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 Provincial Court of Alberta

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

on the 15th, 16th and 17th days of June, 2011 (year), (and by adjournment

on the _____ day of _____, _____ (year)),

before The Honourable Judge C. M. Skene, a Provincial Court Judge,

into the death of Kevin Kenneth IVALL (Name in Full) 31 (Age)

of Harvie Heights, Alberta, Canada (Residence) and the following findings were made:

Date and Time of Death: June 14, 2008 at 1539 hours

Place: #401, 1000 Harvie Heights Road, Harvie Heights, Alberta, Canada

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)).

Ligature Strangulation

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:

See pages 4 to 9

Recommendations for the prevention of similar deaths:

See pages 11 to 12

DATED October 21, 2011 ,2011

at Calgary , Alberta.

The Honourable Judge C. M. Skene
A Judge of the Provincial Court of Alberta

Introduction

1. Kevin Kenneth Ivall (Ivall) tragically took his own life, committing suicide on June 14, 2008.

2. On March 17, 2009 the Fatality Review Board recommended that a public fatality inquiry be held *to review the method of police intervention*, when presented with a young man, barricaded in his room at Banff Boundary Lodge, threatening suicide.

3. The Fatality Inquiry was held in the Calgary Courts Centre on June 15, 16 and 17, 2011. Eleven witnesses testified and over 1000 pages of exhibits were tendered as evidence.

4. After considering all of the evidence in the Fatality Inquiry as a whole, and specifically reviewing the method of police intervention, I find the evidence shows the Royal Canadian Mounted Police (RCMP) responded appropriately to Ivall's behaviour and physical situation.

5. Shortly after Mr. Ivall's death, the RCMP Major Crimes Unit did a thorough investigation, resulting in an Investigation Report, authored by Constable Michael Evans.

6. Constable Evans testified at this Fatality Inquiry into the death of Ivall. During his testimony, he referred to his Report, which he prepared after many hours of reviewing relevant documentation, police notes, interviewing or reviewing the interviews of the individuals, some of whom testified in the Inquiry, and many others. His fact findings include a review of Ivall's actions and interactions with his companions the evening of June 13 and the early morning hours of June 14, 2008. I am attaching a copy of Constable Evans' Investigation Report as Appendix "A" to this Fatality Inquiry Report.

7. To a large extent, my summary of the evidence will repeat his fact findings.

8. I provide a summary or time line of the circumstances under which the death of Ivall took place on June 14, 2008, as disclosed in the testimony and evidence tendered in the Fatality Inquiry. In response to the Fatality Review Board's recommendation of March 17, 2009, I focused on the police response to Ivall's telephone call to 911, Southern Alberta Operational Communications Centre, disclosing that he was going to kill himself.

9. Also in this Fatality Inquiry Report, I summarize the testimony and report of the Medical Examiner.

10. I also summarize the recommendations of an Interested Party – the Ivall family members.

11. Thereafter, I comment on an item that is not relevant to Ivall's death – being the deployment of the distraction device, seconds prior to the RCMP finding Ivall's body.

As will be seen in the facts disclosed in this Fatality Inquiry, the device did not cause Mr. Ivall's death.

12. At the end of this Report, I make my own recommendations to prevent similar deaths.

Brief Summary of the Circumstances under Which Death Occurred

13. Kevin Kenneth Ivall, (DOB June 19, 1976), 31 years old when he committed suicide, spent the evening of June 13 and early morning of June 14, 2008 with acquaintances. He was reported to have consumed a large amount of illicit drugs when he became distraught at his apartment, Room 401, a staff housing unit at Banff Boundary Lodge (the Lodge) in Harvey Heights, Alberta.

14. On the morning of June 14, 2008, Ivall's boss and a maintenance employee of the Lodge went to his apartment and found him to be locked in his bedroom. In their presence, he placed a knife to his throat stating he did not want to live through another birthday, which was five days later.

15. Ivall was the first person to telephone 911. Others called 911 immediately thereafter.

16. Ivall barricaded himself in his apartment. First RCMP responders' information resulted in the RCMP calling in an Emergency Response Team (ERT).

17. Negotiations were commenced by a first responder – Constable Diebel who was coached by a trained RCMP negotiator. Constable Diebel and Ivall spoke to each other off and on for over two hours.

18. The ERT arrived shortly after the time of the last telephone contact with Ivall.

19. Approximately two hours after ERT's arrival, a six member team entered Ivall's barricaded dark apartment. A diversion device or flash bang was thrown into the bathroom when resistance prevented the bathroom door from opening further than six to eight inches.

20. The deceased was found dead on the bathroom floor, with a self applied ligature tied tightly three times around his neck.

21. The diversion device or flash bang caused a perforating injury to the deceased Ivall's abdominal wall. He was dead prior to the time of the injury to his abdomen.

Summary of the RCMP Response

June 14, 2008

22. 1018 hours - Ivall, in his apartment, at the Lodge in Harvey Heights Alberta, telephoned 911, the Southern Alberta Operational Communications Centre (SAOCC), stating, "I've barricaded myself and I'm going to kill myself." Among other things he stated, "I just wanted to warn you ma'am" and "I guarantee by the end of the night, I'll be dead."

23. 1020 hours - Constable Ortega, an on-duty RCMP member of the Canmore Alberta detachment received a radio call asking him to telephone dispatch. Dispatch explained to him that they had received information there was a male in Room 401 at the Lodge in Harvey Heights Alberta who had telephoned 911 stating he had taken some bad drugs and that he intended to kill himself if anyone tried to enter his apartment.

24. Constable Ortega informed his coworkers, Constable Green and Constable Lavery, and all three of them attended the scene of the complaint.

25. Constable Ortega formed the opinion the barricaded, suicidal Ivall, presented a high risk situation for the police officers.

26. Ivall's apartment was in a multiplex building, a staff housing suite with a single door entrance and exit onto the grounds of the Lodge. It had two bedrooms, a kitchenette, an eating area and one small full bathroom.

27. A dispatch call about Ivall's threat of suicide was also directed to the Banff detachment of the RCMP. Constable Murphy and Constable Diebel decided to drive to Harvey Heights to offer support to the Canmore RCMP members.

28. Holly C. and Kathleen A. from the Lodge telephoned the SAOCC reporting an emergency, that Ivall was threatening suicide. They reported that Ivall had a knife to his throat and was high on drugs.

