CANADA
PROVINCE OF NOVA SCOTIA
2000

Case #1052120

IN THE PROVINCIAL COURT

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

IN THE MATTER OF: AN INQUIRY INTO THE CAUSE OF DEATH OF **Adam Bard COMEAU**

REPORT

NQUIRY HEARD BEFORE: The Honourable Judge Patrick H. Curran, JPC

PLACE HEARD: Halifax Provincial Court #6

DATES INQUIRY HEARD: September 17th - 21st ; 24th - 26th ; October 9th - 12th ; 15th- 18th ; 29th, 30th; November 1st, 2001; January 2nd, 4th, 25th, 2002

CROWN COUNSEL:

Susan C. Potts/Mark Scott

COUNSEL FOR INTERESTED PARTIES:

Edward A. Gores, Jonathan Davies, Kelvin L. Gilpin, Kim Franklin	for	*Dept. of Justice, Corrections Division*
Anne S. Derrick, Q.C.	for	Mrs. Sandra Ward, mother of Adam Bard Comeau
Carman G. McCormick, Q.C; Roderick H. Rogers; Christa Hellstrom	for	QEII Health Science Centre & N. S. Hospital
Angela Jones-Rieksts	for	*Halifax Regional Municipality*
Patrick J. Duncan, Q.C.	for	Members of the Halifax Regional Police
Colin J. Clarke, Michael J. Messenger	for	Physicians involved in the care and treatment of Adam Bard Comeau

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INTRODUCTION

(1) Adam Bard Comeau died in the Emergency Room of the Dartmouth General Hospital at about 7:40 p.m. on January 5th, 2000. According to the Medical Examiner's report, the cause of Mr. Comeau's death was "[t]he combined effects of acute blood loss and asphyxia related to the aspiration of blood/clots" and the source of bleeding was "most likely the large area of mucosal and bony injury in the lower jaw, between the lower lip and teeth anteriorly." The Medical Examiner did not suggest a cause of the mucosal and bony injury, but went on to say in the report that "[d]ifficulty in instituting resuscitative measures because of resistance to treatment by the deceased may also have played a role in his death."

(2) The events that led up to Mr. Comeau's death began on December 24th, 1999. This report will refer to those events, the circumstances surrounding his death and whether there are any lessons to be learned from those circumstances that could prevent other deaths in the future.

THE DRIVING INCIDENT

(3) During the afternoon of December 24th, 1999, Adam Bard Comeau entered an equipment compound located at the intersection of Scott Street and Desmond Avenue in Halifax, and stole a 35-ton off-highway truck. The truck was about 11 feet high, 11 feet wide and 30 feet long. Some witnesses referred to it as a Euclid.

(4) The key was probably in the truck when Adam Comeau got in. According to Phillip Long, a retired heavy-equipment product demonstrator, there is a commonly-available standard key for heavy equipment, so keys are generally left in the equipment to be used as needed. According to Mr. Long, a person unfamiliar with heavy equipment would likely have difficulty starting such a vehicle. Adam Comeau had several years experience as a truck driver and had operated vehicles similar to the one he stole. He was also an experienced mechanic.

(5) At about 5:45 p.m. on December 24th, 1999, a driver heading outbound on Highway 103 saw the silhouette of a very large truck ahead, "like a ghost on the highway." The driver noticed that the truck had huge tires and no rear lights. He called 911 to report it.

(6) Constable Denis LeBlanc of the Tantallon Detachment of the RCMP responded to the call. He saw the vehicle and quickly decided to try to stop it. He activated emergency lights, but got no response from the truck. After the truck took Exit 5 from Highway 103 and proceeded towards Hammonds Plains, the constable used his lights and siren, but still got no response. He then called for assistance from the detachment. According to Constable LeBlanc, the truck completely filled a traffic lane and would probably have touched both the yellow and white lines on one side of a two-lane highway.

(7) As he followed the vehicle, Constable LeBlanc pulled to both the shoulder and the center of the highway in the hope that the driver of the truck would see and respond to the constable's lights. When the constable's lights shone into the left or driver's side mirror of the truck, he could see the driver's reflection. He thought he had the driver's attention because the driver looked directly at the

mirror, but there was no indication of response to the lights. Throughout his pursuit, the truck was travelling at a speed of about 50 to 65 kilometers per hour, below the speed limit on the portion of the Hammonds Plains Road patrolled by the RCMP.

(8) Constables Allard and MacPherson came to assist Constable LeBlanc. Their vehicle was equipped with a video camera which they activated after catching up to the truck. The videotape provides some details of what went on during the rest of the driving incident.

