December 5, 2014

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **THE DEATH OF JEFFREY RAY MALLETT**

(Deceased)

(DOD: July 19th, 2008)

Report on Inquest and Recommendations of

The Honourable Judge Doreen Redhead

Issued this 2nd day of December, 2014.

APPEARANCES:

Ms. Jerilee Ryle, Mr. Brian Munn & Mr. David Gray, Inquest Counsel
Mr. Mark Mason, for the R.C.M.P.
Ms. Cathy Guirguis & Mr. Michael McClurg, for the Family

Manitoba

THE FATALITY INQUIRIES ACT

REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: JEFFREY RAY MALLETT

Having held an Inquest respecting the said death on August 27th, 28th, 29th, 30th, 31st, 2012, April 9th and 10th, 2013, and June 5th, 2014, I report as follows:

Jeffrey Ray Mallett came to his death on the 19th day of July, 2008, at Thompson, Manitoba.

The cause of death was bacterial pneumonia.

I hereby make the recommendations as set out on the attached schedule.

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

Dated at the City of Thompson, in Manitoba, this 2nd day of December, 2014.

"Original signed by"
Judge Doreen Redhead

DISTRIBUTION LIST

1. Chief Judge of the Provincial Court of Manitoba
2. Chief Medical Examiner
3. Minister Responsible for *The Fatality Inquiries Act*
4. Deputy Minister of Justice & Attorney General
5. Director of Regional Prosecutions

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: JEFFREY RAY MALLETT

TABLE OF CONTENTS

I. Introduction

[1] The deceased, Mr. Jeffrey Mallett, 37 years of age, died of pneumonia while in custody at Thompson RCMP cells on July 19th, 2008. He had been picked up and lodged a day earlier under the *Intoxicated Persons Detention Act* (*IPDA*).

II. Holding of Inquest

[2] On August 31st, 2010, the Chief Medical Examiner notified the Chief Judge that an inquest into Mr. Mallett's death would be called in accordance with subsection 19(2) of *The Fatality Inquiries Act* for the following reasons:

a) To determine the circumstances relating to Mr. Mallett's death;
b) To examine the method used to monitor detained persons in police detachment cell blocks, particularly as it pertains to:
    (i) The initial assessment of a detainee by police; and
    (ii) Periodic assessment of a detainee while in lock-up; and
c) To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[3] On June 17th, 2011, a standing hearing was held to provide parties with an interest in the matter an opportunity to seek standing at the inquest. The Royal Canadian Mounted Police and the sister of the deceased, Ms. Greta McKay, were granted standing at the inquest.

[4] The inquest began hearing evidence on August 27th, 2012, and on June 5th, 2014, the inquest closed. Evidence was heard over a period of eight (8) days, with thirty five (35) witnesses called to testify.

III. Circumstances Surrounding Mr. Mallett's Death

[5] The inquest heard from a number of individuals who knew, or had interactions with, Mr. Mallett. This evidence provides a helpful chronology of Mr. Mallett's activities in the days leading up to his death.

IV. Events Prior to Lodging

[6] On Monday, July 14th, 2008, Mr. Mallett was admitted to the Thompson General Hospital (TGH) where he had been taken by ambulance. Mr. Mallett's chart indicated that the staff at the TGH noted a history of alcohol abuse as well as frequent trips to the emergency room. At that admission, Mr. Mallett was diagnosed with rhinitis and fever as a result of alcohol withdrawal.

[7] Mr. Walter Martin provided a statement to police that he saw Mr. Mallett two days prior to his death on Thursday, July 17th, 2008, at approximately 3:00 p.m. at the Canadian Tire parking lot. Mr. Martin indicated that Mr. Mallett had been consuming Westminster wine but was not intoxicated. He further indicated that Mr. Mallett had been to the hospital "four days ago". That same day, Mr. James Wood also stated that he and Mr. Mallett had purchased "boot leg stuff". Mr. Wood stated that he and Mr. Mallett started drinking at 7:00 a.m. and Mr. Wood last saw Mr. Mallett around 11:00 a.m. that day. Mr. Wood stated that Mr. Mallett had been in the hospital recently and he would hold his side and complain of hangovers.

[8] Later that day at approximately 8:00 p.m., Constables Bragnalo, Marriot, Brushett and Gower attended the Canadian Tire parking lot after having received a complaint that people were consuming liquor in a vehicle. The officers walked across the street from the detachment to the Canadian Tire parking lot. Constable Bragnalo estimated that the encounter with the individuals in the vehicle was roughly five to eight minutes.

[9] Constable Marriot recalled that there were three or four individuals in the vehicle and that Mr. Mallett was one of them. Mr. Mallett was not arrested as a result of the call. Constable Marriot testified that the incident did not take longer than a couple of minutes as the individuals in the vehicle were asked to leave and all complied without incident.

[10] Constable Brushett noted that while he was speaking with Mr. Mallett, Mr. Mallett was clutching his right side and seemed to be in discomfort. When Mr. Mallett walked away, he limped and was hunched over. When asked by Constable Brushett if he was okay, Mr. Mallett responded that he was and walked in the direction of the Homeless Shelter. He described Mr. Mallett as always friendly, never assaultive or resistant.

[11] Constable Gower also attended the same call. He testified that he was there as back up and did not have any true interaction with the four males that were in the vehicle. Constable Gower recalled that Mr. Mallett appeared to look sluggish, was holding his side and appeared "to have a sore back or something". Constable Gower had some prior dealings with Mr. Mallett and he also described him as always very co-operative.

[12] Mr. Thomas Bradburn testified that he had consumed alcohol with Mr. Mallett the next day on the morning of Friday, July 18th, 2008. That same day, another friend of Mr. Mallett's, Mr. Fred Kirkness, also provided a similar statement that he shared a bottle of Wesminster Sherry with Mr. Mallett.

[13] Ms. Jennifer Hill provided a statement to police that she last saw Mr. Mallett at the Homeless Shelter at approximately 2:00 p.m. that Friday afternoon on July 18th, 2008. In her statement, Ms. Hill indicated that she was aware that Mr. Mallett had consumed both liquor and listerine in the past and that he suffered a seizure approximately one week prior to his death.

[14] Ms. Della Scatch, Mr. Mallett's sister-in-law, testified that she last saw Mr. Mallett on July 18th, 2008, between 3:30 and 4:00 p.m. when he approached her inside the Canadian Tire store and asked her for money. While Mr. Mallett was speaking with her, he was approached by a security guard and asked to leave the store. Ms. Scatch asked Mr. Mallett to wait outside for her as the security guard had warned Mr. Mallett that if he did not leave, the police would be called.

[15] Ms. Scatch exited the store and spoke with Mr. Mallett. She asked him if he wanted to go back to Cross Lake and he told her he did not want to. Their conversation was again interrupted by the security guard who threatened to call the police on Mr. Mallett. Ms. Scatch hugged Mr. Mallett and he walked towards the Homeless Shelter.

