Release Date: July 18, 2025

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***, C.C.S.M. c. F52

AND IN THE MATTER OF: **AARON ROSS, Deceased**

(DATE OF DEATH: September 30, 2019)

Report on Inquest and Recommendations of
Judge Sandra Chapman
Issued this 15th day of July, 2025

APPEARANCES:

Steve Brennan and Jordan Smith, Inquest Counsel
Kimberly Carswell, Counsel for the Winnipeg Police Service
Nicole Beasse, Counsel for the Winnipeg Fire Paramedic Service
Robert Olson and Megan Smith, Counsel for St. Boniface Hospital, Shared Health of Manitoba and the Winnipeg Regional Health Authority

M A N I T O B A

The Fatality Inquiries Act, C.C.S.M. c. F52

Report by Provincial Judge on Inquest

Respecting the death of: Aaron Ross

Having held an Inquest respecting the said death on February 3, 4, 6, 7, 11, 12 and 13, 2025, at the City of Winnipeg, I report as follows:

- The name of the deceased is Aaron Ross
- The deceased came to his death on the 30th day of September 2019
- Cause of death
    1) Immediate cause of death:
        a. Anoxic brain injury due to or as a consequence of;
        b. Complications of cardiac arrest due to or as a consequence of;
        c. Methamphetamine toxicity.
    2) Other significant conditions contributing to death but not causally related to the immediate cause of above:
        a. Physiological stress of struggle and restraint by police.

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

Dated at the City of Winnipeg, in Manitoba, this 15th day of July, 2025.

"Original signed by:
Judge Sandra Chapman
Provincial Court of Manitoba

Copies to:

- Dr. John Younes, Chief Medical Examiner (2 copies)
- Chief Judge Ryan Rolston, Provincial Court of Manitoba
- The Honourable Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act*
- Mr. Jeremy Akerstream, Deputy Minister of Justice and Deputy Attorney General
- Michael Conner, Assistant Deputy Attorney General
- Michele Jules, Executive Director of the Manitoba Prosecution Service
- Steve Brennan and Jordan Smith, Inquest Counsel
- Kimberly Carswell, Counsel for the Winnipeg Police Service
- Nicole Beasse, Counsel for Winnipeg Fire and Paramedic Service
- Robert Olson and Megan Smith, Counsel St. Boniface General Hospital, Shared Health of Manitoba and Winnipeg Regional Health Authority
- Exhibit Coordinator, Provincial Court of Manitoba
- Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba

THE FATALITY INQUIRIES ACT

REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: AARON ROSS

TABLE OF CONTENTS

I. INTRODUCTION

[1] On September 23, 2019, at approximately 12:42 a.m., Winnipeg police officers responded to a well-being call regarding a naked male behaving erratically near the riverbank on Assiniboine Avenue near Kennedy Street. Mr. Ross was observed to be lying on his back yelling randomly. Police officers initially attempted to identify themselves and converse with Mr. Ross who was nonresponsive to them. At one point Mr. Ross jumped up and headed toward the river. Officers attempted to restrain him and he was taken to the ground and handcuffed. Medical assistance had already been summoned due to the concern of excited delirium. Winnipeg Fire and Paramedic Service (WFPS) and an Advanced Care Paramedic from Winnipeg Ambulance Services attended. Mr. Ross suddenly became unresponsive and was resuscitated at the scene. He was transported to St. Boniface Hospital where the return of spontaneous circulation was achieved. He showed no evidence of neurological recovery over the following days and was pronounced deceased on September 30, 2019.

II. MANDATE

[2] On June 24, 2021, an Inquest into the death of Aaron Ross was called by Dr. John K. Younes, the Chief Medical Examiner for the Province of Manitoba. In his letter to the Chief Judge of the Provincial Court of Manitoba at the time, the

Honourable Margaret Wiebe, Dr. Younes directed that the Inquest be held for the following reasons:

1. To fulfill the legislative requirement for an Inquest, as defined in section 19(5)(a) of *The Fatality Inquiries Act*;
2. To determine the circumstances relating to Mr. Ross' death; and
3. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[3] At the time of his death, the applicable section of the *Act* provided as follows:

> Presumption of Inquest:
>
> 19(5) subject to section (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 the death, the deceased person was (i) in the custody of a peace officer; (ii) a resident of 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 Person's Living With a Mental Disability Act*.

