**Release Date: September 7, 2004**

**Manitoba**

# THE PROVINCIAL COURT OF MANITOBA

**IN THE MATTER OF:** ***THE FATALITY INQUIRIES ACT***

**AND IN THE MATTER OF:** **ISOBEL LATHAN**

**APPEARANCES:**

| | |
|---|---|
| Counsel to the Inquest: | Mr. Donovan Dvorak, Crown Attorney |
| For the Parkland Regional Health Authority: | Ms. Candace Everard |
| For the Attorney General of Canada on behalf of the Royal Canadian Mounted Police: | Mr. Scott D. Farlinger |

[1] Isobel Lathan, age 76 years, died on July 29, 2001 as a result of extensive burns she sustained during a fire at St. Christopher's House, the residential care home in which she lived on the third floor, in the Town of Laurier, in the Province of Manitoba.

[2] St. Christopher's House was an older three-storey wood frame construction residential home consisting of a crawl space basement and:

| | |
|---|---|
| Main Floor: | Four bedrooms, living room, dining room, kitchen, craft room, smoking room, utility room and washrooms; |
| Second Floor: | Six bedrooms, living room, family room, office, storage room, kitchen and washrooms; |
| Third Floor: | Eight bedrooms, sewing room, storage room, office and washrooms. |

[3] An investigation conducted by the Office of the Fire Commissioner concluded that the fire had been deliberately set. One Gerald Joseph Currie, age 39, from Nova Scotia, who had received temporary lodging at the residential care home only a few hours before the fire started, being charged with manslaughter and arson for starting the fire, pleaded guilty in May of 2002 to criminal negligence causing death and was sentenced to 18 months gaol.

[4] Earlier, on July 28, 2001, while traveling to Nova Scotia by bus, Currie got off the bus at McCreary, in Manitoba, a short distance from Laurier, where he sought assistance from the local R.C.M.P. for overnight lodging. The R.C.M.P. made arrangements with the owner-operator of St. Christopher's House for Currie to be lodged there overnight and then in the morning for him to board a bus to continue his journey to Nova Scotia.

[5] The Chief Medical Examiner for the Province of Manitoba was of the opinion that, notwithstanding Currie had been dealt with under the ***Criminal Code*** in the criminal courts, there were other issues and concerns that needed to be addressed. Therefore, in accordance with section 19(2) of ***The Fatality Inquiries Act*** he directed that an inquest be held with respect to the death of Isobel Lathan for the following reasons:

(1) To determine the circumstances under which her death occurred;

(2) To determine the availability and adequacy of mental health services to assess acutely psychotic patients in a rural setting in Manitoba; and

(3) To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[6] Subsections 19(1) and 19(2) of ***The Fatality Inquiries Act***, under which the within Inquest was directed, read as follows:

> **CME review of investigation report**
>
> 19(1) Subject to subsection (3), upon receipt of an investigation report, the chief medical examiner shall review the report and determine whether an inquest ought to be held.
>
> **CME to direct holding of an inquest**
>
> 19(2) Where the chief medical examiner determines under subsection (1) that an inquest ought to be held, the chief medical examiner shall direct a provincial judge to hold an inquest.

[7] Subsection (3) referred to in subsection (1) deals with situations under which an inquest is mandatory, none of which are present in the case before us, hence subsection (3) does not apply.

[8] The Chief Medical Examiner's direction to hold an inquest was communicated by correspondence to the Prosecutions Division for the Manitoba Ministry of Justice dated October 9, 2002. A standing hearing was held at the Courthouse in Dauphin, Manitoba, on May 27, 2003. The only persons appearing and applying for standing were Crown Attorney Mr. Donovan Dvorak, Ms. Candace Everard of the law firm of Pitblado representing the Parkland Regional Health Authority and Mr. Scott D. Farlinger of the Attorney General of Canada representing the Royal Canadian Mounted Police.

[9] According to Mr. Dvorak, conducting the Inquest, these two were "the only individuals that applied for standing. We did send out numerous letters to individuals, including the family of the deceased, Ms. Lathan, and we didn't get any response." The Crown also requested that the family have standing and that was ordered, but nobody has appeared for the family.