29. At the Lodge, Constables Ortega, Green and Lavery approached Ivall's apartment and knocked on the door. Ivall came to the door which had a draped glass window. Without opening the door, he looked out the window at the officers.

30. Constable Ortega asked Ivall to open the door and lie on the floor on his stomach. He did not.

31. Ivall had a conversation with Constable Ortega and told him that he had taken some bad drugs; that he did not want to hurt anyone; and that he did not want to hurt a police officer. He stated if the police entered the apartment that he would kill himself. He stated he was very paranoid. Physically, Ivall's eye movements were quick, moving side to side. His pupils were constricted and pinhead size. His facial skin was moist. He had a knife in his hand. Chairs were positioned blocking the door.

32. 1035 hours – SAOCC contacted Corporal Laura Akitt, the supervisor at the Canmore RCMP detachment, and advised her about the crisis at the Lodge and what her members were dealing with.

33. Constable Ortega telephoned Corporal Akitt and informed her that Ivall was barricaded in his apartment and that he was acting extremely irrational. She instructed him to clear the common areas of the Lodge, evacuate other rooms of employees and guests, and to not enter the apartment.

34. 1042 hours - Canmore EMS were requested to attend the scene at the Lodge and arrived at 1045 hours.

35. Constable Diebel and Constable Murphy arrived at the Lodge. Constable Diebel saw Ivall peer out the front door window, scan the surrounding area and then disappear behind the curtain. Ivall looked paranoid, very agitated, and appeared to be shifting. His pupils were pinhole size.

36. Constable Diebel spoke to Ivall through the front door shortly after his arrival at 1045 hours. He told him that they were the police that they were there to help him and were trying to figure out what was going on. Ivall responded "[l]eave me alone. I'm fine" and also "I don't need you guys here. Just leave me alone. Go away." Ivall did not have a shirt on and was holding a cell telephone. Constable Diebel was at the door, trying to speak to Ivall and negotiate a safe conclusion to the crisis for half and hour to 45 minutes. During that time, Ivall would come to the door and peer out, looking beyond Constable Diebel. He described seeing shadows and hearing noises.

37. Ivall told Constable Diebel that he did not want any one coming into his apartment.

38. Consistently throughout his communication with the RCMP, and in particular his conversations with Constable Diebel, Ivall asked for half an hour – that he needed time, but did not give a rationale explanation as to why he needed that time.

39. Also during all communications with Ivall, it was made known by him that he had consumed drugs, which he believed were "bad drugs", that he was seeing things and was hearing voices. He acknowledged he was feeling paranoid. He presented as paranoid.

40. Constable Ortega provided Constable Diebel a cell telephone. Constable Diebel held the cell telephone up to the window and showed Ivall the number. Ivall entered the number into his cell telephone and called Constable Diebel. Call display on the cell telephone revealed what Ivall's cell number was.

41. Constable Diebel was advised that Ivall may be in possession of firearms and as a result moved away from the front door.

42. Corporal Akitt contacted SAOCC and requested a trained negotiator contact her as soon as possible.

43. SAOCC telephoned Inspector Lawrence Aimoe at his home in central Alberta and he agreed to act as the crisis negotiator for the Harvey Heights situation – that being the barricaded and armed Ivall, who was threatening suicide.

44. Inspector Aimoe was put in telephone contact with Corporal Akitt at the scene. The on-scene members of the RCMP, including Constable Diebel, Constable Ortega and others, were instructed by Corporal Akitt, on the advice of Inspector Aimoe, to back well away from the front door of Ivall's apartment.

45. Constable Diebel moved to an office at the Lodge and spoke to Ivall numerous times having a fairly regular dialogue from his first contact at 1045 hours to his last telephone contact with Ivall at 1300 hours.

46. Constable Diebel was given a second cell telephone by Corporal Akitt in order to speak to Inspector Aimoe, the trained negotiator. Other members were patched into that conversation as well.

47. Inspector Aimoe coached Constable Diebel during his negotiations with Ivall. His goal of the negotiations was to calm Ivall down, have him come out of the apartment safely and to get him immediate psychiatric and medical help. The last resort, in the opinion of Inspector Aimoe, would be for the RCMP to enter the apartment and force Ivall out, due to the danger to Ivall, the danger to the police, and the danger to the public. A forced entry into the apartment presented the greatest risk to all.

48. At this time, or shortly thereafter, Superintendent Simpson, Incident Commander, decided to deploy an ERT to deal with the crisis in Harvey Heights. Inspector Aimoe was advised of this decision.

49. A RCMP ERT is a trained multidisciplinary team of RCMP members. Depending upon the event, the team members would include an incident commander, and may include specialists in electronics and technology, a police dog and police dog handler, air support, assaulters and snipers.

50. At approximately this time, Constable Diebel was advised that Ivall had a criminal history for domestic violence and outstanding criminal charges for breach of a recognizance, assault, possession of a weapon and simple possession under the *Controlled Drugs and Substances Act*.

51. Staff Sergeant Shannon Johnson, the NCO in charge of the Canmore detachment arrived at the Lodge in Harvey Heights.

52. 1242 hours - During one telephone conversation with Constable Diebel, Ivall told him that he has been throwing up because of his earlier drug consumption.

53. 1308 hours - From 1308 hours until 1526 hours Constable Diebel made numerous attempts to contact Ivall via telephone, on both the apartment land line and Ivall's cell telephone, without success.

54. Inspector Aimoe was relieved as the trained negotiator for the Harvey Heights crisis and was replaced, at the location, by the ERT primary negotiator Corporal Simcoe, who continued to work with Constable Diebel.

55. Another Lodge room was required to be cleared of guests or employees who had not evacuated earlier.

56. As a result of a failure to communicate with Ivall since 1300 hours [he would not answer his cell telephone or his apartment's landline], a loud speaker or "megabox" was put in place 1435 hours to attempt communication.

57. The ERT were positioning themselves as directed.

58. 1455 hours - One of the ERT members detected a very minor movement appearing to come from Ivall's bathroom and then again another minor movement at 1456 hours, suggesting that Ivall may still be alive.

59. 1512 hours – Incident Commander Simpson authorized the ERT to enter Ivall's apartment. He also authorized the use of a diversionary device, also referred to as a "flash bang", as an entry strategy process. Some time was spent before and after this authorization, discussing and planning the entry and the team member roles.

