CANADA
Province of Alberta

Report to the Minister of Justice and Attorney General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the The Calgary Courts Centre

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

on the 15th day of November, 2010 year, and by adjournment

on the 16th – 18th days of November, 2010 year, and by adjournment

on the 11th day of February 2011 year, and by adjournment

on the 3rd day of June 2011 year, and by adjournment

on the 15th day of July 2011 year, and by adjournment

on the 18th day of July 2011 year

before Judge Cheryl L. Daniel, a Provincial Court Judge,

into the death of **Gene Elliott Moore** (Name in Full) 33 (Age)

of 12200 - 85th Street N.W., Calgary Remand Centre, Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death:	December 13, 2008 between 0012 and 0017 hours [Death was officially pronounced at 0110, December 13, 2008 at Foothills Hospital, Calgary]
Place:	12200 - 85th Street N.W., Calgary Remand Centre ("CRC"), Calgary, Alberta

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

Ensanguination from a self-inflicted razor blade wound measuring 5 centimetres in length by 3 centimetres in width by 1.5 centimetres deep in his right groin area, which such wound completely transected his femoral artery.

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)).

Suicidal

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED:

Prior Arrest – July 11, 2008

[1] Mr. Moore was arrested on July 11, 2008 and processed at the Calgary City Police Service (CPS) Arrest Processing Unit (APU) at 08:22:46 for sexual assault with a weapon, assault with a weapon, and forcible confinement of his girlfriend, Cherie Mellafont. At the time of his booking at the APU, he was interviewed by the Calgary Police Service Paramedic and reported no current suicidal thoughts. He denied having any previous or current mental health treatments, psychiatric medications or mental health hospitalizations. He also denied a history of violence, drug/substance abuse, hearing voices or seeing things that weren't really there. Finally, he denied any history of suicidal thoughts or attempted suicide.

[2] Detective Wymer spoke to Ms. Mellafont after Mr. Moore's bail hearing. He told her that Mr. Moore had adjourned his bail hearing for one week, and advised her of the contact information for the investigating officers. He told her that she should call those officers if there was any contact attempted by Mr. Moore, as a 'no contact' order had been put in place. During that conversation, Ms. Mellafont did not raise any issues about Mr. Moore being suicidal. Had she done so, Detective Wymer would have made notes of same and taken further steps to make notations on his file, in the department's records and with the appropriate personnel.

[3] Detective Wymer was not made aware by Ms. Mellafont that Mr. Moore had pills secreted in his person. Had that been the case, Mr. Moore would have been searched. Had pills been found, charges would have ensued. Detective Wymer testified that had he been aware of any suicide ideation, he would have advised the paramedics, completed a series of reports, noted it in the Pass-On Book, prepared an electronic report and advised his Staff Sergeant. Of note, it was Detective Wymer's usual procedure to type out and print-off a copy of the suicide information, cut it out and paste it on both the Original and Working Copy, highlight it in yellow and put pink stars either side of it. Clearly, had there been any notification of suicide risk, Detective Wymer's informational practice would have brought the suicide risk to everyone's attention.

[4] If Ms. Mellafont spoke to any other officer at APU respecting Mr. Moore's suicidal inclination, no record of it has been located.

[5] Ultimately, it appears all of the above charges were stayed and Mr. Moore was released.

ARREST PROCESSING UNIT ("APU")

Next Arrest – December 6, 2008
Initial Statement of Suicidal Ideation

[6] Mr. Moore was next arrested by Constable John Semple on December 6th, 2008 shortly after 1800, having been caught driving a stolen motor vehicle. At 1902 hours, during an interview with Constable Semple, Mr. Moore advised that a loaded Smith & Wesson 38 Special Revolver containing one round of ammunition in its firing chamber was in the centre console of the stolen vehicle. He stated that the purpose of having the gun was so that he could commit suicide, specifically saying that had he not been arrested: "All of my problems would have been resolved in six hours and you would have found me dead".

[7] This statement was made after he had been booked into Cell 16 and after he had been seen and assessed by the APU Paramedic at 1922. At the time he saw the Paramedic, his responses to the Medical History and Psychiatric History mirrored those from his July arrest and assessment, in that he self-reported nothing relating to a propensity for suicide. While Constable Semple noted that Mr. Moore admitted to APU Medic Lambe that he had smoked cocaine and marijuana approximately an hour and a half before," Medic Lambe inserted an 'X' in the 'No' column with respect to a history of drug/substance abuse, but noted elsewhere on the form: "drug use prior to arrest - cocaine and marijuana."

[8] When Mr. Moore voiced his suicidal ideation, Constable Semple verbally advised his Staff Sergeant, Jim Leung. He also wrote in the PIMS Report: "The accused also stated that the purpose of having the gun was so that he could commit suicide," and later in the report: "The accused stated that his purpose for having the firearm was that all of his problems would be resolved in six hours and you would have found me dead."

[9] Constable Semple also made the following statement in the "Professional Opinion" section of the Occurrence Report:

> It is the opinion of the investigating officers that the accused, Gene Elliot Moore's intentions with the firearm were to harm himself, as well as possibly his ex-girlfriend, Cherie Lynn Mellafont, due to his statement that all his problems would have ended in six hours and you would have found me dead.

[10] At the point of the indication of self-harm, the CPS had a procedure that it was mandated to follow, in that Constable Semple should have (in accordance with Part 2, Chapter J, Authority and Responsibility, s.9(c)(iv)), Arrest Processing Section, Exhibit #6**,** Tab 3, p.12) entered all information detailing the grounds for the belief of the risk for self-harm into:

(a) the Booking Sheet at the APU;
(b) the Occurrence Report (Professional Opinion section); and
(c) the Custodian's Notebook.

He did not comply with s.9(C)(iv)(a) or (c). He was also required by s.9(C)(v) to verbally notify the Staff Sergeant, APU or designate, and the medical staff, of the grounds for his opinion of the risk for self harm. While he did notify his Staff Sergeant, Sergeant Leung, he did not also notify the medical staff. Mr. Moore was not returned to the Medic for subsequent re-assessment.

[11] The final requirement, being the completion of a 'Special Interest Police – CPIC Entry Authorization" form detailing the risk for suicide, was not submitted by Constable Semple to the CPIC Unit via fax as soon as practicable, as required in s.9 (c)(vii). In fact, it was never submitted.

[12] Constable Semple, while believing that Mr. Moore would be transferred to the Calgary Remand Centre (the 'CRC'), did not contact the CRC directly to advise them of Mr. Moore's suicidal ideation because it was not then Standard Operating Procedure for him to do so. He was not aware of any policy requiring him to do so either then or at the time he testified at the Inquiry, although he stated that as a result of this experience, he would contact the CRC personally with such information in the future.

[13] It is clear that suicide was not merely an idea in Mr. Moore's head. He had actually taken action towards that end by stealing the gun and loading it with ammunition for the express purpose of taking his own life. Had he not been stopped by the police, his suicide may well have been completed earlier than it actually was. The fact he had taken action towards completion of suicide significantly raised the level of threat.

APU - Staff Sergeant Jim Leung, December 7, 2008

[14] When advised of Mr. Moore's suicide ideation by Constable Semple, Staff Sergeant Leung made a note on the Original of the APU Booking Sheet for Mr. Moore as Constable Semple watched. Right under Mr. Moore's picture, Staff Sergeant Leung hand wrote in large, printed, underlined words: SUICIDAL DRUGS. The Booking Sheet was dated December 6, 2008. The form initially bore a top/middle label C-16, then the 16 was crossed out and a 2 put in its place. Finally, it morphed into C-17. This Original Booking Sheet was issued on 2008/12/06 and timed at 19:22:19. The 'C' means 'Cell' and the number that follows represents the cell number into which Mr. Moore was sequentially placed.

[15] There is a date stamp on the bottom of the Original Booking Sheet reading December 8th at 0845. It indicates that Mr. Moore made a telephone call at 0736, and ate at 0741 and at 1200. However, the Inquiry was also provided with a copy of an unaltered second original Booking Sheet indicating that Mr. Moore was in Cell C-2. It had the same date and time stamp, but had nothing written on it with respect to any suicide or drug reference. Thus, it appears that a second Original Booking Sheet was generated. As the 'SUICIDAL/DRUGS' notation was not inserted electronically, that notation did not automatically appear on any successive reprints and no one ever manually transferred that important notation onto any subsequent Working or Original copies.

