

I N D E X

R.C.M.P. TOXICOLOGY REPORT	PAGE 1
R.C.M.P. SEROLOGY REPORT	2
R.C.M.P. DOCUMENT EXAMINATION REPORT	3
R.C.M.P. HAIR AND FIBRE REPORT	4
R.C.M.P. FIREARMS SECTION REPORT	5
R.C.M.P. CHEMISTRY REPORT	6
POST OFFICE WARRANT & JOURNAL ADVERTISEMENT	7
CORRESPONDENCE RESULTING FROM ADVERTISEMENT	8 - 9
GIANT TIGER STORE RECEIPT RE WEAPON	10
PIUS X LIST OF STUDENTS AND CLASS SCHEDULE	11
DIARY	12 - 22
OTHER WRITINGS FOUND IN BASEMENT AND BIOLOGY EXAMINATION	23 - 26



Ministry of the
Solicitor
General

Chief Coroner
for Ontario

Public
Safety
Division

26 Grenville Street
Toronto, Ontario
M7A 2G9

Telephone:
416/965-6678

Inquest: Robert Poulin et al
deceased Oct. 27, 1975

WITNESSES

Robert Bedard
Kurniadi Benggawan
Leo Bowes
Cathy Burtyn
David Canning
Glenn Carroll
L.J. Cartwright
Renzo Catana
Margaret Chaput
Spencer Chenier
A.F. Cooper
Daniel Cummings
Robert Darby
Donald Devine
John Dickson
Maureen Dorst
Thomas Flanagan
Stevens Helman
Roy Hoban
Barkley Holbrook
Mark Holleran
Robert Kelly
John King

Ray Lacelle
Leonard Lunney
Hugh Macey
Michael Mageean
Lester McPhee
Pierre Milette
Michael Monette
Malcolm Pearce
Mark Potvin
Mary Poulin
Stewart Poulin
Joan Rabot
John Rabot
Ray Russell
Robert Russell
Roy Russell
Gerry St. Louis
Robin Shaw
Douglas Thompson
Victor Tolgysey
George Tolnai
John Zoschke

The Coroners Act – Province of Ontario
VERDICT OF CORONER'S JURY

We, [REDACTED] of [REDACTED]
[REDACTED] of [REDACTED]
[REDACTED] of [REDACTED]
[REDACTED] of [REDACTED]
[REDACTED] of [REDACTED]

the jury serving on the inquest into the death of

R A B O T

Surname

K I M B E R N A D E T T E

Given Name

aged....., held at Salon "B" 350 Dalhousie St. (Holiday Inn) on the day of
 December..... 19 75....., by Dr. H.B. COTNAM.....

Coroner for Area No. Prov. Ont....., having been duly sworn, have inquired into and determined the following:

1. Name of deceased: Kim Bernadette RABOT Age 17
2. Date and time of death: October 27 1975 Between 9:00 A.M. and 11:00 A.M.
3. Place of death: 5 Warrington Ave. Ottawa Ontario
4. Cause of death: Shock and hemorrhaging from multiple stab wounds and asphyxia
5. By what means: Homicide by Robert Paulin

(continue on reverse side if necessary)

Signatures of Jurors

This verdict was received by me this 4TH day of December..... 19 75.....

H. B. COTNAM B.A. M.D. C.M.
 CHIEF CORONER
 PROVINCE OF ONTARIO

H.B. Cotnam M.D.
 Coroner
Chief Coroner

Residential Area No. Prov. Ont.....

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

25. (1) Where an inquest is held, it shall inquire into and determine,

- (a) who the deceased was;
- (b) how the deceased came to his death;
- (c) when the deceased came to his death;
- (d) where the deceased came to his death, and
- (e) by what means the deceased came to his death.

(2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.

(3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.

(4) A finding that contravenes subsection 2 is improper and shall not be received.

(5) Where a jury fails to deliver a proper finding it shall be discharged.



①

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

Restrictions on the rights of individuals may well be the price we have to pay for civilization. In our opinion certain limitations on existing civil liberties will be necessary to avoid future incidents of this nature. People as individuals must take a more responsible interest in the development of their fellow man.

1. With regard to the availability of firearms, we recommend the following:

@ a firearm ownership permit system be ~~limited to hunting for survival~~ implemented as soon as possible with the following provisions:

- i) valid reasons to receive a permit limited to hunting for survival, police, security, D.V.S., Sport hunting, and long-gun target shooting.

