Release Date: November 8, 2019

IN THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **Jean Paul Beaumont, Deceased**

(DATE OF DEATH: October 14, 2012)

Report on Inquest and Recommendations of Judge Combs
Issued this 4th day of November, 2019

APPEARANCES:

Mr. Ronald Toews and Mr. Brett Rach, Inquest Counsel
Ms. Suzanne Beaumont, Sister of Jean Paul Beaumont
Ms. Delorais Beaumont, Step-Mother of Jean Paul Beaumont
Mr. Sean Boyd, Justice Manitoba, Legal Services Branch on behalf of Manitoba Corrections
Ms. Andrea Epp, Counsel for the City of Brandon, Fire and Emergency Services

M A N I T O B A

The Fatality Inquiries Act
Reported by Provincial Judge on Inquest
Respecting the death of Jean Paul Beaumont

In the morning hours of October 14, 2012 Jean Peal Beaumont was found unresponsive by fellow inmates while he was in custody at Brandon Correctional Institution. Attempts to resuscitate Mr. Beaumont were unsuccessful and he was pronounced dead at 10:15 AM.

Members of Brandon Police Service and the Medical Examiner attended and initially suspected a homicide had occurred. An autopsy was performed and it was determined that death had occurred as a result of a morphine overdose. The source of the drugs and the circumstances surrounding the injection of the drugs was undetermined.

Subsequent investigation revealed that the drugs may have been secreted into the institution by a cell mate during a medical visit into the community.

This report contains my findings and recommendations after having heard and reviewed the evidence presented and hearing from inquest counsel, counsel for Brandon Police Service, counsel for the Provincial Department of Justice (Community Safety Division) hereinafter referred to as “Corrections” and Suzanne Beaumont, sister of Jean Paul Beaumont. A list of witnesses and exhibits are attached.

Pursuant to s. 33(3) of *The Fatal Inquiries Act*, I am ordering that all exhibits be returned to the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application with notice to any party with a privacy interest.

Dated at the City of Brandon, in Manitoba, this 4th day of November, 2019.

"ORIGINAL SIGNED BY:"

John Combs, Judge
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, Chief Medical Examiner (two copies)
2. Chief Judge Margaret Wiebe, Provincial Court of Manitoba
3. Honourable Cliff Cullen, Minister Responsible for *The Fatality Inquiries Act.*
4. Mr. Dave Wright, Deputy Minister of Justice & Deputy Attorney General
5. Michael Mahon, Assistant Deputy Attorney General
6. Ronald Toews, Counsel to the Inquest
7. Brett Rach, Counsel to the Inquest
8. Sean Boyd, Justice Manitoba, Legal Services Branch on behalf of Manitoba Corrections
9. Ms. Suzanne Beaumont, sister of Jean Paul Beaumont
10. Ms. Delorais Beaumont, step-mother of Jean Paul Beaumont
11. Ms. Andrea Epp, Counsel for the City of Brandon, Fire and Emergency Services
12. Exhibit Coordinator, Provincial Court
13. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba

M A N I T O B A

The Fatality Inquiries Act
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Respecting the death of Jean Paul Beaumont

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I. INQUEST MANDATORY

[1] This inquest is deemed mandatory pursuant to s. 19(3) of *The Fatal Inquiries Act* which requires that inquests are required where there are reasonable grounds to believe that someone has died in a correctional institution "as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner".

[2] On April 15, 2016 John K. Younes, then Acting Chief Medical Examiner, directed an inquest be held:

a) to fulfill the mandatory requirement;
b) to determine the circumstances of death;
c) to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

II. STANDING

[3] Standing was granted to the Brandon Police Service initially represented by Robert Patterson and then by Andrea Epp. Standing was granted to Corrections represented by Sean Boyd. Standing was granted to Suzanne Beaumont, sister of the deceased, Jean Paul Beaumont. The step-mother of the deceased, Delorais Beaumont was present during the first day of evidence and was offered standing but chose not to participate in these proceedings herself.

III. WHO WAS JEAN PAUL BEAUMONT AND WHAT WAS THE CAUSE AND CIRCUMSTANCES OF HIS DEATH

[4] Jean Paul Beaumont (hereinafter referred to as "J.P.") died at age 39 after spending a good portion of his adult life in a jail cell. We were told that J.P. was paroled in Winnipeg in around 2004/2005 after serving a lengthy jail sentence. He quickly became well known in police circles as a prominent member of the Zig Zag Crew motorcycle gang. The Zig Zag Crew was and is a support or puppet crew for the Hells Angels Motorcycle Club which has operated in Manitoba since the 1970's.

[5] We heard testimony from Wes Law, a sergeant with the Winnipeg Police Service presently in charge of the Organized Crime and Bike Enforcement Units. As such he is in charge of the gathering of all intelligence gathering related to organized crime for the Winnipeg Police Service. He has had extensive dealings with the biker scene in Winnipeg since approximately 2005. As such Sergeant Law had considerable interaction with J.P. from 2005 until he left Winnipeg in 2011.

