Release Date: August 9th, 2007

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *THE FATALITY INQUIRIES ACT*

AND IN THE MATTER OF: PAUL LAURENT JOUBERT
(Deceased)
(DOD: January 31st, 2005)

Report on Inquest and Recommendations of
The Honourable Judge Ken Champagne
Issued this 3rd day of August 2007

APPEARANCES:

Counsel to the Inquest: Mr. Doug Abra, Q.C.

Counsel for Manitoba Corrections: Mr. Issie Frost and Mr. Sean Boyd

Counsel for Dr. Stanley Yaren: Mr. Tyler Kochanski

Counsel for the Winnipeg Regional Health Authority: Mr. Bill Olson, Q.C. and Mr. Sarantos Mattheos

Counsel for Brandon Regional Health Authority: Mr. David Swayze

Inquest Coordinator: Ms. Betty Owen

M A N I T O B A

The Fatality Inquiries Act

Report by Provincial Judge on Inquest

Respecting the death of: PAUL LAURENT JOUBERT

An Inquest respecting the death of Paul Laurent Joubert was held by me on February 1st, 7th, 8th and 9th, 2007 in Winnipeg, Manitoba. I report the following:

The name of the deceased is **Paul Laurent JOUBERT**.

At the time of his death Paul Laurent Joubert was 39 years old. He was charged with two counts of first degree murder in relation to the death of his parents in September, 2004. He was being held in custody at the Brandon Correctional Centre and was transferred to the PsycHealth Centre within the Health Sciences Centre, Winnipeg, Manitoba on December 21st, 2004. He had a past medical history which included mental illness. Mr. Joubert was an involuntary patient under *The Mental Health Act* and was under "close observation" watch as there was concern he might harm himself. Mr. Joubert was last seen alive at approximately 9:50 a.m. on January 31st, 2005. Approximately 10 or 15 minutes later he was found in his room suspended from the ceiling by a bed sheet. He was taken down and CPR was initiated. Despite aggressive resuscitation attempts, Mr. Joubert was pronounced dead at 10:33 a.m. A medico-legal autopsy confirmed Mr. Joubert died as a result of hanging. The manner of death was suicide.

I make the following recommendations, as set out in the attached schedule.

Attached and forming part of my report is a schedule of all exhibits required to be filed by me.

DATED at the City of Winnipeg, in the Province of Manitoba, this 3rd day of August, 2007.

"Originally signed by"

Ken Champagne
Provincial Court of Manitoba

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Introduction

[1] In September, 2004, Paul Laurent Joubert was charged with two counts of murder in relation to the death of his parents, Noel and Doreen Joubert. Drs. Noel and Doreen Joubert were both well known retired physicians in the Brandon area. After being located, arrested and returned to Manitoba, Paul Joubert was held in custody at the Brandon Correctional Centre (BCC). On September 17th, 2004 Paul Joubert appeared before The Honorable Judge Tarwid in Brandon Provincial Court. The Court made an assessment order pursuant to section 672.13 of the *Criminal Code of Canada*. The order was to determine whether the accused suffered from a mental disorder so as to exempt the accused from criminal responsibility by virtue of section 16(1) of the *Criminal Code* at the time of the act charged against the accused.

[2] Dr. Yaren was to conduct the forensic assessment at the Health Sciences Centre PX3 beginning on September 20th, 2004. Paul Joubert was transferred and admitted to PX3 on September 20th, 2004. Dr. Yaren met with Paul Joubert and it became immediately clear from Paul Joubert that he would not cooperate with the assessment process on the advice of counsel. The forensic assessment could not be completed. Dr. Yaren observed and assessed Paul Joubert for a few days to ensure his mental health was stable and that he was not at risk for self-harm. On September 24th, 2004 Paul Joubert was returned to BCC.

[3] Paul Joubert remained in custody at BCC until December 2004. Mr. Joubert sought an assessment order by an out-of-province forensic psychiatrist as he mistrusted any physician from Manitoba. On December 17th, 2004 Judge Tarwid made a second assessment order. This order was to determine fitness to stand trial and criminal responsibility. The forensic assessment was to be conducted by Dr. Graham Glancy from Ontario. During this timeframe, the nursing staff at BCC were concerned that Mr. Joubert's mental health condition was deteriorating. On December 21st, 2004, Mr. Joubert was again transferred to PX3 and seen by Dr. Yaren. Based on his own observations and the information provided, Dr. Yaren admitted Paul Joubert as an involuntary patient not competent to make treatment decisions pursuant to *The Mental Health Act*. Mr. Joubert was placed on antipsychotic medication and kept under "close observation".

[4] On January 31st, 2005 Paul Laurent Joubert died while resident at the PsycHealth Centre (PX3), Health Sciences Centre in Winnipeg, Manitoba. At approximately 10:05 a.m. Paul Joubert was located hanging by a bed sheet tied to pipes in the ceiling of his room. Resuscitation attempts were unsuccessful.

[5] The immediate cause of his death is not in issue. A medico-legal autopsy performed the same day confirmed Paul Joubert died as a result of hanging. His

death was ruled a suicide by the medical examiner. The circumstances of his death shocked and surprised staff as there was no indication of suicidal ideation or intent to self-harm.

Scope of the Inquest

[6] In accordance with Section 19(3) of *The Fatality Inquiries Act*, an Inquest is mandatory as Mr. Joubert died while resident as an involuntary patient in a psychiatric facility. A copy of the relevant section is set out below:

Inquest mandatory

> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe
>
> > (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
> >
> > (b) that a person died as a result of an act or omission of a Peace Officer in the course of duty;
>
> the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.

