Release Date: October 10, 2018

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act* C.C.S.M. c. F52

AND IN THE MATTER OF: Ali Al Taki, Deceased

Report on Inquest of Judge Timothy Killeen
Issued this 4th day of October 2018

APPEARANCES:

Theresa Cannon, Inquest Counsel
Alan Ladyka, Counsel for the Government of Manitoba (Department of Health, Seniors and Active Living)
Robin Winters, Counsel for the Government of Manitoba (Department of Health, Seniors and Active Living)
Daniel Ryall, Winnipeg Regional Heath Authority Operating as Health Sciences Centre
Andrew Boumford, Counsel for Dr. Julius Alexy and Dr. Steven Kremer

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF ALI AL TAKI

Having held an Inquest respecting the said death on the 15th, 24th and 25th days of January, 2018, and the 5th day of April, 2018, at the City of Winnipeg and the City of Selkirk in Manitoba, I report as follows:

The name of the deceased is: Ali Al Taki.

The deceased died on the 24th day of June, 2016, at the City of Winnipeg, in the Province of Manitoba.

The deceased died by the following means: he was pushed which caused an injury to his head, which resulted in hospitalization. While hospitalized, his condition deteriorated. He contracted bilateral bronchopneumonia due to immobility caused by amyotrophic lateral sclerosis.

I hereby make no recommendations for the reasons set out in the attached report.

Attached hereto and forming part of my report is a list of exhibits required to be filed by me.

Dated at the City of Winnipeg, in Manitoba, this 4th day of October, 2018.

"ORIGINAL SIGNED BY:"
Timothy Killeen, Judge
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, Chief Medical Examiner (2 copies)
2. Chief Judge Margaret Wiebe, Provincial Court of Manitoba
3. Honourable Cliff Cullen, Minister Responsible for *The Fatality Inquiries Act.*
4. Mr. Dave Wright, Deputy Minister of Justice & Deputy Attorney General
5. Michael Mahon, Assistant Deputy Attorney General
6. Theresa Cannon, Counsel to the Inquest
7. Alan Ladyka, Counsel for the Government of Manitoba (Department of Health, Seniors and Active Living)
8. Robin Winters, Counsel for the Government of Manitoba (Department of Health, Seniors and Active Living)
9. Daniel Ryall, Winnipeg Regional Heath Authority Operating as Health Sciences Centre
10. Andrew Boumford, Counsel for Dr. Julius Alexy and Dr. Steven Kremer
11. Exhibit Coordinator, Provincial Court
12. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba

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RESPECTING THE DEATH OF: ALI AL TAKI

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I. MANDATE OF THIS INQUEST

[1] By letter dated May 15, 2017, the then Acting Chief Medical Examiner for the Province of Manitoba, Dr. J. Younes, MD, FRCPC, directed that a Provincial Judge conduct an Inquest into the death of Ali Al Taki for the following reasons:

> 1. to fulfill the requirement for an inquest as defined in section 19(3)(b) of *The Fatality Inquiries Act*;
>
> > **Inquest Mandatory**
> >
> > 19(3) Where, as a result of an investigation, there are reasonable grounds to believe:
> >
> > a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
> > b) that a person died as a result of an act or omission of a peace officer in the course of duty;
> >
> > the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.
>
> 2. to determine the circumstances relating to Mr. Al Taki's death; and,
>
> 3. to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[2] *The Fatality Inquiries Act* requires that a written report of the Inquest be provided to the Minister responsible for administration of the *Act*, (the Minister of Justice), setting forth when, where, and by what means Mr. Al Taki died, as well as the cause and material circumstances of his death. The Inquest Judge has the discretion to make recommendations respecting programs, policies or practices of

the government and the relevant public agencies and/or institutions, or the laws of the Province if, in the Judge's opinion, it would help to reduce the likelihood of deaths occurring in similar circumstances.