[6] Sergeant Law describes J.P. of having had a reputation of being a violent enforcer intimately involved in the Winnipeg drug scene. He was someone who was feared by drug dealers and others involved in the distribution of illegal drugs such as cocaine and methamphetamine.

[7] Eventually J.P.'s methods and behaviour became so unpredictable that according to Sergeant Law, he was kicked out of Hells Angels/Zig Zag program in and around 2006/2007.

[8] In approximately 2008 a rival outlaw motorcycle gang known as the Rock Machine started to establish itself as a rival to the Hells Angels in Winnipeg. J.P.

joined the gang and by 2010 was an influential member. He had gained the title of Sergeant in Arms of the gang and was responsible for enforcement and discipline. Sergeant Law opined that he became the backbone of the Rock Machine gang due to his criminal history and his personality. He was a violent individual who garnered both fear and respect.

[9] In 2009 the Winnipeg Police Force conducted an extensive investigation called Project Divide which resulted in the arrest of numerous Hells Angels and Zig Zag Crew gang members. This resulted in a void in the criminal drug business in Winnipeg and the Rock Machine becoming more prominent in trying to fill that void. This was seen as a threat by the Hells Angels and conflict resulted.

[10] J.P. was in the middle of this conflict and we heard evidence that his residences in Winnipeg were shot up on numerous occasions. J.P. continued to have interactions with the criminal justice system and in late 2011 left Manitoba and moved to Ontario. This move was contrary to existing court orders and a warrant or warrants issued for his arrest. J.P. was arrested in Ontario and returned to Manitoba in mid-2012. After a short period of custody in Winnipeg he was transferred to Brandon Correctional Centre (BCC) where a range specifically designated for Rock Machine members or associates had been established.

[11] J.P. was placed in a unit with approximately four other Rock Machine associates, one individual who had ties to the Hells Angels and others who had no known gang ties. J.P. quickly established himself as the spokesperson for the unit and the individual who other inmates looked up to.

[12] We were able to watch video of the unit which showed a common area with four cells branching off in three directions. Three of the cells housed two inmates and one cell housed four inmates. The video shows that at approximately 10:00 PM on the evening of October 13, 2012 the inmates were getting ready for lockdown, which occurs between 10:25 PM and 11:00 PM. The video shows nothing unusual with normal interaction between the various inmates. There is no sign of any animosity between any of the people shown in the video. One interesting event, however, is that shortly after 10:00 PM as many as seven inmates congregate in the cell occupied by J.P. and another inmate. The camera does not show the interior of any of the cells and there is nothing in the demeanor of any of the inmates shown on the screen that would suggest anything significant was occurring.

[13] The video then shows the lock down of the unit starting at about 10:23 PM. The cells are locked and a count is conducted by the corrections staff confirming that all inmates are accounted for. We heard evidence that J.P. was lying on his top bunk but no determination made as to his well-being.

[14] There was also video of the next morning. The video shows J.P.'s roommate, L.S., exiting his cell at approximately 10:00 AM, looking distraught, and going from cell to cell waking people. The inmates in the unit all appear upset and immediately push the panic button near the unit exit. At the same time they are pounding on the door to the unit and waving, trying to get the attention of the corrections officers.

[15] The officers attend a little over a minute later. They find J.P. on his top bunk unresponsive. They determine him to be deceased. There is no sign of foul play but the officers do detect a small wound on J.P.'s upper back.

[16] The Brandon Police Service are called as well as the medical examiner, Dr. Norman. Dr. Norman initially treats the death as suspicious because of the presence of the wound. Brandon Police Service also investigated the incident as a homicide. Sergeant Andrew was the chief investigator and gave evidence at the inquest.

[17] Sergeant Andrew did not believe that the back wound on J.P.'s back was a puncture and could not find any hole through the mattress on which J.P. was found. This would suggest that no stabbing had occurred through the mattress from the bottom bunk.

[18] All of the plumbing traps and drains from the unit were searched for any evidence that would assist in the investigation. Nothing was located that was of assistance.

[19] Sergeant Andrew interviewed L.S., J.P.'s cellmate who indicated that he had seen J.P. snort seven 100 mg morphine pills and two rails of methamphetamine. Other inmates told the officers that drugs were being consumed by J.P. in the hours leading up to the last time he was seen alive.

[20] An autopsy was performed by Dr. Charles Littman, a forensic pathologist. He firstly confirmed that the wound on J.P.'s back was not a puncture but a

superficial wound which would not cause or contribute to his death. He observed other bruises and minor injuries that would not be life threatening.