[7] On October 24th, 2005 an Inquest was called by the Chief Medical Examiner into the death of Paul Laurent Joubert to address the following:

1. To determine the material circumstances surrounding his death;
2. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[8] Section 33(1) of *The Fatality Inquiries Act* sets out the responsibilities of the presiding judge after the completion of an inquest:

Duties of provincial judge at inquest

> 33(1) After completion of an inquest, the presiding provincial judge shall
>
> > (a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
> >
> > (b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and
> >
> > (c) send a copy of the report to the medical examiner who examined the body of the deceased person;

> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

[9] In addressing those responsibilities, the presiding judge must also be mindful of Section 33(2)(b) of that same *Act* which states:

In camera evidence and culpability

> 33(2) In a report made under subsection (1), a provincial judge …
>
> (b) shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest.

[10] The Fatality Inquiry regarding the January 31st, 2005 death of Paul Laurent Joubert was held over four days, those being February 1st, 7th, 8th and 9th, 2007 in Winnipeg, Manitoba.

[11] Formal standing, or the ability to ask questions and make formal submissions, was granted to the following parties:

1. The Joubert Family consisting of Michelle Joubert Goldstone (sister) and Luc Joubert (uncle) who were not represented by counsel and did not ask questions or make submissions.
2. Manitoba Corrections represented by Mr. Issie Frost and Mr. Sean Boyd.
3. Dr. Stanley Yaren represented by Mr. Tyler Kochanski.
4. The Winnipeg Regional Health Authority represented by Mr. Bill Olson, Q.C. and Mr. Sarantos Mattheos.
5. The Brandon Regional Health Authority represented by Mr. David Swayze.

[12] At the end of the evidence, I invited submissions from all counsel however neither the Crown nor counsel elected to make submissions as to possible recommendations.

[13] I wish to acknowledge and thank all counsel for their contributions to these proceedings. In particular, I want to thank Mr. Doug Abra Q.C., inquiry counsel, for his hard work and organization of the evidence.

[14] I also wish to thank Ms. Betty Owen, Inquest Coordinator, for her preparation and organization of the materials and the exhibits that were filed in this hearing. Her assistance was greatly appreciated.

[15] A total of 13 witnesses were called and numerous documents were filed as exhibits. The Inquest hearings concluded on February 9th, 2007.

Witnesses called at the Inquest

WHAT FOLLOWS IS A SUMMARY OF THE TESTIMONIAL EVIDENCE CALLED AT THE INQUEST, IN ORDER OF APPEARANCE.

Dr. Mano Vipulananthan (Dr. Mano)

[16] Dr. Mano is a licensed Psychiatrist who has worked in Brandon, Manitoba for more than 15 years. Dr. Mano worked in the Brandon Mental Health Centre from August 1991 as a staff Psychiatrist in the Acute Adult Psychiatry inpatient, out patient and rehabilitation department. After the closure of the Brandon Mental Health Centre in 1998, Dr. Mano has worked at the Brandon Regional Health Centre in the Centre for Adult Psychiatry (CAP) as part of a multi-disciplinary team. Among other duties, Dr. Mano also sees out-patients at Community Mental Health (CMH) in Brandon.

[17] Dr. Mano was called to give background information and a history of Paul Joubert's involvement in the mental health system in Brandon, Manitoba. It was noted from the medical records found in exhibit 3, tab B1 that Paul Joubert attended the emergency department of the Brandon Regional Health Centre on October 10th, 1999 complaining about an ulcer caused by his father poisoning him for 30 years. He was seen by the attending doctor, examined and prescribed Losec for an upset stomach. It was specifically noted that Paul Joubert was not suicidal, not homicidal and there was no indication of self-harm. He was discharged that same day.

[18] Paul Joubert next had contact with the mental health system in Brandon on March 13th, 2000. There was an application for an involuntary assessment that was supported by a letter from Paul Joubert's parents.

[19] Drs. Doreen and Noel Joubert were concerned about Paul's behavior. He continued to accuse them of poisoning his water supply and he was threatening to kill them. They described a history of difficulty with Paul and other previous incidents when he threatened violence to a neighbor and other family members.

[20] Dr. Mano was directly responsible for the care of Paul Joubert during this involuntary admission at the CAP. The three-day admission was increased to a 21-day stay. Paul Joubert again complained of abdominal pain and that his father had

been poisoning him and his dog. A psychiatric assessment was completed by Dr. Mano diagnosing that Paul Joubert was Chronic Schizophrenia, Paranoid Type. It was noted that for the first few days Paul Joubert was uncooperative with staff but then participated in interviews and took his medication. He was prescribed Olanzapine which is an antipsychotic drug. By the end of the 21-day admission, Paul Joubert was compliant in taking his medication and no longer fixated about his father poisoning him. He was discharged on April 5th, 2000 with instructions to continue taking Olanzapine. He was also given a prescription for Ranitidine for abdominal discomfort. Dr. Mano discussed follow-up care with Paul Joubert. It was agreed that they would meet at CMH on April 27th, 2000. Paul Joubert called the day after his discharge to indicate that he did not agree with the diagnosis so he would not follow through with the meeting. This concerned Dr. Mano but there was nothing that could be done to ensure compliance unless there was another involuntary order. It was clear from the evidence of Dr. Mano that Paul Joubert was not suicidal at this time.

[21] On January 25th, 2001 there was another involuntary admission of Paul Joubert to the CAP. This admission was again initiated and supported by a letter from Paul Joubert's parents. The concern was an alleged threat by Paul Joubert to harm his brother, Rick. The letter supporting the involuntary admission was written by his mother and signed by his father. It set out the same history and provided much of the same information that was noted for the first involuntary admission on March 13th, 2000.