[4] The *Act* requires that a written report be provided to the Minister responsible for the administration of the *Act* setting forth when, where and by what means Mr. Ross died, as well as the cause and material circumstances of his death. The Inquest Judge has the discretion to make recommendations respecting changes to provincial laws or to programmes, policies, practises of the government or of public agencies

and institutions, to prevent death in similar circumstances. There is also jurisdiction of an Inquest Judge to extend to recommendations which naturally and incidentally arise out of the circumstances of death.

III. STANDING

[5] Mr. Steve Brennan was appointed Inquest counsel. Assisting him at the hearing was Ms. Rachel Smith. A Standing Hearing was conducted on November 30, 2021.

[6] The Winnipeg Police Service (WPS) represented by their legal counsel Ms. Kimberly Carswell, was granted standing.

[7] Winnipeg Fire Paramedic Service (WFPS), represented by Ms. Nicole Beasse, was granted standing.

[8] Shared Health, St. Boniface Hospital and Winnipeg Regional Health Authority, represented by counsel Robert Olson and Megan Smith, were granted standing.

[9] Ms. Angel Ross as designate for the Ross family was granted standing. Ms. Ross and the Ross family elected to have Inquest counsel ask questions on their behalf as they were unable to retain counsel with respect to this matter. They were advised and did in fact raise issues with the Court when there were specific concerns that they felt needed to be raised.

IV. CIRCUMSTANCES OF AARON ROSS' DEATH

Summary of Witness Evidence

[10] Aaron Ross was 27 years old on September 22, 2019. Aaron was a young man who was described as a loving and caring person. He was loyal to his family and loved spending time with his nieces and nephews. Despite some developmental difficulties, he was well read and had a particular interest in History.

[11] Before Aaron's passing, he was described by his case worker at Turning Leaf as making significant strides, including obtaining his photo ID, exploring the possibility of earning his GED and seeking employment. He was surrounded by a strong support network, including his family and the staff at Turning Leaf. At the time of his death he resided with his mother.

[12] Mr. Ross was last seen on the night in question by his mother Shirley Ross. On that evening Mr. Ross had told his mother that he was going to visit his father and that he would then see her later that night. There is no indication that Mr. Ross was under the influence of any intoxicant at that time and in fact there did not appear to be any prior awareness from anybody in Mr. Ross' circle that Mr. Ross used any type of drugs including methamphetamine. Unfortunately, at some point in the evening it is now known that he did in fact have methamphetamine in his system.

[13] Pauline Charriere, a retired teacher, was present at her apartment on Roslyn Road. Ms. Charriere's apartment overlooks the Riverwalk that runs along the

Assiniboine River. Late into evening and early morning of September 23, 2019, with her balcony doors open she heard yelling and stepped outside to see what was happening. She saw a man standing with his arms out yelling "forgive me, mother forgive me" and other nonsensical things. This man was described as naked. As Ms. Charriere watched she saw the individual, later identified as Mr. Ross, put his arms out at his side and fall backwards with his feet facing the river and his head facing Assiniboine Avenue. When he fell, she heard a large crack. She assumed that he had hit his head on the curb that runs along the Riverwalk. She was about to call the police when she heard sirens so assumed somebody else had called so she did not make a call.

[14] As it turned out, Michael Arsenault, also at an apartment on Roslyn Road was apparently hearing and seeing the same behaviour. He described hearing the yelling and watching this individual take his clothes off. He also heard Mr. Ross saying things like "I believe in you Archangel Michael" and other religious phrases that Mr. Arsenault thought were from the Old Testament. He was concerned that Mr. Ross might be a danger to himself, so he initially called the non-emergency line and kept a watch on him. He too witnessed Mr. Ross fall back and hit his head on the curb of the Riverwalk. According to the Winnipeg Police Service (WPS) call history report, the first call for service was at 12:35 a.m.

[15] Constable (Cst.) Ryan Klassen with his partner Cst. Shea received the dispatch call at 12:42 a.m. on the morning of September 23, 2019. The call history noted that there was a male laying on the riverbank screaming and it initially came in as a wellbeing call, priority two.

