May 29, 2014

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL COURT JUDGE ON INQUEST
RESPECTING THE DEATH OF ROBERT WOOD

Having held an inquest respecting the said death on January 6th and 7th, 2014 February 26th, 2014, and May 8th, 2014 at Thompson in Manitoba, I report as follows:

The name of the deceased is Robert Wood.

The deceased came to his death on the 3rd day of January, 2010 at approximately 3:00 a.m. at Winnipeg, in Manitoba.

The deceased came to his death by the following means:
Acute cranio-cerebral trauma due to a fall or falls (see Schedule 1)

I hereby make the recommendations as set out on the attached Schedule 2.

Attached hereto and forming part of my report is a Schedule (Schedule 3) listing all exhibits required to be filed by me.

Dated at the City of Thompson, in Manitoba, this ***26th*** day of ***May***, 2014.

Original signed by Judge B. Colli
Provincial Judge

Cc. Chief Judge of the Provincial Court of Manitoba
Chief Medical Examiner
Minister Responsible for *The Fatality Inquiries Act*
Deputy Minister of Justice & Attorney General
Director of Regional Prosecutions

SCHEDULE I
TO REPORT ON INQUEST

Index

Page No.

I.	**Holding of Inquest..**	**2**
II.	**Synopsis of Evidence...**	**3**
	A. Evidence of Witnesses who Testified.................................	**3**
	B. Statements Filed at the Hearing.......................................	**5**
	C. Other Exhibit..	**6**
	D. Summary of Facts..	**7**
III.	**Factors for Examination..**	**10**
	A. Delay in Treatment..	**10**
	B. The Fall...	**11**
	C. Alcohol..	**13**
IV.	**Necessity of Holding an Inquest...**	**14**
V.	**Conclusion...**	**17**

SCHEDULE 2
TO REPORT ON INQUEST

I.	**Summary of Recommendation...**	**18**

SCHEDULE 3
TO REPORT ON INQUEST

I.	**List of Exhibits..**	**19**

I. Holding of Inquest:

[1] On December 30th, 2009, members of the Nelson House R.C.M.P. detachment arrested Mr. Wood. The officers transported him to the police station where they lodged him in cells. Not long afterwards, he lost his balance and fell backwards hitting his head against the cell's concrete floor. Notwithstanding emergency medical intervention by emergency medical responders, nurses and physicians at the Nelson House Nursing Station, Thompson General Hospital and Winnipeg's Health Sciences Centre, Mr. Wood never recovered consciousness. He was removed from life support on January 1st, 2010. He passed away less than 2 days later in the early morning hours of January 3rd, 2010.

[2] Dr. A. Thambirajah Balachandra, the Chief Medical Examiner for the Province of Manitoba, by letter dated March 26, 2012 directed that an inquest be held into this death "to fulfill the requirement for an inquest as defined in Section 19(3) (a) of *The Fatality Inquiries Act*". That subsection provides:

> *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 involuntaryresident 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...*
>
> *The chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.*

[3] An inquest is mandatory once that direction is given. Section 26(1) of the Act provides:

> 26(1) Where a direction is given by the chief medical examiner under section 19 ... a provincial judge shall conduct an inquest.

[4] The purposes of the inquest are two-fold:

1. To determine the circumstances relating to Mr. Wood's death; and,
2. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[5] Only one party applied for standing as an interested party, namely, the Royal Canadian Mounted Police. Ms. B. Tait has represented it throughout these proceedings. Ms. K. Sweet acted as counsel to the Inquiry. The Inquest began on January 6th, 2014, and continued on the next day. It was adjourned to facilitate the taking of evidence from a further witness and to consider hearing evidence on the design of the jail cell in which Mr. Wood was held. Ms. Tait graciously undertook to obtain information as to possible witnesses. The Inquest reopened on February 26th, 2014. On this date I heard the last of the witnesses who were expected to testify on the events leading to Mr. Wood`s death. On May 8th, 2014, I heard evidence from an employee of the RCMP specifically pertaining to the design of this holding cell. The Inquest closed following brief submissions from counsel.

II. Synopsis of the Evidence and Summary of the Facts:

[6] I do not intend to review the evidence of each witness exhaustively. The facts are straightforward. Given the number of witnesses I heard from, either by way of *viva voce* testimony or through statements given to police, I am surprised that there are so few inconsistencies among the versions of events. The few that do exist do not merit further consideration by me because they are not relevant to any recommendations I might make. Instead, I will list the witnesses I heard from and describe the subject matters of their testimony and then provide a summary of the material facts.