[10] The Inquest commenced on November 19, 2003 in Dauphin, Manitoba, and continued on November 21, 2003.

[11] A total of seven witnesses were heard from and various (eight) exhibits were filed, including photographs of the fire damage.

[12] The Inquest was adjourned to allow for the filing of additional reports, ordering transcripts of the proceedings and the filing of written submissions from counsel. All of this was completed by August 23, 2004.

[13] Evidence was heard and exhibits filed respecting the issues and concerns of the Chief Medical Examiner.

[14] In addition to addressing the concerns of the Chief Medical Examiner, the provincial judge presiding at the Inquest must perform the duties set out in section 33(1) of ***The Fatality Inquiries Act***. After completion of an inquest he "shall make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death". The presiding judge may also "recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest." The Act also provides that the presiding judge shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest.

[15] The material circumstances surrounding the within death were determined to be not simple but unusual and complex and the reasonable likelihood of circumstances similar to the ones that resulted in the death of Isobel Lathan ever arising again determined to be remote.

[16] In the within report I shall make every effort to comply with the statutory duties referred to and make the determinations asked for by the Chief Medical Examiner, by reporting on the facts presented to me, without expressing any opinion on or making a determination with respect to culpability in such a manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the Inquest.

[17] Up front, however, again it should be noted that in the Chief Medical Examiner's letter of October 9, 2002 directing this Inquest he advised that one Gerald Joseph Currie had been charged with manslaughter and arson and later pled guilty to criminal negligence causing the death of Isobel Lathan, the deceased in these proceedings. The Crown Attorney conducting this Inquest in his opening remarks also mentioned this fact. None of this was refuted in the evidence.

[18] Now to report on this Inquest as required in section 33(1) of ***The Fatality Inquiries Act*** and to determine the circumstances under which the death of Isobel Lathan occurred as directed by the Chief Medical Examiner:

> The name of the deceased person is Isobel Lathan.
>
> The time and date of her death was approximately 01:36 a.m. on July 29, 2001.
>
> The place of her death was at St. Christopher's House in Laurier, in the Province of Manitoba.

**Means, Cause and Circumstances**

[19] St. Christopher's House was licenced for 28 residents. At the time in question there were only 24 actually residing there, Isobel Lathan occupying a bedroom on the third floor. Along with most other residents, Ms. Lathan had retired to her respective bedroom for the evening. Shortly after 1:00 a.m. the fire alarm system was activated, the fire alarm panel indicating a fire on the third floor.

[20] Mrs. Knight, the resident manager at the time, together with another resident, Jeff Hawkins, located the fire on the third floor in the bedroom adjacent to Ms. Lathan's. They were unable to gain entry into the burning bedroom due to the door being barricaded from inside, but were able to force the door open inches enough to see what they believed were three separate fires in three different places in the bedroom. An attempt by Jeff Hawkins to extinguish the fire through the small opening was blocked by the occupant from within who refused them entry. Steps were then taken immediately to evacuate the building and summons the local fire department.

[21] Isobel Lathan's room being on the third floor next to the burning bedroom, she was the first resident to be told to evacuate but she replied she had to get her cat and returned to her room. She is told again by Mr. Hawkins and Mrs. Knight to leave the building but doesn't leave and in the ensuing confusion is momentarily overlooked.

[22] The evidence before this Court indicated that had she obeyed the order to vacate, Isobel Lathan would have easily gotten out of the burning building, in fact, would have been the first one out.

[23] All other residents were able to evacuate safely without incident except one other. A Jacob Fediuk, age 73, also residing on the third floor, had difficulty in

wakening. He eventually woke but was injured when the smoke blinded him and he stumbled into the fire, but survived.

[24] The fire department from Laurier was the first to attend, and a second from Ste. Rose arrived shortly after, both properly equipped and numbering a total of about 20 firefighters. Rescues were attempted but proved to be dangerous due to the extent of the fire. Water was applied from the outside immediately. Local R.C.M.P. officers also assisted.

[25] It should be noted that the building had a working fire alarm system and an escape plan. Fire drills were held regularly. It appeared that everyone followed the escape plan other than Isobel Lathan and Jacob Fediuk.

