THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST
RESPECTING THE DEATH OF SHERRILL WILFRED FORBISTER

Having held an inquest respect the said death on October 30th and 31st, November 1st, 2nd and 3rd, 2006 at Norway House in Manitoba, I report as follows:

The name of the deceased is SHERRILL WILFRED FORBISTER

The deceased came to his death on the 16th day of October, 2003 at approximately 11:07 a.m. at Norway House in Manitoba.

The deceased came to his death by the following means:
Alcohol and Diphenhydramine Overdose.(see Schedule 1)

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

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

Dated at the City of Thompson, in Manitoba this 21st day of August, 2007.

_____
Provincial Judge Brian Colli

Copies to: Chief Medical Examiner
Chief Judge of the Provincial Court of Manitoba
Minister in charge of administration of the Fatality Inquiries Act

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SCHEDULE 1
TO REPORT ON INQUEST
RESPECTING THE DEATH OF SHERRILL WILFRED FORBISTER

I. Holding of Inquest

On October 16th, 2003, members of the Norway House R.C.M.P. Detachment arrested Sherrill Wilfred Forbister. They transported him by motor vehicle to the police detachment. Upon arrival at the detachment, police discovered that he had stopped breathing. Despite efforts at resuscitation taken consecutively by police, emergency medical transporters and medical staff at the Norway House hospital, he was pronounced dead about two and one-half hours after his arrest.

The Chief Medical Examiner of the Province of Manitoba by letter, dated June 1st, 2004, directed that an inquest be held into this death to "fulfill the requirement for a mandatory inquest as defined in Section 19(3)" of the Fatality Inquiries Act. That subsection reads as follows:

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

The purposes of the inquest are two-fold:

1. to determine the circumstances under which the death occurred; and,
2. to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

Three parties applied for and obtained standing as interested parties to the inquest, namely, Ms Valerie Forbister, wife of the deceased ultimately represented at the inquest by Ms Kate Kempton, the Royal Canadian Mounted Police represented by Mr. Brian Hay and Ms Pamela Tait-Reaume, daughter of the deceased, who appeared on her own behalf. Ms. Breta Passler acted as counsel to the Inquiry. The Inquest began hearing evidence on October 30th,

2006. Over the next 5 days, I heard the evidence of the witnesses and received most of the exhibits detailed in an attached schedule. The Inquest was adjourned on November 2nd, 2006 to obtain further information and determine if there was a need to hear from further witnesses. On February 9th, 2007, I received all but one of the remaining exhibits and heard final submissions from the parties on the issue of recommendations I might make in my report. I re-opened the inquest on August 17th, 2007 for the purpose of receiving into evidence the interim report of the Ombudsman on the Denis St. Paul Inquest.

I make a comment on the delay experienced in commencing this inquiry. Some of the two and one-half year delay is attributable to scheduling an inquiry involving 3 lawyers who are very busy. Most, however, is attributable to backlog that the Provincial Court is experiencing in northern Manitoba.

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

The following witnesses, seventeen in number, gave evidence on topics as outlined below:

1. events leading up to and surrounding the detention of the deceased
   - Valerie Forbister
   - Robin Lynn Forbister
   - Derek Bruce Forbister
   - Patrick Carl Scott
   - James Robert Forbister
   - Cory Murdock Scribe

2. events occurring between the time of the deceased's detention and his transport to hospital
   - Marshall McGregor
   - Kelly MacQuarrie
   - Cpl Derrick McDiarmid
   - Sgt. Wade Gabriel
   - Patrick Carl Scott

3. Events occurring between the time of the deceased's transport to hospital and pronouncement of death
   - Dion Anderson
   - Dr. Barend Van Jaarsveld

4. Medical Cause of Death
   - Dr. Balachandra
   - Dr. Barend Van Jaarsveld

5. Incidents of Alcohol Poisoning
   - Dr. Balachandra

6. Police Resources in the Community
   - Wade Gabriel
   - Chief Marcel Balfour
   - Sgt. William Tewnian

7. Substance Abuse Programming in the Community
   - Chief Marcel Balfour
   - Susie Albert

8. Emergency Response Resources in the Community
   - Dion Anderson
   - Chief Marcel Balfour

9. Medical and Hospital Resources in the Community
   - Dr. Barend Van Jaarsveld

10. Police Policy and Practice
   - William Tewnian
   - Sgt. Wade Gabriel

I will discuss the evidence in some, although not all, of these areas in more detail later in this report.

There are a lot of inconsistencies in the accounts given by the witnesses as to the events leading up to Mr. Forbister's detention. I don't intend to resolve those conflicts because their resolution would not affect any recommendation I make.

