

RELEASE DATE: OCTOBER 11, 2024



Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act C.C.S.M. c. F52*

AND IN THE MATTER OF: An Inquest into the Death of Jasbir Brar

**Report on Inquest
Judge Eyrikson
Issued this 10th day of October, 2024**

Appearances:

Breanne James, Inquest Counsel

James Koch and Coral Lang, Counsel for the Government of Manitoba
(Department of Justice, Community Safety Division)



Manitoba

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

**REPORT BY PROVINCIAL JUDGE ON AN INQUEST
INTO THE DEATH OF: JASBIR BRAR**

An Inquest respecting the death of Jasbir Brar was held on April 8, 9, 10 and 11, 2024, in the City of Winnipeg, Province of Manitoba.

This report contains my findings, observations, and recommendations. Attached is a list of witnesses who testified at the Inquest as well as a list of the Exhibits which were filed. Pursuant to the provisions of *The Fatality Inquiries Act*, I am ordering that all the 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 Winnipeg, in Manitoba, this 10th day of October, 2024.

Judge Keith Eyrikson

Copies to:

1. Dr. John K. Younes, Chief Medical Examiner (2 copies)
2. Chief Judge Ryan Rolston, Provincial Court of Manitoba
3. Honourable Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act*.
4. Jeremy Akerstream, Deputy Minister of Justice & Deputy Attorney General
5. Michael Conner, Assistant Deputy Attorney General
6. Michele Jules, Executive Director of Manitoba Prosecution Service
7. Counsel to the Inquest Ms. Breanne James
8. Counsel for the Government of Manitoba (Department of justice, Community Safety Division) Mr. James Koch and Ms. Coral Lang
9. Exhibit Coordinator, Provincial Court of Manitoba
10. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba



Manitoba

REPORT BY PROVINCIAL JUDGE ON AN INQUEST INTO THE DEATH OF: JASBIR BRAR

INTRODUCTION

1. In the late evening hours of June 4, 2020, Mr. Jasbir Brar was found hanging by his neck, unconscious and unresponsive, in his cell at the Winnipeg Remand Centre. Unsuccessful efforts were made to revive Mr. Brar but he never regained consciousness. He was declared deceased in the early morning hours of June 5, 2020.
2. Mr. Jasbir Brar was 62 years of age and survived by his wife, and no doubt many individuals who cared for him. While his family understandably chose not to participate in this Inquest, the Court offers its sincere condolences to his family, friends, and all those touched by the tragic and untimely death of Mr. Brar.
3. Earlier that day on June 4, 2020, Mr. Jasbir Brar appeared in the Manitoba Court of Appeal where his original convictions for three counts of sexual assault were upheld. At that point, Mr. Brar was to serve a further 19 months of custody going forward with two years of supervised probation to follow.

4. Mr. Brar was taken into custody from the Manitoba Court of Appeal courtroom and brought to the Winnipeg Remand Centre where he was processed later that morning and early afternoon. Mr. Brar was eventually assigned to cell 585, on the 5th floor of the Winnipeg Remand Centre where he was housed alone. Mr. Brar was locked in his cell, along with all other inmates on the 5th floor in the later evening hours. The last time he was seen alive was at approximately 10:20 p.m. At approximately 11:16 p.m. Winnipeg Remand Centre staff came across him with a towel wrapped around his neck, attached to a sheet secured to the upper bunk in his cell. It was readily apparent he was in medical distress, and unconscious. It quickly became clear the Mr. Brar had hung himself with the sheet and towel cutting off his ability to breath in an attempt to complete suicide.
5. Remand Centre staff acted quickly and used an emergency knife to cut down Mr. Brar when they were able to gain access to his cell. He was then quickly placed on the floor of his cell. Lifesaving measures were attempted by the Winnipeg Remand Centre staff including one of the on-duty nurses, to no avail. Eventually ambulance personnel attended and transported him to the Health Sciences Centre where he was pronounced deceased at 12:37 a.m. on June 5th, 2020. Throughout, Mr. Brar never regained consciousness.