[21] Dr. Littman did not conclude a cause of death until he received the toxicology report. After receiving the toxicology report from the RCMP Forensic Lab, he concluded that the cause of death was a morphine overdose.

[22] The inquest received evidence from Tracy Cherlet, a forensic toxicologist from the Royal Canadian Mounted Police Forensic Lab. She presented and reported on the laboratory report of the blood of J.P. forwarded by the forensic pathologist. It was found that his blood contained 393 nanograms of morphine for every millilitre of blood and 76 nanograms of methamphetamine.

[23] The significant result was the amount of morphine in J.P.'s blood. A level of five to 150 nanograms may be considered therapeutic depending on one's tolerance level. Any amount over 100 nanograms is considered toxic and can result in adverse effects including death. Morphine causes sedation and euphoria while slowing down the heart rate.

[24] It is curious that in the video of J.P. in his cell block on the evening of his death he does not show any signs of impairment or effects from such a great quantity of drugs. It should be noted that the video does not have any audio. J.P. was also described by various witnesses as someone who consumed a lot of drugs and his tolerance level was likely quite high.

[25] It is reasonable however, to accept the fact that J.P. died as a result of an overdose of morphine.

[26] This does not end the issue, however, as there is some question about the circumstances surrounding the death, and whether the ingestion of the lethal quantity of drug was voluntary.

[27] Concerns about the circumstances of J.P.'s death were enhanced when J.P.'s sister, Suzette Beaumont (a participant in this inquest) was provided with an audio tape between two individuals at a party at a home in Gimli. The individual who taped the conversation provided it to Ms. Beaumont. On the tape, an individual who I will call A.P. was heard suggesting that he heard that J.P. was killed by his fellow gang members while he was in jail.

[28] Attempts were made to contact A.P. by Corporal Jody Verspeek, a member of the RCMP Major Crimes Unit. This request was made by Sergeant Andrew of Brandon Police Service, who conducted the investigation of J.P.'s death. The police were unable to locate A.P. and the further investigation went nowhere.

[29] An assessment needs to be done as to whether or not there is evidence which would lead to either a conclusion or a suspicion that J.P.'s death involved foul play.

[30] First of all we have heard that J.P. was a gang member who had a violent history. He had switched from one outlaw motorcycle gang to another and he had been the subject of previous violent acts, including having his house shot up. He was an individual whose safety would always be at risk.

[31] He was an experienced drug user who you might expect would know the effects of drugs and what quantity would be safe. On the other hand, he was described as a reckless individual who liked to party. Two of his fellow inmates gave evidence at the inquest about J.P.'s drug use. L.S. told the police after the death that J.P. was using drugs all day, had consumed a considerable amount of morphine, and was "junked out". At the hearing he claimed not to remember seeing J.P. using drugs. Another inmate, G.S., gave evidence confirming he and J.P. snorted drugs on the day in question.

[32] J.P. was seen in a video appearing quite normal after 10:00 PM. Shortly thereafter, around six other inmates congregated with J.P. in his cell. This is likely the last opportunity that a group of individuals would have an opportunity to forcibly inject J.P. with drugs.

[33] The video does not show the inside of the cell but the behaviour of all the other inmates shows no indication of anything untoward occurring. The people outside the cell show no indication of hearing a struggle. The inmates going in and out of the cell all act perfectly normal and, if a homicide had occurred, it is likely that someone would show some signs of trauma or being distraught.

[34] The pathologist, Dr. Littman also could find no evidence of a struggle. He opines that if J.P. were forcibly injected there would likely be a hemorrhage around the site where the injection occurred. He does accept that a number of people could have held him down, sat on his chest and/or put a pillow over his head. It is pointed out that J.P. was a very physically strong individual and there would likely be some sign of a struggle.

[35] The video of the morning when J.P.'s body was discovered displays behavior on the part of the other inmates that is inconsistent with people who had been involved in a homicide. All of the inmates seem genuinely in shock and react in a manner to be expected, frantically trying to get the attention of corrections to get assistance for their fellow inmate. It is difficult to conceive that a group of inmates could co-ordinate not only the act itself, but the convincing display when the body was discovered.

[36] Although L.S. and G.S. are not the most reliable of witnesses, they were quite convincing in their evidence that they liked J.P. and had no reason to cause him harm. G.S. considered J.P. to be like an older brother.

[37] Although nobody will ever know for sure the circumstances of J.P.'s death, the only evidence before me is that the death was caused by a voluntary excess ingestion of morphine.

IV. HOW DID JEAN PAUL BEAUMONT GET ACCESS TO DRUGS WHILE IN CUSTODY

[38] As a result of J.P.'s death Corrections conducted an internal review of the circumstances surrounding the incident. The review emphasized aspects of the death that involved the actions of corrections staff, including escorts from the institution, review of policies concerning incoming mail, and inmate security checks.

