CANADA
Province of
Alberta

Report to the Minister of Justice

Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Alberta Court of Justice, 601-5th Street S.W.

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

on the 3rd to the 7th day of February, 2025 (year), (and by adjournment

on the 12th and 13th day of March, 2025 (year),

before The Honourable Justice Karim Z. Jivraj, Of the Alberta Court of Justice,

into the death of Deborah Chizoba ONWU (Name in Full) 47 (Age)

of Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death: October 25, 2019, approximately 2:55 a.m.

Place: 1826 – 27 Avenue S.W., Calgary, Alberta (Wood's Homes)

Medical Cause of Death:
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 Inquires Act, Section 1(d)).

Multiple stab wounds

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

Homicide

Circumstances under which Death occurred:

Summary

Wood's Homes Society ("**WHS**") is a non-profit health care facility providing treatment and support for children, adults and families with mental health challenges, including 24-hour live-in therapeutic care services for those with complex behavioral and mental health issues. WHS has around 600 employees, caregivers, and contractors and provides over 30 different programs and services to more than 20,000 clients annually. It has locations in Calgary, Lethbridge, Strathmore, Fort McMurray and Grande Prairie.

Deborah Onwu ("**Onwu**") began her employment with WHS as a Family and Youth Counsellor in January 2016. In the three years prior to her death, Onwu's primary assignment involved the care of a young person with autism. She was well liked by her peers and viewed by management as a competent staff member possessing many strengths. Starting October 3, 2019, Onwu began receiving shifts for the care of Brandon Newman ("Brandon"), a WHS client with complex needs. At the time of her death in the early morning hours on October 25, 2019, Onwu was working an overnight shift in an upstairs unit of a two-storey duplex style residence where Brandon, then 18 years of age, was being temporarily housed. The separate downstairs unit housed another WHS client who was assigned his own staff.

Brandon was admitted to the WHS Intensive Residential program on June 6, 2018, at age 17 after 16 months of incarceration. At the time of his intake, Brandon was under a Permanent Guardianship Order ("**PGO**") with Alberta Children's Services, issued on July 24, 2012. He presented with an extensive history of violence dating back to his early years, and a diagnosis of serious behavioral and mental health disorders which required a 24-hour treatment program capable of managing his high-risk behaviours, mental health concerns, and developmental needs. Brandon had been through multiple residential placement breakdowns due to unmanageable aggressive behaviours. Most notably, in February 2017, he was involved in a violent assault upon a staff member at a Youth Residential Facility in Elk Island which left the victim with permanent injuries. He was referred to WHS by Alberta Children's Services to allow him to be closer to his mother and to help him reintegrate into the community. He was placed into one of WHS's "Temple Programs", designed specifically for individuals presenting with complex needs who required a customized program with an individualized wraparound service and a dedicated team capable of following the client even if they were to physically move homes within WHS (there were several homes under the Temple Program with one or two individuals per home depending on their individual needs).

On March 9, 2019, while still in treatment, Brandon turned 18 years of age. This necessitated a change in his funding agreement and a move to a new treatment home for adults within the WHS program. The Alberta Government through its Persons with Developmental Disabilities (**PDD**) program assumed responsibility to provide funding for Brandon's care (with additional funding expected through AISH). In early April 2019, PDD approved funding for a "specialized placement" for Brandon comprising of a staff to client ratio of 2:1 twenty-four hours a day seven days a week based on his "complex needs". Later that same month however, staff at WHS reduced the staff to client ratio for Brandon's care to 2:1 during daytime hours and 1:1 during nighttime hours (when he was expected to be asleep). Then, following a "case team meeting" held on August 14, 2019, it was determined that a 2:1 staffing ratio during waking hours was proving to be detrimental to Brandon's development, and consequently the daytime staff to client ratio was also reduced to 1:1. It was felt that this would assist with Brandon's transition into a living situation with less restrictions.

Despite being bound by a Probation Order requiring him to reside at WHS, Brandon frequently ran away from the facility (ranging from a few hours up to a few weeks at a time) returning unannounced at times in the middle of the night, and on at least two occasions, in possession of a WHS program (plastic) knife. In the month of October alone (prior to Onwu's death), Brandon had been AWOL from the program a total of 6 times (overnight) and 20 times (for periods of 1-4 hours); had threatened to harm staff with bear mace if followed; had threatened to harm staff if not permitted use of the washer and dryer for his visitors, and had caused property damage by forcibly entering the laundry room.

On October 24, 2019, Brandon had been absent from the program since about 11:30 a.m., and was not present when Onwu started her night shift at around 11:00 p.m. Evidence suggests that Brandon's mother had called the program later in the day and informed staff that she had received information from Brandon's friends that Brandon was at the Marlborough Mall "high as a kite" on methamphetamine. He did not have a key to the program and would have to be let in if he were to return to the program. At approximately 2:00 a.m. on October 25, the downstairs caseworker, Awer Arob ("**Arob**") heard noises in the upstairs unit and phoned Onwu to inquire what was going on. She was told that Brandon had returned and was pacing in the living room; that he was expressing some distress and was off baseline. Onwu assured Arob that she was okay. Arob called Onwu again at 2:07 a.m. and learned that Onwu had locked herself in the secure office area. At 2:38 a.m., Arob heard noises and a loud commotion coming from the upstairs unit. Upon reaching the front door to the upstairs unit, Arob heard Onwu screaming "why are you doing this to me?". Awor began banging on the front door in an attempt to scare Brandon. Upon entering the suite, she witnessed Brandon run out the back door and Onwu stumbling towards the front door stating she had been stabbed. Arob assisted Onwu onto the front lawn and called 911. Onwu was pronounced dead at the scene despite emergency care provided by first responders. She had been stabbed 19 times.

The court heard evidence that the WHS's adult program was consistently understaffed and often had to resort to filling the shortage with casual staff. At the time of Onwu's death, only 4 out of a team of 7 staff members assigned to Brandon were available (largely due to Brandon being away from the program for extended periods of time). The court also heard that a few days prior to Onwu's death, she had told Brandon's key worker that she was afraid of Brandon and didn't feel safe around him.

WHS has implemented significant changes to its programs since Onwu's death to prevent the recurrence of this tragic event. It currently runs three residential facilities under what it now refers to as Personalized Community Care ("**PCC**") Programs (previously the Temple Programs). The PCC Programs represent only a small portion of WHS' overall effort to provide mental health treatment and support to children, youth, families, and young adults across Alberta.

The primary purpose of this inquiry is to examine the circumstances leading to Ms. Onwu's death, and to determine what measures, if any, can be taken to prevent such an occurrence in the future.

Evidence at the Inquiry (in order of appearance):

1. Janet Moynihan – Ms. Moynihan is a Director with the Persons with Developmental Disabilities ("**PDD**") department of the Alberta Government under the Ministry of Seniors, Community and Social Services. She spoke at length of the purpose and function of PDD (a funding program designed to cater to the needs of adults with developmental disabilities). She spoke of PDD's eligibility requirements and testified that because Brandon had already been housed at WHS as a youth through Child and Family Services ("**CFS**"), in the interest of maintaining continuity of care, his contract was expanded to allow for him to transition into WHS's adult program.

