RELEASE DATE: October 25, 2024

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 Deaths of Matthew Fosseneuve, Patrick Gagnon, Michael Bagot, Sean Thompson and Randy Cochrane

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Report on Inquest and Recommendations of
Judge Lindy Choy
Issued: October 22, 2024

APPEARANCES:

K. Mark Lafreniere, Choma Nwachukwu and Lisa Cheyne, Inquest Counsel

Kimberly Carswell, Counsel for the Winnipeg Police Service

Melissa Serbin, Counsel for the family of Randy Cochrane

M A N I T O B A

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATHS OF: Matthew Fosseneuve, Patrick Gagnon, Michael Bagot, Sean Thompson and Randy Cochrane

An inquest respecting the deaths of Matthew Fosseneuve (DOB 17 July 1984), Patrick Gagnon (DOB 17 January 1977), Michael Bagot (DOB 19 February 1979), Sean Thompson (DOB 25 September 1988) and Randy Cochrane (DOB 30 May 1989) was held on November 7, 8, 9, 10, 14, 15, 16, 20, 28, 29, 2023; February 13, 15, 26, 27, 2024; March 18, 2024; April 3, 2024; June 10, 11 and 24, 2024 at the City of Winnipeg in the Province of Manitoba.

This report contains my findings, observations and recommendations. Attached as Exhibit A is a list of witnesses that were called to testify at the inquest, and as Exhibit B is a list of the exhibits that were filed during the inquest. Pursuant to the provisions of *The Fatality Inquiries Act*, I am ordering that all exhibits be returned to the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application, with notice to any party with a privacy interest.

Dated at the City of Winnipeg, Manitoba, this 22nd day of October, 2024.

Original signed by Judge Choy
Judge Lindy Choy
Provincial Court of Manitoba

Copies to:

1. Chief Judge Ryan Rolston, Provincial Court of Manitoba
2. Dr. John Younes, Chief Medical Examiner
3. Hon. Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act*
4. Jeremy Akerstream, Deputy Minister of Justice & Deputy Attorney General
5. Michael Conner, Assistant Deputy Attorney General
6. Michele Jules, Executive Director of Manitoba Prosecution Service
7. SMP Executive Assistants, Crown's Office
8. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba
9. Mark Lafreniere, Choma Nwachukwu and Lisa Cheyne, Inquest Counsel
10. Kimberly Carswell, Counsel for the Winnipeg Police Service
11. Melissa Serbin, Counsel for the Family of Randy Cochrane
12. Exhibit Coordinator, Provincial Court of Manitoba

Manitoba

THE FATALITY INQUIRIES ACT
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RESPECTING THE DEATHS OF: Matthew Fosseneuve, Patrick Gagnon, Michael Bagot, Sean Thompson and Randy Cochrane

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I. INTRODUCTION

Five Fatalities

[1] July 28, 2018: Matthew Fosseneuve was in Winnipeg and was not feeling well. He called his family for help but they lived some distance outside of Winnipeg. They told him to call 911 for assistance in getting to detox. Paramedics responded but before they could help him, he became agitated and aggressive. Police were called for assistance while the ambulance staged nearby. Mr. Fosseneuve resisted police and they had to resort to using a taser to subdue him. While police had him restrained and pinned down, Mr. Fosseneuve suffered a cardiac arrest and died.

[2] October 25, 2018: Patrick Gagnon was relaxing one evening with his partner, consuming some substances, when he became highly agitated and wandered off. He walked down to railway tracks where CN operators were working. When he tried to climb onto the locomotive, police were called. Police arrived, got him off the train and took him to the ground to apply restraints. Shortly thereafter, Mr. Gagnon went limp and was found to have no pulse.

[3] May 24, 2019: Michael Bagot was under the influence of drugs and was seen at various locations around Winnipeg in a frenzied state. At one point, he called 911 stating that people were after him. After several hours, he boarded a city bus, still in a panic, and 911 was called for assistance. Police came and took control of him. They brought him off the bus and onto the sidewalk. Multiple police officers assisted

in holding him down. While he lay restrained, he suffered cardiac arrest and stopped breathing before an ambulance could arrive.

[4] June 26, 2019: Sean Thompson was located by police on the front steps of a residence. He was alleged to have broken into other nearby houses. While attempting to effect arrest, police pulled Mr. Thompson off the steps and pinned him on the ground. They applied handcuffs when Mr. Thompson became unresponsive and stopped breathing.

[5] July 14, 2019: Randy Cochrane was observed by police running, when he collided with their cruiser car. Police gave chase and caught up to him in a rear yard. Handcuffs and a RIPP hobble were applied, and officers pinned him down, while awaiting an ambulance. Before the paramedics could arrive, Mr. Cochrane ceased resistance and went limp.

[6] In just a one-year period, these five men died while being restrained by police and waiting for medical assistance to arrive. In each situation, the person had either methamphetamine or cocaine in their system and was exhibiting hyperactive agitated behaviour, which required medical attention. In each situation, before being able to receive medical assistance, the person first had to be safely brought under control and physically restrained. In the course of being restrained, each of them suffered a medical incident and sadly passed away.

II. MANDATE OF INQUEST AND PARTIES

[7] By letters dated February 28, 2020 and March 6, 2020, the Chief Medical Examiner of the Province of Manitoba ("CME") directed that inquests to be held into the deaths of Matthew Fosseneuve, Patrick Gagnon, Sean Thompson and Michael Bagot, and that these inquests be heard together. Subsequently, by letter dated January 14, 2021, an inquest into the death of Randy Cochrane was ordered. On my recommendation of May 9, 2022, the CME directed that all five of the deaths be heard in the same inquest.

[8] On January 14, 2021, an inquest into the death of Viengxay Chommany was ordered. Mr. Chommany also died while being restrained by police, however he was not under the influence of methamphetamine or cocaine at the time. Although that inquest was held separately, there is significant overlap between the matters examined and I have issued my reports for the two inquests concurrently.

[9] In each of the letters directing an inquest be held, the reasons for the inquest were set out as follows:

> 1. To fulfill the requirement for an inquest, as defined in Section 19(5)(b) of *The Fatality Inquiries Act* (the "*Act*"):
>
> **Presumption of inquest**
>
> **19(5)** Subject to subsections (6) and (7), an inquest into a death must be held if
>
> (a) The chief medical examiner has reasonable grounds to believe that the deceased person died as the result of the use of force by a peace officer who was acting in the course of duty; or
>
> (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,

(iii) an involuntary resident in a facility under *The Mental Health Act*, or
(iv) a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*.

2. To determine the circumstances relating to the death; and
3. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[10] Mark Lafreniere was appointed Inquest Counsel. Prior to the hearing, standing was granted pursuant to section 28(1) of the *Act* to:

- Winnipeg Police Service ("WPS") represented by Kimberly Carswell;
- The family of Randy Cochrane represented by Melissa Serbin.

[11] The inquest took place over 19 days of hearing conducted in Winnipeg and was completed June 24, 2024. Forty-five witnesses testified at the inquest, including three witnesses who were qualified as experts in the areas of police use of force, pharmacology and forensic psychiatry. A complete list of the witnesses who testified is attached as Appendix "A".

[12] This report will first review the circumstances surrounding each of the deaths. It will then examine the use of the term "excited delirium" and the ways in which we currently respond to a person exhibiting this constellation of behaviours. Finally, the report will consider recommendations for changes in programs, polices or practices which would serve to prevent similar deaths from occurring in the future.

III. CIRCUMSTANCES OF DEATHS

Matthew Fosseneuve

[13] Matthew Fosseneuve (DOB: July 17, 1984) was a 34-year-old Indigenous man who grew up in Morden, Manitoba. At a young age he and his twin brother came to live with Kathy and Gerhard Friesen, and became part of their family. Ms. Friesen spoke fondly of what an active child he was and how naturally he took to drumming. Mr. Fosseneuve loved to go fishing and he could make an excellent fish supper. He was an intelligent man who unfortunately struggled with mental health. As an adult, he became involved with alcohol and drugs and suffered from addiction. He was loved as a son and a brother and a father.

[14] On July 28, 2018, Mr. Fosseneuve was in Winnipeg and he had been using substances. The autopsy report noted ethyl alcohol, methamphetamine, amphetamine, mirtazapine, diazepam and metabolites of cocaine and quetiapine in his blood. At about 20:00 he phoned his foster mother and spoke with her for a while. He told her he was not feeling well and asked them for help. She knew it would take over an hour and a half for them to get to Winnipeg and so she told him to call 911 to get medical assistance. During the conversation, the call dropped and she thought he had hung up.

[15] Later that evening at 22:24, Mr. Fosseneuve called 911 from a payphone on Logan Avenue. He told them that he needed to go to detox but as he was being

transferred, the call was disconnected. A two-person primary care paramedic team from Winnipeg Fire Paramedic Service ("WFPS") was then dispatched on a well-being check. When paramedics Evan Walsh and David Kok arrived, they observed Mr. Fosseneuve in the middle of Logan Avenue shouting and waving his arms, disrupting traffic. He noticed the lights and siren of their sprinter van but then picked up a can and threw it at them. The paramedics drove slowly and attempted to engage with Mr. Fosseneuve by talking to him through the window. They asked him what was wrong but he was not able to articulate his chief complaint. It became apparent to the paramedics that they would need help and so they called WPS for assistance. While waiting for WPS, Mr. Fosseneuve started walking and the paramedics lost track of him.

[16] Mr. Fosseneuve then continued onto Princess Street where at about 22:49 he encountered a WPS cadet unit. As he approached, he mumbled some words then raised his arm and threw an item which looked like a brick at them. The cadet vehicle drove around the block then came back to find Mr. Fosseneuve. As they approached him the second time, Mr. Fosseneuve took a piece of orange PVC pipe and threw it spear-like at them. The cadet vehicle stopped and Mr. Fosseneuve approached them. He opened the passenger door and one of the cadets tried to exit the vehicle, but Mr. Fosseneuve pushed the door and caught the cadet's leg in it. The cadet managed to

close the door and Mr. Fosseneuve then started to kick and punch the vehicle. Both cadets got out of the vehicle from the driver's side and deployed their batons.