[39] The review was conducted by Kelly Hapichuk who was the manager of Strategic Planning and Infrastructure with Corrections, and Greg Skelly who was

the Superintendent of Headingly Correctional Institution. The report was dated and presumably completed on March 8, 2013.

[40] The report identified that two main methods of introducing drugs into the institution at this time was through courier envelopes and through community visits by inmates. There is also evidence to suggest that J.P. was utilizing both of these methods.

[41] It was determined that inmates who received courier packages such as Purolator or Express Post were presented to the inmate without being opened. It was learned that drugs were being secreted in the envelopes and provided to inmates without being detected. We learned that such a parcel arrived addressed to J.P. days after his death and this parcel contained drugs.

[42] As a result of learning of these practices, the institution no longer provides inmates with the envelope from courier packages. The packages are opened by corrections staff and only the contents are provided to the inmate.

[43] The more likely source of the drugs that resulted is J.P.'s death is from a community visit by J.P.'s cellmate. He had attended a medical appointment at the Health Sciences Centre in Winnipeg on October 12, 2012. The cellmate, L.S., had an appointment with a specialist in relation to a jaw injury and was transported by corrections staff for that purpose.

[44] After J.P.'s death the Preventative Security Officer's office of BCC conducted an investigation to attempt to determine how the drugs that killed J.P. got into the institution. The investigation included listening to all outgoing

telephone conversations made from J.P.'s unit for a number of days before his death.

[45] The review resulted in the discovery that another inmate, M.V., in J.P.'s unit had arranged to have drugs delivered to the bathroom closest to where L.S. had his doctor's appointment. The arrangement included specifics as to where and when the doctor's appointment was to take place and the location of the bathroom close by. The drugs were to be placed in kinder eggs and attached to the blind side of the toilet tank.

[46] Further intercepted phone calls from the same inmate, M.V., confirmed to his unknown accomplice in the community that the drugs had been received. These drugs were described as "oxies" and were twenty in number. It is assumed that the drugs received included the morphine pills that J.P. allegedly consumed just prior to his death.

[47] L.S. denied that he brought the pills into the institution. He gave evidence at the inquest and claims he had no prior knowledge of where and when his medical appointment was to take place. This is to obviously infer that he could not have participated in planning any drug pickup. He also claims that he was strip searched before and after he left the jail.

[48] Regardless of his denials, it is clear that L.S.'s fellow inmate who was arranging the drug drop knew about the medical appointment. L.S.'s evidence in this regard lacks credibility.

[49] We also were presented with evidence that L.S. was not strip searched when he was returned to the jail. One of the escorting officers testified that the admissions area of the jail was busy when they returned from the appointment so a strip search was not conducted.

[50] It should also be noted that attempts were made to have M.V. testify at the inquest but this was not practicable as he was in custody in Nova Scotia. He was, however, interviewed by inquest counsel by telephone and I permitted a summary of that conversation to be filed as evidence in these proceedings.

[51] M.V. firstly confirmed that when the group of inmates were congregating in J.P.'s cell just prior to lockdown on October 13, drugs were being consumed. Specifically he recalls J.P. snorting or orally consuming morphine. He also asserted that J.P. was showing no signs of distress when they parted that evening and he had no concerns as J.P. was a frequent and experienced drug user.

[52] Although M.V. did not admit overtly to arranging the drug drop, he did infer that he might have been responsible. He suggested that the drug drop was only possible because a corrections officer had given them prior notice to the medical appointment. He suggested this prior knowledge allowed them just enough time to make the arrangements.

[53] Although M.V.'s description of events was presented through counsel and therefore was not given under oath or subject to an in-court cross-examination, the information provided was consistent with much of the other evidence gathered in relation to J.P.'s death. The description of events provided to counsel also were not entirely self-serving which added to its credibility.

[54] M.V. also confirmed that, at the time of J.P.'s death, he was an associate of Hells Angels. This was discussed with him and with J.P. before he was placed in the same unit as Rock Machine members. He considered himself to be a friend of J.P.'s from their past relationship and J.P. vouched for him with his fellow gang members. He did not suggest there were any problems with him being on the unit created for the Rock Machine Gang.

[55] The death of J.P. does raise numerous issues regarding practices and policies within the correctional facilities in Manitoba and, in particular, Brandon Correctional Centre.

V. POLICIES RELATED TO APPOINTMENTS OUTSIDE OF THE INSTITUTION

[56] The first issue is whether inmates should be informed as where and when appointments, medical or otherwise, are to occur outside of the institution. There would seem to be strong evidence in this case that there was prior knowledge of the exact time and location of a medical appointment for J.P.'s cellmate at The Health Science Centre. This likely gave inmates time to arrange for a drug drop.

[57] While it may be impossible in some instances to keep this information from an inmate and it may be obtained directly from the health care provider, all efforts should be made to ensure this information does not come from correction's staff.

