RELEASE DATE: August 29, 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: An Inquest into the Death of Celine Samuel
(Date Of Death: February 1, 2020)

Report on Inquest of
Judge Doreen Redhead
Issued on this 26th day of August 2025

APPEARANCES:

Ms. Theresa Cannon, Inquest Counsel
Ms. Danielle Morrison & Ms. Stacey Soldier, Counsel for the Family
Ms. Erica Haughey & Ms. Samantha Gergely, Counsel for the RCMP
Mr. Christian Monnin, Counsel (as he then was) for the City of Thompson Fire and Emergency Services
Ms. Nicole Smith & Mr. Kevin Tabachnick – Counsel for the Northern Regional Health Authority
Mr. Robert Olson & Ms. Megan Smith, Counsel for Shared Health

M A N I T O B A

THE FATALITY INQUIRIES ACT

REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: CELINE SAMUEL

Having held an Inquest respecting the death of Celine Samuel on March 11, 12, 13, 14, 15, 2024 in Thompson, Manitoba and April 8, 9, 10, 2024 and January 29, 30, 31, 2025 in Winnipeg, Manitoba.

The name of the deceased is Celine Samuel.
The deceased came to her death on the 1st day of February 2020 in Thompson, Manitoba.
The deceased came to her death by the following means:
Acute/subacute subdural hematoma, blunt force trauma and a fall.

I hereby make the recommendations set out on the attached Schedule 2.

Attached hereto and forming part of my report is Schedule 3 listing all Exhibits required to be filed by me.

Dated at the City of Thompson, in Manitoba, this 26th day of August 2025.

"Originial signed by:"
Judge Doreen Redhead
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, Chief Medical Examiner
2. Chief Judge Ryan Rolston, Provincial Court of Manitoba
3. The Honourable Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act*.
4. Jeremy Akerstream, Deputy Minister of Justice & Deputy Attorney General
5. Michael Conner, Assistant Deputy Attorney General
6. Michele Jules, Executive Director of Manitoba Prosecution Service
7. Theresa Cannon, Counsel to the Inquest
8. Erica Haughey and Samantha Gergely, Counsel for the RCMP
9. Danielle Morrison and Stacey Soldier, the family of Celine Samuel
10. John Martens, for the City of Thompson Fire and Emergency Service
11. Nicole Smith and Kevin Tabachnick, Counsel for the Northern Regional Health Authority
12. Robert Olson and Megan Smith, Counsel for Shared Health
13. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba

M A N I T O B A

THE FATALITY INQUIRIES ACT

REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: CELINE SAMUEL

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I. Holding of Inquest

[1] On February 1, 2020, at approximately 19:41 hours, the Thompson Royal Canadian Mounted Police (RCMP) were dispatched to the McDonald's Restaurant for a report that an intoxicated female had fallen off a stool and required assistance. Emergency Medical Services (EMS) also attended. While there, the RCMP and EMS met with Celine Samuel. EMS conducted an assessment of her. She was cleared for detention and lodged into Thompson RCMP cells. At 22:49 hours, Corporal Stuckless conducted cell checks and observed that Ms. Samuel was on the floor of Tank 3 and that her chest could be seen rising and falling.

[2] Approximately 19 minutes later, at 23:08 hours, cell guards conducting their physical cell checks could not determine if she was breathing. Community Safety Officer (CSO) Jonna McDonald entered the cell to check and noticed she was not breathing. Cardiopulmonary resuscitation (CPR) was initiated. EMS attended the scene but resuscitation attempts were not successful. She was declared dead at 23:35 hours.

[3] On September 24, 2021, the Chief Medical Examiner (CME) for the Province of Manitoba notified the Chief Judge that an Inquest into Ms. Samuel's death would be called pursuant to s. 19(5)(b) of *The Fatality Inquiries Act* because at the time of her death, Ms. Samuel was in custody at the Thompson RCMP cells. The purpose of the Inquest is to:

1. determine the circumstances related to Ms. Samuel's death; and
2. determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[4] At the time of the standing hearing, Judge Rambow, who was a resident Judge in Thompson, had conduct of the Inquest. On April 12, 2022, the following parties applied for, and were granted standing at the Inquest:

- Nicole Watt, daughter of Ms. Samuel;
- The RCMP;
- The City of Thompson Fire and Emergency Services;
- The Northern Regional Health Authority; and
- Shared Health.

[5] With Judge Rambow's transfer to The Pas, Judge Redhead was re-assigned conduct of the Inquest.

[6] The change in judge assignment did not impact how slowly this matter proceeded to hearing dates. During the time of Ms. Samuel's death, the world was in the throes of the COVID-19 pandemic, which had a significant impact on the scheduling and hearing of

matters. Many court sittings were cancelled. At that time, the Thompson Court Centre had fifteen (15) circuit court locations, as well as all the matters from the City of Thompson. All hearing dates in every location became extremely backlogged. At the direction of the Chief Judge at the time, Inquest dates that were not yet set, were delayed, to allow the Court to focus on clearing the backlog of criminal matters. Inquest counsel was diligent in requesting that the matter be set but would not be offered hearing dates until well over two and a half years after Ms. Samuel's death. The family waited for this Inquest for a very long time.

[7] Once hearing dates were made available, counsel for the family, by letter dated May 2, 2023, requested that the Court consider expanding the scope of the Inquest to examine whether systemic factors, such as unconscious bias, discrimination, and structural racism, played a role in the death of Ms. Samuel.

[8] After several pre-trial conferences and after hearing submissions of counsel on January 15, 2024, it was decided that the scope of the Inquest would be expanded to determine: if Indigenous specific racism and bias in health care either played a role or impacted the events leading up to Ms. Samuel's death and if so, what can be done to prevent Indigenous specific racism and bias from causing or contributing to future deaths in similar circumstances.

[9] The Inquest began hearing evidence on March 11, 2024, and on January 31, 2025, the Inquest closed. Evidence was heard over a period of eleven (11) days, with sixteen (16) witnesses called to testify. In addition to the witness testimony, four binders of exhibits were tendered, which contained numerous tabs and subtabs and hundreds of pages. In addition, video surveillance (no audio) of the McDonald's Restaurant, as well as an audio of the dispatch of the initial Manitoba Transportation Co-ordinator Centre (MTCC) call, were filed as exhibits.

[10] The report will begin with background information on who Ms. Celine Samel was, followed by a summary of evidence, the issues arising from the evidence and finally ending with recommendations.

II. Background Information on Celine Samuel

[11] Agnes Samuel, the older sister of Celine, provided information about her family and her sister. Her parents, Elizabeth and Abraham Samuel, were residential school survivors and they had 12 children. Ms. Agnes Samuel is the oldest sister in the family and Ms. Celine Samuel was the third oldest.

[12] The family was originally from Brochet but relocated in 1988 to Lac Brochet to get away from the addiction issues in the community.

[13] Ms. Agnes Samuel had fond memories of the family's time in Brochet. On the last day of school, their dad would take them out on the land where they would spend most of the summer, before school started again in the Fall.

[14] Ms. Celine Samuel would later leave Lac Brochet because she could not go to school there. While attending school, she met the father of her children and started her own family.

[15] Ms. Celine Samuel was only 44 years old when she passed. She spoke Dene but was not fluent. She was a loved and cherished mother, grandmother, sister, aunt, and friend to many. She was thoughtful and would remember every member of her family's birthdates. She had a lot of friends; on the streets, in God's Lake Narrows, Brochet and Lac Brochet. She was well known for being outspoken. She was a small person but could speak for herself. She was never violent. She had a supportive immediate family and they would help each other where, and when, they could. Her passing has left a void that can never be filled.

[16] Ms. Agnes Samuel looked out for her sister and always worried about her. It was hard to see her struggling. They were very close and losing her has been very hard. She misses her and has fond memories of her. She remembers a song she liked to listen to.

[17] For a time, Ms. Celine Samuel lived in God's Lake Narrows, Manitoba, where the father of her children was from. She raised her children there and lived in the community. She tried to understand the Cree language. She and her partner would eventually separate, and the end of the relationship was a difficult time for her. She did not consider God's Lake Narrows her home anymore and she left the community. She used substances to cope and ended up unhoused on the streets in Thompson.

[18] When Ms. Agnes Samuel came to Thompson, she would always look out for her sister. She maintained contact with her mainly through Facebook. Healthwise, she believed her sister would take her medication and would speak for herself.

[19] Ms. Agnes Samuel believed that the COVID-19 pandemic caused a lot of harm to relationships and that people started to isolate from one another.

[20] Two weeks before Ms. Celine Samuel passed away, Ms. Agnes Samuel came out for her mom's medical appointment. They had heard that she was medivaced to Winnipeg but they were not sure which hospital. They had also heard she was not dressed for the weather. Ms. Agnes Samuel asked her why she left and she told her she was uncomfortable, she felt like she was strapped down and didn't like it. Ms. Celine Samuel was still wearing a hospital gown when she went to the boarding home. Ms. Agnes Samuel bought her some clothing. She was not sure how she was cleared to leave or if she was given any medication. She constantly worried about her sister. She would always tell her not to worry about her and that she would seek help, especially when she was seizing. The last time she would see her sister alive was at her aunt Bernadette's.

[21] Ms. Agnes Samuel recommended that when a woman says that something is wrong, intoxicated or not, health care providers need to listen. A woman knows when something is wrong with her body. Health care professionals need to examine and follow up on concerns better. When a person is taken by an officer, the officer needs to listen better. We all need to look out for one another.

III. Review of the Evidence

[22] The Inquest heard from an RCMP member and the paramedics who responded to a dispatch at the McDonald's Restaurant (McDonald's) on the evening of February 1, 2020.

Constable Hobbs

[23] At 19:41 hours, Constables Hobbs and Maheu, members of the RCMP, attended to McDonald's in response to the dispatch that an intoxicated female had fallen. They arrived on scene at 19:45 hours.

[24] Constable Hobbs was a new member at the time. He had recently completed training and was working with a field coach. On the day he interacted with Ms. Samuel, it was his second week working in Thompson and only his third shift on the job. As he was new to the job, he did not know Ms. Samuel but believed other officers had previous interactions with her.

[25] Constables Hobbs and Maheu entered McDonald's through the main entrance. Ms. Samuel was sitting but seemed unsteady. She was pleasant. When asked if she was aware of what was going on, Constable Hobbs responded that her understanding was slow. He could smell alcohol on her breath and her speech was slurred. He wanted EMS to assess her because medical concerns are always the first concern of the officers. She could walk but the officers assisted as she walked out the door.

[26] Shortly after the RCMP members arrived, they conducted a "10-10" check, where they look for Canadian Police Information Centre (CPIC) entries and outstanding warrants. Ms. Samuel had no entries or outstanding warrants.

[27] As the evaluation of Ms. Samuel took place with the two paramedics, Constable Hobbs waited by the door. He could not recall if one paramedic was communicating with her more than the other.

[28] After she was cleared by the paramedics, she was free to go but Constable Hobbs had concerns for her safety because he did not have a person to release her to. As a result, he detained her under the Intoxicated Persons Detention Act (IPDA).

[29] While Ms. Samuel was in the vehicle, she told Constable Hobbs that she had a seizure. Counsel for the family asked if Constable Hobbs specifically recalled the words she used to

describe any medical conditions, and he said she had used multiple words but what he recalled was "seizures and Winnipeg".

[30] Constable Hobbs was asked if he was told she had fallen but he did not believe he was made aware of this. He was also of the belief that EMS would have done their assessment as to her injuries and he had no reason to believe that she was not properly assessed by EMS on February 1, 2020.

[31] He was asked how he would assess whether a person should be taken to the hospital or lodged, he responded that he would look at whether the person you are considering lodging could answer basic questions, such as name or date of birth. If she could not answer basic questions, she would have been taken to the hospital for an assessment. He believed that an individual can be lodged under the IPDA if they pose a greater risk to himself, or for safety reasons.

[32] Once they arrived at the detachment, Constable Hobbs completed most of Ms. Samuel's C13 (Binder 1, Tab 11). The personal belongings section would have been completed by the guards.

[33] Less than four hours after her lodging, Ms. Samuel would be found unresponsive in the cell. Constable Hobbs discovered Ms. Samuel's death when he was directed to the area of tank #3. An individual had just been arrested and his field coach was showing him how to facilitate the right to counsel. CSO McDonald was with Ms. Samuel and he noticed that she had saliva around her mouth and nose. Constable Hobbs immediately began CPR. The cell panic alarm may have been hit and a lot of officers started to arrive. EMS took over CPR once they arrived on scene.

[34] The medical emergency button is a big red button by the cell guard desk. Once it is activated, it is very loud and unmistakable. Cell guards can not enter the cells once the medical emergency button is activated, but CSOs can.

[35] Persons lodged under the IPDA can fluctuate and are sometimes impacted by weather conditions. There are generally two to three individuals arrested under the IPDA a day, and there can be as many as ten. There are fewer people picked up in colder weather. Weather can also factor into the decision to lodge an individual. With extreme cold temperatures, intoxicated people left outside can develop hypothermia. If an individual has an address to go to, and there is a responsible sober adult to watch the person, the RCMP will drop them off at that address.

[36] Things have changed in terms of where officers can take individuals who are too intoxicated to care for themselves. The Wellbriety Centre, located on Princeton Drive generally accepts individuals that are intoxicated. The Centre is open 24 hours a day, 7 days a week. At around 10 or 11 p.m., they generally start to turn people away.

[37] When asked if he thought the Wellbriety Centre has helped in terms of assisting the officers in dealing with intoxicated persons, he agreed that it has because they can take more people than the previous homeless shelter. Constable Hobbs was not aware of the type of monitoring, if any, that is done at the Wellbriety Centre.

[38] He has taken a course on reconciliation but did not recall taking any training on Missing and Murdered Indigenous Women and Girls (MMIWG).

[39] With respect to staffing of the RCMP in Thompson, Constable Hobbs testified that the Thompson detachment is usually short-staffed. Training is allowed if "time permits".

Devin Pugh

[40] Devin Pugh worked for the City of Thompson for two and a half years as a primary care paramedic and firefighter in September of 2019.

[41] He completed his training in Alberta. He has not taken any cultural awareness training.

[42] When attending to a call, there are always two ambulance attendants and one person drives and the other focuses on the patient.

[43] In terms of staffing levels in Thompson, the minimum amount of staff is five, and six with the dispatcher. There is a high turnover of staff in Thompson. There is a Captain and four workers that respond to a call. The ambulance gets more calls for service than the fire truck. As of February 1, 2020, there were 556 calls for service in Thompson.

[44] He believed it would be helpful to have the information for the patient's medical history available to the treating paramedics. He was not sure how this could happen but agreed that this would be beneficial.

[45] When the audio dispatch from MTCC, which was believed to be unrecoverable, was in fact recovered, Mr. Pugh was re-called to testify. The main issue to be re-examined was whether the paramedics were made aware of the reason for the 911 dispatch.

[46] Mr. Pugh confirmed that he was one of the attending paramedics that day after video surveillance from McDonald's was played in court.

[47] He was asked by Inquest counsel if he could remember what was happening at that time, and he responded that when the paramedics arrived at McDonald's, the RCMP were making contact with Ms. Samuel. He could see in the video that he is writing things down and he assumed it was name, birthdate and any information the patient could provide at that time. He could not recall if he spoke to anyone else at McDonald's restaurant regarding Ms. Samuel's fall.

[48] After they left McDonald's they went into the ambulance. He could be seen speaking into the radio in his hand.

[49] Mr. Pugh was driving and was writing things on his glove. He believed because he was the closest to her at the time, he wrote down the information. He was getting information from whoever could provide it. Ms. Samuel was able to walk out of the restaurant by herself.

[50] Candace Compton was the dispatcher working that day and she is based in Thompson. Mr. Pugh confirmed that he can obtain information from either dispatcher. There is a dispatch sheet that he would not have seen prior to responding to the call. His only source of information at that point of time would have been the dispatch.

[51] When the six audio snippets from MTCC were played in court, Mr. Pugh confirmed that it was his voice on the audio. In it, dispatch advised that paramedics were required because an intoxicated person had fallen at McDonald's.

[52] When the second ambulance dispatch was played, a person at McDonald's can be heard telling dispatch that the person was intoxicated and fell two times. The person calling also provided the following information about the incident: the fall happened about 10-15 minutes ago; she had fallen off a regular height stool; the person who had fallen was approximately 35 years old; that she was alert, awake and breathing; and there was no visible bleeding. The dispatcher asked what part of her body hit the floor when someone else at the McDonald's restaurant interrupts and the question goes unanswered.

[53] Mr. Pugh responds "Burntwood 702", which confirmed the ambulance unit number and that he received the dispatch. He confirmed he has a radio as a paramedic and that his partner would have also had one.

[54] He was asked the meaning of "pre-alert", and he explained that it means they are still gathering information and then will update you with additional information when it is available. In this case, they received the pre-alert notification and that was all that was received.

[55] He testified that he did not receive any information about her falling. He confirmed that the information was provided in the dispatch when the recording was played for him. When he responded "copy" in this situation, it meant that he received the transmission. He confirmed that according to the sheet, the information would have been passed on to him. Last year when he testified the first time, he did not recall that he received any information that Ms. Samuel had fallen.

[56] In his training, he could not recall if it was recommended to talk to the 911 caller. He did not ask the RCMP officers if they had spoken to the 911 caller or anyone else at

McDonald's. When asked if it would have been a good idea to speak to the 911 caller, he responded that it is a tool that they can use if they know who the caller is, and they have the contact information. The paramedic cannot always trust that the person who called is going to stay on scene. When he attends to a call, he relies on information provided by the patient because sometimes the caller is not always accurate in the information. The caller could be unaware or unsure of things and dispatch gets things mixed up and could hear things incorrectly. As a general guideline, the paramedic will go off the information received from the patient and not necessarily the information received from dispatch.

[57] It is preferable to speak to the patient as they are usually the best source of information. This would also be true if the patient is intoxicated, as long as the person is able to speak clearly, follow general questions and respond appropriately. This would also be true, even if the patient is suspected of having a head injury. If the paramedic does not have any reason to believe that the person is debilitated to any state and is able to have a good conversation with the person, then the patient is the best source of information. For an individual that is going to be lodged and is suspected of being intoxicated, Mr. Pugh still believed that the patient can provide the best information to the paramedics on her medical condition.

[58] His paramedic training provided basic symptoms on a subdural hematoma (SDH). They are trained to look for deficits but one of the main symptoms is dilation of a person's pupils. He does not have training on symptoms related to a re-bleed of a SDH.

[59] The ambulance Patient Care Report (PCR) dated February 1, 2020, was completed by Brad Schneider. Mr. Pugh confirmed that it did not state that Ms. Samuel had a fall. He was also not aware if Mr. Schneider was aware she had a fall. On the report, it was noted that Ms. Samuel's hands were shaking and he does not recall if anyone asked her about this.

[60] He confirmed that the letters "ETOH ++" found in the ambulance report refers to alcohol. The two pluses may be a standard reference to intoxication and that's how Mr. Pugh would reference it if he had completed the report. He cannot speak to this specific reference on this report because Mr. Schneider completed it.

[61] When someone has fallen, different assessments may be done such as looking at gait and pupil size. If the paramedics had been told of multiple falls and hitting her head one or more times, that would have been relevant information. He confirmed that those questions were not asked of Ms. Samuel. Mr. Pugh believed that if the paramedics were told that she had fallen twice and hit her head both times, that Mr. Schneider's assessment of her would have been different. If he had known that she had fallen, the assessment may not have necessarily changed but the decision to transport to the hospital may have

changed. If he had known that she had been transported to Winnipeg for a SDH, how they treated her would probably have changed.

[62] Mr. Pugh understood that the reason the paramedics were called to the McDonald's was to assist the RCMP to medically clear a person for lodging.