[16] With respect to following Standard Operating Procedures, Sergeant Leung was required (once he was aware of Mr. Moore's risk of suicide), pursuant to Part 2, s.4(C) – Arrest Processing Section – Suicide Watch Procedure, of the CPS Policy and Procedures Manual for the Arrest Processing Section (the 'Manual') (Exhibit 6, Tab 8[1]), to have Mr. Moore examined by the on-duty EMS personnel (who have the authority to refuse acceptance of an arrested person and to direct that an arrested person be taken to the hospital). Sergeant Leung did not direct that examination of Mr. Moore to take place.

[17] Sergeant Leung did not recommend that the presenting officer request a psychological examination so that a psychological assessment could be conducted by a court-appointed doctor before a bail hearing was conducted, pursuant to s.4(C)(3)[2]. Neither did he consider using the services of the Crisis Unit for an intervention, as it was anticipated Mr. Moore would be in police custody for an extended period of time, pursuant to s.4(C)(4)[3] of the Manual.

[18] Staff Sergeant Leung did not remember if he told Staff Sergeant Ron DeCoste (who took over the next shift at 0530 on December 7, 2008) that Mr. Moore was suicidal. He did not recall if he asked the Prison Security Officer to add the 'Suicidal/Drugs' comment to the Working Copy of the Booking Sheet. He believed it would be the next shift officer (*i.e*. Decoste) who would be responsible for informing the Bail Hearing Officer of Mr. Moore's suicidal ideation. In any event, the addition of the suicide risk was not made to the Working Copy of the Booking Sheet and the Bail Hearing Officer would not have seen that notation of 'Suicidal/Drugs', until after the Bail Hearing, as that is the only time he would have accessed the Original Booking Sheet.

[19] While Staff Sergeant Leung initiated a suicide watch and put Mr. Moore in Cell #2, he did not have Mr. Moore's clothing confiscated so that he could be dressed in Baby Dolls (essentially two blankets sewn together with head and arm holes) or, alternatively, a white Tyvek (tear-away) suit, although he thought that he made such an order. If he did make such an order, it was not carried out, as it is clear from the evidence from Prison Security Officer Powis and Constable Ramondi, that Mr. Moore was still dressed in his street clothes when he was transported to CRC. Also, the evidence from Staff Sergeant DeCoste and Security Officer DeFrancesco was that Mr. Moore would have been treated quite differently and never moved out of Cell #2 on their watch if he had been wearing Baby Dolls. The only conclusion to be reached is that Mr. Moore always remained in his street clothes because Staff Sergeant Leung did not actually give the order to have him changed into Baby Dolls.

[20] Staff Sergeant Leung explained what happened with respect to the Original Booking Sheet after he began his shift at 1730, by indicating that two copies are computer generated: an Original and a Working Copy. Ultimately, the Original stays with the Staff Sergeant and is filed, while the Working Copy is attached to the Charging

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1 See also, Exhibit 5, Tab 5, section 15(a)(i) – Arrest Processing Section Standard Operating Procedure in place in December, 2008 referencing 'Prisoners – Handling Procedures – Suicide Watch'.

2 Exhibit 6, Tab 8, Appendix I

3 *Ibid*

Package (which includes the Arrest Report, the PIMS statements and the disclosure package). The Working Copy is used by the Bail Hearing Officer and accompanies a prisoner remanded to the CRC.

[21] Both documents were disclosed to this Inquiry. The Original Booking Sheet clearly noted the handwritten words "*Suicidal Drugs"*, but the Working Copy which accompanied Mr. Moore to the CRC did not have those handwritten words or any typewritten notation to the same effect, notwithstanding that all information on the Original Booking Sheet should have been transferred to the Working Copy and should have been entered electronically so those notations appeared on subsequent print-offs.

[22] As a result of this lack of transfer of information, there was no notice on either the Original Working Copy or the subsequently printed amended Original and Working copies with respect to any suicidal ideation. Consequently, when Mr. Moore went for his bail hearing and subsequently to CRC, none of the accompanying paperwork mentioned suicide risk. No person was mandated to ensure that the Original and the Working Copy (either the originals or reprints) or the electronic record were trued up so that they mirrored each other.

[23] Staff Sergeant Leung believed that it was the Hearing Officer who was supposed to ensure that the same information appeared on both the Original and the Working Copy of the Booking Sheet. However, Detective Reden Wymer, the Bail Hearing Officer for Mr. Moore, indicated that it was not the duty of the Hearing Officer to ensure that the Working Copy was trued up with the Original. He indicated that no one had that specific role. It is clear that someone should have that assigned duty before the arrestee is either passed on to another institution or otherwise released.

[24] Staff Sergeant Leung indicated that he would have briefed the succeeding shift Staff Sergeant DeCoste about Mr. Moore, who at that time (being 0530 on December 7th, 2008), would still have been in Cell #2 being monitored for suicide risk. However, Staff Sergeant Leung did not prepare an Information Report identifying Mr. Moore as a person at risk of suicide or significant self-harm, nor did he provide a brief description of the Unit's handling of the at-risk Mr. Moore (all as required by s.4(D)(2) of the Manual).

[25] Correspondingly, no copies of such an Information Report were forwarded to APU, the Identification Section Commander or the CPIC Administrator, who would all thus be advised of the need to immediately enter the suicide risk information about Mr. Moore onto the CPIC system.

[26] Staff Sergeant Leung indicated that it would have been the responsibility of the shift following his (December 7, 2008 at 0530) to ensure that the Original Booking Sheet was trued up with the Working Copy after the Bail Hearing in preparation for Mr. Moore's transfer to the CRC. Staff Sergeant Leung indicated that normally he would have made a notation about a suicide risk in the "Pass-Book", but no such notation actually appeared therein.

[27] With respect to the proper protocol being followed after receipt of information from Constable Semple respecting Mr. Moore's suicide ideation, Staff Sergeant Leung admitted that he did not have Mr. Moore re-examined by the APU Medic, nor did he check to see if Mr. Moore had earlier admitted suicidal ideation to the APU Medic. He did not follow the Standard Operating Procedure set out in s.4(C)(6)(A)[4] of the Manual, which required that he inform the on-duty EMS personnel and other arrest processing section personnel of the suicide risk.

[28] Before being transferred to the CRC, Staff Sergeant Leung indicated that typically, Mr. Moore would have been dressed in Baby Dolls or a white Tyvek suit if he was suicidal. It is out of the norm, he stated, for the CRC to receive someone in Baby Dolls or a Tyvek suit, so had Mr. Moore been so dressed, a visual alert would have triggered a psychiatric follow-up by CRC, with initial placement in an observation cell.

[29] APU Policy, at that time, was that if any active suicidal ideations were identified, a call would be made to the CRC Medical Unit or Deputy Director alerting them to an active suicide risk. Sergeant Leung did not make such a call because Mr. Moore was not transferred to APU on his watch. No one else made the call because it was never communicated to ensuing CPS personnel that Mr. Moore was a serious suicide risk. By the time he left APU he was not even identified as a suicide risk and none of the paperwork accompanying him indicated that he ever had been.

[30] Ironically, Staff Sergeant Leung had attended a Seminar the day before Mr. Moore was booked in APU, put on by Dr. Peter Collins on the topic of *Suicide – Awareness and Intervention*. This seminar was given in response to the suicides of 2 CPS members. The topics covered included passive vs. active suicidal ideation, risk factors, prevention and treatment, and the do's and don'ts of communicating with a suicidal individual. It appeared to be focused on CPS members as opposed to prisoners, but the same awareness developed would apply in both situations.

[31] Having attended this seminar the day before, Staff Sergeant Leung testified that he felt confident in assessing Mr. Moore's risk of suicide as being very low because he had already been screened by the paramedic and there was no history of suicide. Mr. Moore was cooperative and compliant and there was "no problem" with him. Staff Sergeant Leung indicated that he did not see anything that put Mr. Moore high on the scale of suicide risk, and he was satisfied that he presented very little risk, if any at all. However, it was left unexplained how an 'active suicidal ideation' (being the theft of the gun, the loading of it with one bullet, when there were more at hand, and the stated intention of killing himself with it) did not qualify in and of itself as high risk.