[22] Dr. Mano saw Paul Joubert for a three-day assessment. There were no accusations by Paul that his father was poisoning him. Paul denied threatening his brother. Paul agreed to take his medication and a discharge plan was discussed with Paul and his mother. Mrs. Joubert agreed to take Paul home after discharge and she agreed to make arrangements for Paul to see another Psychiatrist. There were no grounds to extend the three-day involuntary admission. It is clear that Paul Joubert was not suicidal at this time. He was discharged on January 29th, 2001.

Corrine Lynne Elliott MSW, RSW

[23] Ms. Elliott has a Masters in Social Work and worked at the CAP in Brandon from 1998-2006 as a Psychiatric Social Worker. She was involved in conducting psychosocial assessments and provided intervention and support to patients and their families. She was also responsible for referring patients to community-based mental health programs and building links and working with community resources and agencies.

[24] Ms. Elliott was part of the multi-disciplinary team that treated Paul Joubert during his admission to the CAP in March 2000. She produced a detailed Social Work Assessment that can be found in exhibit 3, tab B15. She also had minor involvement with Paul Joubert during his third admission to the CAP on July 19th, 2002.

[25] To prepare the social work assessment, Ms. Elliott interviewed Paul, his parents and his sister Michelle. The history provided depicts Paul Joubert as a person who developed anti-social tendencies in his teenage years. He developed a serious substance abuse problem that was eventually controlled and ended in 1998. He appeared to have a history of paranoid persecutory thinking and was suffering from mental illness. However, he was very intelligent and could manipulate his parents. His parents reported spending over $200,000 in efforts to have Paul maintain a wood cutting business and other employment so he could be independent in the community. It was clear that his parents did their best to support him to the point of enabling him and protecting him from further contact with the mental health system or the criminal justice system.

[26] Ms. Elliott had discussions with Paul's parents to ensure they understood he was mentally ill. The discussion revealed how difficult the situation was for Paul's parents. They obviously loved and supported their son but could recognize his illness and had concerns about his actions. Ms. Elliott highlighted enabling behavior for them and spoke about tough love and the possibility of withdrawing support for Paul to ensure that he was responsible for the consequences of his actions.

[27] During the March 2000 admission, Ms. Elliott saw Paul a number of times and also observed him on the ward. She described him as polite but guarded and noted that he had minimal interaction with other patients. He appeared to be a bit of a loner. Ms. Elliott was of the view that Paul continued to use emotional manipulation with his parents, by making them feel guilty for his involuntary admission. At no time, did she ever have a concern that Paul Joubert was suicidal.

[28] Paul Joubert was again admitted to the CAP on July 19th, 2002. Dr. Ian McIntyre was the treating Psychiatrist for this admission. Ms. Elliott had much less involvement during this admission as Paul was refusing any assistance from her. Ms. Elliott did see Paul on the ward during this admission and again had no concerns that he was suicidal. She did attend a meeting with Dr. McIntyre and Paul's parents where she again discussed assistance, support and psycho-education with Doreen and Noel Joubert. Ms. Elliott described that Paul's parents were struggling in knowing how to respond to Paul's behavior. It appeared that Paul's father was expressing a desire to apply "tough love" and his mother was having

difficulties with this approach. Ms. Elliott ensured that they were provided with information of legal, financial and social services resources.

Dr. Karen J. Narduzzi

[29] Dr. Narduzzi is a Clinical Psychologist, who has worked at the CAP in Brandon since August 1998. She is part of the multi-disciplinary team and provides psychological testing, interviewing and therapy to the patients at the CAP. The psychological assessments prepared by Dr. Narduzzi are used to provide information to assist the treatment team in formulating a treatment plan for patients.

[30] Dr. Narduzzi had direct involvement with Paul Joubert during his involuntary admission in March 2000. She met with Paul Joubert on March 20th and 22nd, 2000 for clinical interviews and psychological testing. She also met his parents with Ms. Elliott on March 31st, 2000. After reviewing the information she obtained from Paul Joubert, his parents, the intake assessment and the medical charts, Dr. Narduzzi authored a Psychological Assessment Report. That report is found at exhibit 3, tab B14.

[31] Dr. Narduzzi testified that Paul Joubert attempted to manipulate the psychological testing and his answers resulted in an invalid test. The testing did show that he was defensive, guarded and resistant to consider he may have psychological problems. He underreported on some questions and exaggerated himself in a positive light. He agreed to participate in the testing as he wanted to get out of the hospital. Dr. Narduzzi testified that hostility and authority problems still surfaced even though the test was invalid. Those results were consistent with the clinical presentation as Dr. Narduzzi described feeling his anger in the room even though he was very controlled and polite. It was apparent that Paul Joubert had poor insight into his own behaviour and continued to be at risk for acting out at others in response to his paranoid beliefs. Dr. Narduzzi felt it was important to support and educate his parents about his condition and encourage them to set appropriate limits with their son to minimize risk to family members. This was discussed at the meeting with his parents on March 31st, 2000. In discussing what measures they could take to manage their relationship with Paul it became clear that Doreen Joubert did not want her son treated like a criminal because of his mental illness.

[32] Dr. Narduzzi testified that there was no indication that Paul Joubert was suicidal. He was not at risk for self-harm, he was not depressed, he did not have feelings of hopelessness; rather, he was focused on the future. He wanted to do whatever was necessary to be discharged from the hospital. He did express concern about taking medication. He did not wish to take psychotropic medication as it

would interfere with his ability to use a chainsaw and work as a woodcutter because a side effect of the medication is drowsiness. This information suggested that Paul Joubert had a sense of self-preservation and suicide was not in his mind.