[63] He was asked if he had been made aware that Ms. Samuel had fallen, whether that would change the care she received. He responded that it would all depend on the type of fall. The paramedics were advised that she had fallen but they were not told about the multiple falls and the pre-existing head injury. For someone who has fallen, the paramedics will ask if the person is competent to speak to EMS, if she is clear and vitally stable, then they can rely on that information. The paramedic will assess based on the information provided. In this case, Ms. Samuel was asked if there was any reason she would like to go to the hospital and during the conversation, she said she did not want to go to the hospital. If he had known about the pre-existing head injury, that she had fallen and specifically hit her head, he would have taken her to the hospital.

[64] When asked if he would gather information from RCMP, he replied sometimes he would, and sometimes he would not. Sometimes they share information depending on who arrives on the scene first. He was not aware what information the RCMP get on dispatch.

[65] After the ambulance was cleared, the ambulance went on to respond to another call at Boston Pizza. Mr. Pugh confirmed that even though Thompson is busy, he would not rush through an assessment and would make sure that everything is considered before leaving that situation.

[66] Mr. Pugh is no longer employed at Thompson EMS and is now employed in Winnipeg as a firefighter. He has not worked as a paramedic in Winnipeg.

[67] Recognizing that he was not employed as a paramedic in Winnipeg, he was asked by Inquest counsel to comment on the volume of calls received in the two cities; Winnipeg and Thompson. He responded that Thompson is busy and very understaffed. In his last year in Thompson, the ambulance alone responded to approximately 8000 calls in one year. If you divide that between two ambulances, that is 4000 calls each. There is an ability for staff to work overtime but that is only if staff are available and willing to go in, the end result being that calls for service back up. Winnipeg is also very busy, but there are more resources in Winnipeg.

[68] When asked how much overtime he has been requested to work while in Winnipeg, he replied that it is a bit of a slower season right now, but he might expect a call once every two weeks. While he was working in Thompson, he was called daily to work overtime.

[69] In his new role in Winnipeg, firefighters have a computerized system to see what units are responding to calls, either Winnipeg Police Service (WPS) or firefighter. While he can see how many units are being dispatched, he may not necessarily know the reason the units have been dispatched.

[70] Recommendations he would suggest are having more information available to paramedics and not having to rely on a radio transmission. It is helpful to have something in writing and to be able to read it. More staffing is needed in Thompson but he is aware that Thompson is going through a change in how they hire EMS staff. In Thompson, individuals are hired as a firefighter and paramedic. He was asked why individuals would not want to get both certifications to do both and he responded that it is a lot of work to have and maintain both licences.

Bradley Schneider

[71] Bradley Schneider was the other paramedic working with Mr. Pugh when they were called to McDonald's. He was employed by the City of Thompson as a fire/paramedic for five years and all of his work experience at that point in time, was in that position. His level of training was higher than that of Mr. Pugh, as he was employed as an intermediate care paramedic, which has a larger scope of practice than a primary care paramedic.

[72] The paramedic program in Thompson works in pairs of two in a 10 hour day shift and 14 hour evening shifts, with 4 days off.

[73] There were 8000 calls for service in one year when Mr. Schneider was in Thompson. IPDA calls are a significant part of that number and the majority of those IPDAs are Indigenous. There were a lot of opportunities for overtime in Thompson. Each year, he worked hundreds of hours of overtime. Thompson is very busy with the volume of calls.

[74] In terms of how the paramedics divide their duties when responding to a call, the driver does all the radio communication and does the initial vital sign contact. The other paramedic does the documentation, collecting the information and the nature of the call. Collecting information can be from the patient or bystanders, and is specific to each call.

[75] The paramedics receive calls for intoxication quite often in Thompson. The assessment does not change, regardless of who makes the call. The paramedics cannot transport patients anywhere other than the hospital and cannot drive anyone to the homeless shelter.

[76] In the old dispatch system, there was direct dispatch to a person in Thompson. That person resided in Thompson and was familiar with Thompson. The initial caller would have direct contact with the dispatcher. The dispatcher is physically stationed in the same building as the paramedic.

[77] In the new system, there is a dispatcher in Thompson but there is also a dispatcher in Brandon. The initial call would still be taken in Thompson but only a certain amount of information would be taken, and then the call would be transferred to the MTCC by phone. Often times the initial caller would get frustrated and hang up or would leave out information. There was also a disconnect with the people calling because the dispatcher was in Brandon and was not familiar with Thompson. It is an inefficient and backwards system. There was a whole other system you had to go through to access the paramedic.

[78] The numbers "911" can not be dialed to contact EMS in Thompson. The call would first go through the provincial RCMP line and then would have to be directed to the appropriate service provider. The number to reach emergency services in Thompson is a 10 digit number.

[79] The communication for EMS is all by radio and Thompson still uses a paper PCR.

[80] The calls that come in from dispatch are sometimes completely unrelated to what is going on in a situation. The paramedics are taught that they need to determine the chief complaint and the nature of the call themselves, when they arrive on the scene.

[81] The pre-alert is an MTCC system, where information would be collected and then transferred. When a matter is pre-alert, the paramedic is supposed to wait until the pre-alert is over. Sometimes the pre-alert can last 5 to 10 minutes added response time, which he found was unacceptable. Mr. Schneider preferred just to attend to the call right away, as long as it was safe to do so.

[82] As it was a long time ago, he could not specifically recall the reason the paramedics were called on February 1, 2020, but they would have been able to hear the reason for the dispatch from the radio.

[83] Mr. Schneider did speak with the manager of McDonald's but he does not remember the discussion. He could not recall if he received the specific information that someone had fallen.

[84] When he made contact with Ms. Samuel, she was able to speak, was alert, oriented and was able to answer questions. McDonald's is busy and is a public place and he wanted to get her into the vehicle so the assessment could be done in private.

[85] He confirmed that the PCR indicated that the call was not an emergency. There are 5 codes and priority 1 or 2 would have made it an emergent response where lights and sirens would have been used. With the other codes, 3, 4 & 5, the paramedic would attend but without lights and sirens.

[86] For Ms. Samuel, Mr. Schneider confirmed that he recorded the chief complaint as general illness. It would be inappropriate to write the chief complaint as someone being

intoxicated so it was recommended to write general illness. He cannot remember where he learned this, but he does recall being taught that. If he had information that she had fallen and hit her head, then the chief complaint and mechanism of injury would have been trauma.

[87] Mr. Schneider's notes indicated: Arrived on scene with RCMP. Smelled of ETOH ++. In no visible distress. Ambulatory with a steady gait. Slight hip pain. Her hands were shaking. No chest pain. Strong equal bilateral pulses. No shortness of breath. No abdominal pain. No nausea or vomiting. DCAP – deformities, contusions, burns, lacerations. There was a head to toe assessment. There were none of those noted. Vital signs were stable. She was alert to person, place and time.

[88] He was asked to comment on the "++" after ETOH and he was not entirely sure what it meant but it was just another way to describe having consumed more than one alcoholic drink. He could smell alcohol on Ms. Samuel and she also told him she had been drinking. Her hands were shaking but it could have been because she was nervous or withdrawing from alcohol. Sometimes when people are under the influences of substances, they do not respond appropriately to questions, but Ms. Samuel was able to.

[89] In terms of what questions he would have asked Ms. Samuel upon contact with her, he stated that he would have asked about past medical history or concerns and would have tried to make it easy to understand. He would have asked her what she was doing that day at McDonald's but he does not recall if he asked any of those questions. He writes down the answers to the questions but does not write down the question asked. His training is to focus on the symptoms at the time and everyone has different symptoms of illnesses.

[90] In terms of assessments of patients, it does not make a difference if the call comes from the public or the RCMP; every patient is assessed the same.

[91] He believed at the time that the reason the paramedics were called was for her to be cleared for lodging. He understands now that the reason he was called was because she had fallen.

[92] He recommends a local dispatch for EMS in Thompson because it is much easier to have a local person taking the initial call. People get angry when the call gets transferred from Thompson to Brandon because the transfer process is frustrating and often times, things need to be repeated.

[93] If there was a 911 number to call, it would be much easier to access this. MTCC adds another layer to calls and complicates things. Clear concise communication is important for paramedics.

[94] If the paramedic had access to the patient's current medication that would be helpful.

[95] He had not taken any Indigenous specific training and did not take any TRCC training. He had no knowledge of Treaty 5 or the adhesions.

IV. McDonald's Restaurant Video Surveillance

[96] A copy of the video surveillance, without audio, from McDonald's, labelled Lobby Door/Kiosks was tendered as an exhibit (Binder 1, Tab 1). In addition, a review with timestamps was completed by Inquest counsel as a court aid. At the request of the family, the video was not played in court.

[97] The video covers approximately two hours of surveillance while Ms. Samuel was at the McDonald's on February 1, 2000. For the first hour of the video, Ms. Samuel can be seen sitting on a stool and goes off the video screen, where she leaves and returns. The second hour she can be seen falling off the stool two separate times. The first at time stamp 26:58 and the second at time stamp 38:31.

[98] Just before the first fall, at time stamp 26:44, a person wearing an orange hoodie can be seen placing a McDonald's bag in front of Ms. Samuel. As Ms. Samuel turns around to look at the individual, she can be seen falling off her stool at time stamp 26:58. She falls backwards and her head hits the floor. She is quickly assisted back onto the stool by two males.

[99] Regarding the second fall, at time stamp 38:31, she appears to be repositioning herself on the stool when she falls a second time. The table blocks the view of whether her head hit the floor for the second fall. Individuals attempt to help her back onto the stool but she is not assisted back onto the stool until timestamp 41:40. At time stamp 45:53, the RCMP and paramedics arrive on the scene and the manager can be seen pointing out Ms. Samuel to them. While interacting with the RCMP, she remains on the stool. At time stamp 47:36, she is taken out of McDonald's. She walks out on her own and is not assisted by anyone.

V. Ms. Samuel Found Non-responsive

Jonna McDonald

[100] Jonna McDonald was employed by the City of Thompson as a Community Safety Officer (CSO) for four years ending in June of 2023. She was working at the Thompson detachment when Ms. Samuel's death was discovered.

[101] Monitoring of detainees while lodged is done by cell guards. CSOs can also at times be in the detachment and have more advanced training than cell guards. While on duty, CSOs have peace officer status.

[102] Her shifts were typically day shifts, Monday to Friday. In February 2020, she had been in that position for one year. She had lived in Thompson all of her life but had recently moved.

[103] Her training for the position involved three weeks in Brandon, Manitoba and her only medical training was first aid. CSOs work in pairs and there were only three employed at the time of Ms. Samuel's death.

[104] Ms. McDonald's duties included enforcing city by-laws and looking for public intoxication. She was also responsible for checking responsiveness of prisoners while in cells. How busy the guards were would depend on money available in the community and whether it was the weekend.

[105] Ms. McDonald was working the day Ms. Samuel was lodged and was asked to check on her as a cell guard was concerned that she was not breathing. When Ms. McDonald entered the cell, she saw Ms. Samuel lying face down on her stomach and she looked like she had urinated herself. She shook her and got no response. She tried a pressure point behind her ear and again got no response. When she moved Ms. Samuel onto her back, she noticed she was very pale and was not breathing. She advised the cell guard, who was standing by the door, to call EMS and the members to the cell area because Ms. Samuel was non-responsive.

[106] Constable Hobbs was the first to arrive and immediately started chest compressions while they waited for EMS. Corporal Stuckless and Constable Patel entered the cell area with an AED and the AED pads were applied to Ms. Samuel's chest but no shock was advised. Constable Patel took over administering CPR until EMS arrived. Once EMS arrived, they took over and continued with CPR but resuscitation attempts were not successful.

[107] In her dealings with Ms. Samuel, she was always coherent. She was not sure if anyone mentioned that Ms. Samuel had seizures, that she had fallen, or that she had a SDH.

[108] She knew Ms. Samuel and met her when she started working in the position. She had no issues communicating and she was always nice and kind. She would try and interact with people and see how things were going. She knew nothing about her medical history but she was aware she was Indigenous.

[109] At the time the homeless shelter was small and not well resourced. Most people lodged under the IPDA are Indigenous and have alcohol and substance abuse issues. There are inadequate resources in Thompson for those struggling with addiction issues.

Kelly Laybolt

[110] Kelly Laybolt was a cell guard at the RCMP detachment and had been in that position since 2019. He took on a supervisor role in 2020. He was also working the evening Ms. Samuel was found unresponsive in her cell.

[111] Cell guards are provided in person training when they start their position. He is expected to follow all rules of the RCMP and treat everyone with respect. Ongoing annual training is required and must be repeated every six months.

[112] The difference between cell guards and CSOs is that cell guards help with the monitoring of prisoners and must do checks every 15 minutes. CSOs have more training, can process the individuals coming in and can enter the cells. Cell guards can not enter the cells.

[113] The cell guards are responsible for monitoring prisoners to ensure health and safety. They are also responsible for cleaning the cells and the sinks and toilets within the cells.

[114] Cell guards work in pairs in 12 hour shifts. The area where the cell guards work is approximately 25 to 30 feet by 25 feet. The cells are set up in a "U" shaped pattern.

[115] Cell tanks are on one side and cells have a bench, where the cell tanks do not. Cells are used for individuals who have criminal charges and can sometimes be used to lodge prisoners for court.

[116] Three cell tanks are used for individuals lodged under the IPDA. Tanks 1 & 2 are typically used for males and tank 3 is used for females. Youth are separated from adults.

[117] Each cell has a camera, without audio, and cell guards watch the prisoners on camera and are looking for two consistent breaths or prisoner movement. If something out of the ordinary is suspected, an officer will be called. If there was ever a situation where he had to reach an officer immediately, he could call the watch commander or call over the radio and any available member would respond.

[118] Every person lodged has a prisoner report or a C13 filled out, and the tank that they are placed in is entered on the report and the monitoring sheet. Any personal effects are recorded. The C13s are kept in a clipboard. Some C13s are for prisoners for court and some are for IPDAs, but every lodged person has a C13.

[119] Information on prisoners are kept in two black binders by the cell area. Binder one contains information on the person, when they were lodged and his fingerprints. Binder two contains notes on prisoners including what time they were lodged, when they were released and any observations noted while they were lodged. This information is also recorded in a yellow book. The sheet can hold information for approximately 15 individuals. There is also

a sheet that shows when a prisoner is lodged under the IPDA and when he should be released.

[120] There is a new book called the residency log to track where individuals are from. This information has just started to be tracked about six or eight months ago.

[121] If there are over 25 prisoners lodged, a third guard is called in to work. There are also other situations where a third guard is called in, such as when there is a person lodged who is suspected to have committed a homicide. This happens once or twice a year.

[122] A cell guard would be notified of any illness with persons lodged and that is communicated at shift change. It would also be noted on paper. There are mandatory 15 minute checks and sometimes checks are done more frequently, for example if a prisoner was vomiting. He encourages checks at 13 minutes and tells guards that 15 minutes is the maximum. He follows by watching for the 2 breaths rule, vigilantly. Whether checks are done more often really depends on the situation. The watch commander also does physical checks every 3 to 4 hours and sometimes this is recorded in Black Book 1. Some physically go in and rouse prisoners.

[123] All guards must be familiar with all directives with respect to assessing prisoner responsiveness and seeking medical assistance when required. He does not use the prisoner responsiveness chart as he is not allowed to enter the cells and this directive involves direct contact with prisoners (Binder 1, Tab 16, iii).

[124] He knew Ms. Samuel but did not know how many times he had interactions with her. He never had any issues with her. He was aware that she was susceptible to seizures, and this was recorded on the computer. This was also communicated verbally by the RCMP. He agreed that someone who is prone to seizures and had just fallen should be continuously monitored. He wanted to place her in a tank with another female so someone could alert the guards to any issues. He thought she would be safer with someone else in the cell with her.

[125] Mr. Laybolt had no training in dealing with seizures and his only training is in standard first aid. He would not be able to tell if an intoxicated person is having alcohol induced injuries. He believed that Ms. Samuel was about a five on the intoxication scale. When asked if he believed she was sober enough to take care of herself, he responded that he was not able to make that determination. When she mentioned seizures, he did not ask her any other questions about her medical issues.

[126] He discovered Ms. Samuel was not breathing when he was watching her left side and could not see a consistent breath. He also noted that she had urinated. He asked CSO McDonald to check on her and watched as Ms. Samuel could not be woken up. Ms. McDonald told him to call EMS. Mr. Laybolt went to the desk, hit the red button and called EMS.

Members immediately responded and performed CPR until EMS arrived. Mr. Laybolt stayed at the desk and started recording.

[127] He believes more culturally appropriate social supports are needed in the community and more CSOs to remove individuals from situations, especially in the evenings.

[128] He thought it would be beneficial to have a medically trained person on site to help with detainees and any medical issues. A list of questions to ask prisoners would also help.

[129] He believed the Wellbriety Centre has been a good resource for Thompson and there are less people lodged in cells.

Corporal Julie Stuckless

[130] Corporal Julie Stuckless, an 18 year member of the RCMP, was stationed in Thompson as watch commander from 2016 to 2021.

[131] She supervised between four and eight members and was also in charge of cell guards. The CSOs also work in the Thompson detachment.

[132] Cell guards are required to do quarterly checks on prisoners. Prisoner checks are done mostly from outside the cell and looking through the window slot into the cell. The cell guards are to ensure that all prisoners are breathing and that all prisoner checks are documented.

[133] There could be information to pass on (a pass over) to on coming cell guards, and if so, there is a box to check on the bottom of a sheet. The cell guards also communicate any concerns to other cell guards.

[134] Every shift, she looks at all of the C13s to make sure that they are properly filled out.

[135] An intoxicated person is to be woken up every four hours. To do this, guards will use their keys or bang on the door. When Corporal Stuckless did her check on Ms. Samuel at 22:49 hours, she could see that Ms. Samuel's chest was rising and falling.

[136] The watch commander is not always in the detachment because they could be on the road. On the day Ms. Samuel passed, there were 17 people in cells. They are often trying to sleep and they get angry when you wake them up.

[137] When the guards noticed that Ms. Samuel was not breathing, the protocols were followed.

[138] Paramedics have been called to the Thompson cells for concerns of sick prisoners on many occasions.

[139] If a person is extremely intoxicated, they will be lodged at Thompson cells. Sometimes the person has nowhere to go because family do not want them at home. If the

person is disruptive or violent, the person will not be taken to a residence because of the behaviour.

[140] She believes that she had dealings with Ms. Samuel in the past but she was not certain. She was not sure if she had a residence in Thompson as she had no personal interactions with her.

[141] Thompson has 24 hour policing and staffing levels have always been an issue. She was not sure of the vacancy rate but there were always vacancies due to sick leave, paternity leave, maternity leave and other leaves. The detachments are very short-staffed in the North and members from headquarters are being placed in positions in the North to assist.

[142] In 2014 the Thompson detachment was short members. In 2016, while she was watch commander, she was short members and had to deny vacation leave and members were very upset.

[143] She has taken online training in Aboriginal and First Nation Awareness training in 2014, Cultural Awareness training in 2020 and United Against Racism training in 2022. One in-person course was offered but she has never taken it as it was difficult to take courses that were not mandatory because there had to be a limited number of members scheduled for a shift to be able to participate in non-mandatory training.

[144] The previous homeless shelter was a good resource for the RCMP because the RCMP would not have to lodge if there was a person they could be released to or if they had somewhere to go. If a person is intoxicated, has nowhere else to go and the shelter is full, the RCMP will lodge. This is particularly so in inclement weather. The warmer the weather, the more people would be lodged under the IPDA.

VI. Ms. Samuel's Attendance at Thompson General Hospital Emergency Room in the Weeks Prior to her Death

Dr. Amadu

[145] Dr. Amadu has been a physician since 2005 and has worked at the Thompson General Hospital (TGH) since 2007. He has also worked in the emergency department since 2005. He also has experience working in Gillam, Leaf Rapids and Lynn Lake, all within the province of Manitoba.

