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THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **CLAYTON SCOTT**

APPEARANCES:

Mr. Russ Ridd, Counsel to the Inquest
Mr. Issie Frost and Mr. Sean Boyd, for the Selkirk Mental Health Centre
Mr. Keith Ferbers, for Dr. Clarke Wilkie and Dr. Paul Barchet
(Mr. Todd Campbell and Ms. Allison Kindle appeared for Mr. Ferbers on some dates)
Ms. Kate Kempton, for John and Mary Scott, parents of the deceased, Clayton Scott

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INTRODUCTION:

On February 11th, 2001, Clayton Scott, aged 25 years, of Cross Lake, Manitoba, was found hanging in a men's washroom at the Selkirk Mental Health Centre in Selkirk, Manitoba. At the time of his death he was an involuntary patient under ***The Mental Health Act***. He had been reported missing from his ward on February 9th, 2001. The cause of death was asphyxia due to hanging.

In accordance with ***The Fatality Inquiries Act,*** an inquest was mandatory. Section 19(3) of that Act provides that where a person, while an involuntary resident in a psychiatric facility as defined in ***The Mental Health Act***, dies as a result of a violent act, undue means or negligence or an unexpected or unexplained or suddenly unknown cause, the Chief Medical Examiner shall direct a provincial judge to hold an inquest with respect to the death. On July 11th, 2001, the Chief Medical Examiner, having concluded his own review into the death of Clayton Scott, wrote to the Department of Justice directing this Inquest. The Chief Medical Examiner in his letter directed that an inquest be held into the death for the following reasons:

1. To comply with section 19(3) of the legislation which states that an inquest is mandatory if a person, while an involuntary resident in a psychiatric facility as defined in ***The Mental Health Act***, dies as a result of a violent act;

2. To determine the circumstances relating to Mr. Scott's death; and

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

A standing hearing was held on May 20, 2003. Standing was granted to John and Mary Scott (the parents of the deceased), Drs. Clarke Wilkie and Paul Barchet (attending psychiatrists), and the Selkirk Mental Health Centre. The Inquest was scheduled to commence May 28th, 2003. Shortly prior to that date the deceased's parents retained counsel. Their counsel was not available during the periods scheduled. Therefore, new dates were scheduled and the Inquest commenced October 27th, 2003. I heard three weeks of evidence, concluding on November 28th, 2003. I also, along with the parties, attended to the Selkirk

Mental Health Centre, where observations were made. In addition, I received seventy-nine exhibits into evidence.

At the completion of an inquest, ***The Fatality Inquiries Act*** requires that the presiding judge 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 death and the name of the deceased person, and the material circumstances of the death. The provincial 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 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 that is the subject of the inquest."

The provincial judge providing a report at the end of the inquest must not express an opinion on or make 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.

THE FACTS:

A) SUMMARY VERSION:

On December 21, 2000, Clayton Scott, an aboriginal person from Pimicikamak, also known as the Cross Lake First Nation, was admitted to the Selkirk Mental Health Centre (the "Centre").

Mr. Scott had been diagnosed with schizophrenia in 1992 and this was his fifth admission to that facility. Although he had spoken of committing suicide, both in the past and just prior to admission, Mr. Scott had never attempted to commit suicide. Upon admission, although he said he was "tired of his illness", he denied being suicidal. He was offered, and consented to try, the anti-psychotic medication Clozaril, or Clozapine. Clozaril is the drug most successful in treating individuals with schizophrenia who have not responded to other anti-psychotic medication. It is also the medication that has shown the most success in preventing suicide in schizophrenics.

Mr. Scott was admitted to Ward D9 - a short-term assessment ward for acutely ill patients. Although Mr. Scott often complained of being homesick, he seemingly progressed well and was, at the time of his death, scheduled to

visit a group home for an intake assessment. He also had privileges that allowed him to be anywhere on the grounds of the Centre until 9:00 p.m. each day.

When Mr. Scott did not appear for lunch on February 9, 2001, Mr. Scott's brother, who was also a patient at the Centre, was questioned. He told staff members that Mr. Scott had gone to Winnipeg, which Mr. Scott had done previously, when he absconded from the Centre approximately one month earlier. The staff had no reason to doubt that this had happened and thus did not conduct a search of the Centre, but instead notified the police. Mr. Scott's body was not discovered until two days after he disappeared. He was found in an area that was not normally used on weekends. He was in the shower stall of a washroom, hanging by an extension cord from pipes in the false ceiling.

B) DETAILED VERSION OF FACTS:

1) Family Background and Onset of Illness:

Most of the information about Mr. Scott's background comes from a social history prepared by social worker Ron Oberlin on January 10th, 2001.

Mr. Scott was born July 13th, 1975. He was the son of John and Mary Scott of Cross Lake, Manitoba. Cross Lake is a community of approximately six thousand people, located in northern Manitoba. Mr. Scott's father, John Scott, was employed in the summers cutting brush and trees, and in the winters he worked as a nurse's aid in the seniors' personal care home in Cross Lake. His mother, Mary Scott, had worked as a cashier at the Northern Store in Cross Lake for 28 years.

The Scotts are apparently very caring parents. Dating from his first diagnosis with schizophrenia in September of 1992, they attempted to seek help for Clayton on many occasions. Although apparently not wealthy, because both parents were working consistently, there was enough money in the home.

Clayton Scott was initially on track developmentally and was a contented child, although extremely shy. He did open up somewhat during his adolescence, when he became involved in square dancing and performed in public. Mr. Scott did well in school until 1992, when he was in Grade 9 and sixteen years old. He was smoking marijuana a good deal during that period.

He also became ill then, believing that "an old lady" was after him and therefore refusing to go to school. Around the same time, he told his mother, "Mom, I'm going to be sick. I had a very bad dream." He then behaved in a bizarre fashion for the next few days. For example, when the family ate chicken for their evening meal, Mr. Scott went outside and put the leftover chicken bones in the grass, as opposed to in the garbage can like everyone else. He made some tea for himself and his mother and put a great deal of salt in both. She could not drink the tea, but Mr. Scott did so quite readily. He then began putting ropes around his neck, although he apparently was not attempting suicide, and then began burning himself. He told people that his "grandpa was calling [him]".

Mr. Scott was taken to the nursing station and ultimately admitted to Misericordia Hospital in September of 1992. After initially being diagnosed with schizophrenia, he became increasingly open with others and was no longer shy – he now readily approached people in the store or on the street. He also became violent around the same time, although his psychiatrist later wrote that Mr. Scott's schizophrenia was not an excuse for that type of behaviour.

Between 1992 and 1996, Mr. Scott was treated in Winnipeg, Norway House and Thompson. On some occasions, he was doing well. Other times he complained of abdominal symptoms and hearing voices.

Prior to his illness, Mr. Scott did not have any apparent interest in romantic relationships. He did have several girlfriends after he became ill and, in fact, fathered a child with one 15-year-old girlfriend. That child, Delores Muswagon, was at the time of Mr. Scott's death five years old, and had been adopted by Mr. Scott's older sister, Colleen.

Clayton Scott's younger brother, Joshua, has also been diagnosed with schizophrenia and was a patient with him on the same ward of the Centre at the time of his death. The two brothers were very close.

2) Previous Admissions to the Selkirk Mental Health Centre:

Mr. Scott was admitted to the Selkirk Mental Health Centre a total of five times. The dates were as follows:

January 24 - March 10, 1997

April 10, 1997 - May 28, 1997

November 13, 1997 - November 27, 1997

May 9, 1999 - May 31, 1999

December 21, 2000 - February 9-11, 2001

i) January 24, 1997 - March 10, 1997 Admission:

At the time of this admission to the Centre, Mr. Scott was in such bad condition that he was staring blankly into space and could only speak in unintelligible Cree. He had been non-compliant with his medication for about one month, and had been sniffing gas, smoking marijuana and drinking. Of note was that his brother Joshua, who had had no previous psychiatric history, was at the time exhibiting similar problems. Clayton Scott was delusional regarding his intestinal system and when he started to speak English said that "his stomach and intestines have been removed and that all that remains is a bunch of 'black stuff'".

A note during the January 1997 admission indicates that Mr. Scott's aunt's husband had committed suicide by hanging several years prior.

There was some inappropriate sexual behaviour toward a female staff member in February 1997.

During this admission Mr. Scott reported feeling depressed most of the time. His mother confirmed suicidal ideation. In March 1997, Mr. Scott apparently phoned his mother and told her he was going to kill himself by taking pills. When this was discussed with Mr. Scott, he said that he was lonely because several of his peers had been discharged. He quickly felt better.

During this admission Mr. Scott was noted to be crying because he missed his child. He at times said he was homesick, but agreed to stay in hospital even after Joshua had been discharged.

Mr. Scott was discharged on March 10th, 1997. It was concluded at the time that Mr. Scott's use of multiple substances had exacerbated his symptoms of schizophrenia.

ii) April 10, 1997 - May 28, 1997 Admission:

Mr. Scott had only been discharged one month before. It is noted on Mr. Scott's file that at the time of this admission Mr. Scott Senior was quite ill and was even described as "dying". It was also noted that Alex Blacksmith, the mental health worker in Cross Lake, complained that the family was calling him at all hours of the day and night, complaining about even minor behavioural complaints. The family was obviously experiencing a good deal of stress.

By the end of that admission, however, both parents were visiting for long periods, so Mr. Scott's father had obviously recovered.

Mr. Scott complained of homesickness on April 14th, 1997. On April 22nd, 1997 he was noted by Dr. Willows to be crying uncontrollably for several minutes because of missing his family and child.

The occupational therapy report indicated that Mr. Scott attended occupational therapy only sporadically.

Reverend Doug Longstaffe made a note at the time of discharge. It indicates that Mr. Scott had "maintained a fairly regular contact with me during his stay here and has benefited significantly from support provided by me with reference to his Christian tradition as well as support offered from the visiting aboriginal Elder, Mr. Wilford Abigosis."

iii) November 13, 1997 - November 27, 1997 Admission:

On November 13th, 1997, Mr. Scott was admitted as an involuntary patient – this was changed to voluntary the next day. The diagnosis was "chronic schizophrenia with acute decompensation." The note from the doctor in Cross Lake indicated that the family, alarmed by his aggressive behaviour, angry outbursts and incoherent speech, brought Mr. Scott to the nursing station. He had been rubbing his head with lard, "hearing voices and wants to kill himself."