A. Evidence of Witnesses who testified at the Inquest:

[7] Dr. Charles Littman—Dr. Littman is the pathologist who performed the autopsy. He testified as to the medical and factual cause of death and the types of events that contributed to Mr. Wood’s death.

[8] Cpl. Sheldon Floyd Moore--Cpl. Moore is a police officer who was on duty at the time of the material events and had significant interaction with the deceased. He attended the Video Lottery Terminal (the “VLT”) building in Nelson House, observed and assessed his condition, arrested Mr. Wood at the Nelson House Nursing Station, transported him to the Nelson House RCMP station and lodged him in cells there. He also testified about the hiring of jail guards and their training. Because at the time of these events, he was a constable, I will refer to him in this report as “Cst. Moore”.

[9] Reserve Cst. Laurie Keith Munroe – Cst. Munroe is a retired Staff Sgt. of the RCMP who was hired as part of that Force's "reservist" program to provide additional police resources to northern communities. He had two significant interactions with Mr. Wood during the material events consisting of attending the VLT Building in Nelson House, observing and assessing Mr. Wood in the early evening of December 30th, 2009, and assessing him again in cells after the jail guard notified him that Mr. Wood had fallen and was not moving. He also gave some opinion evidence based on his experience as to the condition of cells and a recommendation as to potential improvements.

[10] Cst. Kevin Theriault – Cst. Theriault is an officer of the RCMP who assisted Cst. Moore with Mr. Wood's arrest and his lodging in cells.

[11] Karen Noreen Hart – Is a security guard employed at the Nelson House Nursing Station. She observed the deceased at the nursing station on two occasions on the evening of December 30th and early morning of December 31st, 2009.

[12] Dr. Lydia Derzko – Dr. Derzko is a physician employed at Nelson House Nursing Station. She was called in to work in the early morning hours of December 31st, 2009, to examine and assess Mr. Wood. She gave opinion evidence as to the nature of the medical intervention that might have saved his life.

[13] Elijah William Joshua Linklater – Mr. Linklater was a jail guard on duty on the evening of December 30th, 2009, at the Nelson House RCMP station. He testified as to his observations of the deceased, including two falls that Mr. Wood took and his efforts to monitor and obtain assistance for him.

[14] Frances Potter – Ms. Potter is a nurse who examined and treated Mr. Wood on the evening of December 30th, 2009, and observed him again in serious condition early the following morning. She testified as to her previous knowledge of Mr. Wood, and her observations of his condition on the evening in question.

[15] Mr. Ron Newman – Mr. Newman is a senior analyst of physical security and threat risk with the Physical Security Branch of the RCMP in Ottawa. He is a co-author of "Harmonized Threat and Risk Assessment", a methodology used by many police forces, the Government of Canada and several national banks.

He has been employed in policing and security for 37 years with two federal departments, military police and RCMP. He gave evidence on the adoption of national standards for RCMP holding cells and the ongoing effort to retrofit all holding cells to conform to those standards. He also testified as to his extensive (I am tempted to describe it as exhaustive) review of the circumstances of the fall sustained by Mr. Wood including extensive discussions and consultations with officers and colleagues, review of the files and security footage and his opinion on potential recommendations for physical changes to holding cells to reduce the risk of injury.

B. Statements filed at the Hearing:

[16] Police statements from the following individuals were filed as separate exhibits at the Inquest:

1. Gail Swanson – Ms. Swanson was an employee at the VLT building. She called the police to have Mr. Wood removed from that building.

2. Fabian Towers – Mr. Towers is one of two EMS attendants who transported Mr. Wood to the nursing station on two occasions on December 30th, 2009, the first from the VLT Building, the second from the RCMP cells.

3. Ronald Redhead – Mr. Redhead is another individual who was present as an inmate in the same cell as Mr. Wood when he fell.

4. Trish Linklater (2) – Ms. Linklater is the second of two EMS attendants who transported Mr. Wood by ambulance on two occasions on December 30th, 2009.

[17] All of these individuals encountered Mr. Wood through the afternoon and/or evening of December 30th, 2009, and supplied information as to the deceased's medical and/or physical condition.

