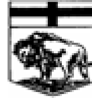
RELEASE DATE: April 21, 2017



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:

COSMO DAMIANO VALENTE

Report on Inquest and Recommendations of
Judge Mary Kate Harvie
Issued this 18th day of April, 2017

APPEARANCES:

Shane Smith and Matthew Armstrong, Counsel to the Inquest
Dan Ryall, appearing for the Winnipeg Regional Health Authority
Mark Mason, General Counsel, Department of Justice
Andrew Boumford for Thor Hansell on a Watching Brief for
Dr. George Assuras

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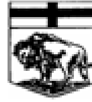

Manitoba

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

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

This report contains my essential findings and recommendations after having reviewed the evidence and the submissions provided by Inquest counsel and counsel for the parties. It contains a list of witnesses who testified and a series of Exhibits that were admitted into evidence. I have had the benefit of having counsel who were extremely well prepared and thorough and worked diligently to review the materials in advance of the hearing. They attended numerous Case Management Conferences, and as a result much of the evidence was tendered by consent. Of the twelve court days originally set, only three were required. I am grateful for their hard work.

Having held an Inquest on January 31st, February 1st and 2nd, 2017, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: Cosmo Damiano Valente.

The deceased came to his death on the 25th day of June, 2012.

The deceased came to his death as a result of a homicide at Stony Mountain Institution, Stony Mountain, Manitoba.

I have made one recommendation for the reasons 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.

Pursuant to the provisions of subsection 33(3) of *The Fatality Inquiries Act*, I am ordering that all Exhibits be returned to the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application with notice to any party with a privacy interest.

Dated at the City of Winnipeg, in Manitoba, this 18th day of April, 2017.

"Original signed by"

____
Judge Mary Kate Harvie

Copies to: Dr. John Younes, A/Chief Medical Examiner
Chief Judge Margaret Wiebe, Provincial Court of Manitoba
The Honourable Heather Stefanson, Minister Responsible for *The Fatality Inquiries Act*
Ms. Julie Frederickson, Deputy Minister of Justice & Attorney General
Mr. Michael Mahon, Assistant Deputy Attorney General
Shane Smith and Matthew Armstrong Counsel to the Inquest
Dan Ryall, Winnipeg Regional Health Authority
Mark Mason, General Counsel, Department of Justice
Andrew Boumford for Thor Hansell on a Watching Brief for Dr. George Assuras

BRIEF SUMMARY OF EVENTS LEADING TO THE DEATH OF COSMO VALENTE

[1] In 2012, Cosmo Damiano Valente, born September 25th, 1942, was a 69 year old inmate serving a sentence at Stony Mountain Institution ("SMI") in Manitoba. Byron Jacob, 24 years of age, was also an inmate at SMI.

[2] On June 12, 2012, inmates Jacob and Valente were engaged in their work programs assigned to work detail in the SMI kitchen. At approximately 8:45 a.m., Mr. Jacob was working at the "dirty end" of the industrial dishwasher. Mr. Jacob's task was to take dirty trays arriving into the dishwasher/kitchen from the morning breakfast, and to place them into the dishwasher. Mr. Valente, working at the opposite or "clean" end of the dishwasher, removed and stacked the trays exiting the dishwasher once they passed through and were cleaned by the industrial strength dishwasher. At the material time, there were nineteen inmates in the secured kitchen area.

[3] In addition to the inmates, there were six kitchen Stewards, employees of SMI, who act as supervisors for the inmates. The kitchen Stewards on duty that day were Ronald Brown, Kenneth Harrison, John Potorieko, Shane Needham, Kulwant Deol and Frank Janz. At the relevant time, all but two of the Stewards were in a meeting. Only two kitchen Stewards were required to be present at all times according to internal practices.

[4] There were two knives in the cutting area of the kitchen. Knives, according to policy, are to be signed out before being brought into the kitchen food preparation area. One of the knives was knife #99 which was signed out to inmate Barry Baker, in accordance with normal sign out procedures.

[5] At approximately 9:00 a.m., Mr. Valente was stabbed by Byron Jacob in the upper left quadrant of his abdomen with knife # 99, which was a six inch kitchen knife. The stab wound was deep, cutting through not only his abdomen, but also penetrating his pancreas (although the injury to the pancreas was not initially observable). Valente then walked towards a door to the stainless steel cooking area of the kitchen, seeking assistance.

