**RELEASE DATE: JULY 20, 2011**

Manitoba

**THE PROVINCIAL COURT OF MANITOBA**

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

**AND IN THE MATTER OF:** **MAURICE PAUL THOMAS**
**(DATE OF DEATH: MAY 7, 2008)**

# Report on Inquest and Recommendations of The Honourable Judge Wanda Garreck Issued this 15th day of July, 2011

**APPEARANCES:**

Ms. Katie Dojack, Provincial Counsel to the Inquest with Ms. Betty Owen, Inquest Coordinator
Mr. Hymie Weinstein, Counsel to Main Street Project
Mr. Michael Jack, Counsel to Winnipeg Fire Paramedic Service and Downtown Business Improvement Zone
Ms. Vivian Rachlis, Counsel to the Winnipeg Regional Health Authority

**RELEASE DATE**: **JULY 20, 2011**

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*THE FATALITY INQUIRIES ACT*

# REPORT BY PROVINCIAL COURT JUDGE ON INQUEST

# RESPECTING THE DEATH OF: MAURICE PAUL THOMAS

# (DATE OF DEATH: MAY 7, 2008)

Dated at the City of Winnipeg, this 15th day of July, 2011.

Original signed by:

***Wanda Garreck***,
Provincial Court Judge

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12. Dr. Littman, Medical Examiner and Pathologist
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Manitoba

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**REPORT BY PROVINCIAL COURT JUDGE ON INQUEST**

**RESPECTING THE DEATH OF: MAURICE PAUL THOMAS**

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## 1. INTRODUCTION:

[1] By letter dated January 18, 2010 the Chief Medical Examiner, Dr. A. Thambirajah Balachandra, directed that an Inquest be held into the death of Maurice Paul Thomas, for the following reasons:

1) to fulfill the requirement for an inquest as defined in section 19(3) of the *Fatality Inquiries Act;*

2) to determine the circumstances relating to Mr. Thomas' death; and,

3) to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[2] Section 19(3) of the *Fatality Inquiries Act* C.C.S.M. c.F52 (Appendix 1), provides in part, that an inquest into a death shall be held, where the person dies while a resident in a correctional institution, jail or prison.

[3] In the case of Maurice Paul Thomas, the evidence is that he died in hospital after being transferred from the Main Street Project. Main Street Project located at 75 Martha Street in Winnipeg, is designated as a detoxification centre under the *Intoxicated Persons Detention Act*, Regulation 331/87 (Appendix 2); it is not designated as a correctional institution, jail or prison. Thus, it would seem that sections 19(1) and (2) are sufficient to enable the Chief Medical Examiner to direct an inquest in this situation rather than 19(3).

[4] On June 22, 2010 standing was given to the parties as they appear in this report. Ms. Dojack had contact with the family of Mr. Thomas and discussed their ability to attend and request standing. The inquest was later advised that one of Mr. Thomas' brothers would be attending the inquest and would seek standing at that time.

[5] When the inquest continued in January 2011, members of Mr. Thomas' family were unable to attend. Ms. Dojack had contact with the family throughout the proceedings to update them and relay information on their behalf.

[6] Evidence was heard January 17-21, 2011 at which time the inquest was adjourned for my written report. The report is to set out when, where and by what means, the deceased person died, the cause of death, the name of the deceased person, if known, and the material circumstances of the death. The report may recommend changes in the programs, policies or practices of the government and

the relevant public agencies or institutions or in the laws of the province where the provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death of Mr. Thomas. (*Fatality Inquiries Act*, (supra), section 33(1)).

## 2. REPORT:

[7] The deceased person is known to be Maurice Paul Thomas.

[8] According to the autopsy report (Exhibit 2-A9), Mr. Thomas was pronounced dead at 17:20 (5:20 p.m.) on May 7, 2008 at the Health Sciences Centre, Winnipeg, Manitoba. The immediate cause of death is noted in the autopsy as anoxic brain injury due to or as a consequence of respiratory arrest due to or as a consequence of acute alcohol intoxication.

### a) MATERIAL CIRCUMSTANCES SURROUNDING THE DEATH OF MR. THOMAS:

[9] Mr. Thomas was located by the Winnipeg Fire Paramedic Service on May 5, 2008 at approximately 21:29 (9:29 p.m.) in the area of the Disraeli Freeway and Main Street in Winnipeg, Manitoba. A two-member crew of the Winnipeg Fire Paramedic Service described Mr. Thomas lying on the sidewalk on his back where he appeared to be asleep.

[10] Primary care level paramedic, Aaron Schlichting, approached Mr. Thomas and completed the patient care report. He testified he was able to wake Mr. Thomas by pinching him on the shoulder. He indicated Mr. Thomas was conscious, alert and oriented to who he was and where he was. Mr. Thomas wanted to go to Main Street Project but he was too tired to walk there on his own. He advised paramedics he had been drinking but was unable to say how much and was not asked what he had been drinking.

[11] Mr. Schlichting testified he checked Mr. Thomas' vital signs and did visual observations. He determined there were no medical complaints and the vital signs did not cause him any concern. Mr. Schlichting concluded that Mr. Thomas was intoxicated by alcohol and he cleared him as appropriate for transport to Main Street Project.

[12] The second member of the crew was first responder and fire fighter, Arnold Jenson. He agreed that Mr. Thomas appeared to be intoxicated as he observed him interacting with his partner Mr. Schlichting.

[13] The Winnipeg Fire Paramedic Service crew contacted the Downtown Business Improvement Zone Patrol (hereafter "Biz Patrol"), to transport Mr. Thomas to the Main Street Project. The Biz Patrol arrived at approximately 21:45

(9:45 p.m.) at the location where the Winnipeg Fire Paramedic Service crew were attending to Mr. Thomas.

[14] Three Biz Patrol members were on scene and two of them testified at the inquest. Both testified they recognized Mr. Thomas as someone they dealt with frequently, on a daily basis and sometimes up to as many as 3 times per day. When they arrived, Winnipeg Fire Paramedic Service members were on scene with Mr. Thomas who was lying on his back and appeared quite intoxicated. The Biz patrol members were advised by the Winnipeg Fire Paramedic Service that Mr. Thomas was cleared to go to the Main Street Project.

[15] They testified they did not receive any paperwork or documentation from Winnipeg Fire Paramedic Service. However, their role as they explained it is to transport people under the *Intoxicated Persons Detention Act.* If paramedics call them it is because the person is medically clear to go to Main Street Project rather than to hospital or for release.

[16] The Biz Patrol and Winnipeg Fire Paramedic Service members assisted Mr. Thomas to the Biz patrol vehicle. They testified Mr. Thomas was unable to walk on his own and needed their assistance to get up, walk and get into the vehicle.

[17] The Biz Patrol members testified they had seen Mr. Thomas this or more intoxicated on previous occasions. They testified Mr. Thomas' level of intoxication did not really change throughout their dealings. They said they had no concerns transporting Mr. Thomas to Main Street Project based on their interaction with him and the fact he had been medically cleared by the Winnipeg Fire Paramedic Service.

[18] Once Mr. Thomas was in the Biz Patrol vehicle they proceeded to the Main Street Project a short distance away at 75 Martha Street. Enroute, Biz Patrol member, Lisa McIntyre, testified she was able to converse with Mr. Thomas in the back of the van. She indicated he was aware he was going to Main Street Project and he said he had a lot to drink in response to her questions. He was conscious and there was minimal conversation. She said she could smell liquor on him.

[19] The Biz Patrol arrived at Main Street Project with Mr. Thomas around 21:50 or 21:55 (9:50 or 9:55 p.m.). All three Biz Patrol members assisted Mr. Thomas out of the van and into the intake area for people detained under the Intoxicated Persons Detention Act (hereafter "IPDA" unit). Two of the Biz Patrol members held Mr. Thomas on either side, while a third member held him by his waistband to assist him with walking. Both testified Mr. Thomas sat down momentarily on the

way in; they believed he was tired and required a rest. One of the Biz Patrol members testified they also needed a rest from assisting him given his physical size.

[20] Once inside the Main Street Project, a video shows Mr. Thomas at the intake counter and sagged over the counter. Those who were present testified he appeared to want to go to sleep. Ms. Aquin testified she retrieved a mat for Mr. Thomas to lie on so they could pull him into a cell to finish a search of his person, given his inability to stand on his own. (Exhibit 2-B34 Intake video of Mr. Thomas).

[21] George Delaronde was working the intake desk at Main Street Project that evening. He testified he was very familiar with Mr. Thomas, a regular client of both the involuntary side and the voluntary shelter at Main Street Project. Mr. Delaronde testified he was advised Mr. Thomas was cleared by Winnipeg Fire Paramedic Service for detention at Main Street Project.

