

RELEASE DATE: November 7, 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 John George
Ettawakapow

Report on Inquest
Senior Judge Brian Colli
Issued this 4th day of November 2024

Appearances:

Ben Wickstrom, Inquest Counsel

Brenna Dixon, Counsel for the RCMP

Jeremy Ettawakapow, Family Representative



Manitoba

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

**REPORT BY PROVINCIAL JUDGE ON AN INQUEST
RESPECTING THE DEATH OF JOHN GEORGE ETTAWAKAPOW**

Having held an inquest respecting the death of John George Ettawakapow on June 17, 18, 19, 20, 21 and July 31, 2024, at The Pas, Manitoba, I report as follows:

The name of the deceased is John George Ettawakapow

The deceased came to his death on the 6th day of October, 2019 at The Pas, Manitoba.

The deceased came to his death by the following means:

Acute alcohol toxicity with additional contributing factors of alcoholic cardiomyopathy, coronary artery atherosclerosis and external neck compression. (See Schedule 1.)

I hereby make the recommendations set out on the attached Schedule 2.

Attached hereto and forming part of my report is Schedule 3 listing all Exhibits required to be filed by me.

Pursuant to the provisions of *The Fatality Inquiries Act*, C.C.S.M c. F52 (the “*Fatality Inquiries Act*”) I am ordering that all the Exhibits be turned over to the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application with notice to any party with a privacy interest. Exhibit 3 consisting of a video of events occurring in Cell 7, The Pas RCMP Detachment on October 5-6, 2019, is subject to a sealing Order and a limited Unsealing Order attached as Schedule 4.

Dated at Thompson in the Province of Manitoba, this 4th day of November, 2024

Original Signed by Sr. Judge B. Colli
Senior Judge Brian Colli

Copies to:

1. Dr. John 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. Mr. 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. Ben Wickstrom, Counsel to the Inquest
8. Brenna Dixon, Counsel to the RCMP
9. Exhibit Coordinator, Provincial Court of Manitoba
10. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba
11. Jeremy Ettawakapow, Family Representative



Manitoba

REPORT BY PROVINCIAL JUDGE ON AN INQUEST
INTO THE DEATH OF: John George Ettawakapow

TABLE OF CONTENTS TO SCHEDULE 1 OF THE INQUEST
RESPECTING THE DEATH OF JOHN GEORGE ETTAWAKAPOW

I.	Holding of Inquest	1
II.	Synopsis of Evidence.....	3
	A. Witnesses	3
	B. Exhibits..	17
III.	Summary of Facts	23
IV.	Previous Inquests	26
V.	Factors for Examination	29
	A. Immediate Medical Attention	30
	B. Early Observation of the Risk	33
	C. An Alternative Way.....	36
VI.	The Sealing Order and Limited Unsealing Order.....	40
VII.	Conclusion	41

SCHEDULE 1
To Report on Inquest
Respecting the Death of John George Ettawakapow

I. HOLDING OF INQUEST

[1] On October 5th, 2019, Royal Canadian Mounted Police (RCMP) Constables (Cst) Joel Hardes and Erica Newbigging arrested John George Ettawakapow for causing a disturbance by being drunk. They lodged him in cells at The Pas Detachment of the RCMP. Several hours later, Corporal (Cpl.) Wiite, the RCMP watch commander, found Mr. Ettawakapow unconscious and unresponsive in the cell. Both police and emergency medical personnel made persistent efforts to revive him without success. He was declared dead just before 2:00 of the morning of October 6th, 2019.

[2] The Chief Medical Examiner (CME) for the Province of Manitoba by letter dated the 11th day of March, 2022 directed that an inquest be held into this death to fulfill the requirement for an inquest as set out in section 19(5)(b) of the *Fatality Inquiries Act*. That subsection reads in part as follows:

19(5). Subject to subsections (6) and (7), an inquest into a death must be held if:

(b) at the time of death, the deceased person was:

- (i) in the custody of a peace officer,
- (ii) a resident in a custodial facility...

[3] The purpose of the inquest is twofold, namely:

- (i) To determine the circumstances relating to the death of John George Ettawakapow and

- (ii) To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[4] Two parties applied for standing as interested parties at this inquest, namely the Royal Canadian Mounted Police (sometimes hereafter referred to as the Force or RCMP) represented successively by Ms. Samantha Gergely and Ms. Brenna Dixon and Mr. Jeremy Ettawakapow, son of the deceased, on his own behalf and on behalf of his family. The family has been waiting for this inquest for a long time. There were two contributors to the delay. The inquest was not called until an internal investigation was completed by the Independent Investigations Unit (IIU) and a decision made about the laying of criminal charges. By the time the investigation was fully completed, Covid had struck resulting in the cancellation of a majority of sittings in our Court across the Province. I was assigned this inquest in the latter part of 2023 and, while I take little credit for it, the proceeding has been going smoothly since. A standing hearing took place on January 5th, 2024 at which time I granted standing to the parties earlier mentioned. The family initially considered retaining a lawyer. Arranging for a lawyer, though, would have resulted in further delay in scheduling and holding the inquest. As a result, the family decided not to retain a lawyer to avoid that additional delay.

[5] The inquest began hearing evidence in The Pas Provincial Court on Monday June 17th, 2024 and continued on the next three days. I heard evidence from several police officers, a civilian member of the RCMP, a guard at The Pas RCMP

Detachment on the night of the material events, the executive director of the Main Street Project in Winnipeg and Dr. John Younes, the Chief Medical Examiner for the Province of Manitoba. On June 21st, 2024 I heard the submissions of counsel on recommendations that I might make in my report. During the inquest, I made an Order sealing one of the Exhibits. I also later granted an application by the Canadian Broadcasting Corporation (the CBC) to unseal the Exhibit for a limited purpose. I will have more to say about the Sealing Order and about its limited unsealing later in this report.

[6] On July 31st, 2024, I re-opened the inquest to consider admitting further items as Exhibits in this case.

II. SYNOPSIS OF EVIDENCE

[7] Nine witnesses testified at this inquest. In addition, I received 14 Exhibits into evidence, including, most significantly, a video of the material events in Cell 7 at The Pas Detachment RCMP. I will summarize the evidence of the witnesses and review some of the Exhibits and then provide a statement of the facts which form the basis for the recommendations I make.

A. Witnesses

1. John Stevenson

[8] Mr. Stevenson was the lead investigator for the IIU assigned to investigate the details of Mr. Ettawakapow's death. He and his team of investigators travelled

to The Pas on October 6th, 2019 and there interviewed all individuals present at the time of Mr. Ettawakapow's death or who had involvement with him from the time of his arrest in the early evening of October 5th, 2019 until he was pronounced dead at 1:56 a.m. October 6th, 2019. He also seized the cell video from police showing the events occurring in the cell from the time that Mr. Ettawakapow was lodged. Mr. Stevenson had retired from the IIU by the time that it issued its final report, tendered as Exhibit 1.

2. Christopher Massart

[9] Inspector Massart is the assistant district officer for Manitoba North District of the RCMP. He has extensive experience as a peace officer, having joined the Force in 2005. His current position requires him to know RCMP policy thoroughly and a large portion of his evidence consisted of reviewing and explaining policy and the duties and expectations of guards.

[10] Police Cell guards, he testified, are employees of the Commissionaires but are hired by the local detachment. Their instruction, generally speaking, comes from or is arranged by the Detachment's Operations Officer who in most Detachments, including The Pas, is the second-in-command of the Detachment. While the training of guards is expected to meet standards set by it, the Force has not established a formal training program. Guards must learn all policy relating to their employment

as guards and once every six months must certify that they have reviewed existing policy including any changes to it.