Because of his high-risk behaviour and risk of homelessness, Brandon was housed in a wrap around staff residence with 24 hour 2-to-1 staff support. Ms. Moynihan acknowledged that Brandon's explosive temper, history of violence, trauma and substance abuse and his vulnerabilities and significant development disability made him a very high risk to himself and to others. As a result, even after he transitioned into adulthood, PDD decided to continue to provide funding for a 2 to 1 staffing support 24 hours a day.

Ms. Moynihan spoke of Brandon's "complex services needs" designation, PDD's role in funding his placement at WHS, and the support services put in place to meet specific desired objectives. She testified that all background information in PDD's possession relating to Brandon "would have been shared" with WHS. Funding would also have been made available to house Brandon in a "secure treatment" facility but wasn't considered an option given that such placement would require his consent (which was unlikely given that he was his own Legal Guardian and was "not buying into the program"). The court heard that Brandon did not want to be supported and wanted the freedom to do as he pleased, including having access to substances and his friends in the community. Ms. Moynihan acknowledged that Brandon did not have a legal guardian once he turned 18, and although CFS had referred the matter to the Office of the Public Guardian ("**OPG**") in anticipation of Brandon turning 18, OPG "backed away" following indications that Brandon's mother and/or grandfather would be applying for guardianship (but never followed through).

Ms. Moynihan spoke of PDD's annual review process for each client as well as its response to the recommendations made by Justice Rosborough following the fatality Inquiry into the death of Valerie Wolski on February 12, 2011. Like Ms. Onwu, Ms. Wolski was a caregiver who was killed by the person she was looking after. It was after Justice Rosborough's report of November 10, 2016, that PDD introduced the "complex needs" designation. Other policy changes were also introduced that allowed for more collaboration with service providers, added resources, and information sharing, all designed to improve care and safety for clients and caregivers. The court heard that all clients designated as complex needs were required to undergo a risk assessment prior to going into service, followed by ongoing periodic assessments to flag any potential risk that they may pose, which are then shared with the agency. In Brandon's case, although his latest risk assessment was completed on October 9, 2019, it wasn't shared with WHS until after Onwu's death. According to Ms. Moynihan, PDD had not been made aware of WHS's decision in April 2019 to reduce Brandon's staff to client ratio to 1:1 despite 24-hour funding for two staff members having been approved and in place despite the frequency and length of Brandon's absence from the program.

Ms. Moynihan testified that "a lot of changes" were introduced into the PDD program in keeping with the recommendations that came out of the Wolski Fatality Inquiry, including strengthening the accreditation process for service providers such as WHS, and the sharing of client information (including findings of risk assessments mandated under the PDD program).

2. Kathleen Rhodes - Ms. Rhodes was Program Manager for the "Temple Programs" at WHS when Onwu lost her life. Part of her responsibility as Program Manager was to supervise the Team Leads who oversaw client day-to-day care. By the time this Fatality Inquiry commenced, Ms. Rhodes had been promoted to the position of Associate Director. She recalled Brandon being a "high-risk special needs" individual who had been referred to WHS by CFS while under a PGO. Brandon's Team Lead at the time was Jamie Johnson. Brandon started out at Woods Home in Temple 4 (Bowness Campus) and was then moved to Temple 3 (in Temple) where he remained until just past his 18th birthday and was then moved (along with his entire frontline staff team) to the Temple program in Beddington under Daina Havens, another Program Manager.

Ms. Rhodes testified that CFS was looking for a place to house Brandon who at the time was serving a custodial sentence at the Edmonton Young Offenders Centre (**EYOC**) where he had been incarcerated for an incident that had occurred at his previous residence at Elk Island. The only information the CFS shared with WHS was that Brandon and another young person had been involved in an assault on a staff member. Despite having twice requested the Critical Incident Report specific to that incident, CFS declined to share the report with WHS, stating only that Brandon "was a follower in that case". In addition to not being provided with a copy of the Critical Incident Report, WHS was prohibited by CFS from contacting or speaking to anyone at Elk Island. Ms. Rhodes and her director at the time, Bjorn Johansson (now CEO of WHS) became aware that the victim of the assault "was very severely injured to the point of permanent disability", but "did not know the details of how that came to transpire". On April 20, 2018, they discovered that Brandon had been convicted of aggravated assault as a result of his involvement in that incident.

Ms. Rhodes acknowledged that Brandon's complex mental health concerns, developmental trauma and cognitive disability together with his aggressive/assaultive behaviour and history of running would have made him hard to place. She testified it was not unusual for WHS to undertake care of individuals with these types of behavioural concerns, and despite Brandon presenting as a "high risk client", WHS felt prepared to manage them. A Supervision Plan with "wraparound service" (a worker accompanying Brandon everywhere he went) was put in place tailored specifically to Brandon's needs, including an 8-month Supervision Order which required him as part of his release from EYOC to reside at WHS. Ms. Rhodes in collaboration with Mr. Johansson decided that Brandon would have a minimum of 2-1 staffing during waking hours (6AM to 11PM) and that the program would have a minimum of 2 overnight awake staff. This was considered a "high level of staffing" during the "assessment phase" to allow everyone working with Brandon to get to know him.

In the summer of 2018, Brandon was moved to a new residence. The home was a bi-level split (upstairs/downstairs duplex) with two separate units (not connected internally), each with its own office/safety room. Within about a week of being at this facility, Brandon went AWOL. A major concern about Brandon going AWOL was that he was known to bring contraband (weapons) back with him to the facility upon his return. WHS's "search protocol" at the time was somewhat restrained and included visual searches, asking the client to turn over the waistband of his/her pants, remove outer clothing, bag searches, and so on). Ms. Rhodes testified WHS's search protocol is now much more robust and includes the use of metal detectors and search vestibules at entry points. Staff are also trained to make sure that anyone returning from a run is not intoxicated by drugs and/or alcohol, and have access to a 24 hour on-call service for assistance.

Ms. Rhodes spoke of the Therapeutic Crisis Intervention ("TCI") training provided to WHS staff to better equip them to assess client behaviour and manage crisis situations. She also spoke of the "safety button" program implemented by WHS to enhance staff safety (each button is equipped with GPS tracking, and when activated, connects the staff member directly with dispatch, and with emergency services, where required). Ms. Rhodes testified that not all clients were assigned their own buttons, and Brandon "was the first client to have his own so to speak". Ms. Rhodes was unaware if the staff brought the button with them when they moved from Beddington to Marda Loop, or if Onwu was wearing a safety button at the time of the incident, or if one was even available in the unit where Brandon was housed. She later came to learn that there was only one safety button between the upstairs and downstairs units.

She testified that Onwu was "just covering staff and probably wouldn't have known Brandon". She described Onwu (who had a degree in psychology and experience in many Care Worker and Family and Youth counsellor positions both in Alberta and Ontario) as "an incredibly skilled staff" knowledgeable in TCI and "incredibly good at orienting other staff and to work with a complex client, as well as others." She noted that before working with Brandon, Onwu had spent two and a half years in a Temple Program caring for a client with significant behaviour and intellectual disability.

Ms. Rhodes acknowledged that prior to Onwu's death, there was no standardised orientation process respecting "secondary work assignments", and spoke of the changes introduced by WHS with respect to their safety and training programs (including use of safety buttons) compared to what was in place prior to Onwu's death. She testified that anyone working alone or in a "high risk setting" is now required to wear a safety button, with "at least one person having it on their neck in every shift".

