RELEASE DATE: December 30, 2015

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***The Fatality Inquiries Act***

AND IN THE MATTER OF: **M.A.**
(DOD: August 30, 2010)

Report on Inquest of
Judge Marvin F. Garfinkel
Issued this 23 day of December, 2015

APPEARANCES:

Counsel appointed pursuant to section 27 of *The Fatality Inquiries Act*: **Mr. Rob Gosman**

M.A. INQUEST
Court List

Judge: Marvin Garfinkel

Inquest Counsel: Rob Gosman

Assistant to Inquest Counsel: Betty Owen

PARTIES WITH STANDING

- **MANITOBA YOUTH CENTRE, MANITOBA CORRECTIONS:** Jim Koch and Sean Boyd, Civil Legal Services, Manitoba Justice
- **WINNIPEG REGIONAL HEALTH AUTHORITY (WRHA):** Daniel Ryall, Associate General Counsel, Winnipeg Regional Health Authority
- **ANISHINAABE CHILD & FAMILY SERVICES:** John Harvie and Devon Mazur, Meyers Weinberg LLP
- **CANADIAN MENTAL HEALTH ASSOCIATION (MANITOBA BRANCH), CANADIAN MENTAL HEALTH ASSOCIATION (WINNIPEG BRANCH) AND THE ABORIGINAL COUNCIL OF WINNIPEG:** Meghan Menzies and Allison Fenske, Public Interest Law Centre
- **DR. SIMON TREPEL:** Keith Ferbers, Aikins, MacAulay & Thorvaldson LLP
- **DR. PAULA BATTLE:** Sandip Sett, St. Mary's Law LLP, Barristers & Solicitors

OTHER PARTIES REPRESENTED BY COUNSEL

- **KELLY-ANN IVORY (STEVENSON):** Scott Gray, MPRG Law Corporation
- **DR. ANIL KAMUR SUD:** Bill Haight, Duboff Edwards Haight & Schachter Law Corporation

Report by Provincial Judge on Inquest

Respecting the death of: M.A.

BAN ON PUBLICATION

Pursuant to section 111 of the *Youth Criminal Justice Act* and the order of Judge Cynthia Devine which order was confirmed by Judge Garfinkel on September 15th, 2014, no person shall publish the name of the deceased young person or any other information related to the young person if it would identify the young person.

INTRODUCTION

[1] By letter dated October 16th, 2012, the Chief Medical Examiner (CME) directed a Provincial Judge to hold an inquest into the death of M.A.

Following a practice that has existed for a while, the CME stated reasons for the inquest to include:

- To determine the circumstances relating to M.A.'s death;
- To review M.A.'s suitability as a participant in the Intensive Rehabilitative Custody and Supervision Program;
- To examine the appropriateness/timeliness of M.A.'s release;
- To examine the suitability of M.A.'s living arrangements upon release;
- To examine the adherence to the original treatment/re-integration plan put in place for M.A., and
- To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[2] These may be referred to as “terms of reference”.

[3] This practice has existed for a while and in many instances may be helpful. However, the authority of the CME is set out in the legislation and the legislation does not give the CME the authority to set out the terms of reference. In this case, the terms of reference, particularly, the reference to review M.A.’s suitability as a participant in a sentence (IRCS) pursuant to the *Youth Criminal Justice Act* (YCJA) and to examine the appropriateness/timeliness of M.A.’s release go much beyond the jurisdiction of a provincial court judge to conduct an inquest. If a sentence is thought to be inappropriate the proper remedy is an appeal, not a review at an inquest.

[4] A very brief description of the circumstances taken from the CME’s letter directing an inquest may be appropriate here.

[5] M.A. had been sentenced on July 29th, 2008 to an IRCS sentence pursuant to YCJA. She was released from the custodial portion of the sentence on July 28th, 2010 and resided with her sister in Winnipeg. On August 29th, 2010, M.A.’s sister and her mother called her but M.A. hung up on both of them. On August 30th, 2010 at 2:43 a.m. the Winnipeg Police Service was called to an address because someone was seen climbing a tree. The police attended at 3:25 a.m. and found M.A. hanging from a tree. The woman was cut down and taken to the Health Sciences Centre. Unfortunately, resuscitation efforts by paramedics and hospital staff were unsuccessful and M.A. was pronounced dead at 4:12 a.m. on August 30, 2010. An autopsy was performed. The cause of death was hanging. The manner of death was suicide.

