

**Release Date: May 11, 2009**

**IN THE PROVINCIAL COURT OF MANITOBA**

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

**AND IN THE MATTER OF: DARLENE ROSE OWENS, Deceased**

**APPEARANCES:**

**Counsel to the Inquest: Ms Deann Sahulka**

**For the Federal Government: Mr. Kevin Staska**

*The Fatality Inquiries Act*

**Report by Provincial Judge on Inquest**

**Respecting the death of: DARLENE ROSE OWENS**

An Inquest respecting the said death having been held by me on September 3<sup>rd</sup> and 8<sup>th</sup>, 2008 at Pauingassi First Nation, Manitoba, and on September 9<sup>th</sup> and November 7<sup>th</sup>, 2008 in Winnipeg, Manitoba, I hereby report as follows:

The name of the deceased is **Darlene Rose Owens**.

At the time of her death, Darlene Owens was 23 years old and living at Pauingassi First Nation.

On the night of October 19, 2005 Ms Owens, having consumed alcohol, went to a residence where her father was staying and caused a disturbance by banging on the door. After she refused to leave, her father, fearing she would break the window in the door, called the Band Constable on duty that night and requested that Ms Owens be detained in cells until she was sober. Band Constables attended and took Ms Owens into custody. She was taken to a trailer being used by the Royal Canadian Mounted Police and the Band Constables as a detention facility. While she was in custody, Ms Owens ripped a piece of her t-shirt which she used to hang herself from the door knob of the cell. She was discovered by Band Constables who made efforts to resuscitate her unsuccessfully. Ms Owens was taken to the nursing station in the community but could not be revived.

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 Winnipeg, in Manitoba, this 6<sup>th</sup> day of May, 2009.

*“Janice L. leMaistre”*

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Janice L. leMaistre, Provincial Judge

Copies to: Dr. A. Thambirajah Balachandra, Chief Medical Examiner (2)  
The Honourable David Chomiak, Minister Responsible for *The Fatality Inquiries Act*  
Mr. Jeffrey Schnoor, Deputy Minister of Justice

The Honourable Raymond E. Wyant, Chief Judge, Manitoba Provincial Court  
Mr. Don Slough, Assistant Deputy Attorney General  
Ms Deann Sahulka, Counsel to the Inquest  
Mr. Kevin Staska, Counsel for the Federal Government

*The Fatality Inquiries Act*

**Report by Provincial Judge on Inquest**

**Respecting the death of: DARLENE OWENS**

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## **INTRODUCTION**

[1] Darlene Owens died while in custody at the holding cells operated by the Royal Canadian Mounted Police (RCMP) at Pauingassi First Nation. During the evening of October 19, 2005, Ms Owens became highly intoxicated and caused a disturbance outside a residence where her father was staying. Her father called the Band Constables for assistance and, when Ms Owens refused to go home, she was taken to cells to be detained until she was sober. She was lodged in cells at approximately 9:00 p.m. At approximately 11:40 p.m. she was found hanging from the knob of the cell door by a piece of her t-shirt that had been ripped off and tied into a noose. Efforts at resuscitation were unsuccessful.

[2] The immediate cause of death is not at issue and was determined by the Medical Examiner to be due to hanging. The manner of death was found to be suicide.

## **SCOPE OF THE INQUEST**

[3] On March 9, 2007 an Inquest was called by the Chief Medical Examiner of the Province of Manitoba to address the following:

1. an Inquest is mandatory as Ms Owens died while in police cells;
2. to determine the circumstances under which the death occurred; and
3. to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[4] The Fatality Inquiry regarding the October 19, 2005 death of Darlene Owens was held for four days being September 3<sup>rd</sup>, 8<sup>th</sup>, 9<sup>th</sup> and November 7<sup>th</sup>, 2008.

[5] A total of eleven witnesses were called and eleven exhibits were filed including the Statement of Michael Owens and the Autopsy Report of Dr. Charles Littman.

[6] The only party attending the Inquest which sought and was granted standing was the Federal Government of Canada.

[7] I very much appreciated the proficient assistance of counsel to the Inquest, Ms Deann Sahulka. I am also grateful for the assistance of counsel for the Federal Government, Mr. Kevin Staska, and Inquest Coordinator, Betty Owen. Finally, I would like to extend my thanks to all of the witnesses who contributed their time and effort and to the community of Pauingassi.

[8] *The Fatality Inquiries Act* sets out at section 33(1) the duties of the presiding judge after the completion of an inquest:

**Duties of provincial judge at inquest**

33(1) After completion of an inquest, the presiding provincial judge shall

(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.

It is not the function of the presiding judge to lay blame with anyone who may have been involved in the death (see *The Fatality Inquiries Act*, section 33(2)).

[9] In his 2005 Inquest Report into the death of Glenn Fiddler, my colleague and brother Judge, Sidney B. Lerner, found the following at paragraphs 301 and 302 of the report:

[301] ... a Provincial Judge presiding at a provincial Inquest is without jurisdiction to make recommendations to the Federal Government specifically directed to the policies, procedures, and management of Federal departments and agencies.

[302] However, a provincial Inquest does have the jurisdiction to make inquiries into the material circumstances of the death of one of its citizens, including, as noted above, a death occurring on First Nation land. While there is a jurisdictional limitation with respect to the nature of the recommendations that may be made as a result of that inquiry, it does not restrict the fact finding aspect of the inquiry. Similarly, the jurisdictional limitation does not prevent the inquiry from identifying, without recommendation, the problems or deficiencies within Federal departments and agencies that may have formed a part of the material circumstances of death.

[10] I am guided by Judge Lerner's findings regarding the scope of this Inquest and any comments made by me regarding Federal departments, including the RCMP, are therefore advisory only.

**WITNESSES (in order of appearance)**

**Shortie Owens**

[11] Mr. Owens lives in Pauingassi with Elsie Crow. His daughter is the deceased, Darlene Rose Owens. Ms Owens' mother, Barbara Jean Owens, passed away and was no longer living in 2005 when Ms Owens died.

[12] Mr. Owens did not recall the date of Ms Owens' death but agreed that it was October 19, 2005. He said that he was staying at Sandra Owens' place and Darlene showed up there drunk. He knew she was drunk because he could smell alcohol on her, she was "wavering" while walking and she was banging on the door. She banged at the windows for quite a while so he contacted the Band Constable.

[13] He testified that he told the Band Constable on the telephone that his daughter was bothering him and that she was drunk. He told the Constable to put her in cells for the night. He does not know when the Constables came as he did not see them although he said it was nighttime when he called. He said that it took quite a while for them to arrive.

[14] Mr. Owens saw Ms Owens drinking earlier in the day but couldn't remember who she was drinking with. She was drinking what he called bean juice.

[15] Mr. Owens did not know where Darlene was living but she was aware that he was living at the residence of Sandra Owens because she had been there before. He did not know whether she seemed upset when she was banging at the door. She had never said anything about wanting to hurt herself and had not tried to hurt herself in the past. When asked whether she drank all the time he responded that she did sometimes but he could not say how often she drank. He was surprised when he heard that she had died.