(9) Constable Allard passed the truck and drove along in front of it with her vehicle's emergency lights activated so as to warn approaching motorists of the hazard. She tried to slow the truck by reducing the speed of her vehicle, but the truck appeared to speed up, so she increased speed to avoid a collision.

(10) At the intersection of Hammonds Plains Road and Pockwock Road the truck went through a red light. Fortunately, the driver of the vehicle entering the intersection from the Pockwock Road had not done so immediately when the light turned green, so there was no collision.

(11) By that time RCMP dispatchers had contacted the Halifax Regional Police, into whose area the truck seemed to be headed. In December 1999 officers in RCMP vehicles were unable to speak directly to officers in regional police vehicles. That problem has since been corrected.

(12) In response to reports from the RCMP, several regional police officers drove their vehicles to the Hammonds Plains Road. One of them, Constable Longley, decided to use his vehicle to block Kearney Lake Road traffic and prevent it from entering the Hammonds Plains Road. He pulled his vehicle as far onto the Kearney Lake Road portion of the intersection as he could, so as to be as

much as possible off the Hammonds Plains Road. Most of the officers who testified said Longley's vehicle was completely off the Hammonds Plains Road, but Constable Longley himself seemed to say otherwise. So did Regional Police Constable Stephenson who was following the Euclid as it approached the intersection. Constable Stephenson also said the Euclid was too wide for one lane, although he and other officers said it "veered off" the Hammonds Plains Road and apparently struck Constable Longley's vehicle deliberately.

(13) As RCMP Constable Allard approached the Kearney Lake Road intersection, she used her vehicle's public address system to warn the regional police officers to get out of the way because the truck was about to strike their car. Constable Boon yelled to Constable Longley when he saw they were going to be hit and both officers managed to get out of harm's way.

(14) The Euclid struck Longley and Boon's vehicle, drove right over part of it and continued on as if nothing had happened. In the understandable confusion and terror at the scene, some of the police officers involved thought one or more officers had been in the police vehicle at the time of the collision and that they undoubtedly had been badly injured or killed. Among the officers who thought fellow officers had been injured or killed was Constable Kevin MacDonald of the regional police. Along with his partner, Constable Mansvelt, he had responded to the call for assistance from the RCMP. Constable Mansvelt was driving their vehicle. Constable MacDonald called for an ambulance and fire truck, while Constable Mansvelt joined in the pursuit of the truck.

(15) Because of the collision and because the truck was then heading towards the heavily-populated area of Bedford, the police began discussing ways of stopping the vehicle. They considered using a spike belt. Most thought that would be ineffective because the tires on the truck were so large. They didn't think the vehicle could be stopped by bullets from a handgun. They began to discuss the use of "lethal force", by which they meant shooting the driver so as to disable him, with the possibility that he would be seriously injured or die.

(16) The truck continued towards Bedford on the Hammonds Plains Road, with Constable Allard's vehicle ahead of it. She slowed her police car again in the hope of slowing the truck, but the truck closed the gap. At one point Constable Allard and her passenger released their seatbelts and unlocked their doors so that they could jump from their car if a collision seemed inevitable. The passenger, Constable MacPherson, drew his gun.

(17) Constable Mansvelt passed the truck and the RCMP vehicles and became the lead vehicle in the procession. Constable MacDonald, the passenger, saw the driver of the truck as they went past. The driver did not look at the police, but just stared straight ahead. Constable Mansvelt drove ahead to the intersection of Hammonds Plains Road and the Bedford Highway. He got out of his car and drew his gun, but the truck pulled onto the Bedford Highway inbound to Halifax and did not pass through the intersection where the constable was standing. The truck nearly collided with a passenger vehicle as it entered the Bedford Highway.

(18) Constable Mansvelt got back into his vehicle and started towards Halifax. He soon passed the truck and became the lead vehicle again. On several occasions Constable Mansvelt slowed his police vehicle. Each time he did so, the truck seemed to accelerate. Constable MacDonald thought the truck would have run over the police car if Constable Mansvelt had not speeded up again. When the truck reached an area where there were construction pylons on the Bedford Highway, it simply plowed through the pylons and sent them flying.

(19) There had been continuing discussions over the radio about using lethal force. There was also the suggestion of using a fire truck, bus or military equipment to block the truck, but there was not enough time to arrange that kind of roadblock before the truck reached the peninsula of Halifax, with its greater population density and narrower streets. Constable Mansvelt asked Superintendent Falkenham for authorization to use lethal force. Superintendent Falkenham replied, "Do what you have to do."