I think it is sufficient to provide a brief summary of the events in order to establish a factual foundation for the recommendations.

Mr. Forbister drank copious quantities of alcohol during the late evening of October 15th and continuing into the morning of October 16th. He did so in the company of a group of younger men, two of whom were his sons and most, if not all, of whom had also consumed excessive amounts of alcohol and/or an illicit drug. Two RCMP officers arrived at the Forbister home during the morning of October 16th, 2003 to investigate calls they had received concerning Wilfred Forbister. There they were confronted with a chaotic situation. I mention only a few of the details. First, and not surprisingly, they came into contact with individuals who were not co-operative with their investigation. They struggled with one whom they sought to detain resulting in injury to that person. Two young men, including the injured man, escaped from their custody. Another broke one of the windows in the police vehicle to assist the injured person to escape. She along with others angrily interfered with their attempts to re-secure the injured individual. Circumstances were such that that they found it necessary to seek and obtain back-up.

Amidst this chaos, police located Mr. Forbister in an outbuilding. He was lying on the floor, shirtless and incontinent, with fresh blood near his eye, snoring. He responded to police by "growling or moaning". He was not able to speak coherently. He was unable to walk on his own. He, at times, appeared resistant, stiffening his arms, clenching his fists and swinging his body and police did struggle with him but I have every reason to believe that this "resistance" was nothing more than the product of a confused and disoriented mind. Most of the difficulty police had with him resulted from the fact that he was a large man who was unable to assist himself. He was unable for example to sit upright in the police vehicle and so the officers ultimately simply laid him out on the seat and swung his legs around so that they were able to close the door.

They arrested him and transported him to the police station, checking on him once to discover that he was "snoring". At the detachment, he was removed from the back of the truck. He wasn't breathing. Several officers and one flight nurse who happened by administered CPR until the emergency medical responder team arrived with the ambulance just over 20 minutes after police called them. They detected a weak pulse at first but en route to the hospital it stopped and thereafter, despite valiant efforts by the EMRs and hospital staff, he died. Mr. Forbister was pronounced dead at 11:07 a.m. on October 16th, 2003, about 90 minutes after his arrival at the hospital.

III. Cause of Death

Alcohol is toxic to the human body. People die from alcohol poisoning every year.

Alcohol's physiological effect is simple; it paralyses the muscles. If sufficient quantities of alcohol are consumed by an individual, that person's breathing will slow and, ultimately, stop. What level of alcohol is sufficient to lead to the risk of death varies from person to person? Dr. Balachandra expressed the opinion that a blood alcohol level of .300mgs./ml. is dangerous and .400 mgs./ml. is "likely fatal" to most individuals. There are cases, however, where individuals have attained .500 or even .600 mgs./ml. without suffering adverse effects. On the other hand, a level of .200 mgs./ml. may be dangerous to some individuals who have little or no prior exposure to alcohol.

In this case Dr. Balachandra, the chief medical officer for the Province, conducted an autopsy of the deceased and came to the conclusion that death resulted from an overdose of alcohol and diphenhydramine. His conclusion was based on the concentration of alcohol found in the deceased's blood and vitreous, the concentration of the drug diphenhydramine in the deceased's blood and the fact he did not discover any other cause of death. There is ample evidence to support his conclusion. Mr. Forbister's blood alcohol concentration was 415mgs/100 mls. more than five times the legal limit for operating a motor vehicle. Of some limited interest is the fact that Mr. Forbister, at the time of

death, was continuing to absorb alcohol into his blood stream at a rate faster than his body could eliminate it. The diphenhydramine concentration was 1142 ngs/ml., more than 11 times the concentration of a therapeutic dose. According to both Dr. Balachandra and Dr. Van Jaarsveld, the physician who attended Mr. Forbister on his admission to hospital, this blood alcohol concentration is at least dangerous and more often than not lethal in and of itself. The diphenhydramine level, while well-above a therapeutic level, was not so high as to itself produce death. It would have required about five times the level found in his blood to produce death. Because it has similar side-effects to alcohol, though, it contributed to his death.

IV. Factors for Examination

Introduction

In making recommendations, I intend to focus on the facts that existed at the scene and within the community and consider what action might be taken by the Province or its agencies to avoid similar tragedies in future. I am cognizant that there is much in this world that is not good and that needs changing and there is much that, though good, could always be improved upon, some of which I heard about at this inquest. I will not however be making any recommendations addressing those matters even though I might consider them woefully deficient unless I am satisfied that the deficiencies contributed to the death in this case.

