# Verdict Explanation

*Jamie Goodwin and Ricardo Wesley*
*March 6 to May 21, 2009*
*Coroners Courts*
*Toronto, Ontario*

**Opening comment:**

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of both the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest and is in no way intended to replace the jury's verdict.

**Participants:**

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**Summary of the Circumstances of the Death**

On January 8, 2006, a fatal fire occurred in the cellblock area of the Nishnawbe-Aski Police Service ("NAPS") detachment in Kashechewan. Two detainees, Ricardo Wesley and Jamie Goodwin, died in this fire. The deaths of Mr. Goodwin and Mr. Wesley were mandatory inquests under Section 10 of the *Coroners Act.* The inquest heard from 23 witnesses.

## Events Surrounding the fire

During the morning of January 8, 2006, NAPS officers detained Mr. Goodwin and Mr. Wesley, who were separately found outdoors in an intoxicated state during very cold weather. Both were taken to the NAPS detachment. Mr. Wesley was searched, and a 'mickey' of vodka was found on his person. The two were placed in separate cells, and a matron was called to oversee them.

Prisoners were to be checked at 15 minute intervals. At the time the fire was first noted, officers in the detachment and the matron were in an office with no direct sightline to the cells. There was no video surveillance of the cells. Upon hearing shouts from the cell area and detecting smoke, they investigated, and found smoke coming from Mr. Wesley's cell. Officers made determined and repeated efforts to unlock the cells, which were impeded by the fact that there was no master key, and that the heat of the fire made the padlocks too hot to hold. Within minutes, smoke and heat made further attempts at rescue impossible, and the officers left the building, which was completely consumed by the fire. Mr. Goodwin and Mr. Wesley died, and several officers involved in the rescue attempts experienced serious physical and psychological harm.

## Conditions in Kashechewan First Nation

The jury heard that Kashechewan First Nation is a small Cree community located on a reserve near the mouth of the Albany River on the James Bay Coast. A winter road to the south operates for approximately 2-3 months a year, and there is a limited summer shipping season during which heavy goods can be moved by barge. Otherwise, regular access is by air, which is expensive and weather-sensitive. Heavy items, such as those used in construction, must be moved by the winter road or by barge during the seasonal windows.

Kashechewan is member of Mushkegowuk Regional Council, which represents communities in the James Bay coastal region; and of the Nishnawbe-Aski Nation, which represents many First Nations communities throughout Northern Ontario.

Kashechewan faces a number of serious problems, which include rates far higher than Canadian averages for unemployment, serious social problems such as domestic violence, addiction (especially to alcohol, with both medical and social consequences), medical conditions such as diabetes, and suicide.

Kashechewan is a 'dry' community, in that it has passed a band by-law prohibiting alcohol beverages. Despite the by-law, alcohol use is widespread, and smuggling is commonplace and difficult to interdict.

The town is sited at a location which is prone to periodic flooding by the Albany River; and, has had serious problems with the safety of its water supply.

At the time of the fire, Kashechewan lacked a fire department. There are plans to operate one in future.

## Nishnawbe-Aski Police Service (NAPS)

Policing in Kashechewan, as in many NAN First Nations, is provided by NAPS. This police service is founded on a Tripartite Agreement among NAN, Canada and Ontario, formulated under Canada's First Nations Policing Policy. Funding is provided 52% by Canada, 48% by Ontario. The service is governed by an independent Board, and administered by a Chief of Police who reports to the Board. The jury heard that the intent behind the creation of NAPS and other similar First Nations police services is to provide policing specific and appropriate to the unique culture and circumstances of First Nations peoples. There was evidence that police in such communities, especially remote fly-in reserves, face challenges substantially different from police in southern Ontario communities.

One challenge is that at least 4 languages are spoken in the communities which NAPS serves: Cree, Oji-Cree, Ojibway and English. The jury heard that it is important for NAPS officers to be able to communicate with each other, with matrons and guards, and with members of the communities NAPS serves.