[18] In addition, I read statements provided to police by several individuals all of which were filed as part of Exhibit 5, the investigation into the death. Those individuals include:

1. Csts. Friesen, Wollman and Storey who had some contact with the deceased during the afternoon or evening of December 30th, 2009.

2. Gabriel Bonner, Lambert Linklater, Lawrence Peterson, John Spence and Grace Moose who were lodged as prisoners at the Nelson House detachment on December 30th.

3. Julie Desjardins and Dora Halcrow, both nurses who provided care to Mr. Wood on his second and final trip to the Nelson House nursing station that night.

4. Nelson Hart who engaged in conversation with Mr. Wood at the Northern Store on the afternoon of December 30th, 2009.

5. Judith Wood, a sister of the deceased, who supplied information to the police about Mr. Wood and his way of life.

6. Matthew Wood – Mr. Wood is a cousin of the deceased who encountered him first at the Northern Store and then again at the VLT building on December 30th, 2009.

7. Wilkie Moose – Mr. Moose was a long-term friend of the deceased who observed him both at the Northern Store and at the VLT Building on December 30th, 2009.

C. Other Exhibits:

[19] There were many other exhibits filed, the largest by far being Exhibit 3 consisting of two binders of materials generated by the police investigation. The exhibits are listed in a separate schedule. I mention only two in particular here because of their significance in assisting me in coming to a decision as to the facts of the case. These are the videos of Mr. Wood that show his fall at the VLT building in the early evening of December 30th and the video of the

"drunk tank" cell which captures him falling twice more after he was lodged there.

D. <u>Summary of Facts:</u>

[20] Mr. Wood was on a drinking binge on December 30th, 2009. He was already well under the influence of liquor by the late afternoon when he was at a convenience store operated by The Northern in Nelson House, Manitoba. Alcohol, which he had in his possession at that time, was confiscated by police who were called there because of the presence of drunks on the premises. The attending officers did not think that he was at risk of hurting himself or others. If they had, they would have arrested him then and there. He was not then so unsteady on his feet that he was at risk of falling over. That changed later that evening. It seems more likely than not that he continued to drink. He ended up at the VLT building at about 7:00 p.m. where he tried unsuccessfully to gain entry. Security wouldn't let him in because he was drunk. Even though he was not allowed to go in, he didn't leave the area, at least not of his own accord. At first he stayed in the lobby of the building. Then he went outside. It was while he was leaning against one of the exit doors that he fell over face-first when someone used it to leave the building. According to the VLT building security video, this happened at 19:20:30 hours. He was helpless once that happened, so he was moved into the VLT building lobby to await the arrival of police and medical personnel. He was unable to respond coherently to Cst. Moore's questions and so he was taken to the nursing station by ambulance and received fluids intravenously to rehydrate him. He started feeling better after a while. As soon as he did, he started moving about. He ignored the nurse's directions to stay put, directions which she gave to avoid him falling and hurting himself. Even though he felt better, he was extremely unsteady and at risk of toppling over if he got to his feet. Because he wouldn't listen to her, Nurse Potter first called the nursing station security and, when that didn't work, the police. The police arrived, had Ms. Potter sign off on their form certifying that Mr. Wood was suitable for lodging, and then took him away, having arrested him for causing a disturbance. The way that they escorted him out of the nursing station gives a good indication of the extent of his incapacitation. Using a desk chair on castors, police rolled him down the nursing station hallways to the outer door. Then, between the two of them, they supported him to the police vehicle. This process was

repeated at the RCMP detachment. It took 2 officers to take off the clothing that they needed him to take off before he could be lodged. That was so because Mr. Wood was not able to do it himself. He was simply too far gone. Meanwhile, Cst. Moore, the arresting officer, had to take care of the mess that Mr. Wood had made in the back seat of the police vehicle en route to the police station. He had urinated in it.

