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THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **LEON HERMAN BIGHETTY**
(DOD: November 27, 2002)

Report on Inquest and Recommendations of
The Honourable Judge Marva J. Smith
Issued this 2nd day of August, 2005

APPEARANCES:

Raegan Rankin, Counsel to the Inquest
Hymie Weinstein, Q.C. for the Main Street Project
Tyler Kochanski for Dr. K. Nguyen

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WITNESS LIST

INTRODUCTION

[1] Leon Herman Bighetty was taken to the Main Street Project ("Project") at 75 Martha Street in Winnipeg at 5:30 p.m. on November 20, 2002 by two Winnipeg Police Officers who believed he was intoxicated. He was detained in a cell at the Project under *The Intoxicated Persons Detention Act*, C.C.S.M., c. I90("IPDA"). The Project has been designated as a place of detention under that legislation.

[2] Some thirteen hours after his admission, at 6:30 a.m. November 21, 2002, staff tried to wake Mr. Bighetty up for discharge. They found him to be completely unresponsive. An ambulance was immediately called and Mr. Bighetty was promptly transported to the Health Sciences Centre ("HSC"). It was discovered there that he was suffering from two subdural hematomas – bleeding in the brain caused by head injury. Toxicology results showed no evidence of alcohol or drugs in his system, but due to the length of time in the Project, it is possible that he had consumed a significant amount of alcohol and it had cleared his system by the time he arrived at the HSC.

[3] By the time he arrived at the hospital the prospects for recovery were bleak. Nonetheless surgery was performed to relieve the pressure on his brain caused by the hematomas. The pressure was relieved but the damage to the brain was irreversible. Mr. Bighetty remained in a coma for six days and was pronounced dead on November 27, 2002. He was only 32 years of age.

[4] An autopsy showed that he suffered from subacute or fairly recent subdural hematomas, as well as chronic or longer standing subdural hematomas, which may have been present for months or even years. These conditions are caused by some injury to the head, such as a blow or a fall or hitting the head against the wall or some object. The older hematomas made him more susceptible to damage from further head injury. The outward symptoms of such a condition could manifest themselves by slurred speech, unsteady gait, difficulty walking and drowsiness, mimicking the symptoms of intoxication. A severe headache would be a further sign of such a condition. At some stage examination of his pupils would indicate abnormal dilation and unresponsiveness to light.

[5] Apparently, with timely medical attention, complete recovery from such medical problems can be achieved.

[6] The Chief Medical Examiner considered that the calling of an inquest was required by s. 19(3) of *The Fatality Enquiries Act*, C.C.S.M. c. F52 which essentially provides that where an individual dies in custody, or as a result of an act

or omission of a peace officer in the course of duty, an inquest is mandatory. The Chief Medical Examiner also directed that this inquest should determine the circumstances under which the death occurred, and determine what, if anything, can be done to prevent other deaths of a similar nature from occurring in the future.

[7] It seems to me that in answering these questions it would be prudent to consider Mr. Bighetty's death as resulting from an undetected but serious medical condition, rather than focusing solely on death from undetected subdural hematomas.

[8] To assist in this task I have heard evidence from a number of witnesses. These include, from the Project, the executive director at the relevant time, Ms Joan Dawkins, the current executive director, Ms Lainie Neal, and all staff with contact with Mr. Bighetty on the day in question. I also heard from the Downtown Biz staff who found Mr. Bighetty, and the Winnipeg Police Service ("WPS") officers who detained Mr. Bighetty and transferred him to the Project. I also attended the Project for a tour.

[9] In addition there was significant medical testimony. I heard from Dr. Khai Nguyen, a family physician who had treated Mr. Bighetty for many years, and had seen him just two days prior to his admission to the Project, Dr. Owen Williams who performed the surgery on Mr. Bighetty, and Dr. Lindy Lee, a highly experienced and qualified Emergency Physician with a particular expertise in addiction issues. I also heard from the medical director of the Winnipeg Remand Centre, Nurse Christopher Ainley, about the admissions procedures for intoxicated and other inmates at the Remand Centre.

[10] As well, I heard from the Chief Medical Examiner, Dr. Thambirajah Balachandra, who explained the results of the autopsy, and from forensic neuropathologist Dr. Marc Del Bigio, who examined the deceased's brain.

[11] Mr. Bighetty's mother, Emma Bighetty, was subpoenaed to attend the proceedings but did not attend. She contacted Ms Rankin, counsel to the inquest, to explain that attending the hearing would be too painful for her. She expressed her concern about her son and other homeless people and those addicted to solvents and inhalants and the hope that recommendations could be made to help the Project perform its job better. She indicated that solvent abuse or sniffing was a major problem for her son. He had been sniffing heavily for about the past three to four years in particular. Although her son did drink, she did not find him to be a serious problem drinker – the serious damage she felt was from the solvent abuse. He did tell her from time to time that he was trying to stop the sniffing. She also

indicated that Mr. Bighetty had fallen and hit his head on a coffee table not too long before his death. As will be seen, it is possible that such an injury could have led to his death, even though it was not a hard blow.

[12] Mr. Bighetty's three brothers attended a portion of the hearings and expressed their appreciation to counsel to the inquest for the effort being made to try to prevent future similar deaths.

[13] The inquest hearings were held in Winnipeg on November 15, 16, 17, 18, 19, 22, 23, 25, 2004 and January 31, 2005. Voluminous exhibits were filed, including a draft new Policy and Procedures Manual that the Project has developed, in part, in response to Mr. Bighetty's death.

[14] The Project was granted standing at the Inquest, as was Dr. Nguyen.

THE INTOXICATED PERSONS DETENTION ACT

[15] IPDA permits a peace officer to take into custody a person that the officer finds intoxicated in a place to which the public has access. A peace officer then has discretion to take the person to a detoxification centre and deliver that person into the custody of the person in charge of the detoxification centre. The Project was designated as a detoxification centre in April 1983. The two other facilities designated as detoxification centres are 170 Doncaster Street in Winnipeg (The Manitoba Youth Centre), and 144 Ross Avenue in The Pas (the Rosaire Centre). Under s. 3 of the Act the person having custody of the intoxicated individual is obliged to release him:

> (a) on his recovering sufficient capacity to remove himself without danger to himself or others and without causing a nuisance; or
>
> (b) if an application is made sooner by a member of the person's family or by a person who appears to be suitable and capable of taking charge of the person, into the charge of that applicant;
>
> but in any case before the expiry of 24 hours after the person was taken into custody.

[16] Section 5 of the Act provides an exemption from liability in favour of a peace officer or a person employed in a detoxification centre or any other person for "anything done in good faith in respect to the taking into custody of any person, the detention and custody of any person or the release of a person under this Act". The Act clearly allows a person to be detained, not as punishment for committing

any offence, but in order to protect the person from suffering harm, causing a nuisance, or doing harm to others.

[17] In my opinion, the fact that an inquest is mandatory under *The Fatality Enquiries Act* when a person is in custody implies that the State must take all reasonable care when taking away a citizen's liberty and placing them in custody. This seems particularly appropriate when those confining an individual are relieved from liability for negligent actions, as long as the acts are done in good faith, as is the case under IPDA.

THE MAIN STREET PROJECT

[18] The Project is a community service non-profit organization which originated in January of 1972. It operates 24 hours a day, 7 days a week. The clients of the Project are among Winnipeg's most disadvantaged. The majority suffer from serious addiction problems. Many are homeless. Many suffer from underlying and co-occurring mental heath diagnoses. Many have been abused in the past, both physically and emotionally, and may have been incarcerated. They face numerous crises that they are not well equipped to address. These include crises related to basic needs – food, clothing, shelter, and medical care. Many are believed to suffer from foetal alcohol spectrum disorder. Many suffer from diabetes, a considerable number the insulin dependant variety. Many have foot problems related to diabetes or other conditions. Some have problems with head lice. Many are prone to seizures. They are vulnerable to abuse and physical attack. They have accidents. About 70% of the client base is Aboriginal (First Nations and Métis). The remainder is Caucasian or Asian. In 2004, there were 33,000 admissions to all the components of the Project.

[19] Until recently the typical client would be in their forties. Because of the increasing prevalence of crystal methamphetamine and especially crack cocaine, the Project now sees many people with substance abuse problems in their twenties.

[20] The Project's mission is to provide "a safe, respectful and accessible place for individuals at risk in our community." The Project "[advocates] for a more inclusive society and [assists] marginalized individuals to make real choices." According to its vision"[e]very individual has a safe place to be, and an opportunity to make real choices."

[21] The Project provides numerous services to its clients. There is an area for dealing with crises of clients – those who drop in with urgent needs for such issues as shelter, clothing, or medical issues needing referral, or simply require a safe space to be for a few hours. During the day, that area is furnished with tables and

chairs and soup and coffee are available several times a day. The area for crises becomes an emergency shelter area at night when tables and chairs are put away and mats are put out for clients to sleep on. A shower can be taken and there is a washer and dryer for cleaning clothes.

[22] During the 2003-2004 fiscal year 7,312 client services were provided in the crisis area, and 1,500 persons were sheltered with total admissions to shelter numbering 19,139. In addition, transport to an address was provided for many shelter clients where that was feasible and safe. This actually understates the number of people using the crisis area, as those who simply drop in for a while without needing a specific service are not included in these statistics. The crisis/shelter area is next to the IPDA area, in terms of physical layout.

[23] The Project has a van which operates 24 hours a day, taking clients to medical appointments, or to the hospital or other appointments, and looking for street people in crisis situations – such as those found outside in cold weather at risk of hypothermia. The van regularly goes out at midnight or 1:00 a.m. for three hours or so, checking back lanes, behind the bars, bus shelters and secluded areas.

[24] There is also a 25 bed short term residential chemical detoxification unit (CDU) where clients wanting to deal with their addictions can obtain help. Four beds are reserved for clients who are very sick at admission. The process of withdrawal can present serious medical concerns. The detoxification area has been the most significant area affected by crack cocaine. One staff member estimated that as high as 90% of that area is taken up by crack cocaine addicts. In the CDU area vital signs such as blood pressure and pulse are regularly taken for the first couple of days. Two staff are on duty in that area.

[25] There is also a residential area attached to the facility called Mainstay. This was intended to be relatively short or medium term as well. However, because of the difficulty of obtaining housing for many clients, especially those with mental health issues, some clients have lived at Mainstay for many years.

[26] The Project was designated as a place of detention under IPDA by the Lieutenant Governor in Council in 1983 on the recommendation of the Attorney General Roland Penner, the Minister responsible for the administration of the Act.

[27] The IPDA area is staffed at all times by one person (with support from the overall Project supervisor on duty) and at peak predicted times - when social assistance cheques come out (bi-weekly), disability payments, OAP (once a month), child tax credit (mid month), GST (every four months) - the Project

attempts to add staff to cover a busy shift. These are the times when clients have money to fuel their addictions.

[28] The busiest time of the day in the IPDA area is 8:00 p.m. to 5:00 a.m. The staff members rotate through the shelter/crisis area, the CDU, the van, and IPDA, generally in two hour intervals. This seems to be a sound concept as the staff persons who oversee the clients in detention are the same ones who may be, at other times, helping them with crisis or shelter needs, or assisting them in the CDU. The idea is that staff members are not jailors, but concerned with the welfare of the clients no matter which area of the Project is being utilized.

[29] The people admitted to IPDA are largely street people who are homeless or near homeless who have substance abuse problems. Many have numerous admissions under IPDA. Ms Dawkins explained that it seems the IPDA area deals with two very different groups of people: those who come once and then never again – those who overdid it at a public party or event – or the core area street people "who are regularly picked up intoxicated in the community because they have inadequate places to live and . . . are in crisis in their lives and chaos in their lives." In the IPDA area in 2004, there were 8,328 admissions.

[30] Detentions for intoxication on alcohol as well as non-potable substances such as hairspray and Listerine are still common, as are detentions related to inhalant and solvent abuse. Often the clients are using more than one substance at a time and sometimes have apparently been slipped something by others without their permission. In recent years, detentions of people intoxicated by crack cocaine, ecstasy and crystal methamphetamine have significantly increased.

[31] Housing the IPDA detainees in the Project was considered to be a progressive and innovative idea in 1983, given that the facility serviced clients on a voluntary basis with a similar profile to those often detained under IPDA. The Project remains unique in Canada, in combining both a voluntary and involuntary components.

[32] Mr. Bighetty was an example of this overlap, as he had been a client in the crisis/shelter areas as well as the CDU. He had been detained under IPDA on several occasions.

[33] The table of services accessed by Mr. Bighetty from the Project (attached as Appendix I) poignantly illustrates that he was a typical marginalized client, with many problems and crises in his short life. The Project provided shelter at times, addressed some of the numerous crises he faced, assisted with medical problems, tried to help him transition to proper housing, supported him in the CDU, and until

his last admission, lodged him safely when he was detained under IPDA. The attached table shows he knew he had to deal with his substance abuse problems, and made a number of efforts to that end, but did not achieve success. At times the problem was lack of a suitable facility or available bed for referral.

[34] Ms Neal testified that there is no treatment facility in the Province of Manitoba for those addicted to solvents. As a result, when chronic sniffers want to deal with their addictions (as Mr. Bighetty did from time to time), they must refer them out-of-province for any specialized treatment. There is one excellent treatment program in Saskatchewan and at least two in Ontario. Ordinarily the referrals out-of-province are paid for by the Band for clients with Treaty status. If that is not possible, Income Assistance will sometimes underwrite the cost if they can be convinced it is a worthwhile investment. In the past year the Project has sent about a dozen individuals out-of-province.

[35] When the IPDA area was originally created in 1983, the detained clients were lined on mattresses or bunks on the floor in an open area. Initially, it was hoped that those housed there would behave similarly to those who voluntarily attended. While some of those detained just “tucked up and went to sleep” (Dawkins p. 87), others, given the combination of intoxicants and forced detention, could display an elevated level of aggression and violent and unpredictable behaviour. There was concern for safety of both staff and clients in the open environment.

[36] As a result, the current designated area with 20 locked cells was designed for IPDA. The cells are quite stark and prison-like in appearance. There is nothing in them, save for a “toilet” that is simply a system of grates even with the flooring, with a flushing mechanism outside of the cells. There are mats on the floor for sleeping. (It should be noted that prior to the designation of the IPDA area at the Project, intoxicated persons were detained at the Public Safety Building, the predecessor to the Winnipeg Remand Centre (“the Centre”). According to the medical director of the Centre, there were many safety problems and a number of deaths at that time.)

[37] In the IPDA area, physical contact between staff and clients is kept to a minimum. Upon admission by policy they do not attend with police in locking up individuals. Nor do they search detainees. Eventually they do have physical contact if necessary to wake them or to attempt to wake them.

[38] Those who work at the Project work with individuals “whose lives have been unbelievably difficult for them, and for that reason there are behaviours and

attitudes and other things that make it a very difficult group" with whom to work with. (Dawkins p. 85) While some of the dedicated and caring staff have worked many years, it takes special skills and patience to work there and turnover is a significant problem.

[39] Ms Neal talked about how important it is that the clients of the Project trust the staff. They choose staff because of their tolerance and empathy as well as their skills. She explained that the trust is fundamental to helping these individuals change their lifestyle.

[40] Ms Dawkins, the executive director at the time of Mr. Bighetty's last admission, testified that the Project has some of the most challenging human beings in our city to work with and is very thinly staffed.

[41] Like many of the Project staff, Judith Dowhos, a former librarian, who has worked at the Project since 1999, impressed me as an exceptionally thoughtful, caring and dedicated person, wanting to make a difference in people's lives and to keep them safe.

> " . . . just working with individuals that have been . . . discarded by maybe the rest of society, looked down upon and to suddenly just bring some light into their lives, and to know that there is an opportunity for them to, to improve their lifestyle. And even though they may not reach high goals in life but just to have their own place and to have three square meals a day and perhaps a chance to, to stop using substances that have caused the grief." (Dowhos p. 45)

[42] She noted that a few individuals who have achieved success have come back to the Project, almost unrecognizable. Others are not able to reach that level of change. For these people "if Main Street Project can offer them the opportunity to be looked after, to receive medical attention if they require medical attention, but to also just give them a friendly, safe place to go . . .", that is an important service.

[43] Mike Todd, who began working at the Project in 1999, testified that Project work is satisfying because staff are "on the front line for people who are down and out. They . . . give them a place, food, clothing, shelter and comfort." They deal with people who may be touched by a simple act of kindness such as having their birthdays recognized with a candle placed in a day old donut.

[44] Bill Dunstone talked about the satisfaction in seeing someone succeed and get their life back on track – going through CDU, getting into a program, moving away from the area and then dropping in occasionally. They often get cards from those whose lives they have helped change. In the drop-in and shelter area there are times when the clients are laughing and having a good time, getting some relief

from the crises in their lives. There is also satisfaction in the van outreach – picking up people that have been injured, taking them for medical care, and driving them home after treatment. By day they drive elderly patients to the Health Action Centre, or to medical appointments, and to legal appointments, and this is appreciated by clients and satisfying to staff.

[45] Mr. Dunstone also talked about the violent people in the IPDA area that tend to run into the walls and hurt themselves. Some people get suicidal. Some threaten staff with violence. People in the shelter area frequently come in who have been assaulted; people have seizures, many are diabetic; some complain of chest pains.

[46] I cannot say enough about the level of dedication and caring of the regular staff who testified. The staff were devastated by the death of Mr. Bighetty, and would welcome recommendations to minimize the possibility of another tragic outcome. The Project is indeed thinly staffed at present, and the need for ongoing training is important.

[47] A day long orientation process was established, involving formal instruction followed by short observation shifts in each of the crisis areas and a regrouping for questions. More recently, one-on-one, on the job orientation was implemented. A senior staff member is initially assigned to work with a new recruit on a training shift. There are a minimum of six such training shifts to follow. Staff must have and maintain basic first aid and CPR. Various additional training sessions are arranged from time to time. Some staff have already upgraded their training to the Emergency Medical Responder level, and that has proven very helpful. A small number have taken primary care paramedic training. Pay levels even for long serving staff are extremely modest.

[48] All staff appeared to welcome and wish for greater opportunities for training. Training is expensive because of staff replacement costs, given that the Project operates on a seven days, 24 hours basis. The former director, Ms Dawkins, indicated the Project needs a regular training budget, which includes staff replacement costs. She admitted that training has been hit and miss, resulting from a need to “beg, borrow and steal here and there” from other budget lines to accommodate training.