[11] Policy comes from three levels in the Force: National, Division and Detachment. Inspector Massart identified each of the policies tendered into evidence, some of which I will refer to later in this report.

[12] He is familiar with the cell facilities in The Pas. There are seven cells, three of which are designed for use by intoxicated persons. There are four regular cells used for individuals who are not intoxicated. The major difference between the two kinds of cells is that those used for intoxicated individuals are stripped of all furnishings in order to reduce the risk of accidental harm from tripping or falling. One of the “drunk tanks” is used for males; the other for females and the third for those who are disturbed or violent.

[13] Inspector Massart estimated that about 2100 people per year are detained in cells in The Pas. Guards, he explained, are to keep watch over the prisoners and make sure each of them is safe. They must make regular checks of intoxicated prisoners to ensure they are breathing because of the risk of alcohol poisoning. To assist the guards in those duties, there is a monitor located at the guards’ desk allowing them to observe all prisoners in each cell. They must, according to policy, physically check on the prisoners at least once every fifteen minutes by attending to the cell and opening a slot in the door to look in. Guards are expected to use the

monitors in between those “physical” checks to keep continuous watch of them. For intoxicated prisoners, guards are to perform a responsiveness check at least once every four hours. While the guards may not enter a cell on their own absent exigent circumstances, they can shout and make noise to rouse a prisoner about whom they have concerns.

[14] The Inspector confirmed that he had viewed the video of Cell 7 for the night in question, Cell 7 being the cell in which Mr. Ettawakapow was lodged. He testified that the video shows another prisoner placing his leg and foot on Mr. Ettawakapow’s neck and face for about forty minutes and Mr. Ettawakapow appearing to respond to the pressure of that leg by raising his arms in apparent efforts to remove it. His efforts continued for about thirteen minutes after which Mr. Ettawakapow did not move again. In his opinion, the placement of the leg on Mr. Ettawakapow’s neck required the guard to intervene. He also testified that the video does not show any physical checks on the cell from the time that Mr. Ettawakapow entered it until Cpl. Wiite discovered him in apparent distress at approximately 1:30 a.m. of October 6th, 2019.

[15] Inspector Massart also commented on police powers of arrest. Drunken individuals may be detained under *The Intoxicated Persons Detention Act, C.C.S.M., c. 190* (the “IPDA”) for their own safety. They may also be arrested to ensure the safety of others or to prevent the commission or continuation of a criminal offence

pursuant to authority granted to police under the *Criminal Code*. His experience as a peace officer is that typically the *IPDA* is used by officers to protect drunken individuals. When asked why officers who arrest intoxicated individuals do not, as a matter of course, have them cleared for custody by medical personnel before lodging them, he advised doctors are not immediately available to police and the wait for a doctor can be daunting. Police receive no priority and must queue up behind all those who are already waiting to see a physician. An officer can spend up to eight hours, most of a shift, waiting in the emergency room of a hospital waiting for a prisoner to be medically assessed. The result is that the community is left with fewer police resources during the time that any officer is tied up at the hospital.

[16] He also testified that since Mr. Ettawakapow's death a new National policy has been developed encouraging arresting officers to use the provisions of the *IPDA* as a last recourse for those individuals who are at risk of harm because of their intoxication. Placement with responsible family members, friends or appropriate community programs should first be ruled out by the arresting officer before he or she places the individual in cells. (See Exhibit 7: OM 19.7 s. 3.3.1.) In addition, he advised that National is developing a course for the formal training of guards.

3. Christopher Donald Woodland

[17] Mr. Woodland is a twenty-year civilian member and manager of Protective Technical Services for the RCMP. His unit is responsible for the protection of RCMP

property and personnel for detachments within the Division. He therefore has knowledge of the video recording system in The Pas Detachment at the time of the events and the changes that have since been made. He testified that the video system in 2019 was digital except for the cameras which were analog. The cameras recorded to a hard drive with a memory capacity of 1.5 terabytes. That memory was sufficient to store ninety days of recordings. After ninety days the recordings were overwritten. The limitation on storage meant that police had up to ninety days from the occurrence of a recorded event to extract that record from the system. The cameras recorded events at a speed of two frames per second in order to ‘go easy’ on storage. Because of that speed, the recordings were grainy and a bit jerky but met the standards of the day. In 2020 the system was upgraded to a purely digital system with a recording speed of thirty frames per second and a memory of thirty terabytes. That memory is large enough to hold one year of events before a recording is overwritten. As a result of the faster speed the video recordings are clear and well-defined and the graininess is eliminated.

4. Rebecca MacDonald

[18] Ms. MacDonald was a guard at The Pas RCMP detachment cells for six years before leaving that employment in 2021. She was one of two guards on duty on the evening of the events leading to Mr. Ettawakapow’s death. It was during her shift that one of his cell mates rested his leg on Mr. Ettawakapow’s neck.

[19] She was familiar with Mr. Ettawakapow. She had guarded him on many previous occasions when he was lodged in cells because of his intoxication. She saw him being lodged in cells that night. He was very intoxicated, in her opinion, so much so that on this occasion, unlike many others, he had to be assisted into the cell area with officers placing him on the restraint chair and rolling him to the cell door. He was incoherent.

[20] She was on duty until just before midnight when she was relieved by another guard. Throughout the evening, the only prisoners in cells were the three who had been lodged in Cell 7. She testified that she was supposed to check on prisoners every fifteen minutes, alternating between physical checks (going to the cell and looking in the window of the cell door) and looking at the monitor. She further testified that she would have intervened if she had observed another man's leg on Mr. Ettawakapow's neck. She did not intervene because she did not notice it.

[21] She testified that her training to become a guard consisted of shadowing an experienced guard who showed her how to do prisoner safety checks and how to safely assist in searching prisoners. She recalled that every so often she did not know how frequently she had to sign a paper certifying that she had read police policy. She also said that she was unaware of the police responsiveness policy. She understood, though, that if she noticed that a prisoner had not moved for thirty minutes, she was to make every effort to wake him by making noise.

5. Eyrin Wiite

[22] Cpl. Witte is an eighteen-year member of the RCMP. In 2019, she was stationed in The Pas and on October 5th, 2019, she was the watch commander on duty during the late afternoon and evening.

[23] Cpl. Wiite was very familiar with Mr. Ettawakapow, often seeing him about the community and frequently stopping to talk to him. He was, she said, a very friendly person who was always laughing and joking. She knew he was a heavy drinker. She was also aware that he was physically disabled and that he often used a walker to make his way around the community.

[24] It was Cpl. Wiite who discovered Mr. Ettawakapow in Cell 7, not moving and not apparently breathing. She noted that his hands and face were discoloured. She kicked the door hoping to make sufficient noise to wake him. He did not respond. She had one of Mr. Ettawakapow's cellmates check on him and, when he signalled to her that things were not right, she called for backup, retrieved the keys to the cell, entered it and checked Mr. Ettawakapow. He was cold to the touch and he was not breathing. She initiated CPR. Other officers started entering the cell and relieved her. They took turns performing CPR until EMS personnel arrived. She then left the cell area to place some phone calls. When she learned that Mr. Ettawakapow had been declared dead, she arranged to secure the body and Cell 7 to await the arrival of the IIU investigative team.

