RELEASE DATE: June 11, 2026

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act*, C.C.S.M. c. F52

AND IN THE MATTER OF: Gary Klein, Deceased
(DATE OF DEATH: December 30, 2019)

Report on Inquest and Recommendations of
Judge Samuel Raposo
Issued this 8th day of June 2026

APPEARANCES:

Kerry UnRuh, Counsel to the Inquest
Brenna Dixon, Counsel for the Attorney General of Canada on behalf of the Royal Canadian Mounted Police
Robert Olson and Megan Smith, Counsel for Shared Health

Manitoba

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

REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: Gary Klein

Having held an Inquest respecting the said death on November 4, 5 and 6, 2025, and December 1, 2025, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: Gary Klein.

The deceased came to his death on the 30th day of December 2019, at the City of Selkirk, in the Province of Manitoba.

The deceased came to his death by the following means: Toxic effects of cocaine.

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

Dated at the City of Winnipeg, in Manitoba, this 8th day of June 2026.

"Original signed by:"
Judge Samuel Raposo
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, Chief Medical Examiner (2 copies)
2. Chief Judge Ryan Rolston, Provincial Court of Manitoba
3. Honourable Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act.*
4. Mr. Jeremy Akerstream (KC), Deputy Minister of Justice and Deputy Attorney General
5. Michael Conner, Assistant Deputy Attorney General
6. Jennifer Mann, Executive Director of the Manitoba Prosecution Service
7. Kerry UnRuh, Counsel to the Inquest
8. Brenna Dixon, Counsel for the Attorney General of Canada on behalf of the Royal Canadian Mounted Police
9. Robert Olson and Megan Smith, Counsel for Shared Health
10. Exhibit Coordinator, Provincial Court of Manitoba
11. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba

Manitoba

THE FATALITY INQUIRIES ACT, C.C.S.M. c. F52
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: Gary Klein

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I. MANDATE OF THIS INQUEST

[1] By letter dated February 18, 2021, the Chief Medical Examiner (CME) for the Province of Manitoba, Dr. John Younes, directed that a Provincial Court judge conduct an Inquest into the death of Gary Klein for the following reasons:

> 1. to fulfill the requirement for an Inquest, as defined in section 19(5)(a) of *The Fatality Inquiries Act*:
>
> **Presumption of Inquest**
>
> 19(5) Subject to subsections (6) and (7), an Inquest into a death must be held if
>
> (a) the chief medical examiner has reasonable grounds to believe that the deceased person died as a result of the use of force by a peace officer who was acting in the course of duty; or
>
> (b) at the time of death, the deceased person was
>
> (i) in the custody of a peace officer,
>
> (ii) a resident in a custodial facility,
>
> (iii) an involuntary resident in a facility under *The Mental Health Act*, or
>
> (iv) a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*.
>
> 2. to determine the circumstances relating to Mr. Klein's death; and,
>
> 3. to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[2] By virtue of section 33(1) of *The Fatality Inquiries Act (*the *Act)*, the presiding provincial judge must:

> (a) make and send a written report of the Inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
> (b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the Inquest; and
> (c) send a copy of the report to the medical examiner who examined the body of the deceased person;

> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the Inquest.

[3] Section 33(2) of *The Fatality Inquiries Act* directs that I not express an opinion as to whether any person is culpable in relation to the death under consideration. Although the *Act* does not prohibit an opinion exonerating a person of culpability, that is not the mandate of an Inquest.

II. INTRODUCTION

[4] Gary Klein passed away on December 30, 2019. He was 54 years of age.

[5] In the early morning hours of December 30, 2019, members of the Selkirk Royal Canadian Mounted Police (RCMP) responded to multiple calls made by Mr. Klein stating that people were shooting arrows at his house and were trying to poison him by pushing needles through the floor.

[6] RCMP officers attended Mr. Klein's residence in Lockport, Manitoba, and determined the complaint to be unfounded. Mr. Klein appeared to be hysterical and was not making sense. Due to his behaviour, officers believed he might have been suffering from a mental disorder. They also suspected that he might have been intoxicated, but they did not observe any outward physical signs of impairment.

[7] Mr. Klein was arrested inside his home without incident under *The Mental Health Act* (*MHA*) and section 31 of the *Criminal Code* for breaching the peace.