[16] Later that day at approximately 4:58 p.m., Constable Rink also had an interaction with Mr. Mallett. At that time, she received a dispatch about an intoxicated person sleeping outside the Homeless Shelter. Constables Rink and Watson attended to the Homeless Shelter. When they arrived, Constable Rink noted that Mr. Mallett was inside sitting on a chair. She was aware that Mr. Mallett had an outstanding warrant. As a result, she phoned the detachment to see if it had been executed. As the warrant had not been executed, she arrested Mr. Mallett for failing to attend court.

[17] In dealing with Mr. Mallett, Constable Rink did not notice anything out of the ordinary and noted that he was able to respond to questions. She testified that he had a slight odor of liquor on his breath and he told her that he "did not want to go to the drunk tank".

[18] Mr. Mallett was transported to the Thompson detachment and placed in one of the *IPDA* cells just until Constable Rink could retrieve his documents. Cell footage indicated that this was approximately 5:23 p.m.

[19] When he walked, he stumbled and Constable Rink asked him if he was okay, to which he responded that he was. Constable Rink asked if he was intoxicated and Mr. Mallett responded that he had consumed some alcohol earlier that morning. Mr. Mallett was particularly concerned about spending the day in the "drunk tank" and Constable Rink assured him that he would not have to.

[20] Constable Rink noted that Mr. Mallett had sweat on his brow, looked a little stiff and that he was holding his mid section. Constable Rink asked him more than once if he was all right and Mr. Mallett assured her he was.

[21] Constable Rink believed that Mr. Mallett was only mildly intoxicated when compared to other times she had dealt with him. She was familiar with Mr. Mallett as she would often see him intoxicated in the downtown area of Thompson. She testified that he was never a difficult person to deal with, even when he had been consuming alcohol.

[22] Constable Watson was a fairly new member of the RCMP in 2008, and was working alongside Constable Rink, her field coach. Constable Watson does not recall much regarding the interaction with Mr. Mallett. She only recalled filling out portions of Mr. Mallett's C13.

[23] Mr. Jeffrey Ready testified that he was employed by Prairie By-Law and was a By-Law enforcement officer with the City of Thompson in July of 2008. One of his duties included patrolling the downtown area of Thompson, mainly the Canadian Tire parking lot and the Homeless Shelter, which are located in and around Churchill Drive. Prairie By-Law officers did not transport intoxicated individuals but would call the RCMP to report the intoxicated person. The RCMP would attend and arrest the individual and lodge them under the *IPDA*.

[24] Mr. Ready testified that he encountered intoxicated persons while employed with Prairie By-Law on a daily basis. His technique in assessing whether a person was intoxicated would vary on a case by case basis but he would normally start by determining whether the individual could carry on a conversation. If he was of the view that the person could care for himself, he would not call the RCMP but would ask the individual not to consume any more alcohol. If he believed that the person was extremely intoxicated, he would call the RCMP.

[25] On July 18th, 2008, Mr. Ready was working the 12:00 p.m. to 10:00 p.m. shift and had three encounters with Mr. Mallett. On the first occasion, he testified that Mr. Mallett was in front of the Homeless Shelter sleeping in the emergency exit door way. The officers approached him and started speaking with him. Mr. Mallett woke up and walked away. At that time, Mr. Mallett did not show any signs of intoxication.

[26] A short time later, Mr. Mallett was found sleeping in the area that connected Extra Foods and the Canadian Tire parking lot. Mr. Ready described the area as a "cobblestone area, I believe, with some benches." Again, the officers initiated conversation and Mr. Mallett got up on his own and left the area. Mr. Ready testified that Mr. Mallett did not stagger when he walked and he did not notice if his speech was slurred.

[27] The third time was approximately an hour to an hour and a half later, when Mr. Ready saw Mr. Mallett sleeping off to the side in a bushy area, close to the mechanic shop of Canadian Tire. On this occasion, Mr. Ready contacted the RCMP as this was the third time he had found Mr. Mallett sleeping in a public area and he wanted to give him a safer place to sleep. In interacting with Mr. Mallett, Mr. Mallett produced a document and mentioned to Mr. Ready that he had to go to court. Mr. Ready returned the document to Mr. Mallett and he put it in his pocket.

[28] Mr. Ready testified that during this last interaction, he believed that Mr. Mallett displayed more signs of intoxication. He described his speech as slurred, his eyes "squinty" and his gait as staggered. In utilizing the Manitoba Liquor Control Commissions, "It's Good Business"

zones of green, yellow and red with yellow being moderate and red being severely intoxicated, Mr. Ready classified Mr. Mallett's intoxication level as between yellow and red.

[29] Mr. Ready contacted the RCMP shortly after 8:00 p.m. and they arrived within five to six minutes. While they waited for the RCMP to arrive, Mr. Mallett was leaning on his elbow on the trunk of the vehicle. Mr. Mallett went in the back of the car and laid down on his left side until the RCMP arrived. Mr. Ready did not believe that Mr. Mallett was injured or ill.

[30] Between the second and third interaction, Mr. Ready testified that although he believed Mr. Mallett displayed additional signs of intoxication, there was no odor of alcohol and Mr. Mallett did not indicate if he had recently consumed any alcohol.

[31] Mr. Sioudom Pathammavong testified that he was also employed by Prairie By-Law and was working alongside Mr. Ready on July 18th, 2008. He testified that on that day, Prairie By-Law received a call regarding someone sleeping by the Canadian Tire garage. When Mr. Ready and he attended that location, two individuals were sleeping; the first was Mr. Fred Kirkness, who Mr. Pathammavong dealt with, and the other was Mr. Mallett.

V. The Lodging of Mr. Mallett

[32] The Thompson RCMP detachment has 11 cells with cells 1, 2 and 3 used to lodge individuals under the *Intoxicated Persons Detention Act* (*IPDA*).

[33] On July 18th, 2008, at approximately 8:07 p.m. Constable Dyke and Corporal Moss were on duty and received a dispatch to send a vehicle as the Prairie By-Law officers had two individuals to lodge under the *IPDA*. When the officers arrived, the Prairie By-Law officers pointed to the back seat of their vehicle and indicated that they had Mr. Mallett in the car. When Constable Dyke looked in the vehicle, he saw an individual lying on his left side that appeared to be sleeping.

[34] Constable Dyke recognized Mr. Mallett as he had previously arrested him under the *IPDA* and he also recalled that he had a tattoo on his arm that said "J Mallett". He noted that he could smell alcohol coming from the back of the vehicle and as Mr. Mallett sat up, he stumbled. Although he believed Mr. Mallett to be intoxicated, he did not inquire if Mr. Mallett had any medical conditions, nor did Mr. Mallett provide any such related information. Mr. Mallett was also not asked if he had recently consumed any alcohol.