[16] Mr. Owens was unable to provide a clear chronology of Ms Owens' life but said that she lived with him when she was quite small.

[17] Mr. Owens said he had never called to have someone locked up for the night before but was aware that this went on from time to time and that it is still going on.

### **Sam Owens**

[18] Sam Owens is the brother of Shortie Owens and the uncle of Darlene Owens.

[19] On the day Ms Owens died Sam Owens had just returned from Winnipeg and was drinking whiskey at his house in the afternoon with Ms Owens and his common law partner, Lucy Pascal.

[20] Mr. Owens said that between the three of them they consumed four bottles of whiskey. He passed out just before dark and before Darlene left. He was unable to recall whether she was drunk. He believes they were drinking together for five hours before he passed out.

[21] He said Ms Owens seemed to be "okay". He did not recall that she was angry or sad or expressed any emotion. She had never talked about hurting herself.

[22] Mr. Owens said that later that night he was arrested by the Band Constables as he was banging on the door where his brother was staying. They were about to take him into cells when they realized something was wrong and released him. He did not find out until later what had taken place.

[23] Mr. Owens said he has been arrested before for being drunk and usually remained in cells for eight hours. There are cameras in the cells now but before there were cameras someone would remain in the trailer to check on him. He did not recall being asked whether there was somewhere else he could be taken for the night before being taken to cells.

### **Nicholas Fisher**

[24] Nicholas Fisher was a Band Constable in Pauingassi in 2005. He did not know Ms Owens well but knew her from the community. He had been working as a Band Constable for a couple of months before Ms Owens' death.

[25] Mr. Fisher was a guard for a short time, then a Night Patrol for eight or nine months before he became a Band Constable. He applied for the job, was interviewed and later hired. The interview consisted of answering a series of questions about what he would do in certain situations. There was only one other Band Constable when he was hired.

[26] Mr. Fisher first became a guard one night when his mother and stepfather were unable to work. As a guard his duties were to check on the prisoners every five minutes and record their activities in a book every 15 minutes. He checked on

the prisoners by looking through a window and observing them in cells. Guards were not to open the door to the cells. If there was a problem with a prisoner he was to call the nursing station so the Band Constable or Night Patrol could be notified. Prisoners were detained for a maximum of eight hours depending on when they were brought into cells.

[27] One night he was asked to assist the Band Constable with an arrest. On the way home that night the Band Constable suggested that he become a Night Patrol.

[28] When Mr. Fisher worked as a Night Patrol there were three other Night Patrols and the four of them would work every night. He worked from 9:00 p.m. to 5:00 a.m., patrolling the community and surrounding area on foot. At first he worked every night but eventually there was a rotation such that he had some days off during the week. His job involved patrolling the community watching out for the younger kids, reporting them to the Band Constable who would take them home, and assisting the Band Constable during calls. If they came across someone who was intoxicated by alcohol or sniff they would turn the person over to the Band Constable. Benjamin Pascal was the only Band Constable and was always on call. The Night Patrols worked in teams of two. Each Night Patrol had a belt with a flashlight, handcuffs and a walkie talkie to contact the command station at the nursing station.

[29] Mr. Fisher was not provided with anything formal in terms of his duties and responsibilities. He was told what his hours were and what to do in some situations.

[30] Mr. Fisher said the Band was looking for a Band Constable and he was hired in mid-October 2005 when he inquired about the job. He did not receive any training although the existing Band Constable, Benjamin Pascal, told him what to do. Mr. Fisher did not receive any medical training such as Cardiopulmonary Resuscitation (CPR) until after Ms Owens' death. He worked as a Band Constable for two years before he left.

[31] As a Night Patrol and Band Constable Mr. Fisher said he was responsible for finding a guard for cells if someone was detained. It was difficult to find guards who complained that their pay cheques were late and that they did not like the late hours. There was a list of names provided to the Band Constable of individuals who could be contacted to guard a prisoner.

[32] Mr. Fisher and Benjamin Pascal were the only two Band Constables working in the community in October 2005. They would alternate working four

hours during the day and four hours during the night and they were on call for 24 hours a day.

[33] Mr. Fisher said that he and Mr. Pascal were not certified in 2005 and so did not have much authority. They would arrest people they found breaking in to locations in the community and they would try to settle disputes between intoxicated individuals. Anything beyond that, he said, required the assistance of the RCMP. Sometimes he let people go without detaining them if he felt they would not cause further trouble.

[34] Mr. Fisher testified that he attended an RCMP three-week training course in Winnipeg in March 2006 so that he would have more policing authority. Benjamin Pascal also attended although he did not complete the course.

### **The night Darlene Owens died**

[35] Nicholas Fisher said that both he and Benjamin Pascal were working the night Ms Owens died as it was during a week when people in the community had just gotten paid. There were many people drinking in the community and they knew it would be a busy time.

[36] Mr. Fisher and Mr. Pascal attended in response to the call placed by Shortie Owens. They saw Ms Owens at the door banging on the window with her fists. She told them that her father was inside and she wanted to be let in so she could sleep. Shortie Owens opened the door and asked them to take her away until morning because she was drinking. Mr. Fisher said that since he was her father that is what they did.

[37] Mr. Fisher said they told Ms Owens that they had no choice but she did not want to go with them. They used force to handcuff her and walk her to cells. She was struggling, trying to get away, cursing at them and at her dad.

[38] Mr. Fisher said Ms Owens smelled strongly of alcohol and had difficulty standing up right. He said that she could barely walk. Based on his observations and what he was told by Shortie Owens he believed she was intoxicated.

[39] Mr. Fisher recalled that the guard on duty that night was Patricia Crow. He said she was already on duty because Geraldine Crow was in cells, having been detained earlier for being intoxicated and fighting with her sister. Mr. Fisher's recollection is not consistent with the guard's log book or with the testimony of Benjamin Pascal which indicate that Ms Owens was detained before Geraldine Crow.

[40] Mr. Fisher said they had trouble finding a guard that night.

[41] Mr. Fisher testified that they asked the female guard to search Ms Owens who was very angry and did not want to be searched. They had to restrain her while the search was being conducted. Ms Owens said she was angry because her father would not let her in the house and that, "he will be sorry in the morning". When they put her in cells she was still angry – kicking on the door and saying that she hated her dad. They left the trailer to continue their patrols telling the guard, who had the log book out, to keep a close eye on Ms Owens.

[42] During the night Mr. Fisher said he and Mr. Pascal received a call to attend the residence of Sam Owens. Lucy Pascal made a complaint and so they detained Sam Owens and took him to the trailer to put him in cells. Before putting Mr. Owens into a cell they had to transfer Ms Owens to the cell with Geraldine Crow.

[43] Mr. Fisher described what happened. Mr. Pascal got the key to open the cell door. Initially he was unable to open the door. He said it was as if Ms Owens was sleeping against it. Mr. Pascal eventually pushed the door open and spoke but Mr. Fisher could not understand what he was saying. Mr. Pascal looked scared and told Mr. Fisher to let Sam go. Mr. Fisher told Mr. Owens to go home and could hear Mr. Pascal on the phone.