[16] Constable Klassen and his partner were on scene at Assiniboine Avenue by the Kennedy Street entrance to the Riverwalk at 12:54 a.m. As soon as they stopped the car to park, they could hear the yelling from the Riverwalk. Before they went down the stairs to the Riverwalk, they requested additional units to attend. They were concerned that this may be an excited delirium situation. Constable Klassen testified that they were aware of the signs to look for regarding what was then referred to as excited delirium, but which is now referred to as an agitated chaotic event. He said they were trained to look for a constellation of events or circumstances which would give rise to that type of situation. In this case they were concerned about the fact that there was the non-stop screaming and yelling of the one person and they were worried that this would be a medical event rather than an event that would require a quick initiative. Constable Klassen and all witnesses at the Inquest testified that the WPS and WFPS no longer use the term excited delirium. These types of incidents are now referred to as an agitated chaotic event.

[17] When Cst. Shea arrived on scene he observed Mr. Ross laying on his back, completely naked with his hands at his sides clenched in a fist. He was screaming

and yelling nonsensically and his eyes were closed. Constable Klassen indicated that they approached Mr. Ross and identified themselves as police officers and that there was no response but just a continued yelling, mumbling and nonsensical things coming from Mr. Ross. Constable Klassen noted that there did appear to be some blood on the back of his head, and that it looked like he had hit his head on the limestone curb of the Riverwalk. Other officers attended to the scene at this time. These officers included Cst. Carswell, Cst. Shurland, Cst. Roy, Cst. Branville, Cst. McRae and Cst. Graffer. At 12:57 a.m. Acting Patrol Sergeant (A/PS) Sine was dispatched to the scene. While enroute he requested an advanced care paramedic to attend as he was concerned that this was an excited delirium event.

[18] The officers testified that while they were standing back from Mr. Ross, observing him, he stood up and started walking towards the river. The officers testified that for the safety of Mr. Ross in case he went into the river and/or any police officers that may have to follow him in, they took hold of him and tried to bring him down to the ground. The officers described Mr. Ross having had an enormous amount of strength at this point which they said is consistent according to their training of an individual in an agitated chaotic event. The officers struggled briefly to get him to the ground. Constable Roy kicked him once or twice in the back of the knee to help bring him down. Within a short period of time, they were able to get Mr. Ross to the ground, face down and handcuffed.

[19] During that time Cst. Shurland took her taser from her belt. She testified that she was the last line of defence before the river. Mr. Ross, however, never got that far, and therefore no taser was deployed. There were no weapons of any kind used on Mr. Ross and the officers together were able to get him to the ground.

[20] Initially while Mr. Ross was on the ground he continued to flail about. Constable Klassen then kneeled on his leg to stop him from kicking. At this point A/PS Sine went back up the stairs to his car on Assiniboine Avenue to get an RIP Hobble so that they would be able to maintain control of Mr. Ross for the WFPS and/or a primary care paramedic who attended to treat him.

[21] At this point, while Mr. Ross was down on the ground, one of the officers noticed that he had stopped yelling and questioned whether or not he had stopped breathing. Mr. Ross was immediately placed onto his back and Cst. Roy intervened and did chest compressions. After four to six compressions he was breathing again so he was placed on his side awaiting WFPS to arrive. Mr. Ross was again speaking nonsensically.

[22] Kevin Hines was the primary care paramedic that attended to the scene. He was dispatched to the call at 1:03:19 a.m. and was enroute to the call at 1:06 a.m. He was at the scene at 1:12:57 a.m. and at Mr. Ross' side at 1:12:59 a.m. Winnipeg Emergency Medical Services with an advanced care paramedic and the medical supervisor arrived at 1:17 a.m.

[23] Mr. Hines testified that he had very little memory as the incident had occurred five years prior to his evidence in court. He did however have his notes from the incident and as a result most of his evidence is contained in his report which is filed as an exhibit in these proceedings. When he arrived, Mr. Ross was stable, and he was able to take his vital signs and was able to place gauze on the injury he had received to his head.

[24] Mr. Hines was unable to calm Mr. Ross down, so it was then that the advanced paramedic Janelle Paluk administered midazolam and haloperidol to Mr. Ross. This assisted sedation then calmed him down.