THE ORDER OF AN INQUEST

6. This Inquest was initiated by Dr. John K. Younes, the Chief Medical Examiner for the Province of Manitoba by way of letter dated May 7, 2021. Dr. Younes confirms therein that the cause of death was hanging and the mechanism of death was suicide.
7. Under section 19(5)(b)(ii) of *The Fatality Inquiries Act* C.C.S.M. c. F52, as Mr. Brar was under the custody of the Manitoba Provincial Corrections System, an inquest has been initiated. The purpose of this Inquest as enacted under the relevant section is to determine the circumstances relating to Mr. Jasbir Brar's death and to determine what, if anything, can be done to prevent similar deaths from occurring in the future.
8. Owing to a variety of factors, not the least of which was the COVID-19 pandemic, this Inquest proceeded on April 8, 9, 10 and 11, 2024.
9. *The Fatality Inquiries Act* is clear that under s. 33(1) of the *Act*, upon completion of the Inquest the Provincial Court Judge must provide the Minister with a written report that sets out the findings respecting the following:
 - (a) the identity of the deceased;
 - (b) the date, time, and place of death;
 - (c) the cause of death;
 - (d) the manner of death;
 - (e) the circumstances in which the death occurred.

10. It is important to note of course that this is not a criminal trial. An Inquest is a creature of statute in which a Provincial Court Judge conducts this inquiry under a very specific and defined set of powers and circumstances. Section 33(2)(b) indicates that within this report, the Provincial Court Judge:

“shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be easily identified as a culpable party in respect of the death that is the subject of the inquest.”

SUMMARY OF THE EVIDENCE

11. Eleven witnesses were called to testify in this matter which included a number of individuals working within the Remand Centre, Sheriffs assigned to security at the courthouse and a nurse employed by the Winnipeg Remand Centre. Attached as Exhibit 2 in this matter is a full listing of all the witnesses who testified in this Inquest.

12. To a person, all of the witnesses called in this matter presented as diligent, forthcoming, credible and reliable. At no time did the Inquest hear any concerns raised about the reliability and credibility of the witnesses by any of the counsel involved in this matter. Further, as Inquest Judge in this matter, I was able to observe and listen to their evidence directly as it appeared in front of me under oath. At no point during the course of the testimony was there any conflicting evidence that need be resolved by a test of reliability or credibility. Simply put

on the important and key pieces of evidence before the Inquest, the witnesses were uniform in their testimony.

13. This Inquest Report would not be properly served by simply reiterating all of the evidence of each and every witness in this matter. When salient and/or relevant however, the Inquest Report will directly deal with the evidence of these individuals.

THE EVENTS OF JUNE 4, 2020

14. At approximately 9:35 a.m., on June 4, 2020, two sheriffs' officers, tasked with security within the courthouse attended to the Manitoba Court of Appeal courtroom to take Mr. Brar into custody after his unsuccessful appeal. Sheriff Officer (Hereinafter "S.O.") Bhawanjot Kaur testified that she came into contact with Mr. Brar and that he appeared to be upset with his head down. This was described by her as normal expected behaviour for a person who had been unsuccessful in their appeal.
15. S.O. Kaur stated that she also spoke with Mr. Brar's wife who was present at the time, and that she did a security pat down search of Mr. Brar as he was coming into custody. She indicated she interacted with him throughout what she felt was a normal unremarkable occurrence of taking someone into custody.
16. S.O. Kaur noted that Mr. Brar was speaking in Punjabi to his wife in their initial interactions. S.O. Kaur was fluent in Punjabi and offered to communicate with

Mr. Brar and his wife in Punjabi; Mr. Brar declined and wished to communicate in English. She also inquired as to any medical conditions, drug use or other things that may affect Mr. Brar's wellbeing or medical situation. She directly asked Mr. Brar if he was feeling suicidal to which he stated, "No". S.O. Kaur noted that he did not hesitate in his answer and that he had no unusual expression on his face. He simply exhibited what S.O. Kaur had come to expect in a situation such as this. Generally speaking, S.O. Kaur testified that at no time did Mr. Brar express anything that led her to believe that he was at risk for self harm or suicide. She simply expressed no concerns with the behaviour of Mr. Brar in her initial interactions with him.