(20) As the vehicles passed Mount St. Vincent University and approached an area of the Bedford Highway bordered by a large concrete wall, Constable Mansvelt brought his police vehicle back alongside the truck. Constable MacDonald shone his flashlight into the driver's face, but got no response. Although Constable MacDonald had already concluded the driver would have to be shot to stop the vehicle, it was not until he received Constable Mansvelt's instruction to position himself to fire that he realized that he was to be the person doing the shooting. He pointed his firearm through the gap between the vehicle's "silent partner" divider and the doorpost and he fired once

through the rear passenger window up towards the driver's head. Immediately, the truck began to slow and it stopped within a short distance.

(21) The driver, Adam Bard Comeau, was removed from the driver's seat of the truck. He was bleeding from the chin. He was arrested and sent by ambulance to the QE II Hospital Emergency Unit.

QE II HEALTH SCIENCES CENTRE

(22) At the emergency department of the QE II Health Sciences Centre, Mr. Comeau was examined by the trauma assessment team. He was bleeding from a wound to the left side of his jaw, and he had a small cut on his left knee. Head and neck x-rays showed a mandibular fracture and a portion of a bullet below his tongue.

(23) Mr. Comeau was then transferred, in stable condition, to the operating room, where his case was turned over to the operating team of Dr. Gordon Whatley, Anesthetist; Dr. Mohammed Wali, Ear, Nose and Throat Specialist; and Dr. Steven Morris, Plastic Surgeon. Due to the possibility that swelling from his injuries might block Mr. Comeau's airway during surgery, Dr. Wali performed a tracheotomy before the jaw surgery, and inserted a #8 Shiley Tracheotomy Tube. Dr. Morris repaired Mr. Comeau's jaw by inserting a metal plate to replace bone lost as a result of the gunshot. He used arch bars and wires to keep the jaw stable and immobile during healing. Dr. Morris made sure there were no protruding wires that might later injure Mr. Comeau. The cut to Mr. Comeau's

knee was stitched. At 11:40 p.m. on December 24th, 1999, Mr. Comeau, in apparently satisfactory condition, was taken to the recovery room.

(24) At 2:25 a.m. on December 25th, 1999, Mr. Comeau was taken from the recovery room to the Burn Unit of the Plastic Surgery floor. The Burn Unit was used because it had the staff and facilities to closely monitor Mr. Comeau's condition immediately following surgery. Mr. Comeau was prescribed medication for pain and possible infection. He remained in the Burn Unit until 10:00 p.m. on December 27th, 1999 when he was transferred to the general Plastic Surgery floor.

(25) Over the next few days Mr. Comeau's condition seemed to continue to improve. At times he picked at his jaw wiring and at times he refused to have his tracheotomy dressing changed. At 7:00 p.m. on December 29th, 1999, the #8 Shiley Tracheotomy Tube inserted during the operation was replaced with a smaller #6 tube.

(26) On December 30th, 1999 a nurse found Mr. Comeau in the bathroom with his tracheotomy tube removed. He told her he had removed the tube to clean it. After that, Mr. Comeau was monitored for breathing problems, but none was observed. X-ray images of Mr. Comeau's jaw taken that same day showed no displaced bone fragments.

(27) On December 31st, 1999 Mr. Comeau was up and about his room and was breathing well. The two Plastic Surgery Residents who had been caring for him during his stay recommended his release from hospital, but Dr. Richard Bendor-Samuel, the attending Plastic Surgery Physician, postponed the decision. He was concerned about Mr. Comeau's circumstances, where he would go

and what care he would get if he left the hospital. If Mr. Comeau had been going home and if he had had a home to go to, Dr. Bendor-Samuel said he would have discharged him on December 31st.

(28) Mr. Comeau continued his apparently good recovery from December 31st to January 3rd. On the morning of January 3rd, Dr. Bendor-Samuel went to Mr. Comeau's room with the two Residents and a nurse. They found Mr. Comeau in the bathroom, apparently brushing his teeth. Dr. Bendor-Samuel examined Mr. Comeau's mouth. He used his gloved hand to check the mouth. He got no blood on the glove, nor was the glove torn during the examination. There were wires and arch bars in place, although Mr. Comeau could open his mouth approximately the width of two fingers, indicating that some wires had been removed. No one testified to seeing wires being removed, but the clear implication of the evidence was that it must have been Mr. Comeau who removed them. In any case, Mr. Comeau's mouth seemed to be healing well.