[6] One of the correctional staff activated the portable Personal Property Alarm ("PPA") and a group of correctional guards (CX's) and security intelligence officers (SIO's) were quickly on scene. Five Nurses then attended to Valente, who showed signs of internal bleeding, until paramedics arrived.

[7] Knife # 99 was found protruding from beneath a plastic bag on a table board in the cutting area. At the same time water in a nearby sink continued to run as the tap had not been turned off.

[8] Mr. Valente was transported to the Health Sciences Centre ("HSC") Emergency section. On arrival, he had a 3 cm left upper quadrant laceration with fat protruding. He had distension, tenderness, and peritonitis of the abdomen. A "FAST" ultrasound was performed and revealed free fluid in the abdomen. A CT scan further revealed a 3.2 cm defect within the anterior abdominal wall in the left upper quadrant. There was high density fluid seen adjacent to loops of small bowel. There was also pneumoperitoneum (air outside the bowel). No other injuries were identified in the scan, including no definitive injury to the pancreas.

[9] Mr. Valente was urgently taken to the operating room, where Dr. Roger Saadia performed a trauma laparotomy. Operative findings include 1.5 L of blood in the abdomen, two lacerations of the proximal small bowel (close junction of duodenum and jejunum). The two areas of laceration were repaired primarily. There was concern that this area would be narrowed so this area was then bypassed with a gastrojejunostomy (more distal in the bowel). No other injuries were identified and he was closed. He was then transferred to the Intensive Care Unit ("ICU").

[10] Postoperatively, Mr. Valente developed respiratory failure and required reintubation. The presumptive diagnosis was acute respiratory distress syndrome.

[11] Over the next few days, Mr. Valente remained in ICU intubated and ventilated. He continued to require active resuscitation as well as vasopressors to support his blood pressure. He went into acute renal failure requiring continuous renal replacement therapy. It was also documented that it was a challenge to ventilate and oxygenate. There were questions regarding possible abdominal compartment syndrome with requests for General Surgery "Gold team" to reassess. There was a CT

scan on June 14, 2012, which showed postoperative changes but was interpreted as no evidence of complication.

[12] Mr. Valente's abdomen remained distended and there were increased bladder pressures. On postoperative day nine (June 21, 2012), there was increased swelling and redness of his abdomen. This was opened in ICU and necrotic tissue was identified. He was taken back to the operating room by Dr. George Assuras for debridement of his abdominal wall and flank for presumed necrotizing myositis. An approximate 20 x15cm area was debrided including subcutaneous tissue, fascia, and muscle. A small hole was made into the peritoneum and copious old blood was expressed.

[13] Mr. Valente did not improve following the operation and worsened postoperatively (increased vasopressor support, increased white blood cell count).

[14] On June 23, 2012, another CT scan was performed which showed fluid in the lesser omentum, parecolic gutters and mesentry. There was some peritoneal enhancement. No drainable collections were seen. He was also found to have a rise in his bilirubin and lipase (pancreatic enzyme). An abdominal ultrasound was performed on June 25, 2012, which showed some free fluid, which could be attributed to a gallstone, however, no acute findings were identified.

[15] After surgery, Mr. Valente continued to deteriorate and developed multi-organ failure. He was deemed not a candidate for further surgery and continued to deteriorate. Mr. Valente succumbed to his injuries and was pronounced dead at 15:25 hours on June 25, 2012.

[16] An autopsy was performed, which revealed an extension of the necrosis into the abdominal wall, peritoneal cavity, and into the adipose tissue involving the spleen, mesentery, tail of pancreas, and left mesocolon. There was necrosis into the distal portion of the pancreas. The stab wound had perforated the jejunum and the pancreas. The leakage of the pancreas caused the enzymes to digest the tissue along the tract up to the skin. Mr. Valente died because of this injury, in spite of treatment.

[17] Byron Jacob pleaded guilty to the charge of Manslaughter, taking responsibility for the death of Mr. Valente. He was sentenced on June 15,

2015 to 10 and ½ years of custody, less time accumulated in pre-sentence custody of 235 days.