Dr. Ian Lochlan McIntyre

[33] Dr. McIntyre has been working as a Psychiatrist in Brandon since 1992. He maintains a private practice with admitting privileges at the hospital, he also works at the CAP and he has done contract work for BCC. Dr. McIntyre was the treating Psychiatrist for Paul Joubert during his third admission to the CAP in July 2002.

[34] Paul Joubert was again subject to an application for an involuntary assessment based on a letter and information from his parents. Noel and Doreen Joubert indicated that they were concerned about their son as he was agitated and angry with them and refused to take medication. Mrs. Joubert reported that Paul had threatened to punch her until she could not breathe anymore. Paul Joubert was admitted to the CAP on July 19th, 2002. Shortly after admission, he escaped from the ward only to return voluntarily two days later.

[35] Dr. McIntyre interviewed Paul Joubert repeatedly over the first week. Paul Joubert continued to demonstrate inflexible thoughts and the recurrent delusional ideation that his father was poisoning him.

[36] Dr. McIntyre spoke to Paul's parents and they hoped that Dr. McIntyre could reach Paul to build a relationship as he was around the same age and gender. In speaking with Paul's parents, Dr. McIntyre discussed the limitations of *The Mental Health Act* and steps that could be taken through the criminal justice system. Dr. McIntyre told the parents that there appeared to be grounds for criminal charges with a possibility for a Court Ordered Forensic Assessment. Mrs. Joubert did not want her son treated as a criminal.

[37] Dr. McIntyre did try to form a relationship with Paul. He was cooperative on neutral matters but mostly uncooperative and distant. Dr. McIntyre testified that Paul Joubert was his most difficult patient to reach. He described Paul as intelligent but uncooperative and inflexible making it extremely difficult to effect any positive change. Paul refused to take his medication. In an effort to obtain compliance from Paul, he was told that this driver's license would be suspended because of his psychiatric illness and lack of treatment. This approach by Dr. McIntyre upset Paul Joubert and he then refused to meet with Dr. McIntyre for interviews, assessment or treatment.

[38] Paul Joubert was settled by his second week at the CAP. He socialized well with other patients and had no problems sleeping or eating. Dr. McIntyre noted that Paul did not manifest any of the disorganization, poor self-care or lack of

motivation, etc. consistent with Schizophrenia and he was given a provisional diagnosis of Bipolar Mood Disorder, Rapid Cycling Type with Psychotic Features. Paul Joubert was discharged on August 8th, 2002. It was hoped that his loss of license might pressure Paul into taking medication and pursuing treatment for his mental illness. Paul Joubert indicated that he would appeal his loss of license with the Department of Motor Vehicle and Licensing. Dr. McIntyre never had a concern that Paul Joubert was suicidal during this admission at the CAP. Paul Joubert was not depressed, he appeared to eat well, he moved around the ward freely and socialized with other patients. He never expressed any suicide ideation, there was no history of attempts and no family concern, so suicide was low on the list of concerns for Paul Joubert.

[39] Dr. McIntyre also testified about his work at BCC and knowing that Paul Joubert was an inmate at BCC from September to December 2004. Dr. McIntyre was contracted to attend BCC on Wednesdays for Psychiatric consultations. The mental health nurses at BCC would make referrals and the inmate could meet with Dr. McIntyre on a voluntary basis. In December 2004 the nurses at BCC had a growing concern about Paul Joubert's mental health as he was not eating or looking after himself. Dr. McIntyre confirmed that Paul Joubert refused to see him and refused any treatment at BCC and as a result of concerns from nursing staff in December 2004 he arranged for the transfer of Paul Joubert to PX3.

Constable Jimmy Anis

[40] Constable Anis has been a member of the Winnipeg Police Service for 11 years. He has worked in the identification section for over four years. He attended PX3 at the PsycHealth Centre on January 31st, 2005 to photograph and process the scene where Paul Joubert committed suicide. He provided the Inquest with a booklet of photographs that were entered as exhibit 7. The series of photographs depict Paul Joubert's room including the open ceiling tile where Paul Joubert was able to access the pipes that run above the ceiling.

Charlotte Marie McWilliams

[41] Ms. McWilliams has worked as a Correctional Officer at BCC for over 13 years. She is a senior unit officer who supervises staff and inmates. She carries out investigations and handles complaints from inmates. She knew Paul Joubert from his stay at BCC from September to December 2004. Ms. McWilliams described how inmates are assessed upon admission to BCC. There is a suicide assessment committee that meets every week to review inmate assessments.

[42] There are three possible suicide assessments at BCC:

SUH- suicide risk high

SUM- suicide risk medium

SUL- suicide risk low

The risk assessment for Paul Joubert occurred on September 13th, 2004 upon his admission to BCC. The assessment is based on questions and answers provided. The computer then generates the assessment. In this case, Paul Joubert was assessed **SUH** by the computer. That assessment level was lowered to **SUM** the same day by BCC staff. Paul Joubert's suicide risk assessment was reviewed weekly by the Suicide Risk Committee at BCC and it remained **SUM** for his entire stay at BCC.

[43] Ms. McWilliams testified that there was nothing unusual with Paul Joubert until December 17th, 2004. On that date, staff received information from Paul Joubert's roommate, David Gray, that Paul was tearing bed sheets and threatening suicide. Ms. McWilliams investigated by searching the cell for evidence. She also had Paul Joubert moved to an observation cell. He denied any suicidal thoughts and nothing was found during the search.

