RELEASE DATE: May 21, 2014

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF:	*The Fatality Inquiries Act* C.C.S.M. c. F52
AND IN THE MATTER OF:	An Inquest into the death of:
	DONALD RAY MOOSE (DATE OF DEATH: October 2, 2009)

Report on Inquest and Recommendations of
Judge Robert Heinrichs
Issued this 15th day of May, 2014

APPEARANCES:

J. Negrea, Crown Counsel
B. Owen, Inquest Co-ordinator
I. Frost and J. Koch, Manitoba Justice, Civil Legal Services,
Counsel for Headingley Correctional Centre, Manitoba Corrections
N. Watson, Counsel for Dr. Atwal, Dr. Bowman and Dr. Waldman
K. Advent, Counsel for the Moose family
A. Gotkin, appearing on behalf of the Moose family

Manitoba

THE FATALITY INQUIRIES ACT, C.C.S.M. c. F52

REPORTED BY A PROVINCIAL JUDGE ON AN INQUEST

RESPECTING THE DEATH OF DONALD RAY MOOSE

Having held an Inquest respecting the death of DONALD RAY MOOSE on October 29 – 31, 2013, November 4 – 7, 2013 and November 12-15, 2013, at the City of Winnipeg, in Manitoba, I report as follows:

The name of the deceased is: DONALD RAY MOOSE

DONALD RAY MOOSE came to his death on the October 2, 2009, at the City of Winnipeg, in the Province of Manitoba.

The cause of death was atheromatous coronary artery disease with a contributing factor of elevated level of Amitriptyline/Nortripyline.

I hereby make the recommendations as set out in the attached report.

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

Dated at the City of Winnipeg, in Manitoba, this 15th day of May, 2014.

Original signed by:
Provincial Court Judge Robert Heinrichs

Manitoba

THE FATALITY INQUIRIES ACT, C.C.S.M. c. F52

REPORT BY PROVINCIAL JUDGE ON AN INQUEST INTO THE DEATH OF:

DONALD RAY MOOSE

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4) Ms Donna Miller, Q.C., Deputy Minister of Justice and Deputy Attorney General
5) Mr. Michael Mahon, Assistant Deputy Attorney General, Prosecutions Division, Manitoba Justice
6) Ms Jacqueline St. Hill, Director, Winnipeg Prosecutions
7) Ms Lorraine Prefontaine, Director, Specialized Prosecutions and Appeals
8) Mr. Russ Ridd, Director of Regional Prosecutions
9) Ms Colleen McDuff, Director of Regional Prosecutions & Legal Education
10) Ms Julia Negrea, Provincial Counsel to the Inquest with Ms. Betty Owen, Inquest Coordinator
11) Mr. Kris Advent and Mr. Saul Simmonds, Counsel for the Moose Family
12) Mr. Irvin (Issie) D. Frost and Mr. Jim Koch, Manitoba Justice, Civil Legal Services, Counsel for Headingley Correctional Centre, Manitoba Corrections
13) Ms Nicole Watson, Counsel for Dr. Atwal, Dr. Bowman and Dr. Waldman
14) Dr. C.D. Littman, Medical Examiner and Pathologist
15) Mr. Mike Anthony, Exhibit Officer, Provincial Court of Manitoba
16) Ms Aimee Fortier, Executive Assistant and Media Representative, Provincial Court of Manitoba

II. INTRODUCTION TO DONALD MOOSE

[1] At the time of his death, Donald Moose was thirty two years of age. He was loved by his family and friends. He was a son; his mother loved him and found him to be a tremendous help. She considered Donald to be her best friend. He was a brother, loved and respected by his sisters. He was a father to five children; he was proud of them and is sorely missed by them. He was an uncle; to some of his nieces and nephews, he was the father they never had.

[2] Donald was proud of his aboriginal heritage. Donald had a difficult upbringing and ongoing health issues, but he was always positive, believing that tomorrow would be better. At the time of his death, he was planning out how he would accomplish his goals and dreams upon his release from custody.

[3] Donald believed in education. He tried to get as much of it as he could. After obtaining his GED from Urban Circle, he obtained certificates in Conflict Resolution and Human Resources. He also received a Masters in International Project Management. He worked with aboriginal youth and was made the first ever Junior Chief by The Assembly of Manitoba Chiefs.

[4] Donald was respected and spoken highly of by his fellow inmates at Headingley Correctional Centre. He had the respect of the correctional officers who worked on his unit. As a result of how he was viewed by everyone, he was given the position of trustee on his unit at the Assiniboine Treatment Centre.

III. THE CALLING OF THIS INQUEST

[5] The Chief Medical Examiner for the Province of Manitoba, Doctor A. Thambirajah Balachandra, sent a letter bearing date October 18, 2011 to the Chief Judge of the Provincial Court directing that, in accordance with *The Fatality Inquiries Act* (the *Act*), an inquest be held into the death of Donald Ray Moose for the following reasons:

1. to fulfill the requirement for a mandatory inquest as defined in section 19(3) of the legislation;

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

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

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

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

IV. MANDATE OF THE INQUEST

[7] Inquests in Manitoba are governed by the *Act* and are presided over by judges of the Provincial Court of Manitoba. The duties and limitations of a judge presiding at an inquest are set out in s. 33 of the *Act*. The primary role of the judge at an inquest is to determine the identity of the deceased, when, where, and by what means, the deceased person died, the cause of death, the material circumstances under which the death occurred and whether the death could have been prevented. Further, a judge may recommend changes in the programs, policies or practices of the government and relevant public agencies or institutions or in the laws of the province, where the judge is of the opinion that such changes would serve to reduce the likelihood of deaths in similar circumstances in the future. There is no authority under the *Act* for a judge to make recommendations to private individuals, businesses or corporations.

[8] There is a statutory limitation placed on a judge presiding at an inquest in Manitoba. Section 33(2) of the *Act* prohibits a judge from expressing any opinion on or making a determination with respect to culpability in respect of the death that is the subject of the inquest. In other words, a judge at an inquest is not permitted to make a finding or express an opinion that someone is responsible for or legally blameworthy in the death of the person that is the subject of the inquest.

[9] The mandate of this inquest is to determine the material circumstances relating to Donald Ray Moose's death and to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

V. PRELIMINARY COURT PROCEEDINGS

A. STANDING

[10] The *Act* provides in section 28(1) that a person who "is substantially and directly interested in the inquest" may attend in person or by counsel and may examine or cross-examine the witnesses called. Standing Hearings were held on April 3, 2012 and March 15, 2013.

[11] On April 3, 2012, standing was granted to Saul Simmons and Kris Advent as counsel on behalf of the Moose family, with Albert Gotkin as the family representative and Irvin Frost and Jim Koch of Manitoba Justice, Civil Legal Services, as counsel for Headingley Correctional Centre, Manitoba Corrections.

[12] On March 15, 2013, standing was granted to Nicole Watson, as counsel for Dr. Atwal, Dr. Bowman and Dr. Waldman. No further individuals or organizations made application for standing.

B. THE MOOSE FAMILY MOTION

[13] On March 22, 2013, the Moose family filed a Notice of Motion, requesting:

1. An Order stating that Crown counsel is in conflict and cannot represent the Applicant in this matter.
2. An Order granting funding to the applicant with respect to legal fees for representation at the Inquest for the deceased.

[14] The Motion was heard by this Court on April 10, 2013 and a decision was given on May, 28, 2013. The Court dismissed the Motion, both with respect to finding that Crown counsel was in a conflict and in not granting funding for legal representation to the Applicant. The Court did, however, asked the Department of Justice to reconsider their denial of funding for legal representation for the Moose family.

VI. SUMMARY OF EVENTS AND AUTOPSY LEADING UP TO THIS INQUEST

A. SUMMARY OF EVENTS OF OCTOBER 2, 2009.

[15] On the 2nd day of October, 2009, Mr. Moose, who was a resident of the Headingley Correctional Centre, died at the Grace General Hospital in the City of Winnipeg, in Manitoba. At approximately 00:30 hours on October 2, 2009, the staff at the Headingley Correctional Centre were advised that Mr. Moose was disoriented and was having difficulty breathing. Mr. Moose was diabetic, and staff at Headingley Correctional Centre administered oral glucose to him at that time, resulting in some improvement in his condition. At 01:30 hours, Mr. Moose was taken by ambulance to the Grace General Hospital in the City of Winnipeg. Mr. Moose continued to have difficulties with his breathing, was

hypertensive and had a decreased level of consciousness. At 02:17 hours, Mr. Moose suffered a cardio-respiratory arrest, was resuscitated by hospital staff, and was then considered for admission to the intensive care unit. At 03:48, Mr. Moose had a second cardiac arrest. Despite prolonged resuscitation, Mr. Moose was pronounced dead at 04:06 hours on October 2, 2009.

B. SUMMARY OF AUTOPSY REPORT RE: CAUSE OF DEATH

[16] A medico-legal autopsy conducted on October 5, 2009, ultimately confirmed the cause of death as Atheromatous Coronary Artery Disease, with contributing factor of elevated level of Amitriptyline/Nortriptyline.

VII. TERMINOLOGY AND ABBREVIATIONS USED IN THIS REPORT

Corrections:

- HCC - Headingley Correctional Centre
- ATC - Assiniboine Treatment Centre
- CO or CO 1 - Correctional Officer
- CO 3 - Supervising Correctional Officer (can be a shift leader or unit supervisor)
- COMS - Corrections Offender Management System
- Code Red – called when there is a medical emergency or other incident happening
- Code Responder - CO's tasked with responding to a Code Red
- DS - Deputy Superintendant
- I/M – inmate
- Muster – daily briefing meeting during morning shift change
- Running Record Report - ongoing reports are recorded here in each inmate's running record.
- SOM - Shift Operation Manager

Medical:

- Alentex - the pharmaceutical company that dispenses medications for Corrections
- Atheromatous Coronary Artery Disease - The compromised function of the coronary arteries, due to an accumulation of deposits and swelling in artery walls. This is often white blood cells which have taken up lipids; these may appear as "fatty streaks" on an autopsy.
- BID – two times a day
- Cardiomegaly - an enlarged heart
- CNS - Central Nervous System

- DPIN – Drug Program Information Network
- Elavil - the registered trade name of the drug Amitriptyline
- EMS - Emergency Medical Services
- ER - Emergency Room
- HSM – Health Services Manager
- ICU – Intensive Care Unit
- IV - Intravenous
- MAR - Medical Administration Record
- Meds – prescribed medications which the inmates received
- ml or mL – millilitres
- ng - nanograms
- Pharmacokinetics - the science of how a drug is handled within the body: how it is absorbed, distributed, metabolized and excreted.
- Psych – Psychiatric
- RN – Registered Nurse
- The Whiteboard – Medical Office note board for the day's notes, including all daily treatments to be given and dressings to be attended to, as well as notes about which inmates are on suicide watch, in need of their blood pressure being taken, or in the methadone program.
- TDM - Therapeutic Drug Monitoring
- TID – three times a day
- Trough level - when a patient's serum levels are at their daily low-point

VIII. WITNESSES FOR THE INQUEST

A. CORRECTIONAL OFFICERS

1. Keith Murphy

a) Introduction

[17] CO 1 Murphy testified that that he has been a correctional officer at HCC for 10 years. In 2009 he was working at ATC. This was a choice he had made; he had requested to work there and had been given specific training for working in the unit, beyond the eleven week core training he received when he started at HCC. CO 1 Murphy explained that the work at ATC is different as it is a treatment centre; therefore, the correctional officers need to be able to be more interactive with the inmates as communication is essential.

b) September 30, 2009

[18] CO 1 Murphy was working the night shift from September 29, 2009 at 7 pm until September 30 at 7 am. From 11 pm on, only three corrections officers were on duty as the inmates were to be in their bunks, the lights having been dimmed. The

corrections officers on duty were responsible to do rounds every 30 minutes. This involved a walk through in each dorm. One officer would be at the entrance door to the dorm while the second officer did a check by walking past all of the bunks and punching the time clock at the far end of the dorm.

[19] In the early morning of September 30, CO 1 Murphy was doing a check in Dorm 2 when he saw that Donald was up and asked if he was okay. Donald told him that he was having trouble breathing. CO 1 Murphy had Donald step out of the dorm into the hallway. He then called the shift supervisor, CO 3 Tischer, to come and see Donald as well. The three of them discussed options, including a trip to the hospital, and a potential long wait to be seen, or to wait until the nurse could see him at ATC later in the morning and listen to his chest. Donald did not look unusual but was uncomfortable as he was having trouble breathing. Donald was not hunched over, he was not wheezing and there were no signs of distress. It appeared to the officers that Donald had a cold. Donald agreed to wait the four or so hours until a nurse could see him there.

[20] Within an hour of this contact with Donald, CO 1 Murphy entered a summary of what had taken place on Donald's Running Record Report. The report time is noted as 3:37 am and reads as follows:

Report time: 2009/09/30 03:37 *Report author:* #118415 MURPHY, K. *Report type:* Cust: Case contact

Outcome: N/A *Remarks:* Trouble Breathing

I/M Moose spoke to me when I was doing a Dorm punch and informed me he was having trouble breathing. I called C03 Tischer to come talk to I/M Moose. During the conversation I noticed that I/M Moose was talking normally and did not seem in any distress. I informed I/M Moose that if we were to take him to the hospital in the middle of the night that we would be waiting a very long time and he would be better off seeing the nurse in the morning so she could listen to his lungs. I/M Moose said he could breath well if he was sitting up. We gave him a few extra blankets from laundry so he could sit up a little better in his bunk. I/M Moose said he was fine with seeing the nurse in the morning.

[21] CO 1 Murphy explained this was only a summary, more was said during the conversation the three of them had. CO 1 Murphy testified that he chose to put this information in Donald's Running Record only; he could also have entered in the log book on the unit, but didn't.

[22] CO 1 Murphy testified that after the conversation with Donald, he kept an eye on him during the rest of his security rounds. During the following two rounds, Donald gave him the "thumbs up". His interpretation of this was that Donald was okay. On the third round, Donald was sleeping; he continued to sleep until 7 am. Extra blankets had been given to Donald, however, CO 1 Murphy can't recall if Donald used them to prop himself up in order to sleep.

[23] CO 1 Murphy recalled that at shift change that morning, during the muster, he told the other officers about what had happened with Donald earlier that morning. He

thought that Donald did see the doctor and the nurse that morning.

[24] CO 1 Murphy testified that Donald was not one of the inmates he case managed. He didn't know anything about Donald's medical condition and he did not have access to Donald's medical charts. He did not know that Donald was a diabetic, but believed that some of the other officers would have been aware of this. CO 1 Murphy thought that he likely only worked one other shift that week, from September 28 at 7 pm until September 29 at 7 am. He had not noticed any deterioration in Donald's condition that week, or in the weeks prior. However, he could only recall having contact with Donald at some point in time on an earlier date when Donald was mopping the floor one night. Donald did not appear to have any difficulty performing his job at that time. CO 1 Murphy had not been made aware of any complaints concerning Donald's health in the weeks leading up to his death, either by officers or inmates, had not noted any concerns in any of the records he'd read, and had not been told that Donald had slumped over a few nights earlier.

c) General Medical Comments

[25] CO 1 Murphy testified that the correctional officers are given medical information concerning the inmates on a "need to know" basis, for example, if an inmate has any allergies or is prone to seizures. Inmates come to the main pod at breakfast, lunch and supper times for their meds. There is a pill box with the names of inmates and their photographs on it to ensure that the right person is getting the right meds. Normally the nurses dispense the meds, but the officers also assist in this. When meds are dispensed later in the evening, around 10:30 or 11:00 pm, the officers dispense them. They are always careful and attentive, as meds can always turn into contraband if not taken; so they go so far as to looking into inmates mouths to make sure they have been swallowed. Safety is paramount at HCC and so random searches for contraband take place regularly. He estimated that complete searches are done at ATC once a week.

[26] CO 1 Murphy explained that there is a nurse on duty at HCC until 8 pm at night and after that medical concerns are dealt with by having the shift supervisor check in if there was a medical concern with an inmate; however if an emergency arose at any time, the Duty Office is called or a Code Red is radioed by any officer. He acknowledged that they have to make a judgment call on occasion, but they always err on the side of caution. He thought HCC made emergency runs to the Grace Hospital at least every other day, as a result.

d) Other comments

[27] CO 1 Murphy testified that there is some racial prejudice evident at HCC. At ATC it involves racial prejudice by inmates toward staff, but not by staff toward inmates. He believes that the staff is very professional and dedicated to working at ATC. When an incident by an inmate has arisen, the offender is immediately addressed by staff in

order to deal with the situation.

[28] CO 1 Murphy testified that the only recommendation he would make is that there be a nurse on call at HCC at all times.

2. Stacey Hauser

[29] CO 1 Hauser has been employed at HCC for more than 13 years and is currently a program facilitator. In October 2009 she was working as a correctional officer at the ATC. She was working a Monday to Friday day shift during this time and had extensive interaction with most of the inmates. She knew Donald quite well; they had general conversations and often talked about sports. She knew that Donald was a diabetic but could not recall if she had ever dispensed meds to him.

[30] In the days leading up to Donald's death she did not notice anything out of the ordinary with him. There were no changes in his skin colour or physical appearance that were a concern. As well, no inmate approached her with concerns about Donald; there were no suggestions that he had become sluggish or had a significant weight gain. If they had, she testified that she would have investigated the complaint or concern herself. As well, if any of the other correctional staff had noted a concern or been told about one, it would likely have been discussed or written up in the daily log book, and there was no discussion of the sort or any note recorded in the log book.

[31] When CO 1 Hauser was shown the Running Record Report for Donald for September 30, 2009, she testified that this was the first she'd seen it. She explained that the running records for each inmate are not something she would read every day - but if there had been a note in the daily log book directing the reader's attention to a particular inmate's running record; she would have found it and read it.

3. Damon Andrews

a) October 1, 2009

[32] CO 1 Andrews testified that he has been a guard at the Headingley Correctional Centre for 16 years. He was working at the Assiniboine Treatment Centre in October 2009. He worked a twelve hour shift from October 1 at 7 pm until October 2 at 7 am. On the evening of October 1, he saw Donald doing his job - mopping the floor - and stopped to talk to him. It appeared to him that Donald was fine at this point in time. He thought that he may also have seen Donald at med dispensing time that evening. CO 1 Andrews testified that he had not noticed anything unusual about Donald in the weeks leading up to his death; as well, he never heard anything from Donald, or anyone else, that Donald was having any difficulties or problems during those weeks. If something had come to his attention in the weeks leading up to Donald's death, he expected that he would have written it up in an incident report.

b) October 2, 2009

[33] At approximately 12:30 am on October 2, he heard a knocking on the dorm door. He and CO 1 McCarthy went to answer. Inmate Blacksmith was knocking at the door and they could see Donald on a cot with Inmate Brass holding him up. Donald's eyes were open and he was breathing rapidly. CO 1 McCarthy began asking Donald questions, but he was not responding. CO 1 Komyshyn joined in and called a Code Red over his radio. Soon the first responders and the shift leader, CO 3 Pollock, were there to assist. They took over Donald's care. CO 1 Andrews was tasked with obtaining the VHS tape for the video surveillance from Dorm 2. He believes it was the shift supervisor CO 3 Pollock who told him to do this. He dated the tape, put it in an evidence bag and brought it to the Duty Office in the main building.

c) Other Comments

[34] CO 1 Andrews testified that he got along well with Donald, who was not a 'complainer'. The reason Donald had the floor mopping job was because he had seniority on the job list and Donald would have requested this particular job.

[35] CO 1 Andrews testified that he had not seen any signs of racial prejudice in the course of his employment. If he had, it would have been addressed immediately.

[36] CO 1 Andrews was of the opinion that the medical concerns of the inmates were being addressed properly at the ATC and he had no recommendations for any needed changes.

4. Mark Komyshyn

a) October 2, 2009

[37] CO 3 Komyshyn has been a corrections officer at HCC for 11 years and in 2009 he was working at ATC as a CO 1. He worked a 12 hour shift from October 1 at 7 pm until October 2 at 7:00 am, together with CO 1 McCarthy and CO 1 Andrews. He was in a back office doing some paperwork when there was a knock on the window to the Dorm 2 door at 12:30 am on October 2. The other two officers were down the hallway in the pod; they arrived at the door first and opened the door to Dorm 2. The inmates were saying that something was wrong with Donald. He was conscious but non-responsive. Their initial assessment, knowing that Donald was diabetic, was that this was diabetic shock.

[38] CO 1 Komyshyn immediately went back to the office and contacted the shift leader, CO 3 Pollock to attend. He then went and retrieved a tube of glucose paste. When he returned, it appeared to the officers that Donald's breathing was laboured and he seemed to be getting worse. CO 1 Komyshyn called a Code Red over his radio so that the Code Responders would attend as well. Donald was on his bunk, hunched over, and having difficulty breathing. Donald recognized CO 1 Komyshyn and tried to say something, but couldn't. Within seconds, CO 3 Pollock arrived. He immediately

asked CO 1 Komyshyn to call the Duty Office to have EMS attend. CO 3 Pollock, who had been given the glucose paste, administered it to Donald and Donald was moved to the back office. Approximately ten Code Responders were present as well. One of them had brought the Code Red bag and video camera.

[39] In the back office Donald was more alert for a short while, perhaps a spike due to the glucose he had received, but then his condition deteriorated. They placed him on a mattress on the floor in the recovery position and kept watching him while waiting for EMS to arrive. When EMS entered the office area at 1:03 am, CO 1 Komyshyn was talking to Donald and continued talking to him as he was placed on the stretcher. Donald was coherent for some of this. EMS did a blood sugar test and stated to the officers that they did not believe this to be diabetic shock. The thought it might be a reaction to medication or misuse of drugs and asked the officers present if they knew whether anything like this was going on with Donald. After Donald left with EMS, CO 3 Pollock asked CO 1 Komyshyn to speak to some of the inmates to follow up on this and to retrieve the meds for Donald and put them in an evidence bag. The Incident Report, typed by CO 1 Komyshyn at 2:11 am, notes that he did speak to Inmates Beaulieu and Brass, but all they could say was that they did not think that Donald had taken any meds or drugs, other than his own, that night.

[40] That Incident Report also has a detailed time line for what happened with Donald that morning. CO 1 Komyshyn testified that for a Code Red call he would have latex gloves on and would write on them with a pen. He would keep referring to his watch to record the time and make brief notes. Later, when he took the gloves off, he transferred the information to a pad of paper until he could prepare the Incident Report. The following is his timeline as recorded in his Incident Report:

Case # 99897

Incident Report
Manitoba
Corrections

E1.4

General report
Author: #112642 KOMYSHYN, M.

Report time: 2009/10/02 02:11

I have recorded the following time lines of the incident:

-0030hours MCCARTHY and ANDREWS attend dorm 2 to investigate knocking on the window.
-0032hours duty office informed of situation.
-0035hours I called CODE RED ATC
-0037hours duty office was called and EMS was requested
-0040hours "instant glucose" was administered by POLLOCK
-0043hours MOOSE moved to back office and observed
-0045hours MOOSE questioned on (Name, Date, Location, Year) unable to answer correctly
-0050hours MOOSE laid on mattress in recovery position
-0053hours MOOSE sat up said couldn't breath having difficulty
-0055hours MOOSE asked same questions again un able to answer correct
-0058hours First responders arrive on unit
-0103hours EMS arrive on unit
-0110hours MOOSE place on stretcher
-0117hours MOOSE left the ATC and placed in ambulance.

Respectfully submitted
CO1 Komyshyn, Mark

b) His relationship with Donald

[41] CO 1 Komyshyn testified that he had a good relationship with Donald. He had first met him in 2007 or 2008 when Donald had been in custody at HCC, and then again for a number of months in 2009 before his death. He felt that the two of them had a connection. Donald was easy going, polite and courteous. He never complained. The two of them could talk about anything. They would talk about Donald's aboriginal culture and his Ukrainian culture. Donald was working on a plan for when he was out of custody; it appeared to CO 1 Komyshyn that Donald didn't minimize things; he wanted to change and improve himself. He knew that Donald was a diabetic, and gave him his meds from time to time. There never was an issue or problem with this. He testified that he is quite certain that if Donald had medical concerns that he would have mentioned this to a nurse, or even to one of the officers.

[42] Co 1 Komyshyn did not recall anything that stood out with Donald in the weeks prior to his death; however, he could also not recall how many shifts he had worked in those weeks**.** He did not see any change in Donald's colour, weight or condition. If he had noticed anything, he would have talked to Donald and to the nurse about it. He did read the log book every time he came on shift and attended the muster, so he was aware of the fact that medical staff had seen Donald a day or two prior to October 1. During the October 1 to October 2 shift; CO 1 Komyshyn could not recall seeing Donald before seeing him in medical distress at 12:30 am. He did not know if Donald had taken his meds that night.

c) Other Comments

[43] CO 1 Komyshyn testified that in his opinion the correctional officers had done everything they could have done for Donald that night. This was not a situation for a defibrillator as Donald was conscious, and he is not trained to use oxygen so he can't comment on whether or not it could have been used in this situation. CO 1 Komyshyn didn't believe that it would be practical to have officers trained in using oxygen, given the number of officers that would need to be trained and the limited use that would be made of. He did, however, recommend that having medical staff on duty later would be helpful; having 24 nursing would be even better. At present, shift supervisors are able to call the nursing staff after hours, but as the inmates' medical records are locked up; it is not necessarily ideal.

[44] CO 1 Komyshyn testified that there was some racism evident at HCC but it was in inmate to inmate situations. He had never seen any racism in relation to the staff.

5. Shift Operations Manager Michael Pollock

a) October 2, 2009

[45] SOM Michael Pollock is now a Shift Operation Manager at HCC. In the fall of

2009, he was a shift leader, referred to as CO 3 Pollock. He was at work on October 2, 2009 when he received a telephone call from CO 1 Komyshyn from ATC at approximately 12:30 am. It concerned an inmate, Donald Moose, and a potential medical emergency. They thought that he was in a diabetic shock situation and so they were asking for CO 3 Pollock to attend. He advised the Shift Operation Manager on duty at the time and left for the ATC. By the time he arrived at the ATC, approximately a minute later, he heard a Code Red being called over his radio.

[46] He entered Dorm 2 at the ATC and saw the inmate on a bottom bunk situated near the front entrance of the dorm. Two corrections officers were attending to the inmate. His recollection is that they were CO 1 Komyshyn and CO 1 McCarthy. The inmate was Donald Moose, someone he did not personally know. Donald was sitting up, but was teetering on the edge of the bunk. He had slurred speech and was breathing slowly, somewhat laboured. He was responding to the correctional officers to some extent; they were of the opinion that it was a diabetic emergency. CO 3 Pollock's assessment was the same as theirs; these were the classic symptoms of diabetic shock. He was told that Donald may have missed one of his medications. (He may have been told which one at the time, but cannot recall what it was now.) By this time the Code Responders were also present. CO 3 Pollock testified that he believed that there were 6 primary code responders on duty that night and that they were all present shortly after he arrived at the dorm.