[3] The Inquest commenced with a notice to the public that a Standing Hearing would be held on August 24, 2017. Standing in this Inquest was granted to Government of Manitoba (Department of Health, Seniors and Active Living), Winnipeg Regional Heath Authority Operating as Health Sciences Centre, Dr. Julius Alexy and Dr. Steven Kremer. The Inquest heard evidence or submissions on January 15, 24, 25 and April 5, 2018, in Winnipeg and Selkirk.

II. INTRODUCTION

[4] The deceased, Mr. Ali Al Taki, was a patient of the Selkirk Mental Health Centre. He was held at the Centre after being found unfit to stand trial on criminal charges. While a patient at the Centre, he was involved in an altercation with another patient. The event was minor in nature, but Mr. Al Taki fell and suffered a head injury. He was transferred to the Selkirk General Hospital and later to the Health Sciences Centre for treatment.

[5] Mr. Al Taki was already suffering from dementia and associated limitations. His health deteriorated until his death on June 24, 2016. I am satisfied from the evidence heard over the course of the inquest that the event which led to his head injury could not have been anticipated and was not preventable. His head injury was not the sole cause of his death, as his disease process was already leading to an early death. Nothing should have been done differently and there are no recommendations with respect to changes in any practice at the facilities involved.

III. BACKGROUND

[6] The deceased was born in Iraq on May 20, 1974. He moved during the war in 1991 and spent five years as a refugee in the Middle East. He later moved to Canada. His life was reportedly productive and normal until he began to have behavioural changes some years before his death. Those changes eventually led his partner to apply for and receive a protection order.

[7] Despite the order, he continued to go near the family home, perhaps to communicate with family members. He was arrested and charged with breaches of that order. He was released on judicial interim release, but was again arrested for violating the protection order and the subsequent release order. After a second form of release, he was re-arrested in December of 2014 and held in custody.

[8] Mr. Al Taki had noticeably changed in his behaviour. His partner spoke to medical staff about what she had observed. He acted differently towards his children. He behaved differently at home. He may have been using drugs. He was not able to maintain employment. Eventually, she had asked him to leave the home and he was homeless. He had likely suffered some deterioration over the last five years of his life, with the impairment having become more prominent over the last couple of years. It appears that the criminal charges arose during the period of more significant cognitive impairment.

[9] In custody, it became obvious that he was suffering from some form of dementia. He was assessed pursuant to a court order. He spent time in the forensic facility at Health Sciences Centre. There was no indication of any mental illness. After an assessment, a number of limitations were noted, including difficulty with speech, communication generally, comprehension, hygiene, eating, swallowing and gait. There was no indication of anything other than dementia. The diagnosis was probable early onset dementia.

[10] Obviously, the diagnosis could not be as complete as what was possible on autopsy. An extensive neurological examination performed as part of the autopsy showed no evidence of tauopathy, such as Alzheimer's disease, but changes consistent with early amyotrophic lateral sclerosis were noted. There was also neuronal loss in the hippocampus consistent with chronic ischemic injury. In any event, the changes in his behaviour and his significant cognitive and other limitations are consistent with that diagnosis.

[11] On November 25, 2015, he was found to be unfit to stand trial. The finding that he was unfit to stand trial also included an order that the Review Board hold a hearing to make a disposition pursuant to section 672.47(1) of the *Criminal Code of*

Canada. The finding on January 13, 2016 was that he was to be detained in a hospital and an order directed the PsycHealth Centre, Health Sciences Centre and the Selkirk Mental Health Centre to have him reside at one of those facilities.

[12] As a result, he became an involuntary patient at the Selkirk Mental Health Centre in the forensic ward. In that location, he was with others who were unfit to stand trial or perhaps not criminally responsible.

IV. AT SELKIRK MENTAL HEALTH CENTRE

[13] The file from his earlier stay at the Health Sciences Centre was sent to the Selkirk Mental Health Centre and reviewed by the treatment team at that centre. The file included the assessments by medical and psychological staff as well as information compiled by social workers. His background reports contained information from his partner as well as a friend in the community.