[21] The police put him in Cell number 3, the drunk tank. This cell is a room bereft of any furnishings or fixtures other than a toilet. The floor is made of concrete. Prisoners may stand or lie down. There is nothing to sit on. Mr. Wood was placed in a prone position in the cell at 10:34 p.m. He remained in that position, more or less unmoving, until just before 11:00 p.m. when he rolled over on to the lap of another inmate. A third inmate disentangled him from the second inmate and propped him up against the wall. At 11:01 p.m., he started crawling towards the toilet. At 11:02 p.m., while standing at the toilet, he lost his balance and fell into the wall. He struggled to get himself back on to his feet and was ultimately successful but then he toppled over one last time. It appears to me from the video that he fell heavily and that the back of his head hit the concrete floor sharply. This fall occurred, according to the video, at 11:05 p.m. Between then and 11:41 p.m. when police entered the cell to check on him, he was almost motionless, although he did roll on to his right side at 11:08 p.m. Mr. Linklater, the guard, observed him fall both times. It is clear from his evidence and the video recordings that he was quite concerned about Mr. Wood, in particular, that he was not moving. He asked the other prisoners in the cell to check on him. These checks are displayed on the security video footage. He went to the cell door and looked in. He did not enter the cell because for a guard to enter a cell under these circumstances would have been contrary to police policy. He did try to contact Cst. Moore on his cell phone but he did not answer. He did not call the police dispatch because he was uncertain about the priority that he should give to Mr. Wood's case. The police were extraordinarily busy that evening answering calls about drunken individuals who were at risk of hurting themselves or others. He did not want to bother them unnecessarily. He decided to wait until one of them was available at the detachment. This happened sometime after 11:30 p.m. when he notified Cst. Munroe. At 11:41 p.m., Cst. Munroe entered the cell, checked on Mr. Wood and decided that emergency medical assistance was required. Cst. Moore called for the ambulance and soon after Mr. Wood was

taken out of the cell by paramedics and returned to the nursing station, this time in critical condition. It did not take long for the doctor and nursing staff at the Nursing Station to determine that Mr. Wood needed much more specialized care than what they could give him at the nursing station. He was en route to Thompson General Hospital before 1:30 a.m. of December 31, 2009 and, a few hours thereafter, he was medevaced by air ambulance to the Health Sciences Centre in Winnipeg. There Mr. Wood was diagnosed with an inter-cranial bleed. The attending physician or physicians determined that medical intervention could not save his life. Dr. Littman testified that given the findings of the autopsy, the only medical intervention that would have saved Mr. Wood's life was an evacuation of the hematoma. The window of opportunity for that procedure to be effective had long since passed by the time of Mr. Wood's arrival in Winnipeg. Palliative care was implemented. Mr. Wood remained on life support until his family was consulted. After that he lingered on until January 3rd, 2010 at 3:00 a.m., when he slipped away. A blood sample taken from him at the Thompson General Hospital was later analysed and it was determined that Mr. Wood had a blood alcohol level of 65 mmol/l which, Dr. Littman advised, equates to a level of .325 mg of alcohol/100mls of blood.

[22] On January 5th, 2010, Dr. Littman performed the autopsy. His findings are fully detailed in his report and elaborated upon in his evidence. His major finding was that Mr. Wood had suffered acute cranio-cerebral trauma as a result of one or more falls. The impact of this injury was made worse by his pneumonia and by old cerebral trauma. The fall causing the injury was contributed to by his state of intoxication.

[23] Did the fall that Mr. Wood sustained in police cells result in the injury that caused death? Quite possibly. He certainly seems to have hit the back of his head sharply on the floor, so sharply that he immediately lost consciousness and never regained it. Moreover, the major injury to the skull, the skull fracture discovered during the autopsy, is also to the back of the head. We can never know with certainty, however, that the major injury to the skull was not caused by other falls. He was, after all, very unsteady on his feet and he was unsteady for some time before he was taken to the Nelson House Nursing Station for the first time that evening. We know that he fell on one other occasion much earlier in the evening. Who is to say that he did not fall

elsewhere? Even so, I am satisfied that it is more likely than not that, if the fall in cells did not cause the major injury leading to death, it contributed in some way to his death, by worsening the bleed and thereby accelerating it.

III. Factors for Examination:

[24] What factors here contributed to the death? I conclude that there are three: excessive consumption of alcohol, the fall sustained by the deceased and delay in diagnosis and treatment. Let's start with the delay in treatment.

A. Delay in Treatment:

[25] There were a couple of factors that contributed to the delay in transporting Mr. Wood to a health facility for treatment after he had fallen.