[47] As a result of his initial assessment, CO 3 Pollock asked to have a tube of glucose brought from the first aid kit. He made the decision to administer it immediately as Donald’s level of consciousness was slipping; he was in a stupor. Donald was still sitting up, with a bit of help, when CO 3 Pollock gave him the glucose. Donald swallowed some of it and some ended up on his cheek and chin. There was almost no reaction from Donald and he was not improving, so CO 3 Pollock directed CO 1 Komyshyn to radio SOM MacLean in order to have emergency medical help called for. The correctional officers then brought Donald to a side office just outside of the dorm as his condition wasn't improving and this would give Donald more privacy for the paramedics when they arrived. With some help, Donald was able to walk to the office. The inmates in Dorm 2 had been quietly watching the events unfold.

[48] Once in the office, Donald's level of consciousness improved; he sat up a bit straighter and was able to answer some questions, though his speech was still somewhat slurred. The first responders and EMS arrived shortly after this. CO 3 Pollock can't recall who arrived first. They checked for vitals, and did some blood sugar testing. CO 3 Pollock outlined for them what had transpired and CO 1 Komyshyn filled in some more details; they passed on Donald's medical information as best as they could. EMS had trouble determining Donald’s blood sugar level, but did not think it was a diabetic shock situation. Within ten minutes of EMS's arrival, they had Donald on a stretcher and were taking him to the emergency vehicle. Two corrections officers were asked to join the paramedics on the trip to the hospital.

[49] During the conversation with EMS, the possible misuse of meds by Donald was raised. As a result, CO 3 Pollock conferred with CO 1 Komyshyn as to which inmates might be able to answer their concerns about this. Inmate Beaulieu and Inmate Brass were mentioned and so CO 3 Pollock and CO 1 Komyshyn took them out of the dorm to speak to them. The inmates told them that they did not believe Donald had been abusing meds. (In his Incident Report prepared that morning, CO 3 Pollock wrongly noted Inmate Brass as having another first name.)

[50] Later that morning the correctional officers who were with Donald at the hospital called CO 3 Pollock to advise that Donald was not doing well and they were looking for more information on Donald. As well, the Emergency Room Doctor from the hospital called the Duty Office to request more information. SOM MacLean spoke with Deputy Superintendant Wardrop and they made the decision to access Donald's medical file in order to fax the information to the hospital. This was an extremely rare situation. The smash box was accessed to obtain a key to the medical office. Donald's paper copy medical file was obtained and they faxed to the hospital the pages the Doctor was asking for. CO 3 Pollock wrote the cover page for the fax and the fax was sent at 3:02 am on October 2.

[51] CO 3 Pollock believed that family had been called during the time that Donald was at the hospital, but wasn't certain of the exact details. He did note that Donald had died at 4:08 am. When it was pointed out that one of the Inquest documents (Exhibit #2, E60.7) noted who SOM McLean called and when, he agreed: Donald's mother was called at approximately 3:55 am, after Donald had crashed for the second time, and a message was left for Donald's step sister at approximately 4:14 am.

[52] CO 3 Pollock had already had a corrections officer secure the video tape of Dorm 2; he now had Donald's medications and personal items from the dorm retrieved and secured as well.

b) Other Comments

[53] CO 3 Pollock testified that all correctional officers have CPR and First Aid training and are required to have regular CPR updates. Supervisors do not receive any further medical training; they have the same core training as any corrections officer. It is the responsibility of each shift leader to assign responders at the start of each shift. Back in 2009 the policy was for one of the responders to bring a hand held camera when a Code Red was called. However, at the time it was generally only used in special situations such as if there was a fight in progress or if there was use of force involved. It was not normally used for medical emergencies, due to privacy issues. That policy was changed approximately two years ago; a hand held camera is now used in medical emergencies until EMS arrives. CO 3 Pollock testified that he did not believe that the policy change came about as a result of Donald's death.

[54] CO 3 Pollock explained that in 2009 there were three cameras set up to record

in Dorm 2. They were fed into one recording through a multiplexer. At the time it was recorded on a VHS tape; since then it has been changed to an automated digital recording. There are newer and better cameras in place and the picture and recording are much improved. The video recording from Dorm 2 when he, CO 3 Pollock and the Code Responders attended to Donald in Dorm 2 that morning was played in Court. While it is a choppy recording and the lighting is dim for part of it, the video shows a sequence of events that is similar to what CO 3 Pollock had described in his testimony.

[55] CO 3 Pollock explained how the green Request Forms work. Inmates can request many different things, including a medical request, through the form. The Corrections Officers do screen the forms to some extent, but most of the forms are directed to the appropriate person or department. The forms are not discarded but kept on the inmate's file. An exception to this is when the request is for a simple matter that can be dealt with quickly and easily; for example, a request for new pants or permission to call a girlfriend might simply be granted and done and the form is discarded. Any medical or dental requests however, will go to the medical office and dealt with there. Inmates are also allowed to hand these request forms directly to the nurse or doctor when they see them. CO 3 Pollock testified that there is no tracking process in place at HCC for where the green forms go when they are handed in.

[56] CO 3 Pollock testified that he has rarely seen any racial prejudice at HCC and when it has happened, it has been by inmates. When it occurs, it is immediately addressed. CO 3 Pollock explained that there are now three aboriginal elders on staff and they do a very good job, helping out in many ways.

[57] Co 3 Pollock explained that the correctional officers do not do blood sugar testing on inmates. It is either self administered or done by a nurse or doctor. He testified that in his opinion they were correct in their initial assessment of Donald being in a diabetic shock situation that morning. As well, he was satisfied with how the response team handled Donald that morning; nothing more could have been done by them. As Donald was conscious at the time, CPR was not called for. CO 3 Pollock explained that they are always able to call EMS when necessary and that was done on this particular morning. They have access to other resources as well, for example, to call an off duty nurse or the medical office at the Remand Centre where someone is on duty 24 hours a day. CO 3 Pollock recommended that longer nursing hours at HCC would be helpful - if not 24/7, then perhaps until 11:30 at night. As well he thought that having electronic medical records would be helpful.

6. Deputy Superintendant James Hand

a) Introduction

[58] James Hand has been in Corrections for 25 years and has been the Deputy Superintendant at HCC for the past year. Prior to this, including during the fall of 2009, he was the Assistance Superintendant of Operations at HCC. As a result of this position,

he was involved in some of the collecting of information, reporting, advising and securing of property in matters related to Donald's death. Additionally, as the current Deputy Superintendant, he is able to comment on what is being done at HCC with respect to policy, training, recruitment and so forth.

b) September 30, 2009

[59] DS Hand had reviewed CO 1 Murphy's note in the running record for Donald on September 30. He testified that what he expects would have happened is that CO 3 Tischer would have talked to the Duty Office that morning about this incident and either he or someone in the Duty Office would have documented this. As well, the medical office would have been advised. It is possible that there may have been some notes on the daily roster, the working sheet, which was used at the morning muster. It may have been discarded after that. As well, a nurse will check with the Duty Office at 8 am to get an update from the night before and they may have been advised of Donald's situation at that time.

[60] DS Hand testified that the Duty Office records were not seized and held at the time and whatever may have been recorded is no longer available. DS Hand explained that shift log notes are a form of communication to pass information on to the next shift. Anything of significance should be captured in a more permanent form elsewhere, for example, on an inmate's running record or on an incident report. Incident reports can be about medical matters, fights, drugs or weapons found and so forth. Supervisors are responsible for reading these reports first thing every morning, so that they know what has happened and to follow up on it, if necessary. Sometimes information is also recorded for preventative security, and this information will not show up on COMS. At this point in time, however, the only documentation that remains, with respect to what occurred on September 30, 2009, is in CO 1 Murphy's note in Donald's running record.

c) October 2, 2009

[61] DS Hand was not on shift in the early hours of October 2, as he normally worked a day shift from 8 am until 4 pm. When he came into work that morning, shortly after 7:00 am, he was immediately advised of Donald's death. His duties that morning included calling the RCMP to advise them of Donald's death. They were concerned that Donald's cell had not been secured; however, DS Hand had to explain to them that Donald was residing in a dorm setting and there were a number of other inmates in this unit. When Donald was taken to the Grace Hospital, there would have been no reason to secure the area at the time. DS Hand explained to the RCMP that once Donald had died, they had removed all of Donald's belongings and bedding and had safely and securely stored them. Photographs of the scene had not been taken before correctional staff had done this. Even with protocol not having been followed, DS Hand did not believe that anything had been lost or that they had hampered the

investigation.

[62] DS Hand's Memorandum to Superintendant Skelly, dated October 2, 2009, outlined that in addition to the telephone conversations he had with the RCMP that morning, DS Hand attempted to reach the charge nurse at the Grace Hospital, spoke with Susan Hamilton at the Medical Examiner's Office, collected the evening punch report from the Duty Office, and collected and seized the belongings and medications for Donald. At 12:20 pm, he met with Constable Gill of the RCMP and outlined what had happened in the hours since Donald had died. He agreed with her that given Donald's time of death, around 4:00 am, contacting the RCMP at 9:00 am was not acceptable, and that the Shift Operations Manager who was on duty that morning should have contacted the RCMP immediately. At 12:45 pm, he escorted Constable Gill to the ATC so that she could interview some of the inmates.

[63] DS Hand testified that Superintendant Skelly gave him the responsibility of obtaining and securing Donald's medical file. An inmate's medical file is to be secured in a locked cabinet in a superintendant's office when there is a death. DS Hand testified that the medical file would have been accessed when the key had been obtained from the smash box earlier that morning. Once the pages had been faxed to the Grace Hospital, the file would have been returned to where it had been taken from and the medical office would have been locked up. The next person that would have had access to the medical office that morning was Nurse Dziadyk, when she came into work.

[64] DS Hand testified that it was not until later in the morning, perhaps around noon, that he would have gone to the medical office and retrieved the file. When asked, he agreed that it could have been sometime in the afternoon; going to the medical office and obtaining Donald's medical file was not something he took note of in his memo to the Superintendant Skelly. DS Hand agreed that it was an error on his part in not documenting this. He simply took the file to his office and secured it. In addition to this medical file, DS Hand also placed Donald's inmate file, the punch records, the videotape and Donald's personal belongings in a locked cabinet in his office. No one else had access to this locked cabinet.

d) Donald's Medical File

[65] The medical file remained in DS Hand's locked cabinet for a number of years and no one touched it. At some point in time in the past year or so, after there had been a request from counsel for the medical file, a number of staff were asked to look for the missing MAR for September, 2009. They did an exhaustive search for it and were not able to find it. DS Hand was asked to comment on the fact that Psych Nurse Unrau had testified that she had seen the September MAR at some point in time during the day on October 1, 2009. He testified that he could not comment on this as he did not know.

e) Staffing The Medical Office

[66] DS Hand testified that staffing levels are always based on need and are reviewed regularly. Recently, HCC has gone from two psych nurses to three, and a medical assistant has been added to work in the medical office. They are always recruiting, but generally able to get the medical staff they need. DS Hand was asked about having 24 hour, 7 day a week nursing staff on duty at HCC. He did not believe this to be necessary. However, he noted that HCC shuts down for new intakes at 11:00 pm, so having nursing staff available until then would be ideal, as there are meds to be dispensed and medical matters to attend to as new inmates arrive. DS Hand explained that there is funding available for having nursing staff working through the evening hours, but there are recruitment issues. These are term positions and some seniority and pension issues that make this more difficult. He is attempting to blend some positions, so that there would be more full time positions; this would make the positions more appealing.

f) The Correctional Officers

[67] DS Hand does have some involvement in the hiring process for correctional officers. He explained that there is a lot of screening that takes place, and when a new employee starts there is a four month review and then another six months of probation (or even longer). Beyond that, correctional officers meet with management two times a year. It is a performance review of sorts, as both the positive and negative are documented.

[68] DS Hand explained that part of the basic core training is aboriginal sensitivity training. If there is ever a complaint about a racist comment or situation, he would deal with it immediately, as it is simply not tolerated. DS Hand testified that he hasn't even heard of a situation recently where there has been a complaint of a racist comment or situation involving one of the correctional officers at HCC. DS Hand noted that around 10% of all employees at HCC are aboriginal and that there is an ongoing effort to recruit more aboriginal staff. He acknowledged that this is necessary as more than 70% of the inmates are aboriginal.

[69] DS Hand testified that all correctional officers have basic First Aid, CPR and defibrillator training, including all of the necessary updates. His opinion is that this training is sufficient to do their job.

g) Staffing And Training For Work At ATC

[70] DS Hand testified that all staff who work at ATC have to take an additional two week training program. There are five or six correctional officers on duty at ATC during the daytime hours and then three correctional officers on duty after lights out. More staff can be called in to help out at ATC at any time and he can add extra staff for short periods of time when there is an immediate need. DS Hand testified that he is satisfied

that they have sufficient staffing levels for ATC; safety and security are not compromised. One of the significant components of working at HCC is communication and building relationships with inmates; this is particularly emphasized at ATC.

h) Inmate Complaints

[71] DS Hand testified that when he was the Assistant Superintendant, he dealt with complaints from inmates. If there was an incident or a complaint, it would be followed up on and normally an incident report would be written up. During the time Donald was at HCC, DS Hand never received a complaint - or heard about a complaint - from Donald. DS Hand testified that an inmate can also make a complaint to the Ombudsman. They can call the Ombudsman directly and letters addressed to the Ombudsman - or a lawyer or the college of nurses - is ever opened and read by the HCC staff.

[72] DS Hand testified that HCC do not have an organized structure for inmate complaints like Stony Mountain Penitentiary where there are inmate committees and a complaint process is in place. He explained that HCC does have inmate trustees, who are the senior inmates and respected by the other inmates. He thought that typically a trustee could be trusted to be a voice for the other inmates.

i) How Donald's Emergency Was Handled

[73] DS Hand has reviewed all of the reports available with respect to the events that led up to Donald being taken by EMS to the Grace Hospital on October 2. He testified that as soon as the inmates brought Donald's failing health to the attention of the staff, the initial responding correctional officers, the Code Responders, and EMS all did their part; everyone did what they should have done and nothing was omitted in their efforts to assist Donald. There was no negative write up or discipline on any staff as a result of how they dealt with Donald at and around the time of his death.

j) What Could Have Been Done Differently?

[74] DS Hand testified that in his opinion, nothing could have been done differently to prevent Donald's death. He did note that there some issues around the recording and keeping of medical information at the time of Donald's death. DS Hand agreed that electronic records would have helped; it is something that HCC is working toward. In the past few years one of the changes made is that all medical information received by fax is time stamped and initialed when received.

[75] DS Hand noted, as well, that the policy on videotaping in a medical emergency is clearer. Now all code calls are videotaped up until the time when outside medical help arrives and takes over.

k) Recommendations

[76] DS Hand testified that having nursing staff on duty until 11:00 pm instead of 7:45 pm would be valuable and they are working toward this. The funding is in place they just need to be able to hire the nursing staff.

[77] DS Hand testified that electronic records in all areas would be helpful; they are working toward this. At the same time, he commented that he thought a dual system would continue as he could not see getting entirely away from paper records.

[78] It was earlier noted that some changes on record keeping have already been put in place; DS Hand testified that as long as they followed what was already in place, he had no other recommendations.

B. INMATES

1. Inmate Beaulieu

[79] Inmate Beaulieu, "Beaulieu", had known Donald for a year or two prior to his death. They had been friends on the "outside", that is, when they were not in custody. Then, during the last four months prior to Donald's' death, they were bunkmates in the ATC. Beaulieu's recollection is that Donald looked great when he first came back into custody; in his words, it looked like Donald had been working out and putting on a bit of muscle.

[80] In the days leading up to Donald's death, Beaulieu noticed that Donald was "bloating", or gaining weight, in his waist and face. What he saw was that Donald's condition was not good. He was getting worse day by day: paler in complexion, becoming more sluggish and having trouble breathing. One day, during that last week, Donald, knowing that he was sick, asked Beaulieu to speak to the guards about his condition. Beaulieu testified that when he asked for a nurse or a Doctor to see Donald, he got the "brush off"; they told him that Donald would have to make the request himself. Beaulieu was aware of the fact that Donald was a diabetic.

[81] Three days before his death, late at night after lights out, Donald passed out in the washroom. Beaulieu and some others went in and helped Donald. He was able to stand and walk back to his bunk where he went to sleep. Donald said that he didn't know what was wrong with him, and also kept saying that he was okay. Beaulieu did not tell any guard, nurse or doctor about what had happened with Donald that night. He doesn't know if Donald or the others told anyone else about this. At some point in time during this last week, however, Donald did get some medical attention. What he told Beaulieu was that the doctor had told him that it was the flu. In his statement given to the RCMP on October 2, 2009, Beaulieu stated that they had sent a nurse over to look at him and that it was the nurse who had told Donald that it was "just the flu, just a bug, and a virus".

[82] During the evening prior to Donald's death, Beaulieu noticed that Donald was

having trouble breathing. At one point in time during the night Donald got up and went to the washroom, with some difficulty. He appeared to be disoriented. When he returned, he was staggering. As Donald sat on his bed, Beaulieu kept asking if he was okay. They were concerned for him and so Inmate Brass alerted the guards. The guards quickly came and looked after Donald. One of the guards put something in Donald's mouth for a diabetic attack; at this time he did not appear to be conscious. A short time later, though, Donald did get up of his own accord and walked out of the dorm with the guards assisting him. When Beaulieu looked through the window of the dorm door and saw that Donald was lying on the floor with some guards around him.

[83] Beaulieu testified that request forms, including medical requests, were frequently filled out by the inmates. He admitted that sometimes the requests were not that important; sometimes they were just done to seek attention. On occasion he did see Donald fill out medical request forms, however, Beaulieu could not recall seeing Donald ever hand a form in to the guards or take one with him when he went to see the nurse. A nurse usually came to the dorm three times a day: at around 9 am, later in the morning and then later in the afternoon. When the meds were given by the nurse or the doctor, it was done in a private area. Beaulieu did get some meds in this way; Beaulieu testified that he felt comfortable talking to the nurse or the doctor about personal medical issues during this time, if necessary.

[84] Beaulieu was aware of inmates having access to meds that were not prescribed. Sometimes meds given were not taken and then snuck back into the dorm. Inmates also had access to other meds not prescribed. Beaulieu knew this happened, but didn't personally see it. One of the reasons that Beaulieu did not say more to the staff about Donald's condition was because he didn't want to draw to their attention any meds that Donald might have been taking that he should not have been taking. In Beaulieu's words, he didn't want to "draw any heat" on Donald.

[85] Beaulieu testified that, in his opinion, Donald should have been checked out earlier by having him sent to a hospital emergency room. He also thought that a practice of alternating doctors and nurses, so that it isn't the same staff all of the time, might help the inmates get better medical treatment.

[86] Beaulieu testified that during his time at HCC, he did not see any prejudice in how he was treated.

2. Inmate Brass

[87] Inmate Brass, "Brass", had been in same dorm as Donald at ATC. At the time of Donald’s death, the two of them had been in the same dorm for two or three months. His bunk was in the opposite corner from Donald. Brass hadn’t known Donald prior this time, but the two of them had bonded, as he believed that Donald was a good person. Donald joked around; got along with everyone, including the guards; he was loved by everyone; was planning his life – writing proposals about his plans.

[88] Brass testified that Donald looked like a healthy person to him at first. Then, in the two or three weeks before he died, Donald started complaining about being sick and, based on Brass's observations, he got progressively worse. Donald walked slowly, sometimes appearing to be in a daze. He was sluggish and seemed to be drugged up. He was sleeping or dozing all of the time. Brass testified that Donald tried to get some help. Donald kept filling out medical request forms, but the nurses just kept giving him some kind of pill to relax and sleep, or meds which didn't help. Brass testified that he saw Donald fill out at least 20 request forms in the three weeks prior to his death. He also saw Donald hand in these forms. Brass also stated that the nurses "brushed him off" and that "they" refused to see him; as "they" did not believe he was actually sick. It was not clear if Brass was referring to the medical staff or the guards, or both. Donald had kept saying, "I have to go to the hospital, there is something wrong." Brass testified that he recalled Donald saying this to at least three guards: Officers Howser, Nightshade and Sawchuk, in addition to saying it to the nurses.

[89] In the days leading up to his death, the way Donald looked had changed: his face was pale yellow, a sickly look, "like a zombie in a movie". During the last week, Donald couldn't lay back or down because of he was having trouble breathing. The guards kept asking him if he was okay and Donald would say, "Yes". However, it was obvious to Brass and the others in the dorm that he was not ok. On the night he died, Donald was yellow in colour; he looked to Brass like he was dead in a coffin. Brass couldn't recall if Donald went for any tests or to see any specialists during this time.

[90] Brass knew that Donald was a diabetic and that the medication he was receiving was metformin. Donald received one pill a day; it was a pill he received in the pod area where medications were distributed a few times a day. In addition, Brass knew that Donald was being given Amitriptyline. Brass had no issue with the medications Donald was getting.

[91] In his statement given to the RCMP in the days following Donald's death, Brass said that Donald gave him some of his extra meds. There was a "50" on the pill. Brass also told the RCMP that Donald was getting meds from some other inmate, but it could have been either the prescribed meds from the nurses or pills he was getting from other inmates. It was common that meds were passed around.

[92] Brass was in the dorm the night that Donald became ill and was taken away by EMS. During the day leading up to that night, Donald had kept saying, "I need to go to the hospital." Donald was having trouble breathing; he had been sitting down and swaying from side to side. Brass testified that on that night it was already past lights out at 11 pm when Inmate Blacksmith and Inmate Flett approached him and said that something was wrong with Donald. They had been in the dorm washroom and heard Donald fall or pass out in a cubicle. Brass went to assist. They carried Donald back to his bunk. Donald looked like he was sick. Brass banged on the door until the guards came. When they arrived he told them what had happened. One of the guards in charge

thought it was a diabetic coma and so they put something down Donald's throat and took him out of the dorm area. This was the last time Brass saw Donald.

[93] Brass was asked to describe the size and setting of the dorm he was in and what a normal day looked like. Brass explained that in their dorm there were 28 inmates; as well, 28 more in the attached dorm. At 7 am the two dorms opened up and they could share a common area, except that they ate lunch in shifts. They had fresh air every day. There was a mixed group of people; not all were aboriginal. At 11 pm, with lights out, there was still dim lighting and the bathroom light was always on. The steel door to the dorm had a window. Two guards came into the dorm every hour and punched a clock at the far end. They would check to make sure everything was okay. In addition, whenever someone knocked on the door, the guards would be there within seconds.

[94] Nurses administered the meds in the morning and the guards would do it at night. You could speak to the nurses about other medical issues in the mornings, if necessary. As well, an inmate could fill out request forms, including for medical requests, at any time, and hand them in.

[95] Brass had issues with the guards and the nurses during the time he was at HCC. In his view, it was a dark, hopeless situation. He had complaints and spoke to the guards a number of times, but would get the brush off. As well, he felt that he didn't get the medical care he needed for his shoulder and arm problems. On the day he testified in court, Brass brought with him a copy of a number of letters (Exhibit 7). Those letters include letters by Brass which list complaints about his medical care and eight letters which complained about the food at the HCC. One of those letters is by Brass; another is by Donald. One of the letters is also signed by approximately 30 inmates.

3. Inmate Blacksmith

[96] Inmate Blacksmith, "Blacksmith", gave a statement to the RCMP on October 2, 2009; he did not testify at the Inquest. Blacksmith stated that he and Donald were good friends. He had noticed the following in the last couple of weeks before Donald's death: Donald had been sick, he was getting pale green, his face was puffed up and he was getting fat.

[97] On the night leading up to Donald's death, Blacksmith had been in the washroom washing up and getting ready for bed. Inmates Flett, Shingoose and Donald were also present. Donald almost fainted and collapsed. They asked him if he was alright and Donald said, "No, I'm sick." Blacksmith suggested that Donald get some sleep and then they kept asking him questions and he didn't answer except to nod. Donald was having breathing problems and the guards intervened and Donald was taken away to the hospital.

[98] Blacksmith pointed out that it upset him that the guards had been laughing at

Donald earlier the night before; he was not sure exactly why they had found it funny. Blacksmith stated that he believed it to be the case that aboriginal inmates were not treated fairly by the guards.

[99] Blacksmith observed that Inmate Redhead had told him that he'd seen Donald take a pill which Inmate McDonald had given him. The conversation relayed to him was that Donald had asked what kind of pill it was, to which he was told that it was a sleeping pill.

4. Inmate McDonald

[100] Inmate McDonald, "McDonald", gave a statement to the RCMP on October 2, 2009, but did not testify at the Inquest. He stated that he had heard from some of the other inmates that Donald had gained a lot of weight. What McDonald himself noticed was that Donald had "bloated up" and gained some inches around his waist in the last week before his death.

[101] McDonald had received some herbal medicine from an elder. When he noticed that Donald had been coughing in the week before his death, he gave Donald some of this medicine. He explained that they call this root medicine "Wegees".

[102] McDonald's recollection of Donald's last night in the dorm is that he seemed alright during the day and then he was coughing and hallucinating or acting funny. He was told by some of the others that Donald had almost fainted in the washroom and then the staff came into the dorm to check up on Donald.

5. Inmate Redhead

[103] Inmate Redhead gave a statement to the RCMP on October 2, 2009; he did not testify at the Inquest. In his statement he explained that he had observed Donald changing in the days leading up to his death. In his words, "he was getting bigger". He also saw Donald looking pale when he was doing his cleaning duties. He noticed Donald's "white face" for about two days prior to his death. When he asked Donald if he was okay, Donald's reply was that he was alright.

6. Inmate Olson

[104] Inmate Olson, "Olson", was interviewed by the RCMP on October 2, 2009; he did not testify at the Inquest. Olson was not in the same dorm as Donald at the time of his death. However, he saw that Donald, in the week leading up to his death, was getting fat really fast and that his face puffy. He thought that this might have been due to Donald being a diabetic.

[105] Olson had information that another inmate in Donald's dorm had been providing Donald with Tylenol T3's outside of the meds dispensed by the medical staff.