I am also mindful of the jurisdictional limits on inquiries conducted under the Act, limits which my colleague, Lerner PJ considered in the *Fiddler Inquest.* During the course of this inquiry, I did hear some evidence on matters which fall within federal authority. In the circumstances of this case, however, I can only make recommendations to the Province or its administrative or regulatory bodies. While I may comment on the evidence that I heard, I will not be making any recommendations addressing matters unless they fall within the authority of the Province.

There are two ways whereby this death might have been avoided. Mr. Forbister might have been saved if he had received medical attention sooner than he did. His death could have been avoided if he had not consumed alcohol excessively or at all.

The first proposition is based upon the evidence of Dr. Balachandra. He testified that Mr. Forbister might have been saved if he had arrived at the hospital breathing and with a pulse. In his opinion, Mr. Forbister had no chance once he stopped breathing and that had already happened by the time the police vehicle arrived at the detachment. The second proposition is self-evident.
I will examine each of these propositions in turn.

A. Quicker Medical Attention

Mr. Forbister was a critically-ill man by the time police discovered him in the outbuilding. Even so he did not arrive at the hospital until 9:39 a.m., an hour or so after the police discovered him in the outbuilding. Between these times, the following significant events occurred: 9:00 a.m. police left the scene with Mr. Forbister, 9:10 a.m. police discovered Mr. Forbister had stopped breathing, 9:11 a.m. dispatch notified the ambulance to attend to the police station, 9:33 a.m. the ambulance arrived at the police station. With the exception of the latter two, which I take from the evidence of Dion Anderson, the times are best estimates.

There are two delays that I will consider. The first and critical delay occurred between the time police found him and recognized that he was in crisis. The second is the delay of the emergency team in responding to the call by police for help. I will consider the emergency response time first.

1. Emergency Response Time

Twenty-two minutes elapsed between the time that police called for emergency assistance for Mr. Forbister and the arrival of the ambulance at the detachment. According to the evidence of Mr. Dion Anderson, supervisor for emergency services for Norway House, this response time is much slower than the average response time for the community of Norway House (10-15 minutes) which itself is slower than the average response time for the Province (9 minutes).

Why did it take as long as it did for an ambulance to arrive? While the community of Norway House has 2 ambulances, the emergency service only staffed one during the day (8:30 a.m.-4:30 p.m.). Beyond that, the service relied on volunteers who were called upon to answer all calls during the evening and night and for supplementary assistance during the day. The one and only ambulance staffed on the day in question was en route to the hospital with the young man injured in the struggle with police when dispatch broadcast the call. When Mr. Anderson, who happened to be working as an emergency medical responder, heard the dispatch, he requested that volunteers be located to respond to the call so that his ambulance could complete the call that it was on. As luck would have it, locating volunteers saved no time because both ambulances, one with volunteers, the other with paid staff, arrived at the police detachment at the same time.

Could things be done differently so that the response time was within an acceptable range? I think there is no doubt of that. If both ambulances had been staffed, the response time would have been reduced by the amount of time it took to call volunteers and muster them at the station. Instead of 22 minutes, I would expect the response time would have been within the average response time for the community, if not the Province. It makes sense to me that if an emergency service has 2 ambulances they should both be staffed so that each

can respond to calls as they come in. Given the population of Norway House, I would be surprised if both ambulances would only rarely be both in use. And indeed, the fact that they are not both staffed I think is reflected in the higher average response time in the community as compared to the Provincial average.

Since this incident, the emergency response situation within the community has in some respects worsened. In 2003 there was provision for the use of the second ambulance as needed with the help of on-call volunteers. Now, as a result of budget cuts, no pretense is made of using the second ambulance at all. Only one ambulance has staff, paid or otherwise, which of course means that one team of emergency medical responders answers all calls within the community in any one shift. This situation, of course, results in increased stress and fatigue on the emergency medical response team because they are expected to answer each and every call and do what they can regardless of the circumstances.

I was told that the salary of the paid staff is inadequate. I was not told how inadequate it is or how it compared to professionals occupying similar positions with similar duties in other places within the Province. I was also told that funding for training of both staff and volunteers is inadequate. How inadequate it is was not particularized although Mr. Anderson did indicate that access to training funds seems to be more a product of chance than planning.

I was told however of one positive change and that is the implementation of a first response program, involving attendance to calls by a team of emergency medical responders to complete an assessment and start any necessary procedures in advance of the ambulance. The first response team has much quicker response time than the ambulance service.

Overall however, I am concerned about the trend of budget cuts and resulting reductions in service. These matters concern me because collectively they suggest that the emergency service program in the community is operating at the edge. The average response times exceed the provincial average and cuts to the program can only worsen the situation. Quick response times to emergency calls may mean the difference between life and death.

