NO. 11682135110101

IN THE CRIMINAL DIVISION OF
THE PROVINCIAL COURT OF ALBERTA

IN THE MATTER OF *THE FATALITY INQUIRIES ACT*
IN THE MATTER OF THE DEATH OF JOSEPH HAMELIN

REPORT TO THE ALBERTA ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT

FINDINGS OF HIS HONOUR, JUDGE T.R. GOODSON

WHEREAS a Public Inquiry was held at the Provincial Courthouse in the Hamlet of Fort Vermilion on the 10th day of December, A.D. 1991 before his Honour Judge T.R. Goodson, a Provincial Court Judge. A jury was not summoned and an Inquiry was held into the death of JOSEPH HAMELIN, aged 47, of Fort Vermilion, in the Province of Alberta, and the following findings were made:

DATE AND TIME OF DEATH:

January 23, 1991 at 02:26 hours.

PLACE:

Royal Canadian Mounted Police Prisoner Cells, Hamlet of Fort Vermilion, in the Province of Alberta.

MEDICAL CAUSE OF DEATH: ("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization - *The Fatality Inquiries Act*, Section 1(d):

Atherosclerotic and Hypertensive Cardiovascular disease with acute ethanol and chlordiazepoxide toxicity as a significant contributing factor.

MANNER OF DEATH: ("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable - *The Fatality Inquiries Act*, Section 1(g):

Some of the evidence indicated some suicidal ideation some several hours prior to the death and the level of blood-alcohol content (300-380 mg/100 ml) confirms the evidence of the deceased's consuming more than 40 ounces of hard liquor. However, the Pathologist's opinion was that the deceased's heart condition was more likely the cause of death rather than alcohol or drug overdose. I therefore conclude the manner of death was natural.

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED:

On January 22, 1991, at 23:03 hours, the deceased was taken by ambulance from a drinking party to the Fort Vermilion Hospital where he was treated for a superficial laceration on the head. He was intoxicated and behaving aggressively. He was well known to the hospital staff and the evidence was that on this occasion he was more intoxicated and aggressive than usual. The hospital staff decided that he was too aggressive to handle in the hospital and a consensus was reached among hospital staff and the ambulance paramedics that he be transported to the nearby Royal Canadian Mounted Police prisoner cells, also located in the Hamlet of Fort Vermilion. Upon arrival, the deceased was arrested for public intoxication and lodged in cells. The hospital staff were aware of the deceased's cardiovascular condition but did not inform the Royal Canadian Mounted Police. The Royal Canadian Mounted Police were aware that he had been transported from the hospital, but were cognizant only of his extreme intoxication. The Officer in Charge noted that the deceased was more intoxicated than usual, and he instructed the guard to keep closer watch over him. The guard checked the prisoner every fifteen minutes and recorded the observations in the Prisoner Log Book. At 01:15 the prisoner was snoring lightly. At 01:29 the prisoner was not breathing. The guard tried to wake him and when the prisoner failed to respond he buzzed the Officer in Charge, who had gone off shift at midnight and was sleeping in a room adjacent to the detachment. The Officer arrived and began CPR at 01:37. Almost simultaneously paramedics and Corporal Self were called to the detachment office. Paramedics arrived at 01:41 and took over resuscitation attempts.

The Doctor was also called and arrived at 01:56. The prisoner did not respond to resuscitation attempts in any way and was pronounced dead by DR. VAN NETTEN at 02:26 hours.

Although the Officer in charge of the cell was not notified of the deceased's heart condition, the civilian guard knew the deceased personally and knew that he had a heart condition.

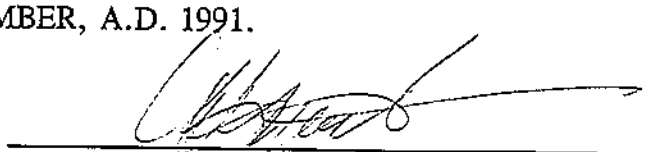
The evidence of the nurse, EVA FEHR, who attended the deceased at the hospital, was that if the patient had been admitted to the hospital, once he fell asleep checks would be made every hour. Therefore, the checks made by the guard would have been considered adequate at the hospital.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS:

The only item of comment is the apparent indecisiveness which occurred at the hospital after the deceased was treated for the laceration. The hospital staff appeared uncertain as to what should be done with the patient.

Although it is my view that it is unlikely that this death could have been prevented even if the deceased had been at the hospital, it would be useful for hospital staffs in remote locations such as Fort Vermilion to develop a special policy and procedure for handling difficult patients. Such policy and procedure is needed not only to handle similar cases but also to handle difficult mental patients generally.

DATED THIS 31 DAY OF DECEMBER, A.D. 1991.



A JUDGE OF THE PROVINCIAL COURT
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