[8] Under section 19(5)(b) of *The Fatality Inquiries Act*, an Inquest was mandatory because the deceased was in the custody of peace officers at the time of his death.

[9] The Inquest was held on November 4, 5 and 6, 2025, and December 1, 2025.

[10] Family members who attended the Inquest described Mr. Klein as a deeply loved father, grandfather, and tradesman, remembered for his strong work ethic, close family ties, and Métis and German heritage.

[11] They described his later struggles with substance use as following the traumatic suicide of his eldest son in 2015 and as arising from profound loss rather than reflecting the essence of who he was.

[12] His addiction was described as a consequence of trauma, not a defining feature of his identity.

III. FINDINGS OF FACT

[13] Pursuant to section 33(1) of the *Act*, I must provide a written report that sets out my findings on this Inquest with respect to the following:

a) the identity of the deceased;
b) the date, time and place of death;
c) the cause of death;
d) the manner of death; and
e) the circumstances in which the death occurred.

[14] The deceased is Gary Klein, male, 54 years old.

[15] Mr. Klein died on December 30, 2019, in Selkirk, Manitoba. He was found to be unresponsive at the Selkirk RCMP detachment and was pronounced dead at approximately 3:06 a.m.

[16] The cause of death was determined to be the toxic effects of cocaine, with cardiomegaly as a contributing factor. Dr. P. Rahaman, M.D., performed the autopsy on December 30, 2019, and prepared a report dated June 26, 2020. The autopsy disclosed cocaine concentrations in Mr. Klein's blood within the toxic-to-lethal range and an enlarged heart weighing 505 grams.

[17] The manner of death was accidental. The autopsy disclosed no suggestions of a traumatic cause of death.

IV. CIRCUMSTANCES OF DEATH

[18] On December 30, 2019, shortly after 2:00 a.m., RCMP officers Constable (Cst.) Beckett and Cst. McKenzie were dispatched to Mr. Klein's

residence after he made multiple 911 calls reporting that unknown individuals were shooting arrows at his house, poisoning him, and pumping needles through the floor.

[19] Call-takers recorded that Mr. Klein's statements were disorganized and difficult to follow. The calls were classified as an *MHA* matter. No medical symptoms were reported, aside from his disorganized and difficult to follow statements.

[20] Both Constables Beckett and McKenzie testified that they had limited prior knowledge of Mr. Klein, though Cst. Beckett recalled having attended Mr. Klein's residence once in 2018. Police database checks conducted by Cst. McKenzie in connection with the dispatch showed that Mr. Klein and his residence had been the subject of numerous prior *MHA*-related calls.

[21] Upon arriving at Mr. Klein's residence, officers observed a vehicle alarm sounding in the driveway, lights on inside the residence, and fresh snow around the home with no visible footprints. Doors to the residence were locked, and the front porch appeared partially obstructed. Officers did not observe signs of forced entry into the home.

[22] Officers heard a male yelling inside the residence and calling for help. They knocked on doors, announced their presence as police, and attempted to have Mr. Klein open the door. Mr. Klein did not respond to these requests and continued yelling statements consistent with fear and distress.

[23] Through a window, officers observed that one bedroom appeared cluttered and barricaded with furniture positioned against an interior door. Sounds of yelling and movement were heard from that area of the house.

[24] Due to concern for Mr. Klein's safety and the lack of response to verbal communication, officers forced entry into the residence. After entering, they proceeded toward the bedroom from which the yelling had been heard.

[25] Mr. Klein was located inside the bedroom. He was yelling that he was being stabbed with needles and that he needed help. Officers instructed him to show his hands. He was holding keys, which he dropped when directed. No resistance toward officers was documented.

[26] Officers observed heightened agitation and delusional statements; however, no visible injuries, blood, or evidence of physical trauma were observed. In addition, officers did not observe physical indicators of intoxication by alcohol or drugs.

[27] Due to the unsafe and cluttered condition of the bedroom, the decision was made to move Mr. Klein into a clearer area of the residence to allow for safer control and assessment. Mr. Klein initially stated that his legs were not working. Officers initially assisted him in moving out of the bedroom; subsequently, he stood and walked independently.

[28] During their interactions with Mr. Klein, he made one further physical complaint: he stated that "his heart was racing." This comment occurred inside the home, after officers had calmed him, and assisted him into a seated position. He accepted water, spoke coherently, and responded to questions at that time.