It didn't here, though, because, according to the evidence of Dr. Balachandra, Mr. Forbister, to have a reasonable chance of survival, would have had to enter the hospital breathing and with a pulse. He had stopped breathing in the police vehicle at or just before his arrival at the police detachment. Valiant efforts were made to resuscitate him without success. I was not told that those efforts were in any way deficient. For that reason I conclude that, even if the emergency responders had arrived at the scene within the provincial average response time, Mr. Forbister's fate was sealed.

But for that conclusion, I would have sought further evidence dealing with the provincial average response time and what systemic changes might be contemplated to improve the response time within the community of Norway House. I would have also sought to hear from the federal authorities in terms of the funding of the emergency response service in Norway House. Even so, based on the evidence that I heard, I feel comfortable making the following comments for consideration by Provincial authorities although I do not make them by way of formal recommendations.

The emergency response program in the community of Norway House is primarily the responsibility of the federal government but there is scope for the involvement of the Province. I was told that the Norway House Emergency Services responds to about 1600 calls per year (which amounts to 4.38 calls per day although, of course, the calls would not be evenly distributed amongst shifts let alone days). About 20% of these calls involve attending the non-reserve portion of the community and that is so even though the non-reserve population is about 5% of the total population of greater Norway House. I was told that the Province does not contribute in any way to capital funding for the emergency services program, including training which, to the extent that it builds expertise within the program, is a capital expenditure. The Province might well consider making some contribution to the program given its primary responsibility for health care of the non-treaty population. It should also consider whether it is providing adequate funding for any ongoing costs of the service attributable to that portion of the community for which it has primary health care responsibility. Given the stresses that exist on the emergency response service, such contributions may make a difference to it, although I have no reason to believe that it would be a panacea.

2. Police Actions

Here I focus on the officers' decision to detain Mr. Forbister in cells without seeking a medical opinion. Could Mr. Forbister have been saved if police, upon leaving the scene, had, instead of turning in to the police station, continued on to the hospital a few minutes further up the road? There is no doubt that Mr. Forbister would have arrived at the hospital 20 minutes sooner than he did. Would that have made a difference? Probably not given that he had entered respiratory collapse by the time of his arrival at the police station. What if, however, his condition had been given a priority that police policy suggests that it should have had? Would the police have left the scene a little sooner, traveled a little more quickly? If they would have, it might have been a close call. I may be indulging in conjecture but, for the purpose of the inquest, I am prepared to conclude that the decision to detain Mr. Forbister without seeking a medical opinion contributed to the risk of death in this case. I therefore will consider the police actions with a view of making formal recommendations for change that might have increased Mr. Forbister's chances and that might in future increase the chances of others who find themselves in a similar plight.

I therefore turn to the decision of the attending officers. I have no doubt that the officers made the decision that they did because they believed that Mr. Forbister was not in crisis and that medical intervention was not required. While this opinion was formed honestly and in good faith, it was erroneous. More to the point, the decision reached to lodge Mr. Forbister in cells without seeking medical attention was not in accordance with the policy of the R.C.M. Police applicable, in my assessment, to the facts of this case, and that was so because the officers were not fully aware of it.

I have already alluded to the existence of the policy. Here is an extract from the primary policy touching on this issue found in the Force's national operational manual.

> *19.2 Assessing Responsiveness/Medical Assistance*
>
> *1.1 It is the responsibility of the first member on the scene to complete an assessment of responsiveness. See App. 19-2-1.*
>
> ***C.*** *If there is any indication that a person is ill, suspected of having alcohol poisoning, a drug overdose, or ingested a combination of alcohol and drugs, concealed drugs internally, or sustained an injury, seek* ***immediate*** *medical assistance.*
>
> ***D.*** *If you locate a person* ***who is not able to walk or talk*** *and the person cannot be roused by speaking to or touching him/her, check for:*
>
> ***1.*** *airway blockage,*
> ***2.*** *irregular breathing,*
> ***3.*** *erratic pulse or no pulse*
> ***4.*** *injuries,*
> ***5.*** *medic alert bracelet*
> ***6.*** *responsiveness to a mildly noxious or painful stimulus, e.g. reaction to pressure applied just behind the ear.*
>
> *A. If you observe any conditions outlined in sec. 3.2, initiate first responder first aid/CPR and seek immediate medical assistance. If possible bring medical assistance to the scene.*
>
> (emphasis mine.)

