750 – 500 Portage Avenue
Winnipeg, Manitoba R3C 3X1
Telephone: (204) 982-9130
Toll Free in Manitoba:
1-800-665-0531
Fax: (204) 942-7803
500 av. Portage, Pièce 750
Winnipeg (MB) R3C 3X1
Téléphone : (204) 982-9130
Sans frais au Manitoba :
1 800 665-0531
Télécopieur : (204) 942-7803

Manitoba Ombudsman

January 28, 2010

The Honourable Ken Champagne
Chief Judge
Provincial Court of Manitoba
5th Floor - 408 York Avenue
Winnipeg, MB R3C 0P9

Dear Chief Judge Champagne:

INQUEST INTO THE DEATH OF ALAN EARLE RUPERT
OUR FILES: 2009-0287 AND 2009-0288

I am writing to advise of the results of the inquiries made by my office concerning the inquest report recommendations dated April 22, 2009, issued by the Honourable Judge T. Lismer into the death of Mr. Alan Earle Rupert.

Alan Rupert came to his death at the Health Sciences Centre in the City of Winnipeg on February 13, 2005, where he was an inpatient from June 7, 2004. The immediate cause of death was aspiration pneumonia, a consequence of quadriplegia, due to a fractured cervical spine he sustained during a fall while in the custody of the Winnipeg Police Service.

The Chief Medical Examiner called an inquest pursuant to *The Fatality Inquiries Act*. The inquest report was released on April 27, 2009.

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a provincial department, agency or municipality. In this case, Judge Lismer made recommendations directed at the Winnipeg Police Service (WPS) and Winnipeg Regional Health Authority (WRHA). The following are the recommendations and the responses:

RECOMMENDATION ONE

I recommend that the regular mandatory training and procedure manuals distributed to each police officer should include that the mind should be focused on all variables that may have a bearing as to the safe conduct of the police officer in circumstances such as that in this inquest. The direction should include that the police officer in each case consider the use of dialogue in the escorting of a person in custody to promote unison with the escorting police officer and orienting his mind as to what is occurring at any given moment. Sergeant Bilton conceded that a running commentary would be useful in many situations.

WPS RESPONSE

Winnipeg Police Service training for recruits and members already covers the importance of communication between members and the person they are escorting, in order that the person being escorted understands what is happening.

RECOMMENDATION TWO

That the police officer give due consideration to the proper and most effective grip on the escorted person's arm and the recognition that the looping of the officer's arm around and above the escorted person's elbow so that the officer's arm is between the arm and the body of the escorted person is an effective grip. In this case the officer appears to have had his grip on the outside of the arm of Mr. Rupert, which proved ineffective in holding on to Mr. Rupert after the slip.

WPS RESPONSE

Members are already taught different grips and techniques for escorting people. Members are taught that the circumstances will always determine which grip is more effective.

RECOMMENDATION THREE

Serious consideration by the police officer to the use of the handrail which was available to stabilize the escort in the event of a slip. The officer in this case did not utilize the handrail for reasons as articulated in his evidence.

WPS RESPONSE

Whether a member grabs for hand rail or other object in order to help stabilize their self will depend on the reactionary response of the individual member at that moment.

RECOMMENDATION FOUR

Consideration by the police officer to the footwear of the escorted person so as to provide him with the best traction available under the circumstances. In this case Mr. Rupert was escorted in his stocking feet, according to the best of the evidence. The officers themselves were unmindful of this and were unable to explain why and where Mr. Rupert's footwear was removed.

WPS RESPONSE

The Winnipeg Police Service already teaches members that, depending on the circumstances, allowing a person to wear suitable footwear is recommended.

RECOMMENDATION FIVE

Consideration by each attending police officer to the positioning of the second officer, in this case Freeman, in front of the escorted person either at the bottom of the stairs or at a distance beyond the kicking range of the escorted person, so as to minimize the effects of any fall.

