Release Date: October 31, 2025

IN 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 Lee Earnshaw
(DATE OF DEATH: June 14, 2021)

Report on Inquest and Recommendations of
Associate Chief Judge Tracey Lord
Issued this 28th day of October 2025

APPEARANCES:

Mr. K. Unruh, Inquest Counsel
Mr. R. Olson, and Ms. M. Smith, Counsel for Shared Health and Winnipeg Regional Health Authority
Mr. M. Alward, Counsel for Main Street Project

M A N I T O B A

The Fatality Inquiries Act

Report by Provincial Judge on Inquest

Respecting the death of: Lee Earnshaw

Having held an Inquest respecting the said death on March 24-28, April 28, 29, May 1, 2025, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: Lee Earnshaw

The deceased came to his death on the 14th day of June, 2021, at the City of Winnipeg, in the Province of Manitoba.

The deceased came to his death by the following means: Mixed drug toxicity

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

DATED at the City of Winnipeg, in Manitoba, this 31st day of October 2025.

"Original Signed by:"
Associate Chief Judge Tracey Lord
Provincial Court of Manitoba

Copies to:

- Dr. John Younes, Chief Medical Examiner (2 copies)
- Chief Judge Ryan Rolston, Provincial Court of Manitoba
- The Honourable Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act.*
- Mr. Jeremy Akerstream, Deputy Minister of Justice & Deputy Attorney General
- Michael Conner, Assistant Deputy Attorney General
- Michele Jules, Executive Director of the Manitoba Prosecution Service
- Mr. K. Unruh, Inquest Counsel
- Mr. R. Olson, and Ms. M. Smith, Counsel for Shared Health and Winnipeg Regional Health Authority
- Mr. M. Alward, Counsel for Main Street Project
- Exhibit Coordinator, Provincial Court of Manitoba
- Ms. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court

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Introduction

[1] Lee Earnshaw (DOB: December 13, 1978) died as a result of an accidental drug overdose on June 14, 2021, at the age of 42. The immediate cause of death was determined to be mixed drug toxicity (fentanyl and methamphetamine). At the time of his death Mr. Earnshaw was living in a homeless encampment in the vicinity of 44 Higgins Avenue in Winnipeg, and had been attempting to access treatment for opioid addiction. An Inquest into Mr. Earnshaw's death was called by the Chief Medical Examiner (CME), Dr. J. Younes on January 27, 2022. (Exhibit 1) In calling the Inquest, Dr. Younes noted that there had been an abrupt and dramatic increase in the number of opioid related deaths in 2020 and 2021 and set out his expectations of the Inquest process:

> It is not my expectation that an inquest will generate sweeping recommendations addressing the development and administration of addiction treatment resources in the province. Rather, it is my hope that the inquest will examine the circumstances at play in the months leading up to Mr. Earnshaw's death, with recommendations targeted at improving the existing system such that future individuals in Mr. Earnshaw's condition will be better served.

Legislative Mandate

[2] Section 19(2)(b) of *The Fatality Inquiries Act* provides that the CME may determine that an Inquest should be held if he or she is of the opinion that an Inquest may enable the presiding judge to recommend changes to provincial laws or the programs, policies and practices of the provincial government or of public agencies or institutions to prevent similar deaths in similar circumstances. The mandate of

this Inquest does not therefore deal with the provision of addiction services by privately run treatment facilities and will largely focus on how the existing system functions in relation to Opioid Use Disorder (OUD).

[3] A Standing Hearing was held on February 9, 2023, at which time, Shared Health/Winnipeg Regional Health Authority (WRHA) and Main Street Project (MSP) were granted standing to participate in the Inquest. The Inquest was held March 24-28, April 28, 29 and May 1, 2025.

[4] Between the calling of the Inquest in 2022 and the Inquest in 2025, the Auditor General of Manitoba provided an Independent Audit Report to the Legislative Assembly of Manitoba on Addiction Treatment Services in Manitoba. (Auditor General Report (AGR), July 2023) (Exhibit 4, Tab 25)

[5] The AGR covers the time between July 1, 2017 and June 30, 2022, and made 15 recommendations for the improvement of addiction treatment services in Manitoba. The report provides helpful additional context for the time period during which Mr. Earnshaw was attempting to access addiction services.

[6] The AGR noted at page 7, “Research shows that the decrease in availability and capacity of substance use treatment and harm reduction services in the early phase of the pandemic, among other factors led to many clients returning to, or engaging in higher-risk substance use, and growing wait times for service.” During

2021, the year of Lee Earnshaw's death, there were 400 confirmed substance related fatalities in Manitoba compared to 335 and 151 in the previous two years.

[7] Ultimately, the Auditor General concluded "that when Manitobans needed them, addictions treatment services were often not available in a timely manner." (AGR page 7)

Lee Earnshaw

[8] Lee Earnshaw was a commercial fisherman in British Columbia, where he lived with his wife and three children. As a result of a serious injury to his hand sustained while fishing, he was prescribed opioid medication. What began as a medical intervention to manage pain gradually turned into opioid dependence and eventually a struggle with opioid addiction.

[9] In 2017 Mr. Earnshaw moved to Grand Rapids, Manitoba to distance himself from a readily available supply of drugs. Ultimately, he moved to Winnipeg where overtime he became homeless, living in an encampment on the banks of the Seine River, all the while continuing to battle opioid addiction.

[10] In a Canadian Broadcasting Corporation (CBC) article posted May 3, 2021, in which Mr. Earnshaw's struggles were highlighted, he advised that he had been "clean" for three years until he began to "dabble" again the year prior and advised as of late he had been using fentanyl.

[11] While living in the encampment Mr. Earnshaw had regular contact with an outreach organization, St. Boniface Street Links (SBSL). With their assistance he made attempts to access addiction treatment. In the CBC article Mr. Earnshaw voiced his disappointment at being turned away from treatment after "psyching himself up and feeling ready to go". Being "ready for treatment" was a common theme throughout the testimony of witnesses called in this Inquest.