[26] The heroic efforts by Jeff Hawkins, one of the younger residents, throughout the fire, deserve mention. These are summed up by Inquest witness Murray Charles Bedford, Fire Investigator for the Province of Manitoba:

> He was amazing. He was up and down those stairs multiple times. He did -- removed many of the residents. He initiated the call to 911, and then passed it on to Mrs. Knight. He even made an effort to go back and try to find the cat, because at this time he though that Isobel Lathan had gotten out. He was an amazing help. He did a lot of work.

[27] In his examination at the Inquest on November 21, 2003, Mr. Bedford was asked by the Crown Attorney, Mr. Dvorak:

> Q Is there anything that the fire department there could have done differently that would have saved Ms. Lathan?
>
> A Saved Ms. Lathan? No.
>
> Q Is there any equipment that they could have had that would have saved her?
>
> A No, I don't believe there is.

[28] Mr. Bedford was also asked whether the building was equipped with a sprinkler system and his answer was "No, there was not." When asked what effect a working sprinkler system would have had he answered "…they probably wouldn't have had a fire. It would have -- it hardly would have gotten going."

[29] Although the third floor room where the fire started belonged to Jeff Hawkins, he was asked earlier by the owners to share it for the evening with Gerald Currie. On agreeing to do so, Currie ironically ordered Hawkins out and

proceeded to lock himself in Hawkins' room and barricaded the door from the inside with furniture. When the fire alarm system sounded, Mrs. Knight and Mr. Hawkins, on only being able to force the door open a few inches, observed three fires of approximately the same size in the bedroom.

[30] According to Mr. Bedford, the facts eliminate the possibility that this was an accidental fire:

> The lack of any visible signs of failure of the electrical system in this room as well as remoteness of the electrical outlets and switches to the points of origin eliminates this as an accidental cause for this fire.

[31] Mr. Bedford concludes in his written report (Exhibit 7):

> Therefore, it is the opinion of the writer that this fire was deliberately set and this opinion is reinforced by the witnesses' accounts. These accounts describe the 3 separate fires of similar size, also the evidence of the dresser drawer rails on the floor and beds and the charred clothing on the floor. The cause of this fire is listed as incendiary.

[32] Gerald Currie, who had locked and barricaded himself in the bedroom, was able to escape through the window onto the roof of the second floor addition and from there with the use of a ladder, and was taken into custody by the attending R.C.M.P.

[33] In further examination by Mr. Dvorak of Mr. Bedford regarding Isobel Lathan:

> Q Were you able to determine whether or not this elderly woman actually did die in the fire?...
>
> A She was -- we did find her in the -- in the fire later. We found her on the second floor in debris from the third floor.
>
> Q So she had been on the third floor and then --
>
> A And collapsed through. She was in the debris from the third floor, so I take -- I figured from that that she had -- she had collapsed on the third floor and when the floor burned, she fell down into the second floor.

## Mental Health Services

[34] The Chief Medical Examiner in directing that an inquest be held in this matter cites as one of the reasons:

> to determine the availability and adequacy of mental health services to assess acutely psychotic patients in a rural setting in Manitoba.

[35] In his letter of October 9, 2002 the Chief Medical Examiner in pointing out that the investigation conducted by the Office of the Fire Commissioner concluded that the fire had been deliberately set by Gerald Joseph Currie who had received temporary lodging at St. Christopher's several hours before the fire started, that subsequently Currie underwent psychiatric assessment and detention as an involuntary patient under ***The Mental Health Act***.

[36] As mentioned earlier in this report, Gerald Currie was initially charged with manslaughter and arson. A court-ordered forensic assessment was done (see Exhibit 1 from the Forensic Services of the Department of Psychiatry dated October 26, 2001) indicating that Currie was likely psychotic up to the time of the offence, as he remains psychotic and that this was a "late onset of Mr. Currie's psychotic illness". However, also according to the assessment, he was "able to demonstrate a good understanding of the functions of the various officers of the court" and "Mr. Currie currently appeared fit to stand trial".