[25] She is aware of the RCMP's responsiveness policy. In fact, as watch commander she is required three times each shift to check on prisoners and make sure they are breathing. It was on one of these checks, the mid-shift check, in which she discovered Mr. Ettawakapow. She was not as familiar with police policy regarding the checks required of guards on prisoners. It was her understanding, like that of Ms. MacDonald, that guards are required to check on the prisoners every fifteen minutes alternating between physical checks done right at the cells and checks done by looking at the monitor.

6. Erica Newbigging

[26] Cst. Newbigging is a five-year member of the RCMP now stationed in Norway House Manitoba. At the time of these events, she had only recently graduated from depot and was stationed in The Pas. She was on duty on the evening of October 5th, 2019. She was partnered with her field coach, Cst Joel Hardes, for part of that shift. She and Cst. Hardes responded to a complaint regarding Mr. Ettawakapow at around 6:45 p.m. They found him behind the radio station in a drunken stupor, with a partially consumed Listerine bottle by his side. Cst. Hardes employed a sternum rub, the application of pressure to the sternum designed to elicit a pain response, to rouse him. Mr. Ettawakapow was able to get up with assistance but took no more than a few steps before he had to be assisted to the truck and lifted up onto the back seat. In her opinion, Mr. Ettawakapow did not talk; he mumbled.

In other words, he was incoherent. Upon arriving at the police station, Cst. Newbigging retrieved a restraint chair on wheels and together the officers pushed him to the cell area where the officers took his personal clothing and effects before lodging him in the cell. She did not see him again until, in response to a call for back-up, she and Cst. Todd returned from patrol and entered the cell to find that CPR was being performed on Mr. Ettawakapow. She took turns at performing CPR and was in the cell when the EMS attendant made the call and pronounced Mr. Ettawakapow dead. Although she was relatively new to the job and to The Pas, she was familiar with Mr. Ettawakapow whom she described as being joyful. She was aware that he had physical limitations.

7. Joel Hardes

[27] Cst. Hardes is a ten-year veteran of the RCMP, currently stationed in Beardy's First Nation, Saskatchewan. He had previously been stationed in Moose Lake, Mr. Ettawakapow's hometown. In 2019, though, he was stationed in The Pas.

[28] He was the field coach for Cst. Newbigging on October 5th, 2019, and was the officer who arrested Mr. Ettawakapow. Cst. Hardes was very familiar with Mr. Ettawakapow, referring to him as "Dot Dot", his nickname. He frequently saw him in the community and often engaged with him, sometimes officially because of his intoxication and sometimes unofficially. He always found him to be in good humour laughing, joking and full of joy. He knew that Mr. Ettawakapow was a hard drinker

and that he was physically disabled. His physical disability made it hard for him to walk at the best of times. He considered him to be a friend, someone for whom he occasionally bought coffee and food. Mr. Ettawakapow, he testified, spoke with a thick accent and most people found him difficult to understand but Cst. Harges, being experienced with the Moose Lake accent, had no trouble understanding him even on that night.

[29] He confirmed that Mr. Ettawakapow was intoxicated from consuming Listerine and that he arrested him for cause disturbance by being drunk. It was his opinion that, while Mr. Ettawakapow was intoxicated, he was able to rouse him and Mr. Ettawakapow could speak intelligibly to him. He had more difficulty walking than usual and he did need assistance. Even so, it was his opinion that Mr. Ettawakapow did not need medical attention and was fit for custody.

[30] When asked about his experience with taking prisoners to the hospital for medical attention, he advised that he had done so on several occasions. His wait time at hospital for medical assessments ranged between thirty minutes at the lower end and two to three hours at the upper end, although he also advised that he had waited for twelve hours on one occasion while waiting for a mental health assessment. He testified that delay in obtaining medical assistance is not a factor for him in deciding whether a prisoner is fit for custody.

[31] Cst. Hardes was also asked if he had considered options for Mr. Ettawakapow other than lodging him in cells. He replied that, given Mr. Ettawakapow's state of intoxication, there was no one who would have been prepared to take responsibility for him. While the homeless shelter in The Pas might have been an option in other circumstances, it was not open until late evening. He was also asked why he had arrested Mr. Ettawakapow for causing a disturbance by being drunk rather than arresting him under the provisions of the *IPDA*. He advised that his practice was to arrest for the offence of cause disturbance where the arrest resulted from a complaint from the public about the drunken person. He would have arrested him under the *IPDA* if there had been no complaint. Even though he arrested him for a criminal offence, Cst. Hardes had no intention of proceeding with any charge against Mr. Ettawakapow.

[32] He testified that while stationed in Moose Lake he had guarded prisoners when he had been unable to locate a suitable person to fill that role. He understood police policy as requiring checks on prisoners every fifteen minutes alternating between physical checks and checks on the monitor.

8. Jamil Mahmood

[33] Mr. Mahmood is the director of the Main Street Project in Winnipeg which operates a wide range of services to the homeless and people suffering from addictions in the City of Winnipeg including, amongst others, permanent and

transitional housing, an infectious diseases program, addictions withdrawal services and a food market.

[34] One of the programs it offers is a Protective Care Program. This program provides safe shelter for intoxicated individuals who have been located and detained by police under the provisions of the *IPDA*. In effect it is an alternative to police custody for intoxicated individuals. The Protective Care Program only accepts individuals into its care from police officers. Every person must be ambulatory (although accommodation is made for those who are physically disabled) and must be intoxicated primarily from alcohol. To ensure that is so, everyone must take a breathalyzer before being accepted into the program. Every person is assessed medically by paramedics to determine if he or she is fit to be lodged. Each person who is admitted is lodged in a cell. The maximum occupancy of each cell is one person. Each of the cells are monitored by two staff members. A staff member does a physical check of each cell every fifteen minutes. That employee must “sign” an electronic check list kept by the door of each cell to indicate that the fifteen minute check has been completed. In addition, a motion-activated video recording system monitors the cell area. Every hour staff wake up cell occupants and obtain an acknowledgement of their presence. Occupants remain in the facility until they are deemed fit for discharge and are assessed once again by paramedics before discharge. The average length of stay of occupants is three to four hours. Mr.

Mahmood advised that the Project does attempt to locate responsible persons to accept the care of occupants particularly when the centre is at or near full occupancy.

[35] The Protective Care Program has been operating in Winnipeg since the early 1990s. It has been a model for other Canadian cities developing their own programs for caring for intoxicated individuals outside of police custody. He advised that the Main Street Project operates the Centre in partnership with the Winnipeg Police Services, Winnipeg Paramedics Service and Department of Justice.

[36] Currently the Main Street Project is considering terminating the program in favour of a Sobering Centre. While Mr. Mahmood did not get into specifics of how a Sobering Centre would be different from the Protective Care Program it was my impression that it would provide safe care to a broader spectrum of individuals who are unable to care for themselves because of their addictions.

[37] Mr. Mahmood advised that the Protective Care Program has had individuals die while in its care. To the best of his knowledge, all of these deaths have occurred because of preexisting conditions and not from failures of the program itself. It was his considered opinion that the Protective Care Program is a safer option for intoxicated individuals than spending time in a police cell.

9. Dr. John Younes

[38] Dr. Younes is the Chief Medical Examiner for the Province of Manitoba, a position to which he was appointed in July 2015. He performed the autopsy on Mr.

Ettawakapow. It is his opinion that three factors significantly contributed to Mr. Ettawakapow's death as follows:

1. Alcohol toxicity
2. Mr. Ettawakapow's pre-existing heart disease (Mr. Ettawakapow suffered from an enlarged heart and stiffening and hardening of the arteries);
3. The placement of the cell occupant's leg across Mr. Ettawakapow's face and neck.

