likewise, being threatened with a criminal charge, being told that the guards make the rules, also caused his conduct to escalate.

Chambers confirmed that the officers told Mr. Young that he had to calm down or they would have to move him downstairs, that his behaviour wouldn't be tolerated. In further cross-examination, Officer Chambers testified that he did not know if Mr. Young used any words suggesting he was going to spit, but he did hear the "hocking sound" as if Young was gathering his spit together. Young never did spit, Chambers says because he wasn't given the opportunity.

Chambers does not recall anyone's hand being placed on Mr. Young's neck and squeezing it after the "hocking" sound was made.

Constable Chambers assumed that all of the cameras in the holding cells, including the camera which showed the entrance to elevator #4, were recording cameras. Since this incident, he has found out that is not the case.

Chambers also testified in cross-examination that the top of Mr. Young's head would have been just above his shoulder height. He stated that Mr. Young, while in the alcove of the elevator door, was trying to push back against him and turn. Chambers insisted, in any event of his resisting, that he was easy to handle.

- **Testimony of Ali Fayad**

At the time of the commencement of this Inquiry, Officer Fayad had been a Provincial Protection Officer with the Department of the Solicitor General for approximately two and one half years. Prior to his employment as a protection officer with Security Operations, he had been a security officer at the Kingsway Garden Mall and had done various jobs for the City of Edmonton at sporting events. At the time of his hiring by the Security Operations Branch, he had no training in prisoner escort or security within the courtroom or holding cells. He had taken a Protective Safety Systems course, which is an officer safety training course given to recruits by the

Edmonton Police Service. He also took another course through Edmonton Police Service called Co-operative Policing and he completed some other courses which involved professionalism, ethics and the use of force. He had as well, training on the protective safety system use of force model which was used by Edmonton Police Services. This was similar to the incident management intervention model used by Security Operations, which Fayad received training on once he was hired by Security Operations.

Initially Fayad operated both as a plain clothes and uniformed officer at the Court House. As a plain clothes officer, he provided security to the judges, general public, lawyers and anyone who came into the Court House. He had no contact with persons in custody, other than when he would make an arrest himself.

At the date of the Inquiry he had been primarily operating in a uniform and prior to the January 22nd, 2004 incident, he had been in uniform for five months straight. As a uniformed officer, he had been given specific training, including the incident management intervention model, the use of force model, various courses on ethics, professionalism and certification of firearms. His induction training took about nine months of his first year of employment. The intervention model and use of force course that he completed involved use of OC pepper spray, the use of the defensive baton and the use of force in general.

In five months leading to the incident of January 22nd, 2004, Officer Fayad had been employed in the youth holding cells on the 4th floor. He had originally been a replacement for another officer who was required elsewhere, however, later volunteered to stay on the Young Offender Unit. He regularly worked the youth holding cells with Constables Simmons, Perrizzolo and Presiznuik. He worked on a one week rotation basis, one week he would be in the back of the courtroom and one week he would be inside the courtroom providing security. That rotation system had been in place for the five months that he had been operating in the youth area.

On January 22nd, 2004, he started work at 8:45 a.m. which was a regular start on the late shift. The late shift was not involved in transportation of prisoners. Fayad's duties involved initially courtroom security in #444, although from time to time he was also responsible for courtroom security in #443. On January 22nd he was security in courtroom #444.

Fayad testified that the docket started at 9:00 a.m. and concluded at approximately 11:05 a.m. The other officer on duty in courtroom #444 was Officer Chambers. Officer Fayad testified that he left the courtroom area at approximately 11:00 a.m. and went into the youth holding cell area. He left the courtroom approximately five minutes before docket court was finished and in advance of Constable Chambers. Officers Fayad and Tomaino were to provide lunch relief for Officers Simmons and Perrizzolo. When Fayad entered the youth holding cells, Tomaino was already there. Fayad and Chambers were the designated officers to provide relief for Simmons and Perrizzolo, but since there was a possibility of docket court going past 11:00 a.m., Tomaino had been dispatched to the youth holding cells. Officer Fayad testified that he was aware of the January 20th incident involving an assault on Officer Simmons and was also aware of the name of the youth involved. Officer Fayad had no interaction or direct contact with Kyle Young on January 20th.

On January 22nd, Officer Fayad was aware that Constable Wadden was attending and indeed he led him through the courtroom and into the cell area. He does not recall having any discussion with Constable Wadden when he left the holding cells, however he testified that he was aware that Wadden was proceeding with charges against Mr. Young.

When Mr. Young's name was called in docket court, Officer Fayad saw who he was and that he was in high profile restraints. When Fayad entered the holding cell area at approximately 11:00 a.m., Officer Perrizzolo told him that Mr. Young was in the female holding cell and had been well

behaved. Perrizzolo did not mention any other prisoners. Officer Fayad assumed that was because Mr. Young was a security concern given the assault of two days previous. Fayad's routine required that he remain as lunch relief until Simmons and Perrizzolo came back, then he would then go for lunch and as long as he was not required in courtroom #444, he would be dispatched to other duties. At approximately 11:05, Officer Chambers came into the holding cell area and advised them that court had concluded. Fayad concluded that Mr. Young heard this, as he started yelling and asking when they were going back, presumably meaning back to EYOC. The officers did not initially respond to Mr. Young's demands and just ignored him until he started rattling the bars in the cell. Officer Fayad testified that they had hoped he would settle down, however his response was the opposite: he began yelling louder and being more demanding. Fayad and Tomaino assumed responsibility for dealing with Young, with Fayad advising Young that they would "leave when we leave". Fayad testified that Young stated "Shut up you fucking piece of shit." He and Tomaino determined that they would remove him from his cell and try and calm him down. Officer Chambers operated the security gate and cell doors from the control pod and Fayad and Tomaino retrieved Mr. Young. He, according to Fayad, came out of the cell of his own volition after they asked him three or four times to do so.

Officer Fayad testified that Mr. Young was told he was causing problems, that he was being too loud and that they wanted him to come out of the cell and for him to calm down. When Young came out of the cell and approached the two officers, he stopped, turned around and looked at Officer Fayad and making a sound as if he was going to spit at him. Constable Tomaino grabbed Mr. Young by the back of the neck and faced Mr. Young away from them. At this point, Mr. Young would have been facing the wall that he would have been looking at as he came out of the cell with Officers Fayad and Tomaino on each side and slightly behind Mr. Young, holding him by an arm. Fayad understood that Mr. Young had a history of spitting. It is clear this was not based on any personal knowledge that he had. He knew that he had been designated high profile as a consequence of his actions two days before involving Officer Simmons.

Officers Fayad and Tomaino moved Mr. Young over towards the elevator area. He was resisting and at one point in time Mr. Young was restrained against the glass tank area and told to calm down. Officer Fayad testified that he does not think that Mr. Young heard him as he was too busy making threats and seemed to be out of control. He testified that he tried to talk to Mr. Young to calm him down, but that had no affect. Mr. Young continued to resist. He was taken by the officers around the corner so he would be out of sight of other prisoners and not able to get them all hyped up. They were also concerned, he testified, that the noise would be disruptive of any court proceedings, as he thought that courtroom #443 was still in session. He testified that Mr. Young resisted the entire distance to where they were taking him. They basically had to drag him, one on each arm.

Officer Tomaino placed Mr. Young in the corner across from the entrance to elevator #4 - **Appendix 1**, area 27231. He stated that Officer Tomaino had Mr. Young in the corner, was holding him by the back of the neck, and that he then stepped back. Mr. Young was pushing back with his head and trying to turn his head around. He heard Officer Tomaino telling Mr. Young to stop making threats or he would be charged. That seemed to have no affect. Mr. Young appeared not to be listening and just continued with his behaviour. He was threatening to kill them and to kill their families and Officer Fayad considered that he was out of control and that the best thing was to get him downstairs into a cell where he could be monitored continuously. Officer Tomaino and he agreed that should be done and that Young should be charged.

Officer Chambers in the interim had come over and taken over from Officer Tomaino and was holding Mr. Young in the corner by the back of the neck. Chambers grabbed Mr. Young's shackles and set him down on his knees in the corner and held him there while Tomaino called for the elevator to be sent up. Fayad heard the response that the elevator would be coming up. When Mr. Young was in the corner with Chambers, he was saying "Bruise me, give me bruises."

Once it was understood that the elevator was coming up, Officer Chambers picked Mr. Young up off the ground, had control of him by the back of the neck and took Mr. Young across to the elevator and positioned him face first on the left side of the elevator entrance in the right angle where the left side of the elevator door intersects with the left elevator door frame or jamb.

Fayad testified that Chambers was standing back from Mr. Young and holding him with his left arm which was fully extended as he stood on Mr. Young's right side. (Chambers testified that he was holding him with his right arm.) Mr. Young appeared to calm down a bit but he was still pushing back with his head, resisting somewhat. Officer Fayad was standing, according to his testimony, about two feet away from where Officer Chambers was standing with Young. Young continued squirming and struggling and Fayad stepped closer to Young and put his right forearm across the upper back shoulder area of Mr. Young, and pushed him forward. He testified that although he put weight on Mr. Young, he never boarded him into the elevator door.

Officer Fayad testified that as soon as he made contact with Mr. Young's shoulder and leaned into him, the door made a loud pop and the left side of the door swung into the hoistway about 45 degrees. Mr. Young fell into the hoistway and Officer Fayad found himself going in behind him. Somehow he was able to hold onto the wall to his left and save himself. He saw Mr. Young falling down the shaft. Mr. Young appeared to rotate in the shaft and he hit something on the left side of the shaft. Officer Fayad then watched him fall all the way down until he lost sight of him and heard a big bang. Officer Fayad looked at Chambers, who went down on one knee, partially covered his face with his hands and said "Oh my God" and then indicated he was going to go downstairs and tell them that they needed help downstairs, not upstairs. Fayad reiterated that the only warning was the loud pop that he heard when the elevator door opened.

Fayad looked at Tomaino and advised him that Young had fallen down the shaft. Tomaino quickly called down to the pod and Fayad went and pulled the emergency alarm and then pressed speed dial to the office advising the officer who answered the phone, that Mr. Young had fallen down the shaft. Fayad advised the officer, whose name was Clyde, that he pushed Young against the elevator door to hold him and Young fell through the shaft. Fayad then ran over to the elevator, looked down and yelled again for Kyle.

Officer Fayad testified that he looked at the top of the elevator door, because that is where he perceived the loud pop noise to have come from. Sgt. Volk and Kelly Wright came to the holding cell area some time between the incident and 11:30. At that time Fayad gave them a short version as to what happened and they then directed him to the Provincial control pod downstairs, where Fayad was then directed to go to the lunchroom. He testified that he began writing notes between 11:20 and 11:25 when he was still upstairs at the 4th floor youth holding cells and then when he went downstairs, he continued with note writing. For the balance of the day he testified that he wrote his notes. He testified that between 12:45 and 15:00 hours, he, Tomaino and Chambers were in the boardroom waiting for something further to occur. At one point there was a session when the three talked with a stenographer and summarized what happened. This discussion with the stenographer was not recorded, but typed by the secretaries. Fayad testified that he was satisfied that the narrative was a brief explanation of what happened. After that he and the other officers went to the police station and gave separate recorded interviews.

Officer Fayad testified that Mr. Young did not utter any sound as the door gave way and he fell down the shaft. He stated that Mr. Young was doing everything he could to get out of Chambers' hold, but he never saw Chambers hold Young with anymore than one hand. He would have expected that had he been in Chambers' position he would have had to put some weight against Mr. Young.

Officer Fayad testified that although he tried to verbalize with Young throughout his contact with him, after removing him from the cell, he did not believe that Mr. Young was listening; as he kept

resisting, yelling and screaming. Officer Fayad stated that his training on how to deal with disruptive individuals covers all persons in custody, whether youth or adult. He further stated that he did not believe that knowing that Mr. Young had an anger management problem or some other issue would have made any difference with respect to the decision to remove him and take him downstairs. It was, in his view, not an option to leave Mr. Young where he was, because he was being too disruptive.

Officer Fayad testified with respect to camera surveillance that he thought the camera viewing the elevator entrance on level 4 would not only monitor activity in the cells, but also record it.

Officer Fayad testified on cross-examination that walking over and putting his arm on Mr. Young's back area was not one activity. He testified that he walked over and stood by Young and Officer Chambers when Young began to squirm, then put his forearm against him and leaned into him. When he walked over to the elevator he saw nothing that caused him to feel he had to help, but when Mr. Young began to squirm more and use his head as leverage, he thought he would assist Chambers by holding Young against the door. Young was at that time struggling and trying everything he could do to get out of Chambers' hold.

Fayad perceived that Officer Chambers was applying very little force to Mr. Young in that he was just standing there with his arm extended outwards, holding him by the back of the neck. Officer Fayad said he extended his arm, made contact with Young and then leaned into him. He testified that he did not "board" him, as in hockey, into the elevator door. Given the pressure that he and Chambers were exerting, he would not expect Young to have been injured if the door hadn't given way.

Fayad confirmed the policy in their standard operating procedure document that offenders being escorted to Court shall be sent with a copy of the original Warrant of Committal and an Offender Profile. Officer Fayad testified that he was never given an Offender Profile when transporting prisoners, but was given copies of warrants. The only paperwork Fayad was ever given at EYOC was if a youth prisoner had a medical condition and needed medicine while at the Court House.

Officer Fayad testified that the whole incident took between 3 and 5 minutes to unfold.

- **Testimony of John Tomaino**

Officer Tomaino testified that as of January, 2004, he had been employed as a Provincial Protection Officer with Court and Prisoner Services for the Solicitor General's Department for approximately 41/2 years. During the month of January, 2004, he worked the shift 8:15 to 12:05, five days a week. He was, despite 41/2 years with the Department, not on permanent staff and he was unaware of why he had not been able to achieve permanent staff status.

On January 22nd, 2004, he was responsible for providing security in courtroom #267, which was an adult drug docket court. He had been working this assignment for almost a year. To the best of his recollection, Tomaino was finished in courtroom #267 around 10:30. He was sent for coffee and told to report to the youth holding cells after coffee break. He testified that he had previously been in the youth holding cells and had been involved in the youth offender courthouse location anywhere from 20 to 40 times as lunch relief. His notes indicate that at 11:05 a.m. he arrived in the young offenders area. Prior to the incident in the youth holding cells with Mr. Young, Tomaino had no familiarity with him, although he had heard of a prior incident. He had not seen any security report relative to Mr. Young dated April 10th, 2003, but he had heard, prior to January 22nd, that one of the officers had been bitten by an individual and he guessed that individual was probably Kyle Young.

By his recollection, after he finished duties in courtroom #267 he had approximately a 25 minute coffee break and then floated until he reported to the young offenders unit. He entered the youth holding cell area through courtroom #444 and upon entry he placed his firearm in the locker that is located in the holding cells. He noted in his testimony, that the youth holding cell area is a small area so that someone's presence was certainly noticeable upon entry. When he entered the youth holding cell area, he thought Constable Fayad was already there. Constable Fayad's testimony on the other hand is that when he entered the area, Officer Tomaino was already there. Tomaino believed as well, that Constable Perrizzolo was present, but he's not sure.

Tomaino testified that Constable Fayad briefed him about the assault on Officer Simmons and told him a Edmonton City Police officer had come that morning to investigate and charge Mr. Young with assault. He testified that Fayad also advised him that Young was the same offender that had bit and spit at Chuck Lamere in a previous incident. Tomaino, after discussing this with Constable Fayad, went back to the holding cell and observed Mr. Young. However he had no interaction with Young and couldn't recall exactly what Young was doing. Neither did he recall anything unusual about Young's demeanor or behavior at that time. Mr. Young was already in the female holding cell when Officer Tomaino observed him and he understood that he was in high profile restraints because of the assault on Officer Simmons. Constable Tomaino testified that he had no idea how long Mr. Young was to remain in the female holding cell. Tomaino expected to be in the youth holding cells for about an hour, and be relieved once the officers that he and Fayad had spelled off had finished their lunch. Tomaino stated that Young started to act up, wanting to know when it was time for lunch - when he was going back. The officers hadn't received any lunches at that time to give to the prisoners and Tomaino told Young "he would go back when we know we're going back". He advised that they didn't know the exact time when anyone would be going back, although it was usually around 2:00 p.m.

Tomaino testified that Young then became very vulgar, distraught and angry, describing him "Like he went from 0 to 100 in a matter of seconds". He started swearing, "when are you taking me back you fucking bitches." He and Fayad agreed that Young should be removed from the cell and separated from the line of sight of other offenders so they could keep some type of order. In addition, Tomaino thought courtroom #443 was still in session and they wanted to reduce noise. Tomaino had proposed that Young be taken around the corner to a certain location across from the elevator and made to stand in the corner to try and settle him down. The corner is located in the area 27231 as shown on **Appendix 1**. Tomaino testified that the decision to remove Young from the cells had occurred before Chambers came in and he believed Chambers came in from courtroom #444 at approximately 11:10 a.m. Chambers and Fayad testified on the other hand that when Chambers entered the youth holding area and advised that court had ended, this was when Mr. Young became vocal. Tomaino testified that Chambers was briefed when he came in and that Chambers then went to the control pod so as to allow the necessary doors to be opened so that Young could be retrieved from his cell.

Officer Tomaino gave fairly detailed testimony commencing at page 537 of the transcript of evidence at the Inquiry, that when they went to retrieve Young he was standing in his cell facing Tomaino and Fayad at approximately the location of the arrow in holding cell #17791 - **Appendix 1**, and that when he was advised to step out of his cell, he stated "I'm not fucking leaving." He stood there and did not move. Tomaino testified that they knew that they would have to go in and remove him. He stated that Young didn't say why he wouldn't leave, he just said "I'm not going, you're going to have to come and get me." Tomaino stated he looked at Fayad and said "okay", knowing that there was a possibility that Young could be very violent even though he was in high profiles. Tomaino went on the right side and Fayad was on the left. When they entered the cell, Young took two steps back but by that time they were at his side. They tried to escort him and he resisted by not walking, so they had to drag him. Tomaino testified that Young became verbally aggressive at that point, saying "Hit me, hit me give me some bruises. You're all fucking dead". They were trying to get him around the corner, which would be the corner at the location of the

control pod in the hallway area #46473 as shown in **Appendix 1**. Tomaino said Young made a motion to spit at Fayad.

Tomaino was cross-examined with respect to the necessity of actually going into the cell and removing Young. After observing the video of the cell, Tomaino agreed that Young did not take two steps backward when they asked him to leave the cell and he did agree that the tape appears to show the movement of someone walking out of the cell on his own. The video tape shows that Mr. Young left the cell that morning at 11:11:57. Fayad and Chambers did not testify that anyone had to enter the cell to get Young, that Young refused to come out of his cell, that he verbally advised them that they would have to come in and get him.

When Young made the motion and the "hocking" sound interpreted as an attempt to spit at Fayad, Tomaino, in the statement given to risk management, testified that he grabbed Young's neck. At the Inquiry he couldn't remember whether it was himself or Fayad who grabbed Young's neck to move his head away from them. Tomaino testified that Young's neck was held to keep his head turned away from either of the officers, only for a short moment, and by the time they reached the control pod area (46473 in **Appendix 1**), his neck had been released. Constable Tomaino testified that Young continued to be verbally aggressive and that he and Fayad were still holding on to him with Chambers now bringing up the rear.

Tomaino testified that he told Young there was a possibility he could be issued a 24 hour confinement, however, if he calmed down, he wouldn't submit one. He doesn't remember what Fayad said, if anything. This apparently occurred once Young had been placed in the corner across from the elevator. Tomaino said he was trying to get Young to calm down, but that none of what he said "got through whatsoever". Young kept swearing and getting more and more agitated and according to Tomaino, said, "Well, when I get out of here I'm going to kill your family. You're all fucking dead".

Tomaino and Fayad decided that Young should be removed downstairs. At this time, Tomaino and Fayad were standing by Young in the corner and Chambers was located at the desk (**Appendix 4**). Tomaino then motioned for Chambers to come over and assume control of Mr. Young and Tomaino testified he contacted Officer Graham in the Provincial Court bubble and asked if there was any room downstairs for a problem child to which he received a positive answer. Tomaino was advised the elevator would be sent up. Chambers then moved Young across the corridor from the location he was standing to the elevator door as shown by the diagonal arrow in area 27231 in **Appendix 1**. Mr. Young was still resisting and still swearing. According to Tomaino, he was not watching at this point and testified that he did not see Chambers move Young over to the elevator door.

Tomaino testified that while he was looking in the Criminal Code with respect to the offence of threatening, he could hear Young being aggressive and angry, so he looked behind and saw that Fayad was approximately 2 ½ feet away from Young. He then saw Fayad had his forearm up and they were bracing Young in the corner. Young was facing into the corner where the trailing edge of the elevator door and the door frame of the elevator meet. Tomaino testified that his back was turned away from this activity for most of the time as he was looking for the Criminal Code section number, and he does not know if Young was actually touching the elevator door in the location where he was being held there. While Tomaino was at the desk looking in the Criminal Code, he heard a loud pop, turned and testified "I see my two officers halfway in the elevator shaft. They managed to catch their balance. At that point, we – I heard inmate Young fall." He testified that he heard no sounds of banging against the elevator door prior to the pop. Once Chambers and Fayad regained their balance, there was a moment of brief and utter shock, Chambers then ran out, Tomaino believes to seek assistance. Fayad assisted Tomaino on the other phone where they contacted the Provincial Court bubble, telling them not to move the elevator at all and for dispatch to get EMS there right away.

Tomaino testified the door looked exactly like a screen door coming off a hinge where it swung open. It had swung open and back a bit towards the inside of the elevator shaft. Officer Tomaino does not recall whether it was the left or right side of the elevator door that had swung open. He stated that the door had not slid at all, "it popped off the tracks or off a hinge or off a pin system and swung inwards". Tomaino testified that he and Fayad remained at the scene and Fayad went over and was calling Mr. Young's name to see if there was any response. Tomaino heard no response. Sgt. Volk and Cst. Wright arrived at the scene and Tomaino and Fayad turned over their flashlight, gave them a brief explanation as to what happened and then just stood back. He and Fayad then separately made their way downstairs to the staff boardroom to wait the arrival of the police and it was there that he prepared his personal notes.

According to Tomaino, Mr. Young fell at approximately 11:25 a.m. He arrives at that conclusion on the basis that it took less than a minute for his supervisor to arrive and he arrived right on the scene at 11:26. Tomaino said he made a mental note of that time. In Tomaino's interview with Edmonton Police Service, he was of the opinion that Mr. Young's falling down the elevator shaft would have been captured on video tape, as he believed there was a camera that directly viewed the entrance to the elevator. He was of the view that the camera recorded what it monitored and Tomaino testified that he told his sergeant to get the video tape to preserve the evidence. Fayad, Tomaino and Chambers were in the boardroom together for a considerable period of time, but Tomaino said they didn't discuss the incident as it unfolded, there wasn't much to talk about, there were lots of officers coming in and out of the room. He agreed that there was some discussion, but it was very minimal. When advised by counsel that courtroom proceedings in 444 ended on January 22nd, 2004 at 11:05:35, Officer Tomaino stated that that would mean that he arrived sooner than the 11:05 that he had noted in his notebook. Tomaino testified he had started making his notes at approximately 11:35 a.m.

Officer Tomaino, in cross-examination, acknowledged that his pre-Inquiry statements do not mention that Mr. Young was asking for lunch, although his testimony at the Inquiry noted that. Officer Tomaino explained that this was something he remembered after the last interview. In response to Mr. Young's inquiries about lunch he believes he said something to the effect, "it's coming right away, you'll get it when we get it".

b. Testimony of Youth L.J.

On January 22nd, 2004, L.J. was 16 years of age and had attended courtroom #444 in the Law Courts building to make an appearance in Youth Court on a matter that he was charged with. At Court he became aware that a warrant had been issued for him, so he was arrested, searched, shackled and taken back into the Youth holding cell area, where he understood he was going to be finger printed, photographed and released. He was placed in the cell area #15338 as shown in **Appendix 1**. In the cell immediately adjacent to him was another individual who he identified later in his testimony as C.M.

Across the corridor from cell 15338 (**Appendix 1**) is cell 17791 which is identified as the cell that Kyle Young was in. From his cell location L.J. could only see a small part of the entrance to the cell that Kyle Young was in. There were two or three other people in the cell located at the end of the corridor. To the best of his recollection, he was placed in his cell between 10:00 and 10:30. L.J. testified that he could hear everything going on in the cell block, including guards talking, although he really wasn't listening to what anyone was saying.

He testified that the individual in the cell next to him had a verbal confrontation with someone who was accusing him of narcing on him. The video of all the cells and the individuals therein recorded the morning of January 22nd, 2004 does show the individual C.M. who appears to be

sleeping most of the time that morning, apparently speaking to someone outside his cell during the course of that morning. L.J. did not know if the discussion was between that fellow and Kyle or someone else. He was positive that there was no one else in the cell with Kyle. He testified that Kyle kept demanding food and kept yelling and that he and Kyle, had somewhat of an argument which lasted less than 5 minutes, although he doesn't really recall what it was about. Ultimately the argument just stopped.

L.J. testified that Kyle kept asking for food and the guards kept ignoring him. He just got louder and louder demanding food. He testified that two guards came to the door, one he described as Lebanese, the other he described as white with big arms. They did not go into the cell, but one reached in and grabbed Kyle behind the neck, pulled him out of the cell and pushed him up against the wall outside the cell door. The wall in question was later clarified by L.J. to be the wall that would be facing the entry of Kyle Young's cell and would be the wall adjacent to the courtroom #444 entrance which is in that area identified as 24716 in **Appendix 1**. He testified that the guards pushed Kyle against the wall and he kind of pushed back with his body. Kyle kept trying to get away. The guards then took him around the corner out of his sight. They had him by the back of the neck and they just kind of pulled him into the area in front of the elevator which is area 27231 in **Appendix 1**. He did not see the guards hit Kyle and believes that they continued to hold on to him, and that he continued to resist.

When asked what happened after Kyle was around the corner out of sight, he said "I just heard some banging around, I wasn't really paying attention". When asked if he could tell what was happening, he said "I couldn't tell, but – I don't know what it was." Later he would testify that he heard three bangs, the last one being louder than the first two, and then he saw one of the guards come around the corner. He appeared to be holding his nose and saying "Oh my God, Oh my God".