[25] Once Mr. Ross had calmed down, the police were able to remove the handcuffs, and he was placed onto a backboard. Unfortunately, at this point Mr. Ross stopped breathing and had no heart rate. Mr. Hines immediately started chest compressions. After approximately two minutes of the CPR compressions Mr. Ross' heartbeat returned and Mr. Hines was able to obtain a pulse. He was then ventilated and carried upstairs and placed into the ambulance where he was intubated and then taken to the St. Boniface Hospital. He arrived at St. Boniface Hospital at 1:56 a.m.

[26] At St. Boniface Hospital, Mr. Ross was triaged at 2:05 a.m. and then transferred to the emergency department as a result of experiencing a cardiac arrest. During that time, Mr. Ross was medically treated but from a neurological

perspective there were some concerns. Dr. Mooney, an ICU physician in the Intensive Care Unit at St. Boniface Hospital took over the care of Mr. Ross on September 27, 2019. Dr. Mooney testified that as a result of a clinical examination and then a follow-up MRI, he determined that Mr. Ross had sustained a catastrophic brain injury. He said that the MRI confirmed the evidence of the anoxic brain injury. Dr. Mooney then said he made recommendations to the family to move to a comfort and care based treatment for Mr. Ross and that Mr. Ross succumbed to his injuries on September 30, 2019.

[27] An autopsy was performed on October 2, 2019, at St. Boniface Hospital. In addition to the pathologist and attendant at the autopsy was the technician Angela Wall, Cst. S. Decender and Cst. P. Bevin of the Identification Section of the WPS and senior investigator S. Overman of the Independent Investigation Unit. Mr. Ross' height measured 170 cm and the body weight was 75 kg. There were external evidence of injury which are noted in the autopsy report that was filed by agreement between counsel. The Chief Medical Examiner for the Province of Manitoba, Dr. Younes, testified at the Inquest with respect to this matter. He indicated that many of the external evidence of injury were scrapes or abrasions or small bruises that were consistent with a short struggle with the police officers. There were also three lacerations noted on his scalp which were consistent with the hitting of his head on

the curb of the Riverwalk. These did not contribute to his death. The autopsy and finding were summarized in the report as:

1. Six shallow to partial thickness scalp lacerations concentrated over the occipital scalp, three of which are closed with surgical staples;
2. Numerous healing contusions and abrasions on the torso and extremities;
3. Pulmonary congestion and edema, with foam in the airways and early pneumonia in the lower lobes;
4. Severe hypoxic ischemic brain damage;
5. Toxicology analysis of blood obtained in hospital September 26, 2019, non contributory.

[28] Dr. Younes testified that the cause of death for Mr. Ross was an anoxic brain injury which was a consequence of the complications of cardiac arrest which was due to consequence of excited delirium which was the result of the psychological stress of the struggle and restraint by police and the combination of methamphetamine. This addition of the contributions of "methamphetamine" was included in Dr. Younes' evidence at the Inquest as Dr. Younes had not been made aware of urine results prior to the Inquest. After he had been advised of the results at the Inquest, he was able to be more specific with respect to his findings than the original autopsy report suggested.

V. DISCUSSION OF EXCITED DELIRIUM AND AGITATED CHAOTIC EVENT

[29] A number of witnesses testified at the Inquest with respect to excited delirium and/or agitated chaotic event. The term excited delirium has fallen out of favour with both WPS, WFPS and the medical community. Dr. Younes indicated that the difficulty with the term "excited delirium" from a medical standpoint was that it was a cause of death without further underlying causes being explained. The WPS testified that they stopped using the term excited delirium because it is in fact a medical term and one that they may not be clinically trained to determine. As a result, the term used now to describe the type of situation that Mr. Ross found himself in is an agitated chaotic event.

[30] Basically, an agitated chaotic event is one where an individual's behaviour suggests to the first responders that this could be a medical event, requiring police intervention, only to the extent that they are required to ensure the safety of the individual or the public. All of the witnesses described what factors they look for in determining whether or not the situation unfolding is possibly an agitated chaotic event. They described looking for characteristics like an individual yelling or screaming nonsensical things, individuals talking to themselves, having superhuman strength, often not being dressed appropriately for the weather and sometimes behaviours such as banging on inanimate structures. The medical evidence suggests