[17] At that moment, several uniformed officers arrived on scene. They approached Mr. Fosseneuve, and D/Sgt. Christmas testified that due to Mr. Fosseneuve's large size and apparent excited delirium, he deployed his conducted energy weapon ("CEW") or taser. Mr. Fosseneuve was still not compliant and so the CEW was deployed on him a second time, at which time he went to the ground.

[18] Once Mr. Fosseneuve was on the ground, he fiercely resisted being restrained by kicking and thrashing side-to-side. He was verbalizing but was mostly incoherent. During the struggle, his shoes had come off and he was kicking the ground so hard that his feet were bleeding. Five officers continued to grapple with him and finally managed to place his arms in handcuffs. Mr. Fosseneuve continued to struggle and kick his legs. Eventually officers were able to apply a RIPP hobble around his ankles. The time was 22:50 and paramedic Kok recognized that chemical sedation was required so a paramedic unit and a medical supervisor was requested.

[19] Mr. Fosseneuve remained combative and thrashing. At 5'10" and 295 lbs, Mr. Fosseneuve was a large man, and multiple officers were required to gain control over him. Due to his large size, Mr. Fosseneuve was "double cuffed" meaning two sets of handcuffs were linked together to secure his arms behind his back so as to cause less strain on his shoulders.

[20] Mr. Fosseneuve was placed on his front in the prone position. In order to keep him from getting up and re-engaging, three of the officers applied a shin pin by leaning the shin area of their legs on his waist, hip and shoulder blades. While in this position, Mr. Fosseneuve was noted by the officers to have lost consciousness. He was immediately moved into the recovery position.

[21] Firefighter paramedics Wash and Kok were called over and checked his pulse. Mr. Fosseneuve revived, and was asked questions. He appeared disoriented, but did provide his name.

[22] A moment later, Mr. Fosseneuve suddenly became agitated again and was rolled back prone on his front to maintain control. He at one point said that he felt like he was going to die, then soon after went silent. Paramedic Walsh testified that they checked for a pulse but were unable to find one, so they flipped him to his back and started performing compressions. At that point, the ambulance pulled up.

[23] The ambulance paramedics gave a different account. Paramedics Dyck and Savard testified that when they arrived at 22:56, Mr. Fosseneuve was face down prone and police and firefighter paramedics were several feet away with no hands on him. They noted that Mr. Fosseneuve was very still and discovered that he was not breathing. They announced that he had no pulse and commenced cardiac arrest protocol. They tried shocking his heart, but were unsuccessful at regaining a pulse.

Emergency measures were continued until Mr. Fosseneuve was taken to hospital, where he was announced deceased.

[24] There is discrepancy in the accounts but for the purposes of this inquest report, my attention focuses on the fact of prone positioning of a restrained individual. All witnesses acknowledge that Mr. Fosseneuve was restrained in the prone position, in the interests of maintaining complete control over him. It is concerning that he was only briefly transitioned to the recovery position when he appeared to lose consciousness, and after reviving, he was moved back into prone.

[25] The Report of Medical Examiner identified cardiac arrhythmia as the immediate cause of death, due to dilated cardiomyopathy. Other significant conditions contributing to death but not causally related were identified as methamphetamine toxicity and physiologic stress of recent physical struggle and restraint. The use of the taser device was not considered to have contributed to death in any way. The report concluded:

> Death in this case was due to the development of a fatal cardiac arrhythmia, arising on the basis of a significantly enlarged and dilated heart. Contributing factors include methamphetamine toxicity, as this drug produces elevation of heart rate and blood pressure and is well known to carry a risk of arrhythmia development. Also, the recent physical struggle during the process of being restrained would significantly elevate the heart rate and blood pressure, also contributing to a surge in catecholamines (adrenaline and noradrenaline), with potentiation of the risk for development of a fatal arrhythmia.

Patrick Rheal Gagnon

[26] Patrick Gagnon (DOB: January 17, 1977) was a 41-year-old francophone man who lived in Winnipeg. He was a hard worker who put in 14-hour days, sometimes

seven days a week and always provided well for his family, especially his daughter whom he is said to have cared for deeply. Mr. Gagnon was someone who loved children, loved animals, and loved his family.

[27] On October 25, 2018, Mr. Gagnon was with his partner relaxing in their garage. He was drinking alcohol and had used some substances. In the early morning hours, between 02:00 and 03:00, Mr. Gagnon started to feel unwell and went outside for some fresh air. He became agitated and paranoid, and accused his partner of drugging him. He became increasingly distressed and so his partner called one of Mr. Gagnon's friends to come over and see if he could calm him down. By the time his friend arrived, Mr. Gagnon had walked down the road and toward the railway tracks at Camiel Sys Street. His friend went to look for him.

[28] Meanwhile, at 03:15, Mr. Gagnon phoned his father saying that he needed help because "someone had roofied him". Mr. Gagnon's father woke his sister up and they drove over.

[29] When they arrived, they found Mr. Gagnon seated on the ground. He was still very agitated and said that someone had put something in his drink. The friend was there coaxing Mr. Gagnon to stand without success. His sister tried to get him to snap out of it, to no avail. They tried to get Mr. Gagnon up but he pushed them away and accused them of trying to hurt him. He then climbed up onto the deck of the

locomotive. He was yelling for help and continued to voice the belief that someone had drugged him.

[30] Railway workers reported that they were operating the locomotive when they saw people walking on the tracks. The conductor called for the train to be stopped and blew the horn to warn the people to get off the tracks but the people kept walking towards the locomotive. They then called the CN dispatcher, who at 03:47 called 911 requesting police assistance.

[31] At 04:04, four WPS officers arrived at almost the same time. They asked the family members to move away and two officers went up on the train to get Mr. Gagnon. Cst. Adolph approached Mr. Gagnon who was now seated against the door to the locomotive engine room. P/Sgt. Murray requested an ambulance as he was concerned it was a drug induced state and he wanted medical on standby. Cst. Adolph engaged Mr. Gagnon in conversation and was able to elicit some personal information. Mr. Gagnon said that he was scared, and he did not believe that they were real police. Cst. Adolph assured him that they were, and asked him to stand up and come with him. He then took hold of Mr. Gagnon's left arm and guided him to the back of the train where the steps were located. At that point he was able to convince Mr. Gagnon come down the ladder off the train.

[32] Upon reaching the ground, Mr. Gagnon grabbed onto the railing to the train and would not let go. The three other officers then moved in and pried him from the

train. Mr. Gagnon resisted, tucking his arms in close to his body and trying to pull away from police. Recognizing that the ground around the tracks was rocky and sharp, the four officers guided Mr. Gagnon away from the side of the train to a nearby grassy area. Once there, Mr. Gagnon was pulled to the ground face down. Mr. Gagnon continued to resist and tuck his arms under his body while yelling and screaming. The struggling continued for several minutes. Cst. Adolph applied two to four knee strikes to Mr. Gagnon's left shoulder at which time the officers were able to gain control of Mr. Gagnon's arm and apply handcuffs. Due to Mr. Gagnon's large build, they used two sets of handcuffs to secure his arms behind his back. At 04:19, P/Sgt. Murray radioed dispatch to put a rush on the ambulance as he believed it to be an excited delirium situation.

[33] Moments later, Mr. Gagnon went limp. He was turned onto his back. He had no pulse and was not responding to his name. At 04:20, the officers deployed NARCAN Nasal Spray and began CPR.

[34] Paramedics arrived at 04:29 and took over medical care. They transported Mr. Gagnon to Concordia Hospital. His condition never stabilized and treatment was withdrawn the following day.

[35] The Report of Medical Examiner identified the immediate cause of death to be hypoxic-ischemic brain damage, due to cardiac arrest, due to excited delirium due to cocaine use.

Michael Bagot

[36] Michael Bagot (DOB: February 19, 1979) was a 40-year-old man of south Asian heritage who was married to Chhaya Bagot and a loving father to their five-year-old son. He was described as a caring and protective man, who was committed to family and friends. His wife describes an act of kindness he performed a week before his death where he purchased $100 worth of hamburgers then went downtown and distributed them to people on the street. That was the kind of person that he was.

[37] On May 22, 2019, Mr. Bagot was unwell and was seen around Winnipeg in a state of distress. At 11:29 in the morning, staff at a restaurant on McPhillips Street reported to police that Mr. Bagot had entered the premises asking for assistance. He appeared to be high, was sweating profusely, and had trouble putting sentences together. He then drove away in his vehicle.

[38] Approximately six minutes later at 11:35, Mr. Bagot himself called 911. He spoke erratically on the phone to the call taker, stating that people were after him but refused to answer any of the call taker's questions.

[39] Further 911 calls were received from various individuals at 11:57, 12:06, 14:03 and 14:11. Mr. Bagot was reported to have been distraught and driving erratically. At 14:03 he was accompanied by a female who was also distressed and at one point appeared to attempt to exit the vehicle, but was pulled back in before the vehicle drove off.

[40] The next 911 call regarding Mr. Bagot was at 17:55 where he was reported to be clinging on to an ambulance in the area of Provencher Boulevard and Tache Avenue. He eventually let go, then wandered in traffic, trying to get into cars. He made his way to a nearby restaurant and entered. Staff called 911 and reported that Mr. Bagot was hallucinating and saying that people were after him. He then ran out into the street, stopping traffic and banging on cars.

[41] After exiting the restaurant, Mr. Bagot himself phoned 911 twice, at 18:01 and 18:03. During those calls, he was incoherent and nonsensical although the call taker could hear him talking about people trying to rob him and hurt him. He could next be heard entering Winnipeg Transit Bus #130 which had been travelling eastbound on Provencher.

[42] Video from the transit bus depicted Mr. Bagot entering onto the bus in an excited state. He was yelling at the driver to shut the doors because someone had a gun. There were other passengers throughout the bus and at one point, Mr. Bagot picked up a parcel belonging to another person but then he released it.

[43] All the while, numerous 911 calls were made by members of the public to report Mr. Bagot's behaviour. The bus driver asked his dispatcher to call for help and at 18:09 Winnipeg Transit Command Centre called 911 to request police assistance.