THE MANDATE OF THE INQUEST

[18] Inquest proceedings in Manitoba are governed by both Common Law and by the statutory provisions of *The Fatality Inquiries Act, C.C.S.M. c.* F52. The duties of a Provincial Judge at an Inquest are set out in s. 33(1) which states:

> 33(1) After completion of an inquest, the presiding provincial judge shall
>
> (a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
>
> (b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and
>
> (c) send a copy of the report to the medical examiner who examined the body of the deceased person;
>
> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

[19] On January 21, 2015, the Chief Medical Examiner ("CME") for the Province of Manitoba called an Inquest into the death of Mr. Valente and identified the following issues to be addressed:

1. To fulfill the requirement for an Inquest, as defined in s. 19(3)(a) of *The Fatality Inquiries Act*;

    > 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;

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

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

[20] As is often the case, the Inquest proceedings were delayed until the criminal prosecution was completed. In this case, while the death occurred in 2012, the CME did not call an Inquest for approximately two and one half years. However, I also note that even if the Inquest had been called earlier, it likely would not have moved forward until the criminal prosecution was complete and all possible appeal periods had expired.

[21] In order to address the issues identified by the CME, considerable disclosure was provided, including the information obtained as part of the criminal investigation. An expert medical report was obtained and filed as an Exhibit by consent. The Court heard from three witnesses, two of whom are employees of SMI and who discussed the physical layout of the kitchen at SMI, the staffing on the day of the incident, and the policies surrounding the hiring of inmates. Finally, a doctor from the HSC was called to discuss comments contained in the expert medical report.

[22] Inquests are unique in nature. The provisions of the *The Fatality Inquiries Act* place specific limitations on the findings to be made by an Inquest judge on issues of culpability. Specifically, s. 33(2) states:

> 33(2) In a report made under subsection (1), a provincial judge.....
>
> (b) shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest.

[23] It is clear from the Common Law that a judge presiding at an Inquest must avoid making findings of culpability but can make findings of fact in order to determine if a death was preventable.

NOTIFICATION PROVIDED TO INTERESTED PARTIES

[24] On November 27, 2015 a Standing Hearing was conducted, and standing was granted to three parties: The Winnipeg Regional Health Authority, represented by Mr. Daniel Ryall; Correctional Services of Canada, represented by Mr. Mark Mason; and Dr. George Assuras, represented by Mr. Thor Hansell. The possibility of Dr. Roger Saadia seeking standing was discussed but not formally sought or granted on that

date. The Court has been advised that Dr. Saadia is retired and now resides in South Africa, and that Crown counsel was unable to contact him. He did not seek standing and has not been involved in the Inquest process. I note as well that the expert report found no fault with Dr. Saadia or the treatment he provided.

[25] The deceased has four next of kin, being his four children, two of whom live in Canada and two who reside in Europe. Crown counsel Shane Smith advised the Court that on October 15, 2015 he contacted by telephone the two Canadian residents. A voice mail message was left for the son of the deceased, Mr. Giuseppe Valente. Mr. Smith advised that he spoke directly to the deceased's daughter, Ms. Rafaella Seed, providing her with information about the standing hearing and the Inquest process. Ms. Seed undertook to notify her siblings of the process and their options. As well, Mr. Smith advised that he contacted all family members by email and provided information as to the standing hearing and the Inquest. The children of Mr. Valente did not seek standing, but were again notified prior to the commencement of the proceedings by Crown counsel by email on December 13, 2016 and by regular mail dated December 15, 2016.

[26] I am satisfied that appropriate attempts were made to notify all interested parties of the proceedings.

ISSUES RAISED BY THE CHIEF MEDICAL EXAMINER

Determining the Circumstances Surrounding the Death

a) The incident at Stony Mountain

[27] Cosmos Damiano Valente was serving a six year sentence for two counts of counselling to commit murder. He applied for and had been assigned to work in the SMI kitchen. The 69 year old Valente had a significant amount of hearing loss and as a result spoke loudly, and was somewhat difficult to communicate with, as English was not his first language. He did, however, have a considerable work ethic and would from time to time express concerns about the lack of effort being employed by his fellow inmates.