3. Daina Havens - Ms. Havens has a master's degree in clinical social work, and a background in holistic healthcare, massage therapy and yoga. She began her employment with WHS as a team leader in June 2018 and was quickly promoted to the role of Program Manager for the Temple Adult Program where she remained until her resignation in 2022. She testified her primary duty as Program Manager was to oversee the team leads who in turn oversaw frontline staff responsible for providing support to the clients. Each client in the Temple Program was assigned a "key worker" who had the "most in-depth knowledge and relationship" with the client and his/her family. The key workers main focus was program development and relationship development as well as fostering trust with the client, and as such, would receive more shifts with the client compared to other members of the care team.

She testified WHS was consistently understaffed (necessitating use of relief/casual staff across the agency who were interested in picking up extra shifts). She testified that WHS policy across all programs made it permissible for frontline staff to take on additional shifts outside of their own programs that became available provided they acquainted themselves with all safety protocols and the behavioural history of the clients they were serving. She testified that given the number of programs available at WHS, it was common for individuals to move between programs.

Ms. Havens spoke of her involvement in the transition planning for Brandon's move from the youth program into the adult program and of the individualized care model (for individuals with development disability needing wraparound 24-hour per day support for day-to-day living); her role within the program, and the policies and systems in place. She spoke of the continuity of Brandon's care and his team moving residences with him when he transitioned into the adult program. She described the "white binder" as a "living file" which contained all of Brandon's information, including his history of treatment, previous placements, treatment plan(s), crisis cycles, interventions and medical history, all of which was accessible by his care staff.

Ms. Havens was aware of Brandon's history of incarceration (for the assault at Elk Island), his history of running, of defiant behaviour and of resistance to treatment when he was transitioned into the adult program but felt it could be addressed by way of a carefully crafted wraparound care, and safety and treatment program tailored to his needs. She confirmed that it was the team leads responsibility to establish work schedules for frontline staff under their supervision, who in Brandon's case was Jamie Johnson (Ms. Johnson was Brandon's team lead at his previous residence in Marda Loop, and she along with her entire team moved with Brandon to Beddington on March 23, 2019, after he turned 18). Ms. Havens confirmed the change in Brandon's daytime staff ratio from 2-to-1 to 1-to-1 occurred at a case team meeting on August 14, 2019, after collaboration with several other individuals including her own supervisor, Teri Basi, and PDD. It was felt that Brandon would feel "less oppressed if there were less eyes on him" thereby decreasing the frequency of his mood dysregulation.

Ms. Havens described the "handover process" between shifts as shift changes that occurred twice a day, once in the morning and once in the afternoon for the 10 to 12-hour shifts, depending on the rotation. Although there was no formalized process in place in 2019, the expectation at the time was that every individual that was on shift that day, save one who would be engaged with the client at that time, would sit in the room with the people coming on shift and go over what had transpired over the last 10 hours and what actions, if any (scheduled appointments etc) had to be taken going forward. Ms. Havens acknowledged that Brandon had the capacity for hiding sharp objects and using them to commit violence. When asked to speak about the impact of Brandon being his own guardian, she stated

> *"Brandon did not want to be housed by our program, did not want treatment, was not interested in compliance, growth in any way, shape, or form. He wanted to do what he wanted to do. And we saw that, not just with Brandon, but with several of our adult clients in transitioning into that space because, again, of that perceived autonomy due to having reached 18".*

She also spoke of WHS's inability to exercise any control over monies received by Brandon through AISH, save for providing a supportive role in managing his expenses.

She described the nature and purpose of Critical Incident Reports, the circumstances in which they were generated (client behaviour escalating to a point which required consultation regarding what steps should be taken) and the reporting structure (during and outside of regular working hours with on-call support). She testified that she did not know Onwu personally and had never met her, but that her name might have come up during her discussions with Ms. Rhodes regarding who was available and willing to assist with Brandon's care. Onwu was not a part of Brandon's team but had been brought in to make up for the short staff. Ms. Havens testified that there would not have been any discussion about Onwu's skill sets and whether she was prepared and/or qualified to handle someone with Brandon's complex diagnosis "because she would've been already providing care for somebody just as complex".

When asked about a complaint made by a former employee to OHS following Onwu's death claiming "*the programs are constantly understaffed and staffed by individuals who have no training or experience and are expected to support children with SEVERE mental health issues*"

[EXHIBIT 1, Tab 22, Page 247], Ms. Havens, referring to some of WHS's complex needs clients acknowledged "*some of our frontline staff don't have the foundational or underlying experience to respond appropriately*".

4. Gareth Fields - Mr. Fields began working for WHS in 2012 alternating between working as a Team Lead and a Family and Youth Counsellor. He was part of the initial team that worked with Brandon on a day-to-day basis when he was first brought into the WHS program, and in April 2019 after Brandon turned 18, moved to Beddington with the rest of Brandon's team and became his key Worker (responsible for his day-to-day needs).

Mr. Fields testified that while staff hadn't received training geared specifically towards taking care of Brandon's complex needs, they had a "lot of training" to carry on their work as Family and Youth counsellors. The only information he had about Brandon before he was brought into the program was "*where he was coming from previously*", with "*some idea of what his diagnosis was at the time*". He was aware of Brandon's incarceration at EYOC, but only discovered it was for "*an attempted murder at Elk Island*" after "*googling the information*".

He testified that Brandon was in a "specialized program" with a dedicated team. He had a 2-to-1 staffing ratio during waking hours ("*literally two people following him around everywhere he went*"), and two overnight staff ("*one of the staff was for Brandon and the other staff was for the other youth*"). Mr. Fields acknowledged that Brandon was considered "high risk" and subject to an intense "supervision plan" requiring staff to maintain eyesight supervision at all times except in "special circumstances" (when he was alone in the washroom or his bedroom), in which case he had to be within earshot. The reason for having eyes on Brandon all the time was "*in case if he became violent or if he was to run away from the program*".

Mr. Fields testified that Brandon had never been violent with him personally, and the only instance he could recall where Brandon came close to being violent was "*where he would like get in staff's faces*", but with no physical contact. Fields could not recall any incident where it became necessary to physically restrain Brandon (whom he described as a "small individual") from committing a violent act. Fields testified that work policy precluded staff from laying hands on a client or locking them in a confined space. Instead, what they were trained to do was to lock themselves in the office ("safe room") and inform the youth to knock on the door and let them know when they had calmed down and were ready to talk. Every office was equipped with a telephone. Fields testified he had a good rapport with Brandon and never had any concerns around violence. He did however acknowledge that Brandon was known to "throw objects and act out aggressively". Brandon also posed the risk of hiding sharp objects in his environment with the intent of using them later as weapons or picking contraband in the community after going AWOL. Fields further testified that any time Brandon returned from a run, he would be subject to a search which included a complete search of all pockets, hoodies, shoes etc. He had never known Brandon to resist a search.

Mr. Fields could not recall Brandon ever expressing negative sentiments against women staff, but did recall Onwu telling him a few days prior to her death that she was scared and did not feel safe working with Brandon. He advised her to raise the matter with either her Team Lead or Program Manager, but was unaware if she did that or not. Mr. Fields was unaware if Onwu had received any training specific to Brandon's care but stated "*I assume when Debbie started working with Brandon, there was the binder in terms of his diagnosis and his crisis cycle .. and anything to do with his history*" (referring to the "white binder").
He testified that the information was also available on the "Kids Database" and the Service Hours Contact Notes (daily log).