[14] He was assessed and monitored as staff tried to determine appropriate procedures for his care. He was initially placed in a high security area where he was away from other patients. His behaviour was described as impulsive, repetitive and with several deficits. During assessments he was found to have had a significant degree of impairment in his ability to manage everyday activities independently. His speech was often incomprehensible. Some of his actions were aggressive, such as refusing to allow staff to remove items from his room or otherwise care for him.

[15] He also had difficulty swallowing, consistent with his medical condition. His diet was limited, including the type of liquids or minced food that he was able to consume. Generally, his disease had taken a significant toll on a relatively young man.

[16] Mr. Al Taki had been placed in the Forensic Program. James Wasio, manager of that program testified about it. It is a long term treatment facility, with many of the patients being there for periods in the range of six months to two years. Others may be there for longer periods. The program provides long term services to deal with psychiatric and related social problems. Patients might arrive as referrals from other facilities or by order of a court or the Review Board. The program is staffed

by psychiatric staff, nurses, physical therapists, occupational therapists and provides considerable supervision. The facility consists of four high security rooms and eighteen medium security rooms.

[17] Security is in place, including monitoring cameras which can pan, scan and zoom. They are monitored through screens in a control room. At the time, the cameras did not record. That was later changed and the system now records.

[18] Mr. Al Taki was placed in a high security room. It was clear that his condition was different from that of the other patients. He was already relatively compromised upon his admission to the unit. His diagnosis, early onset dementia, eliminated the type of recovery goals available for the other patients. Instead, the expectation was that he would likely continue to lose cognitive function.

[19] Mr. Al Taki was supervised and monitored closely. Staff monitored his interaction with other patients. The case plan was that the supervision would be reduced if his condition improved. Initially, one staff member was with him if he was not in his own room. The staffing at the ward included two nurses and two psychiatric assistants, with one fewer staff at night.

[20] He was checked by the staff every quarter of an hour.

[21] As time progressed, he was allowed out of his room to interact with others. He was monitored closely with an attendant with him all the time at first.

[22] It appears that the other patients recognized that Mr. Al Taki was different from them. They got along with him, but appeared to staff to be aware of his cognitive limitations. It was obvious that Mr. Al Taki was more similar to those who were patients in the psycho-geriatric ward. For that reason, a referral was made to the Geriatric Program. Medication was also prescribed. It appeared that he was relatively stable. Staff noted that he would hoard items, particularly food items. He was unable to explain what he was doing, referring to keeping food for his mother. He ate at different times from other patients to avoid interactions with him trying to take food from others.

[23] Mr. Al Taki was a smoker. Initially, this was a problem as he did not have any funds to purchase cigarettes or tobacco. He appeared to be checking for cigarettes or butts in places like the garbage cans. Not long after arrival, money was left for him by another. He was able to use the funds to buy cigarettes and was put on a schedule where he could get cigarettes only at specified times. Mr. Al Taki was initially able to read a clock and understand when he was entitled to get a cigarette. Others also smoked and had similar privileges.

[24] He would come to the desk and gesture that he wanted to smoke. He could smoke only in the courtyard. On the day of the fall, he was in the yard with other patients.

[25] Trevor Spicer was employed at the Selkirk Mental Health Centre as a psychiatric nursing assistant. He was familiar with Mr. Al Taki, whom he described as childlike. He did not normally converse verbally, but instead used hand signals. Mr. Spicer was also familiar with the other patient, who was later involved in the event. That patient was normally settled in his manner. Nothing should have led to a conclusion that there was likely to be a problem of the sort that occurred.

[26] Nancy Lund was one of the nurses working at the ward. She was familiar with all of the patients in the ward. She found the other patients to be friendly and supportive of Mr. Al Taki.

[27] She said that when he first arrived on the ward, Mr. Al Taki had had limited privileges and close supervision. As time had progressed, he had been given greater latitude, including the ability to be in the yard and smoke. The staff monitored his behaviour, including whether he was taking things from the rooms of others. When they were satisfied that he was not, he was allowed to move more freely on the ward.

[28] Dr. S. Kremer had been associated with the Selkirk Mental Health Centre for eighteen years. He was aware of Mr. Al Taki's history, having reviewed all of the information collected during Mr. Al Taki's time at the Health Sciences Centre. A treatment team consisting of psychiatric and nursing staff, therapists and social workers met regularly to plan for treatment for him.

