RELEASE DATE: June 5, 2014

Manitoba

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **DOUGLAS LEON SANDERSON, Deceased**

Report on Inquest of
The Honourable Judge Dale C. Schille
dated this 2nd day of June, 2014

APPEARANCES:

Mr. Mitchell Lavitt, Inquest Counsel
Ms Denise Pambrun, for the City of Winnipeg
Mr. Hymie Weinstein, Q.C., for the Main Street Project
Ms Catherine Tolton and Mr. Dan Ryall, for the Winnipeg Regional Health Authority
Mr. Thor Hansell, for Dr. Ewa Courvoisier-Grzywacz

RELEASE DATE: June 5, 2014

Manitoba

THE FATALITY INQUIRIES ACT

REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF DOUGLAS LEON SANDERSON

Having held an inquest with respect to the death of Douglas Leon Sanderson on November 12, 13, 14 and 15, 2013 and December 3, 4 and 5, 2013 at the City of Winnipeg, in Manitoba, I report as follows:

Douglas Leon Sanderson came to his death on November 30th, 2009 in the City of Winnipeg, in Manitoba.

The cause of death was severe recent blunt force head injury.

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

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

Dated at the City of Winnipeg, in Manitoba, this 2nd day of June, 2014.

Original signed by Judge D. Schille

_____

Dale C. Schille
Provincial Judge

copies to: Dr. A. Thambirajah Balachandra, Chief Medical Examiner (2)
The Honourable K. Champagne, Chief Judge, Provincial Court of Manitoba
The Honourable A. Swan, Minister of Justice and Attorney General
Ms Donna Miller, Q.C., Deputy Minister of Justice and Deputy Attorney General
Mr. Michael Mahon, Assistant Deputy Attorney General
Ms Lorraine Prefontaine, Director of Specialized Prosecutions
Mr. Russ Ridd, Director of Regional Prosecutions

Mr. Mitchell Lavitt, Inquest Counsel
Ms Denise Pambrun
Mr. Hymie Weinstein, Q.C.
Ms Catherine Tolton and Mr. Dan Ryall
Mr. Thor Hansell

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THE FATALITY INQUIRIES ACT
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I. INTRODUCTION

[1] Douglas Leon Sanderson (age 67) died at Health Sciences Centre (HSC) in Winnipeg on November 30th, 2009. On October 18th, 2011 Dr. A. Thambirajah Balachandra, Chief Medical Examiner of Manitoba, sent a letter to the Chief Judge of the Provincial Court of Manitoba.

[2] The letter stated, in part:

> Thus, in accordance with subsection 19(2) of *The Fatality Inquiries Act*, I direct that an inquest be held into the death of Douglas Leon Sanderson for the following reasons:
>
> 1) to determine the circumstances relating to Mr. Sanderson's death, including the appropriateness of the method of assessment used by Winnipeg Fire and Paramedic Service, which "medically cleared" Mr. Sanderson to be taken to Main Street Project;
>
> 2) to examine the method used to monitor detained persons at Main Street Project, particularly as it pertains to:
>
> (a) initial assessment of a detainee; and,
>
> (b) periodic assessment of the detainee while in lock-up; and,
>
> 3) to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[3] *The Fatality Inquiries Act* requires that I make and send a written report of the inquest to the Minister setting forth when, where, and by what means Mr. Sanderson died, as well as the cause and material circumstances of his death. I have the discretion to make recommendations respecting programs, policies or practices of the government and the relevant public agencies and/or institutions, or the laws of the Province if, in my opinion, it would help to reduce the likelihood of deaths occurring in similar circumstances. My mandate does not permit me to express opinion or determine culpability.

II. MATERIAL CIRCUMSTANCES SURROUNDING THE DEATH OF DOUGLAS LEON SANDERSON

[4] On November 27th, 2009 Douglas Leon Sanderson (Mr. Sanderson), age 67, attended the Vendome Hotel in Winnipeg. The deceased arrived before lunch and visited with friends who resided at the hotel and consumed alcohol. Alcohol was consumed in a friend's room as well as in the bar on the main floor of the hotel. Mr. Sanderson was described as being extremely intoxicated. At one point the accused was found on the floor of the bar having fallen off the stool where he was drinking. No one witnessed the fall and it is possible that Mr. Sanderson struck his head when he landed on the floor. The Downtown Business Improvement Zone

Patrol (Biz Patrol) was summoned to assist Mr. Sanderson. A friend of Mr. Sanderson directed the Biz Patrol members to assist Mr. Sanderson upstairs to the friend's room. Mr. Sanderson was unable to walk without assistance. Once upstairs Mr. Sanderson refused to stay in his friend's room and he left and the door shut behind him. Mr. Sanderson was found shortly afterward just outside the door lying on the floor conscious and moaning. Carey Frisette, a friend of Mr. Sanderson, heard the fall and it sounded like his head made significant contact with the floor. Mr. Frisette felt Mr. Sanderson's head and did not detect any sign of injury. An ambulance was called and paramedics arrived and attended to Mr. Sanderson as he lay in the hallway. Visual inspection of Mr. Sanderson noted no visible injuries nor was there any complaint of injury. Paramedics conducted an examination and his vital signs were within normal limits. Mr. Sanderson refused to go to the hospital but agreed to attend to the Main Street Project (MSP) when it was offered. The paramedics summoned the Biz Patrol to transport Mr. Sanderson to the MSP. Paramedics communicated to the Biz Patrol that Mr. Sanderson was medically cleared to be lodged at the MSP. Biz Patrol members took Mr. Sanderson directly into a cell within the *Intoxicated Persons Detention Act* (IPDA) section of the MSP.

[5] On admission the MSP staff was advised that paramedics had medically cleared Mr. Sanderson to be lodged at the facility. Following his admission Mr. Sanderson was checked every 15 minutes and no signs of distress were observed. During the early morning hours staff attempted to rouse Mr. Sanderson for discharge as he had been lodged longer than any of the other detainees and a number of people were waiting for admission. When roused security video showed that Mr. Sanderson had difficulty getting to his feet. As Mr. Sanderson walked down a hallway he fell against the wall and struck his head on a fire extinguisher before falling to the floor. It was assumed that Mr. Sanderson was still too intoxicated to be discharged and he was assisted back to his cell. Approximately 4:45 a.m. staff entered the cell and Mr. Sanderson still appeared intoxicated. Sufficient time had elapsed so that Mr. Sanderson should have become sober and it was feared that he may be suffering from alcohol poisoning. Mr. Sanderson was removed from his cell and placed in a wheelchair in the admissions area and an ambulance summoned. Paramedics attended and noted abnormal vital signs. The left pupil was larger than the right and unresponsive to light. In addition the Glascow Coma Scale score was below normal. Both abnormities in the vital signs are possible indicia of brain injury. Mr. Sanderson was transported to HSC and turned over to another team of paramedics pending admission. Examination done by paramedics at HSC noted similar abnormalities of the eyes as well as the Glascow Coma Scale. The doctor who treated Mr. Sanderson on intake noted the same abnormalities and at least one additional test administered in the emergency room was also potentially indicative of brain injury. Further tests were ordered including a CT scan of Mr. Sanderson's head. The CT scan depicted acute swelling of the brain resulting from head

trauma. Steps were taken to mitigate the effects of the brain swelling including surgery to remove a portion of skull. Medical intervention was unsuccessful and Mr. Sanderson died on November 30th, 2009.

