ALBERTA

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

*Fatality Inquiries Act*

WHEREAS a Public Inquiry was held at the Calgary Court House

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

on the 6 day of March, 2017 (year), (and by adjournment

on the 7 day of March, 2017 (year)),

before Judge Harry M. Van Harten, a Provincial Court Judge,

into the death of Bradly Barry Kowalczyk (Name in Full) (Age)

of _____ (Residence) and the following findings were made:

**Date and Time of Death:** _____

**Place:** _____

**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)).

Asphyxia by Hanging

**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)).

Suicide

**Circumstances under which Death occurred:**

Refer to pages 3 to 5.

**Recommendations for the prevention of similar deaths:**

Refer to page 5

## Introduction

The deceased Bradly Barry Kowalczyk died on the afternoon of September 22, 2014. He died after hanging himself in his jail cell at the Calgary Remand Centre the previous day. This public inquiry into the circumstances of his death leads me to conclude that I cannot make any recommendations so that similar deaths could be prevented.

Before examining the circumstances of Mr. Kowalczyk's death, two things should be noted. First, two of his next-of-kin, his wife Hope Pelletier and his mother Diane Coulliard, who had standing to appear and participate in this inquiry, advised through counsel for the inquiry that they would do neither. They did request a copy of this report and that will be provided.

Second, a critical part of the evidence led at this inquiry consisted of a binder of documents and dvd discs. To assist a reader of this report, a copy of the index of materials is attached as an appendix.

## Circumstances

On September 17, 2014, members of the Calgary Police Service arrested Mr. Kowalczyk at the residence he shared with Jennifer Meawasige. The two had been in a relationship for about one year. Ms. Meawasige described Mr. Kowalczyk's personality as varying from being upbeat to being down and depressed and that his emotions "could turn on a dime". Their relationship was made difficult because she had loaned Mr. Kowalczyk some $48,000.00 over the year they'd been together. She had become aware that he was wanted by police on outstanding warrants for fraud-related offences. She was in regular communication with an R.C.M.P. officer who was investigating Mr. Kowalczyk.

Afraid of being arrested, Mr. Kowalczyk stayed at home as much as possible. Despite this behaviour and the other difficulties, Ms. Meawasige remained with Mr. Kowalczyk in the hope that she might see some of her money back. On the day of his arrest, she found an apology note Mr. Kowalczyk had written her. She thought its tone was suicidal and the told the R.C.M.P. officer about it.

Mr. Kowalczyk was admitted to the Calgary Remand Centre at about 2200 hrs on September 17, 2014. Like all new prisoners, he was subjected to an admission health assessment pursuant to the Alberta Health Services' Admission Health Assessment Guideline. Registered Nurse Kuo Lo conducted the assessment, which includes questions about mental health. The questions are about problematic alcohol or drug use, psychiatric symptoms, whether the patient has ever seen a psychiatrist or psychologist or attempted suicide and whether the patient is currently suicidal. To each of these questions, Mr. Kowalczyk answered that he did not have problems, had never sought professional help and had never been and was not now suicidal.

As a result of this assessment, Mr. Kowalczyk was placed into the Remand Centre's general population. Had Mr. Kowalczyk acknowledged problems with drug or alcohol use, a mental health history or previous suicide attempts, Nurse Lo would have asked more probative questions before making an admission placement decision. Had Mr. Kowalczyk acknowledged being currently suicidal, he would have been placed in the Remand Centre's Observation Unit.

The Observation Unit is block containing eight cells in which inmates are placed after being dressed in "baby dolls", clothing without strings, zippers or other items which could allow the inmate to harm his or herself. The cells are under constant video observation and corrections officers are required to make physical contact with the inmate at least once an hour or more frequently if recommended by the health staff.

Like Nurse Lo, the other health staff members who testified at this inquiry including Tiffany Murray, the Calgary Remand Centre's health services manager, consistently stated that assessment protocols always err on the side of caution when assessing the potential for self-harm; put another way, "There is no grey area is assessing the risk; a person cannot be 'a little bit suicidal". A person either is or is not."