[32] Staff Sergeant Leung's opinion that Mr. Moore presented a low-suicide risk likely explains why Mr. Moore was not immediately put in Baby Dolls with the mandatory protocols in the Manual followed. Given ultimate events, the importance of following protocols set out in the Manual for expert assessment is vital in every circumstance, as Staff Sergeant Leung's informed, but lay opinion, could not have been more wrong.

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[4] Exhibit 6, Tab 8, Appendix I

[33] Staff Sergeant Leung also indicated that there was no indication that Ms. Mellafont called the APU at any time during Mr. Moore's stay there in December. He acknowledged, however, that if such a call had been made, there existed no policy directing such a call to the Staff Sergeant or Acting Sergeant, nor any policy requiring the person receiving the call to make notes of the conversation on the Original, Working or electronic Copy of the Booking Sheet.

APU - Staff Sergeant Ron DeCoste – December 7, 2008

[34] Staff Sergeant Ron DeCoste, who took over from Staff Sergeant Leung at 0530 on December 7, 2008, indicated that he did not recall being told by Staff Sergeant Leung that Mr. Moore was suicidal, nor was that risk noted in the Pass-On Book. As Mr. Moore was not put in Baby Dolls, the fact that he was suicidal was not observably apparent. Other people than those with a suicide risk can be placed in Cell #2, so unless he was told orally of the risk by Staff Sergeant Leung (which he may not have been); or unless it was in the Pass-on Book as a notation (which it was not); or unless he read the Original Booking Sheet (which he did not); it was unlikely that Staff Sergeant DeCoste would know that Mr. Moore presented a suicide risk.

[35] Staff Sergeant DeCoste indicated that he handled suicide risk arrestees much differently than did Staff Sergeant Leung, because on his first day of work in the APU, a woman named Eva Farnel committed suicide on his watch in APU. Accordingly, he became very sensitive to suicide risks and amended his procedures forthwith after that event in 2006. In every case, a suicide risk was visually identified, because he insisted that they immediately be put in Baby Dolls and transferred into Cell #2. He would have personally stamped both the Original and the Working Copy with the "Suicidal" stamp.

[36] However, while he believed that he must have known that Mr. Moore was suicidal, he likely did not consider the threat to be a serious one, as a prior assessment by Staff Sergeant Leung did not result in Mr. Moore being placed in Baby Dolls, meaning Staff Sergeant Leung's risk-assessment relating to Mr. Moore was that he was a low risk. In fact, Staff Sergeant Leung may have orally communicated that low-risk opinion to Staff Sergeant DeCoste. Staff Sergeant DeCoste did not explore the matter further by reading the PIMS Report.

APU - Security Officer De Francesco, December 7, 2008

[37] Mr. Moore had not eaten since his arrest, as it was policy not to feed those on suicide watch. So, at 0736 on December 7th, Security Officer DeFrancesco took Mr. Moore out of Cell #2 fed him, allowed him to make a phone call, and at 0741 ultimately transferred him to Cell #17. The foregoing processes were noted on the Original Booking Sheet by Officer DeFrancesco, so it may be assumed that he would have seen Staff Sergeant Leung's notation that Mr. Moore was suicidal.

[38] Security Officer DeFrancesco does not remember having a conversation with Mr. Moore about his suicide ideation, so he re-constructed what he thought he would have said if he had known that Mr. Moore had actually been classified as suicidal. As a result, his testimony of what actually happened is pure conjecture. He neither made nor

kept a written record of what questions were asked with respect to Mr. Moore's current suicide ideation and what answers were received. The Amended Standard Operating Procedures Manual indicates that prior to release, a notation as to the results of the questioning is to be made on the Booking Sheet, however it does not specify as well that the notation should be made electronically, on both on the Original and Working copies of the Booking Sheet (Exhibit #6, Tab 8, s.13(1)(a)).

[39] Security Officer DeFrancesco had been working in the APU since September of 2004. Prior to that, he was a security guard with 22 years military experience. He had taken the Jailer's Course, but could not recall if it contained any suicide risk awareness or training. Had he been aware that Mr. Moore had expressed a suicide ideation, he testified that he would have asked Mr. Moore if that suicidal ideation still persisted. If Mr. Moore indicated in the negative, then he would have recommended transfer from Cell #2 to Cell #17 for Mr. Moore to await his Bail Hearing, which is what ultimately occurred.

[40] Security Officer DeFrancesco believed he would likely have sought permission for such a cell transfer from Staff Sergeant DeCoste. Staff Sergeant DeCoste testified that he would have routinely approved such a transfer without further inquiry, because he absolutely trusted Security Officer De Francesco's judgment. Neither of them, had this dialogue actually transpired, sought the opinion of a medical professional. Security Officer DeFrancesco, while an experienced jailer had no professional or medical training in suicidal assessment. Staff Sergeant DeCoste had taken the Jailer's course and had also attended Dr. Collins' Suicide Prevention Course a few days earlier. Thus, his view of the risk may have mirrored that of Staff Sergeant Leung, or he may simply have relied on Staff Sergeant Leung's lay assessment that Mr. Moore posed a minimum risk for suicide. Or, it is equally possible that neither of them directed their minds to the issue at all, no record of any such discussion having been kept or recorded.

[41] Security Officer DeFrancesco confirmed that if Mr. Moore had been dressed in Baby Dolls, he would not even have asked him about continued suicide ideation. Mr. Moore would have been transferred right back into Cell #2. To him, a detainee dressed in Baby Dolls represents a more significant risk for suicide, while a detainee dressed in street clothes presents a low risk. That understanding was mirrored by Staff Sergeant DeCoste.

[42] There is no way that either Security Officer DeFrancesco or Staff Sergeant DeCoste would have known that Mr. Moore had secured a loaded gun with the intent to commit suicide the night before, because neither of them read the PIMS Report which contained that information. Since his Jailer's Course, Security Officer DeFrancesco has not had any suicide prevention training. There have been no refresher courses offered to him since he took the original Jailer's course.

The Bail Hearing – December 7, 2008

[43] Constable Burnside, the Bail Hearing Officer, met with Mr. Moore at 0855 on December 7, 2008, when he retrieved him from Cell #17 and took him for his Bail Hearing, which was immediately adjourned until later in the day. He used the Working Copy of the Booking Sheet, which contained no notation of Mr. Moore's suicide risk. He was not visually alerted to any potential suicide risk, as Mr. Moore was not dressed in Baby Dolls, nor was he residing in Cell #2. By the time he retrieved Mr. Moore at 0855, the Original Booking Sheet had been taken off the clip and put in an alphabetical file folder. Constable Burnside did not see the Original Booking Sheet prior to the Bail Hearing.

[44] Security Officer DeFrancesco fed Mr. Moore at 1200 and wrote the time on the Original Booking Sheet. At 1222, Constable Burnside again retrieved Mr. Moore from Cell #17, and took him for his Bail Hearing. At 1228 the hearing was concluded, as an adjournment was requested and granted to Mr. Moore. Mr. Moore was then placed in Cell #18 to await transport to CRC. After the hearing, Constable Burnside did retrieve the Original and made the notes with respect to the adjournment on the bottom of it, but apparently he did not notice the handwritten notation with respect to suicide risk. His attention was simply focused on the bottom part of the Original Booking Sheet, where he wrote the bail hearing result. He did not believe it was his job to ensure both the Original and the Working Copy of the Booking Sheets were true copies of each other.

Revised Booking Sheets

[45] By 1437 on December 7, 2008, a Second Original and Working Copy of the Booking Sheet had been generated. These documents reflected 13 charges (an increase from the original number). It is likely that the Second Original was stapled on top of the Original Booking Sheet, as at 1740 Security Officer Powis noted that he fed Mr. Moore by making a handwritten notation on the Second Original. Once the Second Original was stapled on top of the true Original, the handwritten notation about suicide risk was completely covered.