[26] Mr. Linklater, the jail guard, was not successful in contacting police officers to notify them of the fall. That he was concerned is clearly evident from the security tapes, his evidence at the inquest and his demeanour in giving evidence. This man cared about performing his job well. He was not sure, though, whether it was more important to get help for Mr. Wood or let the police officers deal with the emergency calls they were constantly on that night. Which was the greater emergency? Police policy suggests that he should have contacted central dispatch in the event of any emergency in cells. He did not follow that policy but not because he was negligent or because he didn't care. He just wasn't sure as to whether Mr. Wood's situation was an emergency that required immediate attention by the members. Because he was new to the police station and to its officers he did not want to earn the reputation of being a person who constantly bothered them with questions, particularly while they were busy. So he decided to monitor the situation while he tried to contact the one officer he felt comfortable talking to. He made a mistake because he took too much responsibility on himself. Because he recognized that he made a mistake, he leapt to the conclusion that his error contributed to Mr. Wood's death. He felt so badly about it that he quit his job as a jail guard soon after. Let me be clear about this, if nothing else. It did not.

[27] His keen sense of conscience speaks volumes about him as a human being. I am satisfied that, with his resignation, the Nelson House RCMP lost a fine employee. I was not surprised to learn that he is now employed as an

attendant at the Nelson House Medicine Lodge, where he can directly help people.

[28] The other delays, if such they can be called, are all related to the proximity of these events to a centre that is capable of diagnosing and treating brain injuries. Mr. Wood had to be transported to the nursing station in Nelson House for assessment and then to Thompson General Hospital, the regional health centre, for further assessment. After all of that and, once a decision was made that his needs required greater care, arrangements had to be made for further transportation, this time by air, to the Health Sciences Centre. These delays were all necessary because of protocol and practice but even if the practice be wrong, even if one or more of the delays could have and should have been eliminated because of suspicion of brain injury, even if one could ask "what about directly medevacing him from Nelson House to the Health Sciences Centre?" with some cogency, I would still conclude it would not have mattered. Dr. Littman's evidence was that there is a very small window of opportunity for diagnosis and treatment of these types of injuries, once sustained. He did not say how short only that it had long since expired after Mr. Wood's attendance to the facility. Dr. Derzko went further. The window is so short that only the construction of a sophisticated medical centre in Nelson House, replete with a neurosurgery team and state-of-the-art diagnostic and treatment facility would have made a difference for Mr. Wood. There is no point in belaboring this issue. Mr. Wood died in part because he chose to live in a place that is remote from a sophisticated world class health centre. Any of us living in the north are in the same boat with him. I cannot make a recommendation in this area that would have made a difference for Mr. Wood.

B. <u>The Fall:</u>

[29] The fall experienced by Mr. Wood in the holding cell was unavoidable. It occurred because of his lack of judgment, balance and coordination arising from his intoxicated state. In other words, there is no reason whatever to think that Mr. Wood tripped or was pushed or nudged. He simply spontaneously toppled over.

[30] Is there anything that could have mitigated the impact of his fall? I am sure that there is. The questions though are, "Will the cure be worse than the

disease?" and "Will the costs be prohibitive?" Mr. Newman's testimony addressed these questions. I am satisfied based on his evidence that a change to the cell designed to soften the impact of the type of fall experienced by Mr. Wood would cause other difficulties and probably more difficulties than what would be solved.

[31] For example, the floor in this case was concrete, one of two types of flooring endorsed by the national standards for holding cells and, of the two, the preferred flooring. The concrete is covered by an epoxy which is "pick-proof", meaning bits of it cannot be pried off for use as weapons or for ingestion by dangerous or intoxicated inmates. The epoxy is combined with a granular mixture (primarily quartz) to make the surface slip-proof and easy to clean. A carpeted floor presents a challenge for cell-designers intent on reducing the over-all risk of harm. It would substantially increase the chance of an inmate tripping and present the possibility of the fabrication of a weapon or tool to be used against officers or other inmates or for self-harm. It presents all kinds of problems from a sanitation point of view because carpeting is notoriously dirty and would soak up bodily fluids. It would represent an ongoing infectious threat against all who had contact with it. Padding presents the same types of difficulties.

[32] Mr. Newman's opinion is that the only effective way of dealing with the type of fall involved here that would not increase the risk of injury from other sources would be an individual padded cell or one-on-one supervision. Both would be cost-prohibitive.

[33] Mr. Newman testified to a fact that surprised me. Contrary to my expectations, in-cell falls are an unusual source of injury. All injuries have to be reported and there have only been two in Canada in recent years. One was in 2004 in Atlantic Canada where an inmate was injured and had to have 10 stitches. The second was this case.