5. Jamie Johnson - Ms. Johnson has a Diploma in Child and Youth Care. She started her employment with WHS in 2001 as a Family and Youth Counsellor. She later became a Team Lead and now has the position of Supervisor. As Team Lead, she was tasked by Kathleen Rhodes to work with Brandon when he was first admitted into WHS in 2018. She recalled being provided with a binder containing Brandon's background information

> "*from like birth to where he was currently, his placements, his risk profile, there was some information about kind of what other previous placements had experienced with him so that we could plan for his arrival, and then just kind of what his needs were*".

She was aware that Brandon had assaulted a staff member at his previous residence but was not provided any details. She testified that Brandon's care began with a 2-to-1 staff ratio during daytime hours, and 1-to-1 at night. The reason she was given for the latter was that Brandon slept through the night and presented a lower risk from a safety point. Her responsibilities as Team Lead were to "*oversee the program, make sure there was a solid plan in place for the day and nighttime hours, that the staff were properly taken care of, that there was a supervision plan in place, and documents were kind of captured*".

Ms. Johnson helped Brandon transition into the adult program after he turned 18, and together they planned what the physical layout of the space he would be moving into would look like. She described the office as a place for the staff to go to

"*if they need to be behind a locked door for safety". It was also a place where all the medication was stored, and where staff did their paperwork, took their breaks, and ate their lunch. All "sharps" (knives, can openers, sharpening tools, scissors, lighters, matches etc) were all also stored in the office with counts being done twice a day to make sure nothing was missing*."

Ms. Johnson confirmed that following a team meeting on August 14, 2019, Brandon's daytime staff ratio was reduced from 2-to-1 to 1-to-1 as the team had concluded the higher staff ratio was having a negative impact on his development, which at the time, she believed was the right thing to do. She testified that although Brandon "ran a lot", it did not raise concerns in terms of the risk he posed to staff when he returned, and that he was searched "when safe to do so". When asked to describe the search, she stated, "*It was just verbal. Like open your pockets, lift up your pants so we can see your ankles, shake out anything, and then it was just kind of a search that way*". Because of Brandon's propensity to hide objects in his environment and use them later as weapons (he was once found to be carrying a knife "like a switchblade" which he willingly handed over to staff after a search of his person), he was subjected to a weekly search of his room with staff also doing a daily perimeter search of the building.

When asked if she found Brandon "frightening", she replied "not at all". She testified that at no time did any of her staff express concerns regarding their safety vis a vis Brandon, and stated that had she been approached with any such fear or concern, "*they would be addressed but also documented*". She also could not recall any instance where a member had asked to change teams because of concerns about working with Brandon. She recalled one incident of a phone being thrown at staff, "but that was all". She also recalled Brandon complaining to her at times (usually when he was frustrated because his needs weren't being met) that he didn't like a particular member of the staff, but at no time complained to her about not liking Onwu. She also couldn't recall any instance where a staff member had to be transferred because Brandon had expressed a dislike of him/her.

Ms. Johnson testified that Robert (Bob) Walker took on the role of Team Lead after she went on a two month leave in September 2019. She did some "cross-over training during an afternoon" and spent about "an hour-and-a-half" passing information to Mr. Walker to get him ready for the task. She testified there were two shifts of 11.5 hours each to meet the 24-hour care requirement for Brandon with a one-hour cross-over for the passing of information between incoming and outgoing staff regarding what had transpired and what needed to be done. Ms. Johnson testified that there was a casual roster (members that liked to pick up overtime) that the team lead could tap into if they found themselves short staffed. In addition to getting the cross-over from the outgoing staff, the casual staff was expected to familiarize themselves with the client by reviewing a binder containing information on the client (the "white binder"), which contained a full history on the client as well as "tips and tricks" to assist with his care.

Ms. Johnson testified that prior to her leave of absence, Brandon's level of running had increased. He often returned to the program with pornography, and "*his narrative on what occurred while he was out sometimes was concerning - where he was, what he was doing*".

She testified that Brandon's claim that he was doing drugs while being AWOL, was "*often not observable when he returned to the program*". Although she did not think Brandon was a "heavy drug user", she had often seen him under the influence of marijuana. He at times became verbally aggressive, and made "grand gestures", but she "*never saw anything really come to fruition from his threats*". Although he talked a lot about violence and gang life, it was of little concern to Ms. Johnson who saw it as braggadocio with "*no evidence of that kind of life actually existing*". When asked if she was worried that he would act out violently, she stated "*I didn't have worries about his violence, no*". She did express concern about Brandon's "*street family*", and stated that while efforts were made to limit his association with these individuals, they were limited in what they could do because despite being cognitively delayed and having little or no life and/or management skills, Brandon was an adult and his own guardian and in charge of his own finances (he often met up with his "*street family*" after receiving his AISH money).

With regard to staff safety, Ms. Johnson testified that the physical size of the staff assigned to work with Brandon was not an issue. Each "team" was assigned a safety button which staff were expected to wear especially when working alone. Ms. Johnson acknowledged that there was no system in place at the time to ensure that staff were following that direction, but that the rules respecting the use of safety buttons had become more robust and formalized since Onwu's death.

6. Robert (Bob) Walker - Mr. Walker holds a bachelor's degree in Anthropology. He began his employment with WHS's Inglewood facility as a Family and Youth Counsellor in February 2019. In September that year, at the request of Ms. Havens, he moved to the Beddington location to serve as interim team lead while Ms. Johnson was on leave. He was given an office in the basement of the building and spent a "couple of days" with Ms. Johnson getting acquainted with "*the clients that were in the house at the time, crisis cycles and that kind of thing*". The clients were Brandon Newman (in the upper unit) and another adult resident (in the downstairs unit).

Mr. Walker testified that Brandon was either incarcerated or AWOL for the most part. The first time the two met was on October 3, 2019, when Mr. Walker drove Brandon to court for his court appearance (only to discover that Brandon did not have court that day). Mr. Walker testified that given that his position as team lead was only temporary, no programming changes were introduced to Brandon's care, and most day to day issues were handled by Gareth Fields who "*kept in contact with his mother and set up his doctor's appointments and stuff like that, so if I had any questions, I'd ask Gareth about it*".

7. Michael Cacace - Mr. Cacace began his employment with WHS's Temple/Marda Loop program as a Family and Youth Counsellor in 2015. He testified that he and Ms. Onwu were both hired as counsellors and worked "front-line" in the same program, she overnight, and him during the day. He stated that Ms. Onwu was "*likely one of the most experienced members of her team"*.

Mr. Cacace left WHS at some point but returned in September 2019 as the team lead for the Temple/Marda Loop program. He testified he started with a team of ten staff (Onwu being one of them), and a month later, was assigned another team of equal size (to prepare them for the time when the upper unit, which was vacant when he took over, would also be occupied). He testified that each unit had a security room/office with a viewing window and steel doors that opened outwards to prevent them from being forced open from the outside.