[44] At 18:15 police arrived on scene and Csts. Saydak and McCrady were the first to enter the bus at 18:16:52. Bus surveillance video shows the officers telling Mr. Bagot to put his hands up, which he did. As they approached him, they instructed him to turn around and they motioned to handcuff him. Mr. Bagot tried to avoid them and asked the officers to wait and for "one sec". They immediately pushed him against the window and told him to stop resisting. Insp. Dudek arrived and joined the other officers in trying to apply handcuffs. Mr. Bagot started yelling and tried to get away. Only one handcuff was secured.

[45] The officers immediately took Mr. Bagot to the ground. Csts. Degraff and Simchuk arrived moments later and helped hold Mr. Bagot down to the deck of the bus. The officers told Mr. Bagot to just relax and that he was okay, but Mr. Bagot continued to panic and call for help. Eventually handcuffs were secured and Cst. DeGraff testified that he applied a RIPP hobble to Mr. Bagot's ankles. Cst. McCrady voiced for an ambulance indicating that it was a possible excited delirium and medical assistance was required.

[46] Video surveillance from the nearby restaurant shows that at 18:20, four officers carried Mr. Bagot face-down off the bus. He was placed carefully on the sidewalk, chest down. His arms were handcuffed behind his back and his legs were restrained with a RIPP hobble.

[47] For the next approximately four minutes, Mr. Bagot lay relatively motionless on the ground. The officers stood around him, and one officer held onto the end of the RIPP hobble. Insp. Dudek was by his head, and the other officers were standing around him.

[48] At about 18:24, Mr. Bagot's legs moved up and down, at which time the officers moved closer and held him down. Insp. Dudek remained by his head, and three other officers held him down. At 18:26, an officer made a pillow out of some clothing and placed it under his head.

[49] Several of the WPS officers testified that Mr. Bagot was in a recovery position. CN peace officer Dariusz Rozwadowski who had stopped to assist testified that Mr. Bagot was in a semi-recovery position, noting that the hobbles prevented his knee from coming forward. It is difficult to discern from the restaurant surveillance video the exact positioning, but as noted earlier, Mr. Bagot remained relatively motionless.

[50] At 18:27 WFPS arrived on scene. The evidence of paramedic Jeffrey Peters was that when they arrived, Mr. Bagot was lying on his stomach in the prone position with approximately five officers holding him down. Upon initial assessment, Mr. Bagot did not appear to be breathing. He asked police to remove the handcuffs which they did, and Mr. Bagot was turned over onto his back and CPR and ventilation started. They were able to regain a pulse.

[51] Mr. Bagot was taken to hospital where it was determined that he had suffered a significant injury to the brain due to lack of oxygen. On May 24, 2019, life support was withdrawn and he was pronounced deceased.

[52] The Autopsy Report Form indicated cause of death as being anoxic brain injury with herniation, due to cardiovascular arrest due to complications of cocaine toxicity. Cardiomegaly was identified as a significant condition contributing to death.

Sean Thompson

[53] Sean Thompson (DOB: September 25, 1988) was a 30-year-old Indigenous man in Winnipeg. He was a husband, a father, a son, a brother and more, and was very loved by many. The Thompson family observes traditional practices and the portion of the inquest addressing the circumstances of Sean's death began with a pre-court smudge led by Elder Sharon.

[54] On June 26, 2019, just after 02:30, 911 received multiple calls. One woman reported she could hear a door being kicked in and a woman screaming for help. A resident on Alfred Avenue called to report an unknown male was in her home. He had broken the front window and was smashing things in the home. A home on Aberdeen Avenue called to report that someone had pushed in the screen of the window but did not gain entry. Finally, a resident on Burrows Avenue called to report someone had attempted to break into her home and was still outside yelling.

[55] Csts. Gillespie and Ross were dispatched and arrived at the home on Burrows at 02:42. There they encountered Mr. Thompson on the top of the front step of the residence. He was wrestling with a chair but appeared to lack coordination. There was a laceration on his right forearm and he was bleeding. Cst. Ross noted erratic behaviour including yelling and screaming, heavy sweating, twitching and rapid breathing.

[56] Cst. Gillespie announced "Winnipeg Police" and told Mr. Thompson to get on his stomach. Mr. Thompson tried to be compliant but had difficulty controlling his movements. Cst. Ross easily grabbed the chair and Mr. Thompson rolled down the stairs to the ground. He was lying prone on his stomach when Cst. Gillespie used his left leg to shin pin the right side of Mr. Thompson and then handcuff him. Officers spoke with Mr. Thompson who said his name was Sean but he could not articulate his last name. He said that he had taken two bumps of coke and that his mouth was injured and his leg broken. He then said "I can't breathe" and became unresponsive.

[57] Officers immediately put Mr. Thompson into a modified recovery position off his stomach and administered a sternum rub in hopes of eliciting a response. There was none. Cst. Ross administered NARCAN but it had no effect. Csts. Macki and Verwymeren had arrived as back-up, and at 02:49 Cst. Macki voiced for a rush ambulance. Officers began CPR and continued until the ambulance arrived at 02:55.

[58] Mr. Thompson was taken to hospital, but attempts at resuscitation were unsuccessful. The Autopsy Report form listed mixed drug intoxication from cocaine, methamphetamine and ethanol as the immediate cause of death.

Randy Cochrane

[59] Randy Cochrane (DOB: May 30, 1989) was a 30-year-old man from Fisher River Cree Nation. His mother spoke of what a good son he was, very active and engaged, and how he was able to return to school and graduate even though he had stopped attending earlier. He was also a beloved father and he took good care of his daughters. He taught them how to skate and throw a baseball, and they felt loved and protected by him.

[60] On July 19, 2019, Mr. Cochrane was in Winnipeg. He phoned his mother earlier and told her he was coming home. He asked her not to tell the girls, as he wanted to surprise them. Sadly, this never came to pass.

[61] That afternoon, it was a very hot day at over 30 degrees Celsius. At about 15:46, Community Support Csts. Diack and Argle were driving in their cruiser car in the area of Flora Avenue and Parr Street when they saw Mr. Cochrane. He was running and to their surprise, he collided with their vehicle. He spun off the cruiser, said he was sorry, then kept running. Cst. Argle felt he looked distressed, with his eyes and mouth wide open. The officers saw that he was holding something in his hand which looked like a weapon and so they followed him.

[62] Cst. Argle got out of the cruiser and gave chase, while Cst. Diack drove down Flora Avenue to head them off. Cst. Argle caught up with Mr. Cochrane about four houses down when he saw Mr. Cochrane trying to open the rear door to a residence. He saw that Mr. Cochrane was bleeding from a wound between his shoulder blades. Cst. Argle pulled out his firearm and commanded him to stop and lie on the ground. Mr. Cochrane appeared agitated and sweaty, but he complied and got down on his stomach.

[63] By this point, Cst. Diack arrived and he helped apply handcuffs with arms behind the back. The officers noted that Mr. Cochrane was having difficulty breathing and his feet were still moving and jerking. He was yelling that someone was trying to kill him and also that he needed some water. Cst. Diack used his foot to prod Mr. Cochrane off his stomach and into the recovery position. Both officers were concerned this was an Agitated Chaotic Event, and so Cst. Diack requested an ambulance and backup from the WPS tactical support team ("TST").

[64] Sgt. Loewen, and Csts. McLarty and Trotman arrived on scene at 15:49. Upon arrival, the TST officers immediately placed Mr. Cochrane in the prone position and held him immobile by applying a shin pin to his hips and arms. Csts. Diack and Argle at this point stepped away from Mr. Cochrane and engaged in other tasks. A RIPP hobble was applied to Mr. Cochrane's legs.

[65] While waiting for the ambulance, the TST officers testified that they continued to pin Mr. Cochrane to the grass. Cst. McLarty testified that they monitored his breathing by watching the rise and fall of his back and by trying to get him to talk. Mr. Cochrane was acting erratically, yelling incomprehensibly and at times biting at the grass. Civilian witness statements confirm that yelling could be heard.

[66] Cst. Argle returned and observed that Mr. Cochrane was no longer moving his head and upon examination, noted that his lips were blue. Mr. Cochrane was immediately flipped onto his back and Cst. McLarty commenced CPR which continued for approximately one minute until the arrival of paramedics at 15:55.

[67] Paramedics took over resuscitative efforts and transported Mr. Cochrane directly to hospital, but he could not be revived.

[68] An autopsy was performed which identified the immediate cause of death as the toxic effects of methamphetamine, cocaine and ethanol, with contributing factors listed as cardiomegaly (NYD) and physiological stress associated with pursuit and restraint.

IV. PHYSIOLOGICAL EFFECTS OF COCAINE AND METHAMPHETAMINE

[69] All five men had cocaine, methamphetamine, or both present in their bodies and were exhibiting signs of amphetamine type stimulant intoxication. Substance use was a contributing cause to each of the deaths.

[70] Dr. Gary Glavin provided expert testimony on the pharmacology of drugs and the physiological effects on the human system. Dr. Glavin is a retired professor who has extensive experience in the area of pharmacology, both nationally and internationally. He has testified as an expert in many court proceedings, including as an expert witness in the *Inquest Into the Death of Russell Andrew Spence* (24 April 2020).

[71] Dr. Glavin explained the physiological impact of cocaine on the body, which most notably consists of cardiovascular effects affecting blood flow and greatly altered brain dopamine activity resulting in psychotic-like behaviour in which the individual represents a danger to themselves or to others around them.

[72] The cardiovascular effects of cocaine are varied and potentially lethal. Cocaine is a vasoconstrictor meaning that it constricts or narrows blood vessels throughout the body. Several consequences of vasoconstriction can occur including hypertension, ischemic heart damage, and cardiac arrhythmias. The overall effects of cocaine on the cardiovascular system resemble a large and significant stress response – as if a fight or flight response is being demanded of the body even in the absence of such a requirement.

[73] When in the context of an interaction between a cocaine user and struggle with law enforcement or other personnel, essentially the cocaine in and of itself produces a massive stress response in the user – as defined by increased dopamine

activity in the brain, increased heart rate, increased blood pressure, and potentially, cardiac arrhythmias. Deaths in these types of situations have been analyzed and found to have occurred as a result of a fatal cardiac arrhythmia brought on by the stress of cocaine use combined with the physical exertion and stress caused by forceful engagement.