[44] On December 19th, 2004 Paul Joubert resisted an order to return to his cell, so three staff members were required to ensure that he did return in a safe, orderly manner. Ms. McWilliams testified that Paul Joubert was changing near the end of his stay at BCC. He was withdrawn, not talking and resistant to movement. There was a safety concern with moving him to his cell. On December 21st, 2004 he was transported to PX3.

Jacqueline Elizabeth Aucoin

[45] Ms. Aucoin is a Registered Psychiatric Nurse and employed as the Mental Health Worker at BCC. She has been employed there since 1999 and has held the lone position of full-time Mental Health Worker at BCC since 2002. She is responsible for monitoring the mental health of inmates. She can make referrals to medical staff, provide individual counseling and she is part of the Suicide Risk Committee at BCC. Others on the Suicide Risk Committee include the Chaplin (Bernie Mullins), a Unit Manager and a Unit Staff Worker. Carolyn Bell is a Registered Psychiatric Nurse who is employed as a Medical Nurse I for BCC. Ms. Bell fills in for Ms. Aucoin as the Mental Health Worker when she is away from BCC.

[46] Ms. Aucoin was primarily responsible for Paul Joubert except when she was away on holidays and Carolyn Bell would take over the responsibility. Ms. Aucoin

was involved with Paul Joubert from September 14th, 2004 to December 1st, 2004 when she left for holidays. She would see Mr. Joubert whenever he requested and she ensured that she saw him at least twice per week and sometimes more often. She would discuss how he was feeling, sleeping and eating. He would always deny any suicidal thoughts during the risk assessment. Paul Joubert was discussed weekly at the Suicide Risk Committee meetings and his suicide assessment remained at **SUM.**

[47] There were times during his stay at BCC that Ms. Aucoin had concerns about Paul Joubert. She related an example from October 31st, 2004 when Mr. Joubert was seen crying while reading the obituary of his parents. Ms. Aucoin spoke to him and he denied any suicidal feelings. Ms. Aucoin increased the written observations for Paul Joubert at that time to ensure that he was spoken to by a staff member every two hours. He was normally spoken to every three hours as part of his **SUM** assessment.

[48] On November 8th, 2004, Ms. Aucoin spoke with Paul Joubert to monitor and continue to assess his suicide risk. He reported no thoughts of suicide or self-harm but did complain about chips he believed had been implanted in his jaw to monitor his behavior. He indicated that he wanted to go to PX3 for his psychiatric assessment to explain that this was not his fault. He told Ms. Aucoin that he did not trust the doctors in Brandon. Ms. Aucoin testified the assessment kept getting put off and Mr. Joubert became quite reclusive, refusing to speak with her. The last time she saw Paul Joubert was December 1st, 2004 when he refused to speak with her. Ms. Aucoin was aware that Mr. Joubert continued to have contact with the Chaplin and in her view the **SUM** assessment was still appropriate.

Carolyn Marguerite Bell

[49] Ms. Bell is a Registered Psychiatric Nurse who is employed at BCC as a Medical Nurse I. Her duties and responsibilities are outlined in the position description marked as exhibit 9. She is part of the medical staff which is responsible for the general health of all inmates at BCC. She completed a health care assessment for Paul Joubert when he was admitted on September 13th, 2004.

[50] She was acting as the Mental Health Worker on December 7th, 2004 when she attempted contact with Paul Joubert. He refused to see her and he refused to see the Chaplin. He was given a choice to speak to people or go to the observation cell. He did go back to speaking with the Chaplin.

[51] On December 17th, 2004 Ms. Bell had a discussion with the Chaplin about information he received from David Gray suggesting that Paul Joubert was suicidal. As a result, Paul Joubert was moved to the observation cell. Shortly after

that his behavior with staff deteriorated and Dr. McIntyre arranged for a transfer to PX3 which took place on December 21st, 2004.

Dr. Stanley Yaren

[52] Dr. Yaren is the Director of Forensic Psychiatry in Manitoba and a well-known expert in the field. Dr. Yaren had contact with Paul Joubert at PX3 on two separate occasions. The first was from September 20th, 2004 to September 24th, 2004 when Paul Joubert was admitted for a Court Ordered Forensic Assessment regarding criminal responsibility. Paul Joubert made it clear that he would not cooperate with this assessment. He was polite but firm and indicated that he was following advice of counsel. Dr. Yaren contacted Mr. Joubert's lawyer to discuss the purpose of the Forensic Assessment. He did speak to counsel, David Guttman, who confirmed that he advised Paul Joubert not to say anything and there would be no point in continuing with the assessment. Dr. Yaren observed Paul Joubert to determine if he was at risk for self-harm or deterioration of his mental health. Dr. Yaren was satisfied that Mr. Joubert could look after himself and he was not at risk for self-harm so he was discharged from PX3 and returned to BCC on September 24th, 2004. Dr. Yaren authored a detailed letter to the Brandon Provincial Court outlining why he was unable to complete the Court Ordered Assessment. That letter is found in exhibit 3, tab E6.

[53] On December 21st, 2004 Paul Joubert was again admitted to PX3 at the request of Dr. McIntyre. Dr. Yaren met with Mr. Joubert who politely indicated that he would not cooperate on the basis of his lawyer's instructions. He did say he would speak with an out-of-province Psychiatrist. Upon admission, Dr. Yaren placed Paul Joubert on a "close observation" status to monitor suicide risk.