[35] When they arrived at the detachment, three other individuals were to be lodged. As Mr. Mallett walked into the cell bay area, he stumbled. Corporal Moss completed the C13 form and when he ran a check on Canadian Police Information Centre (CPIC), he noted that Mr. Mallett was on an undertaking to abstain from the consumption of alcohol. As a result, a note "hold for Dyke" was written on the C13 as Mr. Mallett was going to be charged for a breach of

undertaking and released on a promise to appear once sober. Constable Dyke noted that under the *IPDA*, a person can only be lawfully lodged for 24 hours.

[36] Constable Dyke testified that he directed "hold for Dyke" to be written on Mr. Mallett's C13 because he did not want to burden the next officers coming on shift with the responsibility of releasing Mr. Mallett. His intention was to come in early for his next shift so he could deal with Mr. Mallett's release.

[37] Corporal Moss noted that Mr. Mallett's balance was fair, his speech was slurred and he could smell an odor of liquor coming from Mr. Mallett. Corporal Moss did not ask Mr. Mallett if he consumed any alcohol or drugs that day. As Corporal Moss filled out the C13, the words "release when sober" were crossed out and replaced with "hold for Dyke".

[38] Corporal Moss noted that it was a bit chaotic in the booking area as there were a number of officers and individuals that were to be lodged under the *IPDA*. Constable Dyke testified that while he had initially received a call for one person to be lodged, as it turned out, seven people were to be lodged under the *IPDA*.

[39] Constable Kiener was on duty the evening that Mr. Mallett was lodged. She had no direct contact with Mr. Mallett but she recalled seeing him and added that he was being lodged by Corporal Moss and Constable Dyke. She completed the C13 for Gregory Campbell.

VI. Mr. Mallett's "C13"

[40] A C13 is drafted for each prisoner that is lodged and details information such as location of event or arrest, name of the individual, address, date of birth, which cell the prisoner was lodged, prisoner number, follow up and the details as to why the individual was arrested.

[41] With respect to Mr. Mallett, under possible cause of impairment, liquor was circled. Regarding the signs of impairment, fumbling and odor of liquor was also circled. Injuries were crossed out. Balance was noted as "fair" and speech was "slurred". State of mind was noted as "placid". Under consciousness, "sleepy" was circled. The investigator noted was Constable Dyke and Mr. Mallett was noted as being lodged at 20:54 in *IPDA* Cell 2. The location of the arrest was the Canadian Tire parking lot and there was a note on the C13 "hold for Dyke".

VII. Concerns of an Ill Prisoner

[42] Constable Hartnett testified that he was working the 6:00 p.m. to 4 a.m. shift on the evening of Mr. Mallett's death and recalled that it was a typical busy weekend in Thompson. Constable Marriot was in the booking area lodging a female prisoner when Mr. Blaine Snihor, one of the guards, asked Constable Hartnett to check on Mr. Mallett, as there were concerns he was not well.

[43] At approximately 1:30 a.m. on Saturday, July 19th, Constable Hartnett retrieved the keys to the cell and went to *IPDA* cell one to check on Mr. Mallett. Mr. Mallett got up off the floor and came to the door. He testified that he did not believe Mr. Mallett had any difficulties, even though he appeared to walk slow. He noted nothing unusual about his walk and added that it was "the way you would walk when you had been woken up from a sleep". Mr. Mallett approached the door. He was trembling and informed Constable Hartnett that his side hurt. Constable Hartnett testified that he was breathing normally and that Mr. Mallett could speak and he could understand what he was saying. Constable Hartnett testified that Mr. Mallett told him he did not want medical attention.

[44] Constable Hartnett testified that he believed Mr. Mallett was "moderately intoxicated" as he had a minor tremble which Constable Hartnett attributed to alcohol withdrawal. Based on his discussions with Constable Marriot and Mr. Mallett, Constable Hartnett did not believe that Mr. Mallett required medical attention.

[45] Constable Hartnett also testified that Mr. Mallett had been lodged on a number of occasions under the *IPDA*. He was always polite and was never abusive towards the officers.

[46] When Constable Hartnett took Mr. Mallett out of the cell, the event was captured on video surveillance. When counsel for the family asked that Constable Hartnett focus on Mr. Mallett's breathing, Constable Hartnett did not believe that Mr. Mallett's breathing was a concern. Constable Hartnett testified that Mr. Mallett's breathing did not strike him as abnormal, even though he had previously viewed the video. He testified that he had to watch the video again and pay particular attention to the breathing to pick up on it.

[47] Constable Hartnett testified that he had informed Mr. Snihor not to inform the watch commander. He also conceded that he himself had not informed the watch commander of the incident with Mr. Mallett.

[48] Constable Marriot testified that he was also working the 6:00 p.m. to 4:00 a.m. on the day Mr. Mallett passed away. At approximately 1:30 a.m, he was lodging a female prisoner when he was advised by Mr. Blaine Snihor, one of the guards, that Mr. Mallett was not feeling well. Constable Marriott was completing paperwork so Constable Hartnett went to retrieve Mr. Mallett from his cell and was speaking to him. Constable Marriot heard some of the conversation and recalled Constable Hartnett asking Mr. Mallett how he felt and whether he would like an ambulance called. Constable Marriot recalled that Mr. Mallett had four hours left before he was to be released. Mr. Mallett responded that he would do his time and he was returned to his cell.

VIII. Periodic Assessment While in Lock Up

[49] Ms. Lacey Bighetty worked as a guard for the Thompson detachment in July of 2008. She was in the position only for a brief period, approximately three weeks, as she could not find housing. She testified that her main duties were to maintain the security, safety and dignity of the prisoners in care of the RCMP.

[50] On Friday, July 18th, 2008, Ms. Bighetty was working a 12 hour shift from 7:00 p.m. to 7:00 a.m. Saturday, July 19th, with Mr. Blaine Snihor. Ms. Bighetty was responsible for recording the observations of the prisoners and would ask the members for assistance if required. When she began her shift, she would typically login and get information from the other guards regarding the prisoners. She noticed when she began her shift that Mr. Mallett appeared to be sore on one side of his body and she observed him through the cell camera and the prisoner door window. She informed one of the officers who she described as "the shortest one, with the spikey hair" of her concerns regarding Mr. Mallett's behaviour. The officer asked Mr. Mallett if he wanted to go to the hospital and he responded "No". She testified that notes were made in the prisoner log book. She testified that she paid particular attention to Mr. Mallett and would watch him to make sure he was breathing. A few times she checked on Mr. Mallett through the prisoner door window.

[51] Mr. Blaine Snihor testified that he started as a cell guard in March of 2008. On the day that Mr. Mallett passed away, Mr. Snihor was working the evening shift from 7:00 p.m. to 7:00 a.m. He testified that when a guard came on shift, they would typically be briefed about any problems with the prisoners, which could include physical illness or mental health issues.

