Release Date: December 11th, 2006

IN THE PROVINCIAL COURT OF MANITOBA
Winnipeg Centre

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***
S.M. 1989-90, C.30 – Cap. F 52

AND
IN THE MATTER OF: **An Inquest into the Death of**
MELFORD WILLIAM NICKOSHIE

Report on Inquest and Recommendations of
The Honourable Judge Marvin F. Garfinkel
Issued this *6th* day of December, 2006.

APPEARANCES:

Mr. N. Peterson, Provincial Counsel to the Inquest
with Ms. Betty Owens

Mr. I. D. Frost, Counsel for the Department of Corrections

Mr. S. Boyd, Counsel for the Department of Corrections

Ms. K. Carswell, Counsel for the Winnipeg Police Service

Ms. S. Hanlin, Counsel for the Winnipeg Police Service

[1] By letter dated September 12th, 2005, the Chief Medical Examiner directed that an Inquest be held into the death of Melford William Nickoshie, for the following reasons:

1) To fulfill the requirements for a mandatory inquest as defined in section 19(3) of the Act;

2) To determine the circumstances relating to Mr. Nickoshie's death, and;

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

[2] Section 19 (3) of the Act provides:

> Where, as a result of an investigation, there are reasonable grounds to believe
>
> (a) that a person while a resident in a correctional institute, 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 an act or omission of a peace officer in the court of duty;
>
> the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.

[3] With deference, the reference to section 19(3) as a reason for directing an inquest be held must be an error. There is no evidence to show that Mr. Nickoshie, at the time of his death, was a resident in a correctional institution, jail or prison, or while an involuntary resident in a psychiatric facility, or while a resident in a developmental centre. So section 19(3)(a) does not apply.

[4] There is also no evidence to show that Mr. Nickoshie died as a result of an act or omission of a peace officer in the course of duty. So section 19(3)(b) does not apply.

[5] Even if section 19(3)(b) did apply, the Chief Medical Examiner when directing the Inquest must be careful not to contravene section 21, which provides:

> In directing a provincial judge to hold an inquest, the chief medical examiner shall not, with respect to the death or deaths for which the inquest is to be held, express an opinion with respect to culpability in such manner that a person is or could be identified as a culpable party.

[6] Section 19(3)(b) seems to create a circumstance whereby section 21 would not be complied with.

[7] Sections 19(1) and 19(2) are sufficient to enable the Chief Medical Examiner to direct that an Inquest be held.

[8] This Inquest actually began on Friday, March 10th, 2006 at 9:15 a.m. in Courtroom 306 at 408 York Avenue, in Winnipeg, with a Standing Hearing. At that time, the sister of the deceased was present. She requested certain information and certain personal items that had belonged to her brother. She took no further part in the Inquest.

[9] At the conclusion of the Inquest, Crown counsel and counsel for the Police Service assured the Court that the personal items would be provided to the sister.

[10] At the Standing Hearing, standing to participate in the Inquest was given to the Department of Corrections and to the Winnipeg Police Service. The sister of the deceased did not request standing to participate in the Inquest.

[11] At the Standing Hearing, the matter was adjourned to November 6th, 2006 to proceed for five consecutive days to hear and receive testimony and evidence.

[12] On November 6th, 2006, an issue arose upon which I think I must comment (because it has been brought to my attention that the ruling I made has already been transcribed and used in a subsequent Inquest. I think it only fair therefore that that ruling is shared more widely.)

[13] Counsel for the Department of Corrections and the Police Service requested an Order that the nurses' notes and other records from the Health

Sciences Centre be provided as they had requested in writing on earlier dates in August, September and October. Crown counsel was of the view that sufficient documents had been provided.

[14] I ruled that the hospital records were relevant to determine the circumstances relating to the death and to determine what, if anything, can be done to prevent similar deaths from occurring in the future. In my opinion, an Inquest is broad in scope and all information which may bear on the issues should be considered; and that means there must first be disclosure to counsel.

[15] Within a day of my ruling, the material was provided. I commend those individuals who acted so promptly to my Order.

[16] The Inquest then proceeded to completion within the time set for the hearing.

[17] At the conclusion of the Inquest, the Provincial Judge must make a written report setting forth when, where and by what means the deceased person died, the cause of death, the name of the deceased person, if known, and the material circumstances of the death and may 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 Provincial 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 of Mr. Nickoshie (see section 33(1) of the Act).

[18] The Provincial Judge must complete the report no later than six months after conclusion of the Inquest, though an extension of this time limit may be applied for.

[19] This is my written report.

[20] The name of the deceased person is known. His name is **Melford William Nickoshie**.

[21] According to the Autopsy Report (Exhibit #4), he was pronounced dead at 20:00 hours (8:00 p.m.) on December 17th, 2004 at the Health Sciences Centre in Winnipeg, Manitoba. The Autopsy Report also sets out the immediate cause of death as severe recent head injury due to or as a consequence of motor vehicle accident (pedestrian).

[22] When one reads or hears of a motor vehicle accident (pedestrian), one imagines a motor vehicle running into a pedestrian who had been crossing a street. That is not the circumstances of Mr. Nickoshie's accident.

[23] I was not there at the scene of the accident. I did not witness the accident. My understanding of what happened is based upon my accepting testimony of witnesses and reading reports and observing a video.

[24] Mr. Nickoshie was at his sister's residence on December 17th, 2004. Also present was his sister, his brother-in-law, and a friend. They were drinking and ran out of beer. Mr. Nickoshie, his brother-in-law and the friend decided to walk to the Northern Hotel. On the way, on Magnus Avenue, Mr. Nickoshie fell but got up and continued walking.