[46] No one was ever designated to make an electronic notation of the handwritten notation regarding Mr. Moore's suicide ideation, or to true up the Original with the Second Original, the Original Working Copy or the Second Working Copy. Clearly, it is not a good idea to have two 'Originals'. The best practice would be to exactly true up the Second Original, both with handwriting and electronically before destroying the first Original. The best practice would be to never make important handwritten notations on one copy only and certainly to make such notations electronically so that if there were reprints, those notations would automatically be replicated.

[47] Constable Burnside was of the view that it was the Staff Sergeant's job to true up the Original with the Working Copy. He also testified that if Mr. Moore had been in Baby Dolls he would have been put back into Cell #2 after his Bail Hearing. Alarmingly, even presenting a suicide risk would not have prevented Mr. Moore from being taken for a Bail Hearing prior to meeting with a health care professional to assess his mental state,

although there was an option for the Hearing Officer to ask for a psychiatric assessment prior to the bail hearing. Presumably, he might have requested such an assessment had he in anyway been alerted to Mr. Moore's suicidal ideation.

Transfer to CRC – December 8, 2008

[48] Mr. Moore remained in custody at APU through a third shift change. When Staff Sergeant Anderson and Acting Staff Sergeant Jim McManus took over at 1730 on December 7th, Mr. Moore was in Cell #18 awaiting transport by way of a Form 19 to the CRC. By that time, there was still no notation of Mr. Moore's suicidal ideation on the electronic record or on either of the Original or Second Working Copies. The Second Original was likely stapled on top of the true Original with the handwritten notation. There is no mention of Mr. Moore being suicidal in the Pass-On Book and it is unlikely that Staff Sergeant DeCoste told Acting Staff Sergeant McManus that Mr. Moore had ever been suicidal.

[49] Acting Staff Sergeant McManus is an experienced police officer of 23 years. His Acting Staff Sergeant, John Anderson, was filling in for Staff Sergeant Leung, who was absent that day. Acting Staff Sergeant Anderson did not give testimony at the Inquiry, as he was unavailable and had absolutely no memory of the events as they related to Mr. Moore in any case.

[50] Had Sergeant McManus known that Mr. Moore was suicidal, he testified that he would have made a courtesy call to CRC to alert them (although he would not have made a note of doing same) and he would have stamped the Working Copy with the "Suicidal" stamp, so that CRC would have that notification on the transfer document that accompanied Mr. Moore to CRC. Mr. Moore would also have been dressed in Baby Dolls. Constable Ramondi, as well as Security Officer Powis confirmed that Mr. Moore was dressed in street clothes at the time of his transfer.

[51] Acting Staff Sergeant McManus was not sure who separated the Original Booking Sheet and the Working Copy and put the transport packages together. It could have been him or one of the Commissionaires. Like Security Officers DeFrancesco and Powis, Acting Staff Sergeant McManus, despite being assigned to APU from 1997 to 2007, had not had any suicide prevention training prior to December 2008 and to the date of his testimony at the Fatality Inquiry, still has had none.

[52] Mr. Moore was formally transferred out of APU to the CRC on December 8, 2008 shortly after midnight, in his street clothes, and without any indication on the paperwork accompanying him or via telephone alert that he had at any prior time while in CPS custody been actively suicidal and on suicide watch at the APU. The Original Booking Sheet was stamped at 0041, indicating that Mr. Moore had, by that time, actually left APU.

STANDARD OPERATING PROCEDURAL CHANGES RE SUICIDE RISK AT APU

[53] Inspector Tom Hewitt is the Commanding Officer for the APU and has been since June of 2008. He has 25 years experience with the Calgary Police Service ("CPS"). Inspector Hewitt appears to have a good understanding of how to re-vamp the APU and is in the process of ensuring it happens. He is clearly a wise and inspiring leader who has turned the APU from a much-avoided ghetto into a sought-after learning environment for police officers. He well-understands that knowledgeable officers, mentorship, caring and guidance, together with clear, accessible and uniform standard operating procedures and appropriate training opportunities, will better ensure the safety and needs of the detainees in APU custody. What was especially moving was his heartfelt apology to Mr. Moore's mother for the shortcomings in the handling of her son, which she gratefully received and accepted.

[54] He conducted interviews with all of his personnel that had dealings with Mr. Moore while he was in APU custody. All of the relevant APU documents were reviewed and it became apparent that no one had any specific recollection of Mr. Moore. This is probably because the APU handles over 20,000 detainees a year. In 2010 there were 124 detainees with suicidal ideations and 22 attempted suicides. Those numbers were 102 and 12 respectively in the first six months of 2011.

[55] In Inspector Hewitt's view, it appears that Mr. Moore's suicide risk was initially assessed as a 'suicide ideation' and not as 'active suicide' as it properly should have been labeled, because Mr. Moore had a suicide plan, had secured the loaded weapon and had the timing set in his mind. As well, he had a background, current stressors and personal turmoil that raised his risk level.

[56] The way the CPU now handles detainees subject to such a suicide risk has apparently undergone a sea change since 2008, in part due to Judge McIlhargey's recommendations emerging from the Farnel Fatality Inquiry. Those changes to Standard Operating Procedures remain, as they always will be, a work in progress. New evaluation forms and policies have been put into place since December of 2008. However, until the evidence emerged at this Fatality Inquiry, the CPU was unaware of its involvement in failing to communicate Mr. Moore's suicide risk to the CRC.

[57] There are new policies in Part 2, Chapter J Section 9 respecting Prisoners at Risk for Suicide or Significant Self-harm that require notifications, observation, examination by medical personnel and documentation (Exhibit#6, Tabs 30 – 33). In addition, such a detainee must immediately be clothed in Baby Dolls. It is now clear that the responsibility for briefing the succeeding shift regarding prisoners who are at risk for suicide lies with the Staff Sergeant.

[58] Mr. Moore's overt action towards a suicide attempt would today trigger Mr. Moore to be taken immediately to hospital for psychiatric assessment. He would not even be booked into APU cells. Suicidal ideations expressed now result in an immediate assessment by the paramedic at APU. If the detainee is not transferred for psychiatric assessment to a local hospital, he is put in Baby Dolls and put in isolation in Cell #2 on suicide watch.

[59] If a suicide watch is to be lifted today, the procedure upon release does not appear to have changed, in that the releasing officer *may* (but is not required to) request the assistance from EMS (Chapter B, Care of Persons in Custody, Section 3 – Arrest, #9 Release Procedures – Suicidal Arrests (Exhibit #6, Tab 15, s.9(1)(a)-(b)) This omission will be the subject of a specific Recommendation.

[60] However, Inspector Hewitt indicated that today there must be an 'Exit Interview' by a paramedic (which such interview is indicated on the Check List but not in the SOP Manual), the details of which must be recorded. Ideally, such an interview should be conducted and recorded appropriately by the paramedic.

[61] As the computer program relating to entries on the Booking Sheets is weak, there currently remains no audit capability to ascertain who actually logged anything either during the period in question when Mr. Moore was in the APU or currently. The Commander hopes this will be rectified when funds are available to do so.

[62] An Electronic Pass-on Book was instituted in February, 2010. It must be maintained during the shift, and all events of note are recorded on it. The suicide risk is also to be noted on the Booking Sheet (presumably all versions: electronic version, the Original and Working Copy – although it is not so stated in s.9(C)(iv)(a)-(c)), the Occurrence Report (Professional Opinion Section) and the custodian's notebook. Presumably this would include suicide watch prisoners. This is to ensure that nothing is forgotten or missed at the end of the 12 hour shift as might have happened with the hand-written pass-on book in the instant case. Specifically, the use of Baby Dolls must be recorded into the Electronic Pass-On Book. In the perfect world, there will be no further handwritten 'suicidal' notes made only on the Original Booking Sheet, and there will only be one Original and one Working Paper Copy of the Booking Sheet with all copies (including the electronic copy) trued up one to the other.

[63] A Risk Management Committee for APU has been struck and had its first meeting in October 2010. They meet monthly, currently having 30 outstanding issues, with three focusing on Mental Health Issues. The Committee is comprised of a duty Sergeant from each of the four teams working in the APU, a paramedic and the Sergeant of the Corps of Commissionaires.