Appropriateness of the methods of assessment used by Winnipeg Fire Paramedic Service which "medically cleared" Mr. Sanderson for transport to the Main Street Project

[6] Diagnosis of any medical condition for any patient is not an exact science. For the cliental of the MSP that is perhaps particularly true. At the inquest into the death of Leon Herman Bighetty (report issued August 2nd, 2005 by the Honourable Judge Marva Smith), Dr. Lindy Lee, the then Director of Emergency Medical Services at HSC, described the challenge of medically clearing persons for admission to the MSP:

> This is such a high risk group that physicians clearing them as well are going to miss some head injuries and some other medical conditions....Many of them have chronic health problems, past head injuries, seizure disorders, chronic malnutrition, they may have liver disease that leads to bleeding disorders, so even a minor blow on the head can result in a higher chance of having a bleed in your brain.

[7] On November 27th, 2009 Winnipeg Fire Paramedic Service (WFPS) were dispatched to the Vendome Hotel to deal with a patient. The nature of the call was described as "falls". The record of the treatment administered to Mr. Sanderson was recorded in a document entitled "Patient Care Report", a three-page document (Appendix 1). The report is prepared using a handheld electronic tablet upon which a Patient Care Report template is contained. The paramedics scroll through fields within the template and enter specific information. Each call is assigned a run number which is an identifier specific to each call for service. Multiple paramedics have the ability to enter information on different tablets relating to one specific run number. There were at least two separate crews that attended the hotel comprising four individuals. The primary treatment was provided by Paramedics Moharib and Campbell who are both trained as Primary Care Paramedics which is the basic level of training for paramedic certification. Both Moharib and Campbell had virtually no present recollection of this call and relied heavily on the Patient Care Report. The narrative portion of the report which appears on the second page of the report was entered by another paramedic crew that responded to the call for service when Moharib and Campbell were already on scene. The remaining information was inputted by Campbell based on what was verbally relayed by Moharib who was physically dealing with Mr. Sanderson. Paramedic Moharib does not know the source of the information "Substance Abuse" which was entered under the heading Past Medical History.

[8] Paramedic Moharib checked Mr. Sanderson's vital signs once at 8:37 p.m. and again at 9:20 p.m. On both occasions the vital signs were normal with nothing that raised concerns. Vitals signs checked by paramedics in Winnipeg include but are not limited to: blood pressure, pulse, respiration, oxygen saturation, blood glucose level and Glascow Coma Scale. The Glascow Coma Scale (GCS) is a compilation of assessments of the patient's eyes, verbal communication and motor skills. Verbal skills are assessed to see if the patient is verbally responsive to commands and oriented to person, place, time and event. Typically the patient is asked to repeat a simple phrase. Both eyes are checked for pupil size, reaction to movement and reaction to light (variation between the eyes is considered symptomatic of possible brain injury). Assessment of motor skills consists of asking the patient to respond to verbal commands to move a part of their body. Part of the motor skills assessment includes asking the patient to squeeze the paramedic's fingers with each hand. The paramedic is checking not only that the patient is able to follow the command but also that the force of pressure is equal on both sides (variation considered symptomatic of possible brain injury). Based on the assessment a numerical score is generated based on a maximum of 15.

[9] Checking vital signs is a universal standard for diagnostic health care sufficient in my view that any court could take judicial notice of this fact. In dealing with Mr. Sanderson the paramedics employed standard diagnostic tests. On the evidence there is no suggestion that the tests were improperly administered or that the results were improperly recorded. The fact that vital signs were taken on two separate occasions 43 minutes apart with almost identical results enhances the reliability of the results.

[10] Dr. Roy Grierson is the Medical Director of the Winnipeg Fire Paramedic Service and oversees training and policies. Dr. Grierson reviewed the Patient Care Report from November 27th, 2009 and he saw no clinical evidence to indicate that Mr. Sanderson had a brain injury when he was treated nor did he see any history contained in the call report to support it. Dr. Grierson was involved in the formulation of an admissions protocol that is currently used by paramedics working at the MSP to clear persons for admission. Under current protocols used by the MSP staff to conduct an independent medical assessment prior to intake, Mr. Sanderson would still be admitted to the MSP under similar circumstances.

[11] On the evidence it is clear that in the event that Mr. Sanderson had an existing brain injury when medically cleared for admission to the MSP the bleeding had not progressed to the point that vital signs were impacted by symptoms. In short, there was nothing to signal to paramedics the presence of a brain injury. It appears that only complex diagnostic equipment such as a CT scanner could have confirmed the presence of subdural brain bleeding.

[12] In my view the methods used to assess Mr. Sanderson and clear him for transport to the MSP were appropriate.

Assessment of Mr. Sanderson at the Main Street Project upon admission and while detained in lock-up

[13] Policies and procedures now in place at the MSP are vastly different than in November 2009. The changes that have occurred at the MSP were primarily due to recommendations made in the inquests into the deaths of Cheryl Lynn Tom (date of death March 26th, 2007), report issued July 4th 2011, and Maurice Paul Thomas (date of death May 7th, 2008), report issued July 15th, 2011. Both deaths involved persons who had been detained at the MSP as intoxicated persons. The combined number of recommendations from the two inquests totalled 30 and virtually all have been implemented.

[14] For the sake of completeness, a summary of all material changes that have been made at the MSP following the death of Douglas Sanderson will be included later in this report.

[15] Kim Parry was the staff member on duty when Mr. Sanderson was brought in by Biz Patrol staff. The admission process was video recorded without audio. The admission consisted of Ms Parry receiving from Biz Patrol staff Mr. Sanderson's name and a brief description of the circumstances of his detention. It is important to note that Ms Parry was advised that paramedics had medically cleared Mr. Sanderson to be lodged. Ms Parry accessed the MSP computer records which contained information showing that Mr. Sanderson had been lodged on previous occasions and listed limited medical information obtained previously, specifically that he had high blood pressure. The admission process included checking Mr. Sanderson for any sign of physical injury and none was noted. Ms Parry also noted that Mr. Sanderson appeared drunk. Ms Parry noted all this pertinent information on an I.P.D.A. Intake form (Appendix 2). Biz Patrol members walked Mr. Sanderson to the last available cell, number 12, which is equipped with a camera. In November 2009 not all of the cells were equipped with cameras.

[16] After admission the MSP staff did a visual inspection of Mr. Sanderson every 15 minutes which was documented on a check sheet (Appendix 3). Mr. Sanderson was woken every two hours. According to the MSP staff the practice was to have the client verbally confirm that they are alright when they are woken up every two hours. On each check staff noted on the sheet whether Mr. Sanderson was awake, sleeping or moving. Surveillance recording shows during the majority of the time in the IPDA unit Mr. Sanderson was sleeping. Mr. Sanderson is seen moving positions during sleep in a manner that would be considered normal.