He also testified that there was a third guard in the cell area who was female and that it was the female who called the ambulance and the fire truck. (It is, in my view, indisputable that there was no female guard present in the holding cells on the 4th floor at the time the incident took place.) Certainly Officer Simmons had been there previously and in fact was likely there when L.J. was arrested and brought back into the cells from the courtroom area.

L.J. did not know what had happened until he was interviewed by the police at the Remand Centre early that afternoon. He testified that he and the other prisoners were cuffed and shackled together and taken downstairs. He gave a statement that is found in Exhibit 1, Tab 51 which he testified is accurate with two minor exceptions. He was never given a copy of his statement according to his testimony.

In cross-examination by counsel, he stated to the effect that the more the guards ignored Mr. Young's demand for food, the more upset Mr. Young got. The tone of his voice got angry and he started swearing and then two guards came to his cell door. He described the guards as both fairly big men, over 6 feet.

He testified he did not remember hearing the guards tell Kyle to be quiet or stop, or anything like that. He testified that the guards just reached in the cell, grabbed him, pulled him out of the cell and put him against the wall. They then started pushing and shoving and the guards then took Young around the corner to the area by the elevator where L.J. could not see him. He has no recollection of Kyle complaining in terms of pain or anything like that.

With respect to the banging he testified under cross-examination that the last bang was the loudest one, and got his attention. He testified that it was hard to explain as to how loud it was, but he could feel some vibration from it where he was sitting.

L.J. testified on cross-examination that he never heard Kyle tell the guards to "go ahead, leave bruises, bruise me, I want you to leave bruises", or anything similar. Neither does he remember Kyle ever banging on his cell door.

In cross-examination, he was quite certain that there was a female officer present while all this was happening.

He testified as well that he did not personally have any trouble with the guards and they had been nice to him. In describing how the guards moved Kyle from the cell area to the area around the corner as described aforesaid, he said:

> "Well, he's trying, like, to get away. He's trying not to go where they're bringing him. Like, you know how if somebody tries dragging you and you don't want to go that way, your feet aren't really going to go the way you want them – they want them to. That's what he was doing".

Later he testified:

> "Yah, but they had him like up and then he was – kind of had his feet and he kept bringing them forward to stop, and they just pulled him."

c. Other Youths in Cells

Three other youth prisoners, C.M., R.F. and M.C. who were in the holding cells on the 4th floor at the time of the incident were interviewed by Edmonton Police Service and provided written statements. None of these prisoners were called to testify at the Inquiry. C.M. was available but not called because counsel all agreed that given his condition while in the cell and the fact that he was sleeping most of the time, he did not offer this Inquiry any reliable assistance. Counsel also agreed that although C.M.'s written statement was filed as an exhibit in the within proceedings it could not be seen as reliable either.

R.F. was not available to give testimony during the January or June sittings of the Inquiry as he had not been located. He was, at the time of the subject incident, being held in the cell area at the end of the 4th floor cell block, at the opposite end from where the elevator was located. His cell is identified in **Appendix 1** as area 38165 and shown in **Appendix 5** as cell #4.

His statement, found at Tab 50, Binder 2, Exhibit 1, was given between 3:05 and 3:20 p.m. on January 22nd, 2004 and he states therein that he had seen from his cell area the guards open Kyle's cell door. One guard entered and pulled Kyle out and slammed him up against the wall. They then took him around to the area of the elevator. This is difficult to reconcile with the physical layout of the cell area. From the cell area that R.F. was being housed in, it is impossible to see the entrance to the cell that Kyle Young was being held in and one would not be able to see what took place at the entrance to that cell unless one could see around corners.

M.C. was also located in cell #4, and his statement which appears to have been given between 2:30 and 2:50 p.m. on January 22nd, 2004 is reproduced at Tab 49 of Exhibit 1. He described Mr. Young as yelling and screaming at the guards and that he kept calling them "fags" and "gays" and that he wanted to know when he could eat.

Like R.F., he states that the guards opened Mr. Young's cell, went into the cell, grabbed him by the neck and head and removed him. This must be surmisal on his part because as I noted aforesaid, one cannot see the entrance to Kyle Young's cell from the cell in which M.C. was located.

He then states that he saw Mr. Young by the bench in the area of where the computers are and that he was kneeling on the bench with his face against the wall. His view of this area could only have been through the window of the cell operations pod which was not a full length window. It is unlikely that he could see whether someone was kneeling on the bench in that corridor area.

He continued further in his statement indicating that although he could not see what was happening, once the guards moved Mr. Young by the elevator, he could hear Mr. Young screaming profanities and saying "bruise me, bruise me, I dare you". This is very similar to what the guards stated Mr. Young was saying. None of the other youths testified to Mr. Young making these specific comments and certainly the guards would not have had access to the statement given by M.C. to the police on January 22nd, nor would he have had access to their statements given that day in which they used similar wording to describe his comments. M.C. concluded his statement by saying that he heard Kyle say, "oh fuck", then he heard a bang and the guards, to use his words, "started freaking out". One of the guards then yelled for a medic.

7. General Operation, Maintenance, Condition and Failure of Level 4 Hallway Elevator Door

How and why the trailing edge of the subject elevator hallway door came off its hanger and swung into the elevator hoistway, thereby allowing Kyle Young to enter into the hoistway and fall to his death is fundamental to fulfilling the mandate of this Inquiry. To answer that question, the following matters must be considered:

- what was the condition of the hallway door
- were all the components of the subject door present and in proper working condition
- did the door comply with provincial safety code requirements
- what was the nature and level of force applied to the door at the time of its opening
- what is the relationship between the condition of the door and the force needed to cause the door to open in this instance

a. Operation of Level 4 Hallway Elevator Door

The first witness presented to this inquiry was Mr. Allan Griffin, the technical administrator and chief elevator inspector for Alberta Municipal Affairs. His testimony given at that time was directed at explaining the mechanics and operation of elevator doors generally and indeed the subject elevator door. Although the hallway elevator door involved in this particular incident was present in the hearing room, Mr. Griffin used a model elevator door assembly, which, although not to scale, nonetheless served to illustrate the function and operation of the subject elevator hallway door.

A detailed drawing of the actual elevator door assembly involved in this particular incident may be found at **Appendix 6**, this is a copy of the drawing found at page 10 of the Anderson report, Exhibit 1, Binder 1, Tab 63.

Mr. Griffin proceeded to describe the operation of the elevator hallway door mechanism from the vantage point as if one were standing in the hallway looking at the door.

There are two doors involved with the operation of this particular elevator, a hall door and a car door. In the ordinary course of events, the elevator would come to the floor, the door would open, and one would walk into the elevator and proceed to one's destination. In order for the hall

door to open, the elevator car must be present at the landing. Only the elevator car door has power so until the actual elevator car is at the landing, the hall door cannot be opened.

When the elevator reaches the floor, the elevator car door begins to open. When it does, a mechanism on the outside of the car door connects with a mechanism on the inside of the hall door and pulls it open concurrently with the elevator car door. It would appear to most individuals that only one door was opening, when it fact there are two, the elevator car door and the elevator hallway door.

Once the hallway door has been opened, a circuit breaker comes into play so as to prevent the elevator car itself from moving. As long as the hallway door is open, which of course means that ordinarily the elevator door is open as well, the elevator car itself will not move from its location.

Mr. Griffin described the hallway door movement as akin or similar to the movement of a patio screen door. The door moves along a track or header on two rollers. The track or header is machined out of a single piece of metal and the door moves along that track on two rollers attached to the top of the elevator door and which run along the trackway or header. **Appendix 6** also provides a detailed illustration of the roller and track or header mechanism.

Beneath the track upon which the roller moves is found what is described as an upthrust eccentric roller, **Appendix 6**. It's purpose is to prevent the track roller from lifting off the track and becoming dislodged. The upthrust roller is not intended to actually contact the bottom of the track or header, except to prevent the track roller from lifting off the track itself and becoming dislodged in the event that force is applied to the door so as to lift it up, such that the roller could be displaced off the track.

If there is no clearance between the bottom of the track and the upthrust eccentric roller, then the hall door will not move properly or open properly. The roller track or header itself is not perfectly machined so, as the door rolls along the track, the variance in the machining of the track means that the space between the bottom of the track and the eccentric roller may vary. Accordingly, the eccentric upthrust roller must be adjusted so as to allow for clearance at the points along the roller track where the distance between the roller and the bottom of the track is widest. Mr. Griffin suggests that this could be 4 or 5 one thousandths of an inch. He did not however conclude in his testimony that that was a mandatory clearance distance.

There are two eccentric rollers, each of them located under the track roller on the leading and trailing edge of the hallway door.

The elevator hallway door in question in this instance closes from left to right. The right edge of the door as it closes from left to right is described as the leading edge with the left edge being referred to as the trailing edge. The roller that runs along the track or header is usually either plastic in its entirety or plastic with a steel rim. In this case it is plastic with a steel rim. (See photo 82, Exhibit 1, Tab 5, **Appendix 7**) Since the plastic will melt in a fire, the roller mechanism is equipped with a device referred to as a "fire bracket or retainer flange", that serves to prevent the door from falling into the hoistway should the roller melt and the door drop down. This again may be seen in the Anderson & Associates drawing, **Appendix 6**. The retainer flange or fire bracket has no purpose other than to prevent the door from falling into the hoistway should the plastic rollers melt in circumstances of fire.

The bottom of the elevator hallway door runs along a groove in a lower track or sill. Protruding from the bottom of the elevator hallway door, a short distance in from the leading edge and the trailing edge, are two eccentric pins. The eccentric pin near the leading edge of the door inserts into what is described as a plow gib. **Appendix 8**, [which is a reproduction of photo 6 in the Anderson & Associates report], shows the actual plow that was attached to the pin on the leading

edge of the subject door. **Appendix 9** [which is a reproduction of photo 19 in Exhibit 45] illustrates an example of a leading edge plow gib. This particular photo is the plow gib mechanism attached to the hallway door on the 3rd level of elevator hoistway 4.

The plow gib runs along the groove in the sill. For illustrative purposes, **Appendix 10** [which is a reproduction of photo 32 in Exhibit 45], shows a portion of the sill and groove of the subject elevator along which the plow gib would travel in the ordinary opening and closing of the hallway door. Inserted into the plow gib is the eccentric pin which is attached to the bottom of the leading edge of the door; **Appendix 8**. Once installed in the plow gib, it provides the stability to keep the door running along the track. It also serves to remove debris that accumulates in the track.

The trailing edge pin does not, as I have indicated, insert into a plow gib, but runs in its bare condition within the groove in the sill so as to provide some guidance and stability to the door as it moves back and forth on the rollers. An example of the actual pin mechanism with respect to the leading edge and trailing edge, is shown in **Appendix 11** [which is a reproduction of photo 3 in the Anderson & Associates report]. There is a clearance between the trailing edge pin and the sill grove bottom and the sill groove sides. It is not intended that the trailing edge pin have contact with the actual sill.

Both the leading edge pin and plow and the trailing edge pin are attached to the elevator door by virtue of a bracket which is bolted thereon. **Appendix 12** [which is a reproduction of photo 21 in Exhibit 45], shows the bracket attaching the trailing edge pin and also the pin as it is attached to the door and located in the groove in the sill.

Mr. Griffin testified that the configuration of the subject door has been around for some time, probably from 1960 through to about 1985 and these elevator doors remain basically the same today, with some improvements. In 1985, the safety code that dictated elevator safety changed to require door retainers which are metal brackets which can be attached at the top and bottom of the door in each corner area of the door so as to provide protection against the door, for any reason, being pushed into the hoistway. The elevator in question was constructed in 1981 and therefore not subject to the 1985 code and there is no requirement to retrofit the elevator doors to meet the changing code requirements in this regard. These retainers have no function in terms of the actual operation of the door, save to prevent it from falling into the hoistway in the event that the normal mechanisms that would prevent that, fail in some way.

b. Maintenance Requirements and Maintenance of Hallway Elevator Door

i. Testimony of representatives of Alberta Infrastructure and Thyssen Krupp

All matters relating to the elevators at the Edmonton Law Courts are dealt with by Alberta Infrastructure, and in particular, Otto Schienmann, facilities manager for the Law Courts. He testified that all maintenance and repair of the elevators had been performed by Thyssen Krupp on a continuous basis since 1995, with the last renewal of the maintenance and repair contract occurring in April of 2001.

Mr. Schienmann stated that no one from Alberta Infrastructure was involved in setting the maintenance procedures or intervals for elevator maintenance to comply with any legislative requirements. He expected that Thyssen Krupp would be aware of any requirements and comply accordingly. While he admitted that he may have received notices of legislative changes, Mr. Schienmann believed that it fell upon Thyssen Krupp to ensure that the legislative requirements and any changes were complied with. Mr. Schienmann testified that at the time of the renewals, he did not have any discussions with Thyssen Krupp about the maintenance procedures or

intervals. Mr. Schienmann was shown the last page in the logbook for elevator 4, which is entitled “Maintenance Procedure Interval Change Form” and dated April 3, 2000. He testified that he understood that the form allowed Thyssen Krupp to change the frequency of regular maintenance to longer intervals. He also testified that no one from Thyssen Krupp ever spoke with him about changing the maintenance intervals, and he was not aware of the form allowing the change prior to his preparation for the Inquiry.

Gary Schultz, district manager of Thyssen Krupp for the Edmonton area, testified that he was aware that the regulations governing elevator maintenance directed it be performed every three months. However, he considered this a minimum. The primary guide was the specifications contained in the maintenance contract signed by Thyssen Krupp. With respect to the elevators at the Law Courts, the contract stipulated that maintenance was to be performed every month. This requirement had been in effect since 1995.

The documentation used to record the performance of regular maintenance of the elevators at the Law Courts has changed over time. At first all the forms were used nationally, with none pertaining to Alberta only. A form was then developed in Ontario which referred to the Ontario regulation numbers. The mechanics in Alberta had difficulty using it because the Ontario regulation numbers did not match the Alberta regulation numbers, and a practice developed of simply writing ‘regular maintenance’ in the logbook and not using a sheet. Mr. Schultz then got permission to develop an Alberta-specific maintenance form. This was done but, at least initially, the mechanics retained their habit of simply recording that regular maintenance had been done in the logbook. Over time, they got back into the habit of signing the Scheduled Maintenance Work Orders developed by Mr. Schultz.

In addition to producing samples of the various maintenance sheets used over time, Mr. Schultz also produced copies of Thyssen Krupp service tickets and maintenance forms on file for elevator 4.

Mr. Schienmann testified that in addition to maintenance, he understood that the legislation also required regular inspections of the elevators. AEDARSA kept track of which elevators required inspections, and notices were then sent to Alberta Infrastructure, which had to sign a return copy of the inspection notice to confirm its commitment to have the inspection completed. Once done, a report of the inspection was then sent to Mr. Schienmann, as the agent of the owner of the elevator, and to the maintenance company. If any follow-up or repair work was required, this information would also be contained in directives, which were sent with the report. Mr. Schienmann was required to sign off on the report, acknowledging that he was aware of the directives. He believed that AEDARSA was responsible for following up with the maintenance contractor to ensure that the work contained in the directives were completed. Once the work was completed, it was Mr. Schienmann’s understanding that a Directives Completed Verification Form was completed. He would then sign off on this document and return it to AEDARSA, confirming that the owner was aware the necessary follow-up had been completed. He did not believe that the inspector would return to ensure that the follow-up had in fact been completed. It was Mr. Schienmann’s understanding, regardless of who performed the elevator inspection, that the process following inspection was the same from at least the year 2000 to 2004.

With respect to recommendations for upgrades or improved safety to the elevators, Mr. Schienmann agreed that Thyssen Krupp had occasionally provided recommendations on improvements and upgrades. When this occurred, Alberta Infrastructure would usually retain a consultant to see whether or not the costs of the recommendations were reasonable. Prior to January 2004, Mr. Schienmann did not believe that Thyssen Krupp ever made any recommendations regarding the installation of retainers but thought it had made some sort of recommendation about restrictors.

If there were problems with an elevator, Mr. Schienmann's preference was that his office would be contacted and it would then make contact with Thyssen Krupp, unless it was after hours and there was no one in his department. Mr. Schienmann preferred that notice of problems be given to his office by way of completed work order, although his office also dealt with phone calls advising of problems. On the Alberta Infrastructure work order form, there was an area for an employee of Alberta Infrastructure to sign in order to confirm that the repair could proceed. In a situation where the elevator was not functioning, confirmation was not necessary. However, if the necessity for the repair was more questionable, Mr. Schienmann expected that approval of someone from Alberta Infrastructure who had authority to approve repairs would be obtained first. The records of his department had been searched, and all records relating to service calls for elevator 4 had been produced.

Mr. Schienmann expected the elevator mechanics to leave any service tickets for repairs in his onsite office. Any document left at his office and pertaining to the elevators was kept in a single file. At the time of his testimony, Alberta Infrastructure had switched to an electronic system and was recording all repairs electronically. In 2003 however, the only evidence retained by Alberta Infrastructure was the documentation in the file.

Mr. Schultz testified that the elevator mechanics working for Thyssen Krupp used the 52-week lubrication and inspection schedule prepared by the elevator manufacturer, Dover, as a guide when doing elevator maintenance and were also trained to follow the Dover maintenance procedures handbook. The handbook also contained specified time intervals for maintenance. It was Mr. Schultz' evidence that the mechanics employed by Thyssen Krupp were trained to perform detailed monthly maintenance checks of multiple components of the elevator. This testimony was confirmed by David Hearn, a licensed elevator mechanic with Thyssen Krupp, who also gave detailed evidence about the monthly maintenance that he performed. Both the evidence of Mr. Schultz and Mr. Hearn with respect to how the maintenance checks were performed is summarized later in this report.

Mr. Hearn testified that when he performed regular maintenance, he would simply note 'regular maintenance' in the logbook and fill out his time sheets. He would not make a note if he found something he had to repair and did so while performing the maintenance. At the time of the Inquiry, however, his practice had changed, and notes were made of all repairs performed during regular maintenance.

ii. Service Tickets, Scheduled Maintenance Work Orders, and Logbook Entries

Thyssen Krupp maintained a logbook for each elevator it serviced at the Law Courts, and the logbook for prisoner elevator 4 was entered into evidence. The logbook was kept in the machine room for elevator 4. The machine room was kept locked, and the elevator mechanics were the primary people who would access the machine room. Mr. Otto Schienmann testified that no one from Alberta Infrastructure had any formal involvement with the logbooks, and that he expected the elevator mechanics to record all maintenance and any information related to repairs in the logbooks. If Mr. Schienmann was required to be in the machine room for some reason, he would usually have a quick look to see what sort of items had recently been entered.

Mr. Hearn testified that his initials in the logbook commence on April 9, 2002. His initials are then on all the entries up to and including January 11, 2004, except for the entries on August 2002, and December 13, 30, and 31, 2003.

The log entries for elevator 4 commence on July 31, 2000, with the 'nature of the problem' recorded as 'reg. maint. as per check charts'. Mr. Hearn testified that the reference to the 'check charts' meant the 52-week schedule prepared by Dover and the Dover Maintenance Procedures

Handbook. From July 2000 to June of 2002, regular maintenance is recorded as having been performed each and every month, with a notation of 'regular maintenance as per chart' or simply 'regular maintenance'.

From July 2000 to June of 2002, service calls were occasionally necessary to effect repairs. On August 28, 2000, a repair to the transistors was necessary because the car was not working. On December 15, 2000, the car was reported to have trapped passengers. When checked, everything was in working order. As part of the regular maintenance in March, the logbook records that the 'door hold button' was changed. The date of the March regular maintenance is not given, but the entry thereafter indicates that on March 15, 2001, the car would not leave B1 level. The matter was checked, and the door lock was cleaned.

The next service call in the logbook is for May 23, 2001. The record of the problem in the logbook indicates that the hall door at the top landing was pushed off the track and the gib jammed out of the track, against the sill. The door was repaired, and regular maintenance was performed.

Mr. Schultz was questioned about this incident. In addition to the logbook entry, he pulled the file and reviewed the time ticket, then discussed the matter with Don Olson, the mechanic who performed the repair. The only memory Mr. Schulz had of the incident, prior to reviewing his logbook entry and service ticket, was that it had not been a major item.

The service ticket notations indicate that the hall door had moved off the track and became stuck on the 5th floor. The door had been hit from the hallway side and this moved the adjustment of the plow gib assembly at the leading edge enough to jam the door. In order to repair it, Mr. Olsen entered the hoist way and readjusted the gib assembly so that the door could move freely. No replacement of parts was necessary.

At the time of the maintenance call, the elevator was also due for regular maintenance. Rather than return a different day, Mr. Olson chose to perform the monthly maintenance requirements at the same time as the repair, rather than having to re-attend shortly thereafter. Accordingly, in addition to the description of the problem and the necessary repair, Mr. Olsen also recorded in the logbook that regular maintenance had been performed.

According to the maintenance ticket, Mr. Olsen arrived to fix the problem at 10AM and left at 3PM. He advised Mr. Schultz that it took the first hour to repair the door, and three hours to perform the regular maintenance. The remaining hour was Mr. Olsen's lunch break.

Constable Schiewe testified about a time that the door on elevator 4 had been closing, and he put his hand in to stop it. The door opened somewhat, and then the bottom right hand corner popped off the track. He could not remember the date, but thought it had occurred in April or May of 2001 or 2002. He did not fill out a report for this problem until after the Young incident.

The next entry in the logbook which does not concern regular maintenance is February 25, 2002. On that date, AEDARSA performed a safety inspection of the elevator. No problems or repairs are recorded as a result of this inspection, although as part of the regular maintenance on April 9, 2002, the logbook indicates that follow-up in the nature of 'work on directives' was required.

On May 22, 2002, a call was received that the elevator was not leveling. The entry indicates that there was a contact failure, which was presumably repaired. On that date, regular maintenance was also performed. As a result of that regular maintenance, the LTX coil was changed.

There are no entries confirming that regular maintenance had been performed in July and August of 2002. There are notations of problems in each of those months. On July 22, 2002, the

logbook indicates that the car was not always running. The remote control panel was checked, the LTX contacts were cleaned, and the return spring tension was increased. The same problem, however, is recorded on August 22, 2002. The MGA timer, which is recorded as not working on a very intermittent scale, was replaced.

Notations of regular maintenance having been performed resume in September of 2002, and continue on a monthly basis up to and including July 2003. There are no notations in the logbook for August. Entries for regular maintenance then resume on September 2003, and continue for October 29, 2003, November 2003 and December 10, 2003.

Alberta Infrastructure provided service tickets dated April 25, 2003, and May 29, 2003. The first, apparently completed by Sergeant Valk, indicated that the doors would not open on level 2. Mr. Hearn signed the service ticket, indicating that he had completed the repair. For May 29, 2003, the service ticket states that the elevator was stuck on B1. Mr. Hearn signed the ticket and stated that he had reset the switch. Neither of these problems nor repairs are recorded in the logbook.

There were also service tickets produced by Thyssen Krupp for problems not recorded in the logbook. One is dated May 12, 2003. The service ticket does not state the nature of the problem, but notes the operation of the elevator was checked after a fax was received from the Law Courts. The elevator appears to have been shut down for this repair. This was an emergency call, coded as a non-billable repair. Mr. Hearn signed this service ticket.

A service ticket dated October 30, 2003 and received from the files of Thyssen Krupp states that the new key switch was installed. This is coded as a non-billable repair which took 1.5 hours. There is no record of this in the logbook.

Constable Lamer testified about a problem he had with elevator 4 in November of 2003. While waiting for the elevator to return to pick him up, Constable Lamer pushed inward on the middle of the door and it moved slightly. He then pushed harder, and it opened on the north bottom corner. When he pushed in with his foot, it moved 2 or 3 inches. He stated he prepared a quick memo of the day of the incident to report it, but did not follow up any further.

After the Young incident, Constable Lamer testified that he found a copy of the quick memo that he had prepared to report this incident and gave a copy to Constable Tomaino. The logbook and the records produced by Thyssen Krupp and Alberta Infrastructure contain no report of any repair or request for repair in November of 2003. Thyssen Krupp also maintains records of all calls for service it receives. The records for November 12, 13, and 14, 2003, were produced. They contained no record of any call from the Law Courts.

On November 19, 2003, Mr. Hearn testified that he was required to attend at the Law Courts for the purpose of running the elevators to test the new smoke detectors. The service ticket produced by Thyssen Krupp shows this attendance coded as a billable repair. Mr. Schienmann testified that in the fall of 2003, a new fire alarm system was installed, the testing of which required the attendance of the mechanic. There is no record of this in the logbook.

Two other service tickets produced by Thyssen Krupp for December 2003 are also not recorded in the logbook. On December 5, 2003, Mr. Hearn attended to ‘work on a selector problem’. The problem was with not only car #4, but also 1 and 2. It was coded as a non-billable repair which took 3 hours. On December 9, 20003, Mr. Hearn replaced the pawl magnet coil on the selector. Cars 3 and 4 were involved on this non-billable repair that took 5 hours.

On December 13, 2003, the logbook shows that a safety inspection and audit was performed. In the area for recording any necessary follow-up, there is only the signature of Mr. Ian Bagwell,

safety inspector for Lerch Bates.

Alberta Infrastructure retained Lerch Bates to perform a maintenance audit because the maintenance contract with Thyssen Krupp was coming to an end, and Alberta Infrastructure wanted to know if there was any work that Thyssen Krupp should be performing to fulfill its contractual obligations. Shortly after Alberta Infrastructure had retained Lerch Bates to perform the audit, it received notice from AEDARSA that the elevator inspections were due. Alberta Infrastructure requested that Lerch Bates perform the inspection as well, and it agreed.

The elevator inspection was performed by Ian Bagwell, safety codes officer and inspector. In his inspection of elevator 4, Mr. Bagwell found that all safety code aspects were satisfied, and there was no need to advise Alberta Infrastructure of any safety concerns. Mr. Bagwell did issue a directive that a slow speed test of elevator 4 be performed, but this was not indicative of any problems. The directive was issued because Mr. Bagwell was unable to perform the slow speed test during the time he was present at the Law Courts.