[64] Importantly, an information-sharing agreement now exists between Alberta Health Services and the APU paramedics, whereby after an arrestee is discharged from a hospital back into the APU's care, the on-shift paramedic is able to gain access to the hospital's test results for that arrestee. Those records are then shared with any custodial facility that the arrestee is ultimately transferred to, if that facility has medical personnel on-site.

[65] The SOP Manual is revised bi-annually and is currently in the process of a major revision that will be completed in October, 2011. The Manual must be reviewed by all staff bi-annually and there is a sign-off sheet for so doing. Importantly, it is available to all staff on-line, so there should be easy and immediate access for reference to procedural requirements. Other changes include the hiring of an Administrative Staff

Sergeant, whose responsibility it is to ensure consistency of practice and central oversight through review and audit procedures.

[66] In 2008, there were four teams supervised by four different Staff Sergeants. Each had different team practices and procedures. That has changed. Everyone is conducting business under the same rules and guidelines. The Staff Sergeant now has a separate office, where he has the opportunity to reflect, out of the sensory overload intake area environment.

[67] An information report must be provided for each prisoner at risk. It must give a brief description of the Unit's handling of the at-risk prisoner. Copies must be forwarded to the Commander of the Investigative Support Section. A "Special Interest Police – CPIC Entry Authorization" form detailing the risk for suicide must be completed and submitted to the CPIC Unit.

[68] All information received from the arresting officer and the APU respecting the at-risk person must be forwarded to the CRC, Calgary Young Offenders Centre (CYOC) or the medical facility when custody is transferred from the APU to another institution. Booking Sheets are to contain the custodian's grounds for the opinion that the prisoner is at risk for suicide or significant self-harm.

[69] If the prisoner is returned to police custody after a hospital psychiatric assessment, that prisoner will continue to be treated as an at-risk prisoner, the same as he was before such psychiatric assessment. Transport of such an at-risk prisoner is to be, whenever possible, in a two-officer vehicle in the back seat with an officer sitting beside the person at risk.

[70] All officers are required to keep notebooks to record pertinent information relating to self-harm and suicidal tendencies under the Principal Tasks of their respective job descriptions. There is no requirement that calls from members of the public respecting suicidal ideation of prisoners be directed to any one person. Commander Hewitt is aware that should change, and that there should be a requirement for one specified person to keep notes of that conversation and transfer them from that person's respective notebook to the electronic record and onto the Original and Working Copies of the Booking Sheets.

[71] On June 22, 2011, a Revised Learning Objective and Methodology for dealing with persons displaying emotionally disturbed behaviour and suicide intervention was added to the CPS Recruit Training Course Training Standard. This is a 7.5 hour course that fosters recognition of indicators of someone considering suicide. It explains how to properly intervene in a suicide situation through a 2.5 hour session of suicide intervention training, with an interactive presentation, discussion and role plays. The CPS Policy and Procedures Manual is specifically reviewed. Persons working in the APU must also complete the Care in Custody Course, which devotes two hours to the identification and management of suicidal offenders. While it is stated that all personnel should attend this course, it is not presently the case that everyone has. Nor, have there been refresher courses as recommended by Judge McIlhargey in the Fornel

Fatality Inquiry. Commander Hewitt is alive to this issue and expects to correct it in due course.

[72] Of particular importance is the Check Sheet that must be completed after each ideation or attempt at self-harm in custody. Each step in the process must be initialed when completed. Also important is the Transfer of Custody Alert Notification, which is to be faxed to CRC, CYOC and the Sheriffs when an arrestee has been identified as meeting the protocol for notifications in high risk incidents. These changes go a long way to ensuring a detainee at risk of self-harm, does not fall through systemic cracks.

[73] In terms of record-keeping, Inspector Hewitt indicated that as of June 23, 2011, record retention guidelines were changed to reflect a longer retention period for APU documentation.

[74] Inspector Hewitt indicated that it is now the stated responsibility of the Staff Sergeant to ensure that all copies of Booking Sheets are trued up one with the other. However, in the Staff Sergeant's duties, this responsibility should be specifically identified, perhaps under Principal Tasks, #10.

[75] What became crystal clear in Inspector Hewitt's testimony and in counsels' submissions, is that the CPS and the CRC are increasingly being asked to house and manage detainees with very serious health, mental health, and addictions issues, when they are clearly ill-equipped to do so. Their people do not have the training, the expertise, the number of personnel required, the space, or the funding to adequately address the burgeoning need.

[76] The problem identified is that hospitals are off-loading to detention facilities those people who the detention facilities believe should really be kept in a hospital under a doctor's care. This pressure point is not going to fix itself. Those interested parties must meet and establish protocols to identify persons whose risk simply cannot be managed inside a prisoner-detention setting. The Province is then going to have to determine how and where it is going to manage the care of those persons and provide funding for the necessary facilities, staff and ongoing treatment and management that are needed.

CALGARY REMAND CENTRE

Intake Assessment

[77] In December, 2008, the APU file was required to be flagged for suicide risk. If such notification was received by the CRC, upon admission, that person would be taken immediately to the Observation Unit, to be visually monitored 24/7, and to be interviewed and monitored by the General Practitioner (GP) or psychiatrist. That person would not be allowed to leave the Observation Unit until cleared by the psychiatrist. APU policy also dictated that if anyone telephoned the APU with information that a detained person was suicidal, then a call would also be made to the CRC to alert them to that fact, with the appropriate notifications on documents sent to the CRC. Certainly,

had Mr. Moore been flagged as a suicide risk, when the razor went missing, he would have immediately been taken for psychiatric assessment.

[78] Mr. Moore was admitted into the CRC on December 8, 2008. The documents received by the CRC did not include a copy of the Original Booking Sheet with the suicidal notation, nor did the Working Copy accompanying Mr. Moore reflect Sergeant Leung's handwritten warning. The CPS APU Paramedic Assessment made no mention of suicide risk, because Mr. Moore had not been taken back to the Medic after he self-reported his suicide ideation and he did not disclose it when he first met with the APU Medic. In short, there was no indication of suicide risk on any documentation forwarded or on file with Mr. Moore.

[79] The Alberta Solicitor General Correctional Service policy requires that all new admissions to a correctional facility in the Province be medically examined by a nurse. That policy was followed at the CRC. However, there was no requirement that the electronically recorded medical history be reviewed before conducting an intake interview, just in case there was some recent concern which had not yet been added to the paper file, or in case there was something missing in the paper file.

[80] Accordingly, on December 8th, 2008, Megan Wight, a Registered Nurse (RN) with 17 years experience, and who had worked at the CRC since June of 2004, received a fax copy of an Admission Form from the CPS APU. She looked Mr. Moore up in the COMIS system and pulled his file. Specifically she looked to confirm whether or not Mr. Moore had been classified as "Suicide Active" or if he had a "Suicide Record". In Mr. Moore's case, he had a history of depression eight years prior to his admission on December 9, 2008, but nothing of note since that time.

[81] Janelle Spiess is an RN who had been working at the CRC for six years. Along with Nurse Wight, she interviewed Mr. Moore upon his admission. He had no doctor, no medications, and no indication of any psychiatric issues that he shared with the RNs at the time of his admission. Nurses Wight and Spiess reviewed his file and prepared the Admissions Report after completing a cursory medical interview.

[82] In Nurse Wight's six years' experience at the CRC there have been a total of three other inmates, to her knowledge, that have self-harmed with razors.

[83] At the time of his medical interview, Mr. Moore was specifically asked if he had ever attempted suicide and RNs Wight and Spiess observed him as he responded. They watched his body language, listened to the tone of his voice, observed his mood, affect and eyes. He denied prior suicide attempts or having any current suicidal or self-harm ideation or tendency. He voiced no medical concerns and had no known allergies. His affect was bright to cheerful, so he was sent to the general inmate population. Neither RN received or observed anything to indicate Mr. Moore was unstable.