St. Boniface Street Links

Witnesses: Marion Willis, Jared Gerlinger, Laura Marin, Ryan Lampertz

[12] The Inquest heard evidence from Marion Willis, the founder and Executive Director of SBSL, a charitable organization whose mandate is to end homelessness by working to dismantle homeless encampments and housing those who live in them. The organization's focus is to assist those who are homeless, living in poverty, and/or suffering from mental health and addiction issues. SBSL has a long-term community-based recovery program, Morberg House, as well as other recovery beds in the community. The organization also operates an outreach program for those living in homeless encampments. Their outreach team covers the geographical area in the city of Winnipeg east of the Red River, including St. Norbert. It is this arm of SBSL that connected with Lee Earnshaw.

[13] The outreach program's mandate is to build relationships with people living in encampments, connect them to resources, such as income supports and housing

and assist in having mental health and addiction needs met. The team employs former users of the SBSL services who have the lived experience of homelessness and addiction. They gain trust by providing food, as well as harm reduction and first aid supplies when visiting individuals in an effort to get them on the road to recovery while addressing their housing needs.

[14] The outreach team made efforts to ready Mr. Earnshaw for addiction treatment by supporting his efforts to visit Rapid Access to Addiction Medicine (RAAM) clinics as well as to access the services of MSP for withdrawal management (detox).

[15] SBSL staff attempt to keep records of their interactions with the people they encounter but the organization does not have a comprehensive record management system. Records that do exist regarding contact with Lee Earnshaw have been provided but appear to be incomplete. The following is a compilation of the entries made by outreach workers who connected with him.

SBSL involvement with Lee Earnshaw

- February 2021 *Client has agreed to go to Detox and treatment and to get into housing. Writer will be calling to arrange these services* (Exhibit 5, Tab 1)
- March 9, 2021 *LaFleche - Lee, 40s, Indigenous, Male, I did talk with Lee briefly he was pretty sick from withdrawals, but he did say I could put him on the waitlist for Detox. I left message with Detox*. (Exhibit 6, Tab 1)
- March 10-12, 2021, *We brought Lee into the RAAM clinic in hopes of speeding up the process of getting him into detox, we were told there wasn't any beds, but we*

did get him on the waiting list, with a plan to go back on Monday and start his suboxone. (Exhibit 5, Tab 2)

- March 11, 2021, *The morning of this day was spent at RAAM with Lee* (Exhibit 6, Tab 2)
- March 15, 2021, *We did go back on Monday March 15 to get Lee at Lefleche camp, when we arrived, he wasn't there and his friends weren't to sure where he was, we did run into him later that day as we were walking out of Morberg house he was biking by, he said he was sorry and we told him it's all good and that when he's ready he can tell us.* (Exhibit 5, Tab 2)
- March 31, 2021, *La Fleche camp Lee refused services* (Ex.6 Tab 3)
- April 2, 2021, *La Fleche camp Lee was provided nutrition Lee has an infection on his hand, he did not want us to call paramedics and refused transportation to the hospital because he did not want to leave his belongings.* (Exhibit 6, Tab 3)
- April 5, 2021, as above (Exhibit 6, Tab 3)
- April 9, 2021, *Lee Earnshaw confirming that outreach had set up a bed for him at detox tomorrow Lee is requiring a ride to detox in the morning from 743 Sargent I have forwarded to Outreach* (Exhibit 6, Tab 4)
- April 12, 2021, *La Fleche Lee was not here; he could not be located or contacted by phone today. MSP put him in near the middle on the waitlist* (Exhibit 6, Tab 5)
- April 28, 2021, *743 Sargent Lee Earnshaw, 40's Indigenous, Male We were picking him up and getting him ready for withdrawal support, didn't go as planned as he had changed his mind.* Exhibit 5, Tab 4)

- April 28, 2021, *Outreach had phoned Arthur and informed him that they had found Lee but he was not wanting to detox and MH* (Exhibit 6, Tab 6)
- April 29, 2021, *La Fleche Lee refused services seems depressed* (Exhibit 5, Tab 5)
- April 30, 2021, *La Fleche Lee Earnshaw provided nutrition We're planning to put Lee into the EIA portal* (Exhibit 6, Tab 7)
- On May 3, 2021, the CBC article regarding Lee Earnshaw was posted online. (Exhibit 14)
- May 3, 2021, *La Fleche Lee Earnshaw, Indigenous, Male Lee's tent burned down. Nobody was hurt* (Exhibit 5, Tab 6)
- May 4, 2021, *La Fleche Lee Earnshaw, 40's Indigenous Male Provided nutrition Lee is interested in going to Detox on Thursday* (Exhibit 5, Tab 7)
- May 5, 2021, *At Morberg House Lee is having mixed feelings about leaving. I explained to him that he is in a good place and to try and relax, have something to eat. Lee walked off the property and I attempted to convince him to stay but he felt that he was not ready and the pressures of knowing he had drugs back at his camp was too much for him to handle.* (Exhibit 5, Tab 8)
- May 6, 2021, *La Fleche Lee was provided nutrition Lee was uncomfortable at Morberg House, he is firm on coming to house on Monday* (Exhibit 5, Tab 9)

[16] The Inquest heard testimony from some of those with SBSL who had direct contact with Lee Earnshaw in the months before his death.

Jared Gerlinger

[17] In 2021 Jared Gerlinger was an outreach worker at SBSL. He, himself had struggled with addiction as a teen and young adult and had been a successful resident at Morberg House. He subsequently accepted a position as an outreach worker. As part of his duties, he routinely searched the riverbanks, under bridges and in transit shelters looking for people living in encampments or needing assistance. Mr. Gerlinger had significant contact with Lee Earnshaw and took him to access a RAAM clinic at least three times, one of which was successful on March 11, 2021. Mr. Gerlinger also took Mr. Earnshaw to MSP to access detox at least twice, with no success.