[49] The Project is funded primarily by the Winnipeg Regional Health Authority “the WRHA”, with grants attributable to the Crisis and CDU areas. The IPDA area is financed by a fee for service contract with the Winnipeg Police Service for the IPDA area. At present that fee is $35 per admission. The IPDA area also receives indirect support from other areas of the Project, beyond the grant from WPS. The

Province, through the department of Family Services and Housing, provides about $125,000 for the Mainstay component, in per diem grants. In addition, the City of Winnipeg and the United Way provide grants for client services in the Mainstay program. Attached as Appendix II is the Statement of Operations for the Project for the year ending 2004, outlining revenues and expenditures.

[50] Since Mr. Bighetty's death, the Project has been in the process of revamping its policies and procedures concerning the IPDA area of the Project in particular and had a draft document to provide to the Court. The most significant change instituted in relation to this inquest is waking all IPDA clients every four hours and some clients every two hours. The theory behind this is very simple. If someone is intoxicated, their level of consciousness should be improving as the substance is metabolized by their bodies; on the other hand, if the problem is a subdural hematoma or other condition such as a diabetic coma, the condition will worsen, and level of consciousness will decrease. If that happens the person should be promptly sent to the hospital.

[51] The new entry in the manual notes that staff "are often charged with the responsibility and risk of detaining a person who may have serious medical conditions that are not obvious and the person does not declare them. In other situations the detainee may have taken an overdose of drugs or medications." To that end staff must wake the individual at four hour intervals (or less if the staff feels it necessary) and assess the detainee for signs of sobering up and "for any signs of medical concerns."

[52] The four-hour interval of waking has actually been implemented as of August 2004. Ms Neal testified that the four-hour waking was working and not causing any additional problems. She explained that the idea to regularly rouse clients came in part from the tragedy with Mr. Bighetty but also from the fact that there are persons admitted to IPDA who are diabetic or suspected of being diabetic.

[53] I heard also directly from staff who were operating under the new procedure. Ms Dowhos favours the new current practice of waking individuals every four hours, although she explained "some people don't like to be woken up after four hours in their intoxicated condition. They want to sleep. They don't want to be disturbed but when we explain it to them, they understand why we're doing it, and they appreciate it I believe." (p. 39 Dowhos) She estimated that 65%-70% of the people brought in are very cooperative; they just want to sleep or do their time and leave.

[54] Curtis Williamson testified that if staff do not feel safe, or feel as if they may have to restrain an individual, they simply do not open the cell door. Mr. Todd described how he tries flushing the toilets first to wake them up. If that does not work they open up the doors and go in. He explained:

> "I never wake someone up, by shaking their shoulders or anything cause some people come up swinging when we do start shaking them, cause they don't realize where they are."

[55] Dave Warman noted the new policy of waking at not less than every four hours had already proven its value by allowing the staff to detect a diabetic who needed to be hospitalized. A second person was found unconscious due to an apparent drug overdose and was sent to the hospital.

[56] As will be noted later, some medical testimony at the inquest questioned whether the four-hour interval is too long.

[57] The old manual states that "under no circumstances are IPDA's to be accepted if they are passed out or unconscious." The new draft states that MSP does not accept any individual into IPDA who is unconscious or passed out *and not responding to pain stimuli*." This seems to me to be a broadening of the type of individual who will be admitted, but Ms Neal stated it was not intended to be. This needs clarification. It also raises the question of what type of response will be required. I assume it is that the person can be roused; answer some basic questions and perhaps respond to some simple requests such as move their arms. These aspects should be set out to guide staff so a consistent and safe admission process is followed.

[58] Under "reasons" for the revised policy it states that "[i]ndividuals who require assistance in walking are thoroughly assessed prior to admission." While this is undoubtedly necessary, specific components of that assessment should be set out. How will they be assessed? When will they be admitted? When will they be refused admission? Will a supervisor be consulted? The requirement for a thorough assessment also raises the question of what type of qualifications are necessary to do the assessment. I will comment later about this point.

[59] The draft new procedure under IPDA-Monitoring outlines what to look for on the regular fifteen minute visual checks which are done through the door window of the cell. Staff are to watch for movement, as individuals who are passed out or sleeping will move around, but, they are cautioned " individuals with a head injury may not move." Staff are also to look for signs of breathing (chest is moving). Staff are cautioned that "laboured breathing, shallow breathing, gasping

or wheezing are signs of distress and warrant further assessment." Similarly, staff are to look for changes in skin tone or colour. "Skin that appears flushed, blue or purple or clammy may be an indicator of distress and warrant further investigation." Staff must also look for signs and symptoms of withdrawal. The manual notes that the detainee may have tremors, visual or audio hallucinations, or seizures, and are cautioned that these symptoms can become severe and require medical intervention. I note that these reminders are not just theoretical in nature. Ms Neal testified that individuals in the IPDA area frequently manifest signs and symptoms of withdrawal such as tremors, hallucinations or seizures. The new manual also reminds staff to watch for signs of mental illness, as outside agencies may need to assist. This entire section is a helpful addition to the manual. At the same time, it points out the constellation of risks involved and raises the question about the need for timely access to medically trained personnel at the Project.

[60] Ms Neal also provided the Court with a proposed new IPDA monitoring health check sheet. There will be one health checklist for every client admitted to IPDA. Staff will check as to whether the person is awake, sleeping or they observe movement on each 15 minute check. Perhaps there should be a guideline to advise if there is no movement observed in "X" number of checks, further assessment is warranted. Later in the manual it is suggested that if there is no movement in two hours, the detainee should be roused. I understand the manual is to be reviewed by a doctor. It seems to me two hours may be too long in such a situation.

[61] The draft new procedural manual also contains a 10 page supplement on medical information specifically for the IPDA area. The preamble states that the section describes signs and symptoms of the most *common* medical or intoxicant induced conditions that MSP staff can encounter when working with detainees. The list and the details of signs, symptoms and risks are sobering. Staff will be expected to deal with conditions from asthma, diabetes type 1 and type 2, head injuries, heart attacks, seizures, to stroke. They are expected to be familiar with warning signs, to provide some level of treatment (for example giving sugared juice to diabetics), and to determine when an ambulance should be called. In addition to the section on medical conditions, the manual goes on to deal with how staff should respond to potentially suicidal persons. The new manual also contains information on drugs "*commonly* found in the possession of and used by persons presenting in IPDA" along with the signs of overdose for each. (italics are mine) These include benzodiazepines, cocaine, ecstasy, and methamphetamines. There is also a section dealing with prescription medications that detainees have in their possession when admitted, noting the risk of fatality involved in combining some medications. Staff are generally required to refuse access to all medications

including nitroglycerin, because individuals need adequate blood pressure readings to safely use that drug.

[62] There is a new two and one half page section dealing with head injuries. It is quite complete. That section requires staff to look for signs of head injury, to be aware that there can be a head injury with no sign of trauma, and to be alert to the effects of a head injury which are confusion, loss of consciousness, blurred vision, vomiting more than once, severe headache, slurred speech, difficulty breathing, inability to move arms and legs equally on both sides, difficulty walking, pale skin colour, sweating, weakness that is localized on one side of the body, dizziness, seizures, short term memory loss, irritability, eye pupils are not the same size, or blood or clear fluid draining from the nose or ears. It is not clear whether staff are expected to be examining detainees for these signs on admission.

[63] Staff are cautioned as follows:

> "Any person who is not moving even though their breathing may be regular and they may not have been assessed as being at risk of having a head injury will be awakened after 2 hours and reassessed."

This section was put in specifically because of Mr. Bighetty.

[64] There are some guidelines to apply if staff remotely suspect head injuries, including questions to assess the level of consciousness initially and periodically. Later medical testimony suggested that the section on head injuries was very good. My only comment at this stage is to suggest that a structured assessment of levels of consciousness should be undertaken for all detainees, and not only those who are suspected of having a head injury. A person may have a head injury when there is no reason to suspect that is the case.

[65] The plan Ms Neal expressed was to take the new Policy and Procedures Manual to the staff for input and comment, and next to the Board, and that she would also be seeking input from a medical doctor. The Project and those who worked on this document are to be commended for the excellent start they have made.

[66] Before examining the chronology of events that preceded Mr. Bighetty's death, I will make a few comments about previous inquests related to the Project.

PRIOR INQUESTS RELATING TO THE PROJECT

[67] I asked whether there had been previous inquests in the past several years concerning the Project. The information provided was that in the eight years

between July 1994 and November 2002 there have been five such inquests, including the present one. This number is certainly of concern and I thought it prudent to look at past inquest recommendations. While the deaths are tragic for each individual and their families, it also bears noting that during this period, thousands of individuals have been safely detained at the Project. At the same time, there appears to be a familiar theme of undetected serious medical conditions underlying the deaths of these people.

[68] Vance Henderson died of cocaine overdose in 1999 while held at the Project under IPDA. Following an inquest, it was recommended by my colleague The Honourable Judge Howell in August of 2002 that at least some of the cells have video cameras installed to monitor those who may be extremely intoxicated. Former Executive Director Joan Dawkins testified that she felt the issue of deciding who would be placed in monitored cells would be too difficult and the video monitor would not provide as effective monitoring as the staff's visual observation of every cell every fifteen minutes. I do not read Judge Howell's recommendation, however, as suggesting visual checks be discontinued. Ms Dawkins testified that the Board was interested in the option and may have considered it further but it was not implemented. I believe Judge Howell's recommendation was well-founded and needs to be implemented. Ms Neal also indicated that there is a present need for five or six cells with cameras and monitors, particularly for clients the staff members believe are prone to self-harm or at risk for suicide.

[69] I attended the Project and the vantage point at the counter does not allow for direct observation of the cells. With today's technology, video cameras and monitors are not particularly expensive. There should be no further delay in providing these to the Project.

[70] A second recommendation was that employees working in the IPDA area be given training by medical personnel to assist them in identifying intoxicated individuals who may require medical treatment. Specifically, training was to be given to assist the employees to identify individuals who have taken dangerous amounts of intoxicants. The Executive Director indicated that this recommendation was not consistently followed, partly due to funding and partly because "recognizing the difference between someone who is very intoxicated and suffering from a set of symptoms resulting from that, and someone who has moved over into a medically risky condition, is something that even doctors and nurses have an unbelievably hard time doing, making that distinction." (Dawkins p. 102) In my view, as difficult as that task is, the staff needs ongoing training.

[71] According to Ms Dawkins, the issue was what level of training we could reasonably give to lay people that would supplement the common sense approach which is valuable. Some training was provided subsequent to the Henderson inquest, but there were questions about its sustainability or effectiveness. The training did not occur until December 2002, following the death of Mr. Bighetty in November of 2002. Staff testified that the training, while valuable, was not hands on or practical training but more of a lecture format.

[72] The current Executive Director, Ms Neal, indicated her view that all staff should be trained to the Emergency Medical Responder ("EMR") level, and that beyond that, a sustainable training budget was very important. Several current staff now have EMR training, but some still require this training. EMR training involves a hands-on component and would train staff for such procedures as pupil checks.

[73] The last recommendation from the Henderson inquest was that mats should be provided and should only be removed for good reason that has been well documented. That has been implemented.

[74] Robert Marc Brisson died on July 3, 1994 as a result of respiratory failure caused by a drug and alcohol overdose. Earlier that same day, after having first been taken to the Remand Centre, but not having been admitted there due to his state of intoxication, he was taken to the Project and detained there under IPDA. An inquest conducted by my colleague The Honourable Judge Kopstein made the following recommendations on March 16, 1995:

(1) Persons in police custody or protection, in a state of unconsciousness apparently due to the ingestion of alcohol and/or drugs, who cannot be awakened easily, should be transported to a medical facility, or provided otherwise with professional medical attention, without other intervening steps.

(2) In the continued absence of professionally trained health care staff at Main Street Project, persons who are or become unconscious and cannot be aroused easily, should not be admitted, and should be transported to a medical facility.

(3) In the continued absence of professionally trained health care staff at Main Street Project, medical advice should be made available by telephone, and should be accessed by staff immediately in the event of concerns regarding the life status of clients.

(4) A trained health care professional should be made personally available to Main Street Project, either as part of its staff, or on call.

(5) If it is not already policy, or part of a job description, that nursing staff at the Winnipeg Remand Centre personally assess the health status of persons brought by police for admission, a policy should be written and implemented requiring personal assessment.

[75] In the course of this report, I will address some of the recommendations. It is of particular concern that recommendation four was never implemented. Further, without regular rousing which was not required by policy until 2004, it is impossible to know if a person has lapsed into a state of unconsciousness or cannot be easily awakened.

[76] Less than five months later, Judge Kopstein conducted another inquest into the death of Arthur Smitke who died January 16, 1995 following detention at the Project under IPDA. Like Mr. Bighetty, Mr. Smitke died from bilateral acute and chronic subdural hematomas. No specific recommendations were made.

[77] The CME also ordered an inquest into the death of Eric Clipping who died April 28, 1996 after being detained at the Project. He too died as a result of a subdural hematoma that went undetected until it was too late. In that case, however, I am advised, that he had been seen in the hospital prior to his detention at the Project. The inquest hearing was delayed for some time and was only held in May of 2005.

CHRONOLOGY OF EVENTS

[78] As I go through the chronology of events leading to Mr. Bighetty's death, I will also make comments on the evidence related to standard practices, and suggestions for improvements from various witnesses.

Downtown Biz Members Encounter Mr. Bighetty

[79] Troy Slater and Dale Demianiw were both employed with the Downtown Watch in November of 2002. According to Mr. Slater, the job of Downtown Biz staff and volunteers is to promote the safety of the downtown area of Winnipeg.

[80] While in their service centre at 378 Portage Avenue, a member of the public came in on a rainy November 20, 2002 to let them know that there was someone passed out on a bus stop bench at Portage Avenue and Carlton Street. They investigated and found Mr. Bighetty. Mr. Bighetty was sitting on the bench, bent

over with his hands on his legs. His head was down, looking between his legs. When they first called him there was no response and then after tapping his foot, Mr. Bighetty looked up at them. Mr. Slater testified the only thing he really said was his name. One thing that sticks out in his mind is that he could smell garlic on him. He testified that the scent of liquor was also on his breath. The smell was neither overpowering nor a hint but somewhere in the middle.

[81] Mr. Slater's partner, Mr. Demianiw, recalled that the smell of alcohol was strong. He recalls Mr. Bighetty chuckling and then just not saying a word after Mr. Slater suggested he had garlic for supper. He stated there were no visible signs of injuries.

[82] Mr. Slater testified that Mr. Bighetty did not complain of any injuries nor did he complain of sickness, headaches or anything else. According to Mr. Slater, when Mr. Bighetty was asked whether he wanted to go to the drunk tank he nodded his head in the affirmative.

[83] Mr. Demianiw recalled that Mr. Bighetty gave his name as Herman Bighetty. He had a brief conversation with him about that because he knew a Julian Bighetty. Mr. Herman Bighetty just shook his head and kind of nodded in response to the question of whether he knew Julian Bighetty. He was not getting up and trying to walk away; he just sat there and never really made eye contact. Mr. Demianiw did not observe any obvious signs of injury nor to his recollection did Mr. Bighetty complain of any injury. He testified it was a little difficult to understand Mr. Bighetty. There was a slur to his voice. He concluded that Mr. Bighetty could not walk off because of the way he was sitting and the lack of any attempt to get up and walk away. Mr. Demianiw called the WPS to take Mr. Bighetty to the Project.

[84] Unfortunately, due to an error by an inexperienced police officer, neither Mr. Slater nor Mr. Demianiw were interviewed by police about their encounter with Mr. Bighetty until approximately ten months after their dealings with him, and it was only at that time they were made aware of the fact that he had died. The Downtown Biz keeps almost no notes and one member had lost his notes. Because of these facts, where there are conflicts with the evidence of the WPS officers, who did make contemporaneous notes, I must prefer the evidence of the officers.

[85] Mr. Slater testified that at present Downtown Watch personnel are calling the ambulance more than they might have before. Tab D of Exhibit One comprising Downtown Watch Ambassador Information Manual was referred to by Mr. Slater as including a policy for dealing with a conscious, intoxicated

individual. Members are to do a visual assessment of such a person. If they are bleeding or require medical attention beyond first aid, an ambulance should be called. If the person is uncooperative or can't move, police are to be called. If a member finds an apparently unconscious intoxicated person, they are first to do a visual inspection attempting to assess if they are breathing, bleeding, sleeping or passed out from being intoxicated. The next step is to verbally try to wake the person and check to see if they require medical attention beyond first aid. If so, an ambulance is to be called. If the person is uncooperative or cannot move, police are to be called. There is also a similar policy dealing with "An Injured and/or Unconscious Individual Other than IPDA." A similar approach is to be taken, including calling an ambulance if required, except that if an individual is responsive it is suggested the conversation be continued. I think it would be helpful if there were simple questions set out in this manual for Downtown Biz members to ask that would help them gauge level of consciousness

[86] Ms Neal expressed concern about the possibility of special constable status being granted to Downtown Watch employees for the purposes of IPDA detentions. This proposal was initiated without any consultation with the Project. She was concerned that these individuals might not be properly trained and may not appreciate the health risks of intoxicated persons.

[87] Mr. Dunstone was concerned about some recent incidents involving the Downtown Biz Patrol. He stated that if the Biz finds someone passed out they have dragged them over to the facility at the Project and then called the police. Mr. Dunstone was very concerned about this, stating: "…It's our experience that if someone is passed out, you do not move them, you call for help there and then. But to drag them across the streets upsets us very much so. It's something that I've seen happen at least twice." Constable Janine Keen also recalled perhaps once or twice being called by Downtown Biz who had mistaken an individual as being intoxicated when it was diabetic shock.

[88] The Downtown Biz members lack the training and experience of police who are quite used to dealing with intoxicated persons. I am also concerned about expanding the authority of the Downtown Biz without assuring proper training concerning non-violent conflict intervention, and medical and safety issues concerning intoxication.

Winnipeg Police Services Officers Arrive

[89] Mr. Demianiw's recollection is that it took about an hour for the WPS to arrive on the scene. Constable Richard McDougall and Constable Janine Keen in fact received a dispatch at 5:08 p.m. to attend the scene. They arrived at 5:17 p.m.

[90] Mr. Slater testified that when the police came they had to help Mr. Bighetty; he did not get up on his own. However, he did not observe any obvious sign of weakness on either side during that period of time. He also stated it was obvious Mr. Bighetty was not able to walk.