[6] M.A. was initially sentenced on July 29th, 2008 by Chartier, A.C.J.P.C (as he then was) for the offence of manslaughter. At that time she was 16 years old

and she did not have a criminal record. The sentencing judge was presented with a number of reports, an agreed statement of facts and victim impact statements. The conclusion was a joint recommendation for the imposition of a three (3) year IRCS sentence. M.A. had been in custody since July 27th, 2007 but no credit was given for that pre-sentence custody.

[7] The IRCS sentence is a very specialized sentence and concentrates on treatment and rehabilitation. It can be imposed if the provincial director has determined that there is a program available and that the young person's participation is appropriate and the young person is willing to participate. This is a very rare sentence, not usually imposed. At the time of sentencing the judge was told that this type of sentence was imposed six (6) times per year in all of Canada.

[8] The IRCS sentence has two (2) components: a custodial period and a period of supervision in the community. In this case, the custodial period was two (2) years and the community supervision period was one (1) year. M.A. and her co-accused were the first female young people to be sentenced to this sentence in Manitoba.

[9] The judge accepted the joint recommendation and imposed the IRCS sentence. Interestingly, the judge also addressed some terms and conditions of the community supervision by imposing the mandatory conditions and the optional conditions added, as jointly recommended, were that she attend, participate and complete the Intensive Support and Supervision Program (ISSP) and curfew checks by ISSP and Winnipeg Police Service.

[10] M.A. appeared in court on July 27th, 2010 for the purpose of imposing the conditions of the community supervision. This was one day prior to the expiry of

the custodial portion of the sentence. The practice of the Court is to have the original sentencing judge impose the conditions. That judge was assigned to a circuit court outside of Winnipeg and was not available to impose the conditions.

[11] Moreover, pursuant to section 105 of the YCJA, the Provincial Director shall cause the young person to be brought before the Court at least one month prior to the expiry of the custodial portion of the sentence. Obviously this was not done in this case.

[12] As it turned out, I was the judge assigned to sit in the courtroom when the young person appeared to hear the terms of the community supervision. I was presented with the situation and with a joint recommendation from Crown counsel and defence counsel as to the terms of the conditional supervision. No reference was made to the terms imposed by the original sentencing judge. I became aware of those terms only after reading the papers filed during this inquest.

[13] The law, as I understand it, is that a joint recommendation as to sentence should be accepted and imposed unless the sentencing judge thinks that the jointly recommended sentence is contrary to the public interest or is unfit. Given the exigencies and the submissions made and the report I read, I made the order as jointly recommended.

[14] This situation was commented on during a hearing on September 15th, 2014 in courtroom 210. That day was intended to be the beginning of the inquest. However, counsel advised that these September dates were chosen too optimistically; counsel were not quite ready. Consequently, the matter had to be adjourned.

[15] That September hearing dealt with some preliminary matters: standing for one person, publication ban confirmation and setting hearing dates for December 2014. The issue of me being the judge who imposed the conditions of community supervision came up for comment. There was a query as to whether I would recuse myself. I took the position I would not rule nor comment upon that issue in advance of a motion being brought. No motion for recusal was brought and I continued as inquest judge.

[16] It is not fair to make a ruling without hearing argument and consulting precedents. However, by way of a non-binding comment, I don't think I would have recused myself. An inquest is a fact finding inquiry. It is not a trial. There is no finding of blame, liability or guilt. There is no award of damages or imposition of a sentence after an inquest. Moreover, at the hearing in July, the consideration was whether or not the jointly recommended sentence was contrary to that public interest or otherwise unfit. This was not a situation where it could be said I had an apprehension of bias one way or the other with respect to this inquest.

[17] This inquest revealed other systemic issues.

[18] *The Fatal Inquiries Act*, in section 19(3), provides that an inquest is mandatory if a person in a correctional institution dies as a result of a violent act, undue means, negligence or in an unexpected or unexplained manner. Should that be broadened to include someone such as M.A. serving a sentence in the community? M.A. was under the supervision of correction officials.