60. The goal of the entry was to locate Ivall, secure the scene, and bring in EMS as quickly as possible.

61. Six officers were part of the stack that was to make the stealth entry.

62. 1521 hours - Entry was made into Ivall's apartment by ERT. Items such as a sofa, mattress, and chairs barricaded the apartment and a number of these items were placed up against the windows with curtains closed. The apartment was very dark. All rooms, but the bathroom, were cleared and determined to be empty. The last room to be searched was the bathroom. The bathroom door was closed, but had extension cords running down the hallway and under the bathroom door.

63. The team attempted to open the bathroom door but received some resistance, and considered the door to be obstructed or barricaded, perhaps by Ivall, after being unable to open the door more than six to eight inches.

64. A distraction device was deployed and thrown by a team member through the six to eight inch door opening into the small bathroom. Upon detonation, the bathroom door was blown off its hinges and into the apartment.

65. Ivall was found naked on the bathroom floor, his death having been caused earlier by ligature strangulation – suicide.

66. The distraction device, when thrown into the room, bounced off the bathroom vanity and landed and exploded on Ivall's body, causing a significant gaping hole in his abdomen. The device did not cause or contribute to Ivall's death.

67. 1527 hours - Two Canmore EMS were escorted into Ivall's apartment. Paramedic-Firefighter Donelon examined Ivall and observed that he had no pulse, his body was making no sounds, his body was cold and his body had some rigidity. The injury to Ivall's abdomen was not bleeding. There were no signs of life. All indications suggested that Ivall had been dead for an undetermined period of time.

68. 1540 hours - Major Crimes Unit Constable Evans was contacted in Lethbridge to assist with a review of the RCMP response to this incident in Harvey Heights. He was advised that the ERT had just entered Ivall's apartment in Harvey Heights and found Ivall deceased. Constable Evans and Constable McKay were tasked with the

investigation on the basis that the RCMP considered this incident to be an in custody death.

69. Shortly after finding Ivall deceased, the ERT conducted a re-enactment of their entry and the finding of Ivall's body.

70. 1632 hours – Constable Evans contacted Constable Sherrie Brunelle, Forensic Identification Unit, requesting her assistance examining Ivall's apartment, the scene of his death.

71. 1828 hours - Next of kin notification.

72. 2055 hours - Briefing of Constable Evans.

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73. 0100 hours - Ivall's body was removed from his apartment's bathroom.

74. Constable Brunelle continued her examination of the apartment.

75. Constable Brunelle estimated the bathroom to be approximately two and a half metres long by one metre and a half wide.

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76. 1200 hours – Constable Brunelle attended Ivall's apartment with Staff Sergeant Hamm, a blood stain analyst. Staff Sergeant Hamm examined Ivall's bathroom and noted tissue splatter and conducted a tissue analysis. His findings were consistent with the autopsy report, which include that Ivall's abdomen injury was caused by the diversion device after Ivall had died.

Medical Evidence – Cause of Death

77. Dr. Graeme Dowling, Chief Medical Examiner for the Province of Alberta, testified at the Fatality Inquiry.

78. He determined that the cause of Ivall's death was ligature strangulation. The manner of death was suicide. The ligature used was a black cord, referred to by Dr. Dowling as an audio video cable. It was a type of electrical cable containing three wires. The cable was tightly wrapped three times around the circumference of Ivall's neck and then tied in a bow knot at the front of his neck. Two objects were placed between the cable and Ivall's neck. The first object was the casing of a disposable pen. The second object was a kitchen can opener. The two objects increased the pressure on the neck from the ligature.

79. Dr. Dowling explained that when a pressure of approximately 11 to 13 pounds is placed on both sides of the neck, the pressure cuts off the blood supply going from the heart to the brain through the carotid arteries. If the pressure is applied and maintained, unconsciousness may occur in as little as 8 seconds to up to

approximately 15 seconds. If the pressure is maintained for a period of time of two to five minutes, death will ensue. The sustained pressure, caused by the cable tied around Ivall's neck, and contributed to by the added pressure of the pen casing and can opener, caused Ivall's death.

80. Some time after Ivall died, the distraction device was deployed and injured his body, perforating the abdominal wall. His abdominal cavity was exposed and a segment of the colon was perforated.

81. Dr. Dowling testified that if Ivall had been alive when the distraction device was used, "the injury that he received could easily have caused death, not immediately, but over time, given that the injury included damage to the large bowel, the colon which contains fecal material which would, of course be a source of infection."

82. Postmortem toxicology testing showed the presence of methamphetamine (crystal meth.), amphetamine, diltlazem – a heart disease medication, and breakdown products of cocaine and codeine, in Ivall's blood.

83. The exact time of Ivall's death has not been determined. The last confirmed contact with Ivall was 1300 hours, or 1:00 p.m., on June 14, 2008, when he spoke with Constable Diebel on the telephone from his location barricaded in his apartment at the Lodge. At 1531 hours, or 3:31 p.m., the paramedic observed that Ivall was deceased and that his body was cold, among other observations.

Recommendations to Prevent Similar Deaths – <u>suggested by the family</u> of Kevin Kenneth Ivall

84. The RCMP, when faced with a similar situation – a suicidal person, barricaded in a residence, should try to find a family member to: potentially help with negotiations; to obtain medical information; and, to make the family aware of the family member in crisis.

85. The RCMP, in Ivall's event, should have entered his apartment sooner than they did, considering that the resort manager had entered the apartment a couple of times without being harmed.

86. The RCMP should review their use of distraction devices or flash bangs, in particular the use of a distraction device in a small room such as a hotel sized bathroom. The family of Ivall recommended that distraction devices not be used around any person, regardless of the age of the person or the area location of the person.

Scope of the Fatality Inquiry into the death of Kevin Kenneth Ivall

87. *Fatality Inquiries Act*, R.S.A. 2000, Chapter F-9:

s. 53(1) At the conclusion of the public fatality inquiry, the judge shall make a written report to the Minister that shall contain findings as to the following:

(a) the identity of the deceased;

> (b) the date, time and place of death;
> (c) the circumstances under which the death occurred;
> (d) the cause of death;
> (e) the manner of death.
>
> **(2)** A report under subsection (1) may contain recommendations as to the prevention of similar deaths.
>
> **(3)** The findings of the judge shall not contain any findings of legal responsibility or any conclusion of law.
> . . . .