The jury heard that the legislative foundation of NAPS is substantially different from that of police services serving most other municipalities in Ontario, which are regulated by the *Police Services Act.* In contrast, NAPS is a creation of the tripartite agreement, and is not subject to most provisions of the *Police Services Act.* Because it is a funding program without a legislative mandate, it can be discontinued at any time, which negatively affects both staff retention and long-term contracts such as rental agreements. Furthermore, when a police service governed by the *Police Services Act* disagrees with its funder (e.g. the municipality) about the level of funding required to maintain services, there is a binding external review mechanism available in the legislation. No such provision exists for NAPS: Any funding issues are to be resolved among the 3 signatories.

The jury heard evidence that NAPS detachments, especially those in remote communities, suffered from a variety of problems, some of which could affect occupant health and safety. Federal/provincial funding of NAPS does not extend to 'major capital' (essentially, permanent structure) projects, although funding has been provided for new modular detachments, on the grounds that they are movable in future. The jury heard evidence that detachments have improved substantially over the last few years as older buildings have been replaced with newer.

The building of permanent structures in remote communities is considerably more expensive than in southern communities.

For years prior to these two deaths, NAPS and the leaders of the communities it served, had made repeated efforts to obtain funding for replacement buildings, including bringing matters to the ministerial level at both the federal and provincial level.

The jury also heard that housing is scarce and crowded on reserves, so that an officer may have no housing. One police officer witness testified that he had lived, with his family, in a tent for a prolonged period during cold weather when their house was unavailable. This obviously represents a recruitment and retention issue.

The jury heard that the aftermath of the fire left issues between the community and NAPS. Reconciliation was advocated, perhaps through traditional means. As well, community policing, over and above response to calls, was suggested as a method to improve relations.

## History of the Police Building

The NAPS detachment was in a converted residence shared with the Post Office. Among other rooms, it contained a general office, and 4 cells, the doors to which were secured with padlocks of the sort available at a store. (The jury heard that cells are usually secured with locks specifically designed for cells, with oversize keys, and a master key for emergencies.) The cell ultimately occupied by Mr. Wesley contained a mattress which was not fire-retardant. There was no working smoke detector in the building, and no lights in the cells. There were holes in the floor, and no heating in the cells. There were numerous other maintenance issues, many of which affected health and safety of building occupants.

Police working in the detachment, along with staff at the local nursing station, had brought these concerns to the attention of their managers. The building was rented from Kashechewan by NAPS, and there were disputes concerning which of the two was responsible for maintenance and repairs of the building, with both parties

stating that they lacked funds to make necessary repairs, such as replacing a smoke detector or its battery. A previous NAPS Deputy Chief of Police had ordered the cells closed (with prisoners to be taken to nearby Fort Albany). The cells had been re-opened for use since that time, although the authority for re-opening them was not clear.

After discussions among NAPS and the signatories to the tripartite agreement which had lasted for years, funding was approved for construction of a modular detachment. This was delivered to Kashechewan on August 19, 2005. The components were stored at the community airport pending a decision by the Kashechewan Band Council about where to locate the detachment, during which time the old detachment remained in use. The jury heard evidence that the Kashechewan Band Council was considering a number of possible locations and, in light of other crises, including flooding and problems with water and sewage services, had not reached a decision by the end of the construction season (ground preparation is not possible after mid-autumn, the exact time depending on the weather that year).

**FORENSIC EVIDENCE:**

The scene was investigated by police, including NAPS and OPP, the Office of the Fire Marshall, and the Coroner's Office. The bodies were recovered, and autopsy and toxicology were performed.

The pathologist testified that the death of both men was due to smoke inhalation. The toxicologist testified that, at the time of his death, Mr. Goodwin had a blood alcohol concentration of 44 mg/100 mL, and Mr. Wesley about 246 mg/100 mL. For comparison, the legal limit for driving is 80 mg/100 mL. This indicates that Mr. Goodwin was mildly intoxicated, and that Mr. Wesley may have been substantially intoxicated at the time of the deaths.