[29] It was clear that Mr. Al Taki was compromised in his cognitive abilities. He was distractible, had difficulty communicating and it was not clear that he was able to understand things said to him. The deterioration was progressive and that was the basis for the referral to the geriatric program. He was also prescribed medication to attempt to improve his condition. He was also compromised in his abilities in other ways, such as having difficulty swallowing.

[30] Within a few weeks of admission, Mr. Al Taki was allowed into other areas of the ward, but with direct supervision. He was closely monitored, but allowed to interact with others. The only problem was his inability to understand boundaries. Staff were able to monitor that. The other patients also understood that he was different and accommodated his presence as much as possible. He was the only patient in the forensic ward with early onset dementia. Dementia was common on the geriatric ward.

V. THE EVENT THAT CAUSED THE INJURY

[31] On April 18, 2016, Mr. Al Taki followed another patient in the courtyard. At least one other patient was nearby. Others and staff were around the area. No evidence was called from any witness who saw the event. The two people who saw what occurred are both patients on the ward. Both were there as a result of a determination that they were unfit to stand trial or were not criminally responsible. It did not appear likely that they would be able to give evidence that would be helpful in determining what had happened.

[32] The other participant in the event is still a patient on the ward. He remains under an order that he is not fit to stand trial. The determination not to call him as a witness is consistent with the reason that he was committed to the Centre originally.

[33] However, staff and patients were interviewed after the event. The accounts were filed at the Inquest. They are largely consistent. The event was not seen by any staff members and was not recorded, as the video system did not record at the time. The picture that has emerged is somewhat limited, but likely captures what happened.

[34] It appears that patients were in the yard, with some of them smoking. Mr. Al Taki did not have a cigarette at the moment, although he had been smoking earlier in accordance with his schedule. It appears that he reached into or at least near the pocket of the other patient. It is likely that he was reaching for a cigarette. The other patient had not offered him one or agreed to give him one. Mr. Al Taki was apparently just trying to take one from that patient. One of the other patients had described Mr. Al Taki in his statement as being a 'mooch'.

[35] The other patient struck or pushed Mr. Al Taki's arm away. The action does not appear to have been a violent act, but was more of a reflex action. Mr. Al Taki fell to the ground and struck his head.

[36] The other patient involved was suffering from schizophrenia, but had not displayed violent or aggressive behaviour. Although Mr. Al Taki was very frail, there was no reason why he could not be in the yard with others. The event was quick and staff attended to Mr. Al Taki quickly. It was obvious that he had injured his head. The staff immediately began to treat him.

[37] Ms. Lund did not see what happened. She was on the phone when she was told by a psychiatric nursing assistant that a patient had pushed Mr. Al Taki, causing him to fall. She immediately went to him and treated a five centimetre gash to the back of his head. Her greater concern was for the possibility of an internal injury. She determined that he should be transported to the nearby hospital for an examination. Security staff transported him and he was at the Selkirk General Hospital within about 30 minutes of the event. She provided treatment within seconds of the injury. The hospital in Selkirk assessed him and determined that he should be transferred to the Health Sciences Centre.

[38] Ms. Lund made inquiries to try to determine what had happened. She was told that a certain patient had pushed Mr. Al Taki when Mr. Al Taki had reached into that patient's pocket, probably trying to get a cigarette. The other patient was apparently frustrated by the attempt to get a cigarette and pushed Mr. Al Taki's arm away. Mr. Al Taki's balance was compromised and he fell, striking his head. The description from a third patient was that Mr. Al Taki reached into the second patient's pocket to take a cigarette and the patient responded by pushing him.

[39] Mr. Wasio also made inquiries to find out what had happened. The accounts given to him are consistent with the accounts to Ms. Lund and later to the police. After apparently trying to take a cigarette from the other patient, that other patient pushed Mr. Al Taki. He apparently lost his balance and fell, striking his head.