17. After interacting with Mr. Brar at the courthouse S.O. Kaur and another S.O. in her company escorted Mr. Brar, now in custody, through the courthouse to the holding cells in the Provincial Court Building across from the Winnipeg Remand Centre. The escort of Mr. Brar was described as unremarkable. They further processed Mr. Brar in the holding cells.

18. While in the holding cells, S.O. Dennis Oteyza, working with S.O. Kaur, asked Mr. Brar a series of questions, one of which was "are you feeling suicidal right now?" The answer to S.O. Oteyza from Mr. Brar was unequivocally "No". S.O. Oteyza further noted that Mr. Brar appeared coherent and aware and that he saw nothing noteworthy about his responses. S.O. Oteyza testified he felt Mr. Brar

never said or did anything that led him to believe he was at risk for self harm or suicide. He described his mood as appropriate for the situation, and somewhat somber owing to the nature of his lost appeal.

19. Mr. Brar was held for approximately 15 to 20 minutes at the holding cells in the Provincial Court Building. He was then taken via the underground tunnel connecting the Provincial Court Building and the Winnipeg Remand Centre for further processing at the Winnipeg Remand Centre.
20. The officers who transported him noted this was a quick walk between the Provincial Court Building and the Winnipeg Remand Centre and that nothing out of the ordinary appeared to occur. They had no particular concerns whatsoever with the behaviour of Mr. Brar throughout their dealings with him.
21. Later that morning, Mr. Brar was processed for admission into the Winnipeg Remand Centre. Correctional Officer (Hereinafter “C.O.”) Dale Schwartz conducted this admission which necessarily included an interview with a series of standard questions and forms that needed to be filled out.
22. C.O. Schwartz testified that he remembered Mr. Brar, and that he conducted the initial intake with Mr. Brar at the Winnipeg Remand Centre processing area. During this intake, he asked Mr. Brar if he was considering suicide. He noted Mr. Brar shrugged his shoulders and didn’t say anything. He was then directed by C.O. Schwartz that he was on camera, and “it was either a yes or a no”. He

also expressed that he needed to directly hear his response. It was at that time that Mr. Brar responded simply saying “No” to having any thoughts of suicide.

23. He described that Mr. Brar was quiet that day, but that was understandable and expected after losing his appeal and coming into custody. Generally speaking, C.O. Schwartz indicated that he did not appear to be exhibiting any undue distress, and described his demeanour as “okay”. He further stated he had no concern about him being at risk for suicide, noting that there were simply “no signs of it”.

24. C.O. Brooke Olafson also participated in the admissions process for Mr. Brar. Her involvement commenced once C.O. Schwartz’s was concluded. During the course of the intake process with Mr. Brar she filled out the “Suicide Risk Assessment” Form (Exhibit #1 tab 27) which all individuals admitted to the Winnipeg Remand Centre must have completed. The form contains a series of questions directed at assessing an individual’s risk for suicide or self harm.

25. C.O. Olafson testified that in completing the form and her assessment of suicide risk she asked a series of questions. She asked Mr. Brar whether or not anyone in his family or his close friends had committed suicide to which he responded “No”. He further stated he had never attempted suicide before. She also inquired as to whether or not he had a plan to kill himself and he again he said “No”. Mr. Brar further indicated that he had the intention, and a plan, to keep

himself safe while at the Winnipeg Remand Centre. It was also noted that he had no issues of loss or stress and that his wife was supportive, and he could talk to her. C.O. Olafson described him as calm and cooperative during her dealings with him. C.O. Olafson also stated that spiritual and medical care was available to him should he so choose to avail himself of it.

26. Correctional C.O. Olafson also testified that while it appeared to her that Mr. Brar's first language was Punjabi, he appeared to be fluent in English and easily able to communicate in English. When asked, he did not express any desire to have an interpreter or speak in Punjabi about any of these matters.

27. C.O. Olafson was surprised when she heard of the suicide the next day and expressed that she had no concerns at the time about suicide or anything related such as self harm in her entirety of interactions with him.