Laura Marin

[18] Laura Marin worked at SBSL during 2021 as a Psychiatric Nurse, specifically at Morberg House. She met Lee Earnshaw in passing five or six times and spoke to him on one occasion about his care and needs. She and the practicum students working under her tried to come up with strategies to motivate Mr. Earnshaw and to get him to a RAAM clinic. On one occasion, in an effort to support him to abstain from using fentanyl prior to attending the clinic she arranged to have him stay in the garage suite at Morberg House for the night. Unfortunately, Mr. Earnshaw did not stay.

Ryan Lampertz

[19] Ryan Lampertz was employed with SBSL between January and July 2021. He worked primarily at Morberg House but on occasion did go out with the outreach team. On one such occasion, May 5, 2021, he met Lee Earnshaw and spoke with him about accessing detox again and returning to Moberg House for support. He said that Mr. Earnshaw had a significant addiction to opioids and could only go a few hours without using.

Arthur Weldon

[20] Arthur Weldon, an Occupational Therapist at Morberg House confirmed that Mr. Earnshaw did attend Morberg House on May 5, 2021 with the intention of getting through the initial stages of withdrawal before attending the RAAM clinic the next day. Again, unfortunately he did not stay.

[21] On both occasions when he was offered the support of Morberg House, Mr. Earnshaw was unable to stay because he became too ill from opioid withdrawal and needed to use fentanyl. All those at SBSL who dealt with Mr. Earnshaw shared the view that he sincerely wanted help but was so deeply entrenched in opioid use he was simply unable to become prepared for treatment.

Opioid Use Disorder Treatment

Witness – Dr. Erin Knight

[22] The Inquest heard evidence from Dr. Erin Knight, who is a Certified Addiction Physician with a background in Family Medicine. Dr. Knight completed a clinical fellowship in Addiction Medicine in 2016. She is also a professor in the departments of Psychiatry and Family Medicine at the University of Manitoba, and she is the Medical Director of Addiction Services with Health Sciences Centre. Dr. Knight is also the medical lead for RAAM clinics in Manitoba.

[23] Dr. Knight gave general testimony about opioid addiction and treatment, RAAM clinics in Manitoba and commented from the RAAM records about Mr. Earnshaw's visit to a RAAM clinic on March 11, 2021.

[24] Dr. Knight testified that most addiction treatment programs require a period of withdrawal or detoxification (detox) from the substance being used before starting treatment, usually 14 days. Symptoms of opioid withdrawal were described by Dr. Knight as being like the worst flu symptoms imaginable.

[25] For this reason, opioid withdrawal is very unpleasant and difficult to achieve without the medical assistance of Opioid Replacement Therapy (ORT), also referred to interchangeably as Opioid Agonist Therapy (OAT). She described two different approaches to managing withdrawal from opioids using ORT: the traditional method and the micro-induction method.

[26] Both methods replace the use of opioids by relying on drugs called buprenorphine's, but in different dosages. Suboxone is a commonly used buprenorphine in managing opioid withdrawal and is a partial agonist.

[27] An agonist is a substance which initiates a physiological response when combined with a brain receptor. Opioids are full agonists, whereas buprenorphine's like Suboxone are partial agonists.

[28] Buprenorphine's like Suboxone have a very high affinity for the brain's opioid receptors. If the opioid receptors are occupied by a full agonist like fentanyl when Suboxone is administered, it essentially removes the fentanyl from the receptors and takes its place. The result is that the receptors go from being 100% turned on by a full agonist to only 50% turned on by a partial agonist. This precipitates sudden and severe withdrawal.

[29] Traditional ORT requires a period of abstinence before beginning, to ensure the brain receptors are almost empty. This ensures that when the partial agonist is provided, rather than precipitating sudden withdrawal, it relieves withdrawal symptoms. For some opioids, eight hours without use is a sufficient period of abstinence to begin ORT. For those using fentanyl however, a period of 24 to 48 hours is required. This is because illicit fentanyl generally has other substances mixed with it and is unpredictable. If an individual has active fentanyl in their

system, using the traditional starting dose of Suboxone creates a significant risk of precipitated withdrawal, making symptoms substantially worse.

[30] In 2020, the fentanyl crisis prompted the introduction of an alternative opioid replacement therapy called micro-induction or micro-dosing.

[31] Dr. Knight explained that micro-induction was developed as a strategy to support active fentanyl users to begin the withdrawal process. Micro-induction is a method of providing small doses of Suboxone over the course of several days leading up to entry into detox. The purpose of micro-induction is to gradually build up the amount of buprenorphine in the system without precipitating withdrawal, until a dose that will address withdrawal symptoms is possible. There is no minimum period of abstinence required for the start of micro-induction. A person can start it the day they attend the clinic.

[32] Because the doses are small however, micro-induction does not help a person feel better while withdrawing. As a result, people generally continue to use opioids while micro-dosing in order to relieve withdrawal symptoms. The result is that fewer people who receive micro-dosing as compared to traditional ORT actually return to the clinic to continue the treatment. In October 2020 micro-induction was approved as part of the ORT guidelines for RAAM clinics in Manitoba.

[33] Dr. Knight testified that medications like Suboxone are designed for long term treatment of substance use disorder which is a chronic disease and are generally

required for a minimum of one year. The cost of Suboxone is on average twenty to thirty dollars per day and is paid by government health care if a person has treaty status or is on social assistance or employment assistance. Otherwise, the cost would have to be paid by private insurance coverage or paid for out of pocket.