(29) After Dr. Bendor-Samuel's examination, Mr. Comeau made an unprovoked aggressive gesture towards one of the Residents. When Dr. Bendor-Samuel asked him why he had made the gesture, Mr. Comeau said it was just a reflex action. At that point Dr. Bendor-Samuel decided to discharge Mr. Comeau from the hospital and directed one of the Residents to prepare the discharge documents. At about 9:00 a.m. on January 3rd, 2000 Mr. Comeau was discharged into the custody of the Halifax Regional Police. He had had police guards throughout his stay in hospital, but they had merely observed him. The police were given a sealed discharge package for Mr. Comeau, containing a one-page summary of his condition, wirecutters, a tracheotomy spreader, bandages and a prescription for Tylenol 3 for pain.

HALIFAX REGIONAL POLICE

(30) After taking Mr. Comeau from the hospital on the morning of January 3rd, 2000, the officers to whom he had been discharged transported him to the police station in Dartmouth and placed him in the custody of Constable Tom Martin. Constable Martin was the lead investigator in relation to the offences allegedly committed by Mr. Comeau on December 24th, 1999. Constable Martin wanted to get a statement from Mr. Comeau concerning the events surrounding the charges. He eventually did so, after arranging for Mr. Comeau to receive legal advice.

(31) Mr. Comeau was videotaped throughout the time he was in the interview room at the police station. There is nothing on the videotape to show that anything was wrong with him. He seemed to breathe well and speak well, as if not hindered by arch bars, jaw wires or anything else.

(32) In his statement to Constable Martin, Mr. Comeau admitted stealing the Euclid, but denied hitting the police car. Following his statement he was remanded to the Halifax County Correctional Centre in Lower Sackville.

HALIFAX COUNTY CORRECTIONAL CENTRE

(33) Shortly after Mr. Comeau arrived at the Correctional Centre, he was seen by the nurse on duty in the Health Care Unit, Katherine MacDonald. Nurse MacDonald was provided with the items given to the police when Mr. Comeau was discharged from the QE II. Mr. Comeau did not cooperate with her. He would not allow her to look at the tracheal tube site, check his blood pressure or check anything else. He did not answer her questions, but merely repeated them to her. In doing

so he spoke well enough that, if she hadn't received the wirecutters from the hospital, she would not have known that his jaw was wired. After a few minutes, Mr. Comeau became agitated, so Nurse MacDonald had a guard take him to the cell area.

(34) To get more information about Mr. Comeau's condition, Nurse Macdonald called the QE II and spoke with a nurse who had dealt with him there. The QE II nurse said she told Nurse MacDonald that Mr. Comeau was supposed to be on a soft diet, but Nurse MacDonald said otherwise. Later in the afternoon Nurse MacDonald saw Mr. Comeau eat a meal of chicken and rice with no apparent problem.

(35) There was no doctor working at the Correctional Centre on January 3rd, 2000, but one was scheduled to be there the following day, January 4th. Not knowing that Mr. Comeau was scheduled to go to court on the morning of January 4th, the nurse included his name on the list of inmates to be seen by the doctor that day. Mr. Comeau was taken to court before the doctor arrived. In the meantime, however, he was closely observed overnight in a cell by himself. His night appeared to be uneventful. In the morning before Mr. Comeau left for court, another nurse tried to change the bandage on his throat, but he would not let her do so. Instead, he changed the bandage himself without cleaning the site. On the bandage removed by Mr. Comeau, the nurse saw a greenish discharge that she took to be the result of infection.

BEDFORD COURTHOUSE

(36) On the morning of January 4th, 2000 Mr. Comeau was taken to Provincial Court in Bedford. He spent most of the day in the cells at the Provincial Court. He did not complain of any problems to the sheriffs there, nor did they notice any.

(37) The court remanded Mr. Comeau to the forensic facility at the Nova Scotia Hospital for assessment of his mental condition. As he was leaving the courthouse, Mr. Comeau was videotaped by a television station. As in the police videotape the previous morning, there was nothing noticeably wrong with Mr. Comeau. Because of the sheriff's officer's concerns about Mr. Comeau's wired jaw, he was isolated from other prisoners while he was transported to the Nova Scotia Hospital.

NOVA SCOTIA HOSPITAL

(38) Mr. Comeau arrived at the Nova Scotia Hospital about 5:45 p.m. on January 4th, 2000. It was his first admission to that hospital. Upon his arrival he was assessed by two nurses who found him somewhat evasive. Mr. Comeau told the nurses that he had no family and lived on the streets.