On October 3, 2019, Brandon and his team with Mr. Walker as team lead moved into the upstairs unit. The move was temporary "*until a new program could be opened up for him*". Mr. Cacace testified, "*it was made very clear to Kathleen Rhodes and I that this was Bob and Daina's program manager and team lead's responsibility, and that we were staying quite hands-off with it*". Mr. Cacace was not told of Brandon's history of violence or that he was on probation at the time, or of his attack on his caseworker at Elk Island. He was also not informed of Brandon's propensity to hide objects in his environment to use as weapons later, nor had he observed or was made aware of any perimeter searches of the property to check for hidden contraband.

Mr. Cacace testified that having already absorbed another team that was meant to staff the upstairs unit, he had "*a ton of extra staff*" that Brandon's team was able to pull from to fill their staffing gap. He testified that although the upstairs and downstairs units were run independently of each other, all Mr. Walker had to do was message him that he needed someone to cover a shift, and if he had an extra person willing to work that shift, he would send them upstairs. He also testified that if a team member was seconded to another program, it was that program's responsibility (Mr. Walker's in the case of Onwu) to provide the staff with front-line orientation, including any safety issues in relation to the youth being cared for. According to Mr. Cacace, Onwu had worked a few overnight shifts (10:30 PM to 8:30 AM) in Brandon's unit and never raised any concerns with him about her safety.

He testified that there was always a team lead on-call during the night shift whom the staff were encouraged to call in the event of an incident. There was also a secondary on-call person, usually a program manager, who was also available in the event the team lead needed someone to consult. Mr. Cacace testified that his staff were encouraged to call the 911 emergency line any time they felt unsafe. He testified that the only time he received a call while Onwu was on shift with Brandon was on the day of the incident of October 25, 2019, when he received a call from Arob, the worker in the downstairs unit at the time. He testified that although there was a "*large amount of information*" he would have had access to (including the white binder and the kids database), someone should have told him of Brandon's violent history including the incident at Elk Island, and the "*upper level discussions*" that Brandon might not have been a good fit for the program given his complex needs.

Mr. Cacace confirmed that the program was continuously staffed even when Brandon was AWOL, with established protocols to be followed in the event of his return.

8. Kimberly Petelski - Ms. Petelski was a Youth Probation Officer with the City of Calgary when she was assigned to Brandon's file on June 6, 2018, after his lengthy custodial sentence at EYOC and transfer to WHS under a Community Supervision Order ("**CSO**"). She testified that Brandon "*was on different legals at various points in time*", and that his CSO was to be followed by a period of probation. She testified Brandon had "*a lot of cognitive deficits*" and "*capacity issues in terms of his ability to follow through*", and after several violations of his CSO, was again incarcerated to serve out the rest of his sentence and released on February 23, 2019. After his release, he was bound by a Probation Order which required him to report to her on a bi-weekly basis (based on a "risk assessment" that placed him as a "moderate" risk to the community).

Ms. Petelski testified that Brandon did not present as a dangerous individual. Outside of his reporting appointments (also attended by staff from WHS), she attended Brandon's case management meetings and kept regular contact with the program manager, team lead and Brandon's key worker who reported back to her whenever there was a critical incident or if Brandon was violating any terms of his CSO. She testified that no concerns were raised with her by Brandon's care team regarding possession of weapons, or abuse of drugs and/or alcohol.

She testified that it was apparent after turning 18 in March 2019 and no longer being bound by a CSO that Brandon (even though still on probation) felt he had a lot more freedom to do as he pleased. In May 2019, Ms. Petelski breached Brandon for violating the residency condition in his probation order for which he received a sentence of 60 days custody (which he served from June 10 to August 8, 2019), followed by 30 days Community Supervision. On August 13, 2019, he was charged with assault and released with a court date of September 25, 2019. He was again taken into custody for violating his supervision order and charged with another assault. He was released on September 7 into the custody of WHS (with a court date of September 10) and went AWOL that night until his arrest on October 2, 2019. Given that he had several outstanding warrants at the time for missing all his court dates, Ms. Petelski expected him to be remanded in custody pending his next court appearance. Brandon however was released back into the community after a bail hearing with a court date of October 22, 2019. One of the conditions of his release was that he reside at WHS. Ms. Petelski testified that the absence of a curfew condition in Brandon's Release Order meant that he could leave the WHS facility any time he wished so long as he returned to the program.

She testified that Brandon's risk assessment remained at "moderate" because his next assessment was not due until February 2020 (6 months from the previous one) which could have changed his risk rating. She confirmed that a court ordered psychiatric/psychological assessment had found that there would be no point in attempting one-on-one counselling with Brandon given the degree of his cognitive impairment.

9. Lee Baker - In 2019, Mr. Baker worked as an investigator with the Government of Alberta ("**GoA**") Department of Occupational Health and Safety ("**OHS**"). The primary mandate of the agency is to ensure employer compliance with OHS legislation specifically designed to safeguard the health and safety of workers at a worksite.

People interviewed by Mr. Baker during his investigation into Onwu's death included WHS staff, PDD, CFS and Probation. According to Mr. Baker, Onwu "*seemed to have the knowledge and experience required for the position*" (referring to the type of care required for a complex needs client where the client himself was the potential hazard). His investigation found that Brandon had a lengthy and complex history from an early age with "*a lot of medical conditions*", and that he had been in and out of youth homes and incarcerations throughout his life. Mr. Baker concluded following his investigation (around June 24, 2020) that WHS was in compliance with all relevant provisions of the *Occupational Health & Safety Act*, and having taken all necessary "*recurrence prevention steps*", no compliance/stop-work orders and/or administrative penalties were needed (which according to Mr. Walker he would have issued had he been of the opinion that there was a legislative breach of some kind). He testified that the file was referred to Crown's specialized prosecution for further review which also resulted in no further action being taken.

When asked if he had any recommendations for the court from an occupational health and safety perspective, Mr. Baker replied, "*not at this time*".

10. Troy Winters - Mr. Winters is employed by the Canadian Union of Public Employees ("**CUPE**"), Canada's largest trade union with approximately 2,346 Locals representing the interests of over 750,000 members across the country in almost every sector of the Canadian economy. He currently serves as the National Coordinator for Occupational Health & Safety, a position he rose to in January 2025. Prior to that, he held the position of Senior Officer for Health and Safety. He has a broad range of responsibilities including assisting members with all matters related to workplace health and safety (workplace hazards, complaints, investigations, collective bargaining negotiations etc.). On February 19, 2020, Mr. Winters penned a letter to the Chief Medical Examiner calling for a Fatality Inquiry into Ms. Onwu's death, stating:

> *"CUPE feels this inquiry must take place so that those factors that allowed for this murder to happen can be examined, and so that the inquiry may consider recommendations to prevent similar deaths or injuries in Alberta's workplaces".*

Mr. Winters highlighted several parts of the Collective Agreement in place at the time of Onwu's death between Local 4731 (workers of WHS) and WHS (the employer), covering the period October 1, 2016, to September 30, 2020. Article 28 of the Agreement (dedicated to matters related to occupational health and safety) was of special interest. Article 28.02 stated "The Employer will establish a Joint Occupational Health & Safety Committee consisting of the safety officer, two management designates, and three Employee representatives designated by the union". Article 28.05 stated: "The Employer takes its responsibility in promoting a safe, violence-free workplace very seriously. The Employer shall provide mandatory training in procedures for handling potentially violent situations to all staff".