[34] In my opinion, the evidence here does not support a recommendation for a physical change to the national standards for holding cells. The evidence in fact satisfies me that a holding cell that conforms with the national standards, as Cell Number 3 in this case did, is, in the scheme of things, a safe environment for drunken prisoners.

C. Alcohol:

[35] Can there be any doubt that if Mr. Wood had not abused alcohol he would have fallen in cells? Clearly not. He would probably not have fallen and he certainly wouldn't have fallen in cells because he would never have been arrested.

[36] I've written elsewhere, namely in my report on the death of Sheryll Wilfred Forbister, of the devastating impact of substance abuse on all communities in northern Manitoba but in particular on the aboriginal people of the North. I made a recommendation to the Province to provide some seed money to fund the development of an alcohol strategy for Norway House First Nation. I did so because while I concluded that the Province had some responsibility as the major supplier of alcohol within the Province, it was not primarily responsible for funding social services to First Nations. That responsibility belongs to the federal government. I also recommended that the relevant federal departments, in future, be invited to participate in the inquest where it involves the death of a member of a First Nation.

[37] I had the courtesy of a response from the Province regarding the recommendation, although it was not positive. Federal Government departments, who, I was told, were invited to participate in this inquest, simply ignored the invitation.

[38] No one other than the RCMP participated in this inquest. The family of Mr. Woods did not. The First Nations government did not. Federal government agencies did not. Because of this non-participation, I have no evidence of the support services provided to Nisichwayasikh (NCN) First Nation by any level of government, and I have no evidence about the impact of substance abuse on members of NCN First Nation. Of course, I would have to be blind, deaf and brainless to fail to appreciate why we are faced with the overwhelming number of cases the Provincial Court deals with annually in criminal and family courts. In addition I had a scintilla of evidence relating to the size of the addiction problem in Nelson House. The evidence of all the police officers I heard from was that, because there was some money in the community on the day of these events, the officers were confronted with overwhelming numbers of calls reporting drunken individuals. In other words, money that might have been spent on basic necessities was spent instead on alcohol.

[39] Did alcohol contribute to this death? Absolutely. Have governments contributed and do they contribute to this malignancy in aboriginal communities? I think so. (In criminal cases we call this contribution “Gladue factors”.) Can anything be done? We have to remain hopeful. In this case though, I am unable to make any meaningful recommendations.

IV. Necessity of Holding an Inquest:

[40] I’ve already noted the purposes of inquests – determination of the circumstances of death and development of recommendations that would reduce the likelihood of similar deaths in future. I should elaborate on these purposes because there really is a third purpose and the 2nd purpose is not nearly as broad as one might initially think.

[41] The circumstances of death are often, indeed usually, known as result of the chief medical examiner’s investigation under section 9(1) of the Act. More often than not, a significant purpose of the inquest is to make those circumstances, revealed in the investigation, known in a public venue particularly where the deaths have occurred in controversial circumstances. It is not surprising that inquests are mandatory in cases where the deceased dies while confined involuntarily in a prison or hospital or at the hands of a police officer. Those tend to be controversial deaths and, while the circumstances of death may already be known to the “authorities”, it is important that those circumstances be known by more than just the “authorities”. The airing of those circumstances in a public hearing where interested individuals can attend and even participate and challenge the evidence, if they receive standing, achieves a great goal and forms part of the fabric of a free and democratic society.

[42] The recommendations that may be made by an inquest judge are not recommendations at large. The recommendations under section 33(1) of the Act are recommendations relating to “changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province”. Recommendations are not made to just anyone. They are made to a department, agency or institution of the Province.

[43] I will make one final observation before making a recommendation which some may find startling. Inquests make heavy demands on judicial and court resources. When I was a Crown Attorney in the 1980's, longer inquests tended to last no more than a week and most were completed in one or two days. That is no longer the case. Hardly any inquest is set for less than one week and some go on for weeks and weeks. When an inquest of more than one day, which means practically any inquest, is to be set in this part of the Province, it forms part of a queue awaiting the assignment of hearing dates along with multi-day preliminary inquiries and trials of criminal charges. Sometimes, to accommodate an inquest, in-custody days in Thompson or docket days in the fifteen communities outside of Thompson where regional provincial judges sit are cancelled. In other words to hold an inquest costs resources that could easily be used on other matters, including regular circuit courts. It does not surprise me, therefore, that it has taken more than two years since the chief medical examiner directed an inquest into this death to finally complete it.