[17] At 1:58 a.m. Tom Sanderson entered cell 12 where Mr. Sanderson was lodged. Tom Sanderson indicates at the time there were numerous persons awaiting admission to the MSP and his intention was to discharge Mr. Sanderson as he had been there longer than any other client. Video surveillance shows that Mr. Sanderson had considerable difficulty getting to his feet. Mr. Sanderson was on his hands and knees for a period of time and only managed to gain his feet by using the doorframe as support to pull himself up. Once Mr. Sanderson was on his feet Tom Sanderson walked ahead of him leading him down a hallway to the discharge area. Mr. Sanderson was unsteady on his feet and he lost his balance and stumbled into the wall and struck his head on a fire extinguisher mounted on the wall before falling to the cement floor. Tom Sanderson was positioned between the camera and Mr. Sanderson when he contacted the floor; consequently it is unclear whether he was able to use his hands to partially break his fall. Tom Sanderson was walking with his back to him leading him out of the cells and heard but did not see the fall. Tom Sanderson with another staff member lifted Mr. Sanderson to his feet and while supporting him on both sides walked back to his cell, placing him inside in a prayer position. Mr. Sanderson was unable to maintain his position and fell forward and appeared to strike his head on the wall.

[18] Just before 6:00 a.m. Tom Sanderson again entered cell 12 with the intention of discharging Mr. Sanderson. Mr. Sanderson appeared to still be drunk and Tom Sanderson formed the opinion that he might be suffering from alcohol poisoning. Tom Sanderson placed him on a mat and dragged it out into the hallway where the lighting is better and assisted him to a sitting position. Mr. Sanderson was unable to maintain the sitting position unaided and he fell back and appeared to strike his head. Tom Sanderson yelled for help and Mr. Sanderson was placed in a wheelchair and taken to intake pending the arrival of paramedics.

III. SUMMARY OF CHANGES AT THE MAIN STREET PROJECT

[19] As previously indicated there have been wholesale changes to the MSP policies procedures and staffing since November of 2009.

[20] The most significant change involves the addition of an advanced care paramedic at the facility 24 hours a day. There are a dedicated team of paramedics employed by WFPS seconded to work at the MSP. The paramedics are not assigned to work exclusively within the IPDA unit and service other units within the facility. It is my understanding that a majority of the paramedics' shift involves service to IPDA detainees and they can be summoned to provide service or advice at any point by staff. Paramedics are also utilized as a program resource to help develop and administer in-house training. The witnesses associated with the MSP were unanimously of the view the presence of the paramedics has significantly enhanced the quality of service to clients. It appears that the paramedics interact smoothly with the MSP staff and

there is no hesitation on the part of staff to seek assistance from paramedics. The sad reality for many of the disadvantaged clients of the MSP is that the paramedics are their primary health care provider.

[21] Each client is now medically assessed by a paramedic prior to admission to the MSP. This is done despite the fact that each client has been medically cleared prior to transport to the MSP. A new intake assessment form has been developed and implemented which captures significantly more information about the client (Appendix 4). Dr. Grierson was able to describe several instances where the intake assessment conducted by a paramedic resulted in identifying previously undiagnosed medical conditions which resulted in the client being refused admission and instead transported to a hospital. It is Dr. Grierson's opinion that the paramedic intake assessment has likely prevented deaths since implementation.

[22] A protocol for intake assessments has been approved and is currently being implemented for use by all paramedics in the city (Appendix 5).

[23] Staff levels within the IPDA unit have also been enhanced. On November 28th, 2009 Thomas Sanderson was the only permanent staff member on duty and he was assisted by a staff trainee during a very busy night. Currently two permanent staff are on duty during each shift. The paramedic and any trainees are in addition to the two permanent staff.

[24] Presently all 20 cells are equipped with video surveillance cameras.

[25] Cardio Pulmonary Resuscitation masks are located between sets of cells for a total of 10 units.

[26] The wall-mounted fire extinguisher has been relocated to a location that clients do not have to pass.

[27] Training for new staff has been enhanced. Each staff received 64 hours of instruction over a period of two weeks. On each shift one of the two staff must have Emergency Medical Responder (EMR) training or higher.

[28] Staff are now trained to maintain visual observation of clients when escorting them to/from cells.

[29] Staff are now trained in how to position clients to best avoid the client experiencing distress or injury.

[30] A paramedic is now available for consultation relating to the decision to discharge a client.

[31] The monitoring of clients during detention in cells has also been enhanced. A new monitoring form has been developed and implemented. The new form requires the recording of more detailed information about the client during each check (Appendix 6). The frequency of checks has also been increased from every 15 minutes to every 10 minutes. Clients are now woken up more frequently. Now staff wakes the clients each hour for the first two hours and every two hours thereafter. If clients haven't been discharged at six hours they are assessed by a paramedic.

[32] Staff are now equipped with walkie-talkie communication equipment and are expected to carry it with them during periodic checks on clients. It would no longer be necessary for Thomas Sanderson to yell for help the way he did in November 2009.

[33] There is now a protocol in place that if any staff witnesses a client fall the paramedic is summoned to conduct an assessment.

IV. DISCUSSION AND RECOMMENDATIONS

[34] The evidence does not indicate that Mr. Sanderson had an existing brain injury when he was medically cleared for transport to the MSP. Conversely, the evidence is insufficient to support a finding that the brain injury suffered by Mr. Sanderson occurred at the MSP. The physiology of the cause of death was trauma to the brain which caused internal bleeding within the brain resulting in massive swelling of the brain which resulted in death. Comparing the evidence of Dr. Grierson to that of Dr. Marc Del Bigio (Neurological Pathologist, Health Sciences Centre, Professor of Neuropathology, University of Manitoba, Faculty of Medicine) there does appear to be some difference of opinion. Dr. Grierson is a doctor with just under 20 years of experience. Dr. Grierson is currently the Medical Director of the Winnipeg Fire Paramedic Service. That position is half-time; the other half of his practice is spent as an emergency room doctor at HSC. When Dr. Grierson was asked if it would be difficult to determine when the brain bleed actually commenced given there may have been multiple trauma to the head over several hours he answered as follows:

> If it is a large brain bleed of the nature of what happened to Mr. Sanderson the one that actually eventually was the fatal insult. It is going to develop and when you look at the size of that you are going to have some evidence of that reasonably rapidly. A smaller bleed or a more minor head injury might take longer to develop so it is possible that that Mr. Sanderson could have had a minor injury coming into the Main Street Project. I suppose it is possible. There is no clinical evidence to support that and from what I saw

> in the call reports there is no history to support that. Would it have been a fatal injury? No. Not on what I see.

[35] It would appear from that response that Dr. Grierson does not consider as a viable possibility that Mr. Sanderson was admitted to the MSP with a pre-existing injury which ultimately caused his death.

[36] According to Dr. Del Bigio the prognosis for survival and full recovery for Mr. Sanderson was quite favorable with timely medical intervention. Dr. Del Bigio indicated that pre-existing medical conditions could predispose a person to brain injury. It is important for diagnostic purposes to have access to the medical history of the patient in order to assess if any of those risk factors are applicable to the patient. There is evidence that Mr. Sanderson abused alcohol, suffered previous strokes, was 67 years of age and had high blood pressure. All of these factors would impact to predispose him to brain injury. A physiological predisposition to brain injury would result in a decrease of the degree of force required to cause a brain bleed. It is the opinion of Dr. Del Bigio that the degree of force which caused the brain injury in Mr. Sanderson was in the lower continuum of the spectrum. That opinion was founded in part on the lack of visible signs of injury such as bruising. Dr. Del Bigio indicated that either the fall from the stool or the fall in the hallway could have caused the brain injury he observed.