[29] Cst. Beckett testified that he interpreted Mr. Klein's statement that "his heart was racing" as being consistent with his heightened emotional state, describing it as a "fight-or-flight" response rather than an indication of an acute medical emergency.

[30] He noted that Mr. Klein did not exhibit other symptoms that, in his training, would signal medical instability—such as difficulty speaking, inability to respond, foaming at the mouth, visible injury, or signs of overdose or toxicity.

[31] After receiving water, Mr. Klein did not repeat the complaint, and no further cardiac-type symptoms were observed.

[32] On this basis and given concerns related to Mr. Klein's behaviour and the risk that behaviour could pose to EMS or medical personnel in a hospital emergency department, the officers did not seek immediate EMS attendance or direct transport to hospital.

[33] Instead, they planned to bring Mr. Klein to the detachment, where he would be monitored in a controlled environment, assessed by EMS, and later transported to hospital for a mental-health assessment once stable.

[34] The "heart racing" comment did not alter that plan, as it was not interpreted as medically urgent within the officers' training and experience.

[35] After officers determined that Mr. Klein had sufficiently calmed down, he was detained under the *MHA* because they believed he was unable to make safe decisions and was experiencing a mental health crisis. He was also detained for breach of the peace under section 31 of the *Criminal Code*, as the officers believed that, if left unattended, he would likely commit an offence or place himself in danger.

[36] While the officers did not observe any outward signs of intoxication, Mr. Klein's behaviour immediately raised concerns consistent with possible substance use. These included:

- believing people were outside shooting arrows at his house;
- believing someone was "stabbing through the floor"; and
- heightened agitation and paranoia.

[37] These observations led officers to consider that Mr. Klein might be under the influence of substances and/or experiencing a mental health crisis.

[38] Mr. Klein was handcuffed for officer safety and walked with officers from inside the residence to the police vehicle—an RCMP Ford Explorer-style Sports Utility Vehicle (SUV).

[39] He voluntarily laid down in the rear seat of the vehicle and requested to be transported in that position. Officers assessed that he was alert, able to protect his

airway, and showed no signs of vomiting or alcohol intoxication. Based on those observations, the position was considered safe.

[40] While in the back of the vehicle, Mr. Klein began kicking at the rear door/window of the police vehicle. As this was occurring, Mr. Klein's son arrived on scene and approached the police vehicle.

[41] Mr. Klein's son advised officers that Mr. Klein "does cocaine" and that this occurred "fairly often," further noting that similar incidents had previously occurred.

[42] This information represented the first disclosure to attending officers that Mr. Klein had a pattern of previous cocaine use and may have consumed drugs that evening. While this disclosure reinforced the officers' existing suspicion that intoxication was contributing to Mr. Klein's behaviour, it did not alter their immediate operational plan, as Mr. Klein was already secured in the police vehicle and officers intended to transport him to the detachment, lodge him in cells, request EMS attendance at the detachment for medical assessment, and reassess mental-health needs once he was sober and stable.

[43] At approximately 2:20 a.m., officers left the residence with Mr. Klein. Officers observed that during the transport, Mr. Klein was no longer kicking at the door/window in the back of the vehicle. Officers observed that he was quiet and not moving.

[44] The transport from Mr. Klein's residence to the detachment took approximately 16 minutes. Cst. Beckett testified that no significant events occurred during the drive.

[45] At approximately 2:36 a.m., Corporal White received a radio request from Cst. McKenzie for assistance lodging Mr. Klein at the detachment. Corporal White was on night shift at the detachment in his role as Acting Corporal. At the time, he was the only member present at the detachment as others were away on calls.

[46] Upon arriving in the secure bay area of the detachment, Corporal White briefly spoke with Cst. McKenzie who advised that Mr. Klein had been behaving erratically and that there were suspicions of substance use, possibly cocaine.

[47] Cst. McKenzie opened the police vehicle door, attempted to rouse Mr. Klein, and quickly realized something was wrong. Mr. Klein was removed from the vehicle and found to be non-responsive.

[48] Cardiopulmonary resuscitation (CPR) was initiated by Cst. McKenzie and Cst. Beckett. EMS was contacted and Corporal White returned inside the detachment to retrieve an Automated External Defibrillator (AED). Pads were applied to Mr. Klein, however the AED indicated "no shock" - meaning the device analyzed the heart rhythm and determined that an electric shock would not be helpful because the heart was not in a shockable rhythm.