[39] While Dr. Younes does not discount the significance of the first two factors (Mr. Ettawakapow's blood alcohol level was extremely high and his heart condition serious), it was his opinion that Mr. Ettawakapow died after he was unsuccessful in removing the leg from his face, this lack of success stemming from his severe intoxication. It was also his opinion that Mr. Ettawakapow would likely not have died if he had been medically assessed before entering custody. This is so because if medical personnel had become aware of his blood alcohol level, they would have taken steps to monitor his condition and intervene if he had stopped breathing.

B. Exhibits

[40] I do not intend to review each of the filed Exhibits under this heading. The salient factors in some of them have been mentioned in the summaries of the witnesses.

[41] There were a number of police policies tendered, some of which helped me to shape the recommendations which I later set out. I quote from them as follows:

1. Exhibit 4, Guarding Prisoners/Personal Effects Ch.19.3 (Operational Manual The Pas Detachment RCMP)

1. General

1.2 All members of The Pas Detachment will, every six months, read the applicable national and divisional directives and unit supplements pertaining to prisoners in accordance with National OM 19.3.9. An acknowledgment sheet for signature is posted with the above noted documents in the guardroom (The Pas Unit Supplement Appendix 19-3-1)

1.3 The OPS NCO has been appointed as The Pas Detachment member responsible for the orientation, initial training and re-certification of guards/matrons as well as ensuring that each guard/matron, every six months, has read and initialed and understands the guard duties and applicable national and divisional directives and unit supplements pertaining to prisoners as outlined in National OM 19.3.9. An acknowledgment sheet for signature is posted with the above noted documents in the guardroom (The Pas Unit, Supplement Appendix 19-3-2)

1.4 The sign “Assessing Prisoner Responsiveness” will remain displayed in the cell block area at all times.

6. Guard/Matron Responsibilities.

6.1 The primary responsibility of the guard/matron on duty is to monitor prisoners in custody which will include intermittent physical checks not more than 15 minutes apart.

6.1.1 Physical checks of prisoners may necessitate waking the prisoner to confirm the appropriate level of responsiveness outlined in National OM 19.3.2

2. Exhibit 5-OM-Ch.19.2 Assessing Responsiveness and Medical Assistance (National)

1 Definitions

1.1 **Medical practitioner** means a person who is authorized under the laws of the province/territory to practice medicine in that province/territory. This definition is not limited to a physician.

1.2 **Medically trained professional** means a medical practitioner, nurse, paramedic or ambulance attendant.

2 Member

2.1 Assessing Responsiveness

2.1.1 You must complete an assessment of responsiveness before taking a person in police custody. Refer to App. 19-2-01 Assessing Prisoner Responsiveness.

2.1.2 Seek immediate medical assistance and provide the necessary first aid when a person exhibits any of the following:

2.1.2.1 appears to be unconscious, semi-conscious, or there is a marked change in their state of consciousness;

2.1.2.2 displays signs of having sustained a head injury or is reported to have sustained a head injury

- 2.1.2.3 possible drug overdose and/or alcohol poisoning;
- 2.1.3 In areas with limited or no access to a medical practitioner, request assistance from a medically trained professional.

3. Guard

- 3.1 The guard on duty is responsible for determining the responsiveness of each prisoner in cells, and must be familiar with the requirement to assess prisoner responsiveness and conduct assessments. Refer to App. 19-2-1
- 3.2 Do not attempt to determine the degree of responsiveness of a prisoner who appears less than fully conscious. If the prisoner appears to be less than fully conscious, seek immediate medical assistance and ask a member to assist.
- 3.3 Never assume a prisoner is “sleeping it off”. Assess responsiveness as per App. 19-2-1.

[42] The responsiveness flow chart previously mentioned is App. 19-2-1 referred to in Exhibit 5. Because it is a flow chart, it is not easy to reproduce here. Suffice it to say that in assessing prisoner responsiveness, the officer or guard finding a seemingly unconscious person is to assess responsiveness by addressing a check list. Did the person spontaneously waken or was he or she rousable to verbal or painful stimulus? Is the person responding to simple questions or commands? The chart itself warns the officer/guard that alcohol may mask serious disease or injury and directs the officer/guard that, if in doubt, medical assistance must be obtained.

3. Exhibit 9-OM-Ch19.3 Guarding Prisoners and Personal Effects (National)

4. Guard

4.2 Training

4.2.2 Guards will receive training equivalent to that which is outlined in the RCMP Guards Training Course Standard (CTS CL000007) as a condition of employment.

4.5 Monitoring

- 4.5.1 Check prisoners frequently and at irregular intervals to ensure their security and well-being.
 - 4.5.1.1 The intervals are to be no more than 15 minutes apart.
 - 4.5.1.2 These checks must be physical checks, not a check of the CCVE
 - 4.5.1.2.1 The use of CCVE may augment, but not replace, physical checks.

4.5.2 An intoxicated prisoner must be awake or awakened and responsive a minimum of once every four hours. Assess responsiveness according to App. 19-2-1.

4. Exhibit 3-Cell 7 Video

[43] My review of the video confirms that Mr. Ettawakapow entered Cell 7 soon after the cell door opened at 19:11 hours on October 5th, 2019. He was partly carried, partly dragged into the cell and then placed on the cell floor. He was semi-upright at first but slowly his body relaxed so that he was resting on his left side on the floor. Soon after he shifted his body to lay on his back. I did not see him move further until one of the other occupants of the cell placed his leg over Mr. Ettawakapow's neck and lower face at 20:14.17.

[44] He raised his left arm to a semi-upright position briefly at 20:14:30. Between 20:15:02 and 20:19 he raised his right hand a number of times and appeared to be attempting to move the leg from his neck and face. At 20:21:05 his right hand moved on to his chest and that is the last time that he moved in the video.

[45] At 23:53:39, the window on the cell door opened. That is the only time, during the video that the cell window was opened before Cpl. Witte opened it to complete her check of the prisoners at 1:29:26.

5 Exhibit 12-2023-24 -Lodging of Intoxicated Persons in The Pas Cells

[46] Inspector Massart agreed to provide recent statistics on lodging of intoxicated individuals in The Pas Detachment Cells. He provided them by way of a spreadsheet which was admitted into evidence at a virtual sitting of this court on

July 31st, 2024. That spreadsheet shows that between June 1st, 2023 and June 23rd, 2024, 938 intoxicated individuals were lodged in cells having been arrested under the provisions of the *IPDA*, or under the provisions of the *Criminal Code* for breaching the peace or causing a disturbance.

6. Exhibit 13-IIU Bulletin and Report on 2017 Death at Main Street Project

[47] Mr. Mahmood agreed to provide materials to this Court on deaths occurring at the Main Street Project. He supplied copies of inquest reports on two deaths at the Main Street Project, Cheryl Tom and Douglas Sanderson, and a copy of a report on the death of Jeffrey Mallet, a decision of my colleague Judge Redhead on a death in custody at Thompson Detachment RCMP. I will refer to those reports later but for now I turn to a bulletin and report on a 2017 death at the Main Street Project.

[48] These documents were marked as Exhibit 13 at the virtual hearing on July 31st, 2024. The report and bulletin make it clear that the deceased was admitted to the Protective Care Program at the Main Street Project in an intoxicated condition. Soon after he was discovered unconscious in his cells by an attendant who quickly arranged for him to be transported to St. Boniface Hospital where he died two days later. The cause of death was attributed to a toxic combination of alcohol, alprazolam and zopiclone. His position in cell (leaning back against the wall with his face tucked into his chest) was considered a potential contributing factor. The IIU determined that the death arose from an unfortunate combination of

circumstances. The report concluded that the police cadets involved in the arrest should not suffer “consequences” for their actions.