88. The family of Ivall asked that the scope of this public Fatality Inquiry into the death of their son and brother extend to the use of the diversion device or flash bang and that the Inquiry Judge consider making recommendations as to the use of the device by the RCMP and other police forces.

89. The parameters of the Fatality Inquiry, into the death of Kevin Ivall, are to consider the circumstances under which his death occurred on June 14, 2008 and to make recommendations to prevent a similar death or deaths occurring in the future.

90. The cause of death was ligature strangulation. The manner of death was suicide. The diversion device – flash bang did not cause his death or contribute to Ivall's cause of death.

91. Considering the use of the diversion device, or any police policy regarding its use is outside the scope of this Inquiry.

Recommendations to Prevent Similar Deaths

92. The Fatality Review Board recommended that a Public Fatality Inquiry be held to review the method of police intervention. I am cognizant of the fact that I have no jurisdiction to make findings of legal responsibility or make any conclusions of law. I find that the police response to the crisis at the Lodge on the morning of June 14, 2008, and extending into the afternoon, when considered from a critical perspective, shows no deficiency in the methods employed.

93. The RCMP response and method of police intervention showed rational planning, deliberation and an appreciation for the risk to Ivall, the police responders and the public.

94. It was apparent to me that the response-intervention was considered based on education and experience. The evidence in the Inquiry showed that the first responders and those who responded thereafter, sought experienced assistance immediately, showed the responders knew what resources they had at their disposal, and that experience and expertise was available to assist the officers on the scene on short notice.

95. Ivall presented as a high risk of suicide. He described himself as suffering the effects of "bad" drugs. He was exhibiting symptoms of a mental disorder and was threatening suicide. He was hearing voices and seeing things, and was self described as paranoid. He was observed brandishing a knife on more than one occasion and was on release for assault and possession of a weapon. It was known that he had barricaded himself in his apartment.

96. As stated by one of the RCMP witnesses, at the time of the crisis, they did not know what was going on with Ivall, they did not know what his intentions were, and they did not know what was going on in his life. They had no way of knowing what he was capable of or what he was going to do next. It does appear on the evidence in this Fatality Inquiry that a relative or friend may have been a valuable source of information that may have assisted the police in the negotiations and may have added to the ongoing risk assessment.

97. The negotiations with Ivall were considerate, measured and skilled.

98. The actions of the RCMP after the discovery of Ivall's body were also exemplary. Although there are limitations to my jurisdiction as a Judge sitting on a Fatality Inquiry, that report, authored by the Major Crimes Unit, Constable Evans, and attached to this Report as Appendix "A" is very comprehensive and may be a valuable in consideration of future police intervention and the use of diversion devices.

Recommendation One

99. If the police respond to a person exhibiting symptoms of a mental disorder, who is endangering himself or herself or others, or threatening to endanger himself or herself or others, a mental health practitioner such as a psychologist, psychiatrist, or social worker should be consulted, if possible, for advice and assistance.

Recommendation Two

100. If the police respond to a person exhibiting symptoms of a mental disorder, who is endangering himself or herself or others, or threatening to endanger himself or herself or others there, should be an attempt to identify relatives or friends of the person, if possible for information, including medical information, about the person.

101. I make this second recommendation with some qualification. The recommendation should not be interpreted to say that I am recommending that the relative or friend actively assist in the negotiation with the person exhibiting symptoms of a mental disorder. That is the decision of the police and I anticipate would be an infrequently exercised option.

INVESTIGATION REPORT	RAPPORT D'ENQUÊTE	Protected 'A' SECURITY CLASSIFICATION / DESIGNATION CLASSIFICATION/DÉSIGNATION SÉCURITAIRE

RE - OBJET

Kevin Kenneth IVALL B:1976-06-19
Sudden 'In Custody' Death of
Canmore, Alberta June 14, 2008

OTHER FILE REFERENCES AUTRES CONSULTATIONS DE FICHIERS	DIVISION K	DATE 2008-12-10	RCMP FILE REFERENCES CONSULTATION DE FICHIERS DE LA GRC
	SUB-DIVISION - SOUS-DIVISION Southern Alberta District		2008676048
	DETACHMENT - DÉTACHEMENT Lethbridge - Major Crimes Unit		

1. The above investigation was conducted in Canmore, Alberta, by members of 'K' Division Major Crimes, Southern Alberta District, Lethbridge starting on June 14, 2008.

2. On June 14, 2008, S/Sgt A. White of the 'K' Division Major Crimes Unit, Southern Alberta District requested the assistance of Lethbridge Major Crimes Unit (MCU) in the sudden death investigation of Kevin Ivall. The Calgary Medical Examiner's office has classified the death as 'in custody' because of the recent dealings with RCMP members in Canmore.

3. Upon arrival at Canmore, a short briefing was held with Canmore RCMP Detachment NCO i/c S/Sgt Shannon Johnson and members of Canmore Detachment, and Lethbridge MCU. Cst. Michael Evans was appointed the Primary Investigator, for this investigation, by S/Sgt. White - A/OIC 'K' Division Major Crimes, Southern Alberta District. Cst. Evans tasked Cst. Richard McKay - Lethbridge MCU, the role of File Coordinator, while S/Sgt. White maintained the Team Commander position. Cst. Evans implemented the Major Case Management System for this investigation.

4. Areas of investigation:

   a. Initial call for service to Canmore RCMP members;
   b. Identifying and interviewing witnesses, who dealt with Kevin Ivall on the morning of June 14, 2008;
   c. Identifying and reading notes from Canmore RCMP Detachment members who responded to the Banff Boundary Lodge for the call for service;
   d. Identifying and reading the statement of RCMP Emergency Response Team (ERT) members who entered the Banff Boundary Lodge and found Kevin Ivall deceased;
   e. Medical Assessment of Kevin Ivall by Emergency Medical Service;
   f. Autopsy of Kevin Ivall;
   g. Scene Examination by Forensic Identification Section (FIS) and Blood Stain Analyst;
   h. Identifying and interviewing witnesses who were with Kevin Ivall during the evening

of June 13, 2008;

i. Emails from Kevin Ivall's family.