The most recent Collective Agreement between CUPE Local 4731 and WHS for the period October 1, 2023, to September 30, 2026 is almost identical to its predecessor except for the addition of Section 28.07 entitled "Working Alone", which Mr. Winters surmised was added following Onwu's death. According to Mr. Winters, the section contains "*particularly strong language*" designed to offer additional protections to staff who may find themselves working alone.

Joint Occupational Health & Safety Committees are a legislatively required body within an organization with 20 or more workers, and, according to Mr. Winters "*are a leading practise to ensure and improve the safety of a workplace*". He testified that it is one of the "*standing mandates*" in CUPE to make sure that joint health and safety committees are negotiated into their collective agreements. The role of the Committee of inspecting the workplace, investigating incidents, and helping to develop recommendations for the employer (including in the area of training) invariably lead to improvements in the occupational health and safety of the workers within the workplace. The anomaly in the current state of the law however is that matters relating to workplace harassment and violence are not investigated with the health and safety committee, but rather by the employer, and any Report generated as a result of the investigation is not to be shared with the joint health and safety committee or its representative.

According to Mr. Winters, CUPE was actively involved in working with WHS in providing assistance and training to help increase the capacity of its Joint Health and Safety Committee, and as far as known to him, there was no record of any grievances filed by any employee of WHS against their employer. He spoke of the employer's responsibility under the current regulatory regime to conduct an internal investigation any time there is a serious incident, and how that process could be strengthened by including frontline workers as part of the "investigatory team". He pointed out what he referred to as a "weakness in the legislation" where an employer is required to "*make available*" rather than to "*provide"* information to its worker related to workplace hazards and pointed to the "white binder" as an example where critical information pertaining to Brandon while "available" was as the evidence suggests not accessed by Onwu.

At the time of his testimony, Mr. Winters was also the convener of a technical committee developing the Global Occupational Health and Safety standard for the International Organization for Standardization ("ISO"), one of the leading internationally recognized standard-setting bodies. His testimony that the steps taken by WHS since Onwu's death (listed in detail in WHS's document titled "*Wood's Homes Society Continuous improvement and Recurrence Prevention Measures*") share many of the components of the ISO 45001 (the national standard for Occupational Health & Safety management systems), is noteworthy.

11. Michael MacDonell - Mr. MacDonell holds an undergraduate degree in industrial design, and several certificates in areas related to occupational health and safety. He was first hired by WHS as a safety advisor/consultant in the early part of 2020 for matters unrelated to Onwu's death. He currently serves as Director of Health and Safety with WHS, responsible for maintaining "a functioning safety management system while ensuring its continuous improvement". He highlighted the numerous steps taken by WHS to improve workplace health and safety since Onwu's death and to prevent a similar occurrence. The improvements (noted in detail in the WHS document titled *Wood's Homes Society Continuous Improvement and Safety Recurrence Prevention Measures*, [**Exhibit 3, Tab 141**], include (as noted by Mr. MacDonnell during his testimony):

(i) Hiring two certified registered safety professionals with the goal of advancing educational initiatives and fostering continuous improvement in workplace safety practises and policies, as well as implementing systems that are focused on the safety of both clients and staff (including making changes to the physical structure, equipment and fixtures).

(ii) Facility Inspections and Environmental Modifications. This included the engagement of professionals to inspect all Wood's Homes properties to identify and remedy any environmental factors that could contribute to safety risks. Measures included but were not limited to: (a) ensuring lighting was functional and sufficiently illuminated the surrounding areas; (b) installing auxiliary lighting at locations requiring additional lighting; (c) installing peepholes in doors at residential facilities; (d) ensuring that all access have functioning door locks, handles and dead bolts, and (e) ensuring that there are clear sight lines around the buildings.

(iii) All adult live-in residential programs are now staffed on a continuous 2:1 overnight staff ratio with a second staff member immediately available when required.

(iv) In March 2021, acquisition of an additional residential property in Calgary previously operated as a 15-bed transitional youth shelter supporting youth aged 15 to 18 with Children's Services status.

(v) In June 2023, construction of state of the art 10-bedroom purpose built therapeutic residence in Calgary offering critical mental health programs to young people with complex mental health needs.

(vi) Installation of vestibules to provide client shelter upon return after unauthorized absences and to better facilitate safe, controlled searches to address potential contraband (including use of metal detectors and metal detecting wands).

(vii) In August 2020, Wood's Homes initiated a thorough evaluation of its Health and Safety Management System to align with the Alberta Certificate of Recognition (COR) requirements. Efforts entailed "a systematic review and analysis of existing health and safety policies, procedures and practises to identify areas necessitating enhancement". Revised policies, procedures and practises were disseminated to all staff, and a comprehensive implementation plan was developed that encompassed staff training sessions, internal assessments to monitor compliance, and mechanisms for continuous feedback and improvement.

(viii) Wood's Homes completed a comprehensive review of all emergency response procedures with emphasis on having a robust system in place to identify, escalate and report aggressive client behaviour and protect staff during an altercation. Measures include:

(a) More robust on-call supervision procedures especially during evening, overnight and weekends.

(b) Enhanced safety buttons with easy-to-use features with strengthened use and monitoring practices. Multiple buttons are now provided to each program as opposed to one button per program.

(c) Enhanced procedures for responding to aggressive client behaviour, including mandatory contact with management or on-call staff before opening security/office room door after critical incident.

(ix) Implementation of a more robust *Staff Safety Incident Reporting and Investigation* policy, which outlines requirements on reporting safety incidents, including hazards, near misses, incidents, injuries, property damage and any other occurrences of violence and harassment. Development of the Staff Safety Incident Report (SSIR) requiring management review of all safety incidents and the development and implementation of remedial action [MacDonell testified that as the resident "Safety Advisor", he reviews "every single" SSIR that comes in and that all SSIR's are published on their SharePoint site].

(x) Development of a new Risk Assessment Form to gather additional information about the risks prospective clients may pose to staff, and procedures for conducting enquiries and reviews of potential or actual adverse events and areas of risk.

(xi) Development and implementation of an enhanced *Hazard Assessment and Controls* policy (one aspect of which is to identify client behaviours and triggers that increase the risk of violence, enabling staff to apply preventive measures, enhance staff safety, and improve care quality).

(xii) Enhanced training including program specific orientation for staff who transfer across the various Wood's Homes programs to ensure they are competent in the program requirements and familiar with client characteristics (psychological and behavioral) and de-escalation strategies.

(xiii) Access to Behavioral Records and Professional Assessments ("staff are granted complete and unrestricted access to all current behavioral records of individuals under their care , covering at least the preceding year"). Staff also have access to "relevant professional assessments or summaries that provide critical insights into the needs and behaviours of the individuals they support".

(xiv) As a way of enhancing its health and safety management system, Wood's Homes voluntarily pursued COR certification which it received in May 2024 having received a score of 95 percent.

Mr. MacDonnell testified that COR is a recognized accreditation awarded to employers whose health and safety management systems meet the criteria set by Alberta OHS standards. To obtain COR certification, employers must establish a comprehensive health and safety management system and select an appropriate Certifying Partner for assistance in developing and implementing the necessary health and safety protocols. An external audit of the health and safety management system is then conducted by a certified external auditor, with COR jointly issued to successful employers by the Government of Alberta and applicable Certifying Partner.