7. Exhibit 14-Winnipeg Free Press News Article

[49] At my request, an on-line article from the Winnipeg Free Press dated June 19th, 2024 with the headline “Help should have come for man who died in Manitoba RCMP holding cell, inquest hears” was marked as Exhibit 14. The article mainly concerns itself with the evidence heard at the second day of this inquest but its report on that evidence is not the reason why I was interested in having it marked as an exhibit. Instead, its significance to me arises from its reference to the number of people who have died while in police custody, a concern which caused the CBC to publish a series of reports which it styled as its “death in custody project”. While I agree with counsel that, instead of having it filed, I might have simply taken judicial notice of the public concern about the number of in-custody deaths that have occurred in recent years, I thought it helpful to underline to anyone reading this report that the death I am dealing with is just one of a number of individuals who have died in police custody in recent years, most (if not all) of whose deaths, according to our public broadcaster, were preventable.

III. SUMMARY OF FACTS

[50] There are some inconsistencies and contradictions in the evidence. I will not be addressing them because almost all of them are minor and none of them are relevant to the cause of death or to any recommendations that I will be making.

[51] Mr. Ettawakapow, a First Nations man from Moose Lake, Manitoba, was, at the time of his death, a long-time member of the homeless community in The Pas. He was a hard drinker; he was usually under the influence of intoxicating substances. On October 5th, 2019, he was very intoxicated. Police found him passed out by the radio station in The Pas. Csts. Hardes and Newbigging arrested him for causing a disturbance by being drunk and they did so because they had received a complaint about his drunkenness from a member of the public. Cst. Hardes, the senior officer, had no intention of formally charging him with a criminal offence. His purpose in arresting him was to make sure that any disturbance associated with his drunkenness would not be continued and to provide a safe environment for him so that he would not be hurt by his own actions or those of others.

[52] Under police policy Cst. Hardes had to assess him to determine if he was fit to be lodged in custody. He determined that, while Mr. Ettawakapow was intoxicated, he was not so drunk that he needed medical assistance. He came to this conclusion because he was able to rouse him by applying a sternum rub and, once roused, he was able to talk to him. Unlike Cst. Newbigging, he could understand

Mr. Ettawakapow. His accent and his “thick speech” were natural. So were the difficulties that Mr. Ettawakapow had with walking. In his opinion, detention in cells posed no greater risk that night to Mr. Ettawakapow than any of the numerous previous occasions he had been arrested and lodged.

[53] After his arrest, Mr. Ettawakapow was transported to the police detachment and lodged in Cell 7 with two other people at about 7:10 p.m. Things went well enough for him until, about an hour after he had entered the cell, one of his cellmates put his leg across Mr. Ettawakapow’s neck and lower face as he lay on his back on the floor of the cell. It is clear from the video, that the other person, who was also intoxicated, was not attempting to hurt Mr. Ettawakapow; he was merely shifting his body in his sleep to find a more comfortable resting spot. Mr. Ettawakapow tried to move the leg from his neck but because of his weakened and unconscious or semi-conscious condition, he was unable to do so. The leg stayed on and soon after, Mr. Ettawakapow stopped moving forever. I accept Dr. Younes’ evidence, that it is likely that Mr. Ettawakapow died then about five hours before he was discovered. I also accept his opinion that there were three factors that contributed to his death, namely his pre-existing health condition, his state of intoxication (.387mgs of alcohol/100 mls of blood) at the time of his death, and the placement of the leg on his neck and face.

[54] From the video that I have viewed, I conclude there was only one physical check done on the cell from the time Mr. Ettawakapow entered it until Cpl. Wiite conducted her safety check near 1:30 a.m. on October 6th, 2024. The video itself, while jerky and lacking the sharpness and definition of image of HD video, shows the events occurring in the cells clearly enough. (The livestream displayed on the monitor at the guard's station, I am told, would have been much clearer.) The leg stayed on Mr. Ettawakapow for almost forty minutes. I accept Ms. MacDonald's evidence that if she had observed the leg on Mr. Ettawakapow's face, she would have taken action to assist Mr. Ettawakapow. She did not notice it and therefore she did not take any action. By the time help did come, it was too late for Mr. Ettawakapow.

[55] Moreover, while I expect that Ms. MacDonald checked on the prisoners by looking at the video monitor, the checks must have been cursory and insufficient for her to appreciate what was happening in Cell 7. Mr. Ettawakapow, after all, laid in the cell absolutely still for almost five hours before being discovered.

[56] I accept the evidence of all officers who commented on the wait time for medical assistance. There is often significant delay in seeing physicians in the emergency departments in this Province and because police wait in line with all others attending that department for medical assistance, they often have to wait in line for hours at a time.

[57] I also find that RCMP policy regarding the guarding of prisoners imposes an expectation of guards that they monitor prisoners closely. Checks under the policy consist of physical checks on the prisoners by guards attending at the cell doors and peering in. The video system is there to allow the guards to monitor the prisoners in between those checks. As Inspector Massart put it, they are to “keep an eye” on the prisoners at all times. Glancing at the video does not constitute a check under existing policy nor can it, in my assessment, constitute compliance with the primary duty of guards to monitor the prisoners.

IV. PREVIOUS INQUESTS

[58] Under this heading I will summarize the reports on three inquests that were supplied to me from Mr. Mahmood.

[59] In *Inquest respecting the Death of Cheryl Lynn Tom*, issued on July 4th, 2011, my former colleague Judge Umpherville examined the circumstances giving rise to the death of Ms. Tom. Ms. Tom had been arrested under the provisions of the *IPDA* and taken to the Main Street Project on March 26th, 2007, where she was admitted sometime between 7:30 and 8:00 a.m. Checks were completed on her cell every fifteen minutes between 8:00 a.m. and 9:15 a.m. At the next check at 9:25 a.m. she was found unconscious and unresponsive. She was taken to the Health Sciences Centre by ambulance where she died later the same morning. The cause of death was an accidental overdose on multiple prescription drugs. Judge Umpherville made

three recommendations, namely, that paramedics be funded to be at the Main Street Project twenty-four hours per day, that cameras be installed in all cells so that the clients are continuously monitored in between physical checks and that paramedics have access to a breathalyzer so that a paramedic can gauge the level of intoxication, or, if no alcohol is present, the client can be closely monitored or referred for medical attention. I would note that Ms. Tom was in a monitored cell and a paramedic was on duty at the time of her admission. Of the three recommendations, only the third one might have made a difference for her. All of the recommendations were implemented by the Main Street Project

[60] In *Inquest respecting the Death of Douglas Leon Sanderson*, issued on June 5, 2014, the Court considered a death from blunt force trauma to the brain of an individual who had, after being admitted to the Main Street Project Protective Care Program, hit his head on three different occasions while in the Program. On the last occasion, he was transported to the Health Sciences Centre where he died two days later. Judge Schille noted that it was possible that Mr. Sanderson sustained the injury from a fall prior to his admission to the Program. Even so he made recommendations on the basis that the falls at the Program, incurred while staff were making efforts to discharge him, contributed to his death. His recommendations took into account that the Main Street Project had already implemented a broad array of changes to the Program as a result of this and other deaths at the Project. Those changes included

provision of round-the-clock paramedic service to the Project, a paramedical assessment clearing clients for admission, increase of staffing, provision of video surveillance cameras in all cells, provision of a CPR mask in between each pair of cells, relocation of a fire extinguisher (which Mr. Sanderson had hit his head on) to a place where the clients did not pass and increased training of staff amongst others. Judge Schille made a total of four recommendations two of which were that the decision to discharge from the Program be made by a paramedic and that the electronic provincial health record be made available to all paramedics in the field including those at the Main Street Project. While I am not aware as to whether all of the recommendations were acted upon, the evidence I heard suggests that the two I mentioned were.