The investigation of the Fire Marshall determined that the fire had begun in a foam mattress in Mr. Wesley's cell, by application of an open flame. The jury heard evidence of incomplete searches of prisoners, and of smoking and use of open flames in cells. It could not be determined whether the fire was started intentionally or accidentally, for instance by unintentionally dropping a still-lit match onto the mattress. In any event, there was no evidence that the deaths were intended by any person.

The Fire Marshall conducted a test burn, in circumstances very similar to those of the fire. The jury saw a video of the test burns, one done without sprinklers, one with. In the absence of a sprinkler, the fire spread as follows:

***0 minutes***: Open flame applied to mattress

***1 minute***: Flames over a significant area of mattress. Temperature in Mr. Wesley's cell was high but survivable. Release of smoke into corridor adequate to trigger smoke alarm, if one present and working. (There was no working smoke detector in

the detachment at the time of the fire.)

*1 ½ minutes*: Temperature of Mr. Wesley's cell exceeds 100 degrees Celsius (the temperature of boiling water) near ceiling. Air near floor of cell and corridor is still breathable.

*2 minutes*: Temperature of Mr. Wesley's cell 185 degrees near ceiling. Conditions (temperature and toxic smoke) potentially life-threatening in Mr. Wesley's cell.

*2 ½ minutes*: Temperature abruptly increased by 300 degrees in Mr. Wesley's cell, and floor became hotter than ceiling, due to effects of radiant heat. Survival would be unlikely.

*3 minutes*: Conditions in Mr. Goodwin's cell become unsurvivable. The corridor between the cells is filled with dense black smoke at high temperatures.

The Fire Marshall investigator testified that the best way to prevent fire deaths is:

1. Operational smoke detectors in appropriate locations, and
2. Immediate evacuation, if the fire cannot be promptly extinguished.

In this case, there were approximately 3 minutes between the application of flame to the mattress, and an unsurvivable environment. The lack of an operational smoke detector meant the fire went undetected for some of that time. There was no fire extinguisher in the detachment, nor were there sprinklers. Furthermore, there

was no clear evacuation plan, no fire drill, the cells did not have a master key, and the cell keys were small and not clearly labeled. All of these factors combined to hamper a prompt evacuation in the very little time available. Even if there had been a fire department in Kashechewan, the fire spread so rapidly that the victims would have died before trucks could have arrived on scene and firefighters entered the building. The investigator emphasized that entry into a burning building can be dangerous, and should be performed only by trained and qualified persons wearing appropriate protective equipment. This underlines the principle that the best way to prevent deaths in a fire is through an operational smoke detector and immediate evacuation.

The investigator testified that a fire extinguisher, operated by someone with appropriate training, and at an early stage of the fire, might possibly have been effective, but, because of the nature of this fire, might not have succeeded. He also testified that a sprinkler system, if installed and functional, would have triggered, and likely controlled, if not entirely doused the fire. Had sprinklers been present, the combination of heat, smoke and steam in Mr. Wesley's cell might still have been lethal, but Mr. Goodwin's survival would have been much more likely.

The Fire Marshall also testified that the model of fire prevention delivery in Ontario is that municipalities, by law, must provide a minimum level of service. This does not apply in First Nation reserves, and the jury heard that the role of the different governments (First Nations, federal and provincial) in fire prevention on reserves is not entirely clear, and that, at present there is no agency with overall responsibility

for fire inspection of, say, police detachments.