On cross-examination, it was pointed out to Mr. Schienmann that the maintenance audit report from Lerch Bates contained a suggestion that an upgrading plan should be started, and that the first thing to be done should be the addition of door restrictors as required. Mr. Schienmann did not recall anyone from Lerch Bates pointing this recommendation out to him.

The next entry after the safety inspection is on December 30, 2003, when the maintenance speed safety test directed by Mr. Bagwell was performed. New rollers were required. This repair was completed on December 31, 2003.

The last notation in the logbook before the Young incident is January 11, 2004. The notation indicates that regular maintenance was performed.

There is no Scheduled Maintenance Work Order to coincide with the entry for regular maintenance in the logbook for January 11, 2004. Mr. Hearn testified that he made the January 11, 2004 notation in the logbook when he started the maintenance. Because he has to coordinate hoist way maintenance with the regular use of the elevators, Mr. Hearn testified that it was possible that he was not able to access the hoist way on January 11. There was, however, a Scheduled Maintenance Work Order dated January 19, 2004. Mr. Hearn therefore believed that he returned and completed the hoist way maintenance for elevator 4 on January 19, 2004 because it was his standard practice to complete the Scheduled Maintenance Work Order on the day that the maintenance was actually performed.

In reviewing the Scheduled Maintenance Work Order, Mr. Hearn testified that the second column related to elevator 4, and that 4 elevators had been maintained that day. A total of 4 hours was spent checking the 4 elevators. This does not reflect the entire amount of time he spent on maintenance for the 4 elevators in January, but it does reflect the entire time he needed to perform the hoist way maintenance on those 4 elevators.

Thyssen Krupp also supplied a service ticket dated January 21, 2004. The ticket indicates the reason for the call is regular maintenance and inspection. Mr. Schultz testified that the service ticket is traditionally used for a callback, and not for maintenance. Mr. Hearn confirmed that he was the mechanic who completed the service ticket dated January 21, 2004 and that, on that date, he checked all 8 elevators. As he had time, Mr. Hearn went through and checked lighting in the elevators - the light bulbs, the push button lights on each floor, the indicator light which shows which floor the elevator is currently on, and the like. He did not record this in the logbook.

While it therefore appears from the testimony of Mr. Hearn and the service tickets and maintenance work orders provided by Thyssen Krupp that the regular monthly maintenance for

elevator 4 for January, 2004 was not completed until January 21, 2004, in looking solely at the logbook, one would understand that the regular maintenance had been started and completed on January 11, 2004.

In summary, the notations in the logbook generally confirm that maintenance of the elevators was occurring on a monthly basis. Over the course of the 43 months contained in the logbook, only 3 months (July 2002, August 2002, and August 2003) contain no confirmation of the performance of monthly maintenance. More troubling is the number of repairs which are not recorded in the logbook. Mr. Hearn testified that from January 2003 to January 11, 2004, other than the slow speed safety test and the need to replace one of the rollers, nothing beyond regular maintenance was required. This is not consistent with a review of the records produced by Thyssen Krupp and Alberta Infrastructure. From April 25, 2003 to December 9, 2003, the review of service tickets and Alberta Infrastructure Work Orders reveals a total of 7 attendances which were not recorded in the logbook (April 25, 2003; May 12, 2003; May 29, 2003; October 30, 2003; November 19, 2003; December 5, 2003; December 9, 2003). If a mechanic was called to attend to the problem explained by Constable Lamer, this total could be 7, not 8. However, there is no evidence that anyone from either Alberta Infrastructure or Thyssen Krupp was aware of this problem**.**

8. Condition and Failure of Elevator #4 Hallway Door

a. Presence of Trailing Edge Fire or Gib Pin

At the time of this incident, the ability of the subject hallway elevator door to withstand the application of lateral force in the direction of the elevator hoistway so as to maintain its integrity and not open or fall into the elevator hoistway was not dependant upon any one operational component of the door. The door itself is a unit and the strength of the door is a function of the operation of all of its specific components. The hanger roller or track roller is not flat, but concave in shape. It is designed to stay on the track, which is convex in shape. As the door opens and closes, the eccentric upthrust roller is designed to prevent the hanger roller from lifting off the header track that it moves upon.

The leading edge plow gib assembly fits into a groove on the lower sill and maintains consistency in the back and forth movement of the door and at the same time keeps debris from building up in the sill groove. The trailing edge gib pin or fire pin fits within the same groove in the sill as the plow gib and serves to keep the door moving consistently along that groove in the sill track. Should the upper roller come off or melt in fire, both the leading edge plow gib and the trailing edge gib pin or fire pin would remain in the sill groove and assist in preventing the door from falling into the hoistway. The gib pin or fire pin located in the trailing edge area of the hallway door also serves to strengthen the door against outside forces which may be pushing the door towards the inside of the hoistway. The fire (or retainer) flange (**Appendix 7**), which is part of the hanger roller mechanism serves, in the event of the melting of the roller in a fire, to prevent the top of the door from falling into the hoistway.

The actual strength of the door is a combination of all these things acting together. Indeed if any one of these components is not operational or missing the integrity of the door in the sense of its strength is compromised.

Post-incident inspection of the subject door and it's components reveal that the trailing edge gib or fire pin had been fractured such that the lower portion of this eccentric pin, the portion that runs within the groove in the sill of the hallway door, was missing. This is shown in photos 77, 78 and 79 of Exhibit 1, Tab 5, attached hereto as **Appendix 13**. These photographs were taken by Edmonton Police Service shortly after the incident on January 22nd, 2004. The leading edge plow gib was still intact and situated within the sill groove as would be expected in normal course of

operation, however, the plow itself was somewhat damaged and the eccentric pin which connects the leading edge of the door to the plow located in the sill groove was bent.

The pin located in the trailing edge of this subject elevator is eccentric in nature in that the upper portion of the pin that fits into the bracket attached to the bottom of the trailing edge of the hallway door, and the bottom portion of the pin that runs within the sill groove, are offset one from the other and connected to each other as described by William Bear in the Anderson & Associates report, by a hexagonal web. Mr. Bear undertook metallurgical analysis of the broken trailing edge pin and concluded that the fracture origin of the pin is a line origin across the top portion of the hex where the maximum tensile stress occurred in the plane of the hex. Fracture initiated at the top of the hex and propagated downward with a bending component. The hexagonal web is, according to Mr. Bear, 1/8th of an inch in diameter. Mr. Bear concluded that the geometric configuration of the pin, including the pin eccentricity, the failure of two radius section changes, the case hardening heat treatment, the post heat treatment, electroplating and the choice of a re-sulphurized chemistry reduced the pin's resistance to impact or bending stresses in service and made it susceptible to impact failure. He concluded that there was no visual evidence of cumulative service damage to the subject pin and that the fracture of the pin occurred in a single event.

William H. Bear, is a professional engineer with Anderson & Associates Consulting Engineering and is the principle author of the expert report dated March 19th, 2004. Anderson & Associates Consulting Engineering were retained by AEDARSA to determine how the elevator hall door was put into a fail condition, whether the door complied with governing safety codes and also to determine the approximate force or energy required to cause a similar door mechanism failure.

The investigation undertaken principally by Mr. Bear included an inspection of the door mechanism on site and after its removal a metallurgical investigation of certain components, a review of appropriate manufacturer's drawing and applicable code requirements and compliance and impact testing on the subject incident door. It was Mr. Bear's opinion for the reasons I will discuss hereinafter, that the trailing edge gib pin or fire pin had fractured prior to the subject incident and accordingly was not operational at the time of the incident. He was unequivocal in this view.

Mr. Nicholas Keogh of Interact Inspection Corp. was of the same opinion as Mr. Bear. Interact Inspection Corp. was retained by the Edmonton Police Service to investigate the subject incident and in particular, to provide expert opinion as to the amount of force on the elevator door necessary to cause it to open, to determine whether the elevator door and elevator door hardware met code requirements; and to determine if at the time of the incident the elevator, elevator door, or elevator door hardware was faulty. Mr. Keogh and Mr. Demeyer authored the Interact Inspection Corporation Report which may be found at Tab 64 of Exhibit 1 of these proceedings.

Mr. Keogh has been involved in the elevator industry for over 50 years as a mechanic, tester, inspector, elevator service company operator, and director of elevator devices safety branch for the Province of British Columbia. Interact carries out safety inspections for the Federal Government and he, through the company, has been involved in over 100 elevator accident investigation. For purposes of this inquiry, he was accepted as an expert qualified to give opinion evidence in the areas for which he had been retained by the Edmonton Police Service.

Mr. Demeyer is a mechanical engineer with 18 years experience in the elevator industry. He has expertise in elevator modernization and elevator assessment for purposes of determining what is needed to bring the elevator up to date. He is involved in new construction projects and provides professional advice as to code requirements, elevator design, assessment of elevator systems to determine if they are functioning properly, code compliance, upgrade requirements

and maintenance adequacy.

Mark Hughes, P.Eng., also testified in these proceedings and was also of the view that the trailing edge gib pin had been fractured prior to the subject incident and was not functional at the time of the incident. He, like Mr. Keogh and Mr. Demeyer, is in agreement with Mr. Bear in that regard.

Mr. Hughes owns and manages Cintra Engineering, a firm that specializes in such things as motor vehicle accident reconstruction, fire investigation, fire cause and origin determination, failure analysis, equipment malfunction, code review and evaluation of other engineering expert reports and opinions.

Mr. Hughes holds a degree in mechanical engineering and has been qualified in Alberta Courts as an expert in vehicle reconstruction, vehicle dynamics and occupant kinematics (which has to do with the movement of occupants and automobiles involved in a collision). Kinematics is, according to Mr. Hughes, a description of how things move and it is not related solely to situations involving motor vehicle accidents.

Mr. Hughes has also done a considerable amount of work in the area of bio-mechanics and has been published in that regard. He was qualified before this Inquiry as an expert in mechanical engineering with a specialty in accident reconstruction.

Three reports under the signature of Mr. Hughes were filed in these proceedings. Exhibit 60 dated February 16th, 2005 is a review and commentary on the letter report of Keith Jenkins of KJ Consultants Inc., dated January 10th, 2005. Exhibit 59 is a report dated May 5th, 2005 and is a review and analysis and response to the Anderson & Associates Consulting Engineers report, dated March 19th, 2004. Exhibit 61 is a report dated June 22nd and is a review of and response to the report of Keith Jenkins of KJ Consulting Inc. dated June 11th, 2005.

Anderson & Associates Consulting Engineers was retained by AEDARSA the day after the January 22nd, 2004 incident at the Law Courts building. Mr. Bear and a colleague, Richard Henderson, an electrical engineer, attended the Law Courts on the evening of January 23rd, 2004 to observe the sight of the incident. Mr. Bear's report of March 19th, 2004 sets out his observations relative to the accident scene and the steps he took. His viva voce testimony before this Inquiry, to a significant degree repeated and reiterated that which he stated in his report to be what he observed that evening.

The observations he made which are relevant to the question of the presence or absence of the trailing edge gib pin are summarized as follows:

- When he and Mr. Henderson arrived at the Law Courts on the evening of January 23rd, the door assembly had been secured with chains by the Emergency Response Department so as to counter the risk of the door falling into the hoistway.
- The left side of the door (as observed from the hallway) was displaced inwards about 6 inches (0.15m) from its normal position.
- The left nylon roller, that is the roller on the trailing edge of the door, was off its track.
- The door as seen from the shaft side was in a closed position with the lock still engaged
- The front plow gib and swivel pin (gib) were in place although the pin was permanently deformed.
- The top portion of the trailing edge gib pin was in its clamp

- The trailing edge pin remnant was apparently loose in the bracket and removed by the Edmonton Police Service.
- There were no marks observed that could be attributed to fracturing of a pin, in the sill groove or on the sill surface in the range of where the trailing edge gibe pin would sit had the door been in its proper position.
- The sill groove contained an accumulation of debris (hair, fibers, staples, paper clips, etc.) at a location immediately to the left of the leading edge plow gib as it would sit if the door were in an open position. The interlocking fibers gave the debris some strength.
- The sill track exhibited damage on its top as though the trailing edge pin had jumped its groove and impacted the sill and been drug back and forth along the top of the sill until the pin fractured.

Mr. Bear stated that the absence of groove impact damage on the sill at the location where the trailing edge pin would be if the door were closed, the accumulated debris and its location, and the gouging of the sill plate, achieved during his testing, convinced him unequivocally that the rear gib pin was fractured prior to the incident of January 22nd, 2004. He further concluded that there was no accurate method to determine when the pin had previously fractured, noting that it could range from days to months.

b. Absence of Witness Marks

Mr. Bear's photographs and examination of the sill and the sill groove show that the sill, in the location where the trailing edge gib pin would be located when the elevator hallway door was closed, as it was at the time of this incident, displayed no markings, indentations or gouges at right angles or otherwise to the sill groove on the hoistway side that would indicate that the sill or sill groove had been impacted by the gib pin being forced at right angles out of the sill groove. Photo 14 of the Anderson report, **Appendix 14** and Photo 33A, **Appendix 15** hereto, depict this absence of marking or indentation.

It is important to note that the gib pin is made of a significantly harder material than the sill and would be capable of marking the aluminum sill if forced against the right angle of the sill groove or over the top of the sill itself.

In the testing undertaken by William Bear, specifically tests 7 and 9, the failure of the trailing edge gib pin was demonstrated. Both the static test and the dynamic impact test, left the sill marked with indentations created by contact with the trailing edge gib pin as it was dragged or pushed out of the sill groove and dragged across the sill itself. In the static load test 7, the gib pin was bent as it was dragged out of the sill groove and ultimately fractured as it moved at right angles across the sill itself. In the impact test 9, the pin fractured upon coming in contact with the right angle of the sill groove. These markings and indentations are illustrated by photo 33B in the Anderson report which is attached hereto and marked as **Appendix 16**.

The absence of any markings on the sill in the area of the trailing edge gib pin, post-incident, as contrasted by the clear indentations and marking achieved by the test undertaken by Mr. Bear indicated as well, to Mr. Keogh and Mr. Hughes, that the trailing edge gib pin had been fractured prior to the Kyle Young incident.

c. Previous Gouging of Sill Plate

Both Mr. Bear and Mr. Keogh pointed to markings on the hoistway side of the sill groove or track

in the area of where the trailing edge gib pin would be located when the hallway door was open. These markings or gouges run parallel to the sill groove itself. This, opined both Mr. Bear and Mr. Keogh, was consistent with the trailing edge gib pin jumping from the track, landing on the sill and being dragged back and forth until it fractured. The gouges and marks referred to by Mr. Bear and Mr. Keogh are shown in photos 34 and 35 (Exhibit 45) attached hereto as **Appendix** 17; and photos 16 A and B of the Anderson report, which photos are attached hereto as **Appendix 18**.

In addition, Mr. Bear concluded that subsequent to the fracture of the pin, the lower remnant which broke off was caught between the sill and the bottom of the door and dragged, resulting in further gouging and marking as shown in photo 17 in the Anderson report, which photo is marked as **Appendix 19** hereto.

Mr. Keogh pointed out that the hallway door overtravel bolt had been bent, which would indicate that the subject door had previously been opened with significant force. The overtravel bolt serves to prevent the door, when open, from traveling too far on the hanger track and thereby falling off the track. This bent bolt or stop is shown in photo 5, Exhibit 53, attached hereto as **Appendix 20**. Opening the elevator hallway door with such force that the overtravel bolt could be so bent, could also result, according to Mr. Keogh, in the trailing edge gib pin jumping the track, landing on the sill and making the gouges and marks and ultimately causing the fracture of the gib pin.

The only recorded incident that might account for this type of scenario occurred on May 23rd, 2001, when the hallway door apparently jumped from the track as a result of force being applied by a guard who was trying to keep the hallway door open. This was reported and a maintenance report exists, which gives no indication of any repair or replacement of the trailing edge gib pin. (See Exhibit 1, Tab 65)

Mr. Keogh pointed out in his testimony that if the gib pin were broken in such a circumstance, whether it be this one or some other one, when it jumped the sill groove and was dragged back and forth, once the gib pin fractures, the door would then appear to operate quite normally. The point that as the door might appear to be operating in a normal fashion at that point, the incident may not have been reported.

d. Debris in Track

As I have noted aforesaid, Mr. Bear observed that a considerable amount of debris had accumulated in the sill groove or track in a location immediately to the left of where the leading edge plow gib (looking from the hallway) would be located if the door were fully opened. One of the purposes of the plow gib is to keep the track clean and as the door opens or closes, it pushes debris that has accumulated in the track in the direction of the opening or the closing. Mr. Bear and Keogh were both of the opinion that if the rear gib pin were in place, the debris would not have been situate in the location in which it was found. It would, according to their view, have been located in the sill groove or track immediately to the right of where the trailing edge gib pin would have been, had the hallway door being fully closed. This would be further to the right, (looking from the hallway) than where it was actually found.

The sill groove, based upon the Dover drawings, has a depth of .625 inches. By measuring the depth of the slide markings in the sill groove, Mr. Keogh determined that the gib pin protruded into the sill groove .32 inches, which is approximately ½ the depth of the sill groove. Given the personal observations of Mr. Bear as to the texture and the strength of the accumulated debris and its accumulated height in the sill groove, it was his view that if the trailing edge pin were present, it would not be traveling over the debris, but in fact pushing it in the direction of the door

closing, past the point where it was found post-incident. Photos 84,85,86 and 88, Exhibit 1, Tab 5 which are attached hereto as **Appendix 21** illustrate that the debris has accumulated almost to the top of the sill groove.

Mr. Keogh echoed Mr. Bear's view in his report, and in his viva voce testimony, based upon his observation of the photographs of the debris and its location. The location of the debris and its height in the groove and the likelihood given its texture that the debris would move as a cohesive unit as opposed to being pulled apart by the operation of the trailing edge gib pin, contributed to the conclusion reached by Mr. Bear, Mr. Keogh and Mr. Hughes, that the trailing edge gib pin had been fractured previous to the incident involving Kyle Young.

9. Evidence Supporting Presence of Trailing Edge Gib Pin at Time of Incident

What is required for the subject elevator in terms of actual maintenance and the intervals at which maintenance is to be undertaken has been described aforesaid in this report.

The elevator log book with respect to the subject elevator, maintained by the service provider Thyssen Krupp, as required by safety regulation gives no indication of any problem with the trailing edge gib or fire pin, save for an incident noted in the May 23rd, 2001 log book entry. This is the entry that relates to an apparent previous jumping of the track by the gib pin, with a resultant jamming of the gib pin on the elevator sill. There is no record of any parts being replaced in the repair of this problem, which could lead to the inference that the gib pin was not fractured at that time. The entries in the maintenance log illustrate that save for entry dates, December 12th, December 30th, December 31st, 2003, all the required entries since September 24th, 2002 are described as "reg. maint" meaning regular maintenance and then under the action taken portion of the log entry, the description "as per chart" is a reference, according to Mr. Gary Schultz, the district manager for Thyssen Krupp Elevator Company, to the lubrication and inspection schedule attached hereto as **Appendix 22**. This schedule specifies cleaning, oiling and checking of the door hangers, rollers etc. on a semi-annual basis and was originally prepared by the manufacturer of the elevator.

Alberta Regulation 216/97, being the Elevator Devices code regulation, which came into force November 1st, 1998, requires maintenance inspections of elevators to be carried out at least once every three months to ensure compliance, except where time intervals were specified otherwise in the regulation, or the maintenance intervals have been extended up to a period of one year, pursuant to the regulation. The document entitled Maintenance Procedure Interval Change Form letter executed by Mr. Gary Schultz of the company then referred to as Thyssen Dover, now Thyssen Krupp, purports to change the maintenance interval required by the regulation from three months to twelve months. Although this document had been placed in the log book as required by the regulation, there is some question as to whether Municipal Affairs, as owner of the building site, was ever notified of that change.

In any event, Mr. Schultz further testified that the maintenance contract required that the elevators be maintained monthly and that the regulations only represented minimum maintenance requirements. He testified that maintenance would have been undertaken on the subject elevator every month. All the component parts of the landing door would have been looked at by the maintenance mechanic every month.

This is consistent with the log for the subject elevator which has regular maintenance endorsements set out therein on a monthly basis, as opposed to every three months or every twelve months. It was Mr. Schultz's testimony that even though the lubrication and inspection schedule does not require completion monthly of all those items set out therein, the mechanic would every month do the routine ride up on the elevator from inside the hoistway and check the

gibs, the clutch rollers, the interlock, the eccentrics, the rollers. Everything that is on the door would be checked every month, even though the same was not necessarily called for by the schedule or the regulations. It was his evidence that all maintenance mechanics are trained to check for safety at all times. Mr. Schultz stated that even though there is no reference in the log book to doing safety checks on a monthly basis, the mechanics are trained that way. The mechanics have access to a manual that tells them exactly what they are to do each month in addition to whatever is on the schedule for lubrication and inspection. It was his position that every time a mechanic rides up in the elevator, the mechanic does the same thing, and basically has a look at everything that is there.

These monthly maintenance inspections are documented in the log simply under the description "Regular Maintenance". There is no other writing or document generated relative to that undertaking.

a. Testimony of David Hearn

David Hearn, the licensed elevator mechanic who did the regular service and maintenance of the subject elevator for approximately a year and four months prior to the incident, confirmed the evidence of Mr. Schultz that in addition to anything specifically required to be done by the lubrication and inspection schedule, (**Appendix 22**) he would perform eleven other inspection and maintenance actions which are provided for in the maintenance procedure handbook that is used by Thyssen Krupp, attached hereto as **Appendix 23**. These actions would be performed while the mechanic would be riding on the top of the elevator car inside the hoistway. They are as follows:

1. Clean car top
2. Visual and touch inspection of entrances, interlocks, relating cables, door closer, hanger and upthrust rollers, track, clutch rollers, gibs
3. Clean track if required
4. Check and lube door operator, arms, pins, belts and pullies
5. Check car door: hanger rollers, track, skate, contact, gibs, safety edges
6. Check slippers and oilers
7. Visual check of traveling cable for wear, Check equalization of hoist cables
8. Check hoist cables for wear, Check cable connections
9. Check top limit and OT switches
10. Check top car and counter weight sheaves. Lube if required
11. Clean hoistway and entrances. Check all fastenings on guides, (entrances and hanging sheaves.

The aforementioned items are not part of a checklist that Mr. Hearn would carry with him when he was undertaking the monthly maintenance, however he testified that given his extensive experience and knowledge of the maintenance procedures handbook, he would do all of those things as part of the monthly maintenance, just as a matter of course or habit. He would not document performance of those 11 action items, or any other maintenance requirement. Indeed even if something were required to be done as part of the monthly maintenance, it would not necessarily find its way into the log book.

It was Mr. Hearn's evidence that he commenced the January, 2004 maintenance of the subject elevator and hoistway on January 11th, 2004, however the work in the hoistway itself did not commence until January 19th, 2004. A document entitled "Scheduled Maintenance Work Order Alberta", dated January 19th, 2004 is the work order related to the monthly maintenance work commenced on January 11th and completed on January 19th, 2004.

Another document dated January 21st indicates further work being undertaken by Mr. Hearn with respect to the subject elevator. This document, Mr. Hearn testified, related to work only with respect to the elevator car and not the hallway entrance door.

Section 12.2.5.1 of the Elevator Devices Code Regulation, AR 240/203 requires that the maintenance log contain among other things, the year, month and day of maintenance tasks performed with respect to the elevator. The log book for this particular elevator does not contain the maintenance actions described in the items dated January 19th and January 21st. In fact, the log book describes the monthly maintenance as having been done on January 11th, when it was not in fact completed, according to Mr. Hearn, until January 19th, 2004. If the log book is to be accurate, it should describe the extent of what was done and the day it was done, not what is intended to be done.

According to Mr. Hearn, the elevator #4 hallway door would have been checked in accordance with the 11 requirements as set out in the maintenance procedural handbook, **Appendix 23**, when the maintenance was concluded on January 19th, 2004.

Mr. Hearn worked on the subject elevator and three other elevators on January 19th, according to the Scheduled Maintenance Work Order dated January 19th, 2004.

Mr. Hearn testified that part of the maintenance would be done riding up on the top of the elevator and checking visually for damage to the hallway doors. He asserted that he would move the hall doors by hand to see if there was any excessive movement and they would be checked to see that they opened and closed properly. To check the eccentric roller clearance, he testified that the bottom of the door would be grabbed and pulled to the right so that the corner of the door would lift up. In effect, the door would be tipped to see if there was any excessive clearance between the eccentric roller and the bottom of the roller track. This would be done on the left side, that is the leading edge of the door as well. He would then visually check the clearance by way of a flashlight and finally the eccentric roller itself would be felt by his fingers to make sure that it would still rotate; if there was not enough clearance, the roller would not rotate smoothly or at all.

Mr. Hearn advised that he would normally not take an actual measurement of the clearance space between the upthrust roller and the bottom of the roller track. It was his testimony, based upon the maintenance procedures handbook, that the proper clearance between the upthrust roller and the underside of the track was between 4 and 6 thousandths of an inch.

In checking the plow gib and the fire gib as part of the normal monthly maintenance, he testified that visually, as you are riding up on the top of the elevator car, one can see if the gibs are present. He stated that the shape of the gibs would be highlighted by the light coming in from the hallway under the elevator door itself. He did acknowledge however that it would be easier to see that a complete gib pin was missing entirely than it would be to see if only the lower part of the gib pin below the hex was missing, as was the case here.

He also stated that the shaking of the hallway door from the hoistway side is another way of checking the plow gib and the fire gib. If the gibs were broken or bent such shaking would cause a person to notice something. If both pins were gone, there would be excessive lateral movement towards the hoistway if pulled in that direction. If only one pin was gone, he stated that movement of the door would be minimal.

In cross-examination, Mr. Hearn testified that he specifically recalled being in the hoistway of the subject elevator on January 19th and that he examined all the doors that day. To use his words:

> And I would have looked at them, and they would have been there. (referring to the gib

pin or fire pin)

He stated that there were no problems with the fire pins on the door and that he was comfortable stating that the fire pin was there on January 19th. He also stated that he was comfortable saying that the clearance of the upthrust roller was within the acceptable range that day, which, according to his testimony was between 4 and 6 thousandths of an inch. He came to this conclusion again, without any measurement, but by touching and viewing the eccentric upthrust roller location.