WPS RESPONSE

> *Members are already taught to be aware of their surroundings, including the circumstances of the person they are escorting, and that the safety of the person they are escorting is their responsibility.*

RECOMMENDATION SIX

Consideration by the police officer to shackling the person's legs and reducing the kicking range of the escorted person, reducing the risk to the participating officer and reducing the risk of any attempted escape.

WPS RESPONSE

> *Consideration by the member to shackling the escorted person's legs is already discussed during training.*

RECOMMENDATION SEVEN

Every Winnipeg Police Service member in active duty should receive specialized first aid education and training sensitive to an accurate recognition of a potential spinal injury and that a person such as they found Mr. Rupert should not be moved before the arrival of appropriate emergency health care personnel even where the fallen person was not complaining of any injuries but especially when scrapes to the side of the head were noted consistent with contact of the head with the door.

WPS RESPONSE

> *The Winnipeg Police Service's first aid course already teaches recognition of a potential spinal injury as part of the on line portion of the first aid training. This recognition is reinforced during the practical portion of the first aid training.*

WPS TRAINING COMMENT

My office further clarified with the WPS what consideration is given to inquest recommendations in terms of the future training needs of its members. The WPS advised that all inquest recommendations, with an educational component, are forwarded to the Training Division for consideration and where warranted, implemented within training courses.

Additionally, the WPS indicated that all inquest reports involving the Service are made available to its members through the intranet.

RECOMMENDATION EIGHT

Direction to the involved police officer to ensure that in similar circumstances effective arrangements be made for blood samples to be taken and retained for the Chief Medical Examiner and to notify the Office of the Chief Medical Examiner of the serious injury sustained while in police custody. In this case the blood samples were taken from Mr. Rupert upon admission to the hospital but were not retained and were destroyed. This notification would enable the Chief Medical Examiner to consider the extent to the investigation to be conducted and the taking and retaining of blood samples.

WPS RESPONSE

> *The Winnipeg Police Service members are not in a position to make notifications regarding the existence of possible blood samples in such a case. The Personal Health Information Act would preclude the hospital from disclosing the treatment received by a person injured in police custody. As such the Winnipeg Police service believes it would be impossible to comply with this recommendation absent a legislative change.*

My office made further inquiry with the WPS to clarify if there were any administrative improvements that could be made to address the spirit and intent of the Recommendation. The WPS indicated that they gave this matter serious consideration and are of the view that it would be preferable if health care professionals were assigned reporting responsibility for the following reasons:

- The recommended change could potentially have the peace officer who may be accused of wrongdoing in an incident, responsible for notifying the Chief Medical Examiner of a possible death.

- Peace officers are not qualified health care professionals and may be unable to determine the likelihood of death as a result of certain injuries.

- The injured person's condition may deteriorate after peace officers have concluded their involvement and they may not be aware that death is imminent.

- An injured person may not be comfortable with peace officers, who were present when the injury was sustained, becoming directly involved in the collection and use of their personal health information.

The Manitoba Ombudsman, through this report, is bringing this matter to the attention of the WRHA and Chief Medical Examiner should future amendments to legislation be deemed necessary.

RECOMMENDATION NINE

That the policy of the Health Sciences Centre be amended as necessary to provide a reasonable notification to staff by cardex or chart cover or other effective means to alert all personnel involved of the requisite notification of the Chief Medical Examiner in the event of the death of a person in Mr. Rupert's circumstances.

WRHA RESPONSE

Please note the WRHA's response to Recommendation Ten.