However, when interviewed by the staff physician at the Selkirk Mental Health Centre, Mr. Scott denied being suicidal. The file note reads, "(1) he does not feel like hurting himself or others, (2) he hears voices and 'Satan told

him to smoke and inhale gas', (3) he does take street drugs sometimes and drinks six bottles of beer in one hour."

Since his previous discharge that May, his behaviour in the community had been quite chaotic. Mr. Scott admitted that approximately two months previously he had had a rope in his room and was going to commit suicide but became frightened when he thought of how. He was complaining of "auditory hallucinations of several voices commenting on his behaviour, making derogatory comments. These voices increase when he is angry. He also has various visions of Cross Lake and heaven."

On November 14th, 1997, Dr. Jim Willows wrote, "It is likely that this will be a brief admission for Clayton. He has had some bizarre behaviour while at home. However, overall his behaviour at this time appears quite settled and this may represent more a respite for his family than an acute need for psychiatric services." It was also noted that Mr. Scott was "distressed that people are saying cruel things about him in the community."

Three days later, on November 17th, 1997, Dr. Willows wrote, "Clayton's behaviour and demeanour has improved dramatically. When transferred to D9, he immediately became quite happy, friendly and put his arms up in the air to celebrate. Since then he has been minimal management difficulty. He has been friendly and co-operative with staff and peers. When I met with him today, he told me about how at times he becomes suicidal when he is at home because he hates the diagnosis of schizophrenia. He had several unclear concepts about schizophrenia and is worried that people think less of him because of his illness. I discussed the various issues about the illness with him and once clarified, his affect became much brighter. Currently he denies suicidal ideation…Currently he feels quite homesick and wants to be discharged. He does agree to stay in hospital for a few more days."

It was noted in testimony from a mental health worker from Cross Lake, that there is no Cree word for schizophrenia. The closest word means "crazy". It appears that most members of his community did not understand Mr. Scott's illness and some said cruel things about him.

On November 20th, 1997, a note from a psychiatric nurse indicates that Mr. Scott had spoken about past abuse by his uncle "again", stating that "he sniffs and drinks to hurt himself because it is the only time he feels nothing and can't hear Elders telling him to hurt himself". The abuse apparently happened

when he was seven years of age and in 1997 he indicated that he still feared his uncle.

Mr. Scott was also noted to be tearful and felt guilty about a female patient that he had touched inappropriately on his last admission. However, he quickly cheered up.

On November 20th, 1997, Dr. Jim Willows reported: "Since his last assessment, Clayton has continued to do well. He is minimal management difficulty. He is friendly with both staff and peers. Although he has no clear psychotic symptoms, he at times has appeared overly friendly and inappropriately cheerful. When interviewed today he reported how he has a vision of someone masturbating and that he gets embarrassed by this. It is difficult to know whether this is his imagination or a visual hallucination as he has great difficulty explaining this. He also describes how he feels embarrassed when he thinks about sexual issues and his past experiences."

Mr. Scott was reported to be crying on November 21st, 1997 because he missed his child. Such episodes continued throughout that admission. Homesickness was again raised as an occasional problem.

Mr. Scott was discharged back to the community on November 27, 1997. Dr. Willows also indicated in his discharge summary that "A lot of Clayton's behaviour is related to his substance abuse and childlike behaviour and not as a result of psychotic decompensation."

A. Progress in the Community:

On January 15th, 1998 there was a note on file from Dr. Wiltold Widajewicz, the attending psychiatrist in Thompson. Mr. Scott was complaining of difficulties with controlling his anger, related to auditory hallucinations that were in the form of voices telling him to harm himself: "Clayton is able to resist the command hallucinations and denies any suicidal or homicidal plan."

On November 13th, 1998, Dr. Widajewicz's letter indicates, "Clayton complained of feeling depressed and has been experiencing suicidal ideation at times but that he would not act on the same. Clayton denies experiencing any psychotic symptoms and denies any homicidal ideas at present time."

On December 17th, 1998, Dr. Widajewicz noted that Mr. Scott's mental status was stable: "Clayton subjectively expressed his mood has lifted and that he no longer feels depressed since the addition of Paxil to his medication regime. He denied any suicidal/homicidal ideas at present and can be managed in the community."

About 1998, Mr. Scott's mother became concerned enough that she evicted him from the family home and obtained a Peace Bond to keep him away. (Peace Bonds are attainable for only one year at a time and the evidence did not indicate whether further applications were made.) He lived with his paternal grandmother, for whom he had considerable respect, as well as with an aunt.

On January 29th, 1999, Dr. Widajewicz wrote, "Recently Clayton's mental status has deteriorated to the point that he cannot function well in the community….Although Clayton denies any suicidal or homicidal ideas, we have decided to admit him to the Safehouse in Thompson where he will be observed….We are not planning to keep Clayton for longer than a week to a maximum of two weeks at the Safehouse. Should he require a longer hospitalization, he would be transferred to the Selkirk Mental Health Centre."

On February 19th, 1999, Dr. Widajewicz reported, "His mental status is currently stable and he does not endorse any psychotic symptoms. The collateral information from his mother, who was attending the appointment, confirmed that Clayton is doing very well. The only problem remaining is his violent temper which can be, on occasion, out of control. In those cases he gets involved in physical fights with his peers."

On March 25th, 1999, Dr. Widajewicz reported, "Clayton has no subjective complaints except for losing his temper and becoming violent. This was confirmed by collateral information from his brother and his father. More recently Clayton became very violent towards family members and other members in the community. He has been involved in fights and causing some disturbance in the community. His loss of temper is secondary to use of illicit substances. Currently Clayton denies any homicidal/suicidal ideas or psychotic symptoms. He is in a good mood but occasionally when using substances and heavily smoking tobacco, he cannot sleep."

iv) May 9, 1999 - May 31, 1999 Admission:

Mr. Scott was admitted to hospital after his parents and the R.C.M.P. reported that he had voiced suicidal thoughts for one to two weeks. He had also been giving away his personal belongings, saying that he did not need them anymore. His parents reported that he had an extension cord in his room. When seen by Dr. Chaboyer in Cross Lake, he denied the suicidal thoughts. He could not, however, explain why his parents, the R.C.M.P. and the N.A.D.A.P. worker all reported that he had expressed such thoughts.

When Dr. Jim Willows, the treating psychiatrist at the time, spoke to him about the reported suicidal threats, Mr. Scott told him that he made the threats in order to get attention. He said he was not planning to hurt or kill himself or anyone else. Dr. Willows recorded that Mr. Scott said, "I want to live and only die when I am an old man." It was noted that he had expressed suicidal ideation in the past; however, there had not been a problem with suicide attempts. Mr. Scott also told Dr. Willows that he had made threats in the past to get attention. He did admit that he occasionally felt depressed, apparently in regards to his being disturbed by his various symptoms. When questioned about the extension cord in his room, he indicated that it was not put there by him, and said that his parents just were concerned about him doing too many drugs.

During the May 1999 admission there were apparently inappropriate sexual advances by Mr. Scott to both a female and a male patient. There was also a comment by Mr. Scott to the effect that he was "gay". There is, however, no other reference to his believing he was gay, either elsewhere in the file or in the evidence.

On May 31st, 1999, Mr. Scott was discharged to a substance abuse treatment program, the Calder Health Centre in Saskatoon.

Dr. Clarke Wilkie, a psychiatrist who testified at the Inquest, saw Mr. Scott in Cross Lake on February 7th, 2000. At that time Mr. Scott was doing well, primarily, it appears, because he had not been drinking or sniffing. He had also cut down on his marijuana use.

On May 17th of 2000, Dr. Wilkie again saw Mr. Scott in Cross Lake. Again he was doing well, having not consumed alcohol for two to three months,

or marijuana for three months. He had told the mental health worker that he had used solvents in the past to make him forget about his illness.

In the summer of 2000, Mr. Scott allegedly assaulted his father and the police laid charges. These charges were eventually stayed.

On September 20th, 2000 Mr. Scott went to his parents' residence and asked his mother if he could return home to live. She declined his request and he began screaming that he wanted three dollars for some cigarettes. She again denied his request, and he began knocking on the patio doors so hard that Mrs. Scott thought they would break. She called the police but they did not attend. Eventually, Mrs. Scott did allow her son to enter. His hand was very bloodied from knocking so hard. He tried to attack his mother and his sister had to intervene. His mother then called the mental health workers and they arrived to assist.

On December 12th, 2000, Dr. Paul Barchet, a psychiatrist at the Centre, received a telephone call from mental health workers in Cross Lake. They were concerned about Mr. Scott because of his hygiene and because he was getting into arguments with other people. The workers believed that it was not only when Mr. Scott was intoxicated that problems arose. The workers were advised that they should go through the nursing station, and if it was believed that Mr. Scott required admission, Thompson should be contacted, as there were currently no male beds at the Centre.

It should be noted that the community mental heath workers and Crisis Line Program in Cross Lake did much to help both Mr. Scott and his family. At times, when the need was greatest and, I imagine, when funds permitted, he was even provided with twenty-hour supervision and allowed to sleep in the trailer that housed the Crisis Line. Funding for the Crisis Line has since been discontinued.

v) December 21, 2000 Admission:

On December 21st, 2000, Dr. W. Hoeppner, a general practitioner in Cross Lake, saw Mr. Scott and completed an "Application by Physician for an Involuntary Psychiatric Assessment" (Form 4) under ***The Mental Health Act***. Dr. Hoeppner expressed the opinion that Mr. Scott was suffering from a mental disorder and because of the mental disorder he was likely to cause serious harm

to himself and indicated that he was unwilling to undergo a voluntary psychiatric assessment. Dr. Hoeppner noted that Mr. Scott was "hallucinating, seeing devil telling to kill himself, wants to commit suicide". Mr. Scott was therefore transported to the Selkirk Mental Health Centre. Upon arrival, Dr. Clarke Wilkie, a psychiatrist at the Centre, examined him.