[28] Byron Jacobs, the 24 year old perpetrator of this offence, was also working in the kitchen. SMI staff who testified advised that they were not aware of any specific issues identified between these two inmates prior to the stabbing.

[29] There is limited information available as to what sparked the incident between Mr. Valente and Mr. Jacobs. The Court was advised that RCMP investigators interviewed several of the inmates who were working in and around the kitchen at the time of the incident. Although none acknowledged actually seeing the incident occur, one inmate told police that Mr. Jacobs had complained prior to the stabbing that Mr. Valente had called him a derogatory name. In response to this Mr. Jacobs told the inmate that he was going to "punch out" Mr. Valente. Other inmates told police that they heard someone yell "stabbed" but claimed not to have seen what had actually occurred. The investigation of the stabbing commenced immediately after the incident, and the knife used was located in the kitchen area. Mr. Jacobs was charged and he ultimately entered a guilty plea after a preliminary inquiry but prior to trial.

[30] With the benefit of the criminal proceedings, there is little issue as to the "material circumstances of the death", which appears to have been a violent dispute between two inmates with no known previous history of animosity. The more significant issue addressed by the Inquest is whether the SMI policies regarding staffing of the kitchen, the handling of knives by inmates, and the hiring of inmates are appropriate, in determining whether an incident of this nature could be prevented in the future.

Staffing Issues

[31] The Court heard from Mr. John Potorieko, a 22 year employee of SMI. For the last 10 years, Mr. Potorieko has held the position of chief of food services, and as such is responsible for the daily operation of the kitchen. He confirmed that while there have been some issues related to inmates handling kitchen utensils, including incidents of self harming, this is the first incident of an inmate stabbing another in the kitchen.

[32] The kitchen is run by a number of SMI staff members ("Stewards") who supervise a group of inmates who prepare food for delivery to the inmates, clean the dishes and maintain and clean the kitchen area. Mr. Potorieko reviewed a diagram and a number of photographs which were filed as exhibits and which provided the Court with an overview of the physical layout of the SMI kitchen area. The diagrams also identified the location of the incident.

[33] Of concern is the number of Stewards who were supervising the kitchen area at the time of the incident. Mr. Potorieko indicated that just

prior to the incident he attended to the kitchen area and he noted that there was one Steward present. The others who were on shift had left the kitchen area to attend a briefing session in a nearby room. Shortly after arriving in the kitchen Mr. Potorieko heard a loud scream and determined that Mr. Valente had been stabbed. He immediately sought medical assistance and moved Mr. Valente into a secure area.

[34] Mr. Potorieko testified that there is no "written order" as to the ratio of inmates to staff present but that staff had an understanding amongst themselves that "we would never have a person by themselves" with the inmates as "they can't watch everything and supervise the inmates". He also advised that at the time of the incident there should have been "at least three and possibly four" Stewards in the kitchen. There is an agreement that there were actually six on duty at the time of the incident, and that most were not present. After the incident, the informal understanding regarding the number of Stewards remained the same, with a continued effort made not to have one Steward alone with the inmates in the kitchen area.

[35] Although it is unknown whether an increase in number of staff would have prevented this incident, it stands to reason that the presence of the Stewards has, generally speaking, a deterrent effect on the behaviour of the inmates. This is particularly the case since SMI no longer has security staff posted specifically to the kitchen area and the Stewards are now responsible not only for training the inmates but ensuring safety in the kitchen.

[36] I appreciate that the optimal number of Stewards is directly related to the number of inmates present in the kitchen. Having said that, it seems appropriate for SMI to formalize and create a written policy respecting the number of Stewards in the kitchen area, including a provision which states that no Steward should be alone while supervising the kitchen area. I note that SMI has a number of "Standing Orders" which address issues related to the proper functioning of the institution, but as already noted, there is no Standing Order respecting kitchen staffing and supervision.

Recommendation: That SMI develop a written policy and create a "Standing Order" respecting the minimum number of Stewards present in the kitchen area at any one time; and that SMI develop a policy which identifies an appropriate ratio of Stewards to inmates in the kitchen area.