[91] Perhaps the most reliable evidence concerning Mr. Bighetty was provided by Constable McDougall. Constable McDougall not only made notes at the time but also was made aware, the following day, of the fact that Mr. Bighetty had been taken to hospital and may not survive.

[92] When they arrived they found Mr. Bighetty slouched over the bench on the sidewalk. He was sleeping on that bench and kind of on the sidewalk, slouched right over it to the point where he was almost laying on the sidewalk. Mr. Bighetty appeared a little disheveled and seemed to be sleeping. The position he was in did not appear to be a comfortable sleeping position. Constable McDougall felt quite confident that Mr. Bighetty was in fact passed out when he first encountered him.

[93] Constable McDougall tried to awaken Mr. Bighetty by calling him but that was not sufficient. He applied a slight touch to the area just below the ear and that woke him up. He called Mr. Bighetty by name. Mr. Bighetty was able to get up and able to stand with assistance. When asked what he had been drinking, Mr. Bighetty replied "vodka". Signs of impairment observed were slurred speech, slow uneasy movements and the inability to stand without assistance. He had very slow movements even as the officers picked him up and attempted to take him over to the car – it was just very slow, very uneasy movements from his limbs and his entire body. The officer testified that this was not uncommon for those that are intoxicated.

[94] Constable McDougall did not detect any odour of liquor on Mr. Bighetty at the time or even later when he was in the police car. It was the fact that Mr. Bighetty admitted to be drinking vodka and his physical symptoms that led him to believe that Mr. Bighetty was intoxicated. He also recognized Mr. Bighetty as an individual who frequented the downtown area and was often intoxicated. He observed no obvious injuries and decided to transport him to the Project.

[95] Constable McDougall's partner, Constable Keen, testified that what makes Mr. Bighetty's transport to the Main Street Project stand out in her mind was that she had learned of the outcome. Other than that, the dealings with Mr. Bighetty were not unusual or odd. He was intoxicated. He was on a bus bench. He was a routine IPDA. She testified that had Mr. Bighetty complained of a headache and explained that he had fallen that would have alerted them to a potential head injury. In this case she would not have given a head injury any thought.

[96] She was aware that a head injury can also cause an individual to present symptoms as if they were intoxicated. According to Constable McDougall, he received no specific training on subdural hematomas and the fact that they can mimic intoxication. He was familiar with the fact that a diabetic condition can mimic intoxication.

[97] Constable Keen remembered her partner asking what alcohol he had consumed that day and the response being vodka. That stuck out in her mind because it is almost an odd answer for most of the people they attend. Given Mr. Bighetty's difficulty in speaking, I wonder if he was misunderstood on that response.

[98] The main conflict between the evidence of the officers and that of the Downtown Watch members relates to the smell of alcohol. According to the officers, Mr. Bighetty did not smell of alcohol. Nor did they report any odor of solvents. Constable McDougall was quite certain that there was no odor of alcohol even in the police car. He indicated that he would have certainly noted it if there was such an odor. Notwithstanding conventional wisdom about the lack of odor of vodka, Dr. Lee in later testimony expressed the view that there would be an odor if an individual consumed enough to become intoxicated.

[99] Given the medical testimony concerning symptoms of a subdural hematoma, about which more will be said later, I conclude that it is quite possible that all of Mr. Bighetty's symptoms - understandably noted by the officer as consistent with intoxication - were in fact caused by a head injury and not intoxication. When officers take individuals to the Project who do not smell of alcohol or solvents, it would be important to tell staff at the Project about this, and for staff to ask the officers specifically about this. Once at the Project it is difficult to distinguish that odor, as there are always other intoxicated people there and other street life aromas.

Mr. Bighetty is Transported to the Project and Admitted

[100] Constable McDougall testified that he frequently deals with intoxicated persons and on some days has taken as many as four or five individuals to the Project. It would almost be a daily occurrence that some individual would be taken there. His partner Constable Keen testified that she would have taken people to the Project hundreds of times. Of those hundreds of times, something less than ten times had the Project refused to accept an individual.

[101] Constable Keen testified that the staff members at the Project are cautious in that they are not just going to admit any intoxicated person. Certainly the police do not transport unconscious persons there as the Project will not take them. If a person is unconscious officers will call an ambulance. In her experience, if they cannot get an individual to at least sit up on their own, they normally would call an ambulance. She testified that if you have to kind of drag the person into the Project and they cannot answer questions, the staff there will not admit them. Mr. Bighetty was not in that category.

[102] However, when Constables McDougall and Keen arrived on the scene at the Project, Mr. Bighetty was unable to walk to the building on his own. He required help. As noted earlier, he was also unable to walk to the police car on his own when picked up at Portage Avenue and Carlton Street.

[103] Constable McDougall recalled the intake staff member, Cecil McFarlane, as a new person. He did not remember seeing him before and he appeared to be extremely thorough in asking all the questions. It was slow and he seemed to be reading from a page as opposed to those who had been there for a length of time who knew the questions off by heart. He did not recall any difficulties or inability on Mr. Bighetty's part in answering the questions. However the police narrative noted that at the time of admission Mr. Bighetty was responsive but unable to pronounce some words. The intake process took approximately five minutes.

[104] Constable McDougall and his partner remained with Mr. Bighetty during the intake process and then escorted him to his cell. Constable McDougall's dealings concluded at 15:45 p.m.

[105] When Cecil McFarlane testified, he had little recollection of his dealings with Mr. Bighetty. It appears he did not file a written report at the time, despite being requested to do so by the Executive Director. He was not contacted by the police until July 2003, many months after Mr. Bighetty's death. He never gave a statement to the police as he never met with them despite efforts on their part to contact him. Most of his testimony focussed on his standard practices. He had

virtually no independent recollection of his encounter with Mr. Bighetty, although he said the intake process would take about five to ten minutes. I found it somewhat surprising that Mr. McFarlane lacked any independent recollection of his dealings with Mr. Bighetty, given the dramatic events that followed.

[106] "Alcohol beverage – substance problems, client pick up at Carlton". These were his notations on the computer. On the hard copy of the IPDA Intake form, a copy of which is attached as Appendix III, the notation "passed out on sidewalk" appears; under medical conditions "diabetic" was entered and then crossed out. Mr. McFarlane couldn't recall why this occurred but speculated that Mr. Bighetty might have said diabetic or mumbled something. He indicated he was not comfortable with the computer system so, unlike many of the staff, would not usually access it and input information contemporaneously with the admission. It is important that the computer file be considered on admission, as it contains valuable information of past dealings, including health conditions. He could not recall if he was doing the fifteen minute checks that evening, though someone was.

[107] Mr. McFarlane was one of the casual workers the Project needed to call upon from time to time. He was hired sometime in October 2002, the month before Mr. Bighetty's last admission to the Project. He had worked before as an emergency medical responder at a personal care home. He spoke highly of the long serving staff at the Project as dedicated and caring. He felt he needed a position with more hours. Mr. McFarlane found working at the Project an overwhelming experience, and left in March 2003, some four months after Mr. Bighetty's death.

[108] Under the paragraph in the Project's Procedure Manual related to IPDAs that was applicable at the time, it is stated that staff is to check for physical injury, including dried blood, bleeding factors, abrasions, medical bracelet or necklace and further to attempt to ascertain whether the IPDA has medical problems and document IPDA's general condition. If in the opinion of the staff the IPDA admittee requires medical attention, police are to be requested to take the person to the hospital. The manual states "Under no circumstances are IPDAs to be accepted if they are passed out or unconscious. The better safe than sorry rule shall prevail."

[109] Upon IPDA admissions, the procedure manual directs staff to ask questions about the time of apprehension, whether the IPDA was in a fight and if the IPDA was passed out when the police found him or her, whether the police had to use exceptional means to rouse him or her. The existing policy states if the answer to this question is "yes", IPDAs should be checked out at the hospital for possible subdural hematoma or drug overdose. Exceptional means are not defined. In this case, as noted above, the police had to apply pressure behind Mr. Bighetty's ear.

They could not awaken him by calling his name. There is no formal checklist provided for each admission.

[110] I note the procedure manual also indicates that all IPDAs are to be offered a phone call to a responsible adult who may be willing to come and take charge of the IPDA. More than one call may be made on the client's behalf. I note that in practice this procedure does not seem to be followed regularly. There is a further policy that all IPDAs must be informed of the reason for their detention and must be informed of their right to call a lawyer. In practice, this also does not seem to be regularly followed.

[111] As of July 2004, other than the procedure manual which said not to accept unconscious or passed out persons, there were no written procedures concerning assessment for level of consciousness in the IPDA on intake or later on during their detention. Nor were there any special instructions concerning those who could not walk on their own. Ms Neal testified that if someone is extremely intoxicated, the practice has been to ascertain if they are oriented to date, to where they are, to how they got there and what they might be using. There is also visual observation.

[112] Ms Neal explained that at intake staff look for obvious injuries. They look at their hands to see if they are using both of them. They ask about what they have been using - for how long and what the medical issues are. The practice is, if in doubt about medical issues, call an ambulance. I believe Mr. McFarlane may have been hampered by the lack of clear guidelines to assess level of consciousness, and the lack of a simple checklist.

[113] The IPDA intake form has not changed significantly over the years. It also functions as a discharge form. As noted above, there is also a computerized client intake record designed to be used for intake into all areas of the Project, including IPDA. The system is set up so there are pop-up screens with important information. The pop-up screens deal with medical issues, violence, and warrants, as well as information about whether a person is temporarily barred from services due to past disruptive behaviour.

[114] Curtis Williamson described the intake process at IPDA as taking generally three to four minutes involving some conversation with the person at the counter followed by the officers taking the individual to the cells. According to Mr. Williamson staff have discretion not to accept an individual: a) unable to walk on their own power; b) who is under 18; and c) who has an obvious head injury and no medical clearance. This is relatively rare. Mr. Williamson is a regular night shift worker and estimated this may have happened about five times since October

of 2002 when he began working there. (Concerning someone under 18, I expect that Mr. Williamson meant that such a person would not be admitted but directed to the Manitoba Youth Centre, as that facility has also been designated as a place of detention under IPDA.)

[115] Ms Dowhos indicated that she has refused admission based on injuries, cuts to the head, and inability to walk properly. She explained that no one who is unconscious or unable to walk by themselves will be admitted.

[116] I note that according to police and Downtown Biz, Mr. Bighetty was not able to walk on his own. At the same time, as noted above, the officers described this as a normal IPDA admission. Yet according to Mr. Williamson, such an individual might not be admitted at all, and Ms Dowhos testified she would not admit such an individual. I am not clear whether Mr. MacFarlane knew this prompted discretion not to admit Mr. Bighetty or not. When I look in the existing procedure manual as mentioned above, this factor is simply not mentioned.

[117] Mr. Todd indicated it would be very difficult on intake to tell the difference between symptoms of intoxication and a head injury, in the absence of a visible injury to the head. He stated his belief that pupils are usually the first thing to be affected if there is a brain injury. (Later testimony from medical personnel indicated that this is not always the case, and pupil changes can manifest themselves much later.) Mr. Todd noted the matter is complicated because some drugs also can affect dilation of pupils. On the other hand, Ms Dowhos expressed quite understandable reservations about being tasked with such duties as testing pupils on the "PEARL" standard (pupils equal and reactive to light) without medical training. In addition, if a person is not cooperative, there is a risk of the staff person getting hurt. (p. 90) The risk is often greatest when they are first brought in. However, it is also true that police are present and perhaps could assist if such a check is considered valuable.

[118] Getting back to Mr. Bighetty's admission on the night in question, my sense from Mr. McFarlane was that, despite his emergency medical response training, he lacked the confidence and experience that would have come from a greater degree of training, and more regular shifts. He described his shifts as few and far between. I heard testimony that experience in dealing with clients can help staff identify when something is not quite right. Mr. McFarlane was also hampered by the lack of a standard written, detailed, yet practical protocol for the admission of clients which would alert him to exercise discretion and guide him on how to exercise it. He was also potentially hampered by his lack of computer experience. It would

seem better if a single form were developed on the computer to guide the intake process.

[119] A potentially useful example of a protocol to assess responsiveness or level of consciousness was obtained from the R.C.M.P. by counsel to the inquest and filed as part of Exhibit 17, entitled "Assessing Prisoner Responsiveness" and is attached as Appendix IV to this report. It may be helpful for the Project to use this or a similar form as part of the admissions procedure and for subsequent checks as to level of consciousness.

[120] As noted above, Ms Neal also provided information on a draft new Policy and Procedures Manual. Under the draft new policy it states that the Project does not accept any individual into IPDA who is unconscious or passed out and not responding to pain stimuli. For the purposes of the Project, "passed out" means intoxicated to the point of being asleep. If such a person did respond to pain stimuli and spoke to project staff, they would accept them.

[121] It seems to me that the admission process is a critical point of contact among Project staff, the police and the detained person. I will make some recommendations about changes that should increase the potential for identifying those in need of medical care.

Mr. Bighetty's time in the Project from 5:45 p.m. November 20 until 7:04 a.m. November 21

[122] It has been a long standing procedure at the Project that staff does visual checks every 15 minutes to watch for any obvious signs of distress of those detained under IPDA. There is a time clock that staff punch to record these checks. I have no doubt that staff did carry out these checks throughout Mr. Bighetty's stay there. As noted above, Mr. McFarlane did not recall if he had done any 15 minute checks. The time clock punches filed as an exhibit show that checks were done every 15 minutes and it is likely that he was the staff person that did the initial checks.

[123] On the rounds every 15 minutes, staff look for signs of life – has the client moved and are they breathing. (Williamson p. 52) "If they are diabetic, we take note of that." If someone is diabetic, Mr. Williamson checks every five minutes, if he is not busy. There is no requirement or policy that this be done.

[124] According to Ms Neal, at some point during Mr. Bighetty's stay staff noted that he did not move around very much. This fact is reflected in the text of the new

proposed policy and procedures manual which explicitly cautions that persons with head injuries may not move.

[125] Bill Dunstone was working in the IPDA area from 11:45-1:45 a.m. He did the checks – or – if he was busy on intake – may have asked someone else to do some of them. In any event he did not notice Mr. Bighetty having any problems. He was sleeping the whole time, and appeared to be breathing normally and not in distress. Mr. Dunstone seemed to recall that Mr. Bighetty shifted from one side to the other. That was the only thing that he noted.

[126] Ms Dowhos testified that during Mr. Bighetty's stay, she had done a few rounds through the IPDA area, between 1:00 a.m. and 1:45 a.m. She saw nothing unusual during her rounds. She did notice some movement. At times he was on his back and at times on his side.

[127] Dave Warman testified that he was on shift in the IPDA area for a two-hour period from 1:45 a.m. to 3:45 a.m. It was busy and he did only one or two checks; other workers did the other checks. He recalls nothing out of the ordinary.

[128] Mike Todd works the night shift which starts at 11:30 p.m. and finishes around 8:00 a.m. Like the rest of the staff, he has worked in all areas of the Project. On the night in question he worked a two-hour shift in the IPDA area from 3:45 a.m. to 5:45 a.m. When he came on shift there was nothing remarkable related to him about Mr. Bighetty. He made the rounds making a visual check every 15 minutes during that time, or delegated that to another staff if he was too busy.

[129] At about 5:15 a.m. he flushed the toilet in the cell three times (in an attempt to awaken Mr. Bighetty or get his attention.) He also tapped on his foot a couple of times and Mr. Bighetty responded with a mild groan. Mr. Todd assumed Mr. Bighetty was waking up on his own. He decided to check out others who were already awake and waiting to be released.

[130] Curtis Williamson came on shift in the IPDA area November 21st at 5:45 a.m. Mr. Todd told Mr. Williamson, who had only been working at the Project for about 30 days, that he had checked on Mr. Bighetty and he would probably be ready for discharge anytime.

[131] Mr. Williamson did a check at 6:00 a.m. and again at 6:15 a.m. At that time, he noted that Mr. Bighetty had not moved and his eyes were open a little bit. The fact that he had not changed position was not of particular concern because that is not uncommon.

[132] At 6:30 a.m. he decided to wake Mr. Bighetty because he had been in IPDA for 13 hours. He pounded on the door and received no response so he went in. He noted that his breathing was shallow, his skin pale and that he was sweating. He tried to rouse him with a sternal rub unsuccessfully. He looked at his pupils and found them dilated. He was alarmed and called Karen Campbell, the night shift co-ordinator.

[133] Dave Warman, who was working elsewhere in the Project, responded to a call for assistance from Mr. Williamson at 6:30 a.m. When he arrived in the cell he made the same observations as Mr. Williamson. Mr. Bighetty was sweating, breathing shallowly and unresponsive.

[134] Karen Campbell asked Mike Todd who was working elsewhere at the Project to come and check Mr. Bighetty. He took Jeff Daquigan, a Criti-Care paramedic student, with him. They moved Mr. Bighetty on his side and Mr. Daquigan checked vital signs. He was unable to determine a blood pressure, but there was a pulse and Mr. Bighetty was breathing. He was unresponsive. His pupils were fixed and dilated and not responsive to light. An ambulance was called.

[135] Mr. Warman administered low flow oxygen until the ambulance arrived. Mr. Bighetty was transported to the HSC, the ambulance leaving the Project at 7:04 a.m., November 21, 2002.

MEDICAL EVIDENCE

Evidence of Surgeon, Dr. Owen Williams

[136] Once Mr. Bighetty was transported to the HSC he was immediately examined by an emergency physician. A CT scan was taken which showed chronic bilateral hematomas. Neurosurgeon Dr. Owen Williams was consulted promptly. Dr. Williams testified that when Mr. Bighetty arrived at the hospital his Glasgow Coma Scale was 3 which is the lowest possible score. It crossed his mind not to provide any treatment at all because Mr. Bighetty was so badly off. Because he was a relatively young person, Dr. Williams decided to perform an operation “to give him the opportunity to survive”.

[137] Dr. Williams operated on Mr. Bighetty that morning. He drilled through the skull and placed a hole through the inner lining of the skull (the dura) as well as through the membranes of the subdural area. The purpose of this was to allow the liquid or semi-liquid material - in this case the accumulated blood - to drain out on its own, and thus relieve the pressure on the brain. Although the blood was

successfully drained, the damage had been done and was irreversible. Mr. Bighetty remained in a coma and died November 27, 2002.