RECOMMENDATION TEN

In this case the Chief Medical Examiner, Dr. Balachandra, testified that he would have liked to have been informed by the Health Sciences Centre about Mr. Rupert's death before his body was released to the funeral home and before it was embalmed in being readied for the funeral service the next day. In this case it was the police who informed the Chief Medical Examiner about his death. According to the evidence there is an established process followed by the Health Sciences Centre for reporting deaths to the Chief Medical Examiner which include requiring the physician who pronounces death to determine as to whether the death is reportable to the Chief Medical Examiner, whose decision is recorded on the Notification of Death form (Exhibit 8 – the death package). This is subsequently reviewed by the Admissions Office of the Health Sciences Centre which completes the checklist on the reverse side of the Notification of Death. The box in the checklist with a "No" as to his death being reportable but Dr. Easton who pronounced death testified that while he knew that Mr. Rupert sustained a serious injury while in the custody of police he is not the one who filled in that space with a "No". Dr. Balachandra characterized Mr. Rupert's case as an isolated incident which must have slipped through the cracks as a result of the passage of time between the accident and Mr. Rupert's death. I make the recommendation that the physician pronouncing death be instructed to effectively oversee the death package form such as Exhibit 8 to ensure that it is free of any misleading information especially as regards reportability to the Chief Medical Examiner.

WRHA RESPONSE

> *The WRHA is updating, throughout the Winnipeg Health Region, the **Notification of Death form** (from Exhibit 8 - the death package). The Health Sciences Centre is ensuring that the **Check List For Reporting to Medical Examiner's Office As Per Fatalities Act** is located on the first page of the HSC Death Package and that it is visible to the Physician/ Nurse when completing associated paperwork.*
>
> *The Health Sciences Centre has also been working on procedures in Admitting to ensure all staff understand reportable cases and what documentation needs to be completed by physicians, nursing units and Medical Examiner Investigators.*
>
> *In January [2010], the WRHA Health Information Management group completed an inventory of site-specific Notice of Death forms to understand the similarities*

and differences in the various site approaches (and we discovered that there are many). In February, the WRHA struck a working group to draft a regional Notice of Death form.

During this process, we have ascertained that there are also some related issues that could be improved with a focused educational approach. These issues include, but may not be limited to:

1. *the Autopsy Permission form;*

2. *the introduction of a "Death Package" that puts all the required forms together; and*

3. *the existing lack of clarity on who has the responsibility for conversations regarding the need for an autopsy.*

The WRHA provided my office with a letter dated January 13, 2011 which further clarifies what action has been taken in an effort to address Recommendation Ten. The WRHA advised:

I am very pleased to report that our working group is currently meeting with the hospital sites and providing them with the tools to assist them in rolling out their site education. The education sessions have already been delivered to five sites so far and the remaining two sites will be concluded by the end of this week. The sites then have until January 31, 2011 to do their education rollouts. The meetings taking place so far are effectively train-the-trainer sessions. The individuals trained will then lead their site staff educational sessions. The effective date for all seven sites (six acute care sites, plus the Misericordia Health Centre) to begin using the new regional forms for notification of death and consent for autopsy, along with all the other materials in the Death Documentation Package is February 1, 2011.

The education tools (DVD, PowerPoint and the content of the Death Documentation Package) are now partially posted on the WRHA's internal website "Insite". In addition, the WRHA's Chief Medical Officer is being sent a letter on the status of the initiative (further to the discussion that was held at the Medical Executive Committee on November 25, 2010). The CMO is being asked to share the letter and documentation with the site-based Medical Staff Offices so that they can alert the WRHA Medical Staff at their own sites to the new regional processes as well as the forms and effective date for use of those forms.

The Death Documentation Package is contained in a clearly marked envelope and contains the forms that need to be completed when death occurs, along with a checklist and instructions regarding timelines for the various steps. It should be noted the package contains a checklist for those deaths that are reportable to the Chief Medical Examiner pursuant to *The Fatality Inquiries Act*.

CONCLUSION

Based on our review of this matter, it would appear that the Winnipeg Police Service and Winnipeg Regional Health Authority have given reasonable consideration to the inquest report recommendations. As such, our files concerning the Alan Earle Rupert inquest have been closed.

Yours truly,

Original signed by

Irene A. Hamilton
Manitoba Ombudsman

cc: Mr. Jeffrey Schnoor, QC, Deputy Minister of Justice and Deputy Attorney General
Dr. Thambirajah Balachandra, Chief Medical Examiner
Ms Arlene Wilgosh, President and CEO of the WRHA