NOTE: Section 25 of The Coroners Act provides as follows:

25. (1) Where an inquest is held, it shall inquire into and determine,
 - (a) who the deceased was;
 - (b) how the deceased came to his death;
 - (c) when the deceased came to his death;
 - (d) where the deceased came to his death, and
 - (e) by what means the deceased came to his death.
- (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.
- (3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.
- (4) A finding that contravenes subsection 2 is improper and shall not be received.
- (5) Where a jury fails to deliver a proper finding it shall be discharged.

H. B. COTNAM B.A. M.D. C.M.
CHIEF CORONER
PROVINCE OF ONTARIO

2

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

- ii) police or registrar of firearms to have the power of veto with court appeal.
- iii) the licence to include a photo, signature and social insurance number.
- (b) Abolition of currently restricted weapons, except for police security and D.N.D.
- (c) All other firearms, when not in use are to be held in a depository run by approved security agencies. The cost to be borne by firearm owners.
- (d) A government paid-for program to buy and destroy or to make inoperable all firearms turned in by the public.
- (e) Firearms will be sold only to those holding an ownership licence, after a 30 day cooling-off period.
- (f) Ownership licence must be presented to buy ammunition.
- (g) Retailers are to keep records of all sales by model and serial number.

NOTE: Section 25 of The Coroners Act provides as follows:

25. (1) Where an inquest is held, it shall inquire into and determine,
 - (a) who the deceased was;
 - (b) how the deceased came to his death;
 - (c) when the deceased came to his death;
 - (d) where the deceased came to his death, and
 - (e) by what means the deceased came to his death.
- (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.
- (3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.
- (4) A finding that contravenes subsection 2 is improper and shall not be received.
- (5) Where a jury fails to deliver a proper finding it shall be discharged.

H. B. COTNAM B.A. M.D. C.M.
CHIEF CORONER
PROVINCE OF ONTARIO

The Coroners Act – Province of Ontario

VERDICT OF CORONER'S JURY

We, of

..... of

..... of

..... of

..... of

the jury serving on the inquest into the death of

[illegible]

Surname

[illegible]

Given Name

aged....., held at on the day of
..... 19....., by

Coroner for Area No. _____, having been duly sworn, have inquired into and determined the following:

1. Name of deceased:
2. Date and time of death:
3. Place of death:
4. Cause of death:
5. By what means:

(continue on reverse side if necessary)

Foreman

Signatures of Jurors

This verdict was received by me this day of 19.....

Coroner

Residential Area No.

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

(3)

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

(1) Penalties for violations to be mandatory and a minimum of 2 years for illegal possession and 5 years additional for use in commission of a crime.

2. With regard to the availability of pornographic material, we recommend that:

(a) Pornographic be defined as anything showing or representing the genital parts of the human body.

(b) Pornographic material ~~not~~ be ^{boxed} ~~available~~ in Ontario.

3. With regard to the educational system up to Grade XIII, we recommend that:

(a) Attendance systems be implemented which will establish the presence or absence of a student within 30 minutes of the start of the student's day.

NOTE: Section 25 of The Coroners Act provides as follows:

25. (1) Where an inquest is held, it shall inquire into and determine,

- (a) who the deceased was;
- (b) how the deceased came to his death;
- (c) when the deceased came to his death;
- (d) where the deceased came to his death, and
- (e) by what means the deceased came to his death.

(2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.

(3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.

(4) A finding that contravenes subsection 2 is improper and shall not be received.

(5) Where a jury fails to deliver a proper finding it shall be discharged.

1980

H. B. COTNAM B.A. M.D. C.M.
CHIEF CORONER
PROVINCE OF ONTARIO

The Coroners Act – Province of Ontario

VERDICT OF CORONER'S JURY

We, of
..... of
..... of
..... of
..... of

the jury serving on the inquest into the death of

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Surname

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Given Name

aged....., held at on the day of
..... 19....., by

Coroner for Area No., having been duly sworn, have inquired into and determined the following:

- 1. Name of deceased:
- 2. Date and time of death:
- 3. Place of death:
- 4. Cause of death:
- 5. By what means:

.....
.....
.....

(continue on reverse side if necessary)

Foreman

Signatures of Jurors

This verdict was received by me this day of 19.....

Coroner

for Area No.



VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

The Coroners Act – Province of Ontario
VERDICT OF CORONER'S JURY

We, _____

_____ of _____

_____ of _____

_____ of _____

_____ of _____

_____ of _____

the jury serving on the inquest into the death of

P O U L I N

Surname

R O B E R T J A M E S

Given Name

aged 18, held at Salon "B" 350 Dalhousie St. (Holiday Inn) on the 4th day of December 1975, by H.B. COTNAM, M.D.

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

1. Name of deceased: ROBERT JAMES POULIN - Aged 18
2. Date and time of death: October 27, 1975 at approximately 2:20 p.m.
3. Place of death: St. Pius X High School
4. Cause of death: Massive Gunshot wound to Head.
5. By what means: By his own hand - suicide.

(continue on reverse side if necessary)

Signatures of Jurors

This verdict was received by me this 4th day of December 1975

H.B. COTNAM, M.D.
Chief Coroner

Residential Area No. Province of Ontario.

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

[illegible]

25. (1) Where an inquest is held, it shall inquire into and determine,
 - (a) who the deceased was;
 - (b) how the deceased came to his death;
 - (c) when the deceased came to his death;
 - (d) where the deceased came to his death, and
 - (e) by what means the deceased came to his death.
- (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.
- (3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.
- (4) A finding that contravenes subsection 2 is improper and shall not be received.
- (5) Where a jury fails to deliver a proper finding it shall be discharged.

7

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

- ② Unreported absences to be checked with parents within 60 minutes of the start of the student's day.
- ③ Locker searches must be conducted at least once per semester on a random basis.
- ④ All acts of violence or threats of violence in schools are to be reported to the Department of Education for statistical compilation.

4. With regard to the media, we feel that while they play a very necessary role in avoiding future incidents, the reporting of suggestive, explicit details is dangerous. This type of sensational reporting has ~~been~~ occurred during this inquest and is deplored.

NOTE: Section 25 of The Coroners Act provides as follows:

25. (1) Where an inquest is held, it shall inquire into and determine,
- (a) who the deceased was;
 - (b) how the deceased came to his death;
 - (c) when the deceased came to his death;
 - (d) where the deceased came to his death, and
 - (e) by what means the deceased came to his death.
- (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.
- (3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.
- (4) A finding that contravenes subsection 2 is improper and shall not be received.
- (5) Where a jury fails to deliver a proper finding it shall be discharged.



TEBC

The Coroners Act – Province of Ontario

VERDICT OF CORONER'S JURY

We, of

..... of

..... of

..... of

..... of

the jury serving on the inquest into the death of

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Surname

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Given Name

aged....., held at on the day of

..... 19....., by

Coroner for Area No., having been duly sworn, have inquired into and determined the following:

- 1. Name of deceased:
- 2. Date and time of death:
- 3. Place of death:
- 4. Cause of death:
- 5. By what means:

.....

.....

.....

(continue on reverse side if necessary)

Foreman

Signatures of Jurors

This verdict was received by me this day of 19.....

Coroner

for Area No.

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

3

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

5. We support continued funding of psychological research, and public education of mental health problems.

6. We wish to commend the Ottawa Police Force for their continued efforts on behalf of the community, with special mention to those directly involved with the investigation of this incident.

7. With respect to the incident at the school, no doubt acts of heroism occurred, but the whole class is to be commended for its conduct. If the actions of individuals can be identified, these should be specifically recognized and commended by the appropriate organizations.

We emphasize:

Restrictions on the rights of individuals may well be the price we have to pay for civilization.

(FOREMAN)

NOTE: Section 25 of The Coroners Act provides as follows:

25. (1) Where an inquest is held, it shall inquire into and determine,

- (a) who the deceased was;
- (b) how the deceased came to his death;
- (c) when the deceased came to his death;
- (d) where the deceased came to his death, and
- (e) by what means the deceased came to his death.

(2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.

(3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.

(4) A finding that contravenes subsection 2 is improper and shall not be received.

(5) Where a jury fails to deliver a proper finding it shall be discharged.



HBC

The Coroners Act – Province of Ontario
VERDICT OF CORONER'S JURY

We, of
..... of
..... of
..... of
..... of

the jury serving on the inquest into the death of

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Surname

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Given Name

aged....., held at on the day of
..... 19....., by

Coroner for Area No., having been duly sworn, have inquired into and determined the following:

- 1. Name of deceased:
- 2. Date and time of death:
- 3. Place of death:
- 4. Cause of death:
- 5. By what means:

.....
.....
.....