After examining Mr. Scott, Dr. Wilkie completed an "Involuntary Admission Certificate" (Form 6). It indicated that Dr. Wilkie was of the opinion that Clayton Scott was suffering from a mental disorder and because of the mental disorder he was likely to cause serious harm to himself or others or suffer substantial mental or physical deterioration. Dr. Wilkie stated that because of the mental disorder Mr. Scott needed continuing treatment that could reasonably be provided only in a "facility". He stated that Mr. Scott could not be admitted as a voluntary patient because he refused to consent to a voluntary admission. Therefore, on December 21st, 2000, Mr. Scott was admitted to the Selkirk Mental Health Centre.

Dr. Wilkie's admission note of December 21st, 2000 indicates as follows:

> Clayton is admitted for his fifth admission to Selkirk Mental Health Centre and acknowledges ongoing auditory hallucinations in both English and Cree. The patient states that these are female and they will yell at him, in the evenings particularly. The patient states that he also has visions of people masturbating, smoking drugs and has experienced olfactory hallucinations of "a fishy smell". Clayton denies tactile or gustatory hallucinations. He does acknowledge the fear that people are following and listening to him. He feels that others are watching him with cameras, however, does not know who or where the cameras are. He also has concerns that there are microphones hidden, however, again does not know who or why people would do this. Clayton states that these are "psychotic delusions". He goes on to say that "I am tired of my illness." He acknowledges having had thoughts of harming himself in the past, but denies any ongoing suicidal ideation or intent. The patient denies thoughts of harming others. He does acknowledge that he has been masturbating, however, denies doing it in public. Collateral is that the patient has been demonstrating inappropriate behaviour in front of children and others. Clayton acknowledges having some difficulty with sleep. He reports that he has been eating well. The patient spends his day listening to music, watching TV, smoking and visiting. He acknowledges recent alcohol use, however, denies any recent marijuana use. The patient has been taking Clopixol 300 mg. IM q2weeks, as well as Trazodone 150 mg. at h.s., Nozinan 50 mg. at h.s., Cogentin 2 mg. b.i.d. and Paxil 20 mg. b.i.d. Clayton has previously received treatment for substance abuse in addition to his schizophrenia…. Clayton's most recent admission to Selkirk Mental Health Centre was from May 9th to 31st, 1999 when he was discharged with a

> diagnosis of Schizophrenia and Polysubstance Abuse. Clayton has been followed in Cross Lake and has also been by Dr. Widajewicz in Thompson. Patient's brother, Joshua, is currently in hospital and being treated with Clozaril for schizophrenia.
>
> **Mental Status Examination**
>
> …the patient appears to be increasingly distraught with his ongoing symptoms.
>
> **Assessment**
>
> Clayton has had ongoing symptoms of Schizophrenia, Paranoid Type and Polysubstance Abuse. There have been concerns about his behaviour in the community.
>
> **Plan**
>
> Clayton is admitted to the open unit. A trial of Clozaril is discussed with him. The risks and expected benefits are discussed. Clayton is anxious to have a trial of this medication….The possibility of placement in Winnipeg was discussed with members of the systems team involved in Clayton's care prior to his transfer to Selkirk Mental Health Centre.

Due to a lack of resources and as he was the only psychiatrist in that city, apparently Mr. Scott's psychiatrist in Thompson did not, as a matter of practice, prescribe Clozaril. Clozaril did apparently help Mr. Scott in terms of his psychotic symptoms, although not until he reached a dosage of 500 milligrams daily. As a result of his progress, Dr. Wilkie was quite hopeful about him.

Dr. Wilkie indicated in his testimony that Mr. Scott was admitted as an involuntary patient because he would change his mind from day to day as to whether he was willing to remain at the Centre voluntarily.

The involuntary committal was renewed on January 11th, 2001 (Form 7). At that time Dr. Wilkie believed that a continuing involuntary status was necessary in order that Mr. Scott not cause serious harm to another person or suffer substantial mental or physical deterioration. He indicated that Mr. Scott continued to refuse to consent to a voluntary admission. The diagnosis continued to be schizophrenia. Dr. Wilkie observed Mr. Scott to be "distracted by virtue of internal stimuli and disorganized behaviour". He also exhibited "sexually inappropriate behaviour". Mr. Scott was still under this renewal certificate (Form 7) at the time of his death in February of 2001.

Schizophrenia:

According to Dr. Wilkie's testimony, about one percent of the population suffers from schizophrenia. Symptoms might include delusions (bizarre beliefs), hallucinations (hearing, smelling, or tasting something that is not really there or a wrong belief about being touched), disorganized behavior or speech, and/or withdrawal (losing interest in activities previously interested in).

Schizophrenia is a mental illness with no known cause. It is believed that people have a predisposition from their genetic make-up and, under certain stress conditions, will develop schizophrenia. For example, if one monozygotic or "identical" twin has schizophrenia, chances are very high that his or her twin, who has the same genetic make-up, will also develop it.

According to Dr. Wilkie, "the stress diathesis model would imply that some people are very highly loaded to get schizophrenia and would get it no matter what environment they grew up in. However, other people who didn't have a strong genetic loading, under certain stressful environments would be more likely to develop the illness."

Current treatment involves a "biopsychosocial model". According to Dr. Wilkie, that would involve anti-psychotic medication and psychological treatment, as well as providing stimulation, socialization, sheltered workshops, and ensuring that patients are living in a supported home environment.

People with schizophrenia are at high risk to commit suicide. Approximately 40% of schizophrenics attempt suicide. Approximately 10% of schizophrenics do, in fact, commit suicide.

Clozaril or Clozapine:

Mr. Scott had been prescribed various medications over the years. He had had varying degrees of success on them, but had often complained of bodily discomfort, some of which may have been side effects of medication. He had improved each time in hospital but had regressed each time back in Cross Lake. On some occasions there was non-compliance with medication regimes. Sometimes, substance abuse (marijuana, gas sniffing and, to a much lesser extent, alcohol) appear to have contributed to his becoming more ill. Mr. Scott, on occasion, reported using illicit drugs to take away the symptoms

of his illness. On his fifth and last admission, Dr. Wilkie discussed with Mr. Scott, and obtained his consent to try, the drug Clozapine or Clozaril. Clozaril has shown very positive results in treating people who have been resistant to other anti-psychotic medication. It is the drug that offers the most hope for patients who have not responded well to other drugs. It is also the drug that is thought to be most effective in preventing suicide.

However, Clozaril can have the potentially life-threatening side effect of lowering white blood cell counts and predisposing the patient to very serious infections. Therefore, a patient who is prescribed Clozaril must have his or her blood checked weekly for the first twenty-six weeks and bi-weekly after that. According to Dr. Wilkie, a patient should be admitted to hospital to start and become stabilized on Clozaril. Other medications are gradually tapered down and eliminated.

Prescribing Clozaril involves considerable work on the part of the prescribing physician. A blood test must be done before it is started and, at least at the time Mr. Scott was placed on the medication, the results had to be faxed to Montreal for approval. The prescribing doctor then has to supervise the regular blood monitoring. This may become problematic when people return to their home communities. There should be consistent medical care to ensure that the medication is taken, that blood is drawn regularly, that the blood is sent to a laboratory for testing and that the laboratory results are checked when they come back. The laboratory might well be outside the community (there was and is no lab in Cross Lake).

As Dr. Wilkie testified very convincingly at the Inquest, “So although it was a lot of work for me to start people on Clozapine and a lot of work for me to follow them when they went back to their home communities, I felt it was the kind of medication that I would want my son to be on if he had that illness and so I was willing to do that.”

Suicide Prevention:

According to Dr. Wilkie, there are a number “risk factors” for suicide. Risk factors are enduring and thus exist for many months or years. Risk factors include: major mental illness, schizophrenia, a manic depressive illness, major depression, co-morbid substance abuse, a family history of suicide, previous suicide attempts, a history of impulsivity, difficulty with the law, and previous assaults.

"Warning signs" for suicide, on the other hand, are things that come and go. They would include, for example, a person disclosing that he was thinking of killing himself, giving away his personal belongings, looking despondent, having a depressed mood that persists, or making efforts to obtain objects that could be used for committing suicide.

There was no indication of any suicidal ideation, planning activity or suicide attempts during Mr. Scott's last admission to the Selkirk Mental Health Centre. Although suicide had been a concern of Dr. Hoeppner on December 21st, 2000, when Dr. Wilkie interviewed Mr. Scott later the same day, Mr. Scott denied ongoing suicidal ideation or intent. There were no apparent "warning signs" noted by Dr. Wilkie at the time, or by any staff member in the weeks that followed. Although Mr. Scott both complained of and exhibited signs of being homesick, in-between he would appear to "bounce back" and appear quite happy, smiling and joking with staff members. He had been homesick during previous admissions, yet had never attempted suicide. It was not unusual for patients to be homesick while at the Centre.

Without exception, all the numerous staff members who testified at the Inquest were "shocked" when they heard what had happened. They had observed no warning signs.

Events during December 21, 2000 - February 11, 2001 Admission:

A day or two after Mr. Scott's admission, Dr. Wilkie decided he should be given "grounds privileges" - actually the right to be anywhere on the grounds of the Centre and to visit the Mohawk convenience store across the road. That meant he could be away from the ward until 9:00 p.m. each night.

On December 22nd, 2000, Mr. Scott told social worker Ron Oberlin that he was interested in moving into a group home in Winnipeg. The plan was to refer both Mr. Scott and his brother Joshua to Sara Riel Inc., which ran two group homes in Winnipeg. Dr. Wilkie was consulted and indicated that he supported this plan.

Mary Scott also believed that her son should not be immediately returned to Cross Lake. She believed that he needed more help than the community was able to provide. She thought that a community-based mental health group home in Winnipeg would probably be the best option for him, as he could get the help he needed and she could still visit him often.

At one point on December 24th, 2000, Mr. Scott said he did not wish to move into the same place as his brother Joshua. He stated that his brother was going to "punch him" that morning when he told him he could not go home (presumably that was Clayton telling Joshua that he could not go home).

On December 28th, 2000, a female patient reported inappropriate sexual behaviour by Mr. Scott. He denied it.