[22] Mr. Delaronde has worked at Main Street Project for over 13 years. He testified he had seen Mr. Thomas intoxicated on many occasions and at times as intoxicated as he was on this evening. He was familiar with Mr. Thomas' medical history and past drinking habits from earlier contact with him and from information kept in the computer databank. He said he did not ask Mr. Thomas any questions because of his familiarity with him and because Mr. Thomas was very drunk.

[23] Mr. Delaronde was familiar with the fact Mr. Thomas was prone to having seizures. He believed he had seen him seizure in the past but could not recall a specific incident. He testified he would have preferred to put Mr. Thomas in a cell with a camera given his history of seizures but because of the difficulty Mr. Thomas was having walking, he chose to have him put in a cell closest to the front.

[24] The Biz Patrol were having trouble searching and removing the layers of clothing from Mr. Thomas in the intake area, so Mr. Delaronde suggested they take him directly to a cell to make it easier. Mr. Thomas was searched and lodged in cell nineteen by the Biz Patrol without having any conversation with Mr. Delaronde.

[25] The IPDA unit intake sheet indicates that Mr. Thomas was received from the Biz Patrol at 22:00 (10:00 p.m.). All persons having contact with Mr. Thomas to this point testified he was conscious throughout their involvement with him.

[26] Mr. Delaronde testified and video Exhibit 2-B34 confirms that Mr. Thomas was checked by staff of the Main Street Project every 15 minutes from 22:00 to 23:30 (10:00 p.m. - 11:30 p.m.). During these checks, staff can be seen looking through the window of the cell in which Mr. Thomas was lodged and then noting the check on the clipboard outside the door of the cell.

[27] During these checks, which appear to be brief, Mr. Delaronde testified he was looking to see if Mr. Thomas was breathing, whether he was asleep or awake and whether there was at least one breath each time. Mr. Delaronde testified at the 23:15 (11:15 p.m.) check Mr. Thomas was breathing, had not moved and was still asleep. However, he said at the 23:30 (11:30 p.m.) check he could not tell from looking through the window whether Mr. Thomas was still breathing. He testified the window was somewhat scratched which made it somewhat more difficult to ascertain if Mr. Thomas was breathing.

[28] Mr. Delaronde said he went to the desk in the IPDA unit intake area to retrieve keys for the cell and then went into the cell. He attempted to rouse Mr. Thomas by talking to him, touching his foot, and pinching his shoulder area. He did not get a response so he called for help from fellow staff member, Kelvin Hildebrandt, who attended to the cell. Mr. Delaronde stated Mr. Thomas did not appear to be breathing, and he could not detect whether he had a pulse or not.

[29] When Mr. Hildebrandt attended, they turned Mr. Thomas onto his back. Mr. Delaronde said he saw clear liquid on the mat which he believed may have been vomit. Mr. Hildebrandt testified he saw vomit on Mr. Thomas' face, on the mat and in his mouth. Mr. Hildebrandt testified Mr. Thomas was not breathing and had no pulse.

[30] Mr. Hildebrandt ran to get staff at the Main Street Project shelter desk, a short distance away from the IPDA unit intake desk, to call 911 for an ambulance. He returned to start CPR, did a chest compression then went to find a mask to continue. Mr. Hildebrandt says once he returned to the room, two other Main Street Project staff were already in the cell performing CPR on Mr. Thomas.

[31] Main Street Project staff, Daniel Cifuentes performed CPR and testified he saw a little bit of vomit on Mr. Thomas' mouth and only mucous in his mouth when he cleared it for artificial respiration.

[32] The Winnipeg Fire Paramedic Service arrived with ambulance at the Main Street Project and were assessing Mr. Thomas by 23:40 (11:40 p.m.) at which time he was found to have no pulse and was not breathing.

[33] I heard evidence from the Winnipeg Fire Paramedic Service members as to their involvement in and observations of Mr. Thomas at Main Street Project. Winnipeg Fire Paramedic Service member Chris Broughton testified he saw some vomit and a red substance on Mr. Thomas' face. He believed the red substance to be glucose gel. He believed the vomit also had some red substance in it. Chuck Thomas noticed a pinkish substance but was unsure if it was vomit, oral glucose or some other substance. Thomas Walsh did not notice anything around the mouth or face of Mr. Thomas.

[34] It is unclear from the evidence if the liquid on the mat, seen by Main Street Project staff and Winnipeg Fire Paramedic Service members, was vomit or whether it was some other clear fluid from Mr. Thomas' mouth or from some other source.

[35] From the evidence of those involved with Mr. Thomas it cannot be determined what the reddish/pinkish substance was, but it is clear none of the individuals from Winnipeg Fire Paramedic Service, Biz Patrol or Main Street Project provided Mr. Thomas with oral glucose during their involvement with him.

[36] Dr. Littman, the forensic pathologist who performed the autopsy on Mr. Thomas, testified if oral glucose was given, it would not have contributed to the cause of death in this case. He testified if there had been vomiting, it may have aspirated into the lungs and could have contributed to lack of respiration but there were no findings of aspiration at time of autopsy. The medical records in Exhibit 2-A14.1, indicate upon examination at hospital Mr. Thomas' lungs were clear.

[37] Winnipeg Fire Paramedic Service noted the return of a pulse for Mr. Thomas at 23:50 (11:50 p.m.) but no spontaneous breathing. Mr. Thomas was manually assisted with breathing by way of an air bag and intubation. Mr. Thomas was transported to Health Science Centre where he arrived at 00:01 (12:01 a.m.) and remained until May 7, 2008 with no improvement in his condition. He was removed from ventilator and died on May 7, 2008.

[38] Dr. Littman testified Mr. Thomas' blood alcohol level upon entry into the hospital was 664mg% or 143mmol/L. He testified a lethal level of alcohol is usually anything over 350mg%, and Mr. Thomas' level was one of the highest he has seen.

[39] It was Dr. Littman's opinion that Mr. Thomas stopped breathing as a result of his extreme alcohol level thereby causing a cardiac arrest and loss of oxygen to the brain, which resulted in irreversible brain damage. He testified lack of blood

supply to the neurons in the brain will cause irreversible brain damage within 3-5 minutes.

[40] Dr. Littman testified the findings documented by the paramedics upon initial contact with Mr. Thomas did not suggest his life was in danger. He was of the opinion that Mr. Thomas' blood alcohol level must have continued to increase after the initial assessment by the paramedics.

[41] Dr. Littman testified the respiratory arrest in this case was not preventable; however, in some cases anoxic brain injury may not result if there is immediate medical intervention. He suggested this might involve the use of mechanical supports which I understood to mean what is commonly called life support machines. I understood Dr. Littman to say anoxic brain injury may occur even with immediate medical intervention but if the intervention is within 3-5 minutes it will reduce the likelihood of brain injury.

[42] Dr. Littman indicated aside from constant individual monitoring on a one on one basis, with immediate life support intervention in case of arrest, there really is no practical or feasible way of preventing death in a case of such extreme intoxication. Dr. Littman conceded the issue of prevention in cases such as this is out of his area of expertise and experience and the best information would come from those experienced in the field dealing with intoxicated people.

[43] Dr. Littman indicated an important factor to be determined is whether the person's blood alcohol level is increasing or decreasing. However, he acknowledged the only way to determine this would be with an accurate drinking history for the person or with a blood test which would have to be repeated to determine the alcohol level.

[44] Dr. Littman was not able to suggest any method for predicting which intoxicated persons would require constant individual monitoring over those who would not. He emphasized it requires clinical evaluation by people experienced in the field of dealing with intoxicated persons. It was his view that once the extremely intoxicated individual has been identified they require constant monitoring rather than every fifteen minutes.

[45] Dr. Littman offered perhaps the old style of open hospital ward would be better suited to provide constant monitoring. However, he recognized this would not be a practical solution for dealing with intoxicated persons given security concerns, privacy concerns and staffing concerns.

## b) OVERVIEW OF MAIN STREET PROJECT:

[46] From the evidence before me, it is clear Main Street Project in Winnipeg is a unique and ground breaking facility. Main Street Project services some of the most disadvantaged, vulnerable and high-risk people in our community. This facility serves as a model for the rest of Canada and has inquiries and delegations from all across Canada looking to duplicate such a facility.

[47] Main Street Project not only provides a detention facility for those detained under the Intoxicated Persons Detention Act, it provides very close assessment and monitoring of these individuals once admitted into the locked facility. In person checks are done every 15 minutes for each detainee in the IPDA unit. This level of assessment and monitoring appears to be unique to Main Street Project.