28. It should also be noted that as a part of the intake process Mr. Brar was seen by an on-duty nurse at about 1:30 p.m. on June 4th, 2020. The "Health Care Assessment Form" report of this nurse is contained within exhibit #1 at Tab 30. While this form notes a number of health difficulties that Mr. Brar laboured under, the form indicates that there were no suicide or mental health concerns from the nurses perspective.

29. After being processed, Mr. Brar was eventually taken to cell 585 on the 5th floor range of the Winnipeg Remand Centre. He was locked in his cell in the evening hours alone.
30. At that time the Winnipeg Remand Centre policy was for Correctional officers to conduct checks on all in custody individuals every 30 minutes to confirm their well being by visual observation through the window of their cells. They would note their location within the Winnipeg Remand Centre by recording it in their electronic system. This process was referred to as “punch rounds”.
31. The “range” that Mr. Brar was housed in is a series of cells approximately 25 of which are divided onto two floors in front of an open area. Each cell has an individual door and locking mechanism that can be opened either electronically or with a key. For security reasons, a person conducting punch rounds does not carry a master key or individual keys for each cell. A control “pod” is a small observation area overlooking a series of cells and often manned by a C.O. It necessarily overlooks the range so that correctional officers can keep an eye on individuals throughout the ranges.
32. Mr. Brar was last seen alive at approximately 10:20 p.m. when C.O. Dawit Woldeyes had been doing his punch rounds and noticed nothing untoward in relation to Mr. Brar when he looked in on him. C.O. Woldeyes returned at 11:16

p.m. to find Mr. Brar in a position where he had hung himself with a sheet and towel around the bed and his neck.

33. C.O. Woldeyes immediately reacted calling a code red emergency on his radio and attempting to get others to assist him. He testified that he attempted to communicate with Mr. Brar but that he was unconscious was uncommunicative.

34. In prompt fashion, a series of Remand Centre staff members responded to this crisis. There was no one present working in the pod that evening, which was normal and owing at least partially to manpower issues. The electronic system which could have opened the door was also not functional at the time. Nonetheless, there were emergency keys present in the pod and were able to be easily and quickly accessed. These keys were retrieved and used almost immediately to open Mr. Brar's cell. An emergency bag and medical kit was present within the pod which was also utilized. An "emergency knife" was taken from the emergency bag and quickly used to cut through the blanket and towel so that Mr. Brar could be taken down. He was then placed on the floor of his cell where emergency medical assistance was attempted. By all accounts, staff that entered into the room acted as expeditiously as possible and without delay.

35. Tragically, any form of medical intervention was not able to revive Mr. Brar at the Winnipeg Remand Centre by the nurses and other staff who rendered aid. Ambulance personnel attended to the Winnipeg Remand Centre and were also

unable to revive Mr. Brar. He was transported on an emergency basis to the Health Sciences Centre where he was pronounced dead at 12:37 a.m. on June 5th, 2020.

36. Based on the procedures and practices at the Winnipeg Remand Centre, adequate attention appears to have been paid in this case to making numerous and meaningful inquiries of Mr. Brar as to whether he was suicidal or present with a real potential for self harm. I conclude that adequate efforts were in fact made to inquire directly with Mr. Brar and all reasonable available information used to conclude that he did not present as a suicide risk.

37. The cause of death was concluded by Dr. Younes as hanging. I share this conclusion based on the totality of evidence tendered at this inquest. The manner of death as indicated by Dr. Younes was suicide. I also share this conclusion based on the totality of evidence tendered at this inquest.

RECOMMENDATIONS

38. This Inquest has the responsibility and duty to attempt to formulate and provide recommendations that may prevent such a tragedy from unfolding in the future.

Recommendation #1

39. On June 4th, 2020, a number of cells in the Winnipeg Remand Centre had a small opening on the top bunk of the cell between the bunk and a small rectangle shaped window in the cell. This opening would be roughly 6 inches by 6 inches.

It was through this relatively small space that Mr. Bar was able to tie his bedsheet securely around his bunk. He then was able to tie a towel to this sheet and wrap it around his neck to create a noose that would cut off his oxygen and blood supply when he let his entire body hang from this noose. This was the position he was in when found by Winnipeg Remand Centre staff. It is recommended that this space be eliminated from any and all cells where it may be present within the Winnipeg Remand Centre.