[37] Dr. Del Bigio indicated that the rate of bleeding within the brain is proportionate to the size of the blood vessel that is compromised and degree to which it is compromised. There is no way to determine which blood vessel or vessels have been ruptured. Dr. Del Bigio indicated that a large amount of bleeding in the brain could be indicative of a major blood vessel or artery being compromised. It is also possible that a minor injury could result in significant bleeding and that quantity observed is simply a function of time over which the bleeding occurred. Consequently, it is not possible to identify one specific trauma and formally eliminate it as the fatal injury on the basis that the trauma was insufficient to have caused the injury. Similarly, identifying a specific trauma and considering the amount of time that passed before symptoms manifested is also not of assistance in identifying the fatal trauma. Dr. Del Bigio indicated that it is possible an existing brain injury could be exacerbated by a subsequent trauma to the same blood vessel or trauma rupturing an additional blood vessel or vessels.

[38] Dr. Grierson did indicate in his testimony, similar to Dr. Del Bigio, that certain physiological traits may predispose a person to brain bleeding. Dr. Grierson also indicated that predisposition would decrease the amount of force required to cause a brain bleed. Dr. Grierson went on to indicate that a relatively minor degree of force might be sufficient to cause a brain bleed in a predisposed person.

[39] Given that Dr. Del Bigio is a specialist in Neuropathology I would place reliance on his opinion in relation to any specific area where Dr. Grierson's opinion might differ concerning the nature and cause of the injury.

[40] A number of possibilities exist concerning when Mr. Sanderson suffered the brain injury which caused his death. On the evidence it is possible that Mr. Sanderson was admitted to the MSP having already experienced the trauma. It is also possible that the fatal head injury occurred at the MSP. A third scenario is that he was admitted with an existing brain injury which was exacerbated by further injury which occurred at the MSP. All the potential scenarios appear viable as none can be discounted. Consideration of all scenarios in my view gives broadest application to the principal objective of preventing similar deaths in the future.

[41] Making specific recommendations that target preventing similar trauma being suffered by others in the future is obviously frustrated by the fact that it is not possible to identify the source of the trauma.

[42] It is possible that Douglas Sanderson had an existing brain injury when he was medically cleared for admission to the MSP. As stated earlier in this report if Mr. Sanderson was suffering bleeding within his brain when he was assessed at the Vendome Hotel I am satisfied on the evidence that the injury had not progressed to the stage that any symptoms manifested. In the circumstances, in my view, only sophisticated diagnostic equipment was capable of detecting any such existing injury. Such diagnostic testing is not undertaken unless there is some indication that is appropriate. According to Dr. Grierson nothing in the vital signs or history provided, point to an existing brain injury. The diagnostic procedure is clearly enhanced by the fullest information possible. When providing information to paramedics attempting to screen intoxicated persons for transport to the MSP the patient is commonly not in any condition to act as a reliable historian. Mr. Sanderson had a number of medical factors that predisposed him to brain injury. If paramedics had better access to such information the diagnostic process would be significantly enhanced.

[43] In the four and a half years since Douglas Sanderson died there have been wholesale changes made at the MSP relating to staffing, training and procedures. In his testimony at this inquest Dr. Grierson indicated that there is no guarantee that the medical outcome would have been different but he was confident that in similar circumstances Mr. Sanderson would have been treated in a very different manner. In my view the evidence bears out the validity of Dr. Grierson's statement.

[44] Some of the changes instituted at the MSP would have an obvious impact in circumstances similar to those of Mr. Sanderson. Relocating the fire extinguisher away from

the hallway is perhaps most obvious. Today Mr. Sanderson would not be placed in a position that he could not maintain on his own. A client would be placed in the recovery position when put into the cell rather that a prayer position. Staff now maintains visual observation of clients when they are being moved. The current protocol to summon the paramedic in the case of a fall would impact now in similar circumstances.

[45] I have found that the assessment process used by paramedics to clear Mr. Sanderson for the MSP was appropriate. Notwithstanding this finding I note that the development and implementation of a standard admission protocol for the MSP clients has enhanced the diagnostic process that was in place in November of 2009. As stated earlier the protocol will be employed by all city paramedics not just those at the MSP.

[46] The presence of a paramedic is significant in the context of discharging clients. Dr. Grierson viewed the surveillance recording of the attempt to discharge Mr. Sanderson which led to the fall in the hallway. Dr. Grierson indicated that Mr. Sanderson was experiencing sufficient difficulty standing up that he would have immediately discontinued the attempt to discharge. The availability of a paramedic to provide input on when to discharge would, in probability, lead to a different course of action currently. The status quo appears to be effective. Since the paramedics have been on site in excess of 25,000 client discharges have taken place. With the possible exception of Douglas Sanderson no critical incident has ever been associated with a decision to discharge. Notwithstanding the numbers seem to illustrate the current practice is working, several witnesses suggested that client safety would be enhanced if paramedic assessment was mandatory on discharge and put that forward for my consideration as a recommendation.

[47] Currently it is not uncommon during peak periods to have police vehicles lined up down the street with intoxicated persons awaiting admission. The current IPDA facility consisting of 20 beds does not have adequate capacity to meet demand during peak periods. I accept that no staff member at the MSP would attempt to discharge a client that they felt was unfit for release. In my view the demand for beds during peak periods exerts pressure on staff to discharge clients. Keesha Daniels, who is the Program Supervisor of the IPDA unit, described lack of capacity and the resulting wait time as a source of friction between staff and police. Frequently police contact staff to receive an estimate of how long they will have to wait and receive the accurate but frustrating response that it is not possible to estimate. Douglas Sanderson was selected for discharge based on the fact that he had been detained longer than any of the other clients and there was a line of people waiting for admission. The lack of capacity during peak periods and resulting pressure to discharge has at least the potential to place clients at risk.

[48] The MSP had access to limited information relating to Mr. Sanderson which was based on prior admissions. The limited information included the fact that he suffered from high blood pressure. Fuller access to medical information would enhance assessment protocols in place at the MSP.

[49] It appears that Thomas Sanderson was unable to gauge the severity of the fall since he didn't see it. Thomas Sanderson was unaware of the fact that Mr. Sanderson struck his head on the fire extinguisher. The incident was recorded on equipment with playback capability but staff did not have access to the recording equipment. Access is currently only available through the Program Supervisor and therefore limited to when that person is working. When Mr. Sanderson fell the Program Supervisor was not working. In my view the current practice does not optimize the full utility of the recording equipment.

[50] Given the scope of changes instituted at the MSP I make limited recommendations as follows:

1. The decision to discharge a detainee in the IPDA unit of the MSP be made by a paramedic after conducting a medical assessment.

2. That a funding agreement be reached between the Main Street Project, the Winnipeg Police Service, the Winnipeg Regional Health Authority and the Winnipeg Fire Paramedic Service. The agreement should contemplate the need for strategic planning and possible expansion.

3. IPDA staff should have access to video recording equipment on the unit at all times and be able to review previously recorded events.

4. The provincial electronic health record system be made available to paramedics in the field as well as those working at the Main Street Project if this has not already been implemented.

DATED at the City of Winnipeg, in the Province of Manitoba, this 2nd day of June, 2014.