[48] Main Street Project also provides a crisis center during the day with a drop in shelter for those in need of services and a place to sleep. Primary health care services are provided by advanced level paramedics currently on duty twelve hour day shifts, with an expected implementation of round the clock paramedics for April 1, 2011.

[49] The Main Street Project has a transition program that offers a voluntary detoxification program and transition into the community with involvement in the current Winnipeg Housing and Homeless program.

[50] The inquest heard evidence from Mike Foster, director of programs at Main Street Project, and Karen Martin, advanced paramedic from Main Street Project, that the high-risk vulnerable clientele who access the services of Main Street Project would otherwise not likely do so elsewhere. Main Street Project has developed a relationship with a local medical clinic in order to provide follow up care and referrals for primary care medical concerns, in addition to the primary care that is provided on site by the trained staff and medical professionals of Main Street Project.

[51] Mike Foster indicated the role of Main Street Project staff is to build relationships with the people who come for services. The type of people who work there are drawn there because they want to make a difference, support the community and help people like the vulnerable clientele of Main Street Project.

[52] Mr. Foster testified a death such as Mr. Thomas' has a massive impact on all staff who work there, and they carry it with them as a heavy burden, particularly those who were working with or supporting the person at the time of the critical incident. He said through contact at Main Street Project, Mr. Delaronde and Mr. Thomas developed a relationship over the years and Mr. Delaronde was significantly impacted by Mr. Thomas' death.

[53] The inquest heard from Kelvin Hildebrandt, one of the employees of Main Street Project. He was able to provide a glimpse into what Mr. Thomas was like before decline into his addiction. Prior to Mr. Hildebrandt's employment with Main Street Project, he was familiar with Mr. Thomas through a project sponsored by a Winnipeg church where members recorded and produced a music CD. Mr. Hildebrandt testified Mr. Thomas was a talented singer and recorded a song on that CD in 2000. Mr. Hildebrandt described Mr. Thomas as being far more hopeful and positive and less disabled by his addiction at that time.

[54] It was Mr. Hildebrandt's opinion that after Mr. Thomas' common law partner died in 2004 or 2005, Mr. Thomas continued to decline into active addiction. He was of the view Mr. Thomas was like many others in his situation who suffer from addiction without supports in the community and fall victim to a sense of hopelessness. Mr. Hildebrandt said he and Mr. Thomas maintained a special bond from their earlier collaboration and talked about it over the years.

[55] It was apparent from the evidence, the work environment and rapport amongst staff at the Main Street Project is one of support, cooperation and enthusiasm for improvement and change where necessary in order to better serve the people accessing the Main Street Project. It is a challenging environment that exposes the difficulties that arise from severe addictions, mental health issues and homeless or transient lifestyles.

### c) EVIDENCE OF MIKE FOSTER - DIRECTOR OF PROGRAMS AT MAIN STREET PROJECT:

[56] From Mike Foster's evidence, I note there have been a number of changes at Main Street Project since the death of Mr. Thomas in 2008. These changes to the involuntary side of Main Street Project have improved the facility and the services provided. This is the side where people are held when detained under the Intoxicated Persons Detention Act.

[57] Mike Foster has been with Main Street Project for 6 years and is currently responsible for overseeing the detoxification and mainstay units as well as the

outreach program. At this point he is not responsible for the IPDA unit of Main Street Project but does day-to-day supervision of staff in that area.

i. Staffing in the IPDA unit:

[58] Two staff members now work at all times in the IPDA unit rather than one. The staff remain in the IPDA unit for their entire shift rather than rotating throughout the different areas of Main Street Project. This allows for consistent monitoring and detection of changes in condition of detainees' throughout their time in the IPDA unit.

[59] Mr. Foster testified the demand in the IPDA unit is significant and after a short term project of double staffing in 2008 during high intake times, and a short term project in April 2009, Main Street Project committed to having two dedicated staff in the unit at all times.

[60] Mr. Foster did say if there is a severe staff shortage or an emergency situation in one of the other areas, then one of the staff from the IPDA unit would be called upon. He suggested this would be more likely during times when the IPDA unit was not as busy, during the day perhaps. He expressed a desire for this practice to cease being necessary. Mr. Foster felt it unnecessary to add a third staff member in the IPDA unit given that a paramedic is to be available 24 hours per day as of April 1, 2011.

ii. Training for staff in the IPDA unit:

[61] The staff in the IPDA unit all have first aid and CPR training. At present, fifty staff members have training in Emergency Medical Response (EMR), or as primary care paramedics. Mr. Foster testified there was funding in 2009 that allowed training for five core staff to receive EMR training. Those with EMR training provide support to the paramedics and have tools to deal with medical situations well above standard CPR and first aid training.

[62] Mr. Foster testified Main Street Project actively recruits new employees who have EMR training and improvements to wages have made it easier to attract people with this training. However, he indicated staff retention is an issue because a lot of the people with EMR training are students from the EMR colleges and most are moving into paramedic or paramedic support positions which pay well beyond what Main Street Project can pay. Main Street Project is now looking to provide EMR training to the current and new staff who he believes Main Street Project has a stronger capacity to retain.

[63] Mr. Foster recommended EMR training for all IPDA unit staff so they would have increased skill and medical information enabling a higher level of support to the clients. With EMR training staff would be better equipped to conduct the 15 minute checks for each detainee and better able to determine what if any concern to look for during these assessments.

[64] The cost of the EMR training according to his evidence would be about $4000 per staff, including the course cost of $1000 and the cost of shift coverage during the period of study and practical training.

iii. IPDA unit intake and assessment forms:

[65] Mr. Foster indicated new assessment sheets and intake forms for the IPDA unit were introduced in August 2010. [Appendix 4 - Exhibits 6, 7 and 8]. The forms were developed and refined as a result of the observations and knowledge gained over the course of having two full time paramedics on staff at Main Street Project.

[66] These new forms are used for assessing each person coming into the IPDA unit to determine if they are suitable for detention or continued detention or if they need to be transferred to hospital. The assessment is completed regardless of staff familiarity with the person and regardless of how many times the person has previously been at Main Street Project.

[67] Mike Foster was of the view these forms are a substantial improvement over the previous forms and they seem to be working well with the staff. He indicated they have been in use for several months and there will be a review with the paramedics and the program manager of the IPDA unit to see if any further changes should be made. To Mr. Foster's knowledge the staff at Main Street Project are following the direction to fill out the forms as required.

[68] The IPDA unit assessment and monitoring forms, Appendix 4 - Exhibits 7 and 8, outline signs to look for during every fifteen-minute check, and mandate complete waking at one hour, two hours, and four hours. At six hours a complete reassessment is required with the expectation there should be significant improvement; if there is not, then concerns are to be addressed with either the paramedics on staff or the Winnipeg Fire Paramedic Service.

[69] Mr. Foster testified there were a number of meetings with the staff and program manager for the IPDA unit when the forms were introduced. The program manager for the IPDA unit is trained at a nursing level and she provides

training on the forms to core staff who then train new staff. The program manager has a high level of medical knowledge and she along with Mr. Foster were involved in the development of the new forms with the paramedics.

[70] New staff spend significant time with core staff in each area of Main Street Project with the long-term employees sharing their knowledge. One of these core staff who provides training to new employees in the IPDA unit has been with Main Street Project for over 20 years and has considerable experience.

[71] Mr. Foster agreed formalizing training and flow of information between paramedics and the core staff would be helpful. Having paramedics formally provide information to core staff on what to look for and how to conduct assessments would be a very beneficial process given the paramedics' skill level.

[72] The evidence before me suggested it would be helpful to all staff, new and long term, to have a training manual and formal training from the paramedics and program manager. This manual and training would provide all staff with training on how to conduct the assessments on intake to the IPDA unit, as well as how to perform the regular cell checks. This would include training on signs to look for during checks, what to watch for and what changes in condition should cause concern to call paramedics or ambulance. While many of the staff may have learned through experience what to look for, in the evidence before me they did not seem to be able to articulate at what point they ought to be concerned.

iv. Funding for the IPDA unit:

[73] Mr. Foster testified about the various sources of funding for the Main Street Project, and specifically talked about a per intake fee paid by Winnipeg Police Service for each detention under the Intoxicated Persons Detention Act. He testified there is no written agreement confirming the fee, but that it was more of an understanding. For every other funder, Main Street Project has an agreement setting out what the funding is, how long it is in place, how it may be renewable, and what the service is in exchange for that funding.

[74] He testified the rate of $35 per IPDA unit intake since 2001 no longer covers the actual operational cost of this service. Main Street Project unilaterally started to charge an increased fee of $56 as of January 2010 in order to maintain the double staffing per shift in the IPDA unit, which was then increased to $60 as of April 2010. Mr. Foster indicated Winnipeg Police Service has been paying the increased amount even though there is still no written agreement in place for this service.