(39) A short time later, Dr. Gillian Stevens, a General Practitioner on the staff of the hospital, conducted a physical assessment of Mr. Comeau. She found Mr. Comeau "paranoid and suspicious." He refused to allow her to take swabs from the gunshot and tracheotomy sites. She saw a yellowish discharge on the gauze over his tracheotomy site and noted that his jaw was wired. She ordered that

his knee, tracheotomy site and gunshot wound site be cleaned twice daily. She ordered Tylenol for pain and a soft diet.

(40) The next morning, January 5th, staff at the Health Records Department of the Nova Scotia Hospital asked staff of the corresponding unit at the QE II to provide Mr. Comeau's records. The request was marked as "urgent 1-2 days." The QE II Records Department responded to the request within hours, using interdepartmental mail, a standard method of reply. The records did not reach the Nova Scotia Hospital until after Mr. Comeau's death.

(41) At 10:00 p.m. on January 4th Dr. Scott Theriault had conducted a psychiatric assessment of Mr. Comeau. Dr. Theriault did not observe Mr. Comeau to have any physical problems, nor any difficulty speaking. He found Mr. Comeau to be "suspicious and mistrustful." He ordered that Mr. Comeau be admitted to S-4 Forensic Unit, that he receive Haldol for his schizophrenia, that he be placed on close observation with 15-minute checks and that he be placed in the therapeutic quiet room if he became agitated.

(42) When he was taken to S-4 Forensics, Mr. Comeau made some gestures towards other patients as if he wanted to fight with them, although nothing came of his actions. He also asked a nurse if she would like to go to bed with him. When told the question was inappropriate, he said, "Oh well, I thought I would ask." He went to his room at midnight and fell asleep by 12:45 a.m. on January 5th.

(43) Mr. Comeau awoke again at 7:45 a.m. on January 5th. He was examined by a nurse who found drainage coming from the tracheotomy site. He was cooperative with her and expressed no complaints or concerns, although he asked to see a social worker.

(44) Nothing untoward was noted about Mr. Comeau that day until 10:00 a.m., when another patient complained of Mr. Comeau swinging his arms in an intimidating manner. When a nurse spoke to Mr. Comeau about his behaviour, Mr. Comeau said the other patient was his friend, which was not the case.

(45) At 11:40 a.m. Mr. Comeau made a racial slur against another patient. It was the second racist comment he had made since his arrival the previous day. Mr. Comeau was placed in a therapeutic quiet room because of his behaviour and was kept there until between 3:30 and 4:00 p.m. No problems were noted while he was in the quiet room. Upon his release from the room, Mr. Comeau was cooperative with staff and other patients.

(46) Although there was a gap in the close observation checklist for Mr. Comeau from 5:00 p.m. until 5:45 p.m. on January 5th, there is no indication that Mr. Comeau suffered any discomfort or engaged in a dispute with anyone during that time period. S-4 Forensics was a small unit with several staff members present at all times. Any significant disruption would have been seen by a staff member almost immediately.

(47) Between 5:45 p.m. and 6:30 p.m. an orderly checked on Mr. Comeau three times. Each time he was lying on his back awake. He was pleasant with the orderly. He asked the orderly what time the "smoke break" was and was told 6:30 p.m. At 6:00 p.m. a nurse gave Mr. Comeau Tylenol that had been prescribed for him. She noticed nothing unusual about his physical condition. Between about 6:30 and 6:45 p.m., Mr. Comeau was in the smoking room.

(48) At about 6:45 p.m. Mr. Comeau asked an orderly if he could do a wash. The orderly accompanied him to the laundry room. Mr. Comeau put his small bundle of clothes in the washing machine. He bent over to get some detergent from a bucket on the floor, straightened up, immediately bent back over and then, without any warning, began to vomit great amounts of blood. The orderly told Mr. Comeau he was going for help and then ran to the nursing station, screaming that they had a medical emergency. He and other staff ran back to Mr. Comeau while still others called for emergency assistance and went for the "crash cart" containing items needed for emergencies.

(49) At 7:00 p.m. Dr. Tim Bood, the physician on call at the hospital that night, received a pager message regarding the emergency. He reached S-4 within about a minute. Dr. Bood had extensive experience as an emergency doctor. He saw Mr. Comeau standing at the sink in the laundry room, vomiting or spitting up large amounts of blood, more than Dr. Bood had ever seen even in an emergency room. He thought the bleeding was likely from the gastro-intestinal tract, caused by an ulcer, and that it would slow down. Dr. Bood described what he saw as "a nightmare situation by any standard." He said it appeared Mr. Comeau could die from loss of blood or from "aspiration pneumonia", that is, drowning in his own blood breathed into his lungs.