5. Findings:

a. Initial call for service to Canmore Detachment:

i. On Saturday, June 14, 2008, at 10:20 am, a call for service was placed to Southern Alberta District Operational Communication Centre (SAOCC) on 911, by person who identified themselves as Kevin Ivall, who said he was at the Banff boundary Lodge in Room #401. The male said he had barricaded himself and was going to kill himself. The male also said he was in possession of cocaine and was under the influence of drugs. A further call to SAOCC was received by a person who identified themselves as Holly (believed to be Holly C[redacted]), at the Banff Boundary Lodge and she said they had an emergency. Holly said one of their staff members was possibly on drugs, was threatening suicide and had a knife. The call was initially dispatched to Cst. Ortega of Canmore Detachment as a mental health complaint at 10:20 am.
(See Tab 1 for transcript of 911 calls. For a full transcript of all SAOCC radio transmissions, telephone calls and conversations with Ivall, please refer to the attached CD)

b. Identifying and interviewing witnesses, who dealt with Kevin Ivall on the morning of June 14, 2008;

i. Lindsay F[redacted] was interviewed and Cst. Evans has read her statement. F[redacted] works at the Canadian Rockies Chalets, which is affiliated with the Banff Boundary Lodge. She told investigators that on June 14, 2008 at about 9:30 am, she received a telephone call from Kevin Ivall. She said Ivall sounded different and he asked her if she could do him a favour. He wanted her to tell Kathleen A[redacted] (manager) that he was leaving, people were packing up his room and he would be gone within two days. He told her his parents were involved in a car accident and one of them died. He said he had a cab waiting and was heading to the Calgary airport to get a plane.

F[redacted] said she got a call from A[redacted], on unrelated matters, and she told her about what Ivall had told her. She said A[redacted] said she would go and check on Ivall. F[redacted] said about 20 minutes later A[redacted] called her back and told her that she just kicked out three people from Ivall's room.

F[redacted] said Ivall had a 'Facebook' site and he posted a message saying he

was hosting a birthday party on Friday, the 13th at 11:00 pm at the Rocky Mountain Ski Lodge. It said he was supplying the booze, dope and grub. Investigators checked the site out and a copy of the invitation was printed off.
(See Tab 2 for Lindsay F[redacted]r's Statement. For a copy of the Facebook invitation, please refer to the attached CD, in the folder titled - Kevin IVALL)

ii. Shelley H[redacted] was interviewed and Cst. Evans has read her statement. She said she owns Tri-link Management, which holds the management agreement for Banff Boundary Lodge. She said she was called at about 10:30 am on June 14, 2008 and told she was needed at the Lodge, for an emergency. She went to the Lodge and stayed with Cst. Diebel, who was negotiating with Ivall. She said Ivall did not currently have any roommates but had one about a month ago.

iii. Katherine A[redacted] was interviewed and Cst. Evans has read her statement. A[redacted] told investigators that on June 14, 2008 at 9:00 am, F[redacted] told heard that Ivall's had been involved in an car accident and one of them had died. She went to check on his room, #401, where Ivall was staying, and she found an unknown person in the room, whom she kicked out. She could not find Ivall initially in the room but one of the bedrooms were locked.

A[redacted] said she went and got a master key for the bedroom and returned with Trevor D[redacted], a maintenance man, at the Lodge. A[redacted] said she broke the door frame because someone had put a pair of scissors between the frame and door to try and jam it. Inside the room they saw Ivall exiting his bedroom with a baseball bat and a knife. She said Ivall made a slicing motion at this throat and D[redacted] tried to intervene, but it appeared to agitate Ivall. Ivall said he was not going to hurt anybody and that he did not want to live through another birthday. He said he just want some time to sober up. She said her and D[redacted] backed out of the room and called police.

A[redacted] said she saw drugs, drug paraphernalia and some beer bottles inside the room when she first went to check on Ivall.
(See Tab 3 for Katherine A[redacted] and Shelley H[redacted]'s Statements)

iv. Trevor D[redacted] was interviewed and Cst. Evans has read his statement. D[redacted] told investigators that he is a maintenance man at the Banff Boundary Lodge. On June 14, 2008, around 9:30 - 10:00 am, he was unloading some furniture when Kathleen A[redacted] approached him and asked for his assistance to check a room. D[redacted] said Ivall had been pretty much terminated as an employee, at the Banff Boundary Lodge, and when they went into the room, Ivall was standing in the living room. He was told

he had 10 minutes to get his stuff together and they would be back. He said he saw evidence of drug paraphernalia and drugs. D[redacted] said he and A[redacted] returned to the office. When they returned back to the unit, Ivall was on the phone calling police and he was telling them he was under the influence of drugs and was requesting more time to get his belongings together and to vacate the property.

D[redacted] said when they returned the second time, Ivall had a baseball bat started to come at them, in what he described as a threatening manner. Ivall finally put down the bat and D[redacted] moved it from Ivall's reach. D[redacted] said he saw in the back pocket of Ivall's pants a knife. After the bat was put down, Ivall took out the knife and came towards them with it. He put the knife to his throat and wrists and kept repeating he did not want to live another birthday and he did not want to have another birthday, this way.
(See Tab 4 for Trevor D[redacted]'s Statement)

v. Holly C[redacted] was interviewed and Cst. Evans has read her statement. C[redacted] told investigators that she works at the Banff Boundary Lodge, at the front desk. She started her shift at 7:00 am on June 14, 2008. She saw A[redacted] in her office and thought F[redacted]r had called A[redacted]. She saw A[redacted] leave and grab D[redacted]. While A[redacted] was out, Ivall called and asked to speak with A[redacted]. While Ivall was on the phone, A[redacted] returned and turned the conversation over to A[redacted]. C[redacted] said the conversation last about 5 minutes and then A[redacted] and D[redacted] went back to room #401. When A[redacted] returned, she was frantic and asked her to call police. A[redacted] said it was an emergency, he had a bat and a knife, was going after them and they need some more help. C[redacted] said she called the RCMP and they were already aware of the situation and police arrived shortly afterwards.
(See Tab 5 for Holly C[redacted]'s Statement)

c. Identifying and reading notes from Canmore RCMP Detachment members who responded to the Banff Boundary Lodge for the call for service;

i. Cst. Enrique Ortega-Caceres authored a report and Cst. Evans has read the report. Cst. Ortega-Caceres said on June 14, 2008 at 10:20 am, he was dispatched to an urgent matter. He was told that a male by the name of Kevin in room #401 at the Banff Boundary Lodge called 911 saying he took some bad drugs and will kill himself/cut his throat if anyone tries to enter the room and that he has lost his job. He enlisted the assistance of other detachment members.