[138] Most subdural hematomas, Dr. Williams testified, resolve by themselves. Some require medical attention because they enlarge to the point very slowly where the brain itself becomes distorted and people begin to have physical findings such as weakness, paralysis, numbness, loss of speech, even dementia, trouble with walking, headaches, or even a coma. If they are fortunate to arrive in the hospital in an appropriate and timely fashion, their subdural hematomas can be drained and the patients generally do well and recover. Occasionally, people who are in very bad condition can be salvaged but in general the sooner people come to Emergency the better they are when they leave.

[139] When the condition reaches an acute stage, death can occur over a matter of minutes. First the spinal fluid is squeezed out; secondly, the brain allows its veins to collapse in the face of the expanding mass; then the arteries collapse. Once the arteries begin to collapse the blood flow to the brain is going down rapidly which drives up blood pressure. Once the brain is left without blood supply for three minutes it causes irreparable brain injury.

[140] Dr. Williams' suggestion was that anywhere between two weeks, three months and perhaps longer, Mr. Bighetty suffered a blow to his head and over a period of time he had accumulated chronic subdural fluid.

[141] He stressed that this is a very difficult condition to identify. Many patients suffering from a subdural hematoma have no recollection of any trauma or blow.

[142] He noted that you could have fairly large subdural hematomas and have completely normal pupils. It is only when you start to become comatose that the pupils begin to betray the underlying troubles and it may be too late at that point. He felt that it would be prudent to try to rouse individuals at the Project at intervals but given their states of intoxication he was cautious about stating how successful that would be.

[143] In response to a question by the Court about whether there should be a nurse at the Project having regard to subdural hematomas and also evidence that many of the people there are also diabetics or are prone to seizures, he stated that it seemed like a good idea or a reasonable idea. He questioned whether or not there was data to show that it would be effective.

[144] He agreed that alcoholics are more prone to subdural hematomas. Alcoholics tend to fall more, or get involved in situations where they can suffer head injuries.

[145] Dr. Williams stated that if Mr. Bighetty had been brought to the Emergency Department while he was walking and talking he would likely have left the hospital walking and talking.

[146] He stated that this disorder is a very difficult disorder to diagnose until it is very easy to diagnose. In the social milieu of a gentleman suffering from alcoholism or substance abuse the difficulty of diagnosis becomes even more complex.

[147] He suggested that it would not be very fair to ask people who are not very well trained to be expected to provide a high reliability for identification of this disorder, in an environment where there are many people who have many other problems, from diabetes to drug intoxication and alcoholism.

[148] He agreed that a trained medical person working in this environment would be more attuned to the possibility of head injuries but whether this would have a measurable result on outcomes was questionable.

Evidence of Dr. Thambirajah Balachandra, Chief Medical Examiner

[149] Dr. Thambirajah Balachandra, the Chief Medical Examiner, helped interpret the autopsy report prepared by medical examiner Dr. G. Welch, and endorsed by pathologist Dr. Charles Littman. He also testified from his own clinical experience with patients.

[150] He noted the cause of death was bilateral subdural hematoma. He explained that beneath the bone in the head area there is a tough membrane called the “dura” firmly attached to the inside of the skull. Beneath the dura is the arachnoid, then the pia matter, and then the brain itself. He explained that there is therefore a potential space between the dura and the arachnoid membrane through which the veins run from the brain to the dura. He explained that the brain gets blood from arteries which drain into a vein. Inside the brain are veins called sinuses, spaces in which the blood from the brain drains and eventually comes down to the neck and into the heart. There are bridging veins that run from the brain to the sinuses. If these veins rupture they bleed into the subdural space. Since the pressure from the veins is low the bleed often takes place slowly over a long period of time. With slow bleeds it takes a long time for a person to develop symptoms because it keeps bleeding and bleeding but the bleed is initially accommodated in the potential

space. Once it takes up too much room it places pressure on the brain causing symptoms and ultimately brain damage.

[151] The subdural hematoma thus pushes the brain. The pressure causes a severe continuing headache and other localized symptoms to the body. Sometimes the blood presses on nerves which can then affect the sight of the pupil. Pressure can also cause blood supply to certain parts of the brain to be cut off resulting in death of brain cells. Ultimately, when the pressure is increased it can push the brain to such an extent that it will start bleeding inside the brain itself. In the case of Mr. Bighetty, the cause of the death was bilateral subdural hematoma, which means that on both sides of the brain there were collections of blood. Subdural hematomas are sometimes caused by severe head injuries from such causes as traffic accidents.

[152] Apart from that, chronic subdural hematomas are most often seen in older people and alcoholics. He explained that in alcoholics the brain may be a bit smaller because of the chronic alcohol abuse. There is more room for blood to accumulate without initially showing symptoms. Also, because of the effects of alcohol, alcoholics are prone to injuring themselves by falling, stumbling and banging into things, resulting in head injuries. Some alcoholics are vulnerable to assaults or other abuse. Less severe head injuries can cause the rupture of the bridging veins leading to a subdural hematoma. Occasionally, small subdural hematomas may heal themselves. Many of them will bleed to such an extent that they form a large collection. A large hematoma is often enclosed by a membrane as the body tries to absorb the blood. All of a sudden acute bleeding can begin, perhaps caused by a minor blow.

[153] The hematoma then swells and can cause acute symptoms such as one-sided paralysis, capillary changes, signs of increased inter-cranial pressure and then unconsciousness. To confirm a suspected diagnosis of subdural hematoma, a CT scan is performed.

[154] If this condition is untreated, patients will die. If patients attend in time to the hospital and a subdural hematoma is suspected, even in places where there are no CT scans, operations can be conducted to drain the excess blood and relieve the pressure on the brain. Once the pressure is relieved the patient will generally show a dramatic improvement, as long as the pressure is relieved before it has caused secondary damage to the brain.

[155] In the case of Mr. Bighetty, the CT scan showed chronic subdural hematomas on both sides. In addition the autopsy showed that there was a

subacute trauma or hematoma that started the bleed and caused the secondary changes. By the time he attended to the hospital there was clearly severe damage. The brain had been pushed out of place. In addition, some of the pressure impinged on arteries cutting off the blood supply and causing an infarct.

[156] Dr. Balachandra expressed the view that the acute bleed on top of the chronic hematoma that was discovered in Mr. Bighetty was there likely at least two days before he was admitted to the hospital and it could have been much longer. It could have been present for weeks.

[157] Dr. Balachandra indicated that some of the physical symptoms of a subdural hematoma could be mistaken for intoxication, such as difficulty in balance. Difficulty pronouncing words can also be another sign of either alcohol use or head injury. He described other symptoms that could be observed related to changes in the pupils as well as severe headaches and an observed difference in the strength of right and left arm, right and left legs. Reflex tests indicating a disparity or change in reflex response would also suggest a subdural hematoma. A full neurological exam could detect signs of a subdural hematoma. I note that others testifying supported but also qualified this proposition. At some stages, absent a CT scan, neurological changes may not be detectable on physical examination - or very difficult to detect - even though a subdural hematoma is present.

[158] Dr. Balachandra noted that although one would ask a patient if the patient has a history of some kind of injury, in his experience older people, who are susceptible to these injuries, and alcoholics may not remember having injured themselves. The bleeding could also be caused by an injury so minor the patient would not have noted it in any case.

[159] Dr. Balachandra also noted that the toxicology report indicated that there were no alcohol or drugs found in Mr. Bighetty's system by the time he arrived at hospital. However, he explained that it is possible that Mr. Bighetty was in fact intoxicated by alcohol but any alcohol in his body had been metabolized given that he had been at the Project for 13 hours.

[160] Dr. Balachandra expressed considerable concern, however, that it is too easy to assume that someone is drunk when there is some indication of alcohol consumption, when the reality is that a person may be diabetic, they may have a psychiatric problem, or may have a subdural hematoma. He also noted that alcohol consumption itself can pose a severe medical problem. Those who have consumed a high level of alcohol can be taken into custody and the effect of the alcohol in their body may subsequently increase to a critical juncture because the person is

absorbing more. There is a risk of death from the effect of acute alcoholism while in custody, due to central nervous system failure. There is also a risk of death from intoxicated persons vomiting and aspirating.

[161] Dr. Balachandra also agreed that not every person presenting with a headache would be presumed to have a subdural hematoma. Dr. Balachandra explained that if the patient is conscious and has a headache you try to treat the headache. If it does not improve more investigations are taken. He acknowledged that a subdural hematoma can be difficult to diagnose. Dr. Balachandra also acknowledged that subdural hematoma can result in death when the injury itself took place weeks or months before the death occurred.

[162] He also indicated that if a chronic alcoholic complains of headache then an experienced doctor or anyone should consider a subdural hematoma. He reiterated that this was because chronic alcoholics are prone to such injuries and because often the brain is smaller than a usual brain, there is more potential for bleeding.

[163] He also commented on the 15 minute checks as he understood them being performed at the Project and at other centres where people are in custody. He stated that a visual check from outside may be unsatisfactory and risky.

[164] He also testified that a lay person, who conversed with Mr. Bighetty or attempted to do so every hour, could notice a difference in him over time. He would expect that a person with a subdural hematoma would be getting drowsier and would not get up and at some point he would drool.

[165] He also agreed that periodic checks of a person such as Mr. Bighetty by waking him up and seeing whether he is talking, whether he is vomiting, and assessing his condition compared to previous checks would be valuable. In his view, depending on the level of consciousness, checks should be frequent; he suggested at least every half hour in this kind of situation. In this case the Project should have done an initial assessment followed by the periodic assessments.

[166] He noted that the Project could call an ambulance and likely does if there is a major problem such as total unconsciousness, bleeding or some other severe condition. He also agreed, however, that it would not be practical to take every person with signs of drunkenness to a hospital prior to admission to the Project.

[167] His view was that there should be another level where staff can have a consultation with medical personnel where there is doubt. His suggestion was that physicians could be on call to the Project. He indicated that he had spoken to the head doctor at the Emergency Services Department at St. Boniface Hospital

approximately two years ago who had suggested that doctors would be interested in providing an on-call service for a fee. He expressed the view that the Manitoba Liquor Control Commission should contribute to the cost of the increased medical services by on-call physicians.

[168] He suggested that a doctor be called for a person unable to walk or who staggers, and whom Project staff thinks is different from his normal intoxicated state or he is quite different from other people in that he is not raising one side of the arms and legs but moving the other parts, especially if checks demonstrate that he is the same or getting worse instead of improving. Those would be the circumstances in which he advocates calling a doctor. In response, some other witnesses suggested the problem with this could be response time – those symptoms could or would dictate calling an ambulance, rather than waiting for a doctor to attend.

[169] Dr. Balachandra commented on the policy of the Project which was if the staff detect something other than alcohol an ambulance is called. He expressed the concern that if doubts are expressed about a person and the ambulance is called, and this happens very frequently, there will be a call from the head of Ambulance Services and also from the hospital nursing supervisor and complaints from the emergency wards. These concerns would be understandable because the emergency departments also have problems dealing with too many people.

[170] Dr. Balachandra was also asked to comment on the new draft policy documents prepared by the Project dealing with head injuries. Dr. Balachandra expressed the view that had the policy been in place and adhered to Mr. Bighetty would likely have been sent to a hospital earlier. Dr. Balachandra, however, expressed concerns about whether the staff had sufficient training to implement the protocol and assess the warning signs. The signs include “moderate confusion, loss of consciousness, blurred vision, vomiting, severe headache, slurred speech, difficulty breathing, unable to move arms and legs equally on both sides, difficulty walking, pale skin colour, sweating, weakness, dizziness, seizures, short-term memory loss, irritability, difference in eye pupils.”

[171] In terms of the policy, Dr. Balachandra indicated that as he read it he could understand every word of it and appreciate why it is being suggested but, as he indicated, it took him thirty years to do this. Dr. Balachandra emphasized that the protocol was indeed very good provided that it could be implemented and the staff are comfortable following these instructions.

[172] However, he expressed very strong doubts that lay persons could be trained to perform these duties. A nurse who has done plenty of clinical work and is experienced would be able to implement this protocol. Dr. Balachandra indicated that it would cost about $70-$75,000 for an experienced, full-time nurse.

[173] He noted that there are a number of nurse practitioners working in the north in nursing stations with similar skills. He agreed that another option would be to have someone who has training as a paramedic at the Project. When asked if it would be the best option to have a nurse practitioner on staff, he stated “yes” it would be very much better than not having any medical personnel there.

[174] He felt it may be a cheaper alternative to have the on-call doctor system rather than staffing for three shifts of nurses or paramedics. He remained convinced that in cases of doubt it would be helpful to have an on-call system. He thought the costs of a doctor on-call would be $100.00 per call and an on-call nurse, $75.00 per call.

[175] Dr. Balachandra expressed the view that had Mr. Bighetty been taken to the HSC instead of the Project there was a great likelihood he would have survived. His opinion was that medical personnel at the HSC would have diagnosed his condition and operated at an earlier time. The recovery is quite good from these incidents when they are caught even at the stage of initial unconsciousness, according to Dr. Balachandra. Dr. Balachandra also agreed that it was impossible to tell whether the symptoms observed of staggering or slurred speech could have been caused by the subdural hematoma rather than alcohol consumption.

[176] Dr. Balachandra agreed that not everyone coming in to the Project with slurred speech, difficulty with words and difficulty walking ought to be sent to the HSC to be checked out for a bleed in the brain. He emphasized that if a person is admitted to the Project and comes in at, say, 5:00 p.m. and subsequently, such as by 10:00 p.m., the slurring is getting worse rather than better, that is an indicator of a problem. Conversely, if after a number of hours the person is better and pronouncing words better than when he arrived, you know the person is on the road to recovery.

[177] Dr. Balachandra expressed concern and compassion for the people held under IPDA, noting that alcoholism is a sickness, and alcohol can constitute a poison. He was concerned about the fact that there had been other deaths at the Project in recent years and felt some action should be taken to provide needed medical expertise to the Project.

Evidence of Dr. Marc Del Bigio, Neuropathologist

[178] Dr. Del Bigio, a neuropathologist, was asked to perform an autopsy on Mr. Bighetty's brain. He provided the Court with a detailed explanation of the structure of the brain and the nature of the injuries to the deceased's brain that were observed in the course of his examination. He described in more detail some of the findings referred to by Dr. Balachandra in reviewing the autopsy report.

[179] Mr. Bighetty had chronic subdural hematomas, older ones on both sides, and, in addition, newer bleeds which could be characterized as a recent type of damage. He found extensive damage to Mr. Bighetty's brain. He found damage associated with coma, bleeding in the tissue in the middle of the brain, movement of the brain stem as a result of the swelling and bleeding. He found that the damage was such that there were distortions of blood vessels that supply the brain stem. That type of damage is typically associated with a fatal outcome and it is a complication of the original hematomas.

[180] In his conclusions, he found that there was some trauma to the brain subacute which he estimated approximately six to seven days prior to death by history. It must be remembered that Mr. Bighetty was in hospital for approximately six days. During his testimony, Dr. Del Bigio could not say whether the bleeding started two hours after he got into the Project or five hours before. On further examination he agreed that it could have taken place days or weeks before. It was his impression that it was probably fairly gradual bleeding. As a result of his examination, however, he felt fairly confident that it was unlikely that Mr. Bighetty had suffered a particularly hard blow to the brain.

[181] He stressed that Mr. Bighetty had no outward evidence of having fallen, hit his head or being beaten. Yet it would not take much for the pre-existing hematomas to start bleeding again. He reiterated that it was his belief that the bleeding probably occurred very slowly. He stated it would take several hours at a minimum.

[182] He also stated that the pressure inside his head would not increase very quickly initially. However, Mr. Bighetty could have reached a critical point when the pressure started to climb very quickly.

[183] He stated a person who is not intoxicated might complain of a headache before becoming drowsy or weak on one side. He testified that even people with large subdural hematomas often do not die from those conditions.

[184] He said it would be difficult to know which ones are going downhill rather than uphill. A person can be awake without any obvious neurological problems, following which they start complaining of a headache and can go into a coma very quickly. He stated it was conceivable that within one hour a person could go from headache only to coma if there was a rapidly growing blood clot. It should be noted, however, that his evidence was that in this case it was likely a slower bleed.

[185] On further examination, Dr. Del Bigio acknowledged that the bleed could have been ongoing on November 18th when he was seen by Dr. Nguyen and was complaining of a headache. However, Dr. Del Bigio felt the likelihood was that he probably would not have had the bleed on November 18th based on the size of it. The older hematomas that had healed could have been present for months or years; even 10 years would not be out of the question. Dr. Del Bigio stated that the injury could have occurred at the Project or prior to that – even days or weeks would be possible with a very gradual accumulation. A single blow could start the bleeding on both sides because the bleeding was as a result of the membranes with delicate blood vessels having formed from the chronic hematoma.

[186] Dr. Del Bigio agreed that a blow on his head from falling on a coffee table could have been the one that caused this problem. Mr. Bighetty's mother indicated this had happened to Mr. Bighetty some time before his death.

[187] Dr. Del Bigio said it would certainly be impossible to admit every intoxicated person to the hospital to be medically checked out prior to admission to the Project.

[188] Dr. Del Bigio agreed with a suggestion that it would be useful to have a nurse on staff at the Project. He noted that many of the northern communities do not have physicians and hospitals but they have nurse practitioners who are well trained to screen patients and decide whether they need to be flown somewhere. He suggested that someone with that sort of degree of training and confidence would be the appropriate type to have on staff at the Project.

Evidence of Dr. Khai Nguyen – Family Physician to Mr. Bighetty

[189] Dr. Khai Nguyen testified that he treated Herman Bighetty as a family physician beginning in 1992. He described Mr. Bighetty as a very pleasant man when not intoxicated.

[190] On that first occasion Mr. Bighetty came in intoxicated with a big cut on the back of his head. He followed this injury with a return visit. During the following 10 years, Mr. Bighetty came in to see Dr. Nguyen with a history of drinking and

using street drugs, including marijuana and cocaine, and sniffing of solvents. He would also come in with withdrawal symptoms from time to time and was treated with Librium. Dr. Nguyen attempted to counsel him concerning his alcohol and substance abuse problems. He referred him to treatment centres such as the Addictions Foundation of Manitoba. He described the type of counseling that he would often give to Mr. Bighetty and other similar patients. He recalls spending time with Mr. Bighetty talking about his substance abuse problems more than a couple of times.