Appendix 19-2-1, incorporated by reference into it, elaborates upon the policy. The appendix , admirable for its clarity, is a simplified flow chart ("the rousability flow chart") that both indicates the technique to be used in assessing consciousness and the level of consciousness that is required to avoid the necessity of seeking a medical opinion. In a nutshell, the subject of the assessment must be fully oriented and capable of responding to commands. If the subject does not awaken in response to verbal or painful stimulus or, even if

apparently conscious, is non-responsive to simple questions or to simple commands, medical assistance is required. Moreover, it explicitly states that if the officers are in doubt they must call for immediate medical assistance.

What is its purpose? I think it can be inferred from its elements. The first officer at the scene has the responsibility to conduct an assessment to determine if any person there requires medical assistance. If any person demonstrates a lack of consciousness or breathing difficulties, or lack of orientation, medical intervention is required. While it mentions specific medical conditions such as alcohol poisoning or drug overdose, it is not specific to those conditions. It is the symptoms mentioned in the policy, including the flow chart, which trigger the need for medical intervention. Finally if there is doubt, medical intervention is required. From these factors I infer that the policy has, as a whole, the purpose of making police resources available to assist in facilitating the provision of medical attention to those who are or *may be* in need of same. I suspect it is forged in part from sad experience. Police, after all, are often, as they were in this case, the first or first responsible individuals who happen upon those who have put themselves or have been put by others in harm's way. It is clear from the policy that the officers are not to act as diagnosticians. They are to act as funnels to, not gatekeepers of, the health care system.

I conclude that the policy was not followed here because Mr. Forbister was at best only semi-conscious throughout the events. That being so, the policy mandated an assessment of responsiveness in accordance with the "rousability" flow chart. While the officers assessed Mr. Forbister for the purpose of determining his suitability for detention in cells without recourse to medical opinion, that assessment did not include asking the questions and giving the commands contemplated by the policy. I do not think there can be any doubt that Mr. Forbister would have cleared this assessment if it had been completed in accordance with policy.

The officers did not apply the policy because they weren't fully aware of it. In fact neither of them had ever seen the "rousability" flow chart by the time of these events. That is not so because of indolence or lack of concern on their part. Both officers impressed me as being caring and diligent. I am convinced, rather, that their lack of familiarity with the policy results from a combination of a lack of support for individual members in the field and the extreme working conditions existing at the Norway House Detachment.

I was advised several times during the course of testimony of the Force's expectation regarding knowledge of policy by its field officers. In a nutshell, it is this: Members operating in the field are expected to know operational policy; if they don't know it, they are expected to learn it as soon as possible. Is this expectation reasonable given that the operational policy of the Force issued at the National, Divisional and detachment levels, as one might expect, is voluminous. Sgt. William Tewnian, a policy analyst for D. Division of the RCMP,

estimated that, if printed, the operational policy would fill 5-6 volumes and, if the extract I was provided is representative of it, it would not be in large print. As well, is it reasonable given that changes to it occur regularly (monthly or bi-monthly)? It seems to me that the reasonableness of the expectation depends upon the support provided to its officers to learn and apply policy.

That support takes the form of making operational policy, including any changes to it, accessible to officers in the field. The policy is available on the internet and all detachments have internet access. Detachment commanders provide as much support as they can in keeping their officers abreast of policy usually by some form of distribution or posting of it within the detachment. I gather from the evidence, though, that knowledge and familiarity with operational policy is, by and large, a product of individual initiative and the experience of each officer in the field because police cadets do not receive any formal training on it. In other words, officers in the field, for the most part, learn what policy is and how to apply it by reading the operational policy manual and asking questions of others or having it drawn to their attention by their colleagues in the field when particular situations arise.

This reliance on personal initiative and experience in the field is reasonable and non-problematic only if certain assumptions are made. They are:

1. that officers in the field have sufficient time to read policy while working within a detachment
2. that policies are more or less of equal weight in terms of their significance and urgency
3. that all members will either clearly understand the policy if they read it or, in the alternative, will know enough to inquire about the correct interpretation of a policy that they do not understand.

Not all of these assumptions are valid and none of them are valid all of the time.