[44] Mr. Fisher went into the cell and initially thought Ms Owens was passed out. Then he saw something around her neck and he realized what had occurred. Ms Owens was lying against the door and he said it looked as though she was turning blue. He could find no signs of breathing and removed the item around her neck. At that point, Michael Owens arrived and began CPR. At one point Mr. Fisher took over as Mr. Owens was starting to get tired. They continued with their efforts to revive Ms Owens for what he said was a long time or about 10 to 15 minutes. While he did not have any training he watched what Mr. Owens was doing and tried to do the same thing. Ultimately they took Ms Owens to the nursing station.

[45] Mr. Fisher said that Ms Owens did not say anything about wanting to hurt herself that night. He thought she might hurt herself because she was hitting the door and banging her head but he did not think she would try to kill herself. He said she calmed down once they told her they would let her out once she was sober if she stopped banging.

[46] Mr. Fisher said he had never arrested Ms Owens before for being intoxicated.

[47] Since Ms Owens' death Mr. Fisher has attended CPR training arranged by the Band Council in Pauingassi. The Band Council required all Band Constables and Night Patrols to take the training. He also attended RCMP training in March 2006.

[48] Mr. Fisher said the community also received new doors and a camera system for the cells. The new doors do not have knobs on the inside. They have windows that slide open so the prisoner can be spoken with. The camera system allows the guard to see the inside of the whole cell from a monitor.

### **Benjamin Pascal**

[49] Benjamin Pascal said he knew Darlene Owens for about seven years from the time he was about 14 years old. He went to school with her.

[50] Mr. Pascal was first hired as a Band Constable when he was 17 years old (2004). He was working as a Night Patrol for almost a year before he was hired as a Band Constable. There have always been two Band Constables working in the community as far as he could recall. They were scheduled to work eight hours a day but they frequently worked more hours than that.

[51] There was no training provided before he started working as a Band Constable although he attended training in 2006 after Ms Owens' death.

[52] During the course of his employment as a Band Constable, Mr. Pascal made arrests when there were disturbances or assaults. Sometimes he would take people home if they were cooperative.

### **The night Darlene Owens died**

[53] Benjamin Pascal said he was working with Nicholas Fisher the night Ms Owens died and remembers getting a call from the nursing station. He was told that Ms Owens' father was staying at Sandra Owens' residence and he did not want her there.

[54] Mr. Pascal said that when he first saw Ms Owens she was having trouble walking. He spoke with Shortie Owens who said that he wanted her to go "sleep in cells". Mr. Pascal felt Ms Owens was very intoxicated as he could smell liquor on her, she was falling down and he had seen her in this condition previously. While he doesn't recall what she said, he does remember that Ms Owens was upset and swearing at Nicholas Fisher.

[55] Mr. Pascal said they handcuffed Darlene and told her they were taking her to cells. He did not know where she was living at the time. When asked by Inquest counsel whether they asked Darlene if they could take her somewhere else he replied that she wanted to be where her father was but he did not want her there.

[56] Mr. Pascal recalls that Mr. Fisher had to go find a guard while he waited at cells with Ms Owens. Mr. Fisher returned with Patricia Crow who searched Ms Owens, looking for weapons, belts, lighters and other things that needed to be taken away from her before she was left in cells. Initially Ms Owens was angry, banging on the cell door. Mr. Pascal filled out the necessary paperwork and then went back into the community with Mr. Fisher.

[57] Mr. Pascal recalls that he and Mr. Fisher were called back to the jailhouse by the guard who could not see Ms Owens in the cell. He pushed the cell door open and saw her. He said, "It looked like she was hanging herself." He described what he saw. Ms Owens was sitting down against the door with a t-shirt around her neck and around the door handle. Her eyes were open and her mouth was blue.

[58] He said Mr. Fisher went into the cell and tried to administer CPR while he called the (Band) Councillor and the RCMP. Michael Owens arrived. The RCMP told him they needed to administer CPR and check her pulse. He reported that there was no pulse so the RCMP said to take her to the nursing station. They took Ms Owens to the nursing station and then went to get Suzanne Keeper, the Community Health Representative. The RCMP came to Pauingassi the next day.

[59] Mr. Pascal testified that Ms Owens did not say or do anything that led him to believe she might try to hurt herself. While he had dealt with her in the community before, he had not arrested her prior to that day as she had previously been cooperative.

[60] Mr. Pascal continued working as a Band Constable in Pauingassi for about six months after Ms Owens' death. He completed a CPR training course held in Little Grand Rapids but unfortunately was unable to complete the RCMP training course in Winnipeg. While he did not recall having taken CPR training in the past, the Inquest was provided with a certificate (Exhibit 5) confirming that he took a course in May 2004.

[61] Mr. Pascal said that since Ms Owens' death cameras have been installed in cells and there were two guards on duty for a time.

**Lucy Pascal**

[62] Ms Pascal was friends with Darlene Owens. She did not recall drinking with Darlene the day she died nor did she recall seeing Darlene that day. She did not remember the last time she saw Darlene Owens. She remembered drinking with Sam Owens who came back to the community with whiskey. She does not recall ever hearing Darlene say anything about wanting to hurt herself.

**Suzanne Keeper**

[63] Ms Keeper was also friends with Darlene Owens. Ms Keeper was the Community Health Representative for 12 years until late August 2008. Ms Keeper's training included CPR and First Aid. Her responsibilities involved assisting people in the community when required. This included talking to the nurse in Little Grand Rapids for advice. She said a nurse would come into the community during the day three to five days per week as needed but there was no nurse residing in Pauingassi. A doctor attended the community about once per month.

[64] Ms Keeper explained that since 2006 there have been nurses in Pauingassi and a doctor now comes to the community twice a month. Currently there are two full-time nurses residing in the community.

[65] Ms Keeper testified that the night Ms Owens died Robert Owens came to her door. He told her that Ms Owens tied a rope around her neck in cells, she was not breathing and there were no signs of life. Ms Keeper told Mr. Owens to bring Darlene to the nursing station and she arranged to meet them there.

[66] At the nursing station, Ms Keeper checked Darlene's pulse and heartbeat but found no signs of life. She recalled there being a strong smell of alcohol on Ms Owens' body that night.

[67] Ms Keeper said that Ms Owens drank a lot, which she described as being almost every weekend. She had seen Ms Owens become quite intoxicated previously but had never heard her talk about hurting herself.

**Constable David Chalmers**

[68] Constable Chalmers has been a member of the RCMP for seven and a half years with three and a half years of service with the Winnipeg Forensic Identification Unit. His background, experience and training are such that he is a

specialist in crime scene examination which includes the collection and identification of evidence.

[69] On October 20, 2005 Constable Chalmers attended the First Nation community of Pauingassi along with Corporal Mangles to examine the location of Darlene Owens' death. He took photographs of the trailer which contains the cells.