[19] The autopsy of M.A. was done on August 31st, 2010 at 8:30 a.m. The result was a finding that the immediate cause of death was hanging. The manner

of death was suicide. The toxicology report showed alcohol 69 mg/ml; Codeine 87 mg/ml; Oxazepam 7 mg/ml, Lorazepam 33 mg/ml and Quetiapine 9 mg/ml.

[20] The matter then proceeded to the inquest review committee. On December 2nd, 2010 the decision was made that an inquest was not required. This decision was conveyed by the Office of the CME to the A/Director of Prosecutions by letter dated December 3rd, 2010.

[21] On October 6th, 2011 the Inquest Review Committee determined that an inquest should be called. The letter directing that an inquest be held is dated October 16th, 2012. Perhaps there is a typographical error in some papers. No reason was given for the change in position.

[22] If one accepts the proposition that an inquest is a fact finding inquiry but not of such a broad scope as to be a public wide ranging inquiry; and if one accepts the proposition that the objectives or issues are set out in the legislation: make a report, setting forth when, where, and by what means a deceased person died, the cause of death, the name of the deceased and the material circumstances of the death and may make recommendations to change programs, policies or practices in the laws of the Province that would serve to reduce the likeability of similar deaths in similar circumstances. In short, an inquest is to result in a report which would provide specific information which may assist a family or answer questions of the family and make recommendations to prevent deaths in similar circumstances.

[23] In short, a report with recommendations should better the lives of all who live in Manitoba. In order to do that, recommendations must have relevancy and be material. There should be some immediacy. The death of M.A. occurred on August 30th, 2010. Initially an inquest was not required but then on October 6th,

2011 an inquest was required. The direction to hold the inquest was dated October 16th, 2012. The inquest was not completed until September 2015. This, perhaps, makes any recommendations that may be made immaterial or irrelevant. Too many years have passed. Changes may have occurred in the normal cause of events as people become aware of similar situations and how to deal with them.

[24] I would suggest that the legislation be examined with a view to imposing time limits and perhaps saying that the CME cannot change the decision (as to whether or not to direct an inquest) except with permission of a judge (perhaps of the Court of Queen's Bench) and only for full and sufficient reasons. That way there will be transparency and oversight. It would also avoid conflicting situations.

[25] In fact, at a hearing in December 2014, an application by way of a motion was made before me for a declaration that there was no jurisdiction to hold an inquest because the CME first decided no inquest be held and then changed his mind. I declined to make the order. I ruled that an inquest judge has no statutory authority to look behind the direction of the CME. Such an exercise is not necessarily incidental to conducting an inquest.

[26] I pronounced an oral decision. Counsel then advised that a review of my ruling would be applied for in an appellate tribunal. So the inquest had to be adjourned, again.

[27] I adjourned the inquest to March 2015, in anticipation of hearing the decision of the appellate tribunal.

[28] In March, I was advised that the application for review was withdrawn. The matter was set for a 2 week hearing in July. The extra days in September were necessary.

[29] These systemic issues need a systemic response.

[30] Some may wonder why the hearings were set so far in advance. The answer is because co-ordination of several lawyers' diaries was needed. Lawyers are busy. I would not be surprised if a lawyer told me she or he was booking dates into 2017.

[31] Lawyers have to understand that inquests are important hearings. The recommendations may save lives. Lawyers may have to refuse a retainer if they cannot accommodate the times set by the judge. There has to be recognition that an inquest has some urgency and some degree of priority.

[32] After the preliminary matters were dealt with, the hearing of witnesses began on July 20th, 2015 and on that day a lawyer appeared asking for standing on behalf of his client. I refused to grant standing but allowed counsel to be present when his client testified and to ask questions.

[33] The first witness was Robert Meatherall, a toxicologist. Dr. Meatherall was declared an expert capable of giving opinion evidence. In his opinion, the deceased had been drinking alcohol 4 to 6 hours before she passed away. She did not have in her system the antidepressant drug Fluoxetine.