(50) When the bleeding did not stop, Dr. Bood instructed staff to move Mr. Comeau to a stretcher. Mr. Comeau resisted, probably because he was choking on blood. Dr. Bood said Mr. Comeau's struggle could have increased both his loss of blood and the chance of him aspirating blood.

(51) An ambulance arrived from the Dartmouth General Hospital and the ambulance attendants assisted with Mr. Comeau's emergency care. There was so much blood that their work was difficult. Mr. Comeau was clenching his jaw, which Dr. Bood said was not uncommon for someone going through so much stress. They cut the wires so Mr. Comeau's jaw could open more readily. By the time the wires were cut, Mr. Comeau was unconscious. After that the attendants managed to insert a tracheal tube, which improved Mr. Comeau's ability to breathe somewhat. They attached an oxygen supply to the tube.

(52) Besides providing an airway through which Mr. Comeau could breathe, Dr. Bood's second major concern was to try to provide Mr. Comeau with fluids to compensate somewhat for his loss of blood. The emergency team made repeated attempts to provide fluids intravenously, but were unsuccessful. According to Dr. Bood, one of the main reasons why they could not gain access to veins was that the veins were getting smaller as a result of reduced blood flow. Because Mr. Comeau's condition was deteriorating rapidly, Dr. Bood decided to get him to the Dartmouth General Hospital as quickly as possible, rather than make any more attempts to hook up an intravenous fluid supply.

(53) They made the short trip to the Dartmouth General by ambulance. By then Mr. Comeau's blood pressure was 70 over 40 and his pulse rate was 30 or 40 per minute. He needed cardio-pulmonary resuscitation (CPR). Dr. Bood said that, with assisted breathing, Mr. Comeau still appeared alive, in the sense that he still had a pulse.

DARTMOUTH GENERAL HOSPITAL

(54) At 7:30 p.m. when Mr. Comeau arrived at the Dartmouth General, he was treated immediately by Dr. Michael Hebb. Dr. Hebb had been a full-time emergency room physician for 30 years. Dr. Hebb found that the tracheal tube was no longer in place. He and his team made two unsuccessful attempts to replace it. They were also unsuccessful in their attempts to provide an intravenous blood supply. They provided CPR, but within a few minutes they discontinued it and pronounced Mr. Comeau dead.

(55) Dr. Hebb said that during his years as an emergency physician, he had seen many people vomit blood, but couldn't recall anyone dying of it. He said he had seen people with severe mouth injuries, including broken jaws, without any bleeding similar to that of Mr. Comeau. He said he doubted that someone could bleed like that merely as a result of cuts from a wire or a sharp bone. He could not offer any explanation of what had caused Mr. Comeau to bleed so much.

(56) After pronouncing Mr. Comeau dead, Dr. Hebb advised the Medical Examiner's Office of the circumstances surrounding his death and Mr. Comeau's remains were transferred to the Medical Examiner for autopsy.

THE AUTOPSY

(57) On January 6th, 2000 Dr. Joanne Murphy, a pathologist and Medical Examiner, performed an autopsy on Mr. Comeau's body. Dr. Murphy ordered x-rays of Mr. Comeau's body and drug and alcohol tests of his bodily fluids. The tests showed codeine in Mr. Comeau's system, presumably

from the Tylenol he had received on the afternoon of January 5th. There were also traces of alcohol, the source of which is unknown. There was a recent injury to his forehead of an undetermined cause. The autopsy revealed no evidence of bone fragments in his jaw or of an esophageal tumour.

(58) Dr. Murphy determined that Mr. Comeau's cause of death was "the combined effects of acute blood loss and asphyxia", with the probable source of the bleeding being "the large area of mucosa and bony injury in the lower jaw between the lower lip and teeth anteriorly." Dr. Murphy could not determine the source of the injury, but said it could have resulted from Mr. Comeau picking at his mouth, from his eating solid foods, from a blow or from some other unknown cause.