On January 1st, 2001, Mr. Scott was noted crying loudly on the ward saying "I miss my child." He called home and spoke with family members and made no further complaints.

On January 10th, 2001, a female patient reported that Mr. Scott had attempted to force himself on her. He did not deny this. As a result, Mr. Scott was to be observed by staff every fifteen minutes, although he could go out onto the front steps of his building in-between. The R.C.M.P. were contacted. An officer saw Mr. Scott on January 11th, 2001. The officer apparently told Mr. Scott that there would be no charges laid.

On January 12th, 2001, while still being observed every fifteen minutes, Mr. Scott was noted to be absent from the ward at 6:00 p.m. His brother Joshua told staff that Mr. Scott was going "to the bar". Another patient stated that Mr. Scott was overheard telling someone he wanted marijuana. Mr. Scott was located later that evening, wandering the halls at the Health Sciences Centre in Winnipeg. He showed no signs of having consumed drugs or alcohol. He was returned to Selkirk and for some period of time was required to spend his days on D12, a locked ward. He would then return to D9 at 9:00 p.m., when D9 was locked for the night. Mr. Scott remained under observation every fifteen minutes until January 22nd, 2001, when his grounds privileges were restored.

On January 23rd , 2001, Mr. Scott's referral to Sara Riel was completed and forwarded.

On January 25th , 2001, Dr. Wilkie noted that Mr. Scott was tolerating the increased dose of Clozaril well and appeared more settled. There had been no reoccurrence of inappropriate behaviour. The plan was to await the possibility of discharge to Sara Riel or another group home in Winnipeg.

On February 4th, 2001, Mr. Scott was observed to be lying on his bed rocking side to side. He was not listening to music at the time.

On February 5th, 2001, Mr. Scott was heard sobbing while on the pay phone. When asked about this later, he stated he was "very homesick". He called his aunt following this conversation.

On February 7th, 2001, Mr. Scott had a telephone conversation with his mother. Mary Scott relayed the contents and tone at the Inquest. Mr. Scott told her, "Mom, don't worry about me being here and don't worry about -- I'm not going to do anything to harm myself, the only reason why I'm here is because I need help." When asked if Mr. Scott was happy or sad at the time, she said, "He was always happy and he's laughing. He was always full of joy in a conversation."

On February 8th, 2001, the social worker, Ron Oberlin, received a telephone call from Bob Brightnose, the Brighter Futures worker in Cross Lake. Mr. Brightnose stated that Mr. Scott was calling several times a day complaining about being homesick. It was noted that there was an intake assessment scheduled at Sara Riel for February 15th, 2001.

On the same day, Mr. Scott apparently telephoned his sister Colleen. Mr. Scott's mother relayed the conversation for the first time at the Inquest. Mr. Scott, according to her testimony, told his sister that he had sent birthday greetings to his father through the community radio station, that one of the workers at the Centre "wasn't treating him good", that the reason he was in hospital was that he wanted people to help him, that he wanted to tell members of his family that he loved his mom and dad, that he wanted his daughter to be taken good care of, and not to worry about him because he wouldn't do anything to himself but that he would listen to gospel tapes as Colleen suggested. As well, he said he wanted to return home at the end of February.

Apparently Colleen was not concerned by the conversation. Unfortunately Colleen was not called as a witness or available to be called on short notice. The conversation was relayed second-hand, through an interpreter, more than two years after it took place, never apparently having been recorded in the meantime. Therefore, I am not satisfied that the account we heard was completely accurate and thus am hesitant to draw too many conclusions from it.

February 9th , 2001 was the date that Mr. Scott disappeared.

Dr. Wilkie had previously assessed Mr. Scott as doing quite well. He was scheduled to visit Sara Riel Inc. for an intake assessment. He appears to have been in favour of going to that facility, although on some occasions he expressed a preference to return home. He was willing to "give it a try". For the most part, Mr. Scott had had expressed a willingness to do what was necessary to get better. There would have been some waiting period - at least a number of months, before a bed was available. However, it was thought that because Mr. Scott was doing so well it would be unfair to him to put him in any other facility in Winnipeg, and there was nothing comparable available in the North. Sara Riel apparently provides the only group homes in Winnipeg that would offer Mr. Scott the life skills training and preparation to become an independent member of a community. To put him in any other group home, according to a staff member who was very familiar with what was or was not available in Winnipeg, would have meant basically "forgetting" about him. Mr. Scott's family was also in favour of his being released to Sara Riel and did not feel that his problems could be handled by what was then available in Cross Lake.

February 9 - 11, 2001:

On Friday February 9th, 2001 between 8:30 and 9:30 a.m., Mr. Scott asked if he had any money left in his account. He was told that he did not, first by a staff member on the ward, and then by Louella Bell, the Coordinator of Patient Services for the Acute Admissions area. Mr. Scott was not due to receive any more money until the following Monday. Apparently he was quite regularly told he had run out of funds. He did not seem upset upon being told this - Ms. Bell described him as "having a twinkle in his eye" when told. (Mr. Scott received twenty dollars per week in assistance benefits as of some time in January, 2001. Prior to that he had received only ten dollars per week treaty funds. The staff had started to give him ten dollars on Mondays and ten dollars on Fridays, as he was known for immediately spending all his money. However, Mr. Scott convinced staff members to give him an extra two dollars on Monday, February 5th and eight dollars on Tuesday, February 6th. That meant he had no funds until the following Monday, February 12th. However, his family also provided Mr. Scott with a carton of cigarettes per week, as well as some tobacco. The family had asked that the cigarettes be given out one package per day, and that was apparently what was being done.)

Mr. Scott also spoke to an activity instructor between 9:00 and 10:00 a.m. on February 9th, 2001. She asked him if he was coming to occupational therapy at 10:30 a.m. and he told her he was. Nothing in the interaction concerned her, nor did the fact that he did not appear. Mr. Scott only attended about one-half the time and had in the past not appeared after having been reminded.

Mr. Scott was also seen by registered psychiatric nurse Joseph Hadfield between 10:00 and 10:30 a.m. Mr. Hadfield was taking a group out from Ward D9 to go skating. He asked Mr. Scott if he wished to go with them and Mr. Scott said "no". This did not cause Mr. Hadfield any concern, as Mr. Scott "was smiling, seemed happy", and when asked something to the effect of "another time?" responded positively. Mr. Scott had never been skating with Mr. Hadfield on other occasions. Another staff member, Agnes Collins, saw Mr. Scott leaving the ward about 10:30 a.m.

Mr. Scott did not appear for lunch at noon. When he did not appear, Ms. Collins was concerned. She spoke to Mr. Scott's brother Joshua, who was also a patient on D9, between 2:00 and 2:30 p.m. Joshua told her that Clayton "probably" took off for the City. She reported that to staff from the next shift. At that time, since Mr. Scott had "grounds privileges", he was not required to be back on the ward until 9:00 p.m. that evening. Joshua Scott told Ms. Lund, another registered psychiatric nurse on D9, that Clayton had gone to Winnipeg.

Staff members, apparently having no reason to doubt Joshua, and knowing of Mr. Scott's previous unauthorized trip to Winnipeg on January 12th, 2001, believed that that was, indeed, what had occurred. Therefore, contrary to policy, no search was conducted of the building or grounds. For reasons that follow, I have concluded that this was not a factor in Mr. Scott's death.

On Sunday, February 11th, 2001, a stranger was knocking on the inside door of Ward D8, a program area in the Reception Unit, down the hallway from Ward D9. This area was not normally used over the weekend. This man had apparently been looking for a seniors' home across the road from the Reception Unit. He had entered the Reception Unit through an unlocked entrance that led him onto D8, and then could not get out. He was let out and pointed in the right direction, and then the staff member conducted a search of D8. He noticed a foul odour coming from a male washroom area. He went into the washroom and found Mr. Scott in a very narrow shower stall, hanging from a pipe above the false ceiling. Both because of the odour and signs of lividity, or purplish

colour, on the lower parts of Mr. Scott's body, it was apparent that he been dead for some time. He was hanging by an extension cord, presumably one that had gone missing from a staff member's car on February 9th, 2001, sometime before 11:30 a.m. It appears that Mr. Scott was able to climb up into the false ceiling area by using a soap dish and taps as toeholds and then a shower attachment as a grip and possibly also a stepping point.

Dr. Wilkie's discharge summary made the following observations. Mr. Scott was in favour of the plan to place him at Sara Riel. Mr. Scott was not depressed, except infrequently when he commented about being homesick and when he was approached earlier in the admission about his inappropriate sexual behaviour. He had been informed that he had an intake meeting at Sara Riel on February 15th. He had appeared to be pleased by this news. Mr. Scott was calling home frequently and was proud that he obtained a "1-800" number for the Brighter Futures worker in Cross Lake. He did frequently complain about being homesick when he made the calls to these workers. Dr. Wilkie noted that during his admission Mr. Scott had frequent contact with him, often exchanging a few brief Cree phrases that Dr. Wilkie was familiar with. He was noted to be smiling and at no time during the admission did he appear to have depressive symptoms. Initially he had been suffering from psychotic symptoms; however they appeared to respond favourably to Clozaril.

When asked at the Inquest, Dr. Wilkie was not able to identify any signs warning of Mr. Scott's apparent suicide. He referred to *The Houston Case-Control Study of Nearly Lethal Suicide Attempts*, published in 2001 in The Official Journal of the American Association of Suicidology. This study indicated that 24% of adolescents and young adults who committed nearly lethal suicide attempts, attempted to commit suicide less than five minutes after formulating the plan. Although the study did not relate to persons with schizophrenia, it found that, relative to control subjects, the variables of male sex, the subject having had a physical fight within the last year, and feelings of hopelessness distinguished impulsive cases. Mr. Scott was, of course, male, had had at least one physical fight within the last year, and may have experienced feelings of hopelessness.

The Selkirk Mental Health Centre:

The Reception Unit, where Mr. Scott was a patient, opened in 1923. It is an old building and very much has the appearance of an institution. Patients sleep in dormitories, albeit with partial dividers giving some separation to every

four beds. Unless a patient brings in his or her own quilt or bedspread, the bedding is what a patient would have in a regular hospital. Some effort has apparently been made to paint the walls in pleasing colours. However, apparently because some brain-injured patients should not to have too much visual stimulation, most of the building appears quite stark. The staff room is a notable exception, appearing both colourful and cosy.