Although Mr. Hearn testified that he was comfortable saying that he believed the gib pin was in place as of January 19th, he did not testify specifically to having seen it on the date of his inspection. Clearly, his conclusion as to it being present on the 19th is based upon Mr. Hearn's confidence in his inspection procedure. He believes that his inspection procedure would bring any such deficiency to light. Accordingly, as Mr. Hearn did not notice the pin was broken, he hypothesizes that it therefore must have been present.

b. Testimony of Ian Bagwell

Mr. Ian Bagwell, a Safety Codes Officer, Safety Inspector and consultant employed by Lurch Bates, performed an audit and safety codes inspection on behalf of Alberta Infrastructure with respect to the elevators in the Law Courts building in Edmonton, in December of 2003. This audit and safety codes inspection was conducted over a period of three days.

Mr. Bagwell has 28 years of experience in the elevator industry in various capacities, including maintenance, sales, service and all manner of repairs and construction. He holds an international elevator mechanic license and has been a Safety Code Inspector and Officer for in excess of 3 ½ years.

Mr. Bagwell conducted the safety inspection and audit alone and prepared an audit and inspection report. The report is unremarkable with respect to the identification of any deficiencies or defects on the subject elevator. Mr. Bagwell, lists the number of matters that were to be followed up upon by the maintenance operator, however none of these follow ups had anything to do with the condition or operation of the hallway door assembly on the subject elevator. A letter dated January 15th, 2004 outlining the deficiencies Mr. Bagwell had identified was forwarded by Infrastructure to Thyssen Krupp on January 16th, 2004.

In his testimony, Mr. Bagwell outlined the procedure he would normally follow in undertaking the inspection and audit of each elevator hoistway and its components. He would always check the function of the door opening and closing, - he would do this manually from the top of the hoistway car, riding up in the hoistway. From this location, he states that he can see each of the doorway components. He would start by checking the top of the door interlock to make sure that the locks worked properly, then rattle the door to make sure the lock is set properly, then once he has broken the lock as he is driving by, he would open the door and check both ends of the door components, the eccentrics, hanger rollers and so forth. He indicated that when he opened and closed the door, that would tell him whether the door was functioning properly or needed rollers changed or anything like that.

He would then check the eccentrics at each end of the door. This would be done by sight and by touch to make sure that there is only the barest of separation between the eccentric roller and the underside of the hanger roller track. He would use his finger to feel the gap and also a flashlight to view it. Mr. Bagwell stated that he does not measure for any specific separation between the eccentric roller and the underside of the track, but seeks by touch and sight to ensure that there is only the barest of clearance between the track and the eccentric roller. He does not know what

the manufacturer's recommended gap is between the eccentric roller and the bottom of the sill.

Although Mr. Bagwell carries feeler gauges with him, he uses them only if he is left, after his sight and touch testing, with the conclusion that the gap is too large. I gather he would then adjust the gap using a feeler gauge to set what he believes in the circumstance, to be an appropriate gap.

Once he has completed his inspection of the top of the door and checked all the components thereof, he moves to the bottom of the door and lower sill and checks the track and the leading and trailing edge gibs. He checks to make sure that they are present and don't have too much play. He first checks the plow gib by wiggling the door back and forth to make sure that the gib is present and not worn out and he then moves to the trailing edge gib to make sure it's not missing, loose or dragging on the edge of the track. He undertakes this inspection, by moving the door back and forth and listening to see if there is any scraping or dragging in the tracks, which if present, would lead him to the conclusion that some adjustment may be needed.

Although he testified that by using a flashlight he can see into the track where the fire pin or gib pin sits, he acknowledges that one cannot usually see the bottom portion of the gib pin. He states that in fact one may only see one-half to two-thirds of the entire pin. He stated that usually one can see a little bit of the pin above the door clamp and a little bit below the door clamp and the hex, but one can't usually see the bottom portion of the pin.

Mr. Bagwell noted as well that one would have to look more carefully than normal to notice that the bottom portion of the fire pin was broken off. Indeed, he says one would have to look into the actual track to see the bottom of the gib pin. This I take it, means, that simply looking at the gib pin assembly as one goes up the hoistway does not necessarily allow one to ascertain whether the bottom of the gib pin, that is the portion below the hex, and that which sits in on the track, is in fact in place.

Mr. Bagwell testified that he did not remember checking the fire pin with respect to the subject elevator door, but he would expect that he would do so as part of his normal routine.

Mr. Bagwell also indicated that as part of his inspection procedure, he would make use of a safety inspection checklist, a copy of which is attached hereto as **Appendix 24**. It is clear that this checklist is not a list that is filled in with respect to each hoistway or elevator door, but is rather a checklist in a plasticized holder that is used, I conclude, as a reminder or prompter. Mr. Bagwell would refer to the checklist at the conclusion of his inspection to make sure that he had forgotten nothing. This would be done at the bottom of the hoistway after he as completed his inspection. Clearly the fact that a checklist is referred to at the completion of an inspection is not in any real sense conclusive evidence that everything in that checklist was in fact done in a careful and methodical way; especially, when the checklist is only referenced after the inspection work has been done.

When asked about the issue of debris in the track as being indicative of anything, he noted that unless the debris were in an especially high pile in the track, it would not be indicative of anything, so far as he is concerned. The level to which the debris may accumulate may be dependant upon how the fire gibb had been set by the maintenance mechanic or the adjuster on the original installation. Mr. Bagwell made no mention of debris in his inspection report and remembers nothing about debris in the tracks being remarkable.

c. Testimony of Keith Jenkins

Keith Jenkins is a professional engineer with extensive experience in the elevator industry. He

was retained by counsel for the elevator service provider, Thyssen Krupp, and prepared two written reports with respect to the subject incident and elevator and also testified before the Inquiry. He currently is the principle in KJA Consultants Inc. which is an elevator consultant company involved in the design of elevator transportation systems for new buildings, maintenance of elevators, auditing of elevator systems and generally giving advice to owners and managers of buildings with respect to elevators and escalators. The company is principally involved in consulting with owners, developers and builders.

Mr. Jenkins is also a member of the National Association of Elevator Safety Authority and the American Society of Mechanical Engineers. He has previously been qualified to give expert opinion evidence as to the operation and maintenance of elevators. His work has also involved fatality and major injury accident investigation and reconstruction. Mr. Jenkins was accepted by the Inquiry as an expert entitled to give opinion evidence in the operation of elevators and in accident investigation and in accident reconstruction for purposes of the Inquiry. Mr. Jenkins acknowledged that he has no training or expertise in bio-mechanics.

In his report of June 11th, 2005, Mr. Jenkins opines that it is more likely that the fire or gib pin was not broken prior to the incident. He feels that Mr. Bear's "unequivocal" conclusion that the pin was not present is too strong a statement in the circumstances. He discounts the absence of any witness marks, the location of the debris and expresses his confidence in the elevator mechanics that would have undertaken regular maintenance and work on this particular elevator, such that he is of the view that had the pin been missing at the time of the most recent inspection and maintenance activities, it would have been noticed and repaired.

He also points to the lack of any incident reporting as support for his position.

Mr. Jenkins also discounts the grooves and indentations on the sill near the location of the trailing edge gib pin when the door is in the open position as being inconclusive and he asserts that such marks are capable of being made by objects other than the fire pin.

With respect to the matter of the absence of witness marks in the sill, Mr. Jenkins discounts Mr. Bear's test results which demonstrated witness marks on the sill when the fire pins were fractured in static and impact tests. He was of the view that witness marks arising from both one impact test and one static load test did not justify the conclusion that witness marks would always be present if the pin were fractured by application of lateral force to the door.

Originally in his testimony, he stated that in his own testing he did not consistently get a mark from each pin that was broken during the tests. The fact of the matter however is that no record of witness marks was kept or intended to be kept by Mr. Jenkins with respect to his testing and he never paid attention to that issue and frankly has no idea as to whether a witness mark was present with each fracture of a pin during his testing. Certainly his first test left a witness mark, and thereafter he says he couldn't tell because there was no way to determine whether the pin simply followed the same witness groove or not. No effort was made to facilitate the identification of whether new witness marks were made upon each test, despite the significance of this factor as emphasized in the Anderson report. This I find quite remarkable in the circumstances.

Mr. Jenkins also concluded that the position of the debris in the sill track carried little weight and he opined that the rear gib pin or fire pin in a particular position could still result in the debris remaining undisturbed. He was of the view that the gib pin could do one of two things ; it could pass through the debris, or it could push it back and forth. He was inclined to view that the debris was being pushed back and forth by the gib pins and occasionally the gib pin would take some of the debris off the top of the pile and distribute it.

I do not understand how this could be the case. If the debris were high enough and cohesive

enough to be pushed back and forth, how could the pin ever move through it and take some off the top of the pile and distribute it. The evidence of Mr. Bear, who actually saw and touched the debris in the sill, is that it was cohesive enough to move as a lump or a single body. The photos of the debris appear to show it as fairly high in the sill, accumulating nearly to the top of the sill groove and given that the pin itself, would run at least one-half the depth of the groove, as shown by the markings on the side of the sill groove, it is clear that the pin, if present, would be sufficiently low in the sill groove to push this pile of debris back and forth as the door opened and closed. It is also clear that the location of the debris after the incident is not consistent with it being moved back and forth by the leading and trailing edge plow and gib pins. It was located in the position where it would have been deposited by the leading edge plow gib when the door was in a full open position and was not moved by the trailing edge gib pin when the door was closed, prior to the incident.

Mr. Jenkins also noted the regularity of maintenance and the safety audit and inspection by Mr. Bagwell and that some consideration must be given to the fact that notwithstanding Mr. Bagwell's audit and inspection and the regular monthly maintenance of the elevator, the absence of the trailing edge gib pin is neither noted nor discussed. This is of course a valid consideration, however, it is clear from the evidence that neither the maintenance mechanic nor Mr. Bagwell testified as to actually seeing the lower portion of the trailing edge gib pin when undertaking their responsibilities with respect to this elevator. Both were of the view it was present because given their routine of maintenance and inspection, they would expect to have noticed if it was not.

Mr. Bagwell testified that one cannot usually see the bottom of the fire pin and that indeed one would have to look more carefully than normal to determine that the lower portion of the pin was in fact missing. He also acknowledged that if both the leading and trailing edge plow gib and fire pin or gib were not present, that there would be considerable play in the door if it were shaken as part of an inspection from inside the hoistway. If, however, only the fire pin or gib pin were absent, the play would be minimal.

In this regard, I note as well that there was no documentation prepared during the inspection by Mr. Bagwell or regular maintenance by the maintenance mechanic identifying that each and every component and its operation was specifically checked. Although the skill and experience of the mechanic and inspector is not to be overlooked and certainly not questioned by myself, evidence that a routine of inspection normally followed would likely disclose the absence of a component or a defect in a component is not evidence that the component was either present or operational.

Mr. Jenkins also refers to the fact that it would appear that the fire pin was not fractured in any tests without the top hanger roller first coming off the track. Therefore, if the pin fractured prior to the incident, one would expect to find some type of report dealing with a roller having come off its track. Given that there is no such record, he opines that this is evidence in support of his position that the pin was probably present at the time of the incident. In his testimony, he did acknowledge that if the rear gib pin jumped the track as suggested by Mr. Keogh and Mr. Bear, that is as a result of excessive force being used to open the door as evidenced by markings and indentations on the sill, then it is possible that once the pin fractured, the roller could drop back into place on the track, the door would move back into its normal position and it would appear as though the whole system was working normally, therefore resulting in no incident report. It is to be noted, that the roller jumped the track in the tests as a consequence of lateral force, whereas the type of incident referred to by Mr. Keogh and Mr. Bear contemplated the pin jumping the track and being dragged over the sill parallel to the sill groove itself, thus resulting in the markings and indentations described aforesaid.

Overall, Mr. Jenkins did not look at any one thing in support of his position that the fire pin was probably in place at the time of the subject incident. Rather, as he expresses in his report, he

considered all the factors mentioned therein.

d. Conclusion as to the presence or absence of the trailing edge gib (fire pin) at the time of incident

Given all the physical evidence, the testing and the expert opinion presented with respect to the presence or absence of the trailing edge fire or gib pin, I am convinced that the subject fire or gib pin had been fractured prior to the subject incident and therefore that portion of the pin below the hex which would run within the sill groove was missing at the time of the incident. The absence of any witness marks on the sill and the location of the debris in the sill groove primarily convinced me of this fact.

The evidence is clear that the gib pin was made of significantly harder material than the sill and I am satisfied, given the metallurgical evidence of Mr. Bear and given the results of tests #7 and #9 in the Anderson report, that if sufficient lateral force were applied to the subject door so as to result in the fracture of the trailing edge gib pin, there would be witness marks on the sill as a result thereof.

If the pin was present at the time of this incident and fractured as a result of this incident without leaving any witness marks on the sill, I am satisfied the only way this could happen is if the force applied to the door not only pushed it in towards the hoistway, but also lifted it up a sufficient amount so as to result in the pin being actually lifted above the sill, resulting in the door being pushed into the hoistway and the pin not touching the sill. If that occurred, the pin would still have been in a complete and operable condition after the incident. There is no testimonial evidence that after Mr. Young fell into the hoistway, the elevator door swung back in such a fashion that the trailing edge gib pin struck the sill area with such force that it could have fractured. There is no evidence of the door swinging back, nor any physical evidence on the sill that would indicate that the fire pin struck the sill as the door swung back from its opening into the hoistway towards the sill area. I am satisfied this did not happen.

In any event, even if that situation did occur, then it is clear that the fire gib pin in that sequence of events, offered no assistance to the integrity of the door and it did not constrict or impede the opening of the door.

Mr. Jenkins' views with respect to the issue of the absence of witness marks are of no evidentiary value so far as I am concerned. He does not dispute that witness marks were generated by the Bear tests, nor that witness marks occurred in the tests that he undertook. He takes the position that having generated witness marks on tests 7 and 9 as undertaken by Mr. Bear, is not sufficient in the overall circumstances to justify the conclusion that the absence of witness marks means the absence of the intact fire or gib pin. However, Mr. Jenkins knew full well the significance of the absence of witness marks to Mr. Bear's opinion and the result of Mr. Bear's tests with respect to witness marks, yet kept no record or documentation, nor made any effort to determine the presence or absence of witness marks and their regularity as they may or may not have arisen during the course of the tests that he undertook. Mr. Jenkins does not agree with Mr. Bear as to the meaning of the absence of witness marks on the sill, but when given the opportunity to challenge Mr. Bear's conclusions through his own testing, he made no effort to do so. His expression of opinion on this issue in the circumstances is not deserving of any weight.

The physical evidence as to the location of the debris in the sill groove and the absence of witness marks as I have described aforesaid speak clearly and unequivocally to the fracture of the trailing edge gib pin prior to the subject incident. The maintenance regime and the expectation that the absence of the pin would be noted during regular maintenance and/or the audit and inspection by Mr. Bagwell in December of 2003, for the reasons I have discussed

aforesaid, have little weight compared to the physical evidence of the witness marks and the location of the accumulation of debris in the sill groove.

I take no issue with respect to the skill and competence of the maintenance personnel and the other skilled personnel who have inspected or attended this particular elevator and its components and doorways. The fact is that things such as the absence of the lower portion of the trailing edge fire pin could be missed, especially given factors such as lighting and the fact that the hex and upper portion of the gib pin were still present; and given that, according to Mr. Bagwell, one would have to make a special visual effort to confirm the presence of the lower portion of the pin.

With respect to the question of how long the trailing edge gib pin had been fractured, the evidence is not conclusive in that regard. Given the accumulated volume and texture of the debris found in the sill groove, it is in my view, more likely that the pin was in a condition of fracture for weeks, as opposed to days. The presence of the debris is obviously not the strongest of evidence in that regard, however it is weighty enough to lead me to that conclusion.

e. Trailing Edge Upthrust Eccentric Roller Adjustment

A considerable amount of testimony, including expert opinion and documentation was presented to the Inquiry as to the adjustment of the trailing edge upthrust eccentric roller and whether its position at the time of the incident provided any resistance to the opening of the elevator shaft door. There was no consensus amongst the witnesses, including the experts, as to what the gap between the upthrust roller and the bottom of the roller sill should be set at, indeed no one could agree as to whether there was an industry standard let alone what the industry standard was.

According to Mr. Bear's report:

> The purpose of the eccentric rollers is to prevent rocking of the elevator door in the plane of the door as it is opening or closing. If the eccentrics were adjusted near minimal clearance, a side benefit might be eccentric contact with the track that would require an energy expenditure.

It would accordingly likely take more energy to move the roller off the track if the eccentric upthrust roller were adjusted such that some contact between the eccentric roller and the bottom of the roller track occurred in any given incident when lateral force was pushing the elevator hallway door towards the inside of the hoistway.

Mr. Jenkins also concluded that the adjustment of the upthrust eccentric roller would affect the strength of the door and that if the upthrust roller were in fact jammed against the underside of the track, a much better result, in terms of the door would be experienced. I understand that to mean that if such a circumstance existed, greater force would be necessary to knock the hanger roller off the track.

In this case, the trailing edge roller jumped the track. This occurred without any contact between the trailing edge eccentric upthrust roller and the bottom of the track. The leading edge roller, did not jump the track despite the trailing edge of the door swinging into the hoistway. It is significant that the leading edge eccentric upthrust roller was found in a post incident position where it was jammed against the underside of the roller track. Indeed, it was so tightly jammed thereunder that it was necessary to remove the eccentric upthrust roller itself in order to remove the elevator door as it hung from the roller track. This eccentric roller was adjusted so as to prevent the leading edge hanger roller from coming off the track and clearly served its purpose in this instance.

Mr. Keogh was of the view that given that the Dover Corporation manufacturer drawing, suggested that the gap should be set at a minimum of 4 thousandths of an inch at the tightest point between the upthrust roller and the door track, and that the maximum variation in the measurement between the top and bottom of the track should not exceed 6 thousandths of an inch, that the maximum upthrust roller clearance setting should be 10 thousandths of an inch. In this particular case, he found that the actual variation in the track, that is the roller track itself, was 16 thousandths of an inch. Therefore he calculated that the maximum upthrust clearance setting should not exceed 20 thousandths of an inch.

Indeed, what he is saying is that if the roller track itself is perfectly machined so that there is no variations or waves in it, then the upthrust roller should be set with a gap between it and the bottom of the track of 4 thousandths of an inch.

Mr. Bagwell from Lerch Bates had no real opinion as to what the acceptable range of adjustment of the eccentrics would be. It was his position that he was looking for a very close tolerance, but because of the variations in the change of the track itself, the gap could be as much as 125 thousandths of an inch.

Mr. Hearn, the mechanic who had been in charge of maintenance of the subject elevator testified that the Thyssen Krupp handbook calls for the gap to be between 4 and 6 thousandths of an inch at the tightest spot. Since the tracks aren't necessary formed the same all the way across, he indicated that to set the adjustment of the eccentric roller you would find the tightest spot and then would adjust it at that point. This adjustment would normally be done on the initial installation. He indicated he never did any adjustment on the upthrust rollers on elevator #4. He also indicated that he wouldn't be surprised by readings of 35 thousandths, 95 thousandths or 109 thousandths with respect to eccentric gaps. He did not indicate why this would not surprise him.

Mr. Jenkins, in his report, states:

> Below each roller underneath the track a small eccentric is mounted. This eccentric is designed to prevent the door from coming off the track. Typically the eccentric is set to 0- or very near 0- clearance (The Dover drawings indicate that the minimum clearance should be 0.004 inches.) at the tightest point in the travel of the door. This type of form steel track when installed in the field will have some variation along its length so the that the spacing will be wider at other points in the travel of the door. The tightest points will be at the ends of the track and at other points a normal spacing would be between 0 and 0.03.

Despite that comment, when asked whether gaps as high as 109 thousandths of an inch were unacceptable in the industry, he disagreed. He acknowledged that he would expect the range caused by variation of the track itself to be between 0 and 3 thousandths of an inch, however he would accept a larger gap and it could be 125 thousandths of an inch or even larger.

It seems to me that if the eccentric upthrust roller is to assist in preventing the track roller from being pushed off the roller track in a circumstance where lateral force is applied to the door when it is in a closed position, the gap between the upthrust roller and the bottom of the track must be, at least at the trailing and leading edge of the door while in a closed position, less than the depth that the sides of the roller envelope the roller track. It is the sides of the roller as they envelope the track that keep the roller on the track. If lateral force applied to the door can cause the door to lift up such that the roller no longer envelopes the track, then the roller will, assuming some form of continued lateral force, move off the track. If this is not possible without the eccentric upthrust roller jamming against the underside of the track, then it will take more energy or force to

push the roller off the track laterally and therefore the door structure is logically stronger.

No one was able to conclusively determine what the gap was between the eccentric upthrust roller and the roller track at the time of this incident. Mr. Bear came to the conclusion that it was 56 thousandths of an inch**,** however, he acknowledged that his view was based upon the assumption that the eccentric on the roller itself had not been affected as a consequence of the incident. There was some evidence suggesting that this was not the case, so his calculations cannot be seen as conclusive in that regard.

f. Conclusion as to upthrust eccentric roller adjustment

It is clear that unlike the leading edge eccentric roller which did come in contact with the bottom of the track at the time of this incident, the trailing edge eccentric roller did not contact the bottom of the roller track. We can therefore conclude that the gap at the trailing edge of the door, at least with the door in a closed position, was likely more than the depth that the roller itself enveloped the roller track at that point. The trailing edge upthrust eccentric roller at the time of this incident offered no resistance to the hanger roller jumping the hanger track.

10. Expert Evidence - Testing

a. Force Required to Cause Elevator Door Failure

Mr. Bear, in his report, describes the parameter of his undertaking as follows:

- To determine from the physical evidence how the door mechanism failure occurred
- To determine whether the door mechanism was in compliance with the governing codes, and
- To determine the approximate force or energy required to cause a similar door mechanism failure

Anderson and Associates was not required, as part of its retainer, to do an accident reconstruction. Indeed Mr. Bear testified that although the performance of an accident reconstruction would be a nice brief, there were too many variables, such that the reliability would be too low to justify such testing. He felt the results could be more harmful than beneficial.

Mr. Keogh of Intertec Inspection Corporation and Mr. Demeyer of Vertek Elevator Services Inc. were retained by the Edmonton Police Service to do essentially the same thing that Anderson and Associates was retained for. Mr. Keogh and Mr. Demeyer relied in part upon the results of the testing undertaken by Mr. Bear in coming to the conclusions as expressed their report.

Mr. Jenkins prepared two reports for the Inquiry at the direction of counsel for Thyssen Krupp. The first report, dated January 10th, 2005 is primarily theoretical calculations based upon the information made available to Mr. Jenkins previous to the date of the report. His report of June 11th, 2005, is a commentary on other reports filed in the Inquiry, including those of Mr. Anderson and Mr. Keogh. It also includes his conclusions based upon his attempt to reconstruct the incident and thereby determine the velocity of Kyle Young when he came in contact with the door and the force of such impact in foot pounds. Mr. Jenkins attempted to reconstruct the incident despite his testimonial acknowledgement that the happening was a very unique one arising from a fairly exotic combination of events. He opined that it was the kind of incident that, at best, might be re-created 1 out of 100 times. He also acknowledged that he was unable to achieve the re-creation of the event to the extent that he would have liked.

It is not my intention to reproduce in any detailed manner, all the tests undertaken by Mr. Bear and Mr. Jenkins. That type of detail may be gained by reference to the reports themselves. It is my intention to summarize the conclusions reached by Messrs. Bear, Keogh, Demeyer and Jenkins and discuss how those conclusions impact, if at all, on my findings as to the circumstances of this door failure.

i. Anderson & Associates Tests and Conclusions as to Force

Mr. Bear did not attempt to reconstruct this incident. The testing he was retained to do required him to undertake certain tests to determine if the 1975 CSA-B44, "safety code for elevators", was met by the subject elevator door. The 1975 code is the applicable code to this particular door given the date of installation and the fact that code changes were not retrospective in operation. The 1975 code specified that the subject elevator door must withstand 250 pounds force, static load applied perpendicular to and at the center of the elevator door, without being displaced from its guides or suffering any permanent deformation. Conversely, the 1990 code would have required the door to withstand 562 pounds force.

Mr. Bear had concluded in his own mind prior to testing that there was an impact aspect to this door failure and therefore concluded that it was necessary to do some impact testing on the door as well. This was necessary in order to establish the probable force (energy) levels in this particular incident. It was his view that the door structure was amenable to dynamic intervention and therefore some dynamic testing had to be undertaken.

- **Static Tests**

The static load code compliance test was achieved by placing the load within a four inch square in the center of the subject door. The door was, in all respects, so far as they were able to achieve, in the same condition at the time of the test as at the time the incident took place, save for the fact that some tests were undertaken without a trailing edge gib pin and some other tests were undertaken with the pin in place.

The trailing edge eccentric upthrust roller was set with an adjustment between 62 and 67 thousandths of an inch. There was some issue as to whether this in fact reflected the actual trailing edge eccentric upthrust roller adjustment at the time of the incident, however this was ultimately not a matter of any significance in the testing, because whatever the adjustment was at the time of the incident, the trailing edge eccentric upthrust roller did not come in contact with the underside of the roller track. This was also the case in the tests undertaken by Mr. Bear and indeed as well the circumstance in the tests undertaken by Mr. Jenkins. In the end result, if during the test, the eccentric upthrust roller gap had been set so that there was contact between the eccentric and the underside of the roller track, then the testing would not have been done in the same circumstances as the pre-incident door.

The static load testing when applied to the center of the elevator door as required by the code resulted in finding that the re-hung incident door was in compliance with the 1975 code, even when the trailing edge gib pin was missing. As well, it was determined that the subject door re-hung complied with the 1990 code in that it could withstand 570 pounds force without displacement from its guides or without suffering any permanent damage. This was achieved with the trailing edge gib pin in place.

When the static load was placed at the left or trailing edge side of the subject door, that is, 50 inches vertical and 9 inches from the left side of the door, with no trailing edge gib pin, the trailing

edge roller was dislodged off its track at 240 pounds of force. With the trailing edge gib or swivel pin, the door withstood 438 pounds force before the roller was dislodged. This left the retainer plate or flange in a damaged condition, however it had not passed over the track. The door was in this circumstance open about ¼ inch.