[84] Mr. Moore was also interviewed by Ms. Lynn Pickering on December 9th, 2008. She was a correctional service worker, whose job it was to determine if there were any placement issues involving inmates being transferred from the APU, such as gang

associations, drug debts, cell thief, etc. As a result of her interview with Mr. Moore (during which time Mr. Moore was specifically asked if he had any mental health problems, to which he responded in the negative), an Offender History Form was prepared. He was assessed for placement in the general prison population. Mr. Moore was ultimately rated as a minimum security risk and accordingly was admitted into Unit 4, Cell 43.

Missing Razor

[85] Michelle Edgson was a Correctional Officer (CO) on duty in Unit 4 during the afternoon shift from 3 to 11 p.m. on December 10th, 2008. Mr. Moore approached her counter at 2106 hours and asked to sign out a razor. A two-bladed razor was signed out to him and a notation was made in the log book indicating his name, the time he signed it out and his cell number. Inmates are allowed to shave either in their cell or in the shower. In any event, the razor has to be returned by lock-up. The inmate is to physically hand it to the CO who then logs the razor back in. After inspecting it, the CO deposits it in the opaque Sharps container.

[86] By 2140 hours, CO Morla noticed that there was no notation in the log book indicating Mr. Moore had returned the razor. He called Mr. Moore to his desk and asked where the razor was, to which Mr. Moore replied that he had returned it. As CO Edgson was on break, Mr. Moore was sent back to his cell. When she returned from break, CO Morla asked CO Edgson if she had received the razor back and she replied that she had not. There is no return register for the inmate to sign when the razor is returned, nor is there a clear, unbreakable 'Sharps' container for the CO's to visually inspect and count to confirm a return. Often, inmates 'throw' the used razor back at the CO's and do not stay to have the return recorded, or, things are so busy that the return is simply not recorded.

[87] Mr. Moore was called to the desk and asked where his razor was. He indicated that he had handed it back. CO Edgson retorted that he had not, but he maintained that he threw it on the counter when she was busy. She countered that he had not even shaved, and he retorted that he had changed his mind and would shave the next day. She knew that he had not returned it as she is required to examine each razor and she would have remembered examining one that was still clean. She mentioned that to him and he maintained that he did hand it back, quite soon after he had taken it. Not believing Mr. Moore, CO Edgson made a report to Jeff Moore (Correction Police Officer 3 and supervisor of CO Edgson and CO Morla), who ordered that a cell search and strip-search be conducted.

Search for Missing Razor

[88] CO Edgson communicated to CO Morla that both the cell and Mr. Moore were to be searched. Unfortunately, she may not have been specific in stating that the order had been for a strip-search. The searches were instigated soon after lock-up at 2230. Mr. Moore was taken out of his cell. CO Morla searched Mr. Moore with a pat-down search (not a strip-search), while CO Edgson searched the cell. CO Morla could not recall if he searched Mr. Moore's mouth. He had never conducted a search for a razor

before. Neither found the intact razor or either of the razor blades, although CO Morla recalled that he thought he was patting Mr. Moore down looking for the intact or whole razor and not simply a razor blade.

[89] The cell search was quite thorough, with CO Edgson searching for both an intact razor and a razor blade. Everything in the cell was examined from books to shoes and all the furniture and accoutrements. CO Edgson has considerable experience in searching cells. Cells are searched every weekend and randomly throughout the week. The toilet was flushed and CO Edgson testified that she checked under the toilet rim, but that she did not stick her hand under it, nor did she use a mirror to discover if there was anything held under the lip of the toilet. Mr. Moore's razor was not found upon searching either his cell or his person on December 10th. After Mr. Moore's death, the cell was cleaned by other inmates. One reported that when he flushed the toilet, he believed that he saw a razor blade in the bottom of the toilet, but as it was mid-flush, he was unable to retrieve it.

[90] CO Morla had been working for only two months at CRC before the razor went missing on his shift. At that point, he had received a five-day orientation and had attended three shadow shifts before starting work. His training did not involve actually searching a cell, but he was aware that inmates often use toothpaste to secure an item under the toilet lip and that it is difficult to see under the toilet lip without using a mirror. The mirrors are available in the unit, but are not routinely used, nor were they referred to for use in cell searches in his training.

Changes since Mr. Moore's Death

[91] In CO Morla's experience two other razors have gone missing since December 10, 2008 and in both of those cases the entire unit and all the inmates in the unit were searched. It was his experience that only single blade razors were issued. During CO Morla's testimony, it appeared that there was no way to physically determine if Mr. Moore had secreted the razor in his rectum, but that at some time after his demise, the CRC acquired a BOSS Chair. This is a chair that the inmates sit on and which is finely attuned to detecting any metal secreted in rectal and oral cavities.

[92] CO Morla indicated that since Mr. Moore's death, if a razor goes missing, that inmate is immediately sent to the BOSS Chair and is strip-searched. His cell is also searched and if no razor is found, the next step is to send the inmate to Health Care to determine if he is or is not suicidal. Supervisor Moore indicated that it would be a good idea to lockdown inmates until a missing razor is found. He testified that supervised shaving scenarios would not work at the CRC, nor would the use of electric razors. The latter would be impractical because of hygiene issues and the fact there would be more parts for inmates to pilfer. The former would be impractical because of the sheer numbers of inmates who need to shave within a relatively short time frame.

[93] In terms of searching the toilet, Supervisor J. Moore stated that standard practice should be the use of the mirror and a flashlight to search under the toilet lip. Since Mr. Moore's death, Supervisor J. Moore has ordered complete lockdowns and full body and cell searches, as well as the use of the BOSS Chair when a razor has gone missing

Supervisor Moore agreed that mirrors should be used in cell searches and that a written protocol as to what to do when a razor is not returned should be established.

[94] Both CO's Morla and Edgson were relatively new, and CO Morla indicated that he had never seen or been trained with respect to a protocol dealing with missing razors. He felt a protocol and specific training would have been valuable in this circumstance.

Lead up to the Suicide

[95] During the prior two days before his death, Mr. Moore's roommate indicated that Mr. Moore was quite non-communicative. He indicated that "every time I went into my room he was asleep with a towel over his eyes. It took about the first two days before he even said, Hi." It wasn't until Friday, the 12th that his roommate noticed that Mr. Moore was actually talking and moving around. This withdrawn type of behaviour is apparently usual at the CRC and there was nothing out of the ordinary about it.

[96] Mr. Moore's mother, Dessie Moore, spoke to her son for about three minutes around 2144 (approximately two hours before he committed suicide) on December 12th, 2008. She indicated that there was nothing in his telephone call that alerted her to his impending suicide. In fact, his last words to her were "I'll call you later." His former girlfriend, Cherie Mellafont also spoke to him the night he died at approximately 2148 for about three minutes (just after he called his mother).

[97] Ms. Mellafont had been Mr. Moore's girlfriend in July of 2008. Mr. Moore had then been arrested for sexually assaulting her. She believed she spoke to him while he was at APU and was alarmed because he had threatened to commit suicide. She recalled telephoning the APU of CPS in July of 2008 to express her concern that Mr. Moore was at risk of self-harm. Mr. Moore had told her that he "just can't live with the guilt anymore", "that he had done so much wrong" and he was "done with his life." The next day, someone from the police service called to tell her that she had saved his life because they checked him and found pills (of a painkiller nature) in his rectum. Mr. Moore also called her after the pills had been found and thanked her for saving his life. However, as detailed as these allegations are, the APU has no record of Ms. Mellafont's phone call in July, 2008, and no notations were made on Mr. Moore's electronic record or either an original or working copy of the Booking Sheet.

[98] Between July and December, 2008, while he was out of custody, Ms. Mellafont indicated Mr. Moore had been consuming drugs (methamphetamine and crack). During this time, he threatened to harm himself on a number of occasions. He called her on December 12th at 1539 to apologize for taking her father's firearm, her girlfriend's car, about $50,000 worth of property from Encana, and $4,700 from her bank account. She responded to the effect that she hated him and he replied: "That's all I needed to hear."

[99] Later that evening on December 12th, Mr. Moore called her again at 2148. During that last conversation, he told her that he felt horrible for taking the money from her and promised that his mother would bring by $1000. It appeared as if he was trying to make amends. It was a reassuring conversation in which he told her that "everything

was going to be fine." As a result, she was shocked when he committed suicide some three hours later.