[191] Dr. Nguyen saw Mr. Bighetty frequently for alcohol-related problems such as cuts, bruises and injuries to the body or head. During the course of his treatment Mr. Bighetty reported falls at least 10 times during the 10-year period. At least 19 times in the 10 years, he reported assaults to Dr. Nguyen. He also came to Dr. Nguyen about 12 times complaining about a headache. At one point in 1993, due to continued problems with headaches and vomiting, Dr. Nguyen ordered a CT scan. At that time he suspected a subdural hematoma. Unfortunately by the time the appointment was secured they had lost contact with him.

[192] At some point during Dr. Nguyen's treatment of Mr. Bighetty, the doctor received a letter from the Patient Utilization Review Committee alerting him to the fact that his patient was seeing numerous doctors and obtaining prescriptions. Dr. Nguyen, in response to an inquiry from that committee provided the diagnosis of alcoholism/sniffer.

[193] He frequently gave Mr. Bighetty full neurological exams which he described in detail.

[194] The last time he treated Mr. Bighetty was in November of 2002, the month of Mr. Bighetty's death. On November 1st he came to Dr. Nguyen with a cut on his head which he reported as due to a fight he had the night before. The cut was very small. He performed a neurological exam and it was normal.

[195] On November 4th he came in and was provided with Actifed, a decongestant. On November 8th he authorized the pharmacy to dispense Gravol for vomiting. He did not see or examine him on that visit.

[196] On November 12th he came in complaining of an itchy head and obtained some medicated shampoo. On November 14th he came in with an unrelated personal complaint.

[197] The last time Dr. Nguyen saw him was on November 18, 2002, two days before his last admission under IPDA to the Project. Mr. Bighetty was

complaining of a headache. He complained that the headache had lasted three days. Dr. Nguyen performed a neurological exam which was normal. He noted that his patient did not seem to be drowsy or disoriented. He gave him an analgesic, Motrin. He suspected a viral illness. He also testified that based on the normal neurological exam, he did not see a necessity to order the CT scan on that visit. That was the last time he saw him.

[198] On November 18th, because Mr. Bighetty did not report any trauma to the head and the neurological exam was normal, he assumed that the headache was due to some kind of viral illness and there was no need for him to come back. On November 18th, Dr. Nguyen did not give him his standard instruction or caution regarding head injury because he indicated that there was no reason for him to suspect one.

[199] In hindsight, it seems at least possible that this headache was a symptom of the subdural hematoma that ultimately caused Mr. Bighetty's death.

[200] Dr. Nguyen was asked for his suggestions to avoid repetition of Mr. Bighetty's death. He suggested that if the staff at the Project were professional people they should perform a neurological exam. If there is a suspected problem, assessment of the level of consciousness is important. A person with a headache needs to be woken up every one or two hours. If he cannot be roused then the person should be sent to the hospital.

[201] He said that that exam should be repeated every one or two hours to see if there was any change in their level of consciousness. He stressed the need to repeat this type of exam. He stated that in some cases, although you may not be able to pick up anything at a particular point, two hours later a symptom might surface.

[202] If the staff members have no medical training and no medical understanding, they could still be required to wake a client up and gauge his responsiveness. He described the stage between a coma and normal consciousness in that a person may be in a stupor. Normally you can use some sharp object to rouse the person and they can then respond to you.

[203] He stated that after a head injury the time from 18 hours following to 72 hours is a critical time. Normally, symptoms would begin to show within that time frame but sometimes they can be delayed for as long as a week or two.

[204] He emphasized that it is often very difficult if a person comes in with a head injury and is drowsy but at the same time he has signs of intoxication. Dr. Nguyen

also agreed that it is very difficult to do a neurological exam on a very intoxicated person. He agreed that it is difficult even for an experienced professional to determine whether a symptom is the result of a bleed in the brain or the symptoms of intoxication.

[205] Dr. Nguyen said, however, if there is a very intoxicated person where you cannot obtain any information but suspect a head injury, it would be his practice to send him to the hospital for a CT scan. Although a full neurological exam would be difficult, he stated that a pupil examination could be done on an intoxicated person.

[206] He agreed that those with a head injury are less likely to move around in their sleep than those who are simply intoxicated. If someone is sleeping, they should be woken up if there is a suspected head injury every one to two hours. If the person does not respond, you go further to do the test with the pupils to see if they are equal and reactive to light. Dr. Nguyen commented on the new policy of the Project regarding head injuries and stated that he thought it was very good.

[207] Dr. Nguyen also recommended that prevention is the best medicine and that more time, energy and money should be put into prevention of the problems solvent abuse and alcoholism and also the provision of treatment for these addictions. I note other evidence indicated that there is no treatment facility focused on solvent abuse in the Province.

[208] I found Dr. Nguyen to be an extremely caring physician with considerable experience and expertise.

[209] My only suggestion would be that when dealing with an alcoholic with a severe headache, a head injury should always be considered as a possible cause, even in the face of a normal neurological exam, and appropriate instruction or caution provided to the patient about follow-up.

Evidence of Chris Ainley, Medical Director, Winnipeg Remand Centre

[210] Chris Ainley, a trained nurse who is the medical director of the Winnipeg Remand Centre (“the Centre”), testified that every admission to that facility must either be seen by a nurse or medically cleared at a hospital. The Centre is the facility where adults charged with an offence are detained.

[211] There is normally nursing staff on duty seven days a week, 24 hours a day. In the rare event there is no nursing staff, for whatever reason, such as the nurse called in sick and could not be replaced – protocol dictates that any intoxicated

person (as well as any injured person) must be taken to a hospital for medical clearance before they are admitted. This creates problems for police and for medical emergency rooms but is deemed necessary.

[212] If a nurse is on duty, and a person is too intoxicated to go through the regular admissions process, they are housed in a different part of the facility until they are sober enough to go through the more detailed admissions process. The nurse will still see the intoxicated inmate and go through a standard set of questions. These include: Do you have injuries? Are you suicidal? Have you ingested substances other than alcohol? What is your seizure history? Do you have diabetes? What medication are you on? When did you last eat?

[213] In the event there is no nurse on duty, and the inmate has been medically cleared, the correctional officer on duty will still go through similar questions on a medical checklist (a copy is attached as Appendix V). The purpose is to give the officer (or nurse) a sense of what other medical issues the person may have other than being intoxicated. There was concern that the Centre was not getting adequate information from the emergency physician on clearance, and in some cases, such as when an inmate is refused and when the police returned with the inmate within a very short time, that the inmate may not have been thoroughly evaluated.

[214] If there are enough positive answers in terms of medication, injury and history of seizures, in the absence of a nurse on duty, the shift operator's manager has discretion to refuse admittance so that the police will have to take the person to another hospital. When in doubt, the protocol states refuse admission.

[215] When the nurse is on duty, similar questions are asked and the rule in that case as well is to send the person out if in any doubt.

[216] In the Centre, a nurse sees every person that comes in, but intoxicated patients are seen before the police leave in case the Centre will not accept them for any reason. In addition to the questions that are asked, the Centre relies on past knowledge due to the number of repeat inmates. The old file is pulled immediately.

[217] If an admission claims that they have a head injury, the nurse would assess their level of consciousness, determine visual acuity, response of the eyes appropriately and evenly to light, assess gait, ask if they are nauseated or have a headache, and check grip strength for weaknesses on one side.

[218] Intoxicated inmates at the Centre are observed twice an hour (as indeed are all inmates). Those who may be suicidal are under camera observation and directly viewed every fifteen minutes.

[219] At the Centre there is a medical unit. Sometimes intoxicated persons with medical issues or seizure histories are taken to the five bed medical unit for closer observation and monitoring.

[220] Mr. Ainley estimated that in a year approximately 500 admissions are intoxicated and taken to the basement area of the Centre after being seen by a nurse. About 35 or 40 of these might be sent to the hospital for clearance after having been seen by the nurse. The nurse assesses for levels of consciousness; if someone is unable to answer questions or if they have to be aided in a great way to get to the counter, generally the Centre will not accept them.

[221] Mr. Ainley testified that head injury and intoxication symptoms mimic each other to a great degree, so it very difficult to know when you need to have follow-up. His only suggestion was if you suspect a head injury, a person should be woken up more regularly. He doubted having the presence of a nurse at the Project would make any difference in the outcome for someone like Mr. Bighetty.

[222] Prior to 1983, the Centre took persons detained under IPDA. He stated it was a nerve racking thing "as you took people in without knowing their histories." There was a lot of opposition by police to sending them out (to hospitals). There were consequences in that people died while under detention.

[223] Mr. Ainley felt that a nurse is not needed to know that somebody is not rousable. He did agree that the CDU area of Project might well need medical supervision, due to serious complications that can arise in the withdrawal process.

[224] Mr. Ainley explained that if someone being admitted to the Centre indicated they had a headache, the nurse would further question them – did they remember any injury that might have caused that headache – how long has it been since their last drink – are they nauseated. The nurse might also do physical checks – blood pressure, eyes, check gait, grip strength and vision. Mr. Ainley was unaware that the Project did not have nearly as extensive a medical checklist as that used by Centre staff for admission of an intoxicated person. He agreed it would be prudent to go through a checklist.

[225] Concerning follow-up questions and checks, he suggested a lay person could be trained. He stressed the value of on the job experience, past experience and knowing who is being dealt with. He agreed that if a person's symptoms are as a result of alcohol intoxication, they will lessen and if they are the result of a head injury, they may be increasing. He agreed that monitoring is needed to determine which is present, but felt the new waking policy of the Project addressed this.

[226] The medical risks in admitting someone very intoxicated are undetected injury, undetected chronic illness, undetected seizure disorders, and the possibility of deliriums tremens - a condition which can be extremely dangerous. The Centre has standing orders to give medications to forestall DTs. Obviously these cannot be provided at the Project, due to the absence of medically trained staff.

[227] He felt the Centre intake form would be a good place to start in designing an intake form for the Project. If a person has a history of seizures related to alcohol or epilepsy, they are more likely to seize if they are intoxicated. He felt that this would be an example of an instance where the Project might send a person out for medical clearance. In the Centre, if they know the patient, given that they have a standing order for and can give medication, they may not send the person out.

[228] If the Project has someone with a seizure disorder who is intoxicated, he recommends that they be sent out to be assessed medically at the hospital. At the Centre if they know that the person has a real seizure disorder, based on past experience, they will admit the person and give them medications, which a nurse can administer. The issue is complicated, however, as sometimes individuals abuse seizure disorder medications, and request them even when they do not have such a disorder. So he suggested if the Project has great experience with a person and they have never seized, perhaps they would not have to send them out. Obviously, if the Centre had a nurse, that nurse could also likely have certain standing orders that would allow dispensing of medication.

[229] Concerning insulin-dependent diabetics, he stated these people should be assessed at a hospital. Normally the Centre will also send out intoxicated insulin dependant diabetics, despite having a nursing staff.

[230] He also acknowledged that there would be difficulties in asking questions of intoxicated persons. The Project might have an even more difficult time, as the people there may be more intoxicated than those the Centre sees, who have normally been in police custody for a longer time.

[231] In the IPDA area in 2004, there were 8,328 admissions at the Project and a total of approximately 33,000 admissions to all of the components. That compares to approximately 6,000 total admissions to the Centre, about 500 of whom are determined to be intoxicated. The Centre has about 300 residents at any one time.

[232] I believe Mr. Ainley underestimates the value of his medical training and experience, perhaps because it is second nature to him. The problem with leaving lay people to administer protocols, as helpful as that can be, is that the exercise of judgment and discretion is often called for and it is unfair to expect non-medically

trained personnel to exercise the kind of judgment that medically trained professionals themselves may often find difficult.

[233] I think this inquest also points to the need for the Centre (and the Manitoba Youth Centre if one does not exist there) to implement a policy for periodic rousing of apparently intoxicated individuals to assess level of consciousness to ensure that the apparent intoxication is not masking some other health problem.

Evidence of Dr. Lindy Lee, Specialist in Emergency Medicine

[234] Dr. Lindy Lee, a medical doctor with a specialty in emergency medicine, worked at the HSC Emergency from 1980 until 2004, the last several years as the Director of HSC Emergency. She is the medical manager of the addictions unit of the HSC (formerly the chemical withdrawal unit). She has been actively pursuing community links related to addictions issues. She impressed me as a dedicated, thoughtful, caring and very skilled physician.

[235] At the HSC, the initial exams are done by the nurse, and patients are left under the supervision of a nurse, who is to check them every hour until they can be examined by the doctor. The nurse will check to see if the person can talk to the nurse and sit up in a wheelchair. If the patient looks worse than on arrival or is sweating, with laboured breathing or unresponsive, vital signs and blood sugar would be repeated and a request for the doctor to see the patient more rapidly would be made.

[236] Dr. Lee testified about the difficulties of looking for medical illness in a very intoxicated person that presents at Emergency in hospital. Besides taking vital signs and checking blood glucose, the most important thing after that is the person's overall level of consciousness. The history is often unavailable or unreliable coming from the patient. Nonetheless, she believes it essential to ask about medication, seizures, diabetes and potential overdose.

[237] Next she would do a physical examination looking for signs that might suggest trauma or overdose. The pupils would be examined as well as the head for scalp bruises. While this is occurring the overall level of consciousness is assessed: clarity of speech, facial expression, ability to stand by themselves, are they able to walk. She would then review the patient's chart. If there are any worries she would not clear a person to be taken to the Project, but would assess the patient again in one hour to be sure there are progressive signs of waking.

[238] Over time, she looks for more spontaneous movement on the bed, more spontaneous eye movement, more verbalization; when they are roused it should

require less and less of a force to rouse them. Pupils are checked again, and reaction to pain such as pinching should be equal on both sides. If the person is intoxicated, the person should be progressively waking up. In most cases, she would definitely expect improvement in the response of person intoxicated by alcohol within one to two hours.

[239] Persons who are chronic users of inhalants present particular problems because their baseline physical examination changes. They may have a chronic staggering gait and appear to be mentally challenged. If intoxication by alcohol is present in a chronic sniffer, it is sometimes difficult to tell which is caused by alcohol consumption and which is just the baseline physical damage that they have suffered. However, even with solvent abuse, Dr. Lee would expect them to wake up and become more appropriate, as time passes. She noted that it is obvious if someone has been sniffing because of the odor.

[240] Even having three or four individuals waiting for IPDA clearance can present significant difficulties for the Emergency room. If all IPDA detainees were brought to the hospital for medical clearance, this would cause a lot of difficulties for Emergency departments.

[241] In order to prevent a recurrence of Mr. Bighetty's situation, Dr. Lee stressed the need to have a protocol to check and record at set intervals signs that the person is awakening or developing the expected increased level of consciousness.

[242] A physical exam would not be needed in all cases, but for the person who is on the floor and apparently sleeping there has to be a definite attempt to try and rouse the person to see if they can talk, attempt to sit up, and whether their level of consciousness has improved or worsened. She added that it would probably take at least two people to do this safely. Occasionally people who are woken up can become suddenly very aggressive. If a person had a history of violence or was very physically large, even two would not be safe.

[243] Dr. Lee has been part of a Project addressing the large number of intoxicated persons taken to the HSC rather than IPDA. The goal was actually to see if more of them could be safely taken to the Project. Dr. Lee added, concerning patients cleared at the HSC to the Project that . . .

> "This is such a high risk group of people that physicians clearing them as well are going to miss some head injuries and some other medical conditions."

[244] She elaborated:

> "Many of them have chronic health problems, past head injuries, seizure disorders, chronic malnutrition, they may have liver disease then leads to bleeding disorders, so even a minor blow on the head can result in a higher chance of having a bleed into your brain. They're often estranged from reliable family and friends, so you don't have anyone around to look out for them or give an accurate history. And they're also seen so frequently in emergency and in other places where care is given that I'm sure that complete examinations are not always done, or they're just there so often and their problems appear so severe and so entrenched and they appear so resistant to helpful initiatives. We have some clients who have come in more than five times in a week in this state and been sent to Main Street Project."

[245] In addition, she testified a higher percentage have diabetes. Their lifestyle also results in trauma. They are often in a tremendous fog so they can't provide important information to medical professionals.

[246] Dr. Lee noted that the clients of the Project as a group are at a higher risk for undetected subdural hematomas than the general population.

[247] Clients in the 25 bed CDU unit at the Project also have a lot of chronic health problems, and they are at risk as well from the physical process of withdrawal. They may be nauseated and vomiting. They are at risk of seizures. Some have pneumonia or other illness that stopped them from drinking, and these medical conditions become apparent as they go through withdrawal. Many have skin conditions. Some have mental illness. In sum, they are a high risk population with multiple medical problems.

[248] A nurse could be a useful screening mechanism in the CDU area to determine if medical clearance is required and to indicate if it is urgent or non urgent.

[249] In the IPDA area, a person with a history of seizures needs closer observation. Most of the patients with a history of frequent seizures should be sent to the hospital for an evaluation, unless the seizures were very dated. In addition, she testified that diabetics on insulin should go to emergency for clearance.

[250] If someone is simply intoxicated they should be waking up within a matter of hours. When you wake them up, the overall level of consciousness and presence or absence of confusion are the most important aspects. She felt that pupil checks are not a tremendous screening tool unless undertaken as part of a complete exam.

[251] Even with check-ups every two hours, there will be the occasional person missed who has a fatal or bad outcome.

[252] During the 15 minute rounds Project staff should be able to see respiratory patterns, whether someone is choking, whether they are having seizures or other problems, whether they are easily rousable to verbal stimuli.

[253] A reasonable protocol should be developed to approach the clients at regular intervals for observation, and depending on what is observed, to take further steps. The benefit of a protocol would be to catch more problem cases at an earlier stage where medical help could be requested.

[254] Dr. Lee stated the most important thing is to do a baseline examination whether you use a narrative or a scale and then repeat the procedure after an interval, to note any changes.

[255] Dr. Lee's testimony was that persons who appear to be sleeping may not be sleeping. She felt a four hour waking interval, which is the new protocol at the Project, was too long and potentially unsafe. Two hour waking intervals would be more prudent as a general rule.

[256] She did, however, acknowledge that in some cases a person can deteriorate very rapidly even within a two-hour period. In Mr. Bighetty's case, however, given the number of hours he had been there, he should have been completely and easily roused long before the last check that found him unresponsive.

[257] In addition, when more than six hours has passed, she recommended a complete waking and checks to make sure the person can talk and is not confused. While she acknowledged that there is a range of intoxication to clearing that is variable from person to person, a protocol could be developed for complete rousing.

[258] Dr. Lee felt it would not be feasible at all to consider having a physician available to Project 24 hours a day, 365 days a week. However, she felt a case could be made for a nurse or paramedic.