[61] The last inquest to which I was referred is *Inquest respecting the Death of Jeffrey Ray Mallet*, issued December 2nd, 2014, a death arising in RCMP cells in Thompson. Mr. Mallet was initially arrested under the provisions of the *IPDA* but police later discovered that he was in breach of a bail condition and therefore was going to be held in custody on a criminal charge. He was found dead in the cells long after his arrest and following complaints by him of being ill. According to the Chief Medical Examiner, he had likely been dead for between six and ten hours before police discovered his body. The cause of death was bacterial pneumonia. Judge Redhead made recommendations that all persons arrested under the *IPDA* be

medically cleared before they are lodged in cells and that the City of Thompson establish a detoxification centre similar to the Main Street Project. I am told that while some progress has been made on those recommendations, neither has been fully implemented, the first because of a lack of paramedical resources.

V. FACTORS FOR EXAMINATION

[62] In 2019 the CBC published a series of articles dealing with individuals who died in police custody and detailing research suggesting that many of these cases were preventable and occurred as a result of a deficiency in police handling of intoxicated individuals. Mr. Ettawakapow was one of those individuals whose death was the subject of the CBC study.

[63] I have no knowledge of any of the cases cited by the CBC other than Mr. Ettawakapow, but I agree with the conclusion reached regarding Mr. Ettawakapow, namely that help should have come to him much sooner than it did. His death was a tragedy that might have been prevented and deaths like his might be avoided in future if certain steps are taken by the authorities to reduce the risk of harm. In other words, we need to make sure, as best we can, that help does come in time for others who find themselves in need.

[64] I have identified three areas to canvass for potential recommendations, namely:

- A. immediate medical attention
- B. early observation of the risk that caused Mr. Ettawakapow's death.

C. an alternative way of dealing with severely intoxicated individuals.

A. Immediate Medical Attention

[65] Mr. Ettawakapow was very drunk on the night that these events happened. His blood alcohol level at the time of his death was .387 mgs in 100 mls of blood. That blood alcohol level contributed to his death. According to Dr. Younes, if medical intervention had been sought and had medical personnel become aware of his blood alcohol level, they would have monitored him to ensure that he did not stop breathing. If that had happened, Mr. Ettawakapow would surely have survived the night.

[66] Why was medical intervention not sought? Police policy does not require medical intervention for intoxication, as such. Instead, the arresting officer is to consider whether the state of intoxication is so severe that medical intervention ought to be sought. The responsiveness flow chart forming part of Exhibit 5 specifies that if the individual cannot be roused to consciousness or is unable to speak or is unable to answer simple questions correctly or if the officer is in any doubt about the possibility of alcohol poisoning, the officer must seek medication attention for him. (See Exhibit 5: OM-Ch. 19.2. Assessing Responsiveness and Medical Assistance.) Cst. Hardes assessed Mr. Ettawakapow based on the test set out in the flow chart. Mr. Ettawakapow passed that test. I do not quibble with him.

[67] Cst. Hardes' reasoning was based in part on how hard a drinker Mr. Ettawakapow was. He believed that Mr. Ettawakapow was better able to tolerate alcohol than those who had a shorter history of abusing alcohol. The trouble with this reasoning is that, unbeknownst to Cst. Hardes, Mr. Ettawakapow was extremely unhealthy which, if I understand Dr. Younes' evidence correctly, made him more, not less, susceptible to succumbing to alcohol poisoning and, for that matter, to a random leg being placed on his neck.

[68] Inspector Massart was asked by Ms. Dixon, "Why aren't all severely intoxicated individuals medically assessed?" His reply was a practical one. If that happened, he testified, police would lose a lot of personnel because each intoxicated person who is in custody has to be accompanied by a police officer and they face the same daunting line-ups as all other people needing medical services in the Province. One officer testified that he once waited twelve hours to have an individual in his care seen by a doctor. Twelve hours is longer than a "normal" shift for a police officer! I would conclude, based on the evidence that I heard, that a "normal" wait time would be a wait of hours not minutes.

[69] Though that evidence saddens me, it does not surprise me. Even so, it seems to me that making police wait for hours on end to have a person in their custody medically assessed by a doctor is absurd. Our health care system should not be draining police resources and thereby putting community safety at risk. Surely a

practical solution could be developed to eliminate this by-product of a strained health care system. But this is a topic I need not concern myself with here.

[70] I am not recommending that all intoxicated persons be seen by a doctor. I am suggesting, instead, that they be medically examined by a health care professional to determine if each is fit to be lodged in police cells. That person might be a nurse or a paramedic. The Main Street Project, for example, has a dedicated team of paramedics who assess each individual before they are lodged in its Protective Care Program. Surely similar resources can be found in many communities in the Province and certainly these resources exist in The Pas.

[71] I am therefore recommending that, in coordination with the RCMP, the Department of Health design and implement a program that would provide to police holding an intoxicated person in custody quick and easy access to a medical assessment to determine that person's fitness to be lodged in cells. That program should be dedicated to the assessments I am proposing or, in the alternative give priority to the assessments. The medical personnel performing the assessments, whether a nurse, paramedic or other medical professional, should have access to the medical information of the person being assessed. The program should be made available in all communities where the necessary medical resources exist.

I recognize in making this recommendation that I am not eliminating wait times for police. If the paramedic or nurse decides to refer the person to a doctor, then the

police will still need to wait but presumably only because there is a good reason to. The recommendation would, where the resources exist, eliminate the need for police, who often have no medical background, to make the decision without knowledge of underlying health conditions. If this kind of program had existed and been available for Mr. Ettawakapow, it is likely he would have been referred to a physician given his frail health and elevated blood alcohol level.

B. Early Observation of the Risk

[72] Ms. MacDonald testified that if she had noticed the leg on Mr. Ettawakapow, she would have intervened and taken steps to have it removed. Would that have made a difference to him? The answer to that is yes, at least it would have if she had noticed it when it happened or soon after. Why did she not notice it when it happened or at least at some point during the forty minute span that the leg rested on his neck and face? Here are my thoughts on this question.

[73] There appears to be some confusion about how a guard discharges his or her primary responsibility and what “checks” consist of under police policy. The primary responsibility of the guard on duty is “to monitor prisoners in custody which will include intermittent physical checks...” (See Exhibit 4, OM The Pas Detachment, s. 6.1) To “monitor” means to watch and check a situation carefully (Cambridge.(n.d.) Cambridge org. dictionary. Retrieved August 1, 2024, from <https://www.dictionary.cambridge.org>). Both Ms. MacDonald and two of the

officers believed that the policy required that the guard “check” on prisoners by alternating between looking at the monitor or by looking in the cell door every fifteen minutes. I would strongly suggest that a guard cannot “monitor” prisoners at all by simply glancing at the monitor or by simply looking into the cell. The provision of the monitor at the guard’s station is for the purpose of allowing the guard to watch the prisoners in between his or her physical checks on them. In other words, Inspector Massart has it completely right, in my assessment, when he stated in his evidence that the monitor is there for the guards to keep an eye on the prisoners.

[74] I am satisfied that the prisoners were not “monitored” that night. They were checked on sporadically by the guards glancing at the monitor and by one physical check at the cell door just before midnight. This explains, in my assessment, why the leg was missed and why Mr. Ettawakapow lay motionless in the cell for more than five hours before Cpl. Wiite noticed that he needed help. In my assessment, if police policy had been followed, it is likely that Mr. Ettawakapow would not have died that night.