The Suicide

[100] The Deputy Director of Operations at the CRC, Mr. Baecker, has been with Corrections since 1985. He reviewed the policy with respect to "Counts of Offenders". This is a policy that requires CO's to go from cell to cell looking in through the cell window for signs of life (movement and breathing), using flashlights if required, but usually with a night light. This cell count was performed at approximately midnight on December 13th by Antoinette Sparrow, a CPO 2. Ms. Sparrow had worked the 1500 to 2300 shift on December 12th and had stayed to work a double shift from 2300 on December 12th to 0700 on December 13th.

[101] After muster (during which she was not alerted to any special problems on Unit 4 or to the missing razor issue) she attended at Unit 4 to do her formal takeover inmate count before 2300 when lights were turned out.

[102] At 2357, she completed a formal walk through looking for signs of life in each inmate in each of the cells. She watched for movement, listened for breathing or snoring and shone a light onto an inmate if she had doubts any of them were alive. She noted signs of life with respect to Mr. Moore.

[103] However, shortly after midnight, there was a call from Mr. Moore's cell. Mr. Moore's roommate was panicked, yelling: "There's something wrong with this guy!" Ms. Sparrow could hear moaning in the background and she could hear Mr. Moore's roommate kicking at the door. Ms. Sparrow ran to the cell after flicking on the emergency lights. She arrived to see blood on the wall beside the lower bunk where Mr. Moore was lying and immediately called Code 99 – Unit 4 over her radio. By this time Mr. Moore was grey – very ashen.

[104] Ms. Sparrow was not allowed by protocol to enter the cell without another staff member present, regardless of what she saw in the cell. Within minutes, assistance arrived. She opened the cell door and lifted the blanket a little. At that point, the Emergency Response Team arrived and instructed her to put pressure where the wound was. Mr. Moore was breathing, making gasping noises.

[105] Jamie Dos Santos was the responding nurse on the Emergency Response Team. She had ten years experience at the CRC by December 13, 2008 when she received the call to attend Unit 4 at 0010. She raced to the scene and arrived within two minutes at 0012 with her nurse partner Heather Hatch. Nurse Dos Santos observed blood on the wall. Mr. Moore was gasping for air and was covered with blankets and clothing. When she removed the bedding she could see a bunch of towels stuffed between his legs. When she removed the towel, the femoral blood spurted towards her and she knew he had cut his femoral artery. Mr. Moore was, by that point, unconscious, and according to the Medical Examiner, there was nothing that could have been done at that point to reverse brain death which occurred over the next few minutes.

[106] She put the towel back in place across the bleeding area and checked the other leg but could see no source of bleeding. She instructed the two correctional officers present to hold the towels in place and maintain pressure so as to minimize the bleeding. To her, it looked like Mr. Moore had already lost a considerable amount of blood, perhaps as much as two liters.

[107] Mr. Moore was immediately given oxygen by Nurse Hatch, but there was no 'non-rebreather' mask in the medical bag, so Nurse Hatch had to use the bag valve mask until another medical bag arrived that contained a non-rebreather mask, which she then changed out for the bag valve mask. The non-rebreather mask gives a higher concentration of oxygen than the bag valve mask which doesn't remove any carbon dioxide. Even had the non-rebreather mask been initially present, more oxygen would not have assisted Mr. Moore; his terminal problem was excessive blood loss.

[108] Nurse Dos Santos determined that it was vital to attempt to replenish fluids so she tried to start an IV, but Mr. Moore had lost so much blood that his veins had collapsed. Since she did not get 'back flash' (blood in the tube to show you have hit the vein), she was unable to determine if the needle was actually in the vein. It might have been that by then, the heart was no longer pumping and the vein had totally collapsed, as Dr. Belenky testified that the vein would collapse after the loss of two liters of blood. Collapsed veins were likely the reason she did not get the 'back flash'.

[109] In any event, she tried a smaller gauge needle, but his breathing started getting slower and further apart and then it ceased. She had never been trained to put in an intravenous IV and was not qualified to even attempt that procedure (which only an ER nurse might have been able to do in a hospital). Even had she been able to effect the procedure with a large bore needle, the likelihood is that given the number of minutes it would take to replace the two liters of lost blood with other fluid, it would have been much too late to assist Mr. Moore. Mr. Moore did not have a radial or carotid pulse and there was no heartbeat when she listened for a heartbeat with her stethoscope.

[110] Once there was no heartbeat, Nurse Dos Santos commenced chest compressions, which forced some vomit to emerge from Mr. Moore's mouth. Nurse Hatch attempted to suction it away and discern if there was an airway blockage. Nurse Hatch had already noted that Mr. Moore did not have a gag reflex, so she had inserted the oral airway and started doing artificial respirations with the bag valve mask hooked up to the oxygen. However, by this time, it was too late. Mr. Moore succumbed to extreme exsanguination sometime between 0012 and 0017, well before the EMS arrived on scene at 0026.

[111] Dr. Michael Belenky testified that once the femoral artery was completely transected, it would take only two minutes until Mr. Moore was unconscious and that brain death would irreversibly occur within five minutes. His medical cause of death was a self-inflicted complete transection of the femoral artery that caused an acute tubular necrosis and ultimately terminal exsanguination (or acute blood loss). When the blood stopped flowing to the brain, an irreversible state occurred and he died. In retrospect, Dr. Belenky testified that there was nothing the responding nurses could have done to save Mr. Moore. By the time they arrived, Mr. Moore was in an

irreversible state and his brain was dying. He succumbed only minutes into their attendance with him.

[112] At some point, Nurse Dos Santos saw the razor used by Mr. Moore to cut his femoral artery lying on a ledge of the bed frame near Mr. Moore's head.

CRC PROCEDURES

[113] With respect to the procedure followed by nursing staff in 2008 once notified an inmate might be suicidal, Nurse Dos Santos indicated they would call an inmate down right away to conduct an interview and would refer the inmate to the psychologist. It would be an immediate process and the inmate would be put on a suicide watch in observation cells. That never happened in this instance because there was no recorded history, no paperwork to indicate he required a special assessment, and no self-disclosure.

[114] Nurse Dos Santos indicated that over the last 12 years she has had no outside training or refresher courses. She relied on the Internet and Dr. Gillespie for updates on medical advancements. With the CRC coming under the auspices of the Calgary Health Region, she was hopeful there would be more opportunity for refresher or training courses.

[115] She also indicated that the current procedure for doing a complete inventory for the 'Code' bags is ineffective because a complete inventory is not done before the bag is resealed. There are five 'Code 99' bags and two nurses' medical bags. Nurse Dos Santos indicated it would be ideal if someone would be designated on every shift to check the medical bags, count the inventory and replace any used, missing or expired items. In this later regard, she suggested that a list be kept in a clear packet on the front of each bag to indicate when, for example an IV solution expires. If not attached directly to the bag, she suggested such a list could be wall mounted or put in a binder. In this case, there was nothing actually missing from the nursing bag itself. As such, it does not seem within the purview of this Inquiry to make any recommendation with respect to either the five Code 99 or two Nurses' bags, as what was needed for this emergency was contained in them.

[116] However, the missing non-rebreather mask should have been attached to the oxygen tank that was brought to the unit, but it wasn't. Nurse Dos Santos indicated that a recommendation should be that someone be designated to replace the non-rebreather masks after every use and attach it to the oxygen tank. Nurse Hatch recommended that as well as a non-rebreather mask being attached to the oxygen tank, someone should be designated to ensure one is also included in the nurses' bag.

[117] Over time, the Alberta Correctional Services has adopted new practices in an effort to eliminate security concerns presented by razors and razor blades. Since the death of Mr. Moore, both provincial policy and Standard Operating Procedures have been amended. At the CRC, the razor log books not only track who was issued a razor,

including time out and back in, but there is also an inventory control process that has been established.