[25] On Selkirk Avenue, in front of what was the Windmill Restaurant, Mr. Nickoshie approached a taxi. There was a conversation. Mr. Nickoshie was holding the glass window of the front passenger door of the taxi. The driver decided not to accept Mr. Nickoshie as a fare and he began to drive away.

[26] Mr. Nickoshie fell off the taxi and was lying on the street. The taxi driver circled around, through an alley, and back to the scene. The driver saw that Mr. Nickoshie was bleeding from his nose.

[27] As the driver was calling the police, a cruiser car drove up. The officers observed Mr. Nickoshie lying on his back on the street. He appeared to be intoxicated, but he was able to stand on his own. He also responded to the officers' questions.

[28] Mr. Nickoshie was detained under ***The Intoxicated Persons Detention Act***. He cooperated with the police officers and entered the back of the cruiser car. He was taken to the District 3 Police Station on Hartford Street.

[29] At the Police Station, it was determined that Mr. Nickoshie was bound by a probation order. He was charged with breaching that Order.

[30] There was one witness who related somewhat different circumstances of Mr. Nickoshie's interaction with the taxi. According to this witness, Mr. Nickoshie tried to get a ride in the taxi. Mr. Nickoshie opened the back door but, before he could get in, the taxi drove away. Mr. Nickoshie apparently held onto the door frame of the taxi while the taxi zig-zagged. Mr. Nickoshie fell off.

[31] I found it very difficult to accept this witness's version of the event and prefer the other evidence. The description of the event with Mr. Nickoshie holding onto the door frame and then to the roof of the taxi, is highly improbable. However, the upshot is the same. Mr. Nickoshie fell to the roadway and was lying on the street when the police arrived.

[32] Mr. Nickoshie was not handcuffed at the scene, nor when he was taken to the Police Station. He was cooperative. One officer observed dried blood in a nostril.

[33] Mr. Nickoshie was paraded before the Sergeant and the Sergeant was also of the opinion that Mr. Nickoshie was intoxicated. The provisions of ***The Charter of Rights*** relating to a person's rights upon detention were read to Mr. Nickoshie. He declined to call a lawyer.

[34] The decision was made to detain Mr. Nickoshie at the Provincial Remand Centre. The officers handcuffed Mr. Nickoshie and drove him to the Remand Centre. Mr. Nickoshie was handcuffed because that is the procedure required by the Remand Centre for the reason of security and safety.

[35] There is a video showing Mr. Nickoshie coming into the Remand Centre and his interaction with the staff there. This video is Exhibit #6. Mr. Nickoshie walked into the Remand Centre between the two police officers. He was placed on a bench in a holding room.

[36] While the officers were doing the paper work at the admissions desk, and while waiting on the nurse, Mr. Nickoshie slid off the bench and landed on the floor, probably hitting his head on a metal divider in the room.

[37] Mr. Nickoshie was seen by the nurse and it was obvious his condition had deteriorated. He had trouble standing and walking. He was not as coherent as he initially was. The nurse decided he must be taken to the hospital, and the police officers took him there.

[38] Mr. Nickoshie was admitted to the Emergency Department at approximately 3:51 a.m. on December 17th, 2004. At the hospital he was deeply comatose. A CT scan was performed. Surgery was not possible, and he died in the ward.

[39] According to the Autopsy Report, the blood alcohol level was 45 mml/l and the Toxicology Report showed ethanol to be 182 mg/dl.

[40] Mr. Nickoshie had a sad history of alcohol and drub abuse with many visits to the Emergency Department following fights and injuries. In 1993, he was hit on the head with a piece of wood. In 1997, he was kicked in the head and found unconscious. In 1998, he was again kicked in the head. A diagnosis of post-concussion syndrome was made. In 2001, he still had poor short-term memory. The diagnosis for Mr. Nickoshie in 2001 was chronic ethanol toxicity combined with possible hypoxic brain damage.

[41] The Major Crimes Unit of the Winnipeg Police Service investigated the circumstances. No charges were laid against the taxi driver nor anyone else.

[42] These are the material circumstances, as I understand them to be, with respect to the death of Melford William Nickoshie.

[43] At the conclusion of the Report, the Provincial Judge may recommend changes as stated earlier. Those recommendations, in my opinion, are to be reasonable and capable of being implemented. They must be practicable. There must be a political will to effect positive change and there must be available the necessary resources to give effect to the recommendations.

[44] In this case, I can think of no reasonable, practical recommendations to make which would serve to reduce deaths in similar circumstances. For

example, it is unreasonable and impractical to require cruiser cars to be equipped with CT scanners. It would also be unreasonable and impractical to require police officers to be trained to use CT scanners and to read the results. Also, it would not be reasonable to have a CT scanner at the Remand Centre, because even if it showed a problem, quick attention would be needed in an operating room to deal with that problem. The Remand Centre is not a hospital providing medical services.

[45] In my opinion, from the time the police officers came upon the scene on Selkirk Avenue until the time Mr. Nickoshie died, the professionals who dealt with Mr. Nickoshie did so in a professional way according to the policies and procedures required of them. To all appearances, Mr. Nickoshie seemed to be intoxicated and, given the results of the blood work, he was. That level of intoxication was complicated by his pre-existing medical problems.

[46] All of which is respectfully submitted this *6th* day of December, 2006, at the City of Winnipeg, in Manitoba.

Original signed by

Judge Marvin F. Garfinkel