(continue on reverse side if necessary)

Foreman

Signatures of Jurors

This verdict was received by me this day of 19.....

Coroner

for Area No.

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

44561-3-7-93-1

We, _____ of _____
 _____ of _____
 _____ of _____
 _____ of _____
 _____ of _____

[illegible]

K	I	M		B	E	R	N	A	D	E	T	T	E				
---	---	---	--	---	---	---	---	---	---	---	---	---	---	--	--	--	--

aged 17, held at Salon "B", 350 Dalhousie St. (Holiday Inn) on the 1st, 2nd, 3rd, & 4th day of May 1968.

December 19 75, by H.B. COTNAM, M.D.
Province of
Coroner for Area No. Ontario, having been duly sworn, have inquired into and determined the

1. Name of deceased: KIM BERNADETTE RABOT - Aged 17
2. Date and time of death: October 27, 1975, between 9:00 a.m. and 11:00 a.m.
3. Place of death: 5 Warrington Drive, OTTAWA, Ontario.
4. Cause of death: Shock and hemorrhaging from multiple stab wounds and Asphyxia.
5. By what means: Homicide by Robert Poulin.

(continue on reverse side if necessary)

Signatures of Jurors

This verdict was received by me this 4th day of December 19 75

H. B. COTNAM, M.D.

Chief Coroner

Province of Ontario.
Residential Area No.

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

This image shows a single page from a notebook or ledger. It features approximately 20 evenly spaced horizontal blue lines across its entire width. The margins are uniform on all sides, and there are no vertical lines, text, or other markings present.

NOTE: Section 25 of The Coroners Act provides as follows:

25. (1) Where an inquest is held, it shall inquire into and determine,
 - (a) who the deceased was;
 - (b) how the deceased came to his death;
 - (c) when the deceased came to his death;
 - (d) where the deceased came to his death, and
 - (e) by what means the deceased came to his death.
- (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.
- (3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.
- (4) A finding that contravenes subsection 2 is improper and shall not be received.
- (5) Where a jury fails to deliver a proper finding it shall be discharged.

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

RESTRICTIONS ON THE RIGHTS OF INDIVIDUALS MAY WELL BE THE PRICE WE HAVE TO PAY FOR CIVILIZATION. IN OUR OPINION, CERTAIN LIMITATIONS ON EXISTING CIVIL LIBERTIES WILL BE NECESSARY TO AVOID FUTURE INCIDENTS OF THIS NATURE. PEOPLE AS INDIVIDUALS MUST TAKE A MORE RESPONSIBLE INTEREST IN THE DEVELOPMENT OF THEIR FELLOW MAN.

1. WITH REGARD TO THE AVAILABILITY OF FIREARMS, WE RECOMMEND THE FOLLOWING:

(a) A FIREARM OWNERSHIP PERMIT SYSTEM BE IMPLEMENTED AS SOON AS POSSIBLE WITH THE FOLLOWING PROVISIONS.

(1) VALID REASONS TO RECEIVE A PERMIT LIMITED TO HUNTING FOR SURVIVAL, POLICE, SECURITY, D.N.D., SPORT HUNTING, AND LONG-GUN TARGET SHOOTING.

(2) POLICE OR REGISTRAR OF FIREARMS TO HAVE THE POWER OF VETO WITH COURT APPEAL.

(3) THE LICENSE TO INCLUDE A PHOTO, SIGNATURE AND SOCIAL INSURANCE NUMBER.

(b) ABOLITION OF CURRENTLY RESTRICTED WEAPONS, EXCEPT FOR POLICE SECURITY AND D.N.D.

(c) ALL OTHER FIREARMS, WHEN NOT IN USE, ARE TO BE HELD IN A DEPOSITORY RUN BY APPROVED SECURITY AGENCIES. THE COST TO BE BORNE BY FIREARM OWNERS.

(d) A GOVERNMENT PAID FOR PROGRAM TO BUY AND DESTROY OR TO MAKE INOPERABLE ALL FIREARMS TURNED IN BY THE PUBLIC.

CONTINUED/2

NOTE: Section 25 of The Coroners Act provides as follows:

25. (1) Where an inquest is held, it shall inquire into and determine,

- (a) who the deceased was;
- (b) how the deceased came to his death;
- (c) when the deceased came to his death;
- (d) where the deceased came to his death, and
- (e) by what means the deceased came to his death.