[49] EMS arrived at the detachment and took over care of Mr. Klein, but he was later pronounced dead at the Selkirk RCMP detachment at approximately 3:06 a.m.

V. RCMP POLICIES AND PROCEDURES

[50] Inspector Jared Hall testified regarding RCMP policy, operational practice, and the circumstances relevant to Mr. Klein's death. He has over 27 years of experience and previously supervised operations at the Selkirk RCMP detachment, giving him familiarity with local policing.

[51] The officers arrested Mr. Klein pursuant to section 31 of the *Criminal Code* (breach of the peace) and section 12 of the *MHA*, each of which provided an independent and lawful basis for taking him into custody. Their decision was grounded in the behaviour they observed, the information available at the time, and the limited statutory authorities applicable within a private residence.

[52] Upon arrival, officers encountered Mr. Klein in a state described in the evidence as agitated, delirious, and displaying episodes of disorganized or delusional behaviour. His repeated 911 calls, escalating distress, and inability to regulate his

conduct created an ongoing situation that officers reasonably believed would continue or worsen without intervention.

[53] Inspector Hall indicated that such circumstances fall squarely within the preventive purpose of section 31, which, when used in appropriate circumstances, permits officers to bring a situation to an end or prevent further escalation, particularly where no other *Criminal Code* or provincial authority applies inside a private dwelling.

[54] At the same time, the officers formed the view that Mr. Klein met the criteria under section 12 of the *MHA*, given the observable indicators of a mental health crisis and the associated risk to his safety.

[55] As Inspector Hall explained, the officers had a duty to respond, and either authority—breach of the peace or *MHA*—would have been appropriate on its own. Their use of both was, in his words, "*at worst, a redundancy*," reflecting an effort to ensure they were fully justified in depriving a person of liberty in the absence of any criminal offence.

[56] In summary, the officers' rationale for arrest was grounded in:

- the need to prevent a continuing breach of the peace, arising from Mr. Klein's escalating behaviour and repeated emergency calls;
- the need to secure his safety under the *MHA*, based on observable signs of mental health deterioration; and
- the absence of any other lawful authority—such as *The Intoxicated Persons Detention Act* (*IPDA*) or causing a disturbance—which do not apply within a private residence.

[57] Their decision reflected the preventive, safety-driven purpose of both statutory provisions and was consistent with the operational guidance described in the RCMP's Operational Manual (OM).

[58] Inspector Hall explained that the OM is a national policy framework governing arrest, detention, and medical assessment. Divisional or detachment-level policies may supplement but cannot override the OM.

[59] The officers' decision to arrest Mr. Klein under section 31 of the *Criminal Code* (breach of the peace) and section 12 of *The Mental Health Act* was consistent with the requirements, structure, and intent of the OM, particularly the Arrest & Detention policy (OM 18.1) and the Responsiveness/Medical Assistance policy (OM 19.2).

[60] OM 18.1 and OM 19.2 operate together: OM 18.1 addresses when medical clearance is required before lodging a detainee, while OM 19.2 governs responsiveness assessments and the circumstances in which medical assistance must be sought. The evidence established that the officers complied with both policy streams as they applied to the circumstances they confronted.

[61] The policy requires officers to identify relevant indicators, conduct ongoing assessments, and consider medical assistance. The officers did so: they monitored Mr. Klein throughout their interaction and formed the view that medical evaluation was required, but that it need not occur at the scene before transport or by way of immediate transport to hospital.

[62] Inspector Hall indicated that consistent with OM 19.2's safety-based approach, the officers determined that the most appropriate and secure location for medical assessment was the detachment. Inspector Hall confirmed that their intention was to call EMS at the detachment.

[63] OM 19.2 does not mandate that medical assessment occur at the scene; it requires that officers ensure such assessment occurs in a manner that protects the safety of the detainee, the officers, and the public.

[64] Given Mr. Klein's agitation and the risks associated with transporting him directly to the emergency department, the officers' plan to secure him first and then request EMS was consistent with the operational flexibility built into OM 19.2.

[65] Inspector Hall indicated that the officers complied with section 7.2.3 of OM 18.1, which governs when medical clearance is mandatory before a detainee is lodged in cells, including under section 7.2.3.4, which requires medical clearance where there is an indication of combined drug and alcohol ingestion.