The witnesses also referred to the application of Alberta Health Services' Policy Level 3 entitled "Care of Suicidal and/or Acutely Mentally Unstable Patients." (Tab 34 (G) of Exhibit "1") This policy covers all provincial correctional institutions.

On the subject of screening and assessment, the Policy provides:

> The AHS *Care of Suicidal and/or Acutely Mentally Unstable Patients in a Provincial Correctional Facility Procedure* outlines a systematic approach to risk assessment, ongoing reassessment and treatment for patients at risk of self-harm and/or harm from others. ***(Emphasis added)***

That systematic approach was carefully applied in this case. For that reason, when the R.C.M.P. officer, to whom Ms. Meawasige had shown the apology note and expressed her concern about Mr. Kowalczyk's mental state, called the Remand Centre with this information, Mr. Kowalczyk was reassessed by Nurse Alana Wade. Nurse Wade found Mr. Kowalczyk made appropriate eye contact with her, denied being suicidal and contracted safety with her. She clearly explained that health unit services were available anytime to Mr. Kowalczyk. Nurse Wade found Mr. Kowalczyk neither to have suicidal ideation nor to be actively suicidal.

Nurse Wade had Mr. Kowalczyk returned to his unit. Because hers was a reassessment, Nurse Wade made a referral to have one of the health unit psychologists, none of whom were on duty at the time of the reassessment, see Mr. Kowalczyk. That referral never resulted in a meeting because Mr. Kowalcyzk had a Friday, September 19, 2014 video court appearance and the psychologists are not on

site on weekends. The health staff has access to psychological assistance on weekends in "acute cases", a description not fitting Mr. Kowalczyk's situation.

After Nurse Wade's reassessment, Mr. Kowalczyk's stay at the Remand Centre was apparently unremarkable over the approximately four days before his death. During this time, he had several telephone discussions with Ms. Meawasige. She said that Mr. Kowalczyk was trying to persuade her to assist him in obtaining judicial interim release and to resume their relationship. She persistently made it clear to him that she would do neither. While Mr. Kowalczyk was not pleased with her position, Ms. Meawasige did not note any concerns of the sort she had shared with the R.C.M.P. officer.

Their last telephone conversation concluded at approximately 1330 hrs on September 21, 2014. The conversation ended with an agreement that they would speak again that evening. That was about one half hour before Mr. Kowalczyk re-entered his cell near the end of "day room time", the period in which the inmates could be out of their cells and in the unit's common area. Shortly thereafter, Mr. Kowalczyk hanged himself.

There is absolutely no question that the emergency response to the Code 99, signaling that Mr. Kowalczyk was in distress, was first rate. The corrections officers, the health staff, the fire department and the emergency medical services personnel responded quickly and did everything they could to save Mr. Kowalczyk's life and get him to the hospital. Once there, Mr. Kowalczyk received the best possible care before being pronounced dead.

## Conclusion

Part of the evidence led at this inquiry was Cory Maennchen's testimony. He is an experienced correctional officer and was the Remand Centre's acting Assistant Deputy Director on duty at the time of Mr. Kowalczyk's hanging.

Prefacing it as speculative, he offered the theory that Mr. Kowalczyk did not actually want to take his own life but, rather, make a foiled attempt to do so in an attempt to persuade Ms. Meawsige to change her position on assisting him. He based this on the facts that Mr. Kowalczyk did not, through two mental health assessments, present as suicidal, that his stay at remand was otherwise unremarkable, that he was trying to persuade Ms. Meawsige to come to his aid in their telephone conversations, that he'd planned a further phone call with her and that he would have been aware that his act of hanging would be discovered very quickly by his cell mate, as it occurred at the very end of day room time.