[75] Mr. Foster was of the opinion an agreement is crucial in order to ensure the actual operational cost of this service is being covered and so Main Street Project can do future planning. He stated if the fee was insufficient to cover actual operating costs for holding intoxicated persons under the Intoxicated Persons Detention Act, the service would have to be discontinued.

[76] Mr. Foster hoped a recommendation would be made to have a written agreement implemented between Main Street Project and Winnipeg Police Service with respect to this fee per detention in the IPDA unit. He said it is important the agreement cover the actual cost of the service, and the nature of the service so that everyone has an understanding of what each side is responsible for and at what cost.

v. Cameras in the IPDA unit:

[77] There are now five holding cells in the IPDA unit that are equipped with cameras to assist in monitoring the condition of the detained person. Mr. Foster encouraged a recommendation to have cameras in all fifteen of the remaining holding cells. He recognizes cameras cannot see everything and cannot replace the regular visual checks done by staff.

[78] He testified cameras assist in monitoring for seizures or self harming behaviour. However, they cannot replace the necessity of in person checks done every fifteen minutes to detect breathing, which is not observable by the cameras.

[79] Mr. Foster estimated the cost of the cameras at about $1500 each for fifteen rooms, plus the cost of expanding the central monitoring computer software system to accommodate the additional cameras estimated at $2500.

vi. Other improvements and services provided in the IPDA unit:

[80] Mr. Foster testified a bottle of drinking water is now left in each cell with each detainee, which has improved delivery of service without compromising safety of staff.

[81] Mr. Foster testified the expectation now is for staff to carry cell keys at all times when doing the fifteen-minute checks in the IPDA unit. He indicated masks for performing CPR and artificial respiration are now outside each cell and readily available.

[82] Mr. Foster indicated high quality radios are now available and staff are expected to carry them at all times when doing the checks and assessments of

individuals detained in the IPDA unit. This enables communication with all staff as well as the shift coordinator. The cost of these radios was about $4000 in total.

[83] Mr. Foster indicated paramedics carry cell phones rather than radios and staff contact them on their cell phones. He agreed having the paramedics carry radios would assist with faster and easier communication with the IPDA unit staff. The cost would be about $400 per radio and he expected they would move forward with implementing this change.

vii. Detentions in the IPDA unit:

[84] Mr. Foster gave the total number of intakes to the IPDA unit as follows:

| | |
|---|---|
| 2007 | 8,541 intakes |
| 2008 | 10,156 intakes |
| 2009 | 11,019 intakes |
| 2010 | 10,959 intakes |

[85] He indicated a total of 40,061, although it appears to actually be 40,675 total IPDA unit intakes from 2007-2010. Mr. Foster testified that during the period 2007-2010, there were three deaths on the IPDA unit.

[86] He testified he knew Maurice Thomas as a regular client of the Main Street Project having been detained in the IPDA unit 389 times, the voluntary shelter 779 times and 17 times in the detoxification side of Main Street Project between 1998 and 2008.

viii. Paramedics at Main Street Project:

[87] Mr. Foster testified to the benefits of having the paramedics on staff from 7:00 a.m. to 7:00 p.m. He said the paramedics play a significant role in assessment of detainees in the IPDA unit, bringing a high degree of medical training and support to core staff in the unit.

[88] The paramedics provide primary health care support in the shelter and other areas of Main Street Project when they are not involved with an intake in the IPDA unit. They build relationships with clients who otherwise may not access necessary health care services in the community. They deliver on site services which are very valuable to Main Street Project clientele who have a high level of chronic health issues.

[89] The paramedics assist staff in developing knowledge and skill sets to which they would otherwise not have access. Mr. Foster very clearly indicated the expectation to have sufficient paramedics as of April 1, 2011 to staff the facility round the clock will be a phenomenal benefit to the facility.

[90] Mr. Foster testified the presence of the paramedics has significantly reduced the number of ambulance calls to Main Street Project; however, he stated if they were available 24 hours a day, it would have a substantial impact on all detainees in the IPDA unit. I understood from the evidence it would further decrease the number of patients who would require ambulance and transfer to hospital for assessment before being accepted into Main Street Project.

[91] Mr. Foster indicated it is critical to Main Street Project and him as program manager to finalize the full time paramedic program expected to begin April 1, 2011. After adjourning the inquest, counsel forwarded a letter with attachment which confirms this commitment, see Appendix 3.

[92] Mr. Foster confirmed there have been inquiries and visiting delegations from all across Canada looking at Main Street Project as the best model of a service provider in this area.

### d) EVIDENCE OF KAREN MARTIN, ADVANCED CARE PARAMEDIC AT MAIN STREET PROJECT:

[93] Ms. Martin has been an advanced care paramedic for 18 years, working at the Main Street Project since September 2009. She is one of three paramedics now at Main Street Project, the third having recently finished training.

[94] She testified Main Street Project paramedics treat in the IPDA unit, the drop in center, the detoxification center, the mainstay program and the transition unit. They provide care which includes; wound care, care for infections, care during seizures pending ambulance arrival, care for chronic health issues and referrals to doctors where necessary.

[95] The Main Street Project paramedics have a partnership with the Health Action Clinic and Dr. Bennett, the director. Referrals are made to the nurse practitioners at that clinic, which is across the street from Main Street Project.

[96] Ms. Martin indicated an advanced paramedic operates with a set of protocols that allow provision of care as required without the necessity of advance authority from a medical supervisor. She explained this is different than a nurse who must

get a written order from a doctor in advance before providing care. She further explained that some of the skills an advanced care paramedic provides are not part of the skill set of a nurse and getting advance authorization before providing care is not practical at Main Street Project.

[97] Ms. Martin explained an advanced care paramedic can provide care to patients in cardiac arrest or respiratory arrest. They can intubate, administer seizure and overdose medication, treat hypoglycaemia, provide intravenous intervention and perform advanced airway procedures including trachea incisions where necessary.

[98] In the IPDA unit when paramedics are on shift, they are involved with every person brought in for detention. Their role was described as instrumental in adding to the level of assessment done at intake. The assessment starts with the paramedic observing the interaction between the detainee, the people bringing them in, and the staff at the IPDA unit intake desk. If there are any concerns with the observations, the paramedic will intervene immediately and take over the assessment to determine if in fact the person should be diverted to hospital.

[99] Ms. Martin explained if the person is unconscious they are not admitted. She described the assessment to include observations of the following things: speech pattern, whether the person is lethargic, able to speak or falling asleep mid sentence, able to move all their limbs or have any difficulty on one side, and able to answer questions appropriately.

[100] Ms. Martin testified once the intake staff has completed the process with the person, the paramedic then does the medical assessment. The paramedic asks a series of questions to determine if the person knows where they are, what substances they have been using or if they have used drugs or pills.

[101] A check of pupils is done for signs of drug overdose, a blood pressure is taken and a determination is made whether the person can follow commands to do the checks, that is, can they give their arm and roll up their sleeve.

[102] Vital signs are taken including the following checks: pulse; respiratory pattern; breathing fast, slow, or irregular; oxygen saturations and blood sugar. An overall physical examination is done for signs of any trauma or ingestion of pills or drugs. Once the paramedic has looked at how the person is interacting and what their vital signs are, they determine if it is safe for the person to go into a cell.

[103] Ms. Martin explained the paramedics fill out a patient care report similar to ones filled out by Winnipeg Fire Paramedic Service in the field. This form is in addition to the one filled out by staff of Main Street Project. The longer preadmission form for the intake staff at Main Street Project on the IPDA unit came into effect in August 2010. (Appendix 4 – Exhibit 6) The purpose of the form was to have some type of medical assessment done, even while paramedics were not on duty. All the questions on the assessment form are incorporated into the paramedic's assessment and are put into the patient care report.

[104] Ms. Martin reviewed when it is appropriate to accept someone to Main Street Project for detention. She testified in order for someone to be detained at Main Street Project the person cannot have any head injury or acute overdose. They must have the ability to walk in to the facility with assistance but not being dragged in by the armpits, and they must have the ability to verbalize. If the person cannot walk or talk, the concern is they may have a compromised airway and if left in a cell there is the possibility of choking.

[105] Ms. Martin indicated once the person is detained at Main Street Project, there is no set guideline or routine for the paramedics to redo vital signs unless staff make a request. She said if paramedics do reassess the person in the cells it is rarely necessary to retake the vital signs. In her experience with the 1700 assessments at Main Street Project they have not seen a need to implement regular checks or reassessments of detainees by the paramedics. It appears to her that the staff checks and calling for the paramedics as needed is working.