Mr. MacDonnell also testified that aside from achieving COR certification, in July 2023, WHS was awarded "Exemplary Standing" for the fourth consecutive time by Accreditation Canada.

12. Bjorn Johansson - Mr. Johansson currently serves as Chief Executive Officer of WHS, a position he assumed on May 1, 2020. He has a Master's degree in Social Work and a Diploma in Criminology and has been with WHS for 34 years. He expressed deep remorse over the death of Deborah Onwu, referring to the incident as "*the worst thing that can happen to an organisation*". He testified that although he had never personally worked with Ms. Onwu, she was very well regarded in the WHS organization and viewed by her peers as a competent member of the staff who was "*able to be in many different environments*".

Mr. Johansson acknowledged that the "vast majority" of WCB claims in the two years leading up to Onwu's death were related to "youth aggression", and that youth aggression presented the "biggest risk" to the organization. He echoed the testimony of Mr. MacDonnell regarding the changes made by the organization in recent years, stating "*we are no longer just client centred as an organisation; we are making every attempt to make sure that staff safety is as important as client safety*". He testified that the innovations brought about by WHS are a "work in progress", and that the organization has already seen a "significant decrease in the number of lost time claims" (from serious incidents of physical harm). On the issue of programs being understaffed and its impact on staff to client ratio, he stated:

> *So at that time, we had six buildings, we only have three now, and that's really, really important. You saw the plans for, which we call now lighthouse, which is a program for five young people. And the reason that's important is we realized this from a staff safety perspective, -- we cannot run those programs when we have one team, and even two is a challenge at times, so we now run a program with five clients and about 30 frontline staff, therapists, and OT, and leaders working in that. So it's a significant change. Also allows us to manage that (INDISCERNIBLE), all the things that Mike MacDonell spoke about related to technology, dual egress, ability to manage that. So that's -- that's important.*
>
> *We still have two other programs, one that's a two client. Again, connected, not anymore, this idea of having someone have to go outside. But, again, allows for about 16 staff to work together so that we are not challenged by that 2 to 1 issue that, you know, that if we don't have two clients there then we don't run it.*
>
> *We still have a one-client space that for some clients is necessary. We have not -- our last client left a few months ago we're looking at, but that is a high, high acuity with at least 14, 16 staff, and we won't run it if we don't have that amount of staff. The funder's not willing to run that. So, that has changed significantly and I just wanted to be clear about that. That's the new environment we're in.*

With regard to the "Client Pre-Admission Violence Risk and Safety Assessment" alluded to by Mr. MacDonnell in his testimony, Mr. Johansson confirmed that all relevant information including all critical events and risk factors including risk(s) related to the safety of staff and others are "*100 percent shared with our staff*", referring to that as "*a very significant change in practice*" since Onwu's death. He also referred to WHS' COR certification as "*part of Debbie's legacy*" and a significant step towards ensuring staff safety.

13. Dr. Waqar Waheed - Dr. Waheed is a registered psychiatrist with a specialty in child and adolescent psychiatry, forensic psychiatry, addiction medicine, neuropsychiatry, and psychosomatic medicine. He works at the Alberta Children's Hospital and runs a clinic in downtown in Calgary where he also sees patients referred to him from the Calgary Young Offenders Centre ("**CYOC**"). From his meetings with Brandon and his review of Brandon's treatment history at EYOC and the Alberta Hospital, he diagnosed Brandon with Oppositional Defiant Disorder; severe Attention Deficit Hyperactivity Disorder; Reactive Attachment Disorder; Conduct Disorder; Low Cognitive Ability; Organic Brain Syndrome (including possible fetal alcohol spectrum), and Bipolar Mood Disorder. Dr. Waheed noted that Brandon also had a history of "stimulant drug abuse", and when asked if Brandon was "dangerous", stated:

> *"he was dangerous to the extent that he had a fair amount of difficulties with ADHD, impulse control, mood symptoms in the context of known substance use history in the community. All those factors are factors that elevate the risk level for violence. So, yes, I did have concerns about his likely risk of violence".*

He spoke of the elevated risk to the patient and the community when someone with Brandon's mental health diagnosis fails to take their prescribed medication or follow a regular treatment regime, and the need/option in such cases of severe mental disorder and a demonstrated inability/unwillingness to comply with treatment of utilizing Community Treatment Orders to protect the person as well as the community in which they reside. Dr. Waheed also deemed the effect of combining alcohol and/or other illicit drugs (including cannabis) with medicine typically used to treat ADHD as "very worrisome". In Brandon's case (although it was unclear if he was actually abusing illicit drugs despite his bragging about it), it could seriously escalate his risky behaviour.

14. Rob Feagan - Mr. Feagan serves as the Executive Director of Prevention Services with OHS. He spoke generally of the requirements of the Certificate of Recognition (COR) program, the audit and recertification process, and the consequences of noncompliance, and acknowledged the strong support received in the last five years "from Children and Family Services to put dollars into health and safety for these types of organizations" (resulting in enhanced training for the staff).

When asked why CFS would have refused to share the Critical Incident Report relating to Brandon's involvement in the Elk Island incident with WHS, he testified "*if charges haven't been laid yet and the investigation is ongoing, typically those things are not shared at that point in time*". When asked "what types of advancements or changes you would like to see made in this industry within Alberta", he opined that while there had been a general lack of commitment on the part of both industry and government to channel adequate funding into health and safety management systems, CFS's decision to inject additional funding into some of their contracts to advance health and safety as well as training was a step in the right direction.

15. Awer Arob - Ms. Arob had been employed with WHS for about three years as a Family and Youth Counsellor before Onwu was killed. She testified that although she had never had any direct dealings with Brandon, he was present at a program she had worked at previously, and that she had felt unsafe around him because of his "aggressive behaviours". She described Brandon as "manipulative of other boys in the program" and not being nice to his roommates. She had been providing care to a client in the lower suite at the Marda Loop location for about a year when Brandon and his team moved into the upper unit (which had its own separate entrance). Because of how he had made her feel previously, she told her team leader when Brandon moved into the upper unit that she was "not interested" in working with him. She testified that although there was a team that worked "upstairs" and separate team that worked "downstairs", each with their "own client", both teams had Mr. Cacace as their "leader", and the teams often checked in with each other on the phone.

Arob testified that she had worked with Onwu at Marda Loop for about a year. On October 25, 2019, Arob was working the 8 pm to 7 am shift. She recalled Onwu starting her shift around 11 pm and the two of them sharing some snacks in the downstairs office and Onwu returning to the upstairs unit. She recalled speaking to Onwu on the phone close to midnight and learning that Brandon was AWOL. At around 2:07 am, Arob heard footsteps of "somebody walking, you know, back and forth", and phoned Onwu to inquire what was going on. Onwu told her "*the boy came back from AWOL*" and that he was "*walking back and forth between the kitchen and the living room*". Onwu reassured her she was fine, and that she was in her office with the door locked. Around 2:38 am, Arob heard random footsteps and what sounded like "people fighting" and "her screaming". She grabbed the keys to the upstairs unit and ran outside to access the door to Onwu's unit. She was in a state of panic and struggled to find the right key to open the door, and when she did finally find the right key, she banged hard on the door before opening it in an attempt to scare Brandon. When she opened the door, she saw him run across the kitchen and Onwu running towards the door, meeting her at the top of the stairs where she collapsed. Awor testified that Onwu was too heavy for her to carry down the stairs, so she laid her down and ran downstairs to grab her cell phone to call 911. She testified that the two units shared a single telephone line and that Onwu had taken the "home phone" (handset) to the upstairs unit "to check in with the other programs".