(59) Photographs taken during the autopsy show what appears like a hole below Mr. Comeau's lower front teeth. There was no evidence presented at the inquiry of Mr. Comeau receiving a blow around his teeth at any time after he was shot on December 24th, 1999. There was evidence of him eating solid food on the afternoon of January 4th, 2000 at the Halifax County Correctional Centre, but no evidence of him complaining about or appearing to have suffered any injury or discomfort as a result of consuming that food or any other food. There was evidence of Mr. Comeau removing the tracheal tube and some of the jaw wires and of his picking at his mouth. There was no evidence, however, of him bleeding or having a hole of some kind below his teeth before the catastrophic events at the Nova Scotia Hospital on the evening of January 5th, 2000.

MR COMEAU AND HIS FAMILY

(60) Until just a few years just before his death, Mr. Comeau had been a productive member of society. He was employed as both a mechanic and heavy-equipment operator. Despite those skills, life began to grow difficult for Mr. Comeau and he lived his last few years mainly on the streets of Halifax.

(61) Although Mr. Comeau told several people between December 24th, 1999 and January 5th, 2000 that he had no family, in fact he had a family that maintained interest and concern about him right up to the time of his death. From time to time, Mr. Comeau's mother, Mrs. Sandra Ward, came to downtown Halifax from her home in Sackville. When she did so, she looked for Mr. Comeau. The last time she saw him on the street was in the fall of 1999. At that time she invited him, as she had before, to come home and live with her, but he declined. He told her he was fine.

(62) When Mrs. Ward learned that Mr. Comeau was in hospital as a result of being shot on December 24th, she went to the QE II to see him. She visited him several times while he was there. On January 3rd she went to the QE II, only to be told that Mr. Comeau had been discharged that morning and taken into custody by the police. She did not learn Mr. Comeau was at the Nova Scotia Hospital until January 5th. Because that was her wedding anniversary and there was a freezing rain storm, she decided to wait until the next day to visit him. She went to the Nova Scotia Hospital on the morning of January 6th, only to be told that Mr. Comeau had died the previous evening.

CONCLUSIONS

(63) Mr. Comeau died at the Dartmouth General Hospital on January 5th, 2000 from the combined effects of acute blood loss and asphyxia related to the aspiration of blood or blood clots. The source of the bleeding was an injured area below his lower front teeth. The cause of that injury cannot be determined from the available evidence. There is no reason to believe the injury was the result of inadequate care by health or justice officials or that it was caused by the consumption of food or by the actions of another inmate or patient. The gunshot fired by Constable MacDonald did not cause Mr. Comeau's death. The bullet did not produce the injury through which the bleeding occurred. Constable MacDonald had fired the shot at Mr. Comeau because there was no other way to stop the truck at the time, and there was imminent risk of injury or death to others on or near the highway and approaching streets.

(64) The evidence indicates that Mr. Comeau received the best medical care available in this area at all three hospitals in which he was cared for. There is no reason to believe that the quality of care he received was reduced in any way because he was facing criminal charges or because he had been living on the streets during the last years of his life. If anything, he received better than usual care as a result of his circumstances when Dr. Bendor-Samuel decided to keep him in the QE II for a few extra days.

RECOMMENDATIONS CONSIDERED

(65) Section 16(3) of the *Fatality Inquiries Act* states:

> The judge may include in his report recommendations, if any, with respect to measures that might prevent a future mishap of a similar nature and may recommend that a further inquiry be held.

Communication Among Institutions

(66) A considerable amount of evidence was presented at the inquiry about alleged deficiencies in the transfer of Mr. Comeau's medical information between and among institutions that dealt with him on and after December 24th, 1999: the QE II Health Sciences Centre, the Halifax County Correctional Centre, the Nova Scotia Hospital and the Nova Scotia Medical Examiner's Office. There were suggestions that the Nova Scotia Hospital, in particular, failed despite repeated requests to provide the Medical Examiner's Office with information in hospital files needed for the autopsy. The evidence at the inquiry did not support those suggestions.

(67) When Mr. Comeau was discharged from the QE II on January 3rd, 2000, he seemed to be recovering well from his injuries and treatment. That did not change until the very moment he began to bleed to death on the evening of January 5th. Meanwhile, he was seen by a nurse at the Correctional Centre who read his discharge summary from the QE II and obtained more information about him from a nurse there. Shortly after Mr. Comeau arrived at the Nova Scotia Hospital, the doctor who examined him took notice of his condition and asked for reports on him to be obtained from the QE II. Although the request that was sent to the QE II the next day contained the word

"urgent", it also contained the words "1-2 days", hardly indicating an emergency. In fact, staff at the Records Section of the QE II sent a response to the request through regular channels on the same day they received it.