[54] Dr. Yaren observed Paul Joubert, collected information from BCC and spoke with his sister, Michelle Joubert Goldstone. On December 23rd, 2004, after considering all of this information, Dr. Yaren was of the view that Paul Joubert met the criteria under *The Mental Health Act* for involuntary admission and involuntary treatment.

[55] Dr. Yaren informed Mr. Joubert of his involuntary admission and all of his rights under *The Mental Health Act*. Dr. Yaren then contacted Mr. Guttman and left a message to inform him that Paul Joubert had been admitted as an involuntary patient at PX3. Mr. Guttman called Dr. Yaren and angrily protested Mr. Joubert's involuntary admission. Dr. Yaren described Mr. Guttman as quite threatening and insulting and stated that Dr. Yaren would be in serious trouble if he treated Paul Joubert. Two days later, Mr. Guttman apologized for his actions. Dr. Yaren prepared a detailed file note about all of this, which is found in exhibit 3, tab D29.

[56] It is clear that this unfortunate exchange with Mr. Guttman did not impact Dr. Yaren's course of treatment for Paul Joubert. Dr. Yaren did treat Mr. Joubert by prescribing antipsychotic medication. Mr. Joubert was given the choice of taking Olanzapine orally or, if he refused, by injection. He agreed to take a similar medication orally. Dr. Yaren and the rest of the medical staff gave Paul Joubert complete care for his entire stay at PX3.

[57] Dr. Yaren was aware that there was a Court Order for a forensic assessment regarding criminal responsibility and fitness to stand trial. That assessment was to be conducted by Dr. Graham Glancy from Ontario. Dr. Yaren knows Dr. Glancy and tried to assist him with obtaining licensing and admitting privileges by contacting the College of Physicians and Surgeons and the Winnipeg Regional Health Authority. Dr. Yaren confirmed that Dr. Glancy never did make it to Manitoba to conduct the assessment.

[58] Dr. Yaren testified that Paul Joubert remained under "close observation" from December 21st, 2004 until his death on January 31st, 2005. Dr. Yaren described the different levels of observation utilized at PX3:

> **Close Observation** requires that a nurse or delegate observe the patient every 15 minutes. The 15-minute interval is varied to prevent a regular pattern of observation. The written policy is found in exhibit 3, tab F1.
>
> **Suicide Observation** is an increased level of observation that has a nurse or delegate observing the patient every 15 minutes or more often as indicated. The patient is under constant observation during high-risk activities such as bathing. The written policy is found in exhibit 3, tab F2.
>
> **Constant Observation** is an increased level of observation that has a continuous one-to-one monitoring of the patient. The written policy is found in exhibit 3, tab F3.

[59] Dr. Yaren testified that he always has a general concern about suicide for patients at PX3 as the residents there suffer from some form of mental illness, are frequently facing very serious criminal charges and can easily become very depressed. Paul Joubert did not exhibit signs of suicide. Dr. Yaren noted that he was taking care of his hygiene, grooming and nutrition. He was future orientated in his thinking and had no past history or pattern of suicide behavior. Further, Paul Joubert was acting in a self-protection mode by following his lawyer's advice and not speaking to staff at PX3 regarding an assessment.

[60] Dr. Yaren diagnosed Mr. Joubert as suffering from Paranoid Schizophrenia and he was treated with antipsychotic medication for his entire stay at PX3.

[61] Dr. Yaren testified that he was working on January 31st, 2005 and witnessed the resuscitation attempts by emergency staff. He and the rest of the medical staff at PX3 were completely surprised by Mr. Joubert's death. It was a totally unexpected event that Dr. Yaren would never have predicted based on his information and observations of Paul Joubert as there were no indicators that he was suicidal.

[62] Dr. Yaren confirmed that since this suicide the physical environment at PX3 was changed to ensure that patients are unable to access anything above the ceiling. Dr. Yaren also testified that he believes the policies for the different levels of observation are appropriate. He described a need to balance the environment of PX3 with the treatment of patients as constant observation could be detrimental to an individual's treatment plan.

Glenda Karen Burrows

[63] Ms. Burrows is a Registered Psychiatric Nurse who has been working in this area since 1978. She is employed at PX3 and was involved with Paul Joubert during his second admission. She was his primary care nurse from the time of his admission in December 2004 until his death on January 31st, 2005. She would observe Paul Joubert throughout the day as part of an ongoing assessment. She was involved in his treatment plan and would have discussions with the doctors. She tried to build a relationship with Mr. Joubert by explaining her role and engaging him in conversation. She found it difficult to connect with Paul Joubert as he would only give short answers to questions and would limit conversations to his own agenda. He was only interested in being assessed by Dr. Glancy and he was frustrated with the delay as he felt the assessment would get him released from the hospital. She noted that Mr. Joubert called his lawyer and left messages on many occasions and would be frustrated if there was not an immediate call back.

[64] Ms. Burrows confirmed that Paul Joubert was under "close observation" and she or other staff would check on him every 15 minutes. The 15-minute interval was varied to ensure patients did not observe a constant pattern of observation. She noted that PX3 is a secured and locked ward where the residents are free to move around within the ward. Paul Joubert's room was located 10 feet away from a nurse's desk. It was not unusual for him to open his door and peek out. She or another staff member would then try to engage him in conversation. Ms. Burrows confirmed that over the course of her lengthy career she has been involved with patients who were suicidal. At no time did she have a concern that Paul Joubert was suicidal.