(2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.

(3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.

(4) A finding that contravenes subsection 2 is improper and shall not be received.

(5) Where a jury fails to deliver a proper finding it shall be discharged.

The Coroners Act – Province of Ontario

VERDICT OF CORONER'S JURY

We, of

..... of

..... of

..... of

..... of

the jury serving on the inquest into the death of

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Surname

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Given Name

aged....., held at on the day of

..... 19....., by

Coroner for Area No., having been duly sworn, have inquired into and determined the following:

- 1. Name of deceased:
- 2. Date and time of death:
- 3. Place of death:
- 4. Cause of death:
- 5. By what means:

.....

.....

.....

(continue on reverse side if necessary)

.....

Foreman

.....

.....

.....

Signatures of Jurors

This verdict was received by me this day of 19.....

.....

Coroner

Residential Area No.

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

- (e) FIREARMS WILL BE SOLD ONLY TO THOSE HOLDING AN OWNERSHIP LICENSE, AFTER A 30-DAY COOLING-OFF PERIOD.
- (f) OWNERSHIP LICENSE MUST BE PRESENTED TO BUY AMMUNITION.
- (g) RETAILERS ARE TO KEEP RECORDS OF ALL SALES BY MODEL AND SERIAL NUMBER.
- (h) PENALTIES FOR VIOLATIONS TO BE MANDATORY AND A MINIMUM OF TWO YEARS FOR ILLEGAL POSSESSION AND FIVE YEARS ADDITIONAL FOR USE IN COMMISSION OF A CRIME.

2. WITH REGARD TO THE AVAILABILITY OF PORNOGRAPHIC MATERIAL, WE RECOMMEND THAT:

- (a) PORNOGRAPHIC BE DEFINED AS ANYTHING SHOWING OR REPRESENTING THE GENITAL PARTS OF THE HUMAN BODY.
- (b) PORNOGRAPHIC MATERIAL BE BANNED IN ONTARIO.

3. WITH REGARD TO THE EDUCATIONAL SYSTEM UP TO GRADE XIII, WE RECOMMEND THAT:

- (a) ATTENDANCE SYSTEMS BE IMPLEMENTED WHICH WILL ESTABLISH THE PRESENCE OR ABSENCE OF A STUDENT WITHIN THIRTY MINUTES OF THE START OF THE STUDENT'S DAY.
- (b) UNREPORTED ABSENCES TO BE CHECKED WITH PARENTS WITHIN SIXTY MINUTES OF THE START OF THE STUDENT'S DAY.
- (c) LOCKER SEARCHES MUST BE CONDUCTED AT LEAST ONCE PER SEMESTER ON A RANDOM BASIS.
- (d) ALL ACTS OF VIOLENCE OR THREATS OF VIOLENCE IN SCHOOLS ARE TO BE REPORTED TO THE DEPARTMENT OF EDUCATION FOR STATISTICAL COMPILATION.

CONTINUED/3

NOTE: Section 25 of The Coroners Act provides as follows:

- 25. (1) Where an inquest is held, it shall inquire into and determine,
 - (a) who the deceased was;
 - (b) how the deceased came to his death;
 - (c) when the deceased came to his death;
 - (d) where the deceased came to his death, and
 - (e) by what means the deceased came to his death.
- (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.
- (3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.
- (4) A finding that contravenes subsection 2 is improper and shall not be received.
- (5) Where a jury fails to deliver a proper finding it shall be discharged.

The Coroners Act – Province of Ontario

VERDICT OF CORONER'S JURY

We, of
 of
 of
 of
 of

the jury serving on the inquest into the death of

[illegible]

Surname

[illegible]

Given Name

aged....., held at on the day of
..... 19....., by

Coroner for Area No. _____, having been duly sworn, have inquired into and determined the following:

1. Name of deceased:
2. Date and time of death:
3. Place of death:
4. Cause of death:
5. By what means:

(continue on reverse side if necessary)

Foreman

Signatures of Jurors

This verdict was received by me this day of 19.....

.....
Coroner

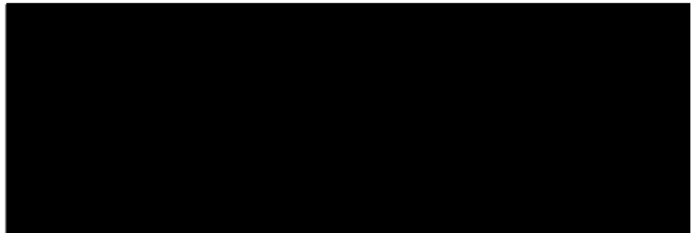
Residential Area No.