[146] He is the head of emergency room (ER) and is still practicing but also has an administrative role. No one is an employee, and the physicians are on contract or are locum doctors. He also provides on call service to the nursing stations for referrals for individuals living in First Nation communities. Any referrals are faxed to the emergency department. Recommendations are made and if resources are not available in the community, the patient

will be medivaced to Thompson, if Thompson has the ability to provide resources not available in the nursing station or smaller hospitals. The doctor working the ER could also receive up to 50 calls a day from the nursing stations.

[147] The TGH ER is staffed 40 hours a day for three doctors in 10 hour shifts. The volume of patients seen is equivalent to Brandon, the second largest city in the Province of Manitoba. Brandon also has a neurologist and other resources that Thompson does not. Selkirk also has a radiologist.

[148] A physician working in the TGH emergency room on the 11:00 p.m. to 8:00 a.m. shift, works alone. There is only one doctor available during that time. There are six nurses working at night and seven nurses working during the day.

[149] The busiest times for the ER tend to be between 5:00 p.m. and 6:00 p.m., midnight and 1:00 a.m. or 2:00 a.m. for individuals who need to be medivaced. Whether or not a plane is available depends on the pilot duty hours and whether the pilot is legally able to fly according to the transport regulations. Sometimes pilots are "dutied" out, which means that they have to rest in order to be able to fly again.

[150] The TGH ER has outgrown its space. It is too small to address the number of patients that are seen on a daily basis. There are insufficient resources to deal with addictions and mental health issues.

[151] With respect to access to patient records, the clinic uses Accuro, and these can not be reviewed within each other, and some doctors have access and others do not. If a person accesses an individual patient's chart, a warning box pops up advising that it is a breach to look at a patient's medical records if you are not providing care to them.

[152] The alcohol withdrawal flow sheet (Binder 1, Tab 23) is not used anymore. A new protocol was developed to address complications related to alcohol withdrawal. It is similar but is more comprehensive and is two pages long.

[153] Dr. Amadu knew Ms. Samuel. She was very quiet and soft spoken. He was aware that she struggled with addictions and complications related to that. He knew she was originally from Lac Brochet.

[154] He was asked why a CT scan was not ordered when he treated her to rule out a further brain bleed and he responded that a CT scan has 400 times the amount of radiation of an X-ray. Radiation cause cells to change and can lead to cancer and he wanted to limit her exposure to something that could harm her. He also agreed that any brain bleed is significant.

[155] He was asked about reference to a seizure medication in Ms. Samuel's chart that was never filled. He responded that if he came across that, he would have found out what the medication was and would have re-written the prescription.

[156] He was asked how he would gather medical information on a patient if he could not get it from the patient herself, he responded that he would ask the person who brought them in. If there is no family member or person with her that could provide information you need, you could get phone numbers and contact collaterals that way. Some of the population has social media and sometimes you can contact that way also.

[157] He does not like to label patients "frequent fliers" because it creates a stereotype from the doctors in the medical system.

[158] Education on Indigenous people is mandatory for all doctors and is voluntary for Agency doctors. He recently completed a course on Indigenous specific racism in October. It was a weekly course that he did online, and it was a voluntary program.

[159] He has in the past interacted with Manitoba Keewatinowi Okimakanak (MKO) for advocacy support for patients.

[160] In terms of recommendations, he suggested that Thompson could use a bigger space in the ER given the volume of patients they see everyday. Also, doctors need more resources and supports to refer patients to, in order to address addictions and mental health issues.

Dr. Sarker

[161] Dr. Sarker has been a family doctor in Thompson for 14 years. He has previously worked in Bangladesh. He has taken courses but is not sure if he took any course on implicit bias or racism.

[162] He works in the TGH ER. It is small but very busy. There are 10 beds in the department and it also receives patients from the nursing stations. More treatment beds would help in treating patients. At night, there is only one doctor working in the ER. The doctor in the ER also takes phone calls from the nursing stations. It is a demanding position as you have to manage the volume of patients and calls. He can see anywhere from 80 to 110 patients a day in the ER.

[163] There is a sub-intensive care unit where the patient is not sick enough for intensive care but is not stable.

[164] There is 24 hour on call coverage for a radiologist and a lab technician for blood work.

[165] There is a shortage of nurses and nurses are often exhausted from working long hours.

[166] In terms of accessing a patient's medical records, all emergency rooms in Manitoba use a program called Emergency Department Information System (EDIS). Some physicians have access to EDIS, and others do not. The physicians in the ER do not have access to Federal Health medical records (any nursing stations).

[167] He has in the past had contact with MKO regarding issues with patients and travel back to home communities. In this particular case (not related to Ms. Samuel), a person was medivaced from his home community and there were issues getting the patient back home. Contact was made with a representative at MKO to assist and the issue was resolved. He believes this is a good program. However, the position is not staffed 24 hours 7 days a week and sometimes issues arise when there is no worker to assist the hospital.

[168] Since 2020, Indigenous Elders have been working at the hospital and provide services when requested by the patient.

[169] In January of 2020, Dr. Sarker treated Ms. Celine Samuel on two occasions. He did not remember treating Ms. Samuel.

[170] On January 11, 2020, Ms. Samuel attended the TGH and was seen by Dr. Sarker. When Ms. Samuel arrived at TGH ER on January 11, 2020, she received a triage score of 1 (Binder 2, Tab 28, page 11), which is the highest priority. Ms. Samuel was brought to TGH ER because she had multiple seizures in a short period of time. While she was at the ER, she seized five times. He wanted to see if she was bleeding or if there was a tumor, and ordered a CT scan of her head and consulted with the neurosurgeon. He was not able to thoroughly review her medical history because it was a life-threatening condition. She was medivaced to Winnipeg and the flight came right away. They were fortunate to get a flight right away because sometimes they are not able to.

[171] He found out she left Health Sciences Centre (HSC) after she was sent on January 11, 2020. He could not find out what happened as he would not have been notified if she left before her treatment was complete. He suspected that she may have needed surgery to drain the blood as there was a 1.1 centimeter hematoma and that is a considerable amount of blood.

[172] He had access to Ms. Samuel's CT scan but he did not have access to notes of the doctor. He had also seen a repeat CT scan.

[173] He was not familiar with the document "leaving against medical advice" and was not aware that she had left HSC before her treatment was completed. The TGH ER doctor does not have the ability to follow up with a patient.

[174] Dr. Sarker treated Ms. Samuel again January 26, 2020, at 2:34 a.m. (Binder 2, Tab 28, page 5.) This time, he recognized her when he saw her. Dr Sarker told Ms. Samuel not to fall or bang her head as it could cause a brain re-bleed.

[175] He would not have known about the other ER visits. Dr. Sarker ordered another CT scan and did not see any notes from Dr. Bilko, the neurosurgeon. He was asked about the delay in the note from Dr. Bilko and he explained that sometimes the doctor is busy and not able to do the note right away. Cardiologists usually do their reports right away and reports of specialists are usually done within a week.

[176] The treatment for hematoma usually involves monitoring for 24 hours to watch for a brain bleed. Sometimes hematomas can get better on their own. If there was a seizure or vomiting, a new CT scan would need to be done. CT scans have a lot of radiation, can cause harm to the human body and that is why they are not done unless absolutely necessary.

[177] Dr. Sarker has in the past been asked by the RCMP to clear a detainee for lodging. He has previously signed the medical clearance forms. The physician can not give any patient information to the RCMP. With respect to the term of "medical history", Dr. Sarker confirmed that medical history means the history from that day or night.

[178] RCMP are frequently called to assist the ER for disruptive, intoxicated patients and Form 4 and 14 *Mental Health Act* matters. Form 4 are for high risk for self-harm or other mental heath issues and Form 14 are to bring a high risk patient into the ER, where they are a risk to himself or to others.

[179] In terms of recommendations, Dr. Sarker was of the view that given the volume of patients the Thompson ER see on a daily basis, it would be beneficial to have more than one ER physician working in the evening. In addition, more detox beds are required to deal with the amount of patients that present at the ER with addiction issues. Typically, these patients come in the middle of the night and if there is a bed available, they will be kept until sober and discuss treatment options. Most times, there are no beds available. Orthopedic follow ups are also currently done by the ER and it would assist with patient volume if these follow ups could be done somewhere else, other than the ER.

VII. Northern Patient Transport, Paramedic Training, 911 System in the North, Medical Records, CPU and MSP Protocols

Doctor Grierson

[180] Doctor Grierson is the Chief Medical Officer (CMO) for emergency response for Shared Health and has been in that role since 2019. He has 25 years of experience working at HSC, with five years as a resident.

[181] He is also responsible, at a high level for the co-ordination and management of patient care in terms of patient transport, by ground or air. When a patient is transported from home to hospital or transfers between hospitals, he would oversee the medical care that is provided. That would include overseeing other physicians that work in the system or directly with the frontline paramedics. He also oversees, at a high level, the protocols that were written to guide the paramedics in their care and practice. In his role with the fire paramedic service in Winnipeg, he is one of the physicians that works directly with the frontline paramedics. In his CMO role, he in a sense oversees his own operations. He is the medical director for the Winnipeg Fire Paramedic Service and he has been in that role since 2002. In this role he would author the care maps and protocols to the paramedics and oversee quality improvement initiatives and review equipment periodically. He would also oversee medical policies and protocols specifically for Winnipeg. In his Shared Health role, he oversees his own program as well as other physicians.

[182] Shared Health has service purchase agreements for paramedic staff that covers Winnipeg, Thompson and Brandon. Shared Health directly operates frontline EMS services in four zones North, South, West and East and those would correlate with Northern Health Region, Southern Health Sante Sud, Prairie Mountain Health and the Interlake Eastern Regional Health Authority.

[183] There was a service purchase agreement between Shared Health and the City of Thompson from 2019 that came up for renewal during the pandemic, which is currently being negotiated. The City of Thompson has given notice that they are stepping away from providing EMS but currently there is no agreement and negotiations are still taking place. Doctor Grierson emphasized that even if the funding arrangement does change, services will not be compromised.

[184] To be a paramedic there are standards of education and licensing requirements that are required across the country. These standards would be established by the National Occupational Competency Profiles that were created by the Paramedic Association of Canada in 2011. Those are the standards that the educational institutes are held to when they are accredited. Once you have been through an accredited program, you can write a national licensing exam. Once you pass that exam, you can obtain a paramedic license from each of the individual provinces. The skills are intended to be transferrable so that the training is very similar regardless of which province you are in. Once you have a license in one province, it is straightforward to obtain a license in another province.

[185] In December of 2020, in the province of Manitoba, paramedics became a self regulated profession overseen by the College of Paramedics of Manitoba. There are approximately 21 regulations under *The Health Professions Act*, nine of which, would apply to paramedics. The College of Paramedics has outlined the scope of practice for each level

of the paramedic program. The introductory level is an Emergency Medical Responder (EMR) that is a licensed paramedic level. The next level is a Primary Care Paramedic, an Advanced Care Paramedic and then a Critical Care Paramedic. Each one of those levels has a set scope of practice.

[186] One of his roles is to ensure that the treatment protocols and the care that the paramedics provide when they arrive on scene is up to the medical standard of practicing and that it is the standard of care you would get in the hospital.

[187] He teaches that the chief complaint has to be what the patient tells you is wrong with them. He also teaches his paramedics not to use intoxication as the chief complaint.

[188] In the spring of 2021, online medical support was made available to paramedics. Paramedics can access the service by calling Brandon where four medical doctors can provide medical advice. There would be one physician on call 24/7 and paramedics could access by calling MTCC in Brandon and would request online medical support and they would be immediately connected by telephone. If paramedics had any questions about patient care, they could call this service. The paramedic could provide symptoms of patients and seek guidance of what the medical condition may be or seek destination advice in which facility would be more appropriate given the suspected illness. Sometimes it may be in a cardiac arrest and the paramedic would seek guidance on whether to continue with resuscitation. This is a new service where any paramedic outside of Winnipeg can call and access that support. In the fall of 2024, that phone call was transitioned into a Virtual Emergency Care and Transfer Resource Service (VECTRS) to streamline the process. There would be times when the paramedics called MTCC and the call operators would be busy answering 911 calls. The VECTRS model allows the paramedics more ready access to a physician. In this model, there is an advanced care paramedic available 24/7 who handles the phone calls initially and in the VECTRS centre, there is an experienced trained emergency physician that can offer clinical advice. One of the four physicians are on call as a back up to support the service.

[189] In terms of record keeping, Thompson still uses a paper system while Winnipeg went to an electronic paper system in 2006. The electronic Patient Care Report (PCR) ensures accuracy and legibility because the electronic form is sent to the hospital. Most times it gets there on time.

[190] STARS and Lifeflight use electronic PCRs because it is critical care transport.

[191] A frontline paramedic does not have access to past medical history. Even with an electronic PCR, access is limited. Access to an electronic patient report, i.e. hospital records in Winnipeg, is also very limited and restricted due to privacy legislation. This information is also stored in a different area and is separate from electronic PCRs.

[192] HSC has a hybrid system. Admissions are electronic and handwritten records are sometimes not accessible.

[193] There is a transition happening on the information systems in hospitals. There is a plan to move Manitoba to an electronic system and this is currently being worked on with Shared Health and Digital Health. Manitoba is the only province that still uses a paper based system. There is a plan to move to electronic PCRs in the next 24 months and the roll out will be gradual to some parts of the province first.

[194] Air ambulance travel, or Lifeflight, is used for the most serious illness or injury. For basic air ambulance travel, there is an expectation for a friend or family member to travel with the patient. There are some conditions and the escort must be in good health himself. There are sometimes limitations based on the equipment the provider needs to transport. There are also weight restrictions on flights that factor in, and this factor is up to the pilot flying the medivac.

[195] Dr. Grierson was familiar with an Inquest that took place as a result of a detainee at Main Street Project (MSP). In 2005, Mr. Bighetty was taken into the MSP under IPDA. Staff at MSP called the ambulance because he had an intercranial hemorrhage. At the MSP, a nurse or nurse practitioner is on site. Dr. Grierson has been involved in, and was working through, all the recommendations of that Inquest. As he worked through implementing the recommendations, he wondered who would be the best suited at the time to provide that support as there was not a lot of nurse practitioners available. He hand picked a person who previously worked as a paramedic because he felt like he had to identify a specific skill set for this position.

[196] As a result of another Inquest in 2009, he was able to secure funding for a position to do primary care and support work for all the individuals lodged at MSP.

[197] In April of 2020, there would have been a change in how individuals were processed due to the COVID-19 pandemic.

[198] There was recognition for the need of an advanced care paramedic at Central Processing Unit (CPU) 24 hours a day, 7 days a week.

[199] The community paramedic position manages a caseload of patients, either IPDA or other patients. The community paramedic documents on the electronic PCR and this was beneficial. They can also provide some other basic skills, such as wound care. They had a base level that was the same as a paramedic but had other skills.

[200] The initial intake assessment at CPU could be conducted by ambulance or fire department. If the person is transferred IPDA, there is another secondary assessment. The

assessments determine if the detainee needs to be taken to a hospital instead of being lodged.

[201] There are four teams that work four days on and four days off. Dr. Grierson notes that one paramedic has seen 25% of these patients and that everyone must be evaluated.

[202] The Winnipeg Fire Paramedic Service has a Patient Care Protocol for adults that outline factors that need to be considered in clearing an intoxicated person for admission under IPDA (Binder 3, Tab 45 Tab E).

[203] The Winnipeg Fire Paramedic Service Community Paramedic Protocol for adults outline the assessment that needs to be undertaken when clearing an intoxicated person for lodging at MSP (Binder 3, Tab 45, Tab F).

[204] There are two levels of monitoring at MSP. One involves opening the door to look inside at the individual. The other involves the staff entering every 15 minutes and this monitoring happens around the clock.

[205] The MSP can also test blood sugar and has a breathalyzer machine available. If an individual appears to be impaired but does not have any alcohol in his system, then he is sent to the hospital because they do not know what is going on with the person. A person can not leave MSP until he is sober.

[206] There is a discharge protocol for MSP (Binder 3, Tab 45, Tab G). The discharge report states that an intoxicated person can only be released to a family member or law enforcement (Binder 3, Tab 45, Tab H).

[207] The Paramedic Protocol at CPU is specific to CPU only (Binder 3, Tab 45, Tab I) All individuals brought to MSP are not in custody but are impaired to some degree. At the CPU, the person is in custody but may not necessarily be impaired.

[208] Since 2016, approximately 2.2% have been sent to the hospital for further care. CPU sees only a small percentage of those individuals.

[209] There are similar programs in Alberta and the western provinces and there is a plan to expand the program to Brandon. The Brandon program will be similar to MSP.

[210] Regarding quick access to EMS North of 53, he noted that this is not easy. Any person that wants to access EMS, must call a 10 digit number.

[211] In this particular case, Dr. Grierson noted that the reason for the 911 call is a fall, but not every fall requires an ambulance. Like with anything, every case is fact specific.

[212] He was of the view that both paramedics have a roll to play in patient care when at the scene and that when a paramedic is assessing a patient, history and pre-existing conditions are all important. Sometimes vital signs are helpful.

[213] Regarding symptoms of a SDH, Dr. Grierson has seen many patients with this condition and not everything is black and white. He has seen patients with this condition in a coma. Some patients could have no symptoms and the condition is discovered by accident during a test. With this type of condition, there is a wide spectrum of symptoms and sometimes it is apparent and sometimes it is not. A person could have headache, imbalance, nausea. The shaking of the hands could be a symptom of a re-bleed. As a person ages the brain shrinks and atrophies. A person at risk of a SDH is at risk for another SDH until the injury heals.

[214] The only way to confirm a brain re-bleed is with a CT or MRI scan. Radiation from tests is always a concern and one CT scan is equivalent to two months of normal environmental radiation. As with anything, there are risks and benefits. The risks can be explained to a competent person and if they do not have the capacity, you can act on their behalf (implied consent).

[215] If a person has a re-bleed of a SDH it would trigger a consultation to a neurosurgeon. Fluid shifts in the brain and sometimes that normal re-shifting can result in a re-bleed, without further trauma.

[216] He recommends a project similar to MSP be available in Thompson.

[217] Counsel for the City of Thompson Fire and Emergency Services asked Dr. Grierson about the challenges of medically clearing a patient in a high-risk population. In the Sanderson Inquest report, at paragraph 6, Judge Schille stated that diagnosis of any medical condition is not an exact science. Within that same paragraph, there is a reference to an Inquest into the death of Leon Herman Bighetty (report issued August 2, 2005, by the Honourable Judge Marva Smith). In that report, Dr. Lindy Lee, the then Director of Emergency Medical Services at HSC, described the challenge of medically clearing persons for admission to MSP:

> This is such a high risk group that physicians clearing them as well are going to miss some head injuries and some other medical conditions….Many of them have chronic health problems, past head injuries, seizure disorders, chronic malnutrition, they may have liver disease that leads to bleeding disorders, so even a minor blow on the head can result in a higher chance of having a bleed in your brain.

[218] Doctor Grierson responded that the practice of medicine has changed since that report was issued in 2005 for two reasons; the availability of a CT scan at that time was limited and there was also more of a focus on observation of head injury. There was a recognition that if you were clearing a patient to be lodged under IPDA, there would be no one monitoring that person and there was always a concern that the condition would worsen. There would need to be close monitoring to ensure that the recovery is following

the course. Relying on a clinical evaluation for a SDH is not a reliable way to diagnose a worsening SDH. If there was ever a concern that the patient was not recovering, a CT or MRI scan would need to be completed. Now, if there was a requirement to medically clear a patient with a SDH, the only way to do that reliably would be to complete a CT or MRI scan.