The Control of Knives and Sharp Instruments

[37] At the time of the incident, SMI had in place a “Standing Order” respecting the control of knives, meat forks and other sharp instruments in the kitchen area. In order to facilitate food preparation, knives and other sharp instruments were issued to inmates for work in the kitchen. These items were subsequently collected and returned. Standing Order number 880-1 was filed as part of Exhibit 2, the booklet of agreed documents.

[38] The knife used in this incident was appropriately signed out to another inmate, not Mr. Jacobs. It is not completely clear how Mr. Jacobs came to be in possession of the knife, which was recovered in the kitchen immediately after the incident. It seems that Mr. Jacobs was able to grab the knife when the other inmate momentarily left it on the counter. There is no evidence of premeditation or collusion between Mr. Jacobs and the individual who signed out the knife.

[39] After this incident the policy respecting knives was reviewed and consideration was given to introducing the “tethering” of knives to a specific work station. This policy was ultimately rejected as the presence of the tethers can actually create the risk that the tether will be used as a ligature. I am satisfied that SMI has appropriately considered this issue and that there will be no recommendations regarding a change to this policy.

Physical Layout of the Kitchen and Security Cameras

[40] A further concern relates to the physical layout of the SMI kitchen area, specifically with respect to certain “blind spots” and the potential for incidents to occur out of the visual sight of the Stewards. However, the Court heard evidence with respect to some renovations which are being undertaken at the institution. This will include the installation of security cameras in the kitchen area which will facilitate observing the inmates while they are working.

[41] None of the witnesses were prepared to go so far as to say that the presence of cameras would have prevented this incident, and confirmed that incidents have taken place in other areas which are monitored by cameras. It is impossible to know whether those measures would have had a deterrent effect on Mr. Byron. However, presumably their presence will add to the deterrent effect and will assist in the ongoing supervision over the inmates.

[42] Given that these steps have already been taken it will not be necessary to make any recommendations in this regard.

Hiring of Inmates for the Kitchen Duties

[43] The Court heard evidence from Mr. Christopher Ritchie, who holds the position of Assistant Warden of Operations of the Maximum Security Unit at SMI. Mr. Ritchie's duties include the general oversight of operations within the institution, including the kitchen.

[44] At the time of the incident, Mr. Ritchie advised that both Mr. Valente and Mr. Jacobs had been classified as "medium security" inmates. Mr. Valente had been employed in the kitchen since September, 2010 and Mr. Jacobs since April, 2012. Mr. Ritchie was unaware of any previous difficulties between the two inmates.

[45] It should be noted that Mr. Valente was initially sentenced on September 14, 2009. His Intake Health Status Assessment was completed at SMI on October 14, 2009 and at that time a psychology referral was made. Medical staff completed a survey of his condition at the time, but no formal diagnosis was determined. As of May 12, 2010, it was noted that he may be experiencing "possible dementia" and "depressive disorder" in addition to a number of physical ailments. He was referred to the Institution's Department of Psychology for a cognitive assessment. The assessment concluded that Mr. Valente presented with very low cognitive and memory function, but could not diagnose formal dementia. Psych check-ups were completed by physicians throughout the remainder of 2010 and 2011, and his condition was determined to be status quo. Mr. Ritchie confirmed in his evidence that Mr. Valente had been assigned to the "structured living unit", where there is greater access to physiological and other mental health services. However, Mr. Ritchie also testified that none of the tests or reports suggested that Mr. Valente was unfit to work in the kitchen.

[46] In 2012, the employment of any inmate in the kitchen would begin with the inmate completing an "Inmate Employment Application Form", a copy of which was filed as Exhibit 5. After an employment application form was completed, it was reviewed by a variety of departments and individuals, including the inmate's parole officer, his unit's Correctional Officer and a SMI Security Intelligence Officer. Final approval of any application is given by the "Work Board" as chaired by the Program

Manager. Mr. Ritchie confirmed that the process now is generally the same as was in place in 2012, with some improvements to the forms and the structure of the process.

[47] Mr. Ritchie also confirmed that the kitchen is generally viewed as being one of the more “desirable” work assignments, and as a result there were less incidents of what he described as “inmate infractions or poor inmate behaviour”.

[48] There is no evidence of any deficiencies in the work application policies and no need for any recommendations in this regard.