[70] Constable Chalmers testified that the cells are inside a trailer located approximately 25 feet from the RCMP patrol cabin. Cell number two was 1.8 by 3 metres and had a toilet and sink unit. The total height of the door was 201 centimetres (cm) from the top of the door to the floor. The viewing port or window was 45 cm long and 19 cm high and was 149 cm from the floor to the bottom of the viewing port. The knob on the door was one metre from the floor.

[71] Constable Chalmers found that pushing on the knob from the outside of the cell caused a slight gap between the knob and the collar of approximately seven millimetres which was "quite apparent". He said the door knob mechanism was loose and the knob needed only a simple push or pull to create the gap. No twisting of the knob was necessary. He said the knob could be tightened to reduce the gap. The knob itself did not appear to be damaged. The door to the cell could be opened and closed without touching the knob by using the key which could be turned and used like a knob.

### **Dave Grayson**

[72] Dave Grayson has been a civilian member of the RCMP for 21 years. He is with the Protective Technical Services section and is in part responsible for anything associated with protecting persons and property. He also provides investigative assistance for detachments investigating a matter involving security. Mr. Grayson was tasked with removing and repairing the lock so the cell could be put back in use.

[73] Mr. Grayson said he attended Pauingassi First Nation on October 23, 2005 with Corporal Thompson. He took photographs and prepared a report regarding his findings.

[74] Mr. Grayson described the knob design as a standard design for detention lock hardware. The knob was manufactured by Folger Adams and was marketed as a safety design. He said the knob on the inside of the cell is smooth so that it cannot be used as a hanging point. This type of lock is still manufactured and approved for use.

[75] After Ms Owens' death Mr. Grayson said the RCMP found approximately 30 cells throughout the Province with locks similar to the one in the Pauingassi cell. Changes were made to make them all safer. Most cells in the Province now have sliding doors without knobs, however, there was not enough room in the trailer in Pauingassi to install a sliding door.

[76] Mr. Grayson said there are two versions of the type of lock found in the cell in Pauingassi that are approved for use – one with a knob and one without. He said he initially installed a lock without a knob on the inside of the cell door. However, the RCMP became concerned that the door could close behind an officer who would then have no way of getting out of the cell. As a result Mr. Grayson returned to Pauingassi and installed a knob inside the cell.

[77] Mr. Grayson said that when he examined the knob after removing it from the inside of the cell door he found that the set screws were loose. This caused what he described as "play" between the inner knob and the trim. When he tightened the screws the knob could not be rotated off or loosened. But when the screws were loose the knob could be rotated all the way off.

[78] Mr. Grayson found marks on the spindle consistent with the screws having been properly tightened at some point. He also found wear on the corner of the spindles which would be consistent with the knob being loose. He was, however, confident that when the knob was installed it was done properly with very little airspace which I take to mean without the rather large gap that was present at the time of Ms Owens' death. He noted that there needs to be some movement in the knob without which the knob would not turn at all.

[79] Mr. Grayson testified that the version of this type of lock currently being used includes what he described as a shoulder – one piece slides over the other – to eliminate the possibility of a gap as large as seven millimetres. This was not available when he was reinstalling the knob on the inside of the cell door. As such, arrangements were made for a local machine shop to manufacture a copy of the knob with the shoulder. The new design does not completely eliminate the gap but reduces it to the thickness of a business card. While concerns remain that this could still be used as a hanging point, Mr. Grayson said that it would not be very apparent to someone in the cell.

[80] Mr. Grayson's conclusion was that the set screws became loose on the knob and this allowed it to be spun open creating the gap. He did not know what caused the screws to become loose but speculated, based on tests he conducted, that rattling the knob back and forth could have caused the screws to become loose. He

said that this would be the sort of repair his office would perform based on a service call but no such call was received.

[81] Mr. Grayson speculated further that the loose set screws may not have been noticeable or they may have just become loose on the night of October 19, 2005. However, he felt it unlikely that aggressive rattling that night alone would have caused the set screws to loosen. He added that the trailer was brought to Pauingassi on the winter road which may have caused sufficient rattling to loosen the screws and that expansion and contraction due to extreme temperature fluctuations could cause the screws to become loose.

[82] Mr. Grayson said the gap on the knob could be reduced by tightening the knob and then the set screws. He did not observe any wear on the lock mechanism that would indicate the knob would be subject to further loosening in the future.

[83] Mr. Grayson advised that the preference now is to use a sliding door in cells. Unfortunately there is insufficient space for a sliding door in this trailer. The alternative which has been approved for use is a door without an inside knob that swings out rather than in so that it can be pushed open without a knob if it closes accidentally.

[84] Mr. Grayson reviewed a report completed by Chuck Koch in August 2005 generated as part of a province-wide review of cells being operated by the RCMP. Mr. Koch worked for the Asset Management Section of the RCMP which is responsible for overseeing construction, design and renovation projects. The review of cells was conducted to determine the number of cells in the Province that met existing standards and the work required to upgrade cells which did not meet the standards. The goal was to ensure the safety of officers, prisoners and others who work in and use the cells. As far as Mr. Grayson was aware, this was the first time a province-wide review had been undertaken in a number of years.

[85] Mr. Koch did not identify any problems with the locking mechanism on the door in his report. While the door itself did not meet existing standards and was identified for replacement, the lock did meet existing standards.

[86] Mr. Grayson testified that if problems regarding the design of cells are identified, the RCMP determines whether a "retrofit" of all cells in the Province needs to be undertaken. He described a problem identified with the sliding doors in cells. He said that all such doors in the Province were examined and modified to eliminate the problem.

[87] Mr. Grayson said that regular inspections by his section are not conducted on RCMP cells. He and his colleagues are called in only when a problem is reported. He identified a lack of resources as the reason regular inspections are not being done. He said his section is usually called in by the RCMP Detachment Commander who might notice a problem during a patrol.

[88] Mr. Grayson confirmed that he was not advised of any problems with the cell door prior to the death of Ms Owens. He was, however, aware of an attempted hanging which he recalled occurring in Portage la Prairie at least 15 years ago. In that case, fabric was wedged into the door knob in cells. The knob was found to have been installed properly and he was not aware of anything being done as a result of that incident.

### **Corporal Douglas Thompson**

[89] Corporal Thompson was a member of the RCMP for 23 years prior to his retirement in January 2006. He was in Little Grand Rapids from July 2001 until his retirement. On October 19, 2005 he received a call from another officer regarding the death of Darlene Owens. There were no officers in Pauingassi at the time of Ms Owens' death. Corporal Thompson spoke with members of the community that night but did not want to interfere with ongoing efforts to resuscitate Ms Owens. When he phoned back later he was informed that Ms Owens had not survived. The RCMP were unable to travel to Pauingassi at that point. It was approximately midnight and therefore not safe to negotiate the rapids on the river between Little Grand Rapids and Pauingassi. There are no roads at this time of year between the communities. Ultimately Corporal Thompson determined that the situation was secure and he would go to the community in the morning.

[90] Corporal Thompson went into Pauingassi by boat the next morning while another officer waited for the major crimes investigators coming from Winnipeg. He confirmed that the cells and Ms Owens were secure to protect the integrity of the investigation to determine what had occurred.