[75] How can we avoid this type of event in future? I would reply with two words-proper training. Presently the only requirement of policy is that the training of guards meets certain standards. (See Exhibit 5, OM-ch.19.3, s. 4.1.2.2.) I was not told what those standards are. In this case, for Ms. MacDonald, training took the form of her shadowing a senior guard for an unspecified period of time and signing

a form every six months indicating that she had read the policy. Clearly this is not enough. I am told that a training course for guards is being developed. I am not aware of its form or content. I hope though that it will emphasize the importance of the primary function of the guard and the importance of fully appreciating what the guard is observing when that guard looks into a cell.

[76] While I do not have formal recommendations for the RCMP, I would make two suggestions. I heard from Mr. Mahmood who advised that like guards at police cells, attendants in the Protective Care Program operated by the Main Street Project are required to physically check the cells every fifteen minutes. In addition, the guard is required to signify that the check has been made by “signing” right at the cell (Mr. Mahmood referred to it as a “punch”.) I would suggest that this format is a good one and should be considered for implementation by the police. The second also arises from the evidence of Mr. Mahmood. Attendants at the Main Street Project are required to rouse the occupants by having each acknowledge their presence once each hour. In this case I am mindful that in all probability Mr. Ettawakapow lay dead in the cell for several hours before being discovered. Knowledge of this fact cannot be comforting to the family. An hourly responsiveness check, depending on its timing, might not have made a difference to him but at least it would have resulted in efforts to help him sooner.

C. An Alternative Way

[77] It was plain to me that Inspector Massart was saddened by what happened to Mr. Ettawakapow. Mr. Ettawakapow died in police care from a preventable cause. He needed help but he did not receive it. All of the police officers who testified were similarly saddened by these events.

[78] It is easy for some of us to write off the most vulnerable in our society - the weak, the powerless, the homeless, the addicts. I would observe though that there are only two reasons why a guard is provided to “guard” people or things, namely, to prevent that person or thing from escaping so others are not harmed or to protect someone or something from being harmed, hurt or taken. It is for the second reason that we employ guards for those such as Mr. Ettawakapow.

[79] Is it an accident that we use the term guard in this context in the same way as we do for protecting treasure? I think not. Mr. Ettawakapow and others like him are human beings and in my assessment intrinsically valuable. They are, in a manner of speaking, human treasure and I only need to recall the words that Mr. Jeremy Ettawakapow used in summing up his dad to confirm my view. He was a good man; he was more than just his addiction. He was loved by his family. This sentiment was shared by others. All of the police officers who spent time in The Pas knew him and liked him. He was a joy to be around. He was considered a friend. He was always happy and smiling.

[80] Police custody for those who are intoxicated is preferable to leaving those same individuals unprotected and at the mercy of the elements or of predators. But is there a better system? Several communities across our country have decided that there is.

[81] I heard about one of those programs at this inquest. The Main Street Project has been operating its Protective Care Program for more than thirty years. Mr. Mahmood, its executive director, considers it to be a better and safer system for caring for intoxicated individuals than the current system in use in the rest of the Province.

[82] Is it? There have been a number of inquests examining the deaths of individuals occurring at the Main Street Project. I have referred to two of these already, Cheryl Tom and Douglas Sanderson. The inquest reports on these two deaths refer to other deaths involving the Main Street Project. Does this mean that the quality of care at the Program is deficient or that it is no safer than putting individuals in police custody?

[83] What struck me about the reports of Judges Umpherville and Schille is that both noted the willingness of the decision makers at the Main Street Project to learn from the tragedies occurring at the program and to make changes to it to avoid a recurrence. As a result, the Protective Care Program has safeguards that are entirely absent from police cells.

[84] For example, every prospective client of the Main Street Project must pass a medical assessment administered by medical personnel having access to medical files of the prospective client before being admitted to the program. It is true that before being lodged in police cells, persons arrested under the *IPDA* must be assessed but the assessment is done by the arresting officer who may or may not have any medical training and who definitely does not have access to the detainee's medical record.

[85] The Main Street Project keeps individuals only for a short period, the average stay being three hours. To be discharged the client must again clear a medical assessment. None of this applies to police detentions. The Main Street Project has frequent checks and constant monitoring and frequent responsiveness checks. Police cells have some of these safeguards but the responsiveness checks are required only once every four hours (longer than the average stay at the Main Street Project).

[86] The Main Street Project has training in place for its staff. There is no formal training program in place for cell guards, at least not yet.

[87] The fact is that individuals lodged in police cells and individuals lodged in the Main Street Project are at high risk of injury and death because of their addictions. They are more likely to suffer from chronic health conditions that are aggravated by intoxicants. The Main Street Project has shown its dedication to the service it provides by making changes that circumstances show are necessary or

advisable. I think it unlikely that the RCMP would be willing or even able to design a program that has the safeguards available to the Main Street Project. While the Main Street Project and the local police station may provide a similar service to intoxicated individuals, they are oceans apart in their respective approaches to that service. In the end police stations lodge prisoners; the Main Street Project lodges patients or clients.

[88] I was provided with statistics on individuals who might be eligible for an alternative form of care in The Pas. Between June 1st, 2023 and June 18th, 2024, RCMP in The Pas lodged 938 intoxicated individuals, 138 of these being persons detained under the provisions of the *IPDA*, the balance for breach of peace or cause disturbance under the *Criminal Code*. (See Exhibit 12.) I conclude from this statistic that there is likely sufficient demand to warrant looking at establishing an alternative form of care for these individuals.

[89] I therefore recommend that the Department of Justice partner with other stakeholders to form a working group to study the viability of establishing in The Pas a safe shelter for intoxicated persons arrested by police as an alternative to holding those individuals in police cells. Potential stakeholders I suggest would be the Department of Health, OCN First Nation and other First Nations in the vicinity of The Pas such as Mosakahiken Cree Nation (Moose Lake), Chemawawin First Nation (Easterville), Misipawistik Cree Nation (Grand Rapids) the homeless shelter

in The Pas, The Pas Town Council, RCMP, Manitoba Keewatinowi Okimakanak and Addictions Foundation Manitoba, to mention a few.

[90] I have no interest in putting any limits on the type of program that members of the working group are interested in designing. I would simply suggest that they look at the Main Street Project and other similar projects in Canada offering safe shelter as an alternative to police custody prior to designing a program specifically for The Pas. Such a program would in my estimate, if well designed, eliminate the type of death that Mr. Ettawakapow suffered and would also free up police resources to deal with other threats to community safety.

VI. THE SEALING ORDER AND LIMITED UNSEALING ORDER

[91] Soon after the cell video was tendered in evidence as Exhibit 3, inquest counsel made a summary application seeking an Order sealing that Exhibit. Ms. Dixon supported the application. Privacy interests of several individuals depicted in the video were at stake and the video contains stark imagery of a human death. I agreed with counsels' concerns about what use might be made of this video and in particular a use or uses that would violate the Ettawakapow family's dignity and the privacy interest of others. I granted the Order sought by Mr. Wickstrom.