[66] As Inspector Hall noted, the officers had information suggesting possible cocaine use, but no overt signs of alcohol consumption. In those circumstances, the trigger for medical clearance under section 7.2.3.4 was not met on the information available to them.

[67] Inspector Hall indicated that, in these circumstances, OM 18.1 did not require immediate medical clearance before transport. He further explained that the officers' intention was not to lodge Mr. Klein in cells without medical assessment, but to obtain that assessment once he could be safely secured. In that respect, the officers complied with OM 18.1's overarching duty to ensure detainee safety and appropriately relied on OM 19.2's broader medical-assistance framework.

[68] Taken together, it was Inspector Hall's opinion that the officers' actions demonstrated compliance with both OM 18.1 and OM 19.2. They identified relevant indicators, conducted ongoing assessment, and formed a plan to obtain medical assistance in accordance with policy.

VI. SELKIRK REGIONAL HEALTH CENTRE: EMERGENCY ROOM (ER) POLICIES AND PRACTICES

[69] Both officers testified that, on prior occasions, they had attended the Selkirk Regional Health Centre emergency department with individuals who were, or appeared to be, intoxicated for the purpose of an *MHA* assessment, but were told to leave and return once the individual was sober.

[70] Both officers stated that those prior experiences informed their decision-making in this case and contributed to their view that taking Mr. Klein to the detachment was the most appropriate course of action.

[71] Katie Hibbs, a Regional Manager with the Interlake-Eastern Regional Health Authority, testified that the Selkirk Regional Health Centre operates under a "no wrong door" policy, pursuant to which no patient is turned away, including those who are intoxicated, agitated, or brought by the RCMP.

[72] She explained that all patients are triaged within minutes of arrival and that intoxication does not justify refusal of a patient. While a mental-health assessment may be delayed because of intoxication, the patient remains in the emergency department under supervision, and the emergency physician determines the level of supervision required, including whether the RCMP must remain.

[73] Ms. Hibbs further testified that she was not aware of any practice of telling the RCMP to "bring the person back when sober," and that such a practice would be contrary to policy.

VII. SELKIRK RCMP PRACTICE: REQUESTING EMERGENCY MEDICAL SERVICES (EMS) ASSISTANCE

[74] Both officers testified that, at the time of their dealings with Mr. Klein, the Selkirk RCMP detachment had developed a practice of requesting EMS attendance at the detachment to medically clear detainees before lodging.

[75] Dr. Robert Grierson, Shared Health's Chief Medical Officer for emergency response services, confirmed that, before 2019, some RCMP detachments—including Selkirk—had developed such a practice. He testified, however, that it was never supported by any EMS protocol or policy and was formally prohibited once EMS governance moved under Shared Health in April 2019.

[76] Dr. Grierson further explained that, since April 2019, when the RCMP call EMS to assess a person in custody at a detachment, paramedics must transport that

person to an emergency department or hospital for proper medical evaluation; they no longer conduct the assessment at the detachment.

[77] If the person is under arrest, the RCMP must accompany the ambulance. He also noted that ambulances have space for only one paramedic and one police officer in the rear.

[78] Although Dr. Grierson acknowledged that rural geography and EMS workload may delay ambulance response times, he indicated that those factors do not alter the requirement that individuals receive a proper medical assessment.

VIII. DISCUSSION OF AGITATED CHAOTIC EVENTS (ACE)

[79] The term "excited delirium" was previously used to describe a cluster of signs and symptoms thought to be associated with chronic stimulant use. It was once believed that a person using a stimulant such as cocaine could enter a delirious state and, while in that state, suffer cardiac arrest and die. The terminology has since shifted from "excited delirium" to "agitated chaotic event" ("ACE").

[80] Dr. Grierson testified that ACE presentations should be treated as medical emergencies—a "mind-body disconnect"—rather than approached on the assumption that the person is simply intoxicated or solely experiencing a mental health crisis. From a medical perspective, he indicated that the symptoms Mr. Klein exhibited — delusions, agitation, fluctuating behaviour, stimulant use, and complaints that his heart was racing — constituted a high-risk medical emergency.

[81] He explained that those symptoms are consistent with stimulant-induced agitation, which carries a known risk of sudden cardiac arrest. In his view, a person experiencing ACE requires a rapid response, behavioural de-escalation and, in many cases, immediate medical intervention.