**The jury reached the following verdict:**

**(See Attached Verdict and Recommendations)**

**Closing comment:**

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that this is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence,

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# Verdict of Coroner's Jury

We the undersigned _____ of *Toronto*

_____ of *Toronto*

_____ of *Toronto*

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_____ of *Toronto*

the jury serving on the inquest into the death of :

Surname: *Goodwin* | Given names: *Jamie*

Aged: *20* held at *Toronto, Ontario*

From the *March 6th* to the *May 21st* 20 *09*

By Dr. *David Eden* Coroner for Ontario

having been duly sworn, have inquired into and determined the following:

| | | |
|---|---|---|
| 1. | Name of deceased | *Jamie Goodwin* |
| 2. | Date and time of death | *9th January, 2006 (Supplemental Finding: Presumed to have died on 8th January, 2006)* |
| 3. | Place of Death | *Kashechewan, Ontario* |
| 4. | Cause of death | *Smoke Inhalation* |
| 5. | By what means | *Accident* |

Original signed by: Foreman

Original signed by jurors

The verdict was received on the *21st* day of *May* 20 *09*

Original signed by Coroner

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# Verdict of Coroner's Jury

We the undersigned _____ of *Toronto*

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the jury serving on the inquest into the death of :

Surname: *Wesley* | Given names: *Ricardo*

Aged: *22* held at *Toronto, Ontario*

From the *March 6th* to the *May 21st* 20 *09*

By Dr. *David Eden* Coroner for Ontario

having been duly sworn, have inquired into and determined the following:

| | | |
|---|---|---|
| 1. | Name of deceased | *Richardo Wesley* |
| 2. | Date and time of death | *9th January, 2006 (Supplemental Finding: Presumed to have died on 8th January, 2006)* |
| 3. | Place of Death | *Kashechewan, Ontario* |
| 4. | Cause of death | *Smoke Inhalation* |
| 5. | By what means | *Accident* |

Original signed by: Foreman

Original signed by jurors

The verdict was received on the *21sh* day of *May* 20 *09*

Original signed by Coroner

**Recommendations Concerning the Coroner's Inquest into the Death of:**

**Ricardo Wesley & Jamie Goodwin**

***The following recommendations are not necessarily in order of priority.***

## PREAMBLE

The jury has made the following recommendations largely as they relate to the Nishnawbe-Aski Police Service and its policing delivery. We would note, however, that many of the recommendations could be relevant to other First Nations policing services in Ontario and Canada.

Due to the seriousness and circumstances of these two deaths, we hope that the recommendations outlined here be widely disseminated within First Nations and relevant government agencies throughout Canada.

*We the Jury recommend that:*

1. In order to have transparency to this process we recommend that this document be translated into Cree, Ojibway and Oji-cree and be easily accessible to Nishnawbe-Aski Nation members.

## FIRE SAFETY

2. First Nations, Canada and Ontario should work together to develop a fire safety model that closely resembles that which applies to municipalities and includes an enforcement mechanism.

3. Nishnawbe-Aski Nation (NAN), in consultation with the Ontario Fire Marshall' s office, should develop and implement models for the delivery of services and programs for fire protection, prevention and safety, consistent with s.2(1)(a) of the *Fire Protection and Prevention Act.*

4. Consideration should be given to exceeding minimum building standards in new police detachments in communities where fire suppression services are not readily available.

5. Nishnawbe-Aski Police Service (NAPS) should immediately develop and implement plans for Fire Safety for each police detachment utilizing the best practices contained in the Model National Building and Fire Codes and the Ontario Fire Code.

6. Fire safety plan should require an interconnected smoke alarm system that is regularly maintained and tested.

7. Fire safety plan should require continuous video monitoring in occupied holding cells.

8. Fire safety plan should require regularly maintained fire extinguishers throughout all holding facilities.

9. Fire safety plan should require training for police officers in the use of fire prevention and suppression equipment in the police detachment. It is recommended that the test burn video from this inquest be provided as a training tool.

10. Fire safety plan should require sprinkler systems in detachments with detention facilities.

11. Fire safety plan should require posted emergency evacuation plans.

12. Practical training (i.e. fire drills and emergency evacuation) for police officers, guards and matrons should be provided. These drills should be conducted regularly and documented (minimum annually).

13. Standard correctional locking mechanisms should be used on cell doors and a single key to access all cells should be located in a secure but readily available location for staff access.

14. The use of foam mattresses in holding cells should be strictly prohibited. Any materials used in the cellblock areas should be of the appropriate fire resistance or flame spread rating.