[91] After the RCMP investigation regarding the circumstances of Ms Owens' death was concluded the trailer was shut down for approximately one month. Corporal Thompson would not allow it to be used until the cell door was fixed to ensure that no one else would be hurt.

[92] Corporal Thompson advised that the trailer was brought to Pauingassi in the spring of 2005 from Bissett after the previous trailer burned down on November 27, 2004. Renovations of the trailer were undertaken for approximately

one month. The renovations included redoing the roof, the flooring and the walls. Corporal Thompson understood that the locksmith had redone the locks while the trailer was still in Bissett.

[93] In retrospect, he said, a new trailer should have been built. I took this to refer to the amount of work that had to be done to refurbish the trailer brought from Bissett.

[94] Once the renovation work was completed in August 2005 the trailer was inspected by Chuck Koch who went through the trailer until he was completely satisfied with the work that had been done. At the time of the inspection, it was pointed out by Corporal Thompson that one cell door was not locking properly. The locksmith repaired the problem and rekeyed the lock.

[95] Corporal Thompson explained that the RCMP were responsible for the maintenance of the trailer. This included arranging to have it cleaned and checking it every time a member was in the community to ensure everything was working properly. He said that checking on the trailer was one of their priorities when they attended the community – making sure it was clean, the water was running and there was nothing in the cells that should not be there. Whenever a problem was identified the trailer was shut down. For instance, on a couple of occasions he said the toilets were not working properly and one time there was a leak in the roof. If there were problems with the cell doors they would call someone to do the repair. If there were other problems they would hire someone from the community to perform the repair. For instance, they had a regular plumber they used for plumbing repairs.

[96] At the beginning of the month in October 2005 Corporal Thompson and other members were in Pauingassi for Court. On October 11, 2005 there was a stabbing in the community and they lodged prisoners in the cells. Corporal Thompson looked over the trailer himself to ensure there were no problems.

[97] Corporal Thompson testified that there were plans to change the cell doors and that the trailer needed some general repairs but there were no problems with the locks.

[98] Corporal Thompson recalled that in October 2005 Benjamin Pascal was the Band Constable in Pauingassi and Nicholas Fisher was helping him. Corporal Thompson was aware that they were not accredited; in other words, they were not peace officers or special constables. He was concerned about this and said so but there was no one else who could provide the necessary policing services in the community.

[99] Corporal Thompson explained that being a Band Constable is not a popular job in this small community where most of the residents are related to one another. Indeed, he said he worked with 18 different Band Constables in four years. As an example of how difficult it was to find people who were able to take on the responsibility, he explained that on a couple of occasions he took the key to the trailer away from the Band Constable on duty for being intoxicated.

[100] The Band Constables were hired and paid by the Band. The only power Corporal Thompson felt he had if he had any concerns about who was being hired was to refuse to provide the key to the RCMP cells. He did just that on three or four occasions. Out of the 18 different Band Constables he worked with only one was accredited but unfortunately he started drinking and was unable to work for a period of time.

[101] The RCMP provided training to Band Constables but only to the extent that Corporal Thompson was satisfied that they knew their duties. He made efforts to have them complete paperwork in order to track what they were doing with prisoners. As far as he was aware, 99% of the detentions were as a result of intoxication that invariably led to fighting or other criminal activity. When asked whether it was part of the Band Constables' duties to detain intoxicated individuals he said that it was "pushing" their duties. He knew that they did not have training or weapons and had concerns for their safety as a result.

[102] Corporal Thompson explained that the guards in Pauingassi were hired by the RCMP but paid by the Commissionaires. Training for the guards involved getting them familiar with the office. They were told to check on prisoners every 15 minutes and document the time and what the prisoner was doing. If the guard did not speak English then the Band Constable who spoke Cree would explain what was required.

[103] Corporal Thompson was aware that the guard on duty the night of Ms Owens' death, Patricia Crow, had been used a few times as a temporary guard but he had not had the chance to provide her with any training. He arranged for Benjamin Pascal to receive CPR training in May 2004.

### **Winona Embuldeniya**

[104] Winona Embuldeniya has been employed by Public Safety and Emergency Preparedness Canada since 2004 as the Regional Manager of the Aboriginal Policing Directorate. Her duties as Regional Manager include implementing the First Nations Policing Policy, implementing and monitoring the Band Constable

Program and monitoring grant agreements associated with the First Nations Policing Policy and the Band Constable Program.

[105] Ms Embuldeniya testified that the First Nations Policing Policy was established in 1992 to replace Circular 55 and to provide First Nations with access to professional policing on reserves. Circular 55 was published in 1971 by the Department of Indian Affairs and regulates the Band Constable Program. She explained that professional policing services refer to police services administered by a First Nation such as the Dakota Ojibway Police Service or other provincial police services such as the RCMP which may provide service to First Nations. Under the First Nations Policing Program, First Nations without their own police service would generally engage in a tripartite agreement involving the First Nation and the Federal and Provincial governments which provides for both RCMP and First Nations policing services in the community and may provide for the possibility of transition to a police service administered by the First Nation.

[106] Ms Embuldeniya said the Band Constable Program in Manitoba is a "grants and contributions program" in which the Federal government provides funds to the Band which is expected to provide a Band employee to enforce Band bylaws. The Band Constable Program is intended to supplement but not replace RCMP services in the community.

[107] Ms Embuldeniya explained that Band Constables only have the authority to enforce Band bylaws. Individuals who have received the designation of Special Constable have the authority to enforce provincial statutes and the *Criminal Code of Canada* and therefore have the power to arrest and detain.

[108] Circular 55 did not require First Nations to have individuals appointed as Special Constables. While this was recommended, Ms Embuldeniya said it would be unfair of government to discontinue funding for bylaw enforcement to compel compliance when the funding available is so limited. When asked whether it is important in her view for a community such as Pauingassi to have Special Constables, Ms Embuldeniya replied that it is more important for the community to have RCMP services.

[109] Ms Embuldeniya testified that pursuant to the Band Constable Program, the Band is responsible for hiring the Band Constables. Funding for the Band Constable program is provided by the Department of Indian Affairs on a per capita basis. Funding for one Band Constable is provided to the Band in Pauingassi in the amount of \$39,063 per year. The funding level has not changed since 1992.

The Band may hire more than the one Band Constable funded by the Federal government but no additional funds will be provided by government.

[110] Ms Embuldeniya testified that the Band is responsible for sending the Aboriginal Policing Directorate a Band Council Resolution or a notice letter confirming any new hiring or any changes to existing Band Constables. Often this information is provided to the Aboriginal Policing Directorate on an informal basis. As long as the Band advises that someone is employed as a Band Constable, the funding will be provided. If a Band has not employed a Band Constable for a long period of time, the funds will not be provided. However, this has never happened in the time that Ms Embuldeniya has been with the Aboriginal Policing Directorate.

[111] All Constables hired by the Band are provided with access to training by the Aboriginal Policing Directorate. There is no limit to the number of Band Constables who may attend the training so any additional Band Constables hired by the Band (beyond the funding provided) are eligible to attend the training.