[219] Every resident, regardless of location, should have access to a reliable emergency response system such as 911. There are dead zones in Manitoba where a person can not call EMS. Shared Health has an idea of where these zones are for cellular service. There are no dead zones for radio.

VIII. The Family's Expert

Dr. Marcia Anderson

[220] Dr. Anderson graduated in 2002. Most of her experience is in internal medicine in clinical practice in cardiology. She also has experience in general internal medicine and sees patients at the adult medical clinic at the Grace Hospital in Winnipeg.

[221] She herself has experienced racism as an Indigenous person and has worked with Shared Health in a project called disrupting racism.

[222] She shared her own personal experience of having to advocate for her father after he suffered a heart attack. She believed that her advocacy helped save his life. She never talked about the incident with her father until after the death of Brian Sinclair.

[223] Dr. Anderson was called as the family's expert to offer an opinion as to whether Indigenous specific racism and bias in health care either played a role or impacted the events leading up to Ms. Samuel's death and if so, what can be done to prevent Indigenous specific racism and bias from causing or contributing to future deaths in similar circumstances.

[224] She described how racism in the health care system began with how colonizers have created policies that have historically not been based on trust but rather distrust. Some examples are: malnutrition in residential schools, segregated health system for Indigenous patients, inadequate housing, prevention from leaving reserves without passes from Indian agents, medical experimentation on children in residential school. This distrust of the system can result in a higher percentage of Indigenous patients leaving Against Medical Advice (AMA) or leaving without being seen.

[225] These practices have resulted in the colonizing factors that lead to social determinants of health being lower for Indigenous patients. These policies have a direct relationship on the ability to purchase nutritious food, the ability to own property or having less access to spacious housing (where overcrowding contributes to spread of disease) and

increased stress levels leading to hypertension and increased cortisol levels, which contribute to diabetes and heart disease.

[226] In order to reduce and eliminate health care disparities for Indigenous people, there needs to be a housing first approach, universal basic income policies and increases in public health advocates.

[227] As part of her forming her opinion on whether Ms. Samuel received biased care, Dr. Anderson reviewed the files from all parties as well as the autopsy report.

[228] Ms. Samuel was a 44 year old female with a history of gastroesophageal reflux disease (GERD) and hypertension. She also had an alcohol use disorder, with seizures that she reported due to withdrawal. At the time of her death she was un/underhoused.

[229] On January 9, 2020, there was a 911 call for her after a witnessed seizure in a public location that lasted two to five minutes. The ER physician notes that there are no neurological abnormalities and that there was no indication for advanced imaging or anti-epileptic start up. Ms. Samuel described a period of two days where she had a headache and she was prescribed Toradol by injection.

[230] The next day, January 10, 2020, Ms. Samuel is booked into cells by the RCMP under IPDA at 15:45 and released at 23:15. Notes from Corporal Duffy note that she fell in her cell during her detention which caused serious injuries to her face. One of the officers believed that is when Ms. Samuel's health began to deteriorate.

[231] On January 11, 2020, Ms. Samuel attended the TGH at 3:39 with headache and hypertension. She described a severe headache associated with dizziness, which was worse when she shook her head. She was prescribed Arthrotec and Gravol and discharged at 4:22.

[232] Ms. Samuel is lodged under IPDA at 7:28 and released at 15:50 to EMS. While in the cell, she was observed to have a seizure, then had several more seizures witnessed by paramedics and in the TGH ER. A CT scan of her head was done which revealed an acute SDH with subtle falcine herniation and an age indeterminate right medial orbital blowout fracture. At this point, Ms. Samuel was very ill and had decreasing level of consciousness. She was sedated, intubated and transferred to HSC for care and consideration of neurosurgery. She developed a fever. Her blood work revealed that she had a blood infection and was put on antibiotics.

[233] While at HSC, her level of consciousness improved and she was extubated. She continued to have headaches. Another CT scan of her head showed that the size of the SDH was stable and surgery was not completed but the plan was for clinical observation and ongoing treatment with anti-epileptic medication and antibiotics. One of the notes documented that Ms. Samuel had been visiting the ER for health care for the last two weeks.

[234] On January 14, 2020, the physiotherapist notes indicated dizziness and unsteady gait and suggested that Ms. Samuel needed three to five more days until she could be safely discharged. Notes indicate that Ms. Samuel was concerned about her personal belongings, i.e. her jackets, sweaters and identification that may have been left behind in Thompson.

[235] A nursing entry from that same date indicates that Ms. Samuel had taken out her own I.V. and the dressing from her neck where her central line had been. Ms. Samuel refused antibiotics as she believed they were making her sick. Physician notes indicate a discussion with Ms. Samuel about competency concerns and it was documented that Ms. Samuel understood the risks associated with SDH, which included seizures and possible death. It was also documented that she understood that she was being treated for a possible blood infection.

[236] Ms. Samuel signed the "AMA form" and left in two hospital gowns, pants and blue booties. It is not documented if she was told what to watch out for as signs that she should return to the ER for care, and there is no record of discharge information sent to the TGH for any potential follow up.

[237] On January 19, 2020, Ms. Samuel attended to the TGH ER with sensory loss/paresthesia. She reported headache, dizziness and paresthesia. The prior SDH and transfer to HSC are noted. Ms. Samuel is noted to smell of alcohol, be intoxicated and slurring her speech. The physician documents that she presented with left leg swelling and no headache. She was discharged to the shelter.

[238] On January 21, 2020, she attended to the ER at 16:20 and the triage form documents hypertension, headache, nausea with emesis and a reported seizure the day before. She left without seeing a physician.

[239] On January 22, 2020, she attended to the ER twice. The first was at 2:17 and the triage note documented her concern that she was hungover and she feared she would have a seizure because she had a withdrawal seizure before. At 4:30 she was seen by a physician who discharged her with alcohol cessation advice. Later, at 23:55, she was seen again with a note that she was experiencing anxiety and a fear that she would again have a seizure because she has had seizures after she has experienced anxiety.

[240] On January 23, 2020, at 3:20 the RCMP were called to remove Ms. Samuel and she was lodged in cells until 13:15.

[241] On January 24, 2020, she attended to the ER at 3:14 due to a "one week headache". She was triaged but left without seeing a physician. Alcohol use was noted.

[242] On January 25, 2020, at 2:44 she went to the ER and complained of a headache and light-headedness. She left without seeing a physician. Alcohol use was noted.

[243] On January 26, 2020, at 2:34 she attended to the ER and the triage note indicated "headache, light-headedness and dizziness with nausea and vomiting". Alcohol intake was noted. She was assessed by a physician who noted that she had no place to go and that she had come to the ER with two other friends who were intoxicated. The plan was to discharge her in the morning.

[244] On January 29, 2020, at 23:26 Ms. Samuel attended the ER with headache, nausea and vomiting. She was seen by a physician at 2:00 who prescribed her Gravol and diazepam. She was released on January 30, 2020, at 2:15.

[245] On February 1, 2020, the RCMP were called because Ms. Samuel was at McDonald's and fell off a stool. She was assessed by EMS who observed no visible signs of distress. She had admitted alcohol consumption and was left in the care of the RCMP, with no further care needed by EMS.

[246] She was lodged into a cell at 20:13. RCMP documents that around 22:49 she was lying on the floor of the cell and observed to be breathing. Between 23:04 and 23:08, she was noted by a guard to be unresponsive and not breathing. Emergency assistance was called and CPR initiated. EMS arrived at 23:12 and continued attempts to resuscitate Ms. Samuel. She remained asystolic throughout the attempted resuscitation and was pronounced dead at 23:35.

[247] An autopsy was conducted on February 3, 2020, and the cause of death was found to be the combined effects of acute/subacute SDH and acute alcohol intoxication.

[248] It was Dr. Anderson's opinion that bias, systemic racism and anti-Indigenous racism in health care systems may have contributed to the death of Ms. Samuel in five ways: Symptoms attributable to alcohol use/misuse and other causes not explored; Bias or Stigma Associated with Alcohol Use/Misuse and Intersectionality; "Irresponsible/Non-Compliers" and Leaving AMA; Frequent fliers and Apprehension under the IPDA.

[249] With respect to symptoms attributed to alcohol use/misuse and other causes not explored, Dr. Anderson noted that Ms. Samuel had 11 TGH ER visits between January 9-29, 2020. Alcohol use was noted on each occasion. The increase in frequency is significantly more than her prior pattern of ER attendance. While this could be related to social factors like a change in housing status, it could also be an important indicator of a change in her health status. It is not clear when the first or second SDH occurred but at that time the ER physician determined it as being related to alcohol withdrawal and no imaging was needed. It is possible that stereotypes around Indigenous people and intoxication contributed to a finding that her symptoms were related to alcohol without further investigation until the multiple seizures occurred.

[250] With respect to the bias or stigma associated with alcohol use/misuse and intersectionality, Ms. Samuel did use alcohol and the effects of intoxication may have masked symptoms of a SDH. For example, unsteady gait or urinary incontinence could be due to intoxication or a SDH or both. However, in a patient with a very recent SDH that was not completely treated, the most critical diagnosis was to rule out a worsening or new SDH. Indigenous women and girls are at a higher risk than Indigenous men for experiences of racism and discrimination in the health care system.

[251] Regarding the labels of "Irresponsible/Non-Compliers" and Leaving AMA, Indigenous people were significantly more likely than other patients to leave the hospital against medical advice (AMA). This was attributable to negative experiences in health care settings that result in Indigenous people avoiding health care. This could be perceived by some health care providers as evidence of irresponsibility or being non-compliant with a treatment plan. However, Dr. Anderson says this needs to be considered through the lens of risk-benefit analysis. Indigenous people make calculated decisions about the benefits of seeking or staying in a health care setting with the risks of harm. In the case of Ms. Samuel, there is little documentation of challenges prior to her leaving AMA. There was no documentation of her being offered or requesting any supports of Indigenous health programs or services. On January 14, 2020, it was documented that she removed her own I.V. and was concerned about her personal effects. She was determined to be competent, yet she left the hospital in mid-January with two hospital gowns, pants and booties. There is insufficient information to understand why she left. There was no documentation on what Ms. Samuel was provided in terms of when to go to the hospital again, which is common when individuals are discharged from a health care setting. The Canadian Medical Protective Association provides a checklist for physicians when a patient is leaving AMA. There is no documentation that efforts were made to provide informed discharge advice.

[252] Indigenous people can also be labelled "frequent fliers" when they attend to the ER frequently. In Ms. Samuel's case, she attended Thompson ER 11 times, with one attendance requiring a medivac to HSC for critical care. The bias towards Indigenous people as "frequent fliers" is that they are using the health care system inappropriately and taking resources away from more deserving people. While Ms. Samuel did use alcohol, she also had recent critical illness with ongoing and new symptoms that required reassessment of the SDH. It is possible that these stereotypes of being a "frequent flier" with multiple interactions with RCMP, paramedics and ER contributed to the belief that she did not need further medical care and that created missed opportunities for the health care system to intervene and treat the new/worsening SDH.

[253] Lastly, Ms. Samuel was lodged in cells by the RCMP five times between January 9 and February 1, 2020. On one of those occasions she had multiple seizures and this led to

the initial diagnosis of the SDH. Symptoms that are attributable to severe illness can be incorrectly attributable to alcohol intake and not properly explored. Paramedics and police officers are as likely as other individuals working in the health care system to hold the same stereotypes about Indigenous people. The assumption that an Indigenous person's symptoms or behaviours are due to alcohol and alcohol alone, have been repeatedly demonstrated to cause harm by causing delayed or misdiagnosis of serious health conditions. Further consideration of how these biases contribute to harm through the lack of sufficient individualized risk and medical assessment prior to detention is required.

[254] Dr. Anderson testified that bad outcomes happen, regardless of malicious intent. The system is designed to have unequal outcomes for Indigenous patients and that is where the harm lies. She believed that some of the wording used to document Ms. Samuel's visits to the TGH ER showed a pattern of anti-Indigenous stereotypes and bias and that sometimes the wording was an apparent assumption of her social issues.

[255] She would like to see ongoing learning in cultural safety. There is a power imbalance when seeking care and some patients are demeaned or disempowered because of who they are. There needs to be ongoing learning and self reflection of service providers. Evaluation of the patient experience is important because it provides feedback on patient's experience with professionals within the medical field. This is important but it also requires an ongoing investment of time and energy to effect change.

[256] One aspect she has been reflecting on is how important it is to have an understanding of the history of Indigenous health care and the segregated hospital for Indigenous people. These hospitals were not developed with the mindset or intention to provide care. Looking at the experience of Indigenous patients in sanitoriums, the intent was to isolate and to stop the spread.

[257] There is a study out of Alberta which found that Indigenous people get lower triage scores for exactly the same thing as a non-Indigenous person who presented at a medical facility. An Indigenous person will be forced to wait longer and if you leave, it is your choice to leave before being seen by a physician.

[258] In her review of the files, she noted that the Thompson ER always made sure that she was discharged to somewhere – either the shelter or the RCMP.

[259] With respect to her admission to HSC and leaving AMA during the winter of January 2020, documentation is sparse. If an individual was going to leave AMA, there should have been more effort put into explaining things and persuading her to stay. There needs to be a change in approach to how the medical profession handles patients who leave AMA.

[260] With respect to the CT scan and whether another one should have been done, Dr. Anderson does not think doing another CT scan would have been unreasonable given her

medical history. According to a study done in Denmark, there is a higher risk for a re-bleed doing surgery that is not required.

[261] In Ms. Samuel's case, Dr. Anderson believed that in addition to ordering another CT scan, other non-invasive tests could have been done such as a pupils check, the reflex hammer, testing strength using your hand and the pin to test feeling. The results of these tests could all have been potential warning signs of a worsening SDH.

[262] She was uncomfortable with how Ms. Samuel was referenced in her medical records when "alcohol use disorder" and "alcohol abuse" was noted on her chart. Dr. Anderson says while this needs to be documented, the abbreviation "ETOH" is also used and would not trigger the same reaction. The amount of time alcohol use is noted on discharge seems to indicate that she was attending for no reason and that all of her complaints were related to alcohol use. Dr. Anderson believed that it was apparent to her that she experienced racism. It is documented that she is frequently showing up intoxicated and her non-compliance is documented.

[263] She agreed that supports are very important in general, especially in a medivac situation but she conceded that this is difficult to do in the medivac situation due to the pressures of time.

[264] There needs to be an increase in the representation of Indigenous people in the health field and supports offered to Indigenous patients that use health services. Indigenous people want to feel a sense of community and this is particularly important in a health care setting.

[265] There is a lack of sharing of information within the health care system. There is dis-jointed medical records and a lot of remoteness and the difficulties that come with that. First Nations and Inuit Health Branch in First Nations primarily rely on facsimile machines to transmit information. There is a disconnect in how information is shared between systems.

[266] She agreed that a program similar to MSP would be beneficial in Thompson if it came with the appropriate resources. Having a detox centre separate from the RCMP (like MSP) is preferable rather than having medically training personnel in a police facility. Having a paramedic on site 24/7 would be beneficial as she believed people would be more willing to share health information with health care providers than the RCMP.

IX. Resources Available in Thompson for the Unhoused

Gina Spence

[267] Gina Spence, the Manager of the Wellbriety Centre (the Centre) since October of 2022, provided information on the Centre itself and the supports it offers.

[268] The Centre opened on July 1, 2023, and is located at 504 Princeton Drive in Thompson, Manitoba. It operates 24 hours a day, 365 days a year. There is 24 hour security. The Centre is funded by the Department of Families and funding was just recently approved for transitional housing.

[269] The City of Thompson pays for the heat and electricity for the Centre and the Centre does not have to pay rent. Kelvin Lynxleg, the Executive Director of MKO, works closely with the City of Thompson with respect to any issues with the Centre.

[270] The building which houses the Centre has three floors and is fenced. The first floor is the only floor currently in use. The second floor was almost complete but was not in use at the time she provided her evidence. The second floor is waiting for renovations to be completed, staffing and funding. There are plans to use the basement as overflow.

[271] The centre employs 28 staff and has one health care aid, three addiction support workers and multiple safety monitors. The role of the safety monitors is to keep, and make sure, everyone is safe.

[272] The health care aid works Monday to Friday from 8:30 a.m. to 4:30 p.m. and assists the residents that have mobility issues with daily activities and wound care. She would like to have a nurse or doctor visit the Centre once every two weeks.

[273] There is a staggered shift for addiction support. The worker assists participants with obtaining identification, getting into treatment, and working on short-term and long-term goals.

[274] Staff are trained in crisis intervention and first aid/CPR. There are three staff on the main floor at all times, with additional staff if the basement is being used.

[275] Staff can assist with laundry and getting clothing from the donation room.

[276] Participants provide their name, birth date and treaty number and indicate whether they are Métis, Status or non-Status on admission. Participants also provide their medical history and are asked about their medication and appointments. Prescriptions are locked up and dispensed by Centre staff.

[277] The main floor has 44 rooms with transitional beds. The Centre has 13 to 14 female beds, 25 male beds and approximately 25 emergency shelter matts. The Centre can have up to 100 people in the building at one time.

[278] The Centre provides three meals a day and a snack. There are six tables and enough for 50 participants to eat at one time. They can also take food to their rooms.

[279] Participants usually leave the Centre between 6:00 a.m. and 8:00 a.m.

[280] If a participant is caught with alcohol, they get a warning and get kicked out of the program. Naloxone is on site for suspected drug overdose.

[281] The majority of residents at the Centre have addictions or have a diagnosed mental illness.

[282] The RCMP frequently drop off individuals who are intoxicated and have no place to go. If a person is brought to the Centre and is extremely intoxicated, staff do regular checks to ensure well being. When a person is asleep, staff also make sure no one is harming them. All residents are checked every 15 minutes and there is a spreadsheet that records date, time and general well being. On occasion, participants have had to be woken up.

[283] If the health care aid is not available and medical assistance is required, EMS is called. They do have three participants at the Centre that have seizures daily and EMS is called frequently for those participants.

[284] In terms of services offered, a counsellor is available and has a flexible schedule. The counsellor is able to make referrals to the Addictions Foundation of Manitoba (AFM), the Detox Centre and Canadian Mental Health Association (CMHA).

[285] Ms. Spence has contacts with RCMP, Men Are Part of the Solution (MAPS) and other resources in the City of Thompson. Outside resources such as Ma-Mow-We-Tak Friendship Centre, the YWCA and CMHA offer programs for participants during the day and Centre staff also do training.

[286] The Centre has a medical van and two drivers who are also safety monitors. There is one driver working at all times. The driver regularly drives around the community and looks for people who are sleeping in public areas or for those who may need assistance. Taxi slips can be provided to participants from the TGH to the Centre but they can also be provided to other places, other than the hospital.

[287] There is a pre-transitional and transitional housing program to help the participants obtain housing. However, finding participants housing is a challenge because a lot of participants lose their residence because of an active addiction.

[288] If someone at the Centre is assaultive or disruptive the RCMP will be called.

[289] The Centre generally does not turn anyone away and the maximum amount of people they have had at one time was 100 to 110. They average 69 to 75 participants per day. Unusual weather can cause spikes in admissions.

[290] Treatment centre beds are difficult to get and the waiting list is long. There are currently only six detox beds and that is not enough to meet the needs of Northern Manitoba.

[291] The biggest challenge for the Centre is staffing as staff frequently call in sick. Staff also need to be willing to take on the burden of working with someone with an active addiction, as it is a challenging position to be in.

[292] She recommends more training for Centre staff on mental health and the different types of drugs and alcohol. There are talks to have a detox centre and would be a good resource for Thompson because there is definitely a need. However, this would require more trained staff.