[58] While we understand this is now standard practice, it should be reinforced by establishing a Standing Order directing all staff not to discuss with inmates times and locations of community appointments.

[59] The second issue involves a review of the training given to correction's officers who escort inmates into the community.

[60] Evidence was presented that all escorts into the community are conducted by two escort officers designated the primary escort officer and one as secondary. The primary escorting officer has training as to how to conduct clothed and unclothed searches of inmates, how to conduct a search of a room and how to use special weapons such as OC spray and a collapsible baton. The secondary escorting officer is also trained to do searches but not how to use the special weapons. The training presently is restricted to searches of rooms within the institution and there is no special training of rooms outside of the institution, such as public washrooms. The primary escorting officer testified in this inquest and confirmed that he has never been specifically trained as to how to search a toilet. The escorting officer also testified that L.S. was allowed to use the washroom closest to his appointment location as another option "wasn't available". He also conceded that his search of the washroom may not have been as thorough as usual as he was reluctant to leave L.S. alone outside the washroom with the secondary escort officer who was a female untrained as an escort.

[61] After this incident occurred, notice in writing was sent to all staff reminding them to always choose the less obvious washroom when accompanying inmates outside of the facility. It is conceded, however, that

training of escorts should be enhanced to ensure skills applicable for searches away from the institution.

[62] A third issue related to community visits by inmates is the degree to which they are searched upon their re-entry into the institution.

[63] Presently three levels of search are identified. The least invasive is the pat down or over clothing search. The next level is the unclothed or strip search. The third and most invasive search is the search conducted in a "dry" cell. This involves an inmate being isolated in a cell and left there until there have been three substantial bowel movements. The inmate is monitored closely and the excretion from the bowel movements are retained and screened for contraband.

[64] The pat down or clothed search is the typical search utilized when someone is being escorted out of the institution. This is logical as there is typically no reason to suspect anyone is interested in secreting contraband out of custody. An unclothed or strip search is usually conducted when someone is being brought back into the institution. This search method includes the inmates being asked to squat and cough. This would hopefully assist in determining whether the inmate had contraband hidden in the anal cavity. This method will obviously not always determine if someone is carrying contraband. The "dry" cell method is extremely invasive and humiliating and is only utilized if corrections staff have strong reason to believe that contraband is being smuggled into the institution.

[65] In this case there was no information prior to J.P.'s death that his cellmate might be bringing drugs into the jail. Therefore a "dry" cell search was not conducted. However, an unclothed search should have been conducted but

appears to have not been done. The primary escorting officer testified that he asked the L.S. be strip searched but does not know if it happened. The secondary escorting officer gave evidence that L.S. was never strip searched as the admitting area was busy and L.S. was sent to his cell without a proper search being completed.

[66] The present policy regarding the type of searches to be conducted in certain circumstances seems reasonable. Dry cell searches should only be conducted when there is reason to suspect such a search is necessary. Strip searches after a community escort seems reasonable but corrections staff needs to be reminded that such searches should always be conducted, even if the institution is busy.

VI. BODY SCANNERS

[67] In some institutions decisions about the time of search to be conducted on an inmate returning from a community visit will be eliminated. Corrections is introducing body scanners as a search tool. The body scanners are far less invasive in that a fully clothed inmate can be scanned and the image produced will disclose any contraband on or in the inmate's body. This instrument will presumably eliminate the need for any strip searches or even more invasive searches such as the dry cell process.

[68] Apparently scanners have been installed in three correctional institutions. It is recommended that they be installed, at least, in any institution where inmates are being housed to serve a sentence of incarceration. It is these institutions

where inmates are more likely to attempt to bring contraband with them or have it delivered in some fashion.

VII. POLICIES CONCERNING INMATE SURVEILLANCE AND WELL-BEING CHECKS

[69] We can conclude that J.P. died sometime between approximately 10:15 PM in the evening and 10:00 AM the following morning. In that intervening period corrections officers conducted numerous well-being checks of all the inmates including J.P. It is clear that the checks were of inconsistent quality and did not fully determine the well-being of the inmates.

[70] We were told the official counts of inmates occurs four times a day. Of relevance to this inquiry is that counts were conducted at 10:30 PM and, then again, in the early morning around 5:30 AM. We heard from a number of corrections officers in this inquest and there seems to be no consistent policy or practice as to the duties or responsibilities of the officers conducting the count at the end of the day. There is no doubt that the expectation is that there will be an accounting of all inmates in that a determination is made that the right number of inmates are physically present in each cell.

[71] There was also a suggestion that the late evening count is also expected to be a check of the well-being of all inmates. This process does not include the corrections officer entering the cell to actually interact with the inmates. The typical practice seems to be that the officer will check the inside of the cell, perhaps with the aid of a flashlight, and will ensure that there are the correct number of inmates in the cell and there is no sign of distress. This might include

looking for signs of a struggle or the presence of blood. If an inmate is apparently sleeping and there are no other signs which would raise concerns, no attempts are made to determine if the inmate is in distress or even deceased.