With the roller off the track and the retainer flange still on the inside of the track, static force was increased to 190 pounds which resulted in the retainer flange coming over the top of the track and then it diminished to 130 pounds as the door was pushed open on the left side to about 13 inches. The only resistance at this point in time was the twisting of the leading edge roller and gib and the door latch itself. To move the door past 12 to 13 inches required only 110 pounds of force which would not be hard for any individual to do, subject only to their size. The Anderson testers did it by just standing and pushing on the door.

Although the code required static testing to be undertaken, Mr. Bear in his testimony noted that it is almost impossible to obtain a pure static force. There are some static forces in the world he stated, but almost all components fail from either repeated loadings that stress the part, - that is, loading and unloading, fatigue, or that they fail as a result of an impact load. Impact loads depend on how fast you apply the load. The faster the load is applied, the higher the peak force is going to be.

- **Impact Tests**

Although the Elevator Safety Code requirements do not include impact resistance capacity, it was Mr. Bear's conclusion that impact testing more realistically represented the door's resistance to abuse, accidental or otherwise. Mr. Bear did not believe that the incident occurred as a result of a pure static load being applied to the door, but that there was an impact component to the incident.

The impact testing was not however intended to be a reconstruction of the accident but rather only a basis on which to provide some data as to the kind of forces, static and impact, that could put the door in the post-incident condition. Both the static and impact testing procedure and tests were video recorded. The impact testing implemented by Mr. Bear was modeled on the American National Standards Institute 297.1 entitled, "Safety Performance Specifications and Methods of Testing for Safety Glazing Materials Used in Buildings"; this employed an impactor which had some compliance and attempted to resemble the impact of a person. The methodology of Mr. Bear's testing was not challenged by any of the parties.

I do not intend to detail herein how the impact tests were done, or analyze in any detailed fashion, all of the results of the testing. The results of the impact testing may be summarized as follows:

- With no trailing edge gib pin in place, the human impact that transfers 50 ft. lb. energy to the door at mid-height and near the left side of the door would be sufficient to dislodge the rear roller and, if a person or object continued to lean against the partially dislodged door, it is likely that the retainer flange would pass over the track. The maximum impact that the door with no rear gib pin could withstand and prevent the incident was no greater than 50 ft. lbs. This is equivalent to the energy of a 150 pound individual traveling at 3.2 mph (5.1 km/h) if 100% of the kinetic energy was transferred at impact.
- With no trailing edge gib pin, both the rear roller and the retainer flange displaced over the track with an input energy of 79 ft. lbs.
- With the trailing edge gib pin in place, 92 ft. lbs. impact energy would be sufficient to dislodge the rear roller and retainer flange and fracture the rear gib pin.

Mr. Bear concluded that the January 22nd, 2004 incident could have occurred at an energy transfer of 50 to 79 ft. lbs. In his viva voce testimony, Mr. Bear likened 50 ft. lbs. of energy to a sort of "pee wee hockey check". This would be at the "lower level of the scale" in his estimation.

Certainly it would appear that all that was necessary to dislodge the door in the condition it was in was minimal impact or impulse energy.

Mr. Bear was also of the view that the subject incident involved both static and impact force and energy. It was his testimony that if one or more bodies were pressed against the elevator door, and then another body came and applied some additional pressure, this would be a form of dynamic impact. This would represent a dynamic force component that would create an impulse that would momentarily raise the peak force on the door, beyond what would be the steady static force.

It is important to remember that Mr. Bear's tests were not an attempt to reconstruct the incident, but rather only to establish the minimal amount of static force or dynamic (impact) energy necessary to put the door into its post-incident position, both with the trailing edge gib pin and without the same. His test did not establish how much force or energy was actually exerted in the incident, but only what was minimally necessary to achieve the post-incident status of the door. It was clear in Mr. Bear's mind that 240 pounds force could be exerted by the guards in the circumstances of the incident so as to generate the failure of the door. It was also clear that 50 ft. lbs. of energy was a minimal amount of impact energy and that given the weight of the guards and the sudden imposition of force against the back and shoulders of Mr. Young by Officer Fayad, which thereby pushed him harder against the door; it would seem that an energy transfer of 50 to 79 ft. lbs. would be easily achievable.

It would not, given the testimony before the Inquiry, take a significant amount of energy or force to achieve the post-incident condition of the subject elevator door.

ii. KJA Reconstruction

May 21st through 23rd, 2005, Mr. Jenkins undertook fourteen tests directed at trying to establish the velocity at which Mr. Young was projected into the hoistway upon the failure of the door. These fourteen tests are described in the KJA report of June 11th, 2005 and the actual testing procedures and tests were captured on CD Rom. This testing was an effort to work out the sequence of events or some scenario that would give the same results as the subject event.

In his first report, dated January 10th, 2005, Mr. Jenkins started with the fact that Mr. Young had hit his head on the fish plate bracket located on the north wall to the left of the hoistway entrance after he fell through into the hoistway. From this he went backwards to the landing door and made theoretical calculations of what horizontal velocity would be required to get Mr. Young from the landing to that point. He then made calculations of what his kinetic energy would be given his weight and velocity. Then going back from that he tried to theoretically arrive at what force would be required to open the door and then taking those two energies together, try to calculate what the total kinetic energy involved was. He calculated the kinetic energy on that basis at impact to be 139 ft. lbs. assuming that only Kyle Young hit the door. The impact energy would be greater if each of the guards had horizontal velocity after impact against the door. He found the calculation of this added impact to be nebulous and therefore he ignored it. 139 ft. lbs. is, of course, significantly more energy than would be necessary to place the door in its post-incident position, given the accepted tests of Mr. Bear.

Mr. Jenkins, in his testimony, acknowledged that his first report, was theoretical and that he is not

very strong on theory as a means of getting an answer. He notes that his theories are worthy of consideration, but that the testing undertaken and reviewed in his second report, is of more interest.

The testing undertaking was an attempt to reconstruct the incident to see if the testers could get it to happen again. If the same results could be achieved, then the force and energy actually applied and expended could be measured. This evidence could be used to test the guards' version of events as it related to the force and/or energy applied by the guards to Mr. Young and concurrently the elevator door.

The actual test procedures and components were described by the KJA report as follows:

- 4.1.1 – the tests were done using a crash dummy located in the vertical position on the front of a cart
- 4.1.2 – the cart was allowed to roll down an inclined plain and to strike the door
- 4.1.3 – the incline of the plain was altered to achieve different impact velocities
- 4.1.4 – weights were added to the cart so that the combined weight of the cart, crash dummy and weights totaled 675 +/- 5 pounds
- 4.1.5 – we used a 50th percentile male (Standard Crash Test Dummy), slightly modified to reduce the weight (remove lower leg sections) to 149 +/- 2 pounds (approximately the weight of Kyle Young).
- 4.1.6 – the entrance used was of the same type and dimensions as the entrance at the accident site except the opposite hand; meaning that the door opened from left to right (viewed from outside the elevator) rather than right to left. The door was identical to the one on the L4 landing of the elevator at the time of the accident.
- 4.1.7 – the crash cart was arranged so that the crash dummy struck the door in a roughly vertical position with the crash dummy still at sill level.
- 4.1.8 – after each test unless otherwise noted, damaged components were replaced and the door readjusted.
- 4.1.9 – the tests took place over three days from 2005-05-21 to 2005-05-23.
- 4.1.10 – eight cameras were used; four in the hoistway and four outside the hoistway. The data from the cameras was stored in two computers. It should be noted in reviewing the data on the two computers that there is a difference in the computer time between the two computers of about 3 to 5 seconds. Two additional cameras not connected to the computers were also used. However, these two additional cameras did not generate significant information.
- 4.1.11 – the target point was established in the hoistway at the location where the prisoner's head hit in the actual accident
- 4.1.12 – a temporary plywood flooring was installed in the hoistway to allow the crash dummy to fall only a few feet beyond the target point.
- 4.1.13 – on some of the tests, bungee cords were used to accelerate the cart in the first 5-6 inches of travel.

The test results are detailed in the report and a summary of the results is set out in the Sintra Engineering Inc. report of January 22nd, 2005, Exhibit 61 and this result summary is attached hereto as **Appendix 25**.

It was Mr. Jenkins' position that test 6 of the 14 undertaken, came closest to replicating what took place in the actual incident. His conclusion in that regard is based upon the fact that it was in this test circumstance that the head of the dummy projected into the hoistway, and came closest to the target point. It did not hit the target point and how close it actually came was not measured. Test 6 had the trailing edge gib pin in place, the eccentric upthrust roller adjusted at 30 thousandths of an inch, and involved the cart and dummy, at a combined weight of 675 pounds,

being projected at the doorway at a velocity of 10.75 km/second with the apparent resultant impact energy of 1,006.87 ft. lbs.

It is my view that if a reconstruction is going to be meaningful in terms of re-creating an accident and therefore have evidentiary value, it is necessary that the test results be virtually the same as the actual incident. That is not the case in any of the test results achieved by KJA, including test 6 which Mr. Jenkins opines achieves the closest comparable results to the actual incident. Mr. Jenkins testified that the tests were trying to achieve an end result whereby the dummy was projected into the hoistway and wherein the dummy's head would come in contact with the fish plate bracket as the head of Mr. Young purportedly did; and that the testing was also intended to concurrently achieve the end result of the elevator door being left in the same position as the post-incident elevator door.

Test 6 does not achieve either of these desired results. The hallway door was not left in the post-incident position, but knocked completely off the leading and trailing edge rollers and but for being restrained, would have fallen completely into the hoistway. That is not what actually occurred and although Mr. Jenkins argues that the hallway door almost came off both rollers in the actual incident,- the fact is that it did not. Further, the dummy's head did not achieve contact or even near contact with the fish plate bracket. Suffice it to say that the fact that in this particular test, the dummy's head came closer to the fish plate bracket than in any other test, does not make test 6 an accurate representation of what took place in the actual incident. Neither test 6, nor any of the other tests is a reliable replication of the subject incident and accordingly, none of the tests have any evidentiary value in terms of the purpose for which they were undertaken. The tests are not an accurate replication of the incident and cannot therefore be used to make reliable calculations relative to the force or energy employed in this incident.

It is to be noted that in each of the tests a sled and dummy weighing 675 pounds is projected into the elevator door. This weight was used because it was understood to be the combined weight of the two guards and Mr. Young. The testing contemplates both guards and Mr. Young coming into contact with the door with some velocity. Of note, however, is the fact that Mr. Jenkins was of the view in his initial report that it would be difficult to see how all three people could hit the door with the same velocity and that it can be reasoned that Mr. Young hit the door alone. He contemplated that if the two guards and Mr. Young hit the door with the same velocity, all at the same time, that all three would likely have gone into the shaft. Despite this initial position, the KJA testing assumed that all three persons hit the door with the same velocity.

The test results achieved by Mr. Jenkins offer this Inquiry no reliable evidence insofar as reconstructing this incident is concerned. The subject incident was, as Mr. Jenkins acknowledged an exotic and unique circumstance which at best, might be re-created one in a hundred times. Mr. Jenkins acknowledged that the testing did not get the results that they were seeking.

Mr. Bear was of the view that there are so many variables in this particular incident that it was very dangerous to try and go back and calculate how hard an individual hit the outside of the elevator door. He testified that this was the kind of science that could do more damage than good.

The KJA tests were directed at trying to reconstruct the accident and thereby come to a calculation as to what velocity of contact could achieve the same results as the incident, specifically the projection of Kyle Young into the elevator hoistway and the striking of his head on the fish plate and the concurrent leaving of the elevator door in its post-incident position.

What the testing of KJA did do was prove Mr. Bear's and Mr. Hughes' assertions that there were too many variables in the present circumstances to achieve reliable results which would

represent a reconstruction of what happened in this particular incident. The KJA tests simply served to prove that the incident could not be reconstructed reliably, at least in the manner undertaken by KJA.

11. Credibility of Guards' Testimony

a. Review

Issue was taken with respect to the credibility of the testimony of the guards as to how this incident occurred, specifically the amount of force applied by the guard or guards to Kyle Young at the time the elevator door failed. The guards' credibility was challenged on the basis that there were inconsistencies in their respective testimonies; that there were opportunities for collusion amongst the three guards in terms of describing what happened; and that the physical evidence and some of the expert evidence before the Inquiry demonstrated that the testimony of the guards was not credible.

Although, earlier in this report I have summarized the evidence of the guards and other witnesses in the cell block, I have not discussed the issue of the guards' credibility heretofore because to properly do that it was necessary for me to come to conclusions with respect to the physical evidence, that is the condition of the door and the expert evidence with respect to the force or energy necessary to cause the failure of the door, before the issue of credibility could be effectively assessed.

The credibility of the guards' testimony and for that matter any other witness when they testify, must be assessed, not only by considering the witnesses' forthrightness and their apparent sincerity, but also by considering the testimony in the context of the facts that are not in dispute, whether arising from testimonial or physical evidence. It is by measuring the witnesses' testimonial evidence against known facts, that the credibility of a witness may more accurately be assessed.

It would indeed be wrong to assess the credibility of a witness on the basis solely of his or her demeanor and apparent sincerity. A witness's credibility is not determined by how practiced or polished he or she may be in giving evidence before a tribunal. Every witness, regardless of occupation, gender, nationality, color or other characteristic is at the commencement of his or her testimony presumed to be telling the truth. No one is entitled to greater credibility because of who or what they are and there is no hierarchy of witness credibility. (See: ***R.D.S. v. The Queen***, (1997) 118 C.C.C. (3d) 353, S.C.C.) It is only after a witness has been tested under oath and that evidence weighed in the context of its own internal and external consistencies and inconsistencies and when that evidence is compared to the facts that are clearly proven that a conclusion may be reached as to the credibility of a particular witness.

The issue of the trustworthiness and reliability of the testimony of Officers Tomaino, Fayad and Chambers as it relates to the removal of Mr. Young from his cell, transporting him to the elevator area and the events that occurred there has been assessed and commented on in both the written submissions filed by counsel, as well as oral submissions presented before the Inquiry. It is to be noted that each of these officers was examined and cross-examined extensively by counsel who had in their possession copies of all notes, statements, interviews and/or transcripts of testimony from other inquiries made by or given by all three of the aforesaid officers. Most counsel, I believe, also had the benefit of the video evidence of Kyle Young in his cell prior to being removed and the statements of other youths being held in the cells on the fourth floor when the tragedy occurred.

Examination and cross-examination was detailed and each and every perceived or actual

inconsistency between the individual officer's testimony, his notes or previous statements, was raised and questioned upon. There is indeed some inconsistency between the testimony given by the officers and their notes, prior statements, and interviews and also some inconsistency amongst the three officers in their testimony before this Inquiry.

Only the three guards, Chambers, Fayad and Tomaino were present and witnessed the actual incident whereupon the elevator door failed and Kyle Young fell. There were no other witnesses to this actual happening. The youth L.J. was present in the cell block and located in a cell that allowed him to view the entry to the cell Kyle Young was situated in, as well as the corridor leading from this cell to the location near the elevator door entrance way. L.J., from his cell location, could only see to the end of the corridor, not the area in front of the actual elevator door. He did not see the actual event, or what immediately preceded it.

Accordingly, if the testimony of the three guards as to what took place at the elevator door is to be discredited, their evidence must be either found:

a. to be so far fetched as to not be deserving of any consideration;
b. to suffer from such material internal and/or external inconsistencies that it cannot be relied upon as accurate or trustworthy;
c. to be contrary to the physical evidence such that it cannot be accurate; or
d. to be materially contradicted by other reliable evidence on other material matters such that the inference may be drawn that the officers' testimony with respect to the happenings at the elevator door is not reliable or trustworthy.

Although the testimony of the three officers differs in some ways, one from the other, and even in some minor ways from their own individual pre-Inquiry statements or interviews, none of those inconsistencies, as they relate to what happened at the elevator door and what immediately preceded that event are such as to make their evidence inherently unreliable and therefore not worthy of credit.

It is clear that the three officers were sequestered together in a room after the event for some hours during which time they made their notes and jointly prepared a narrative to a secretary for purposes of briefing superiors. It was suggested that these circumstances gave the three officers an opportunity to jointly frame or tailor their version of the events so that each officer's testimony was consistent and in keeping with the others and that therefore their testimonies are unreliable.

It is accurate to say that this sequestration, for lack of a better word, indeed did give these three officers the opportunity to do just that. The question however is whether they in fact did so?

Certainly it can be said that the procedure followed in this circumstance was not the best; it is preferable that in such a situation, the witnesses be separated. The fact however, that witnesses are put together after an incident and thereby left with an opportunity to collude on or tailor their evidence, does not in the absence of any other evidence, lead to any negative inference about the credibility of their testimony.

In this case it cannot be said that the individual statements or testimony of the witnesses is so identical as to justify such a negative inference. Although their statements and testimonies are generally consistent with respect to what happened, they are far from identical and indeed exhibit different recollections on a number of matters. Neither are their respective statements and testimonies articulated in such a manner as to suggest collusion. It is to be noted as well that Officer Fayad gave an account of what happened to Constable Wright within minutes of the event occurring. This account can be seen as consistent with his pre-Inquiry statements and interviews and indeed ultimately with his testimony before this Inquiry. Given that Fayad's testimony and statements are consistent with his account to Constable Wright, that would mean that Chambers

and Tomaino would have, and indeed were prepared to adapt their individual versions of this event to coincide with Fayad's account of the events which had already been provided to Constable Wright. I do not believe that to be the case. Neither Chambers nor Tomaino struck me as the kind of individual who was prepared to compromise his position or life so that another could avoid consequences if a wrongful act had occurred.

It is also to be noted that each officer was interviewed separately by the police shortly after their sequestration, yet their respective versions of the events differ. If they had tailored their evidence so as to match each other's, the statements given by the respective officers would, I think, have been substantially more similar in nature than is demonstrated. Finally, as I have indicated aforesaid, these officers were examined and cross-examined thoroughly at the Inquiry and there is no reason or basis demonstrated in the evidence to justify a conclusion that they contrived or colluded or tailored their statements, interviews or testimonies so as to be the same and so as to mislead.

b. Evidence of L.J.

The youth, L.J. who was located in the cell identified as 15338 in **Appendix 1** and whose evidence has been summarized aforesaid, confirms in his testimony the disturbance created by Mr. Young and described for the most part, by the three officers in their statements and testimony. It was noted in the submissions made by counsel that the officers do not comment on Mr. Young demanding food or lunch in their statements, but only in their testimony before the Inquiry. L.J.'s testimony does confirm Mr. Young's demands in that regard, so the fact that the guards did not comment on it does not seem to me to be anything more than oversight on their part if we are to accept L.J.'s testimony as reliable.

L.J.'s glass cell and its location allowed him to view the entrance area to the cell in which Mr. Young was located and also allowed him to see the corridor leading from Mr. Young's cell to the location of the guards' desk which is adjacent to the area in front of the subject elevator, which could not be viewed by L.J. Photograph 7, Exhibit 21, attached hereto as **Appendix 4** illustrates part of what L.J. could see looking from his cell to the security officers' desk adjacent to the elevator entrance way. Photo 8, Exhibit 21, attached hereto as **Appendix 26** shows the view from the security officers' desk, looking back through the glass into the cell that L.J. was located in.

Although there are some differences between L.J.'s testimony and the testimony of the three guards as to the removal of Mr. Young from his cell and the sequence of events after his removal, these differences are not, in my view, significant and do not undermine the substantive testimony of the guards.

L.J. testified that two guards came to the entrance of Mr. Young's cell and removed him. He stated that they did not actually go into the cell, but rather one guard reached in and grabbed him by the back of the neck. He was then moved by the two guards past the control bubble and pushed up against the wall on the opposite side of the corridor to the control bubble in the area marked 46473 in **Appendix 1**. Officer Fayad in his testimony indicated that Officer Tomaino grabbed Mr. Young by the neck when he came out of his cell on their demand; Officer Fayad's testimony was not clear whether Mr. Young was grabbed by the back of the neck immediately upon coming out of his cell area, or at a point further down the corridor. Officer Tomaino initially indicated that Mr. Young had to be pulled out of his cell by the officers, but that is clearly not the case as demonstrated by the video evidence of Mr. Young in his cell prior to the incident. He was clearly mistaken in that recollection and acknowledged the same in cross-examination. Officer Chambers had no recollection of Officers Tomaino or Fayad going into Mr. Young's cell

and certainly the youth, L.J. did not indicate that either officer actually went in the cell to get Mr. Young.

L.J. testified that there was a scuffle between Mr. Young and the guards once he was removed out of the cell which involved some pushing and shoving. It was at this point that Mr. Young was pushed up against the wall by the guards.

Officer Chambers testified that once they had walked Mr. Young past the control bubble in which he was located, and once he had attended to closing the door to the entrance of the cell area, he observed Mr. Young resisting Officers Fayad and Tomaino in the area near the bench located in the corridor in between the entrance to courtroom 444 and the guards' desk.

The youth L.J. observed Mr. Young being forcibly moved down the corridor by the two officers, one with his hand on the back of Mr. Young's neck. He noted that Mr. Young was resisting the whole time. The guards took him around the corner at the end of the corridor near the guards' workstation and L.J. lost sight of him at that time.

L.J. indicated that he saw no one strike or punch Mr. Young, nor did he have any recollection of Mr. Young complaining about pain or anything like that. Neither does he recall hearing Mr. Young say anything to the guards about "leaving bruises on him", nor did he recall Kyle banging on his cell door. The video evidence does show Mr. Young on a couple of occasions, before being removed from his cell, holding on to his cell door bars and he appears, at least in one instance, to be pulling on them. Whether that could be the banging on the cell door that the guards referred to is not determinable.

After the guards took Mr. Young around the corner to the area in front of the elevator, L.J. testified that he heard what he described as "banging around". He acknowledges that he was not really paying attention and only when he heard the last of what he thought were three bangs did his attention get revived. Shortly after the last bang, one of the officers appeared from the area in front of the elevator with his hands over his face saying, "Oh my God, oh my God". Officer Fayad testified that when the elevator door opened it did so with a loud bang. Officer Chambers does not recall hearing any such noise. Officer Fayad's evidence in this regard is certainly consistent with L.J. with respect to the loud pop or bang and the fact that after Mr. Young fell into the elevator shaft, he witnessed Officer Chambers go down on one knee and say "oh my God, oh my God".

Officer Fayad testified to hearing a loud noise as well after Mr. Young fell into the hoistway and disappeared into the darkness. It can be reasoned that this noise emanated from Mr. Young landing on top of the elevator as will be discussed hereinafter. Given that, L.J. indicated that it was after he heard the last bang or noise that he saw the officer come around the corner appearing to hold his face and saying "Oh my God, Oh my God", it is likely that the last noise he heard was Mr. Young striking the top of the elevator as he fell. The other noise heard by L.J. and Officer Fayad is likely the hall door popping off the top roller.

L.J. specifically recalls a female officer being present during the incident and was adamant concerning that point in his testimony. It is clear that Officer Simmons had been in the area earlier in the morning and that Constable Wright had arrived on the scene after the incident, however it is absolutely clear that there was no female officer present when this incident took place. L.J. has likely simply transposed one of the officers that he saw before the incident or after into the time frame of the incident.

L.J.'s evidence appears generally to be reliable, despite his assertion that a female officer was present at the time of the incident. That mistaken recollection simply demonstrates that although his evidence is generally reliable, he does not have a perfect recollection of the events.

The testimony of the guards is not inconsistent with L.J., although certainly there are some differences as to where in the corridor leading from Mr. Young's cell to the area in front of the elevator things occurred. This was not a great distance and things happened relatively quickly so some differences as to where the scuffle occurred, and where Mr. Young was pushed up against the wall, do not in my view undermine the substantive consistency between the guards' testimony and that of L.J. The differences between L.J.'s testimony and the officers as to the description of events relating to Mr. Young's removal from the cell and the guards' movement of Mr. Young down the corridor to the area in front of the elevator, do not undermine the credibility of the officers' testimony. With the exception of Officer Tomaino's mistaken recollection that Mr. Young had to be actually removed from his cell, the testimony of the guards is generally consistent in all material matters amongst themselves and with the testimony of L.J.

The video evidence of Mr. Young in his cell area illustrates as described by the guards' testimony, that Mr. Young was, with some vigor, vocalizing something just before he was removed from his cell. The video shows him animated and speaking for a short time just before he was removed from his cell at 11:11:57 which is the time as shown on the video recording. The video also shows that he was speaking loudly enough to disturb others as shown by the reaction of the three youths in the group cell (area 38162, **Appendix 1**) whereupon concurrent with his vocalization their attention is immediately drawn to the window and door area of their cell, facing the direction of Mr. Young's cell up the corridor. Their view would be as shown in photo 19, Exhibit 21, attached hereto as **Appendix 27**. Mr. Young's cell would have been on the corridor wall to the left and although they could not see Mr. Young, it would appear from the video that the three youths in the group cell were reacting to Mr. Young speaking as shown in the video. By their actions, it would appear that he was speaking loud enough for them to hear.

Overall, in considering the testimony of the security officers and L.J.'s testimony, it is my view that they are materially consistent, one with the other, and that L.J.'s testimony does not undermine the credibility and reliability of the guards' testimony.

c. Other Evidence

With respect to the issue of whether any other evidence such as physical evidence and the expert testimony, undermines the reliability and trustworthiness of the testimony of the guards, (most specifically with respect to the issue of the force that Fayad and Chambers say was applied to Mr. Young at the location of the elevator door), I have already concluded that given the condition of the subject elevator door, minimal force applied to the trailing edge area of the door would cause the roller to jump the hanger track and ultimately open as described by the guards and shown by the testing of Anderson and Associates. Although, as I have said, Mr. Bear's tests do not identify how much force was used, it is in my view clear that the minimal force described by the guards as having been applied to Mr. Young at the trailing edge of the elevator door, was capable of causing the door to open as so described by them.

d. Conclusion as to Credibility of Guards' Testimony

Given all the matters that I have referred to aforesaid and recognizing some minor differences in the testimony of the guards as between themselves, and as compared to the testimony of the youth L.J., I find no basis on which to conclude that the testimony of the three officers has been discredited. The fact that there are some differences in their individual recollection as between each other and their recollection as compared to the youth L.J., does not in the circumstances as a whole, give me cause to question their credibility. Neither is their evidence in terms of the force applied to Mr. Young at the elevator door site inconsistent with the physical and expert evidence

as I have found and described aforesaid. Accordingly, I conclude that the guards' description of the events immediately preceding the failure of the elevator door and what took place at the location of the elevator door with Mr. Young are credit worthy.