While en route to the scene, SAOCC updated him that the manager of the Banff Boundary Lodge had also called regarding the male in room

#401.The manager requested police assistance to evict the male. She further said she had gone into the subject's room to check on him. The manager saw the subject with a knife across the neck, making a cutting motion and saying if she came in he would kill himself. She exited the room and called the police.

Cst. Ortega-Caceres said he arrived at 10:35 am and he met with Kathleen A[redacted], manager of the Banff Boundary Lodge. He said he met members at the front parking lot and showed members where room #401 was. A[redacted] provided writer with a set of keys for room #401. Cst. Ortega-Caceres said he carefully approached room #401 and made contact with a Caucasian male peeked out the door window. He said the room was barricaded and the door was locked. He confirmed the male was Ivall and attempted to persuade the subject to open the door and lie down on his stomach. Ivall said he had taken some bad drugs and did not want to hurt anyone. He said he was only dangerous to himself and wanted some time to come down from his high and would not open the door. Ivall further said that if members entered the room that he would kill himself and he was very paranoid. Cst. Ortega-Caceres said Ivall displayed signs that were consistent with a person who was paranoid and saw what appeared to be a knife handle. He said Ivall had barricaded the front door with some chairs.

Investigators began conducting background checks and Cst. Ortega-Caceres was told Ivall had a record for violence with weapons, family violence, possession of a controlled substance. Checks for firearms were conducted on CFRO and he was told Ivall had some registered to him. (It was later learned that the above information was not correct. They were registered a different subject with the same surname, with an address in Cochrane.) **(For a copy of the CFRO check, please refer to the attached CD, under the folder - Kevin IVALL)**

At 11:00 am, Cst. Ortega-Caceres contacted his supervisor, Cpl. Laura Akitt and advised her of the situation. Cst. Ortega-Caceres said, one of the members, Cst. Tim Diebel arrived on scene and commenced negotiating with Ivall through the door and intermittently by cell phone. Cpl. Akitt told Cst. Ortega-Caceres that she had advised S/Sgt Johnson and ERT had been requested. Detachment member secured the perimeter around the hotel room and nearby guests were evacuated.

At 3:26 pm, Cst. Ortega-Caceres said ERT entered the room and he heard a loud noise. At 3:35 pm, ERT requested EMS, which had been staged nearby, to approach room #401. Shortly afterwards, EMS exited and pronounced Ivall was deceased.

(See Tab 6 for Cst. Ortega-Caceres's General Report)

ii. Cst. Tim Diebel authored a report and Cst. Evans has read the report. Cst. Diebel said on June 14, 2008, at approximately 10:23 am, he heard, over the police radio, about an urgent request for assistance about a suicidal male held up in room #401 at the Banff Boundary Lodge. He had just finished his shift in Banff and he attended and offered his assistance.

Cst. Diebel arrived at the Lodge at approximately 10:45 am. He met with Cst. Ortega-Caceres at room #401. He saw the windows on the front of the room were drawn and there was a heavy brown blanket in the window of the door. Cst. Diebel knocked at the door and made contact with Ivall. Ivall said "*leave me alone. I'm fine*" and that he did not require any help, he just needed time. Cst. Diebel confirmed with Ivall that he had some knives but there were no other weapons inside. Cst. Diebel said Ivall appeared to be displaying paranoid behaviour.

Cst. Diebel said he began negotiating with Ivall. He spoke through the door to Ivall and then he began to communicate with Ivall over a cellular telephone. Ivall said it was not his intention to hurt any police officers. He liased Insp. Lawrence Aimoe, a negotiator, and relocated to a more secure area which was quieter for him to continue negotiations with Ivall because he had already developed a rapport with Ivall.

Ivall told Cst. Diebel that he was naked in the bathroom and that he had been throwing up. Eventually Ivall agree he needed medical attention but for a half an hour to meditate and have another bath. Ivall said he would come out after the half hour. Cst. Diebel told Ivall he call him back in 10 minutes. Cst. Diebel said this was the last conversation he had with was Ivall around 1:00 pm. Cst. Diebel called Ivall back 10 minutes later but could not make contact about with Ivall.
(See Tab 7 for Cst. Diebel's Supplementary Report. For a complete transcript of negotiations please refer to the attached CD)

d. Identifying and reading the statement of RCMP Emergency Response Team members who entered the Banff Boundary Lodge and found Kevin Ivall deceased;

i. Cst. Garth Jenkins, Canmore GIS interviewed members from the Emergence Response Team (ERT) and they conducted a walk through of the scene. Cst. Evans has read the interview and walk through. Cpl. Guy Johnson and Cst. Ron Lyver, from Red Deer ERT, provided an explanation of the ERT response. Cst. Lyver said they staged in [redacted] and readied for a stealth entry into room #401.

Cst. Johnson said he was at the front of the team and he had the master key for the door. He said they opened the door and he could feel resistance on the door. He said he saw there was the stuff on the floor and chairs by the door. He said they were able to get the team into the room.

Cst. Lyver said he was the first in he saw these chairs in front of the kitchen area. He said there was a bed railing positioned in the hallway and all the windows were blocked by either couches or bedding, so everything was blacked out here. Cst. Lyver said he noticed was two extension cord wires running across the hallway. He said they were aware that possibly take a bath. So they checked the other two bedrooms and just like the other rooms, they were blacked out. A kitchen table was actually propped right up against the window, in one bedroom and a mattress and then the frame was leaning against the window, in the other bedroom.

Cst. Lyver said they felt if the bathroom door was shut, he would have been barricaded himself inside there. He said one guy propped the door approximately six to eight inches but there was something behind it. Cst. Lyver said they pushed the door further open and he went to throw a diversionary device in. He said as he was releasing the device, he caught a glimpse of his hand, so he tossed it above his hand. Cst. Lyver said because of the small size of the bathroom, the bathroom door was blown off it's hinges, out towards the hallway. They placed the door in one of the bedrooms, out of the way.