The Medical Care Received by Mr. Valente

[49] Immediately following the incident Mr. Valente was attended to by nurses in the institution. Paramedics were called and he was taken to the HSC emergency. On arrival, he had a “FAST” ultrasound and a CT scan further revealed the extent of the abdominal injuries. Mr. Valente was taken to the operating room on an urgent basis where Dr. Roger Saadia performed a trauma laparotomy. Operative findings include 1.5L of blood in the abdomen, two lacerations of the proximal small bowel (close junction of duodenum and jejunum). The two areas of laceration were repaired primarily. No other injuries were identified and he was closed. He was then transferred to the Intensive Care Unit (“ICU”).

[50] Postoperatively, he developed respiratory failure and required reintubation. Mr. Valente’s abdomen remained distended and there were increased bladder pressures. On postoperative day nine (June 21, 2012), there was increased swelling and redness of his abdomen. Further procedures were undertaken which did not improve his condition.

[51] On June 23, 2012, another CT scan was performed and another abdominal ultrasound was performed on June 25, 2012, which showed some free fluid, which could be attributed to a gallstone, however, no acute findings were identified.

[52] After surgery, Mr. Valente continued to deteriorate and developed multi-organ failure. He was deemed not a candidate for further surgery and continued to deteriorate. Mr. Valente succumbed to his injuries and was pronounced dead at 15:25 hours on June 25, 2012.

[53] An autopsy was performed, which revealed an extension of the necrosis into the abdominal wall, peritoneal cavity, and into the adipose tissue involving the spleen, mesentery, tail of pancreas, and left mesocolon. There was necrosis into the distal portion of the pancreas. The stab wound had perforated the jejunum and the pancreas. These injuries were not detected during the initial surgery and repair. The leakage of the pancreas caused the enzymes to digest the tissue along the tract up to the skin. Mr. Valente died because of this injury, in spite of treatment.

[54] Given the findings in the autopsy, Crown counsel retained the services of Dr. David Konkin, a General Surgeon licensed to practice in the Province of British Columbia. Dr. Konkin is the Department Head of Surgery (Local), Eagle Ridge Hospital, and the Regional Division Head of General Surgery, Fraser Health Authority. In addition, he is a Clinical Assistant Professor in the Department of Surgery, Division of General Surgery, at the University of British Columbia. He describes himself as maintaining "a broad scope of practice in General Surgery with a strong focus on hernias and colorectal disease."

[55] Dr. Konkin's report was filed as part of Exhibit 2, the booklet of agreed documents. In his report, Dr. Konkin confirmed that he received a full copy of Mr. Valente's hospital records, including the triage assessments, the nursing notes and records, the operative reports and all related imaging reports. He also outlined his own independent research. His report was prepared with a view to providing an expert opinion as to whether the care received by Mr. Valente at the HSC "met the standard of care."

[56] After reviewing the course of Mr. Valente's medical care, Dr. Konkin discussed the various organs impacted by the stabbing, including the pancreas. In doing so, Dr. Konkin made the following observation:

> The incidence of pancreatic injuries in trauma are low. However, there is significant morbidity and mortality when it does occur due to its close relationship to the major abdominal vessels. It is also sometimes challenging to diagnosis [sic] due to its retroperitoneal location.

[57] Dr. Konkin's report confirmed that postoperatively, Mr. Valente "was very sick" but considered that his condition was "not uncommon following severe trauma." When his condition did not improve, Dr. Konkin noted that

the ICU physicians commented on “possible abdominal compartment syndrome” but noted that because Mr. Valente was not returned to the operating room, he assumed that the surgeons felt:

> “that there was no abdominal compartment syndrome that need to be dealt with. It is common for the ICU physicians to be concerned with this diagnosis but it is not a straightforward diagnosis and many times, surgeons delay taking patients back to the OR as the risk of surgery can outweigh the benefits. I see no concern with this approach”

[58] Dr. Konkin’s report reviewed the remainder of Mr. Valente’s treatment, including the various scans, noting that “there was nothing on the imaging that would have pointed the physicians to a pancreatic injury. Therefore, there was no reason for this to be considered.” Even as Mr. Valente’s condition continued to deteriorate, Dr. Konkin noted that the “soft tissue” infection which developed “was actively managed in an expedited fashion. This is a unique complication of trauma and life-threatening in its own right.” While noting the option of a laparotomy could have been more extensively considered, and may well have been but not documented, Dr. Konkin commented that “even if a laparotomy was performed.... there is a high chance the pancreatic injury still would not have been identified and the patient’s course would not have been altered.”

