



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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the _____ the Law Courts
in the _____ City _____ of _____ Edmonton _____, in the Province of Alberta,
(City, Town or Village) (Name of City, Town, Village)
on the _____ 18th to 22nd _____ day of _____ November _____, _____ 2013 _____, (and by adjournment
year
on the _____ day of _____, _____),
year
before _____ The Honourable Leo J. Burgess _____, a Provincial Court Judge,
into the death of _____ Brenda Mary Moreside _____ 44 _____
(Name in Full) (Age)
of _____ 5024 – 45 Street, High Prairie, Alberta _____ and the following findings were made:
(Residence)

Date and Time of Death: _____ The morning of February 13, 2005. _____

Place: _____ 5024 – 45 Street, High Prairie, 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)).

Multiple stab wounds.

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)).

Homicide

Circumstances under which Death occurred:

Stan Willier and the deceased, Brenda Moreside, were common-law partners. Willier normally worked in the Fort McMurray area but returned to their shared residence in High Prairie, Alberta when not working. On February 12th, 2005 Willier and Moreside went out drinking to celebrate Moreside's birthday. Moreside was not allowed in the establishment they chose to go to because she had previously been banned. Willier stayed at that establishment until approximately 2:00 a.m. on February 13th at which time he returned to the residence. He did not have a key to the residence but obtained entry by removing plastic over a previously broken window and climbing into the residence. Moreside returned after Willier had entered the residence. Both were drunk. Moreside's blood alcohol level at the autopsy was .180.

Moreside was upset that Willier was in the residence and telephoned police to report the incident. She was connected to a civilian operator operating out of Edmonton. That civilian operator determined that Willier was entitled to be at the residence and found that there had been a previous incident report of difficulties between Moreside and Willier in August of 2004. The civilian operator contacted on-duty police in High Prairie and asked whether she should have another officer called in to investigate the situation but was told by the on-duty officer that that officer would handle the matter and make the phone call to Ms. Moreside.

When the civilian operator was talking to Moreside, Ms. Moreside stated that she did not want to have Willier arrested as he would lose his job but wanted them to come and take him away from the residence. The operator advised that he was legally entitled to be at the residence and they could not arrest him for public drunkenness in a private place. The civilian operator talked to the constable on duty and confirmed that he would contact Moreside.

The constable on duty attempted to call Moreside and was unsuccessful the first instance but was successful on a second opportunity shortly after 6:00 a.m. within minutes of Ms. Moreside's call to the RCMP.

Ms. Moreside indicated she was most unhappy at having Willier there but confirmed that she did not want to have him arrested but merely removed from the premises and taken to a drunk tank. This particular conversation between the constable and Ms. Moreside concluded with the officer suggesting to Ms. Moreside that both Moreside and Willier should get some sleep and deal with the situation in the morning.

Later, police investigations indicated that Willier left the residence to go to other relatives in the afternoon of February 13th.

Ms. Moreside's body was found by police investigating her apparent absence from other activities on February 25th, 2005. Officers attended at the residence, kicked the door in and found Ms. Moreside's body with multiple stab wounds in the residence.

On the autopsy some defensive wounds were found on Ms. Moreside indicating the likelihood of a struggle.

Willier later plead guilty to a manslaughter charge and received a sentence of 13½ years. In agreed facts entered at his guilty plea he acknowledged that Moreside had come towards him with a knife. A struggle ensued during which he took control of the knife and the death of Ms. Moreside from multiple stab wounds resulted. It is very clear that both people were intoxicated.

The only record of a previous involvement between Moreside and Willier with the RCMP is the situation in August of 2004 which resulted in no charges.

Evidence was received of a criminal record showing much violence in Willier's past.

The death of Ms. Moreside qualifies as domestic violence and is subject to review according to various police and provincial protocols on that basis.