that an agitated chaotic event is often as a result of either drug use or a mental health issue. Physiologically it was described that what occurs is that the individual's adrenaline increases to the point that the heart rate increases such that the electrical impulses in the heart can put an individual into cardiac arrest. As a result, the training by the WPS is that police officers should not physically engage with the individual if possible and keep the individual as calm as possible until such time as the medical team can arrive. That can alleviate any further increase in adrenaline. On attendance, a paramedic in some cases can provide oral medication that can calm the individual down and therefore reduce the heartrate. However, that is only available if the patient is able to consent. If the individual is in the state where no consent is able to be obtained, such as Mr. Ross, an advanced care paramedic needs to attend to the scene. They are the only individuals trained to sedate a patient with the sedation used here. If the individual is sedated and calm, the hope is that this will bring the heartrate down and the patient can avoid ultimate cardiac arrest and death. The sooner an advanced care paramedic can reach the patient, therefore, is imperative. Dr. Younes described how difficult it is to know how much of the physical restraint is associated with the increase in adrenaline versus the increase in adrenaline from the use of methamphetamine in the system. He testified that more methamphetamine in the system could mean the less that the struggle could be a contributing factor. Similarly, the less amount of methamphetamine could mean that

the struggle was more of a contributing cause. Dr. Younes said in either case, the more quickly an individual can be chemically restrained, the more quickly his heartrate and blood pressure drops. In this case he said it is possible that if an advanced care paramedic was present prior to the police having to restrain Mr. Ross to perform a chemical sedation, Mr. Ross' outcome could have been different.

[31] During the course of this Inquest we heard evidence with respect to the training of the WPS with respect to an agitated chaotic event as well as the training with respect to the WFPS and paramedics as well. It is clear that all parties agree that the least involvement with the individual from the police service is the best. However, it is important to have as many officers present at the scene as possible because if there has to be an intervention with respect to the individual, that intervention should be quick and involve the least amount of time needed to restrain the individual. It is clear that the police are also trained to request medical attention to the scene as soon as possible in the hope of bringing the individual's heart rate down.

[32] I also was referred to the recommendations that were made in the Viengxay Chommany Inquest Report by my colleague Judge Choy on October 22, 2024. Her recommendations included two target areas including moderation of a person's behaviour and training of such to the WPS. Secondarily she recommended that the WPS and WFPS jointly establish a specialized unit specifically trained to respond to

agitated chaotic events. Judge Choy indicated that dispatching both a WPS officer and a medically trained individual to administer chemical restraint if required would reduce the gap time and transition agitated individuals to care sooner. It is clear that there has continued to be ongoing training and education with respect to understanding agitated chaotic events and the evidence here suggested follow up on the recommendations of Judge Choy.

VI. RECOMMENTATION TO PREVENT SIMILAR DEATH IN THE FUTURE

[33] After considering all of the evidence before me, it is my view that the WPS followed the appropriate protocols in their dealings with Mr. Ross. The police officers immediately noted that they were dealing with a potential agitated chaotic event and as a result called out for further officers to assist, and called out for WFPS. Acting Patrol Sergeant Sine also recognized an agitated chaotic event and also called for an advanced care paramedic upon his attendance to the scene. The officers initially stayed back from Mr. Ross and tried to communicate with him. The officers only intervened with Mr. Ross when his safety was in question and did so in a manner that was the shortest time possible. There is no evidence to suggest that they used any excessive force while restraining Mr. Ross. And all evidence suggests the force used was reasonable in the circumstances. The evidence also suggests the officers provided medical assistance briefly with CPR when they believed it was

required. Mr. Ross was kept calm and on his side in the recovery position until the paramedics and advanced care paramedic arrived. Unfortunately, even with chemical sedation in this case, tragic consequences occurred for Mr. Ross. Judge Choy has previously made recommendations respecting a plan to reduce the gap time between the police response and the medically trained individual attending on scene. I am told those recommendations are being looked into.

[34] I cannot say in this case that the attendance of the advanced care paramedic with the police would have made a difference but possibly it may have. Given that Judge Choy has most recently made that recommendation, there is nothing further at this time that I can recommend, notwithstanding the tragic consequences to Mr. Ross.