X. Record Keeping, Cultural Sensitivity, Physicians at TGH ER Clearing Prisoners for Lodging

Chad Munro

[293] Chad Munro is the Vice President of the Health Services and Acute Care and is the Chief Nursing officer for the Northern Regional Health Authority (NRHA). He has worked with the NRHA since 2008, in a regional capacity and is based in The Pas, Manitoba. He has experience as a registered nurse and has experience in an ER setting. He was a Regional Clinical Educator in Nursing in 2014 and just prior to his current position, he was the Clinical Change Lead in a Regional Capacity for the NRHA involved with assistant transformation.

[294] Day to day, as the Vice President of Acute Health Services and the Chief Nursing Officer, he is responsible for the multi-disciplinary health care team for the provision of care through the acute care portfolio. This would include the emergency department in-patient services for medicine, obstetrical services, acute psychiatry, surgery, dialysis and chemotherapy. He is also the Chief for Nursing throughout the programs and services delivered on behalf of NHRA and is responsible for the multi-disciplinary collaboration of health care providers and teams ensuring that the policies are up to date and reflective of best practices and integrating client-centred approaches to patient centric care, across the portfolios and ultimately working towards the 2023 to 2028 strategic directions set forth by the Board of Directors. In the region, there are six sites which have emergency rooms, three of them are in the main centres and include Flin Flon, The Pas and Thompson. All of these sites are EDIS compatible. The other ER sites are not integrated with EDIS.

[295] The issues with the availability of EDIS are complex. NRHA went live with EDIS in 2017 and there are other stakeholders such as Indigenous health service providers that complicate the accessibility of EDIS. The availability of EDIS through Shared Health is a provincial platform that is dependant on the amount and volume of patient visits per year that would qualify the ER for the EDIS platform.

[296] There have been a lot of changes in terms of providing cultural sensitivity training since the death of Ms. Samuel in 2020. The NRHA offers a two day session, with the first day focussing on history of the Treaties, colonization and unconscious bias. The second day

focuses on a cultural and land-based session looking at traditional medicinal practices. The second day also includes knowledge of residential school survivors.

[297] There are some staff that will not be able to take the training, such as locums and temps, because there is no ability to track whether they have taken the training because so many individuals provide services on a short-term basis. It is difficult to track who has taken the culturally appropriate training as 27 different agencies provide services and NRHA can not be sure who is providing services, and when. All of the service providers are coming from within Canada.

[298] The declaration to eliminate all forms of Indigenous Specific Racism (Binder 1, Tab 24, E ii) is a strategic policy that the NRHA is committed to. In partnership with MKO and Keewatinohk Inniniw Minoaywin (KIM), the NRHA has signed a declaration to eliminate all forms of racism towards Indigenous people in the health region. The goal is to ensure equal access to safe, respectful, timely and high quality health care.

[299] Episodic care for someone who does not have a health care provider, would include a social worker, Indigenous services, other care advocates and members of the care team identifying care needs.

[300] On February 22, 2023, the emergency department co-ordinated care plan guidelines were implemented (Binder 1, Tab 24, F). The policy recognized that there are several clients with complete medical or psychosocial needs who may present to Emergency Departments (EDs). In order to meet the needs of the clients, the Northern Health Region (NHR) is committed to working with the client, families and alternate decision makers, health care teams and social service partners to develop a co-ordinated care plan (CCP). CCPs may also be used on a short-term basis for clients who require specific interventions under *The Public Health Act* (PHA).

[301] Referrals for ED co-ordinated care plans could come from a number of different service providers, some examples could include AFM Thompson, Anxiety Disorders Association of Manitoba, Mood Disorders of Manitoba. (A full listing of potential referrals can be found at Binder 1, Tab 23, F.)

[302] How this would work is that if a person presents to an ED, a notification may pop up that a care plan exists. The plan would be a useful source of information for health care providers to have access to.

[303] Since May of 2023, racial identity and data is being collected in order to understand the needs of the region. There is a hospital related harm index.

[304] Some of the issues that are being worked on is a flagging system at triage. There needs to be a mechanism for flagging visits if someone is visiting a number of times.

Individuals can not go and look into a person's chart as looking at previous records would be a breach of the *Privacy Act*. If the patient discloses something, that could allow more follow-up to get additional information.

[305] When asked if the TGH ER physicians would have the ability to clear prisoners for lodging, Mr. Munro responded that the ER doctors at TGH currently do not have the resources and capacity to do this.

[306] He agreed that it would be helpful if EMS could access patient's medical information when they are providing care.

XI. Resources in the Health Care System for Indigenous Patients and Goals to become an Anti-Racist Organization

Charlene Lafreniere

[307] Charlene Lafreniere is the Chief Indigenous Health Officer for the NRHA and has been in that role since September of 2019. This was a newly created position based on the restructuring of the organization.

[308] She was born and raised in Thompson. She has a Bachelor of Arts degree from the University of Winnipeg. She also has a Masters Degree in Arts and Leadership with Royal Roads University.

[309] She has two distinct roles: one with NRHA and the other with Shared Health. She spends 40% of her time with the NRHA in her role there and the other 60% is spent with Shared Health.

[310] She has worked in various roles. She was at University College of the North for approximately eight or nine years as the Director of Institutional Advancement. She has served on City Council for Thompson as a councillor for two four year terms. She also sat on the Thompson Neighbourhood Renewal Corporation as the Executive Director doing community development. She has also worked for MKO in various justice programs.

[311] When she was hired, there was no Indigenous Health Department. Part of her role was to understand how this would operate and what was needed to get it started. There was work needed in terms of developing a wisdom council and working with Indigenous partners specifically around informing the work. They needed to look at cultural proficiency and Indigenous cultural safety training. The work has evolved since she has started to include developing an Indigenous specific anti-racism policy. Developing and implementing a policy is the large focus of the role.

[312] Keewatinohk Inniniw Minoayawin (KIM) is a partnership with NRHA and is a full-time equivalent program which was originally in the ER. KIM has a program that includes

Indigenous Birth Helpers with a care team that can do outreach to the Indigenous population.

[313] They have spent a couple of years with KIM and MKO discussing and developing the joint declaration to eliminate all forms of Indigenous specific racism. A lot of time was invested developing relationships and working on drafts of the declaration.

[314] Since September of 2019, she has worked with other leaders to expand the program.

[315] With some funding she was able to create an Indigenous health co-ordinator position which helped the program work on an operational level. That person started in August of 2021. By April of 2022, the four Indigenous liaison workers that existed within the region became a department.

[316] The program worked on Indigenous Elders being a part of the hospital setting.

[317] In February of 2023, an Indigenous Elder program was implemented at TGH. There is also a position for The Pas and Flin Flon.

[318] The board has also supported the work of the wisdom counsel and having a position to help support that work. The purpose is to have knowledge and wisdom that comes from Indigenous traditional ways of knowing and healing as well as the medical and clinical understanding of health. The intention is to bring those positions together.

[319] The Indigenous liaison workers are in the hospital setting and can provide language support, only in Cree at this time. They do not have a liaison worker that speaks Dene. The role would be to help patients with whatever their needs are in the moment, which could be just helping them to navigate the health system. There are only two positions, so there is not 24/7 coverage and there is only cross over for shift change. These positions cover the entire hospital not just the ER. They do a lot of support with palliative care also.

[320] The role of KIM has also changed in the last little while. The program has about three full time equivalent resources in the hospital and that has increased. The original focus was for the ER but it has expanded to include throughout the hospital. External advocates in the health setting are important because they can work together and fill in gaps.

[321] The Sākihiwēwin Client Advocate Program has been in existence since April of 2023 and provides services from 7:30 a.m. to 11:30 p.m. Monday to Friday. The program has a worker who can support and advocate for Indigenous patients when accessing health care. The program was housed in the TGH in May of that same year. In terms of providing services, the ER has been prioritized. However, there are more resources available, and they are switching how the staffing model is working and will be able to provide support throughout the hospital.

[322] Another available resource is the Patient/Resident/Client Advocate Agreement that can assist by providing the help of a trusted friend or family member to provide support when a patient is accessing health services. The form includes frequently asked questions and an authorization for the patient as to what role the patient would like the advocate to take. Some examples include accessing medical health records, arranging appointments, being present to write down instructions and explaining things to the patient. If the role the patient wants the advocate to play is not listed, there is a line for "other" which can be filled out (Binder 2, Tab 25 B).

[323] The Patient Advocate agreement is based on the Shared Health guidelines and what they have in the Northern Region is a form for patient experience and feedback. KIM as an organization also has a consent form that the Northern Region worked to develop. Through a year of learning, there will be changes made to the consent form. The intention is to have the process be seamless for the patient and to be clear on what the consent is for, and that the obligations around privacy are respected.

[324] KIM also has Indigenous birth helpers that are permitted to work in the hospital. Space is limited in the maternity ward so there is currently no space for the helpers, but they are considered a part of the care team when the forms are signed by the patient. There is an understanding that they are welcome to provide support when requested. They also do outreach in the TGH when requested. The program can provide services to any First Nation communities when requested.

[325] The Indigenous Elder/Knowledge Keeper provides an Indigenous approach to health and wellness through support and guidance to patients, families and staff in the NHR. One of the goals of the position is to ensure Indigenous perspectives and cultural knowledge are provided in conjunction with NHR Vision, Mission and Values. (Binder 1, Tab 24 D i.) The Elder can work throughout the hospital. There is only one Elder at the present time but there is a demand for more Elder support to work with patients and staff.

[326] There is an Indigenous Health Co-ordinator that would help to ensure Indigenous values and principles are incorporated into care (Binder 1, Tab 24 D ii).

[327] There is also a social worker position available but that program does not fall under the health department.

[328] There is no signage in Indigenous languages at the hospital at present time. There are some documents that have been translated into Indigenous languages.

[329] The program could use more Elders' support with the wards and staff. The Patients Bill of Rights could also be translated to Cree.

[330] Translation services is a challenge as there are over 200 languages spoken in the Province of Manitoba. There is presently an on-demand service that is available which was not previously. There is also a caution around using virtual translations and some of the challenges related to that.

[331] Through the quality risk department, there was a re-structuring of a position that was once a community engagement co-ordinator. That position was re-structured into Public Relations and Indigenous Experience Co-ordinator and that allowed an Indigenous patient to raise any concerns with an Indigenous support person.

[332] The NHR has a five year strategic plan which operates from 2023 to 2028. An environment scan shows that 72.6% of those in the region identify as Indigenous (Binder 1, Tab 24, p. 5).

[333] Eliminating Indigenous specific racism was one of the objectives/priorities identified as an issue in the strategic plan.

[334] In terms of training, the NHR currently provides two days of cultural proficiency and Indigenous cultural safety training. The days are not back to back. One day is in the morning in a classroom setting and is based on experiential type of activities where the participants recognize bias and stereotyping and learn about the continuum of cultural proficiency and cultural safety and where we hope to be as individuals and as a system. The afternoon is a blanket exercise and is a simulation of the history of Indigenous people in Canada from an Indigenous perspective. There is a circle after which a de-brief is done on what was learned. The second day is a day on the land and it is a way of learning how Indigenous people practice on the land and heal. There are Indigenous knowledge keepers that provide information.

[335] The NHR meets regularly with KIM and other partners to support becoming an anti-racist organization. KIM is leading that program and offers a five hour mandatory online course that talks about what racism is and what the effects of racism are on patients and their families. Currently the program is not mandatory for locums, but work needs to be done in this area. This was a call to action in 2015 so there should be an expectation that staff have to complete this training.

[336] On September 29, 2023, a new policy was implemented to address Indigenous specific racism (Binder 1, Tab 24 E). The policy was shared internally just after the release date. The program is in a learning and implementation phase of this policy. This policy connects to other policies that are part of the organization's practices. Those processes have also been refined to address the policy before this one. The patient experience now dovetails into human resources so it is in both systems where there is a complaint around racism and

if an issue needs to be looked at further. This was one of the things that Indigenous people wanted in order to address racism.

[337] In terms of what programs are available, there are 8 to 10 classroom sessions a year and about 8 for a land based program. The training can accommodate 50 to 55 participants. There are 5 to 15 spaces for other partners such as the RCMP and Vale. The training is held in different communities through the year and is offered in The Pas, Flin Flon and Thompson. The land-based program is held at Mile 20, just outside of Thompson. There is also a new partnership with Frontier School Division for a land based program for the west side of the province.

[338] The policy is huge and requires a focus on implementation and evaluation for it to be meaningful and to truly effect system change.

[339] Staff need support and an understanding on how to investigate a race based complaint. Managers would be responsible for investigating race based complaints. In order to do that, there needs to be training and support provided to the staff on how to recognize racism and how to conduct an investigation.

[340] There is a working group and mentors that are being supported to help those working on this task. Education, measuring success and evaluation of the program is crucial so that changes can be made. There is also a provincial policy that is in the development phase. NHR is a part of that network.

[341] Having Indigenous specific support is required in order to build trust. Having Indigenous specific job titles and social workers is also very important to patient's experience with the health care system.

[342] The program is also looking at the patient experience at the ER. In those settings, the lead clinicians would take on investigating race based complainants.

[343] An Indigenous representative workforce working with elders in trauma informed care is crucial. There is a lot of hope attached to the Wisdom Council in terms of helping inform NHR and being innovative and creative on how to increase opportunities. Traditional resources need to be built in, including how to harvest and use traditional medicines. Care needs to be trauma informed in order to recognize the needs of those accessing services; residential school survivors and others with a history of trauma rooted in colonialism. At the present time, the Wisdom Council is a paid co-ordinator. There is a recognition that there needs to be someone dedicated to bringing partners together.

[344] A discharge support co-ordinator is also crucial. When they hear about racism and challenges with jurisdiction, patients need advocacy and support navigating the system.

[345] In Thompson, it has already been raised that the space is too small to have all of these programs running. The program also deals with the challenge of staffing vacancies. These barriers create hardships for staffing, patients and their families.

[346] Digital systems need to communicate so that relevant medical information can be accessed and shared. This would be very helpful for patients in their health journey.

[347] Having permanent staff at the NHR would be beneficial and having more Indigenous staff would definitely advance the program. This can also be supported provincially. The Northern Region is impacted the greatest by Agency staff.

[348] The importance of the data is important and making changes based on the data. It can really show where the disparities are. There needs to be a continuous improvement in health and there has to be cultural safety and anti-racism standards.

[349] In the Shared Health role, collection of the Race, Ethnicity and Indigenous (REI) patient identity data is very new. Collection of the data can impact the care and the health outcomes of various patients being provided health care, specifically people who identify as Indigenous. Work has been done in this area for a while but the actual collection of data is lacking. This work is led by Dr. Marcia Anderson and her team. The important thing is ensuring that the governance is done in a respectful and meaningful way.

[350] With respect to what the REI data hopes to capture, it could be anything from triage scores, waiting times, pain control and you could layer this data on to see if the experiences are showing up as different. The focus of the program is on collecting and interpreting data.

[351] With respect to research with, or about Indigenous people, Indigenous people want to ensure Ownership, Control, Access and Possession (OCAP) and there are principles and expectations that go with each of those principles. OCAS was developed for the Metis Nation and the first three words are the same as in OCAP but the P is switched out for an S and the S switched out for Stewardship. The goal is to ensure that the data that is being collected is used to improve the patient experience and to make positive changes.

[352] All Service Delivery Organizations (SDOs) are collecting this information on check-in at hospitals in Manitoba. The information is collected by a script that was developed and lead by Dr. Marcia Anderson. Training was provided on how to collect the information and there are regular check ins with the managers. Ms. Lafreniere was informed that 95% of the people are responding to the information. She has not been updated as to whether that number has changed.

[353] There are seven SDOs with five regions and Shared Health and Cancer Care. All SDOs have Indigenous Health Departments but they are small. There are about 110 Indigenous specific positions out of approximately 55,000 positions in total. Those are Indigenous

specific positions, and the individuals employed in these positions are not necessarily Indigenous.

[354] Shared Health is also an SDO but they have an operations function like NHR and other regions would. Shared Health is a fairly new program and its role is to lead and co-ordinate the provincial health system. The goal is to create an Indigenous health department within Shared Health and working with all of the SDOs/health regions to do the same through the Indigenous health operating model. That is the collective work of understanding the functions and roles of Indigenous health, what the current state of Indigenous health positions are, and what does the future state of Indigenous health look like.

[355] She has three people working with her. A project manager and two business analysts that support the work. Part of her job is to get a team in place at Shared Health.

[356] There is a digital roadmap and plan to address the digital needs of systems talking to each other within the provincial and federal systems. The organization is aware that this definitely impacts Indigenous patients, especially on discharge.

[357] Shared Health developed a racial climate survey to learn how racism is experienced by Manitoba SDO staff. A summary of the survey is as follows: 6,677 staff across Manitoba SDOs participated in the survey (13% response rate). Twenty-eight percent (28%) identified as members of an Indigenous, Black or Racialized community (22% of Manitobans self-identified as a visible minority, 18% self-identified as Indigenous in the 2021 Census). Participants described a lack of diversity in leadership positions across the province. Only 18% of white participants had leadership roles and only 9% of Indigenous, Black or Racialized respondents were in similar roles. Forty-four percent (44%) had not participated in any Indigenous awareness training programs, either through their work or postsecondary institution in the last five years. Fifty-eight percent (58%) of participants believed their workplace had policies and procedures to address racism but of these, only 45% thought these policies were effective. Forty-nine percent (49%) of participants did not know how to report an incident of racism and 65% said in the past year they had never reported an incident of racism they experienced or witnessed.

[358] The racial climate survey gives something measurable. All the SDOs participated in this. This was done in conjunction with University of Manitoba (U of M). There is a disrupting racism steering committee. There was a response rate of 13% amongst staff. Given the subject matter, they were advised that this is a good response rate. In your typical survey, this may not have been considered a good response rate. The Northern Region had a higher response rate.

[359] Data informs on a few tracks. It does inform those who may have experienced racism and what it included. The results of the study also inform education. How are we mobilizing

the system to become anti-racist? How are we holding people accountable when racism is found to be present? Also looking at programs with an anti-racism lens, such as debriefing and being trauma informed. The survey is a measurable guide for the system in terms of the actions required and what needs to be done. It is a measurable goal to hold the system accountable. Where the report is the same for both organizations, is in the recommendations.

[360] Ongomiizwin is an Indigenous Institute of Health and Healing that developed a new Indigenous Cultural Safety Training in Manitoba. The training is broken down into two modules. Level 1 contains five modules and covers Introduction to Indigenous Health and Wellness, the Impact of Colonization on Indigenous Health, Foundations for Cultural Safety in Health Care, Foundations of Racism and Anti-Racism and Addressing Racism in Health Care. Level 2 also has five modules and covers topics such as Intersectionality and Indigenous Health, Understanding Calls to Action and Calls for Justice, Indigenous Health in Context I: Métis, Inuit and First Nations, Indigenous Health in Context II: Urban, Rural/Remote, and On-reserve and Weaving it all Together: Integrating Culturally Safe and Anti-Racist Health Care Practice to Advance Indigenous Health.

[361] The Truth and Reconciliation Tool aims to ensure knowledge has been acquired among health care teams about legislation and guidance that is relevant to the health system, and to help teams explore how to apply legislation and guidance calls. The tools can take many forms, but the intention is to create space for teams to learn, plan and for action. At the end of the document, there is a summary of the actions. This tool has been used by different teams and it is revised based on feedback.

[362] The hope is that each SDO will create an Indigenous health program, expand it and come together as an Indigenous health network and share information.

[363] Addictions and mental health resources are also raised as an issue by Indigenous People. There is a need to look at alternative ways of addressing these issues, such as land-based programs.

[364] Trauma informed care training is important and it needs to be made available to the service providers. This is key in emergency room departments where things are very busy and demanding.

[365] There are two days of training available, online and in person. Time and resources are the barriers to implementing. The training offered by Ongomiizwin should be mandatory because this is important. Structural change needs to happen. It has to be a policy that the training be taken. This is not an either/or proposition. We need to have a better understanding of what it costs to not do this training. The approach needs to be proactive

as opposed to reactive. The changes can not happen without education. Real harms happen from racism that can not be quantified when it comes to health care.