[106] Ms. Martin testified a person in hospital does not necessarily get checked every 15 minutes if they are stable. If they are a critical or an acute patient they get monitored every five minutes. If monitored every five minutes it may not have prevented what occurred in this case she explained, because damage to the brain can occur in less than five minutes.

[107] From my review of the evidence of those who interacted with Mr. Thomas, the video of Mr. Thomas coming into the IPDA intake unit, and Ms. Martin's evidence with respect to the current practice at Main Street Project; it seems if the current intake process was in place in 2008 Mr. Thomas likely would have been diverted to hospital. I say this given the obvious difficulty he was having walking and standing and his limited ability to converse. If he had remained at Main Street Project he may have been reassessed sooner by paramedics to determine if he was still appropriate for detention.

[108] However, with the evidence before me, including that of Drs. Littman and Grierson, had Mr. Thomas been diverted to hospital rather than detained at Main Street Project, I am unable to conclude any different outcome would necessarily have followed given his extreme level of intoxication and the very small window of opportunity available in these cases for medical intervention.

[109] Ms. Martin testified in 2009, the paramedics at Main Street Project assessed 889 intoxicated people for detention under the Intoxicated Persons Detention Act. Of those people, 12 were sent on to hospital for further evaluation. In 2010 to November 30, the paramedics at Main Street Project assessed 704 intoxicated persons under the Intoxicated Persons Detention Act and nine were sent on to hospital for care.

[110] She related in 2009 the total number of ambulance calls to the entire Main Street Project facility was 569, of which 33 were from the paramedics and the remainder were from the staff. Ms. Martin was of the view having paramedics available full time would further reduce the total number of ambulance calls to Main Street Project. This she said is because many of the primary care reasons which result in ambulance calls are treatable by the paramedics.

[111] The paramedics complete assessments and tests for all IPDA unit intakes. Ms. Martin testified this is the case regardless of whether the person is a known regular client to the facility or not.

[112] Ms. Martin went on to say there is no way of measuring or predicting if someone's alcohol level is rising. She said perhaps a breathalyzer machine result would give some information with respect to alcohol level, but would have to be repeated to determine if the level was rising. She was of the view some intake patients may not be able to blow into a breathalyzer for various reasons including their level of intoxication. She concluded the breathalyzer result may be helpful only to determine if the person has any alcohol at all in their system or if their intoxication is from something other than alcohol.

[113] Ms. Martin reviewed Exhibit 8 [Appendix 4], the detainee assessment check list for wake up required at one hour, and then after two and four hours. This form has been used at Main Street Project since August 2010 on the recommendation of the paramedics to have clients woken within one hour rather than two hours as it was previously.

[114] The one-hour and subsequent wakeup checks are designed to observe and note a number of factors including breathing rate per minute, skin color, and to

determine through conversation if the person knows where they are and if they can converse.

[115] At the six-hour check, staff are to decide if they have seen an improvement throughout the patients stay and if not they call for ambulance and get the person to hospital. She testified paramedics explain in lay terms the person should not appear to be getting more drunk but should appear to be getting more sober. The staff at Main Street Project are following these checks and monitoring quite closely according to Ms. Martin's understanding.

[116] Ms. Martin testified there have been informal education sessions with staff, but indicated it is very difficult to teach lay people paramedic training. The paramedics give staff guidelines as to what is normal and what is not normal when doing the assessments. She indicated there is no written guideline provided by the paramedics as to what staff should be looking for in terms of what is normal or not, or what should be a concern or not. She was unsure if Main Street Project management has provided staff with such information and commented that there is a high staff turnover. She said the paramedics commonly interact with staff and answer questions.

[117] Ms. Martin agreed there are areas where input from paramedics to staff could be helpful such as what normal breathing is and what symptoms should cause concern during the assessments. She agreed paramedics could work with Main Street Project and staff on development in these areas.

[118] It was Ms. Martin's opinion the one-hour wake up check is appropriate and has been successful in catching concerns with no negative results from this time frame. She did not see any need to further reduce the one-hour wake up check. She explained waking the detainee during the checks done by staff means talking to the person to see if they respond, seeing if their eyes are open and speaking to them through the door.

[119] Ms. Martin delivers presentations to the training academy police cadet class for the Winnipeg Police Service on what to look for when determining if someone can be detained at Main Street Project or whether they require hospital attention. She also provides information on some of the common intoxicating substances and what Winnipeg Police Service can expect from the staff when they come to Main Street Project.

[120] Ms. Martin recommended there be cameras in every cell in the IPDA unit. This she said would enhance monitoring between the 15-minute checks, and is an

added safety net when dealing with high-risk population. She testified Main Street Project deals with about 10,000 high risk people every year and there is no way of absolutely preventing an adverse result in every case, no matter how much monitoring or how much skill the professionals have.

[121] Ms. Martin reviewed Exhibit 2-A18, the patient care report for Maurice Thomas, filled out by Winnipeg Fire Paramedic Service when they first came into contact with Mr. Thomas at Main and Disraeli on May 5, 2008. Ms. Martin was of the opinion it lacked information. She felt there needed to be a full systems assessment along with more narrative about that assessment, including the central nervous system, respiratory system, urinary assessment and any signs of trauma.

[122] In reviewing the patient care report, she indicated that a 93% oxygen saturation would be concerning to her, so she would go further and do a more thorough assessment. She described this would include listening to the lungs and assessing if there was shortness of breath and documenting these findings. If there was shortness of breath with secretions detected in the lungs she indicated she would send the person to the hospital.

[123] On Exhibit 2-A18 the respirations were noted as adequate so Ms. Martin testified if there were no sounds from the chest then 93% oxygen saturation would be adequate. She said she would also look at whether the person could carry on a verbal conversation. If they could not really talk because of intoxication she would be concerned with their ability to protect their airway, vomiting and choking.

[124] She testified if the person was unable to talk and if it could be because of their level of intoxication, the person would need to go to hospital for closer monitoring as they may have too much alcohol in their body to be appropriate for Main Street Project.

[125] In December 2010, Main Street Project paramedics trained the Winnipeg Fire Paramedic Service on what is required for assessment in the field, what to look for with intoxicated persons and how to document those assessments. Since these training sessions, Ms. Martin indicated they have seen a marked improvement on completion of the forms.

[126] She confirmed she and the other paramedics at the Main Street Project contact the Winnipeg Fire Paramedic Service crew or the medical supervisor if the patient care reports need clarification or improvement. This contact or clarification is now rarely required given the improvements in the reporting according to Ms. Martin.

[127] She testified she and her colleague, advanced care paramedic Ryan Sneath, are developing training packages based on their experience in assessing approximately 1700-1800 intoxicated persons coming to the Main Street Project since January 2009 in order to deliver appropriate training to the incoming paramedics at Main Street Paramedics.

### e) EVIDENCE OF DR. GRIERSON:

[128] Dr. Grierson is a medical doctor in the emergency department of the Health Science Center and he is also the medical director for the Winnipeg Fire Paramedic Service.

[129] As medical director for the Winnipeg Fire Paramedic Service, Dr. Grierson is responsible for issuing protocols which govern the care provided by all paramedics in Manitoba. He is also responsible for teaching and continuing medical education with Manitoba paramedics.

[130] From Dr. Grierson's evidence it is clear that setting a protocol for medically clearing intoxicated persons is a very difficult and complex task given all the variables involved. He testified there is no clear method for determining who is safe for clearance and who may require further medical care due to level of intoxication.

[131] Dr. Grierson explained protocols are developed in the following way: first an issue is identified as needing a protocol; the protocol review committee comprised of the medical director, assistant medical director and representatives from the Winnipeg Fire Paramedic Service then develop the protocol; the developed protocol is then submitted to the medical advisory committee.

[132] The medical advisory committee is a group of administrators, physicians, and paramedics all of whom fill an advisory role to the medical director. The committee has 20 members, half of whom are physicians from a broad spectrum of specialty areas to ensure medical issues are covered. The remaining members include two certified toxicologists, representatives from administration and training with the Winnipeg Regional Health Authority and paramedics representing all levels from the Winnipeg Fire Paramedic Service. The goal of the committee is to cover issues requiring medical expertise as well as issues involving the practical delivery of the protocol.

[133] Once the protocol is approved by the medical director, it is accessible to all paramedics from laptops in their vehicles. Teaching and training on the protocol is

done by the medical supervisors during in-services. Training on a more in depth protocol is done at the annual continuing education seminar where every paramedic is trained at the academy.

[134] Dr. Grierson testified there currently is no accepted protocol in place with the Winnipeg Fire Paramedic Service for clearance of intoxicated persons. Reference to a protocol was made by Charles Thomas, medical supervisor for Winnipeg Fire Paramedic Service paramedics. However, Dr. Grierson indicated the protocol referred to is out of date having been approved in 1994 (revised in 1999), and is no longer available on line to Winnipeg Fire Paramedic Service personnel.