C. PARAMEDIC

1. Verne Glass

[106] Paramedic Verne Glass was working overnight as a paramedic at Oak Bluff. At 12:39 am on October 2, 2009, he and his partner received a dispatch to attend to the Headingley Correctional Centre; the dispatch was noted as "emergent", or life threatening. They left at 12:43 am, with their emergency vehicle's lights and siren on. They arrived at HCC at 1:01 am. It then took a couple of minutes for them to get into the area where Donald was now located.

[107] The first responders from the rural municipality were already there and had done an initial assessment of Donald. The primary care report the first responders gave to the paramedics was that they had done a blood glucose test; earlier the guards had given Donald 25 mg of oral glucose. The paramedics first observations of Donald were as follows: he was sitting on the floor with assistance, the sounds he made were incomprehensible, and he opened his eyes to the sound of someone's voice, so he was conscious but not coherent. They were told that Donald was on two types of oral medication and on some "psych meds". Donald had a rapid heartbeat and an unobtainable blood pressure. They were not sure what was wrong, other than that it was not a blood sugar problem, as his glucose level tested at 16.4 - which is high. At this time the two urgent care matters were his vital signs: his blood pressure and his fast heart rate. At this time of night, the guards did not have access to Donald's medical chart.

[108] The paramedics and Donald, together with a guard or two (he can't recall if it was one or two that came along), left for the hospital at 1:30 am. Paramedic Glass was attending to Donald in the back of the ambulance while his partner drove. Once they were in the ambulance and on their way to the hospital, Paramedic Glass did some tests on Donald and kept giving him saline to try and increase his blood pressure. Approximately five minutes after they had left the jail, Donald coughed heavily and sat upright. For a minute he was alert and able to follow commands. He then relaxed and became more lethargic again. Donald's breathing, which had been 30 breaths a minute, had slowed down to 24 breaths a minute, still considered rapid, by the time they arrived at the hospital. They were also able to obtain a blood pressure reading of 117/62. They arrived at the Grace Hospital at 1:41 am and took Donald into emergency, where Grace Hospital emergency staff took over.

[109] While still in the hospital, Paramedic Glass completed the Ambulance Patient Care Report. Some of the other observations he made in that report included that:

1. He had checked Donald's abdomen, which was soft, but no swelling was noted; he did this to check for internal bleeding and could detect no significant blood loss;

2. Donald's breathing was deep and rapid and he was given oxygen;

3. Donald's skin was warm and dry when they first saw Donald; by the time they arrived at the hospital, Donald's skin was cool and dry.

[110] Paramedic Glass agreed that the glucose level they received when testing Donald - 16.4 - was high. He attributed it to the glucose or orange juice the guards had just given to Donald. Paramedic Glass testified that given the information the guards had at the time, administering glucose was a reasonable option. He does not believe that it caused any harm to Donald.

[111] Paramedic Glass testified that he has attended HCC on many occasions and does not believe that there was any delay in getting to the jail or to the patient. He believed that he and his partner got all of the information they needed from the guards and the first responders. Having more information - or even Donald's medical chart - would not have caused him to do anything differently. He had no recommendations to make as he doesn't think anything different could have been done in this situation.

D. MEDICAL STAFF

1. Psych Nurse - Phyllis Unrau

a) Background

[112] Phyllis Unrau has been a psych nurse at HCC since 2008. Prior to this she was an RN for seven years. Psych Nurse Unrau testified that there are now three psych nurses at HCC. In the fall of 2009 there were to be two psych nurses, but there was a period of time where her co-worker had left and she was alone. Her duties in 2009 included triaging all of the green request forms for their department, assisting in the running of their two weekly clinics, processing the blood work assessments and doing some counselling.

b) ATC Clinics

[113] In 2009, they would attend to ACT once every six to eight weeks, or sooner if there were enough inmates to see. This was Dr. Waldman’s regular unit to attend as he had some specialized training for the sexual offenders housed on the unit. If ever she thought there was a situation which was acute, she and the psychiatrist would attend on an immediate basis. On an average visit to ATC, they would see between seven and nine patients, from just after lunch until 4:30 or 5:30 pm.

c) Donald’s 2009 Admission

[114] Psych Nurse Unrau had met Donald during a previous admission to HCC, likely in 2007. She testified that she knew Donald quite well. She considered him to be soft spoken, articulate and co-operative. According to the records, Donald was in custody

and transferred to HCC on March 30, 2009. He completed the following offender request form that same day.

Headingley Correctional Centre
=20-04 Administrative Forms Standa...

E 22.8

Headingley Correctional Centre
Offender Request Form
(If you have more than one request, please submit another form.)

Name: Donald Moose (Print) Date: March 30/09

Case Manager: Duncan (Print) Location: DNU

Contact your Case Manager if you have questions about any of the following:

Treatment Centers *(Anchorage, Tamarack, Behavioral Health Foundation, MMF Offender Employment Program, etc)*: ☐

Employment Opportunities: ☐ Identification Forms *(Birth Certificate, Social Insurance card, etc)*: ☐

Your Property: ☐ Clothing: ☐ Visiting Department: ☐ Offender Programs ☐

Other: *(Please specify)* _____

Check the appropriate box for assistance from Internal Departments or Outside Agencies

Internal Requests	Outside Agencies
Case Manager: ☐ Records ☐ Accounts: ☐ Health Care Services: ☐ School: ☐ Spiritual Care Services: ☐ Unit Supervisor: ☐ nit Manager: ☐ D/Superintendent: ☐ Superintendent: ☐ Other: *(Please specify)* Doctor	John Howard Society: ☐ *(Use this agency if you need help after your release from custody.)* Salvation Army: ☐ *(Check here if you need to speak to a Salvation Army volunteer while in custody. Contact your Case Manager for access to a Salvation Army treatment centre.)*

Brief Explanation *(Explain why you want to contact one of the above. Do not write "personal reasons or personal")*:
I would like to ask for my medication please. I take the followins Does of medication every day, I need to request the levels are not correct.
please see back →
(Continue on reverse side if necessary)

Offender's Signature: [signature]

Referred for action to: _____ *(Print)*

Forwarding Officer's Signature: _____ Date: _____

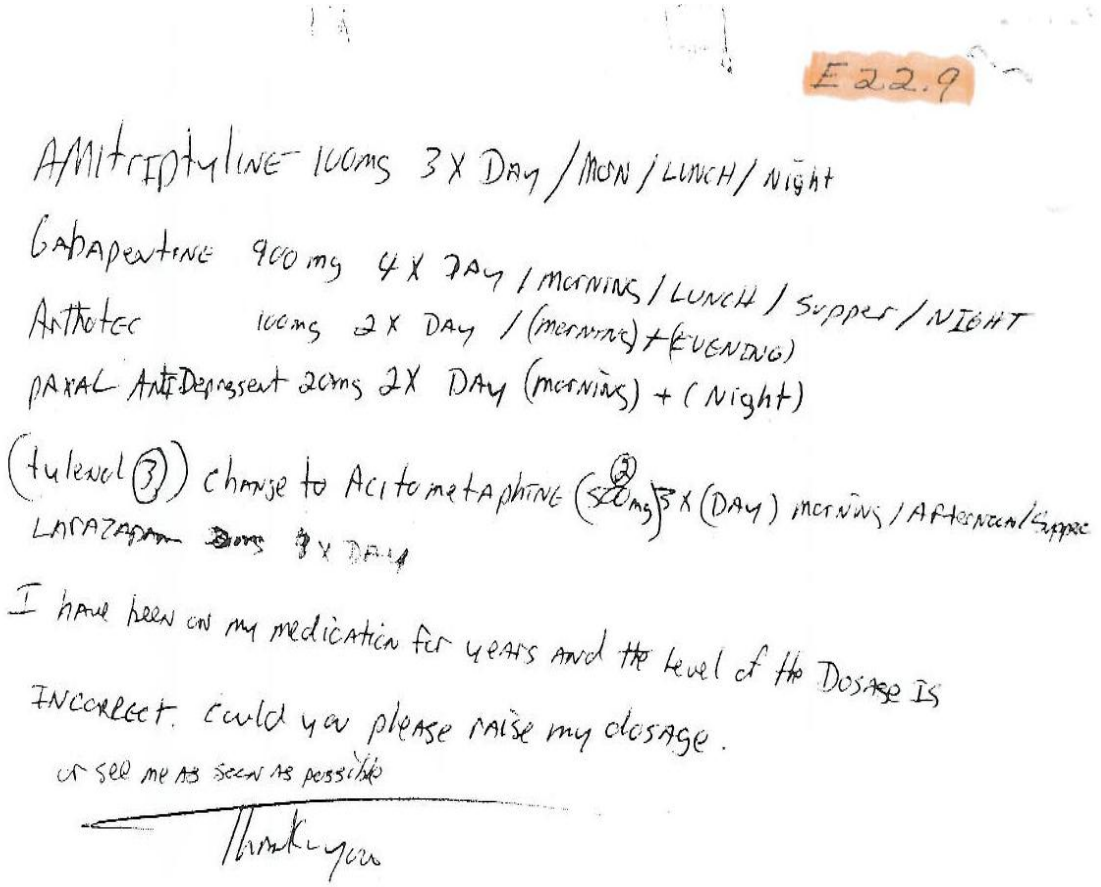
Action taken or interview summary:

_____

_____

_____

Date Completed: _____ Officer's Signature: _____



E22.9

Amitriptyline 100ms 3X Day / Morn / Lunch / Night

Gabapentine 900 mg 4X Day / Mornings / Lunch / Supper / Night

Antotec 100ms 2X Day / (morning) + (Evening)

Paxal Anti Depressent 20ms 2X Day (mornings) + (Night)

(tylenol (3)) change to Acitometaphine (500mg) 3X (Day) mornins / Afternoon / Supper

Lorazapam ~~Doms~~ 3X Day

I have been on my medication for years and the level of the Dosage is Incorrect. Could you please raise my dosage.

or see me as soon as possible

Thank you

d) April 2009

[115] Psych Nurse Unrau saw Donald on April 2 and wrote a number of notes in his file. These included that Donald denied using street drugs on the street, but confirmed that he was on a number of meds. She also wrote that Donald had lost a lot of weight; she testified that it was more than twenty pounds. Given the meds he was on and his request to increase the Amitriptyline, Psych Nurse Unrau noted that they would review the meds the next time they had clinic at ATC.

[116] Donald next sent in the following offender request form on April 13, 2009:

E 22.7

h/a's anxiety little sleep because of Removal?

Headingley Correctional Centre
#20-04 Administrative Forms Standing Order

E 22.6

Headingley Correctional Centre
Offender Request Form
(If you have more than one request, please submit another form.)

Name: Donald R. MOOSE (Print) Date: April 13/2009

Case Manager: MRS. Bruce (Print) Location: AIC

Contact your Case Manager if you have questions about any of the following:

Treatment Centers *(Anchorage, Tamarack, Behavioral Health Foundation, MMF Offender Employment Program, etc)*: ☐

Employment Opportunities: ☐ Identification Forms *(Birth Certificate, Social Insurance card, etc)*: ☐

Your Property: ☐ Clothing: ☐ Visiting Department: ☐ Offender Programs ☐

Other: *(Please specify)* _____

Check the appropriate box for assistance from Internal Departments or Outside Agencies

Internal Requests	Outside Agencies
Case Manager: ☐ Records ☐ Accounts: ☐ Health Care Services: ☑ School: ☐ Spiritual Care Services: ☐ Unit Supervisor: ☐ Unit Manager: ☐ D/Superintendent: ☐ Superintendent: ☐ Other: *(Please specify)* _____	John Howard Society: ☐ *(Use this agency if you need help after your release from custody.)* Salvation Army: ☐ *(Check here if you need to speak to a Salvation Army volunteer while in custody. Contact your Case Manager for access to a Salvation Army treatment centre.)*

Brief Explanation *(Explain why you want to contact one of the above. Do not write "personal reasons or personal")*:
I would like to see the doctor about my medication, this all wrong dosage. I was set on a regular routine already on the outside. I'm waiting patiently for your answer.
(Continue on reverse side if necessary)

Offender's Signature: Donald Ray Moose

Referred for action to: _____ (Print)

Forwarding Officer's Signature: _____ Date: _____

Action taken or interview summary:

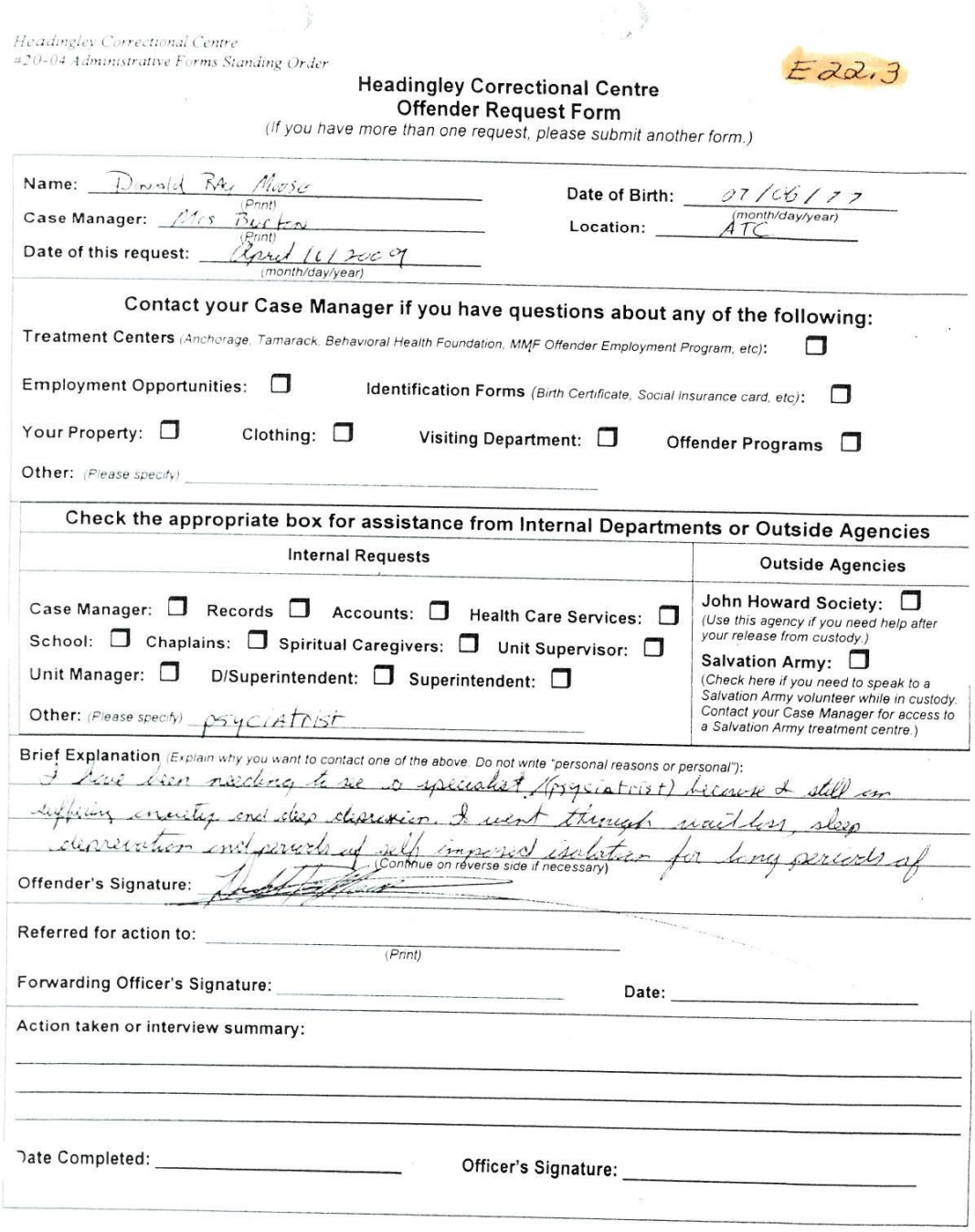
_____

_____

_____

Date Completed: _____ Officer's Signature: _____

[117] Donald then completed the following offender request form on April 16, 2009:



Headingley Correctional Centre
#20-04 Administrative Forms Standing Order

E22.3

Headingley Correctional Centre
Offender Request Form
(If you have more than one request, please submit another form.)

Name: Donald Ray Moose (Print)
Date of Birth: 07/06/77 (month/day/year)
Case Manager: Mrs Burton (Print)
Location: ATC
Date of this request: April 16/2009 (month/day/year)

Contact your Case Manager if you have questions about any of the following:

Treatment Centers *(Anchorage, Tamarack, Behavioral Health Foundation, MMF Offender Employment Program, etc)*: ☐
Employment Opportunities: ☐ Identification Forms *(Birth Certificate, Social Insurance card, etc)*: ☐
Your Property: ☐ Clothing: ☐ Visiting Department: ☐ Offender Programs ☐
Other: *(Please specify)* _____

Check the appropriate box for assistance from Internal Departments or Outside Agencies

Internal Requests	Outside Agencies
Case Manager: ☐ Records ☐ Accounts: ☐ Health Care Services: ☐ School: ☐ Chaplains: ☐ Spiritual Caregivers: ☐ Unit Supervisor: ☐ Unit Manager: ☐ D/Superintendent: ☐ Superintendent: ☐ Other: *(Please specify)* psyciatrist	John Howard Society: ☐ *(Use this agency if you need help after your release from custody.)* Salvation Army: ☐ *(Check here if you need to speak to a Salvation Army volunteer while in custody. Contact your Case Manager for access to a Salvation Army treatment centre.)*

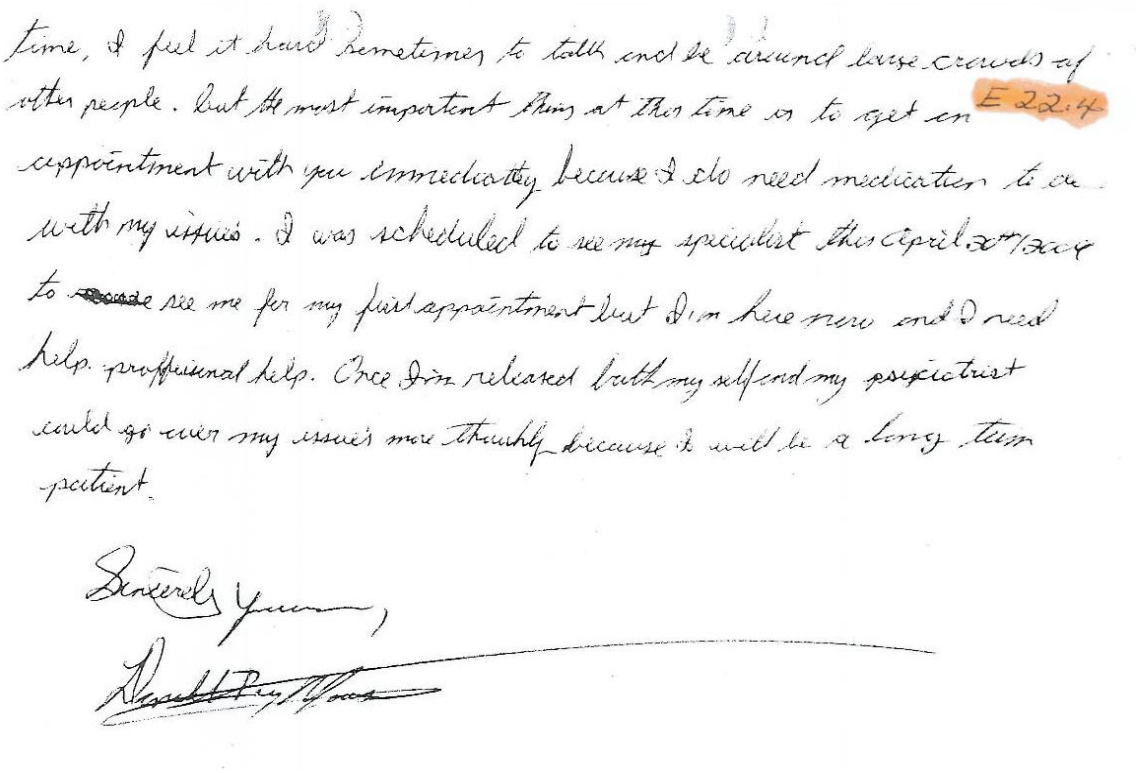
Brief Explanation *(Explain why you want to contact one of the above. Do not write "personal reasons or personal")*:
I have been needing to see a specialist (psyciatrist) because I still am suffering anxiety and sleep disorder. I went through months, sleep disorder and periods of self imposed isolation for long periods of
(Continue on reverse side if necessary)

Offender's Signature: [signature]

Referred for action to: _____ (Print)
Forwarding Officer's Signature: _____ Date: _____

Action taken or interview summary:
_____
_____
_____

Date Completed: _____ Officer's Signature: _____



time, I feel it hard sometimes to talk and be around large crowds of other people. But the most important thing at this time is to get an E 22:4 appointment with you immediately because I do need medication to do with my issues. I was scheduled to see my specialist this April 20th/2009 to ~~decide~~ see me for my first appointment but I'm here now and I need help. proffesional help. Once I'm released both my self and my psychiatrist could go over my issues more thuroughly because it will be a long term patient.

Sincerely Yours,

Donald Ray Moose

[118] Psych Nurse Unrau could not recall exactly what happened as a result of these two request forms, however, a review of the notes on Donald's medical file shows that she did see Donald on April 20, noting that he was still complaining of anxiety and lack of sleep and wanting to change one of his meds. She noted that he appeared gaunt and emaciated. He was booked to be seen the following day, but then the clinic at ATC was changed to a few days later; she confirmed that it was on April 28 that Dr. Waldman saw Donald and changed some of his meds, including an increase in Amitriptyline.

e) May – July 2009

[119] Psych Nurse Unrau testified that she had some concerns about the high levels of Amitriptyline she then saw in Donald's blood test results over the next few months. She recalls specifically speaking to Dr. Waldman about this on at least one occasion. Given the passage of time, she had difficulty recalling the order of when the test results came back and exactly when she spoke to Dr. Waldman about it. The test results were 322 on May 27, 115 on June 25 and 260 on July 30. She confirmed that Dr. Waldman saw Donald on May 26.

[120] Psych Nurse Unrau wrote several pages of notes in Donald's medical file between June 25 and June 29, noting her concerns and observations, as follows:

09.06.25 10⁰⁰ AM	Elavil	Amitriptyline level drawn — [illegible]
09.06.26 12:45 hrs	Y note	C/o of irritation ++, sweating, pacing, tension (crushing things in his hands), negative thoughts of shooting people. Brands himself. Talking louder and wanting to get in a piss fight & people on a daily basis. Spells last 1½ hrs.

Justice

E16.4

Subject: Nursing Documentation

HEALTH SERVICE PROGRESS NOTES

Page: ____ Facility: HCC

Name: MOOSE, DONALD Date of Birth (year/month/day): 72.07.06

Offender #:

Date / Time	Focus	Progress Notes
09.06.26 12⁴⁵ hrs.	Y note.	Is having trial on Thu/2009 re charges of sex-guilty. Has convicted 3 wks ago he is diabetic. Is on maximum dose of Elavil. Last level was high. Another level drawn June 25/09 re c/o of excessive joint pain. Claims was to have knee surgery @ HSC April 20/09? (Dr. Silver) Wondering what's happening with this. Called S+B re Elavil level. Is still incomplete at this time. Staff called saying inmate more confused than usual. Is booked for Dr. Waldman on return fr. holiday. Nurse to reassess symptoms on Monday. [illegible]
09.06.26 13:45	Y note	V.S. 14 3/93 O2 96% room air p. 124. T. 98.6°F. Inmate to keep record of B.S.'s for Doctor. Feels irritation spells were d/t ↓ and d/c of Lorazepam ↑.

E16.3

Date / Time	Focus	Progress Notes
09.06.29 13:45	* note.	Rapid and T3's and Restoral. Major complaint at present is headache neck pain migraines + knees. NOA is following on pre-scheduled knee surgery. States on this dose of Elavil since 2006. symptoms Probably not due to ↑ levels of Amitriptyline? Still waiting results of last level. Thinks irritation ↓ing somewhat. Still not sleeping properly. Pre review ē Dr. Atwal Thursday + Dr. J. Waldman July 22/09 on return from holidays. Was given info re ↓ anxiety through psychological techniques. — Unrau/sm

[121] Psych Nurse Unrau next had contact with Donald on July 30, when she obtained a blood sample, which had been ordered by Dr. Waldman on July 21 when he saw Donald. Dr. Waldman wrote that day that they should follow up with Donald in six weeks.

f) August 2009

[122] The next clinic at ATC was on August 25. Donald was on the list to be seen by them; however, there was a resident psychiatrist with Dr. Waldman, in training that day, and there were nine inmates to see. Psych Nurse Unrau testified that Donald had been sleeping that afternoon, and when they finished with the eighth person on the list, it was already 5:30 pm. Dr. Waldman indicated that he needed to go and they agreed to add Donald to the next clinic. As it turned out, the next clinic was scheduled for October, as Dr. Waldman was away in September. As Dr. Waldman and Phyllis Unrau were walking back to the main building, she flipped through the chart and saw that the reason she had Donald was on the list was because she thought his Amitriptyline levels were a lot higher than they should have been. Dr. Waldman told her that he was going on holidays and that Dr. Atwal should be consulted, if necessary. Her note in Donald's medical file stated, "No time to see today".

g) September 2009

[123] Sometime before September 8, Psych Nurse Unrau received a call from the unit at ATC that Donald wasn't feeling well and so she put in a request on the whiteboard to have a doctor see him. Dr. Raubenheimer then did see him on September 8. Psych Nurse Unrau could not tell from the notes she read whether Donald's Amitriptyline levels were discussed or checked, so she wrote on the whiteboard and put a "sticky" in his file saying, "Elavil level is increased. Needs an assessment. Not feeling well." or words to that effect. She also wrote on Donald's MAR for September to check his Elavil level as it was up. She recalled this specifically because after Donald died she went and checked the MAR and confirmed that she had written it on the page. Psych Nurse Unrau testified that to the best of her recollection, this MAR was now in Donald's file. This is the missing MAR sheet.

h) Other Comments

[124] Psych Nurse Unrau did not return to ATC during September and so she never saw Donald alive again. When asked what could have been done differently prior to Donald's death, Phyllis testified that she could have documented in more detail what she wrote on the whiteboard and that more could have been done to check Donald's Amitriptyline levels.

[125] Psych Nurse Unrau agreed that she is not a doctor and that sometimes there are reasons why the prescribing doctor will have the levels of Amitriptyline – or other drugs – at an above normal level for therapeutic reasons. She agreed that there were some questions about whether the level they had obtained was actually a "trough" level as Donald hadn't been too sure about when or if he'd taken his last dose of Amitriptyline.