[44] It is disappointing to me that it has been a fruitless exercise in accomplishing any of the purposes of the hearing. The circumstances of the death were well known. No one expressed an interested in obtaining standing at this inquest even though invitations were extended to both the 1st Nation government and to the family. No member of the public attended any part of the hearing. The evidence that I heard along with the general lack of interest from the public makes it clear that this death was not controversial.

[45] Moreover, I have not made any recommendation to the Province to reduce the likelihood of similar deaths in future. Indeed, the only government agency that I could make recommendations to is the Royal Canadian Mounted Police. It was fairly clear to me from the very outset that there was little likelihood of that because it appeared to me that the police had not contributed to the death. I was aware that the one small area of inquiry, the use of materials in holding cells to soften the blow of a fall by an inmate, was unlikely to result in a recommendation from me because of the trade-off effect of an increased risk from other sources.

[46] In summary, then, this inquest seemed unnecessary to me, even though it was mandatory. It came at a cost—the loss of more than 2 full hearing days

that could have been assigned to other cases. I rush to add that only 2 days were initially assigned to this case in an effort to mitigate the costs to judicial and court resources.

[47] The holding of this inquest satisfies the requirements of the Act but, given the lack of interest in it and lack of recommendations arising from it, it strikes me as a hollow accomplishment because it did not attain any of the goals that we should expect from an inquest. It seems to me that we would have achieved greater results from allocating those court and judicial resources elsewhere.

[48] I therefore recommend that the Province consider changing the *Fatality Inquiries Act* to permit an assigned inquest judge to exercise his or her discretion to cancel a mandatory inquest where:

(a) No person, other than a police force or provincial government department or agency, has applied for standing at the inquest;

(b) No member of the public has expressed an interest in attending the inquest, and;

(c) The inquest judge determines after review of the investigative material collected under s. 9(1) of the Fatality Inquires Act and any submissions by inquest counsel or any party having standing that an inquest is unlikely to result in recommendations under s. 33(1) of the Act.

[49] Each of these factors bears directly on one or more of the three purposes of an inquest mentioned earlier-- to determine the circumstances of the death, to make them public and to make recommendations that might avoid similar deaths in future. I am firmly of the view that if all three of these conditions are met the devotion of any further resources to inquiring into the death is simply not worth the cost.

V. Conclusion:

[50] I thank counsel to the inquest, Ms. Sweet, who took up the challenge of assuming conduct of this file rather late in the day after previously assigned counsel left the Province for greener pastures. She did an admirable job. I also thank Ms. Tait for the excellent job she did in procuring very useful evidence for this inquest. I am indebted to both.

[51] I attach hereto a separate schedule setting out the sole recommendation that I am making.

SCHEDULE 2
TO REPORT ON INQUEST
INTO THE DEATH OF ROBERT THOMAS WOOD

I. SUMMARY OF RECOMMENDATION

1. The Province consider making an amendment to the *Fatality Inquiries Act*, to permit the assigned inquest judge to cancel a mandatory inquest under s. 26(1) of the *Act* arising from the direction of the Chief Medical Examiner under s. 19(2) of the *Act* where:

(a) No person, other than a police force or provincial government department or agency, has applied for standing at the inquest;

(b) No member of the public has expressed an interest in attending the inquest, and;

(c) The inquest judge determines after review of the investigative material collected under s. 9(1) of the Fatality Inquires Act and any submissions by inquest counsel or any party having standing that an inquest is unlikely to result in recommendations under s. 33(1) of the Act.

SCHEDULE 3
TO REPORT ON INQUEST
INTO THE DEATH OF ROBERT THOMAS WOOD

I. LIST OF EXHIBITS

Exhibit 1	Copy of letter from Chief Medical Examiner directing Inquest
Exhibit 2	Documents received by the inquest office from CME's office
Exhibit 3.1	Volume 1 of investigation into death containing Appendices Numbered 1-44
Exhibit 3.2	Volume 2 of investigation into death containing Appendices Numbered 45-86
Exhibit 4	Transcript of Statement of Gail Swanson
Exhibit 5	Transcript of Statements of Trisha Linklater
Exhibit 6	Transcript of Statement of Fabian Towers
Exhibit 7	Transcript of Statement of Ronald Redhead
Exhibit 8	Fit-Up standards for RCMP detachment holding cells
Exhibit 9	Sign-Off Sheet for Cell 3 Nelson House RCMP detachment