[135] Dr. Grierson testified current medical literature does not support one protocol or one process over another for the clearance of intoxicated persons. The common theme in the text books is clinical judgment must be used. That is, a subjective process based on experience is required because of variables such as tolerance, habituated vs. unhabituated alcoholics' reactions and the fact that blood ethanol levels correlate poorly with degree of intoxication.

[136] However, Dr. Grierson testified he is now satisfied there is evidence from the field to support the development of a protocol for clearing intoxicated persons. This evidence he said, comes directly from the work and information gathered and documented by the two paramedics on staff at Main Street Project.

[137] The Main Street Project paramedics have developed and used criteria in their assessments over a sufficient time period to evaluate intoxicated people coming in to the Main Street Project. They evaluated approximately 1100 intoxicated people and based on the criteria used to clear these people, Dr. Grierson is of the opinion his committee now has the evidence to go forward with development of a protocol for use by all paramedics in the field.

[138] This protocol is currently with the protocol review committee for drafting and will go to the medical advisory committee for approval. Dr. Grierson expected this process could be completed by April 2011. Once completed he expected this protocol would be unveiled through a training package delivered by the medical supervisors and he expected it could be completed within a thirty day period.

[139] Dr. Grierson testified this is a groundbreaking development which promises to have a very positive and beneficial impact in assisting with evaluation of intoxicated persons. Given the lack of evidence based data in this area, Dr. Grierson expected the information gathered by the paramedics at Main Street

Project will be submitted for publication. Dr. Grierson is of the view this is one example of the absolutely crucial and important work carried out by the dedicated paramedics who work at the Main Street Project.

[140] Dr. Grierson testified he is aware of delegations of medical directors from all across Canada who have toured the Main Street Project and been astounded at the level of care and safety given to intoxicated persons at the facility. It is his understanding there is nothing close to this level of service in other jurisdictions.

[141] With respect to clearing intoxicated persons, Dr. Grierson testified numbers alone are not helpful. That is, vital signs or blood alcohol levels cannot determine who may or may not require hospitalization. He emphasized it must be a clinical assessment based on observation and experience which requires the exercise of judgment.

[142] Dr. Grierson testified about his experience as an emergency department physician responsible for clearing several intoxicated persons per shift. It was clear he had extensive experience in the assessment of intoxicated persons and he explained how he goes about assessing an intoxicated person.

[143] Dr. Grierson explained he first looks at the overall level of consciousness of the patient; that is, are they awake and alert, are they talking and able to answer questions or are they drowsy and have to be nudged to wake up, or are they completely comatose. He said each level of intoxication will dictate a different course of care.

[144] If someone comes to the hospital for clearance for detention at Main Street Project, Dr. Grierson considers whether the person is alert and oriented to person, place, time, and event; whether they are able to answer questions and whether there is any evidence of trauma. A physical examination is completed, a history is taken, drug use is assessed and a review of any psychiatric problems is completed. If everything seems fine, then vital signs are taken which includes blood glucose level and an assessment of ability to walk either independently or with minimal assistance. The person would then be cleared and may even be discharged if they can look after themselves or if a family member can look after them. If the person is not able to look after themselves then they would be cleared for detention at Main Street Project.

[145] The second type of scenario will be the person who can be roused to a loud voice or nudge, who is probably not able to walk independently and who probably will require a fair bit of assistance. These people need to be watched further which

Dr. Grierson explained means someone needs to be checking on them, at hospital or Main Street Project. He testified someone needs to be able to rouse them and watch them to see if they are getting more sober or deeper into a level of unconsciousness. If alcohol intoxicated, they will clear over time. They do not require blood work or a CT scan they just require someone to check on them.

[146] He testified simply taking blood alcohol level is not a useful tool and is a very poor predictor of outcome. He said there is no test or technology which would determine if the person is going to become more or less intoxicated over time. The only way of predicting this is based on history if given correctly and even this is not the most accurate predictor.

[147] Dr. Grierson testified the process of clearing an intoxicated person at hospital could take two to three hours minimum before they are seen by a doctor depending on how they present to triage. This estimate applied to the first category of intoxicated person to whom he referred. If cleared for transport to the Main Street Project, they then wait to be transported by Winnipeg Police Service. This process can take up to six, seven, or as much as 12 hours in the emergency department to conclude. Cleared for Main Street Project simply means someone sober and responsible needs to keep an eye on the person.

[148] The second category of intoxicated person, who is drowsy but able to wake with a nudge or being spoken to, would likely be seen immediately or within 10-15 minutes in the emergency department. He testified the third category, someone with a Glasgow coma score of 13 or lower, would be seen sooner. This third type of patient needs to be checked and Dr. Grierson testified in hospital this would likely be done with vital signs being taken every hour depending on the area of care within the hospital.

[149] Dr. Grierson testified the detail and documentation of the checks done at Main Street Project are significant and provide a very good safety net for the care of the intoxicated person who falls into the second category he described. Main Street Project monitors every 15 minutes with checks which are likely more frequent than if the person were in hospital. He indicated short of having every intoxicated person in an intensive care unit with a nurse dedicated to him full time, there really is no better method of preventing a critical occurrence than that which the Main Street Project currently utilizes. He was of the opinion intensive care and a dedicated nurse for every intoxicated patient would not only be impractical but also unreasonable.

[150] Dr. Grierson testified in his opinion, it is not necessary for patient safety nor is it practical that all intoxicated persons be cleared by a doctor before going to the Main Street Project. He further testified if all intoxicated persons had to be medically cleared at an emergency room, it would mean an additional 11,000 or 12,000 people which would overwhelm the system and divert care from those who are generally much more acutely ill.

[151] Over a two-year period based on the number of people cleared by paramedics at Main Street Project and by paramedics in the field, only 1% had to be sent to hospital. Dr. Grierson testified as a medical director, these numbers provide a huge reassurance that the care provided to intoxicated persons and the clearance process done by the Winnipeg Fire Paramedic Service and Main Street Project paramedics is working quite well.

[152] Dr. Grierson provided background information regarding the normal range for vital signs taken in the context in which the person is observed. He then went on to review the patient care report prepared by Winnipeg Fire Paramedic Service during their interaction with Maurice Thomas at 21:30 on May 5, 2008. (Ex2-A18). Dr. Grierson testified he would not have had any concerns clearing Maurice Thomas for detention to the Main Street Project based on the information recorded in the patient care report.

[153] Dr. Grierson commented at the time this patient care report was filled out, it was a time of transition within the Winnipeg Fire Paramedic Service from a written report to a computer report. With the initial use of these computer reports the narrative portion was not being fully completed. He suggested in the case of Mr. Thomas, the narrative portion of the report could have been expanded upon to include history of drinking and more detail. He said the situation has greatly improved with ongoing training on the system and updates to the software making it more user friendly.

[154] Dr. Grierson testified the patient care reports are now faxed to the paramedics at the Main Street Project which was not the case in 2008. If paramedics are on duty at the Main Street Project they have almost immediate access to the patient care report upon completion. This allows the paramedic to see changes in condition from the initial assessment to their assessment. If paramedics are not on duty the reports remain in a locked office at Main Street Project because of privacy issues under the *Personal Health Information Act*.

[155] He indicated and Karen Martin confirmed, if there is concern about the completeness of the report or questions about the information in the report, the

paramedics at Main Street Project contact the Winnipeg Fire Paramedic Service crew who authored the report.

[156] Dr. Grierson testified having paramedics at Main Street Project came out of a recommendation from a previous inquest report that suggested nurse practitioners for Main Street Project. Upon consideration of this recommendation it was determined that nurse practitioners are difficult to find with the skill set required to provide medical care to the Main Street Project.

[157] It was determined that Ryan Sneath, an advanced care paramedic and nurse, would be hired to conduct a pilot project to provide care to the Main Street Project. At that time, Dr. Bennett director of the Health Action Centre agreed to provide oversight for the primary medical care and Dr. Grierson agreed to provide medical oversight for the acute, emergency care at the Main Street Project.

[158] Drs. Grierson and Bennett meet regularly with and support the paramedics at Main Street Project. Dr. Grierson was very much in favor and stressed the importance of funding full time round the clock paramedics at Main Street Project. Based on his experience with the paramedics at Main Street Project, he stated they are providing care for an underserviced population with limited access to health care and they provide phenomenal access to that care. This is in addition to the care and level of safety they provide to the IPDA unit detainees, only 1% of whom had to be sent on to hospital for care.