[74] Similarly, methamphetamine use produces a stress like response in the body characterized by greatly increased central nervous system arousal, increased heart rate, increased blood pressure, diversion of blood from internal organs to muscles and results in an intense feeling of pleasure and euphoria. All amphetamines share several properties in common including they are analeptic (anti-sleep), anorectic (anti-appetite) and anti-fatigue compounds.

[75] Dr. Glavin opined that:

> Overall and taking into consideration the direct effects of methamphetamine on the heart and cardiovascular system, the general stress of a situation in which a methamphetamine user is interacting with law enforcement personnel as well as any physical activity such as running or struggling that may be involved and then factoring in pre-existing cardiovascular disease or abnormalities (even subclinical and/or undiagnosed conditions), there is little doubt that the probability of a serious adverse cardiac event occurring rises significantly with use of this drug.

[76] Dr. Glavin advised that the literature concerning the concurrent use of cocaine and methamphetamine is sparse and is largely limited to anecdotal reports and case reports. He stated that both drugs are stimulants and produce similar effects. When the drugs are used concomitantly, their effects are more than just additive and likely potentiating, meaning that their combined effects are much greater than when either

drug is used alone. There is an even greater risk of severe cardiovascular damage when both drugs are combined. The overdose potential is also increased. The euphoria or "high" produced by the combined use of cocaine and methamphetamine is more intense and prolonged, as is the "crash" that follows. The chance of severe hyperthermia possibly leading to renal (kidney) failure and death increases with the concomitant use of these drugs.

[77] The evidence of Dr. Glavin makes it clear that a focused approach is needed when dealing with individuals who have consumed cocaine and/or methamphetamine. The drugs cause significant stress response on the body and the probability of a serious adverse cardiac event occurring rises significantly when these stimulants are in an individual's system.

[78] The manner in which police and first responders provide assistance to individuals under the influence of cocaine and/or methamphetamine must take this danger into account.

V. DISCUSSION OF "EXCITED DELIRIUM"

[79] The use of the term "excited delirium" was an issue in this inquest. In all five of the incidents, the deceased were exhibiting behaviour which has been described in the literature as: "a state of extreme mental and physiological excitement, characterized by extreme agitation, hyperthermia, hostility, exceptional strength and endurance without apparent fatigue" (see Simon Baldwin et al, "Adverse outcomes

in non-fatal use of force encounters involving excited delirium syndrome" (2021), Police Practice and Research, DOI: 10.1080/15614263.2021.1958682, citing Morrison & Sadler (2001) at p. 46).

Autopsy Reports

[80] Only one of the autopsy reports lists "excited delirium" as a contributing cause of death. This was the May 10, 2019 Autopsy Report completed by Dr. Charles Littman, in respect of Patrick Gagnon.

[81] In the report completed for Mr. Gagnon, Part I stated:

(a) Hypoxic-ischemic brain damage, DUE TO or as a consequence of

(b) Cardiac arrest, DUE TO or as a consequence of

(c) Excited delirium, DUE TO or as a consequence of

(d) Cocaine use.

[82] Dr. Littman testified at the inquest and explained that when the report was completed, the term "excited delirium" was used to describe a constellation of features that would have been present at the time of death. It would not be a cause of death in and of itself, and would have to be qualified as to the cause of that excited delirium. In Mr. Gagnon's case, the excited delirium was qualified as being due to cocaine usage.

[83] The practice today would be to either leave the term excited delirium out, recognizing that it just describes the behaviour prior to collapsing, or to say that there

was cocaine associated hyperactive delirium. Another alternative would be to simply state that the cardiac arrest was due to cocaine use.

Position of Chief Medical Examiner's Office

[84] A statement from Dr. John Younes, CME, indicated that the office of the CME no longer uses the term "excited delirium" in its reports. He explained that the use of the term has evolved over time. Historically, the term was coined to describe a collection of signs and symptoms thought to be caused by chronic stimulant use. It was initially believed that a chronic user of a stimulant such as cocaine could go into a state of delirium and while in that state would go into cardiac arrest and die. In many cases, when the death was attributed to excited delirium, no further inquiry was made into the cause of death, thereby leaving other potential contributing factors uninvestigated.

[85] The approach now taken is to consider excited delirium as describing a state of acute psychomotor agitation, but is not sufficient on its own to be listed as the cause of death without the attendant underlying cause of the condition. The practice of the CME is to provide the underlying basis for the state of excited delirium, either in the cause of death statement or in the narrative summary of events.

WPS Terminology

[86] The terminology used by WPS has changed from "excited delirium" to "agitated chaotic event" ("ACE"). Cst. John Russell, WPS Officer Safety Instructor

advised that the reason for the change was to shift the focus from a medical diagnosis, which officers are not trained to provide, to viewing the behavioural cues as a whole. The WPS policy procedures and training on ACE is to treat them as a medical emergency.

WFPS Terminology

[87] Prior to 2018, WFPS used what was called "Excited Delirium Protocol". This terminology has been eliminated, although its content is very similar to what is now in use. WFPS now has protocols for dealing with individuals with "Amphetamine Type Stimulant Toxicity" and "Agitated Patient Chemical/Physical Restraint".

Other Police Forces

[88] Sgt. Kelly Keith was qualified as an expert in police use of force and use of force training. Sgt. Keith has 34 years of police experience with multiple police departments and has in various capacities provided training to a wide range of peace officers both nationally and internationally. On the issue of excited delirium (which he referred to as "hyperactive delirium with agitation," the term used by the American College of Emergency Physicians), Sgt. Keith advised that throughout Canada, police officers are taught to assess the totality of the circumstances based on behaviours, signs and reported symptoms. If they conclude it applies to the situation, medical assistance for the person must be obtained as quickly as possible.

[89] Sgt. Keith acknowledged controversy over the use of the term "excited delirium" but said that from a policing point of view, what is occurring medically within a person or what to call it is outside the police officer's realm of expertise. The police training focuses on identifying the behaviours, signs and reported symptoms and recognizing that it is a medical emergency.

Theory of Death in Cases of Excited Delirium

[90] The five deaths being examined in this inquest occurred when each of the men involved were exhibiting the behavioural characteristics of excited delirium. The CME statement indicated that there are competing theories regarding how to explain the ultimate cause of death in situations where a person dies while in a state of excited delirium:

> The majority view is that during a struggle with police, the deceased develops cardiac arrhythmia which results in cardiac arrest and, eventually, death.
>
> (a) Cardiac arrythmia can result from the introduction of an extreme level of adrenaline in the deceased's bloodstream. During a maximal effort struggle, the extreme emotions, duress, and exertion can create a dangerous surge of adrenaline.
>
> (b) The use of stimulant drugs will result in high levels of adrenaline in the user's bloodstream. A psychotic episode caused by a mental illness such as schizoaffective disorder or schizophrenia can also produce elevated levels of adrenaline.
>
> (c) The high level of adrenaline results in an elevated heart rate and an increase in the amount of oxygen required by the heart. Cardiac arrhythmia may result from an imbalance in the supply and demand of oxygen in the heart. If the heart does not receive enough oxygen, the cardiac electrical system may not function properly and can produce an arrhythmia.
>
> (d) Many individuals who develop fatal cardiac arrhythmia also have underlying heart disease such as coronary artery atherosclerosis, hypertensive heart disease or a bad heart valve. An enlarged heart will result in excessive demand for oxygen, while bad coronary arteries can result in reduced supply of blood to the heart. An individual who suffers from such conditions will be

> predisposed to developing cardiac arrhythmia. If an excessive amount of adrenaline raises their heart rate, this risk increases.
>
> (e) In a violent, prolonged interaction with police, an individual who is in an excited state caused by drugs or mental illness can develop cardiac arrhythmia from the high levels of adrenaline in their bloodstream. This, in turn, can cause cardiac arrest.
>
> A competing theory is that the cause of death is acidosis. It is proposed that a prolonged struggle results in the buildup of lactic acid which lowers blood pH to a dangerous level. This may be compounded by respiratory acidosis if the subject has their torso compressed by the weight of others, preventing them from making full respiratory movement and expelling carbon dioxide. At this time, the belief that this process alone accounts for deaths occurring during restraint is not widely held.

[91] Understanding the specific cause of death in these situations remains uncertain due to the lack of definitive studies. The difficulty in obtaining good data remains the challenge. What is clear, however, is that regardless of the specific physiological process involved, the simple fact of engaging in a maximal effort struggle while in this heightened state greatly increases the risk of developing cardiac arrhythmia.

Terminology

[92] Overall, it appears that for a variety of social and cultural reasons, use of the term “excited delirium” has become problematic. The concern for some is that the term is non-specific and its use suggests the delirium itself as the cause of death thereby obfuscating potential contributing factors. For others, the term is believed to be of diagnostic significance, and therefore use of the term is to be avoided.

[93] In the context of this inquest, I view the term "excited delirium" as simply referring to the constellation of behavioural traits. For the purposes of this report, I will refer to the behaviour as hyperactive agitation.

VI. WPS AND WFPS PROTOCOLS FOR DEALING WITH HYPERACTIVE AGITATION

[94] In both this inquest and the companion inquest into the death of Viengxay Chommany, I heard extensive evidence regarding how WPS and WFPS respond to calls for assistance regarding individuals who are exhibiting hyperactive agitated behaviour. While all of the deceased in this inquest had amphetamine type stimulants in their systems which contributed to their behaviour, Mr. Chommany did not. His behaviour was believed to be caused solely by mental illness.

[95] The two etiologies are not mutually exclusive, and in the cases of Mr. Fosseneuve and Mr. Bagot, there is evidence suggesting that they lived with mental health issues, in addition to substance abuse.

[96] Regardless of whether an individual's agitated behaviour is rooted in psychosis or in substance use, according to the report of Sgt. Keith, the constellation of symptoms typically observed include the following features:

- Pain tolerance;
- Constant/ near constant activity;
- Not responsive to police presence;

- Superhuman strength;
- Rapid breathing;
- Does not fatigue;
- Naked/inappropriately clothed;
- Sweating profusely;
- Tactile hyperthermia;
- Glass attraction/destruction.