[52] He explained that a when a prisoner is lodged, the prisoner is assigned a number along with the date and time of when he was lodged. Guards are also responsible for ensuring prisoners were provided their meals and intoxicated prisoners were never provided meals as a result of choking hazards.

[53] Mr. Snihor testified that the most important role of a guard is the health and safety of the prisoners. If there was a request by one of the prisoners to see a doctor or an ambulance, the watch commander would have to be notified. He noted that there was a direct line to the watch commander. If the watch commander could not be reached by the front desk, the police radios would be utilized. If you had to go on the police radio, all the officers could hear and someone would respond almost immediately.

[54] Mr. Snihor testified that checks are done every fifteen minutes and could include physically going up to the door, sliding open the window and looking at the prisoners to ensure that their chests are rising and falling. He noted that in the past, they have had prisoners who are shallow breathers and that these prisoners would have to be watched closely. In addition to

the physical checks, Mr. Snihor testified that each cell is equipped with a camera, which allows you to monitor what is happening in the cell from the guard's desk.

[55] On the day that Mr. Mallett passed away, Mr. Snihor recalled hearing a knock on the door of *IPDA* cell one. He did not recall the exact time but Mr. Snihor went to see what was wrong. He went to the cell and opened the sliding door slot and was informed by one of the prisoners that Mr. Mallett was not feeling well. As a result of receiving this information, Mr. Snihor went to inform an officer. Constable Hartnett responded to the call. Constable Hartnett took Mr. Mallett out of the cell. Mr. Snihor recalled that the officer asked Mr. Mallett if he was okay and Mr. Mallett responded that he was and that he wanted to go back to sleep. Mr. Mallett was then returned to his cell.

[56] Mr. Snihor recalled Constable Hartnett asking the guards to keep an eye on Mr. Mallett. In his testimony, Mr. Snihor did not recall if he communicated any concerns regarding Mr. Mallett to the incoming cell guards during the shift change. However, in his statement to police, Mr. Snihor indicated that he had told Ms. Bighetty to keep an eye on Mr. Mallett. However, based on the evidence this appears to be inaccurate as Ms. Bighetty and Mr. Snihor were working the same shift.

[57] In Mr. Snihor's statement to police, which he could not remember, but qualified that it would have been true, he stated that Mr. Mallett was sweating underneath his eyes and was holding his side. In his testimony, Mr. Snihor remembered that Mr. Mallett was sweating from his forehead.

[58] After Mr. Mallett was removed from the cell at 1:30 a.m., Mr. Snihor testified that he continued to do visual checks on Mr. Mallett until between 5:00 a.m. and 5:45 a.m.

[59] Ms. Gail Wyness testified that she worked the 7:00 a.m. to 7:00 p.m. shift on Saturday, July 19th, 2008, the day that Mr. Mallett died. Ms. Wyness testified that her main responsibility was to watch over prisoners and to make sure they were taken care of. If there were any major concerns, she was to call the watch commander.

[60] She testified that there was no information shared by the guards regarding Mr. Mallett when she came onto her shift. Ms. Wyness testified that prisoners are not fed meals until after their six to eight hour "sobering up" period due to choking hazards. She could not account for the fact that Mr. Mallett had not been ordered a breakfast, when he was clearly past the "sobering up" period. Ms. Wyness testified that when she did her checks, she believed that Mr. Mallett was sleeping.

[61] Ms. Danielle McIntyre was working the 7:00 a.m. to 7:00 p.m. shift with Ms. Gail Wyness. Ms. McIntyre had just recently started as a guard and had only been employed for approximately two months. She could not recall being told of any concerns with any prisoners

when she started her shift that morning. At the time of Mr. Mallett's death she did not recall whether there was a policy regarding the routine checks of prisoners. She testified that there has since been a policy change and guards are now required to check on prisoners every 15 minutes. She did not recall doing any checks on prisoners during her shift.

IX. Discovery of Mr. Mallett's Death

[62] Constable Hemmerling testified that he was acting watch commander on the day that Mr. Mallett died. He explained that the watch commander acts as a shift commander that would provide assistance and guidance to the members on duty. In addition, the shift commander is responsible for ensuring the safety and security of the prisoners in the cell block. The shift commander would also ensure that all of the policies with respect to how long people could be lodged were adhered to.

[63] Constable Hemmerling only began to act as watch commander when he had been moved to "A" watch and at the time of Mr. Mallett's death, had only been on that watch for three and a half weeks.

[64] On Saturday, July 19th, 2008, at approximately 12:30 p.m., Constable Hemmerling attended the cell holding area as he was going to move Mr. Mallett from a *IPDA* cell to a holding cell. Constable Hemmerling went to *IPDA* cell two and called out Mr. Mallett's name but nobody responded. Constable Hemmerling then went to *IPDA* cell one and called out for Mr. Mallett. Another prisoner was awake and identified Mr. Mallett. Constable Hemmerling asked if he could wake him. The other prisoner tried to shake Mr. Mallett and Constable Hemmerling could see that Mr. Mallett's arms and body were quite stiff. At that point, Constable Hemmerling instructed the prisoner to move away from Mr. Mallett and he bent over and put his hands on Mr. Mallett. He noticed Mr. Mallett's eyes were partially opened, his body was very stiff, his chest was not moving and there were no signs of life. Constable Hemmerling believed that he had been deceased for some time and as a result, resuscitation was not attempted.

[65] Constable Hemmerling took the names of the three other prisoners in the *IPDA* cell with Mr. Mallett and moved them to another cell. Constable Hemmerling notified the other members on the watch, the guards and matrons and also requested that Sargeant Rob Collen be notified of the death.

[66] Constable Hemmerling completed the preliminary report of death and the advance report of a human death. Constable Hemmerling could not recall being told about any concerns with respect to Mr. Mallett.

[67] Constable Dumont-Fontaine testified that he was working the day shift from 6:00 a.m. to 4:00 p.m. on Saturday, July 19th. He received a call from Constable Hemmerling at around

12:30 p.m. and rushed to the detachment. He was notified of the death when he arrived in the cell area.

[68] Constable Dumont-Fontaine called Sargeant Collen and notified him of the death. Sargeant Collen instructed Constable Dumont-Fontaine to seize the C13 and secure the cell.

[69] At approximately 12:40 p.m., Sargeant Leben was contacted by a desk clerk at the Thompson detachment and was notified of the death. At approximately 1:07 p.m., Sargeant Leben was contacted by Sargeant Collen, the Operation's Non Commissioned Officer (NCO) for the Thompson detachment, that there was going to be an investigation and Sargeant Collen requested that Sargeant Leben attend the detachment cell block to assist with the investigation. Sargeant Collen contacted the serious crimes unit in Winnipeg.

[70] At 1:12 p.m, Sargeant Collen contacted Dr. Rich, the medical examiner to request his attendance at the detachment. Dr. Rich arrived at 1:46 p.m. Dr. Rich attended to the body of Mr. Mallett, confirmed he was deceased and authorized an autopsy.