[126] Psych Nurse Unrau had some recommendations. She noted that she was quite diligent in completing the "Problem List" sheets to go on the front of the inmates' medical files; however, only about 50% of them were ever completed. As well, being more diligent in recording some of the messages on the whiteboard onto medical files was a concern she noted. She also commented that there was now a policy that everything was signed in triplicate, for example, the blood work, to ensure that they could know that the doctors had seen it. These were areas where Psych Nurse Unrau thought there was now better file management and record keeping and that it could still be improved on.

[127] Psych Nurse Unrau noted that there was now a morning report where all of the medical staff – both the regular nurses and the psych nurses exchanged information. She noted that there has in the past been little communication between the doctors and psychiatrists and suggested that there could be more meetings between them; a more holistic, collaborative care model being used.

2. Psychiatrist - Dr. Jeffrey C. Waldman

a) Introduction

[128] Dr. Waldman is a forensic psychiatrist and had a contract with HCC for approximately seven years, including throughout 2009. The contract with HCC was to see inmates at a clinic he ran on Tuesday afternoons. On average he would see between six and twelve patients. He and a psych nurse would go from unit to unit to run these clinics on a week by week basis. Dr. Waldman testified that the time he spent with individual inmates was comparable with how he ran his private practice outside of HCC, which at the time was a general psychiatric practice. Whenever there was a new patient to be seen, a psych nurse would first see the inmate and then he would take between 30 and 40 minutes to do an initial assessment. In addition to this, whenever the psych nurse, Psych Nurse Unrau, felt it necessary, he would consult with her outside of those clinic hours. Dr. Waldman testified that he had no concerns with the ability of the psych nurses at HCC; Psych Nurse Unrau, in particular, was very experienced.

[129] Dr. Waldman testified that there is a high level of psychiatric illness within the corrections system, particularly with bipolar illness and schizophrenia. Dr. Waldman felt that he was able to provide adequate treatment with the time allotted; he testified that the psychiatric care standards at HCC were excellent and that the care the inmates received was quicker and more efficient than in the community. Prior to each clinic, he and the nurse would discuss the issues to be dealt with for each patient; he would read the green request form or forms, if one or more had been completed by the inmate; and if it was a follow up appointment, he would review the last notes on the inmate`s file. The psych charts and MAR sheets were what he would look at; he did not have access to the other medical records. At any time in their initial assessment or with any follow up appointment, if he felt that the concern had little to do with providing psychiatric care, he would have the nurse follow it up with Dr. Atwal, through the regular medical clinic. As well, on occasion, if there was a reason to rule out other causes of psychiatric illnesses, Dr. Waldman would refer the inmate to the appropriate specialist. An example of this would be where an inmate has previously had a head injury and it could be that seizures are complicating the psychiatric diagnosis.

b) April 28, 2009 Clinic

[130] Dr. Waldman recalls first treating Donald at HCC in 2008. His recollection was that Donald was always fairly thin, so when he again saw Donald in the spring of 2009, he did not notice any weight change. He first saw Donald at their clinic at ATC on April 28, and spent 20 to 30 minutes with him. Donald had been distressed – anxious and agitated - when he was previously treating him and he was the same on this day. They discussed the pros and cons of the numerous meds Donald was on and what he was asking for on an ongoing basis. There was some negotiating; this resulted in a plan to decrease the Paxil and resume the meds as before. The intention was to continue with Amitriptyline and eliminate the other antidepressant. On the Medication Order he

filled out that day, Dr. Waldman reduced the Paxil to 20 milligrams (it had been 40 milligrams) a day and increased the Elavil, or Amitriptyline, to a total dose of 200 milligrams a day, 50 mg in the morning, 50 mg at noon and 100 mg at bedtime. While the Medication Order record for Dr. Steigerwald from March 30 is not that clear, the MAR for April had Donald receiving 25 mg three times a day.

[131] Amitriptyline is a tricyclic and not typically a first line antidepressant now. Newer antidepressants have fewer side effects and are less dangerous in an overdose situation than Amitriptyline. Amitriptyline, however, is less likely to affect sleep cycles and sleep disturbance; Donald had successfully taken Amitriptyline before, and with his pattern of sleep disturbance, Dr. Waldman thought it better to try Amitriptyline, rather than Prozac or Trazadone.

[132] Dr. Waldman continued the prescription for Gabapentin, started by Dr. Steigerwald on March 30 and added Zopiclone. As well, Donald had told him that he`d been using Seroquel on the street and so Dr. Waldman ordered some screening tests to rule out that his distress wasn`t something like a thyroid problem.

c) May 26, 2009 Clinic

[133] Dr. Waldman next saw Donald at clinic on May 26. His notes record that Donald was complaining of lots of pain. Dr. Waldman`s observation was that Donald was presenting as very similar to a previous mood episode and that there were some signs of paranoia. Previously the Amitriptyline had stabilized this and so Dr. Waldman explained to Donald that he needed to be patient with the medication, as antidepressants often take six to eight weeks to be effective. Donald was asking for more meds, so Dr. Waldman ordered a blood level test to see if it would be safe to increase the Amitriptyline. His notes also asked for a follow up in four weeks.

d) The May 27 Blood Test

[134] The following is the report concerning the May 27 blood test:

23

Hôpital général St-Boniface General Hospital

BIOCHEMISTRY

E 20.6

Patient: MOOSE, DONALD
Born 6 Jul 77 M 31 History # PHN108335369
Location: ASSINIBOINE CLINIC LAB.
Doctor: WALDMAN, JEFFREY CHARLE, PHIN # 108335369

Lab # C106570-9 Collected on 27 May 09 at 14:00
Your reference - 09071328

	RESULTS	REFERENCE	UNIT
Amitriptyline	119		ug/L
Nortriptyline	203		
TOTAL	322*	Ther. (Trough) 125-200	ug/L
		Toxic >500	

Last dose not available
Next dose not available
Collected 14:00 27 May 09

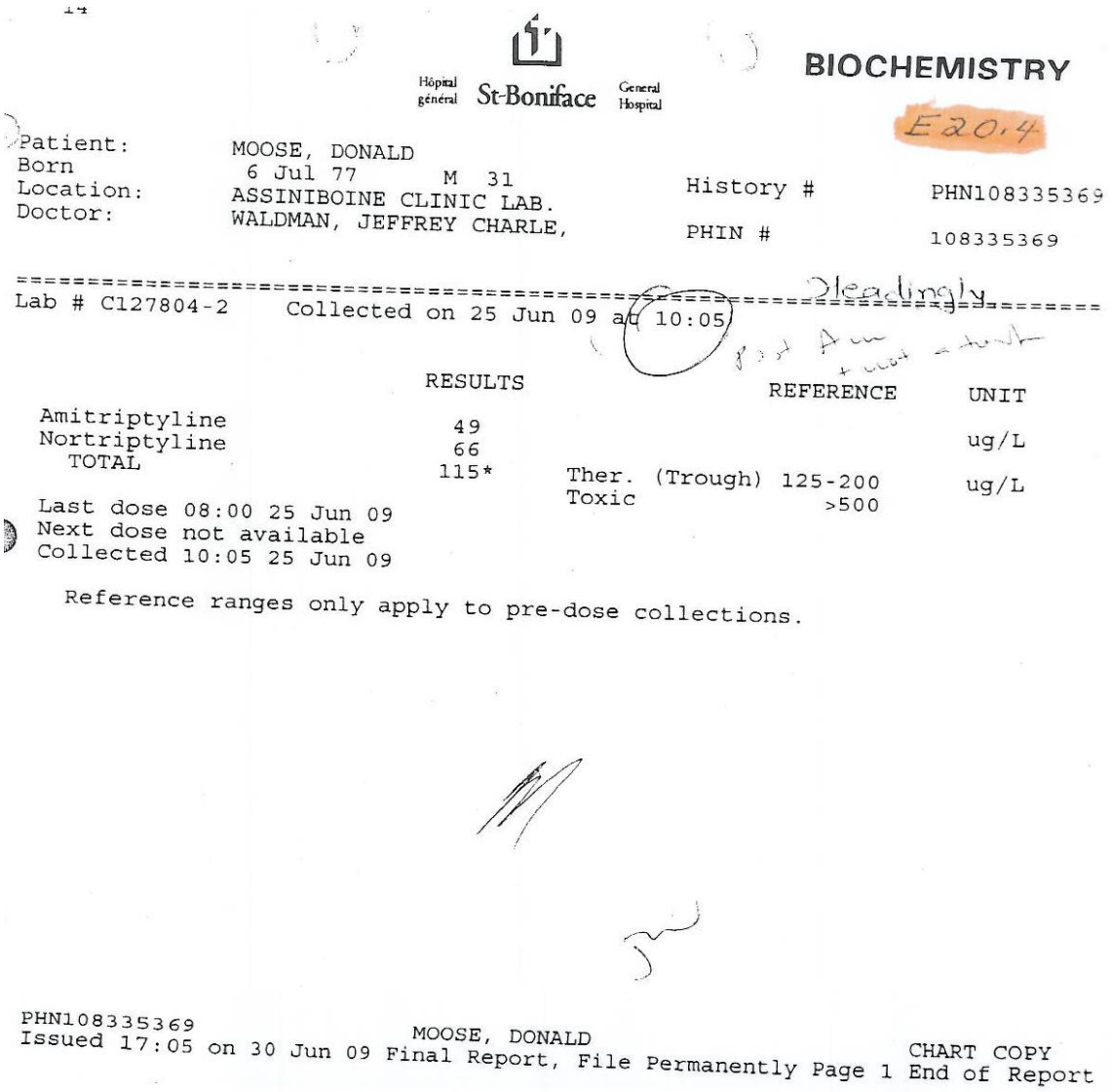
Reference ranges only apply to pre-dose collections.

PHN108335369 MOOSE, DONALD CHART COPY
Issued 17:05 on 3 Jun 09 Final Report, File Permanently Page 1 End of Report

[135] Donald`s blood level test came in at 322 and the report notes that a therapeutic level is 125 – 200 and that a toxic level is over 500. However, Dr. Waldman explained that he deemed this to be a safe level due to the following factors: The blood was drawn at HCC at 2 pm, after Donald had Amitriptyline in his system by way of a 50 mg dose in the morning and another 50 mg dose at noon. Two hours after taking a dose, a blood test result would show peak absorption and that was the result he was seeing; this was not at a trough level. As well, even at 322 it was not at a toxic level. However, as this was not a trough level, he did ask for a further blood level test.

e) The June 25 Blood Test

[136] A further blood sample was sent in on June 25. The following is the report concerning that test:



Hôpital général St-Boniface General Hospital

BIOCHEMISTRY

E20.4

Patient: MOOSE, DONALD
Born 6 Jul 77 M 31
Location: ASSINIBOINE CLINIC LAB.
Doctor: WALDMAN, JEFFREY CHARLE,

History # PHN108335369
PHIN # 108335369

Lab # C127804-2 Collected on 25 Jun 09 at 10:05

	RESULTS	REFERENCE	UNIT
Amitriptyline	49		
Nortriptyline	66		ug/L
TOTAL	115*	Ther. (Trough) 125-200	
		Toxic >500	ug/L

Last dose 08:00 25 Jun 09
Next dose not available
Collected 10:05 25 Jun 09

Reference ranges only apply to pre-dose collections.

PHN108335369 MOOSE, DONALD CHART COPY
Issued 17:05 on 30 Jun 09 Final Report, File Permanently Page 1 End of Report

[137] This sample was drawn at 10:05 am and resulted in a level of 115, just below what is considered therapeutic. Dr. Waldman noted that this was also not a true trough reading as the blood was drawn after Donald`s morning dose of 50 mg had been taken.

f) JULY 21, 2009 CLINIC

[138] Dr. Waldman next saw Donald on July 21. He estimated that this was a five to ten minute appointment. At that time he noted that Donald`s mental status was much improved and he was showing more appropriate emotion. Donald was still irritable and became negative when discussing the circumstances of his arrest. Donald was still asking for an increase in his meds and given the last Amitriptyline level they had received, Dr. Waldman believed it would be safe to increase the Amitriptyline dose. Donald was familiar with how Amitriptyline had helped him in the past and both of

them knew that he had previously been receiving 300 mg a day. This is a significant amount and not a dose that Dr. Waldman would normally take a patient to, but believed it to be appropriate in Donald`s circumstances. Therefore, the Elavil was increased to 300 mg a day: still remaining at 50 mg in the morning, but now 100 mg at noon and 150 mg at bedtime. As well, Donald still had issues with anxiety, pain and sleep disturbance, so he increased the Zopiclone dose. Dr. Waldman ordered a further blood level test and noted that there should be a follow up visit in six weeks.

g) The July 30 Blood Test

[139] A further blood sample was collected on July 30. Here is the report on it:

21

Hôpital général St-Boniface General Hospital

BIOCHEMISTRY

E 18

Patient: MOOSE, DONALD
Born 6 Jul 77 M 32 History # PHN108335369
Location: ASSINIBOINE CLINIC LAB.
Doctor: WALDMAN, JEFFREY C PHIN # 108335369

Lab # C151327-1 Collected on 30 Jul 09 at 11:29
Your reference - 09100127

	RESULTS	REFERENCE	UNIT
Amitriptyline	158		ug/L
Nortriptyline	102		
TOTAL	260*	Ther. (Trough) 125-200	ug/L
		Toxic >500	

Last dose not available
Next dose not available
Collected 11:29 30 Jul 09

Reference ranges only apply to pre-dose collections.

PHN108335369 MOOSE, DONALD CHART COPY
Issued 17:05 on 4 Aug 09 Final Report, File Permanently Page 1 End of Repor

[140] It was noted that this sample was drawn later in the morning, but apparently after Donald had received the 50mg dose earlier that morning. Dr. Waldman`s only comment on this result was that it wasn`t a peak level or a trough level; it was a little higher than he would have expected, but still at a very safe level. As Donald seemed to be getting better and the dose he was on seemed to be at a safe level, the same urgency that existed earlier was not there. Dr. Waldman testified that if he had seen Donald again, he may have ordered another test.

h) August 25 Clinic

[141] Donald was on the list to see Dr. Waldman at the ATC clinic on August 25. This would have been the six week follow up visit. Dr. Waldman was made aware of the note from the psych nurse recorded on Donald`s file, which stated, “No time to see

today``, but could not comment on why that happened. He has no recollection of that day. When asked if he would have been concerned about Donald being bumped from the list, Dr. Waldman testified that the last time he had seen Donald, the month prior, he had stabilized and the missed appointment would likely not have concerned him. Dr. Waldman could not answer why he did not see Donald in September, if he had been bumped to the next month.

i) Conclusions And Recommendations

[142] Dr. Waldman was asked about the high level – over 600 - that was recorded from the blood taken from Donald at the Grace Hospital three hours before his death. Dr. Waldman found this to be surprisingly high, but pointed out that this was not a trough level, as the blood sample had been obtained some four hours after Donald`s had taken his night time dose of 150 mg.

[143] Dr. Waldman did not believe that there was anything that could have been done in the days or weeks leading up to Donald's death that would have prevented it; he testified that given the cause of Donald's death, it really was outside his area of expertise.

[144] Dr. Waldman testified that as he hadn't worked at HCC in three years, he would not be able to make any recommendations concerning the psych department. When he did work at HCC on contract, he felt that he was able to do the job he was asked to do, without any interference from HCC at all. There were never any issues with his practice being compromised while working at HCC or with meeting his ethical obligations as a psychiatrist. He did point out that the needs are significant and it is important to have enough nurses.

[145] Dr. Waldman did agree that there are different models of care between general practitioners and psychiatrists. While he didn`t feel that there was any gap in the communication process between him and Dr. Atwal, he did agree that it would likely have been helpful to have worked more closely with Dr. Atwal.

2. Nurse - Adrian Sichewski

a) Background

[146] Nurse Adrian Sichewski has been employed at HCC as a R.N. for 15 years. He is one of the full time nurses; he normally works 15 twelve hour shifts in a month. He knew Donald as an inmate, but had limited contact with him. Nurse Sichewski did not recall when he first met him or what Donald's health was like when he last came into HCC. For the medical staff, Donald was an average inmate as he did not have a lot of issues for them to deal with. Donald was a quiet inmate and never caused any problems. Nurse Sichewski does not recall ever seeing him at the medical clinic.

b) October 1, 2009

[147] Nurse Sichewski did work a shift at HCC on October 1, 2009, and one of the tasks he performed was to prepare the weekly meds for Donald. Nurse Sichewski explained that after they were put together, he then noted it in Donald's MAR for the month of October and initialed it. According to the MAR for October, Nurse Sichewski gave Donald his 50 mg Amitriptyline tablet at 8 am and again at noon. He did not recall that anything out of the ordinary that happened with Donald or that was mentioned or discussed during his shift; otherwise, he would have made a note of it. The other meds for the week would have been left by him for the staff at ATC as the first of the meds were scheduled to be given at 10:00 pm that night.

[148] Nurse Sichewski did not recall hearing about the early morning, September 30 incident with Donald at his morning meeting on October 1. Nurse Sichewski could not recall if he had worked on September 30. Nurse Sichewski testified that protocol would be that if there was a medical incident overnight it would be reported to the Duty Office or his supervisor. As well he expects that Donald would have been referred to the medical staff on duty the morning of September 30 and that they would have looked after Donald at that time.

[149] Normally Nurse Sichewski would look at an inmate's previous day's meds to see if they had been given, but Nurse Sichewski cannot recall if, when he filled out Donald's MAR sheet for the first week of October, 2009, he saw the record of the previous meds given, on the September sheet. He was not aware of any missed meds with Donald.

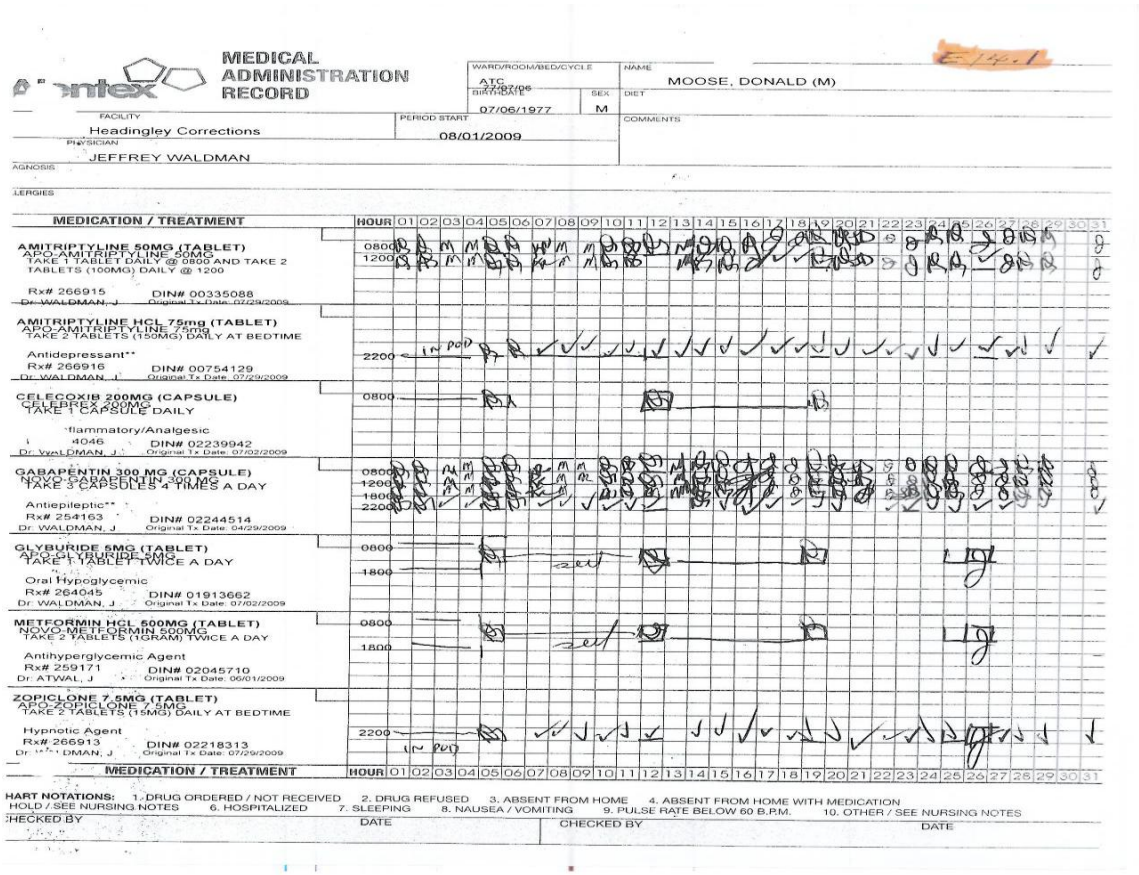
c) Staffing The Medical Office

[150] Nurse Sichewski testified that, during the day time hours, there were normally four or five nurses and two or three psych nurses on duty at HCC. Most of the time, this is sufficient staff for what needs to be done. Nurse Dziadyk is his supervisor; she is the health service manager, as she was in 2009. Nurse Sichewski's opinion was that all of the medical staff had a good working relationship with each other.

d) Med Check Days And MAR'S

[151] On med check days, Wednesdays, there would generally be an extra nurse on duty to assist. Med check days involved taking note of and checking all of the blister packs for the inmates which are received from Alentex and preparing the weekly meds to go to each of the units, where they are kept and distributed to each of the inmates on a daily basis. Nurse Sichewski testified that what they received from Alentex is reliable; most of the questions that they had were with respect to the legibility of what they had received and making certain that they were filling a certain prescription correctly. Med dispensing is somewhat different at ATC as the nurses are not at this unit as often and so the meds are placed in a med dispensing box and are more often given out by correctional officers.

[152] The meds are noted on each inmate's monthly MAR – the Medical Administration Record – kept in a separate binder for the month. Not all of the nurses have the same way of recording the meds. Sometimes there are initials and sometimes checkmarks or underscore lines. A common practice is to note certain of the medications for the week as being distributed to the individual unit, even if it is the correctional officers that will be giving the inmate the meds at the noted times each day. An example of the different ways the nurses dealt with this can be seen on the MAR for August 2009:



MEDICAL ADMINISTRATION RECORD

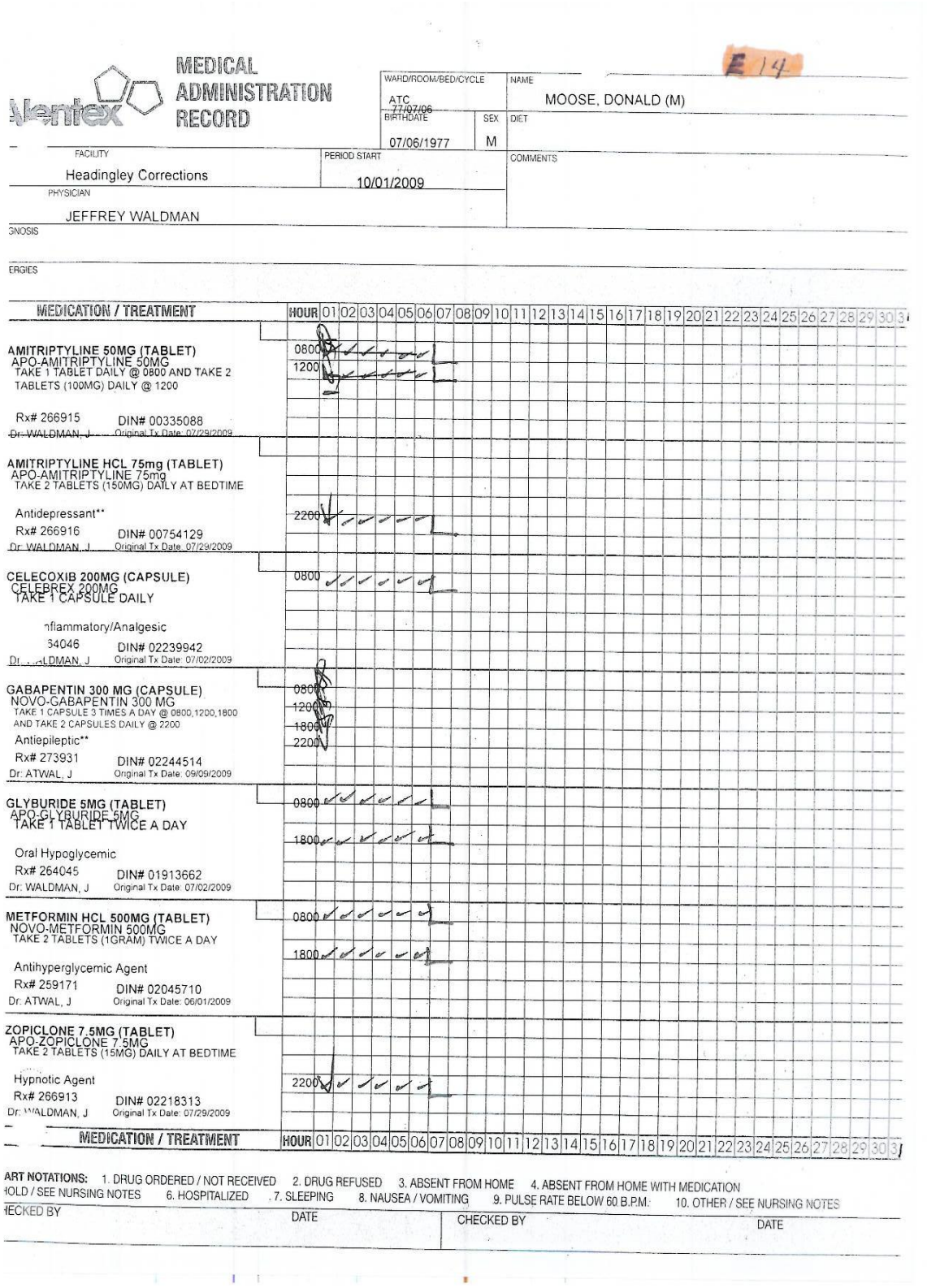
FACILITY: Headingley Corrections
PHYSICIAN: JEFFREY WALDMAN
PERIOD START: 08/01/2009
NAME: MOOSE, DONALD (M)
BIRTHDATE: 07/06/1977
SEX: M
DIET:
COMMENTS:

MEDICATION / TREATMENT	HOUR
AMITRIPTYLINE 50MG (TABLET) APO-AMITRIPTYLINE 50MG TAKE 1 TABLET DAILY @ 0800 AND TAKE 2 TABLETS (100MG) DAILY @ 1200 Rx# 266915 DIN# 00335088 Dr: WALDMAN, J Original Tx Date: 07/29/2009	0800, 1200
AMITRIPTYLINE HCL 75mg (TABLET) APO-AMITRIPTYLINE 75mg TAKE 2 TABLETS (150MG) DAILY AT BEDTIME Antidepressant** Rx# 266916 DIN# 00754129 Dr: WALDMAN, J Original Tx Date: 07/29/2009	2200
CELECOXIB 200MG (CAPSULE) CELEBREX 200MG TAKE 1 CAPSULE DAILY flammatory/Analgesic 4046 DIN# 02239942 Dr: WALDMAN, J Original Tx Date: 07/02/2009	0800
GABAPENTIN 300 MG (CAPSULE) NOVO-GABAPENTIN 300 MG TAKE 3 CAPSULES 4 TIMES A DAY Antiepileptic** Rx# 254163 DIN# 02244514 Dr: WALDMAN, J Original Tx Date: 04/29/2009	0800, 1200, 1800, 2200
GLYBURIDE 5MG (TABLET) APO-GLYBURIDE 5MG TAKE 1 TABLET TWICE A DAY Oral Hypoglycemic Rx# 264045 DIN# 01913662 Dr: WALDMAN, J Original Tx Date: 07/02/2009	0800, 1800
METFORMIN HCL 500MG (TABLET) NOVO-METFORMIN 500MG TAKE 2 TABLETS (1GRAM) TWICE A DAY Antihyperglycemic Agent Rx# 259171 DIN# 02045710 Dr: ATWAL, J Original Tx Date: 06/01/2009	0800, 1800
ZOPICLONE 7.5MG (TABLET) APO-ZOPICLONE 7.5MG TAKE 2 TABLETS (15MG) DAILY AT BEDTIME Hypnotic Agent Rx# 266913 DIN# 02218313 Dr: WALDMAN, J Original Tx Date: 07/29/2009	2200
MEDICATION / TREATMENT	HOUR

HART NOTATIONS: 1. DRUG ORDERED / NOT RECEIVED 2. DRUG REFUSED 3. ABSENT FROM HOME 4. ABSENT FROM HOME WITH MEDICATION HOLD / SEE NURSING NOTES 6. HOSPITALIZED 7. SLEEPING 8. NAUSEA / VOMITING 9. PULSE RATE BELOW 60 B.P.M. 10. OTHER / SEE NURSING NOTES

CHECKED BY DATE CHECKED BY DATE

[153] The September 2009 MAR for Donald is missing. This is of concern and will be discussed later in this report. Here is the October 2009 MAR for Donald:



E 14

MEDICAL ADMINISTRATION RECORD

WARD/ROOM/BED/CYCLE: ATC
NAME: MOOSE, DONALD (M)
BIRTHDATE: ~~77/07/06~~ 07/06/1977
SEX: M
DIET:
FACILITY: Headingley Corrections
PERIOD START: 10/01/2009
COMMENTS:
PHYSICIAN: JEFFREY WALDMAN
DIAGNOSIS:
ALLERGIES:

MEDICATION / TREATMENT	HOUR
AMITRIPTYLINE 50MG (TABLET) APO-AMITRIPTYLINE 50MG TAKE 1 TABLET DAILY @ 0800 AND TAKE 2 TABLETS (100MG) DAILY @ 1200 Rx# 266915 DIN# 00335088 Dr: WALDMAN, J Original Tx Date: 07/29/2009	0800 1200
AMITRIPTYLINE HCL 75mg (TABLET) APO-AMITRIPTYLINE 75mg TAKE 2 TABLETS (150MG) DAILY AT BEDTIME Antidepressant** Rx# 266916 DIN# 00754129 Dr: WALDMAN, J Original Tx Date: 07/29/2009	2200
CELECOXIB 200MG (CAPSULE) CELEBREX 200MG TAKE 1 CAPSULE DAILY nflammatory/Analgesic 34046 DIN# 02239942 Dr: ...LDMAN, J Original Tx Date: 07/02/2009	0800
GABAPENTIN 300 MG (CAPSULE) NOVO-GABAPENTIN 300 MG TAKE 1 CAPSULE 3 TIMES A DAY @ 0800,1200,1800 AND TAKE 2 CAPSULES DAILY @ 2200 Antiepileptic** Rx# 273931 DIN# 02244514 Dr: ATWAL, J Original Tx Date: 09/09/2009	0800 1200 1800 2200
GLYBURIDE 5MG (TABLET) APO-GLYBURIDE 5MG TAKE 1 TABLET TWICE A DAY Oral Hypoglycemic Rx# 264045 DIN# 01913662 Dr: WALDMAN, J Original Tx Date: 07/02/2009	0800 1800
METFORMIN HCL 500MG (TABLET) NOVO-METFORMIN 500MG TAKE 2 TABLETS (1GRAM) TWICE A DAY Antihyperglycemic Agent Rx# 259171 DIN# 02045710 Dr: ATWAL, J Original Tx Date: 06/01/2009	0800 1800
ZOPICLONE 7.5MG (TABLET) APO-ZOPICLONE 7.5MG TAKE 2 TABLETS (15MG) DAILY AT BEDTIME Hypnotic Agent Rx# 266913 DIN# 02218313 Dr: WALDMAN, J Original Tx Date: 07/29/2009	2200

MEDICATION / TREATMENT — HOUR 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

CHART NOTATIONS: 1. DRUG ORDERED / NOT RECEIVED 2. DRUG REFUSED 3. ABSENT FROM HOME 4. ABSENT FROM HOME WITH MEDICATION HOLD / SEE NURSING NOTES 6. HOSPITALIZED 7. SLEEPING 8. NAUSEA / VOMITING 9. PULSE RATE BELOW 60 B.P.M. 10. OTHER / SEE NURSING NOTES

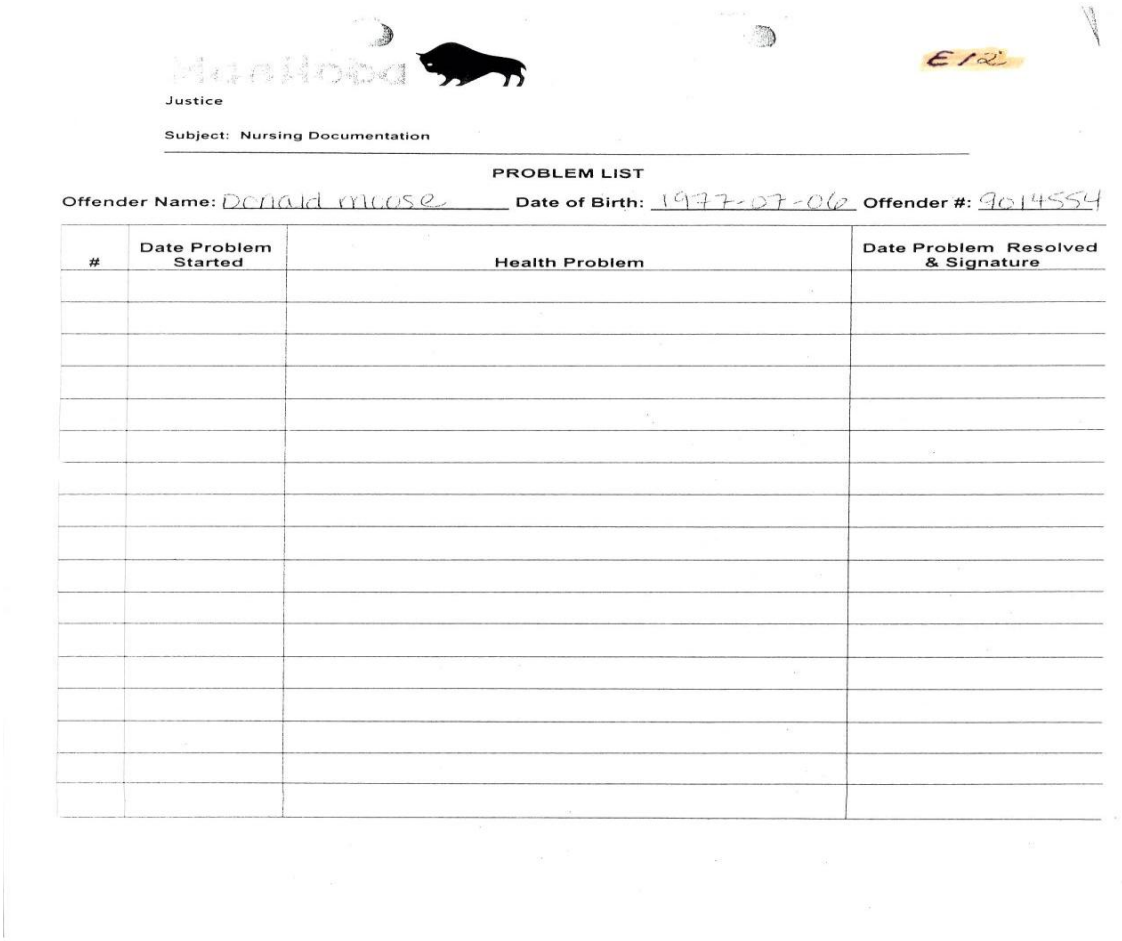
CHECKED BY DATE CHECKED BY DATE

[154] Nurse Sichewski testified that his reading of what is recorded on this sheet is as follows:

- He gave the 8 am and noon Amitriptyline and Gabapentin meds, as well as the 6 pm Gabapentin med to Donald himself, and initialled this in the MAR.
- He prepared the meds for Donald for the week and gave them to the pod at ATC for the correctional officers to give out daily.
- Someone accidentally checked the Amitriptyline doses for 8 and noon as being meds to be left in the pod; later it was realized that these would be given by the medical staff and so they were stroked off.

e) The Problem List

[155] Nurse Sichewski testified that each inmate has their own medical file and that the cover page on each inmate file is a sheet called a "Problem List". It is to give the medical staff a quick rundown of medical and psychiatric diagnoses for the inmate. The following is a copy of Donald's page:



Justice

Subject: Nursing Documentation

E12

PROBLEM LIST

Offender Name: Donald moose Date of Birth: 1977-07-06 Offender #: 9014554

#	Date Problem Started	Health Problem	Date Problem Resolved & Signature

[156] Nurse Sichewski admitted that it was not common for an inmate's "Problem List" page to be blank, like it was for Donald. Nurse Sichewski testified that it should

have been filled out for Donald and does not know why it wasn't. Although the information that would have been written on this page could probably be located elsewhere in the file, it would have been a helpful thing to have at the front of the file.

f) The Green Request Forms

[157] Nurse Sichewski testified that each morning, the medical staff will pick up the green request forms and sort through all of them, making sure that all of the requests which sound more acute or needing of further medical attention are addressed that day. Some of the requests require a simple answer and may be informally given to the inmate. However, one way or another, all of the request forms that come into the medical department are answered.

g) Medical Clinics And Files

[158] Nurse Sichewski testified that there is a separate file for the medical clinics which they run. Here they keep the relevant notes for what happens in the clinic; for example, the dressings that are changed, blood pressure results and so forth. On each clinic day they try to see all of the inmates who are on the list to be seen. If an inmate is not seen on a clinic day but were on the list to be seen, they would be rebooked for priority on the next clinic day. Generally, the inmates are seen by the doctor with the nurse present as well. The doctors are the ones who make the outside referrals, but the communication is good between the doctors and nurses, so there are times when he is free to give his input and express his own opinion.

[159] The medical files are confidential; the correctional staff cannot access them. As well, while the medical staff could potentially review the corrections log books or incident reports, they don't, as they have their own records for the information they need. When he, or any other nurse, attends to a unit for rounds, they will take along the medical files of any of the inmates they need to see.

h) The Missing MAR

[160] Nurse Sichewski testified that he was aware of the missing MAR for Donald for September, 2009. He participated, together with others, in searching everywhere possible to locate it. It was not found. The normal practice is for the MAR sheets to be pulled at the end of each month and then placed in the appropriate inmate's medical file. Nurse Sichewski was not aware of any chart auditing ever being done to see if pages were missing on any other occasions.

I) Other Comments

[161] The nurses will be aware of which inmates have diabetes. If any inmate is diagnosed with diabetes while in custody, the RNs will take the time to explain to the

inmate what this will mean for them. This may include checking the Blood Sugar Records as often as the doctor requests.

[162] Nurse Sichewski testified that he did not have any specific or special training to deal with aboriginal inmates or aboriginal issues. However, as a health professional, he did not feel that there were any issues in dealing with inmates on the basis of their heritage; everyone is treated equally as a patient.

[163] Nurse Sichewski could not think of anything that could have been done differently to prevent Donald's death. He did not believe that 24 hour nursing staff at HCC would have made a difference in this situation. He was satisfied with having nurses on duty until around 7:45 pm, as it currently is. His explanation for this was that the correctional staff all has First Aid and CPR training, and can always call for emergency help, if necessary.

[164] However, Nurse Sichewski did have a recommendation that there be a minimum staffing requirement for nurses, so that if there are call-ins for illness or any other reasons, that they would have to be filled in. The concern he expressed was because there are days when there just isn't enough medical staff on duty, and being short staffed means a greater potential for errors to occur.

4. Physician – Dr. Jasdeep Atwal

a) Background And The Providing Of Services To HCC

[165] Dr. Atwal is a general practitioner and has a full time family practice at the Assiniboine Clinic in Winnipeg. Since approximately 2005 he has also had a contract with HCC to provide medical services to inmates. In 2009, he was attending two 1/2 day clinics a week at HCC; he also provided on call service to the nursing staff by way of telephone contact. In 2009, the clinics were on Mondays (Tuesdays if it was after a long weekend) and Thursdays. He was responsible for all of the inmates at the time and generally saw around 40 patients on each 1/2 day clinic. A nurse from HCC is always present. The nurses would book the appointments on an "as needed" basis; those that need to be seen that day would be seen, even if he went longer than four hours. Sometimes an inmate would be bumped to the next clinic if necessary, but only if a "code" call had caused jail lockdown resulting in a delay or if a number of patients took unusually long, and they had determined that it was a situation that could wait for a few days. The inmates would attend as a unit or a block and he would see all of them before the next set of patients came. He would normally spend between 5 and 15 minutes with each patient. Dr. Atwal noted that this is similar to the time he normally spent with his patients in private practice; he testified that he believed this to be sufficient time to provide proper medical service. Given the nature or kind of question or problem the patient had, he would sometimes refer them to some other professional such as the public health nurse or for a psych appointment with Dr. Waldman, or even for a dental appointment.

[166] Dr. Atwal estimated that on average, one in four inmates saw a psychiatrist or a psych nurse. This was higher than in private practice. He regularly made referrals to the psych department; however, if he saw the patient during a clinic, he might have prescribed something in the interim, or the evening when he is on call, if an inmate was becoming psychotic, he would prescribe something to deal with the situation on hand.

b) DONALD'S CLINIC APPOINTMENTS WITH DR. ATWAL

[167] According to the medical records, Dr. Atwal had first seen Donald in 2006 during an earlier admission to HCC. He could not specifically recall Donald from that time. There are file notes from Donald seeing Dr. Atwal during earlier admissions on July 6, July 13, July 27 and September 7, 2006. In 2007, Donald saw Dr. Atwal on January 11, January 27, February 8, May 7, July 30, August 7, August 20, and December 24; as well, Donald saw Dr. Atwal on Feb. 4 and July 3, 2008. There are also file notes from other general practitioners who saw Donald from time to time.

[168] Of note, from these earlier clinic appointments with Dr. Atwal, are the following:

i. On January 11, 2007, Dr. Atwal did a complete assessment on Donald as he had been assaulted the week before. This included X-rays and a CT scan.

ii. On January 22, 2007, Dr. Atwal wrote that Donald was complaining of chronic headaches; however, he had reviewed the chest X-ray and the CT scan had been normal, so he wrote that "watchful waiting" was to be the course of action. As well, he noted that Donald had been prescribed Elavil or Amitriptyline for pain management.

iii. On December 24, 2007, Donald advised Dr. Atwal that five members of his family had died since he had come into custody. During these seven months his mood had been down and Dr. Atwal noted mild depression symptoms, but that Donald was not suicidal. Donald explained to him that he knew he needed to deal with his issues and he had programs, including an Elder program, coming up. Dr. Atwal increased Donald's Elavil dose and referred him for a psych appointment.

[169] After Donald's last admission to HCC in March 2009, Dr. Atwal saw Donald on April 30, June 1, July 2 and October 1, 2009. His clinic notes and testimony describe the following:

i. After Donald was transferred to HCC on March 30, 2009, Dr. Atwal first saw Donald on April 30. His notes indicate that Donald wanted Motrin, in the amount of 400 milligrams three times a day, for headaches. Dr. Atwal testified that he would have discussed the previous use and

effectiveness of this particular drug and dose for Donald. Donald advised him that this had worked in the past, so Dr. Atwal prescribed it.

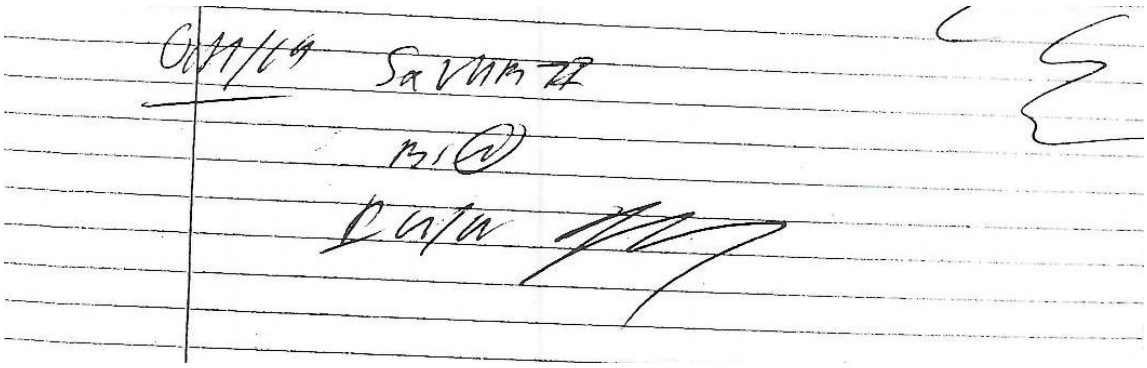
ii. Dr. Atwal next saw Donald on June 1, 2009. He booked Donald for a clinic visit that day in order to advise him of what he had seen in the blood work done for Dr. Waldman. The sugar levels were elevated, so they did a further blood sugar on him that day; the reading was 22.1. As a result of the two tests, Dr. Atwal advised Donald that he had a diagnosis of Type 2 Diabetes. Dr. Atwal then had a lengthy talk with Donald to explain diabetes to him: what it is, how to control it, and what can happen if it is not treated. Dr. Atwal advised him that he should use Accu-Cheks, a glucometer check, four times a day. He had a kit ordered in, with instructions for the nurses to see Donald with the machine and teach him how to use it. Dr. Atwal also started Donald on Metformin, which he described as a first line therapy for Type 2 Diabetes.

iii. On the next clinic appointment on July 2, Dr. Atwal talked to Donald about the blood sugar levels. The glucose had been decreasing to 13 or 14. Dr. Atwal had put him on Metformin, but wanted the sugars down to less than 10 on a regular basis. As a result, Dr. Atwal added in the medication called Glyburide. Dr. Atwal explained that this is a second agent used to help out with diabetes. As well, Dr. Atwal noted that they switched the anti-inflammatory to Celebrex instead of Motrin. He wasn't certain why, but speculated that it was because it is easier on the stomach and has less side effects associated with it.

iv. Dr. Atwal did not see Donald in August; Donald was next seen by his replacement, Dr. Raubenheimer, on September 8 (there is confusion on the date - in some places it is recorded as August 9), as Dr. Atwal was away. Dr. Atwal's reading of Dr. Raubenheimer's note is, "Bilateral knee pain, increased Gabapentin, 300 milligrams: one am, one noon, one pm, two at HS (meaning at bedtime)". Dr. Atwal testified that he would have trusted the doctor to get the needed information to make the decision to increase this medication. Dr. Atwal stated that he would likely have reviewed this note before his next appointment with Donald. What was written in the note did not raise any concerns with Dr. Atwal.

c) The October 1, 2009 Clinic Appointment

[170] Dr. Atwal last saw Donald on October 1. The following is the note he wrote after seeing him:



[171] Dr. Atwal testified that what this note read is as follows: "October 1, 2009. Symptoms of a viral upper respiratory tract infection. Respiratory exam: normal. Advised watchful/waiting. Signed, Dr. Atwal." What this meant to Dr. Atwal was that Donald had a cough, a cold, a runny nose; however, his lungs were clear. Dr. Atwal testified that he would have checked Donald's ears, nose and throat. His assessment was that Donald had a virus which would run its course. However, if things got worse, Donald would be reassessed; hence the words "watchful waiting".

[172] Dr. Atwal testified that he could not recall if any mention was made of the fact that there had been an incident with Donald having trouble breathing in the early hours of September 30. However, he noted that as a doctor you always assess the patient who is before you; how they are presenting at the time you see them. Dr. Atwal testified that on October 1, he did not note that Donald had any edema, bloating or puffiness. Additionally, he did not observe - and he was not told about - any swelling in Donald's legs. If any of this had been seen by him or had come to his attention, it would have been noted by him. Based on his notes, he would have expected the nurses to monitor Donald's situation.

d) Prescribing Amitriptyline

[173] Dr. Atwal testified that as a general practitioner, he would prescribe Amitriptyline on occasion. This would generally be limited to situations of chronic pain, when he would prescribe a low dose to be taken at bedtime. He would not monitor these levels, as the dose would be low. Dr. Atwal testified that he was aware that toxicity can occur when the doses are high. If a patient had anxiety or depression, he would normally prescribe SSRI's, such as Paxil, Prozac or Celexa. In Donald's case, there was a time where he saw Dr. Atwal and talked about depression due to family circumstances. On that visit, Dr. Atwal increased Donald's Amitriptyline dose; however, at the same time he also made a follow-up psych appointment for Donald. This would be Dr. Atwal's normal practice; if Amitriptyline was being prescribed for something other than pain management, he would let the psychiatrist deal with it.

e) Blood Pressure

[174] Dr. Atwal testified that the taking of blood pressure of patients, whether in private practice or with an inmate at HCC, is only done when it is deemed pertinent. Dr. Atwal noted that Donald's blood pressure had been taken at one point in time and recorded as 143/93. (This reading was recorded by the psych nurse, Psych Nurse Unrau in her June 26, 2009 note.) Dr. Atwal testified that at this level he would not have initiated medication at this time because Donald was going through a lot with the diabetes. His plan was to have the blood pressure readdressed at his next clinic appointment regarding the diabetes. There appears to be no record of this actually happening at any of the next clinic appointments.

[175] It was pointed out to Dr. Atwal that during an earlier stay at Brandon Correctional Centre, likely in 2006 (although the date is not noted); Donald had been given some medical treatment after it was observed that he had severe hypertension (high blood pressure). Dr. Atwal was not aware of this, as this was not part of Donald's medical file which he had been able to review at HCC. The full file had not been sent from Brandon. If he had been given that information, Dr. Atwal testified that he would have followed up on Donald's blood pressure in a timely manner.

f) Coronary Artery Disease

[176] Dr. Atwal testified that it was very unusual for a 32 year old male, such as Donald, to have significant coronary artery disease. Dr. Atwal explained that if a male that age had coronary artery disease, you would only expect a 5, 10 or 15% blockage, and not the large amount of coronary artery disease which Donald had. Dr. Atwal was asked if diabetes could contribute to coronary artery disease. He explained that a person would have to have diabetes for at least 10 years before there would be organ damage; even then, it would be micro vascular, that is, affecting the smallest arteries. Dr. Atwal testified that the significant risk factors for coronary artery disease are smoking, drug abuse, age and gender (higher risk in males). Dr. Atwal also explained that high blood pressure can be a risk factor for coronary artery disease. Dr. Atwal noted that the risks for heart disease are reduced when inmates are in custody, as they are not smoking, they are consuming less fast food, and there is less chance for drug abuse.

[177] Dr. Atwal testified that diet, exercise and not smoking are significant steps to take to prevent heart disease. Dr. Atwal explained that in his visits with Donald, he would have encouraged Donald to do all three.

[178] Dr. Atwal explained that coronary artery disease involves the narrowing of the arteries. Typically, the arteries would have to narrow to around 70 or 80% before a symptom such as angina presents itself. Reviewing an Electrocardiogram or doing a blood exam to see if the marker troponin is present are ways in which heart disease can sometimes be spotted; however, coronary artery disease is often not detected until a significant medical event occurs. The unexpected aspect of Donald's coronary

artery disease is that there was a very sudden progression from asymptomatic, to symptomatic, to death.

g) Medical Care At HCC

[179] Dr. Atwal testified that inmates receive good medical care while at HCC. Inmates are usually seen within a week of when an appointment is requested; if there is some urgency involved, they will be seen immediately. Dr. Atwal testified that the medical staff at HCC are very experienced; they know their job. Dr. Atwal trusts their decision making ability; the inmates, who need help on a regular basis, get the appropriate medical care. From what he has observed, when there are outside referrals made, inmates will see consultants just as quickly as any of his private practice patients. If there is some urgency of the situation, HCC will run the inmate to the Grace Hospital for immediate testing. Based on his observations over time, Dr. Atwal believes that the medical care standards are higher at HCC than in the community at large.

h) Medical Records And DPIN

[180] Dr. Atwal testified that he is provided with the inmate's medical file before seeing him as a patient. The information he needs is readily available; usually what he needs is the most recent information. As noted earlier, the medical files at HCC don't always have all of an inmate's medical information from when he was in custody previously. In Donald's case, there had been a time a number of years earlier when he had been in custody at Brandon Correctional Centre. According to Dr. Atwal, all that the HCC medical file had from Brandon was a synopsis of what was in the Brandon file.

[181] DPIN was not accessible to the medical staff at HCC in 2009. It is now available to them and Dr. Atwal does access it from time to time. He does find it to be helpful in certain situations.

[182] Dr. Atwal was asked to comment on the fact that in the front of Donald's file, the Problem List sheet was blank. He agreed that it is a useful thing to have on a medical record; it may have been helpful in Donald's situation if it had been completed.

i) What Could Have Been Done To Prevent Donald's Death?

[183] Dr. Atwal testified that in his opinion there wasn't anything that could have been done in the months, weeks, or days leading up to Donald's death that could have prevented it. In support of this opinion, Dr. Atwal noted the following from the medical information available from around Donald's time of death:

a. the EKG showed a normal heart rhythm,

b. there were no Q waves, meaning no previous infarct noted,

c. there were no ST elevations or depression to suggest ischemia,

d. EMS had noted no fluid in his lungs, and

e. there was no swelling in his legs noted.