[34] In essence, as I understood his evidence, there was nothing in M.A.'s body to cause her death. She may have been a little drunk and she did not take her

antidepressant medication. She may have taken T3's, 4 or 5 pills all at once, but not enough to cause death. She would have been relaxed.

[35] The next witness was Constable Michael Hawley, a member of the Winnipeg Police Service. He testified a call was received by police at 2:43 a.m. on August 30, 2010. He and his partner were dispatched at 3:15 a.m. and they arrived at the scene at 3:25 a.m. The officer did not give me the impression that this delay of some 32 minutes was unusual. Calls are dispatched according to priority. The initial concern was someone climbing a tree in a back yard. Half an hour would be a usual response time. They found the deceased hanging and he described the scene. M.A. was dead. She was cold. She was not breathing. There was no pulse. An ambulance and a supervisor were called for.

[36] The officer spoke to M.A.'s mother at the hospital and was told that the mother had spoken to M.A. at about 10:30 p.m. the night before and because M.A. did not sound right, the mother told M.A. to come home; but M.A. did not return home.

[37] The next witness was Troy Pauls, who was an attending Advance Care Paramedic at the time. He saw the body hanging. The body was cut down and treatment was initiated but there was no hope of resuscitating the patient.

[38] Sadly, M.A. came from a troubled background. Her upbringing has been described as chaotic. She went into care at about age five (5) with Winnipeg Child and Family Services. That care was transferred to Anishinaabe Child and Family Services (ACFS). Even while she was in care, M.A. was difficult to stabilize and control. She ran from her placement. She had about 20 placements while in care. However, she did not have a criminal record until she was 16 years old and was sentenced for manslaughter to the specialized IRCS sentence.

[39] M.A. suffered from depression, anxiety and many other mental conditions that were diagnosed while she was in custody in MYC.

[40] She was placed into custody at MYC upon her arrest in July 2007. She was not given any credit for the time spent in MYC prior to being sentenced.

[41] However, while in MYC she was initially difficult. She attempted suicide 4 times and was placed in observation about 28 times.

[42] A psychologist and mental health nurse worked with her and there seemed to be some improvement in her behaviour. She did well in school in MYC.

[43] However, her behaviour did not improve to the extent that she was allowed unescorted leaves from MYC to assist her to re-integrate into the community. She only had escorted leaves into the community despite the difficulties. No application was made to vary the sentence.

[44] An IRCS team was established at MYC and a psychologist was retained to provide services to M.A.

[45] Obviously a decision had been made that M.A., despite her difficulties, and her co-accused were candidates for an IRCS sentence. There may have been only 1 or 2 prior IRCS sentences in Manitoba. Certainly, they were the first females to be sentenced to that specialized sentence.

[46] The IRCS sentence requires an assessment and a report to be prepared. The order pursuant to section 34 of the YCJA was made. However, the

psychologist was not told a report was required for consideration of an IRCS sentence. At that time, the template for a section 34 order for a forensic assessment did not have a space for consideration of an IRCS sentence. Consequently, the psychologist did not assess M.A. and prepare the report with consideration of an IRCS sentence.

[47] The IRCS team had a difficult time planning for M.A. in the community. She did not want to reside anywhere else but with her sister. This seemed somewhat problematic but given her history of absconding from placements and there being no other adequate resource, the decision was made to allow her to reside with her sister.

[48] While in MYC, M.A. became an adult. She was no longer a ward of the agency (ACFS). The agency had no obligation to act as her guardian but did agree to provide extended care such as shelter and maintenance. The social workers from the Agency sat on the IRCS team. This raises the question: would a parent sit on the IRCS team?

[49] There was much discussion about the Agency providing a support worker for M.A. while she was in the community. This was not done. I suggest that consideration be given to the issue of having a guardian or parent sit on the IRCS team. The IRCS sentence comes from the authority of the YCJA. While there may be some child welfare issues, the main concern is to rehabilitate the young person as defined in the YCJA.