12. Kyle Young's Medication and the Incident of January 22nd, 2004

a. Kyle Young's prescribed medication

When Kyle Young was arrested on January 19th, 2004 by the Edmonton Police Service, he advised them that he had been prescribed Prozac and Resperdal and that he had not taken any medication for two weeks.

When taken to EYOC on the evening of January 19th, 2004 where he was to be held pending Court appearance, he met first with Mr. Don Livingstone in Admissions and Discharge. According to Mr. Livingstone, Kyle did not have any medication in his possession. Mr. Livingstone completed a portion of the Young Offenders Intake and COMIS Admission Record that he is charged with doing and also completed the Suicide/self-harm Screen form. Given that in the past (November, 2002), there had been some indication of suicide ideation on Kyle's part, Mr. Livingstone required that he be assessed by a staff nurse before being put into any specific holding unit. Mr. Livingstone testified that he recalled nothing unusual about Kyle's behaviour that night.

Sherri Roles, one of the staff registered nurses at EYOC, attended at Admissions and Discharge and interviewed Kyle. She testified that she knew him from before, but had never had any difficulties with him so she had no preconceived ideas as to what to expect. At the time of his interview, Young was calm, cooperative and participatory.

Young advised her that he was on Resperdal and Prozac and that he had not taken this medication for two weeks. Although the discharge note of December 11th, 2003 sets out what medication he was on at the time of his release from EYOC in September 2003, Nurse Roles did not assume that he was necessarily still on that medication five months later. She felt that the combination of Prozac and Resperdal was unusual, but nonetheless, this is what she was told by Kyle and noted the same on the Young Offenders Intake and COMIS Admission Record, recording as well Kyle's indication that his medication was for anger and hyperactivity.

Nurse Roles testified that had he indicated to her that he had been off his medication for only a few days, she would have tried to confirm that medication and what dosage he was taking and then arranged for those meds to continue without further medical order. However, given that he had been off his medication, according to his statement, for two weeks, Nurse Roles testified that protocol required that he see a doctor before the medication could be continued. She stated that this procedure is followed for safety reasons. If the individual has been on the street, it is not possible to know what alcohol and drug intake there has been and how the medication might react, in that circumstance. Further, given the fact that he was, according to his statement, off the drugs for a period of time, it may not be appropriate to reinstate him on the medication at the same dosage as previously prescribed without a doctor's direction.

Nurse Roles testified that if an emergent situation were presented, the protocol would be to follow up immediately with a doctor as to the continuation of medication. Nurse Roles determined there was no emergent situation in this particular circumstance and an appointment was made for Kyle to see Dr. Sarah Matthews, on January 22nd, 2004 at EYOC.

Dr. Matthews, one of the psychiatrists who attended the Edmonton Young Offenders Centre regularly to deal with young people testified that it is routine practice for a nurse to have a doctor

see a young person if it is deemed necessary, a few days after admission to the Young Offenders Centre. She stated that if there is a serious concern because of the way the young person is presenting when admitted, it is possible for the nurse to contact the doctor right away. If the young person is clearly psychotic or there is something not right with him, the staff would either get a hold of her or Dr. Mejia to see the young person on an emergency basis. She was in agreement with the nurse's decision not to continue the medication for Kyle, given his indication that he had not been on his medication for two weeks prior to his arrest. In her view, that was proper for the nurse to do in the circumstances. It would not have been proper for her to have continued his medication, indeed she notes that she would not necessarily have prescribed him the same medication without doing a further assessment in any event.

Nurse Roles concluded that he presented as stable and needed no monitoring in his cell. She testified that she spent 20 minutes to half an hour with him at Admission and Discharge at EYOC and saw no red flags or any reason for concern. As far as she was concerned, he was suitable for regular housing in EYOC.

Nurse Roles further advised that she was never made aware of the confrontation between Mr. Young and Officer Simmons that occurred at the Law Courts on January 20th, 2004. She opined that had this been brought to her attention, she may have referred him to a psychologist for further evaluation.

After Young had been released from Youth Custody on September 11th, 2003 he returned to live with his mother. While in custody prior to September 11th, 2003, Kyle had been prescribed and taking Tetracyclin for his acne, Resperdal, and Clonidine. Upon his release a notice was issued by the Health Care Unit at the EYOC, advising his parents/guardians of what had been prescribed for him and the dosage to be taken and how to arrange for a prescription for the medication to be filled at Mrs. Young's pharmacy. There is no record at EYOC of any request made with respect to filling the prescription for Kyle as directed in the release information. Nor is there any record of Dr. Arnold issuing any prescription for the medication or similar medication prior to October 6th, 2003. It is clear, that when Kyle was released from EYOC on September 11th, 2003, he was not released with any of the medication that had been prescribed. Despite those facts, Mrs. Young testified that as a result of Kyle seeming to be overly groggy in the mornings on the medication prescribed, she took him to see her family doctor on October 6th, 2003. Dr. Arnold directed that the two 2 mg Resperdal pills to be taken in the p.m. should be reduced to one pill. In Dr. Arnold's notes he indicates that as of October 6th, Kyle was to take 1 mg of Resperdal at 8:00 a.m. for one month and the 9:00 p.m. Resperdal was reduced from 2 mg to 1 mg.

There is no evidence that anyone prescribed medication for Kyle between September 11th and October 6th, so it is difficult to understand how Kyle, according to Mrs. Young, could complain of being groggy when it does not appear that he had any medication to take between September 11th and October 6th.

Mrs. Young described Kyle generally as being a difficult child from as early as six or seven years of age. She noted being contacted for the first time by police when Kyle was only seven years old, although she did not elaborate on the nature of that contact.

She further testified that at a very young age, he had shown signs of ADHD, he had a low level of alertness, trouble learning at school, a high level of distractibility, difficulty focusing on repetitive tasks, difficulty organizing tasks, he often lost things, he was forgetful in his daily activities, he was impulsive, he never seemed to think before he carried out an action, he acted with no forethought and without considering consequences, and he was generally fidgety. She stated that he did not exhibit all of these characteristics when he was on his medication.

Mrs. Young also testified that when Kyle was about eleven years of age, he was first placed into a group home, and from that point in time on he spent most of his time in foster care. While in care, it was her understanding that he had trouble in every one of his foster placements, he was aggressive towards others and he would often run away.

Mrs. Young testified that when Kyle was taking his medication, he wasn't really any different than any other young person his age. Despite that, she testified that he was a highly unpredictable individual.

Mrs. Young testified that she believed he was taking his medication prior to his arrest on January 19th and that she specifically remembers reminding him on the morning of January 19th before he left the house, to take his medication and that he in fact did so. She acknowledged that Kyle had a history of difficulty in complying with respect to taking his medication and that she did not actually see him take his medication all the time, but she estimated that she saw him take pills every evening and three out of four mornings.

The Resperdal prescription had been refilled on December 4th according to the pharmacy report at which time a quantity of forty eight 1 mg pills were issued. This was sufficient, according to the pharmacy report, to provide him with 12 daily dosages with respect to this drug. At the time of his death, there were 13 Resperdal pills remaining in the pill bottle in which they were kept. Mrs. Young testified that she would usually wait until there were only 2 or 3 pills left and then she would get a refill.

Before Kyle left the Young Offenders Center in September, 2003, he was taking one 1 mg pill of Resperdal in the a.m. and two 2 mg Resperdal pills in the p.m. as well as .1 mg of Clonodine in the p.m. Resperdal had been prescribed for him previously by Dr. Matthews on his discharge from Alberta Hospital in December of 2002 and Clonodine had been subsequently prescribed by Dr. Mejia and continued by Dr. Matthews.

Resperdal is an anti-psychotic medication which when given in low dosage is used to improve cognitive flexibility and diminish anger and temper. When he was discharged from Alberta Hospital in December of 2002, he was on a 1 mg dose of Resperdal twice daily. This was designed to improve frontal lobe function and help settle his anger and volatility. When he left the Edmonton Young Offenders Center in September, 2003, it would appear that the dosage of Resperdal had been increased substantially as he was taking 5 mg per day as opposed to 2 mg.

It is difficult to determine exactly what dosage of medication Kyle was supposed to be on. On October 6th, it appears that Dr. Arnold reduced his dosage of Resperdal from 5 mg per day to 2 mg or at the most 3 mg per day. Despite that, on October 7th, the day after the appointment with Dr. Arnold and the apparent variation of his dosage as shown by his notes, a prescription for 150 1 mg pills of Resperdal was filled, which according to the pharmacy summary was sufficient dosage for 30 days. That would assume that Kyle was still taking 5 mg of Resperdal per day. That would seem unusual given the testimony of Mrs. Young that he had seemed overly groggy in the mornings when he was on that dosage and that had prompted Dr. Arnold to change the dosage.

On November 12th, Dr. Arnold's notes include a prescription renewing the medication as specified in the nurse's medication notes of September 11th, 2003 issued upon his discharge from Edmonton Young Offenders Center. Whether that meant that he was to abide by the nurse's note directions as amended by him on October 6th, or not is impossible to determine. On November 13th, 2003, a prescription or renewal for 60 Resperdal was filled, which indicated a dosage for 15 days. The dosage for Resperdal on October 7th would indicate 5 mg per day for 30 days, while the dosage of November 13th for Resperdal would indicate 4 mg of per day for 15 days. There seems to be no rhyme nor reason why at this point in time he would be taking 4 mg

of Resperdal. Previously he had taken 5 mg or 2 or 3 mg per day. The doctor's notes of November 12th, 2003 do not indicate why the change. Indeed the Resperdal pill bottle for the November 13th prescription directed four 1 mg pills of Resperdal to be taken daily, two in the a.m. and two in the p.m. On December 4th the prescription was filled for 48 Resperdal pills which was the adequate dosage for 12 days. Again, this would be on the basis of 4 pills per day, the same as the prescription indicated as issued on November 13th, 2003. If the pills were taken as directed, Kyle would have been out of the Resperdal pills by December 16th, 2003. In fact, there were still 13 Resperdal pills in the bottle at the time of his death. That would seem to indicate that the Resperdal was not being taken as directed. Even if he was only taking two pills per day, one in the a.m. and one in the p.m., he would have been out of Resperdal by the end of December, 2003, given that he only received 48 pills on December 4th.

Mrs. Young's assertion that he had been taking his pills diligently and that she had seen him take most of the pills is in my view mistaken and an optimistic assumption on her part. She was of the view that he had been taking the medication not because she saw him take it, but because she perceived his behaviour and conduct to be consistent with his conduct and behaviour as she believed was demonstrated when he was on his medication. That is, she asserted that his behaviour was relatively normal, when he was taking his pills.

It is clear however that things were somewhat different in December, as by her testimony he had terminated his scholastic efforts, he was not involved in any meaningful daytime activities, he had not been successful in looking for a job, he was associating with friends that were older and she felt were a negative influence, and she suspected that he was using marijuana. According to Court Liaison Officer Visser's notes of January 21st, 2004, Mrs. Young described Kyle on that date as being disrespectful and rude and that she did not feel mentally or emotionally strong enough to continue to parent him and that she did not want him to return to her home after he was released. She testified before the Inquiry that she did recall such a discussion but felt that it was at an earlier time, perhaps when he was in custody in August and September of 2003. She did acknowledge that her memory is not very good and certainly throughout her testimony, she was unsure about many things.

I have no reason to doubt that Mr. Visser had such a conversation with her and am satisfied that the comments he attributes to her were in fact her sentiments and views as expressed to him on January 21st, 2004. Mr. Visser is a Court Liaison Officer who was charged with preparing a conditional community supervision post-suspension report for court purposes, with respect to an alleged violation of a deferred custody and supervision order that had bound Kyle since September 23rd, 2003. There is no suggestion in the evidence that he had any prior contact or discussions with Mrs. Young, and that combined with the fact that had the duty to prepare this report satisfies me that he did speak with her on that date and she did make those comments to him.

Mrs. Young's description of her son as given to Mr. Visser on January 21st, is not consistent with her assertion that he must have been taking his medication because his conduct was consistent with such a fact. The conduct she describes is more consistent with her description of him when he is not taking meds than when he was. Further, if Mrs. Young was cognizant of his actually taking his pills on a day to day basis, she would have also, I believe, been cognizant of the fact that she would have had to renew the pills in late December. She testified that on January 19th he took his last Clonodine and that she was going to renew the prescription for him. That would indicate that he was not taking his pills regularly because on November 12th, he was prescribed 30 Clonodine pills which was a 30 day dosage and there is no indication of any refill of that prescription before his death. That meant that the 30 Clonodine pills had been taken over a period of 2 ½ months as opposed to the 30 days as the dosage contemplated.

I have no confidence whatsoever in Mrs. Young's testimony with respect matter whether or not

Kyle was taking his pills as prescribed, up to and including January 19th, 2004. She is clearly, in my view, mistaken in her assertions in that regard.

Kyle indicated to Nurse Roles that he had not taken his pills for two weeks and that seems to be consistent with the evidence before the Inquiry as to prescriptions and refills. Whether prior to that time he had been regularly taking the pills is questionable, given that if he had been taking the Clonodine daily as required, then he would have been out of Clonodine by the 11th day of December and he would have been out of Resperdal by the 16th day of December.

Historically, Kyle had acknowledged on a number of occasions he either failed or refused to take the prescribed medication. In October of 2001, he advised the nurse at EYOC that he had been prescribed Ritalin and Resperdal, but he had not taken them for some weeks and was sporadic in taking them before that. In November of 2002 when he was again admitted to EYOC he advised the nurse that he had refused to take meds for the past year. He also advised Dr. Matthews upon admission to Alberta Hospital on November 19th, 2002 that he had not been taking his medication prior to his admission. In February of 2003, he indicated to staff at EYOC that he had taken medication since his release in December of 2002. When he was admitted to EYOC on May 8th, 2003, he told the nurse he ran out of the meds he had been released on, and on his admission to EYOC on May 31st, he advised he wasn't on medication.

Accordingly, given all of the evidence, and despite Mrs. Young's assertions which I believe simply to be mistaken, it is, in my view, highly probable that when Kyle Young advised Nurse Roles that he had not taken medications for two weeks, that was an accurate statement. It is also, I believe, highly probable that even prior to that two week time frame, he had not taken his medication on a regular basis as prescribed.

b. Effects of Medication or Lack of Medication on Kyle Young's Behaviour

Mrs. Young testified that Kyle was diagnosed with Attention Deficit Disorder (ADD) at 6 or 7 years of age and that in her words, he has always been on Resperdal. He was also prescribed Ritalin for a while and that was later changed to Clonidine, as she recalls it.

Dr. Sarah Matthews holds a fellowship in psychiatry with the Royal College of Physicians and Surgeons of Alberta. She has practiced psychiatry privately since 1982 and has been a consulting psychiatrist at a number of institutions throughout Alberta and for many years has looked after the in-patient out-patient adolescent program at Glenrose Hospital. She has practiced in mental health clinics in rural areas, from Hinton to Drumheller and worked for a year and a half at Alberta Hospital with the Adolescent Forensic Program. For the past four years she has been attending Edmonton Young Offenders Center and looking after young people therein and she has specialized in diagnosis and treatment of children, youths and their families with special interests in psychotic illness, substance abuse disorder and mood disorders. Dr. Matthews' contact with Kyle Young was in an institutional setting, and she did not ever see him on a private basis. She attended him in Alberta Hospital and in the Edmonton Young Offenders Centre. The first time she came in contact with Kyle was at the Edmonton Young Offenders Centre on November 18th, 2002. At that time he was not taking any medication. On November 19th he was admitted at her direction to Alberta Hospital for an assessment as she thought that he was in need of some psychiatric intervention. On intake he was described by Dr. Matthews as follows:

> At the time of admission, Kyle presented as a thin 15 year old looking his stated age, eye contact was adequate. He was hyperactive, impulsive, and swore frequently throughout his conversation. No vocal or motor ticks were apparent. He was generally co-operative and spontaneous. There was an aura of sadness with intermittent tearfulness and super-

> imposed anger at the world. His self-esteem seemed quite low. He had poor focus and concentration with mild pressure of speech. There is no psychotic thought processes. Kyle had some insight and expressed some motivation to change if only to avoid further problems. He admitted that he was often despondent about his life circumstances and at times felt life was not worth going on. Admission diagnosis included conduct disorder, substance abuse and dysthymia.

Once admitted he was given Dexedrine, Risperidone, and Lorazepam. During his stay in hospital, Dr. Matthews described his conduct as follows:

> Kyle clearly had difficulties with emotional control. He tended to view the world as an angry, hurtful proposition and frequently misinterpreted others' behaviour and intent as being aggressive, critical, or rejecting. He tended to project blame onto others without accepting any personal responsibility. He became easily overwhelmed and tearful. When frustrated, he either expressed anger, or withdrew and stopped trying. When Kyle was settled and in control, he became more able to communicate co-operatively. At such times, he was able to recognize some of his own contribution to his problems, but remained very ambivalent regarding the need for treatment or change.
>
> During his time in hospital, he engaged in criminal talk. He required several periods of time out for aggressive behaviour. He received 24 hour dorm confinement for smuggling cigarettes and a lighter onto the unit and smoking in his bedroom.

Dr. Matthew's diagnosis on discharge, based upon DSM-IV was:

> I. Conduct disorder
> Substance abuse
> Mood disorder NOS
>
> II. Anti-social personality traits
>
> III. Nil
>
> IV. Incarceration, rejection by family, nature of current charges
>
> V. GAF Admission: 50
> GAF on discharge: 50

She considered that his functioning was no better when he left Alberta Hospital than when he was admitted. He was a very troubled young man who was very volatile, impulsive and unpredictable.

At discharge he was prescribed Resperdal to address his anger and temper, Citalopram, an anti-depressant to assist in improving his mood, Quatiapine to help him settle and sleep at night and Dextroanphetamine to assist in improving his attention.

Dr. Matthews concluded that Kyle was going to continue to be in difficulty and need some sort of assistance. His problems were not going to resolve spontaneously. Dr. Matthews saw Kyle again on March 5th and 6th, at EYOC, March 14th at EYOC, April 14th at EYOC and September 3rd at EYOC, all in 2003. Despite the medication prescribed, things did not seem to change for Kyle. Dr. Matthews concluded that the medication did not have any significant impact on Kyle's functioning.

Although Dr. Matthews recognized that there were elements of ADHD, ADD and ODD, in Kyle's

emotional and psychiatric makeup, these were not his primary problems, according to her diagnosis. In her view, his primary difficulty was his emotional volatility and his impulsivity in that he lived in the immediate world. If he didn't like a decision you made with respect to him, he wouldn't co-operate. If he wanted something which he thought he could get by co-operating, he would co-operate.

Dr. Matthews testified that when she saw him in September of 2003, Kyle's problems hadn't really changed and he was increasingly in difficulty in the community with respect to substance abuse and delinquent behaviour. She testified that she felt her diagnosis in December of 2002 was still a valid assessment of his condition and problems as at September, 2003.

Dr. Matthews also noted that even when he was supposedly on his medication, he acted out in a violent fashion. In March, 2003 while supposedly on medication, he had gotten into a fight with a peer at EYOC. On April 10th, 2003, there had been an incident with a CAPS officer, again, while Kyle was supposedly on medication. In August, 2003, while in Alberta Hospital for a Court ordered psychiatric assessment by Dr. Mejia, the hospital records described him as rude to staff and threatening at times to peers and he apparently got into two physical altercations with a co-patient. None of these incidents appear to surprise Dr. Matthews, given her conclusion that the medication was not of significant advantage in assisting Kyle with decision making and interactions with other people. In hindsight, she concluded that had she seen Kyle on January 22nd, 2004, she would likely have discussed with him whether the medications should or would continue. Dr. Matthews reiterated throughout her testimony that Kyle's major problem was his emotional volatility, impulsivity and unpredictability.

Dr. Matthews was also of the view, - (although she noted that she felt he was usually not taking his medication, except when he was in EYOC), that if he had been on medication up until his arrest, missing only a few days of meds wouldn't have made any difference. It would take some time before the reservoir of medication in one's system would be used up, so that if the medication was in his system at the time of his arrest, and if it was serving to reduce his volatile and impulsive behaviour, which she doubted, then it would have continued to do so.

Dr. Matthews does express the opinion that had he not been on medication when arrested and then put on Resperdal upon admittance, that it is likely, that it would have taken ten days before the medication would have had a therapeutic affect, if any, on Mr. Young.

Dr. Matthews was not surprised when advised that Kyle was co-operative when he was arrested on January 19th, 2004, that he didn't misbehave when confined to his cell, and that he exhibited no behavioral problems when first taken to Court on January 20th. Neither did it surprise her that he got into a confrontation with the CAPS officer on January 20th, or that he had been physically aggressive in April of 2003 against three much larger CAPS officers. He would not, according to Dr. Matthews, take into consideration the fact that he was much smaller than the officers, he would act in the immediate moment.

Neither did it surprise Dr. Matthews that he was not upset upon being placed in the ZAMA unit and required to wear baby dolls. Again, she reiterated that he lived in the immediate moment and was unpredictable. One day he would accept a certain decision and the next day he would not. Something that triggered him one day, wouldn't trigger him the next.

c. Conclusions as to effect of presence or absence of medication on Kyle Young's behaviour on January 22nd, 2004

I have concluded, that the probability is very high that Kyle Young was not taking his medications

as prescribed and as he advised for at least two weeks prior to his arrest on January 19th, 2004. It is also highly probable that even prior to that date, his adherence to his medication scheduled was not consistent. It is also my view that in any event of that circumstance, given evidence of Kyle's previous aggressive behaviour against peers, co-patients, staff and CAPS officers, even while supposedly taking his medications, and given the assessment and testimony of Dr. Matthews, that even if Kyle had been placed on medications immediately upon being arrested and admitted to EYOC, it would not have made any difference in terms of his conduct. Putting him back on his meds for a couple of days would not, given the testimony of Dr. Matthews, have made any difference, and in any event, it is Dr. Matthew's view, which I believe to be consistent with past experience with Kyle, that the medication did not offer him any real therapeutic value insofar as reducing his volatility, impulsivity and unpredictability.

If Kyle had actually been taking his medication as at the time of his arrest, not taking his medication for a couple of days prior to this instance, would not have made any difference given that there would have been a reservoir of the medication in his system. If that were the case, then Kyle's volatility exhibited on the January 20th assault on the CAPS officer and his volatility exhibited on January 22nd as described aforesaid, simply support Dr. Matthew's assessment that the medications provided no therapeutic value.

It is my conclusion that the evidence before this Inquiry, other than in a purely speculative sense, does not demonstrate any causal relationship between Kyle's death and the fact that he was not provided with prescribed medication, from the time of his arrest until the time of the incident leading to his death.

13. Pre-incident treatment of Kyle Young by EYOC Personnel and Courthouse Security as a factor leading to the incident of January 22nd, 2004

It is asserted by the Young family through counsel that Kyle Young was mistreated by personnel at EYOC and the Edmonton Law Courts and the youth criminal justice system in general, and that this mistreatment was a "significant contributing factor" leading to the incident of January 22nd, 2004.

Counsel asserts that Mr. Young was mistreated in a number of ways and that this mistreatment provided a foundation for his outburst on January 22nd, 2004 which ultimately led to his removal from his cell. Factors referred to by counsel are summarized as follows:

- not being given his medication on January 19th, 2004 upon arrest and admission to EYOC
- prior altercations with courthouse security personnel
- failure of courthouse security to comply with and follow policy with respect to the complaint of Kyle Young that he had been assaulted by a security officer at the courthouse on April 10th, 2003
- failure to preserve the video tape of the alleged incident of April 10th, 2003
- being placed in the ZAMA unit at EYOC as a result of his assaultive behaviour on January 20th, 2004 without a hearing or independent review
- the conditions under which he was housed in the ZAMA and subsequently the Wabasca unit at EYOC
- uncomfortable rides in the prison van from EYOC to the Courts and then not having enough food on January 22nd, 2004

With respect, there is no evidence before this Inquiry so as to allow me to conclude that any of the specific factual circumstances mentioned above served directly to cause or increase any

animosity he may have held against EYOC or Court Security personnel. He exhibited no anger or unhappiness or ill-feeling with respect to not receiving any medication upon his arrest and admission to EYOC. Indeed he indicated he had not taken medication for two weeks preceding his admission and he did not request that he be given any medication.

There is no evidence that the authorities' failure to investigate further his complaint of assault in April of 2003 resulted in any specific increase in animosity that he may have held against Court or EYOC security or the youth criminal justice system in general. He made no complaint, and the documentation relevant to the incident seemed to suggest that he had not decided what he wanted to do with respect to this alleged assault. Mr. Young did not verbalize anger at this failure, either at the time or later, and did not seek to have the matter followed through. That is not a reason for the investigation not to have been completed, however, the point is that there is no evidence suggesting that he was angered or felt mistreated by this failure.

Neither is there any evidence that shows any manifestation of anger for being placed upon the ZAMA unit after his assaultive behaviour of January 20th, 2004. Although it would appear that his confinement to the ZAMA unit was disciplinary in nature, it is clear from the testimony of Kevin Joseph Keiser, Program Director at EYOC that at the disciplinary hearing held on January 21st, 2004, at EYOC, Mr. Young accepted full responsibility for his conduct on January 20th and he described Mr. Young as being very receptive, open and reasonable, and that he displayed no demeanor issues, nor was he agitated at all.

While on the Zama unit, despite being clothed in baby doll protective clothing, he displayed no signs of animosity or anger or agitation, such that would demonstrate that he felt that he was being mistreated at the time. Nor did he verbalize any such feelings to any of the EYOC personnel at the time, or later. Likewise, when transferred to the Wabasca unit on January 21st after the discipline hearing, he did not display any signs of animosity, anger or agitation, but was accepting of his designation.