When asked what could be done to avoid such an occurrence in the future, Arob testified that Onwu's death would likely have been avoided if there had been someone else working with her that night. She also suggested that clients be subjected to a more robust search protocol when returning to the residence after being AWOL (it is believed that Brandon returned to the program with a knife on his person).

Note: Nancy Uwangue**,** Ms. Onwu's sister, was present throughout the inquiry via Webex, and was afforded the opportunity to ask questions of all the witnesses.

Recommendations for the prevention of similar deaths:

The areas of concern highlighted during the inquiry that may to some extent have contributed to Ms. Onwu's death (lack of information on the extent of the risk posed by Brandon to his care-givers; extent of training (especially for casual staff); staffing ratios/shortages; physical structures for specialized programs for clients prone to violence; search protocols; have to a large extent already been addressed in the changes in policies and procedures implemented by WHS in the years that have followed Ms. Onwu's tragic death. The one area that remains of concern is the inter-agency sharing of information, or lack thereof.

Recommendation #1: **Sharing of information between Agencies.**It is clear from the evidence heard at the Inquiry that neither CFS nor Elk Island disclosed to WHS the full extent of Brandon's involvement in the violent incident at Elk Island and the injuries suffered by the worker there prior to Brandon's transfer to WHS. This remained the case despite several requests by WHS for a copy of the "critical incident report" pertaining to the said incident. A transparent disclosure of violence related hazards posed by a client is not only critical to a receiving agency's decision whether or not it is willing and/or able to accept such a client, but would greatly assist the receiving agency in properly assessing the risk posed by such a client, and in developing appropriate risk mitigation strategies and training programs. I would therefore recommend the Government of Alberta amend its Occupational Health and Safety legislation to make it obligatory for agencies engaged in transferring care of at-risk youth and/or young adults to share critical information pertaining to such individual(s) where they have committed or threatened to commit acts of violence, or present a risk of committing violence (physical and/or psychological) to themselves and/or to others, and for the agency/employer in receipt of such information to share that information with their employees at risk of such harm.

To ensure adequate and timely disclosure between agencies, I recommend the Government add the following provisions (or similar language) to the *Occupational Health and Safety Code*, Alta Reg 191/2021 (adopted from CUPE's final submissions):

> *Duty to Disclose Client/Patient History of Violence or Harassment*
>
> *1(1) Where an employer transfers care, service, or responsibility for a client or patient to another employer, and the transferring employer has knowledge of a history of violence or harassment associated with that client or patient, the transferring employer shall:*
>
> > *(a) disclose sufficient information about the client's or patient's history of violence or harassment to the receiving employer to enable the receiving employer to:*
> >
> > > *(i) conduct an appropriate hazard assessment, and*
> > >
> > > *(ii) implement reasonable controls to protect workers from the potential hazard of workplace violence or harassment;*
> >
> > *(b) make the disclosure in writing prior to the transfer where practicable, or as soon as reasonably practicable after an emergency transfer;*
> >
> > *(c) limit the disclosure to information that is necessary to protect the health and safety of workers at the receiving employer; and*
> >
> > *(d) maintain records of such disclosures for a period of not less than 3 years.*
>
> *(2) An employer receiving information under subsection (1) shall:*
>
> > *(a) use the information only for the purpose of protecting worker health and safety;*
> >
> > *(b) incorporate the information into hazard assessments required under section 7 of this Code;*

> *(c) develop appropriate controls to protect workers from the identified hazards; and*
>
> *(d) limit access to the information to those who require it to ensure worker safety.*
>
> *(3) The disclosure obligations in this section shall supersede any confidentiality provisions, except where prohibited by law.*
>
> *(4) For the purposes of this section, "history of violence or harassment" means any documented incident where a client or patient has:*
>
> *(a) engaged in physical assault or attempted assault;*
>
> *(b) made threats of violence;*
>
> *(c) engaged in sexually inappropriate behavior; or*
>
> *(d) demonstrated a pattern of abusive, threatening, or intimidating behavior*
>
> *toward any worker or other client while under the care or service provision of the originating employer.*

Recommendation #2: **Sharing Information with Employees/Frontline Workers.**
While it is clear from the evidence that a considerable amount of information pertaining to Brandon's complex needs and his tendency to run and resort to threats/violence was "available" to Ms. Onwu had she chosen to avail herself of that information (the "white binder and Kids Database), the extent of the information she possessed about the degree of the risk he posed remains unclear. I recommend the Government of Alberta amend its occupational health and safety legislation to make it obligatory for employers in such cases to implement procedures that would ensure that workers are *made aware* of a client's history and changes in behaviour related to violence and/or harassment, including but not limited to the implementation of a mandatory client behavior reporting system that disseminates information related to a client's violent and/or threatening behaviour to all affected employees as soon as practicable following the occurrence of said incident.

Recommendation #3: **Trustee & Guardianship of minors at the threshold of adulthood.**
I recommend that the Government of Alberta consider introducing legislation that would allow the Office of the Public Guardian and Trustee to automatically assume Trustee and Guardianship status over any minor transitioning into adulthood who is patently unable to handle his or her own affairs due to cognitive impairment. In such case(s), where there is no family member able and/or willing to act as a Guardian, the Office of the Public Guardian and Trustee would automatically become a Guardian for that individual on their 18th birthday. In Brandon's case, although there was talk of his mother assuming the role of legal guardian once he turned 18, nothing was done in that regard and Brandon, despite his significant cognitive impairment, began managing his own affairs once he turned 18 (including monies he received through AISH) putting himself and others at risk.

<u>Recommendation #4</u>: **Sector-Specific Occupational Health and Safety Standards**

Mr. MacDonell testified that there is a significant lack of guidance documents for health and safety practitioners in this sector, and that sector-specific guidance standards would help ensure that all organisations that provide the same type of services as WHS are working to improve workplace health and safety and prevent similar deaths. A recent example of this as pointed out by CUPE's counsel is the National Long-Term Care Services Standard (completed at the request of the federal government: https://healthstandards.org/standards/national-long-term-care-services-standard/) created by The Standards Council of Canada (SCC), Health Standards Organization (HSO), and the Canadian Standards Association (CSA Group) who worked collaboratively to develop two new national standards for long-term care.

I recommend the Government of Alberta explore the viability of developing such comprehensive occupational health and safety standards specific to this sector (through a recognized standards-setting organization such as the Canadian Standards Association (CSA Group) or the Canadian General Standards Board (CGSB)), and that the development process allow for balanced representation from all relevant stakeholders, including (i) frontline workers and their representatives (unions or associations), (ii) employers/management, (iii) Government regulators, (iv) subject-matter experts in workplace violence prevention, (v) client advocates and representatives, and (vi) occupational health and safety professionals.

The standards would have to be incorporated into the *Occupational Health and Safety Code,* and an implementation framework with clear timelines for organizations to achieve compliance with these standards would also have to be created.

DATED August 11, 2025

at Calgary, Alberta.

Original Signed

Karim Z. Jivraj
Justice of the Alberta Court of Justice