[159] In his opinion, it is very important to have eight more paramedics at Main Street Project in order to service 24 hours seven days per week. The clientele of Main Street Project is consistent and steady throughout the facility; it is always busy according to Dr. Grierson. He is of the view provision of care in the IPDA unit as well as providing primary care in the other areas of Main Street Project are equally important from a medical perspective.

[160] Dr. Grierson was strongly opposed to any recommendation requiring mandatory medical clearance of all intoxicated persons by a hospital prior to detention at Main Street Project. He was of the opinion such a requirement is neither necessary nor would it necessarily prevent critical incidents like the one involving Mr. Thomas.

[161] Dr. Grierson was of the view a breathalyser test result is not nearly as valuable as the clinical assessment done by the paramedics. The only place he felt a breathalyser result may be beneficial would be in a case where the person appeared intoxicated and blew zero on the machine, this would indicate something

other than alcohol as the cause of intoxication and these people should then go to hospital. Conversely he said, if they blew a really high reading on the breathalyser, it would be consistent with their intoxicated condition being by alcohol, but these people would still have to be watched for changes in their condition.

[162] Dr. Grierson did not see any harm coming from use of a breathalyser result so long as used by people like the paramedics at Main Street Project who are trained. The test results in his view would never be a substitute for good clinical judgment.

[163] In response to a question, Dr. Grierson indicated in his opinion immediate intervention by medical professionals would not necessarily have resulted in a different result for Mr. Thomas. That is, even if Mr. Thomas had been in a hospital, Dr. Grierson could not say that Mr. Thomas' situation would have turned out any differently. He was of the opinion short of full time paramedics there really is not much more that could be put in place to make the situation any safer at Main Street Project.

[164] Dr. Grierson testified knowing what to expect in terms of changes in condition of an intoxicated person and knowing what period of time over which to expect these changes is dependent on each individual person and their initial level of intoxication and initial evaluation. The mid-level intoxicated person should be examined clinically. That is, can they talk and walk and are there gross signs of inebriation. He testified it is not necessarily based on vital signs so much as on clinical observations.

[165] Dr. Grierson is familiar with the forms, Exhibits 6, 7, and 8 [Appendix 4], used by Main Street Project for evaluation of intoxicated persons and he had no concerns or suggestions for improvement of the forms. Based on the evidence coming out of the Main Street Project and the volume of assessments done, Dr. Grierson is confident the paramedics are doing a very good job in assessing and monitoring the intoxicated clientele detained at Main Street Project.

[166] This is a summary of the evidence called on this inquest.

## 3. DISCUSSION OF RECOMMENDATIONS:

[167] I turn now to a discussion of the recommendations and the basis for my recommendations. Many of these recommendations will confirm changes already made and in place at Main Street Project subsequent to Mr. Thomas' death in 2008.

[168] I conclude from the evidence having paramedics on staff at Main Street Project is a vital component to the safe operation of the facility and greatly improves the quality of care for the people who rely on Main Street Project for service. It appears from the evidence that having qualified paramedics on staff at all times is necessary and crucial to assist in prevention of critical incidents. In addition to the service they provide in assessing and evaluating incoming detainees under the Intoxicated Persons Detention Act they also provide invaluable medical services to the rest of Main Street Project.

[169] Given the changes to the evaluation process in the IPDA unit, and the involvement of paramedics in assessing every person at intake, it may be that Mr. Thomas would not have been accepted into Main Street Project if assessed today. Ms. Martin testified that if an individual cannot walk or talk they will not be accepted into Main Street Project and will be referred to hospital.

[170] The paramedics certainly have the experience in the field dealing with intoxicated persons and as Dr. Littman testified, they seem to be in the best position to make the clinical evaluation as to who is appropriate to stay at Main Street Project and who should go on to hospital. The paramedics at Main Street Project are highly qualified according to Dr. Grierson given the documented experience they have had so far in evaluating over 1100 intoxicated persons.

[171] It would seem that having paramedics on staff full time using the criteria for evaluation of intoxicated persons developed by the paramedics and Main Street Project management, critical incidents like the one involving Mr. Thomas are far less likely to occur in the future. Paramedics on staff at Main Street Project now re-evaluate everyone coming into the IPDA unit. They are available for ongoing assessment and monitoring of the person regardless of whether the person was cleared by medical personnel prior to arriving at Main Street Project. This is a significant improvement for the overall safety of people being detained in the IPDA unit.

[172] Dr. Littman suggested something akin to the old style open hospital wards may assist in one on one monitoring. However, he recognized this is not his area of

expertise and deferred to those in the field working with intoxicated persons. He was of the view shared by Dr. Grierson and Ms. Martin that certain individuals require closer monitoring than that which can be provided at Main Street Project and those individuals are directed to hospital.

[173] From the evidence it appears the assessments done by the paramedics at Main Street Project are working as the best tool to assist in the determination of who requires hospitalization and who is appropriate for detention at Main Street Project. No one suggested that all intoxicated persons require hospital clearance prior to detention at Main Street Project, and in many cases it appears intoxicated persons get similar or more frequent monitoring at Main Street Project as at hospital.

[174] I recommend funding for paramedics on a full time twenty four hour, seven day a week rotation as currently committed to Main Street Project.

[175] I would not recommend a policy requiring all persons be taken to hospital for medical clearance prior to detention at Main Street Project. I am satisfied with the current intake process done by paramedics at Main Street Project, this is not necessary and would divert resources from those more acutely in need. I am satisfied it would not greatly assist in determining who requires more constant monitoring nor would it necessarily result in any more frequent monitoring than already provided by Main Street Project.

[176] I recommend funding for EMR training for all staff in the IPDA unit. This training would better able them to perform the assessments of each detainee and detect any signs of concern that would require intervention by medical personnel

[177] I recommend funding for the IPDA unit managers along with Main Street Project paramedics to develop a training manual for staff. This manual should include how to conduct the assessments at the regular checks and what to look for, including signs that should cause concern, changes to watch for and how changes are to be interpreted. The purpose of the manual would be to teach staff how to monitor and how to identify what is significant so they clearly understand what they are looking for and why.

[178] I recommend funding for staff training. The evidence from the staff working in the IPDA unit as well as Karen Martin and Mike Foster suggests there is a great deal of experience and on the job training by very dedicated staff. However, I was not satisfied there is sufficient training and clarity on how to conduct the

assessment checks. This training would cover topics discussed in the training manual which I have recommended be developed by Main Street Project.

[179] As I understand it, paramedics currently rely on the staff to alert them to the need for reassessment of detainees. In addition to this practice and not to detract from it, I recommend paramedics reassess individuals detained at Main Street Project at set intervals after their initial assessment. Now that paramedics are available 24 hours a day, it would be better to have a defined procedure for when reassessment is to be done by paramedics.

[180] I recommend the paramedics determine when and how this reassessment procedure should be implemented given their level of training and experience in the field dealing with intoxicated persons. The point of having paramedics involved in reassessing detainees is to assist in early detection of medical concerns that require intervention, in order to help prevent them from becoming critical incidents.

[181] I recommend finalization of a protocol for medically clearing intoxicated people. Dr. Grierson testified a protocol is being developed for paramedics to deal with assessment of intoxicated persons in the field. I would strongly encourage this protocol move forward as quickly as possible if it has not already been implemented, given the anticipated date was April 2011.

[182] I recommend any assessment of an intoxicated person include questions related to the persons drinking history. It appeared from the evidence, particularly of Dr. Littman, that the issue of alcohol absorption may be a critical piece of information for those caring for intoxicated persons. The drinking history would assist in predicting whether alcohol absorption is continuing to increase or if it is expected to decrease thereby determining the level of care required for the person. I appreciate this may be difficult information to accurately obtain but I recommend that every assessment include questions related to the drinking history.

[183] I make no recommendation on implementing use of a breathalyzer machine at Main Street Project. From the evidence it seems it would be of minimal assistance and would not be practical in the Main Street Project setting. Many individuals would not be capable of providing a breath sample, and the results would only be helpful if there was no indication of alcohol, thereby suggesting intoxication from a source other than alcohol.

[184] Similarly, I make no recommendation on use of blood test results at Main Street Project. The evidence suggests it would not be of assistance without some

means for testing and interpreting the results. Both of these tests would in any event, require repetition in order to determine if the level has increased or decreased from taking of the first sample.

[185] I am satisfied from the evidence, the best way of determining who is suitable for detention at Main Street Project is one that involves the exercise of judgment by experienced medical professionals in the field. I am not satisfied the use of test results from blood or breath would enhance the assessment process utilized by Main Street Project.

[186] I recommend funding for cameras in each of the remaining fifteen cells and for updating the computer monitoring system to accommodate the cameras in the IPDA unit. This would assist in the constant monitoring of individuals.