[184] Dr. Atwal noted that access to better, more complete record keeping, or electronic records, would not have prevented Donald's death.

j) RECOMMENDATIONS

i. Dr. Atwal testified that he is very well aware of the fact that, for political and other reasons, health care money is almost entirely spent on finding and treating disease after it has happened. Dr. Atwal wished that more focus and money could be spent on prevention. He noted, for example, that there are often times where they look after an inmate and by the time he is released from custody, the inmate is in much better physical and mental condition, only to come back into custody some time later in a worse situation.

ii. Dr. Atwal observed that, in his opinion, a lot of inmates are on a high number of meds when they come into custody; some of these meds are highly addictive. While in custody, he and others in the medical staff do their best to get the individuals off of these meds, if possible. Then the inmate is released from custody and there appears to be no follow up or continuity of medical care. Dr. Atwal testified that he is aware of freedom of choice and the ability of individuals to choose their doctors, but he wished there could be some way of ensuring that there was continuity in the medical care plan for the inmate.

iii. Dr. Atwal testified that he now has computerized electronic medical records in his private practice. The result is more information and quicker access to that information. Things such as chart audits are possible with electronic medical records. As well, if the medical records from other institutions and hospitals were available, a more complete picture of a patient could be seen. Dr. Atwal is aware that Corrections is moving toward electronic records; in his opinion this will be very helpful for the medical staff at HCC.

5. Health Services Manager - Betty-Mae Dziadyk

a) Background And Duties

[185] Nurse Betty-Mae Dziadyk is the Health Services Manager at HCC, and has been since 2007 (as the acting manager for the first four years). She became an RN in 1974, and worked at the St. Boniface Hospital for 15 years, including as a head nurse for the last 7 years. She then worked at Corrections as a nurse for a number of years before

her present managerial role. Nurse Dziadyk reports directly to the Assistant Superintendent of Operations or the Deputy Superintendent.

[186] Her responsibility is to ensure that offenders have the appropriate health care. A typical day begins with her getting updates from the Duty Office, by way of the Shift Operations Manager or Shift Leader. What she needs to know from them is:

- Did anything happen overnight?
- Are there any offenders in the hospital?
- Is there anyone on head injury protocol?
- Is there anyone that she needs to know about that should be followed up on medically when a nurse gets to their unit?

[187] She then sets up a plan for the day and runs the morning report, which usually lasts for around thirty minutes. The Whiteboard is used to keep track of the items that need to be attended to on a daily basis and is constantly updated.

b) Staffing

[188] The medical department has HCC divided into five areas and the daily plan includes dividing up the workload. At the time she testified, Nurse Dziadyk had a staff of 17 nurses, the supervisor and herself. There are 9 general duty nurses who work full time, 2 full time psych nurses, 1 term full time psych nurse, and part time and casual nurses. Every day 5 nurses are scheduled: 4 have a 12 hour shift from 8:05 am to 7:45 pm and one has an 8 hour shift from 8:05 am to 3:45 pm. The Health Services Supervisor is a fairly recent addition to the staffing, and this has resulted in her having very little general duty nursing to do, although she is still directly involved on occasion.

c) Training

[189] Nurse Dziadyk testified that they could always use more nurses in her department. However, there is never an issue with having overtime approved. Hiring nurses for HCC is sometimes an issue; recruiting has its challenges. However, there is no problem with retention. Most nurses enjoy the work once they are there. The work is challenging, but it is a very safe working environment and the nurses have a lot of autonomy in their position. She feels that the general public has the impression that HCC isn't be a safe working environment; however, there are always corrections officers around. They will accompany offenders to the medical office and a nurse can always ask an officer to be present in the room with them at any time, without issue. On occasion, as well, an officer will advise that they will be remaining in the room, for their own security reasons.

[190] When a nurse starts his or her employment at HCC, there is a two week orientation. They are "buddied" with another nurse; they will cover:

- policy and procedure
- the units and kinds of offenders they will be dealing with
- inmate requests
- rounds
- meds
- the organization of medical records, including charting and legibility
- safety and security issues

[191] There is no specific aboriginal awareness that is covered during the orientation. They are introduced to the Aboriginal Elders who work at HCC; Nurse Dziadyk testified that they are excellent and that there is good communication between the nurses and the Elders. There has been a nurse with an aboriginal heritage on staff for a number of years.

[192] The HCC Standing Order on Offender Health Services sets out the following Purpose:

Purpose

1. To ensure the quality and accessibility of essential health services to incarcerated offenders at Headingley Correctional Centre.
2. To reflect community standards in the provisions of services for the physical and mental well being of offenders
3. To provide direction on the applicability of non-essential health services.

[193] The HCC Standing Order on Policy:

Policy

Authority

3. Section 2(1)(b) of the *Correctional Services Act* (Manitoba) describes the general principle of the Act as "...the safe, secure and humane accommodation of persons who are in lawful custody":

3.1 section 37 of the Act provides for the examination of an offender by a health professional to assess the status of an offender's physical and mental health;

3.2 section 13 of the *Corrections and Conditional Release Act* (Canada) requires a certificate to be completed by a facility transferring an offender setting out available health information and also states, "...whether or not the person appears to be suffering from a dangerous, infectious or contagious disease;

3.3 *The Personal Health Information Act* (Manitoba) states

3.3.1 section 13(2) limits the amount of collected personal health information to what is reasonably necessary to accomplish the purpose of its collection,

3.3.2 section 15(1)(a) requires the health care staff to inform the offender of the purpose for which the information is being collected,

3.3.3 section 22(2) requires disclosure by the offender's consent unless it is reasonably believed that disclosure to non medical staff is (b)...necessary to prevent or lessen a serious or immediate threat to

(i) the mental or physical health or the safety of the individual the information is about or another individual, or

(ii) public health or public safety..."

Health Assessment

4. A health care staff member will complete a health assessment on each new offender, within the first 24 hours after admission or by the next working day.

Suicide Risk Assessment

5. Each Suicide Risk Assessment, prepared as part of the Institutional Security Assessment by the designated Correctional Officer, will be made available to the health care staff, as soon as practicable:

5.1 Suicide Risk Assessments will be dealt with as required under the policy on suicide prevention **(See Standing Order 55-08 Suicide Prevention and Intervention).**

Medical Exam

6. A full medical examination of offenders, by the contract physician, is not required:

6.1 The contract physician will see all offenders on the basis of need.

Psychiatric Services

7. Referral to a psychiatrist will be made through the health care unit and may be made as the result of the admission history, a suicide risk assessment at a medium or high level, a review of existing psychiatric care plans, a court ordered assessment or as a result of an offender's request, or staff member's referral:

[194] Nurse Dziadyk testified that her assessment is that the medical unit meets these purpose and policy standards. In fact, her opinion is that the health care the inmates receive at HCC exceeds what the community at large outside of HCC receives. This is

not to say that improvements can't be made; they are constantly looking at ways to improve the health care the medical unit at HCC provides.

[195] Nurse Dziadyk testified that there is a system in place for an informal review whenever there is an incident or an issue; however performance reviews or evaluations do not happen as often as they should. She testified that at present they were happening only once every few years, but that they should be yearly. She attributed this to lack of resources - just not enough time to get it done. Random chart audits by a Health Service Manager from another correctional facility is something that has happened in the past, again, this was something that didn`t happen in the year prior, due to budget constraints.

a) Donald Moose

[196] Nurse Dziadyk knew Donald from his time at HCC. Her first recollection of him is from when he was an inmate in the main building. He was often concerned about wanting some more meds. She does not recall noticing any significant change in Donald's appearance when he came back into HCC in 2009.

[197] For their clinic on September 8, 2009, one of the other nurses had entered Donald Moose's name on the list of people to see. When the offender is seen on a clinic day, the doctor will make a note in the patient's medical file, in the progress notes; the nurses' practice was to also make a small notation beside the patient's name in the clinic book or "doctor's book", which had the names of all of the offenders which were being seen in the clinic that day, for quick reference. Nurse Dziadyk testified that she was working in the clinic that day and that she wrote a note behind his name as follows:

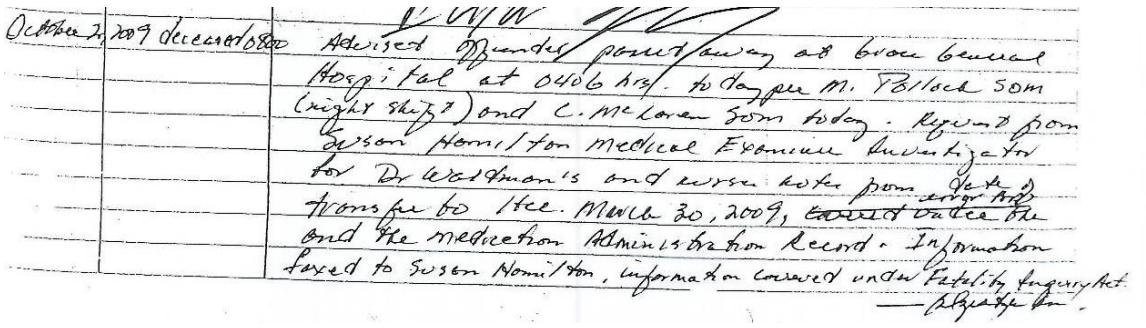
[198] Nurse Dziadyk explained that this note meant that Donald was complaining of neck and knee pain and so the doctor increased his Gabapentin to 600 mg, to be taken at bedtime.

[199] Nurse Dziadyk does not recall being given any information about Donald feeling dizzy and having trouble breathing during the early morning hours of September 30, 2009. She cannot recall anything like this being discussed later at the morning report. Nurse Dziadyk testified that if she had heard about it, it would have been followed up on.

[200] According to the medical files, she was with Dr. Atwal in their clinic on October 1. Donald was seen that day, and her note in the clinic book from that day is as follows:

[201] Nurse Dziadyk's explanation of this brief note is that Donald was complaining of the flu and that his cough was worse. Nurse Dziadyk testified that Dr. Atwal did auscultate Donald's chest and observed that Donald's lungs were clear. If there had been any other complaint by Donald, such as shortness of breath or dizziness, she would have made a note of it. Dr. Atwal's assessment was that there was no need of immediate follow up, by way of sending Donald to the hospital. Nurse Dziadyk explained that there were often examinations done in the clinic which resulted in the patient being sent directly to the hospital.

[202] In the early hours of October 2, 2009 when Donald was taken by EMS to the Grace Hospital, Nurse Dziadyk was not working. When she arrived at work that morning, at 7:50 am, she was advised of Donald's death. She then wrote the following note in Donald's medical file:

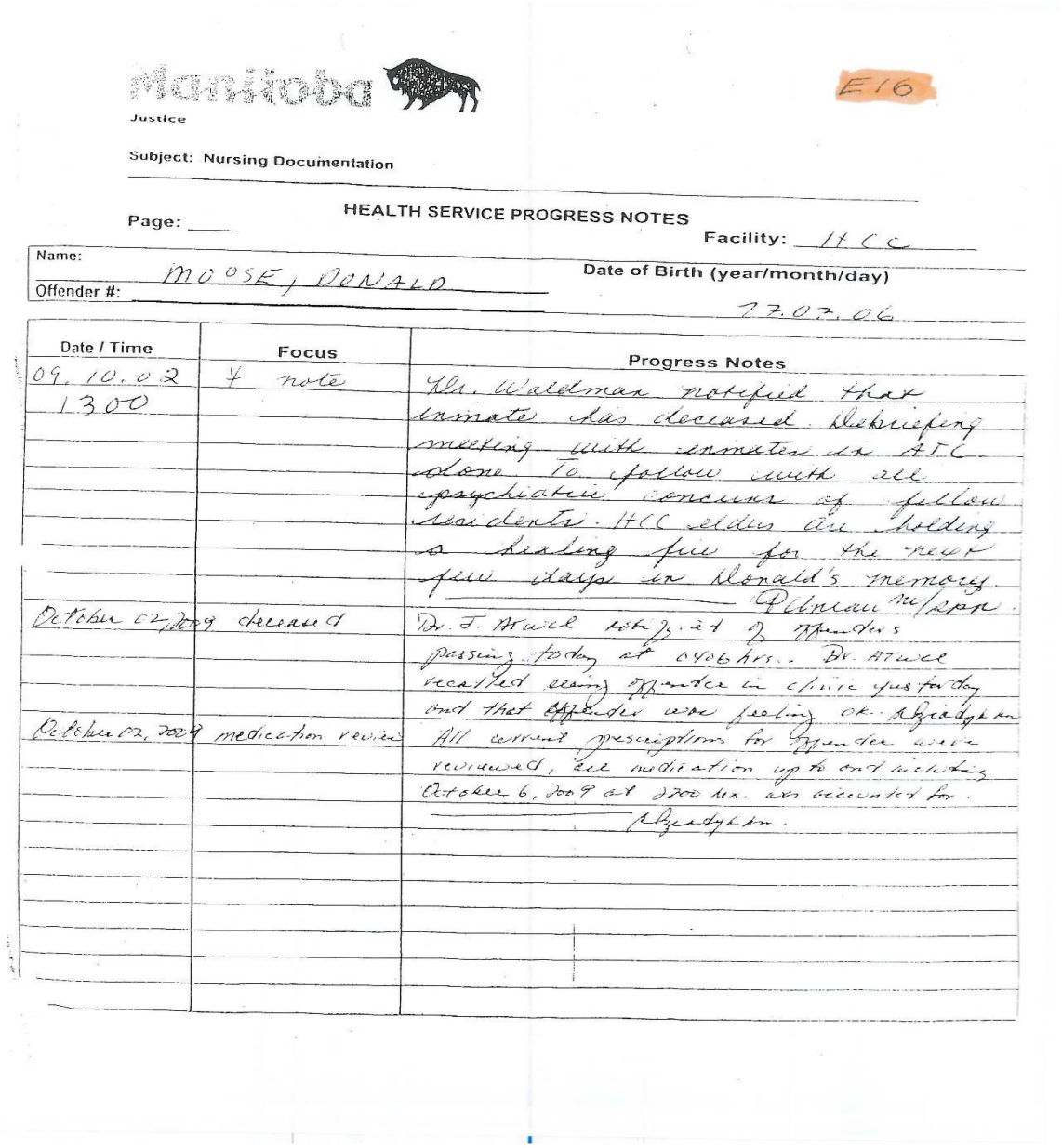


[203] Nurse Dziadyk explained that the note means that it was written on the file at 8:00 am and that it said:

> "Advised offender passed away at Grace General Hospital at 0406 hrs today per M. Pollock SOM (night shift) and C. McLaren SOM today. Request from Susan Hamilton Medical Examiner Investigator for Dr. Waldman's and nurses notes from date of transfer to HCC. March 30, 2009, covered under the ("covered under the" are stroked out and "error" with her initials are written over the top of it) and the Medical Administration Record. Information faxed to Susan Hamilton, information covered under Fatality Inquiry Act."

[204] Nurse Dziadyk then signed this note. Nurse Dziadyk testified that she cannot recall if all of the MARs from March 2009 up to that date were actually faxed; in particular, she cannot recall if it included the September 2009 MAR. She did recall that there was no follow up phone call asking her if she had sent everything or telling her that she had missed sending a record.

[205] Later in the day, Nurse Dziadyk made two further notes in Donald's medical file, one with respect to her phone call to Dr. Atwal and the other concerning her review of Donald's meds. Nurse Dziadyk testified that it would appear that this note had to have been made by her sometime after Psych Nurse Unrau's psych note at 1:00 pm. The entire page is as follows:



Manitoba
Justice

E16

Subject: Nursing Documentation

Page: ___

HEALTH SERVICE PROGRESS NOTES

Facility: HCC

Name:
Offender #: MOOSE, DONALD

Date of Birth (year/month/day)
72.07.06

Date / Time	Focus	Progress Notes
09.10.02 1300	F note	Mr. Waldman notified that inmate has deceased. Debriefing meeting with inmates on A.T.C. done to follow with all psychiatric concerns of fellow residents. HCC cells are holding a heading pic for the next few days in Donald's memory. Alonzo RN/SPN.
October 02, 2009	deceased	Dr. J. Atwal notified of offenders passing today at 0406 hrs. Dr. Atwal recalled seeing offender in clinic yesterday and that offender was feeling ok. Dziadyk RN.
October 02, 2009	medication review	All current prescriptions for offender were reviewed, see medication up to and including October 6, 2009 at 2200 hrs. are accounted for. Dziadyk RN.

b) Medical Administration Record (MAR)

[206] Nurse Dziadyk testified that the MARs are kept in separate binders for each of the units and are changed on a monthly basis. At the end of the month, the sheets are placed in each individual`s medical file. As there are sometimes changes to an individual`s meds during the month, the nurses take the time to ensure that the correct updated information is transferred over to the next month. The MAR binders are kept in the medical unit and are part of the confidential medical information kept in the medical unit.

[207] Nurse Dziadyk was asked about the missing MAR for September 2009. She explained that it was not until a long time later, probably in 2012, when legal counsel asked to see it that they realized that they could not locate it in Donald`s medical file. They then searched every possible place to try and find it, even checking the medical files of other inmates by the surname of Moose who were in HCC at that time. It was never found.

c) Securing Donald's File After His Death

[208] Nurse Dziadyk testified that Donald`s medical file would have been secured by Superintendent Skelly, and this meant that the physical file would have gone to his office, either by him picking it up at the medical unit or by her walking it over to the Superintendent`s office. She can no longer recall which it was on this occasion, or exactly when it happened. Given her notes, made after 1:00 pm that day, it would likely have been later in the afternoon. As well, Nurse Dziadyk recalled walking over to ATC to check what meds assigned to Donald were still there, in order to verify if the meds to October 6 were accounted for, prior to her writing the part of the note about the medication review. Nurse Dziadyk agreed that in order to do this review, she would likely have needed to see the September 2009 MAR sheet. If it had not been in the file at the time, she would have remembered this.

d) Medications

[209] The medical staff at HCC manages around 700 prescriptions a week. The doctors note the required meds for each patient on the Physician`s Medication Orders sheets and sign the form. After every clinic the medical office assistant faxes the sheets to Alentex, the company contracted to fill the orders. There are often calls from Alentex asking to clarify an order. The nurses are responsible to check the individual blister packs when they arrive at HCC; the nurses all communicate with Alentex on a regular basis. Nurse Dziadyk testified that Alentex does a very careful job as there are very few mistakes.

[210] Nurse Dziadyk testified that DPIN was not used at HCC in 2009. As of 2011 that changed and now it is regularly used at HCC. This has been a helpful change.

[211] There are some drugs, such as Acetaminophen and Ibruprofen, which do not need a doctor`s prescription; the nurses allow inmates to self administer these. When they are given out in a bubble pack, they are to last up to 28 days. The nurses do monitor this to some extent. Nurse Dziadyk testified that, in spite of their efforts, inmates do cheek, palm or hide meds from time to time and the inappropriate sharing of meds does occur.

e) The Green Offender Request Forms

[212] Any Request Forms which an inmate has completed and pertains to a medical question or issue comes to the medical unit. Nurse Dziadyk testified that they are placed on the inmate`s medical file and are answered or dealt with. The nurses can either use the Progress Notes to record what was done or write on the green Request Form itself; the Progress notes, however, must reflect what has been done. The forms become a part of the inmate`s medical record and remain on file until the inmate is discharged.

f) After Hours Medical Care

[213] Nurse Dziadyk testified that in 2009 - as at the present time - if the correctional officers have any medical questions or uncertainty about what to do after hours, when there is no medical staff on duty at HCC, they can always call her at home. She will either answer the question or provide direction as to what should be done. Nurse Dziadyk testified that she only gets around two or three calls of this sort a year. As the correctional officers have CPR and First Aid training, they are able to handle many situations themselves, or make the decision that this is a medical emergency warranting immediate action.

g) Recommendations

[214] Nurse Dziadyk's only recommendation was to improve oral and written communication between correctional staff and nurses, nurses and doctors, and between the general medical staff and the psych staff.

E. EMERGENCY ROOM HOSPITAL STAFF

1. Dr. Thomas Bowman

a) Background

[215] Dr. Bowman has been an emergency room doctor at the Grace General Hospital since July 1990. He is also a Lecturer and Clinical Instructor with the University of Manitoba, Faculty of Medicine, in the Department of Emergency Medicine. In 2009, the ER at the Grace General Hospital, was staffed by two doctors until 1 am, leaving a single doctor in emergency until the morning staff came in at 7 am.

b) Initial Assessment

[216] On October 2, EMS brought Donald Moose into their emergency room at 1:44 am, and so Dr. Bowman was the only emergency physician on duty at the time. An ER triage nurse immediately assessed Donald. The Triage Assessment Score was completed by 1:49 am and Donald was assessed as a "1", which is most emergent, meaning that the patient needs to be seen immediately. (The completed CTAS, Canadian Triage Assessment Score, is found Exhibit #2, C4.)

[217] According to his watch, Dr. Bowman first saw Donald at 1:48 am. At this time Donald was conscious, but not coherent. The information that the paramedics gave Dr. Bowman was that Donald had been found unresponsive in his cell by correctional staff and that they had given him oral glucose. The paramedics found that Donald had low blood pressure, but a quick measure of his blood glucose showed that his blood sugar was not low when the paramedics were first assessing him at HCC. Dr. Bowman was also told that Donald had non-insulin dependent diabetes and some form of psychiatric history. Donald had appeared agitated to them at times. The paramedics gave him an IV of saline and his blood pressure had gone up to 117/70. The paramedics did not give Dr. Bowman any information about any meds Donald may have been taking.

[218] Dr. Bowman's initial observation of Donald was that he was quite short of breath. He listened to Donald's chest and it sounded like he was wheezing, a sign of bronchospasm. He noted no crepitations, which would have indicated pulmonary edema. When Dr. Bowman asked Donald if he was short of breath, he seemed to understand and answered yes to the doctor's question. His respiratory rate was 24 to 28 per minute, which meant that he was really breathing hard. His oxygen saturation rate was 100% on the 10 litre mask. His blood pressure was 117/72. In normal circumstances this would be an acceptable blood pressure; however, not knowing Donald's history and considering that Donald was breathing and working hard, Dr. Bowman considered this a possible low blood pressure. Donald had an S1 and S2 heart sound, which is normal.

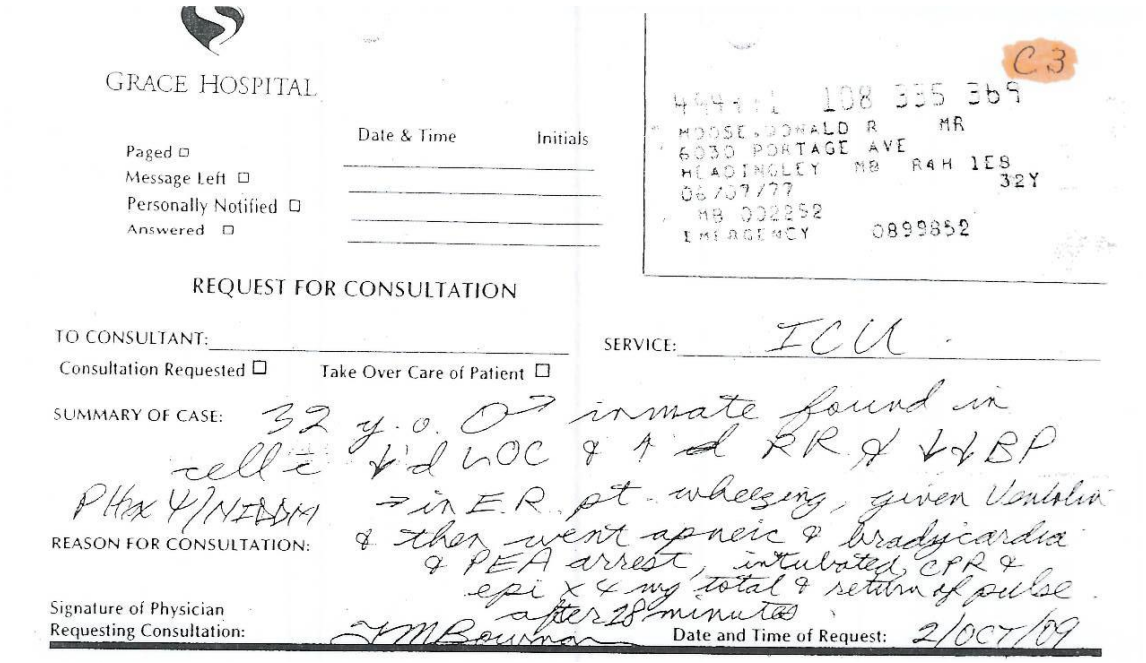
[219] Donald denied having abdominal pain; Dr. Bowman noted that the abdomen was soft and non-tender, indicating no abdominal problems. He noted that Donald's skin colour was poor. Given the oxygen he was getting, this was an indication to him that Donald was in physiological distress from having to work really hard at breathing. Dr. Bowman noted no edema of his extremities, that is, he saw no swelling of the legs.

[220] Based on his initial observations, Dr. Bowman was looking at respiratory or cardiac causes for this shortness of breath. A chest x-ray was taken, and Dr. Bowman's interpretation of it was that Donald had an enlarged heart and infiltrates in both lungs (shadows on the lungs), the right more than the left. These findings led him to believe that it was possibly congestive heart failure or pneumonia. Dr. Bowman's recollection of the sequence of events is that he was coming from the viewing computer work

station, where he had just looked at Donald's digital x-ray, and going to the stretcher bay area where Donald was, when he had a cardiac crash.

c) The First Code Blue

[221] The "Code Blue" was called at 2:17 am. From his notes, Dr. Bowman was able to recount that Donald had become apnoeic, that is, he had stopped breathing and his heart rate had dropped significantly. This is called bradycardia, the term for a very slow heart rate when there is no circulation of blood. They began chest compressions to try and stimulate Donald's heart and used a bag valve mask for ventilation, which includes inserting an endotracheal tube. Medication was also given to try and re-start the heart. The resuscitation efforts continued until 2:35 am, when they obtained a return of spontaneous circulation, that is, a pulse. After this they consulted with ICU, the intensive care unit, to come and see Donald, as this was where he would now need to be admitted to. The following is Dr. Bowman's written request:



GRACE HOSPITAL

C3

108 335 369
MOOSE, DONALD R MR
6030 PORTAGE AVE
HEADINGLEY MB R4H 1E8 32Y
08/07/77
MB 002252
EMERGENCY 0899852

Paged ☐ Message Left ☐ Personally Notified ☐ Answered ☐ Date & Time Initials

REQUEST FOR CONSULTATION

TO CONSULTANT: SERVICE: ICU

Consultation Requested ☐ Take Over Care of Patient ☐

SUMMARY OF CASE: 32 y.o. ♂ inmate found in cell ↓'d LOC & ↑'d RR & ↓ BP → in E.R. pt. wheezing, given Ventolin & then went apneic & bradycardic & PEA arrest, intubated, CPR & epi x 4 mg total & return of pulse after 18 minutes

PHx ↓/NIDDM

REASON FOR CONSULTATION:

Signature of Physician Requesting Consultation: J M Bowman Date and Time of Request: 2/OCT/09

[222] Dr. Bowman explained that this meant:

> "A 32 year old male inmate found in cell with decreased level of consciousness, and increased respiratory rate, and a very decreased blood pressure. He had some sort of a psychiatric past history, as well as the non-insulin dependent diabetes mellitus. In the Emergency Room, the patient was wheezing. He was given Ventolin, and was to be given Ativan; however, before it could be administered, Donald went apnoeic and bradycardic, and there was Pulseless Electrical Activity (PEA) arrest. He was intubated and given CPR. He was given Epinephrine at times, four milligrams total over the resuscitation, and his pulse returned after 18

minutes. (The Code Blue Resuscitation Record has the times and what was given and done during this resuscitation. See Exhibit #2, C2.)