[112] According to Ms Embuldeniya any training or accreditation is provided after the Band Constable has been hired by the Band. The Aboriginal Policing Directorate arranges for annual training for Band Constables in Manitoba. There are up to 27 seats available each year for training. Priority is given to First Nations which have in their employ Band Constables who have not yet received training and which do not have other trained constables currently working. The next priority is to ensure that at least half of those working as Band Constables have the training and, finally, to update those Band Constables who received their training four years or more previously.

[113] Ms Embuldeniya pointed out there is no requirement for training for Band Constables. However, training is required before Special Constable status can be attained. The Aboriginal Policing Directorate funds all costs associated with the training except for transportation which is the Band's responsibility. The cost of the training is approximately \$8500 to \$9500 per person per session.

[114] In addition to arranging and providing training, the Aboriginal Policing Directorate conducts criminal record and child abuse registry checks of individuals hired as Band Constables.

[115] Ms Embuldeniya described the efforts she made in 2004 and 2005 to provide training to the Band Constables employed in Pauingassi. In November 2005 the Band provided her with the names of the Band Constables, Benjamin Pascal and Nicholas Fisher, who were to attend the training program scheduled for January

2005. However the registration forms and necessary checks were not provided by the Band by the required deadline and Band Constables Pascal and Fisher were therefore unable to attend the training.

[116] Ms Embuldeniya indicated that another training session was scheduled for March 2006 after the death of Darlene Owens. Both Benjamin Pascal and Nicholas Fisher registered and attended the program. Unfortunately Benjamin Pascal did not complete the program. Ms Embuldeniya said she was concerned, based on information she received, that Mr. Pascal was still suffering as a result of the tragic death of Darlene Owens and that this may have hampered his ability to complete the program. Nicholas Fisher completed the training program and received his Special Constable appointment. Unfortunately, he quit approximately six months later and the Band was unable to find anyone else to step in.

[117] Ms Embuldeniya testified that her department did not know First Nations in Manitoba were arresting people and detaining them in non-standard cells. Since the release of the report by The Honourable Judge Lerner regarding the death of Glenn Fiddler (The Fiddler Report), her department has advised First Nations in Manitoba that they are not allowed to detain in Band-owned cells. She also said her department wanted to make sure Band Constables were aware of certain things such as how to conduct a proper search and what items should be removed from the possession of a prisoner being detained in cells. Ms Embuldeniya also referred to the report by The Honourable Judge Thompson regarding the death of Rachel Wood (The Wood Report) as being instrumental, along with The Fiddler Report, in the elimination of Band-owned cells and to changes to the Band Constable Program.

[118] In September of 2005 Ms Embuldeniya said she became concerned that Pauingassi needed special attention due to what was described to her as a "crisis situation" in the community and that part of the issue was a lack of policing. She said the community was fraught with violence and children addicted to solvents and this has led to many tragedies. At the time, there was a small RCMP detachment in Little Grand Rapids which would provide policing services to Pauingassi. When the RCMP received a call during the day, they would dispatch members to respond. If the call was received at night, the members would be dispatched the following day. She said the RCMP sought to increase their member complement by one so they would be able to provide regular patrols to Pauingassi.

[119] Ms Embuldeniya's concerns did not extend to the Band Constable Program in Pauingassi. By way of explanation she told the Inquest about an incident in Pauingassi in December 2004 during which the two Band Constables saved the life

of a man who was stabbed and beaten at a house party. The Band Constables had not received any prior training and she felt they were doing the best job they could in the circumstances.

[120] As of October 2005 information had not been provided to the Band Council in Pauingassi regarding the scope of authority of Band Constables.

Ms Embuldeniya testified that since that time recommendations in The Fiddler Report have been implemented. First Nations have now been advised by Ms Embuldeniya that they are not permitted to operate their own cells and funding will be withdrawn if her department learns that a First Nation is doing so. She has further advised First Nations in Manitoba that individuals providing policing services within the First Nation who have not been appointed Special Constable are only permitted to arrest and detain to enforce Band bylaws. Any other arrest or detention should be referred to the RCMP.

[121] Ms Embuldeniya reiterated the issues heard by the Inquest relating to the difficulties regarding the recruitment and training of Band Constables – there are few people in the community who are able or prepared to take on the responsibility; it is difficult for the Band to be without policing services (bylaw enforcement) while Band Constables are away attending training; it is difficult for individuals to be away from home for three weeks of training, particularly when family emergencies arise; and, the course is difficult to complete.

### **Patricia Crow**

[122] Ms Crow lived in Pauingassi for approximately three years. She was a guard three or four times before the night Ms Owens was brought in. The first time she worked as a guard was about two months before this night. The Band Constables, Nicholas Fisher and Benjamin Pascal, would pick her up when they needed her as a guard in cells. She said they asked her because they could not find anyone else willing to guard.

[123] Ms Crow said she was told by the Band Constables to check the prisoners every 10 minutes and write down in a log book what the prisoners talked about, what they were doing and what time they were sleeping. No one else gave her any instruction about what to do when she was guarding prisoners. She did not receive any training prior to becoming a guard. She did not have any medical training, such as CPR, prior to working as a guard.

[124] When she worked as a guard Ms Crow said she marked down the times she worked, signed her name on the time sheet on the wall and was then paid for her work. She guarded men and women in cells. She was aware that there were other

female guards in the community but the Band Constables would not ask anyone who had been drinking to work as a guard that day.

[125] Ms Crow would usually work for seven hours. She was not permitted to give prisoners anything to drink, eat or smoke. She was given a key to the cells but she was not allowed to open the cells except in an emergency. She was able to look into the cells through a window in the door.

[126] On the night that Ms Owens was brought in, Ms Crow recalls that she was picked up around 10:00 p.m. by Band Constables Pascal and Fisher. She was already asleep but agreed to go with them to guard. She had not been drinking that night. Ms Crow asked who was in cells and was told Ms Owens was there. When she asked what happened, the Band Constables told her that Ms Owens was making trouble house-to-house and they took her in.

[127] When Ms Crow arrived at the trailer, she said Ms Owens was in cells. She was not told whether Ms Owens was intoxicated. Band Constables Fisher and Pascal filled out their paperwork and left. She explained that it took about 10 or 15 minutes for them to complete their paperwork.

[128] Ms Crow recalls that Ms Owens was in the first cell. She reviewed her log book and said that Geraldine Crow was brought in at about 11:00 p.m. and that she was drunk. Ms Crow said she was checking the prisoners every 10 minutes but does not recall what time she discovered that Ms Owens had "hurt herself". Ms Crow said that after she had been there for one hour Ms Owens was quiet.

[129] Ms Crow said that when Geraldine Crow came in she was yelling and kicking the door. At that point Ms Crow recalls having a brief conversation with Ms Owens during which she told her who she was and who had been brought in. Ms Owens asked Ms Crow to phone one of the Councillors to see if she could be released. Ms Crow said she called Michael Owens who told her that Darlene would be detained for seven hours. She told Ms Owens this but received no response.