[37] It also came out in evidence at this Inquest that earlier on July 28, 2001 before getting off a bus at McCreary Currie had started a small fire on the bus.

[38] It has been of great concern why someone with such a history of mental illness and questionable behaviour was lodged for the night at St. Christopher's House and not taken to a mental health facility, St. Christopher's House being only a private group home for the mentally challenged, people with disabilities and seniors, believed to be operating on the pattern of the Salvation Army but not necessarily affiliated with it.

[39] This question, with the benefit of hindsight, is quite proper and was dealt with at considerable length throughout the examination of the witnesses.

[40] Evidence on the availability and adequacy of mental health services in rural settings in Manitoba was received from two witnesses respecting, in particular, the situation in the Parklands Region of which Laurier, Ste. Rose, McCreary and Dauphin form a part. The first witness on this question was Andre Amity Lorrain, a mental health worker in the Mobile Crisis Unit, a part of Community and Mental Health in Dauphin, an arm of the Parkland Regional Health Authority. The second witness in this regard was Walter Gary Meadows, the Director of Mental Health Services for the Parkland Regional Health Authority.

[41] In addition to the evidence of Mr. Lorrain and Mr. Meadows, evidence was received from Staff Sergeant Gary James White of the R.C.M.P. stationed in "D" Division Criminal Operations section, part of its responsibilities being dealing with the development of division operation policy within Manitoba. Generally the policies of the R.C.M.P. in dealing with persons who an officer might suspect to be mentally ill are set out in great detail in "Division Policy" filed as Exhibit 5 in these proceedings. Sergeant White generalizes that it is "the responsibility of our members when they encounter someone to determine whether or not -- or whether or not they believe the person is a danger to themselves or a danger to the general public". Then, if it is determined that the person is a danger "the officer has the authority under the Mental Health Act to take that person to a physician who would assess that individual, and should the physician agree…responsibility of the officer to escort that person to a mental health facility".

[42] There were four people who had contact with Gerald Currie between the time he was picked up on that highway after getting off the bus and the time he was taken to St. Christopher's House to spend the night there. The four persons in the order of contact and involvement were:

(1) Constable Andre Jarrid St-Pierre;

(2) Constable Richard Kurt Schroder;

(3) Corporal Graham Carl MacRae; and

(4) Andre Amity Lorrain.

## (1) Constable Andre Jarrid St-Pierre

[43] A member of the R.C.M.P. with two years' service at the time. Was on duty in a marked police vehicle approximately two miles south of McCreary when flagged down by Currie waving his arms and carrying but not wearing a shirt at 19:31 hours on July 28, 2001:

(a) Currie tells Constable St-Pierre "people were trying to kill him over a medical malpractice lawsuit against a doctor in Edmonton";

(b) Currie tells St-Pierre he jumped off the Greyhound bus on his way to Halifax because he believed somebody was after him;

(c) Currie appeared "very distraught" requesting assistance from the police;

(d) St-Pierre contacts Constable Schroder to meet and offer assistance;

(e) St-Pierre checks with telecoms for warrants against Currie. None. But R.C.M.P. Airport Detachment in Edmonton indicate Currie a subject of interest;

(f) St-Pierre satisfied no criminal offence;

(g) St-Pierre believes Currie acting "bizarrely" with "paranoia"'

(h) Currie tells St-Pierre the doctor in Edmonton infected him with Lyme's disease;

(i) St-Pierre had no grounds to hold Currie;

(j) St-Pierre had no concerns Currie would hurt himself or anybody else;

(k) St-Pierre makes note in notebook "He appeared M.H.A." (for ***Mental Health Act***) because Currie's behaviour was "definitely abnormal";

(l) Edmonton Airport R.C.M.P. had Currie entered as a subject of interest because he had jumped off a shuttle bus leaving his personal effects behind.

[44] In transferring Currie to Constable Schroder further down the highway at 19:50, St-Pierre does not recall how much of the above he mentioned to Schroder at the time, particularly that Currie was a subject of interest in Edmonton for jumping off a shuttle bus and leaving his personal effects behind. Nor did St-Pierre recall telling Schroder that Currie believed someone was threatening him on the bus before McCreary.