[72] In the case of J.P., at the 10:30 PM count, he was thought to be sleeping in his top bunk. His feet were facing the door to the cell and it could not be determined if he was well without entering the cell or in some way trying to waken him. We now know that J.P. could have been in distress, unconscious or even deceased when the 10:30 PM count was conducted.

[73] Checks were also conducted throughout the night and in the early morning and we were told that these checks also are to monitor the inmate count and to check on the well-being of the inmates. We knew from the video of the cell area that in certain instances the corrections officers did not even look into the cell doors. In other instances a check was done of each cell area using a flashlight. The guards who conducted these rounds all testified there was no sign of J.P. being in any distress. Obviously, if at anytime an actual determination had been made of J.P.'s well-being, a different outcome may have occurred.

[74] Many of the corrections officers who testified were asked about the feasibility of enhancing the checks to ensure the well-being of inmates. It seems impractical for safety and manpower reasons to actually enter the cells or wake up inmates during the night to ensure that each inmate is alive and well. Inmates would obviously resist such intrusion and such constant monitoring would not be reasonable. It does seem reasonable, however, that, when the late evening count is done, that there be a determination that each inmate is alive and well. Whether such a check would actually involve verbal interaction with the inmate or some

other means of confirming well-being should be the subject of discussion. A policy of direction to the corrections officers conducting the late night count should be crafted that includes an actual conclusion that each inmate is alive and well.

VIII. POLICY CONCERNING SEARCHES OF CELLS FOR CONTRABAND

[75] Correctional officer Bobi Edge testified that random searches are done of all the cells within the institution. A monthly schedule is created to ensure that all of the ranges with the institution are searched regularly. Gang units are searched more regularly because of the increased risk of contraband being located.

[76] The searches are random so inmates do not know what day their unit will be searched. All of the random searches, however, are conducted at the same time being 6:00 PM. This time is chosen for staffing and scheduling reasons. Ms. Edge agreed that searches could be conducted at different times but would be less optimal from a staffing perspective. She agreed, however, that the searches would be more effective if inmates did not know when searches were being conducted.

[77] This issue was not explored with any detail at the inquest so I will not be making any recommendation concerning enhancing the randomness of the searches. It makes sense, however, that Corrections explore the options of developing a less predicable pattern of searches from a timing perspective.

IX. THE INSTALLATION OF PANIC ALARMS IN ALL INDIVIDUAL CELLS

[78] Brandon Correctional Centre has panic alarms in each of the cell units located near the exit door. This obviously permits the corrections officer who is monitoring the video surveillance of the unit to observe who is pushing the panic alarm button. The same officer would then be able to some extent assess whether or not an emergency existed which required immediate intervention.

[79] When inmates are locked in their cells, they have no access to the panic alarm and the only way to get the attention of the correction officer in each case of an emergency is to yell or bang on the door of their cell. If a particular inmate is in distress or incapable of yelling or banging on the door, it is expected that that inmate's cellmate or cellmates would have to alert the corrections officers. Obviously, having panic alarms in each cell would enhance the safety of the inmates as it is a much more effective way of calling for assistance.

[80] It would seem that the two reasons for not installing panic buttons in each cell is twofold. Firstly, the cost is a consideration. No evidence as presented about the cost but presumably it would be a consideration. The second consideration is that the existence of alarms in each cell would result in numerous instances where the alarm button would be utilized where no emergency existed. It is argued that this would put an extra burden on staff resources.

[81] It seems to me that inmate safety should be a primary consideration. If the installation of panic buttons in each cell would enhance inmate safety and the cost is not prohibitive, there should at least be exploration as to the feasibility of

doing so. This could be done by determining if any other correctional facilities have installed panic buttons in each cell and what experiences have resulted. The institution could also install such devices in a small portion of the institution and monitor any problems or benefits that result therefrom.

[82] As far as the death of J.P. is concerned, having panic alarms in each cell likely would not have prevented his death. We do not have evidence to suggest he would have been able to push a panic alarm nor would his cellmate have done so based on the likely circumstances of J.P.'s death.

X. POLICY OF SEGREGATING GANG INMATES

[83] In 2012 a special unit was created at BCC to house members of the Rock Machine gang. J.P. was a member of that gang and was placed in that unit along with other Rock Machine members. Evidence was also presented that one associate of the Hells Angels was also placed in that unit along with others who had no gang ties.

[84] Alan Logan who was the Security Prevention Officer at BCC at the time, indicated that once gang membership or affiliation was determined, a decision would be made as to where the inmate should be placed in the institution.