Over the years, there has been a dramatic decrease in the number of patients held in mental health centres. The Brandon Mental Health Centre has been closed, and there has been a drop in the patient population at Selkirk from 1,200 in 1957 to approximately 261 in-patient beds today. This is largely due to new and improved drug treatment.

The Selkirk Mental Health Centre provides short-term and acute in-patient mental health services to Manitoba residents of the Interlake, Northeast Manitoba, Southeast Manitoba, the Norman and Churchill regions and the Burntwood region, which includes Cross Lake. It also has an agreement with the Government of Nunavut to provide in-patient services to Nunavut residents.

There are ten psychiatric beds at the Thompson General Hospital. There are, however, no locked facilities in Thompson or anywhere else in the North.

Aboriginal Patients at the Selkirk Mental Health Centre:

Clayton Scott was an aboriginal person from the Cross Lake First Nation. His first language was Cree. I heard various opinions regarding Mr. Scott's ability to speak and understand English. Staff at the Centre believed that this was not a problem, but Mr. Scott's mother and at least one community mental health worker believed that it was. Mary Scott testified that Mr. Scott could only understand English "a little bit". Probably the truth is somewhere in-between. Mr. Scott obviously communicated a great deal of information to English-speaking medical personnel over the years. However, to communicate feelings, something Mr. Scott did not do readily in any event, doing so in English was, I am sure, especially problematic. It does not appear that at the time of Mr. Scott's death there were Cree-speaking staff at the Centre. Other than perhaps one or two part-time Friendship Workers, it does not appear that this situation has changed much today.

In terms of aboriginal culture and spirituality, Mr. Scott's family is Roman Catholic. There is only one reference on file indicating that he had accessed any spiritual or cultural services at the Centre, and that reference indicated that during one 1997 admission he had had continuing contact with both a Christian minister and an aboriginal Elder.

Since Mr. Scott's death, the Centre, largely due to money coming from the Nunavut government, has expanded its aboriginal programming. There are now more aboriginal Friendship Workers and a full-time aboriginal Elder, with plans for a further increase in this type of staff. There is a non-denominational spiritual centre that focuses on aboriginal spirituality. Various aboriginal cultural activities such as smudging ceremonies, pipe ceremonies, dancing and sweat lodges take place. Some aboriginal awareness programming has also been provided to staff.

Dr. Clarke Wilkie:

Dr. Clarke Wilkie, Clayton Scott's psychiatrist, was an impressive and very helpful witness. He graduated from medical school in 1977, and became a psychiatrist in 1997. From January 1979 to December 1980, he was a family practitioner in Norway House. From January 1981 to August 1993 he was based in Dauphin. While there, he continued his interest in delivering health care to First Nations people, frequently flying in to run clinics to communities in northern Manitoba. During his psychiatry residency from August 1993 to August 1997, he continued to fly in to work in the North. He also participated in a number of aboriginal activities, such as sweat lodges, in order to increase his sensitivity to aboriginal patients. Since September 1997 he has been a staff psychiatrist at the Selkirk Mental Health Centre. His patients are on the acute and intensive care in-patient wards. The majority of his caseload is composed of aboriginal and Inuit patients from isolated communities. He has conducted scheduled psychiatry consultation clinics in Nunavut and northern Manitoba. He was an expert witness at a coroner's inquest on suicide amongst First Nations adolescents in Thunder Bay, Ontario in December of 1999. He is an assistant professor at the University of Manitoba, Department of Psychiatry, and has been since 2001. Dr. Wilkie has done presentations on cross-cultural psychiatry and other related topics such as "cluster suicides" in First Nations communities.

It is my opinion that, other than perhaps having an aboriginal physician, Mr. Scott could not have had a more culturally sensitive psychiatrist. Nor could

we have had a more helpful expert to testify on the areas of schizophrenia and suicide as they relate to First Nations patients. It is notable that, although Dr. Wilkie has written and presented on the issue of cluster suicides in First Nations communities, he apparently did not see Mr. Scott's apparent suicide as part of that phenomenon. Instead, he saw it as primarily the result of Mr. Scott's schizophrenia.

RECOMMENDATIONS OF THE TREATING PSYCHIATRIST:

In his discharge summary, Dr. Wilkie stated, "On reflecting on the tragic outcome, one factor that possibly could have influenced the outcome would have been the availability of a fully-staffed group home living situation for individuals with mental illness in Clayton's home community. This has been raised with agencies in the past."

During the Inquest, Dr. Wilkie expanded on his suggestion regarding a group home in Cross Lake. It was his belief that a group home could be justified in a number of larger First Nations communities in Manitoba – perhaps four or five. He testified that, with a professional manager, such group homes could be staffed by lay people from the community and would offer First Nations people suffering from mental illness a chance to stay near their families. Such group homes would serve both a preventative function and also provide a place where such individuals could return after hospitalization. They would be especially useful for people who are on Clozaril, in order to facilitate monitoring of their compliance with medication and their blood testing. Group homes would also provide employment to other community residents. Apparently there is a similar mental health group home in Iqaluit, Nunavut. It is working quite well.

Dr. Wilkie also said that if there was anything that could have been done differently it would have been to put Mr. Scott on Clozaril earlier. That would have meant that Mr. Scott did not have as long to "get tired of his illness", since Clozaril is such a positive drug and Mr. Scott would have responded to it at an earlier point in time. In fact, Dr. Wilkie relayed the story of one schizophrenic on Clozaril who, as a result, no longer believed himself to be ill.

Dr. Wilkie did not put Mr. Scott on Clozaril in the spring of 2000 for a number of reasons. Doing so would have necessitated Mr. Scott being admitted to hospital for a period of time. Dr. Wilkie was reluctant to interfere with the medication regime of the treating psychiatrist from Thompson, who, not

believing he had the resources to do so, did not prescribe Clozaril to any of his patients. And finally, there was not at the time a regular treatment team in Cross Lake to follow Mr. Scott. That is, there was no resident physician and there was a high turnover of nursing staff at the nursing station. Therefore, there could be no assurance that the taking of medication would be monitored or that blood would regularly be taken for testing, sent to a laboratory, and lab results checked.

Dr. Paul Barchet, also a psychiatrist at the Selkirk Mental Health Centre, had "pioneered" the use of Clozaril in the North. This occurred in the late 1990's, but required some extraordinary steps by him to ensure, for example, that patients could get weekly and then bi-weekly monitoring of their white blood counts.

Dr. Wilkie also recommended that communities such as Cross Lake have a registered psychiatric nurse or medical social worker attached to the nursing station, in order that psychiatric patients could be followed. He expressed some frustration that the last time he went in to Cross Lake to see psychiatric patients, not one patient showed up for his or her appointment. This would, of course, have made his trip a waste of both time and money. This was in contrast to Norway House, where a medical social worker on staff knew which patients should be seen, made the appropriate arrangements, and provided follow-up afterward. If a patient did not attend for an appointment, that social worker, familiar with the patient and where he or she lived, would drive Dr. Wilkie to make a home visit. Similarly, in Dr. Wilkie's work in the Arctic, registered psychiatric nurses, working in nurse practitioner or advance placement roles, fulfil a similarly useful function - even assessing the patients and then telephoning Dr. Wilkie, who is able to prescribe medication over the phone.

CONCLUSIONS:

Was Clayton Scott's death a suicide?

I conclude that it was. There is no other reasonable conclusion. There is no indication that anyone had a reason to want to kill Clayton Scott. Moreover, physically it would have been almost impossible to do so. Mr. Scott died in a very confined area, where it would have been next to impossible for another person to stand beside him. He was also very high up and could not reasonably have been put in that position by another person. There were no signs of struggle either in the washroom where he died or on his body or clothes. The

suggestion was made that perhaps Mr. Scott could have been forced to hang himself by another person at the end of a gun. However, that would not be a reasonable conclusion as it would, of course, be easier for another person to simply shoot Mr. Scott. In all of the circumstances, therefore, I conclude that that Mr. Scott committed suicide.

Did Clayton Scott plan to commit suicide or did he act impulsively?

I conclude that Clayton Scott almost certainly acted impulsively.

Mr. Scott had over the years expressed suicidal thoughts in his own community. He had had such things as an extension cord and a rope in his room at Cross Lake. However, there were no warning signs that could have predicted that he was going to commit suicide during his last admission to the Selkirk Mental Health Centre. He denied being suicidal when interviewed by Dr. Wilkie. He never expressed suicidal thoughts to any staff member. Although he was homesick at times and crying as a result of this, he did not exhibit symptoms of clinical depression. He had been similarly homesick during previous admissions without attempting suicide. He did not show any evidence of prior planning, such as accumulating items to use to commit suicide or giving away his belongings. In fact, between 8:30 and 9:30 a.m. on February 9th, 2001, the day he most certainly committed suicide, he was asking for money, presumably because he planned to go and spend it, not to kill himself.

As I cannot conclusively pinpoint whether Mr. Scott committed suicide on the morning of February 9th, 2001, due to the delay in finding his body, this makes the exercise of determining whether he acted impulsively more difficult. However, I do note that the extension cord with which he most certainly hung himself was taken before 11:30 a.m. on February 9th, 2001. Mr. Scott did not appear for lunch on February 9th. He had no money to buy food elsewhere. It is therefore most likely that he committed suicide before lunch on February 9th, 2001.

Such a conclusion is arrived at somewhat in the face of the testimony of a staff member who looked into the washroom on D8 later that afternoon, and did not see Mr. Scott. However, perhaps because the curtain to the shower stall was closed, or because Mr. Scott was hanging quite far off the ground, the staff member might not have seen Mr. Scott. The staff member was not searching

for Mr. Scott at the time, but rather just checking to see if everyone had left the area.

It is remotely possible that Mr. Scott took the cord and then left and tried to get a ride into Winnipeg, was unsuccessful and then returned to hang himself, but such a conclusion would not be reasonable in the circumstances. I believe Mr. Scott probably decided to commit suicide and committed suicide some time after 10:30 a.m. February 9th, when he was last seen, and lunchtime that day.