[97] As seen in the five inquest cases, the hyperactive agitated behaviour often escalates to the point where a call is made to 911 asking for assistance. Typically, police become involved after being dispatched at the request of WFPS, friends/family, members of the public, or by the individual themselves.

WPS Procedure

[98] Cst. Russell advised that WPS training provides that ACE incidents are to be treated as a medical emergency. Officers are to ensure that appropriate resources are on hand for the situation which would include paramedics for sedation and use of CEWs or swarm technique to attempt to incapacitate the individual so restraints can be applied quickly with minimal physical force. After restraints are applied, officers are instructed to control the individual with the least amount of intervention possible and place them in the recovery position, noting that some restraint may remain necessary if they are still at risk of harming themselves or others.

[99] The swarm technique occurs when a team of members goes hands-on with the individual to quickly gain control. The technique involves officers individually taking control of a certain part of the subject's body to hold them until restraints can be applied and/or medical intervention can occur. It is designed to avoid any pressure on the back, spine and diaphragm. Once the individual is restrained, they are moved into the recovery position as long as it is safe to do so for all parties, including the subject, any bystanders, the officers and paramedics.

[100] WPS members are trained to recognize various known behavioural cues of an ACE or drug-related psychosis with the mindset of obtaining medical attention for the individual first, before any criminal concerns are addressed. During training, police recruits are provided classroom training, practical skills and a dynamic scenario where an individual is suffering from an ACE. The recruit is to demonstrate their ability to act appropriately by recognizing the ACE, calling for back-up and requesting paramedics without physically engaging the individual until resources are in place or exigent circumstances exist, such as the prevention of self-harm or harm to any other individual.

WFPS Procedure

[101] Dr. Robert Grierson, the Medical Director for WFPS testified and explained that there are two main levels of paramedics: primary care paramedics ("PCP") and advanced care paramedics ("ACP"). The latter includes what was previously

referred to as supervisors, who have additional training and skills to function in high-risk low-volume circumstances. In the last five years, they have introduced a level called "advanced care paramedic practitioner" who are not supervisors but have advanced training. The PCP often arrives on scene earlier and will deliver basic critical and symptom relief interactions to the patient. ACPs have a greater range of treatment options available to them, including medication, electrical interventions and traumatic interventions.

[102] Dr. Grierson outlined the WFPS response when a patient is described as experiencing an agitated event. The two applicable policies are "Amphetamine Type Stimulant Toxicity" and "Agitated Patient Chemical/Physical Restraint" which are treatment protocols designed in conjunction with WPS at Joint Operations meetings.

[103] Prior to 2018, WFPS used what was called the "Excited Delirium Protocol". This has been discontinued, although its content is very similar to what is now in use. Dr. Grierson provided flowcharts for the Amphetamine Type Stimulant Toxicity and Agitated Patient Chemical/Physical Restraint policies.

[104] In the Amphetamine Type Stimulant Toxicity policy, the signs and symptoms of amphetamine type stimulant intoxication are described as including:

- Euphoria, hypervigilance, impulsivity;
- Agitation, irritability, anger;
- Psychomotor agitation (pacing, restless, rapid/pressured speech);

- Flushed cheeks, sweating, dilated pupils;
- Hypertension, tachycardia;
- New or worsening mental health symptoms (anxiety, panic, hallucinations, paranoia).

[105] The patient may be offered to voluntarily take olanzapine in the form of an oral disintegrating tablet.

[106] If the patient's condition is escalating or they are starting to show signs and symptoms of impending violence, the protocol changes to the Agitated Patient Chemical/Physical Restraint policy. This policy contemplates injection of haloperidol or midazolam and transport to the Health Sciences Centre.

[107] If the patient is confirmed to show signs or symptoms of violence or impending violence, or is a violently agitated patient requiring full restraint, paramedics are to establish the safety of personnel and patient, attempt verbal de-escalation and consider possible organic causes of agitation.

[108] If the situation is escalating or there is a threat of harm, paramedics are to call for assistance and ensure police are on scene. For physical restraint, the WFPS guidelines are as follows:

- A minimum of six people should be present during physical restraint to allow for control of head and each limb.

- Highest ranking medical personnel should assume the role of medical team leader and monitor the patient's airway/breathing.
- While gaining initial control, it may be acceptable to temporarily restrain the patient in a prone position.
- The patient should never be maintained or transported prone as this has been associated with positional asphyxia.
- Patients should never be "hog tied" (i.e.: feet restrained to hands and face down).
- If a patient vomits they should immediately be put in the recovery position and suctioned for airway protection.

911 Call Takers and Dispatchers

[109] New call takers are trained on how to process events that fit the behavioural cues of an ACE during their initial training. The training is based directly from ACE Standard Operating Guidelines ("SOG") and is reinforced with simulated calls. As well, a member from the WPS Officer Safety Unit attends the class to present the topic. Call takers, through questioning and caller comments, are trained to identify ACE situations. Alternatively, an officer on scene can inform that dispatcher of the type of event. The SOG can be retrieved on the computer terminal and notification is made to WFPS that an ACP is required.

WPS-WFPS Response

[110] Overall, the WPS-WFPS response to calls involving a hyperactive agitated individual generally unfolds as follows. WPS is dispatched to respond to a call for assistance. When they arrive, the individual is exhibiting hyperactive, agitated behaviour. Once the WPS officer recognizes the ACE situation, it is considered a medical emergency, and an advanced care paramedic is requested to manage the situation pharmacologically by administering chemical restraint.

[111] Sometimes, WFPS is the first to be dispatched. In those cases, once the paramedics recognize that the situation is escalating or there is a threat of harm, WPS assistance is requested.

[112] As WFPS policy is that paramedics are not to administer medical care until such time as the individual is under control, the responsibility rests with WPS to moderate the individual's behaviour to the point where the medical care/chemical restraint can be given.

VII. IDENTIFYING TARGET AREAS

[113] In reviewing the events surrounding the five deaths, as well as the death of Viengxay Chommany in the companion inquest, I have identified two areas where improvements could be made:

- Target Area 1: How to moderate the agitated individual's behaviour to enable administration of medical care; and

- Target Area 2: How to minimize the time between when police have brought the individual's behaviour under control, and when the sedative can be administered.

Target Area 1: How to Moderate the Person's Behaviour

[114] Police are charged with the very difficult task of subduing the hyperactive agitated individual into a state where chemical restraint can be safely administered. They are responsible for making the situation safe for the paramedics, the individual, and the police themselves. It must be recognized that they are carrying out this task in an uncontrolled, non-clinical setting which may be fraught with unknown dangers, including concealed weapons.

[115] There were two practices examined during the course of this inquest and the companion inquest:

i. De-escalation

ii. Restraint techniques

De-escalation

Current WPS Training

[116] WPS Officer Safety Unit provided information regarding police training. New recruits undergo 21 weeks of academic training and 16 weeks in-field training.

[117] As police members progress, all are required to complete skillset recertification throughout their career to ensure their knowledge and skills remain

up to date. The mandatory areas of recertification are firearms recertification, police vehicle operation, active response tactics (active shooter or homicide in progress training), use of force recertification, conducted energy weapons recertification, tactical trauma care, emergency first aid/CPR, mental health awareness and support training, and bias awareness.

[118] On the specific area of de-escalation training and mental health knowledge, Cst. Russell advised:

> The Police Service recognizes public concerns about incidents of excessive use of force and the negative perception of using force to restrain aggressive individuals who are experiencing a mental health crisis. Officers are trained to negotiate dynamic scenarios where they must balance their personal safety, the safety of the public and the safety of the person in crisis. Recruits and police service members now participate in training and practice scenarios where communication and de-escalation skills are tested; they learn about various mental health diagnosis and to recognize common mental health symptoms as well as resources and programs available to assist officers when responding to calls for service where an individual is struggling with their mental health.

[119] Communication and de-escalation strategies taught to members include:

- Tactical communication, which is the straightforward logic driven direction that members provide to the public on a regular basis. It consists of greeting, reasoning, requesting cooperation, and then acting.
- Crisis communication, which is utilized where a person is in a highly emotional state, but is still able to understand the logical cause and effect directions given by the officer. The tool used for de-escalation has the acronym LEAPS: Listen, empathize, ask questions, paraphrase, summarize.

- Verbal de-escalation strategies including deflection phrases, tactical deception and command presence.
- Other concepts include adherence to "the Golden Rule," being aware of communication challenges, mental health recognition, and being exposed to high stress decision making scenarios.

[120] Recruits undergo a 12-hour unit specifically devoted to communication and de-escalation, and all officers receive bi-annual refresher training on strategies to be used. The training includes several live scenarios which test the member's ability to make decisions under stress. Officers also receive numerous hours of verbal de-escalation training embedded throughout the curriculum within various training programs.

[121] In 2023, in-service training that members take began to include a refresher on ACE incidents, to ensure members were up to date on practices and techniques. Key points include: treating the incident first and foremost as a medical emergency; ensuring appropriate resources are on-hand for the situation (paramedics for sedation, use of CEW's or swarm technique to incapacitate the individual so restraints can be applied quickly and with minimal physical force). After restraints are applied, controlling the individual with the least amount of intervention possible and placing them into the recovery position, noting that some restraint may remain necessary if they are still at risk of harming themselves or others.

Execution of De-Escalation Techniques

[122] Dr. Skye Rousseau provided testimony as an expert in forensic psychiatry. Dr. Rousseau is a Psychiatrist with Adult Forensic Services and Assistant Professor with the University of Manitoba. He has been a psychiatrist since 2017 and has worked in MD Care, in Corrections at the Winnipeg Remand Centre, and as part of the Forensic Assertive Community Treatment Team in Winnipeg.

[123] Dr. Rousseau conducted a review of the circumstances surrounding the five fatalities to consider whether, from a psychiatric point of view, verbal de-escalation or other interventions could reasonably be used to delay or forestall the use of force. Dr. Rousseau explained that he asked himself whether a different approach could achieve a different outcome.