[40] The other patient had not displayed violent or aggressive behaviour in the past. In fact, this was the only circumstance where someone had been injured in that yard. Staff were present around where this happened. It was a momentary event, not a disagreement or argument or fight. Nothing had happened to alert anyone to a developing situation that could deteriorate. Instead, it was over as soon as it began.

[41] Although staff were aware of Mr. Al Taki's behaviour in trying to get cigarettes from others, it was not anticipated that an event like this would occur. There was no point in trying to change his behaviour. His cognitive limitations prevented him from learning to change. The other patients did not appear troubled by his behaviour. They appeared to understand that his illness was different. None had reacted violently to his actions.

[42] The alternatives to allowing him to be in the courtyard with others were limited. Smoking was not permitted inside his room. Even if it had been permitted, it would have been unwise or dangerous to allow him to smoke alone in his room. It could also have caused problems for other patients wanting the same sort of privilege.

[43] Allowing him to smoke in the courtyard only if he was alone was not feasible. It would have required all other patients to leave, again causing potential problems. Cutting off his ability to smoke would probably have raised his anxiety level, but would not have removed the problem. The issue was not so much his smoking, as his inability to understand that he could not take things, such as cigarettes, from others. The only way to prevent this event would have been to completely isolate Mr. Al Taki from all other patients. In addition to not being feasible, it would probably have been cruel to Mr. Al Taki.

[44] Instead, allowing him to have some activity while being monitored was the best course. The push by another patient was quick and unanticipated. The event did not continue after that brief moment. This was not a violent act, sustained over even a few seconds.

[45] The patient who pushed Mr. Al Taki was interviewed by police, but was never charged criminally. That decision was appropriate for several reasons. His action was almost certainly not a criminal act. It appears to have been a reflexive act to push away an arm when someone reached into his pocket without invitation. The evidence against him was likely unreliable. As well, the diagnosis of the patient meant that even if charged, he would have been found unfit to stand trial, ending matters with him being ordered to be held as he already was.

[46] Instead, the other patient lost privileges as a result of this event. His privileges were still limited more than a year after the death.

VI. AFTER MR. AL TAKI WAS INJURED

[47] The medical file was presented and there was considerable evidence concerning Mr. Al Taki's treatment in hospital. The examination and cross-examination largely dealt with whether the treatment after the injury had included a proper diet, considering his limitations in swallowing. It was clear that Mr. Al Taki required a modified diet with a particular consistency in his food. He was not able to properly eat a diet which included a mixed consistency. Considerable time was spent examining whether his diet may have contributed to further medical problems, such as aspiration of food. There was extensive evidence and examination concerning his stay in hospital. The contents of his medical file were produced and reviewed.

[48] It is not in the public interest to review the details of Mr. Al Taki's care in hospital, other than to say that he was treated appropriately. Several factors played a part in his deteriorating health. The head injury which had been the immediate cause of his hospitalization did nothing to improve his situation. However, his neurological changes, unrelated to the injury, caused significant deterioration in his ability to communicate, to swallow, to comprehend his situation and cumulatively

those factors led to his death. The assessment conducted at the Health Sciences Centre was that he was close to his neurological baseline; that is his neurological condition upon admission. In another patient, the injury would heal naturally. Had he presented with only the injury, but not the dementia, he would have been placed into therapy to allow him to return to work and his normal life. Instead, the dementia prevented that from happening. Ultimately, he developed pneumonia. He was given reasonable care until his death on June 24, 2016.

[49] Mr. Al Taki received appropriate care, but continued to deteriorate until his passing on June 24, 2016. There was nothing further that should have been done to treat him. The care at the Selkirk General Hospital and at the Health Sciences Centre was appropriate to treat his head injury. Nothing could reverse the dementia or alleviate the problems caused by that dementia.

[50] A number of conditions or events led to Mr. Al Taki's death. His cognitive deterioration was well advanced at the time that he was admitted to the Selkirk Mental Health Centre. Indeed, that was the basis of the finding that he was unfit to stand trial. Although he was closely monitored, it was neither feasible nor appropriate to prevent him from having any interaction with others. Locking him alone in a room could have been cruel.