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

[35] It is clear that an Inquest Judge has jurisdiction in some circumstances to make recommendations which arise out of the material circumstances of the death which could be in the public interest. Originally the Chief Medical Examiner in this case, Dr. Younes, was unable to say for sure whether or not the underlying circumstance with respect to Mr. Ross' behaviour was as a result of any specific substance abuse because there was no blood sample analyzed that would have given Dr. Younes that information. Further, although there was a urine sample taken which did note that

methamphetamine was found in Mr. Ross' system, that the urine sample result never made it to the Chief Medial Examiner's office. Originally there was a concern that maybe a sample of blood had gone missing and that this sample would have assisted Dr. Younes at the time of autopsy.

[36] As a result, four witnesses were called at the Inquest to look into what happened to the blood sample that apparently went missing after the arrival of Mr. Ross at the hospital. All the medical evidence indicated that even if that blood sample had not gone missing, it would not have assisted Dr. Younes. It actually became clear that the sample that went missing was a duplicate of an earlier sample. Likely then it would not have been analyzed in any event. More importantly however, is that it would not have been analyzed for any quantitative value of any drug in Mr. Ross' system, nor would it have been analyzed with respect to methamphetamine.

[37] However, when Dr. Younes testified he asked the Court to consider recommending that, in a situation where a person is admitted in what appears to be an event like this, the emergency doctor requests a sample of blood be taken upon admission. Further, he requested that the blood be stored in a "grey stopper" vial. He requested that the doctor note that the sample is to be kept for analysis until such time as the individual is recovered and released from hospital or in the event of death,

released by the Chief Medical Examiner's office. Dr. Younes indicated that it would be significant to him in determination as to the cause of an individual's death.

[38] Angela Ross, who spoke on behalf of the Ross family, also asked that the Court consider making this recommendation. Ms. Ross told us how difficult it had been for the family to understand how this incident had occurred given that no one in the family had any previous knowledge that he had been involved in the ingestion of any drugs.

[39] As a result of Dr. Younes' recommendation, evidence was called on behalf of Shared Health of Manitoba, Winnipeg Regional Health Authority and St. Boniface Hospital. There were concerns raised to this recommendation by Dr. Mooney, an ICU physician in Intensive Care at the St. Boniface Hospital, Dr. Jasmine Heuring who is the Director of Diagnostic Services for Lab Operations at Health Sciences Centre, St. Boniface Hospital, Misericordia Hospital and some smaller hospitals as well, and Dr. Grierson who is an emergency physician, medical director for WFPS, an advisor to the WPS on medical matters and Chief Medical Officer for Emergency Response Services.

[40] There were numerous concerns raised with respect to the recommendation as requested by Dr. Younes. Those concerns had to do with the ethics of a doctor requesting blood for a purpose other than medical care, how to obtain blood from a patient then without their consent, how the doctors would be able to determine what

patients this should be taken from and what patients not to take it from, how that blood would eventually be stored and where it would be stored amongst others. The evidence disclosed that further discussions would be required before such a recommendation could be made.

[41] As a result, and after hearing all of the evidence and discussions with counsel, I do make the following recommendation with respect to this matter:

> That a working group, to include the Chief Medical Examiner, leadership for clinical care, leadership for emergency medicine, leadership for clinical toxicology, medical leadership for emergency response services and pre-hospital care, leadership of laboratory and diagnostic services, and a medical ethicist, be established to examine patient care events resulting from consumed drug toxicity and determine the feasibility of ensuring a reliable blood sample is available for toxicological analysis at the time of autopsy recognizing the public interest of such an evaluated process.

[42] As indicated earlier, Dr. Younes had also testified that he had not received the urine sample analysis at the time of autopsy. It is apparent that had he received it, this sample would have confirmed methamphetamine in Mr. Ross' system. The lack of confirmation did not affect Dr. Younes' findings as to the cause of death, but it did add hardship to the family of Mr. Ross which is very unfortunate. It was not

made clear to us in the evidence as to why urinalysis was not provided. However, I was told that Dr. Grierson would look into why those results were not available to Dr. Younes at the time of autopsy presumably to ensure that this type of miscommunication does not occur in the future. I make no formal recommendation in this regard.