40. The Winnipeg Remand Centre has taken actions to seal up this space that exists between the top bunk and the window in not only cell 585 (the cell of Mr. Brar) but in each and every other cell that has similar or like physical layout. All counsel in this matter and I were able to attend to the Winnipeg Remand Centre for a tour of not only cell 585 but other relevant areas of the Winnipeg Remand Centre. We were able to observe firsthand this space had been sealed securely using a combination of screws and adhesive material to adhere a metal plate sealing up any space between the bunk and the window. While difficult to predict each and every form of mechanism an individual may use to try to complete suicide, the actions taken by the Winnipeg Remand Centre in this circumstance eliminate at least one avenue of potential suicide. This recommendation to seal off this space in any cells where it is present has been fully implemented.

Recommendation #2

41. Staff at the Winnipeg Remand Centre upon being hired are required to familiarize themselves with the standing order regarding suicide prevention as well as undertake suicide prevention training. Best practices indicate that the suicide prevention refresher training course should be done once every two years.
42. Owing to the COVID-19 pandemic, as well as difficulty in accessing the refresher training program, not all staff at the time of the incident were up to date on the suicide prevention refresher training. While efforts have certainly stepped up, and continue, to alleviate the backlog from the COVID-19 pandemic, the Inquest has heard evidence that not each and every member of staff has completed this refresher training course within the two-year period of time. It is recommended that resourcing be made available and priority be given to the policy that each and every staff member at the Winnipeg Remand Centre take the suicide prevention refresher course within the two-year time frame.

Recommendation #3

43. It is further recommended that when at all possible, videotaping of each and every critical incident such as this should take place. Handheld video cameras, or like technology, are not significantly cost prohibitive in this day and age. The ability of Remand Centre staff and management to review these videos may help

clarify any issues surrounding a critical incident itself as well as provide learning opportunities so that better care and effective emergency responses can be given in each and every situation. The Inquest has heard evidence that this has in fact become policy of the Winnipeg Remand Centre and that cameras have been provided, and priority given, so that this recommended videotape can take place in these critical incidents.

Recommendation #4

44. It is recommended that all in custody individuals be visually observed a minimum of once every 30 minutes after lockdown has occurred at the Winnipeg Remand Centre. Owing to manpower shortages and the COVID-19 pandemic affecting these already existing manpower shortages, visual checks every half hour were not being done routinely on all inmates. In Mr. Brar's case, he was left unseen by a guard for 56 minutes before he was discovered hanging in his cell.

45. The Inquest has heard direct evidence that this entire system has been revamped and revitalized so that there are strong protections so that each and every inmate will be visually viewed at least once every half hour. A recommendation of the Inquest is this policy continues such that each and every inmate is visually seen through the cell door at least a minimum of once every 30 minutes after lockdown.

Recommendation #5

46. It is further recommended that a formal report be authored by each and every nurse that is involved in a critical incident such as this. It has been the practice of the Winnipeg Remand Centre that when two or more nurses are involved in a critical incident that one will author the report on behalf of both of them. It is the Inquest's recommendation that a formal report from each specific nurse participant in a critical care incident will provide a more full, broad, and complete picture of what may have occurred. It is the Inquest's understanding that this has now become policy at the Winnipeg Remand Centre and each and every nurse must file a specific report.

Recommendation #6

47. Nurse coverage at the Winnipeg Remand Centre is critical. It is abundantly clear based on the evidence heard at the Inquest that nurses provide a vital and important role at the Winnipeg Remand Centre. This is of course a custodial facility where individuals cannot leave easily and a facility in which many individuals live on the margins of our society presenting with significant health and medical needs.

48. Evidence was led at this Inquest that roughly 90% of the time an overnight shift has only one nurse on duty; despite the fact that the evidence was uncontroverted that 2 nurses should be on duty at all times during the overnight

shift. On June 4th, 2020, there were luckily 2 nurses on duty. There was evidence led at the Inquest that owing to staff shortages there was a one-hour period of time where between the day and night shift there was no nurse on duty at all at the Winnipeg Remand Centre. This is unacceptable, and a significant issue.