[124] At the outset, Dr. Rousseau clarified that when considering the correct approach, it is not necessary to distinguish between whether the behaviour is rooted in substance induced intoxication as opposed to primary endogenous mental illness. In real life situations, responders would not be able to determine the etiology of a person's behaviour in an acute situation. It is very difficult to distinguish the difference between substance induced psychosis/intoxication and psychosis itself, even in a clinical setting.

[125] Dr. Rousseau concluded that in the circumstances surrounding Mr. Fosseneuve, Mr. Cochrane and Mr. Thompson, there was imminent threat and risk

of harm such that it was fitting to resort to using physical means to control the individual. In his opinion, it was unlikely that a different approach by responding officers would have been reasonable given the situation they encountered, or would have made much difference in the outcome.

[126] With respect to Mr. Gagnon and Mr. Bagot, however, he opined that a different approach may have led to a better outcome.

[127] In the case of Mr. Gagnon, Dr. Rousseau noted that although Mr. Gagnon was acting in a reckless manner, it is possible that with time and further negotiating with police, he may have been able to be calmed further. Mr. Gagnon had initially responded to the officer's verbal direction. In cases of sudden, acute substance induced paranoia, usually as time elapses and the substance wears off, the paranoia will diminish.

[128] Dr. Rousseau indicated that he was not able to offer a strong opinion, but said that police could have spent more time using de-escalation techniques to help wait out the paranoia inducing effects of the substances and reassure Mr. Gagnon they were there to keep him safe.

[129] It was also my observation that as soon as Mr. Gagnon got off the train and grabbed onto the railing, multiple officers converged on him issuing commands. He had earlier responded favourably to Cst. Adolph's engagement with him. There may

have been opportunity to spend more time interacting with Mr. Gagnon in a less physical and forceful manner before guiding him to the ground and pinning him.

[130] A communication strategy limiting contact between police and a subject to one lead officer may have led to a better outcome. It is agitating to have multiple officers speaking to a distressed person at once. Some guidance on establishing a calm co-ordinated approach to communicating with the subject would be beneficial.

[131] In the case of Mr. Bagot, Dr. Rousseau opined that some attempt at verbal de-escalation would have been indicated but was not used, and that this may have improved the outcome. The interval of time between police entering the bus and physically restraining him was about 28 seconds. It does not appear that any attempt was made to dialogue with Mr. Bagot to understand what his concerns were or to try to de-escalate the situation. Mr. Bagot appears only to have used physical force in the form of resistance, yet he was restrained physically and resisted forcefully during the process. Multiple officers held him down while he was in a paranoid agitated state.

[132] Dr. Rousseau noted that agitation and paranoia while in a state of psychosis is an extreme stress to a person. Cocaine toxicity is associated with arrhythmias and sudden death. Unless there is imminent risk of harm to an officer or others, the best approach is to use simple de-escalation techniques. Given Mr. Bagot's presentation, it is not possible to say with confidence that a different outcome would have been

achieved, but in Dr. Rousseau's opinion, a better outcome would have been much more probable if officers would have at least attempted some verbal de-escalation techniques.

[133] Sgt. Keith similarly suggested that in a perfect world, it may have been preferable to have the passengers exit the bus and then isolate Mr. Bagot on the bus until advanced paramedic care arrived. WPS officers could then swarm Mr. Bagot decreasing his struggling time, get physical control and paramedics could immediately give medical aid.

[134] As previously noted, engaging in a maximal effort struggle while in a hyperactive agitated state greatly heightens the risk of cardiac arrhythmia. Combined with the possibility of cocaine or methamphetamine intoxication, the probability of a serious cardiac event is high. In my opinion, if there is any way to reduce or eliminate prolonged physical interaction with police, it should be attempted. Officers should be encouraged to resist the immediate instinct to forcefully restrain and instead should attempt to take a more measured approach towards moderating the subject's behaviour.

Restraint Techniques

[135] If verbal de-escalation or other non-physical attempts to subdue the individual have had no effect and a reasonable amount of time has elapsed, police may be left with no other alternative but to physically restrain the individual.

Current WPS Training

[136] As outlined earlier, WPS police officers are trained to incapacitate the individual so restraints can be applied quickly with minimal physical force, and after restraints are applied, officers are instructed to control the individual with the least amount of intervention possible. Once restrained, the individual is moved into the recovery position so long as it is safe to do so.

[137] The use of force expert Sgt. Keith discussed the WPS policy as follows:

> Cst. Russell advised that from 2011 to present WPS Officers are taught that when dealing with a violent subject they are to restrain the subject in the prone position. The officers apply what is called a shin pin restraint to the subject's buttocks area. A shin pin describes where an officer's foot is on the ground and the shin is pinning the subject down while handcuffs are applied. Cst. Russell advised that the goal is for the officers to only use this as a transitional position where the WPS members get the subject off the prone position when possible.
>
> Cst. Russell advised that starting in 2016 WPS members were taught that when a subject was exhibiting signs of what was at that time referred to as Excited Delirium, they were to wait for paramedics to attend the area if feasible. When paramedics arrived, they would stage nearby and wait for police to get physical control. It was recommended, if possible, to have a multiple member approach and to attempt avoiding applying pressure on the subject's back and were not to leave the subject in the prone position even by themselves. Once the subject was restrained, they were to have paramedics on scene to deal with any medical concerns.
>
> Since 2018 and continuing presently, WPS officers are trained that prone handcuffing is used for an active fighting subject and/or a subject that is high risk (ie. possible gun). A rip hobble (leg/ankle restraint) will be applied to prevent kicking and thrashing of the legs. Cst. Russell advised that the shin pin stays on while the rip hobble is applied at which time, the subject would be placed into the recovery position.

Cuffs On, Cops Off

[138] Sgt. Keith identified that the WPS policy is not specific as to how long a subject may be maintained in the prone position. While it is clear that the goal is to be transitioned to a side-lying recovery position, it is not clear what should be done

in cases where the subject is combative. If the subject is still struggling, at what point should the transition occur and when can it be done safely?

[139] The studies surrounding the effects of police prone restraint are inconclusive. I was provided with some literature on the topic and there are no conclusive studies identifying a relationship between subject positioning and occurrence of sudden in-custody death. One challenge is that it is impossible to replicate the conditions present when an individual in a state of hyperactive delirium with agitation is placed in a prone position.

[140] Sgt. Keith advocated for a "cuffs on, cops off" approach whereby having control of the subject does not necessarily mean the subject is compliant. Once handcuffs are applied, risk is greatly mitigated and the subject may be placed on their side, sitting position or back, despite still being agitated and struggling. It is an assessment-based approach, with the understanding that limiting the time a subject is restrained in the prone position is best practice and should be done unless a risk assessment concludes that the safety of the subject, officers and third parties cannot be maintained.

Execution of Restraint Techniques

[141] It is notable that in each of the five cases, the individuals were placed in the prone position, and in some instances there is evidence suggesting that they were maintained there for a period of time.

[142] In the case of Mr. Fosseneuve, he was brought to the ground by a CEW deployed at 22:50. He was then restrained by handcuffs and a RIPP hobble. He remained combative so three officers placed him in a shin pin. At one point, he was noted to have lost consciousness, so officers briefly placed him in a recovery position, where he revived. They then placed him back into a face down position, where he remained until about 22:56 when it was discovered he had no pulse. He was held prone for approximately six minutes.

[143] In the case of Mr. Gagnon, he lost consciousness relatively soon after being guided into the prone position to apply handcuffs. No RIPP hobble was applied.

[144] In the case of Mr. Bagot, he was quite swiftly taken to the ground on the bus deck, then struggled for about three minutes before he was taken off the bus and placed prone on the sidewalk. As soon as he lifted his RIPP-hobbled legs, officers went hands on to hold him immobile. He was in the prone position, or a partial recovery position, for approximately 10 minutes.

[145] In the case of Mr. Thompson, he was lying in the prone position with a shin pin applied for a very short time when he said he could not breathe and became unresponsive.

[146] Finally, Mr. Cochrane had initially been placed in the prone position when he indicated he could not breathe. He was moved into the recovery position, where he revived. Unfortunately, when the TST officers arrived, they immediately placed him

back into a prone position and applied a RIPP hobble. He was held in place with three officers applying a shin pin for approximately five minutes, before he was observed to be in medical distress.

[147] It is notable that all five of the men were described to be of larger build, and all had a body mass index of over 25. It is also notable that all of them had been strenuously exerting themselves even before engaging with police. In the case of Mr. Bagot, he had been known to be in an excited state for several hours prior.

[148] While the literature is inconclusive as to whether there is any increased risk of harm associated with maintaining a hyperactive agitated individual in the prone position, from a common-sense perspective, many people would describe the placement as being uncomfortable and restrictive. Sgt. Keith's report included anecdotal reports of training and exercise incidents where participants describe trouble with breathing when placed in the prone position after physical exertion. It is also a position of tactical disadvantage which I believe most people would be naturally inclined to resist, thus causing yet more stress.

[149] Combined with our knowledge about the physiological effects of cocaine and methamphetamine and the increased risk of a cardiac event, it seems clear that minimizing the amount of time a handcuffed person is kept in the prone position must be emphasized in WPS training. This practice is already part of the instruction given to WPS members, but direction regarding the length of time the prone position

may be maintained is imprecise. Members should be educated on the physiological risk factors which are present and be encouraged to restrain individuals in the prone position for the least amount of time possible. This would especially be the case in situations where the subject had already indicated trouble breathing in the prone position, as was the case with both Mr. Fosseneuve and Mr. Cochrane.

[150] I would also support Sgt. Keith's suggestion of a "cuffs on, cops off" assessment-based approach. While some of the testimony given by officers at the inquest suggested that holding the individuals down was necessary for safety reasons, I believe that once handcuffs and a RIPP hobble are applied, the ability of officers to control the risk of escape should be manageable. As observed by Sgt. Keith, having control of a subject does not necessarily require the subject to be compliant.

[151] Finally, in the cases of Mr. Fosseneuve, Mr. Bagot and Mr. Cochrane, the evidence is unclear as to when the fact that breathing had stopped was detected. An individual who is restrained with arms and legs tied is in an incredibly vulnerable position. Officers should be paying close and careful attention to the individual's physiological status at all times to ensure that assistance is available the moment it is required. Mere visual checks may not be sufficient.