[187] I recommend the addition of cameras not detract at all from the assessments that are currently conducted by Main Street Project staff on a regular fifteen minute basis and the hourly wake up assessments.

[188] I recommend finalization of a written agreement as soon as possible between Main Street Project and the Winnipeg Police Service with respect to the fee paid for each person detained at Main Street Project under the Intoxicated Persons Detention Act. This agreement should set out a fee which reflects the actual cost of providing the service, the expected service to be provided, the length of the agreement and the renewal options for the agreement.

[189] I recommend Winnipeg Fire Paramedic Service paramedics continue using the patient care reports by fully documenting and completing the narrative portion with respect to observations and evaluations completed in the field. I understand that ongoing training has alleviated concerns in this area. I encourage regular training of new paramedics in this area by Main Street Project paramedics or other medical professionals with similar field experience evaluating intoxicated persons.

[190] I recommend funding to allow paramedics at Main Street Project to carry radios at all times so that IPDA unit staff can contact them immediately as needed. I understood this may have been implemented already.

[191] I recommend the current practice of having CPR masks and gloves available outside each cell in the IPDA unit continue. This allows staff to enter the room immediately where necessary without having to retrieve equipment from another area.

[192] I recommend the current practice of IPDA unit staff carrying cell keys with them at all times continue. This will prevent delay in entering a cell when necessary.

[193] I recommend the current practice of having two staff members dedicated to the IPDA unit continue and that these staff give first priority to the IPDA unit at all times. Given that paramedics are now to be available 24 hours a day, I do not see a need to recommend adding a third staff to the IPDA unit.

[194] I recommend each shift in the IPDA unit have one person designated responsible for communicating information to outside medical personnel in any critical incident or incident involving their attendance. This would ensure the necessary information is given in order to assist in providing medical care to the patient. If there is one person designated responsible as the "information provider" for each shift, it will prevent frustration in communication like that expressed by the Winnipeg Fire Paramedic Service members in the case of Mr. Thomas.

[195] I recommend funding for Main Street Project to upgrade cells as necessary including replacement of windows in the doors so staff can confidently conduct their fifteen minute assessments. If the views are obstructed by scratches or otherwise, staff may not be able to make a full assessment or may be required to enter the room when they otherwise would not have been so required.

## 4. WITNESS LIST

1) Dr. Charles Littman, Medical Examiner and Pathologist

2) Aaron Schlichting, Paramedic, Winnipeg Fire Paramedic Service

3) Lise Annette Aquin, Outreach Worker, Downtown Business Improvement Zone

4) Lisa Marie McIntyre, Ambassador, Downtown Business Improvement Zone

5) Kelvin Jon Hildebrand, former Crises Worker at Main Street Project

6) Cory Tanguay, Crises Worker, Main Street Project

7) Daniel Cifuentes, former Crises Worker, Main Street Project

8) Thomas James Walsh, former Crises Worker, Main Street Project

9) Jerry George Delaronde, Crises Worker, Main Street Project

10) Christopher Broughton, Paramedic, Winnipeg Fire Paramedic Service

11) Arnold Jansen, Firefighter, Winnipeg Fire Paramedic Service

12) Charles Murray Thomas, Medical Supervisor, Winnipeg Fire Paramedic Service

13) Karen Virginia Martin, Paramedic, Winnipeg Fire Paramedic Service at Main Street Project

14) Dr. Robert Andrew Grierson, Medical Director of Winnipeg Fire Paramedic Service and Emergency Physician at Health Sciences Centre

15) Michael Foster, Program Manager, Main Street Project

## 5. EXHIBIT LIST

| Exhibit No. | Description |
|---|---|
| **EXHIBIT #1** | Letter dated January 18, 2010 from the Chief Medical Examiner, Dr. A. Thambirajah Balachandra (3 pages) |
| **EXHIBIT #2** | A corrugated folder containing a copy of documentation, Sections I – IV, being referenced in court |
| **EXHIBIT #3** | Copy of *The Intoxicated Persons Detention Act* and Detoxification Centres Regulation (3 pages) |
| **EXHIBIT #4** | Floor plan of cells at Main Street Project (1 page) |
| **EXHIBIT #5** | Revised I.P.D.A. Intake sheet (1 page) |
| **EXHIBIT #6** | I.P.D.A. Pre-Admission Assessment (1 page) |
| **EXHIBIT #7** | Revised Detainee Monitoring sheet (1 page) |
| **EXHIBIT #8** | Detainee Assessment Checklist (1 page) |
| **EXHIBIT #9** | Emergency Treatment Guidelines: Appendix – Glasgow Coma Scale, Manitoba Health (1 page) |
| **EXHIBIT #10** | Curriculum Vitae of Dr. Charles D. Littman, Pathologist at Health Sciences Centre |
| **EXHIBIT #11** | EMS Incident Details for Ambulance #1 (2 pages) |
| **EXHIBIT #12** | EMS Incident Details for Ambulance #2 (3 pages) |
| **EXHIBIT #13** | Patient Care Report used at Main Street Project by paramedics of Winnipeg Fire Paramedic Service (2 pages) |
| **EXHIBIT #14** | Main Street Project IPDA Data (1 page) |

**EXHIBIT #15** BLS Protocol – Acute Alcohol Ingestion, Approved 94/01/25 and Revised 99/03/01 (3 pages)

**EXHIBIT #16** Article from Tintinalli's Emergency Medicine entitled *Ethanol* (4 pages)

## 6. APPENDIX LIST

APPENDIX 1 – *The Fatality Inquiries Act*, C.C.S.M. C. F52, s.19

APPENDIX 2 - *The Intoxicated Persons Detention Act Regulation* 331/87 R

APPENDIX 3 - Letter with Winnipeg Regional Health Authority press release dated March 10, 2011

APPENDIX 4 – Assessment sheets and Intake forms Exhibits 6, 7 and 8

## 7. LIST OF RECOMMENDATIONS:

1. Funding for Main Street Project to employ paramedics up to the advanced care level, 24 hours, seven days a week as currently committed.

2. Funding for cameras in each of the remaining fifteen cells and for updating the computer monitoring system to accommodate the cameras in the IPDA unit at Main Street Project.

3. Funding for EMR training to be provided to all IPDA unit staff of Main Street Project.

4. Funding for the IPDA unit managers along with Main Street Project paramedics to develop a training manual for staff. The manual should include how to conduct the assessments at the regular checks and what to look for, including signs that should cause concern, changes to watch for and how changes are to be interpreted. It should include guidance on when to call for re-assessment or assistance from the paramedics.

5. Funding to fully train the IPDA unit staff at Main Street Project on the procedures contained in the manual developed in recommendation #3, as well as funding for ongoing training in the area of assessments and what to look for when monitoring detainees. This training would be for all new staff and current staff as refresher training, to be repeated at regular intervals.

6. Development and implementation of a procedure for paramedics to re-assess Main Street Project detainees at defined intervals.

7. Finalization and implementation of the protocol for clearing intoxicated persons in the field, currently under development by the Medical Advisory Committee and the Medical Director for the Winnipeg Fire Paramedic Service.

8. All assessments of intoxicated persons for clearance to the Main Street Project include a set of questions designed to illicit information for predicting an increasing alcohol level. These questions would illicit

drinking history including what the person has consumed, how much they have consumed and their drinking pattern.

9. Finalization of a written agreement as soon as possible between Main Street Project and the Winnipeg Police Service with respect to the fee paid for each person detained at Main Street Project under the Intoxicated Persons Detention Act. This agreement would set out the fee which reflects the actual cost of providing the service, the expected service to be provided, the length of the agreement and the renewal options for the agreement

10. Winnipeg Fire Paramedic Service paramedics continue to use the patient care reports by fully documenting and completing the narrative portion with respect to observations and evaluations completed in the field, when assessing intoxicated persons.

11. Funding to allow paramedics at Main Street Project to carry radios with them at all times so IPDA unit staff can contact them immediately as needed.

13. Continue the current practice of having masks for CPR and gloves available outside each cell in the IPDA unit at Main Street Project.

14. Continue the current practice of IPDA unit staff at Main Street Project carrying cell door keys at all times.

15. Continue the current practice of two staff members dedicated to the IPDA unit at Main Street Project and these staff give first priority to the IPDA unit at all times.

16. Each shift in the IPDA unit of Main Street Project have one person designated as the person responsible for communicating information to outside medical personnel in any critical incident or incident involving their attendance.

17. Funding to upgrade cells in the IPDA unit at Main Street Project as necessary, including replacement of windows in the cell doors to prevent obstruction of view during the fifteen minute assessments done by staff.