In the case of Norway House detachment, at least, officers do not have sufficient time to read and learn policy. I heard a lot of evidence describing the extreme working conditions existing for RCMP officers within the community. On the one hand, the detachment was faced with an increased incidence in crime and other matters requiring police attendance. On the other, support to it had been reduced. The Band Constable program was severely cut. The detachment did not have adequate support staff. Members had to attend all calls, many of which were formerly handled by the band constable program. The detachment commander who occupies, at least in theory, an administrative position was answering calls himself regularly. All officers put in overtime. (Sgt. Gabriel testified that he questioned any claims of overtime ***under*** 20 hours per pay period.) Officers were doing their own clerical work. I was advised that proactive police work in the community was practically non-existent as all available resources were taken up responding to calls. I could but need not go on

because this subject has already been commented upon by my colleague Stewart PJ in his report on the inquest into the death of Dennis St. Paul. Suffice it to say that I echo his comments and recommendation regarding the provision of further police resources to that community. I heard from several of the officers serving in the detachment at the time, many of whom stated that they did not have time to read much policy. Given the conditions existing then, I have no doubt that that is so. Bearing in mind that most officers were junior and many in their first posting, how can it be reasonable to expect those officers to know policy and to correctly apply it in emergent circumstances?

Have things improved? There was some improvement in police resources by the time that this hearing commenced. At the time of these events, the Norway House RCMP detachment had ten operational positions, consisting of eight constables and one corporal (one other constable was, for internal reasons, not available for duty). Since then, two additional positions have been added (one constable position and one corporal). The most significant improvement, however, occurred in the band constable program to which funding was restored to undo most of the cuts previously made to it. I hasten to add that additional funding was not provided by the federal government. Instead the Chief and Counsel made some hard decisions and decided to cut funding to other programs. In other words, the band is paying the price for more police resources by reducing other social services including the emergency service program discussed earlier in this report. Because I would not describe Norway House as being over-resourced in any social service, I do not consider cutting social services as being the best method of financing increased police resources. Surely a community that already knows enough about deprivation should not have to subsidize basic policing through infliction of further deprivation.

There is reason, however, for some optimism for further improvement given the contents of the interim report of the Ombudsman on the St. Paul Inquest recommendations dated June 18th, 2007. I quote from that report as follows:

> *"In consultation with the Province of Manitoba, the RCMP has increased its policing resource establishment in Norway House to 13 members from the 9 member establishment that was in place at the time of the shooting. The RCMP has recently advised that they are seeking funding approval in May 2007 for tenders to be sent out in June 2007 for the construction of two new housing duplexes (four units) tentatively scheduled for completion in late fall 2007. When completed, they anticipate staffing these units with between 4-6 new policing resources. The completion of these housing units will allow for the continued staffing of the Norway House detachment to reach the recommended establishment of 19 members. In the interim, on an as required basis, the RCMP continues to employ temporary deployments and newly arrived and as yet unassigned cadets to cover off any immediate operational policing priorities that are identified".*

I urge the Province to continue its efforts at improving police service to the community of Norway House to an acceptable level as soon as possible.

Not all policies are of equal weight. Some address routine matters; others bear on matters of life and death. Officer safety and the provision of medical attention to those in need are examples of the latter. In busy detachments, particularly when those detachments, such as Norway House, are comprised of junior officers, officers will not necessarily have the time to read and learn policy or to inquire about it before being required to handle an emergency. The chaotic situation confronting the officers at the scene here typifies the type of emergency where there is no time to inquire about policy that is not fully known and appreciated by the officer.

Finally, reliance on self-teaching and experience assumes that officers who may have read the policy or had it brought to their attention in the past have correctly interpreted or have been provided the correct interpretation of it. Here both officers, one of whom was not junior in experience, were generally aware of the policy of assessing individuals at the scene for the purpose of determining whether medical assistance should be sought but neither was fully familiar with it.

While I understand that experience is a valid method of training and that formal training on all policy is neither practicable nor, given the nature of policy to change, efficient, it strikes me that certain “core” policies, and by that I mean policies applicable to emergent situations in which human life or safety is or may be at stake, should be the subject of formal training. Knowledge of its existence, its details and how to apply it should not be left to individual initiative or experience of members in the field. Familiarity and understanding of it should be a requirement of all field officers before they enter the field.

I therefore make the following recommendations:

1. “Core” policies of the RCM Police, as previously defined, should be identified for the purpose of developing formal training for all cadets and all field officers. I will not elaborate on the nature of the training or its delivery. It seems to me that several existing courses which touch upon core policy (eg. IMIM training) could be easily adapted to accommodate its delivery.

2. In future no cadet enter the field without verification of his/her understanding of “core” policy.

3. That every step be taken to implement the recommendation of Judge Stewart in the St. Paul Inquest regarding the provision of adequate police resources to Norway House as soon as possible.