[65] Ms. Burrows was working on January 31st, 2005. She recalls seeing Paul Joubert that morning outside his room walking in the ward. Later she was at the nursing desk and saw Mr. Joubert peek out of his door just as he had done many times before. He then closed the door and Ms. Burrows continued with her work. Approximately 15 minutes later, around 10:05 a.m., Ms. Burrows went to check on him. She opened the door to his room to find him suspended from the ceiling by a bed sheet. She immediately called a "code blue" for assistance and lifted his body by the legs. Another staff member climbed up to untie the bed sheet. He was lowered to the floor and immediate attempts at resuscitation began. Other medical staff attended to assist and within minutes the emergency care team arrived with a crash cart and aggressive resuscitation attempts were initiated. Paul Joubert was never revived and the "code blue" was called at 10:33 a.m.

Dawn Ann Bollman

[66] Ms. Bollman is a Registered Psychiatric Nurse who is employed as the manager of patient care for the PsycHealth Centre at the Health Sciences Centre in Winnipeg, Manitoba. She is responsible for overall patient care at the PsycHealth Centre including PX3. Ms. Bollman is able to monitor patient care through regular KARDEX rounds. These meetings are held every Monday and Thursday when all members of the treatment team meet to discuss each patient on the ward. It is a multi-disciplinary approach that discusses assessment, treatment and future plans for each patient. In addition to these regular meetings, Ms. Bollman is on the ward 45 to 60 minutes each day making observations and discussing patients with the doctors and nurses. Paul Joubert was discussed every Monday and Thursday that he was a resident of PX3. The nature of the discussions included his symptoms, his lack of cooperation for treatment and what could be done to connect and build a relationship with the man.

[67] As part of her responsibilities, Ms. Bollman also receives complaints from patients about the staff. She confirmed that Paul Joubert never complained about any staff member while he was resident at PX3.

[68] Ms. Bollman testified that the policies setting out the levels of observation for the patients are appropriate for the needs of the Unit. She agreed that the different levels of observation allow for a balance between the need to protect the patients and treatment. She noted that a nurse can order an increased level of observation but it cannot be reduced without approval of a physician.

[69] Ms. Bollman was also aware that the Health Sciences Centre reviewed the circumstances surrounding the death of Paul Joubert. A Final Review Team Report was created that can be found at exhibit 13. There was a recommendation that the suspended ceiling tiles be replaced with a solid, secure and safe alternative.

Ms. Bollman confirmed that the ceiling tiles in the PsycHealth Centre have been replaced.

Richard Craig

[70] Mr. Craig is employed by the Winnipeg Regional Health Authority as Manager of Capital Planning and Construction. Mr. Craig was tasked with the responsibility to implement the recommendation from the Final Review Team Report to replace the suspended ceiling tiles in the PsycHealth Centre. Mr. Craig explained that a suspended ceiling is required to allow access to electrical or plumbing conduit that runs above the ceiling. A study was undertaken that involved collecting information from various institutions in the United States and Canada about different types of ceiling products that would be safe and secure and allow access for maintenance.

[71] After collecting information, a mock-up room was built to test different products. The first product was a metal ceiling. Staff were requested to try and gain access into the ceiling and were able to do so by damaging the ceiling and creating a hole through the metal.

[72] The next product was an impact resistant drywall designed with no joints in the ceiling. Staff members were requested to break the ceiling with a chair. Mr. Craig described a rather large man using all of his strength smashing the ceiling with a chair. He was unable to penetrate the ceiling and there was no structural damage to the product. There are trap doors that are part of this product that allow access into the ceiling. The trap doors are made of solid steel and lock with a key. The trap doors were tested in the same way and at the same time and also withstood any damage.

[73] Filed as exhibit 14C is a report for the Ceiling Replacement Project in the PsycHealth Centre. This report confirms that a total of 75 in-patient bedrooms located on seven wards in the PsycHealth Centre have had the ceiling tiles replaced.

David Allan Guttman

[74] Mr. Guttman is a criminal defense lawyer practicing law since his Call to The Bar in 1986. He was retained to represent Paul Joubert in September 2004. He appeared in Brandon Provincial Court on September 17th, 2004 and objected to the Crown's application for a forensic assessment on the issue of criminal responsibility. Mr. Guttman was concerned about the application as he did not have disclosure of the Crown's case and he was concerned about who would conduct the assessment as Mr. Joubert did not trust any Manitoba doctors.

[75] Mr. Guttman confirms that he spoke with Dr. Yaren in September 2004 when Mr. Joubert was transported to PX3. He told Dr. Yaren that he intended to review the assessment order in a higher court and Dr. Yaren would not receive cooperation from Mr. Joubert. He confirmed that he told Dr. Yaren that it was no use proceeding with the assessment as Mr. Joubert did not trust Manitoba doctors and he had advised his client not to cooperate with the assessment. Mr. Guttman did review the order of Judge Tarwid, seeking to have it quashed in the Court of Queen's Bench. That application was granted by Mykle J. on October 18th, 2004. The written decision from Mykle J. can be found at exhibit 11.

[76] Mr. Guttman next became involved in discussions with the Crown to have Dr. Glancy conduct a forensic assessment of Mr. Joubert for fitness and criminal responsibility. On December 17th, 2004 Judge Tarwid did make the order for this assessment. On December, 21st, 2004 Mr. Joubert was admitted to PX3 because of the concern from staff at BCC. Mr. Guttman confirmed that he had a heated conversation with Dr. Yaren about Paul Joubert on December 23rd, 2004. He conceded that he was angry and hostile towards Dr. Yaren and called Dr. Yaren on December 25th, 2004 to apologize for his behavior.