15. To eliminate the risk of prisoners having access to ignition sources while in custody, proper search procedures should be strictly followed by officers upon arrest and prior to the incarceration of prisoners. If there is any doubt as to whether or not a prisoner was searched, the search should be repeated.

16. Police officers should search cells between occupancies.

17. Any cell that is deemed unsafe should not be used.

18. Any maintenance or repair issue at a police detachment, affecting the health or safety of building occupants, should be managed as a high priority.

19. Smoking should be strictly prohibited in holding cells.

20. There should be adequate heating in the cells.

21. Fire Safety Plans should be prominently be displayed in each NAPS detachment and that they be reviewed annually and modified according to current best practices.

22. Leasing or rental arrangements between NAPS and NAN First Nations should include clear and specific provisions regarding responsibility for timely and effective cleaning, maintenance and repairs of detachments. Remedies and/or enforcement mechanisms need to be provided for circumstances in which delays may risk or compromise the health and safety of building occupants.

## FIRE INSPECTION

23. Canada, Ministry of Community Safety and Correctional Services (MCSCS), NAPS Board and Police Service, the NAN Tribal Councils and the Chiefs and Councils of the NAN First Nations should work together to ensure that the appropriate fire safety inspections of police detachments are carried out in all of the NAN communities and that identified deficiencies are remedied.

24. Canada and Ontario should provide funding to NAPS to secure independent fire safety inspection services for the NAPS detachments.

25. Effective immediately and pending further action pursuant to (24) above, police detachments should be added to the list of major public band buildings that are provided with fire inspection and fire engineering services by the Fire Prevention Services Division of the Labour Program of Human Resources and Skills Development Canada (HRSDC).

26. NAPS should develop a protocol so that each individual detachment is responsible for ensuring the proper functioning of fire safety equipment on a regular basis.

27. NAPS should assess the feasibility of a fire safety officer position who would conduct inspections, training and drills, record management, etc.

## ADEQUACY OF RESOURCES

28. First Nations, Canada and Ontario should work together to ensure that policing standards and services levels in First Nations communities are equivalent to those in non-First Nations communities in Ontario.

29. Canada and Ontario should develop a method for establishing equivalence in policing standards and services between First Nations and non-First Nations communities. The unique characteristics of remote NAN communities should be addressed.

30. Canada and Ontario should provide NAPS with the funding required to ensure that the communities it serves receive the same level and quality of policing services and infrastructure that non-First Nations communities receive. Funding levels should be sufficient to allow NAPS to comply with adequacy standards set out in the Ontario *Police Services Act* and the *Policing Standards Manual* of the MCSCS and Royal Canadian Mounted Police (RCMP) guidelines.

31. An operational review of NAPS, in consultation with NAN, should be immediately undertaken.

32. The operational review should define common goals and objectives based on the observations and findings of an independent party that is mutually agreed upon by Canada, Ontario and NAN.

33. It is recommended that Canada and Ontario pay the cost of this operational review.

34. The operational review should consider the uniqueness of the NAN communities, and the requirements of the NAPS police service for adequate staffing, organizational structure, and infrastructure. Particular consideration should be given to the remoteness of the communities, the lack of social services, the lack of officer housing, officer retention issues, high transportation costs and the growing population.

35. The funding provided by Canada and Ontario should be sufficient to ensure that the needs identified by the operational review are implemented.

36. Canada, Ontario and NAN should retain a mutually agreeable independent consultant to conduct a comprehensive evaluation of the costs of appropriate policing in remote First Nations communities in Ontario. This evaluation requires the development of a method to cost unique, remote/fly-in police services.

37. Canada and Ontario should provide funding for this evaluation under clause 12 of the Tripartite Agreement.

38. NAPS should develop a business plan outlining its vision, goals and objectives for policing the NAN communities.

39. Permanent purpose-built detachments speaks to equality of service, pride of policing and professionalism. The standard for NAPS detachments should be brick and mortar buildings.