> "I think you could make a case for having a nurse or a paramedic available both for Main Street Project in the IPDA area and in their detox [CDU] area, because they also have significant medical concerns in their detox area, and they're side by side, which sometimes makes the whole thing more feasible because you have more duties to give a person." (Volume 7, page 99)

[259] She testified that:

> "In the IPDA area, I think either [a nurse or a paramedic] would be quite adequate at screening for head injuries and other medical complications. In the detox [CDU] area where people have more longstanding health problems, I think a nurse would provide better service."

[260] In addition, of course, the inquest heard evidence that the crisis and shelter clients also frequently present with medical issues that could be addressed by a skilled nurse at the Centre.

DISCUSSION OF THE NEED FOR MEDICAL EXPERTISE AT THE PROJECT

[261] Based particularly on the evidence of the various doctors who testified, and the fact that a prior inquest has recommended medical expertise to be provided at the Project, serious consideration of this issue is warranted.

[262] All of the doctors who testified agreed that a medically trained person such as an experienced nurse may be able to more readily detect medical conditions that are serious and warrant transfer to hospital.

[263] According to former Executive Director Joan Dawkins, the cost of a level two nurse on site 24 hours a day, seven days a week would amount to $270,000.00 a year for base salary and benefits. Relief dollars, training dollars and space issues may also be required. Other testimony emphasized that a highly skilled and experienced nurse would be required at a cost of $70-$75,000 per staff year.

[264] After consideration and doing a cost benefit analysis, Ms Dawkins indicated that it was deemed that this would not be a worthwhile investment of scarce dollars. It was unclear whether this analysis was undertaken by the WHRA or the Project. At the time she testified she was employed with WHRA.

[265] As far as an on-call service suggested by Dr. Balachandra (at $100.00 per call for a doctor, $75.00 per call for a nurse), there would be issues of cost and response time and Ms Dawkins questioned whether the net result would be better than the present reliance on the 911 ambulance system.

[266] Ms Dawkins expressed her view that staff in the IPDA area work generally effectively to identity medical crises when they arise and was sceptical that "layering on" nursing staff would make a difference in preventing deaths such as those which have been the subject of inquests. Similar scepticism was expressed

concerning having an additional trained paramedic. On the other hand, further paramedic type training for staff would be helpful.

[267] Mr. Ainley had similar views, indicating anyone can be trained to awaken detainees and to assess levels of consciousness.

[268] Ms Neal felt that having a nurse on staff at the project would be extremely valuable, but with all the overwhelming health care and other needs in the inner city that it was not likely a realistic goal. She felt that it would be essential to have a nurse practitioner for at least 8-12 hours a week, not necessarily only for the IPDA area but particularly for those clients that they work with in the drop-in and shelter and in the CDU who do not access medical services as they should.

[269] Mr. Williamson testified that quite a few times subsequent to admission an ambulance is required, most often for seizures, or for those who couldn't get up or respond.

[270] Mr. Warman advised that an ambulance is called when anyone appears to be having a seizure.

[271] Ms Dowhos also testified that she has had to call for an ambulance at least ten times in the IPDA area. Usually it concerns individuals having seizures, or experiencing chest pains. Once a person had complaints of sore feet, which turned out to be frozen. There are a number of clients who are seizure prone as well as a number with problems arising from diabetes.

[272] Mike Todd also testified that he could recall at least a couple of hundred times when individuals from IPDA area had to be transported by ambulance from the Project.

[273] Project records show that from April 1, 2004 to November 17, 2004 alone, there were 5,586 admissions to the IPDA area. Of these, 42 individuals were transported by ambulance out of IPDA.

[274] Mr. Todd testified that ambulances are mainly called for the shelter and IPDA area. The most common reason ambulances are called is for seizures. The standard protocol is that an ambulance is called whenever someone has a seizure. Ambulances are called when staff is concerned about insulin/sugar levels for diabetics and on other occasions when a person is unconscious or when staff is unsure of a possible medical condition and history.

[275] He testified that “we get a lot of people that want to get out of the drunk tank so they do say they have medical conditions and try to get out via an ambulance.” With first-times, he testified it is harder to tell whether they are actually having problems or not.

[276] He stated that during his five-year tenure there have been about a dozen instances of clients in IPDA and the shelter who have gotten progressively worse while they were there and have lost consciousness and ambulances have been called.

[277] Mr. Williamson testified that “if we had a nurse on staff or something like that, you know, somebody that you could go to with all of your medical concerns that would be very helpful.” (Williamson p. 67) There are many challenges on the job, and one that is a particular concern is dealing with medical concerns, as it is not uncommon for clients to have medical concerns.

[278] Mr. Williamson elaborated on the reasons the Project could benefit with the addition of a nurse on staff. A nurse could administer medication, take blood pressure, identify if someone is in diabetic shock or having a seizure. He indicated that the Project as a whole deals with diabetics, the seizure prone, those with HIV and Hepatitis C very frequently, virtually every day. In addition, they frequently deal with people with scabies, and untreated wounds which are infected or gangrenous, as well as individuals with a host of mental health issues such as schizophrenia, depression and anxiety. Isolating the IPDA area, he estimated that diabetics would be encountered at least once a week, those prone to seizures or having seizures every couple of days, and they would deal with those with HIV and mental health issues probably once a week.

[279] Mr. Warman testified that having paramedics at the Project may be as beneficial as having a nurse or doctor. He also suggested that increasing the base requirements from first aid and CPR to Emergency Medical Responder would be a good idea. Some staff have already achieved that level, and a few have their Primary Care Paramedic (PCP) training.

[280] Ms Dowhos indicated that there is always someone with a medical condition in the building – a seizure, not taking medication, general health, people going through withdrawal in the detoxification unit, gangrene and other conditions related to foot care.

[281] Mr. Warman indicated that since the incident involving Mr. Bighetty, they have had some training on head injuries. They look for bruising around the eyes or

behind the ears, obvious signs of blood or swelling, unequal pupils or pupils that do not dilate or react to light.

[282] Ms Dowhos suggested more advanced training in identifying unseen medical conditions would be of assistance. She felt that a dedicated health professional such as a nurse or paramedic who was trained to look for specifics of problems that might go undetected by a crisis worker would be of great benefit.

[283] Mr. Mike Todd, who was a very impressive witness, was asked what he thought would help staff dealing with people who might have medical problems or might have head injuries.

> "I think the biggest problem we have at work is just that people aren't familiar with all the medical conditions and things that could happen . . . I think education would be the biggest difference . . . Because . . . we're only supposed to be working at a first aid, basic first aid level and that just touches the surface on medical conditions. So I think that's [sic] a lot of things where people are hesitant because they're not really aware of what to look for."

[284] He himself had on his own taken a primary care paramedic training course in the summer of 2004. Since then, staff members have regularly turned to him with concerns. As part of his course he spent 15 days, 24 hours on call, working at Cross Lake with Michelle Memorial Ambulance Service. For that he used his vacation time. He also spent two, 12-hour shifts in the emergency room at St. Boniface Hospital, and one, eight-hour shift at Western Surgical. The course cost $8,000, which he financed himself.

[285] For day-to-day operations for clients at the Project, he thought it would be beneficial to have a nurse or doctor on site. A lot of times clients do not like going to the hospital, either because they feel they are treated poorly there, or because they neglect themselves. In an emergency setting, he didn't think an on site doctor would make much of a difference as there is very quick response time for ambulance service.

[286] He returned to the education theme: making staff very aware of what to look for, how to deal with things properly, how to handle crisis situations properly: "I think that'll make the biggest difference out of anything." (p. 71)

[287] He also testified that having a trained paramedic on every shift would be very useful and would put a lot of other staff members at ease who do not feel comfortable with medical procedures.

[288] He concluded however by observing that:

> " . . . 90 percent of the job is learned on the job because it's that kind of environment. No two shifts are ever the same. . . . it's a very diverse workplace that we work in."

[289] In sum, he recommends a paramedic on every shift, or a nurse trained in emergency procedures. He explained that a nurse would be beneficial for non-emergency purposes as well. As the chemical withdrawal unit at the HSC is closed, the CDU unit of the Project gets busier with more clients with medical issues related to detoxification. As noted above, crisis and shelter clients are frequently in need of medical attention.

[290] A nurse could provide more in-depth medical care than a paramedic. Paramedics are trained to spot problems and keep patients alive until they arrive at hospital. Nurses have a broader range of training and can screen to spot urgent problems, provide effective monitoring and also treatment for non-urgent problems.

[291] The main difficulty lies in the fact that, to ensure the safety of those detained under IPDA, admitting staff need to perform the equivalent function of a medically trained person, yet the Project is not funded to permit such personnel to be hired. One has only to look at the new manual with its delineation of the range of serious medical problems and drugs that will be *commonly* encountered to conclude that it is not fair or reasonable to detainees or the staff to leave the Project without appropriately trained medical staff.

[292] I note that the Manitoba Youth Centre and the Winnipeg Remand Centre, the only other facilities that admit persons on a seven day a week, 24 hour a day basis have a nurse on duty at all times. In my opinion, persons of questionable consciousness should definitely be examined by a medically trained person before being confined to a cell. I note that such a policy has been explicitly adopted by some RCMP detachments. See *Roy v. B.C. (A.G.)* 2005, B.C.J. No. 293, (application for leave to appeal filed), rev'g 2002 B.C.J. No. 1587. A copy of paragraphs 63-65 from the trial judgment which sets out the policies is attached as Appendix VI.

[293] In addition, if persons of questionable consciousness are lodged in cells, medical staff should be available to monitor their progress or act as a resource to those checking on them. It is difficult to lay down a set of rules to govern all clients, because different clients call for the exercise of medical judgment. Given this, it seems that either there must be on site medical expertise or clients of questionable consciousness need to be cleared elsewhere.

[294] The alternative of requiring all apparently intoxicated persons to be medically cleared at a hospital would overwhelm emergency departments at hospitals, given that there are approximately 8,000 admissions to the Project in a given year. Such a procedure would be extremely costly in terms of police time, and would clog up emergency departments with challenging patients to the detriment of other patients.

[295] I find it ironic that government has seen fit to provide 24 hour nursing expertise at the Remand Centre so that every person charged with an offence and detained is medically screened by a nurse prior to admission, yet those who have not allegedly committed any offence at all but are detained simply for intoxication are provided with a significantly lesser standard of care. This continues despite past inquest recommendations that medically trained personnel should be available on staff or otherwise to the Project.

[296] This is even more ironic because the higher risk group of detained individuals comprises those who are intoxicated – by definition 100% of those detained at the Project. Only a relatively small percentage of overall admissions to the Remand Centre are found to be intoxicated.

[297] There is no doubt that in addition to the IPDA area, a nurse could provide invaluable service to the CDU, shelter and crisis components as well; service that cannot help but result in a better quality of life for the disadvantaged the Project serves; service that can address problems before they become more serious and costly for the health care system.

[298] There are undoubtedly substantial real costs to the health care system resulting from the failure to fund the Project sufficiently to allow a nurse on staff. Non-medically trained personnel may have to send more people to hospital than would a trained medical staff clogging overburdened emergency rooms. Conversely a medically trained person may be more attuned to pick up a warning sign and send someone to hospital sooner so that a health issue can be addressed before tragedy occurs. In areas of the Project such as the CDU, shelter and crisis, a nurse would be able to provide medical care that is urgent, non-urgent and prevention oriented which cannot help but reduce costs elsewhere in the health care system.

[299] When the State detains people who as a group present significant health risks that are magnified by apparent intoxication, I think there is a corresponding duty to take reasonable efforts to ensure they are safe. As noted above, one way to do this would be to send every IPDA detainee to the hospital for medical clearance.

Given the numbers involved, this could have a crippling effect on emergency wards at hospitals. Yet it is simply not reasonable or fair to leave the triaging and care of this large group of at-risk detained individuals solely to non-medically trained staff at the Project. I find the case for medically trained staff at the Project is compelling.

RECOMMENDATIONS

[300] Mr. Bighetty died because of subdural hematomas that were not detected until it was too late for him. The hematomas that led to his death were caused by some injury or blow to the head that likely occurred some time prior to his detention at the Project.

[301] Given the large number of individuals detained under IPDA at the Project, and the considerable risks involved, the staff there has safeguarded many thousands of people from doing harm to themselves or others while intoxicated, and are be commended for the difficult job they do.

[302] There is no way to guarantee that future deaths of a person in custody under IPDA will never occur. Nonetheless I believe there are lessons to be learned from the death of Mr. Herman Bighetty that will help to significantly reduce the risk of reoccurrence of this type of tragedy. As a society we will be measured by how the most disadvantaged and vulnerable among us are treated. These are the people who the Project serves. Therefore I make the following recommendations:

(1) At least five of the twenty cells should have video monitors for those clients at risk of self harm or who otherwise need closer supervision due to questionable consciousness or otherwise. This was previously recommended by Judge Howell, and should be a priority. Given that the administration of IPDA is assigned to the Minister of Justice, the Provincial Department of Justice should provide the one-time funding for this expenditure.

(2) All existing Project staff be provided with and required to undertake Emergency Medical Responder training within the next 18 months.

(3) New staff recruits must have Emergency Medical Responder training as a minimum qualification.

(4) A sustainable budget should be provided to the Project for ongoing staff training.

(5) The effectiveness of all of the recommendations depends on retaining and recruiting skilled and caring staff serving the public good dealing with very challenging people in a difficult and sometimes dangerous work environment. The current pay levels clearly fail to adequately reflect the skill, effort, responsibility and new training required and need to be improved through enhanced grants and per diem rates.

(6) The Project should update the admission process intake form to include a detailed protocol or medical checklist with all parts required to be filled out. The checklist used for staff at the Winnipeg Remand Centre attached as Appendix IV should be considered and adopted or amended. Every admission should be considered as someone who may suffer from a potentially serious medical condition, such as a head injury, diabetes, susceptibility to seizures, drug overdose, epilepsy or stroke. The intake form should include questions related to these risk areas.

(7) Simple indicators of level of consciousness must be included in the checklist as a baseline on intake, so that subsequent checks can determine if level of consciousness is increasing or not. The attached Appendix IV, “Assessing Prisoner Responsiveness”, can be used as a starting point and adapted as prudent.

(8) The checklist should be prepared in consultation with a physician with expertise and experience in emergency medicine, who will assess whether or when pupil checks and similar exams should be included.

(9) If the inmate is too intoxicated or violent to allow completion of the checklist, this should be noted. Such a person may need to be sent to hospital or placed in a cell at IPDA with video monitoring. An effort to obtain the missing information should be made as soon as is reasonably possible.

(10) Staff on duty for IPDA admissions should be computer literate, so as a person is admitted, file information related to health concerns is readily obtained.

(11) If possible, admissions to IPDA should be done by experienced regularly employed staff, rather than casual staff. The intake process is a very important triage process for determining whether an individual be sent to hospital or not for clearance.

(12) Any person known or suspected to have a head injury other than an obviously superficial scratch or abrasion is not to be admitted to the Project unless medically cleared by a physician. Staff should be provided with regular training to recognize indicators of possible head injuries.

(13) Any person known to be an insulin dependent diabetic should not be admitted to the Project unless medically cleared by a physician.

(14) Any person known or suspected to be subject to frequent or recent seizures may not be admitted to the Project unless medically cleared by a physician.

(15) Any person believed to be a non-insulin dependant diabetic who is detained shall have their blood glucose level checked as frequently as indicated by a protocol to be developed in conjunction with a medical doctor with appropriate expertise in the area.

(16) The supervisor on duty should always be consulted before any person unable to walk unaided is admitted. The Project should seek direction from a qualified specialist such as Dr. Lee as to under what circumstances such a person can or should be admitted and what special precautions should be taken including the frequency of attempts to rouse such an individual. These should be incorporated into the admission checklist and observation protocols.

(17) Not less than every two hours, staff should take steps to rouse all clients detained under IPDA, and apparently sleeping, to assess their level of consciousness. A simple protocol should be developed in consultation with a medical doctor, which will allow staff to assess the level of consciousness compared to intake and the previous rousing. If the level of consciousness is not showing the type of improvement expected, the client should be sent to the hospital.

(18) Given the greater staff demands and safety issues presented by the two hour rousing, funding needs to be adjusted so there are two staff members on duty in the IPDA area at all times.

(19) The WPS should remain at the Project after admitting an individual for a brief time if requested to act as backup to the Project staff who are attempting to rouse other clients previously admitted for the level of consciousness checks, in case of violence. If after a trial period this

does not prove workable, some other means of assuring staff safety during rousing should be developed. A lone staff member should never attempt to rouse a client unless the client has a history with the Project of consistent non-violence.

(20) If an individual has been detained for six hours, staff should be required to completely wake the client to make sure the person can talk and is appropriately aware of his/her situation. A simple protocol and checklist should be developed for this purpose.

(21) After the six hour check, the two hour checks should continue in the event the person is not ready or able to be discharged after six hours.

(22) The 15 minute rounds of visual inspection for obvious signs of distress should continue.

(23) The exercise of preparing the protocols and checklists referred to in paragraphs 6 to 8, 16, 17 and 20 should be appropriately funded by a grant from the WRHA and the City of Winnipeg.

(24) A highly skilled nurse practitioner, similar to those employed in northern nursing stations, comfortable with the caring philosophy of the project, should be on staff at the Project and available for admissions and consults on IPDA clients, and to provide nursing care in other areas of the Project at all times. As a start, and at a minimum, such a nurse practitioner should be available daily from 8:00 p.m. to 5:00 a.m. beginning with the next fiscal year (as of April 1, 2006). The costs should be shared by the City of Winnipeg (through increase of per diem rates or otherwise), the WRHA and the Department of Justice, unless otherwise agreed. Depending on the skill and experience of the nurse, some of those who otherwise would immediately be sent to hospital under paragraphs 12 to 16 above or otherwise may perhaps remain under close monitoring by the nurse who can assess on an ongoing basis the need to send them to hospital.

(25) For times when a nurse is not on staff at the Project, the possibility of on call systems such a requesting a nurse from the Winnipeg Remand Centre or other nearby health facility to attend for a consultation should be investigated by the Project.

(26) Downtown Biz should update their policies to deal with persons who are conscious, persons who are unconscious and persons of questionable consciousness. The materials should also be updated to caution that symptoms similar to intoxication can result from subdural hematomas from a head injury including one with no visible signs, or diabetic conditions. In addition, the materials should caution that alcohol may mask diabetes, head injury including subdural hematoma, drug overdose, epilepsy or stroke.