[366] With respect to transportation on flights, sometimes patients are denied boarding flights back home due to intoxication. She has heard about this and there are conversations happening with the airlines about this issue. Ms. Lafreniere was not aware of the details of the discussions.

[367] The challenges of escorts are residency and whether they fall under Northern Patient Transportation or First Nations Inuit Health Branch. She is aware the issues exist and there is frustration amongst patients and loved ones, but she is not aware of all of the specific details.

[368] The calls to action in the TRCC need to be implemented. Everything is rooted in these calls for action. People have spent a lot of time on these reports sharing experiences. Recommendations have been made based on their experiences and those recommendations need to be implemented. It is important for people to know that it is recognized that racism in health care exists, that leadership is working to address it and that the calls inform the work when dealing with Indigenous patients.

XII. Leaving Against Medical Advice

Dr. Pelletier

[369] Dr. Pelletier is the Chief Medical officer at HSC. She oversees all physicians and clinical physicians, and her experience includes working in a hospital setting, including in an ER setting.

[370] She had no prior knowledge or interactions with Ms. Samuel but provided testimony regarding the topic of leaving against medical advice. With respect to Ms. Samuel leaving against medical advice, Dr. Pelletier testified that the most responsible for reviewing this information with the patient is the attending physician. A social worker can sometimes assist and the doctor would take that into consideration, but she would do her own assessment. The patient needs to have explained to them the risks and benefits of treatment and she needs to understand the medical complications.

[371] Whether or not the patient has capacity is task and time specific. Every patient has the capacity to consent to treatment and it is all case specific. If the patient is very sick, the bar is higher. Informed discharge needs to be provided. If you leave, then this could happen. The physician should see if what has been explained to the person, can be explained back, to ensure that they understand. Once you are satisfied that they understand the risks, the patient has the capacity to make the decision about care.

[372] Other factors that need to be considered in determining capacity is whether the patient has dementia, is under the influence of drugs and or alcohol, a brain injury or an infection impacting their ability to make a decision. Capacity can fluctuate. The number one guiding principle is the patient has autonomy first and foremost, and you have to respect the decision they make.

[373] With respect to contacting family members to discuss the patient's health care, the physician needs to respect the health information of the patient and there needs to be consent from the patient to disclose any medication information. Every patient is allowed to make decisions about her own body and her medical treatment.

[374] Sometimes if health care providers probe to find out why patients want to leave, it will be because they have pets or children that need to be cared for. If this is the case, sometimes the physician can involve other teams to assist. Other times, the person wants to leave because they want to ingest illegal substances to calm down. In those situations, the physician can employ harm reduction techniques to see what can be offered to give a similar effect.

[375] Social workers are available 24 hours a day. They are often on the wards but there is no one there in the evening. At the end of the day, if a patient is refusing to stay, you cannot force them to. Sadly, even if the patient has a life threatening condition and he chooses to leave, the physician can not do anything to prevent them from leaving. The presumption is capacity.

[376] A certificate of incapacity, or a Form 21, goes to the Chief Psychiatrist for consideration. This form is completed when a physician believes a person is unable to care for themself and not able to make reasonable decisions about their person or property due to a mental condition. If the person leaves, the person is brought back by the police.

[377] Dr. Pelletier is aware that Indigenous patients do not feel safe in health care settings. This is a wider issue to be looked at and there are different approaches to deal with this.

[378] When asked about Ms. Samuel leaving against medical advice, she stated that a lot was not documented. Depending on the concern, there would have been other options that could have been explored such as a site-to-site transfer. They could have looked into whether she could have been medivaced back to Thompson if there was a bed available. If she was sent back, funding for her transport back could have been explored with Indigenous Services Canada or Medical Services. However, some surgeons like to oversee their patients until they are ready to release to another hospital.

[379] In some situations, next of kin can be notified but if the patient says that they do not want you to contact next of kin, they can not be contacted. In some cases, patients are allowed an escort and in others, escorts are not approved.

[380] In medical school and residency, she took a course on Aboriginal awareness.

[381] When asked if she had any recommendations, she said that it was difficult to say. A lot of patients do need care and leave for a multitude of reasons. Patients need to feel that they are at a safe place and health care providers need to meet patients where they are at. She believed that the hospitals need more Indigenous staff employed in health care positions.

XIII. Resources Available for Indigenous Patients Medivaced from the North in Winnipeg

Bonita Kehler

[382] Bonita Kehler provided information about the Indigenous Health services available to Indigenous patients at the Winnipeg Regional Health Authority (WRHA). She has been working in this department in various roles for over 19 years.

[383] She is the Integration Manager for Indigenous Health and they provide services in three streams. The integration and central support area is the hub of the program. It is the centralized area for the program and takes all referrals and any inquiries that come out of the referrals. Integration relates to how they work with the community and within the acute peer settings.

[384] There is a stream for patient services and the main component in that program is the interpreting resource worker. This is important because this person is the first point of contact so it is a unique role to the WRHA. There was always a service for interpretation provided but there was a recognition of a need to expand that program. When the worker meets with the family, an assessment is done and if there is a need for secondary services, that would also be accessed. Secondary services could include discharge planning. An example might be a person who went in for an amputation and their living arrangements are not wheelchair accessible. The program would be able to assist with looking at obtaining housing options for that individual.

[385] Another area is the patient advocate program. A patient may raise concerns about being mistreated due to race and the patient advocate could also assist in that regard. There are also spiritual and cultural care providers that can provide services to Indigenous patients, for example, for prayer or smudging.

[386] The third stream is workforce development and education team. The program focuses on recruitment, retention and outreach to try and build a representative workforce. With the education piece, there is an Indigenous Cultural Awareness workshop. There are a lot of requests from outside the organization to assist with the education and awareness program in other SDOs.

[387] She oversees the centralized support team to see how they could work better with other programs in other organizations, and within the acute care team itself.

[388] Referrals can be patient initiated or referred by someone else. There are 35 positions and approximately 31 to 32 are filled. Some are on leave. There are 11 full time Interpreter/Resource workers and there are four at HSC. They work seven days a week from 8:00 a.m. to 7:00 p.m. Monday to Friday and 9:00 a.m. to 5:00 p.m. on the weekends. This is mainly for the interpretation component because it is a very big program. The program tries to link up as much as they can according to language but sometimes this is difficult. Language is probably 20 to 30% of the work that they do. They provide language services in Ojibway, Cree and Oji-Cree. If there is a language that they can not provide translation services in, the program will try and find someone to provide translation services in that particular dialect.

[389] The largest component is the resource work. The worker could be called to the ward to assist with discharge work, possibly transportation or to assist with accommodations until the patient can get back home to his community. They also work with the health care teams and provide support when required.

[390] She believes they could double their team and they would still be busy.

[391] The program tries to connect with patients within 24 hours of admission and any interaction with a client is electronically documented by the program.

[392] There is a co-ordinator at HSC and St. Boniface and they oversee where everyone is and where the workers can provide the most services.

[393] Two staff were hired to provide services in the Spiritual/Health Care Provider role. One is located in Winnipeg covering the whole region and the other was called to Churchill back in the Fall. There is one patient advocate and his role is to identify and resolve concerns for the patients. Other programs or resources may need to be brought into the picture to fully address patient issues. They have also received calls from patients who have been discharged and believe that the treatment they received was not proper and the advocate will also assist in those situations.

[394] There are two discharge planning co-ordinators for the region.

[395] The services are only provided when the patient is on site. Once the patient leaves and goes home, there is no ability to provide ongoing support. She believes that this is something that can be expanded to include, if there was funding.

[396] The program provides an Indigenous Cultural Awareness workshop which consists of two half days and the training can be in person or virtual. The workshop could be available to anyone working in Shared Health. The training, while highly recommended, is not

mandatory. She believes that the training should be mandatory and leadership should advocate for it.

[397] She is not part of the newer online program being developed by the U of M. The previous program was a Manitoba Indigenous Cultural Safety training program and that was all delivered online and will be wrapped up at the end of the 2024 fiscal year. There are some other organizations that need to take the training and that will still be done but the program will wrap up by the end of May of 2024.

[398] Her staff have experienced racism and the hope would be that people would see things differently after taking the training. There are a lot of misconceptions about Indigenous people that could be addressed by taking the program.

[399] Her team did not have any interaction with Ms. Samuel but services could have definitely been provided to her. If she wanted to access the program, they would have connected with her and completed an assessment. They would have assisted with chart review and talked with her. Some patients are not comfortable providing information to a non-Indigenous person. Establishing a relationship is key and getting to know them is also very important. You can help develop a plan based on the patient's support system. If the patient is not interested in the service, they do not have to use the program. The program could have also connected with family members if there was a way. The team will do what they can to get patient supports in place and that can be by phone or a video call.

[400] For patients that leave against medical advice, they have encountered this. They will find out why the patient wants to leave and what the program can do to get the patient to stay. If a person is of sound mind and wants to leave, they can not prevent them from leaving. Sometimes it can be something as simple as a phone call to someone at home to convince them to stay.

[401] The number for the program is advertised by a poster in a public area and there is a central intake line number that has never changed.

[402] The program also has access to a clothing depo to get the person clothing if they were medivaced and did not have proper clothing.

[403] There is no signage up in Indigenous languages at the HSC. She believes this would be beneficial to have for those patients whose first language is not English. At HSC, there are departments or zones with colours and animals. Regarding this practice, she was aware of the cultural component and how animals are regarded in the Indigenous culture. She believed that referring to zone with animals may be viewed as offensive.

[404] Her workers have been questioned by staff even though they are properly identified and are permitted to be in the area. The issues have largely been with nurses or other staff.

[405] Some of the recommendations Ms. Kehler made related to quick contact with the program; the sooner that a patient can get someone from her team involved, the sooner they can provide support and hope for more positive outcomes.

[406] Given that there are a lot of transfers to HSC, it would be helpful to have more than four workers.

[407] In February of 2020, there would have been five to seven staff available in the program to provide services. There were patient advocates but none would have been on site at HSC during that time.

XIV. Inquest Reports Examining Deaths in Similar Circumstances

[408] Counsel provided copies of reports of three other Inquests, namely: an Inquest respecting the Death of Douglas Leon Sanderson, an Inquest respecting the Death of Jeffrey Ray Mallett an Inquest respecting the Death of John George Ettawakapow.

[409] In the Inquest respecting the Death of Douglas Leon Sanderson, released June 2, 2014, the Inquest report examined the death of Mr. Sanderson after he had been medically cleared to be lodged at MSP. He was regularly checked every 15 minutes and showed no signs of distress. While staff were preparing to discharge him, he had difficulty getting to his feet. As he walked down a hallway, he fell against the wall and struck his head on a fire extinguisher and fell to the floor. He was still disoriented and staff assumed he was still too intoxicated to be discharged and he was assisted back to his cell. When staff checked on him, he still appeared intoxicated. Fearing he may have alcohol poisoning, an ambulance was called. When the paramedics assessed him, they noted possible indicia of brain injury. Further tests were completed and a CT scan of Mr. Sanderson's head revealed acute swelling of the brain resulting from head trauma. Medical intervention was not successful and he later died.

[410] There were a number of changes instituted at MSP after the death of Mr. Sanderson. Of the four recommendations suggested by Judge Schille, only one may be relevant to the current Inquest and that is recommendation 4 that the provincial electronic health record system be made available to paramedics in the field as well as those working at MSP.

[411] In the Inquest respecting the Death of Jeffrey Ray Mallett released December 5, 2014, Mr. Mallett died of a treatable illness, bacterial pneumonia, having been lodged in cells under the IPDA a day earlier. He struggled with addiction issues and at the time of his passing was unhoused. Mr. Mallet was not well when he was lodged and his condition worsened while in cells. He was at one point taken out of his cell and asked if he wanted medical attention and he declined. He would later die in police custody. I presided over that Inquest and made two recommendations that are yet to be implemented, due to resource constraints. The first recommendation had to do with obtaining a medical clearance for an

individual before he could be lodged in the Thompson cells IPDA to rule out any pre-existing medical conditions. The second recommendation was that Thompson establish a detoxication centre, similar to MSP, with rehabilitative services and programs to provide long term support to individuals with substance abuse issues. Both of these recommendations are relevant to the current Inquest.

[412] In the Inquest into the Death of John George Ettawakapow, dated November 7, 2024, Senior Judge Brian Colli was tasked to examine the death around Mr. Ettawakapow who was lodged under the IPDA. Mr. Ettawakapow was extremely intoxicated and was lodged with other detainees. As Mr. Ettawakapow laid on his back on the cell floor, another detainee put his leg across Mr. Ettawakapow's neck and lower face. This whole event being captured on video surveillance. Mr. Ettawakapow attempted to move the leg from his neck but did not have the strength to remove it. Dr. Younes testified that he was likely dead for about five hours before it was discovered. The cause of death was his pre-existing health condition, his state of intoxication (3.87 mgs of alcohol/100 mls of blood) at the time of his death and the placement of the leg on his neck and face. Senior Judge Colli made two recommendations, as follows:

1. In coordination with the RCMP, the Department of Health design and implement a program that would provide to police officers holding an intoxicated person in custody quick and easy access to medical assessment to determine that person's fitness to be lodged in cells. The program offered should be dedicated to those assessments or, in the alternative, give priority to them. The medical personnel, be they nurses or paramedics, should have access to medical files of that person. This program should be available in all communities where there are qualified medical personnel to perform this service.
2. The Department of Justice partner with other stakeholders to form a working group to study the viability of establishing in The Pas a safe shelter for intoxicated persons arrested by police as an alternative to holding those individuals in police cells. Potential stakeholders I suggest would be the Department of Health, Opaskwayak Cree First Nation and other First Nations in the vicinity of The Pas such as Mosakahiken Cree Nation (Moose Lake), Chemawawin First Nation (Easterville), Misipawisktik Cree Nation (Grand Rapids), the Homeless Shelter in The Pas, The Pas Town Council, RCMP, Manitoba Keewatinowi Okimakanak and Addictions Foundation of Manitoba to mention a few.

[413] Both of the principles in these recommendations would be relevant to the current Inquest, with adaptations, to include stakeholders from the Thompson region.

XV. Summary

[414] On February 1, 2020, Ms. Samuel was lodged under the IPDA after a call from McDonald's that she was intoxicated and fell from a stool on which she was sitting, twice. Video surveillance and the MTCC call both confirmed that Ms. Samuel had fallen and struck her head. The treating paramedics, Mr. Pugh and Mr. Schneider, both testified that they were not aware that she had fallen and hit her head and that was the reason for the call. Both testified that they believed the reason for the call was to conduct an assessment of Ms. Samuel and to clear her for lodging.

[415] The treating paramedics were not aware that Ms. Samuel had been recently treated for a SDH.

[416] Constable Hobbs believed that Ms. Samuel was cleared for lodging and he had no reason to believe that EMS would not have conducted a proper assessment of her. He made a decision to lodge Ms. Samuel under the IPDA because he had no one to release her to. Less than four hours later she would be found unresponsive in the Thompson cells.

[417] The Court heard evidence that the RCMP have from time to time requested that a medical doctor clear a detainee for lodging and that Dr. Sarker has seen these forms and has completed and signed same.

[418] Thompson ER physicians Doctors Amadu and Sarker both treated Ms. Samuel in the weeks before her passing. They both testified an individual with a SDH could experience headaches due to increase in intercranial pressure. The following symptoms could also be caused from a further build up of pressure: vomiting, not being able to talk and progressive headache, and these symptoms would be indicative of a re-bleed. On January 11, 2020, Ms. Samuel was transferred to HSC via medivac to get treatment for a SDH. She left before completing treatment and signed an AMA form. Dr. Pelletier testified that her leaving AMA was not known or documented by the physician that referred her to HSC. Ms. Kehler testified that services could have been provided to Ms. Samuel, had Ms. Samuel been made aware that these services existed.

[419] On January 26, 2020, when Ms. Samuel attended to the TGH ER, Dr. Sarker testified in order to assess if there was a re-bleed, he decided to observe her and had her sleep on a gurney in the hallway so staff could watch her closely. During the three hours she was observed, she slept comfortably and did not complain of pain or vomiting. Her symptoms did not appear to worsen during observation. When Ms. Samuel attended the TGH ER again on January 29, 2020, and presented with symptoms of headache, nausea and a fear that she may have a seizure, he did not believe that she had a re-bleed due to the severity of the headache and the nausea and due to the fact that she had a steady gait. She was prescribed medication to prevent seizures and was discharged. The physician also testified

that diagnosis can be difficult as some symptoms can present after the consumption of alcohol. The only definitive way to rule out a re-bleed would have been to do a CT scan, and the doctors expressed concern about limiting her exposure to unnecessary radiation.

[420] Dr. Anderson was called as an expert to testify as to the expanded scope of the Inquest on whether Indigenous specific racism and bias in health care played a role in the events leading up to Ms. Samuel's death, and if so, what can be done to prevent Indigenous specific racism and bias from contributing to future deaths in similar circumstances. It was the opinion of Dr. Anderson that Ms. Samuel did experience racism and bias in the health care system. There were several issues flowing from the evidence that helped inform and focus specific recommendations of the parties.

XVI. Themes Emerging from the Evidence

IPDA Detentions

[421] There was differing testimony about whether Thompson RCMP were using paramedics to "medically clear" detainees prior to lodging. A directive issued and released by Shared Health on February 19, 2020, stated that it was outside the scope of EMS regulations and the scope of work for paramedics to be "clearing" patients at the request of law enforcement. Mr. Pugh testified that it was common for paramedics to be called up by RCMP to clear patients. Corporal Stuckless testified that only a medical practitioner can clear a detainee for lodging. Counsel for the City of Thompson Fire and Emergency Services submits that the practice of calling upon paramedics to medically clear detainees into cells must stop until there is a true detoxification centre.

[422] Counsel for the RCMP submit that the focus on the RCMP must be on policing activities and that RCMP are not medical practitioners. They do not have the capacity for medical monitoring of detainees. They do not have access to health records of detainees, nor do they know how to interpret health records. They do not have the resources available to provide wraparound support available at places such as the Wellbriety Centre or the Main Street Project.

[423] It is not practical for all detainees to be cleared by TGH, nor is it required by RCMP policy or the law. It is not practical, given the current resources and that the average wait time at the ER is 4.2 hours.

[424] Mr. Munro similarly testified that the TGH ER physicians do not have the resources or capacity to clear prisoners for lodging under the IPDA.

[425] With respect to recommendations from the RCMP on IPDA detentions, the RCMP are open to consultations with the province to work towards removing detentions pursuant to the IPDA from the Thompson detachment and instead house IPDA detainees in a

detoxification centre separate from the RCMP. The RCMP are also open to considering any provincial initiative to fund paramedics in cells. However, if the latter were implemented, it would be the first of its kind in the country and would require many consultations with stakeholders prior to implementation.

[426] Thompson does not have a designated detoxification centre and if an individual is to be detained under IPDA, and he has no where else to go, or no one to be released to, he will be lodged in Thompson cells.

[427] Dr. Grierson provided information on the MSP detoxification program that exists in Winnipeg. Advanced care community paramedics are involved in admission and discharge of detainees and are available on site for ongoing evaluations. He recommended a detoxification centre, similar to the MSP, be established in Thompson and that the program have paramedic staff available 24/7, to conduct assessments, reassessments and continued monitoring while in detention. It was the submission of counsel for the City of Thompson Fire and Emergency Services that having such a centre would not only save lives, but it would also take the pressure off overburdened medical and law enforcement agencies.