40. NAPS should establish a Property Management Department that has access to appropriate resources and staff. This department is encouraged to investigate funding options for apprentice training to develop in-house skilled workers.

41. NAN should conduct a research and policy review on the funding and availability of suitable housing for NAPS officers. Ontario and Canada should provide funding for this review.

42. Where housing is available, NAPS officers should be encouraged to police in communities other than their own to minimize policing family and friends, and to foster professionalism and respect.

43. It is recognized that as many as nineteen (19) of the NAPS detachments do not meet National Building Code standards and do not have sprinkler systems installed. It is recommended that Canada, Ontario and NAN convene a meeting no later than June 30, 2009 to determine the most expeditious way to resolve this serious problem. Further, it is recommended that remedial plans and strategies arrived at through the negotiations be forwarded to the Director General of the Aboriginal Policing Directorate (Canada) and the Minister of Community Safety and Correctional Services (Ontario) no later than October 30, 2009 for immediate action.

44. In the absence of resolution, pursuant to (43), holding cells in all detachments with unsafe conditions should be closed.

## LEGISLATIVE ACTION

45. NAN, Canada and Ontario should work together to establish a legislative framework for NAPS, pursuant to section 9 of the *Nishnawbe-Aski Police Service Agreement*. As well, other First Nations in Ontario serviced by First Nations police services should be invited to participate in this process. The federal government should take the lead in promoting this negotiation process.

46. Ontario should amend existing legislation to provide the NAPS Police Board with the same opportunities and rights as a municipal police board (under section 39 of the Ontario *Police Services Act*) to appeal to an independent commission for a hearing and a binding decision regarding the adequacy of its budget.

47. NAN should be adequately funded by Canada and Ontario to be able to meaningfully and actively participate in consultations and negotiations about a legislative framework for NAPS.

48. NAN, Canada and Ontario should work together to establish flexible and innovative mechanisms for addressing health and safety issues at NAPS detachments in a timely manner.

## NAPS TRAINING, POLICIES AND PROCEDURES

49. As a professional police service, NAPS should define clear roles and responsibilities within their organizational structure. There should be clear reporting, accountability, and disciplinary mechanisms in place, including those related specifically to health and safety.

50. All officers within the NAPS organization should have the ability to address health and safety issues in a timely fashion.

51. NAPS should develop and implement policies for the search and management of prisoners based on "best practices" models that draw on OPP and RCMP policies and procedures.

52. NAPS officers should be properly trained in policies and procedures relating to the search and management of prisoners. These procedures should be reviewed at block training.

53. In the physical absence of a NAPS Sergeant, all NAPS detachments should have a designated officer-in-charge in the community at all times.

54. NAPS should take appropriate measures to ensure that policies and procedures such as searching of prisoners and prohibition of smoking in cells are strictly followed and enforced.

55. NAPS should work with the NAN First Nations to develop protocols for enforcing band by-laws for public intoxication which includes alternatives for detention in a police lock-up. Consideration should be given to the safety of the intoxicated person, the safety of other persons, and the resources available within the community.

56. Form E-120 ("Prison Arrest Record") should be amended to add a requirement that the officer notes the justification for detention pursuant to a band by-law. Officers should indicate what alternatives to detention that were taken, as well as into whose custody the person was released.

57. NAPS should develop a protocol to determine suitable durations of incarceration due to intoxication.

58. Form E-120 should be amended to include the signing off of a search performed at the time of arrest, time of lodging, and time of transfer.

59. Prisoners detained in holding cells should be physically checked every 15 minutes with more frequent checks when prisoners are heavily intoxicated, or when at risk for medical emergency, self harm, or violence.

60. NAPS should develop and implement policies and procedures pertaining to the responsibilities of guards and matrons based on a "best practices" model that draws on OPP and RCMP policies and procedures.

61. NAPS should identify which policies and procedures are appropriate to be translated into Ojibway, Cree and/or Oji-Cree.

62. Considering NAPS officers, guards and matrons do not necessarily speak a common language, NAPS should develop a protocol for officer / guard rotations that ensures clear communication between all NAPS personnel within their detachments, at all times.