Target Area 2: How to Minimize the Time Gap

[152] This area concerns how to expedite the delivery of chemical sedation to the individual. Target Area 2 addresses how to create efficiencies so resources can be deployed with the least amount of delay possible.

Dispatch

[153] The current practice is that when police identify an event as an ACE, they label it as a medical situation and will call for an ambulance.

[154] In the cases before the inquest, there is some variance as to how the ambulances were requested. In the Fosseneuve incident, paramedic Kok called for assistance in chemical sedation after he had initially interacted with Mr. Fosseneuve. In Gagnon, P/Sgt. Murray recognized at an early stage that Mr. Gagnon was in a drug induced state and that medical should be on standby. In Bagot, the first three officers on the transit bus recognized it was a medical emergency and the matter was voiced as an ACE by Cst. McCrady. In Thompson, the events occurred very quickly and there was no time to call for an ambulance before Mr. Thompson became unresponsive. Finally, in Cochrane, both officers recognized the situation to be an ACE event and Cst. Diack requested both an ambulance and TST back-up.

[155] In all of the cases, there was no significant delay in calling for an ambulance. I note, however, that there were some officers who testified that they initially did not identify the situation as being an ACE event. Reinforcement of training on

recognizing the behavioural cues of an ACE would be beneficial to some WPS members, and I understand that this has already been occurring since 2023.

[156] As discussed earlier, there are two types of paramedics: PCP and ACP. Only the later group are authorized to administer haloperidol or midazolam, which is the medication used for chemical restraint. So while the first responder on scene is typically a fire engine which is staffed with a PCP, an ACP is required to be on scene to sedate.

[157] The triage system used for 911 calls is called the Medical Priority Dispatch System ("MPDS"). The evidence of Dr. Grierson was that the MPDS is a prioritization system which was developed using robust data based on actual experience. The MPDS utilizes an algorithm developed from the data to guide medical dispatch for 911 call-taking. He testified that the use of discretion by 911 dispatchers in determining resources outside the MPDS would be inefficient and a safety risk.

[158] Sgt. Keith had suggested that changes be made to the manner in which 911 calls are sent out. The goal of that suggestion was to facilitate better sharing of background information so that the first responders on scene have a better understanding of what the patient is experiencing. Given the highly specific and methodical manner in which 911 calls are currently processed, I do not think that I have enough information to support making any recommendation for changes in the

way 911 calls from the public are received and resourced. I am informed that there is ongoing dialogue between WPS and WFPS through Joint Operations meetings to discuss ways in which resources may be more efficiently dispatched. Given the processes in place, I decline to make any recommendations in this regard.

Administration of Chemical Restraint

[159] I heard testimony from the pharmacology expert Dr. Glavin suggesting equipping police with ketamine for injection to agitated individuals, similar to the way that the medication NARCAN has evolved to become part of the standard issued equipment used by WPS officers. If a sedative medication could be identified for situations involving hyperactive agitation, this could very much speed up response time. He cited some early research where a singular bolus dose of ketamine administered intramuscularly was effective for use in controlling acutely agitated patients.

[160] Dr. Glavin suggested that ketamine could be a viable and effective tool for use in the pre-hospital setting in the case of persons exhibiting agitated/excited delirium. It produces rapid sedation, thereby minimizing the amount of struggle and physical exertion required to bring the affected person under control. Dr. Glavin acknowledged that use of ketamine would be dependent upon appropriate clinical trials, but pending such research, it may be useful to give some consideration to its use.

[161] WFPS Medical Officer Dr. Grierson provided evidence outlining current practices for chemical restraint. The policy is reviewed and assessed by their Medical Advisory Committee. The current combination of haloperidol and midazolam has a long history of use in combination, and that experience makes them safer to use. Dr. Grierson expressed concern about use of ketamine outside of a hospital setting in the absence of medical personnel due to risk of adverse reactions. The effects of ketamine are rapid, within 30 seconds to 3 minutes so medical personnel must be present when it is administered to address any complications which may potentially arise.

[162] I conclude that while the concept of equipping WPS officers with chemical restraint is sound, we are not yet at a stage where a suitable medication is identified and further research is required.

Communication

WPS/WFPS/911

[163] Sgt. Keith had suggested that dispatchers, police and paramedics engage in a collaborative training approach to ensure a smooth transition from one service area to the next. This would also enable better flow of real time information. This training should include reality-based scenarios where all three departments train together as this would help to develop a unified approach at all stages of interaction with the agitated individual.

[164] A training video made by the collaborative group of 911 call takers, WPS and WFPS would also assist training and could be used as well as a reminder for pre-training.

[165] A supplementary report co-authored by Cst. Russell and data analyst Alana Odokeychuk was filed. The report addressed the suggestion of ACE multi-agency training and advised that the number of WPS, WFPS and dispatcher staff involved would be approximately 2,610. The report identified concerns with instituting multi-agency scenario training including duplication of existing training programs, little-to-no job function overlap at ACE incidents, incompatible schedules, and the opportunity cost of additional training days.

[166] Dr. Grierson advised that WFPS already meets regularly with WPS through their Joint Operations committee and discusses issues such as this to ensure that both agencies are proactively addressing issues such as agitated patients. Neither system operates in a vacuum. He advised that dispatcher's actions are dictated by MPDS and paramedics have the appropriate training to provide necessary medical treatment. Joint scenario-based training would logistically be almost impossible, and with limited available training time, the concern is that necessary medical and other mandatory training would be displaced by this training.

[167] In my view, the concept of transition training has significant potential. There was testimony at the inquest from paramedics who indicated that when arriving on

scene, they were not aware of all of the relevant information which was already known by police. Further, the ACE scenario-based training WPS members currently receive focuses on recognizing the ACE event and restraining the individual, but once the subject is handcuffed, the scenario ends. It would be beneficial to extend the scenario to include how to deal with the individual in the interim, until such time as chemical restraint can be administered.

[168] Jointly held reality-based scenarios, however, would not be necessary to effect this learning.

[169] In my view, the Joint Operations committee should continue to share information and train to ensure smooth transition from one service to the next. A training video showing the ideal response to an ACE event from start to finish could be useful to demonstrate the proper handling of the situation, and should not require an inordinate amount of education time to incorporate.

Winnipeg Transit

[170] The initial police interaction with Mr. Bagot unfolded on a Winnipeg Transit bus. I heard evidence from Bradley Freund, the chief instructor with Winnipeg Transit who reviewed the training and procedures followed by Winnipeg Transit drivers. The two main focus areas in driver training are safe driving and customer service. Drivers take two programs which focus on safety and de-escalation training: Transit Assault Prevention Strategy (“TRAPS”) and Transit In-Service Program

("TRIPS"). The programs utilize both academic content and real-life scenarios and educate operators on a wide range of safety topics, including how to recognize when problematic situations may occur, and how to effectively communicate and potentially de-escalate.

[171] With respect to equipment, all buses have two-way radios and if an operator is in a dangerous situation, they are to contact Central Control if they feel a situation is developing. Central Control will then assist the operator by dispatching an on-street inspector to the bus, or they can call 911 if warranted. Since June 2024, buses are now equipped with a live feed, so Control Centre has the ability to follow events occurring on the bus in real time. There is, however, no direct communication between the driver and 911.

[172] In my view, the requirement to have all information transmitted through the Control Centre is cumbersome and could potentially cause critical delay. It would be beneficial to incorporate technology to enable 911 dispatch to have direct communication with the driver, without the requirement to have Control Centre as an intermediary. The ability to have three-way communication would address this concern.

VIII. NEW INITIATIVES

Winnipeg Transit Community Safety Team

[173] The Winnipeg Transit Community Safety Team ("CST") is a new initiative created to address concerns about an increased need for safety measures in the Winnipeg transit system. The team consists of 21 safety officers, 2 supervisors and 2 support staff, who are led by Dr. Robert Chrismas, a former WPS Staff Sargeant. It represents a new approach to policing which aims at collaboration and a greater focus on addressing social issues.

[174] The safety officers maintain safety and keep the peace in the community by intervening in incidents, detaining and/or administering first aid where necessary. They provide a visible point of contact for customer information and reassurance. CST will liase with stakeholders to share information and collaborate to develop and implement safety related strategies. They work closely with other agencies providing services in the field like the Downtown Community Safety Partnership, Main Street Project, Ndinawe and other similar agencies.

[175] The focus is on de-escalation and a trauma-informed approach intended to mitigate issues before they become bigger problems. Assistance is mostly focussed on unhoused individuals and people suffering from addictions or mental health issues. It is more of a social work approach, but with the authority to enforce and detain under *The Intoxicated Persons Detention Act* or *The Mental Health Act*, if

necessary. When safety officers are dealing with violent persons, they are taught to try to de-escalate while maintaining a safe distance, assessing and isolating the threat if possible, then contacting police as necessary.

[176] Safety officers have more time than WPS or WFPS to engage with citizens in crisis and direct them to the appropriate resource or support agency. The program is currently intended to address issues related to use of the transit system, but the hope is to expand the services more widely in the future.

Specialized WPS/WFPS ACE Unit

[177] Dr. Grierson spoke about a joint initiative between WPS and WFPS which was conceived at their Joint Operations meetings. The concept involves pairing an ACP paramedic with a WPS officer and specifically dispatching these pairings to calls where ACE is identified. This specialized unit where an ACP is embedded with police would have the ability to immediately administer chemical restraint and could be dispatched for high risk agitated patients.

[178] The concept is still only at the proposal stage and further refinements will be required, but Dr. Grierson advised that the incidence of agitated events is profoundly on the rise and creation of this specialized unit is justifiable based on volume.

IX. AREAS FOR FURTHER STUDY

[179] A challenge often encountered in inquests is in trying to limit the scope of the matters addressed. There are so many issues that cry out for further examination, but

it is impossible include them all. An inquest judge must prevent the proceedings from becoming a roving inquiry into matters of general public concern. A number of suggestions were made for recommendations arising out of the inquest. Some of them certainly sounded meritorious, however I only heard limited information regarding the issue and the practicality of the recommendation. The topics are listed below. I decline to put forward the following suggested recommendations not because I disagree with them, but rather because there is insufficient evidentiary foundation to be able to publish them as formal recommendations arising from the inquest.