VIII. CONCLUSION

[43] Mr. Ross' untimely death was a tragic incident. Unfortunately, these types of incidents are more and more prevalent in the Province of Manitoba. The evidence in this Inquest indicated that there are up to 1,000 calls per month for service on agitated chaotic events. According to Dr. Younes, every month in Manitoba we have 15-20 deaths due to "stimulant toxicity". The training of police officers and fire paramedics and advanced paramedics has increased over the years since Mr. Ross' demise. However, even back in 2019 policies were in place to deal with these matters and in my opinion the police officers and the paramedics all performed in accordance with the relevant policies and their training. Their actions were reasonable in the circumstances.

[44] The call out for service was based on the evidence of the eyewitnesses in this matter for a well-being check. The police officers determined within minutes of arriving at the scene that this was likely a medical incident and called for backup assistance as well as medical intervention. Their training had taught them that the

more officers the better in that if the individual required restraint, a restraint would have to come as quickly and smoothly as possible so as to not agitate the individual. Further, their training taught them that the sooner medical assistance was available, the quicker sedation could be applied if required and again the safer it would be for the individual involved in this particular matter.

[45] The officers attended to the scene and attempted to converse with Mr. Ross. It was clear that he was unresponsive to them and therefore they did not initiate any involvement with him until they felt that his safety was at risk. It was only upon Mr. Ross getting up and heading towards the river that the officers used soft hand control to bring him to the ground. When they were concerned that he may not be breathing they immediately gave him chest compressions and kept him on his side in this recovery position until the medical authorities attended.

[46] Once the paramedic and the advanced care paramedic were on scene and realized that the agitation was such that it required sedation, the advanced paramedic followed her protocol and provided the sedation to Mr. Ross. When they realized that he went into cardiac arrest, they immediately provided medical intervention and Aaron Ross was stable upon entering into the ambulance.

[47] Unfortunately, as a result of the cardiac arrest Mr. Ross was denied the oxygen his brain required and subsequently, he passed away.

[48] In this case there is no evidence that the police or medical personnel could have done anything more than they did. Given those circumstances there are no recommendations I can make to prevent similar deaths from occurring in the future. However, as previously indicated, I can make a recommendation that may be in the public interest, to assist the Chief Medical Examiner in these matters.

"Original signed by:
SANDRA CHAPMAN, P.J.

Appendix A to the Inquest Report in the Death of Aaron Ross

WITNESS LIST:

1. Pauline Charriere
2. Michael Arsenault
3. Constable Ryan Klassen
4. Constable Jean-Guy Roy
5. Constable Maurice Banville
6. Constable Tamara Shurland
7. Detective Thomas Sine
8. Dr. John Younes
9. Kevin Hynes
10. Nicki Kiezer
11. Constable Ian Bale
12. Jasmine Heuring
13. Dr. Mooney
14. Dr. Grierson
15. Shirley Ross, by statement
16. Angel Ross, by statement

Appendix B to the Inquest Report in the Death of Aaron Ross

EXHIBIT LIST

1. Notice of Inquest by Chief Medical Examiner
2. Media Notice for Today's Hearing
3. Inquest binders – Three volumes and black/red USB drive
   (See Table of Contents to Inquest binders, Tabs A to D, as Appendix C)
4. Agreed Statement of Facts in the Fatality Inquiry of Viengxay Chommany
5. Bound Photo Book
6. USB containing video audio statement of Brendan Fast and Janelle Paluk
7. One-page letter by Nikki Keizer
8. Laboratory records, materials retention policy
9. Statement by Angel Ross

Appendix C to the Inquest Report in the Death of Aaron Ross

INQUEST OF ROSS, AARON

INDEX

53 IIU Officer notes- Muir
54 IIU Officer notes- Moncrieffe
55 IIU Officer notes- Overman
56 IIU Officer notes- Plessis
57 Consent for release of personal health information Ross, Aaron
58 Medical records from St. Boniface Ross, Aaron
59 Medical records from Fire Paramedic Service Ross, Aaron
60 Fire Paramedic Service request form
61 Fire Paramedic Service personal health access form- Ross, Aaron
62 CPIC Transaction Results
63 Interview request form for Officer Klassen
64 Interview request form for Officer Shea
65 Email/Annotator notes and map from civilian Jorge Hernandez
66 Audio statement and photos from civilian Pauline Charriere
67 Audio statement/ hand written notes and photos from civilian Mike Arsenault
68 Audio statement from civilian Shirley Ross
69 Audio Statement and photos form civilian Marisa Backe
70 Audio statement from civilian Ronald Ross
71 Interview plan and annotator notes from civilian Steve Bradley
72 Interview plan /annotator notes and map from civilian Jenelle Paluk
73 Interview plan/ annotator notes and map from civilian Mike Bastl
74 Annotator notes and interview plan from civilian Kevin Hynes
75 Annotator notes and interview plan from civilian Brendan Fast
76 Interview plan and annotator notes from Officer Sparrow
77 Interview plan and annotator notes from Officer Carswell
78 Interview plan and annotator notes from Officer Shurland
79 Interview plan/ notes and annotator notes from Officer Banville
80 Interview plan and annotator notes from Officer Roy
81 Interview plan and annotator notes from Officer Sine
82 Annotator notes from Officer Shea
83 Annotator notes from Officer Klassen