[51] The staff and other patients were aware of his condition. Nothing that had happened in the time since his arrival on the forensic ward would have led to a conclusion that another patient might assault him. Staff were around, but the event was quick and unanticipated.

[52] It was also an event which would have been minor, but for Mr. Al Taki's condition. It caused him to lose his balance and fall. It appears that his cognitive impairment may have affected his balance, as well as his other faculties.

VII. THE AUTOPSY REPORT

[53] The Autopsy Report of the Medical Examiner was initially produced in a preliminary form. It listed the medical cause of death as blunt head trauma. It listed

the manner of death as homicide. It also noted as another significant condition the presence of dementia, not yet diagnosed.

[54] The preliminary autopsy report was dated June 28, 2016, or shortly after Mr. Al Taki's death. There was later extensive examination to determine the nature of the dementia. The neurological pathologist determined that the main neurodegenerative pathology was consistent with early amyotrophic lateral sclerosis. A further comment was made with respect to the examination for genetic mutation, but the results are not relevant. It was clear that the deceased had a chronic degenerative neurological condition. That was consistent with the observations of his deterioration over time. It was an examination of his brain which could be done only at autopsy.

[55] At the time of the death, *The Fatality Inquiries Act* C.C.S.M. c. F52 read as follows:

> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe
>
> > (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
> > (b) that a person died as a result of an act or omission of a peace officer in the course of duty;
> >
> > the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.

For those reasons, the Inquest was mandatory if the cause was a violent act.

[56] Two things changed as the Inquest was under way. The first was that *The Fatality Inquiries Act* was amended.

[57] The relevant changes are set out in the addition of subsections 19(5) and (6).

> 19(5) Subject to subsections (6) and (7), an inquest into a death must be held if
>
> > (a) the chief medical examiner has reasonable grounds to believe that the deceased person died as the result of the use of force by a peace officer who was acting in the course of duty; or
> > (b) at the time of death, the deceased person was
> > (i) in the custody of a peace officer,
> > (ii) a resident in a custodial facility,
> > (iii) an involuntary resident in a facility under *The Mental Health Act*, or
> > (iv) a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*.
>
> 19(6) An inquest is not required if a death occurred in any of the circumstances set out in clause (5)(b) if the chief medical examiner is satisfied that
>
> > (a) the death was due to natural causes and was not preventable and the public interest would not be served by holding an inquest into the death; or
> > (b) there was no meaningful connection between the death and the nature or quality of supervision or care provided to the deceased person by reason of the deceased person's status or circumstances as set out in clause (5)(b).

[58] The second relevant change was that the medical examiner reviewed all of the information provided after the preliminary autopsy report was completed and changed the cause of death for the final report. I find nothing unusual or inappropriate in him doing so. Rather, he reviewed the medical reports generated during Mr. Al Taki's stay in hospital and the neurological examination and properly concluded that the immediate cause of death was bilateral bronchopneumonia due to immobility due to blunt head trauma. The other significant conditions contributing to the death but not causally related to the immediate causes were frontotemporal lobar degeneration and early changes of amyotrophic lateral sclerosis. The manner of death was still recorded as homicide.

[59] Had the amended legislation been in force at the time of the death, it is unlikely that an Inquest would have been required. The issue that is of concern to

the public is whether the conditions or supervision at the Selkirk Mental Health Centre caused or contributed to his death. In my view, they did not.

[60] Mr. Al Taki's death was a sad event. Nothing should have been done differently while he was hospitalized. There are no recommendations.

I respectfully conclude and submit this Report on this 4th day of October 2018, at the City of Winnipeg, in the Province of Manitoba.

"ORIGINAL SIGNED BY:"

Timothy Killeen, Judge
Provincial Court of Manitoba

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

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APPENDIX A - EXHIBIT LIST

Exhibit No.	Description
1	*Curriculum Vitae* of Dr. Charles Littman
2	Floor Plan of Alfred Barnett Building
3	Binder of Documents Regarding the Inquest
4	Amended Report of the Medical Examiner dated November 18, 2016