Original signed by Judge D. Schille

_____

Dale C. Schille
Provincial Judge

APPENDIX 1

See G-3

FINAL

Patient Care Report

Winnipeg Fire Paramedic Service (985)

185 KING STREET
2nd Floor
WINNIPEG, MB R3B 1J1
(204) 986-6380 Ext.

Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

Incident #:2009091755
Date of Service: 11/27/2009
Patient Name: LEON SANDERSON
Hospital Health Record #:

CREW INFO

Vehicle : SQ102
Crew #1: Mohanb, Philip
Crew #2: Campbell, Greg
Doc'd By: Mohanb, Philip
Platoon: Platoon 1

RESPONSE INFO

Call Type: BLS
Run Number: 200909175502
Response Priority: Emergency: (4)
Nature Of Call: Falls
Catchment Area:
Location: <None>
#31 308 FORT ST
WINNIPEG, __ _____

DISPOSITION

Outcome: WFPS Assessment, Transport by WPS
Dest. Reason:
Transport Code:
Condition at Dest.:
Level of care: Primary Care Paramedic
Pt. Transported:
Destination: <None>
Winnipeg, MB ____

TIMES

PCR Created: 11-27-09 20:38
WFPS at Patient:
Triage:
Transfer of Care:
PCR Completed: 11-27-09 21:29

PATIENT INFORMATION

Name : LEON SANDERSON
PHIN :
Sex : Male
Phone :
DOB : 07/01/1942 (67 yrs)
Home Addr. :
DL Info :
Weight :
Mailing Addr. :
Personal Effects :
Left With :
Doctor:
Comments :

NEXT OF KIN

Name :
Relationship :
Phone :
Home Addr. :

INSURANCE

Blue Cross
MB BC Contract # :
MB BC Group # :
National BC Policy # :
National BC ID # :
Military BC # :

Federal Medical Services
Treaty # :
Band Name :

Other
Prov. Assist. Cert # :
Dept. Veterans Affairs :
Other Payment Provider :

Work-related Injury
Work-Related : No
Employer Name :
Employer Address :

IMPRESSIONS

Primary Impression: Poisoning/OD: Isolated Alcohol Ingestion

FINAL

Patient Care Report

Winnipeg Fire Paramedic Service (985)

185 KING STREET
2nd Floor
WINNIPEG, MB R3B 1J1
(204) 986-6380 Ext.

Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

Incident #:2009091755
Date of Service: 11/27/2009
Patient Name: LEON SANDERSON
Hospital Health Record #:

NARRATIVE

WEMS Paramedic 45 - Called for a intoxicated male lying on a carpeted 3rd floor. No obvious signs of trauma and patient denied any complaints. Pt apparantly was brought up to his room earlier by down town biz. On arrival WFD 102 on scene with patient. Patient lying on floor, uncooperative, not willing to get off the floor. Report and VS obtained from 102. When asked if the patient wanted to go to the hospital, he said no. When offered to the 75 martha he said yes. Pt was moving all limbs actively. Strong smell of ETOH from patient.

200's notified. WFD 102 remained on scene with patient. all v/s w/in normal ranges pt requesting to go to msp. downtown biz picked pt up prior to police coming

VITAL SIGNS

Time	BP	Pulse	Respiratory	SPO2	EtCO2	SPCO	BGL)	GCS
20:37	108/70 Auscultated	81, Strong, Regular	16, Normal	95%, Source: Room Air			7.9 mmol/	E4 + V5 + M6 = 15

Temp=36.8 C Skin Temp=Normal Skin Color=Normal Skin Moisure=Normal Lung Sounds Left=Normal / Clear Lung Sounds Right=Normal / Clear Cap. Refill=Normal
Pupil size: Left=4, Right=4 Pupil Reacts: Left=Reactive, Right=Reactive Pupil Dilation: Left=Normal, Right=Normal
Level of Consciousness: Alert; Arm Movement: Left=Normal, Right=Normal;

Completed By: Moharib, Philip

21:20	112/72 Auscultated	82, Strong, Regular	16, Normal	96%			n/a	E4 + V5 + M6 = 15

Temp=36.8 C Skin Temp=Normal Skin Color=Normal Skin Moisure=Normal Lung Sounds Left=Normal / Clear Lung Sounds Right=Normal / Clear Cap. Refill=Normal
Pupil size: Left=4, Right=4 Pupil Reacts: Left=Reactive, Right=Reactive Pupil Dilation: Left=Normal, Right=Normal
Level of Consciousness: Alert; Arm Movement: Left=Normal, Right=Normal;

Completed By: Moharib, Philip

HISTORY

Allergies
Unknown

Chief Complaint
Poisoning/Overdose/Exposure - Substance Abuse - Alcohol

Medications
Unknown -

Past Medical History
Substance Abuse

FINAL

Patient Care Report

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Winnipeg Regional Health Authority
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Incident #:2009091755
Date of Service: 11/27/2009
Patient Name: LEON SANDERSON
Hospital Health Record #:

ASSESSMENTS

11/27/2009 20:40:17 By: Bale, Ross

Body Area	Assessment	Body Area	Assessment
Airway	Patent Patent :	Breathing	Normal Respirations Normal Respirations :
Circulation	Skin - Dry, Skin - Warm Skin - Dry : Skin - Warm :	LOC	A & O to Person,Place,Time,Event A & O to Person,Place,Time,Event :
Disability	Neuro Intact Neuro Intact :		

11/27/2009 20:41:17 By: Moharib, Philip

Body Area	Assessment	Body Area	Assessment
Airway	Patent Patent :	Breathing	Normal Respirations Normal Respirations :
Circulation	Pulses - Radial - Normal (2+) Pulses - Radial - Normal (2+) :	LOC	A & O to Person,Place,Time,Event A & O to Person,Place,Time,Event :