[92] Before the inquest concluded in June, the CBC made a summary application to unseal the Exhibit to permit publication of the video. It was amenable to conditions and restrictions on its use. Mr. Jeremy Ettawakapow, on behalf of the

family, consented to the CBC's application. His view was that the publication of the video might assist in increasing public awareness of in-custody deaths and in further establishing the need to improve the safety of those who are held in custody for their own safety. Although inquest counsel and counsel for the RCMP opposed the application, I granted an Order to unseal the Exhibit. I permitted CBC to make a copy of the Exhibit but restricted the use of the video to that portion of it beginning after Mr. Ettawakapow's entry into the cell and ending with the removal of the leg from his face. The Order required that all faces of those individuals depicted in the video other than Mr. Ettawakapow be blurred and prohibited publication of any information identifying or tending to identify those individuals. It also required the CBC to destroy any copy of the video that did not comply with the Order and, at Mr. Wickstrom's suggestion, to file an affidavit attesting to the fact that it had done so. I granted the Order because of the family's support for its release and publication and because the limited Unsealing Order protected the privacy interests of all individuals depicted in it.

VII. CONCLUSION

[93] I was blessed to have good counsel on this inquest. My thanks go to Mr. Ben Wickstrom and Ms. Brenna Dixon for their capable assistance in planning this inquest, in the mustering of evidence and in the shaping of recommendations. I also thank Mr. Jeremy Ettawakapow for his calm and resolute presence throughout these

proceedings. I do hope that the inquest satisfies the family's questions and concerns as to how their son and father died.

[94] They can take pride in the efforts they have taken to ensure, as best they can, that his death will not have been in vain and that similar deaths may be avoided in future.

SCHEDULE 2
TO REPORT ON INQUEST INTO THE DEATH OF JOHN GEORGE
ETTAWAKAPOW

SUMMARY OF RECOMMENDATIONS

1. In coordination with the RCMP, the Department of Health design and implement a program that would provide to police officers holding an intoxicated person in custody quick and easy access to a medical assessment to determine that person's fitness to be lodged in cells. The program offered should be dedicated to those assessments or, in the alternative, give priority to them. The medical personnel, be they nurses or paramedics, should have access to medical files of that person. This program should be available in all communities where there are qualified medical personnel to perform this service.

2. The Department of Justice partner with other stakeholders to form a working group to study the viability of establishing in The Pas a safe shelter for intoxicated persons arrested by police as an alternative to holding those individuals in police cells. Potential stakeholders I suggest would be the Department of Health, Opaskwayak Cree First Nation and other First Nations in the vicinity of The Pas such as Mosakahiken Cree Nation (Moose Lake), Chemawawin First Nation (Easterville), Misipawistik Cree Nation (Grand Rapids) the Homeless Shelter in The Pas, The Pas Town Council, RCMP, Manitoba Keewatinowi Okimakanak and Addictions Foundation Manitoba to mention a few.

**SCHEDULE 3
TO REPORT ON INQUEST INTO THE DEATH OF JOHN GEORGE
ETTAWAKAPOW**

LIST OF EXHIBITS

Exhibit 1	Final Report of IIU
Exhibit 2	Autopsy and Neuropathology Reports
Exhibit 3	Video recording of Cell 7 on USB
Exhibit 4	Excerpt from The Pas RCMP Operation Manual Chap. No. 19.1, 19.2 and 19.3
Exhibit 5	Excerpt of RCMP National Operation Manual Policy Ch. 19.2 with responsiveness flow chart
Exhibit 6	Excerpt of RCMP National Policy Ch. 19.5 In-Custody Death
Exhibit 7	Excerpts of RCMP National Operating Policy Ch. 18.1 (arrest and detention), Ch. 19.3 (Guarding prisoners), Ch. 19.7 (Guarding Emotionally disturbed persons) Ch. 37.6 (Emotionally disturbed prisoners) Ch. 37.15 (Well-being and Wellness Checks on the Safety of a person)
Exhibit 8	Excerpt of The Pas Detachment Operating Manual Ch. 19.9 (release of prisoners)
Exhibit 9	Excerpt of National RCMP operating Manual Ch. 19.3 (guarding Prisoners and personal effects)
Exhibit 10	RCMP-PTSB PTSS Work Order
Exhibit 11	Letter from Chief Medical Examiner dated March 11, 2022 directing that Inquest be held
Exhibit 12	Spreadsheet showing statistics on lodging of intoxicated persons in The Pas RCMP cells June 2023-June 2024
Exhibit 13	Bulletin and Final Report of IIU on Death from 2017
Exhibit 14	CBC news article June 19, 2024-Help should have come for man who died in Manitoba RCMP holding cell, inquest hears

SCHEDULE 4 TO REPORT ON INQUEST INTO THE DEATH OF JOHN GEORGE ETTAWAKAPOW

“SEALING ORDER AND LIMITED UNSEALING ORDER”

File no.558-38072

IN THE PROVINCIAL COURT

The Pas Centre

RE: IN the INQUEST into the DEATH of JOHN GEORGE ETTAWAKAPOW

ORDER



WHEREAS:

- a) The Court is engaged in an inquest into the death of John George Ettawakapow;
- b) The Court has received into evidence, and placed under seal, a video depicting the death of Mr. Ettawakapow (the “Video”); and
- c) Canadian Broadcasting Corporation has brought an application that was heard before me for access to the Video; and
- d) The family of John George Ettawakapow consented to the application.

IT IS HEREBY ORDERED THAT:

- 1) Canadian Broadcasting Corporation shall be provided with a copy of the Video by the Court, on the following conditions:
 - a. Only the portions of the Video that begin after Mr. Ettawakapow has been placed in his cell and the cell door has been closed and end immediately after the other individual depicted in the Video has removed his leg from Mr. Ettawakapow’s neck may be broadcast (the “Permissible Broadcast Portion”);
 - b. Canadian Broadcasting Corporation must edit the Video such that it retains only a copy of the Permissible Broadcast Portion. Any other version of the Video must be destroyed.
 - c. Within thirty (30) days after destroying the Video, a Senior Editorial Manager from Canadian Broadcasting Corporation will file a sworn affidavit with the Court attesting to the fact the previous paragraph of this Order has been complied with;
 - d. Canadian Broadcasting Corporation shall not identify, nor shall they publish any information that would tend to identify, any individual depicted in the Permissible Broadcast Portion other than Mr. Ettawakapow, and shall obscure their faces prior to broadcast.
- 2) If Canadian Broadcasting Corporation wishes to access any portion of the Video other than the Permissible Broadcast Portion in the future, they may do so by filing an application to be heard by me or another judge of competent jurisdiction.

June 21, 2024


 J. Doyle
 Staff Justice of the Peace
 and for the Province of Manitoba

 Colli, J.

**PROVINCIAL COURT OF MANITOBA
The Pas Centre**

The Honourable Senior Judge Colli

the 17th day of June, 2024

IN THE MATTER OF:

THE INQUEST INTO THE DEATH OF JOHN GEORGE ETTAWAKPOW

ORDER

WHEREAS the video evidence contained on the USB entered as exhibit 3 in this matter contains video footage of the death of John Ettawakapow;

WHEREAS it is not in the public interest for that video footage to be used for any purpose beyond its use in this Inquest;

WHEREAS there are privacy interests in the video relating to third parties present on video;

WHEREAS section 33(3) of *Fatality Inquiries Act* provides that a provincial judge may order exhibits tendered at an inquest to be disposed of in such manner as the provincial judge considers appropriate;

THIS COURT ORDERS THAT:

- 1) Exhibit 3 be sealed and that the public (including the media) shall not have access to it until or unless there is a further order of the Court.

J. Doyle
Staff Justice of the Peace
in and for the Province of Manitoba

OBO PJ Colli

The Honourable
Senior Judge Brian Colli

**PROVINCIAL
COURT**
AUG 09 2024
THE PAS, MANITOBA