Chemical restraint to be administered by primary care paramedics or police officers

[180] The concept of putting a sedative in the toolbelt of police officers, similar to equipping them with NARCAN, was suggested by Dr. Glavin. Dr. Grierson indicated some concerns with the use of ketamine specifically, but was open to consideration of a different medication if safety concerns could be addressed. The concept of more rapid administration of pharmacologic restraint is sound, but the issue remains as to whether any such medication is available. Further research is required in that regard.

AEDs in cruiser cars

[181] An automatic external defibrillator ("AED") is a device which can be used to treat a person who suffers sudden cardiac arrest. I did not hear much evidence related to AEDs but several officer witnesses indicated that they felt if an AED was available it may have assisted before the ambulance arrived. Further consideration may be warranted regarding the utility of equipping cruiser cars with this equipment.

Body cameras on police

[182] Video footage of police interactions would provide valuable information in incidents such as these. There are, however, resource issues associated with the provision and maintenance of the equipment, storage of data and privacy concerns. Ms. Carswell advised that the WPS has already requested funding for a pilot project. Further consideration may be warranted regarding the feasibility and use of body cameras for police officers engaged in their duties.

X. RECOMMENDATIONS TO PREVENT SIMILAR DEATHS FROM OCCURRING IN THE FUTURE

[183] Based on the foregoing review, I make the following recommendations to prevent death from occurring in similar circumstances.

Proactive Intervention

[184] **I recommend that all levels of government continue to commit resources towards support for persons living with substance abuse issues.** The common

contributing factor across all of the deaths is the detrimental effects of stimulant drug use. The increase in ACE incidents has been described in this inquest as profound, and it cannot be denied that further resources to address these challenges are critically required going forward to prevent further deaths. We cannot ignore the root cause of the problem.

[185] **I recommend that the City of Winnipeg continue its support and funding for the Community Safety Team**. The new program headed by Dr. Robert Chrismas has the potential to create effective ways of helping people before they reach a crisis point. With its focus on de-escalation and utilizing a trauma-informed approach, it represents a forward thinking and compassionate way of assisting unhoused individuals and persons suffering from addictions or mental health issues.

Target Area 1: Moderation of Person's Behaviour

[186] **I recommend that WPS review their policy and training on responding to ACE events**. In 2023, WPS in-service training began to include a refresher on ACE incidents. If it does not already, ACE training should include the following:

i. Emphasis on the use of alternative or de-escalation techniques prior to defaulting to physical restraint, including having one lead contact between police and the subject, and use of crisis communication skills.

ii. Education on the significant stress response the subject may be experiencing due to amphetamine-type stimulant intoxication and the potential for a serious adverse cardiac event.

iii. In reviewing the five incidents, it was not always apparent whether responding officers were actively considering the physiological demands on the individuals they were restraining. Recognizing that officers are responding in the moment to dynamic and unpredictable situations, there could nevertheless be benefit in further instruction on how to restrain and monitor hyperactive agitated individuals. In particular, ACE training should emphasize:

a) Subjects be maintained in the prone position for the minimum amount of time possible;

b) Recognition that having control of the subject does not necessarily require the subject to be compliant; and

c) The need for close observation of the restrained subject with specific protocol to monitor breathing other than mere visual checks.

Target Area 2: Reduce Gap Time

[187] **I recommend that WPS and WFPS jointly establish a specialized unit specifically trained to respond to agitated chaotic events.** The WPS and WFPS already have a Joint Operations committee which meets regularly to discuss issues of overlap. Ms. Carswell indicated that the WPS is open to forming an ACE unit and

I fully support this initiative as being one which could prevent deaths in the future. Dispatching both a WPS officer and a medically trained individual with the ability to administer chemical restraint if required would greatly reduce the gap time and transition hyperactive agitated individuals into care sooner.

[188] **I recommend that Winnipeg Transit incorporate capacity in their communication systems to enable direct contact between drivers and 911 call takers.** Upgrades to communication equipment on transit buses has already been implemented, with the ability for Central Control to access live visual feed from bus cameras. Further upgrades to the transit communication systems are planned for the near future, and incorporation of a direct link to enable 911 dispatch to speak directly with the driver would greatly improve communication.

[189] **I recommend that WPS/WFPS/911 each provide its members with training which specifically addresses the transition of a subject from one service to the next.** This training could include a video demonstrating how an ACE event should be handled from start to finish.

XI. RECOMMENDATIONS WHICH ARISE OUT OF THE MATERIAL CIRCUMSTANCES OF DEATH

[190] **I recommend Victim Services support for families of the deceased for whom an inquest has been convened.** This was an issue identified by inquest counsel. It does not specifically fall within the mandate of this inquest under the *Act*,

but is worth commenting on. Families affected by inquests are given the option of applying for standing, but this is a significant undertaking, both financially and emotionally. There should be some provision for assistance for families of the deceased, regardless of whether they have sought standing in the inquest.

[191] I heard from the families of the deceased men, and it is clear that many are left struggling to make sense of what has happened to them and their loved one. It is especially hard on the children who have lost a parent.

[192] Mr. Lafreniere made the following submission, with which I completely agree:

> When someone's loved one dies it is heartbreaking. It is more traumatizing when that death occurs during an interaction with the police. Having to go through an IIU process, and then wait, then have an inquest called and go through that process is something that is difficult to navigate. The reality is, the families only become aware of the evidence about what happened to their loved ones if they are able to meet with inquest counsel before court, and during the court process itself. Yet they have no supports available to them. Had there been any criminal charges that arose from the same incident, supports would be available. Victim Services would be involved. Counselling and other services would be made available. Yet for the same incident, a death, when there is no criminal charge, but a different court process, an inquest, there is nothing. Respectfully it is the submission of inquest counsel that this is a systems gap that should be addressed.

XII. CONCLUSION

[193] Matthew Fosseneuve, Patrick Gagnon, Michael Bagot, Sean Thompson and Randy Cochrane all tragically died sooner than they should have. I wish to again express my deepest condolences to their families. I hope that through the process of

this inquest, their loved ones have gained some insight into what happened, and that my recommendations will someday assist in preventing another untimely death.

[194] My thanks go to all counsel for their organized and responsive submissions, and to the witnesses for their contributions in helping us to understand how we might do things better going forward.

[195] I respectfully conclude this report on October 22, 2024, at the City of Winnipeg, in the Province of Manitoba.

Original signed by Judge Choy

CHOY, P.J.

M A N I T O B A

THE FATALITY INQUIRIES ACT

REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATHS OF: Matthew Fosseneuve, Patrick Gagnon, Michael Bagot, Sean Thompson and Randy Cochrane

APPENDIX "A" – WITNESS LIST

1. Dallas Huston
2. Cst. Mark Adolph
3. Cst. Jonathan Kiazyk
4. P/Sgt. Craig Hodgson
5. Chhaya Bagot
6. Cst. Patrick Saydak
7. Insp. Kristalee Dudek
8. Cst. Ryan McCrady
9. Cst. Dariusz Rozwadowski
10. Jeffrey Peters
11. Cst. Fred DeGraff
12. Cst. Courtney Ross
13. Cst. Dave Macki
14. Cst. Theodore Spruyt
15. Cst. Derek Verwymeren
16. Kathy Friesen
17. Cst. Ryan Haney
18. Cst. Greg Harron
19. Cst. Sarah Kerr
20. P/Sgt. Saif Khan
21. Cst. Matthew Robb
22. Cadet Brett Sparrow
23. Cadet Kyle McKay
24. Keenan Dyck
25. Alix Savard
26. P/Sgt. Donald Murray
27. Darryl Arsenault
28. Margie Cochrane
29. Beedoshi Cochrane
30. Cst. Tim Diack
31. Cst. Thomas Argle
32. Cst. Ian McLarty
33. Cst. Eric Trotman
34. Cst. Joseph McKenzie
35. Sgt. Tyler Loewen
36. D/Sgt. James Christmas
37. Evan Walsh
38. Cst. John Russell
39. Sgt. David Kelly Keith
40. Dr. Gary Glavin
41. Dr. Skye Rousseau
42. Dr. Charles Littman
43. Dr. Robert Chrismas
44. Bradley Jason Freund
45. Dr. Robert Grierson

MANITOBA

THE FATALITY INQUIRIES ACT

REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATHS OF: Matthew Fosseneuve, Patrick Gagnon, Michael Bagot, Sean Thompson and Randy Cochrane

APPENDIX "B" – EXHIBIT LIST

Exhibit No.	Description
1.	Binder re: Patrick Gagnon
2.	Binder re: Michael Bagot
3.	Package of Photos of M. Bagot
4.	Binder re: Sean Thompson
5.	Photograph of M. Fosseneuve
6.	Binder re: Matthew Fosseneuve
7.	Photo of M. Cochrane
8.	Binder re: Randy Cochrane
9.	Curriculum Vitae of Cst. John M. J. Russell
10.	Winnipeg Police Training Information Compiled by Cst. John M. J. Russell
11.	Reality-Based Training Scenarios by Cst. John M. J. Russell
12.	Curriculum Vitae of Sgt. Kelly Keith
13.	Expert Report of Sgt. Kelly Keith
14.	Appendices to Expert Report
15.	Curriculum Vitae of Dr. Gary B. Glavin

16. Expert Report of Dr. Gary Glavin
17. Curriculum Vitae of Dr. Skye Rousseau
18. Expert Report of Dr. Skye Rousseau
19. Will-Say Evidence of Dr. John Younes
20. Curriculum Vitae of Dr. Charles David Littman
21. City of Winnipeg Council Minutes re: Community Safety Team – January 25, 2024
22. Job Description of Safety Officer – Community Safety Team
23. Job Description of Safety Officer Supervisor – Community Safety Team
24. Report Prepared by Cst. Russell and Alana Odokeychuk dated June 6, 2024
25. Curriculum Vitae of Dr. Robert A. Grierson
26. Winnipeg Fire Paramedic Service Patient Care Protocol – Amphetamine Type Stimulant Toxicity
27. Winnipeg Fire Paramedic Service Patient Care Protocol – Agitated Patient Chemical/Physical Restraint