Cst. Lyver said they found Ivall on the floor. He noticed the injury to Ivall's abdomen, that he believed was from the diversionary device. He said there was no movement by Ivall and he was quite certain that Ivall had passed away. He said they then called for EMS to come in right away and check Ivall. Cst. Lvyer saw Ivall had a belt wrapped around his throat and what he thought were scissors in his throat.
(See Tab 8 for a copy ERT Re-enactment Statement. See Tab 9 for full planned drawing of the rooms. See Tab 10 for scene photographs)

e. Medical Assessment of Kevin Ivall by Emergency Medical Service:

i. Becky Donelon was interviewed and Cst. Evans has read her statement:

Donelon said she and Lynn Scheopp were staged in the area of Harvey Heights and Elk Run Road, at approximately 10:40 am, on June 14, 2008. She is a Paramedic Fire Fighter with the Canmore Fire Department. They waited until they were called to the scene. She said around 3:30 pm, they

were called to come to the scene. They were met by ERT and went directly to the bathroom. She said the body was supine on the floor, with what looked like stereo cords, plyers and a belt around his neck. She saw the trauma to the lower left quadrant of the abdomen, by the hip, but the wound was not bleeding. She said there was no blood or emesis on the floors, walls or around the patient. She said the body was extremely cold to touch, he was rigored, stiff to move, to some degree there was dependent poolings, which she said were definite signs of death. She said the entire body was very pale, white and cyanosised. by his sides She said the pupils were fixed and she checked both the carotid and radial pulse, which were absent and the left the scene. Donelon has 15 years experience as a medic.
(See Tab 11 for Becky Donelon's Statement)

ii. Lynn Schoepp was also interviewed and Cst. Evans has read her statement. She did not have any direct interaction with Ivall and confirmed Donelon's statement. **(For a copy of Lynn Schoepp's Statement, please refer to the attached CD)**

f. Autopsy of Kevin Ivall:

i. On June 16, 2008, Cst. Chris Reister, with Cst. Sherrie Brunelle of Forensic Identification Section - Calgary, attended the autopsy of Kevin Ivall. Cst. Reister said the Chief Medical Examiner - Dr. Graeme Dowling completed the autopsy.

ii. On October 6, 2008, Dr Dowling authored a report on the autopsy of Kevin Ivall and Cst. Evans has read the report. Dr. Dowling said there was an audio/video cable extended three times around the circumference of the neck and tied in a non slip knot over the front of the neck. The cylinder of a disposable pen and one arm of a can opener were in place between the ligature and the decedent's skin of the left side of his neck in order to increase pressure from the ligature to his neck. Dr. Dowling noted that all three items could have been placed there by the decedent. Dr. Dowling also noted there was an abundant tiny pinpoint bleeding sites (petechiae) of the face above the ligature. He said the petechiae indicated the decedent was alive when the ligature was placed around his neck.

Dr. Dowling said the injury caused by the distractionary device caused a perforating injury of the front of the abdominal wall, such that the abdominal cavity was exposed and a segment of the colon was perforated. He said there was no evidence of any form of living reaction to this injury within the depth of the wound and on small explosive abrasions located adjacent to

the wound. This was an indicator that the decedent was dead at the time the distractionary device was deployed. A Postmortem toxicology report indicates the presence of drugs in the blood.

Dr. Dowling said the cause of death has been attributed to ligature strangulation. He said though there are indicators the decedent was dead when the distractionary device was deployed, Dr. Dowling noted had Ivall been alive, the abdominal injury caused by the distractionary device was of sufficient severity to be a potential cause of death.
(See Tab 12 for the Medical Examiner's Report)

g. Scene Examination by Forensic Identification Section and Blood Stain Analyst;

i. Cst. Sherrie Brunelle from Forensic Identification in Calgary attended the Banff Boundary Lodge and she authored a report detailing her findings and Cst. Evans has read her report:

Cst. Brunelle found several blankets and clothing items bunched both under and behind the front door. She said a twin mattress was against the north window, the living room couch was upended and placed in front of the east window. She further noted the kitchen chairs were in the living room and on their sides.

She said the north east bedroom had the kitchen table pushed up against the bedroom window. She found a butcher knife on floor, in front of the bed. She found a pin clip from diversionary device by the entrance door, to the bedroom. She also said an orange electrical and black electrical cord ran from the room to the bathroom. Cst. Brunelle said the south bedroom had both mattresses on their sides, leaning against the west wall, underneath the bedroom window. She said the bathroom door was found in the bedroom on its side.

Cst. Brunelle found the deceased naked, lying on his back in the bathroom. His head was touching the north side of the door jamb, his knees were bent, with both feet underneath a kitchen chair, that was in the bathroom. There was a black audio visual cord tied around his neck. She noted the knot was located around the throat area. There was a can opener and a cylinder of a pen lodged underneath the cable, on the left side of the neck. There was a long trickle of red substance that had streamed from the mouth area and down both cheeks. She also noted the gaping injury on the lower left side of the abdomen.

She said the bathtub was filled with water and she found two knives in the

bathroom. She said there was small particles of flesh visible on the walls, countertop, cupboards and ceiling. She said she examined the bathroom door and door frame and there were flesh particles visible on the inside of the door and portions along the centre part of the door had black smears. There was a brass hook on the upper edge of the door but it was concluded that it was not strong enough to support the weight of a body.
(See Tab 13 for the Forensic Identification Report)

ii. Cpl. Tom Pack from Forensic Identification in Calgary also attended the Banff Boundary Lodge, to assist Cst. Brunelle. He authored a report, which Cst. Evans has read, and Cpl. Pack's report concurs with Cst. Brunelle's report.
(For a copy of Cpl. Pack's report, please refer to the attached CD, under the folder - Scene Examination)

iii. S/Sgt Dean Hamm from Regional Forensic Identification Section in Edmonton attended the Banff Boundary Lodge, on June 18, 2008 and he authored a report detailing his findings and Cst. Evans has read his report:

S/Sgt Hamm's documented two key findings/results from his analysis of the scene.

1. the bloodstain patterns and biological material present at the scene are consistent with injuries and findings documented in the autopsy report.