B. Excessive Alcohol Consumption

Mr. Forbister died because he drank a staggering amount of alcohol. His case is not unique. In the 5 year period from 2000-2004, 75 people in Manitoba died from the same cause. I confess that this statistic surprised me. I thought it would be lower. What surprised me more, however, is that there seems to be no connection between the incidence of death from this cause to factors such as race, age, gender, geography or socio-economic status. What can be done by the Province to reduce the incidence of death associated with this cause? There are two areas that I will canvas, namely public education on the risk of death associated with the use of alcohol and assistance to the community of Norway House in relation to alcohol abuse.

1. Public Education

My impression is that there is a need for public education on the risk of death associated with the abuse of alcohol. I say this not only because I was surprised by the frequency of death in the Province from this cause but also because of Dr. Balachandra's evidence that the frequency of death is not well-known. To me it is self-evident that information and education on health risks may modify behaviour. The more information that an individual has on a health risk the more likely he or she is to be influenced by that risk. Similarly, individuals are more likely to be influenced by more specific information simply because they are more likely to personalize it. Therefore, more information is better than less and more specific information is better than less in achieving the goal of public education. Because alcohol abuse poses a significant challenge to public health and because the Government of Manitoba has a responsibility of providing health care to its citizens, the government has a responsibility to ensure that information on this risk is available to the public.

I am concerned that relevant and important information collected by the government may not be accessible to the public. Dr. Balachandra advised during the course of his testimony that statistics on the incidence and frequency of death are readily available to his office. I think it fair to say that he agreed that the provision of this information to the public could play an important role in educating the public on the risk of death associated with abuse of alcohol. He advised, however, that he felt constrained in releasing this information because of privacy laws. I was provided with statistics relating to the gender and age of those individuals who died from alcohol poisoning. No statistics were provided relating to the other factors mentioned by him in his evidence.

Quite frankly I find this lack of public access to information surprising. I am disappointed with the constraints placed upon the Chief Medical Examiner's Officer in supplying information to the public. Privacy laws are intended to protect the identity of individuals. I see no conflict necessarily arising from the respective roles of government in releasing information bearing on public health

and education, on the one hand, and protecting information at its disposal that would, if released, invade the privacy of individuals. Certain information is clearly non-identifying. The core statistic of 75 deaths in a 5 year period is an example of non-identifying information. Certain kinds of information on personal attributes of those who died, such as age, gender, and, in most cases occupation, are so generic that it too could be released. Some information, such as place of death, might be too specific, depending, of course, upon the place. But surely the region where the death occurred could safely be released.

Because there seems to be some uncertainty about the amount and nature of the information which may be released in conformity with the privacy statute, I recommend that the Department of Justice review with the Office of the Chief Medical Examiner the information at its disposal pertaining to deaths caused by alcohol poisoning to determine what information may be released in conformity with privacy law. Emphasis should be placed on developing a policy of maximum disclosure that is consistent with the provincial privacy statute.

The role of government in this area, in my assessment, goes beyond merely making the information available for public release. In order to further the goal of public health, the information ought to be disseminated as broadly as possible. This responsibility arises not only as a result of the Province's role in public health, but also because of its virtual monopoly on the lawful sale of alcohol in the Province. Consumers have a specific interest in the risks associated with misuse of the product they have purchased. I therefore recommend that the Department of Health and the Manitoba Liquor Control Commission jointly develop a strategy for publishing that information accessible to the public on deaths arising from alcohol poisoning to ensure its broad dissemination.

2. Assistance to the Community of Norway House

While the risk of death from alcohol poisoning may be no greater in one area of the Province than another, the impact of alcohol abuse has burdened some communities more than others. I need not elaborate on what the fallout of increasing substance abuse has been on those communities other than to say it includes higher crime and suicide rates, a greater incidence of ARND among children and more children in the care of child protection agencies. But this does not adequately communicate the human misery and suffering associated with it. Substance abuse destroys the dignity of those souls within its addictive grasp. It distorts and destroys human relationships. It is a corrosive evil within our society.

Norway House is a community that has borne and continues to bear more than its proportionate share of the human misery and suffering associated with substance abuse. Both the evidence in this case and my experience suggest that there are few individuals in that community who have not been affected, if not permanently scarred, by it. I heard evidence relating to the struggles of Band leadership to provide desperately-needed services to its citizens and the hard

choices faced by the Chief and Council in allocating insufficient dollars to a host of services directed at pressing social issues. I have already mentioned that the band constable program received more money at the expense of a cut to the emergency response service and that service was not the only program to suffer cuts. Another was the Community Wellness Program and that Program provides, amongst other things, counseling for substance abuse! Ms Kempton urged that I make a recommendation to the federal government that it increase financing for substance abuse rehabilitation services. I decline but not because they are not needed. They are. I do so because I have no jurisdiction to make it in the circumstances of this case. I refer again to the decision of Judge Lerner in the *Fiddler Inquest* who set out the circumstances where a recommendation to the federal government might appropriately be made.