(68) As to any alleged lack of cooperation by the hospitals with the Medical Examiner's Office, the evidence satisfies me that the hospitals provided substantially what the Medical Examiner's Office requested. The requests were not very specific and the responses were reasonable. If more information were needed, it was open to the Medical Examiner's Office to have made more specific requests to the staff of the records sections of the hospitals and their superiors.

(69) As an offshoot of the concern expressed about the transfer of information among institutions, it was suggested to me during the inquiry that the Nova Scotia Hospital was not cooperating properly with the inquiry itself. I did not find that to be the case.

(70) It is clear that record keeping at a hospital is a massive and complex undertaking. The essential records are those which relate to the care, treatment and condition of patients. My impression is that the hospitals who dealt with Mr. Comeau had good and readily retrievable records for those purposes. There are other, less formal, records also kept in hospitals, dealing with such things as the duties of certain employees and their activities on particular days. Records of that kind might not be cross-referenced with patient names. They also might not be or seem particularly significant beyond a particular day or shift in a particular unit. The surprising thing to me is not that some of that material from January 2000 might no longer be retrievable, but rather that so much of

it was presented at the inquiry. The diligence of Crown Counsel and others provided the inquiry with a massive body of evidence.

(71) We do not know whether the consumption of solid food after leaving the QE II contributed in any way to Mr. Comeau's death. Still, it would no doubt have been best for police, justice and health officials who dealt with Mr. Comeau after his discharge from the QE II to have known the diet prescribed for him. However, when Mr. Comeau left the QE II, hospital staff had no way of knowing that within a day he would be in the Correctional Centre, the court and the Nova Scotia Hospital. He was not discharged to another institution. He was dealt with much the same as if he were being discharged to go home, although hospital staff gave his discharge summary and the wirecutters to the police. At the time, everyone thought Mr. Comeau was recovering well from his injuries and surgery. There was some minor concern about possible infection around the tracheal incision on his throat, but no one seemed to think that was an emergency.

(72) There may be a case for better sharing of health information as people pass between health and justice services and institutions. That need was noted in an earlier fatality inquiry: see the inquiry into the death of John Arthur Legge, 1988. The circumstances of the present case, however, do not warrant a further recommendation of that kind.

Amendments to ***Fatality Inquiries Act***

(73) Crown counsel has suggested that I recommend several changes to the *Act* itself. In my view, recommendations of that kind are beyond the scope of s.16(3) of the *Act* and, in any case, are not

warranted by the circumstances of this inquiry. Besides, during the course of this inquiry the Nova Scotia Legislature repealed the *Fatality Inquiries Act* and replaced it with the *Fatality Investigations Act*, S.N.S. 2001, c.31. There is no longer a *Fatality Inquiries Act* to be amended.

(74) Counsel for Mr. Comeau's mother said the *Act* should authorize the presiding judge to recommend to the Minister of Justice that public funding be provided for legal representation of an interested party before the inquiry. Although publicly-funded counsel for Mrs. Ward made a substantial contribution to the inquiry, I do not support that recommendation. As stated in the previous paragraph, I consider amendments to the *Act* outside the scope of s.16(3). I also think the Minister of Justice is in a better position than the court to decide when and how public money should be spent on inquiries.

Separation of "Not Criminally Responsible" and "Assessment" Patients

(75) Crown counsel recommended that persons who have been found "not criminally responsible" under the **Criminal Code** and persons who have been remanded for assessment be kept in separate units in forensic facilities. Although such a separation may be appropriate and may now exist in the new East Coast Forensic Facility, there is no reason to believe from the evidence on this inquiry that the lack of separation in the Forensic Unit at the Nova Scotia Hospital had anything to do with the death of Mr. Comeau.

Medical Audit Committee

(76) The Medical Audit Committee of the Nova Scotia Hospital conducted a review of the care Mr. Comeau received at that hospital before his death. Section 60 of the *Nova Scotia Evidence Act* excuses a witness from answering any questions related to proceedings before hospital committees, such as the Medical Audit Committee, established for the purpose of improvement in hospital care. The "privilege" established by s.60 in no way limited the ability of the Medical Examiner or the inquiry to obtain information from medical and other staff at the hospital. The existence of a form of "privilege" for the workings of the Medical Audit Committee encourages frank discussion at the hospital shortly after a death occurs and is likely to reduce the risk of a similar "mishap" occurring again. I can see no reason to recommend that the privilege be eliminated or that some other form of "in house" death review be required at the hospital.

Heavy Equipment Security

(77) The Department of Transportation and Public Works should examine whether keys need to be left in heavy equipment in order to ensure reasonably prompt use of the vehicles when required.