[82] The evidence in this Inquest makes clear that, for first responders attending a scene, differentiating among the causes of acute and severe agitation poses a significant challenge for both police and medical personnel.

[83] Even in a clinical setting, determining the precise cause of an ACE presentation requires comprehensive medical evaluation. It is therefore unrealistic to expect a first responder, in a high-stress and fast-moving encounter, to distinguish reliably between stimulant ingestion and mental illness. The evidence also established that highly intense police-citizen encounters can themselves be a significant trigger and may, at times, induce or intensify agitated behaviour in vulnerable individuals.

[84] For that reason, standardized crisis-response approaches focused on safely containing the situation while obtaining rapid EMS or paramedic assistance are of central importance.

IX. MISALIGNMENT BETWEEN RCMP AND HEALTH SERVICES

[85] The evidence established several clear misalignments between the RCMP and Health Services. First, it appeared that police dispatch did not use structured triage tools capable of identifying medical or mental health emergencies. There was very little evidence regarding the training received by call takers in identifying possible ACE presentations or conveying that information to attending officers. By contrast, EMS uses triage tools designed to identify high-risk presentations; however, the evidence suggested that the two systems were not aligned.

[86] Second, RCMP members believed that the Selkirk emergency department sometimes refused intoxicated individuals and that EMS could medically clear detainees at the detachment. Health system witnesses testified that both beliefs were incorrect and contrary to policy.

[87] The evidence suggests that these misunderstandings influenced the RCMP decision not to seek EMS or hospital assessment for Mr. Klein before arriving at the detachment.

[88] The evidence also established that there was no embedded EMS presence at the Selkirk detachment to support medical decision-making, nor any protocol by which officers could obtain on-demand access to a medical professional.

[89] Timely access to medical assistance is important because presentations consistent with ACE may involve rapidly evolving medical risk, and the evidence in this Inquest demonstrates that prompt medical support is essential to the safe management of individuals exhibiting behaviours and symptoms consistent with ACE.

X. AREAS FOR FURTHER STUDY

[90] A recurring challenge in Inquests is the need to confine the proceedings to matters properly within their scope. Many of the issues raised in the evidence warrant further examination; however, it is neither possible nor appropriate to address them all in this Report.

[91] An Inquest judge must guard against the proceeding becoming a roving inquiry into matters of general public concern. A number of proposed recommendations emerged during the Inquest. Some appeared meritorious; however, the evidentiary record before me was limited with respect to those issues and the practical feasibility of the proposals.

[92] The topics that follow are therefore identified as matters for further study. I do not advance them as formal recommendations, not because I reject them, but because the evidentiary foundation is insufficient to support doing so.

1. Amendments to Privacy Legislation to Allow 911 Operators Access to Medical Records

[93] It was suggested that the Province consider the following measures:

a) Establishing a process that would allow pertinent medical records to be accessible to 911 communication operators and front-line paramedics. This could be particularly helpful in

circumstances involving a perceived mental health crisis, where accurate historical information may be difficult to obtain. Any such process would require amendments to applicable privacy legislation;

b) Permitting 911 communication operators to relay necessary medical information to police responding to calls involving a perceived mental health crisis. This, too, would require amendments to applicable privacy legislation.

[94] Any such proposal would also require privacy impact assessments to examine the potential effects on personal privacy and to consider reasonable measures to mitigate those effects.

[95] However, I was not provided with specific information about the triage system used for 911 calls, the criteria used to prioritize matters as *MHA* calls, or whether any protocol or training has been implemented to assist 911 operators in identifying possible ACE presentations.

[96] In the absence of evidence concerning how 911 calls are currently processed and prioritized, I do not have a sufficient evidentiary foundation to support a recommendation regarding changes to the manner in which public 911 calls are received and resourced.

[97] This issue warrants further study and research.

2. Simultaneous Dispatch of Police and EMS

[98] It was also suggested that the Province consider the simultaneous dispatch of police and EMS to calls involving significant mental health concerns.