[71] At 2:16 p.m, Sargeant Collen contacted the Cross Lake detachment so attempts could be made to notify Mr. Mallett's next of kin.

[72] At 3:24 p.m., Sargeant Leben attended the cell and observed Mr. Mallett lying on the cell floor. At 4:48 p.m., Sargeant Leben entered the cell wearing an officer protection suit and made further notes of the deceased. He also took photographs and measurements of the cell block and seized exhibits. Two vehicles, the first being a RCMP vehicle and the second, a by-law enforcement vehicle, were also photographed. At approximately 5:15 p.m., Constable Randell assisted Sargeant Leben in the preparation of the deceased's body from the Thompson cell so Constable Randell could assume custody of the body.

[73] Constable Gower was working the 8:00 p.m. to 6:00 a.m. shift July 18th to 19th, and was Acting Watch Commander for "C" watch. He did not recall being notified of any ill prisoners during his shift.

X. Other Individuals Lodged with Mr. Mallett

[74] Mr. Joseph Tssessaze testified that he was lodged under the *IPDA* the day Mr. Mallett passed away. Mr. Tssessaze testified that Mr. Mallett was shaking and sweating. Mr. Tssessaze asked Mr. Mallett if he was okay and Mr. Mallett responded that he was. Mr. Tssessaze was released at 6:00 a.m. the day Mr. Mallett was found dead. Mr. Tssessaze did not recall Mr. Mallett leaving or returning to the cell.

[75] Mr. Kenneth Munroe was another prisoner lodged in the cell with Mr. Mallett the day his death was discovered. He recalled Constable Hemmerling coming to the cell and calling out Mr.

Mallett's name. When nobody responded, Mr. Munroe assumed the person lying beside him was Mr. Mallett and so the officer asked if he could wake him up. When Mr. Munroe touched Mr. Mallett, he was cold and he noticed he was not breathing. He informed the officer that he believed Mr. Mallett was dead. Constable Hemmerling ordered the prisoners against the corner of the cell and they were taken out one by one into a different cell.

[76] Mr. Gregory Campbell was also in the cell with Mr. Mallett when his death was discovered. Mr. Campbell testified that Mr. Mallett did not respond when his name was called and when they tried to wake him, they discovered he was dead. He testified that the door on the cell window would open every hour and someone would look through to check on the prisoners.

XI. *The Cause of Death*

[77] On July 21st, 2008, Dr. Balachandra performed the autopsy on Mr. Mallett and determined the cause of death to be bacterial pneumonia. When asked to estimate Mr. Mallett's time of death, Dr. Balachandra testified that he believed that Mr. Mallett was probably deceased between six and ten hours before he was found. He noted that the previous medical history for Mr. Mallett included repeated visits to the Thompson General Hospital for alcohol related issues and high blood pressure.

[78] Dr. Balachandra could not positively say whether Mr. Mallett was intoxicated when he was lodged. While Dr. Balachandra expected alcohol to be present in Mr. Mallett's urine sample, he also expressed an opinion that any alcohol could have been eliminated by the time the sample was taken.

[79] Dr. Balachandra noted that Mr. Mallett's lungs were very heavy and based on his naked eye examination; there was pneumonia in both lungs. The pneumonia was present more on the right side than on the left side, particularly on the lower lobes, or the back of the lungs. He explained that the lung is an organ full of air and it should be "spongy" to the touch. In Mr. Mallett's case, the lungs were firm and solid which meant no air could enter the lungs.

[80] In addition to the issues with Mr. Mallett's lungs, Dr. Balachandra testified that his heart was enlarged. Mr. Mallett had hypertension, which meant that the heart had to work harder to pump blood. Dr. Balachandra testified that if a person uses alcohol for extended periods of time, the heart can become enlarged.

[81] It was also noted that Mr. Mallett's liver was enlarged and showed "fatty change", with one of the possible causes being alcoholism.

[82] With respect to typical symptoms of pneumonia, Dr. Balachandra testified that these could include fever, chest pain, and referred abdominal pain. The pain may be referred to the

abdomen because sometimes the body does not know the source of the pain. He explained that sometimes an individual may feel pain in his abdomen, when in reality; the pain is originating in the chest. Additional symptoms may be difficulty breathing, sweating and coughing.

[83] In terms of progression of the illness, Dr. Balachandra testified that this will vary from person to person. For a person with a lower immune system and a poor diet, the progression of pneumonia will be quicker. Others with a strong immune system can fight the illness for a couple of days. He testified that the chronic use of alcohol and substance abuse go hand in hand with many other factors, such as nutrition, lifestyle, etc. For a person who is abusing substances, the immune system is not as strong, and he is less resistant to fight infections such as pneumonia.

[84] Dr. Balachandra could not estimate as to what point a person could not recover from pneumonia as it would vary from person to person, depending on the individual's general health.

[85] Dr. Balachandra recommended that an initial assessment of any person lodged should be completed by a nurse practitioner to exclude any under lying illness. He added that it is wrong to assume that a person is intoxicated unless you can prove otherwise. He added that there should be a checklist of what is to be observed, which should include a physical check.

[86] Dr. Balachandra believed that a proactive approach was needed to deal with addictions and stated that as health care professionals, there is a need to adjust the mode of treatment and deal with the health concerns and not just "dump it on the RCMP to deal with". He stressed the need for a collaborative effort amongst all the stakeholders which includes education with the aim being prevention.

XII. Royal Canadian Mounted Police (RCMP) Operations Manual

[87] The roles and responsibilities of all RCMP members are set out in the operational manual. The policy covered guidelines and procedures for a number of areas. Examples of some of the topics covered include: booking in prisoners; procedures for sheriffs; handling of personal effects; release of prisoner; use of reports; the C13 report and dealing with medical emergencies.

[88] The policy is approximately 30 to 40 pages and was kept in the steno pool area, which was an area readily accessible to all members. It was the member's responsibility to review the policy. Sargeant Collen testified members were not given a deadline and it would not be unusual if it took the member 6 months to review the policy.

[89] Sargeant Jarvie was not on duty at the time of Mr. Mallett's death and he had no involvement in the investigation. However, Sargeant Jarvie was stationed at the RCMP

detachment in Thompson and was the second in command. He reported to two others above him; the first was Inspector Keith Finn and the second was Inspector Ken Polson. As Staff Sergeant, Jarvie's role was primarily administrative and he looked after the timesheets, member's leave, policy detachment, annual performance plan and any other duties that were assigned to him.

[90] Sargeant Jarvie created an electronic version of the Operational Manual and emailed each member a copy so they could save it on their desktop for easy reference. Once the email is opened, Sargeant Jarvie prints a copy of the email confirmation and keeps it as a record. In using this procedure, he is making the policy available and he requests that member's exercise due diligence in reviewing the policy.

[91] Sargeant Collen was responsible for ensuring policies were followed. If policies were not followed, it could be noted on a performance review or disciplinary action could be taken in the form of a written reprimand. He has in the past disciplined a member for not following policy, but added that it was not on this particular case.