[45] Constable St-Pierre has no contact or discussion with Corporal MacRae until the next day.

## (2) Constable Richard Kurt Schroder

[46] A member of the R.C.M.P. with 13 years' service at the time working the night shift with Corporal MacRae:

(a) Meeting up with Constable St-Pierre on Highway 5 Schroder says St-Pierre told him "this guy was running from some people that were supposed to be chasing him";

(b) Driving back to the Ste. Rose Detachment Currie tells Schroder he is on his way back east to his home province from Edmonton and some people on the bus chasing him – had Lyme disease – doctor misdiagnosed him – suing the doctor – doctor sending these people after him;

(c) Currie "definitely acting in a very strange behaviour";

(d) Schroder introduces Currie to Corporal MacRae. "We felt that he was unstable."

(e) Schroder contacts sister of Currie in Nova Scotia; as Currie had no money sister indicated she would provide some. Currie still had a bus ticket;

(f) Currie did not indicate he was going to harm self or anybody else;

(g) Schroder says keeping Currie in the cells overnight not an option "because he hadn't committed an offence", Currie having asked to stay over in the cells;

(h) Schroder contacts St. Christopher's House for lodging for one night, explaining to Mrs. Knight he "had a gentleman here who was a little off centre, down on his luck, and needed a place to stay";

(i) Schroder had dealt with Currie about two hours before dropping Currie off at St. Christopher's House;

(j) In examination by Ms. Everard Schroder advises his search also disclosed Currie convicted on a drug charge "a long time ago";

(k) In examination by Ms. Everard says at no time did Currie tell him someone trying to kill him, nor does he recall St-Pierre telling him other than people following him;

(l) Doesn't recall St-Pierre telling him Currie on the run for about one week, only that Currie "was off centre and he wasn't making much sense" and "that he felt he may be a candidate for involuntary assessment";

(m) Neither Currie nor St-Pierre told Schroder someone was threatening him on the bus;

(n) Schroder felt Currie was off centre: "I didn't feel that he was unstable.";

(o) Schroder was advised by C.P.I.C. entry that Currie did in fact jump off the bus in Edmonton leaving his personal effects behind.

**(3) <u>Corporal Graham Carl MacRae</u>**

[47] A member of the R.C.M.P. for 21 years at the time working that evening in the office; asked by Constable Schroder to speak to Currie:

(a) Currie picked up hitchhiking;

(b) Had no shirt on;

(c) Told by Currie on a bus from Alberta to the Maritimes to rejoin his family;

(d) Currie felt someone was watching him on the bus; asked the bus to stop in McCreary and got off;

(e) Currie felt doctors in Alberta not treating him properly so he left;

(f) Corporal MacRae had some concern Currie might have "some mental problems";

(g) Currie had done nothing of a criminal nature. "We were more trying to find him some help.";

(h) Currie "was coherent in speaking to me" (MacRae);

(i) Currie "had a plan, a fairly concrete plan";

(j) Currie provided MacRae with name of his sister and a phone number;

(k) We phoned his sister and she was expecting him;

(l) Other than the fact he felt people were watching him he "seemed completely rational";

(m) "Still, I was rather concerned." and had him talk to the Mobile Crisis worker from Dauphin over the phone;

(n) "There was no concern at that time that he was an immediate threat to himself or others, so we were just trying to facilitate his safe journey home.";

(o) Currie spoke to the Mobile Crisis worker for about five minutes;

(p) Currie handed the phone back to MacRae. MacRae and Crisis worker Lorrain spoke, concurring Currie not a risk to self or others, had a pretty concrete plan, all right for him to continue on his way;

(q) In speaking with Currie's sister over the phone she advised he had no mental health problems that she was aware of;

(r) We arranged for him to stay the night at St. Christopher's House;

(s) Currie seemed very content with the plan;

(t) In examination by Ms. Everard Currie did not indicate someone threatened him on the bus nor someone trying to kill him;

(u) MacRae not aware Currie left his luggage behind on shuttle bus in Edmonton;

(v) MacRae not aware Currie "on the run for the last week";

(w) MacRae would not go so far describing Currie as "distraught";

(x) Currie asked to stay in cells overnight but not having committed a crime "we couldn't justify keeping him in cells";

(y) MacRae "initially asked Mr. Currie if he was interested in going to the hospital to talk to a doctor. He indicated he wasn't, and I felt this was a very viable solution to have him talk to a mental health professional.";

(z) MacRae: "it was summer and lots of people don't wear shirts";

(aa) Currie and Lorrain could have spoken on the phone for ten or more minutes instead of five.