TRAUMA

no trauma entered

SCORES

no trauma scores entered

TREATMENT SUMMARY

no treatments entered

CTAS

no CTAS Score entered

SIGNATURES

no signatures entered

CREW INFORMATION

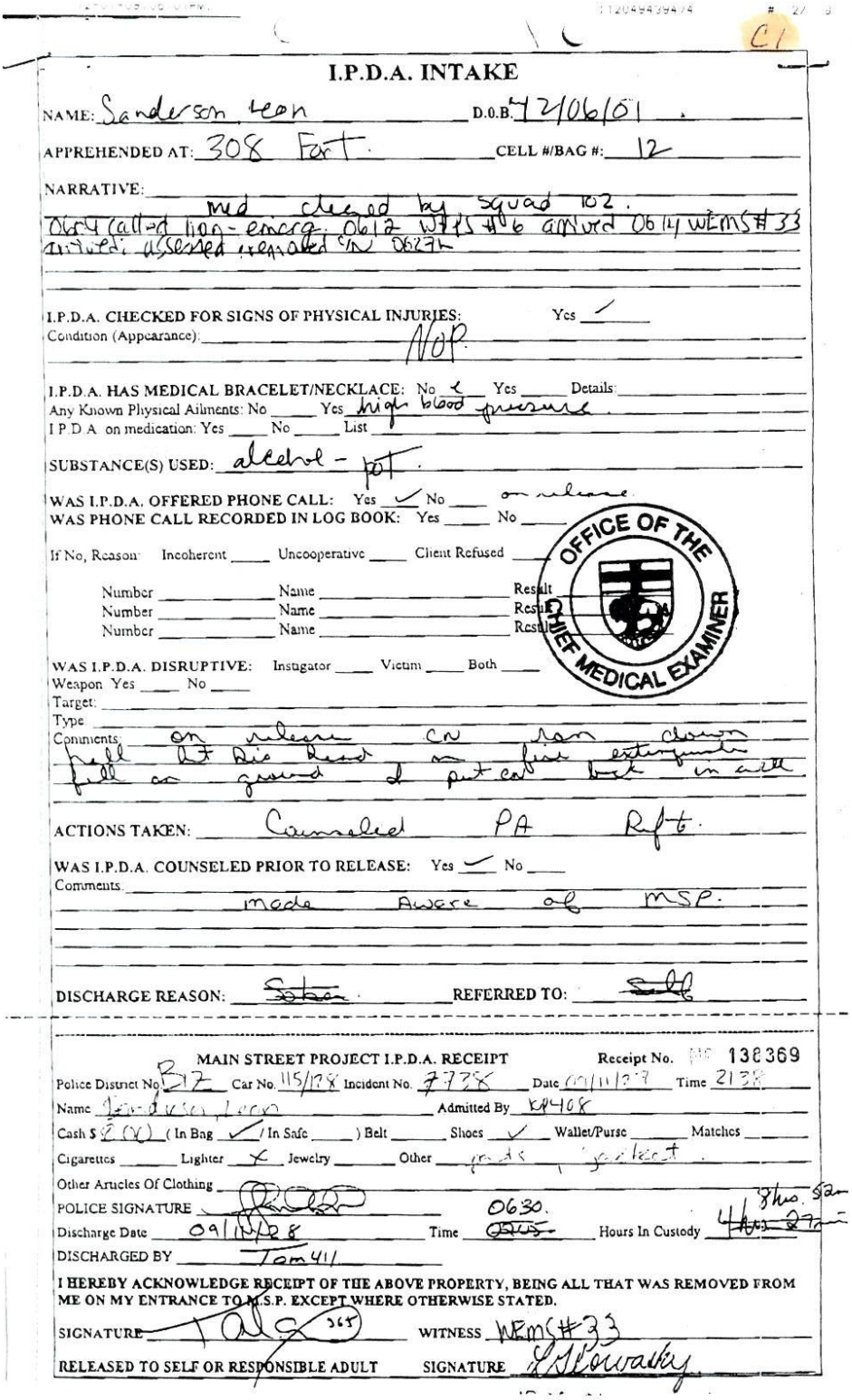
Start Date/Time : 11/27/2009 17:43

Crew #	Name	Crew #	Name
1989	Moharib, Philip	1263	Campbell, Greg

License: 9126

x _____ x _____

APPENDIX 2



C1

I.P.D.A. INTAKE

NAME: Sanderson, Leon D.O.B. 12/06/01

APPREHENDED AT: 308 Fort CELL #/BAG #: 12

NARRATIVE:
med cleared by squad 102.
0614 called Hop - emerg. 0612 WFPS #6 arrived 0614 WEMS #33 arrived. assessed remarked CN 0627h

I.P.D.A. CHECKED FOR SIGNS OF PHYSICAL INJURIES: Yes ✓
Condition (Appearance): NAD

I.P.D.A. HAS MEDICAL BRACELET/NECKLACE: No ✓ Yes ____ Details: ____
Any Known Physical Ailments: No ____ Yes high blood pressure
I P D A on medication: Yes ____ No ____ List ____

SUBSTANCE(S) USED: alcohol - pot.

WAS I.P.D.A. OFFERED PHONE CALL: Yes ✓ No ____ on release
WAS PHONE CALL RECORDED IN LOG BOOK: Yes ____ No ____

If No, Reason: Incoherent ____ Uncooperative ____ Client Refused ____

Number ____ Name ____ Result ____
Number ____ Name ____ Result ____
Number ____ Name ____ Result ____

OFFICE OF THE CHIEF MEDICAL EXAMINER

WAS I.P.D.A. DISRUPTIVE: Instigator ____ Victim ____ Both ____
Weapon Yes ____ No ____
Target: ____
Type ____
Comments: on release CN ran down fell bt Rio Road on gravel & put cast back in arm

ACTIONS TAKEN: Counseled PA Rfte.

WAS I.P.D.A. COUNSELED PRIOR TO RELEASE: Yes ✓ No ____
Comments: made Aware of MSP.

DISCHARGE REASON: Sober REFERRED TO: Self

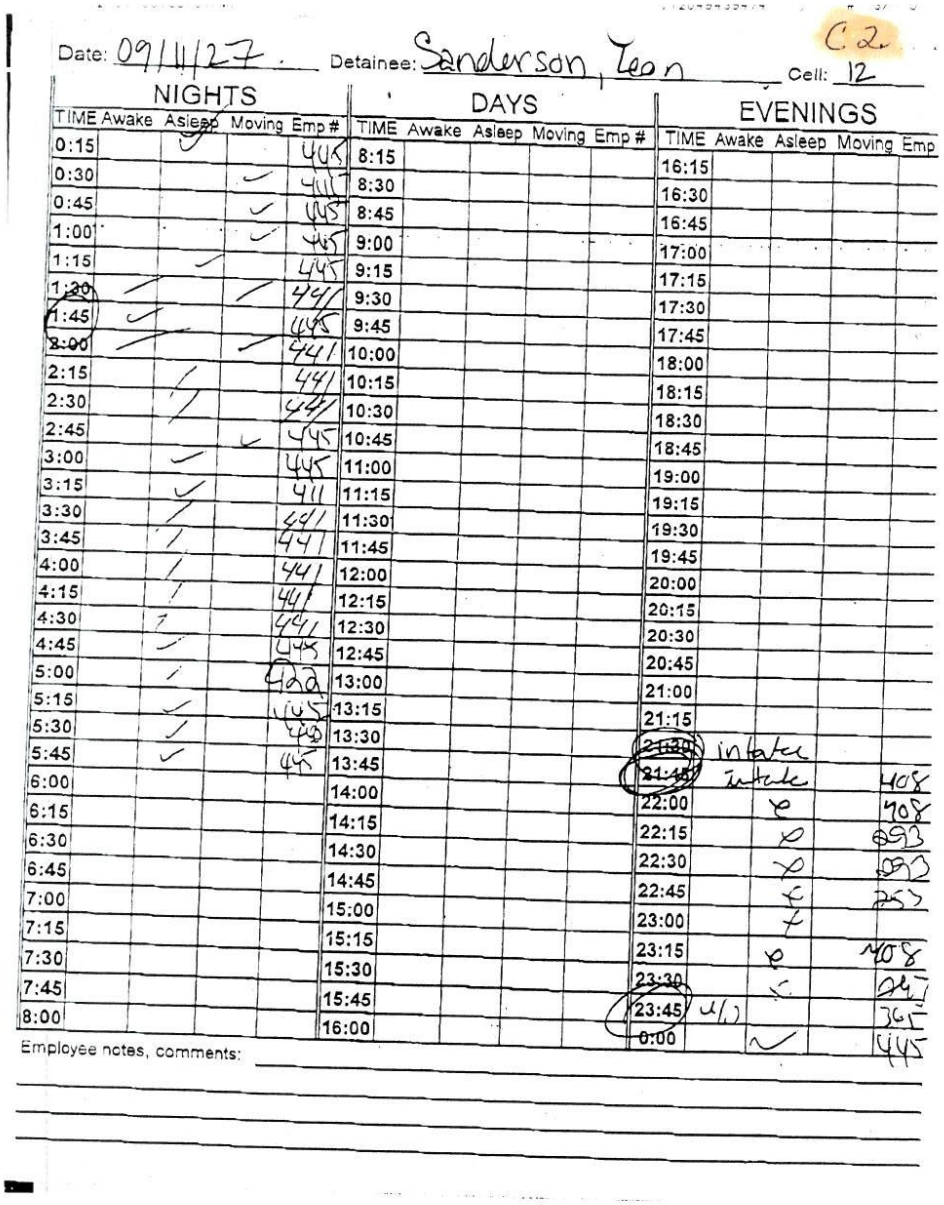
MAIN STREET PROJECT I.P.D.A. RECEIPT Receipt No. 136369