Mr. Maennchen could not offer any suggestions as to how similar deaths might be prevented except for two are that clearly unreasonable. The first was that every prisoner could be constantly monitored one-on-one by a corrections officer. The second was that all prisoners could be constantly monitored by closed circuit television in their cell. Both of these suggestions are unreasonable because of their extremely high

economic costs and the grave concern about their negative effect on inmate privacy, privacy which is, in any event, relatively limited for any prisoner in a correctional facility.

This inquiry accepts Mr. Maennchen's theory about why Mr. Kowalczyk acted as he did and his opinion that there are no reasonable suggestions to be made about how to prevent similar deaths.

## Recommendations

Therefore, this inquiry makes no recommendations as to how similar deaths may be prevented.

DATED March 23, 2017 ,2017

at Calgary , Alberta.

*Original signed by*

H. M. Van Harten
A Judge of the Provincial Court of Alberta

**BRADLY BARRY KOWALCZYK**

**FATALITY INQUIRY**

**EXHIBIT BINDER**

## Medical Examiner's Records

1. Certificate of Medical Examiner.
2. Confidential Autopsy Report Form.
3. Autopsy Report.
4. Toxicology Report.
5. Calgary Police Service Report for Complaint #: 14369788.

## Board of Inquiry Records

6. Inmate Information.
7. Background Information.
8. Description of the Incident.
9. Findings.
10. Summary and Conclusion.
11. Recommendations.
12. Incident Reports, CRC Emergency Response Report and Staff Reports.
13. Offender Profile Report, CPS arrest form and court orders.
14. Shift Log Inquiry, Log Book, Note, Shift Log Report, document entitled "Central Control Shift Change".
15. September 24, 2014 Memorandum from Patty Kohl to Susan Wigle entitled "Incident Synopsis – Medical Emergency Involving Inmate Bradly Kowalczyk".
16. Adult Centre Operations Branch Policy Manual Policies and Procedures:
    A. Admission – General – Number 8.00.00
    B. Medical Examinations – Number 8.00.06
    C. Medium Security Area Unit Routines / Unit Officer Duties – Number 10.00.01 F
    D. Emergency Codes – Number 10.00.09
    E. Emergency Code 99 Procedures – Number 11.00.00
    F. Suicide and Apparent Suicide – Number 20.10.04
17. Interview of Scott Conrad, Acting Correctional Peace Officer III.
18. Interview of David LeClair, CPO I.
19. Interview of Michael Kitto, CPO I.
20. Interview of Jeff Liberty, CPO II.

21. Interview of Steven Swaney, CPO III and Acting Assistant Deputy Director.
22. Interview of Dustin Munford, CPO II.
23. Interview of Tiffany Murray, Health Services Manager.
24. Interview of Stephanie St. John, Registered Nurse.
25. Interview of Kayla Gibson, RN.
26. Interview of Alana Wade, RN.
27. Interview of Jayce Beaven.
28. Photographs of cell and contents.
29. Telephone Interception documents and disc of audio recordings.
30. disc of CCTV footage.

**Alberta Health Services Records**

31. Calgary Remand Centre Health File.
32. EMS Patient Care Record.
33. Foothills Medical Centre records (relevant records only).
34. Policies/Protocols/Guidelines:
    A. Admission Health Assessment Guideline
    B. The Delivery of Health Care to Patients in Provincial Correctional Facilities
    C. Essential Health Services Within Provincial Correctional Facilities
    D. Emergency Response
    E. CRC Health Services SOP: Suicidal and/or Mentally Unstable Inmates/Offenders – Identification and Management
    F. CRC Health Services SOP: Suicide and Apparent Suicide
    G. Care of Suicidal and/or Acutely Mentally Unstable Patients (HCS-157)
    H. Care of Suicidal and/or Acutely Mentally Unstable Patients (HCS-157-01)
    I. Care of Patients Following Attempted Suicide

**Calgary Remand Centre Records**

35. Case Note Report - Custody.
36. Bed History Report.
37. Unit 1 Log Book.
38. Shift Log Report for CRC-1 September 17-21, 2014.
39. Staff Placement Sheets September 18-22, 2014.
40. Incident Reports.