[48] In examination by Mr. Farlinger, when asked why the decision to contact Mr. Lorrain at the Mobile Crisis Unit:

> A There is two reasons. One, we felt that this gentleman did have a mental problem, although he did not appear to be at risk -- immediate risk to himself or others…they would have greater expertise than ourselves in dealing with mental issues…and get as many opinions as possible to make the best assessment.

## (4) Andre Amity Lorrain

[49] A mental health worker in the Mobile Crisis Unit of Community and Mental Health in Dauphin since of October of 2000:

(a) We do "crisis intervention and we assess to see if they're at risk to themselves" under ***The Mental Health Act***;

(b) Corporal MacRae phoned him that a gentleman had stopped the police, brought to detachment, asked if I would talk to him;

(c) MacRae told Lorrain didn't feel Currie at risk but would like Lorrain to speak to him;

(d) "I did not ask him as far as why he got off the bus";

(e) Currie stated he had some problems in Edmonton with a doctor;

(f) I asked him, "So, is anybody following you as far as on the bus from Edmonton to Nova Scotia" and he said "No";

(g) Asked Corporal MacRae if I should come to the detachment and he said no need to;

(h) At the time there were two resident psychiatrists at the Dauphin hospital in the Parklands area;

(i) Lorrain came to the conclusion Currie not dangerous and that his delusions "were not significant and they were located strictly in Edmonton";

(j) Currie was "very cordial" – his "answers were coherent" and "he had a very well thought out plan as far as getting to Nova Scotia";

(k) If Lorrain had known Currie had started a fire on the bus he "would have went for a face-to-face" instead of a phone interview;

(l) In examination by Ms. Everard neither MacRae nor Currie told him Currie felt someone trying to kill him;

(m) Neither MacRae nor Currie told him Currie left his luggage behind on the shuttle bus in Edmonton;

(n) Neither MacRae nor Currie told him Currie was being threatened on the bus when he got off in McCreary;

(o) Lorrain did not know Currie had made requests of police to be put in touch with an undercover officer in Nova Scotia;

(p) Lorrain did not know Currie told police he had been on the run for the last week;

(q) Lorrain did not know Currie was not wearing a shirt when picked up at side of the road;

(r) Lorrain did not know Currie:

(i) appeared very distraught when picked up;

(ii) asked bus to stop and ran away from the bus;

(iii) told police he felt he was being followed;

(iv) told MacRae he felt he was being hunted;

(s) Everard:

> Q If you had known any or some or all of those things would it have changed the course of action that you pursued?
>
> A Yes, it would have. I would have went for a face-to-face assessment.

(t) All Lorrain can do is the assessment; from there it goes to the psychiatric doctor on call. He makes that determination. Lorrain does not have the authority to do an involuntary admission.

[50] The above outlines the information before each of the four persons who had contact with Currie before he was dropped off at St. Christopher's House. It also outlines their opinions regarding Currie's condition and reasons for taking the action taken.

[51] Of relevance, I believe also, are the comments of Dr. Waldman contained in the Forensic Assessment dated October 26, 2001, filed as Exhibit 1 in these proceedings. I highlight in particular that when initially assessed in August 2001 Mr. Currie "was presenting as a vague, guarded and suspicious individual who only superficially cooperated with the assessment process". Later, "continued to be superficially cooperative" and "superficially pleasant until discussions are directed to the assessment process. At that point he generally becomes guarded, suspicious and argumentative."

[52] Finally, as referred to earlier, notice of Currie having started a fire on the bus before getting off at McCreary did not come to any of the four persons above until the bus driver could be reached several days after the fire at St. Christopher's House.