[50] Also, I think a deadline should be imposed when something has to be done. In this case, a deadline should have been imposed upon the Agency to provide a support worker. If that deadline was not met and the IRCS team thought a support worker was necessary, the Department of Corrections and

Probation should have provided that worker. I think clarifying the role of the child caring agency in these circumstances is very important. The mother of M.A. expressed her understanding of what the ACFS would provide to M.A. in this case. What the mother anticipated being provided was not provided. It seems to me that Corrections must be in charge while a person is serving a sentence. In this case, M.A. stopped being a ward but ACFS agreed to extend care by providing maintenance and residence. The Agency should not give an impression it would do more. Corrections must act in control. Deadlines should be set and if not met, Corrections should take appropriate steps.

[51] In fact, M.A. had a “Big Sister”. As I understand it, the big sister is a volunteer working with young people. The big sister met M.A. at one of her placements when M.A. was 10 years old and then was a help to M.A. through release from MYC. She went with M.A. to movies, the Forks (in Winnipeg), out to eat and just hung around together. It was a casual relationship but certainly helped M.A. The big sister was a safe person for M.A.

[52] M.A. had phoned the big sister on August 28, 2010 to arrange to meet the big sister. The big sister was going away and could not meet that day; but they agreed to meet at their regular Monday.

[53] According to the big sister, M.A. did well in structure but being in the community was a problem and concern because M.A. was having a lot of freedom after not having a lot of freedom for a long time.

[54] This, I think, was also the opinion of the IRCS team. At MYC, by the time she was ready to be released, M.A. was stable. She was taking medication for her depression. She had done well academically. She was making plans to

attend school in September. She had long term plans to become, perhaps, a massage therapist. She was seeing her psychologist.

[55] The only concern was that she may have established some bad relationships in MYC. M.A.'s sister was concerned about the person, who she also associated with in the community, was a gang member and was helping M.A. to do drugs. On the night she committed suicide, the sister thought M.A. was acting weird. M.A. looked drunk or on something when she came home around 4 p.m. The next morning M.A. was dead.

[56] M.A.'s sister was concerned for M.A. However, she was not given the terms of the community supervision. She did have a list of names and phone numbers of people to call for assistance and support which was attached to her fridge. She also did meet with the probation officer and others. She was also told what to watch out for.

[57] The bottom line is that M.A. was a high risk. But no one anticipated her suicide.

[58] The main issue is to consider what, if any, recommendations can be made to prevent suicidal deaths in the future in similar circumstances of M.A. Of course people are unique; each person is an individual and specific plans have to be organized to meet the needs of the particular person.

[59] In order to assist me, one party retained a psychologist from Ontario. He was qualified as an expert and he presented a report with his recommendations.

[60] I think it was a good idea to have an independent person review this situation. This expert was from Ontario. Comparing Manitoba to Ontario is not fair. Ontario has a larger population. There are more resources available. There have been more IRCS sentences in Ontario than in Manitoba. This psychologist probably has personally dealt with more IRCS sentenced young people than are sentenced in Manitoba. The expert really only did a file review. He did not hear the testimony presented at this inquest.

[61] I also don't think this expert was aware of the precedents in Manitoba requiring a sentencing judge to accept a joint recommendation unless that recommendation is unfit or contrary to the public interest.

[62] Nevertheless, counsel used the expert's report and recommendations as the basis for their submissions. There are five (5) pages of recommendations from this expert. The basic observation was that there were process and systematic issues that may have contributed to M.A. being ill prepared for release. Also there was not a complete use of the forensic services, in the completion of assessments, updating assessments, providing management and treatment options for her.

[63] While those counsel who made submissions and recommendations used the Ontario psychologist's report and recommendations as a basis, it was acknowledged that some of his recommendations had already been implemented, or did not apply. For example, the recommendation was made that Crown attorneys and judges should have opportunities to attend conferences to learn about IRCS sentences. This recommendation should not have been submitted. Crown attorneys, defence counsel and judges do have opportunities to attend conferences, to learn, discuss and exchange opinions with regard to all aspects of youth law. People working with young people as probation officers or

counsellors at MYC have opportunities to attend seminars and conferences dealing with wide ranging topics including IRCS sentences. The expert psychologist may not have been aware that these opportunities to attend seminars and conferences are available.

[64] There was a submission that a recommendation be made that an IRCS sentence be developed in an individualized specific way to meet the circumstances of the particular young person. As I understood the evidence, that was what was planned for M.A. Unfortunately, there was not sufficient time for the plan to be implemented.

