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Manitoba Ombudsman

June 6, 2011

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 DEATHS OF SHAWN JONES, RAYNOLD GERLING AND BRIAN PALMQUIST AT STONY MOUNTAIN INSTITUTION
OUR FILE: 2011-0186

I am writing to advise of the results of the inquiries made by my office concerning the inquest report recommendations dated October 29, 2010, issued by the Honourable Judge Robert Pollack into the deaths of Shawn Jones, Raymond Gerling and Brian Palmquist.

Shawn Jones came to his death on May 12, 2006 at the Stony Mountain Institution in the Province of Manitoba. Mr. Jones ingested a quantity of Amitriptyline and Methadone, the toxicity of which caused his death.

Raynold Gerling came to his death on December 11, 2006 at the Stony Mountain Institution in the Province of Manitoba. Mr. Gerling ingested a quantity of Methadone, the toxicity of which caused his death.

Brian Palmquist came to his death on November 18, 2007 at the Stony Mountain Institution in the Province of Manitoba. Mr. Palmquist ingested a quantity of Methadone and Fluvoxamine, the toxicity of which caused his death.

The Chief Medical Examiner called an inquest pursuant to subsection 19(3) of *The Fatality Inquiries Act*. The inquest report was released on November 5, 2010.

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 Pollack made three recommendations, one of which was directed at the Office of the Chief Medical Examiner (OCME). The following is the recommendation and the response received:

RECOMMENDATION THREE

That the Minister of Justice responsible for the administration of *The Fatality Inquiries Act* and the Minister of Public Safety and Emergency Preparedness responsible for the administration of the *Corrections and Conditional Release Act* take all necessary steps to secure a liaison between the office of the Chief Medical Officer and the Correctional Service of Canada, the essential particulars of which should include:

1. **The CME will notify the CSC as soon as practicable upon determining the cause of death of an inmate at SMI.**

2. **The CSC will notify the CME as soon as practicable upon convening a Board of Investigation into a death of an inmate at SMI.**

3. **The CSC and CME will disclose the results of its respective investigations into the death of an inmate at SMI.**

RESPONSE FROM THE OCME

1. *The OCME understands the importance of providing information to CSC with respect to findings related to the death of an inmate. The OCME will provide a verbal preliminary autopsy report to the CSC investigator upon request. Verbal updates will also be provided to the CSC investigator upon request. A final autopsy report and medical examiner's report will be provided upon receipt of a written request from CSC indicating that the reports are required for the purpose of conducting the investigation under Section 19(1) of the Corrections and Conditional Release Act. The CSC should be aware that reports may take three to six months to finalize. If the death is a homicide or possible homicide the same process will be followed except that the release of information will be subject to the approval of the police investigating the death, or, of the crown attorney if charges have been laid or are pending with respect to the death.*

2. *The OCME will assume that an investigation will be conducted by the CSC when an inmate dies while in custody.*

3. *The OCME also views such sharing as desirable. The OCME will make a written request to the Director General, Incident Investigations, for a copy of the investigation report. The OCME will not disclose the CSC investigation report to a third party, and will direct the third party to the Access to Information and Privacy Division. In situations where the death results in an inquest under The Fatality Inquiries Act the OCME will include the CSC investigation report as part of the OCME investigation file which will be provided to the provincial judge assigned to hold the inquest. The judge will be advised of the disclosure restrictions with respect to the CSC investigation report.*

Please refer to Item 1 under Recommendation #3 regarding the process for the OCME disclosure of information to the CSC. The autopsy report and medical examiner's report must also not be disclosed by the CSC to a third party without the permission of the OCME.

Based on our review of this matter, it would appear that the Office of the Chief Medical Examiner has given reasonable consideration to the inquest report recommendation. As such, our file concerning this inquest has 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