[428] Shared Health also endorses both of the recommendations on the Mallett Inquest but suggested that the recommendations be refined to include ongoing monitoring. Dr. Grierson recommended persons being detained under the IPDA should be first assessed by a medical professional to determine whether they need to be transported to a hospital. If they are not taken to a hospital and are detained, detainees should be monitored, re-evaluated and re-assessed until it is determined that they are safe to be discharged. The continued monitoring and assessment by a trained medical professional is key. Dr. Grierson's belief, which is informed by the data, is that the model currently operating at MSP saves lives. Since 2016, 2.2% of detainees that come through MSP as IPDA are sent to hospital. If this recommendation is implemented, the exact model of delivery would need to be explored and tailored to the needs the particular community.

[429] The Court heard evidence that since the Wellbriety Centre opened, it has greater capacity then the previous homeless shelter to accept people that may otherwise be lodged by the RCMP under IPDA. While not statistically supported, the RCMP members were of the view that the Wellbriety centre has been a good resource for the RCMP and it was the belief that there have been less IPDA detentions in RCMP cells since the Wellbriety Centre opened. I note however, in this particular case, in terms of what could have been done to prevent Ms. Samuel's death, had she been taken to the Wellbriety Centre, she likely would have suffered the same fate there.

[430] On the IPDA detentions, the following recommendations have been suggested by the parties.

Recommendations

Inquest Counsel recommendations:

- Before lodging someone in Thompson cells under the IPDA, a medical clearance for an individual be obtained to rule out pre-existing medical conditions. In addition, there needs to be ongoing monitoring, re-evaluation and re-assessment of that person by a medical professional while he is on site; and
- Thompson establish a detoxication centre, similar to MSP with rehabilitative services and programs to provide long term support to individuals with substance abuse issues.

RCMP recommendations:

- The RCMP are open to consultations with the province to work towards removing detentions pursuant to the IPDA from the Thompson detachment and instead house IPDA detainees in a detoxification centre separate from the RCMP; and
- The RCMP are also open to considering any provincial initiative to fund paramedics in cells. However, if this was implemented, it would be the first of its kind in the country and would require many consultations with stakeholders prior to implementation.

City of Thompson Fire and Emergency Services recommendations:

- That a detoxification centre, similar to MSP, be established in Thompson and that the program have paramedic staff available 24/7, to conduct assessments, reassessments and continued monitoring while in detention; and
- That the Wellbriety Centre be staffed by community paramedics, with advanced critical care training. While we wait for this to happen, having staff available at the detention centre should happen.

NRHA recommendations:

- A true detoxification centre is needed in Thompson. Wellbriety Centre has increased capacity but more funding is required for proper medical monitoring; and
- If the Court is inclined to make IPDA assessments a priority for TGH, the NRHA would like the recommendation to include a fully funded medical professional (either a doctor or a nurse) who is dedicated to IPDA assessments (as opposed to adding IPDA assessments to an already overburdened ER department and requiring the IPDA assessment to be a priority).

Shared Health recommendations:

- Shared Heath endorses both recommendations of Inquest counsel;
- Persons being detained under the IPDA should be first assessed by a medical professional to determine whether they need to be transported to a hospital. If they are not taken to a hospital and are detained, they should be monitored, re-evaluated and re-assessed until it is determined they are safe to be discharged; and
- Thompson establish a detoxification centre, similar to MSP.

Counsel for the Family support all of these recommendations.

XVII. Communication and Access to Medical Information

[431] There were several issues related to communication and access to relevant medical information that emerged from the evidence.

[432] When the paramedics and RCMP responded to the call, there was a break down in communication about why they were called, with the paramedics believing that they were there to clear Ms. Samuel for lodging and the RCMP believing they were called to lodge Ms. Samuel under IPDA. It is also clear based on the evidence that the dispatch call indicated that Ms. Samuel had fallen twice and hit her head. The paramedics testified that the patient is the best source of information, yet no questions were asked of her why they were called, or if she had any information to provide to the paramedics on her health condition. Constable Hobbs testified that while they were enroute to the detachment, Ms. Samuel mentioned "Winnipeg and seizures". While he could not remember the specific words she said, those two words alone could have been important information which may have assisted the paramedics in their assessment. There was a belief that because Ms. Samuel had no visible injuries, she was not injured. However, both paramedics testified that they did not have any information on Ms. Samuel's SDH and her recent falls and if they had, she would have been taken to the hospital.

[433] On the issue of communication, one had to do with the inability for Thompson residents to dial "911" to connect with EMS, which can delay matters.

[434] The multiple dispatchers used, the RCMP, MTCC and Thompson dispatch, caused delays, frustration for callers to have to repeat information, sometimes several times, and would result in crucial information not being passed on. The different dispatch systems could result in missed or inconsistent information being passed on to service providers. Mr. Schneider called it an inefficient and backwards system. I would agree. I likened it to playing a game of "telephone". Except this is no game. People's lives could be at stake.

[435] There is no protocol for Thompson cell guards and the RCMP officers to pass along voluntary self-disclosed medical information to incoming staff. This could potentially impact the level of monitoring for a detainee who may have a health condition.

[436] Given *The Personal Health Information Ac*t (PHIA), there are limits on what medical professionals can share with the RCMP regarding a detainee.

[437] There was also evidence provided about accessibility of medical information that could be shared amongst different health providers and health regions. It was the submission of Shared Health that there needed to be an expansion of universal medical electronic documents and access to medical records across all SDOs in Manitoba. Privacy legislation ensures the security and confidentiality of a person's health information. The PHIA sets out the rights and responsibilities for individuals and organizations. While the PHIA has valid goals of ensuring patient's privacy and confidentiality with respect to his personal health information are respected, there are times when accessing a person's medical history is crucial for the person's treatment plan. I can not foresee a situation where an individual who is seeking medical treatment would not want the physician or health care provider that is treating him, to have access to all of the relevant information. To that end, the limits in the accessibility of an individual's medical records needs to be appropriately balanced to assist a health care provider in accessing relevant medical records of a patient in order to formulate a treatment plan. If a legislative amendment is required to achieve this, then the process should be explored.

[438] There were several issues identified on the accessibility of medical information that could be shared amongst different health providers and health regions. Some examples are as follows:

- Thompson Fire and Emergency Services still uses paper PCRs and they do not have access to any medical records of past patient visits (electronic PCRs are only used in Winnipeg);
- TGH ER doctors do not have access or a flagging system to alert them to ER visits regarding the same patient within a short period of time, but a doctor can search up past visits;
- HSC ER records are available for review by Thompson ER doctors but can only be done when the patient is returning for treatment. Once a patient is admitted to HSC, those patient records are not on the same EDIS system and a Thompson ER would not have access and would have to contact the medical records unit to obtain those records, which could take time;
- Ms. Samuel did not have a family doctor and there was no physician provided with the results of her SDH treatment;
- Dr. Beiko, neurosurgeon at HSC, did not complete the discharge summary until March 7, 2020, so this information was not available to a Thompson ER physician;

- TGH ER doctors did not know that Ms. Samuel left HSC prior to completing her treatment, as these documents were not accessible to them in EDIS; and
- Dr. Pelletier testified that it would have been standard for Ms. Samuel to have a follow up neurology appointment, but this was not documented on her chart. A letter would have been sent to her address but as she had no fixed address, and no family physician, she was not notified of any follow up care.

[439] There was a discussion amongst service providers of the pros and cons of a flagging system for frequent emergency room visits but some concerns noted were that it would just add to the "frequent flier" stereotype. Mr. Munro testified that a flagging system at triage was currently being worked on as he believed that there needed to be a mechanism for flagging visits if someone is visiting an ER a number of times in a short period of time.

[440] On the issues of communication and access to medical information, counsel make the following recommendations.

Recommendations

Inquest Counsel recommendations:

- Universal provincial 911 system;
- Expansion of ePCRs across Manitoba, which would include the ability for paramedics to receive electronic dispatching information; and
- Expansion of universal medical electronic documentation and access to medical records across SDOs in Manitoba.

RCMP recommendations:

- First responders arriving on a scene should be provided with all of the information required for them to do their jobs, as well as knowledge as to why they are being dispatched to a scene.

Thompson Fire and Emergency Services recommendations:

- Implementation of a Universal provincial 911 system and elimination of local dispatch;
- Expansion of electronic PCRs across the province which includes the ability of paramedics to receive electronic dispatching information;
- Expansion of universal electronic documentation including access to medical records across SDOs in Manitoba;

- With respect to electronic PCRs and electronic dispatch, have the system integrated with 911 or next generation 911, which would have GSP data from cellular phones to pinpoint or track callers' exact location;
- The goal of Shared Health to expand electronic PCRs within 24 months must be met; and
- There must be better co-ordination of inter-agency communication regarding a 911 call. This is a shared responsibility that can not be neglected.

NRHA recommendations:

- A single documentation platform across all medical centres in Manitoba; and
- A flagging system in EDIS, when a patient has recently had multiple visits (currently in development by NRHA).

Shared Health recommendations:

- Universal provincial 911 system;
- Expansion of ePCRs across Manitoba which could include the ability for paramedics to receive electronic dispatching information. Shared Health is in the process of expanding this to outside of Winnipeg; and
- Expansion of universal medical electronic documentation and access to medical records across SDOs in Manitoba.

Counsel for the family of Ms. Samuel support the recommendations of all counsel.

XVIII. Resource Issues

[441] Do more with less. This was a recurrent theme in this Inquest. The RCMP, paramedics and Thompson ER physicians all testified how under-resourced Thompson is. Corporal Stuckless testified that the RCMP are chronically short members, and she had to deny leave to the RCMP members when she was in Thompson, which resulted in very upset staff. She also testified that detachments are so short staffed that management are being put in positions to temporarily fill vacancies. Constable Hobbs, a fairly new member at the time, also testified that the Thompson detachment is usually short staffed.

[442] Paramedics Pugh and Schneider both testified that while they worked in Thompson, they were provided multiple opportunities for overtime. While Mr. Pugh testified that he would not be rushing through an assessment even though the paramedics were extremely busy, the paramedics were dispatched to another call at the Boston Pizza restaurant right after they were done dealing with Ms. Samuel. There is also a high turnover of paramedic staff in Thompson because staff would be called upon daily to work overtime.

[443] Doctors Amadu and Sarker both testified that TGH ER is extremely busy. Dr. Sarker testified that a doctor could see anywhere from 80 to 110 patients a day. In addition to the physical patients presenting at the ER for care, Dr. Amadu testified that the physician working could also receive up 50 calls a day from the nursing stations. The Thompson ER only has one physician working form 10:00 p.m. to 8:00 a.m. Blood work and other diagnostic services are only provided on an on call basis in the evening. In addition, the Thompson ER provides follow up for intravenous antibiotics, wound care and casting/orthopedic services.

[444] There are only 10 treatment beds in the Thompson ER. There is a lack of AFM detox beds. Dr. Sarker testified that if he had more bed space available, he may keep some patients with addiction issues until sober to talk about treatment options.

[445] Ms. Kehler talked about the positions available in Winnipeg to provide services to Indigenous patients and said that even if they double the amount of Interpreter Resource workers, the staff would still be busy. There was no one available to provide translation services in the Dene language but they hope to provide services for all Indigenous dialects on request.

[446] Shared Health agreed that improvements can be made in the delivery of health services in Thompson. Shared Health agrees with Inquest counsel's submission that determining those appropriate changes and models of delivery should be left to the health care experts and SDOs, who can in part, analyze relevant data to ensure appropriate allocation of resources. Shared Health is committed to working with its partners in delivery of health care, including NHRA and Thompson Fire and Emergency Services to ensure resource allocation and to ensure the most efficient use of resources.

[447] Counsel for the City of Thompson Fire and Emergency Services highlighted the testimony of Dr Grierson. Dr. Grierson testified that the lack of resources is something that ails the system as a whole. However, the impact is far greater in the regions and even greater in the North. Staff are overworked and under resourced and that is across all systems. The Inquest heard from the paramedics that there is a high turnover of paramedics and an almost daily occurrence of staff called in to work overtime. The need for service outpaced the two ambulances in operation.

[448] Counsel for Thompson Fire and Emergency Services submits that there needs to be an expansion of health services available to residents of the North. In particular regard to Thompson Fire and Emergency Services, the expansion and proper funding of paramedic services are paramount based on the evidence regarding the unit hour utilization and number of paramedics. This is not sustainable. Increased staffing for paramedics and in the TGH ER, are required. There is only one ambulance bay at the TGH. There are two

ambulances currently. More ambulance bays are required to reduce wait times to provide patient ambulance care at the TGH.

[449] More resources are required for addictions, trauma, mental health issues and outreach in Thompson. This is needed to ensure efficient and optimum services and stripped to its core, these resources are required to save lives.

[450] On the issue of additional resources, counsel make the following recommendations.

Recommendations

Inquest Counsel recommendations:

- Expansion of health services available to the residents of Thompson. SDOs are the best positioned to determine the needs of the North. However, Dr. Sarker recommended that moving out non-emergent services such as wound care, the casting clinic and intravenous antibiotics would be a good place to start to relieve some of the strain in the ER;
- Adding a minor injury clinic could be explored, as was done in Brandon, Manitoba;
- Increasing the number of ER physicians, nurses and diagnostic services in Thompson; and
- Expansion of paramedic services in Thompson during peak times to bring the unit hour utilization percentage to within 30 to 35% (Tab 46 D).

RCMP recommendations:

- The majority of the submissions advanced by Inquest Counsel do not touch on the mandate of the RCMP, and the RCMP takes no position on these recommendations.

City of Thompson Fire and Emergency Services recommendations:

- Expansion and adequate funding of paramedic services in Thompson;
- Increase staffing for the paramedic service in Thompson;
- Increase staffing at the TGH ER; and
- Increase the number of ambulance bays at TGH ER. There is currently only one bay but there are two ambulances.

NRHA recommendations:

- Increase the bed space for the THG ER. The current resource of 10 beds is insufficient to meet the demand;

- Having further hours of physician coverage would be advantageous, and more appropriately distributed for coverage based on the demands of the TGH ED (41 hours of coverage for TGH compared to 56 hours of coverage for Brandon);
- Increased amount of nursing staff and clinical support staff (unit assistant/clerk, health care aid);
- Twenty-four hour coverage by a radiologist, lab technician, CT technicians; and
- Funding to allow outpatient programs to occur outside of the TGH ER, such as a minor injury/illness clinic suggested by Inquest Counsel.

Shared Health recommendations on resource issues:

- Improvement in the delivery of health services available to the residents of Thompson;
- Improvement in the delivery of paramedic services available to the residents of Thompson; and
- More client discharge support for patients in Manitoba, including more resources to allow transportation back to the community of origin and increasing medical escorts.

Counsel for the family of Ms. Samuel support the recommendations of all counsel.

XIX. Against Medical Advice (AMA)/Discharges

[451] Ms. Agnes Samuel testified that her sister told her she left HSC because she felt like she was tied down and was being experimented on. Ms. Kehler testified that had she been connected with the Indigenous Resource worker, things may have been different and they may have been able to persuade her to stay. Dr. Pelletier testified that they may have been able to medivac her back to Thompson to the TGH, if her concern was that she did not want to stay in Winnipeg. As the AMA/Discharge was not properly documented, we are left to wonder and speculate why Ms. Samuel chose to leave. Dr. Pelletier also believed that health care professionals need to educate themselves on providing trauma informed care.

[452] Dr. Pelletier and Dr. Anderson both testified about the importance of outpatient planning, including scheduling follow up appointments and patients being made aware of when to go back to an ER if certain symptoms present.

[453] On the issue of AMA/Discharges, counsel make the following recommendations.

Recommendations

Inquest Counsel recommendations:

- More client discharge support for patients in Manitoba including more resources to allow transportation back to home communities and increasing medical escorts.

RCMP recommendations:

- The majority of the submissions advanced by Inquest Counsel do not touch on the mandate of the RCMP, and the RCMP takes no position on these recommendations.

NRHA recommendations:

- More robust accommodations for patients when flown in from their community of origin; and
- When Indigenous patients are discharged, that additional support be provided to allow transportation back to the community of origin. In addition, that the use of medical escorts for Indigenous patients be increased.

Shared Health recommendations:

- More client discharge support for patients in Manitoba, including more resources to allow transportation back to home communities and increasing medical escorts.

Counsel for the family of Ms. Samuel support the recommendations of all counsel.

XX. Systemic Racism and Bias in the Manitoba Health Care System

[454] Dr. Anderson provided expert testimony that Ms. Samuel experienced racism by the health care system in the weeks leading up to her death.

[455] She specifically noted minimizing symptoms, use of language such as "alcohol abuser", and lack of diagnostic follow up to her complaints and discharge information that did not correspond with treatment of her complaints on some visits.

[456] She also had concerns about personal medical information being passed along to the RCMP. She believed that it would be better to have a detox centre separate from the RCMP detachment, like MSP, rather than have a medically trained person in a police facility. She felt that Indigenous people would be more likely to share health information with health care providers than voluntarily providing medical information to the RCMP.

[457] The NRHA, HSC and Shared Health all acknowledge that systemic racism exists in health care.

[458] Counsel for Thompson Fire and Emergency Services submit that the Inquest benefited greatly from report and evidence of Dr. Anderson. Her finding that Ms. Samuel experienced Indigenous specific racism during her interactions with the health care system in the weeks leading up to her death is undeniable. All parties to the Inquest have shared the steps they have taken, and continue to take, to address this important issue. It is obvious that there is still much to do. This work, no matter how rigorous and difficult it is, can not stop.

[459] Shared Health has made a commitment to improve health equity by identifying and addressing gaps that exist in access, experience and outcomes for racialized individuals, including Indigenous patients. Work is underway to create an Indigenous health operating model, collection of REI data to gather health outcome data, use of the racial climate survey report, development of the TRCC tool and development of new cultural safety racism training. Shared Health has implemented the following: a broader education and training plan; the Racism Disrupted Steering Committee; the development of a plan to disrupt and dismantle racism; and development of anti-racism policies. There is much work to be done and Shared Health has made a commitment to action.

[460] Shared Health has developed a steering committee, along with an action plan to disrupt racism. Shared Health has also created a number of Indigenous Health positions to aim to have a representative workforce and to provide support to patients in the North accessing health services. Ms. Lafreniere testified as to the number of positions that have been created to provide these services. In addition, there is a process in place that is currently being developed to deal with complaints of racism in the health system.

[461] The NRHA recognizes that Indigenous specific racism exists and must be eliminated from the health care system as well as from all of Manitoba's institutions. As part of the calls to justice of the TRCC and many other organizations calling for reconciliation, systemic Indigenous specific racism must be acknowledged and addressed.

[462] Ms. Lafreniere testified that NRHA has recently created an Indigenous Health Department which has recently been expanded to include Elders/Knowledge keepers, Indigenous liaison workers and allowing KIM funded Sākihiwēwin Patient Advocates to work in the TGH.

[463] NRHA offers a mandatory two day cultural proficiency and safety training course that has a classroom component with a day on the land. The training is only mandatory for employees but Ms. Lafreniere, Ms. Kehler and Dr. Anderson all were of the view that the training should be mandatory for all service providers. Some of the challenges with making it mandatory were that there was no way to track if a service provider has taken the training because a lot of physicians are locums or agency staff.

[464] RCMP has cultural safety training for members but not for cell guards. No training is required for the City of Thompson paramedics and both paramedics testified that they have never taken any training or education related to Indigenous people.

[465] Racism in the health care field can take many forms, including that Indigenous patients are less likely to feel their needs are taken seriously, assuming that patients are drunk or on substances, patients being discharged without proper support and follow up, frequent flyer stereotypes and that patients do not take responsibility for their health or are

non-compliant with medical advice. Dr. Anderson was of the view that bad outcomes can happen, regardless of malicious intent, and that is where the harm lies.

[466] Dr. Anderson stated that it is not known if the death of Ms. Samuel could have been prevented or not. However, it was her evidence that Ms. Samuel received biased health care because of who she was and improvements can and must be made.