Required Review

Although this death occurred in 2005 the Fatality Inquiry was not convened until November of 2013 as a result of many legal processes including appeals of the criminal proceedings in the matter of Ms. Moreside's death.

One should remember historically that domestic violence as a separate purvey of police activity and involvement of the justice situation did not really start to take place until the early 2000s.

Much of the research now available into these fields has been received in periods of time since this incident took place and many new risk assessment procedures have been formulated that were not in place at the time of Ms. Moreside's homicide.

Much time at the Inquiry was spent on a detailed review of all matters within the RCMP chain of command relative to domestic violence and I am satisfied that all reviews that were required into this 2005 homicide were taken and completed satisfactorily. There is an incredible chain of information indicating reviews at both a local, regional and detachment level indicating the RCMP's concern that their members receive the best possible training in dealing with situations of domestic violence.

It is not the purpose of this Inquiry to find fault in police procedures on a case by case basis.

Domestic Violence Policy Initiatives in the Province of Alberta

In viewing these particular circumstances and its relation to domestic violence it is important to look at policy only in respect of the time lines involved by this trial.

One must remember that although Ms. Moreside was killed in February of 2005, by the time Mr. Willier was charged, had a preliminary inquiry, had a first trial in the Court of Queen's Bench where he was acquitted, appealed to the Court of Appeal where the acquittal was reversed, had that appeal appealed to the Supreme Court of Canada where a new trial was ordered and the matter finally remitted back to the Court of Queen's Bench for a guilty plea to the manslaughter charges on June 6, 2011, the normal periods for holding a fatality inquiry into the death have long since passed. It might be normal for a fatality inquiry to be held within 2½ to 3 years from the date of the death but certainly this was not the case in respect of Brenda Moreside.

In looking at it from a domestic violence perspective it is important to look at the kind of things which happened in respect of domestic violence in the Province of Alberta largely during the period of time that had passed.

Only in respect of northern Alberta it should be noted that the first specialists as far as prosecutors go in respect of domestic violence were appointed in the fall of 2001. The Inquiry heard evidence of the progression of domestic violence policies and procedures in the Province from one of those two Crowns which were appointed in 2001. Those two Crowns largely trained themselves through attendance at various other jurisdictions which had family violence procedures in place. In approximately 2004 one of them was moved to the head office at the Department Justice and Solicitor General (as it now is) to develop a policy in respect of how family and domestic violence was to be handled in the Province of Alberta by prosecution services and police services.

During those early years seminar-type classes were offered for police officers at 7:30 in the mornings and during this time remote education programs were set up which allowed largely RCMP officers to remotely access training programs in respect of domestic violence. It is uncertain whether any of these programs were mandated as compulsory for officers and may very well have been at that period of time only done as officers were available for training or made themselves available for training. It would appear that a formal document called *Domestic Violence for Police and Prosecutors* was first produced in 2006 with an update on that handbook being made in 2009 and another in 2013.

With the 2009 revisions to the domestic violence guidelines for plea, the Family Violence Investigation Report (F.V.I.R.) and the Integrated Risk and Threat Assessment Centre (I-TRAC) were created.

F.V.I.R. was created as an assessment tool for frontline police to use in their interaction with domestic violence situations. The use of F.V.I.R. was mandated by the police chiefs across the Province in 2006 but it is unclear as to whether or not it was instituted at the front lines in any manner for some years and may as at the date of the writing of this report not be used on a regular basis throughout the Province of Alberta. Its use would depend on the level of training and the focus of the police agencies in various locations throughout the province.

Although F.V.I.R. and I-TRAC were formally recognized in the 2009 revisions of the manual it would appear that they may have in fact been in existence through various pilots as early as 2006.

The purpose of I-TRAC was to provide an agency which could coordinate threat assessment and assess imminent risk and the need for public awareness and police training into finding a strategy for safety. They do formalized threat assessments which are only as good as the information which they in fact can only do based upon the information which they received. The initial purpose of I-TRAC was to provide police training but it would appear from the evidence received that the training aspect seems to have diminished over the past number of years as police focus on gang crime and intellectual property crime seems to have increased.