That being said, however, the Province of Manitoba has a broad interest in the issue of substance abuse within the community. The Liquor Control Commission has some responsibility to encourage appropriate consumption of its product. In addition, the damages and costs of substance abuse do not fall exclusively in the federal domain. No community is an island unaffected and untouched by the problems of another. Communities are not vacuum-sealed to contain social problems within their boundaries. Even if the federal government is solely responsible for the health care of the substance abuser, the Province will undoubtedly be responsible for the education, health care or fostering of some of his or her direct or indirect victims and the costs of prosecuting the misbehaviour of the substance abuser.

Communities such as Norway House need to develop a plan, if they have not already done so, to address the rising incidence of substance abuse within the community. That plan should be aimed at much more than offering rehabilitation services to addicts. It should be aimed at changing acceptance and approval of alcohol abuse by that portion of the population who engage in it or who are at risk of doing so and at promoting moderation or temperance as a way of life for all. I did not hear that the community had developed a substance abuse strategy or action plan. That doesn't mean that it hasn't. In either event, however, the Province may be able to play a supportive role in the development or implementation of a substance abuse strategy. I therefore recommend that the Province of Manitoba and the Manitoba Liquor Control Commission provide some funding to the community of Norway House in furtherance of its alcohol abuse strategy or, if no cohesive strategy exists, provide seed money for the purpose of developing such a strategy.

V. Conclusion

From time to time throughout the course of this report I have alluded to the jurisdictional limits upon this inquiry. In cases such as these it is often difficult to formulate meaningful recommendations in the absence of the federal government or any of its agencies at the inquiry simply because it plays such an

important role in the provision of social services to First Nations communities. In this case, its absence constrained me from considering recommendations relating to the provision of police services to the community through a tri-partite agreement and limited the recommendations I considered with respect to the provision of other social services. I am of the opinion that the federal government should be invited to participate as a matter of course in any fatal inquiry where the death occurs in a First Nations community. Its participation will increase the resources available to the inquiry and make it more likely that meaningful recommendations will be made.

I thank all counsel for their participation in this inquiry and in particular their patience in awaiting this report. I single out counsel to the inquiry, Ms Breta Passler, for special mention. Her efforts went beyond the call of duty.

I attach hereto a summary of the recommendations made by me throughout the course of this report.

SCHEDULE 2
TO REPORT ON INQUEST
INTO DEATH OF SHERRILL WILFRED FORBISTER

SUMMARY OF RECOMMENDATIONS

1. Core policies of the RCMP, being those applicable to emergent circumstances in which human life or safety is or may be at stake, be identified for the purpose of developing formal training for all cadets and all field officers.

2. In future, no RCMP cadet be employed in an operational position of the force without verification of his/her understanding of core policy.

3. Every step be taken to implement as soon as possible the recommendation of Judge Stewart in the St. Paul Inquest regarding the provision of adequate police resources in Northern Manitoba.

4. The Department of Justice review with the Office of the Chief Medical Examiner that information at its disposal pertaining to deaths caused by alcohol poisoning to determine what information may be released to the public in compliance with privacy law. Emphasis should be placed on developing a policy of maximum disclosure that is consistent with the provincial privacy statute.

5. The Department of Health and the Manitoba Liquor Control Commission jointly develop a strategy for publishing that information accessible to the public on deaths arising from alcohol poisoning to ensure its broad dissemination.

6. The Province of Manitoba and the Manitoba Liquor Control Commission consider providing some funding to Norway House First Nation in furtherance of that community's alcohol strategy or, if no cohesive strategy exists, provide seed money for the purpose of developing one.

SCHEDULE 111
TO REPORT ON DEATH OF SHERRILL WILFRED FORBISTER

LIST OF EXHIBITS

1. Letter of Dr. Balachandra
2. Binder of materials (Black)
3. Enlarged photograph of portion of Norway House
4. Diagram
5. Rousability flowchart
6. Weather Report
7. 2004 “D” Division Resource Priority Listing
8. Curriculum Vitae
9. Crime Statistic Report
10. Correspondence
11. 2006 Correspondence
12. Norway House Policing 2004 Report
13. Report on Administrative Review
14. RCMP Policy National and Divisional
15. IMIM Policy and Diagram
16. Community Wellness Program documents
17. Transcript of Proceedings – Inquest of Dennis St. Paul
18. Graph and Chart – Acute alcohol deaths in Manitoba (2000-2004)
19. Provincial Policy Services Agreement, April 1, 1992