[85] The gang membership would be determined using a six point criteria as follows:

a) Self identified as a member of the gang.
b) Associates with certain gang members of associates.

c) Displays gang paraphernalia or tattoos.
d) A court has determined gang membership.
e) There has been involvement in gang related crimes.
f) There is reliable information or intelligence confirming gang membership.

[86] J.P. confirmed he had an association with the Rock Machine and Mr. Logan testified that his placement in the unit was discussed with other gang members who had no difficulties with him. Mr. Logan did not detect any untoward danger in placing J.P. on the Rock Machine unit.

[87] Mr. Logan also pointed out that gang members were put together so that staff would be extra vigilant to ensure that no contraband or weapons were brought into the institution. The gang unit would be subject to more frequent searches and phone calls and mail would be monitored more closely. Gang members were not eligible to work in the institution and could not move around as freely as other inmates. Their visiting was restricted and any visits that did occur would be through a glass telephone booth with direct supervision.

[88] Gang members are kept segregated because they are considered inherently dangerous and segregation allows them to be more closely monitored and to have their privileges restricted. It also reduces the risk of danger to other inmates of being intimidated or harmed physically. It also makes recruitment into the gang much more difficult.

[89] There are also problems with segregating gangs within an institution. If a particular inmate is deemed to be disloyal or for some reason falls out of favour, the risk level for the inmate is obviously greatly enhanced by being in a gang unit. The creation of a gang unit also allows its members to more easily

formulate and carry out schemes such as bringing drugs or contraband into the institution. In the case at hand it would seem J.P. was able to obtain drugs in jail with the assistance of at least two fellow inmates. The inmates did not seem to be members of the same gang, but gang connections arguably were a contributing factor in facilitating the drug drop and delivery.

[90] There are obviously arguments for and against segregating gangs in a personal institution. Rather than having a hard-and-fast rule, Corrections should have the discretion as to when such a segregated gang unit should be created. I am satisfied that Corrections is well aware of the pros and cons of doing so.

[91] This issue was considered by Judge Schille in the St. Paul inquest report in 2015 and summarized the issue as follows:

> [14] Segregation of gangs may have the unintended consequence of legitimizing the gang and enhancing its reputation, however, integration has attendant problems with recruitment of general population inmates being the most obvious. The ultimate goal of Corrections concerning gangs is to promote appropriate compliant behaviour.
> [15] Corrections constantly monitors the situation within the institution to gauge the effectiveness of the existing approach. Segregation, as it existed at the time of this death, is not a consequence of a firm policy to separate gang members from the general inmate population. It is recognized that a firm segregation policy would likely be counterproductive to moderate behaviour of gang members. Existing policy does allow gang members to be dispersed within general population within the institution as necessary. The potential of dispersing a gang within the institution is an effective management tool.
> [16] As the preceding description illustrates, current gang policy is personified by flexibility. Gang members by definition subscribe to a criminal value system and are deeply entrenched in a criminal lifestyle. Such individuals represent a significant challenge to effectively supervise and manage. The reality is that gang members constitute a high risk within an institution. There has been no material change in gang policies since this death. Based

> on the evidence heard at this Inquest, no aspect of gang policies and procedure is identified as in need of revision.

[92] I agree with Judge Schille and I will not be making any recommendation that Corrections change its policy regarding the segregation of gang inmates.

XI. POLICY OF INVOLVING POLICE WHEN CONTRABAND IS SEIZED IN AN INSTITUTION

[93] We heard form various witnesses about their understanding of when police are notified if contraband, such as drugs and weapons, are found in the institution. While senior administrators testified that a policy existed that police were always notified when contraband was located, other correction officers believed otherwise. Their understanding was that the matter could be dealt with internally and could result in sanctions such as the removal of privileges, segregation or fines.

[94] It would seem strange that an individual could potentially receive a reduced sanction for committing a crime in a jail cell as opposed to when he or she is on the street. It is hard to understand why trafficking in drugs or carrying a concealed weapon or one with a dangerous purpose in a jail would not be subject to criminal charges.

[95] I would recommend that a formal policy or standing order be established that would direct Corrections to report to police any instances where contraband such as illegal drugs and weapons are found within the institution.

[96] Such a policy may have the effect of deterring inmates in the future from secreting drugs into a penal institution.

XII. SUMMARY OF RECOMMENDATIONS

[97] As a result of an internal review by Corrections, many existing policies were re-confirmed and others implemented to reduce the chance of an incident involving a drug overdose from re-occurring.