It is only reasonable to conclude that despite the spartan conditions and extreme limitations imposed upon persons held in the Zama or Wabasca units, Mr. Young understood why he was there and was accepting of the same.

Whether Mr. Young ought to have had legal counsel to assist him at the discipline hearing, or whether he ought to have had a hearing with the benefit of legal counsel before it was determined that he would be placed on the Zama unit are factors for consideration in terms of prisoner's rights, however there is no evidence that the failure of Mr. Young to have the benefit of those rights or procedures, manifested in Mr. Young any feelings of animosity or anger against EYOC, court security personnel or the youth criminal justice system.

There is no evidence of any unusual or remarkable conduct on the part of Kyle Young on the morning of January 22nd, 2004. He exhibited no signs of agitation or anger while at EYOC waiting for transport to the courthouse and there was no indication of any problems with him during transport or at the courthouse until he began acting out just prior to his removal from his cell. His agitation appears to have been centred on when he was going to go back to EYOC and when he was going to be fed. By that time he had been at the courthouse for approximately 3 hours and had not had anything to eat since approximately 7:30 that morning. Given his assertions and desire to eat, one can certainly assume that at that point in time in the morning, he was hungry. He had not however, been mistreated in the sense that he had been deprived or denied food. No one had been fed at that time and lunch had not even arrived at the courthouse for prisoners. The anger he exhibited at that time was the manifestation of his volatility and unpredictability. He lived, as Dr. Matthews says and the evidence would support, in the moment and that is how he chose to react in those circumstances at that time. Young's conduct in his cell that morning, had nothing to do directly with any perceived mistreatment. It is entirely reasonable

to conclude that Kyle Young likely had animosity towards EYOC personnel and court security personnel and the youth justice system in a general sense. That animosity was part of his makeup, his background and his life experience, given his ongoing contact with the youth criminal justice system, arising from his anti-social behaviour. His outbursts on January 20th involving Officer Simmons and on January 22nd which led to the removal from his cell, were shaped by his deep-seated, anti-social behaviour, his volatility and his unpredictability. On those days, he chose to act as he did, not because he perceived he had been mistreated previously, but because at that time and place and in that circumstance and in that moment, it suited his impulsivity.

There is no evidence before me of mistreatment of Kyle James Young, by EYOC or Court Security personnel, prior to his arrest on January 19th or subsequent thereto. Neither is there any evidence presented of any growing animosity on his part against EYOC officials or Court Security officials as a result of what he perceived to be mistreatment. There is, so far as the evidence discloses, no correlation between his acting out and outbursts on January 20th and January 22nd, 2004 and his previous interaction with EYOC personnel or Court Security officers. His outbursts on those days, were a consequence of his impulsivity and unpredictability, not a consequence of how he had been treated by the youth criminal justice system in the past.

C. Conclusions as to Circumstances Leading to Failure of Elevator Hallway Door and Fall of Kyle James Young into Elevator Hoistway

The testimony of the three guards, Tomaino, Chambers and Fayad, the testimony of the youth, L.J., who was present in the holding cells at the time of the subject incident, the physical evidence, the relevant documentary evidence, the evidence relating to the load testing of the subject elevator door, and the expert opinion evidence provided, cumulatively leads me to the following conclusions as to how Kyle James Young fell into the subject elevator hoistway to his death and the circumstances that immediately preceded that happening.

On January 22nd at 11:11:57, Kyle James Young was removed from his holding cell by Officers Tomaino and Fayad as a consequence of the disturbance he had created as described by the testimony of the guards and the youth L.J. He was removed, initially as part of an effort to get him to settle down. The intention of the guards was to move him to a location across from the subject elevator, thereby separating him from the cell area where other youth prisoners were being held so as to allow them to try and reason with him and thereby calm him down. Once out of his cell he continued yelling, and resisted the guards when they began to move him down the corridor to the area in front of the elevator. He was at all times, while in his cell, and when removed from his cell, in high profile restraints which include shackles on each ankle, his hands cuffed in front of his body and the cuffs connected to the ankle shackles by a chain. This had the result of restricting his hands from moving above his waist. (A photo of the actual high profile restraints used on Kyle are shown in photo 136, Exhibit 21, which is attached hereto as **Appendix 28**)

There is no evidence before the Inquiry that shows that he was mistreated or that inappropriate force was used upon him to transfer him from his cell area down the corridor to the area in front of the elevator.

Once in the area across from the elevator door, he was placed face first against the wall near the exit door, which was the door that allowed the security guards and other personnel entry to the stairway and access to other floors, (See area marked 27231 in **Appendix 1**). Photograph 1, Exhibit 45 attached hereto as **Appendix 29** shows the exit door. Photograph 2 in Exhibit 45 attached hereto as **Appendix 30** shows the elevator door across from the exit door.

Mr. Young was initially under the control of Officers Tomaino and Fayad at this location. Officer Fayad stepped back from actual control and he was left in the hands of Officer Tomaino. He continued to struggle and verbalize and Officer Chambers stepped in and took control of Mr. Young while Officer Tomaino returned to the security work desk to look in the Criminal Code and determine what charge could be laid against Mr. Young for threats that he was allegedly making at the time, against the officers and their families. Once Officer Chambers took control of Mr. Young, put him down on his knees and continued to have him face the wall. Mr. Young continued to struggle and make threats towards the guards and their families and it was decided that he would be transferred downstairs to a holding cell where he would not disturb anyone else and where he could be watched on a continual basis. Officer Tomaino called for the elevator to come and pick up Mr. Young and was advised that it was on its way. Officer Chambers understood that the elevator was being sent up and in anticipation of its arrival, raised Mr. Young to his feet and with his right hand on the back of Mr. Young's neck to control him, he directed and forced him across the hallway into a location whereby he was positioned face first into the right angle at which the trailing edge of the elevator door intersected with the left side of the elevator door frame or jamb. Photograph 2, Exhibit 45 attached hereto as **Appendix 30** shows the left side of the elevator door and the left door frame post-incident.

It can be reasoned that while positioned in this location by Officer Chambers, Mr. Young's right shoulder area, would have been in contact with the trailing edge (left edge) of the elevator door. Although Officer Chambers indicated that he was holding him only with his right hand on the back of Mr. Young's neck and his extended right arm, and that he was not exerting much lateral force pushing him into this described position, given that Mr. Young continued to struggle, some lateral force would have to have been exerted by Officer Chambers to keep Mr. Young in this position. That would mean that some force was being applied to the trailing or left edge of the elevator door as a consequence of Mr. Young being forced against that door coincidently with being forced into the position as described by Officer Chambers.

Officer Fayad was standing to the left of Officer Chambers as he held Mr. Young against the elevator door frame and the elevator door. He was positioned approximately two paces back from Mr. Young and his location would mean that he would be looking more at the left side and left area of Mr. Young's back as opposed to Officer Chambers, who would be looking at the full back of Mr. Young as he held him in that position. Mr. Young, according to the accepted evidence, continued to struggle, pushing back against Officer Chambers' control with his neck and his body, limited of course by his high profile shackles. Officer Fayad observed his continued struggling and although not called upon by Officer Chambers to assist, in the immediacy of the moment, he moved the two paces towards Mr. Young, placing his right forearm against the left shoulder and back area of Mr. Young and exerted force against him to stop his struggling. Although already positioned with his right shoulder against the trailing edge of the elevator door, Officer Fayad's act resulted in Mr. Young suddenly being pushed harder against the trailing (left) edge of the elevator door.

Unbeknownst to Officers Fayad and Chambers or to anyone else, the integrity of the elevator door, in particular the strength of the left side of the door to resist lateral force, had been compromised by the previous fracture of the gib or fire pin and the improper adjustment of the eccentric upthrust roller. In this condition, the trailing edge of the elevator door was susceptible to opening with the application of minimal dynamic energy and/or static force. The sudden application of minimal force resulting from Officer Fayad's placing of his right forearm against the left shoulder and back area of Mr. Young and pushing, was sufficient in combination with the minimal static force being generated against the door as Mr. Young was held there by Officer Chambers, to result in the hanger roller and ultimately the retainer flange jumping the roller track. Given that there was no trailing edge gib or fire pin, the elevator door opened at the trailing edge like a door on hinges. At the time the door suddenly opened as described, Officer Fayad would still have been exerting force against the back of Mr. Young which resulted in Mr. Young being

pushed into the hoistway through what post-incident investigation established was, at its fullest, a 14 inch opening between the left edge of the elevator door as it opened into the hoistway and the elevator hallway door frame.

Officer Fayad, given the direction of force he was applying to the back of Mr. Young, followed Mr. Young partly into the opening, however he was able somehow to catch himself before he too fell into the hoistway. There was some evidence that Officer Chambers may have grabbed Officer Fayad as he was moving into the hoistway, however it is not clear whether that was indeed the case.

Mr. Young was in high profile restraints and given his location at the time the force was applied to him, it would appear he had no ability or opportunity to grab onto anything to prevent his fall, whether it be a door jamb or one of the guards themselves. One can only speculate whether had he not been restrained, he could have done anything in the circumstances to resist entry into the hoistway. Officer Fayad was behind Mr. Young and not in restraints and almost went in the hoistway himself.

It is clear that the opening of the elevator door was a sudden and unexpected happening. It is also clear in my view for the reasons I have expressed, that this door opened on the trailing edge as a result of minimal force and/or energy being applied to it. The evidence does not support the suggestion that Mr. Young was thrown against the door or run against the door by the guards.

Given the minimal force I find was applied, it is my conclusion that had the integrity of the trailing edge of the elevator not been compromised by the absence of an intact fire or gib pin, and the non or mis-adjustment of the eccentric upthrust roller at the trailing edge, it is probable that this door would not have opened and this tragic incident would not have occurred.

It is clear on the evidence that the subject door complied with the 1975 Safety Code requirements as to the application of static force loads and indeed even the 1990 requirements if the trailing edge gib pin were in place, such compliance with the 1975 Safety Code was not enough however to prevent this incident. The code tests are administered in the center of the door and executed by the application of static loads. Mr. Bear makes it clear in his expert testimony that in his view, the application of pure static force is not likely in the real word, as failure usually occurs as a combination of static and impact or dynamic energy. The code testing as required for the subject door does not require strength testing in the corners of the door, or on the trailing and leading edge of the door. Had Mr. Young been pushed against the center of the subject door, given the force applied to him, it is probable that this incident would not have occurred.

D. Movement of Kyle Young – Post-entry into the Elevator and Cause of Death

a. Movement in Elevator Shaft

The elevator shaft that Kyle Young fell down is referred to as elevator #4, device ID #E812505 and is located in the Edmonton Law Courts Provincial Court side. The elevator has six stops/doors and opens into the following areas:

Level 4 west – holding facilities for courtroom #444/443
Level 3 west – holding facilities for courtroom #354/351
Level 2 west – holding facilities for courtroom #265/266
Level B1 – adult holding cells/ECR tunnel
Level B2 – young offenders sally port
Level B3 – mechanical room

Kyle Young entered the elevator shaft at Level 4.

Once Kyle Young entered the shaft, Officer Chambers described his body as rotating in a counterclockwise motion. His right shoulder seemed to be going forward and his left shoulder was turning back towards Officer Chambers as he observed him falling. Officer Fayad also recalls Kyle Young's body rotating upon entry into the shaft.

Both Chambers and Fayad also testified that Kyle Young's body appeared to hit something on the left hand side of the elevator shaft and then fall down the shaft into the darkness. They both heard a loud bang after he disappeared.

A post-incident examination of the shaft area located some hair and skin on a bolt which secured two pieces of one of the two rails located on the north and south shaft walls which rails guide the elevator's vertical motion. **Appendix 31** hereto, shows the guide rail to the left of the L4 elevator entrance, as one looks up from the top of the elevator car stopped near the L3 entrance. The location of the subject bolt on the guide rail is shown by a small black arrow on a white background in the bottom right hand area of the photograph. This is approximately 9 feet from the bottom sill of the L4 door mechanism. **Appendix 32** hereto shows photographs of the bolt head and the bolt head and nut portion of the subject bolt respectively, with hair showing on the top of the bolt in the latter photo. This is depicted more clearly in a close up photograph shown in **Appendix 33** hereto.

In his fall, Kyle Young sustained a laceration type injury to his left eyebrow area and the left rear crown of his head, both of which, according to the testimony of Dr. Dowling, the forensic pathologist who conducted the autopsy on Kyle Young's body, could be consistent with striking the subject bolt.

No DNA testing was undertaken with respect to the skin and hair sample found, however, I believe on balance this to be the skin and hair of the deceased. There is no other reasonable explanation, and it is located in the area where both Chambers and Fayad testified he came into contact with something, although they did not know what he hit or what part of his body hit it.

Constable Hughes of the Edmonton Police Service Crime Scene Examination Unit arrived at the Court House scene at 1336 hours and from the B3 location at the bottom of the elevator shaft, observed the body of Kyle Young wedged between the elevator car and the rail of the counterweight. The elevator car rails, as I indicated, are located on the north and south walls of the elevator shaft and the counterweight guidance rails are located on the west wall of the shaft. The body was hanging between the elevator and the west wall of the elevator shaft more or less in the southwest corner of the elevator shaft, he was hanging in between the elevator and the west wall of the elevator shaft and he was facing the southwest corner of the shaft. The majority of his body was hanging below the bottom of the elevator with his chest, shoulder and head area actually located between the elevator car and the west wall.

A metal bracket, connected to the west wall, the purpose of which is to in part hold the southern most counterweight guideline rail in place, protrudes into the hoistway past the actual rail leaving a separation of only inches between the end of the bracket and the edge of the elevator car as it goes up and down the shaft, **Appendices 34, 35 and 36**. This bracket prevented Kyle Young from slipping through the space between the west side of the elevator and the west wall of the elevator shaft; his neck lodged on the bracket and he died at this location.

In viewing the top of the elevator car from the second floor elevator opening, Constable Hughes observed a shoe on the top of the car and what appeared to be a broken window. At 1830 hours, with further investigation she observed that the top of the elevator car had a three tiered metal

light box located in the southwestern quadrant of the top of the car, **Appendix 37**.

The running shoe which had been observed by Constable Hughes was located a little bit to the right of the centre point of the top of the car; **Appendix 38**. The other running shoe was found on the floor of the mechanical room (B3) almost directly below where the deceased was found hanging.

b. Cause of Death of Kyle James Young

In conducting the formal autopsy of Kyle Young, Dr. Dowling made a number of findings with respect to the condition of his body and the cause of death. His findings include the following:

1. multiple external abrasions, bruises and small lacerations
2. several abrasions and bruises located over anterior and both lateral surfaces of neck and under surface of mandible
3. petechiae of right upper and lower eyelids
4. single petechiae over conjunctiva of right eye
5. superficial bruising within soft tissues over right side of neck
6. small amount of bruising with inferior end of omohyoid muscle
7. small amount of bruising adjacent to joint between left greater cornu and body of hyoid bone
8. hyoid bone and thyroid cartilage intact
9. scattered perural contusions
10. some bruising within para-aoreic soft tissues, with aorta intact
11. some bruising in soft tissues anterior to intervertebral discs between 2nd and 3rd and 4th lumbar vertebrae with intervertebral discs and verberal column in tact
12. petechiae of both legs below level of knees
13. handcuffs and ankle cuffs in place, with skin indentations beneath cuffs
14. no natural disease process identified to account for death
15. no ethanol or other intoxicating drugs present in post-mortem blood

Dr. Dowling determined that Kyle Young died as a result of hanging (ie. neck suspension from elevator shaft support bracket).

In his viva voce testimony, Dr. Dowling made the following comments:

> Yes. Basically, if you view the photograph and the other photographs, you will see that his neck has been compressed or there is pressure on his neck from this metal support, I guess that's the best word I can use for it, that is coming out of the wall.

and:

> Yes. And he is basically suspended by his neck on that object. What this does is it puts pressure on the neck and the blood vessels of the neck, such that it cuts off the blood supply to the brain.

Dr. Dowling stated that once sufficient pressure is put on the neck so as to compress the blood vessels, unconsciousness will occur within 6 to 10 seconds with irreversible damage to the brain, likely to begin within three minutes and become progressively worse. He opined that death could occur within 3 to 5 minutes or as long as 15 minutes, however, in any event of the time of death, irreversible brain damage will have occurred by 3 minutes. Dr. Dowling would not say if the flow of blood to Kyle Young had been fully cut off, however, it was clear to him that there was enough of a reduction to cause the brain to die. It was his view that even if Kyle had been rescued within

5 minutes of his neck suspension beginning that he would in any event have suffered irreversible brain damage. He was not able to comment on whether Kyle Young was conscious at the time he lodged on the bracket as there was no actual physical trauma to the brain, however, he stated that one may lose consciousness without physical injury so he could not give any meaningful statement as to whether Kyle was or was not conscious at the time he commenced hanging by the bracket.

Had Kyle Young been conscious when his neck lodged on the counterweight rail brace, even though he was in high profile restraints, it is in my view likely that if he had remained conscious, he could have extricated himself from that particular position. However, given that loss of consciousness can occur within 6 to 10 seconds of pressure being placed on the blood vessels in the neck, it is possible that even if conscious at the time he got caught up that he lost consciousness quickly thereafter before he could free himself. It is impossible to come to any conclusions on this point.

Dr. Dowling stated as well that all of Kyle Young's injuries have the appearance of having occurred at the same time, however he stated he could not tell absolutely whether they had happened within a few minutes or hours before the actual incident. There is no evidence of observable bodily injury to Kyle Young before he fell.

Dr. Dowling agreed that the right angle injury on Kyle Young's back could have been caused by his body striking the light fixture located on the top of the elevator car, **Appendices 38 and 39**.

In response to a question by the Court, Dr. Dowling asserted that had Kyle Young directly fallen and caught his neck on the bracket, the injury to his neck and head, I infer from his statement, would have been horrendous. It was clear to the doctor that something slowed his fall down, but whether it was hitting the top of the elevator, or simply going in between the elevator and the wall, he did not know.

It is my finding that given the damage to the light box on top of the elevator; its location in the southwest quadrant of the elevator; the location where Kyle Young ended up hanging in between the elevator and elevator shaft; the location of Kyle Young's running shoe found on top of the elevator; the right angle abrasion on Kyle Young's back which is consistent with a corner of the light fixture; and the fact that the direct trauma to his neck and jaw was not severe, that Kyle Young fell down the shaft onto the light fixture on top of the elevator car. He then either bounced off or rolled off the elevator and down in between the west wall of the elevator shaft and the elevator itself, where he was caught by the neck by the counterweight rail bracket that protruded out in the elevator shaft in which position he remained until he died as a consequence of hanging. Had he directly fallen between the elevator and the wall, it is not likely that his shoe would have remained on the elevator at the location where it was observed and found, nor would the light fixture have likely been broken as it was.

E. Policy and Procedures - Non-Compliance

The Public Security Safety Operations Branch Policies and Procedures Manual of Alberta Justice contains the policy directives and guidelines that have been developed by Alberta Justice for the guidance of all security personnel. Changes to that policy can only be made through the office of the Executive Director.

Mr. Mel Bertsch was the Director of Security Operations for the Northern Region and he testified that the policy manual is continually being changed and updated. The changes are forwarded to each location where a copy of the policy manual is located and someone at that location is

charged with removing the old policy and replacing it with the new one.

Mr. Bertsch did not know the extent to which the policy and procedure manual was actually used in the training of security recruits or whether each officer is given a copy of the policy manual. He advised that in the courthouse setting in Edmonton, there are thirteen copies available throughout the building, which can be accessed by security personnel at will.

Mr. Bertsch testified that there is no one specifically charged with ensuring that all the policy manuals located in various offices in courthouses throughout Alberta are actually up to date.

Emergency Standing Orders (ESO) are directives about what officers are to do in emergency situations. These would be kept in a separate binder from the policy manual, but in the same area of access. Standard Operating Procedures (SOP) are a spin-off of the main policies which are for specific procedures in a particular law court. SOPs would be kept in the same manual as the main policies, but they would be found on yellow paper.

Mr. Bertsch advised the Inquiry that security personnel were expected to follow and comply with policies set out in the procedure manual and that if a breach of policy occurred, the officer was subject to a warning, reprimand or even suspension.

1. Standard Operating Procedure (SOP) No.9.05.02 – August 12th, 2002

This SOP deals generally with escorting prisoners. Item 2 therein provides that:

> Court and Prisoner Security and police shall adhere to their own policies respecting escorts of offenders.

Item 4 provides:

> … . Offenders being escorted to Court shall be sent with a copy of the original Warrant of Committal and an Offender Profile. …

So far as I am able to determine from the evidence before this Inquiry, no Warrant of Committal or Offender Profile was provided to Officers Perrizzolo or Simmons when they picked up Kyle Young from EYOC on the morning of January 22nd, 2004. There is no evidence that would indicate that when they departed from the courthouse to EYOC to pick up Mr. Young and other prisoners, that Offender Profiles for their prisoners were in their possession, nor is there evidence that Offender Profiles were provide to them at EYOC. Neither officer was aware that Mr. Young suffered from an emotional or behaviour condition, although given the incident of January 20th in which they were both involved, both officers understood that he had been violent on that date and was a security risk**.**

The Movement Report, which would have been provided to Simmons and Perrizzolo at EYOC, simply indicates that Mr. Young is considered high profile. No other material or other documentation was provided to the officers.

The Offender Profile referred to in the aforementioned directive, is a reference to the COMIS report. The COMIS report identifies the date of birth, the admittance, the records, the incarcerations, classifications, movement and other information as it pertains to a specific prisoner. It may also provide information with respect to behaviour or anything else concerning a particular individual that staff should be cautioned about

Although the protection officers in charge of pick up and escorting of prisoners from EYOC have

access to COMIS, Officer Perrizzolo testified that on January 22nd, 2004, he did not see the COMIS report with respect to Kyle Young, nor were they provided with a copy of the COMIS report (offender profile) as contemplated by the policy directive. In this instance, the officers were aware of the incident of January 20th, 2004, however not aware of any specific behavioral difficulties or conditions that Kyle Young was subject to and had there been different officers picking up Kyle Young, it is reasonable to conclude that they may not have known about the incident on January 20th.

Neither am I able to determine whether the COMIS information (offender profile information) with respect to Kyle Young was up to date and included reference to the incident of January 20th, which would be important for escorting officers to know about.

Policy requires that the Warrant of Committal and an Offender Profile are to be sent with the prisoner being escorted. That did not occur on January 22nd, 2004 with respect to Mr. Young as he was transported from EYOC to the Law Courts. I am left with the impression that this procedure is generally not followed in the fullest sense. The escorting officers may be aware from other information or even having seen an Offender Profile as to the circumstances of individual prisoners they are escorting, however the policy requires that the Offender Profile accompany the prisoner. It is not full compliance with policy to simply know about the Offender Profile. It must accompany the prisoner.

2. Restraining Violent and/or Emotionally Disturbed Persons/Prisoners (Policy and Procedures Manual No.4.1.6)

In this regard, the policy manual states:

> Persons/prisoners who are potentially suicidal or have been segregated because of emotionally disturbed behaviour shall be restrained, if necessary, to prevent them from inflicting self-injury.

The procedure to be followed by a Provincial constable/security officer in a circumstance involving violent and/or emotional disturbed prisoners is:

> a. contact the sergeant/supervisor as soon as the subject displays emotional behaviour
> b. attempt to control the situation by reassuring the subject and opening up an avenue of conversation
> c. take measures available to avoid any injury until assistance arrives

In this case, Mr. Young had been designated as violent, given the incident of January 20th, 2004. This resulted in his categorization as high profile and the resultant high profile restraints and his segregation from other prisoners at the courthouse.

It is clear that on January 22nd while in the cell, he did not become physically violent, but he was angry and upset and certainly creating a disturbance and refusing to stop. He was already in high profile restraints and separated from other prisoners, so no steps needed to be taken to protect him from himself or others. No contact was made with the supervisor once he began to act out and no serious attempt was made to calm him down while he was in his cell. Indeed his removal from his cell, which was intended to assist in calming him, caused an escalation in his emotional outburst.

It is arguable that this policy was not intended to cover this particular situation, however, given all the circumstances, following this policy would have been prudent. This directive seems generally to support the position that prisoners exhibiting violent or emotional behavior are not to be

removed from their cells, except in emergent situations without the security officer contacting the supervisor first.

On January 22nd, 2004 Kyle Young was removed from his cell in an effort to calm him down, and prevent the disturbance of other prisoners or the Court that was still in session. This was to be done by moving Kyle Young to a non-secure location near the elevator on the 4th floor and then have him face the wall while an officer or officers spoke to him to try and calm him down. This procedure is not authorized by policy, and if Mr. Young was violent or emotional, it appears this action was contrary to the policy. If he did not fit in that particular policy, his removal appears to be something that was determined by the individual guards at the time and in the circumstances. This procedure seems to be a practice followed by some of the officers and apparently unbeknownst to senior officials. Since this incident, this practice has been, I understand, prohibited by Security Branch officials.

3. Separation of witnesses, inmates and/or staff Article 3.6.3

Article 3.6.3 of the Policy and Procedure Manual is entitled, Use of Force and Alleged Assaults. The policy states:

> All incidents of assaults or alleged assaults, committed by or allegedly committed by a staff member, prisoner or member of the public, shall be the subject of an internal investigation.

The standard section of the said policy provides that:

> Employees are authorized to use only sufficient force or restraint that is reasonable and necessary under the circumstances to subdue or control aggressive or otherwise difficult to manage prisoners, as well as members of the public. Excessive use of force constitutes assault and is subject to possible criminal charges and/or disciplinary action including dismissal.

The procedures under the said policy require that an employee shall:

> a. report immediately any incident requiring the use of force on a prisoner or the general public, regardless of whether it is believed the force used was reasonable and/or necessary under the circumstances.

The procedures also set out that the administrator officer/supervisor shall, among other things, upon being advised of an alleged assault or use of force on a prisoner or the general public:

> c. separate witnesses, inmates and/or staff members if it appears an assault or excess use of force has occurred.