[92] Sargeant Corner has been a staff Sargeant and Operations NCO at the Thompson detachment since July of 2011. As the Operations' NCO, Sargeant Corner was responsible for the operational aspects of the municipal detachment in Thompson.

XIII. Training of Guards and Matrons

[93] Sargeant Corner's responsibilities included ensuring that the guards and matrons were properly trained and oriented to meet the requirements of the block procedures. He explained that for approximately 40 to 60 hours of their initial employment, their training included an introduction to the cellblock procedures, which included how to monitor and log actions and observations. He was also responsible for conducting the security clearance and ensuring that the guards meet the basic standards, such as having first aid and CPR training.

[94] Every six months, the Staff Sargeant will meet as a group with the guards and the matrons to review the cellblock policies. If there are any changes that resulted from legislation or any other type of policy, these would be reviewed. He explained that it also acts as a refresher to update the matrons and guards with respect to policy that has not changed.

XIV. Additional Training of Members

[95] At the Thompson detachment, a number of training programs were either already in place or were set to be in place. The first was divisional and was an Aboriginal and First Nations Awareness Course, which is mandatory for all RCMP officers in the Province. The course provided information with respect to who Aboriginal people are, and pointed out the differences

between a Métis individual and a status individual. He summarized the course as "culturally sensitizing" members with the view of removing biases and false beliefs.

[96] In addition, Mr. John Donovan, the local director for Addictions Foundation of Manitoba, has presented at the detachment in Thompson. Mr. Donovan would come on a monthly basis every Thursday morning for about 30 minutes to educate the members on how to recognize symptoms related to substance abuse and some of the health risks associated with substance abuse. This presentation was made to all four watches and to the member's servicing the rural municipal detachments.

[97] Having Mr. Donovan come to educate the members was a recognition by management that a large component of the individuals dealt with by the Thompson detachment are users of substances and new members would have little to no experience in dealing with individuals who are suffering from an addiction. Sargent Corner testified that the intent was to have the presentation completed when new members were scheduled to start at the Thompson detachment.

[98] Another area that the detachment is looking at additional training has to do with mental health and a "mental health first aid course", which has been recently started in Edmonton. The course aims to educate on symptoms associated with mental illness.

XV. Resources Available in Thompson for Substance Abuse

[99] The inquest heard testimony regarding the high volume of persons picked up and lodged in Thompson under the IPDA. Most, if not all of these individuals, are addicted to substances.

[100] Mr. John Donovan, now retired, was the Director of the Addictions Foundation of Manitoba (AFM) for the Northern Region and had been in his position for twelve years. Mr. Donovan testified as to the resources available in Thompson.

[101] In April of 2010, the new AFM building in Thompson opened. It currently has 24 beds. When it first opened, there were 18 beds with six beds for a halfway house. After a year, these beds were transitioned to treatment beds as well. There are also outpatient programs available for youth, adults and family. Mr. Donovan estimates that about 80 percent of the people referred to the AFM are from outlying communities, while the other 20 percent are from Thompson.

[102] In 2008, Mr. Donovan was also the Chair of the Board of Directors for the Thompson Homeless Shelter. He testified that staff at the Homeless Shelter would assist individuals to get into treatment at AFM, if they wished to enter treatment.

[103] Mr. Donovan believed that the RCMP did not have the capacity to manage the number of individuals lodged under the IPDA, but he recognized that it was necessary. He recommended that Thompson have something similar to the Main Street Project but qualified that it would have to be adapted to the needs of Thompson.

[104] Mr. Donovan estimated that addictions account for 70 percent of every medical problem in Northern Manitoba and that the medical community is lacking in terms of how to work with individuals suffering from addictions.

XVI. Resources Available in Thompson for the Homeless

[105] Ms. Paullette Simkins, the Executive Director of the Thompson Homeless Shelter (THS) since January of 2010, provided information as to the programs and services offered by the THS.

[106] The purpose of the THS is to provide food and shelter, 24 hours a day, 7 days a week, 365 days a year to individuals over 18 years of age. The THS employs 8 full time and 2 part time staff. The shelter employs a shelter co-ordinator and a community outreach mentor. Staff are trained in many areas including: Mental Health First Aid; First Aid; CPR; suicide alternate alertness for everyone talk; and applied suicide intervention skills training. Staff also has a good working knowledge of homeless individuals and family information system (HIFIS).

[107] The shelter has 24 mats for individuals to sleep on in the evening, laundry and shower facilities, and a kitchen. There is coffee, tea and some programming, available all day.

[108] In order to access the shelter, the individual needs to be homeless and not highly intoxicated. A person's intoxication level would be assessed on a case by case basis but generally if the person could identify himself, write his name and was not being disruptive, he would be permitted to stay at the Shelter.

[109] When a person first arrives at the Shelter, an extensive interview is completed by a staff member to get the person's history including such things as identification, any medication, and where they are from. A plan is developed based on that interview to focus on certain issues, for example, the issue could be addictions. If it were housing, the staff work with that individual to develop a plan to obtain housing.

[110] Questions are also asked about alcohol or drug consumption such as what was consumed, when and how much. The staff would generally see the individual on a daily basis and staff would get to know the person and whether or not the individual has consumed alcohol. Medical questionnaires are completed and an individual is asked if there are any outstanding medical issues that need to be addressed. Medications are held by staff and are administered according to the prescription.

[111] One of the key players at the shelter is the outreach mentor, who acts as an advocate and a case manager for the clients. The outreach worker is Cree speaking and acts as a support person, assisting the client in obtaining identification, scheduling and attending appointments.

[112] The shelter door closes at 10:00 p.m. and individuals are woken up at 7:00 a.m. Programs are available to individuals on a voluntary basis and can include having an elder come in to do storytelling, a sharing circle or smudging. There are a number of presentations which include topics such as nutrition, education and training, resume writing, self help and outreach. The programming is provided in conjunction with the Canadian Mental Health Association, of which Ms. Simkins is also the Executive Director.

[113] Ms. Simkins estimated that 97 percent of the clients that use the services of the shelter are Aboriginal.

[114] Ms. Simkins also stressed the need for a detoxification centre in Thompson and additional transitional housing, with accompanying supports attached, to assist those individuals that have just completed treatment.

[115] Mr. Donovan and Ms. Simkins both recommended that additional resources were required in Thompson to deal with the large number of individuals lodged under the *IPDA*.

XVII. The Main Street Project (MSP)

[116] Ms. Keesha Daniels, Director of Programs for the Main Street Project (MSP) in Winnipeg for the past three and a half years, provided information as to the services and programs offered by the MSP. Ms. Daniels is responsible for the general operations and program delivery for the MSP. She explained that the MSP is a not for profit organization that assists marginalized individuals in crisis deal with addictions, mental health issues and homelessness.