As indicated previously, Dr. Wilkie referred to the Houston study regarding impulsive suicide attempts, a study that was filed as an exhibit at this Inquest. That study found that at least 24% of people intending to actually commit suicide, people who are not necessarily mentally ill, formulate the intent within five minutes of the attempt itself. Those impulsive individuals are more likely to be male, are more likely to have had a physical fight within the last year, and are more likely to have a sense of hopelessness. Other studies mentioned in the same article found the rate of impulsive suicides to be even higher.

Given these types of statistics, and especially with a population of mentally ill individuals and schizophrenics, who have an approximately 40% chance of attempting suicide, an institution like the Selkirk Mental Health Centre is put in a very difficult position. Dr. Wilkie estimated that at any time the Centre would have a large number of patients, probably in excess of 100, who have a number of risk factors for suicide.

Could the Selkirk Mental Health Centre have prevented Clayton Scott from committing suicide?

I conclude that there was nothing the staff at the Selkirk Mental Health Centre could or should have done to prevent Mr. Scott's suicide. There were no warning signs. All staff members acted in both professional and caring manners throughout his admission. I was not only impressed, but also somewhat surprised, by their obviously sincere emotional reactions, to both Mr. Scott's death and to the pain of his family members. The Selkirk Mental Health Centre and its patients are indeed fortunate to have such dedicated staff.

Other than putting everyone under one-to-one observation or in locked wards, suicides might happen at any time. In this light, it is perhaps remarkable

that I am aware of only three previous suicides committed by patients at the Selkirk Mental Health Centre since 1990.

On another level, Clayton Scott's suicide was, if not preventable, not entirely, at least with the benefit of hindsight, a surprise. He had certainly voiced suicidal thoughts over the years, especially in his home community. He had had a rope and an extension cord in his room there at various times. He, however, when questioned, denied that he was going to commit suicide. On at least one occasion he said he would not because he did not want "to go to hell." On another occasion, he said that he made suicide threats in order to "get attention".

It is possible that Mr. Scott decided somewhat in advance that he would commit suicide. In hindsight, the conversation that he had with his sister Colleen on February 8th, 2001, the day before I have concluded he committed suicide, might, had they known of it, have been a warning sign to staff. On the other hand, I do not think that if this had been the case, he would been asking for money on February 9th.

Why did Clayton Scott commit suicide?

This is a much more difficult question and one that I cannot answer. Mr. Scott did not tell anyone that he was going to commit suicide or leave a note explaining his reasons.

I could, therefore, simply state that the reason for the suicide could not be determined. However, I do not believe that that would be particularly helpful in preventing future suicides among patients at the Selkirk Mental Health Centre. Therefore, I will examine what I believe to be the two most likely reasons for Mr. Scott's suicide. They may well be interrelated. They may well apply to other patients at the Centre, and especially to the high percentage of aboriginal patients. Therefore, I believe that the recommendations may go some way towards preventing "similar deaths from occurring in the future" and fall within the mandate of this Inquest.

The most likely reason for Clayton Scott's suicide, in my opinion, was his schizophrenia and the fact that he was "tired of his illness".

This was the "one concerning thing and the most concerning thing" about the initial interview that Dr. Wilkie had with Clayton Scott when he was admitted on December 21st, 2000. However, Dr. Wilkie and Mr. Scott then had a discussion in which Dr. Wilkie explained to Mr. Scott that Mr. Scott did not have the illness because he was a "bad person". He also explained the potential help offered by the medication Clozaril, a medication that Dr. Wilkie suggested and that Mr. Scott consented to try. Clozaril is the medication that has shown the most success in treating schizophrenia in people who have not responded well to other drugs.

Based partially on that discussion and also, I am sure, on Mr. Scott's prior history, the decision was later made not to unduly restrict Mr. Scott. He was given grounds privileges within a day or two. With the benefit of hindsight, no issue can be taken with that decision. Patients are apparently at higher risk to commit suicide upon admission, than they are after they have been in hospital for some time. There were no suicide attempts during the first month and one-half of Mr. Scott's stay at the Centre. Even if he had been restricted initially, his privileges would most certainly have been expanded during that time, as he apparently was doing quite well and was being processed for discharge.

Dr. Wilkie, also in hindsight, indicated that he wished that he could have had Mr. Scott placed on Clozaril earlier, so that Mr. Scott would not have had so much time to get "tired of his illness". There were a number of reasons why that was not done. Mr. Scott was under the care of a psychiatrist from Thompson and that psychiatrist did not prescribe Clozaril due to lack of resources. Putting Mr. Scott on Clozaril would have necessitated Mr. Scott being admitted to hospital. It would also have necessitated having a consistency of care that was not available in Cross Lake at the time. There was no regular treatment team to follow Mr. Scott, no resident physician in Cross Lake to whom the monitoring could be transferred, and there was a high turnover of nurses at the nursing station. Prescribing Clozaril requires weekly and then bi-weekly taking of blood samples, as a well as requiring that the samples are sent to a laboratory and that the lab results are checked when they are returned.

All of this leads me to conclude that if there had been more resources, or at least more consistently available resources, in the community of Cross Lake or in the North generally, perhaps Mr. Scott could have been put on Clozaril

earlier and not had so much time to become "tired of his illness" and commit suicide.

Dr. Wilkie also suggested that a group home in Cross Lake would have been of great assistance. In addition to providing monitoring of behaviour, medication and blood work, as well as socialization and activity, the existence of such a home could serve to educate community members about mental illness. In addition, Dr. Wilkie testified that there is research to show that people with schizophrenia often do better in what are sometimes referred to as "third world environments". Such environments share some characteristics with First Nations communities in Canada. For example, a person would not feel "different" just because he was unemployed. Dr. Wilkie noted that Mr. Scott had been homesick so far away from his family and community. So, concluded Dr. Wilkie, "it is possible that if there was a fully staffed group home in Cross Lake that perhaps Clayton would have been on different medication earlier in his life. He may not have had as long a time to get tired of his illness and so it's possible that he could have had enhanced treatment at any earlier stage."

I agree. A group home would also have meant that the Scott family and the community mental health workers did not have to constantly deal with Mr. Scott's disruptive behaviour. He could have been monitored to make sure that he was taking his medication. He could have been given activities to help make him feel that he was a productive member of the community. Finally, hopefully the community itself could have been educated about mental illness, so that Mr. Scott would not have been teased about being "crazy".

There were, and are, in Cross Lake community mental health workers, who are lay people employed by the First Nation, either as part of the Brighter Futures or the Building Healthy Communities programs. These people are dedicated and hard working. They supported Clayton Scott and his family through many difficult times. They at times provided around-the-clock monitoring and a bed in a trailer for Clayton Scott. I was saddened to hear that funding for the "crisis line" that responded to crises experienced by band members had been terminated. It appeared that it was providing a very useful service.

The community health workers sometimes suffered "burn-out". Housing shortages in Cross Lake apparently meant that neither Mr. Scott nor his brother Joshua, although both adults, qualified for their own or shared housing. A

group home, staffed twenty-four hours per day, would most certainly have helped.

There may sometimes be a lack of communication and/or a co-operative working relationship between the nursing station and the First Nation's staff. As a result, psychiatric patients may not always be followed in the best possible manner, given the resources that are presently available. For example, on the occasion when Dr. Wilkie went in to Cross Lake and had not one patient appear for an appointment, a better utilization of community mental health workers may have meant that those patients could have been located. Also, when patients are discharged from the Selkirk Mental Health Centre to a First Nations community, there is no follow-up unless an individual psychiatrist has made arrangements. Selkirk Mental Health Centre discharge summaries regarding Mr. Scott were regularly sent to the nursing station in Cross Lake, but only sometimes sent to the First Nation's community mental health workers.

Perhaps at least partially because of a lack of consistent care in Cross Lake, Mr. Scott went through what was referred to by Dr. Anthon Meyer, Cross Lake's new medical director, and very impressive witness, as "a vicious cycle".

After being diagnosed at age 16 in 1992, Mr. Scott had undergone many changes of medication prescribed by a number of different doctors. He at times got better, usually while in hospital, and was discharged back to the community. Then, perhaps after non-compliance with medication and/or using non-prescription drugs, he got worse. According to Mr. Scott, he sometimes used the other drugs to make the symptoms of his illness go away. In addition, Mr. Scott often had physical, or at least to him physical, symptoms where he felt like his stomach was coming out or some other complaint relating to the abdominal area. On top of the psychological and physical complaints, Mr. Scott suffered from being treated badly in his community, no doubt due a lack of community understanding of his illness. He was usually unemployed, at least partly due to his illness. He was, at least for a time, barred from his parents' home, yet was unable to get housing of his own.

Mr. Scott's family and caregivers, the community mental health workers, suffered, too. They needed respite from his bizarre and sometimes aggressive behaviour. They needed respite from his demands, which often came in the middle of the night, when Mr. Scott could not sleep, but when his caregivers needed to. His psychiatrist characterized one of Mr. Scott's admissions as resulting for the most part from his family needing respite from his behaviour.

He would then be taken out of the community either to Winnipeg or Thompson or, for the last five admissions, to the Selkirk Mental Health Centre. There he would gradually get better and be released back to Cross Lake, where eventually the downward spiral would begin again.

It is quite conceivable that Clayton Scott became so tired of this cycle, and of still not being well, that he eventually decided to put it to an end.

The second possible reason for Mr. Scott's suicide, in my opinion, is that he was homesick and that homesickness triggered his suicide. This is a less likely reason, in my view, but may well be related. Mr. Scott complained often during his last admission about being homesick. On the other hand, he had made similar complaints during both that admission and previous admissions, but never before attempted suicide. Mr. Scott would complain about being homesick and even cry, and then would bounce back and appear to be happy. During his last admission however, there seemed to be a continuing complaint about being homesick in the last two days before his death. He was phoning the Brighter Futures toll-free line in Cross Lake repeatedly and he was observed sobbing and complaining about being homesick. Although he voiced a willingness to go to Sara Riel House, there was some evidence that this was a source of some ambivalence for him. Although he had an intake appointment the following week, he still faced a lengthy waiting period and then a long time in Winnipeg before he could return home.