[34] Many primary care providers like family doctors are reluctant to take on patients requiring ORT because their needs can be complex, requiring additional support and referral to other care providers. There continues to be significant stigma attached to addiction treatment in general, that may also fuel this reluctance.

[35] The number of primary care providers who administer ORT is small and they generally work in team-based clinics like RAAM, where those additional support services are available.

[36] Dr. Knight testifies that the treatment of substance use disorder has been introduced into family medicine training and exposure to the disorder during residency is mandatory in the academic curriculum of medical school in Manitoba. Despite this, she testified that fellowship opportunities to specialize in addiction treatment often go unused. So, while the demand for ORT is rising dramatically in the community, the number of physicians who will administer it is not.

[37] She testified that she and others continue to encourage primary care physicians to include ORT in their practices by providing information and support whenever possible.

March 11, 2021 – Lee Earnshaw visit to Rapid Access to Addition Medicine Clinic at River Point Centre, 146 Magnus Avenue.

Witnesses: Dr. Erin Knight, Jeffrey Schmitz, Ryan Menard, Jared Gerlinger

[38] On Thursday, March 11, 2021, Jared Gerlinger of SBSL was successful in having Mr. Earnshaw seen by staff at the River Point Centre (RPC) RAAM clinic. At that time the RPC clinic was run by the Addictions Foundation of Manitoba (AFM).

[39] Mr. Earnshaw first met with Nurse Jeffrey Schmitz who filled out the MB RAAM Initial Clinical Assessment Form (Exhibit. 4, Tab 37). In the section of the form entitled Reason for Presenting to RAAM, Mr. Schmitz recorded what appears to be a verbatim response from Lee Earnshaw.

> I'd like to go to detox for opiate withdrawal. I'm not sure how it works in Manitoba, was hoping for methadone withdrawal in detox, done that before in Vancouver, it eased coming off opiates. Was on methadone for a couple of years, just kept going up and kept using. Not looking for methadone Rx. Just want to get to detox and be somewhere to get it out of my system.

[40] In terms of his history, Mr. Earnshaw reported using crystal methamphetamine mixed with fentanyl daily since the summer of 2020, and having used both at 7:00 a.m. that morning. The last page of this form should have been completed by Dr. Poulin but for unknown reasons was not.

[41] After seeing Nurse Schmitz, Mr. Earnshaw next saw Ryan Menard, a Rehabilitation Counsellor and Dr. Poulin. Mr. Menard filled out the Rehabilitation Counsellor Assessment Form (Exhibit. 4, Tab 38).

[42] The three discussed the benefits of beginning Suboxone treatment to be followed by detox, to which Mr. Earnshaw agreed. However, because Mr. Earnshaw had consumed fentanyl that morning, he could not begin traditional ORT Suboxone treatment that day and was required to return on Monday, March 15, 2021, after a 24-hour period of abstinence to begin treatment.

[43] Despite micro-dosing having been approved in 2020, according to Mr. Schmitz and Mr. Menard the RAAM clinic used only the traditional method of Suboxone treatment, not micro-dosing. Dr. Knight confirmed this by indicating that in 2021 RAAM clinics did not have pre-packaged bubble packs of micro-doses. Mr. Menard also confirmed there were no RAAM beds available at MSP on March 11, 2021.

[44] SBSL staff were unable to locate Lee Earnshaw on March 15, 2021, to return with him to the clinic. On March 17, 2021, Mr. Schmitz made a note that SBSL had located Mr. Earnshaw, but as it was late in the day they were advised to take Mr. Earnshaw to a RAAM clinic the next morning at 9:30 a.m. Mr. Earnshaw did not attend to a clinic on March 18, 2021.

Rapid Access to Addiction Medicine

Witnesses: Dr. Erin Knight, Danielle Carignan Svenne, Erika Hunzinger, Crystal Cyr.

Dr. Erin Knight

[45] Dr. Knight is currently the Medical Lead for RAAM clinics throughout Manitoba. In 2021 she shared that role with Dr. Jeanette Poulin.

[46] In this role, and in conjunction with the RAAM Hub, she is responsible for developing policies and guidelines for managing care within the clinics and providing support for clinical decision making. The RAAM Hub is comprised of representatives from all RAAM clinics in the province and meets bi-weekly. There are currently three clinics in Winnipeg and one in each of Brandon, Selkirk, Thompson and Portage la Prairie.

[47] Dr. Knight gave evidence about how the clinics are operated, their policies and procedures and what changes have occurred since 2021.

[48] In 2021 there were two RAAM clinics in Winnipeg:

1. Crisis Response Centre (CRC), at 817 Bannatyne Avenue (run by Shared Health).
2. River Point Centre (RPC), at 146 Magnus Avenue (run by AFM in 2021, now run by Shared Health since April 2022).

[49] The first RAAM location to open in 2018 was the CRC clinic. By 2021 the RPC clinic was also operating. As the two clinics were run by different entities, they operated independently from one another, with different staffing and operational guidelines.

[50] The RAAM clinics were intended, as the name suggests, to provide timely short-term outpatient services with limited walk-in clinic hours during the day. In general, they operate on a first come, first served basis.

[51] In 2021 the clinic at CRC had greater capacity than RPC to see patients, and while RPC operated on a fairly strict first come first served basis, CRC had some ability to triage those waiting to determine individual needs.

[52] Dr. Knight confirmed from their inception, RAAM clinics have lacked the capacity to provide services to all who present themselves for care. This was the case in 2021 and remained the case in 2022, when in preparing their report, the office of the Auditor General observed a clinic day and noted only 3 out of 12 patients who attended received care.

[53] Based on unaudited data provided by Shared Health for the 12-month period between July 1, 2021 and June 30, 2022, 853 individuals who attended CRC RAAM were turned away without receiving services, and 276 individuals were turned away from RPC RAAM without receiving services. (AGR Exhibit. 4, Tab 25, page. 17)

[54] Dr. Knight confirmed that capacity issues continue today despite a number of positive changes that have occurred since 2021.