[223] Dr. Bowman explained that the PEA meant that they were getting an electrical wave form on the monitor, but there was no corresponding effective contraction of the heart muscle. He thought that this may have been due to Donald's breathing problems, that he may have become hypoxic, meaning a low oxygen level.

[224] Dr. Bowman completed an Emergency Report Form, which he testified was filled in shortly after his initial assessment of Donald, when time allowed or when EKG or lab results came back. Some of the notes were a repeat of what was on his written request to ICU, but he also wrote more observations and details down. At some point in time, he wrote the note querying if this was a meds ingestion. He is not certain when he wrote that note.

[225] He noted that Donald was to be tested for salicytes (aspirin), alcohol and acetaminophen. These all came back negative. An EKG, X-rays and CCU lab (coronary lab tests) were ordered and blood gases were to be examined. The EKG showed sinus tachycardia and Dr. Bowman wrote a summary of the blood values when he received them:

a. potassium was in the normal range,

b. sodium was just below the normal range, but not clinically significant,

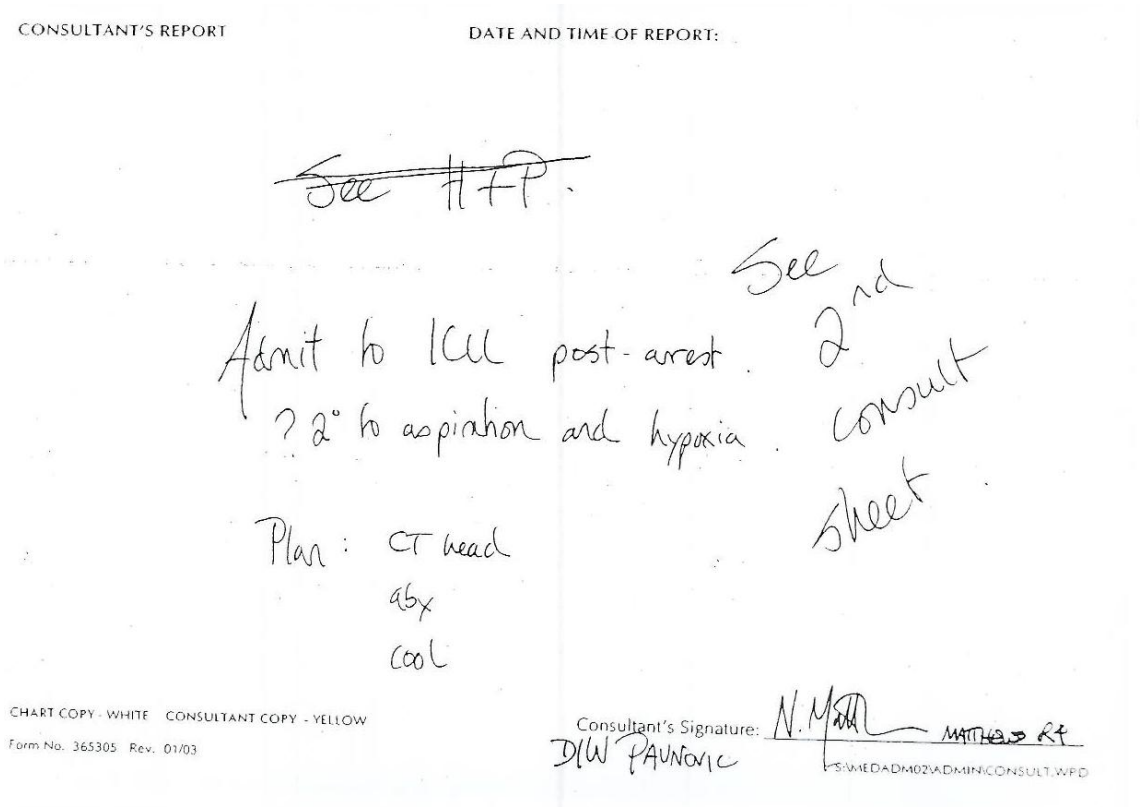
c. CK, a cardiac enzyme marker, was a little above the normal range,

d. troponin was negative, meaning no cardiac muscle damage, and

e. glucose was at 14.

d) The ICU Consultation

[226] Dr. Bowman was then asked to explain the following notes from Dr. Matthews, the consultant from ICU, found on the bottom half of the requisition form he had completed:



CONSULTANT'S REPORT

DATE AND TIME OF REPORT:

~~See #FP.~~

Admit to ICU post-arrest. See 2nd consult sheet.
? 2° to aspiration and hypoxia

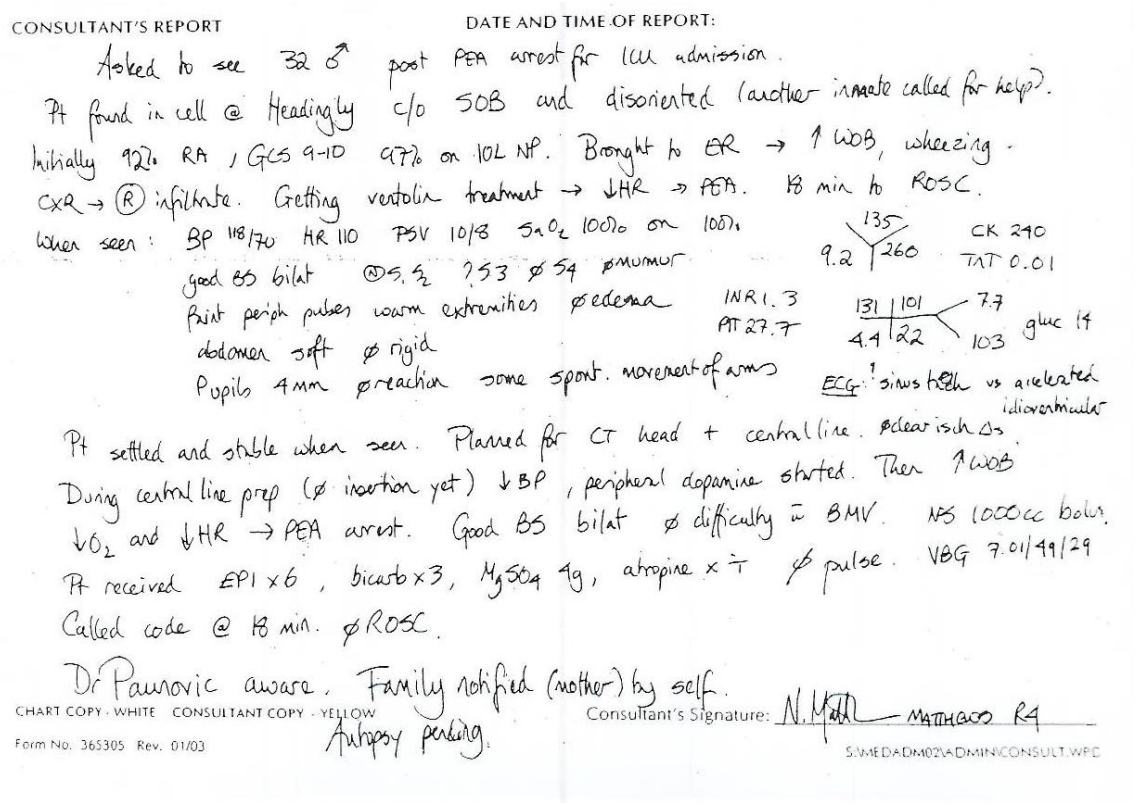
Plan: CT head
abx
cool

CHART COPY - WHITE CONSULTANT COPY - YELLOW
Form No. 365305 Rev. 01/03

Consultant's Signature: N. Matthews RT
D/W PAUNOVIC
S:\MEDADM02\ADMIN\CONSULT.WPD

[227] Dr. Bowman explained that Dr. Matthews was asking to have Donald admitted to the ICU and was questioning if it was aspiration and hypoxia. His plan was to get a CT of Donald's head, to check for any undiagnosed neurological problem such as a bleed or a stroke, to treat him with antibiotics and to cool the patient down. Dr. Bowman explained that patients were often cooled down in the post arrest recovery stage as it can help preserve brain function.

[228] The second page of the Request for Consultation contains Dr. Matthews' detailed notes:



CONSULTANT'S REPORT

DATE AND TIME OF REPORT:

Asked to see 32 ♂ post PEA arrest for ICU admission.
Pt found in cell @ Headingly c/o SOB and disoriented (another inmate called for help).
Initially 92% RA, GCS 9-10 97% on 10L NP. Brought to ER → ↑ WOB, wheezing.
CXR → (R) infiltrate. Getting ventolin treatment → ↓HR → PEA. 18 min to ROSC.
When seen: BP 118/70 HR 110 PSV 10/8 SaO_2 100% on 100%
good BS bilat S1 S2 ? S3 ø S4 ø murmur
Brisk periph pulses warm extremities ø edema
abdomen soft ø rigid
Pupils 4mm ø reaction some spont. movement of arms
135 / 9.2 / 260 CK 240 TNT 0.01
INR 1.3 PT 27.7
131 | 101 | 7.7 / 4.4 | 22 | 103 gluc 14
ECG: ? sinus tach vs accelerated idioventricular
Pt settled and stable when seen. Planned for CT head + central line. ø clear ischemic Δs.
During central line prep (ø insertion yet) ↓BP, peripheral dopamine started. Then ↑ WOB
↓O_2 and ↓HR → PEA arrest. Good BS bilat ø difficulty w/ BMV. NS 1000cc bolus.
Pt received EPI x6, bicarb x3, $MgSO_4$ 4g, atropine x ? ø pulse. VBG 7.01/49/29
Called code @ 18 min. ø ROSC.
Dr Paunovic aware. Family notified (mother) by self.
Autopsy pending.

CHART COPY - WHITE CONSULTANT COPY - YELLOW

Consultant's Signature: N. Matthews MATTHEWS R4

Form No. 365305 Rev. 01/03

S:\MEDADM02\ADMIN\CONSULT.WPD

[229] Dr. Bowman explained that these notes meant the following to him:

> "Asked to see 32 year old male, post PEA arrest for ICU admission. Patient found in cell at Headingley, complained of shortness of breath and disoriented (another inmate called for help). Initially he had a 92% oxygenation. (Dr. Bowman explained that this would have been obtained by the paramedics by way of a finger probe.) His Glasgow Coma Scale was 9 to 10. (Dr. Bowman explained that this is a scale of 3 to 15, with 15 being fully alert and conscious and 3 being basically in a coma.) 97 % on 10 litres nasal prong was noted. (Dr. Bowman explained that they would have applied oxygen after Donald arrived at the hospital and his oxygen saturation increased to 97% as a result.) Donald was brought to the emergency room and was exhibiting signs of increased work of breathing and he was wheezing. Chest x-ray showed right infiltrates. Donald was getting Ventolin for treatment when he had a decreased heart rate and PEA arrest. It took 18 minutes to get to return of circulation.
>
> When Dr. Matthews saw him, Donald's blood pressure was 118/70 and his heart rate was 110. PSV 10/8, Dr. Bowman explained, was the ventilator setting. He was on 100% oxygen being supplied by the ventilator. There were good breath sounds bilaterally and his S1 and S2 heart sound were normal. Dr. Matthews had a query about S3, an additional heart sound, which can be an indicator of congestive heart failure. There was no S4, indicating no murmur.

> Bilateral peripheral pulses, warm extremities and no edema. (Dr. Bowman explained that this was in reference to the lower limbs.) His abdomen was soft, not rigid. His pupils are 4 millimitres and they were not reacting. There was some spontaneous movement of his arms.
>
> The numbers to the right of that paragraph are referring to the blood work which had come back. Dr. Bowman is not sure exactly when that information came back as the lab work usually takes some time. Underneath those numbers is a note with a question mark. Dr. Matthews cannot tell whether the EKG showed sinus tachycardia versus an accelerated idioventricular rhythm. Dr. Bowman explained that this meant that Donald had a heart rhythm, but that they couldn't tell if it was coming from the sinus node or from down in the ventricles.
>
> The next paragraph notes that when Dr. Matthews saw Donald, he had settled and was stable. Dr. Matthews ordered a CT scan on his head and inserted a central line, which is a large catheter going into the jugular vein in his neck. Dr. Bowman explained that this allowed for medications to be given more quickly and this line usually worked better and longer than a peripheral line in the arms. Dr. Matthews then noted "no clear ischemic changes", meaning that there were no signs of coronary artery blockage.

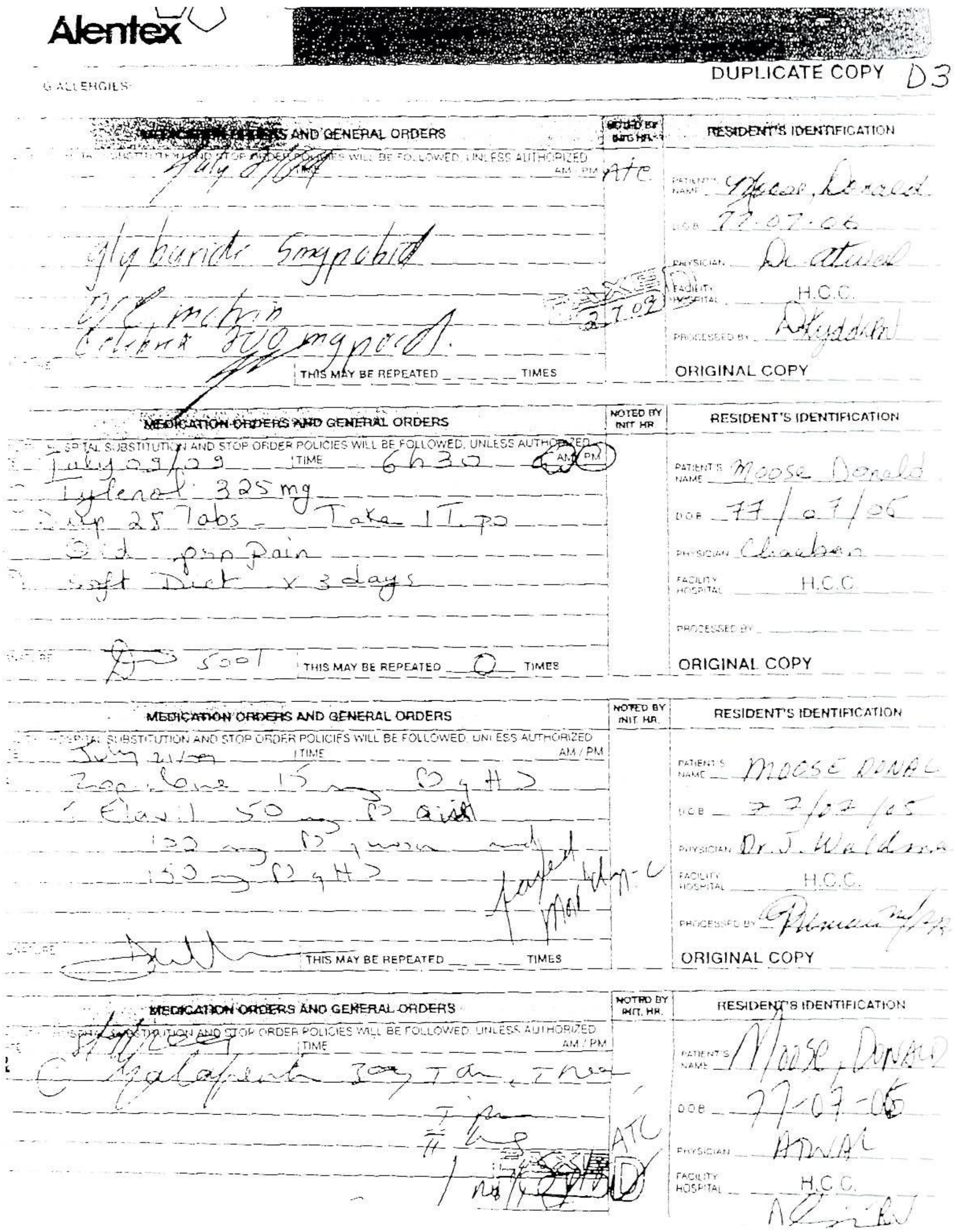
e) The Second Code Blue

[230] During the central line preparation, before the insertion, Donald's blood pressure went down; as a result, peripheral Dopamine was started. Then it was noted that there was increased work in breathing. Dr. Bowman pointed out that this may have been Donald fighting the ventilator a bit, or that he was becoming harder to ventilate. The oxygen saturation level was going down and he had a decreased heart rate, and then there was Pulse Electrical Activity arrest, a cardiac crash. Dr. Bowman testified that the good breath sounds bilaterally would appear to indicate that the ventilator tube was still in place; however they changed to manually “bag” Donald, so that they could respond more quickly.

[231] Normal saline 1000 cc bolus (meaning freely via IV) was given during resuscitation and then Dr. Matthews recorded the standard resuscitation drugs which were given to Donald over the next short while: six doses of epinephrine, three doses of sodium bicarbonate, four grams of magnesium sulphate and atropine. The carbon dioxide and oxygen levels were recorded and then the “called” code came, after eighteen minutes of failed resuscitation. There was no return of spontaneous circulation. The times, and what was given or attempted, is also recorded in the Code Blue Resuscitation Record (found at Exhibit #2, C 2.1)

f) The HCC Medical Records

[232] Dr. Bowman testified that at some point in time ER received some faxed medical records from HCC on Donald. He was not sure when they arrived or when he first saw them except that it was after Donald's first cardiac arrest had started. Dr. Bowman recalled seeing the time of 3:02 am on one of the documents. He wasn't sure what was all in this fax, but he did recall seeing the following med request page:


Alentex [redacted]

DUPLICATE COPY D3

ALLERGIES:

MEDICATION ORDERS AND GENERAL ORDERS — NOTED BY INIT. HR. — RESIDENT'S IDENTIFICATION

HOSPITAL SUBSTITUTION AND STOP ORDER POLICIES WILL BE FOLLOWED, UNLESS AUTHORIZED

July 8/09 — Atc

PATIENT'S NAME: Moose, Donald
D.O.B.: 77-07-06

glyburide 5mg po bid

PHYSICIAN: Dr. [illegible]
FACILITY / HOSPITAL: H.C.C.

Metformin
Celebrex 200mg po OD

PROCESSED BY: [illegible]

THIS MAY BE REPEATED ____ TIMES — ORIGINAL COPY

MEDICATION ORDERS AND GENERAL ORDERS — NOTED BY INIT. HR. — RESIDENT'S IDENTIFICATION

HOSPITAL SUBSTITUTION AND STOP ORDER POLICIES WILL BE FOLLOWED, UNLESS AUTHORIZED

July 09/09 TIME 6h30 AM/PM

PATIENT'S NAME: Moose Donald
D.O.B.: 77/07/06

Tylenol 325mg
Disp 25 Tabs Take 1 T po
QID prn Pain
Soft Diet x 3 days

PHYSICIAN: Claeban
FACILITY / HOSPITAL: H.C.C.
PROCESSED BY:

5001 THIS MAY BE REPEATED 0 TIMES — ORIGINAL COPY

MEDICATION ORDERS AND GENERAL ORDERS — NOTED BY INIT. HR. — RESIDENT'S IDENTIFICATION

HOSPITAL SUBSTITUTION AND STOP ORDER POLICIES WILL BE FOLLOWED, UNLESS AUTHORIZED

July 21/09 TIME AM / PM

PATIENT'S NAME: MOOSE DONAL
D.O.B.: 77/07/05

PHYSICIAN: Dr. J. Waldman
FACILITY / HOSPITAL: H.C.C.
PROCESSED BY: [illegible]

THIS MAY BE REPEATED ____ TIMES — ORIGINAL COPY

MEDICATION ORDERS AND GENERAL ORDERS — NOTED BY INIT. HR. — RESIDENT'S IDENTIFICATION

HOSPITAL SUBSTITUTION AND STOP ORDER POLICIES WILL BE FOLLOWED, UNLESS AUTHORIZED

TIME AM / PM

Gabapentin 300 T [illegible]

ATC

PATIENT'S NAME: Moose, Donald
D.O.B.: 77-07-06
PHYSICIAN: [illegible]
FACILITY / HOSPITAL: H.C.C.

[233] When Dr. Bowman reviewed that list, he thought that there was a possibility of drug overdose by Donald. Dr. Bowman could not recall if he had asked the nurses or the ward clerk to request further medical information from HCC. When asked to identify some of the other pages that had been faxed by HCC, Dr. Bowman testified that he did not recall seeing any of this information during the morning of October 2, or much later when reviewing their chart while preparing for this Inquest.

[234] As a result of EMS not being able to provide Dr. Bowman with any information concerning the medications that Donald was on when they brought him in to ER and due to not receiving the faxed medication list from HCC until later, Dr. Bowman did not know that Donald was on a high dose of Amitriptyline when the first cardiac arrest started. When asked about this, Dr. Bowman observed that in this case it probably would not have made any difference. This was due to the fact that their first concerns were with investigating why Donald was so short of breath, and then, within thirty minutes, they were in an emergent situation until Donald died. Dr. Bowman also testified that he could not recall ever seeing someone in emergency that had an Amitriptyline related cardiac arrest.

g) What Could Have Been Done Differently?

[235] Dr. Bowman was asked to comment on what he had been told had happened to Donald each step of the way that morning. He explained that the correctional staff could not have done anything more than they did that morning when they found him unresponsive. As well, the paramedics did what they were able to do. Once Donald arrived at the Grace Hospital, he deteriorated very quickly, and ER could only treat him on an emergent basis once the first cardiac event started happening. Dr. Bowman did note that it would have been helpful to have Donald's medical records from HCC from the moment he arrived at ER, especially since Donald was not able to answer any questions they might have had for him.

[236] Dr. Bowman was also asked to comment on the incident at HCC two nights before Donald's death when he had been having trouble breathing. Dr. Bowman explained that without knowing the cause of his shortness of breath 36 hours earlier it would only be speculating to say that it would have made a difference if Donald had been brought into ER at that time, rather than having a nurse see him later that morning at HCC. When the paramedics examined Donald at HCC they found no wheezing, the bilateral air entry was clear and normal, Donald's skin was warm and dry and they noted no change in skin colour. Yet an hour later when being examined at ER, all of this had changed; there had been significant deterioration in Donald's condition. He speculated that if Donald had been brought into ER that night, they might have done a chest x-ray, EKG and/or blood test; however, none of these may have shown any abnormality at the time.

[237] Dr. Bowman noted that none of the examinations or tests done on Donald when he arrived at ER that morning pointed towards coronary artery disease, and

there was no evidence of any symptoms or signs which would have indicated longstanding congestive heart failure. Dr. Bowman testified that the acutely dilated, or large, heart seen on the chest x-ray appeared to be as a result of the episode of congestive heart failure that morning. He explained that when someone has had a longstanding enlargement of the heart, an EKG will note a hypertrophy (or enlargement) to the left ventricular. That was not noted in Donald's x-ray.

[238] As well, the fact there was a lack of previous ischemia or infarct found in his heart during the autopsy, meant that there may never have been any symptoms which presented themselves prior to that morning. Additionally, based on the troponin levels they obtained, there had not been any injury to the cardiac muscles in the previous two days.

[239] When asked about any other training that could or should be provided to correctional officers, Dr. Bowman testified that he did not believe there was any training or education that the correctional staff could take that would improve their ability to spot heart disease and other diseases of that sort.

h) Recommendations

[240] Dr. Bowman testified that what might have helped the night that Donald was brought into ER was better medical and medication information. He pointed out that Donald was not in good enough health to answer the questions he had for him and so they had to rely on what EMS and the correctional officers told them and on what they observed. This could have been improved by having EMS or the HCC staff bring with them Donald's medical file, by having eChart available or by having Donald's medications available on DPIN. Dr. Bowman acknowledged that DPIN is better now and is expanding to more places - such as corrections, and that eCharting is being rolled out to more places and institutions. Basically, Dr. Bowman was in favour of anything, and everything, that can give them quicker, better and more detailed medical information at ER.

[241] When asked what, if anything, could be done to improve the medical care at HCC, or any custodial setting, Dr. Bowman thought that it would be reasonable to have 24/7 nursing, so that the correctional officers would not be the ones having to make a medical assessment in circumstances such as the one that Donald had presented with two nights earlier and again that morning.

F. PATHOLOGIST

1. Dr. Charles Littman

a) Introduction

[242] Dr. Littman is a forensic pathologist at the Health Sciences Centre. He is also a medical examiner for the Office of the Chief Medical Examiner, Province of Manitoba (OCME), and an Associate Professor, Department of Pathology, University of Manitoba. As a forensic pathologist, the majority of autopsies that he performs are under the Fatality Inquiries Act.

b) Donald Moose Autopsy

[243] In Winnipeg, all autopsies are performed either at the Health Sciences Centre or at the St. Boniface Hospital. When someone dies at the Grace General Hospital, their body is taken to the HSC for an autopsy. Dr. Littman was on duty on October 5, 2009, and since that was the morning that Donald's body was brought in, he did the autopsy. Dr. Littman began the autopsy at 8:45 am and completed it that day, likely sometime later that morning.

c) The Preliminary Report Of Death

[244] Dt. Littman issued a preliminary report of death within 48 hours of the autopsy. Given the extent of the significant coronary artery disease which he had observed during the autopsy, he felt he could state that the cause of death was atheromatous coronary artery disease and that the ancillary tests wouldn't change that opinion.

d) The Autopsy Report Released On December 10, 2009

[245] When Dr. Littman released his Autopsy Report on December 10, 2009, his findings were:

- Cardiomegaly (595 g).
- Atheromatous coronary artery disease.
- Amitriptyline overdose.

