



Report to the Minister of Justice Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Grande Prairie Courthouse
in the City of Grande Prairie, in the Province of Alberta,
(City, Town or Village) (Name of City, Town, Village)
on the ninth day of November, 2022, (and by adjournment
year
on the tenth day of November, 2022),
year
before B. R. Hougestol, a Provincial Court Judge,
into the death of Haley Marie Penney 16
(Name in Full) (Age)
of no fixed address and the following findings were made:
(Residence)

Date and Time of Death: February 23, 2017

Place: University of Alberta Hospital

Medical Cause of Death:

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

The Medical Examiner determined the cause of death to be an overdose of Fentanyl and Methamphetamine. This was confirmed by a Toxicology Report.

Manner of Death:

("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *Fatality Inquiries Act*, Section 1(h)).

On February 19, 2017, just before noon the deceased was found unconscious in a hotel room. She was first discovered by "friends" who were sharing the room. This group of "friends" were seemingly regular drug users, as was Haley. Haley was a long-term user of street drugs. Her disclosure to PCHAD personnel was that from age 14 she used cocaine, crack cocaine, mushrooms, acid, GHB, methamphetamine and fentanyl. On the day of the tragedy she was being monitored by the "friends" as they considered her condition unsettling. Just before noon Haley was seen to be vomiting. The decision was made to call 911 by one of the "friends. Haley was assessed by responding EMS at 12:03pm.

In police interviews the “friends” were clear that Haley was seen using Fentanyl. When her condition became concerning there was some activity by the “friends towards accessing Naloxone and ultimately, they did call 911. It is to be noted that at the date of death (February 23, 2017) Naloxone was not nearly as accessible as now.

Given the historic drug use and the witnessed recent Fentanyl use by Haley there is no evidence pointing to anything but an accidental overdose.

Circumstances under which Death occurred:

Haley was 16 years old at the time of death. She would have turned 17 in two months. Haley had been largely living on her own, likely on the street, for about 2-3 months prior to her death. She was a long-term drug user. Haley’s “friends” indicate that she was trading sex for drugs. Haley was not working nor attending school. Haley had poor family supports. She was in a poor relationship with an older man. Haley had historically been in good contact with some supportive friends and with assigned social worker.

Haley was not under an active status with the Director of Child Welfare. There had been a long history of CFSA involvement going back to 2001. Haley never became subject to a Permanent Guardianship Order. Most recently she had entered into an Enhancement Agreement with Youth. This ran from November 9, 2016, to January 17, 2017. This overlapped with a PCHAD placement November 15-25, 2016. The Enhancement Agreement was closed in mid-January 2017 due to a lack of contact.

Sadly, the most ominous and predictive comments are found in the PCHAD assessment from November 2016. The assessor’s comments are on page 1:

“You deny that crystal methamphetamine has any negative impact on your life and do not plan to make changes to your use”

“You last used in July 2016 and plan to use Fentanyl again as you deny that it has a negative impact on your life”

This self-reporting by Haley makes the likelihood of any successful rehabilitation much less. This self-reporting shows a downhill slide from some of her earlier work with counsellors and social workers where she presented as motivated to combat what she knew was a problem.

Recommendations for the prevention of similar deaths:

The above facts lead to several questions. First, should more have been expected of the PCHAD program? Second, were there other steps the Director staff could have taken when Haley fell out of contact in January 2017.

PCHAD:

The PCHAD program is limited to stabilization, assessment and referral of persons falling under it. The program is time limited to 10 days.

The question of whether the program provides the correct scope or duration has been under ongoing consideration by the appropriate governmental authorities. What it should do is far more complicated than this report could address. Suffice it to say that the program will assist in some situations and not in others. A key to longer term success is triggering ongoing treatment or rehabilitation. The family of Haley and this writer wonder if some smoother or potentially

mandatory transition into residential treatment should be considered as part of the PCHAD Program.

Other Steps by Director?

The file contacts between Haley and her various workers demonstrated that there was regular and well-informed contact. The last worker was clearly involved and supportive. The workers all knew well the issues that Haley faced, and timely help was held out to her. For Haley's part she was honest and clearly knew the workers were there to help her. The Enhancement Agreement was an effort to assist. Haley has a track record of cyclical contact and non-contact. Her lifestyle would make this expected.

Options for the Director are difficult and often counterproductive where the subject is only 14 months away from being an adult. An Apprehension and Secure Services Order would have theoretically been options but would be contra-indicated by the overall cooperation Haley had presented in part.

Summary

It is recommended that the Government continue to study the PCHAD program and consider how it might be better coupled with after PCHAD therapy.

DATED February 17, 2023,

at Grande Prairie, Alberta.

Original Signed



B. R. Hougestol
A Judge of the Provincial Court of Alberta