Erika Hunzinger

[55] Erika Hunzinger has been employed by Shared Health at the CRC in different capacities since 2015. In 2021 she was the Acting Director of Crisis Services, including the RAAM clinic. Once her acting status ended, she returned to being the Manager of RAAM at CRC. When Shared Health took over the clinic at RPC in 2022, it also came under her direction.

[56] Ms. Hunzinger confirmed that in 2021 it was common for people to be turned away from the CRC clinic without being seen, and that often their having attended at the clinic was not recorded.

Danielle Carignan Svenne

[57] Danielle Carignan Svenne has been employed by Shared Health as a Health Services Manager since July 2022. She is currently responsible for both the CRC and RPC clinics, which now operate under the same policies and procedures. Ms. Carignan Svenne gave evidence as to the operational changes that have occurred since 2021 designed to provide increased access.

[58] In terms of expanded clinic hours, the CRC has added an additional full day clinic on Saturday and has a second nurse position in place, as well as an additional

administrative support position. This has allowed for a more coordinated intake and referral process.

[59] In 2021 a person waiting in line at either clinic would have been seen by frontline staff such as a crisis worker or an administrative support person. A patient's presence at the clinic, and their identifying and contact information would not necessarily have been documented if they were turned away without seeing a doctor and redirected to another clinic location. There was little to no assessment of the medical status of those waiting in line and no standard method of record keeping for those who were turned away.

[60] A new intake and referral policy ensures that everyone who attends the clinic is seen by a nurse to evaluate their medical condition. They are also seen by a peer support worker who provides additional support and information if it is necessary to redirect them to another clinic location.

[61] Individuals are now medically assessed prior to the clinic opening during a registration period and have the option to either stay and wait or to return when the clinic opens and a doctor is present. They are then seen on a first come, first served basis, absent exceptional circumstances.

[62] The provision of additional staff at the CRC clinic has ensured that even if someone cannot be seen by a doctor the day they attend the clinic, they are now receiving more comprehensive evaluation and assistance.

[63] Medical history and contact information are now recorded and kept regardless of whether a person is seen in the clinic that day, and some effort is made to ensure that someone who repeatedly seeks services is prioritized upon return.

[64] It is still the case that if an individual cannot be seen that day they are redirected to the next available clinic.

[65] When someone currently presents at a RAAM clinic without one of the noted means for financial coverage, or without a Manitoba health card, staff will assist with a referral to obtain the required funding if eligible.

[66] Finally, RAAM clinics now have the means to use micro-dosing of Suboxone if it is determined to be the appropriate method of ORT.

Additional Rapid Access to Addiction Medicine clinic opened in Winnipeg

Witness: Crystal Cyr

[67] Crystal Cyr is the Director of the third RAAM clinic to open in Winnipeg in August 2023 at the Aboriginal Health and Wellness Centre (AHWC), 181 Higgins Avenue. This clinic is funded by Shared Health but is independently run by the Aboriginal Health and Wellness Centre.

[68] This location operates two walk-in clinics per week on Tuesday and Thursday. Registration begins at 11:00 a.m., with the clinic opening at noon on Tuesdays and 1:00 p.m. on Thursdays. These start times are later than the other

RAAM clinics and were designed to service some of the patients re-directed from the CRC and RPC clinics, which open at 9:30 a.m. for registration.

[69] The clinic follows the same standard policies and procedures as the other RAAM clinics, and while it also has features unique to treating Indigenous patients, all patients are welcome.

[70] The AHWC clinic hires Indigenous staff whenever possible and has a unique physical layout and operational process designed to remove the hierarchy between physician and patient. This acknowledges that many of their patients have had negative experiences in traditional health care settings.

[71] The clinic has a "greeter" who helps patients fill out the required forms when registering and remains present with those in the culturally safe circular gathering room while they wait. Drumming, music and smudging can be a part of the waiting process in this space. There is also a separate recovery room for those to rest in after receiving medication.

[72] This clinic includes an Indigenous social planner position. This person is tasked with connecting patients to other non-medical cultural services such as sweat lodges or other ceremonies.

[73] The AHWC clinic employs two registered nurses and two psychiatric nurses who triage patients once they have registered. The centre also employs a medical office assistant and two counsellors.

[74] As many of their patients are unhoused, having them attend during clinic hours and for follow-up appointments is challenging. When follow-up appointments are missed counsellors will go out into the community in an effort to locate the patient and bring them into the clinic for their appointment.

[75] In addition, the AHWC RAAM operates a mobile clinic on Saturdays using a refurbished ambulance. They commonly set up temporary tent clinics in the vicinity of a shelter and provide the same walk-in services as a permanent clinic.

Remote Access to Rapid Access to Addiction Medicine

Witnesses: Dr. Erin Knight, Danielle Carignan Svenne, Crystal Cyr

[76] RAAM can now be accessed remotely through the "Digital Front Door". This is a nurse led walk-in clinic that provides remote access to a RAAM clinic for anyone with internet access. This service is particularly useful for those living in rural or remote locations as an initial point of contact. Medical history can be gathered and educational information provided before the effort is made to undertake in-person travel to a clinic. The AHWC is the default clinic for all those from the North seeking services.

[77] After the initial remote assessment, a program called the "Northern Pathway" allows for those from rural and remote communities to travel to Winnipeg to access a RAAM clinic in person and receive their initial treatments of Suboxone. They are then ideally moved to monthly injections supported by other clinics, such as

Manitoba Opioid Support and Treatment (MOST) or a primary health care provider, rather than having to return to a RAAM clinic.

[78] For the most part, the Digital Front Door is not useful for those who are unhoused. However, the AHWC clinic is exploring ways for individuals to access the portal from a shelter or for those who find themselves in custody also from the Winnipeg Remand Centre (WRC).