[246] Dr. Littman listed the cause of death as, "Amitriptyline overdose with contributory factor of atheromatous coronary artery disease." On the Autopsy Report Form the Amitriptyline overdose was listed as the "Part I, Immediate Cause of Death", or primary cause of death. Atheromatous coronary artery disease was listed under "Part II, Other Significant Conditions Contributing to the Death But Not Causally Related to the Immediate Cause Above".

[247] By this time, Dr. Littman had received the toxicology report from Dr. Meatherall, dated November 17, 2009. That report had found that the blood level for Amitriptyline was 1192 ng/mL and for Nortriptyline was 643 ng/mL, for a total of 1835 ng/mL. As Dr. Littman explained in the letter to the Crown, filed as Exhibit # 13:

> "These levels were in the range quoted in the literature (ref.) "as an indicator of lethality. . . and poses little likelihood of error". Despite the

> fact that levels were measured in a sample collected at autopsy which was performed 3 days after death, the reference also states "there is little evidence that post-mortem elevations in blood levels cause frequent problems in differentiating lethal from non-lethal levels (overdose from non-overdose cases)". Furthermore, the main increase was in the parent drug (Amitriptyline) with a lesser amount of its active metabolite (Nortriptyline) - the ratio was 2:1 - indicating that this was an acute overdose."

[248] Dr. Littman testified that he would generally talk back and forth with the toxicologist when asking for, obtaining and reviewing results; however, he couldn't recall consulting directly with Dr. Meatherall when dealing with these results in the fall of 2009.

[249] Dr. Littman explained that on a death certificate you can only have one cause of death. Sometimes there is more than one contributing factor to a death and this means that he will have to make a choice, a judgment call. What he found in Donald's autopsy was severe coronary artery disease, with evidence of acute damage to his heart; however he believed at the time that the acute overdose of Amitriptyline, which does have a cardio toxic effect, was the major cause of Donald's death.

e) The Autopsy Report, Dated October 1, 2013

[250] Dr. Littman testified that in preparation for testifying at this Inquest, he spoke with Dr. Meatherall about the toxicology report. In their discussion, they spoke about the blood specimen which was drawn from Donald when he arrived at the Grace Hospital some three hours before his death. Dr. Meatherall explained to him that back in 2009, this sample had been screened for drugs by way of a new drug testing method in their lab and that no levels were reported as a result. However, Dr. Meatherall reviewed the results and estimated that the levels of Amitriptyline and Nortriptyline were elevated, but nowhere close to the lethal range as had been reported in the post-mortem sample which Dr. Littman relied on in his earlier Autopsy Report. As well, the estimated levels were on a 1:1 ratio. Dr. Meatherall's actual estimates were, Amitriptyline: 318 ng/mL and Nortriptyline: 314 ng/mL. Dr. Littman offered two explanations for why the levels were so much higher in the blood screened three days after Donald's death:

i. Donald had taken a dose of Amitriptyline shortly before being taken to the Grace Hospital; therefore it was still being absorbed into his blood while he was in significant medical difficulty. At the time of his death it may well have been at its highest level.

ii. The phenomenon of post-mortem redistribution caused the drugs, which are stored in the muscle or fatty tissues, to leech into the blood. This can cause the

levels to be significantly higher in the blood after death, than a blood specimen from before death would show.

iii. Based on this new information, Dr. Littman changed his opinion. He now believed that the acute changes in the heart were more significant than the elevated level of Amitriptyline. He therefore revised the primary cause of death to being atheromatous coronary artery disease with the elevated levels of Amitriptyline and Nortriptyline being a contributing cause. Dr. Littman noted that there is always the risk, even if it is quite remote, that Amitriptyline can trigger an arrhythmic episode and even sudden death; the risk increases when heart disease is present, and is even greater when someone has significant coronary artery disease, such as Donald had. Even this increased risk is a small risk. Dr. Littman noted that the benefits of drugs like Amitriptyline far outweigh the risks, but it is always to be assessed and monitored.

f) Donald's Cardiovascular System

[251] Dr. Littman testified that Donald's heart weighed 595 grams, which is enlarged even for someone of Donald's weight, which was 96 kilograms, that is, over 200 lbs. This was indicative that either the heart was not functioning adequately, or that Donald had high blood pressure. The atria, the top chamber where the blood pumps from, showed that Donald had a small hole in his heart that was there from birth; however, Dr. Littman didn't see this as a problem. There were no clots within the appendages. The ventricles showed no evidence of scarring or mottling. The right ventricle measured 0.2 centimeters and the left ventricle was 1.3 centimeters; this was slightly bigger than normal, but the weight was in the normal range.

[252] When examining the coronary arteries, a sectioning of the vessels showed severe occlusive atheroma; there was blockage in all three major vessels. In particular, there was severe objecting occlusive atheroma in the left anterior descending artery; this is the artery which supplies blood to the anterior portion of the heart and the septum. There wasn't a thrombus, or acute event, here that caused this; it was something that had been happening gradually over time. Dr. Littman explained that Donald's coronary arteries were just as bad in the weeks or month before his death, and perhaps even six months earlier.

[253] The examination of Donald's heart showed acute ischemic changes in the anterior and septal sections. There was no scarring, revealing old infarcts or ischemia; these were microscopic acute changes which pointed to an ischemia that had just happened. These acute ischemic changes could have been the result of being medicated with Amitriptyline, but it is also possible that something such as having a large meal could have contributed to it. Dr. Littman explained that when the body diverts blood to the intestine to help with digestion after eating a large meal, this can reduce the blood pressure that is to be pumping blood around the coronary arteries. Something happened to cause an acute ischemic event in Donald's heart, but Dr.

Littman can only speculate as to which of a number of possible factors contributed to this event. Dr. Littman explained that even though the coronary artery disease was quite advanced, or "serious", it is not unusual for there to have been no warning signs, that there were no symptoms which had previously presented themselves.

g) Other Autopsy Findings

[254] Dr. Littman's examination of Donald's lungs showed patchy antracosis, indicative of him being a smoker. The lungs also showed marked congestion. This may have been due to the ischemic event which had just occurred, or as a result of the fluids pumped into Donald during the resuscitation attempts. All of Donald's other body systems, including the liver, were noted as unremarkable.

h) Conclusions And Recommendations

[255] Dr. Littman observed that even with knowing that Donald smoked, was overweight and had some history of diabetes, the finding of severe coronary artery disease in Donald, a 32 year old male, was surprising, though not unusual. Dr. Littman was asked if Donald's death was preventable. He commented that coronary artery disease is treatable; it is possible that this death could have been prevented if the disease had been found at an earlier time. He noted, however, that coronary artery disease remains a leading cause of death in western society, so it often goes undetected until it is too late.

[256] Dr. Littman had no recommendations to make.

G. PHARMACIST

1. Richard Thurmeier

a) Background

[257] Richard Thurmeier is the senior pharmacist at the St. Boniface General Hospital. His role as the senior pharmacist at the hospital is largely administrative and supportive. He is also keeps a clinic placement with the hospital's mental health program. He explained that this involves direct patient care; he believes that it is helpful to stay active in having some direct contact with patients. He is also involved in teaching, as an Associate Professor in Psychiatric Practice - Faculty of Pharmacy, for the University of Manitoba.

b) His Role In This Inquest

[258] Richard Thurmeier was asked to review the file information concerning Donald's death and then explain the medications Donald was on at the time, any pertinent pharmacologic, toxicologic and pharmacokinetic factors, provide his opinion regarding the tests and monitoring recommended for patients, and explain the signs and

symptoms that might be indicative of excessive amounts of Amitriptyline in an individual's system. His detailed report for the Inquest is found at Exhibit #16.

c) Donald's Medications

[259] Richard Thurmeier reviewed Exhibit # 2 - E6 - Donald's Medical Administration Record (MAR) for October, 2009, and explained the following with respect to the meds listed:

1. CELECOXIB (also known by its registered name, Celebrex) is a potent anti-inflammatory agent, prescribed for Osteoarthritis, Rheumatoid Arthritis and other sources of painful inflammation. Donald's dose was 200 mg per day, which is within the usual adult dose range. Richard Thurmeier explained that side effects are usually minor and he did not note anything in the Inquest file that caused him any concern about the side effects or amount of this medication that was being given to Donald.

2 & 3. GLYBURIDE (also known by its registered name, DiaBeta) and METFORMIN (also known by its registered name, Glucophage) are drugs used in the management of type II Diabetes (also known as NIDDM or Adult-Onset Diabetes). They are used to assist in bringing the blood sugar levels down to a target range in a patient. They are capable of causing an excessive drop in blood sugar levels, leading to a hypoglycemic state. Richard Thurmeier noted that there are studies which suggest that patients taking Amitriptyline are at higher risk of these hypoglycemic events.

4. ZOPICLONE (also known by its registered name, Imovane) is generally used for short-term symptomatic relief of insomnia. It is somewhat similar to the Benzodiazepines like Lorazepam and Xanax, but tends to have a lower potential for dependency. The drug monographs indicate a recommended dose of 5 to 7.5 mg per day (taken at bedtime); however, psychiatrists often prescribe dosages of 15 mg at bedtime. This is the dose Donald was on at the time. Richard Thurmeier explained that the drug is usually prescribed for a relatively short period of time, to help a patient when there is problematic sleep occurring, and then to withdraw the drug after a time. However, when a patient has a chronic sleep disorder or concurrent psychiatric issues, Zopiclone is sometimes prescribed for extended periods. (Donald had been on Zopiclone since April 30, 2009, first in the amount of 7.5 mg a day, and this was increased to 15 mg a day on July 21, 2009.)

5. GABAPENTIN (also known by its registered name, Neurontin) is a medication that was initially developed as an anticonvulsant, but is now

commonly used as a mood stabilizer (for example, for Bipolar Disorder) and for a variety of chronic pain disorders. Adult dosages may range from 300 to 3600 mg per day. Donald was taking 1500 mg a day, well within the therapeutic range. Gabapentin can cause some depression of the central nervous system (CNS); it is quite common for patients to feel quite drowsy when they are first taking the medication. Tolerance for the medication develops soon enough and so this is not an ongoing problem. (Donald had been on this medication since March 2009, it had been slightly increased from 1200 mg a day to 1500 mg a day on September 8, 2009.)

6. AMITRIPTYLINE (also known by its registered name, Elavil) is a Tricyclic Antidepressant (TCA). It is prescribed for depressive illness and anxiety disorders and is also useful in the management of recurrent or chronic pain. It may also help for sleep problems, but is generally not recommended for use just as a sedative-hypnotic. Richard Thurmeier writes in his report that, "Amitriptyline's effectiveness, and its potential for toxicity, are due in part to Nortriptyline. Nortriptyline is a pharmacologically active metabolite of Amitriptyline." He explains this as follows:

> "Amitriptyline and Nortriptyline demonstrate a dose-response relationship. Simply put, the higher the dosage the greater the likelihood of symptom response, functional recovery, and relapse prevention. In practice then, a prescriber who sees a partial response in a patient's symptoms at a given dosage will generally consider the pros and cons of increasing the dosage. This is especially true when the patient is not experiencing side effects. For TCAs, prescribers will generally use serum drug levels in order to maximize effectiveness while ensuring patient safety."

[260] Therefore, the goal is to find the lowest dose which works, that is, effectively treats the patient. As Richard Thurmeier explains in his report, "The most clinically useful levels are obtained once the patient is at a "steady state" (that is, when the amount of drug eliminated from the body is equal to the amount of drug which is absorbed by the body, over a 24-hour period)." It is expected that a male in his 30's, like Donald, would reach a steady-state within 5 to 7 days of taking a regular dosage (unless he has liver dysfunction). To determine the effectiveness, and to ensure it is not at a toxic level, a blood sample is obtained and examined. Richard Thurmeier explained that while 75 to 200 nanograms per litre may be noted as the recommended blood level, the therapeutic range is often between 200 and 250. When blood is to be drawn for analysis, the goal is to obtain a sample when the patient is at or close to a trough level. This targeted level is a combination of the Amitriptyline and Nortriptyline.

[261] The usual dosage when a patient is being treated for depression is 50 to 150 mg per day. This may be increased over time to 300 mgs, and there are rare occasions when it is even prescribed at up to 400 mg per day. At the time of his death, Donald was on a dose of 300 mg of Amitriptyline a day. This was broken up as follows: 50 mg at 8:00 am, 100 mg at 12:00 pm, and 150 mg at bedtime.

IX. SUMMARY AND CONCLUSIONS

[262] This Inquest Report has included a detailed summary of the evidence given by the witnesses and the evidence filed as exhibits. Every detail of the interactions with Donald, whether by an inmate, correctional staff, medical staff or emergency personnel has been carefully retold in this report. What emerges is a picture of an institution which took good care of its inmates, a busy medical staff that provided quality care for the inmates, and emergency personnel who did what they could with all of their professional ability and experience, during Donald's medical crisis.

[263] There are also some concerns with what was, or wasn't taken note of or done along the way. A number of the witnesses agreed that things could have been done better, or should have been done differently. While these matters of concern did not contribute to Donald's death, the following observations are noteworthy:

1. The correctional officers who testified clearly care about their job and the inmates they are responsible for. The CO's who work at ATC want to be there; they have to ask to work there and receive extra training for the job. In spite of this, a number of the inmates from ATC who testified and provided statements to the RCMP for this Inquest felt that they were not being heard or taken seriously when they brought their concerns to the staff. It may be that this is the reality of life in a custody setting; however, it was noteworthy that this distrust was not something any of the CO's mentioned when they testified. Perhaps this helps explain the discrepancy between what the inmates and the correctional officers have said. The inmates had concerns about Donald’s condition in the days leading up to his death and told the correctional staff about their concerns. However, the testimony of the correctional officers was that they did not notice this deterioration in Donald’s health or recall any inmates express any concerns to them about his condition.

2. There were some problems with how information was recorded by correctional staff and how information was passed on from one shift to another at HCC. The September 30 incident with Donald is an example of this. A medical situation arose overnight and was handled by the correctional officers on duty. DS Hand testified that what should have happened is that:

a.) the overnight staff would talk to the Duty Office about the incident,

b.) it would be recorded in the notes, and

c.) it would be discussed at the morning meeting.

This may in fact be what did happen; however, DS Hand does not know and there is no documentation confirming that any of this happened. The only remaining documented note is what was in Donald's Running Record Report, created by CO Murphy at 3:37 am on September 30.

Not only is there no notation about what was discussed with the Duty Office or at the morning meeting, there are also no medical records concerning Donald being seen by a nurse that morning. That had been what was discussed and decided during the early morning incident with Donald, but we don't know if it happened. (On the next day, October 1, Donald was seen at the medical clinic by Dr. Atwal, with the assistance of Nurse Dziadyk. Their notes cover the concerns they had with respect to Donald's health that day, but do not specifically mention anything about the September 30 incident or mention if Donald was seen by anyone on September 30. In addition to this, Nurse Sichewski testified that he would have seen Donald at 8 am and at noon on October 1, when giving him his meds.)

DS Hand also admitted that it had been an error on his part to not note exactly when, on October 2, he had walked to the medical office and obtained Donald's medical file and then secured it under lock and key. If he had recorded when he had done this, it may have assisted in trying to determine when the September MAR went missing and where it might have ended up, as Psych Nurse Unrau was very clear in her testimony that she had reviewed Donald's medical file on October 2, and seen the September MAR, with her hand written note on it.

3. Some witnesses suggested that HCC should have 24/7 nursing, in other words, a nurse on duty at all times. Others did not agree with this, however, there was a consensus that HCC should have nurses on duty through the entire evening. At present, nurses are on duty until around 7:45 pm; this would mean that there would be a nurse on duty until at least 11:00 pm. As DS Hand explained, the funding for this is in place, but there have been recruitment issues.

At the present time, when a medical situation arises at a time when there are no nurses on duty, it is up to the correctional officers or Code Responders on duty to assess and provide assistance to an inmate, at

least until EMS arrives. All CO's have First Aid and CPR training; however, it would appear that even the Code Responders do not have the necessary training to make use of all of the equipment available to them for a medical emergency.

4. There were some issues with the recording of notes or charting on Donald's medical file. The blank Problem List sheet on Donald's medical file stands out. Nurse Sichewski testified that these forms are usually completed for inmate's medical files; he does not know why it wasn't filled out for Donald. The Problem List, or a similar page on an electronic file, should contain a synopsis of any significant medical issues the patient might have. If it had been appropriately filled out and updated from time to time, this might have been a valuable page to fax or email to ER that morning when Donald was rushed to the Grace Hospital.

   If the Problem Sheet had been appropriately used and passed on, it might also have contained a summary from the Brandon Correctional Centre concerning Donald's high blood pressure when he was there in 2006. As well, if a family medical history had ever been obtained from Donald, this page might have noted the family history of cardiovascular disease. These are all examples of possible notes which potentially could have made a difference in Donald's ongoing care prior to October 2.

   Dr. Atwal's October 1 note, on Donald's medical file, has a number of abbreviations that the doctor used and this note is difficult for even a trained nurse to read and understand. It may have been a busy clinic that day; however, less than 24 hours after Dr. Atwal wrote that note, Donald had been taken by EMS to the Grace Hospital and died in their ER. While it appears not to have mattered in Donald's circumstances, understanding Dr. Atwal's medical assessment from the day prior might have been extremely important for the emergency medical providers that day. There is a reason why all medical professions are to be legible and comprehensible when writing notes on a medical file. This is a good example of why it is important.

5. It appears that medical file audits and performance reviews are not done on a regular and consistent basis; the missed file audits may be due to budget constraints and the less than frequent performance reviews may be due to workload issues. If a file audit of Donald's medical file had taken place, it is likely that the blank Problem Sheet would have been seen. As noted earlier, having an appropriately completed Problem Sheet might have been helpful.

6. The missing MAR is of great concern; what happened to it remains a mystery to this day. It appears not to have been part of the faxed

medical information sent by HCC to the Grace Hospital that morning; it is clear that Psych Nurse Dziadyk saw it on October 2; it probably had been pulled from the general September MAR's binder before then; and it likely was not on Donald's medical file when DS Hand took custody of the file and locked it up in his office. Given the fact that Amitriptyline overdose was listed as the primary cause of death on the Autopsy Report on December 10, 2009 and not changed until October 1, 2013, not having a record of what doses of Amitriptyline Donald was actually given, and when, in the month before he died, must have been significantly troubling to the Moose family and a number of the witnesses who testified at the Inquest. The missing MAR remains a significant concern for this Inquest; however, not knowing what happened to it makes it difficult to comment further on it or make any recommendations as a result.

7. Donald was in custody for lengthy periods of time on several occasions before he died. It is surprising that given the number of times Donald was seen by nurses and doctors during those months that no nurse or doctor ever recorded a family medical history for Donald. It may be that they he never volunteered the information, it may be that no one ever asked him, it may be that someone asked and he wouldn't or couldn't answer, or that the information was given but never recorded on his file. Given the history of cardiovascular disease present in his family, this information may have assisted in someone taking some further steps to assess, test or treat Donald. It is information that might have helped Donald have a better treatment outcome.

8. There appears not to be a lot of general education about one's personal health offered to inmates at HCC. As cardiovascular disease is a leading cause of illness and death for aboriginal people and HCC has a disproportionally high aboriginal population, there should be some personal health care education or workshops designed to educate inmates in this area, with a particular focus on learning about your own family medical history and the importance of sharing that information with your health care providers.

9. Inmates who have diabetes are encouraged to regularly check and chart their blood sugar levels. It is surprising that there is no similar option for inmates with respect to checking their own blood pressure. Relatively inexpensive user friendly machines could be purchased and place in each of the units. Given the medical complications that can arise from high blood pressure, this would be worth the cost.

10. Psych Nurse Dziadyk was concerned about the amount of Amitriptyline that Donald had been prescribed and the high blood level results they had received when testing his blood. Dr. Waldman was not so concerned, because of:

    a.) his knowledge that Donald's previous treatment had been successful with a high dose of Amitriptyline,

    b.) the fact that the blood level results were not trough levels, given when Donald had last taken a dose of Amitriptyline and when Donald's blood had been drawn for testing, and

    c.) the slow and steady increases in Donald's doses appeared to be having the desired result; in his opinion, Donald was now at or near the right dose.

    While this is what Dr. Waldman testified to, it is clear that he did not write all of these observations down on Donald's medical file and he appears to not have explained this thoroughly enough to Psych Nurse Unrau. It would appear that a better effort could have been made in co-ordinating the timing of the taking of Donald's blood. All that was needed was for Donald's blood to be drawn just prior to his morning meds being taken. This is an example of where communication between the nurses and the psych nurses or psychiatrist would have been helpful.

    Again, given the longstanding finding of Amitriptyline overdose as being the primary cause of death, clear and detailed notes about why he was providing more than the recommended dose would have been helpful. How, or to what extent an elevated level of Amitriptyline/Nortriptyline contributed to the atheromatous coronary artery disease which caused Donald's death may never be known, however, more detailed information about Dr. Waldman's course of treatment would have made it easier to assess what had happened, when looking back after Donald's death.

X. RECOMMENDATIONS:

<u>Recommendation #1</u>: That HCC - and other provincial correctional facilities - formalize a system for inmate complaints that includes an inmate's committee or an inmate representative from each unit who is delegated to bring complaints or issues to the attention of the staff.

[264] This can include any concerns: food, clothing, etc., but in particular, if there is any medical or mental health concerns about another inmate, no matter how insignificant it may seem to be, that they will be heard and addressed by the staff.

[265] The evidence this Inquest has heard showed that the correctional officers are sensitive to the needs of the inmates and appear to care about them. This may be particularly so in a unit such as ATC, where they have to request to work and then receive extra training to work there; however, even at ATC there was a general mistrust of the staff by the inmates. A number of them felt they weren't being heard; that there was no point in telling them that they were concerned for Donald's health. If the staff had been told about the inmates concerns for Donald's health when they first saw something, it is possible that Donald might have had a better treatment outcome.

[266] While there are inmates who are trustees within the provincial system, what is being contemplated here is for a more specific purpose. It is readily acknowledged that having an inmates' committee or inmates' representative on each unit will be more difficult in the provincial corrections system where inmates are there for shorter periods of time and being moved about more frequently. There will need to be some creative solutions to make these committees or representatives function well, but it is worth effort to try and make this work.

> **Recommendation #2: That HCC - and other provincial correctional facilities - continually evaluate, review and improve their medical record keeping, including expanding electronic and DPIN records as much as possible. This should include the ability to share those records with hospital emergency rooms.**

[267] It is important that all inmate medical file records have a patient summary, or "Problem Sheet" completed and kept up to date so that when an urgent matter or emergency arises with respect to any inmate, there is a brief and relevant summary available for quick access. As well, the Problem Sheet, or similar pages on an electronic file, should be checked and updated at the time of an inmate's release from custody so that it presents an accurate reflection of the inmate's medical issues at that time. This page should be readily accessible to them if he or she ever returns to custody. Accurate, clear and concise medical documentation which facilitates communication and assists with continuity of care for each individual inmate is what is to be strived for. This should be equally true of all nurses, doctors, psych nurses, and psychiatrists working within or for the corrections system.

> **Recommendation #3: That HCC extend nursing hours to 11 pm as soon as possible.**

[268] This Inquest was advised that the funding was in place but that there had been recruitment issues. Based on the evidence given at this Inquest, this should remain a priority for HCC. In addition, HCC should continually review all overnight medical situations with a view to reassessing the merit of 24 hour staffing. This should include evaluating every medical situation that arises during a time when there is no nursing staff on duty and assessing what difference a nurse might have made if he or she had been available for that situation.

<u>Recommendation #4</u>: That HCC - and other provincial correctional facilities - develop and regularly offer a public health information program or workshop for inmates that is specifically geared to heart disease.

[269] As this Inquest has heard, heart disease is a leading cause of death in Canada, and it often goes undetected until it is too late.

[270] This program or workshop should include information about how important it is to give the medical staff an accurate family medical history, the signs and symptoms of heart disease, how your diet can help, and how you can take control and care of your own health, both when in custody and once out.

[271] **Hopefully, the preceding recommendations will result in the prevention of another death in the same manner that resulted in the untimely passing of the late Mr. Donald Moose.**

Dated at the City of Winnipeg, in Manitoba, this 15th day of May, 2014.

Original signed by:

Provincial Court Judge Robert Heinrichs

Manitoba

THE FATALITY INQUIRIES ACT, C.C.S.M. c. F52

REPORT BY PROVINCIAL JUDGE ON AN INQUEST INTO THE DEATH OF:

DONALD RAY MOOSE

(DATE OF DEATH: October 2, 2009)

EXHIBIT LIST

Description

1. EX 1 Letter calling the Inquest (A2 in Section I of the documents)

2. Ex 2 Accordion file of documents Section I: A-D (CME's material) and Section II: E (Headingley Correctional Centre materials)

3. EX 3 Bound copy of Supplemental documents provided by Headingley Correctional Centre

4. EX 4 Video of dorm and correctional officers' response dated October 2, 2009

5. EX 5 Annotated timeline of video of Assiniboine Treatment Centre Dorm, HCC on October 2, 2009

6. EX 6 Photograph of Donald Ray Moose

7. Ex 7 Compilations of Handwritten Letters

8. EX 8 Staff Training and Development MB Correction's Basic Training 10 Week Program

9. EX 9 Shift Pattern

10. EX 10 Pay period for September 26 to October 9, 2009

11. EX 11 Curriculum Vitae of Charles D. Littman

12. EX 12 Autopsy Report Form

13. EX 13 Letter dated October 1, 2013 from Diagnostic Services of Manitoba, Health Sciences Centre prepared by C. Littman, MBChB, FRCPC, DipRCPath, Pathologist together with email to J. Negrea from Robert Meatherall dated October 16, 2013.

14. EX14 Curriculum Vitae Thomas Maxwell Bowman

15. EX 15 Curriculum Vitae of Rick R. Thurmeier

16. EX 16 St. Boniface General Hospital Report prepared by Rick Thurmeier, R.Ph., BSc. Pharm., BSc Chem.

17. EX 17 Curriculum Vitae of Dr. Jasdeep Atwal

18. EX 18 Headingley Correctional Centre Blood Sugar Record together with attached Health Service Progress Notes (2 pages)

19. EX 19 Curriculum Vitae of Jeffrey C. Waldman, MD, FRCPC

20. EX A Medical Clinic Record Book

21. EX B Psych. Clinic Record Book (May through October)

22. EX 20 Manitoba Justice Invitation, Culturally Appropriate Program together with Outline of Topics