63. NAPS should implement a notification of next of kin policy.

64. NAPS should develop a protocol for officer, guard and prisoner ratios. Consideration should be given for additional staffing for the continuous monitoring of individuals where a safety concern exists. Specialized officers visiting communities for investigations should not be considered as part of the detachment complement for that day.

## COMMUNITY HEALTH/ WELL BEING/ RECONCILIATION & INTITATIVES

65. First Nations, Canada and Ontario governments should ensure that counseling is made available to family members on First Nation Reserves after sudden deaths.

66. Counseling should be made available for the families of Ricardo Wesley and Jamie Goodwin, provided they wish to participate.

67. Counseling should be made available for the NAPS employees involved in the Kashechewan detachment fire, provided they wish to participate.

68. NAN, Canada and Ontario governments should work together to develop flexible, innovative and effective responses to the problems posed by alcohol and drug abuse in NAN First Nations. In particular, Canada should conduct a study on the feasibility of establishing detoxification centres on NAN First Nation reserves.

69. Reconciliation measures, such as a community feast, should be undertaken between the families of the deceased, the people of Kashechewan, and the NAPS employees.

70. NAPS should continue its initiatives to improve relations between its police service and the NAN First Nation communities it serves. In addition, NAPS should continue its development of proactive policing policies and programs for these communities.

71. Canada, Ontario and NAPS should create specific community policing officers with special emphasis on alcohol and drug abuse education and prevention.

72. The Kashechewan First Nation should consider holding a community meeting to determine whether the membership supports amending or repealing the current intoxication band by-law.

## INFORMATION SHARING

73. The Director General of Aboriginal Policing Directorate (DG-APD) should develop a protocol to provide information with respect to deaths arising from similar circumstances in First Nations Policing.

74. This protocol should require that a police service that receives recommendations from a provincial inquest or inquiry relating to an in-custody death forwards the recommendations to the DG-APD and its provincial equivalent.

75. This protocol should require that a police service investigating an in-custody death in which it is discovered that unsafe premises, practices or procedures may have contributed to the death be reported to the DG-APD, the provincial equivalent and the force that detained the deceased. The report should set out the circumstances of the death and any identifying factors that may have contributed to the death.

76. This protocol should require that the DG-APD forward, forthwith, any recommendations and reports made pursuant to (73) and (74) above to all First Nations Police Services.

77. This protocol should require that the DG-APD confirm that all First Nation Police Forces have reviewed the report and recommendations; identified if the unsafe premises, practices or procedures are applicable to their service; and if actions have been taken or if actions are not required.

78. This protocol should identify if any additional funding or resources are required pursuant to (76), to address any unsafe premise, practices or procedures.

## FUNDING

79. Canada and Ontario should agree that the funding split set out in the tripartite agreement should not prohibit either level of government from providing funding in excess of the 52-48% arrangement.

80. Canada and Ontario negotiators should visit NAN communities and NAPS detachments to gain a better understanding of the unique needs and challenges of policing within this remote region. Canada and Ontario should provide funding for their negotiators to undertake such travel.

81. Canada should amend the terms and conditions of the First Nations Policing Policy (FNPP) to allow for major capital funding.

82. Canada, Ontario and NAN should amend the terms of the Tripartite Agreement to allow for major capital funding.

83. Sections 14.2 and 15.1 in the Tripartite Agreement should be amended to include a binding arbitration process.

84. Section 16.1 in the Tripartite Agreement should be reevaluated considering the binding arbitration process pursuant to (82) above.

85. Canada should create an advocacy position within the Federal Government to assist First Nation communities in identifying and accessing programs, funding, and services.

86. Contextual evidence provided at this inquest has suggested many contributing factors to these deaths. A public inquiry or Royal Commission should be conducted for the NAN communities which addresses parity of services, community health and safety, and quality of life.

**Closing comment:**

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that this is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that the error can be corrected.

Presiding Coroner

2009-05-27
(date)