[79] Dr. Knight, Ms. Carignan Svenne and Ms. Cyr all confirmed the numbers of individuals presenting at RAAM clinics with opioid use disorder has risen. These individuals require longer ongoing treatment with a doctor than those with addiction to other substances. This has resulted in an increase in the number of required follow up appointments with a doctor. This increase reduces the clinic time available for first time walk-in patients. Statistics for 2021/2022 show that of 8486 visits, over 7000 were for follow up appointments, as opposed to first time patients.

[80] At page 25 of the AGR it is noted that for the years 2018/19, 81 people received ORT at a RAAM clinic, whereas in 2021/22 this increased to 944. (Exhibit 4, Tab 25)

[81] All reiterated that this was not the type of care the RAAM clinics were designed to provide and has further impacted the capacity to see those who are looking for assistance on any given day.

Main Street Project

Witnesses: Jamil Mahmood, Dawn Cumming, Trevor Aikman

[82] The Inquest heard testimony from several witnesses about the Withdrawal Management Services (WMS), also known as detox, offered by MSP. Services for men operate out of 75 Martha Street. Corresponding services for women operate out of RPC. Much of the evidence focussed on how the WMS men`s program operated in 2021, as compared to how services are provided now.

[83] In addition to WMS, MSP also offers shelter services, protective care for people detained under *The Intoxicated Persons Detention Act, CCSM c.190* as well as various outreach programs in the community.

[84] Jamil Mahmood is the executive director of MSP. He has been in that position since January 2021. Dawn Cumming was the director of WMS in 2021, and Trevor Aikman is the current program manager of WMS since December 2022.

[85] MSP provides 14-day withdrawal or detox services. As a rule, abstinence for 14 days is required for admission into most, but not all, addiction treatment facilities. In addition, a medical clearance form from a physician or nurse practitioner, completed within 72 hours is required upon admission to MSP. If someone attends without medical clearance a referral to a RAAM clinic is made to obtain one.

[86] While there can be exceptions in the case of an existing period of abstinence, to begin opioid withdrawal, a person must also have started ORT therapy and have a prescription for either methadone or Suboxone.

[87] Historically, the need for detox beds has always been greater than the availability MSP could offer. There has always been a waiting list to access a bed. In 2021 this was exacerbated by the COVID-19 pandemic.

[88] In 2021, the men's facility at 75 Martha Street had 21 detox beds, reduced from 28 beds due to the requirement to socially distance during the pandemic.

[89] Symptomatic clients attached to the various MSP services were housed at hotel COVID isolation sites rather than at 75 Martha Street.

[90] According to Mr. Mahmood, in 2021, MSP employed one nurse and one nurse practitioner. By necessity, nursing staff were redeployed to the isolation sites to care for those individuals with COVID. As a result, they were less able to care for those accessing WMS. In addition, the detox facility had to close on two occasions due to staff shortages caused by illness. These factors caused the number of people on the wait list to grow. By the end of the pandemic there were between 50 to 100 people waiting for a bed.

[91] When the RAAM clinics opened in 2020, eight additional beds were added to WMS (four men's and four women's) funded by the WRHA.

[92] In 2021, of the 21 available beds for men, four were reserved for RAAM referrals, four were reserved for hospital referrals and the remainder were designated for community members wanting to access detox without a specific referral. It is the individuals without a specific referral that occupy the waitlist.

[93] Every morning MSP staff email the various RAAM clinics throughout the province to advise them how many RAAM beds are available. Generally speaking, if no referrals are made by the RAAM clinics on any given day, the reserved beds go unused.

[94] This is confirmed by Exhibits 10 and 11 which are spreadsheets showing the occupancy of detox beds on any given day from January 2018 to April 2025, for the men's and women's facilities.

[95] In 2021 those on the waitlist would be contacted a few days in advance of a bed being available in order for them to obtain the required 72-hour medical clearance and any required prescription. In some cases, for various reasons, those contacted would opt not to access the available bed. This was the case with Lee Earnshaw.

[96] While there is no record of Mr. Earnshaw being brought to MSP by SBSL outreach workers, there is a record of direct contact with him in the months of April and May 2021.

[97] On April 12, 2021, Mr. Earnshaw called MSP himself to enter detox. An intake interview was conducted, and he was placed on the waitlist.

[98] On May 15, 2021 MSP staff called him back to advise a bed was going to be available for him. Mr. Earnshaw said he was not yet on ORT and asked to be moved down the waitlist two weeks in order to arrange it. MSP called him again on May 25, 2021, but he did not return their call. (Exhibit 4, Tab 23)

[99] Jamil Mahmood and Trevor Aikman gave evidence as to the positive changes that have occurred with the WMS since the end of the pandemic.

[100] With the opening of AHWC RAAM clinic in 2022, two additional beds have been designated as RAAM beds at each location to address the increased number of referrals.

[101] Government funding was received for a one-year period to hire one intake worker, at each location. These two additional workers resulted in a more robust intake process, increased contact with those awaiting a bed and an ability to go into the community to locate those like Mr. Earnshaw, who are unhoused and may not have a phone or regular way to be contacted. After the government funding lapsed, MSP continued to fund the two intake positions using private doner funds.

[102] In addition to new staff, a new procedure has been implemented to better manage the waitlist. Upon completion of the intake process, when someone is placed

on the waitlist, they are now given a confirmed bed date. This also resulted in a more effective use of available beds. The waitlist is now between 30 to 50 people.

[103] Bed usage is also now more actively monitored to allow for a more flexible approach. This ensures more people needing a bed can access one even in some cases, if the category of bed required is technically full.

[104] MSP now tracks RAAM referrals to keep a record of who is referred but does not ultimately arrive.