49. It is no surprise to any resident of Manitoba that health care is strained. Finding and employing qualified nurses for virtually any medical facility can be difficult in Manitoba. Finding those same nurses that are desirous of working in a custodial facility is no doubt much more difficult. However, it is simply vital that full nursing staffing levels be maintained at the Winnipeg Remand Centre.

50. It is recommended that substantial financial incentives be offered to assist in the recruitment and retention of nurses at the Winnipeg Remand Centre. This Court understands through the evidence presented at the Inquest that the staffing numbers remain problematic, and recruitment is a very present issue. It is this Inquest's strong recommendation that these financial incentives be instituted forthwith and to the level where real recruitment and retention meaningfully occurs as the Winnipeg Remand Centre.

Recommendation #7

51. Anyone exhibiting any form of suicidal or self harm concerns is put on a special unit at the Winnipeg Remand Centre where they are monitored via video until there are no longer concerns for their safety. Those with a low risk assessment

after coming into the Winnipeg Remand Centre are simply placed in a regular cell without any video monitoring. This was the situation for Mr. Brar.

52. It is this Inquest's recommendation that any individual coming into the Winnipeg Remand Centre be monitored via video in their cell for a time frame of 48 hours. While not foolproof, this will provide Winnipeg Remand Centre staff the ability to monitor those individuals for the first 48 hours where they may have difficulty acclimatizing to a stressful living situation. This may act to allow Winnipeg Remand Centre staff to more closely monitor individuals and their health and safety in the initial phases of the integration process who show no signs of concern for suicide or self harm.

Recommendation #8

53. It is further recommended by this Inquest that pod officers be assigned around the clock on a 24-hour, 7 day a week basis. This will allow individual correctional officers to monitor to a great extent what is occurring on the ranges on a real time basis. Something out of the ordinary, such as what tragically occurred here, may be more able to be spotted more readily and as a result assistance provided on a more timely basis.

Recommendation #9

54. A tragic death such as this can have many consequences, not only on the family and friends involved, but upon the frontline participants in the justice system

that encounter it. It is recommended that the Winnipeg Remand Centre continue in their efforts to establish and provide peer support and wellness committees at the Winnipeg Remand Centre. Based on the evidence heard in this Inquest, many individuals were affected by this incident and peer support and wellness committees can only serve to benefit these frontline workers. The evidence at the Inquest is that this has been done and continues to be done on a go-forward basis.

CONCLUSION

55. I once again express my condolences to the family of Mr. Brar, and those affected by this tragedy. I wish to express my thanks to all counsel involved in this matter for their professional, diligent, and collaborative approach.
56. I respectfully conclude and submit this Inquest Report authored and completed on this day 10th of October 2024, at the City of Winnipeg, in the Province of Manitoba.

Judge Keith Eyrikson
Provincial Court of Manitoba



Manitoba

REPORT BY PROVINCIAL JUDGE ON AN INQUEST
INTO THE DEATH OF: JASBIR BRAR

APPENDIX “A” - WITNESS LIST

- 1. Sherriff Dennis Oteyza**
- 2. Sheriff Bhawanjot Kaur**
- 3. CO1 Brooke Olafson**
- 4. CO1 Dale Schwartz**
- 5. CO1 Dawait Waldeyes**
- 6. CO3 Dominic Dasylva**
- 7. CO1 Sarina Van Leeuwan**
- 8. CO3 Daniel Wasslen**
- 9. CO1 Angela Wieresma**
- 10. Nurse Paula Ewen**
- 11. CC0 Christine Reimer**



Manitoba

REPORT BY PROVINCIAL JUDGE ON AN INQUEST
INTO THE DEATH OF: JASBIR BRAR

APPENDIX “B” - EXHIBIT LIST

- EX S-1 Book of Authorities**
- EX S-2 Witness List**
- EX S-3 Letter dated May 7, 2021 to Chief Judge Wiebe from John K. Younes, MD, FRCPC**
- EX S-4 Report of Medical Examination dated January 31, 2021**
- EX S-5 Photos of the Emergency Knife**
- EX S-6 WRC Punch Round Version 1**
- EX S-7 Photo of the top bunk**