[130] When asked whether Ms Owens was upset, Ms Crow responded that she was okay and that she just started talking. She said Ms Owens told her she did not know why she got picked up. Ms Owens also asked Ms Crow to call Benjamin Pascal to find out whether she could be released. He also said no. Ms Crow told Ms Owens that if she slept for a couple of hours they would let her out. At first Ms Owens was talking to Geraldine Crow but then she was quiet after that.

[131] Ms Crow testified that Geraldine Crow was brought in at about 11:00 p.m. and was highly intoxicated. She was trying to fight the constables. She was banging on the doors and yelling that she wanted to get out. She was placed in a separate cell from Darlene. The Band Constables filled out paperwork and then left after about 10 minutes.

[132] Ms Crow said that she did not think that Ms Owens was that drunk. Ms Owens did not seem upset; she just wanted to get out of cells. The last time Ms Crow checked on Ms Owens, she was lying down on the floor and so Ms Crow thought she was asleep.

[133] Ms Crow recalls that she called the Band Constables to return to the trailer because Geraldine Crow was kicking the cell door and making a lot of noise. This is inconsistent with the testimony of Mr. Pascal who said she called them back because she could not see Ms Owens in cells and Mr. Fisher who said they returned to lock Sam Owens in cells.

[134] When Band Constables Pascal and Fisher returned to the trailer Ms Crow said she had trouble unlocking the trailer door for them. She was not checking on the prisoners while she was trying to get the door open.

[135] When the Band Constables went to check on Ms Owens she noticed that initially they had trouble opening the door and then they found her unconscious. Eventually they took her to the nursing station. Ms Crow remained at the trailer guarding Geraldine Crow until the Band Constables returned and took them both home.

[136] After Ms Owens' death Ms Crow said she was asked to attend CPR training but she did not. She did not guard again as she was too upset by what happened. When asked what has changed since Ms Owens' death, Ms Crow said they now require two guards and they have a TV that allows the guards to watch what the prisoners are doing.

### **Michael Owens**

[137] Efforts were made to have Michael Owens testify. A subpoena was issued and telephone calls were made to Mr. Owens while the Inquest was being conducted in Pauingassi. While we were told that Mr. Owens would attend or was on his way, he did not attend. It was clear that he did not wish to testify and so his statement was filed in evidence (see Exhibit 9) and will form part of the record of these proceedings. I wish to make it clear that I do not infer any bad will on the part of Mr. Owens. Those involved in the efforts to revive Darlene Owens on the

night of her death have been deeply affected by this tragedy. I conclude that the failure of Mr. Owens to attend the Inquest was likely due to emotional trauma and a desire to avoid reliving the events.

[138] In his statement provided to RCMP Constable Baker on October 20, 2005, Mr. Owens indicated that he was awakened at about midnight by a call on the walkie talkie about a death in cells. He went to the trailer and entered the cell with Benjamin Pascal. He saw Darlene Owens in the cell with a piece of her t-shirt tied around her throat. He removed the piece of t-shirt from around her neck by pulling it over her head and immediately checked for a pulse and heartbeat. He found neither but noted that her body was still warm. Mr. Owens began to move Ms Owens' body around in an effort to get her circulation going. He also commenced CPR with chest compressions and breaths which he continued for what he estimated was 20 minutes. Nicholas Fisher was assisting him and he asked Mr. Fisher to take over performing CPR so that he could speak to the RCMP on the telephone. Ultimately, Mr. Owens determined that they needed to get Ms Owens to the nursing station and asked someone to contact Suzanne Keeper, the Community Health Worker. Ms Keeper was already at the nursing station when they arrived with Ms Owens. Mr. Owens and Ms Keeper spoke with the nurse from Little Grand Rapids on the telephone for advice but were unable to revive Ms Owens.

[139] While Mr. Owens was giving Ms Owens mouth to mouth he noted the smell of alcohol. He saw her earlier that day at about 1:30 and during a brief conversation with her he determined that she had not been drinking at that point.

### **Dr. Charles Littman**

[140] Dr. Littman's final report, including the toxicology report, was filed as an exhibit in lieu of his testimony (see Exhibit 2).

[141] Dr. Littman performed an autopsy on Darlene Owens' body on October 21, 2005. In his final report dated December 20, 2005, Dr. Littman lists the cause of death as hanging. His findings at autopsy included neck abrasions and contusions and acute alcohol intoxication.

[142] The report indicates that at the time of her death Ms Owens was wearing a t-shirt which was found at autopsy to be torn down the left side and missing the left arm and a portion of the left side of the chest. A piece of fabric similar to the t-shirt was found in cells where Ms Owens died. It was tied in a noose. This was presumably the fabric Ms Owens ripped from her t-shirt and used to hang herself.

[143] The evidence of trauma was found to include:

- Evidence of a ligature mark around the neck which was consistent with the ligature seized from cells;
- A vertical bruise over the thyroid cartilage; and
- Bruising on the jaw, right bicep, right wrist and right ankle.

[144] Ms Owens' blood was found to contain 194 mg% ethanol while the vitreous contained 244 mg%. This is in excess of double the legal limit and further evidence of significant intoxication. The presence of other drugs was not detected.

## **ASSESSMENTS AND RECOMMENDATIONS**

### **Detention of Prisoners**

[145] Circular 55 provides Band Constables with the authority to enforce Band bylaws and indicates that any situation requiring detention of a community member should be referred to the RCMP (responsible Senior Police Force). As such, it appears that the Band Constables lacked the authority to detain Darlene Owens. However, they did not appear to have an alternative in the circumstances. Ms Owens was intoxicated and causing a disturbance outside the home where her father was residing because he refused to let her inside. Her father asked them to take her to cells and she refused to be taken anywhere else. Detaining intoxicated persons until sober continues to be a common practice in Pauingassi and the Band Constables were doing the best they could in the circumstances and with the options they had available to them.

*Recommendation – All Band Constables who are not peace officers (Special Constables) be provided with the training and authority to detain prisoners in Pauingassi First Nation.*

### **Guards**

[146] Issues exist regarding the recruitment and compensation of guards in the community of Pauingassi. It was clear from the evidence that it is difficult to find people willing to work as guards in Pauingassi. It requires members of the community to work on short, if any, notice and to work through the night in many cases for very little remuneration. The working conditions are often trying to say the least.

[147] Ms Crow described the situation on the night of October 19, 2005. She was woken up by Band Constables Pascal and Fisher at approximately 10:00 p.m. that night and asked to guard for them. She asked them to find someone else but they told her they could not so she agreed to help out. She knew they needed to find someone who had not been drinking. After Ms Owens' death, Ms Crow declined to work as a guard as she found it too difficult to guard people who were intoxicated and behaving erratically.