Apparently many patients at the Selkirk Mental Health Centre are homesick and this is not surprising. For aboriginal people, it is probably an even more strongly-held emotion. Many are sent to the Selkirk Mental Health Centre as the first time they have lived outside of their own communities. They are living in a non-aboriginal environment with few, if any, people who speak their own language. They are away from their own close-knit families and communities.

Obviously, the only way to prevent such homesickness is to have aboriginal people treated in their own communities. This is a big and perhaps insurmountable goal, as people with severe mental illness and psychotic symptoms often need closed settings and careful monitoring, as well as the expertise of psychiatrists and other mental health professionals. However, that does not mean that attempts should not be made to keep aboriginal people in their communities where possible. Even the process of transporting them out of their communities for medical care is not only expensive (in the late 1990's, for

example, Cross Lake Medical Transportation was spending approximately 4.5 million dollars annually on patient transport), but also traumatic. We heard that Clayton Scott, at least on his first admission to the Selkirk Mental Health Centre, was escorted out of the community by R.C.M.P. officers, who were required by policy to put him in handcuffs. Mr. Scott was at the time a young person who was sick, no doubt scared, and not charged with a criminal offence.

Since it is unlikely however, that all such admissions will end any time in the near future, the Selkirk Mental Health Centre can only attempt to make the facility as homelike and as sensitive to the needs of its patients as possible.

In the long term, the Inquest heard, the plan is for physical improvements so that patients, rather than being housed in dormitories, will have their own rooms. There is also a plan to separate the brain-injured patients, who have different needs and capabilities, from those with mental illness. These are positive initiatives and I hope they are approved and implemented in the near future.

In the short term, I would hope that the Selkirk Mental Health Centre will do what it can to at least make the Centre as homelike as possible. For example, all residents, not just those who can afford them, should have personal quilts or bedspreads on their beds. There should also be consultation with a psychologist and an interior decorator to see if there are other ways to make the Centre more homelike. To help aboriginal residents feel more at home, every effort should be made to hire aboriginal staff, especially those who are able to speak their native languages, and to continue training other staff to be as culturally sensitive as possible.

Previous Inquests into Suicides of Patients at the Selkirk Mental Health Centre:

I was provided with reports of three other inquests that concerned patients held involuntarily at the Centre. Their deaths occurred in 1990, 1991, and 1995.

Paul Luneau hung himself in a clothes closet. The recommendation of Judge Cramer was that “breakaway bars” be installed in all clothes closets to which patients might have access.

Robert Russick was also a schizophrenic. He, too, had tried for a number of years to cope with his illness in a smaller community, The Pas. However, apparently because of a lack of both hospital and community resources in The Pas, he was sent to Selkirk. He jumped from a water tower located on the grounds of the Centre. Judge Guy's recommendations centered on the lack of resources in Mr. Russick's home community. He recommended that The Pas Health Complex have designated short-term psychiatric beds, more professional psychiatric support, twenty-four hour crisis response services, and a multi-disciplinary approach to provide long-term case management and follow-up. It was also stated that long-term rehabilitation and care of individuals with schizophrenia required the "education, co-operation and collaboration of the entire community in the treatment of the mentally ill". Mr. Russick was also a heavy smoker, and while at Selkirk had no money for cigarettes. Although not found to be an immediate cause, it may have been an "aggravating or stress related factor" in his suicide. In terms of the physical location, corrective steps had already been taken to prevent access to the water tower. Judge Guy noted that "no facility such as a Mental Health Centre can ever be foolproof".

Garry Lychuk hung himself from the Selkirk Bridge, away from the grounds of the Selkirk Mental Health Centre. He was held at the time under order of the Criminal Code Board of Review, having been found not criminally responsible for the offence of Second Degree Murder. Mr. Lychuk also had privileges to be anywhere on the grounds of the Centre. As is still the case, there was no supervision or monitoring of patients on the grounds. Mr. Lychuk left the grounds, went into Selkirk and hung himself from a bridge. As in the case of Mr. Scott, Mr. Lychuk appeared fine when last seen by staff and his suicide was unforeseen. Judge Lismer noted that although Mr. Lychuk had progressed in terms of his mental disorder to the point where he had been placed on an open ward and granted grounds privileges, medical evidence indicated that his recovery could be "abruptly reversed by a spontaneous relapse". Judge Lismer therefore recommended that the "Criminal Board of Review, when approving ground privileges in similar circumstances, specifically direct an ongoing monitoring of the behavior and location of the patient exercising the unescorted ground privileges, by available means, including personal and visual observation by members of the staff, closed circuit television covering the grounds of the Centre, the utilization of wrist or ankle bracelets so electronically tuned as to pinpoint the whereabouts of the wearer at all times, and/or such other devices now readily available".

I considered making similar recommendations regarding cameras and electronic monitoring, but was strongly discouraged from doing so by counsel for the Centre, as well as by Mr. Patrick Ward, a witness at the Inquest. Mr. Ward was, at the time of Mr. Scott's death, the Director of Patient Program Delivery at the Centre. His training was as a registered nurse and a registered psychiatric nurse, and he had worked there for more than twenty-five years. When asked if he had given any thought to whether patients could or should be monitored by way of electric bracelet or cameras on the grounds, he answered, "I've given a lot to thought to that over time and I'm recommending that that not be a recommendation…It has to do with respect and dignity for people, particularly the mentally ill. They are not at the Selkirk Mental Health Centre because they are criminals, they are there because unfortunately they're ill and we are providing treatment and we should provide as normal as possible environments for the person while they're there. Yes, there are times when there are some restrictions placed upon those people, but it is my view that we must continue to be very strong on dignity, respect at all times for the person who is mentally ill, actually for anybody but particularly in my case, the mentally ill." No other professional witness at this Inquest made recommendations similar to those of Judge Lismer. However, the only recommendation of Mr. Scott's mother, Mary, was that there be better supervision of patients.

RECOMMENDATIONS:

The Selkirk Mental Health Centre:

I recommend that the Selkirk Mental Health Centre:

1. Attempt to hire qualified aboriginal staff, who are able to speak their native languages. It is clear that Clayton Scott's first and usual language was Cree, and it may be that being able to speak to at least one staff member in his own language may have alleviated somewhat his feelings of homesickness.

2. Continue to educate its staff regarding aboriginal culture, so as to increase understanding of its aboriginal patients. This would hopefully not only help make the patients feel more at home and better understood, but might also increase sensitivity as to possible warning signs of suicide.

3. Facilitate visits by family members, including taking steps to find or create short-term accommodation for them while they are visiting the Centre. Counsel for the Centre suggested that the Centre consider, as part of the current redevelopment initiative, construction of apartment space, or other lodging or rooms, to accommodate families who may be visiting from remote communities. It was suggested, and I would concur, that such facilities could achieve a double purpose, serving, in some cases, as a pre-discharge environment to help prepare patients for release into the community.

4. Take steps to make the Centre as homelike as possible. To do this, steps may be as simple as providing personalized quilts for beds to as far reaching as providing individual rooms. Prior to new construction, the Centre should consider consulting with an interior designer, perhaps working in the company of a psychologist, to look into possible changes to make the Centre more homelike and less institutional.

5. Continue with plans to separate brain-injured patients from those who are mentally ill.

6. Educate family members of patients on suicide risk factors and warning signs, in order to enable families to identify warning signs. Families should also be encouraged to report to staff of the Centre any concerns that might arise during telephone conversations or visits.

7. Conduct regular training in suicide prevention for its staff.

8. Conduct regular surveys, as have been done in the past, to eliminate, where possible, items which may be used to commit suicide. In saying this, I recognize that it would be both undesirable and impractical to provide a totally sterile environment. I also appreciate that a patient desperate to commit suicide will likely find a way, even if it means leaving the Centre. I recognize that it is impossible to eliminate all items, as items such as sheets will and should be available to patients. I also believe that extension cords are a necessity in our cold winters. However, perhaps there are items that can be eliminated.

9. Conduct regular surveys to eliminate, where possible, places where patients can commit suicide. Steps have already been taken, for example, to replace showerheads that are long enough to attach something to or climb up on. Steps have already been taken to ensure that unoccupied areas in ward D8 are kept locked. However, patients have access, when they have grounds privileges, to other buildings and parts of the grounds. I suggest that these be surveyed to see if there are other places that could pose similar risks. Steps should be taken to ensure either that staff secure areas that are not in use or that doors lock automatically.

10. Consider carefully whether to give patients who have a history of suicide threats, privileges to leave the ward unaccompanied. I make this recommendation somewhat hesitantly. I certainly do not believe that the decision to give Clayton Scott "grounds privileges" was in any way wrong. I also believe these decisions are made very carefully by professionals with a great deal of expertise and experience. I recognize that there are therapeutic reasons for giving patients as much autonomy as possible. However, Mary Scott, Clayton Scott's mother, made the point at the Inquest that she thought the patients should be "supervised". Families who take steps to have their family members admitted as involuntary patients must have the belief that they will be safer in hospital than in the community. Other patients who may follow Clayton Scott onto short-term acute assessment wards, such as D9, may have a history of suicidal ideation or attempts, and may not be as well-known by staff. They may well have involuntary status because they "pose a danger to themselves". Perhaps such patients should have their files "red-flagged", in some way, as possibly posing a risk to commit suicide, and privileges to leave the ward unaccompanied granted cautiously. Perhaps some sort of "buddy system" might work in some cases.

The Government of Manitoba

I recommend that the Government of Manitoba:

1. Continue with the capital improvements planned for the Selkirk Mental Health Centre, specifically with plans to separate brain-injured patients from those who suffer from mental illness, and to provide more private sleeping accommodation for mentally ill patients.

2. Do what is necessary to ensure that northern First Nation communities have the necessary number of both family practitioners (full-time and resident in communities where the need justifies) and visiting psychiatrists to provide proper and continuous care to aboriginal persons suffering from mental health problems.

3. Encourage the development of, and fund, group homes, so that persons with mental illnesses can be kept in their own communities and released back to their communities, wherever possible and as soon as possible.