[117] The building is a renovated warehouse that has several different components and in each component is a program to help assist individuals during certain difficult periods in their lives. Ms. Daniels outlined a number of the services that the MSP offers but the focus of this report will be the intoxicated persons' detention area and the detox facility.

[118] The intoxicated persons' detention area is a unit where individuals are brought in by Winnipeg Police or the Winnipeg cadets for either causing a disturbance or for public intoxication. The individuals are brought in and detained under the Act by the staff at the MSP, monitored and then released back into the community.

[119] The intoxicated persons' detention unit has 20 cells and each unit is three by four feet and is locked. There is a glass viewing area on each door which permits staff to see into each

unit. Each cell also has a camera so detainees can be monitored by staff. In each unit, there is a mat and a grate in the floor for the person to relieve himself. Bottled water is periodically provided.

[120] When a detainee is brought into the MSP, an interview is conducted with the detainee and information is also provided by the police to the staff in terms of where the person was picked up along with any other relevant information. Detainees are assessed by a paramedic on arrival, which includes a head to toe neuro assessment, vital signs assessment and blood sugar level check. A breathlyzer may also be used to check for the presence of alcohol.

[121] The paramedic makes the decision to approve or deny admission into the unit. If the decision to lodge was not approved, Ms. Daniels noted that it would usually be as a result of a medical condition and the individual would be transported by the police or the cadets to the hospital.

[122] When detainees first arrive, the initial interview includes getting the individuals particulars, such as name, date of birth, medical history, whether they are on any medications, what alcohol was consumed, when and how much, what they remember of where they were, etc. The person is also asked if he has been there before.

[123] The intoxicated persons' detention unit is staffed 24 hours a day 7 days a week with two staff per shift. Paramedics are usually on site but may not necessarily be in that particular unit.

[124] Detainees are monitored by physical checks every 10 minutes by one or both staff. The physical checks are documented and notes are taken as to whether the person was sitting, standing or lying down, asleep or awake. Any behaviour is noted. In addition to the physical checks, every hour, a staff member will physically go into the cell and rouse the detainee if he is asleep and try to engage in conversation. By doing this, staff are trying to assess whether the detainee is alert and oriented. Staff are also trying to determine whether the person is becoming less intoxicated during their stay. On occasion, the paramedics are used in the 10 minute and 1 hour periodic checks for those detainees who are either highly intoxicated or have underlying medical conditions (i.e. a history of seizures or diabetes).

[125] The facility is regularly at capacity, which is generally 700 to 900 intakes per month. However, Ms. Daniels noted that 2012 saw a spike in admissions, with an excess of 1000 per month.

[126] There is no minimum time to lodge but the maximum time is 24 hours. If an individual requires a stay longer than 24 hours, the paramedics would be called to assist in making contact with the hospital to see if the person can be admitted as there would usually be a medical reason if the person could not be released after 24 hours.

[127] Once a person is ready to be released there is a post-admission interview where the staff will assess alertness and orientation. The detainee is asked if he has a safe place to go. The detainee is provided with a phone call, a sandwich, a drink and brochure with information on the services offered by MSP.

[128] Another unit within the MSP is the detox facility, which is a non-medical, ten day stay to help an individual safely withdraw from an acute or binge substance episode. Within the detox unit, there are trained counsellors and staff that assist the individual with the physical and psychological effects of withdrawing from substance abuse.

[129] The detox unit can accomodate 25 individuals (10 women and 15 men). Ms. Daniels explained that the term "non-medical" means that there is no physician or nurse onsite to assist with any of the medication or withdrawal symptoms. Each person that is referred for admission into detox must have a medical clearance done by a physician or a nurse practitioner. The medical clearance form is to ensure any medications that are required for the ten day stay are available. In addition, programs and one on one support are provided to individuals who are at the detox facility.

[130] The detox facility is considered a voluntary program but it is locked and once an individual leaves, he may not be able to return. Trips out of detox are usually supervised and trips that are permitted are tailored around getting the individual into a treatment program. The person may have a court appearance and appointments with psychiatrists, which the staff will escort the person to.

[131] Ms. Daniels recommended a questionnaire be completed with the individuals picked up under the *IPDA* and could include what was consumed, when, and how much, whether the individual has any medical conditions (diabetes, high blood pressure, allergies), whether there are any medications, whether they have a history of mental illness. Ms. Daniels believed that this system works well at MSP and she was of the view that individuals are more likely to share this information with staff than the police.

XVIII. Intoxicated Persons and Mental Health Assessments

[132] As the inquest heard about the large number of individuals lodged under the *IPDA* in Thompson, a representative from the Northern Regional Health Authority (NRHA-formerly the Burntwood Regional Health Authority) was called to testify with respect to the hospital's policies and how intoxicated persons who are in custody and are brought in for mental health assessments, are dealt with by the hospital.

[133] Dr. Amadu testified that he is the Director of Emergency Services at the NRHA and is responsible for the supervision and attendance at the emergency room for the provision of

services. His responsibilities also included developing policies and protocols of the emergency room.

[134] Dr. Amadu testified that no policies within the NRHA emergency room exist with respect to admission of intoxicated persons into the hospital. Rather, the decision to admit is not dependent upon alcohol levels and is made on a case by case basis and is dependent on the patient's condition, the result of his assessment and accompanying medical needs.

[135] For individuals who attend for mental health issues, the decision to admit is based on the results of a mental health assessment. If the individual was intoxicated, the assessment may be delayed and the RCMP would be required to bring the person back when the person was sober enough for the assessment to be completed. If the person had been assessed as being unstable, he would be kept in the emergency room with an RCMP officer until he was sober enough for an assessment to be completed.

[136] If an individual was admitted because of alcohol withdrawal, the typical admission time would be 72 hours. If after this time period, the individual required admission for other medical reasons or because he is not improving, the time would be extended.

[137] With respect to how the hospital assesses whether an individual is withdrawing from alcohol, Dr. Amadu testified that there is a chart or a checklist that lists a number of factors to look at. These factors are a result of a questionnaire based on the responses given by the individuals. Responses are assigned values and based on those values, a decision is made as to whether or not the individual requires observation in the emergency room. If it is below a certain number and the person does not have any other medical reason to be admitted, then he can be discharged.

[138] Dr. Amadu testified that there are regular meetings (every three months) between hospital administration and the local RCMP which are attended by the medical officer of health, a nurse, an officer and a clinical resource nurse for the emergency room. Occasionally the Chief of staff and a Crown Attorney have attended the meetings. The purpose of the meetings is to collaborate with the RCMP to see how they can best deal with patients that come in and require emergency room services.

[139] As a result of these meetings, Dr. Amadu testified there has been significant improvement in the understanding of the roles of the emergency room and the RCMP and less delay in moving individuals between the RCMP and the TGH emergency room.