Police District No. B12 Car No. 115/128 Incident No. 7735 Date 09/11/18 Time 2138
Name Sanderson, Leon Admitted By KH408
Cash $ 2.00 (In Bag ✓ / In Safe ____) Belt ____ Shoes ✓ Wallet/Purse ____ Matches ____
Cigarettes ____ Lighter X Jewelry ____ Other ____
Other Articles Of Clothing ____
POLICE SIGNATURE ____ 0630. 8hrs. 52m
Discharge Date 09/12/18 Time 0505 Hours In Custody 4hrs 27m
DISCHARGED BY Tom 411

I HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE PROPERTY, BEING ALL THAT WAS REMOVED FROM ME ON MY ENTRANCE TO M.S.P. EXCEPT WHERE OTHERWISE STATED.

SIGNATURE ____ WITNESS WEMS #33
RELEASED TO SELF OR RESPONSIBLE ADULT SIGNATURE ____

APPENDIX 3



Date: 09/11/27 Detainee: Sanderson, Leon C.2 Cell: 12

NIGHTS					DAYS					EVENINGS				
TIME	Awake	Asleep	Moving	Emp #	TIME	Awake	Asleep	Moving	Emp #	TIME	Awake	Asleep	Moving	Emp
0:15				445	8:15					16:15				
0:30				441	8:30					16:30				
0:45				445	8:45					16:45				
1:00				445	9:00					17:00				
1:15				445	9:15					17:15				
1:30				441	9:30					17:30				
1:45				445	9:45					17:45				
8:00				441	10:00					18:00				
2:15				441	10:15					18:15				
2:30				441	10:30					18:30				
2:45				445	10:45					18:45				
3:00				445	11:00					19:00				
3:15				441	11:15					19:15				
3:30				441	11:30					19:30				
3:45				441	11:45					19:45				
4:00				441	12:00					20:00				
4:15				441	12:15					20:15				
4:30				441	12:30					20:30				
4:45				445	12:45					20:45				
5:00				420	13:00					21:00				
5:15				445	13:15					21:15				
5:30				420	13:30					21:30	intake			
5:45				445	13:45					21:45	intake			408
6:00					14:00					22:00		✓		408
6:15					14:15					22:15		✓		893
6:30					14:30					22:30		✓		893
6:45					14:45					22:45		✓		253
7:00					15:00					23:00		✓		
7:15					15:15					23:15		✓		408
7:30					15:30					23:30		✓		344
7:45					15:45					23:45	u/j			365
8:00					16:00					0:00		✓		445

Employee notes, comments:

APPENDIX 4

I.P.D.A Pre-Admission Assessment

Name: _____ Date: _____ Time: _____

Name & Emp # of Intake Assessor: _____ Full/Partial pre Intake: □ Full □ Partial

General Assessment Information

Medically cleared prior to arrival: □Yes □ No If yes, by whom/where: _____ Unit #: _____

Does individual have a medical alert bracelet: □Yes □ No If yes, details: _____

Does Client Tracking System or HIFIS indicate medical condition(s): □Yes □No If yes, details: _____

Does individual indicate current medical conditions(s): □Yes □No If yes, details (if they indicate diabetes, note if they are taking any medication/insulin and how much here): _____

Does individual state current injury or pain of any kind: □ Yes □ No If yes, details: _____

Does individual require significant support to stand, or to walk to counter: □Yes □No If yes, details: _____

What substance(s) does individual indicate using: _____

Observed Assessment Information

Individual appears to display:

1. Unconsciousness: □ Yes □ No
2. Signs of trauma or injury that require medical attention: □ Yes □ No
3. Signs of head trauma (bleeding, bruising, swelling): □ Yes □ No
4. Inability to communicate (language, mental health, speech impairment, respiratory issues): □ Yes □ No
5. Signs of medication/illicit drug overdose (as reported by individual or via belongings check): □ Yes □ No

If yes: Type(s): _____

Amount ingested: _____ Time: _____ Amount prescribed: _____

Medically cleared on MSP request: □ Yes □ No If no, by whom/where: _____

*If paramedics are unavailable and any of the observed assessments indicate 'yes', the individual is to be denied access to IPDA until medical clearance is achieved, unless achieved prior to arrival at MSP. IPDA Workers are encouraged to trust their instincts, their knowledge of core clientele and their normal behaviours. **If you don't know, say no**.

I.P.D.A Post-Admission Assessment

1. Is this your first time here?	□ Yes □ No	If yes, provide brochure & explain services If no, proceed to next question
2. Do you know where you are?	□ Yes □ No	If yes, proceed to next question If no, provide brochure & describe landmarks
3. Do you have any plans to harm yourself?	□ Yes □ No	If yes, provide brochure & call supports, if needed If no, proceed to next question
4. Do you have a plan on getting to a safe place?	□ Yes □ No	If yes, proceed to next question If no, explore options & provide transportation
5. Would you like a sandwich and/or coffee?	□ Yes □ No	If yes, provide premade sandwich and/or coffee If no, proceed to next question
6. Do you need additional clothes/socks/shoes?	□ Yes □ No	If yes, provide available resources If no, proceed to next question
7. Do you know what services we provide?	□ Yes □ No	If yes, continue with discharge If no, provide brochure & explain services

Name & Emp # of Discharge Assessor: _____ Date: _____

Time: _____

APPENDIX 5

#9

PCP to Medical Supervisor

ICP to Medical Supervisor

ACP and Medical Supervisor

Medical Supervisor only

Winnipeg Fire Paramedic Service

Patient Care Protocol

Adult (18 years and greater)

Admission to Intoxicated Persons Detention Area (IPDA)

For MSP paramedic use only

- ¤Perform primary survey to determine life-threatening medical conditions
- ¤Initiate immediate resuscitative care to correct life-threatening medical conditions and maintain vital functions
  ¤Evaluate most critical chief complaint
- ¤Signs of intoxication [a]
- ¤Consider differential diagnosis and condition of the patient [b]
- ¤Signs of Overdose or decreased LOC (Go to appropriate protocol) [c]
- ¤Perform systems assessment and obtain complete medical history and Vital Signs
- Admittance to IPDA area is not indicated if the patient meets **ANY** of the following criteria [d]:
  - ¤ Signs of significant trauma
  - ¤ GCS score < 14
  - ¤ Signs of head trauma/injury
  - ¤ Inability to ambulate
  - ¤ Inability to verbalize
  - ¤ Focal neurological deficit
  - ¤ Indication of acute overdose
  - ¤ Poor general Impression
  - ¤ Unstable vital signs

Created by RG/EW Aug/2011
Reviewed by PRC: Oct/2011
Approved by MAC: Nov/2011

MSP.01

Winnipeg Fire Paramedic Service
Patient Care Protocol
Adult (18 years and greater)
Admission to Intoxicated Persons Detention Area (IPDA)
For MSP paramedic use only

a. Signs and symptoms of ethanol intoxication include slurred speech, disinhibited behaviour, central nervous system depression, and altered coordination.

b. Manifestation of serious head injury may be identical to, or clouded by, ethanol intoxication. Be aware that mixed and/or unknown overdoses can cause multiple signs and symptoms that may be treated in other protocols (ex. Seizures, hypovolemia, arrhythmias, etc.)

c. Identify substances used, amount and timeline.

d. Clinically important features of the mental status and GCS; pupils for size, reactivity, and anisocoria; cranial nerve function; motor, sensory and brainstem functions; deep tendon reflexes; and noting any development of decorticate of decerebrate posturing.