[99] This suggestion arose from the evidence concerning ACE incidents and the difficulty first responders face, at the outset, in distinguishing between a mental health crisis and a stimulant-related medical emergency. A simultaneous response could, in some circumstances, reduce delay in obtaining medical assessment while

also assisting with scene safety and containment. However, the evidentiary record before me was insufficient to support a formal recommendation on this issue. I was not provided with evidence regarding dispatch protocols, resource implications, operational feasibility in rural settings, or the extent to which existing police and EMS systems could realistically support such a model. For those reasons, I do not advance this as a recommendation, but identify it as a matter that may warrant further study.

XI. RECOMMENDATIONS

[100] On the basis of the foregoing review, I make the following recommendations with a view to reducing the likelihood of deaths occurring in similar circumstances.

1. Proactive Intervention

[101] *Recommendation #1: It is recommended that all levels of government continue to commit resources to supporting persons living with substance use issues.*

[102] Although the increase in substance use-related deaths and ACE incidents more generally was not the primary focus of this Inquest, the evidence nevertheless underscores the need for continued resources to address the challenges associated with stimulant use and ACE presentations in order to reduce the risk of further deaths.

2. EMS Paramedics On-Site at the Selkirk Detachment

[103] *Recommendation #2: It is recommended that the Province consider whether a paramedic should be stationed at the Selkirk Detachment on a 24/7 basis to provide medical clearance before lodging in cells and to deliver continuous care, similar to the model implemented in Brandon.*

[104] Dr. Grierson indicated that placements in other communities have allowed paramedics to undertake additional health-related and community-based duties while on site. Consideration of such a model could involve a working group,

including the RCMP, Shared Health, and other stakeholders, to assess detachment size and other relevant criteria for implementation.

[105] This recommendation responds to a significant gap between the need for timely medical assessment of detainees presenting with possible ACE and the absence of any embedded medical support at the Selkirk detachment. An on-site paramedic could assist in providing prompt assessment, continuous care where required, and safer decision-making before lodging in cells.

3. On-Demand Access to Medical Professionals

[106] *Recommendation #3: It is recommended that the Province consider whether it would be helpful, advisable, or feasible to make doctors or other necessary medical professionals available by video or audio conference to assist EMS or other health care staff in conducting medical and mental health assessments at the point of detention or upon arrival at the detachment, similar to the Health Links 24/7 program currently operated by the Province.*

[107] This recommendation responds to a significant gap identified in this Inquest: namely, that responders may be required to manage a person presenting with possible ACE in circumstances where prompt medical judgment is needed but no immediate access to a medical professional exists. Remote access by video or audio may assist in bridging that gap.

4. Alignment of Police and Health Services Resources

[108] *Recommendation #4: It is recommended that the Interlake-Eastern Regional Health Authority and the RCMP jointly consider options to improve resource allocation and coordination, including training personnel to receive and safely monitor aggressive persons brought by the RCMP to health care facilities.*

[109] This recommendation responds to the concern that differing assumptions and practices between the RCMP and health services may impede timely access to

appropriate medical assessment for persons presenting in crisis. Greater coordination and training may assist in reducing that risk.

XII. FINAL COMMENTS

[110] I thank all counsel for their diligent and helpful contributions during this Inquest. Their assistance was greatly appreciated.

[111] I again extend my condolences to the family and friends of Gary Klein. His death was tragic. I hope that through this Inquest, his loved ones have gained some understanding of what occurred and that these recommendations may assist in preventing similar deaths in the future.

[112] I respectfully conclude and submit this Report on this 8th day of June 2026, at the City of Winnipeg, in the Province of Manitoba.

"Original signed by:"
Judge Samuel Raposo
Provincial Court of Manitoba

Manitoba

THE FATALITY INQUIRIES ACT, C.C.S.M. c. F52
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: Gary Klein

APPENDIX 'A' – EXHIBIT LIST

Exhibit No.	Description
1.	Letter from Chief Medical Examiner dated February 18, 2021
2.	Media release for standing hearing of Klein, Gary, dated November 9, 2022
3.	Binder containing the Agreed Documents
4.	Sealed envelope containing USB drive – Secure Bay video of the RCMP Detachment Selkirk
5.	Letter from the Deceased's family
6.	Copy of *The Mental Health Act*
7.	Emergency room physician assessment level of supervision form AC-7-G-03
8.	Transfer of custody of an apprehended involuntary patient under *The Mental Health Act* from law enforcement (RCMP) to a qualified person AC-7-P-12
9.	Copy of section 31 of the *Criminal Code*
10.	Copy of the recommendations made by Inquest counsel