   I heard during the Inquest that there were no appropriate group homes in the North. There was apparently only one in Winnipeg, Sara Riel Inc., that provided the life skills training and support that Clayton Scott, or someone like him, would need to become a productive and independent member of society. Ideally, such group homes should be as near to the person's home community as possible – in communities big enough to support them, such as perhaps Cross Lake, right in that community. This will require that the Government of Manitoba, if it does not establish group homes itself, pay per diem rates high enough to encourage either private enterprise or non-profit organizations to establish and maintain such group homes.

   It is one thing to reduce the number of patients that are held in hospital, but money should be put into community programs so that those patients can be properly maintained in the community. It costs somewhere in the area of $282.58 per day to keep a patient in the Selkirk Mental Health Centre. There are apparently presently lengthy waiting periods for group home beds. For Sara Riel Inc., for example, the waiting period for male patients in November 2003 was six to eight months! Obviously, there would be cost savings if those patients did not have to wait for lengthy periods of time to be released into a group home in the community. It was also distressing to learn that most other mental health group homes in the province provide only basic physical care and supervision, but not life skills training. It was said that to put Mr. Scott into any group home in Winnipeg, other than Sara Riel, would have meant "basically forgetting about him". There should be more group homes that provide life skills training.

4. In its role as regulator, appreciate the need for such group homes and facilitate their operation.

The Government of Canada:

The federal government was not represented at the Inquest. I, as well as counsel for the Centre and counsel to the Inquest, questioned whether I have jurisdiction to make recommendations regarding the federal government. I do not propose to decide that issue at this time. In any event, any recommendations I make regarding the federal government, as indeed in regards to the provincial government, are only recommendations. Because the federal government was not represented at the Inquest, however, I hesitate to make recommendations, as was urged by counsel for Mr. Scott's parents, in regards to specific staffing levels at Cross Lake. I do believe, though, that there was sufficient evidence that psychiatric care was not as accessible, nor as consistently available, to Mr. Scott, as it would have been had he lived in a less remote area than Cross Lake. For example, he had many different medication regimes, was not placed on Clozaril at an earlier time, and had many periods of hospitalization far away from his home.

I would, therefore, urge the federal government to:

1. Take steps to increase the level of psychiatric services available in First Nations communities by way of regularly attending psychiatrists, perhaps providing follow-up by tele-health video links, and by providing registered psychiatric nurses, medical social workers, or similarly trained individuals, to be available to monitor psychiatric patients' care on a continuing basis.

2. Consider re-establishing funding to the Cross Lake Crisis Line or some similar program to provide crisis response to people in the community and, where necessary, respite services to families.

3. Establish mental health group homes in First Nations communities where the numbers would warrant them. This would allow individuals to be maintained in their communities for longer periods of time and would have a preventative effect. It would also allow for individuals to be returned home earlier if they did have to be removed from the community during the acute stages of their illnesses.

4. In order to facilitate the treatment of schizophrenic patients on Clozaril, establish laboratories in the communities where the population can support them, so that the necessary blood work can be done at regular intervals.

I respectfully submit my recommendations and conclude this Report this 27th day of January, 2004, at the City of Winnipeg, in Manitoba.

"J. Elliott"

Judith A. Elliott, Provincial Judge

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **CLAYTON SCOTT**

EXHIBIT LIST

Exhibit No.	Description
1	Letter from Chief Medical Examiner dated July 11th, 2001 ordering the Inquest
2	Medical Examiner's report regarding cause of death
3	Curriculum Vitae of Sergeant J.H. Hiebert
4	Two booklets of photographs - photographs taken at the scene and at the autopsy
5	Drawing of scene prepared by Sergeant J.H. Hiebert
6	Involuntary Admission Certificate for Clayton Scott dated December 22nd, 2000
7	Order for Return of Patient Absent Without Permission and Description of Person Absent Without Permission dated February 9th, 2001
8	Selkirk Mental Health Centre clinical file and chart re: Clayton Scott
9	General Incident Report dated February 9, 2001 re: missing extension cord

Exhibit No.	Description
10	Selkirk Mental Health Centre Psychiatric Nursing Assistant Position Description
11	General Incident Report regarding discovery of body of Clayton Scott dated February 11th, 2001
12	Statement of Denis Karatchuk dated February 11th, 2001
13	Personal notes of Denis Karatchuk regarding incident of February 11th, 2001
14	Selkirk Mental Health Centre Program Policy Manual
14A	Policy on Patients Absent Without Leave dated November, 1999
14B	Policy on Privileges for Patients dated June, 1998
14C	Policy on Patients Absent Without Leave dated January, 2003
14D	Policy on Observation – One to One dated June, 2000
14E	Policy on Observation Specified dated June, 2000
14F	Policy on Observation Record dated June, 2000
15	Statement of Vera Kowalchuk dated February 11th, 2001
16	Statement of Vera Kowalchuk (undated)
17	Selkirk Mental Health Centre Position Description Staff Nurse
18	Observation Records re: Clayton Scott (18 pages) January 10th to 21st, 2001
19	Vital Signs Records re: Clayton Scott December 21st, 2000 to February 9th, 2001

Exhibit No.	Description
20	Medication Administration Records re: Clayton Scott (7 pages)
21	Patient Progress Report regarding Clayton Scott December 21st, 2000 to February 11th, 2001 (16 pages)
22	Census of number of patients on ward February 9th to 11th, 2001
23	Order for Return of Patient and Description of Patient dated January 12th, 2001
24	General Incident Report regarding Clayton Scott absent from ward dated February 9th, 2001
25	Selkirk Mental Health Centre Information Packages made available to patients on admission and discharge
26	Selkirk Mental Health Centre Position Description Co-ordinator of Patient Services dated September 15th, 1998
27	Trust Fund records for Clayton Scott December 21st, 2000 to February 6th, 2001
28	Duties of Staff in Charge of Acute Admissions and Intensive Care Program P.M. and Weekends dated November 12th, 1993
29	Map of Selkirk Mental Health Centre and grounds
30	Pages from Communication Book February 5th to 12th, 2001
31	Occupational Therapy Initial Interview with Clayton Scott dated December 28th, 2000
32	Occupational Therapy Treatment Plan re: Clayton Scott December, 2000 to February, 2001
33	Occupational Therapy Treatment Plan for Clayton Scott May 11th, 1999

Exhibit No.	Description
34	Occupational Therapy Report re: Clayton Scott May 29th, 1997
35	Occupational Therapy Assessment and Recommendation re: Clayton Scott dated December 28th, 2000
36	Canadian Occupational Performance Measure re: Clayton Scott
37	Selkirk Mental Health Centre Position Description Occupational Therapist
38	Selkirk Mental Health Centre Position Description Activities Instructor II
39	Selkirk Mental Health Centre Position Description Social Worker dated June, 1999
40	Social Assessment re: Clayton Scott dated December 22nd, 2000
41	Social History re: Clayton Scott dated January 10th, 2001
42	Confirmation of Intake Assessment Appointment at Sara Riel for Clayton Scott on February 15th, 2001
43	Sara Riel Community Rehabilitation Program Referral Form re: Clayton Scott
44	Consent for Release of Information re: Clayton Scott
45	Curriculum Vitae of Dr. Clarke Wilkie
46	J.A. Hildes Northern Medical Unit Patient Summary re: Clayton Scott May 17th, 2000
47	J.A. Hildes Northern Medical Unit Patient Summary re: Clayton Scott February 7th, 2000
48	Selkirk Mental Health Centre Admission Report re: Clayton Scott dated December 21st, 2000

Exhibit No.	Description
49	Consent by Clayton Scott regarding treatment with Clozapine dated December 22nd, 2000
50	Physician's Order Sheet re: medication and blood work re: Clayton Scott December, 2000 to February, 2001
51	Selkirk Mental Health Centre Death Summary re: Clayton Scott February 12th, 2001 by Dr. Clarke Wilkie
52	Curriculum Vitae of Dr. Paul Barchet
53	Province of Manitoba Job Description of Director of Patient Program Delivery August, 2000
54	Summary of In-Services attended 2001 to 2003, Selkirk Mental Health Centre staff members
55	Memorandum re: Aboriginal Services Resourcing and Organization dated November 14th, 2002
56	Selkirk Mental Health Centre Services Provided to Aboriginal Patients
57	Selkirk Mental Health Centre Cultural Activity Programs dated April 5th, 2001
58	Evaluation of the Cultural Activities Program
59	Manitoba Telehealth Network Sites Map and Overview
60	CCHSA Recommendations and Responses re: Privacy of Patients dated November 20th, 2003
61	Title page of Selkirk Mental Health Centre General Policy Manual dated December, 2001
62	Selkirk Mental Health Centre Aboriginal Cultural Teachings booklet
63	Organizational Structure Manitoba Health

Exhibit No.	Description
64	Organizational Structure Selkirk Mental Health Centre
65	Pimicikamak Health Services Referral from Margaret Scott to Alex Blacksmith re: Clayton Scott dated December 11th, 2000
66	Housing Request re: Clayton Scott dated May 6th, 1999
67	Notes of Community Health Worker re: Clayton Scott December 11th, 2000
68	Pimicikamak Crisis Intervention Program file re: Clayton Scott (63 pages)
69	Cross Lake First Nation Crisis Intervention Program Statistics
70	Community Health Status Assessment of Cross Lake by Dr. Joel Kettner dated February, 1990
71	Winnipeg Free Press newspaper clipping re: video-link potential dated October 25th, 2003
72	Letter by Dr. Walter W. Rosser dated March 16th, 1999
73	Letter by Dr. Arthur Kleinman dated March 11th, 1999
74	Cross Lake Nursing Station file/records re: Clayton Scott
75	Press Release by Pimicikamak Cree Nation Declaration of Health Care State of Emergency March 16th, 1999
76	Cross Lake First Nation Health Services facsimile transmission sheet from Howard Halcrow dated November 21st, 2003
77	*The Social Services Administration Act* Residential Care Facilities Regulation dated November 14th, 1988

Exhibit No.	**Description**
78	Document prepared by Dr. Anton Meyer November 25th, 2003, providing overview of health services available to people in Cross Lake
79	*The Houston Case Control Study of Nearly Lethal Suicide Attempts*