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September 21, 2017

The Honourable Margaret Wiebe
Chief Judge
Provincial Court of Manitoba
5th Floor – 408 York Avenue
Winnipeg, MB R3C 0P9

Inquest into the death of Rudolph James Starr
Our file 2013-0402

Dear Chief Judge Wiebe:

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.

I am writing to advise you of the results of the inquiries made by my office concerning the inquest report recommendations into the death of Mr. Rudolph James Starr. The inquest report, dated November 27, 2013, was issued by the Honourable Judge Carena C. Roller.

Mr. Starr died on June 22, 2009 in Selkirk, Manitoba after RCMP officers attempted to calm his erratic behaviour due to a drug overdose. An autopsy report concluded that Mr. Starr died as a result of an accidental diphenhydramine overdose.

In her inquest report, the Honourable Judge Roller made one recommendation which involves Manitoba Justice as follows:

Recommendation:

[69] While having complete toxicology reports avaiable for the inquest may not have the effect of reducing the likelihood of deaths in circumstances similar to those of Mr. Starr, it would improve the ability of future Inquests to fully consider the material circumstances surrounding each death. It is therefore recommended that the deceased's DPIN dispensing history for the six months prior to death form the basis of toxicology screening at autopsy when investigating the cause in an overdose – suspected or confirmed.

We made inquiries with Manitoba Justice and we were advised on February 21, 2014 that the Office of the Chief Medical Examiner, together with Manitoba Justice, would pursue the matter with Manitoba Health.

RESPONSE FROM MANITOBA JUSTICE, February 21, 2014:

> *According to A.T. Balachandra, Chief Medical Examiner, when an investigation into a death is initiated under* The Fatality Inquiries Act, *the drug history of the deceased is vital information and can be used to determine if an autopsy is necessary. In most medicolegal cases, a six-month DPIN record is forwarded (if available), along with the specimens collected at autopsy, to the Biochemistry laboratory at St. Boniface General Hospital. However, the Office of the Chief Medical Examiner often experiences delays when accessing the system through Manitoba Health for DPIN histories. Thus, when DPIN's are not readily available, the laboratory will proceed with testing – without the information.*
>
> *It would appear that appropriate and improved accessibility, or even direct access, to DPIN histories would allow the OCME to provide critical information, in a timely manner, to medical examiners, autopsy pathologists, and laboratories, as well as the police in criminal cases where the specimens are tested by the RCMP. The OCME, together with Manitoba Justice, will pursue this matter with Manitoba Health and, in due course, will advise the Manitoba Ombudsman of the results of their discussions.*

We followed up on March 3, 2014, and again on August 22, 2016, and we were advised on October 11, 2016 that the recommendation is considered "Complete: Alternative Solution" as below.

RESPONSE FROM MANITOBA JUSTICE, October 11, 2016:

> *I have been informed the recommendation is now considered "Complete: Alternative Solution."*
>
> *Discussions among the Office of the Chief Medical Examiner (OCME), Manitoba Health, and eHealth have failed to reach an agreement to allow the OCME access to eHealth for the DPIN history due to Manitoba Health and eHealth being unable to agree on the form and administration of such an agreement. As a result, the OCME has decided not to pursue an agreement at this time as the barriers are beyond their control.*
>
> *As an alternative, the OCME has an informal arrangement that allows for the DPIN history to be provided to the St. Boniface Hospital Biochemistry Laboratory for toxicological testing. It is important to note toxicological testing does not search for specific compounds. Rather, it screens for known drugs or poisons and produces a report that can be compared to DPIN histories and other information obtained during the course of an investigation, which ultimately, will be used to determine the cause and manner of death.*
>
> *This solution, although not entirely ideal, will ensure the continuation of timely and effective investigations and satisfies the spirit of the recommendation.*

Given that the department has provided its full response to the judge's recommendation, we will be concluding our monitoring of the implementation of the Rudolph James Starr inquest recommendation.

Please note, an electronic copy of this report will be posted on the Manitoba Ombudsman website: www.ombudsman.mb.ca.

Yours truly,

Charlene Paquin
Manitoba Ombudsman

cc: Mr. Mark O'Rourke, Director, OCME
Dr. John K. Younes, Acting Chief Medical Examiner
Ms. Karen Herd, Deputy Minister Health, Seniors and Active Living
Mr. Dave Wright, Deputy Minister of Justice and Deputy Attorney General