[467] Counsel for the family commend the family for pushing for the scope of the Inquest to be expanded to look at whether systemic racism and bias played a role in Ms. Samuel's death. Counsel also thank the parties for agreeing that this was an important issue that needed examination. The family is very grateful that Dr. Anderson agreed, and was able to provide her expert evidence on this issue. It is clear from the evidence that Ms. Samuel was in a very vulnerable position and she needed the support of a patient advocate when she left HSC in January of 2020. It is also undeniable that she needed the support of her family in her dealings with the hospital and in particular, her medivac to Winnipeg during that same time.

[468] I am confident that all parties are committed to making changes to prevent future deaths from occurring in similar circumstances. There is recognition that additional resources and political will are required to effect change. All parties, including Indigenous stakeholders and organizations, and the community at large, need to work together. As Ms. Agnes Samuel said we need "to look out for one another" to bring about meaningful change in the health care system and in the City of Thompson to prevent a similar tragedy from occurring again in the future.

[469] On the issue of systemic racism and bias in the Manitoba health care system, counsel make the following recommendations.

Recommendations

Inquest Counsel recommendations:

- Mandatory cultural safety and anti-racism training, including an annual or continual learning requirement, for all medical and clinic staff in Manitoba, including paramedics, locum and Agency staff;
- Continued creation and expansion of an Indigenous Health Department in all SDOs in Manitoba to allow for an increase in the number of Indigenous liaison workers, Elder/Knowledge Keepers and Indigenous health services roles to ensure patient support, navigation, advocacy and access to traditional health and healing practices; and
- Increase in the number of Indigenous health staff, system wide, to ensure a representative workforce.

RCMP recommendations:

- The majority of the submissions advanced by Inquest Counsel do not touch on the mandate of the RCMP, and the RCMP takes no position on these recommendations.

City of Thompson Fire and Emergency Services recommendations:

- There must be mandatory cultural safety and anti-racism training, including continual learning requirements of all medical staff, including paramedics. Cultural training, standardized Shared Health training available to all paramedics and then localized by local agency or Shared Health, specific to First Peoples in the region. Thompson needs a formalized orientation of training and re-training and ongoing education, planned in conjunction with the province;
- Continued creation and expansion of Indigenous health departments in all SDOs in Manitoba to allow for increase in the number of Indigenous liaison workers, Elder/Knowledge Keepers and other expanded Indigenous health services roles; and
- Increase the number of Indigenous staff in all heath care fields for a more representative workforce.

NRHA recommendations:

- Funding for a 24/7 social worker and MKO advocate (ideally Indigenous positions);
- Requiring that first responders, Agency nurses and locum physicians provide written confirmation of cultural proficiency training to employers;
- A shift in critical incident reporting to apply a lens of reviewing for racism and bias; and
- Systemic racism is about rules that are inherently racist, accordingly, the NRHA suggests that as one of the recommendations of the Inquest, as recommended by Dr. Anderson, that a third party should review the policies of the parties involved to determine if there exists inherent racism within the policies.

Shared Health recommendations: (adopts all Inquest Counsel recommendations)

- Mandatory cultural safety and anti-racism training, including an annual or continual learning requirement for all medical and clinical staff in Manitoba, including paramedics, locum or Agency staff;
- Continued creation and expansion of an Indigenous Health Department in all SDOs to allow for an increase in the number of Indigenous liaison workers, Elder/Knowledge Keepers and other expanded Indigenous health services roles so

there is more system navigation and support and access to traditional health and healing practices; and

- Increase in the number of Indigenous staff in all health care fields for a more representative workforce.

Counsel for the family of Ms. Samuel support the recommendations of all counsel.

XXI. Closing Comments

[470] I do not want to end this Inquest on a negative note but there were two issues that arose during the course of the proceedings that need to be addressed. The first has to do with the late disclosure of the MTCC recording. It highlighted another difficult theme of this Inquest. After the paramedics had already been called to testify, an MTCC recording that was thought not to be recoverable, was in fact recovered and disclosed by Shared Health. This resulted in an adjournment to determine what, if any, impact this audio recording would have on the proceedings. The family of Ms. Samuel were not happy and were suspicious. And rightfully so. They waited a long time for this Inquest and this yet was another delay. For those in the court system, we know this can happen from time to time and the proper remedy is an adjournment of the proceedings. The family, I suspect, took this as a system trying to hide wrongdoing and withhold information. It is yet another stark reminder of the immense distrust that exists between Indigenous people and various institutions.

[471] The second incident I wanted to address was the unfortunate incident that occurred at the Winnipeg Courthouse when Councillor Modest Tssessaze had his ceremonial drum questioned by security. Ms. Cannon summed it up best when she stated in her submissions: "This Inquest has been about racism and bias and clearly this action only hits home how far we have to go in being culturally attune and respectful. It demonstrates that reconciliation is an ongoing action that requires commitment and attention everyday. Let this reminder be part of this Inquest's legacy". This incident should have never happened. Regrettably, it is another example of the lack of understanding and respect displayed by non-Indigenous individuals about the significance and importance of ceremonial objects in Indigenous culture.

[472] Despite these events, I am hopeful that the family can take comfort in knowing that these issues, as uncomfortable and awkward as they were, were addressed in an open and honest fashion.

[473] There is an acknowledgment that racism exists in the health care system. NRHA and Shared Health are committed to facing it head on and have already begun the work to address it. As Ms. Lafreniere stated in her testimony, we need to look at the costs of not making changes. A preventable death and an Inquest are the costs. This report suggests

many recommendations on how to prevent a similar tragedy from occurring again. It is my sincere hope that each and every recommendation are seriously considered and implemented.

XXII. Acknowledgments

[474] Many thanks to counsel for all of their assistance in this Inquest. I was fortunate to have professional, respectful and prepared counsel. I want to particularly thank Ms. Theresa Cannon for all of her hard work in seeing this Inquest through its completion. She did her best to address any concerns of the family and did so with much care and compassion.

[475] Thank you to all of the individuals who took time to testify in the Inquest, particularly all of those in the health care field. I am aware that it took time away from their busy practice to provide information to the Court that is extremely helpful in shaping recommendations.

[476] I want to acknowledge the parties who observed the Inquest proceedings. Your presence shows the family that this is important. Your presence shows that Ms. Samuel mattered. Your presence shows that you care.

[477] MKO was gracious in allowing us to use their facility for a week in Thompson and it needs to be acknowledged. MKO staff also provided spiritual and traditional support to the family for the duration of the Inquest. Candace House also provided support to the family for the first time ever in an Inquest, and I want to acknowledge and thank them for the assistance they provided to the family.

[478] Last, but not least, I want to acknowledge the family of Ms. Celine Samuel. Losing a loved one to natural causes is extremely difficult. Knowing that your loved one passed in the circumstances that Ms. Celine Samuel did, just compounds the loss and trauma. Her sister, father of her children, her children and other family supports observed several days of the Inquest. As in my last and only other Inquest I have presided over, it was the sister of the deceased that sat through every day. I want to acknowledge Ms. Agnes Samuel for sitting through these difficult, trying proceedings. While listening to the last moments of her sister's life, she displayed much strength and courage. Mahsi Cho.

"Original signed by:"
DOREEN REDHEAD, P.J.

M A N I T O B A

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: Celine Samuel

Schedule 1
To Report on Inquest Respecting the Death of Celine Samuel
Witness List

Agnes Marie Samuel	Sister of Celine Samuel
Constable Travis Hobbs	RCMP, Thompson Detachment
Devin Pugh	Primary Care Paramedic and firefighter
Bradley Robert Schneider	Paramedic, partner of Devin Pugh
Jonna McDonald	Community Safety Officer, City of Thompson
Kelly Laybolt	Cell Guard at RCMP Detachment, Thompson
Corporal Julie Stuckless	RCMP Thompson Detachment
Dr. Adam Ahmed Amadu	Doctor, Thompson General Hospital
Dr. Arun Kumer Sarker	Doctor, Thompson General Hospital
Dr. Robert Grierson	Chief Medical Officer, Emergency Response, Shared Health
Dr. Marcia Anderson	Family Expert Witness
Gina Spence	Manager Wellbreity Centre, Thompson

Chad Willian Munro	Vice President, Northern Regional Health Authority
Charlene Lafreniere	Chief Indigenous Health Officer, Northern Regional Health Authority
Dr. Manon Pelletier	Chief Medical Officer, Health Sciences Centre
Bonita Kehler	Integration Manager for Indigenous Health, Winnipeg Regional Health Authority

M A N I T O B A

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: Celine Samuel

Schedule 2
To Report on Inquest Respecting the Death of Celine Samuel
Summary of Recommendations

Recommendations Re: Intoxicated Persons Detention Act (IPDA) Detentions

Inquest Counsel recommendations:

- Before lodging someone in Thompson cells under the IPDA, a medical clearance for an individual be obtained to rule out pre-existing medical conditions. In addition, there needs to be ongoing monitoring, re-evaluation and re-assessment of that person by a medical professional while he is on site; and
- Thompson establish a detoxication centre, similar to MSP with rehabilitative services and programs to provide long term support to individuals with substance abuse issues.

RCMP recommendations:

- The RCMP are open to consultations with the province to work towards removing detentions pursuant to the IPDA from the Thompson detachment and instead house IPDA detainees in a detoxification centre separate from the RCMP; and
- The RCMP are also open to considering any provincial initiative to fund paramedics in cells. However, if this was implemented, it would be the first of its kind in the country and would require many consultations with stakeholders prior to implementation.

City of Thompson Fire and Emergency Services recommendations:

- That a detoxification centre, similar to MSP, be established in Thompson and that the program have paramedic staff available 24/7, to conduct assessments, reassessments and continued monitoring while in detention; and

- That the Wellbriety Centre be staffed by community paramedics, with advanced critical care training. While we wait for this to happen, having staff available at the detention centre should happen.

NRHA recommendations:

- A true detoxification centre is needed in Thompson. Wellbriety Centre has increased capacity but more funding is required for proper medical monitoring; and
- If the Court is inclined to make IPDA assessments a priority for TGH, the NRHA would like the recommendation to include a fully funded medical professional (either a doctor or a nurse) who is dedicated to IPDA assessments (as opposed to adding IPDA assessments to an already overburdened ER department and requiring the IPDA assessment to be a priority)

Shared Health recommendations:

- Shared Heath endorses both recommendations of Inquest counsel;
- Persons being detained under the IPDA should be first assessed by a medical professional to determine whether they need to be transported to a hospital. If they are not taken to a hospital and are detained, they should be monitored, re-evaluated and re-assessed until it is determined they are safe to be discharged; and
- Thompson establish a detoxification centre, similar to MSP.

Counsel for the Family support all of these recommendations.

Recommendations Re: Communication and Access to Medical Information

Inquest Counsel recommendations:

- Universal provincial 911 system;
- Expansion of ePCRs across Manitoba, which would include the ability for paramedics to receive electronic dispatching information; and
- Expansion of universal medical electronic documentation and access to medical records across SDOs in Manitoba.

RCMP recommendations:

- First responders arriving on a scene should be provided with all of the information required for them to do their jobs, as well as knowledge as to why they are being dispatched to a scene.

Thompson Fire and Emergency Services recommendations:

- Implementation of a Universal provincial 911 system and elimination of local dispatch;
- Expansion of electronic PCRs across the province which includes the ability of paramedics to receive electronic dispatching information;
- Expansion of universal electronic documentation including access to medical records across SDOs in Manitoba;
- With respect to electronic PCRs and electronic dispatch, have the system integrated with 911 or next generation 911, which would have GPS data from cellular phones to pinpoint or track callers exact location;
- The goal of Shared Health to expand electronic PCRs within 24 months must be met; and
- There must be better co-ordination of inter-agency communication regarding a 911 call. This is a shared responsibility that can not be neglected.

NRHA recommendations:

- A single documentation platform across all medical centres in Manitoba; and
- A flagging system in EDIS, when a patient has recently had multiple visits (currently in development by NRHA).

Shared Health recommendations:

- Universal provincial 911 system;
- Expansion of ePCRs across Manitoba which could include the ability for paramedics to receive electronic dispatching information. Shared Health is in the process of expanding this to outside of Winnipeg; and
- Expansion of universal medical electronic documentation and access to medical records across SDOs in Manitoba.

Counsel for the family of Ms. Samuel support the recommendations of all counsel.

Recommendations Re: Resource Issues

Inquest Counsel recommendations:

- Expansion of health services available to the residents of Thompson. SDOs are the best positioned to determine the needs of the North. However, Dr. Sarker recommended that moving out non-emergent services such as wound care, the

casting clinic and intravenous antibiotics would be a good place to start to relieve some of the strain in the ER;

- Adding a minor injury clinic could be explored, as was done in Brandon, Manitoba;
- Increasing the number of ER physicians, nurses and diagnostic services in Thompson; and
- Expansion of paramedic services in Thompson during peak times to bring the unit hour utilization percentage to within 30 to 35% (Tab 46 D).

RCMP recommendations:

- The majority of the submissions advanced by Inquest Counsel do not touch on the mandate of the RCMP and the RCMP takes no position on these recommendations.

City of Thompson Fire and Emergency Services recommendations:

- Expansion and adequate funding of paramedic services in Thompson;
- Increase staffing for the paramedic service in Thompson;
- Increase staffing at the TGH ER; and
- Increase the number of ambulance bays at TGH ER. There is currently only one bay but there are two ambulances.

NRHA recommendations:

- Increase the bed space for the THG ER. The current resource of 10 beds is insufficient to meet the demand;
- Having further hours of physician coverage would be advantageous, and more appropriately distributed for coverage based on the demands of the TGH ED (41 hours of coverage for TGH compared to 56 hours of coverage for Brandon);
- Increased amount of nursing staff and clinical support staff (unit assistant/clerk, health care aid);
- Twenty-four hour coverage by a radiologist, lab technician, CT technicians; and
- Funding to allow outpatient programs to occur outside of the TGH ER, such as a minor injury/illness clinic suggested by Inquest Counsel.

Shared Health recommendations on resource issues:

- Improvement in the delivery of health services available to the residents of Thompson;

- Improvement in the delivery of paramedic services available to the residents of Thompson; and
- More client discharge support for patients in Manitoba, including more resources to allow transportation back to the community of origin and increasing medical escorts.

Counsel for the family of Ms. Samuel support the recommendations of all counsel.

Recommendations Re: Against Medical Advice (AMA)/Discharges

Inquest Counsel recommendations:

- More client discharge support for patients in Manitoba including more resources to allow transportation back to home communities and increasing medical escorts.

RCMP recommendations:

- The majority of the submissions advanced by Inquest Counsel do not touch on the mandate of the RCMP, and the RCMP takes no position on these recommendations.

NRHA recommendations:

- More robust accommodations for patients when flown in from their community of origin; and
- When Indigenous patients are discharged, that additional support be provided to allow transportation back to the community of origin. In addition, that the use of medical escorts for Indigenous patients be increased.

Shared Health recommendations:

- More client discharge support for patients in Manitoba, including more resources to allow transportation back to home communities and increasing medical escorts.

Counsel for the family of Ms. Samuel support the recommendations of all counsel.

Recommendations Re: Systemic Racism and Bias in the Manitoba Health Care System

Inquest Counsel recommendations:

- Mandatory cultural safety and anti-racism training, including an annual or continual learning requirement, for all medical and clinic staff in Manitoba, including paramedics, locum and Agency staff;
- Continued creation and expansion of an Indigenous Health Department in all SDOs in Manitoba to allow for an increase in the number of Indigenous liaison workers, Elder/Knowledge Keepers and Indigenous health services roles to ensure patient

support, navigation, advocacy and access to traditional health and healing practices; and

- Increase in the number of Indigenous health staff, system wide, to ensure a representative workforce.

RCMP recommendations:

- The majority of the submissions advanced by Inquest Counsel do not touch on the mandate of the RCMP, and the RCMP takes no position on these recommendations.

City of Thompson Fire and Emergency Services recommendations:

- There must be mandatory cultural safety and anti-racism training, including continual learning requirements of all medical staff, including paramedics. Cultural training, standardized Shared Health training available to all paramedics and then localized by local agency or Shared Health, specific to First Peoples in the region. Thompson needs a formalized orientation of training and re-training and ongoing education, planned in conjunction with the province;
- Continued creation and expansion of Indigenous health departments in all SDOs in Manitoba to allow for increase in the number of Indigenous liaison workers, Elder/Knowledge Keepers and other expanded Indigenous health services roles; and
- Increase the number of Indigenous staff in all heath care fields for a more representative workforce.

NRHA recommendations:

- Funding for a 24/7 social worker and MKO advocate (ideally Indigenous positions);
- Requiring that first responders, Agency nurses and locum physicians provide written confirmation of cultural proficiency training to employers;
- A shift in critical incident reporting to apply a lens of reviewing for racism and bias; and
- Systemic racism is about rules that are inherently racist, accordingly, the NRHA suggests that as one of the recommendations of the Inquest, as recommended by Dr. Anderson, that a third party should review the policies of the parties involved to determine if there exists inherent racisms within the policies.

Shared Health recommendations: (adopts all Inquest Counsel recommendations)

- Mandatory cultural safety and anti-racism training, including an annual or continual learning requirement for all medical and clinical staff in Manitoba, including paramedics, locum or Agency staff;

- Continued creation and expansion of an Indigenous Health Department in all SDOs to allow for an increase in the number of Indigenous liaison workers, Elder/Knowledge Keepers and other expanded Indigenous health services roles so there is more system navigation and support and access to traditional health and healing practices; and
- Increase in the number of Indigenous Staff in all health care fields for a more representative workforce.

Counsel for the family of Ms. Samuel support the recommendations of all counsel.

M A N I T O B A

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: Celine Samuel

Schedule 3
Report on Inquest into the Death of Celine Samuel
List of Exhibits

The Court was presented with Binders numbered 1 – 4 and various documents were referred to in the Inquest though none were assigned Exhibit numbers. Therefore these binders will be retained by Exhibit Control, with a copy of this Inquest Report, should they need to be accessed in future. Listed below is the Binder reference number, document name and page and paragraph in which they are referenced, followed by copies of the Binder indexes.

Page and [Para.]	Binder Reference	Document
5 [32]	Binder 1, Tab 11	C13 Prisoner Report
13 [96]	Binder 1, Tab 1	McDonald's Video Surveillance
16 [123]	Binder 1, Tab 16 iii	Reference to prisoner responsiveness chart
19 [152]	Binder 1, Tab 23	Alcohol withdrawal flow sheet
21 [170]	Binder 2, Tab 28 p.11	TGH Triage Score January 11, 2020
22 [174]	Binder 2, Tab 28 p.5	Dr. Sarker January 26, 2020
26 [202]	Binder 3, Tab 45 Tab E	WFPS Patient Care protocol under IPDA
26 [203]	Binder 3, Tab 45 Tab F	WFPS Assessment for lodging at MSP
26 [206]	Binder 3, Tab 45 Tab G	Discharge Protocol for MSP

26 [207]	Binder 3, Tab 45 Tab I	Paramedic Protocol at CPU
38 [298]	Binder 1, Tab 24 E ii	NRHA Declaration to Eliminate all Forms of Indigenous Specific Racism
38 [300]	Binder 1, Tab 24 F	Emergency Department Co-ordinated Care Plan Guidelines
38 [301]	Binder 1, Tab 23 F	Referrals for Emergency Department Co-ordinator Care Plan Service Providers
41 [322]	Binder 2, Tab 25 B	Patient/Resident/Client Advocate Agreement
41 [325]	Binder 1, Tab 24 Di	Indigenous Elder/Knowledge Keeper
41 [326]	Binder 1, Tab 24 Dii	Indigenous Health Co-ordinator
42 [332]	Binder 1, Tab 24 p.5	NHR Five Year Strategic Plan Environment Scan
42 [336]	Binder 1, Tab 24 E	Policy Implemented to Address Indigenous Specific Racism, September 29, 2023

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