Winnipeg Police Disclosure .....Tab B

Tab
84 911 Audio
85 Air 1 Recordings
86 Radio Audio
87 Audio Recording Action Report
88 WPS Call History 2019-09-23
89 Autopsy- Photographs
90 Use of Force Report Initiated 2019-09-30
91 Use of Force Report 2019-09-23
92 Forensic Ident Report- Officer Aessie- 2019-09-30
93 Forensic Ident Report- Officer S. Desender & P. Bevan- 2019-10-02
94 Forensic Ident Request Form- 2019-09-23
95 Narrative- Officers Carswell & Shurland 2019-09-30
96 Narrative- Officers Klassen & Shea 2019-09-30
97 Narrative- Officers Kroeker & Olson 2019-09-23
98 Narrative- Officer T. Sine 2019-09-23
99 Narrative- Officers Sparrow & Beaver 2019-09-23
100 Officer Notes- Banville
101 Officer Notes- Carswell
102 Officer Notes- Desender
103 Officer Notes- Graefer
104 Officer Notes- Klassen
105 Officer Notes- Kroeker
106 Officer Notes- Roy
107 Officer Notes- Shurland
108 Officer Notes- Sine

Chief Medical Examiner Disclosure .....Tab C

Tab

109 Autopsy Report from Dr. Younes 2019-10-02
110 Fatality Inquires Act Autopsy Authority
111 File status medical examiner cases
112 Inquest Request form
113 Medical examiner investigator notes
114 Medical certificate of death Ross, Aaron
115 Neuropathology report
116 PDIN dispensing history
117 Preminary autopsy report
118 Protocol- Provision of OCME file to Crown counsel
119 Report of Medical examiner
120 Shared health diagnostic imaging report
121 St. Boniface Biochemistry reports
122 St. Boniface hospital discharge summary
123 St. Boniface hospital history and physical
124 St. Boniface progress notes
125 Toxicology report
126 Preliminary report of death
127 WFPS patient care report

Winnipeg Fire Paramedic Service & Shared Health Disclosure.....Tab D

Tab

128 Patient Care Report (AARON ROSS)
129 EMS Incident details
130 Rescue Company Report
131 Neurological Assessment Record
132 Adult Ventilatory Support Record
133 Ongoing Adult Ventilatory Support Record
134 Cumulative fluid Balance Record
135 24 Hr Fluid Balance Record (intensive care flow sheet)
136 Authorization to Review and Record of Disclosure to Chief Medical Examiner Office (Mar 12, 2020)
137 Inpatient Demographics Sheet
138 Formal Notice of Correction Patient Documentation
139 Authorization to Review and Record of Disclosure to Chief Medical Examiner Office (Sept 30, 2019)
140 Notification of Death
141 Emergency Treatment Record
142 Triage Assessment Score
143 St Boniface Admission Agreement
144 St Boniface General hospital Order Requisition (sept 24, 2019 16:48 Hrs)
145 Medication mixture Log sheet
146 Prolonged Portable ICMS OTT EEG Report
147 St Boniface General hospital Order Requisition (sept 24, 2019 15:12 Hrs)
148 WRHA Cardiac Sciences Routine Record
149 EKG Rhythm Strips
150 Respiratory Sheet
151 St Boniface Medical Records Part 3- Integrated Progress Notes
152 St Boniface Medical Records- Laboratory Results
153 St Boniface Medical Records- Emergency Care and Assessment Records
154 Vital Signs
155 St Boniface Medical Records- Electronic Patient Record (visit)
156 Miscellaneous