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

4. WITH REGARD TO THE MEDIA, WE FEEL THAT WHILE THEY PLAY A VERY NECESSARY ROLE IN AVOIDING FUTURE INCIDENTS, THE REPORTING OF SUGGESTIVE, EXPLICIT DETAILS IS DANGEROUS. THIS TYPE OF SENSATIONAL REPORTING HAS OCCURRED DURING THIS INQUEST AND IS DEPLORED.
5. WE SUPPORT CONTINUED FUNDING OF PSYCHOLOGICAL RESEARCH AND PUBLIC EDUCATION OF MENTAL HEALTH PROBLEMS.
6. WE WISH TO COMMEND THE OTTAWA POLICE FORCE FOR THEIR CONTINUED EFFORTS ON BEHALF OF THE COMMUNITY, WITH SPECIAL MENTION TO THOSE DIRECTLY INVOLVED WITH THE INVESTIGATION OF THIS INCIDENT.
7. WITH RESPECT TO THE INCIDENT AT THE SCHOOL, NO DOUBT ACTS OF HEROISM OCCURRED, BUT THE WHOLE CLASS IS TO BE COMMENDED FOR ITS CONDUCT. IF THE ACTIONS OF INDIVIDUALS CAN BE IDENTIFIED, THESE SHOULD BE SPECIFICALLY RECOGNIZED AND COMMENDED BY THE APPROPRIATE ORGANIZATIONS.

WE EMPHASIZE: RESTRICTIONS ON THE RIGHTS OF INDIVIDUALS MAY WELL BE THE PRICE WE HAVE TO PAY FOR CIVILIZATION.



NOTE: Section 25 of The Coroners Act provides as follows:

25. (1) Where an inquest is held, it shall inquire into and determine,
 - (a) who the deceased was;
 - (b) how the deceased came to his death;
 - (c) when the deceased came to his death;
 - (d) where the deceased came to his death, and
 - (e) by what means the deceased came to his death.
- (2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection 1.
- (3) Subject to subsection 2, the jury may make recommendations in respect of any matter arising out of the inquest.
- (4) A finding that contravenes subsection 2 is improper and shall not be received.
- (5) Where a jury fails to deliver a proper finding it shall be discharged.

The Coroners Act – Province of Ontario

VERDICT OF CORONER’S JURY

We, _____ of _____

_____ of _____

_____ of _____

_____ of _____

_____ of _____

the jury serving on the inquest into the death of

<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>
Surname	Given Name

aged_____, held at _____ on the _____ day of _____

_____ 19_____, by _____

Coroner for Area No. _____, having been duly sworn, have inquired into and determined the following:

- 1. Name of deceased: _____
- 2. Date and time of death: _____
- 3. Place of death: _____
- 4. Cause of death: _____
- 5. By what means: _____

(continue on reverse side if necessary)

_____ Foreman

Signatures of Jurors

This verdict was received by me this _____ day of _____ 19_____

_____ Coroner

Residential Area No. _____

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY

The Coroners Act – Province of Ontario
VERDICT OF CORONER'S JURY

We,

... of

... of

... of

... of

... of

the jury serving on the inquest into the death of

P O U L I N

Surname

R o b e r t J a m e s

Given Name

aged....., held at Salon "B" 350 Dalhousie St. (Holiday Inn) on the day of

December

19 75

by DR. H.B. COTNAM

Coroner for Area No. Prov. Ont., having been duly sworn, have inquired into and determined the following:

1. Name of deceased: Robert James POULIN age 18
2. Date and time of death: October 27 1975 at approx 2:20 P.M.
3. Place of death: St Pius X High School
4. Cause of death: Massive gun shot wound to the head
5. By what means: by his own hand - suicide

(continue on reverse side if necessary)

Signatures of Jurors

(FOREMAN)

This verdict was received by me this 4TH day of December 19 75



H.B. Cotnam M.D.
Coroner
Chief Coroner.
Residential Area No. Prov. Ont.

VERDICT MUST BE FORWARDED TO THE CHIEF CORONER AND A COPY TO THE CROWN ATTORNEY