[65] Candidly, I must say that I am not inclined to make any formal recommendations. Throughout this report, I have made observations and comments about the process. For example, the need for inquests to be held within a reasonable time after the death. I have made other observations but after 5 years from the date of death, so much has changed; experience with IRCS has resulted in a more specific, detailed procedure being implemented. I have also made an observation about the need for the provincial director to diarize the matter so the young person is brought before the court 30 days before the expiry of the custodial portion. I also observed the court practice is to have the original sentencing judge pronounce the conditions of the community portion of the sentence. That was not done in this case.

[66] This inquest, as so many of them do, showed that people try to do the best they can based on experience, training and available resources. But formal recommendations at this late stage would be immaterial given the lengthy time that has past.

[67] The death of M.A. was a tragedy. My understanding is that there was a treatment plan created for M.A. However, there are not sufficient resources to keep someone with her 24 hours a day. She was structured as much as possible. Her sister kept her busy. Nonetheless, M.A. fell back into anti-social behaviour. That behaviour was exemplified by not speaking to her sister and mother on the night that she died.

[68] This concludes my report.

[69] A list of witnesses is attached as Appendix A.

[70] The exhibit list is Appendix B. The exhibits will be kept in the exhibit room of the Court.

[71] Pursuant to section 33(1)(b) of *The Fatalities Inquest Act,* the evidence has been transcribed.

[72] The transcripts shall be kept with the exhibits and will be provided to the Minister upon the request of the Minister.

[73] All of which is respectfully submitted.

"ORIGINAL SIGNED BY:"

Marvin F. Garfinkel, P.J.

APPENDIX A

LIST OF WITNESSES CALLED AT THE INQUEST

1. Robert Meatherall
2. Michael Hawley
3. Troy Pauls
4. Kent William Somers
5. Anne Walker
6. Brenda-Lee Johnstone
7. Paula Battle
8. Sonya Houle
9. Shirley Prieston
10. Nicole Starr
11. Simon Trepel
12. Kelly-Ann Stevenson\
13. Maureen Authwaite
14. Anil Kumar Sud
15. Nancy Doll
16. Narmie Mendoza
17. Vera Anderson
18. Louis Albert Goulet
19. Jeffrey Wong
20. Shelley Marie Haughey
21. Garry William Fisher
22. Margo Charlene Lee

APPENDIX B

LIST OF EXHIBITS

Exhibit No.	Description
1.	Letter dated October 16, 2012 from the CME directing inquest
2.	Photos of M.A.
3.	5 Binders of documents
4.	YCJA: IRCS sentence process
5.	CV of Robert Meatherall
6.	Toxicology report undated
7.	CV of Kent Somers
8.	Notes of Brenda-Lee Johnstone
9.	CV of Paula Battle
10.	Agreement between Manitoba and Paula Battle dated January 5, 2009 for delivery of psychological services
11.	Agreement between Manitoba and Paula Battle dated April 1, 2010 for delivery of psychological services
12.	CV of Simon Patrick Trepel
13.	Medical chart rates
14.	Summary of mental health initiatives
15.	Binder of Correction Policies
16.	Inquest recommendations and plan
17.	Report and recommendations from Jeffrey Wong
18.	Case study Kinark CFS (Ontario)
19.	Transcript of proceedings July 29, 2008
20.	A & B transcripts of proceedings July 27, 2010
21.	CV of Garry William Fisher
22.	Mental Health Resource Guide

DISTRIBUTION LIST

1. Chief Judge Ken Champagne, Provincial Court of Manitoba
2. Dr. A. Thambirajah Balachandra, Chief Medical Examiner
3. The Honourable Gord MacIntosh, Minister Responsible for *The Fatality Inquiries Act,* Minister of Justice and Attorney General
4. Mr. Rob Gosman, Inquest Counsel
5. Ms. Julie Frederickson, Deputy Minister of Justice & Deputy Attorney General
6. Ms. Lorraine Prefontaine, Director of Specialized Prosecutions and Appeals
7. Exhibit Officer, Provincial Court
8. Ms. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court