In this case, the three CAPS officers were not separated after the incident, but put together in a room where they proceeded to make their notes and indeed, to some extent, collaborated on a summary provided in response to a direction given by their superior, Mr. Bertsch. No one appears to have considered whether this particular policy applied in these circumstances. It appears to have been treated initially, not as a use of force or possible assault situation, but rather as an incident covered by a different policy, particularly, 4.1.7, which required that all security operations staff directly involved in the incident would be required to attend a debriefing. Ironically, until the reports were prepared and completed by the officers involved in this particular case, it would not be possible to determine if this was a circumstance where the policy relating to

possible assault or excessive use of force was applicable. Certainly this was an incident where use of force on a prisoner was employed and that should have signaled the use of that policy until such time as it became clear that it was not applicable in the circumstances. By the time the officers completed their reports in circumstances where they were not separated, it would be too late to meaningfully implement that aspect of the policy.

It would have been preferable in the circumstances to implement the witness separation provision under the policy until the administrator/supervisor was in a position where he or she could clearly conclude that it was not an assault situation or an excessive use of force situation.

F. Protection Officer – Young Offender Training

Security personnel recruited for security operations are required to have a minimum of two years in a law enforcement related field which may include, Law Enforcement diploma, certificate, or experience with Brinks, military reserves, security firms, or anything that relates to law enforcement or security handling.

The trainees are required to have a Class 4 driver's license, first aid training and CPR certification. They must also have a medical, CPIC clearance and Motor Vehicle abstract. Fitness standards required to be met by recruits is the same as that of the Royal Canadian Mounted Police. If the recruit comes with the aforementioned qualifications, then they go through an interview process with a panel of sergeants and Human Resources people. Once brought on duty, they are supervised by a field training officer who scrutinizes them, assists in their training and provides assessments. Recruits brought to duty also do a three week initial training program. They are also taught emergency driving, are provided with some training in the law by legal counsel and sometimes even judges. They take courses on infectious diseases and are provided with forty hours of intervention model training.

New officers brought to duty are also provided with 20 hours of training in the use of firearms and are also taught the use of batons, O.C. pepper spray and handcuffs. They are put through a five day firearms training course which is the same as the Royal Canadian Mounted Police program.

The trainee works with a field supervisor and trainer for a number of months and this trainer will perform assessments with respect to the recruit's progress under his supervision. Annual performance reviews are done on each officer and if evidence is found that suggests further training in any particular area is required, it is given to the officer.

There is no special training with respect to the handling of youth prisoners as distinct from adult prisoners.

Mr. Bertsch testified that to his knowledge there is no jurisdiction in Canada that provides specific training with respect to the handling of prisoners in the Youth Criminal Justice system. In this regard, I note that the National Union of Correctional Officers and Youth Facility Workers working session report, Ottawa, September 22nd and 23rd, 2005 which may be found at www.nupge.ca/publications, makes specific reference to training with respect to handling of youth prisoners. It is of interest to note that Alberta appears not to be part of that National Union, or at least did not attend that session. It would appear that there are training programs with respect to handling of youth prisoners.

Commencing in October of 2005, the Department of Solicitor General and Public Security designed a full day course with the objective of providing some formal training specifically in the area of dealing with young offenders. The objectives of the program are set in the written argument submitted on behalf of the Solicitor General and Public Security Department which

specifically states:

1. to examine the Youth Criminal Justice Act and how it impacts the handling of young offenders
2. to consider the issue of suicides amongst young offenders
3. to examine some of the demographics of young offenders; and
4. to discuss mental health as it relates to diagnosis and DSMIV

The first course in that regard was offered to new recruits on October 6th, 2005.

PART II

Recommendations for the Prevention of Similar Deaths:

1. Introduction

Section 53(2) of the Fatality Inquiries Act RSA 2000 Ch.F-9, provides that a Fatality Inquiry Report:

> May contain recommendations as to the prevention of similar deaths.

There is no restriction in terms of the recommendations that I may make in this regard. The parameters of the recommendations are, I believe, defined by the purposes of the Fatality Inquiry. In ***Mercier v.Alberta (Alberta Attorney General)***, supra, the Court of Appeal essentially adopted the view that the Fatality Inquiry process serves the following purposes:

- to assist and reassure the public by exposing the circumstances of the death, thereby dulling speculation, making the public aware of the circumstances which put human life at risk
- to reassure the public that the authorities are taking appropriate measures to protect human life
- to ensure that the justice system operates properly because through the Fatality Inquiry, it will investigate and review the work of the medical examiner and scrutinize the role that other parts of the justice system have played.

Given that the scrutinization of the justice system is an incidental part of any Fatality Inquiry, recommendations that relate to improving the system, thereby hopefully creating an environment wherein it may be less likely that the circumstances leading to the death of a human being could occur, are within the broad purview of the Fatality Inquiry.

I am mindful of Kent, J.'s admonishment in ***Calgary (City) Police Service v. Alberta (Report of Inquiry into Death of Isaac Mercier***), 1998 A.J. No.1452, that the further the recommendations move from the facts which can be directly related to the death being investigated, the greater the risk that the judge conducting the Inquiry will exceed his or her jurisdiction. Nonetheless I am of the view that if the recommendations serve to improve that portion of the justice system under which the individual was controlled at the time of his or her death, then even though the recommendations are not directly related to the death of the individual, except in a peripheral manner, they nonetheless serve that purpose intended by the Fatality Inquiries Act, that is to reduce the risk of similar deaths.

Some of the recommendations I make hereunder are self-evident as to their intent and purpose and require no further elaboration given the facts and conclusions that I have reached aforesaid. Others require comment so as to give context to their intent and purpose.

2. Safety and Maintenance of Elevators

a. Government Response

Although the subject elevator hallway door complied with 1975 Safety Code strength requirements, those Code requirements did not address the circumstances that arose in this case. The trailing edge eccentric upthrust roller was not adjusted as at the time of the incident so as to serve it's intended purpose of restricting movement of the roller off the roller track and the trailing edge (fire) gib pin was fractured below the hex and thereby left the trailing edge lower corner of the subject hallway door without guidance or restriction of movement towards the hoistway. These findings raise issues relative to safety and maintenance requirements with respect to elevator hallway doors.

Since the tragic death of Kyle James Young on January 22nd, 2004 the Government of Alberta, through the Department of Municipal Affairs and Alberta Infrastructure, has taken a number of steps to address elevator safety in courthouse and correctional centres and also started the process of reviewing Safety Code requirements with respect to elevator operation and maintenance generally throughout the province. It is worthwhile to mention some of these steps as they provide some background and context for the recommendations that will be made in this regard.

Subsequent to the incident of January 22nd, 2004, Alberta Infrastructure engaged Bamborough and Associates Inc. to complete a risk analysis report relating to hoistway doors on all prisoner handling elevators that are the responsibility of Alberta Infrastructure. The report was issued on September 1st, 2004 and it provided a number of general recommendations for Infrastructure to improve elevator maintenance quality and reduce potential risk. The general suggestions made are:

- Contract with elevator companies to provide full maintenance on all the elevators. Presently, there are different types of contractual documents existing.
- Formalize auditing of elevator maintenance quality by engaging elevator consultants
- Improved communication between your staff and the elevator maintenance providers to ensure necessary work/repairs on the elevators that are purchased
- Improved documentation of work performed on elevators, including but not limited to, call backs
- Consider upgrades or repairs to the elevators that are above and beyond the maintenance agreement requirements
- Reduce the harsh use of the equipment (suspected only based on the review of call back records at certain times)

The report also identifies certain specific action items that the consultant suggests be undertaken by Alberta Infrastructure; these include:

- Survey all your elevators (not just prisoner handling elevators) to determine if hoistway door retainers exist. This will establish a database for future reference.
- Start a review of all your maintenance documents, determine your needs and consider upgrading all maintenance contracts to full maintenance status. We recommend you

utilize the services of an elevator consultant to work with your staff.

- Review the existing model of recording call backs on a site by site basis.
- Review policy to select the inspection supplier.
- Consider a formal program to audit the maintenance quality by utilizing an elevator consultant.
- Request proposals with budget pricing for maintenance providers to improve the safety of the hoistway doors and the overall safety of all prisoner handling elevator handling equipment relating to door operation. Although the existing equipment meets Code requirements, Infrastructure may wish to implement some of the suggested upgrades.

Of particular note, the report comments that:

> Log books should contain a record of all maintenance and repair activities including call backs. Quite often these on site log books are unreliable. …

Alberta Infrastructure also retained Vinspec Ltd. to do an inspection of the elevators at the Law Courts building in Edmonton and make recommendations relative to their safety and maintenance. This report, I believe, was issued to Infrastructure on the December 2nd, 2004. It recommended short term, the installation of supplemental upper and lower door retainers on the elevator hoistway doors in any elevator in the Law Courts complex that may be subjected to misuse or mechanical damage.

Long term, the suggestion made in the report is that a complete modernization of all elevators in the Law Courts, Edmonton should be considered.

As a result of the Bamborough report, Alberta Infrastructure and Transportation developed a prisoner handling elevator action plan, attached hereto as **Appendix 39**, with respect to prisoner handling elevators throughout Alberta.

Further, a Prisoner Elevator Review Committee made up of Property Management and Technical Services was established to review specific items identified in the prisoner handling elevator action plan. The terms of reference of this committee include:

1. establishing a process for ongoing maintenance audits including
   a. type of service
   b. frequency of service
   c. method of procuring services

2. reviewing the process for selecting in service safety inspection suppliers

3. reviewing existing maintenance contract documents to:
   a. identify concerns and inconsistencies
   b. draft new maintenance specifications
   c. establish guidelines for consistent use

4. review existing safety inspection documents to:
   a. identify concerns and inconsistencies
   b. draft elevator's safety inspection specifications
   c. establish guidelines for consistent use

The prisoner handling elevator action plan specifically identifies what recommendations have been made and who the recommendations are to be fulfilled by. Some of the recommendations

included in the action plan are:

1. Conduct a survey to gather detailed information to help determine potential upgrades

2. Install supplementary hoistway door retainers on the prisoner elevators at the Edmonton Law Courts

3. Establish a process for ongoing maintenance audits

4. Provide recommendations to senior management of Alberta Infrastructure and Transportation

5. Review results of survey that was completed December 23rd, 2004 to determine upgrades to consider

6. Provide recommendations and budget estimates to senior management

7. Review process for selecting the biennial in-service safety inspection supplier

8. Review the existing maintenance contract documents and procedures. Identify any concerns and inconsistencies

9. Draft new elevator maintenance specifications with guidelines for consistent use

10. Review existing biennial safety inspection documents. Identify any concerns and inconsistencies

11. Draft elevator safety inspection specifications with guidelines for consistent use.

Reference to the Alberta Infrastructure and Transportation Prisoner Handling Elevator Action Plan, will identify which of these matters has been embarked upon and/or completed. In particular, one of the recommendations of the action plan was the establishment of supplemental hoistway retainers on all prisoner elevators at Edmonton Law Courts. This recommendation was implemented and completed by December 30th, 2004. Further, a survey to gather information on potential upgrades and the condition of various components of elevator hoistway doors was completed by December 23rd, 2004 and a proposed budget was prepared with respect to upgrades that were recommended. Funding of approximately $300,000.00 was approved for the upgrades recommended in conjunction with the survey completed December 23rd, 2004 and as per the action plan, all upgrades for elevators outside the Edmonton Law Courts were to be completed by August 31st, 2006. **Appendix 40** attached hereto identifies both the estimated upgrade costs and the upgrades being contemplated.

Further, on January 3rd, the Deputy Minister of Municipal Affairs approved the establishment of a Task Force to Review the Safety Requirements for Elevators. The purpose of the task force is set out in the Terms of Reference document, which provides:

> To determine if regulatory and technical changes are required for passenger elevators operating in Alberta in light of the accident at the Law Courts building, January 22nd, 2004.

The stated objective of the task force is:

> Prepare a report with recommendations for the Minister, which is supported by the Elevator Technical Council and the Safety Codes Council.

The scope of the task force undertaking is stated as:

> Review existing codes and standards, as well as reports and information relative to the Law Courts building accident and draw conclusions as to:
>
> - Whether changes to codes and standards are necessary, and if so, explain how changes should be applied.

It is anticipated that a report with recommendations would be submitted to the Minister no longer than five months after the completion of this Inquiry.

b. Recommendations

Generally speaking, I adopt and repeat the recommendations made in the Bamborough and Associates report as outlined aforesaid and the recommendations included in the Alberta Infrastructure and Transportation Prisoner Handling Elevator Action Plan. More specifically, although they may overlap with the recommendations of the Bamborough report and the Prisoner Handling Elevator Action Plan, I recommend:

> **1. Require by regulation that all elevators be equipped with hoistway door retainers and the time frame over which they must be installed and depending upon an assessment as to the costs associated therewith, consider in appropriate circumstances, subsidization by government of the costs associated with such a retrospective fitting.**
>
> **2. Establish by regulation uniform maintenance specifications and requirements for all elevators.**
>
> **3. Establish by regulation or otherwise, a uniform maintenance checklist that identifies all steps to be undertaken by the maintenance provider which checklist must be completed and certified under the hand of the maintenance personnel providing the specified maintenance and require a copy of the checklist be retained with the maintenance log book for the subject elevator, as well as provide a copy of the completed certified checklist to the operator of the subject elevator.**
>
> **4. Establish by regulation or otherwise that there be entered into the elevator maintenance log book required to be kept for each elevator, a description of any and all maintenance activity related to the said elevator, whether it be repair of components, replacement of components or adjustment thereof or otherwise and that the said work be fully described, dated and certified under the hand of the individual providing the service.**
>
> **5. Establish by regulation or otherwise a uniform checklist for purposes of inspection and/or auditing of elevators as required by law, which checklist must be completed and certified under the hand of the inspector or auditor undertaking inspection or audit and that a copy of the completed and certified inspection or audit checklist be retained with the elevator maintenance log book for the subject elevator and that a copy of the said inspection or audit checklist completed and certified inspection or audit checklist be provided to the operator of the subject elevator.**

3. Extended Confinement in Holding Cell - Recommendations

On January 20th, 2004, Kyle James Young left the Court at 8:20 a.m. and returned with some other young offenders at 17:30 p.m. On January 22nd, 2004, Mr.Young had been confined in the cell at Admissions and Discharge at EYOC while he waited pickup by Provincial Protection Officers for transportation to the Law Courts. He was fed while waiting in the cell, then confined in the transport van when picked up at EYOC and then confined in a youth holding cell on the 4th floor of the Law Courts building. With the exception of his appearance in Court that morning, he was confined at the courthouse from approximately 8:30 a.m. until the time he was removed from his cell at approximately 11:12 a.m. which immediately preceded his fall.

He had nothing to eat after the breakfast which was provided to him in the holding cell at EYOC at approximately 7:30 a.m. Indeed, on January 22nd, 2004, one of the things he was complaining about was when he would receive lunch. The length of time he spent in confinement at the court house and the fact that he had nothing to eat since approximately 7:30 in the morning, I believe contributed to some extent to his outburst in his cell that ultimately led to his removal.

Accordingly, I make the following recommendations:

> **1. That except when the law requires the same, all appearances before the Court for youth prisoners be via courthouse video link.**
> I believe that as of July 4th, 2006, most Remand Centres throughout Alberta, including the Edmonton Young Offenders Centre, will have courthouse video link capabilities.
>
> **2. That all accused in custody who must attend court in person be provided with some mid-morning nourishment.**

4. Provincial Protection Officer Training re Young Offenders - Recommendations

Provincial Protection Officers receive no special training in the handling of young offenders in custody. The Department of Solicitor General and Public Security has developed a one day training program to, among other things, examine the principles of the Youth Criminal Justice Act and how it impacts the handling of young offenders.

Almost every legal system recognizes that children and adolescents differ from adults and in that context recognize that they should not be made accountable in the same way as adults.

Nicholas Balla, in his text ***Youth Criminal Justice***, Irwin Law, 2003 at p.2 thereof, made the following comment which I endorse fully and which I believe is relevant to the issue of officer training:

> … adolescence is a time of great change and development as parents, teachers and youths themselves know. Sometimes adolescents seem quite childish, while at other times they act like adults or at least want to be treated like adults. Adolescence is a period of growing self-awareness and increasing autonomy. It is a period of life when changing authority figures and testing limits become very important. Adolescence tend to want new challenges and excitement, to be more concerned about the immediate consequences, rather than with their long term well being. They are also more susceptible to peer pressure than adults. While adolescents are accumulating knowledge of the world around them, the often lack judgment and maturity. Frequently, they feel as thought they are “invulnerable”, and act in an impulsive and irresponsible fashion.

The Youth Criminal Justice Act recognizes that a youth is considered to be in a state of diminished responsibility, morally and intellectually. The system recognizes that adolescents often lack a fully developed adult sense of moral judgment and do not have the intellectual capacity to fully appreciate the consequence of their acts. The Youth Justice System also recognizes that because adolescents generally lack the judgment and knowledge to participate effectively in the court process and that they are more vulnerable in the process itself than adults. Therefore, a special system of justice with special rules was developed in part to address this vulnerability.

The vulnerabilities of the adolescent are no less significant when they are placed in a custodial environment. It is important that all individuals handling adolescents in a custodial setting, understand the vulnerability of youths and the characteristics of adolescents that are recognized in the Youth Criminal Justice System in Canada.

I make the following recommendation:

> **1. That the Department of the Solicitor General develop and implement a program of training for all Provincial Protection Officers handling young offenders in a custodial environment, which program would identify the differences between adolescents and adults and develop and provide strategies for the handling of young offenders in a custodial environment, recognizing their distinct and unique characteristics; and that time frames be fixed for ongoing training.**

5. Video Recording Cameras – Recommendations

In the youth holding cell area on the 4th floor of the Edmonton Law Courts, there are video cameras that record activities in all the cells, save for the plexi-glass cell. There are no video cameras recording in the area of the entrance to the prisoner elevator on the 4th floor. There is a camera focused on the elevator door area which transmits images of that area to the elevator operations pod in the basement of the courthouse. The camera does not record those images, but simply allows the operator in the pod to visualize what is happening at the elevator entrance so as to allow the operator to open and close the hoistway door when the elevator is being used for transportation.

There can be no doubt that it would have been in everyone's interest to have had a video recording of the events that occurred in the area of the elevator door on the 4th floor preceding Kyle James Young's fall into the elevator hoistway through the subject door. It is likely that such real evidence would have made the process of determining what happened in this tragic instance much more efficient.

It is in the interests of all individuals in custody, as well as all security personal controlling and handling such individuals, whether they be youth or adult prisoners and overall in the interest of the administration of justice that all aspects of the prisoner handling area in courthouses throughout the province, whether with respect to adult prisoners or youth prisoners, save for washroom areas, and areas set aside for consultation with legal counsel, be subject to video recording.

I recommend the following:

> **1. That recording cameras be installed throughout all prisoner holding areas in courthouses throughout the Province of Alberta, which cameras will record all aspects of the holding areas with the exception of the washroom areas and the**

areas set aside for legal consultation.

2. That notices be posted in all such holding areas advising of such recording.

3. That video records of any incident involving an assault or use of force or threat thereof in relation to any prisoner or prisoners and/or security officers or other members of staff shall be retained intact until their erasure is authorized in writing by the Executive Director of Security Operations Branch, which authorization shall identify the recording as the video record authorized to be erased and which authorization shall be retained by the Executive Director of Security Operations; and that all other recordings be preserved intact for not less than two weeks from the date on which they were recorded.

6. Use of High Profile Restraints - Recommendations

On January 22nd, 2004 as a consequence of his assault on a Provincial Protection Officer in the youth holding cell area on January 20th, Kyle James Young was placed in high profile restraints, that is, handcuffs and leg shackles connected by a chain in the front of his body. Given his high profile status, he was also on January 22nd, separated from other prisoners while in holding at the courthouse. This separation is done for the protection of the prisoner, as the high profile restraints not only significantly reduce the individual's ability to move and thereby restrict the individual's ability to act out physically against another individual, they also reduce their ability to protect themselves from others.

On January 22nd Mr. Young remained in the high profile restraints in his cell, even though no one else was in the cell with him. It appears to be common practice to leave those designated as high profile in their restraints even though they are alone and in their holding cell. One of the reasons for this practice, given the evidence at the Inquiry, is that it would require two officers to be available for purposes of removing and/or putting the high profile restraints on the individual. This seems however to pose more of an inconvenience to the protection officers than anything else.

Although I recognize that protection personnel must look equally to the safety of themselves and the prisoner and that each prisoner presents a different set of circumstances to consider, there is no reason for an individual to be left in full high-profile restraints when left in solitary in his cell for hours at a time because it may be more convenient in the circumstances. Except in circumstances where the prisoner represents a serious safety risk for even two trained security officers, a solitary prisoner left in his cell should not, I believe, be required to wear full high profile restraints while in the cell.

I recognize that each case must be looked at individually and that in one instance it may be appropriate to only remove the chain connecting the handcuffs and shackles, while in another both the handcuffs and chains may be removed. Nonetheless, I believe removal of the restraints in such circumstances must be at least considered by the security personnel and acted upon as the circumstances may dictate. Protection personnel should not start from the presumption that high profile restraints should remain in place, but rather from the position that they should not, unless serious safety issues would be presented by their removal in total or in part.

In the event the full restraints must be left on the prisoner, even while in solitary confinement, protection personnel should be regularly checking, not only that the restraints are secure, but also that the restraints are not too tight.

It was suggested during the course of the Inquiry that had Kyle James Young not been in high profile restraints at the time that he fell, he would have had some opportunity at least to prevent his own fall. I did not come to any conclusions with respect to that, although the fact that Officer Fayad who was behind him and had exerted the pressure upon him which led to the hoistway door opening, almost went through the entrance himself, would suggest that it is unlikely that had he only been in handcuffs and shackles he could have saved himself.

Given his designation as a high profile offender as a result of his assault of the protection officer two days earlier, keeping him in high profile restraints while outside of his cell, appears to be proper compliance with then existing policy and in any event appropriate in all the circumstances. It may nonetheless be said that in circumstances where the high profile restraints create a potential endangerment of the prisoner, specific steps must be taken by security to remove that danger either by changing the nature of the restraints or by some other method. For example, if the prisoner were required in high profile restraints to walk down a set of stairs, where, if the individual were to trip or fall they could not protect themselves as a consequence of the employment of the high profile restraints, security personnel would have to judge that circumstance and take steps to maintain the safety of the individual.

I make the following recommendation:

> **I recommend that the Department of the Solicitor General and Security Operations Branch review the issue of the "use of high profile restraints" and develop a more thorough policy as to when and under what circumstances such restraints should be used, having regard to the need for such restraints and the potential danger that they raise to the safety and well-being of the prisoner.**

7. Security Branch Policy and Procedures - Recommendations

Previously in this report, under the heading Policy and Procedure Non-Compliance, I commented upon three instances of apparent procedure irregularities that were demonstrated on the evidence presented to this Inquiry. I did not come to any conclusion as to whether the apparent irregularities, were causally related to the subject incident.

Dealing first with policy in general, it is clear from the testimony of Scott Yost, a training officer for recruits for Securities Branch, that he considered the policy and procedures thereof to be in a state of "disarray" and he recommended that the policies be "cleaned up".

Although Mr. Bertsch, the Director of Security Operations for the Northern Region, did not, in his testimony use such strong language, he did testify to the fact that there is no specific directive requiring that policy changes noted by memo be put into policy manuals, indeed he was not sure whether the policy manuals in court locations were up to date. Neither was he sure of the extent to which the policy and procedure manual was used in the training and orientation of new recruits. He was not aware of the policy requirement as to what information was to be provided to the protection officer when picking up prisoners from EYOC for transport to court, nor was he aware of the policy with respect to the paper work that youths were to be sent to court with, ie. an Offender Profile. Neither did he believe that his officers were aware of such policies. Mr. Bertsch also indicated that he was not aware of the fact that some of his officers were removing young offenders from their cells to calm them down.

Although the evidence with respect to the extent of the knowledge that the protection officers have with respect to policy and procedure is minimal, it would appear, given the comments by Officer Yost and Mr. Bertsch, and the circumstances present in this case, that there is reason to believe that the policies and procedures set out in the manual (Tab 10, Exhibit 1, Binder 1) are

not necessarily well known, or always applied.

Whether full compliance with the policies I have mentioned aforesaid by security personnel in this particular instance would have made any difference to the outcome of this matter is impossible to say, nonetheless, the better administration of justice and the hope that full and complete knowledge and compliance with policy might make a difference in the future justifies, in my view, some recommendations.

I make the following recommendations:

> **1. I recommend that the Securities Branch of the Solicitor General's Department should take steps to design and implement a procedure by which all policy and procedure manuals will be brought up to date and kept up to date in a timely fashion, including all ESO's and SOP's issued.**
>
> **2. I recommend that the Securities Branch of the Solicitor General's Department design and implement a procedure or protocol by which all changes to policy and procedural manuals or updating thereof, be made known to all Security Operations personnel and that copies of such policy changes or amendments be provided in writing to all protection personnel.**
>
> **3. I recommend that the study of the policy and procedures set out in the Policy and Procedures Manual be part of every protection officers training program and that the ongoing training program of all protection officers include periodic review of all policies and procedures setout in the Policy and Procedures Manual.**

8. Baby Doll Clothing - Recommendations

Although I have concluded that there is no causal connection between Mr. Young's actions on January 22nd, 2004 and the fact that he was placed on the Zama unit at EYOC on January 20th, 2004 and required to wear baby doll clothing. Nonetheless, I believe that in the context of the better administration of justice, the use of baby doll clothing requires some comment. Kyle Young was placed on the Zama unit because of his assaultive behaviour towards a protection officer at the courthouse on January 20th. He was placed there for discipline purposes and he was required to wear baby doll clothing. He was not a suicide risk, nor was there a risk that he might otherwise cause harm to himself.

In my view, the use of baby doll clothing for discipline purposes is inappropriate. Its use can have no purpose in such circumstances except to demean, and demeaning an individual is not a justifiable disciplinary action.

The Inquiry was advised that baby doll clothing is no longer used for discipline purposes. I have no reason to believe that is not an accurate reflection of circumstances as they exist presently, nonetheless, I make the following recommendation:

> **I recommend that no individual, whether in custody in a youth centre or an adult centre be required to wear baby doll clothing, except in circumstances where the well being of that individual requires the same.**

DATED April 13th, 2006 ,

at Edmonton , Alberta.

A Judge of the Provincial Court of Alberta

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