[118] From 78 incident reports between 2008 and 2010, 15% involved a razor blade. The degree of noted injuries ranged from superficial scratches to an injury requiring 70 sutures. A 30 day-review for June 2010 of Unit 4 at CRC was undertaken to track the number of razors that were not returned. Of 641 issued 3 were not returned. In 2008, five razors blades were noted in the contraband log, with 8 in 2009 and 11 between January and September of 2010. Razor blades have been concealed in a cell or on the living unit itself, and in obscure hiding places such as a pen lid or in books. They can be used for anything, such as cutting hair or as a weapon. During 2008 to 2010, there were 7 assaults involving a home-made knife (although it was not documented as to whether or not a razor blade was part of the knife). There have been two razor-related deaths in the Alberta Correctional System since 1985.

[119] What was not provided during this Fatality Inquiry was a full and complete audit of how much of a problem the loss of razors in Provincial Correctional Institutions really is. The only way to determine this is by doing a formal audit from kept records.

[120] With respect to training related to searches, this Inquiry heard that sometimes the gap between a new recruit being hired and actually receiving a nine week course can be as much as 12 months. Certainly, during this very real gap, searches of both the cell and the inmate are critical aspects for officer and inmate safety that need to be adequately addressed.

[121] I note that the Solicitor General Correctional Services already has an Emergency Medical Plan SOP number 20.05.06, which provides in section 3 that the Central Control Area Supervisor is to appoint a ‘recorder’ to keep an accurate table of events as they occur.

RECOMMENDATIONS

1) *Respecting Procedures at the Arrest Processing Unit of the Calgary Police Department*

1. The APU Arrest Release Detention Work Flow Process flowchart requires modification to the last point where notifications are made on transfer of custody to another institution.

2. The CPS Policy and Procedures with respect to report writing should be clarified to ensure accurate and consistent reporting of a suicide attempt or ideation across the CPS.

3. With respect to Part 2, Chapter B of the APU Standard Operating Procedures (“SOP”) Manual, a new Section 16 should be written with respect to the detention and transfer of custody of high risk detainees, specifically to notify the

staff of the facility who takes custody of a high risk (including suicide risk) detainee that a specific risk exists with respect to that detainee.

4. Notification of staff of facilities who take custody of high risk detainees should be referenced in the APU SOP Manual in Part 2, Chapter J, Section 9, Subsection 2F and in Part 2, Chapter K, Section 13, which is the section relating to the transport of suicidal persons. It should also be amended to reflect the necessity for use of the 'silent partner' or vans with a cage in transporting high-risk detainees.

5. There should be random audits performed (at least annually) by the APU Administrative Staff Sergeant to ensure that all policies and procedures are being followed with respect to detainees who have been identified as a suicide risk. In order to facilitate such audits, the computer program used at the APU should be updated to permit the auditor to determine who made each electronic entry.

6. These audits should be reviewed to determine whether further education or training in the application of Standard Operating Procedures with respect to the handling of suicide risk detainees is necessary.

7. All current APU Staff should immediately receive suicide prevention education and training. Prior to transferring into the APU all future staff should have received suicide prevention education and training similar to that set out in Exhibit 6, Tab 39 and 40[5]. Records should be kept as to who has received that training. Annual refresher courses should be scheduled and attended by all APU personnel.

8. The task of ensuring that at all material times the Original and Working Copy of the Booking Sheet and its electronic source are true copies of each other prior to transfer or discharge of a detainee from the APU should be specifically listed as Principle Task #10 under the Staff Sergeant's duties, perhaps reading as follows:

> #10 Set up procedures for handling the flow of paperwork, ensure all electronic, Original and Working Copies of Booking Sheets are true copies of each other at all material times and ensure that all procedures are followed.

9. There should be only one Original and Working copy of the Booking Sheet at any given time. Any pre-existing copies should be destroyed after all relevant information is transferred to the amended Original, Working and Electronic copies of the Booking Sheet.

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[5] Tab 39 – Print out of a Power Point Presentation on Suicide Prevention
Tab 40 – Print out of a Power Point Presentation on Suicide Prevention – CPS-Care of Persons in Custody

10. There should be no handwritten notifications of Suicide risk made on either the Original or Working Copy of the Booking Sheet unless the same notifications are made on all of the Original, Working Copy and Electronic copy of the Booking Sheet. The Original, Working and Electronic copies of the Booking Sheet should contain a specific field relating to suicide risk that must be filled out, with any change in suicide risk to also be noted.

11. A Protocol should be developed for the appropriate assessment of a detainee who has been identified as having a suicide ideation or as being actively suicidal prior to that detainee's Bail Hearing.

12. One person on each shift should be designated to take calls from the public with respect to a detainee's risk of self-harm. Protocols should be inserted into the APU SOP Manual requiring that person to transfer the notes from that call onto the Original, Working and Electronic copies of the Booking Sheet, as well as all other material documentation as required by the APU SOP Manual.

13. If a detainee is identified as a suicide risk, any change to that designation while in APU custody must be dictated by specific Standard Operating Procedures in the Manual that must be followed prior to the implementation of such a change in status. Such procedure must be amended to require a formal assessment by qualified medical personnel with records of the reason for such change in status to be recorded on the Original, Working and Electronic copies of the Booking Sheet and in other requisite documents as required by the SOP Manual.

14. If a detainee is indentified as a suicide risk (whether active or ideation) an Exit Assessment by a Paramedic should be mandated by a specific Standard Operating Procedure prior to such a detainee's release from custody, with the Paramedic being required to keep a record of the Exit Assessment and reasons for release without follow-up psychiatric care, on the Original, Working and Electronic copies of the Booking Sheet and on any other documents as required in the Standard Operating Procedures Manual.

15. A protocol should be developed between Alberta Health Care, the CRC, the CYOC and the CPS as to the circumstances that must exist before a detainee identified as a suicide risk should be sent back to CPS, CYOC or CRC custody after psychiatric or psychological assessment by an Alberta Health Care professional outside those respective institutions. This Protocol should be applied Provincially.

2) *Respecting Procedures at the Calgary Remand Centre*

1. Procedures 5 and 6 of the CRC Standard Operating Procedure Section Unit Routines Number 02:15:27 entitled Issue of Safety Razors, be amended to read as follows:

5) Upon receipt of the razor, ***the Officer shall cause the inmate returning it to initial a Return Razor Log***. The Officer shall inspect the razor to ensure it is in an unaltered condition.

6) Dispose of the razor in a ***clear unbreakable Sharps container***, ***which container shall be emptied after each shift, so that officers may keep a visual count of razors returned*****.**

2. A Standard Operating Procedure be developed with respect to procedures to be followed when a razor goes missing. Suggestions for inclusion would be to:

   a) immediately lock down the Unit;

   b) conduct an immediate strip-search of the inmate who did not return the razor;

   c) conduct an immediate BOSS chair search of all inmates on the Unit;

   d) conduct an immediate cell and general unit search, which such search shall include the use of a mirror search under the rim of the toilet bowl;

   e) make a notation on the Razor Record and flag it to indicate that a razor is missing, who signed it out and when, and communicate that to the next shift officer so that the next shift officer can be alerted to the missing razor;

   f) communicate the results of the search to the Supervisor, orally and in writing advising how, who and what was searched, and what, if anything, was recovered;

   g) keep a record of how many razors go missing and forward that information quarterly to the Standards and Audits department;

   h) if the razor is not found, the inmate who failed to return it should, after the strip and BOSS search is complete, be sent to the Nursing Unit for interview, assessment by the Psychologist and, if necessary, placement on suicide watch.

3. The four-day initial training program that all new recruits receive include exposure to the above policies and protocols with respect to accounting for and searching for missing razors. Specifically, new recruits should be shown how to conduct a cell search in an actual cell. The use of mirrors in such searches should form a part of that education.

4. Mirrors for use in toilet bowl searches be either readily available on each unit for use during a cell search or personally assigned to each officer for use as required.

5. A formal annual audit should be conducted to determine the extent of incidents involving razors in all Alberta Correctional Institutions and such action as is deemed advisable as a result should be taken.

6. A Corrections Service Worker should be required to review every inmate's medical history on the computer immediately before conducting an intake interview, just in case there is some recent concern which has not yet been added to the paper file, or in case there is something missing in the paper file.

DATED October 11, 2011 ,

at Calgary , Alberta.

Judge Cheryl L. Daniel
A Judge of the Provincial Court of Alberta