[105] It was acknowledged that while the goal is to have all beds used at all times, there still remain times when that does not occur. (Exhibit 10 and 11)

Destigmatizing Addiction

[106] Despite the efforts of many, addiction remains a highly stigmatized condition and is more often than not cloaked in secrecy and shame. Mr. Earnshaw did not share the full details of his struggles with his family, and they were not aware of the full extent of his personal circumstances. The stigma attached to addiction pervades society and effects the attention and care that those suffering receive. This extends to the manner in which it is funded by health care, the number of medical students who choose it as a specialty and the number of primary care physicians who care for patients on ORT, to name a few. Addiction is an illness like any other and should be viewed as such by those funding the health care system.

“Ready for Treatment”

[107] One of the reoccurring themes in the testimony of the Inquest witnesses was the concept of being “ready for treatment”. Being “ready for treatment” can mean different things to different people at certain points in the process of addiction treatment.

[108] For example, to those providing care at a RAAM clinic, one criteria for being “ready for treatment” is being abstinent for the period of time required to begin ORT. As became clear, an individual may have to be “ready for treatment” several times before actually receiving care at a RAAM clinic if the line up is too long or a detox bed is not available.

[109] To those conducting the admission process at MSP, being “ready for treatment” means having the required medical clearance and having the required prescription for ORT.

[110] As reported by the CBC in May 2021, for Lee Earnshaw being “ready for treatment” meant being psyched up and feeling ready to go.

[111] To the person seeking treatment, being “ready for treatment” means one simple thing. **I need help today!** It is this meaning of being “ready for treatment” that guides the recommendations of this report.

Gaps and Barriers

[112] Private treatment can be very costly and is not an option accessible to most people who suffer from addiction. As such, access to publicly funded treatment becomes critical. Mr. Earnshaw encountered barriers and fell through gaps in his attempts to access treatment for his addiction to opioids.

[113] Mr. Earnshaw's lack of stable housing and access to basic technology, such as telephone or internet made it difficult for him to communicate with service providers, other than in person, and vice versa. In 2021 organizations such as MSP had limited ability to provide outreach to maintain contact with those who had contacted them indicating interest in detox and addiction treatment.

[114] Because there are limited primary care physicians providing ORT, most individuals like Lee Earnshaw who are seeking treatment must access a doctor through a public clinic such as RAAM, where hours are limited and many who attend are turned away without seeing a doctor.

[115] Opioid addiction, particularly when fentanyl is involved requires a longer period of abstinence before beginning traditional ORT. Mr. Earnshaw was not able to achieve this. Despite being authorized for use in 2021, RAAM clinics were not offering the option of micro-induction to those actively using fentanyl.

[116] Even if Mr. Earnshaw had been able to start ORT the day he attended the RAAM clinic, and proceed with a prescription to MSP for detox, there were no RAAM beds available that day.

[117] It is unknown, had Mr. Earnshaw received a prescription for ORT whether he had the required status for financial coverage or whether that would have been yet another barrier to him receiving treatment.

[118] In addition to the specific gaps and barriers encountered by Lee Earnshaw in 2021, additional issues were identified by witnesses at the Inquest in 2025. The sum echo many of the findings and recommendations of the Auditor General's report from 2023 regarding the accessibility of addiction treatment in the publicly funded system. As such, many of the recommendations in this report will mirror those made by the Auditor General.

Recommendations

[119] In listening to the Inquest witnesses, it became clear that those who work in the area of addiction treatment are both dedicated and tireless in what must feel like a daily uphill battle to provide needed care. It is abundantly clear the resources available to those requiring publicly funded addiction care are extremely limited when compared to the growing need. It is also clear the need for help comes at all times of the day or night. When asked for their own recommendations, every witness began by highlighting the need for increased funding in the sphere of addiction

treatment. This includes resources to increase staffing, from intake workers to outreach workers, nurses and ORT prescribing physicians. Funding for additional detox beds and additional treatment beds is also required so that those reaching out for help are not turned away without receiving the health care they require.

Recommendation 1: Increase Access to Rapid Access to Addiction Medicine Clinics

- It is recommended that the number of RAAM clinics operating in Manitoba be increased to reflect the growing need for treatment. It is further recommended that the walk-in clinic hours of operation be increased to five days per week and that the CRC RAAM clinic operate with extended evening and weekend hours. This will necessitate an increase in staff at all levels.

Recommendation 2: Increase Access to Opioid Replacement Therapy Prescribing Physicians and Micro-dosing

- It is recommended that incentives be provided to those in medical school to specialize in addiction treatment and that incentives be provided to primary care physicians to include ORT as part of their regular practice. This would provide additional avenues for access to treatment outside of team-based clinics such as RAAM, and reduce the time spent at RAAM clinics for follow-up appointments. This in turn would allow for greater opportunity for walk-in patients to be seen on the first day they present for assistance.

Recommendation 3: Financial Coverage for Required Medication

- Many of those who present at RAAM clinics may not be in a position to pay for ORT, have insurance plans or proof they qualify due to their status. It is recommended that provincial health care provide coverage for ORT to those who do not have any source of financial coverage from some other avenue.

Recommendation 4: Expansion of Withdrawal Management Beds

- It is recommended that the number of detox beds throughout the Province of Manitoba be increased to reflect the growing need for treatment. In addition, it is recommended that facilities such as MSP who provide WMS, provide detox beds that are medically supervised to accommodate those on ORT immediately upon starting the medication. This will require an increase in funding for medically trained staff such as nurse practitioners and physicians.

Recommendation 5: Expansion of Treatment Facilities

- It is recommended that the number of treatment beds throughout the Province of Manitoba be increased to reflect the growing need for residential addiction treatment.