(27) Downtown Biz should not be authorized to detain individuals under IPDA without training to deal professionally and safely with such individuals, and only after consultation with the Project's executive director.

(28) WPS officers should have specific training on head injuries and the fact that those with substance abuse problems face an increased risk of subdural hematomas and the fact that symptoms of a subdural hematoma can be similar to that of intoxication. When this can be safely done, members should follow procedures similar to those set out in RCMP operational manual "Assessing Prisoner Responsiveness" attached as Appendix IV to this document.

(29) The College of Physicians and Surgeons, after consulting with a physician with appropriate expertise, should issue an advisory or reminder to physicians to the effect that when a chronic alcoholic or solvent abuser complains of a headache, a head injury or subdural hematoma be suspected as a possible cause regardless of the alcoholic's inability to relate that an injury has occurred, even where a neurological exam may be normal, and that the patient should be cautioned accordingly.

(30) The Medical Director of the Winnipeg Remand Centre should develop and implement a policy for periodic rousing of apparently intoxicated individuals to assess level of consciousness to ensure that the apparent intoxication is not masking some other health problem. (The same should apply to the Manitoba Youth Centre as well as the Rosaire Centre if such policies do not exist there.)

(31) That the Minister of Health for the Province should set up an in-province adult facility for the treatment of those addicted to inhalants.

Dated at the City of Winnipeg, in Manitoba, this 2nd day of August, 2005.

_____

Marva J. Smith
Provincial Judge

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **LEON HERMAN BIGHETTY**
(DOD: November 27, 2002)

EXHIBIT LIST

EXHIBIT NO.	DESCRIPTION
1	BINDER OF MATERIALS – DOCUMENTS RECEIVED BY THE CROWN

SECTION A: DOCUMENTS FROM THE OFFICE OF THE CHIEF MEDICAL EXAMINER

A1 Letter to The Honourable Chief Judge Raymond E. Wyant from A. Balachandra, Chief Medical Examiner dated May 15, 2003 re: calling an inquest into the death of Leon Herman Bighetty (2 pgs)
A2 Report of Medical Examiner (1pg)
A3 Autopsy Report Form (5 pgs)
A4 Neuropathology Consultation (2 pgs)
A5 St. Boniface General Hospital Laboratories (1pg)
A6 Letter to The Honourable Chief Judge Raymond E. Wyant from A. Balachandra, Chief Medical Examiner dated May 15, 2003 re: calling an inquest into the death of Leon Herman Bighetty (2 pgs)
A7 Report of Medical Examiner (1pg)
A8 Autopsy Report Form (5 pgs)
A9 Neuropathology Consultation (2 pgs)
A10 St. Boniface General Hospital Laboratories (1pg)

SECTION B: DOCUMENTS FROM THE WINNIPEG POLICE SERVICE

B1 Winnipeg Police Service Inter-office Memorandum to

EXHIBIT NO.	DESCRIPTION
	S/Sgt. D. Thorne Division #11 from D/Sgt. H. Schlamp #1597/11 dated March 11, 2004 re: outstanding interview with Cecil McFarlane (1 pg)
B2	Incident Report (2 pg)
B3	Narrative recorded by #2250 Castagna (3 pgs)
B4	Narrative recorded by #1597 (6 pgs)
B5	Letter to D/Sgt. Schlamp, Winnipeg Police Service from Susan Lucko, HRT, Medico-Legal Correspondent, Medical Information Department of HSC dated July 17, 2003 re: documents pertaining to Leon Bighetty (1 pg)
B6	Death Summary (1 pg)
B7	Adult Emergency Record (1 pg)
B8	Operative Report (1 pg)
B9	Transfer Summary (2 pgs)
B10	Ambulance Patient Care Report (2 pgs)
B11	FAX Transmission Cover Sheet (1 pg)
B12	Autopsy Report Form (5pgs)
B13	Neuropathology Consultation (2 pgs)
B14	St. Boniface General Hospital Laboratories (2 pgs)
B15	Narrative recorded by #2142 McDougall (2 pgs)
B16	Police Calls #239719 & #240218 (2 pgs)
B17	The Intoxicated Persons Detention Act Intake Form (I.P.D.A.) (1pg)
B18	Main Street Project Incident Reports (unsigned) (6 pgs)
B19	The MSP electronic file entries with readable text (4 pgs)
B20	Officer's Notes by #2250 Castagna (6 pgs)
B21	Statement of Troy Slater (2 pgs)
B22	Statement of Cecil McFarlane (blank form) (1 pg)
B23	Intoxicated Persons Detention Act (I.P.D.A.) (13 pgs)
SECTION C: DOCUMENTS FROM THE MAIN STREET PROJECT, INC.	
C1	The Intoxicated Persons Detention Act Intake Form (I.P.D.A.) on Leon Bighetty (1pg)
C2	Intake Notes for Herman Leon Bighetty 70/05/06 (3 pgs)
C3	The MSP electronic file entries with readable text (10 pgs)
C4	Main Street Project Incident Reports (12 pgs)
C5	Memo to Mary-Anne Robinson, Winnipeg Regional Health Authority from Joan Dawkins, Executive Director, Main Street Project dated November 26, 2002 re: Incident – Transport to Hospital – November 21, 2002 (2 pgs)

EXHIBIT NO.	DESCRIPTION
	C6 Section #6: the entire section on IPDA from the Main Street Project policy/procedure manual (28 pgs)
	C7 Main Street Project, INC. Annual Report 2003 – 2004 (28 pgs)
	C8 Main Floor Plan of Main Street Project, Inc. (1 pg)
	SECTION D: DOCUMENTS FROM THE BIZ DOWNTOWN WATCH
	D1 Downtown Watch Ambassador Information Manual (23 pgs)
2	DOCUMENT OF MAIN STREET PROJECT ADMISSIONS
3	DRAFT MANUAL FOR MAIN STREET PROJECT
4	COMPUTER PRINTOUT FROM THE MAIN STREET PROJECT
5	PHOTOGRAPHS
6	LETTER FROM MEDICAL REVIEW COMMITTEE
7	REMAND CENTRE INFORMATION
8	COPY OF VANCE HENDERSON REPORT
9	LETTER DATED JULY 30, 2004 FROM MCLENNAN ROSS, RE GEORGE SPADY CENTRE
10	DOCUMENT FROM SASKATOON POLICE SERVICE
11	TIME PUNCHES
12	MAIN STREET PROJECT – BIGHETTY
13	IPDA DAILY REPORT - NOVEMBER 20, 2002
14	MAIN STREET PROJECT DETOX INTAKE FORM

EXHIBIT NO.	DESCRIPTION
15	MAIN STREET PROJECT DETOX/DISCHARGE FORM
16	HEALTH CARE ASSESSMENT FORM
17	COPY OF POLICY FROM CRIMINAL OPERATIONS RCMP REGARDING ASSESSING RESPONSIVENESS AND MEDICAL ASSISTANCE
18	CURRICULUM VITAES OF MEDICAL WITNESSES

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **LEON HERMAN BIGHETTY**
(DOD: November 27, 2002)

WITNESS LIST

1. Dr. Thambirajah Balachandra
2. Troy Slater
3. Dale Demianiw
4. Constable Richard McDougall
5. Constable Janine Keen
6. Cecil McFarlane
7. Curtis Williamson
8. Karen Campbell
9. Bill Dunstone
10. David Warman
11. Judith Dowhos
12. Jeff Daquigan
13. Michael Todd
14. Dr. Khai Nguyen
15. Joan Dawkins
16. Lainie Neal
17. Dr. Marc Del Bigio
18. Dr. Owen Williams
19. Christopher Ainley
20. Dr. Lindy Lee

APPENDIX "I"
Table of Herman Bighetty's Admissions to the Project

	Branch	Date/time In	Date/time Out	Length of Stay	Notes/other	Physical Condition	Substances	Actions	Referred to:
1	IPDA	99/06/28	99/06/28	4 hrs, 10 mins	Apprehended Intox at admission	No observed problem	Inhalants /solvents	Counseling	Self
2	Crisis	99/09/02	99/09/02	10 mins	Social worker is requesting detox. He has spent last 2 weeks in St. Boniface hospital and is being discharged. He is a solvent abuser, currently no fixed address, some medical issues, minor cognitive deficit and coordination problems characteristic of solvent abusers.				Other (MSP worker)
3	IPDA	99/11/06 17:35	99/11/07	9 hrs, 10 mins	Client was picked up at 555 Furby.	No observed problems	Inhalants/ solvents	Personal Assist counseling	Self
4	Crisis	99/11/20 22:14	99/11/21 23:59	1 day, 2 hrs	Leon has requested trans from HSC to 555 Furby. Client has facial scabs, looks like a P.O.W. thin looking, bent	Sick	Inhalants/ solvents Med. Health issues, substance abuse	Transportation van	St. Boniface Hospital
5	Crisis	99/11/23 19:59	99/11/23 20:35	36 mins	St. Boniface Hospital phoned asking for transfer for client. They were unable to say where he is going. MSP will comply.	No observed problems		Referred to MSP Worker, Transportation van	Self
6	Crisis	00/02/06 21:07	00/02/07 00:55	3 hrs, 48 mins	Client's friend called to request transfer from 555 Furby St. to HSC. MSP will comply. HSC called for return transfer. Will pick up	Injured, other		Referred to MSP Worker	HSC Emergency Self

7	Shelter	00/03/24 14:40	00/03/25 6:30	15 hrs, 50 mins	Client is requesting detox at this time he is sober and in the shelter area	No observed problems	substance abuse		Self
8	IPDA	00/04/02 15:35	00/04/02 20:35	5 hrs	Client picked up	No observed problems	Inhalants/ solvents	Personal assist	Self
9	IPDA	00/07/07 17:35	00/07/07 22:06	4 hrs. 31 mins	Client picked up	No observed problems	Inhalants/ solvents Other addictions	Counseling	self
10	Crisis	00/12/28 12:02	00/12/28 13:40	1 hr 38 mins	HSC called inquiring about bed space in CDU. They are currently assessing client but feel he is not sick enough for CWU. They will be calling back when client is ready for pick up to come to MSP. Transport to MPS, assessed for detox. Admit to detox	Sick	substance abuse	counseling	MSP Detox
11	Detox	00/12/28 13:40	01/01/02 12:15	4 days, 23 hrs	Client says he has sniffed every day for the past 5 years and last used yesterday. Client was beaten up a week ago and cleared by HSC Emergency. Client has chosen not to take any pain killers. Client would like to be set up at St. Norbert Foundation. Client got up and became increasingly shaky with a slight headache. Vital signs taken. Transported by Van to HSC Client returned to unit. Client needs to see a physician for some analgesics for his cracked left elbow and for the bruising on his back. Client was given valium to use every 6 hours while in detox. Medication counted and secure.	sick	alcohol, cocaine, marijuana, Inhalants/ solvents Medical health issues	counseling, personal assist, personal assist, Transportation van	hsc emergency , hSC emergency , self
12	IPDA	01/01/07 20:10	01/01/08 1:04	4 hrs 54 mins	Client picked up	no observed problems	Inhalants/ solvents	counseling, personal assist	self

13	Crisis	01/01/28	01/01/28	37 mins	HSC required transfer for client to 555 Spence. Complied. Client was brought back to MSP for crash but decided to phone WPS to lay charges against his assailants. (Throwing him out a three storey building). WPS told him to report the assault in person. Van patrol will transport him to safety building to make a statement. Client driven home to 555 Spence.	no observed problems	alcohol beverage substance abuse	referred to transportation van, counseling	MSP Emergency shelter WPS district # 1 Self
14	Crisis	01/02/04	01/02/04	40 mins	HSC Emergency called requesting transfer for client to 75 Martha. Client is interested in detox. He has been expressing some suicidal thoughts but has been assessed by HSC staff and is medically cleared and not presently at high risk for suicide. Will provide transfer for client.	No observed problem	Inhalants/ solvents substance abuse, suicidal	Personal Assist counseling	MSP Detox
15	Detox	01/02/04	01/02/14	9 days, 10 hrs	Assessed vitals are ok and he is doing ok now as he was suicidal earlier today. Lost his wife and child in a fire and can't shake it. No Meds or appts	No observed problem	Alcohol beverage, Prescription drug Medical health issues Substance Abuse, suicidal	Counseling, Personal assist Trans. Van	Self void: Concare case worker St. Norbert Foundation Medical clinics
16	IPDA	01/02/16	01/02/16	4 hrs, 20 mins	Client apprehended, Portage Place	No observed problem	Inhalants/ solvents	Personal assist	Self
17	Concare	01/02/22	01/02/22	30 mins	Client called and I called St. Norbert Foundation and client is 3rd or 4th on their list now. He will keep in touch with us and them. I also counseled client to be and or get straight as he could not go there with chemicals on board		substance abuse	ongoing counseling	St. Norbert Foundation
18	Concare	01/03/14	01/03/14	1 min	Intake at Behavioural Foundation informs us that they have a bed available for client.			Personal assist	Self

19	Shelter	01/09/07	01/09/08	12 hrs, 16 mins		No observed problem			Self
20	Shelter	01/09/08	01/09/08	1 hr, 35 mins	Client last used last night is sober and eligible for detox	No observed problem	Alcohol and beverage, accommodations, substance abuse		MSP Detox
21	Detox	01/09/08	01/09/17	8 days, 13 hrs	Client complaining of multiple pain and injuries from a beating. Taken to Misericordia Urgent Care. Phoned the hospital re: the client. He is sleeping at this time, they will call us for pick up when he awakes. Client returned at 9:00, asked if he could return to emergency as he forgot to ask for meds. Gave client ride to HSC Emergency at 11:05.	Injured, sick	Inhalants/ solvents, Alcohol beverage, alcohol non beverage, cocaine/ crack, Marijuana Medical health issues substance abuse	Counseling, personal assist, Trans. Van	Pritchard House, Aboriginal Centre, Misericordia HSC Emergency, self
22	Shelter	01/10/23	01/10/23	4 hrs, 10 mins	Client requesting detox. Will come back after having supper at UGM. Client returned sober from UGM	no observed problem	Inhalants/ solvents		
23	Detox	01/10/23	01/10/25	2 days, 0 hrs	Client admitted	No observed problem	Inhalants/ solvents, alcohol non beverage, alcohol beverage, cocaine/ crack, Talwin & Ritalin Substance abuse	counseling Personal assist	Self

24	IPDA	02/01/07	02/01/08	6 hrs, 26 mins	Client picked up at 555 Furby	no observed problem	alcohol beverage	Counseling Personal assist	Self
25	Shelter	02/07/06	02/07/07	7 hrs, 20 mins	Client is requesting CDU. Didn't have time to do proper assess	sick			Self
26	Shelter	02/07/13	02/07/13	2 hrs, 30 mins	Client crashed in shelter area, intox, last drink a couple of hours ago. Explained that client needs to have a plan, has stated he would like to go into ATP, perhaps St. Norbert Foundation, has agreed to crash until he is sober enough to be admitted, no meds or upcoming Appts.	no observed problem		personal assist	MSP Detox self
27	Shelter	02/07/20	02/07/21	8 hrs, 12 mins	Client requesting detox. Client last used last evening. Client stated he wanted to get into a long term program.	no observed problem		MSP Detox	Self
28	IPDA	02/08/21	02/08/22	17 hrs, 17 mins	Medically cleared from HSC Emergency.	no observed problem	alcohol beverage	counseling personal assist	Self
29	Shelter	02/08/22	02/08/22	4 hrs, 31 mins		no observed problem			Self
30	Crisis	02/08/22	02/08/22	7 mins	Client came to shelter, looking quite beat up. Didn't know what happened. Transported to HSC		medical health issues	personal assist	HSC Emergency

31	IPDA	02/11/20	02/11/21	13 hrs, 29 mins	Client picked up at Carlton and Portage for being passed out on sidewalk. Curtis went to wake client up for discharge. Client unresponsive to workers attempts to wake him up. Curtis then called KarenC and DaveW. Client assessed and ambulance called for client as he is irregular. MikeT was summoned to IPDA also and gave the client oxygen. Ambulance takes client to hospital. As a side note, client was checked by myself (MikeT). At approximately 5:15 toilet was flushed 3 times and client was tapped on foot a couple of times by myself and client responded by a mild groan. It was assumed client was waking up so was given time to wake up on his own.	no observed problem	alcohol beverage substance abuse	Personal assist	Ambulance service

APPENDIX "II"

MAIN STREET PROJECT INC.

STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
FOR THE YEAR ENDED MARCH 31, 2004

	Crisis and Detoxification Centre $	I.P.D.A. $	Mainstay (Residential Component) $	Mainstay (Client Services) $	Transition Team $	Other Projects $	2004 $	2003 $
Revenues								
Grants					92,365	19,584	111,949	213,772
Federal Government							1,355,612	1,277,536
WRHA	1,355,612						101,950	151,950
United Way of Winnipeg				101,950			112,259	106,518
City of Winnipeg				112,259				
Community Development					6,600		6,600	
Per diem payments							291,410	267,155
City of Winnipeg Police		291,410					128,328	132,760
Province of Manitoba			71,530	56,798			22,078	45,328
Other			14,187	7,891			3,817	42,929
Donations						3,817	5,584	6,042
Interest	5,584						5,048	23,804
Other						5,048	12,000	
Transfer from MHA				12,000			68,150	68,150
Manitoba Housing Subsidy			68,150					
	1,361,196	291,410	153,867	290,898	98,965	28,449	2,224,785	2,335,944
Expenses								
Wages and benefits	1,058,252	173,804	12,000	263,733	187,330		1,695,119	1,627,075
Purchased materials and services	230,567	57,563	111,905	77,212	22,518		499,765	551,182
Amortization of capital assets			10,270				10,270	9,711
Mortgage interest			57,817				57,817	58,380
Renovations						23,183	23,183	
	1,288,819	231,367	191,992	340,945	209,848	23,183	2,286,154	2,246,348
Excess (deficiency) of revenues over expenses	72,377	60,043	(38,125)	(50,047)	(110,883)	5,266	(61,369)	89,596
Loss on sale of 105 Galt				(22,353)			(22,353)	
Fund balances, beginning of year	131,655	118,511	43,125	17,120		112,716	423,127	324,338
Excess remitted to M.H.A.								
Organizational Review							22,291	9,193
Allowable surplus from prior year	22,291						0	
Interfund transfers	(5,857)	(110,883)			110,883	5,857		
Fund balances, end of year	220,466	67,671	5,000	(55,280)	-	123,839	361,696	423,127

The accompanying notes are an integral part of this statement

APPENDIX "III"

C1

I.P.D.A. INTAKE

NAME: Biggety, Herman D.O.B. 70/05/06

APPREHENDED AT: Carlton + Portage CELL #/BAG #: 1

NARRATIVE: Passed out on sidewalk

06:30 Heard to wake up. C/N and he would not respond. Told Karen she came to IPDA. 06:32. Karen called ambulance. 06:33, Mike + Dave administer oxygen. 07:04 c/n taken in ambulance

I.P.D.A. CHECKED FOR SIGNS OF PHYSICAL INJURIES: Yes ✓

Condition (Appearance): NOP

I.P.D.A. HAS MEDICAL BRACELET/NECKLACE: No ✓ Yes ____ Details: ____

Any Known Physical Ailments: No ~~✓~~ Yes ✓ Diabetes cm

I.P.D.A. on medication: Yes ____ No ✓ List ____

SUBSTANCE(S) USED: Alcohol

WAS I.P.D.A. OFFERED PHONE CALL: Yes ____ No ✓

WAS PHONE CALL RECORDED IN LOG BOOK: Yes ____ No ____

If No, Reason: Incoherent ____ Uncooperative ____ Client Refused ____

Number ____ Name ____ Result ____

Number ____ Name ____ Result ____

Number ____ Name ____ Result ____

WAS I.P.D.A. DISRUPTIVE: Instigator ____ Victim ____ Both ____

Weapon Yes ____ No ____

Target: ____

Type: ____

Comments: ____

ACTIONS TAKEN: P/A, Referred to

WAS I.P.D.A. COUNSELED PRIOR TO RELEASE: Yes ____ No ✓

Comments: Taken by ambulance

DISCHARGE REASON: Taken by ambulance REFERRED TO: Ambulance service, 06:4

MAIN STREET PROJECT I.P.D.A. RECEIPT Receipt No. № 75906

Police District No. 1 Car No. E104 Incident No. 239 719 Date 02/11/20 Time 06:35

Name Biggetty Herman Admitted By Cecil

Cash $ ____ (In Bag ____ / In Safe ____) Belt ✓ Shoes ✓ Wallet/Purse ____ Matches ____

Cigarettes ____ Lighter ____ Jewelry ____ Other ____

Other Articles Of Clothing Jacket (Red)

POLICE SIGNATURE ____

Discharge Date 02/11/20 Time 07:04 Hours In Custody 13hrs, 28 min

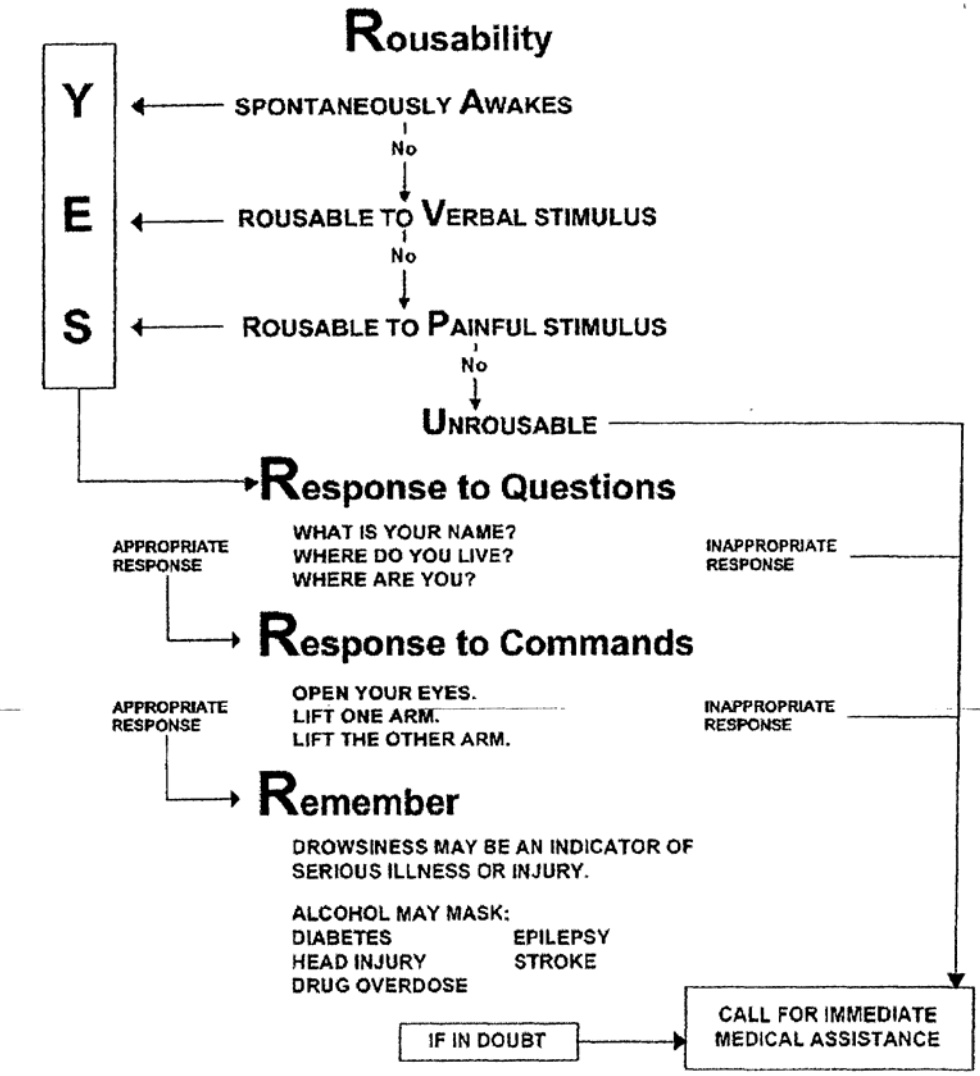
DISCHARGED BY Curtis Virgil

I HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE PROPERTY, BEING ALL THAT WAS REMOVED FROM ME ON MY ENTRANCE TO M.S.P. EXCEPT WHERE OTHERWISE STATED.

SIGNATURE ____ WITNESS ____

APPENDIX "IV"

App. 19-2-1 - Assessing Prisoner Responsiveness



APPENDIX "V"

Winnipeg Remand Centre
Medical Intake Checklist

IN THE EVENT OF A NURSING SHORTAGE ALL INTOXICATED OR INJURED ARRESTEES SHOULD HAVE BEEN SEEN AT A HOSPITAL PRIOR TO BEING BROUGHT TO THE W.R.C.

1.) Do you have seizures? _____

2.) Do you have Epilepsy? _____

3.) When was your last seizure? _____

4.) Was your seizure related to drinking alcohol? _____

5.) Have you been taking your medications? _____

- **If unable to double bunk, the inmate should be on camera.**
- **If he/she has been drinking, the inmate should be seen at the hospital.**
- **Someone who has alcohol related seizures and who has been drinking should be seen at the hospital before admission.**
- **An Epileptic who has not been taking their medications should be double bunked and placed on the *lower* bunk.**

6.) Are you Diabetic? _____

7.) Do you take Insulin? _____

8.) If yes, when did you last take Insulin? _____

9.) When did you last eat? _____

- **Diabetics who take Insulin are of particular concern if they haven't eaten – *please provide them with food.***
- **Intoxicated Diabetics who take Insulin should be seen at hospital.**
- **Diabetics who don't take Insulin may be admitted.**

10.) Do you have any injuries? _____

11.) If yes, where are they? _____

12.) Has your vision been affected by your injury? _____

13.) Have you thrown up? _____

14.) Do you have a headache? _____ How bad is it? _____

- **Head injuries are of particular concern.**
- **Any arrestee with a head injury should be seen at the hospital (use your discretion when the injury is obviously minor) before admission.**
- **Signs of a serious head injury include; vision changes, nausea & vomiting, severe or increasingly severe headache, confusion and increasingly difficult to rouse.**
- **Penetrating injuries, deep lacerations and possible broken bones should all be sent out to hospital for assessment.**

- ***If a new arrestee is admitted with a head injury, regular checks are required.***

15.) Do you have a history of heart disease? _____

16.) Are you on medications for your heart? _____

17.) If yes, have you been taking your medications regularly? _____

18.) Do you need "Nitros" or "Nitro-spray" with you? _____

- **To assess the need for immediate medical attention, use your CPR training (chest pain?, shortness of breath?, sweating?, nausea?, etc.).**
- **Inmates who carry "Nitros or Nitro-spray" with them should be allowed to do so in custody (tablets in a glass jar may be put into a brown paper envelope).**
- **A picture of Nitrolingual Spray and of nitro tablets is included with this checklist.**
- **If in doubt the tablets can be checked at a 24-hr. pharmacy.**

- **Inmates with Asthma can wait to receive any oral medication they may be on.**
- **If they are admitted with inhalers, they should be given access to them.**
- **If breathing problems occur and are not controlled by the inhaler; the inmate needs to go to the hospital.**

If in doubt, send them out.

ca/nov.00

APPENDIX "VI"
Excerpts from Roy v. B.C.(A.G.) 2005, BCJ, No. 293

¶ 63 The National RCMP Operational policy includes the following provision concerning medical treatment for prisoners and mentally disturbed persons:

> E.3.a. If there is any indication that a person in your custody is ill, suspected of acute alcohol poisoning or a drug overdose, injured or not fully conscious, even if the person denies same, ensure that he/she:
>
> 1. is examined by a qualified medical practitioner;
>
> 2. receives immediate medical treatment; and
>
> 3. is not placed in a cell unless a medical examination finds him/her fit to be incarcerated.

¶ 64 The R.C.M.P. policy for British Columbia that deals with medical treatment for prisoners and mentally disturbed persons states:

> Questionable Consciousness
>
> 1. A person who is ill, injured, unconscious or of questionable consciousness at the time of arrest shall not be placed in a cell UNLESS medically examined and found fit to be incarcerated.
>
> 2. Questionable Consciousness means:
>
> 1. a person is either conscious or questionable. If questionable, medical attention is needed immediately. Members will not attempt to determine the degree of consciousness of a person who appears to be less than fully conscious.
>
> 3. Chronic Alcoholics
>
> 1. Chronic alcoholics may suffer from Subdural Hematoma (hemorrhage of the brain or bleeding of the brain, between it and the skull). This condition is caused by a deterioration of the blood vessels due to the abuse of alcohol and can be set off by a slight blow to the head.
>
> 2. Members should familiarize themselves with symptoms related to Subdural Hematoma as early medical treatment could prevent a needless death. Symptoms are recognized in persons who:
>
> - cannot easily be aroused from sleep;
>
> - have difficulty communicating;
>
> - are drowsy; or

- have little or no reaction to parts of their body.

¶ 65 The White Rock Detachment Operational Policy includes the following with respect to prisoners and mentally disturbed persons:

> MEDICAL TREATMENT
>
> 1.a. If there is any indication that a person in the care or custody of the R.C.M.P. is sick, injured or of questionable consciousness, immediately obtain medical aid. Any medical treatment administered is to be noted on C-13. (i.e. taken to hospital/given pain killers, etc.)
>
> b. A person who is ill, injured, unconscious or of questionable consciousness at the time of arrest shall not be placed in a cell unless medically examined and found fit to be incarcerated.

APPENDIX "VII"

RECOMMENDATIONS

(1) At least five of the twenty cells should have video monitors for those clients at risk of self harm or who otherwise need closer supervision due to questionable consciousness or otherwise. This was previously recommended by Judge Howell, and should be a priority. Given that the administration of IPDA is assigned to the Minister of Justice, the Provincial Department of Justice should provide the one-time funding for this expenditure.

(2) All existing Project staff be provided with and required to undertake Emergency Medical Responder training within the next 18 months.

(3) New staff recruits must have Emergency Medical Responder training as a minimum qualification.

(4) A sustainable budget should be provided to the Project for ongoing staff training.

(5) The effectiveness of all of the recommendations depends on retaining and recruiting skilled and caring staff serving the public good dealing with very challenging people in a difficult and sometimes dangerous work environment. The current pay levels clearly fail to adequately reflect the skill, effort, responsibility and new training required and need to be improved through enhanced grants and per diem rates.

(6) The Project should update the admission process intake form to include a detailed protocol or medical checklist with all parts required to be filled out. The checklist used for staff at the Winnipeg Remand Centre attached as Appendix IV should be considered and adopted or amended. Every admission should be considered as someone who may suffer from a potentially serious medical condition, such as a head injury, diabetes, susceptibility to seizures, drug overdose, epilepsy or stroke. The intake form should include questions related to these risk areas.

(7) Simple indicators of level of consciousness must be included in the checklist as a baseline on intake, so that subsequent checks can determine if level of consciousness is increasing or not. The attached Appendix IV, "Assessing Prisoner Responsiveness", can be used as a starting point and adapted as prudent.

(8) The checklist should be prepared in consultation with a physician with expertise and experience in emergency medicine, who will assess whether or when pupil checks and similar exams should be included.

(9) If the inmate is too intoxicated or violent to allow completion of the checklist, this should be noted. Such a person may need to be sent to hospital or placed in a cell at IPDA with video monitoring. An effort to obtain the missing information should be made as soon as is reasonably possible.

(10) Staff on duty for IPDA admissions should be computer literate, so as a person is admitted, file information related to health concerns is readily obtained.

(11) If possible, admissions to IPDA should be done by experienced regularly employed staff, rather than casual staff. The intake process is a very important triage process for determining whether an individual be sent to hospital or not for clearance.

(12) Any person known or suspected to have a head injury other than an obviously superficial scratch or abrasion is not to be admitted to the Project unless medically cleared by a physician. Staff should be provided with regular training to recognize indicators of possible head injuries.

(13) Any person known to be an insulin dependent diabetic should not be admitted to the Project unless medically cleared by a physician.

(14) Any person known or suspected to be subject to frequent or recent seizures may not be admitted to the Project unless medically cleared by a physician.

(15) Any person believed to be a non-insulin dependant diabetic who is detained shall have their blood glucose level checked as frequently as indicated by a protocol to be developed in conjunction with a medical doctor with appropriate expertise in the area.

(16) The supervisor on duty should always be consulted before any person unable to walk unaided is admitted. The Project should seek direction from a qualified specialist such as Dr. Lee as to under what circumstances such a person can or should be admitted and what special precautions should be taken including the frequency of attempts to rouse such an individual. These should be incorporated into the admission checklist and observation protocols.

(17) Not less than every two hours, staff should take steps to rouse all clients detained under IPDA, and apparently sleeping, to assess their level of consciousness. A simple protocol should be developed in consultation with a

medical doctor, which will allow staff to assess the level of consciousness compared to intake and the previous rousing. If the level of consciousness is not showing the type of improvement expected, the client should be sent to the hospital.

(18) Given the greater staff demands and safety issues presented by the two hour rousing, funding needs to be adjusted so there are two staff members on duty in the IPDA area at all times.

(19) The WPS should remain at the Project after admitting an individual for a brief time if requested to act as backup to the Project staff who are attempting to rouse other clients previously admitted for the level of consciousness checks, in case of violence. If after a trial period this does not prove workable, some other means of assuring staff safety during rousing should be developed. A lone staff member should never attempt to rouse a client unless the client has a history with the Project of consistent non-violence.

(20) If an individual has been detained for six hours, staff should be required to completely wake the client to make sure the person can talk and is appropriately aware of his/her situation. A simple protocol and checklist should be developed for this purpose.

(21) After the six hour check, the two hour checks should continue in the event the person is not ready or able to be discharged after six hours.

(22) The 15 minute rounds of visual inspection for obvious signs of distress should continue.

(23) The exercise of preparing the protocols and checklists referred to in paragraphs 6 to 8, 16, 17 and 20 should be appropriately funded by a grant from the WRHA and the City of Winnipeg.

(24) A highly skilled nurse practitioner, similar to those employed in northern nursing stations, comfortable with the caring philosophy of the project, should be on staff at the Project and available for admissions and consults on IPDA clients, and to provide nursing care in other areas of the Project at all times. As a start, and at a minimum, such a nurse practitioner should be available daily from 8:00 p.m. to 5:00 a.m. beginning with the next fiscal year (as of April 1, 2006). The costs should be shared by the City of Winnipeg (through increase of per diem rates or otherwise), the WRHA and the Department of Justice, unless otherwise agreed. Depending on the skill and experience of the nurse, some of those who otherwise would immediately be sent to hospital under paragraphs 12 to 16 above or

otherwise may perhaps remain under close monitoring by the nurse who can assess on an ongoing basis the need to send them to hospital.

(25) For times when a nurse is not on staff at the Project, the possibility of on call systems such a requesting a nurse from the Winnipeg Remand Centre or other nearby health facility to attend for a consultation should be investigated by the Project.

(26) Downtown Biz should update their policies to deal with persons who are conscious, persons who are unconscious and persons of questionable consciousness. The materials should also be updated to caution that symptoms similar to intoxication can result from subdural hematomas from a head injury including one with no visible signs, or diabetic conditions. In addition, the materials should caution that alcohol may mask diabetes, head injury including subdural hematoma, drug overdose, epilepsy or stroke.

(27) Downtown Biz should not be authorized to detain individuals under IPDA without training to deal professionally and safely with such individuals, and only after consultation with the Project's executive director.

(28) WPS officers should have specific training on head injuries and the fact that those with substance abuse problems face an increased risk of subdural hematomas and the fact that symptoms of a subdural hematoma can be similar to that of intoxication. When this can be safely done, members should follow procedures similar to those set out in RCMP operational manual "Assessing Prisoner Responsiveness" attached as Appendix IV to this document.

(29) The College of Physicians and Surgeons, after consulting with a physician with appropriate expertise, should issue an advisory or reminder to physicians to the effect that when a chronic alcoholic or solvent abuser complains of a headache, a head injury or subdural hematoma be suspected as a possible cause regardless of the alcoholic's inability to relate that an injury has occurred, even where a neurological exam may be normal, and that the patient should be cautioned accordingly.

(30) The Medical Director of the Winnipeg Remand Centre should develop and implement a policy for periodic rousing of apparently intoxicated individuals to assess level of consciousness to ensure that the apparent intoxication is not masking some other health problem. (The same should apply to the Manitoba Youth Centre as well as the Rosaire Centre if such policies do not exist there.)

(31) That the Minister of Health for the Province should set up an in-province adult facility for the treatment of those addicted to inhalants.