[53] In all of the above I believe I have covered when, where and by what means Isobel Lathan died, the cause of death and the material circumstances of her death. I also believe I have made the first two determinations asked for by the Chief Medical Examiner. More particularly, I have determined that there are available and adequate mental health services to assess acutely psychotic patients in the Parkland rural area in Manitoba.

[54] The third and final determination asked for by the Chief Medical Examiner falls within the category of my duties set out in section 33(1) of ***The Fatality Inquiries Act*** that I may recommend changes in programs, policies or practices of the government and relevant public agencies or institutions or in the laws of the province where I may be of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death of Isobel Lathan.

[55] Again, it must be remembered that there is a distinction between the set of facts that was known and acted upon by the three peace officers and Mr. Lorrain and also Mrs. Knight up to the starting of the fire at St. Christopher's House and the additional facts that became known after the fire was set.

## Recommendations

[56] Having had the benefit of hearing all of the before and after facts and circumstances and the hindsight that follows, I make the following recommendations:

(1) There was evidence at the Inquest that had St. Christopher's House been equipped with a sprinkler system, there probably would not have been a fire. While the Manitoba Building and other codes do not require older buildings such as St. Christopher's House to install a sprinkler system, it is recommended that the applicable provincial and federal legislation and codes be revisited and studied with a view to making older residential care facilities and other older residential buildings safer by requiring the installation of sprinkler systems therein which would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death of Isobel Lathan where a fire might be deliberately set as well as in circumstances where fires might be set through negligence or accident.

(2) It is also recommended that residential care and similar facilities continue to follow an emergency evacuation plan and procedure approved by their respective local fire departments, with regular fire and other emergency evacuation drills, that the importance of same be emphasized to all residents, staff and other occupants and that all participate in such drills and procedures.

(3) Counsel for the Parkland Regional Health Authority in her submission to this Inquest submits that:

> The R.H.A. submits, based on all of the foregoing, that there were adequate mental health services available to deal with Currie on the night in question. Unfortunately, due to a serious lack of communication, those services were not effectively utilized.

In this regard, referring to the R.C.M.P. Division Policy (Exhibit 5) in these proceedings and the evidence of Staff Sergeant Gary James White, it would seem that the existing programs, policies and practices of the R.C.M.P. are adequate and no change is necessary, but that the importance of their observance and timely communication be stressed, particularly of all relevant facts including strange behaviour,

recognizing the difficult time restraints officers are working under and the fact that a subject may not be under arrest or even a suspect.

## Exhibits

[57] The documents, photographs and other material tendered as exhibits at the hearing on November 19, 2003 and November 21, 2003 are the following:

1 Letter from Health Sciences Centre Forensic Services to Dauphin Court Unit dated October 26, 2001;

2 Continuation Report of Constable St-Pierre dated July 28, 2001;

3 Preliminary Report from Westlake R.C.M.P. Detachment, File 2001-2190;

4 C.P.I.C. printout dated August 01, 2001;

5 R.C.M.P. Division Policy and National Policy;

6 Curriculum Vitae of Murray Charles Bedford;

7 Binder containing Fire Investigation reports and photographs;

8 Statement of Andre A. Lorrain dated July 28, 2001.

[58] In addition to the exhibits tendered at the hearings, the following letters and documents were later submitted at my request:

A. Copy of letter from Chief Medical Examiner to Director of Prosecutions dated October 9, 2002;

B. Admission Routine at Psychiatric Unit for Dauphin Regional Health Centre;

C. Report respecting licencing of Residential Care Facilities and Fire Codes;

D. Written submission of Scott D. Farlinger for the R.C.M.P.;

E. Written submission of Candace Everard for the Parkland Regional Health Authority;

F. Letter from Crown Attorney Donovan Dvorak dated August 24, 2004;

G. Transcript of Proceedings (Volume 1) of proceedings November 19, 2003;

H. Transcript of Proceedings (Volume 2) of proceedings November 21, 2003.

[59] I respectfully submit my recommendations and conclude this Report this 1st day of September, 2004, at the City of Winnipeg, in Manitoba.

*Original signed by Judge Kenneth B. Peters*

Kenneth B. Peters, Provincial Judge