[77] Mr. Guttman described his ongoing contact with Paul Joubert while he was a resident at PX3 from December 21st, 2004 until his death on January 31st, 2005. He confirmed that he attended PX3 on two occasions to visit with Paul Joubert and he had regular ongoing phone contact with Mr. Joubert. He indicated that Mr. Joubert would phone him daily and sometimes two to three times a day. Mr. Guttman recalls speaking with Paul Joubert over the phone on January 29th and 30th, 2005. Mr. Joubert usually expressed a concern about the delay in having Dr. Glancy attend to Manitoba to complete the forensic assessment. Mr. Guttman indicated that he would explain the reasons for the delay and Mr. Joubert would be calm by the end of the conversations.

[78] Mr. Guttman clearly recalls Dr. Yaren calling him on January 31st, 2005 to inform him of Paul Joubert's death. Mr. Guttman described a feeling of shock and disbelief as his suicide was completely unexpected by Mr. Guttman as there was no indication from Paul Joubert that he was thinking about suicide.

Review of Evidence/Conclusions

[79] After reviewing all of the evidence presented at this Inquest there are a number of conclusions that can be made.

[80] First, it is clear that Paul Joubert was an intelligent man who suffered from mental illness and this was recognized by his parents, the health care professionals in Brandon, the correctional staff at BCC and the staff at PX3. Without exception, all of the people who testified about their contact with Paul Joubert can be

described as caring, professional and dedicated individuals who did their best to perform their roles and assist Mr. Joubert.

[81] Second, the evidence confirms that relevant information about Paul Joubert and his background was passed along and shared with all of the institutions that had contact with Mr. Joubert. The CAP obtained information from the Brandon General Hospital. This information and history of Paul Joubert was passed along to BCC and in turn that information was passed on to PX3.

[82] Third, the policies and assessments regarding suicide risk at BCC are appropriate. Although Mr. Joubert remained at **SUM** while a resident at BCC, the supervision by staff led to concerns that resulted in Mr. Joubert's appropriate transfer to PX3.

[83] Fourth, the policies and assessments for suicide risk and level of required observation are appropriate at PX3. I accept and endorse Dr. Yaren's view that the three levels of observation, **Close Observation, Suicide Observation and Constant Observation,** allow for a balance between safety of the patients in the environment at PX3 and the treatment of the individual.

[84] Fifth, the death of Paul Joubert came as a complete shock and surprise to the staff at PX3. The staff at PX3 are highly trained professionals who treat some of the most fragile people in society. Paul Joubert was assessed and reassessed on an ongoing basis for suicide risk. He was observed every 15 minutes. He did not display any signs consistent with suicidal ideation or self-harm yet he took his own life by accessing pipes above the ceiling tiles to hang himself. This highlights a problem with the physical environment at PX3. That problem has been corrected.

RECOMMENDATION NO. 1

[85] I recommend that the policies outlining the different levels of observation utilized at PX3 be maintained as they allow for the appropriate balance between safety in the environment and treatment of the patient.

RECOMMENDATION NO. 2

[86] I endorse the change of the ceiling tiles throughout the PsycHealth Centre at the Health Sciences Centre in Winnipeg, Manitoba. I recommend that the Province of Manitoba conduct a review of all facilities in the Province where mentally ill patients reside to ensure the ceilings are safe, secure and inaccessible by residents.

M A N I T O B A

The Fatality Inquiries Act

Schedule of Exhibits Attached to Provincial Judge's Report

Respecting the death of Paul Laurent JOUBERT

Exhibit No.	Description
1.	Letter from the Chief Medical Examiner, Dr. Balachandra, dated October 24, 2005 directing that an inquest be held into the death of Paul Laurent Joubert.
2.	Autopsy report of Paul Laurent Joubert, dated February 1, 2005.
3.	Binder of documents compiled by Inquest Coordinator, Betty Owen.
4.	Curriculum Vitae of Dr. Mano Vipulananthan.
5.	Curriculum Vitae of Corrine Elliott.
6.	Curriculum Vitae of Dr. Karen Narduzzi.
7.	Booklet of photographs of PX3 provided by Constable Jimy Anis, Winnipeg Police Service.
8.	Position Description for a Corrections Officer III.
9.	Position description for Medical Nurse I.
10.	Curriculum Vitae of Dr. Stanley Yaren.
11.	Written decision of The Honorable Justice Mykle MBQB dated October 18, 2004.
12.	Curriculum Vitae of Dawn Ann Bollman.

13. Memorandum from Health Sciences Centre dated December 22, 2005 Re: Final Review Team Report-Recommendations.

14-A. Diagram PX3, PsycHealth Centre.

14-B. Health Sciences Centre PsycHealth Centre Net Floor Areas (description and sizes of rooms).

14-C. Ceiling Replacement Project in PsycHealth Centre (total of 75 in-patient bedrooms) completed on January 18, 2007.

DISTRIBUTION LIST

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4. Mr. Ron Perozzo, Deputy Minister of Justice & Deputy Attorney General
5. Mr. Don Slough, Assistant Deputy Attorney General
6. Mr. Doug Abra, Q.C., Counsel to the Inquest
7. Mr. Issie Frost and Mr. Sean Boyd, Counsel for Manitoba Corrections
8. Mr. Tyler Kochanski, Counsel for Dr. Stanley Yaren
9. Mr. Bill Olson, Q.C. and Mr. Sarantos Mattheos, Counsel for Winnipeg Regional Health Authority
10. Mr. David Swayze, Counsel for Brandon Regional Health Authority
11. Mr. Brian Kaplan, Director of Regional Prosecutions and Education
12. Ms. Michelle Joubert Goldstone, party to Inquest and sister of Paul Laurent Joubert
13. Mr. Luc Joubert, party to Inquest and uncle to Paul Laurent Joubert
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