*Recommendation – The Province initiate negotiations with the Federal government and Pauingassi First Nation to establish a program with appropriate funding for the recruitment of guards to ensure an adequate pool of qualified individuals is available when required.*

[148] Ms Crow testified that she received little, if any, training prior to working as a guard. She said that she was instructed by the Band Constables to check on the prisoners every 10 minutes and record in the log book what they were talking about, what they were doing and what time they slept. This is somewhat inconsistent with the entries in the log book and the evidence of the Band Constables. The log book contains entries every 15 minutes and while it does indicate certain activities such as "still awake", "still talking" and "still kicking the door", it does not contain any information as to what the prisoners were talking about. The Band Constables testified that the checks were to occur every 15 minutes.

[149] The ability of the guard to prevent harmful behaviour by prisoners is not only related to their ability to observe the prisoners. They must also be able to recognize harmful behaviour and take appropriate steps to intervene when necessary.

*Recommendation – All cell guards in Pauingassi be required to attend appropriate training to ensure prisoner safety including suicide prevention and recognition.*

### **Community Policing**

[150] While not necessarily a factor that directly contributed to Ms Owens' death, the Inquest heard evidence that similar problems exist regarding recruitment and retention of Night Patrols and Band Constables.

[151] The need for enhanced First Nation Policing Programs was identified in The Wood Report. As a result, a working group was created to define the role of Band Constables, to establish training standards for Band Constables, to establish

supervision and management of properly-trained Band Constables and to determine whether an enhanced Band Constable Program could be cost-shared.

*Recommendation – The Province continue to work with the Federal government and First Nations to address deficiencies regarding recruitment, retention, standards and training of community policing services.*

[152] "It seems clear from a review of the literature from other inquests on hanging fatalities, that death by hanging can come very quickly, in as little as a minute." (see The Wood Report, paragraph 115) It is unclear whether CPR properly administered could have saved Ms Owens. However, all Band Constables, Night Patrols, Guards and other persons responsible for prisoner safety should have regular First Aid and CPR training to ensure they are equipped to provide basic emergency care when required. The Inquest heard evidence that CPR training is now required for Band Constables and Guards in Pauingassi First Nation.

*Recommendation – Regular First Aid and CPR training continue to be required for all individuals holding the positions of Band Constable, Night Patrol and Guard in First Nations communities in Manitoba.*

## Cells

[153] At the time of Ms Owens' death, guards were told by the Band Constable to check on prisoners every 15 minutes and document what was observed. The check was conducted by looking through a viewing port that was 45 cm long and 19 cm high.

[154] There is some discrepancy in the evidence in terms of what caused the Band Constables to enter Ms Owens' cell. Ms Crow, who was the guard on duty that night, testified that she called the Band Constables to come to cells due to the behaviour of the other prisoner, Geraldine Crow, who was kicking the door of her cell. Mr. Pascal testified that he and Mr. Fisher were called back to cells by Patricia Crow who could not see Darlene Owens in her cell. Mr. Fisher testified that they brought Sam Owens in to be lodged in cells and so had to move Darlene Owens to the other cell with Geraldine Crow. When I consider the testimony of the witnesses in conjunction with the notes recorded in the log book I find that Mr. Fisher's testimony is the more likely description of what occurred. The log book entries made by Ms Crow on October 18, 2005 for the relevant time period are set out below:

10:45 Geraldine still kicking the door  
11:00 Darlene and Geraldine both still awake  
11:15 both still awake  
11:15 both still talking  
11:30 both still awake  
- Sam Owen just came in  
11:45 wake Geraldine

[155] This chronology seems to confirm that Geraldine Crow was no longer kicking the door, that the last time Ms Crow checked on both prisoners they were awake and that Sam Owen came in before Ms Owens was discovered hanging from the cell door.

[156] The Inquest heard evidence that since Ms Owens' death and as a result of the recommendation in The Wood Report calling for mandatory Closed Circuit TV monitoring of all holding cells in Manitoba, cameras have been installed in cells which allow the guards to constantly monitor the condition of prisoners in cells. This is a vast improvement and might have prevented Ms Owens' death considering the steps she appears to have taken including ripping her t-shirt, tying it into a noose around her neck and hanging herself from the door knob.

*Recommendation – Maintain the camera monitoring systems in cells in the Province to ensure they are in proper working order.*

[157] The trailer being used as a detention facility at the time of Ms Owens' death was in good condition. It had been brought from Bissett after the old trailer burned down and was renovated once it arrived in Pauingassi. The renovations were completed in August 2005 two months before Ms Owens' death. After the renovations were completed the trailer was inspected and a lock was repaired.

[158] While the lock on the cell door containing the knob used as a ligature point is still approved for use, the inspection identified deficiencies on the door itself and replacement of the door was recommended. The Cell Inspection Report prepared by Mr. Koch also notes for both cells one and two, "Cannot view entire cell from only viewport in cell door."

[159] On October 11, 2005, Corporal Thompson was in Pauingassi and, when a prisoner was lodged in cells, he conducted an inspection of the cells himself to ensure it was clean and everything was working properly. He noted no problems.

[160] Subsequent to Ms Owens' death, the RCMP (Protective Technical Services) found approximately 30 cells throughout the Province with similar locking mechanisms. While the lock is common on swinging cell doors, it is no longer the current standard. Changes have been made to make the cells safer. Most cells now have sliding doors without knobs. However, there is insufficient room in the trailer in Pauingassi to install a sliding door. The current approved design is a door without a knob that swings out so it can be pushed open if it closes accidentally. According to Mr. Grayson, there is no perfect lock. However, it is clear that the RCMP are concerned with safety of prisoners, members, Band Constables and guards and make every effort to address problems or issues as they arise.

[161] Mr. Grayson testified that when the cell was inspected by Mr. Koch, they were in the process of assessing all cells within Manitoba. He believed this was the first time this had been done in a number of years. He further indicated that any changes or developments in cell construction would not necessarily result in a province-wide retrofit. From his evidence I infer that if the issue relates to safety concerns, the cells would be updated. But, if existing standards are being met, there would be no province-wide review and update. He further indicated that, while he is not responsible for funding, existing resources do not permit regular inspections of cells. His section is responsible for responding to problems brought to their attention.

*Recommendation – The Province initiate negotiations with the Federal government and First Nations to establish regular inspections of RCMP cells to verify they meet current standards and to establish regular reviews of existing standards to ensure they are up-to-date with developments in the industry.*

Dated at the City of Winnipeg, in Manitoba, this 6<sup>th</sup> day of May, 2009.

*“Janice L. leMaistre”*

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Janice L. leMaistre, Provincial Judge

**EXHIBIT LIST**

**Schedule of Exhibits Attached to Provincial Judge's Report**

<b><u>Exhibit No.</u></b>	<b><u>Description</u></b>
1	Drawing by Nicholas Fisher of the cell door lock
2	Autopsy report of Dr. Littman with toxicology report
3	Weather report from Berens River for October 19, 2005
4	Department of Indian Affairs Circular 55 from 1971
5	CPR certificate for Benjamin Pascal dated May 2004
6	Memorandum of Understanding – RCMP and Pauingassi First Nation regarding the use of cell facilities
7	Six booklets of photos – trailer and cells
8	Diagram by Corporal Mangles of trailer and cell number two
9	Statement of Michael Owens
10	Guard's book
11	Band Constable Program Documents