The Police Advisory Committee (PAC) is a body composed of representatives from many police services in the Province of Alberta. It is this body that mandates standard practices and mandatory practices across the province. In 2007 fourteen pilots were run using F.V.I.R. and those pilots were deemed to be successful and it is those pilots that lead to the supposed mandatory use of F.V.I.R. by all police forces and enforce the inclusion of F.V.I.R. in the aforementioned 2009 update to the police and prosecutorial guidelines.

The inquiry was told that PAC has the power to mandate practices for police forces across the province and it would appear that PAC has been instrumental in the creation of a new training module relative to domestic violence made available in the spring of 2013.

Another board which seems to exist is the Law Enforcement and Oversight Board which has as one of its mandates the Alberta Policing Standard Manual which includes mandatory statements for practice of policy in Alberta and has an adherence audit attached to it.

It would thus appear that much thought and policy work has been done over the past 13 years into the problems created by domestic and family violence.

The Inquiry also heard that the civilian operators since this incident are now much more educated and reviewed in respect of the practices they use in taking calls from private citizens. Indeed training now devoted to these operators is in the writer's view exemplary compared to the guidance that early operators such as at the time of Ms. Moreside's death. There is now a rigorous regime in place for how these private operators function with full advisory services provided to them by policing services and into the extent of the officer on the line.

Recommendations for the prevention of similar deaths:

It is always difficult to make recommendations especially in the circumstances of this fatality inquiry where the death took place in February of 2005 and the fatality inquiry was not held until November of 2013 due to the delays involved in the legal process of trials, appeals and finally giving some finality to the Criminal Code charges assessed against Ms. Moreside's common-law spouse. However, some observations and recommendations can be made bearing in mind that the RCMP being the police service involved in this incident has undertaken a full and comprehensive review of the circumstances of the death and has of its own accord introduced many new policies and controls within their domestic violence setting of their operations.

1. Police services that utilize non-police telephone operators ensure that such operators are trained in their jobs especially in respect of recognition of risk factors in domestic violence situations but in all personal risk situations.
2. Police services should institute programs of domestic violence, risk assessment and management in their recruit training programs and continue to those programs into all of their field officers with a

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systems set up to monitor continuing education by all field officers in respect of domestic violence risk situations and management of domestic violence situations and indeed all personal risk situations.

3. Programs should be set up in all police situations to monitor the performance of officers in their early stages of coming into field work so as to ensure that those officers receive the necessary backup and guidance to allow them to develop their skills especially in respect of domestic violence situations.
4. That police services on a national, regional and local basis develop a domestic violence policy and thereafter advise the community and all necessary agencies of that policy and institute programs within their ranks to enforce such a policy.
5. That police services either through the Police Advisory Commission or through their own offices adopt a procedure whereby when a domestic violence situation arises, as defined by the existing domestic violence handbook, officers intervening in such a situation are required to complete for their files a document such as the FVIR form (Family Violence Investigation Report) and ensure that policy in respect of completion of such document is consistent within its ranks and that a review process of such reports be set up within their police services to ensure that when appropriate referrals are made to I-TRAC (Integrated Threat and Risk Assessment Centre) for analysis and return assessments to the police services so that they might monitor risk concerns.
6. That governmental agencies ensure that institutions such as I-TRAC continue to be funded and functional and available to all levels of operations within the province where risk assessments are required.
7. That a Provincial Death Review Committee continue its now fledgling operation much along the lines of its Ontario equivalent to ensure that all domestic violence deaths are reviewed and recommendations made to appropriate bodies to ensure that steps can be taken to prevent such deaths so much as are possible.

DATED December 4, 2014,

at Edmonton, Alberta.

The Honourable Judge James K. Wheatley
on behalf of
The Honourable Judge Leo J. Burgess