[140] In September of 2012, a process with the NRHA was initiated as a result of the inefficiency of the RCMP to deal with individuals with mental health issues if the individual was intoxicated and could not provide consent due to his intoxication level. In the past, RCMP members would have been otherwise unavailable for anywhere from five to eight hours

because they would be sitting with a prisoner with mental health concerns waiting for him to be sober enough to consent to treatment.

[141] The RCMP have now secured a block of time from 11:00 a.m. to 12:00 p.m., Monday to Friday, where a prisoner with mental health issues can be assessed by a nurse. If there is a prisoner that needs to be assessed, a phone call will be made between 8:30 a.m. and 9:00 a.m. and a nurse will attend the detachment for the purposes of providing a mental health assessment. The nurse would typically be called to do a mental health assessment if the prisoner made a threat to harm himself. After the assessment was complete, the nurse would make a determination as to whether the individual should be released or taken to the hospital for further treatment.

[142] Prior to the implementation of this system, Sargeant Corner testified that having the officers wait at the TGH with intoxicated individuals who required a mental health assessment caused strain on RCMP resources. Often times, the officer was required to act as guard duty at the TGH for extended periods of time and it pulled resources away from the officer's primary function. Most times, one officer was required but at times, two would sit and wait with the individual waiting for an assessment.

[143] A typical shift at the Thompson detachment consisted of a watch of seven individuals which would be a corporal with six constables for 10 hours shifts. If one or two constables were unavailable because they were required at the TGH, then the detachment's ability to respond to calls was impeded. Due to vacations, training and other reasons, full complement is rare. Most often there were four members on any given watch and often times members would be called to assist if the detachment was short on officers.

XIX. Changes Implemented at Thompson Detachment Since Mr. Mallett's Death

[144] The inquest heard that a number of significant changes were implemented by the Thompson detachment following the death of Mr. Mallett. The highlights are as follows:

> The "Assessing Prisoner Responsiveness Checklist", is now displayed on a large yellow poster on the wall in the cellblock area;
>
> Policies are now sent electronically and monthly meetings with supervisors are held to stress the importance of reviewing the policy. In addition, Policies are now accessible on a shared drive and can be accessed by any member;
>
> In addition to the 15 minute checks on prisoners, there have been recent changes in RCMP policy which require that each prisoner who has been lodged and is not awake because of substance abuse, be woken up every four hours to determine his state of health;

There is now a separate book for recording information regarding prisoner checks, prisoner information and the recording of any notes or problems with prisoners. This information is much more detailed than what existed in 2008;

Mr. Donovan has presented information regarding addictions, including how to recognize symptoms of substance abuse, the health risks associated with substance abuse and alcohol withdrawal to all four watches at the Thompson RCMP detachment. Mr. Donovan reported that information was very well received and was scheduled to be repeated, for first time members and also as a refresher for those who have already participated in the session; and

Additional cameras have been installed in the cell block area in order to eliminate blind spots that existed in 2008.

XX. Summary

[145] The inquest heard from a number of individuals who had contact with Mr. Mallett on the days leading up to his death. Hospital records indicated that Mr. Mallett had been admitted into the hospital approximately a week prior his death for rhitinis and fever as a result of alcohol withdrawal.

[146] There was evidence that Mr. Mallett had consumed alcohol with some friends in the days before his death. Officers that dealt with him the day before and the day of his death all noticed some signs or symptoms that Mr. Mallett may have been ill, but when Mr. Mallett was asked if he was okay, he always assured people that he was. I can only speculate that Mr. Mallett did not know his illness was as serious as it was and that he required medical care.

[147] After Mr. Mallett was lodged, another individual in his cell complained that Mr. Mallett was not well and a guard was alerted. Mr. Snihor was concerned enough that he requested that an officer go and see what was wrong with Mr. Mallett. The result was that Mr. Mallett was taken out of his cell and asked if he wanted medical attention, his dire condition having been mistaken for alcohol withdrawal. In my viewing of the cell video footage, it is clear at least to me, that something is not right with Mr. Mallett. His balance is unsteady, his breathing is not normal, he is clutching his side and is complaining of pain. Yet, nobody was concerned enough to get Mr. Mallett medical attention. This is particularly troubling in light of the fact that most, if not all of the officers, testified that Mr. Mallett was never difficult to deal with. He was always co-operative, agreeable and respectful. It was not his nature to challenge authority. If nobody believed Mr. Mallett was sick, he was not going to argue otherwise. And he didn't.

[148] It is also clear in Mr. Mallett's case, although there were concerns that he was not well, this information was not communicated to the guards and matrons coming on to the next shift. And although guards and matrons testified that they continued to do checks on Mr. Mallett, his death was not discovered for several hours.

[149] As previously mentioned, the Thompson detachment has implemented a number of changes since the death of Mr. Mallett, a summary of which was provided earlier in this report. The Thompson detachment's proactive approach in this regard is to be commended. It is my hope that those changes which have been already implemented, along with the recommendations attached to this report, will help to reduce similar deaths in Thompson cells in the future.

[150] Lastly, I would like to express my gratitude to counsel. Counsel worked very hard in seeing this inquest to its conclusion. All were well prepared and the Court was very fortunate to have their assistance in this inquest. Finally, I want to particularly acknowledge Ms. Greta McKay, for her strength and courage, in attending every day of the inquest into her brother's death.

TO REPORT ON INQUEST
INTO THE DEATH OF JEFFREY RAY MALLETT

SUMMARY OF RECOMMENDATIONS

1. Before lodging an individual in the Thompson Cells under the IPDA, a medical clearance for the individual be obtained to rule out any pre-existing medical conditions; and

2. That Thompson establishes a detoxification centre, similar to the Main Street Project, with rehabilitative services and programs to provide long term support to individuals with substance abuse issues.

TO REPORT ON INQUEST
INTO THE DEATH OF JEFFREY RAY MALLETT

LIST OF EXHIBITS

Exhibit 1	Letter to CJ Ken Champagne
Exhibit 2	Inquest Documents
Exhibit 3	Three volumes – 1, 2, 3: Black binders
Exhibit 4	Schematic - Cell Block Area of Thompson RCMP detachment
Exhibit 5	Diagram of Cell
Exhibit 6	Cell Coverage Video
Exhibit 7	Booklet of Photographs
Exhibit 8	References of Behaviour By-Law
Exhibit 9	Letter from Barbara Scatch
Exhibit 10	Letter from Barbara Scatch
Exhibit 11	Recommendations from Ms. McKay
Exhibit 12	Statement of Constable Boileau
Exhibit 13	Report of Christine Hudley
Exhibit 14	Responsiveness Checklist
Exhibit 15	Prisoner Movement Log
Exhibit 16	Guard Observation Book
Exhibit 17	Handout
Exhibit 18	History – Northern Detox Inc.
Exhibit 19	List of Acronyms
Exhibit 20	Alcohol Withdrawal Flow Sheet
Exhibit 21	Alcohol Withdrawal Assessment Scoring Guidelines