[98] My recommendations are as follows:

a) The existing policy of conducting rounds of inmate units in a proper manner needs to continue to be reinforced. Officers should at least go to the window of each cell and ensure that each inmate is accounted for and there is no sign of anything untoward. The evening count should include some engagement between the corrections officer conducting the count and each inmate to ensure the inmate is alive and well.
b) Inmates should not be given the envelopes and packaging from any parcels or courier deliveries. I am told this policy has been implemented.
c) A standing order should be issued directing staff and nurses not to advise inmates in advance of the time or location of any medical or community visits.
d) A directive has been sent to escort officers that, when escorting inmates on medical or community visits, the inmate should not, when possible, be permitted to use washroom facilities which would be typically utilized. A washroom on a different floor or part of the building should be used. If a washroom has more than one stall, the inmate should not choose the stall to be used.

e) Escort officers should have enhanced training in conducting searches of premises outside of the institution.
f) Escort officers need to be reminded about strip searches of all inmates returning to the institution from medical or community visits. This has apparently been done.
g) Body scanners are being installed in some institutions, which eliminates the need for strip searches. These scanners should be installed in any institution housing sentenced prisoners.
h) Corrections should explore the option of installing panic alarms in all individual cells.
i) A policy or standing order should be implemented mandating Corrections to report all incidents where weapons or illegal drugs are found within the institution.

I respectfully conclude and submit this Report on this 4th day of November 2019, at the City of Brandon, in the Province of Manitoba.

"ORIGINAL SIGNED BY:"

John Combs, Judge
Provincial Court of Manitoba

M A N I T O B A

THE FATALITY INQUIRIES ACT, C.C.S.M. C F52

REPORTED BY PROVINCIAL JUDGE ON AN INQUEST

RESPECTING THE DEATH OF JEAN PAUL BEAUMONT

APPENDIX A – WITNESS LIST

1. Bobi Edge (formerly Bobi Soroka), Correctional Officer
2. Adam Gregory Paul Sedor, Correctional Officer
3. Sarah Wiseman, Correctional Officer
4. Alan William Logan, Correctional Officer (Preventative Security Officer at material time)
5. James Waddell-Hodgson, Correctional Officer
6. Donald Warren Carnegie, Correctional Officer
7. Sergeant Michael Melanson, Brandon Police Service
8. Sergeant David Andrew, Brandon Police Service
9. Delton Kallusky, Corrections (Assistant Preventative Security Officer)
10. Tracy Cherlet, Forensic Toxicologist
11. Robert Wayne Maushalf, Correctional Officer
12. Aimee Wood, Correctional Officer
13. Sean Williams, Correctional Officer
14. Curtis Christie, RCMP
15. Dr. Charles Littman, Pathologist
16. Sergeant Wes Law, Winnipeg Police Service
17. Tanya Webb, Head Sheriff
18. Kelly Todd Hapichuk, Manitoba Corrections
19. Derek Michael Sucheck, Manitoba Corrections
20. G.S., former inmate at BCC
21. Alan Peacock, Manitoba Corrections
22. L.S., former inmate at BCC
23. Corporal Jody Verspeek, RCMP
24. Jason Fryer, Manitoba Corrections

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APPENDIX B – EXHIBIT LIST

Exhibit No.	Description
1.	Divisional Review in the death of Jean Paul Beaumont - dated March 8, 2013
2.	JP Beaumont review recommendations 2013.03.08
3.	Delton Kallusky report
4.	CV of Tracy Cherlet
5.	Forensic report by Ms. Chung (ph)
6.	Brandon Correctional Center Operational Flow Chart
7.	CD of Audio Recording
8.	Autopsy Report
9.	CD of Autopsy Photos
10.	CV Sergeant Wes Law, Winnipeg Police Service
11.	Policy and Procedure Manual for Sheriffs - filed by R. Toews
12.	JP Beaumont Review Recommendation 2013.03.08
13.	Email from Sean Boyd to Ron Toews August 22, 2018
14.	Email from Charlotte McWilliams to Ron Toews May 31, 2013 - 2 post orders
15.	BCC Standing Orders Issue date April 25, 2005, Communications offender mail

16. BCC Standing Orders Issue date July 24, 2018, Escort (Community) and Transfer of Inmates (Adults Only)
17. BCC Standing Orders Issue date January 4, 2008, Community Escort and Transfer of Offenders
18. BCC Standing Orders Issue date July 24, 2018, Hospital & Off-Site Medical Supervision (Adult)
19. BCC Standing Orders Issue date December 16, 2015, Hospital & Off-Site Medical Supervision (Adult)
20. BCC Standing Orders Issue date August 2, 2018, Mail (Adults & Youth)
21. Standing Order on Contraband Issue date March 31, 2008
22. Supplementary Report - Summaries of Statements of Ms. Beaumont & Ms. Strykiwsky (aka Vincent) – August, 2018
23. Supplementary Report - Summaries of Statements of Ms. Beaumont & Ms. Strykiwsky (aka Vincent) - June, 2018
24. Video of JP Beaumont Cell/Unit At Bcc
25. Security Rounds by Officer Fryer & Slack (Jackson) – BCC
26. Video of BCC Cell Security Check
27. Crown Attorney Ron Toews Notes with M.V. phone conversation