[59] Dr. Konkin ended with the following observation:

> In summary, there was a missed pancreatic injury at the initial OR, but it is acknowledged that this can be a difficult diagnosis to make. There was poor documentation by the general surgery service in the progress notes; however, I see no specific deviation of the expected care of Mr. Valente during his hospitalization. His initial injuries in combination with his development of a necrotizing abdominal wall infection were life-threatening and he eventually succumbed to this despite the efforts of the medical staff at Winnipeg Health Science Center.”

[60] In response to the suggestion that “there was poor documentation by the general surgery service” Dr. Perry Gray testified as to the specific procedures in place at the HSC. Dr. Gray is the Vice President and Chief Medical Officer, as well as the Acting Chief Operating Officer, of the HSC. Dr. Gray testified that after his surgery Mr. Valente was admitted to the

Surgical Intensive Care Unit (SICU), during which time he would have been under the primary care of the SICU attending physician. Dr. Gray's experience is that the surgical team is readily available to those working in SICU, and if a member of the surgical team has a suggestion respecting the care of the patient, they may either share it verbally with the SICU physician or write it on the chart. However, it would be the role of the SICU physician to direct the treatment of the patient under their care.

[61] When asked about the specifics of Mr. Valente's chart as it related to the documentation by the surgical service, Dr. Gray acknowledged that "there was not a lot of documentation," but found that it was "not atypical for that service," emphasizing the availability of the surgical team and the level of communication between them and the SICU physicians. Dr. Gray noted as well that nowhere in Dr. Konkin's report did he suggest that the level of documentation impacted the care provided to Mr. Valente or the outcome of the medical intervention.

[62] Given the findings made by Dr. Konkin and the explanation provided by Dr. Gray, I am satisfied that the treatment received by Mr. Valente at the HSC met the standard of care. Any concerns expressed about the level of documentation did not impact the outcome of this case. There are no recommendations to be made respecting the medical care provided.

Conclusion

[63] The death of Mr. Cosmo Valente was a tragic event. He died as a result of the criminal act of another inmate. I find that his death was as a result of homicide. The date of his death was June 25, 2012.

RECOMMENDATION

[64] That SMI develop a written policy and create a "Standing Order" respecting the minimum number of Stewards present in the kitchen area at any one time; And that SMI develop a policy which identifies an appropriate ratio of Stewards to inmates in the kitchen area.

Dated at the City of Winnipeg, in Manitoba, this 18th day of April, 2017.

"Original signed by"

____

Judge Mary Kate Harvie

Appendix "A"

To the Inquest Report of Judge Mary Kate Harvie dated April 18, 2017, into the Death of Cosmo Damiano Valente

LIST OF WITNESSES

1. **Dr. Perry Ronald Gray**
2. **Mr. John Potorieko**
3. **Mr. Christopher John Ritchie**

INQUEST SITTING DATES
(Does not include numerous Case Management Conference Dates)

1. **November 27, 2015- Standing Hearing**
2. **October 3, 2016 - Appearance to discuss Scope of the Inquest**
3. **January 31, 2017- Dr. Perry Gray**
4. **February 1, 2017- Mr. John Potorieko**

   - Mr. Christopher Ritchie
5. **February 2, 2017- Submissions on evidence and respecting possible recommendations**

EXHIBIT LIST

1. **Letter dated January 21, 2015 from the Office of the Chief Medical Examiner- setting out the terms of the Inquest**

2. **Booklet of Materials- with 16 tabs- containing documents and reports related to the death of Cosmo Valente and to the operations of Stony Mountain Institution**

3. **Diagram of Stony Mountain Institution Kitchen Area**

4. **Booklet of 49 Photographs of the Stony Mountain Institution Kitchen Area**

5. **Inmate Employment Application Form**