2. The location and distribution of the bloodstain patterns and biological material are consistent with the reported position and location in which the body of Kevin Ivall was found.
(See Tab 14 for the Bloodstain Pattern Analysis Report)

h. Identifying and interviewing witnesses who were with Kevin Ivall during the evening of June 13, 2008:

i. Nicolas B[redacted] was interviewed and Cst. Evans has read his statement. B[redacted] said he went to the Rocky Mountain Ski Lodge, around midnight, the night before Ivall's death (June 13, 2008), for a birthday party. He said he met Kevin Ivall at the Lodge and they went to the bar for drinks. Kevin Ivall said "I'don't feel well, I'm going to go out a little, to the garage." B[redacted] said also present were Jenny G[redacted], Yannick A[redacted] and Jean S[redacted], and Natalie. He said Natalie left earlier in the morning. Ivall said he also had taken speed and ecstasy. B[redacted]r said said Ivall tried to make himself throw up several times. After Ivall came down from the mushrooms, they did a little cocaine, around 7:30 am. B[redacted] said Ivall called in sick

and a lady came to the door and kicked them out of the room. B[redacted] said she left and was coming back with a man, B[redacted] said Ivall told them to "get out of here, get out". He said Ivall was panicking and hid beside a mattress and said "let me come down" and "call me later." B[redacted] said he left Ivall his cell phone. B[redacted] said he called Ivall after they left and Ivall told him the police were there and to "call back 911 and tell them to calm down, if not, if the police come in, I'll kill myself." B[redacted] denied that Ivall was depressed.
(See Tab 15 for Nicolas Boucher's Statement)

ii. Jenny G[redacted] was interviewed and Cst. Evans has read the her statement. G[redacted] said she was with Ivall on June 13, 2008 and they were at the Rocky Mountain Ski Lodge and went to the bar. She said afterwards they came back to her place and then about 2:30 - 3:00 am Ivall, B[redacted], A[redacted] and Jean S[redacted] left and went to Ivall's place to continue with the party. G[redacted] said on June 14, 2008, at approximately 09:45 am, B[redacted], A[redacted] and Jean S[redacted] returned home and said that Ivall was not doing well. She said she called Ivall and he told her "the police, the police are outside, they're waiting to kill me." She said she spoke with Ivall a few times during the morning and he kept telling her "give me a half-hour. Let me come down and I'll call you back." She said she last spoke with Ivall around 12:30 pm on June 14, 2008. G[redacted] said Ivall had ingested a lot of mushrooms on the evening of Friday, June 13, 2008.
(See Tab 16 for Jenny Grondin's Statement)

i. Emails from Kevin Ivall's family:

i. Cst. Jenkins liaised with Kevin Ivall's family, during the NOK, who were residing in Quebec. Ivall's sister, Suzanne Gaureault, forwarded to Cst. Jenkins four emails that Kevin Ivall had sent the family from September 2007 to June 7, 2008. In the emails and specifically, the most recent email (June 7, 2008), there are no threats of suicide.
(See Tab 17 for a copy of the June 7 2008 email. For all emails, refer to the attached CD under Kevin Ivall's folder)

6. Conclusion:

a. In conclusion, there is no evidence to link the cause of death of Kevin Ivall to direct actions by the RCMP. The reasons for this are as follows:

i. On June 13, 2008, Kevin Ivall hosted his own birthday party where drugs and alcohol were present. This was corroborated by associates Nicolas

B[redacted], Jenny G[redacted], and a 'Facebook' website, as outlined by co-worker Lindsay F[redacted]. Manager, Kathleen A[redacted] and Maintenance Personnel, Trevor D[redacted], also said when they visited Ivall's room, they saw evidence of alcohol and drug consumption. This is further corroborated by the Medical Examiner's Toxicology Report.

ii. On the morning of June 14, 2008, Kathleen A[redacted] and Trevor D[redacted] went to Kevin Ivall's, after being told that Ivall had telephoned the front counter and told them his parents had been involved in an automobile collision killing one of his parents. When A[redacted] and D[redacted] went into the room, A[redacted] said a pair of scissors had been jammed between the door frame and door. ERT found the front door difficult to assess, upon their entry and FIS noted several items in the doorway, possibility in an attempt to barricade himself. FIS and ERT also located several large items in front of the windows further indicating Ivall was attempting to barricade himself.

iii. When they got into the room, Ivall exited a bedroom with a baseball bat and also had a knife in his pocket, which he took out after he put down the bat. Though Ivall did not make any motions to strike at A[redacted] or D[redacted] with the bat or knife, they felt threatened by Ivall. Ivall made indications, putting the knife to his throat which is corroborated by both A[redacted] and D[redacted]'s statement. Ivall's suicidal indications are corroborated by the initial call to SAOCC by Ivall and when Cst. Ortega-Caceres when initially approached the room and Ivall said he was dangerous to himself and would kill himself if anyone entered the room. Further suicidal indications are corroborated by Nicholas B[redacted] and Jenny G[redacted], friends who were with Ivall during the early morning of June 14, 2008.

iv. Cst. Diebel said he did not have any further contact with Kevin Ivall past 1:00 pm on June 14, 2008. After ERT entered the room, at approximately 3:25 pm, Kevin Ivall was found. Emergency Medical Services assessed Ivall and they said Ivall was cold to the touch, had fixed pupils, lividity was settling low on the body and rigor had set in, as outlined by Paramedic Becky Donelon, indicating that Ivall had been deceased prior to ERT's entry into the room. This is further corroborated by the Dr. Dowling's report.

v. S/Sgt Hamm said the bloodstain patterns and biological material at the scene are consistent with the injuries documented in the autopsy report and with the reported position and location where Kevin Ivall's body was found.

vi. Dr. Dowling requested a video showing the deployment of a distractionary device to assist him with understanding how the device works. A short video clip was provided to Dr. Dowling. **(To view these clips please refer to the attached**

CD, under the folder ERT Re-enactment)

vii. The cause of death of Kevin Ivall was ligature strangulation, as outlined in Dr. Dowling's report, and Ivall was not alive when the distractionary device was deployed and caused the abdominal injury. It should be noted though, as documented by Dr. Dowling, had Kevin Ivall been alive when the distractionary device landed on him, the injury sustained would have been serious enough to potentially cause the death of Kevin Ivall.

b. Sgt. Bartley has reviewed this file and agrees with the above conclusions.

I am available to discuss this investigation and findings should you have any questions.

(Michael Evans) Cst.
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