Medical Director

Associate Medical Director

Created by RG/EW Aug/2011
Reviewed by PRC: Oct/2011
Approved by MAC: Nov/2011

APPENDIX 6

Detainee Monitoring

Date: _____ Detainee: _____ Cell: 11

NIGHTS										DAYS										EVENINGS									
AWAKE				ASLEEP						AWAKE				ASLEEP						AWAKE				ASLEEP					
TIMES	SIT	STAND	LAY	SIDE	BACK	STOMACH	UPRIGHT	EMP #		TIMES	SIT	STAND	LAY	SIDE	BACK	STOMACH	UPRIGHT	EMP #		TIMES	SIT	STAND	LAY	SIDE	BACK	STOMACH	UPRIGHT	EMP #	
0:10										8:10										16:10									
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8:00										16:00										0:00									

Employee notes, comments: _____

* Highlight the **one hour** interval that detainee is put in cell and record this time in the Detainee Assessment Checklist
* Highlight every **two hours** *from the time of intake* and record this time in the Detainee Assessment Checklists

Detainee Assessment Checklist

13

Date: _____ Detainee: _____ Cell: _____

TIMES	ASSESSMENTS
1 hour: **Scheduled** **Completed**	Respiratory Rate: _____ (count breathing for 30 seconds, then times by 2) Pattern: _____ (e.g. steady, rapid, shallow, none etc.) Skin Color/Condition: _____ (e.g. normal, blue, red, pale etc.) Level of Consciousness: _____ (e.g. Alert (awake, answering questions, blinking eyes etc.) & Oriented x0, x1, x2, x3 or x4 (to person, place, time and event) Actions Taken: _____ **Emp #** _____
2 hours: **Scheduled** **Completed**	Respiratory Rate: _____ (count breathing for 30 seconds, then times by 2) Pattern: _____ (e.g. steady, rapid, shallow, none etc.) Skin Color/Condition: _____ (e.g. normal, blue, red, pale etc.) Level of Consciousness: _____ (e.g. Alert (awake, answering questions, blinking eyes etc.) & Oriented x0, x1, x2, x3 or x4 (to person, place, time and event) Actions Taken: _____ **Emp #** _____
4 hours: **Scheduled** **Completed**	Respiratory Rate: _____ (count breathing for 30 seconds, then times by 2) Pattern: _____ (e.g. steady, rapid, shallow, none etc.) Skin Color/Condition: _____ (e.g. normal, blue, red, pale etc.) Level of Consciousness: _____ (e.g. Alert (awake, answering questions, blinking eyes etc.) & Oriented x0, x1, x2, x3 or x4 (to person, place, time and event) Actions Taken: _____ **Emp #** _____
6 hours: **Scheduled** **Completed**	Respiratory Rate: _____ (count breathing for 30 seconds, then times by 2) Pattern: _____ (e.g. steady, rapid, shallow, none etc.) Skin Color/Condition: _____ (e.g. normal, blue, red, pale, yellow, clammy etc.) Level of Consciousness: _____ (e.g. Alert (awake, answering questions, blinking eyes etc.) & Oriented x0, x1, x2, x3 or x4 (to person, place, time and event) Actions Taken: _____ **Emp #** _____

*** If client has been detained for longer than 6 hours with no improvement in condition, IPDA Workers shall document their observations and reassess using the Pre-Admission Assessment Form. When in doubt, IPDA Workers should call on-site medical personnel or 911 for assistance.**

Has client's condition improved? **Y ☐** **N ☐**

If no, what actions were taken? _____

8 hours: **Scheduled** **Completed**	Respiratory Rate: _____ (count breathing for 30 seconds, then times by 2) Pattern: _____ (e.g. steady, rapid, shallow, none etc.) Skin Color/Condition: _____ (e.g. normal, blue, red, pale etc.) Level of Consciousness: _____ (e.g. Alert (awake, answering questions, blinking eyes etc.) & Oriented x0, x1, x2, x3 or x4 (to person, place, time and event) Actions Taken: _____ **Emp #** _____
10 hours: **Scheduled** **Completed**	Respiratory Rate: _____ (count breathing for 30 seconds, then times by 2) Pattern: _____ (e.g. steady, rapid, shallow, none etc.) Skin Color/Condition: _____ (e.g. normal, blue, red, pale etc.) Level of Consciousness: _____ (e.g. Alert (awake, answering questions, blinking eyes etc.) & Oriented x0, x1, x2, x3 or x4 (to person, place, time and event) Actions Taken: _____ **Emp #** _____

WITNESS LIST

Winnipeg Fire Paramedic Service

Greg Campbell
Philip Moharib
Ross Bale
Ian Dunn
Alex Babinsky
Scott Pettitt
Brent Bekiaris
Lisa Glowasky
Dr. Roy Grierson

Main Street Project

Kim Parry
Tara May
Tom Sanderson
Arleen Mentuck
Keesha Daniels
Ryan Sneath

Civilians

Eric Tomm
Victor Sowany
Cary Fisette

Downtown Watch

Lisa McIntyre
Jen Deridder
Attila Luka
Wade Weisner

Medical Doctors

Dr. M. Del Bigio
Dr. Ewa Courvoisier-Grzywacz

EXHIBIT LIST

Exhibit #1: Letter from Dr. A. Thambirajah Balachandra, Chief Medical Examiner, calling the inquest dated October 18, 2011 (5 pages)

Exhibit #2 Accordion file folder of documents received by the Inquest Office
Section I: A-D; Section II: E; Section III: F; Section IV: G; and Section V: H

Exhibit #3: Winnipeg Fire Paramedic Service – Patient Care Report dated November 28, 2009 marked "See D7" (4 pages)

Exhibit #4: Winnipeg Fire Paramedic Service – Patient Care Report dated November 27, 2009 marked "See G3" (3 pages)

Exhibit #5: Handwritten notes of Wade Weisner (2 pages)

Exhibit #6: Disk of video surveillance of November 28, 2009 from Main Street Project

Exhibit #7: Four-page typed history

Exhibit #8: Winnipeg Fire Paramedic Service Outline for Main Street Project Staff training (2 pages)

Exhibit #9: Winnipeg Fire Paramedic Service Patient Care Protocol, Admission to Intoxicated Persons Detention Area (IPDA) (2 pages)

Exhibit #10: Blank I.P.D.A. Pre-Admission Assessment form (1 page)

Exhibit #11: Blank Detainee Monitoring form (1 page)

Exhibit #12: Blank Detainee Assessment Checklist form (1 page)

Exhibit #13: Autopsy (Neuropathology) 2009M953 (D.S.) Summary of Findings (Marc Del Bigio MD FRCPC) (7 pages)

Exhibit #14: Résumé of Helen Clark (6 pages)

Exhibit #15: Report of Ewa Courvoisier-Grzywacz, MD CCFP(EM) (12 pages)