[120] With respect to Recommendations 1-5, the limited access to addiction treatment is particularly critical in the North. This is evidenced by the fact that many Northerners, particularly those who are Indigenous, must travel to Winnipeg for treatment. Increasing access to ORT prescribing physicians, WMS and addiction

treatment to those residing in the North not only provides the same level of medical care to Manitobans regardless of where they live in the province, but also serves to alleviate pressure on resources in Winnipeg, particularly at the Aboriginal Health and Wellness Centre RAAM clinic.

See also AGR Recommendation #13

[121] One of the primary gaps identified by Inquest witnesses was the lack of connection and coordination between the various organizations responsible for the continuing and interconnected phases of addiction recovery. In the transition from one phase to the next, individuals often relapse, lose motivation or simply fall out of communication. For example, after crossing the hurdle of being seen by a physician and obtaining medical clearance for detox, an individual may have to wait days or even weeks, to access a detox bed. In the intervening time, it is a challenge to abstain when returning to the same environment/community where using was/is prevalent. Even if a bed is available, witnesses reported that in some cases individuals fail to navigate the trip from the RAAM clinic to MSP. Likewise, once a 14-day period of detox is completed, a treatment bed may not be immediately available, and an individual may have to return to the same environment/community where using was /is prevalent and wait days or even weeks to enter a facility. Once a bed becomes available it can be equally challenging to locate the individual to advise of bed availability. The result is a lost opportunity to begin the treatment process. What is

required is a seamless transition from the point of "being ready for treatment" to accessing a treatment bed.

Recommendation 6: Co-Location of Prescribing Physicians, Withdrawal Management Services and Treatment Facilities

- It is recommended that multi-phase facilities be created throughout Manitoba in which all addiction related services are located together to address the gaps in both time and physical location in which individuals become lost to the system. Some of the Inquest witnesses expressed concern with co-locating WMS and treatment services, as it may be triggering to those in treatment to have contact with those going through the detox process.
- To be clear, the recommendation is not that co location of addiction services combine the two populations but rather that it create physical proximity within the same geographical footprint to allow for seamless transition from one phase of recovery to the next.
- Co-locating services is even more critical in rural and northern locations where individuals may have to travel vast distances to transition from one treatment phase to the next.

  See also AGR Recommendation #10

[122] Evidence from the St. Boniface Street Links and Main Street Project witnesses provided a unique perspective on the challenges faced in maintaining contact and

providing support to those who have voiced a willingness to treat their addiction. MSP witnesses said that having funding for an additional intake staff allowed for enhanced communication with those on their waitlist, including those who were unhoused. For example, providing transportation to a RAAM clinic, or providing assistance in filling an ORT prescription and obtaining financial coverage for same reduces barriers faced by many and creates a network of support for those who otherwise have none.

[123] Establishing a method of communication and support may keep an individual engaged and trusting in the process while awaiting an appointment or a bed date. This is particularly critical when dealing with those who are unhoused.

[124] Further, the need for support does not end with the completion of treatment. Treating an addiction, particularly opioid addiction may be a lifelong journey. As in the case of someone awaiting a treatment bed in circumstances that make it difficult to abstain, support and community outreach is likewise needed post treatment. Without continued support, those who return to the circumstances that may have given rise to the addiction are less likely to be successful in recovery.

Recommendation 7: Dedicated Community Outreach Services

- Outreach is essential in assisting those who ask for help to prepare to begin, to stay motivated throughout and to remain substance free post treatment. It is recommended that existing or new addiction service providers enhance

community outreach to provide support and assistance throughout the process including addressing collateral needs such as housing, financial support and other healthcare needs.

See also AGR recommendation #'s 11 and 14

[125] It is clear that the nature of the addictions many are facing has changed substantially in recent years. Models created in the past to treat addiction to certain substances, such as alcohol, may not be applicable to current substances in high use, such as opioids.

[126] The traditional models of 21- or 28-day residential treatment may work for addiction to alcohol or other substances but may not be effective for opioid addiction, which requires longer sustained treatment.

[127] Further, not everyone who is addicted requires residential treatment if they have sufficient support and monitoring in the community. Many who are suffering from addiction maintain regular employment and have families they support. The risk of losing employment or contact or worse custody of children can be an impediment to participating in residential treatment. With sufficient support many may be able to remain in the community with their families and continue employment, particularly given the long-term nature of treatment required to treat opioid addiction. One size does not fit all.

Recommendation 8: Flexible Treatment Models

- It is recommended that models of addiction treatment be expanded from a focus on bed-based treatment to other models where individuals are supported in place, in the community, including long term community-based aftercare.

  See also AGR Recommendation #'s 11 and 14

Conclusion

[128] Members of Mr. Earnshaw's family attended the Inquest daily and continue to grieve his loss. They graciously shared memories of him through photographs and a written submission. (Exhibits 8 and 13). While I am unable to say one or even a combination of these recommendations would have prevented Mr. Earnshaw's death, I am however hopeful that these recommendations will increase the likelihood that someone in Mr. Earnshaw's circumstances will meet with success when they ask for help.

"Original Signed by:"
TRACEY LORD, ACJ

REPORT BY PROVINCIAL JUDGE ON AN INQUEST
INTO THE DEATH OF: Lee Earnshaw

APPENDIX "A" - EXHIBIT LIST

1. Letter from Chief Medical Examiner dates January 27, 2022
2. Notice of Standing Hearing dated January 17, 2023
3. Consent Orders of Disclosure x3
4. Inquest binder #1
5. St. Boniface Street Links Disclosure
6. St. Boniface Street Links additional Disclosure
7. List of Recommendations (written by Marion Willis)
8. Photo's of Lee Earnshaw
9. RAAM Clinic Data slides
10. Main Street Project bed occupancy spreadsheet – Male
11. Main Street Project bed occupancy spreadsheet – Female
12. Main Street Project Email Chain
13. Family statement about Lee Earnshaw
14. CBC Article on Lee Earnshaw dated May 3, 2021
15. Crown's Recommendations