

RELEASE DATE: April 14, 2026



Manitoba

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: James Stewart, Deceased

(DATE OF DEATH: November 4, 2020)

**Report on Inquest and Recommendations of
Judge R. Finlayson
Issued this 9th day of April 2026**

APPEARANCES:

Kristee Logan, Inquest Counsel
Kimberly Carswell, Counsel for the Winnipeg Police Service
Allie Derwin, Counsel for the Winnipeg Police Service
Phillip Cramer, Counsel for the Stewart Family
Nicole Beasse, Counsel for Winnipeg Fire Paramedic Service
Neil Steen, Counsel for Shared Health



Manitoba

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

RESPECTING THE DEATH OF: JAMES STEWART

Having held an Inquest respecting the said death on May 26, 2025; June 18, 2025; and October 7 and 10, 2025 at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: James Stewart.

The deceased came to his death on the 4th day of November 2020, at the City of Winnipeg, in the Province of Manitoba.

The deceased came to his death by the following means: Drug Overdose

I hereby make three recommendations for the reasons set out in the attached report.

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

Dated at the City of Winnipeg, in Manitoba, this 9th day of April 2026.

“Original signed by”

Judge R. Finlayson
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, Chief Medical Examiner (2 copies)
2. Chief Judge Ryan Rolston, Provincial Court of Manitoba
3. Honourable Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act*.
4. Mr. Jeremy Akerstream, Deputy Minister of Justice & Deputy Attorney General
5. Michael Conner, Assistant Deputy Attorney General
6. Jennifer Mann, Executive Director of the Manitoba Prosecution Service
7. Kristee Logan, Counsel to the Inquest
8. Kimberly Carswell and Allie Derwin, Counsel for the Winnipeg Police Service
9. Phillip Cramer, Counsel for the Stewart Family
10. Nicole Beasse, Counsel for Winnipeg Fire Paramedic Service
11. Neil Steen, Counsel for Shared Health
12. Exhibit Coordinator, Provincial Court
13. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba



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RESPECTING THE DEATH OF: JAMES STEWART

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EXHIBIT LIST

WINNIPEG POLICE SERVICE ROUTINE ORDER

I. MANDATE OF THIS INQUEST

[1] By letter dated November 10, 2021, the Chief Medical Examiner for the Province of Manitoba, Dr. John Younes, directed that a Provincial Court judge conduct an Inquest into the death of James Stewart for the following reasons:

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

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

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

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

[3] Section 33(2) of *The Fatality Inquiries Act* directs that I do not express an opinion that any person is culpable in relation to the death under consideration. While the *Act* contains no prohibition in relation to opinion absolving any person of culpability in relation to the death under consideration, it is important to note that is not the mandate of any Inquest.

II. INTRODUCTION

[4] A standing hearing was held on December 5, 2023, in which counsel for the sister of the accused and the Winnipeg Police Service (WPS) were granted standing. The Inquest was held on May 26, 2025; June 18, 2025; and October 7 and 10, 2025.

I will note that all counsel, with the exception of Mr. Cramer, all are employed by other than the Province of Manitoba or The City of Winnipeg. There is, therefore, no issue as to the funding of all counsel except for Mr. Cramer.

[5] As I understand Mr. Cramer made an application to the government for funding to support his role as counsel to the family at the Inquest. That application was denied. I will deal with this situation later in my recommendations.

[6] An Inquest in these circumstances is mandatory pursuant to section 7.1(1)(i) of *The Fatality Inquiries Act*.

III. THE EVIDENCE

[7] My report will include a summary of each witness who testified in this matter as well as a list of recommendations as to how to present further similar occurrences.

[8] By way of summary, Mr. Stewart died while in police custody in the early morning hours of November 4, 2020. His death was caused by a self-administered quantity of illegal drugs commonly known as methamphetamine. Mr. Stewart was a long-time drug consumer and addict. At the time of his death, he was facing criminal charges of possession of narcotics. He had a pending court date in one month. It appears as if Mr. Stewart had just acquired a large quantity of drugs which he was in the process of packaging for resale when he encountered the police. He panicked as one might expect. He was afraid of being arrested and detained in police custody especially while under the influence of drugs. The amount of drugs that he consumed during this time was a lethal quantity. When the foil that the drugs were wrapped in started to come apart some time later the overdose of illegal drugs caused the almost immediate death of Mr. Stewart.

1. WITNESSES

a. Angela Christine Stewart

[9] The first witness called by Inquest counsel Ms. Logan was Angela Christine Stewart, the sister of the deceased. She was examined by her counsel Mr. Cramer.

[10] Angela Christine Stewart testified as to the early upbringing of herself, her sister and Mr. Stewart. She testified that she and her two siblings were adopted early in their childhood. She advised that they were abused in many respects by the Stewarts and it was particularly difficult for Mr. Stewart who became involved with drugs around the age of 15. Subsequently between the ages of 15 and 20, Mr. Stewart

started using cocaine and hanging with the wrong people. By the time he was 21 years of age he was using cocaine regularly and sometimes going on long binges.

[11] From the evidence of Angela Christine Stewart, it is clear to me that by the time he was 21 years of age, Mr. Stewart was a hard-core addict. There is no evidence that Mr. Stewart tried to seek counselling or assistance with this addiction.

[12] Angela Christine Stewart testified that given her brother's addiction and the fact that she was starting her own family at about this time she had little communication with her brother.

[13] From her testimony it seems that communication between her and her brother might have increased after the birth of his son but again his addiction affected his relationship with his son's mother which probably also impacted his relationship with his sister.

[14] Angela Christine Stewart testified that the deceased shared with her that he had been arrested for drug-related charges and that he was very paranoid as he thought the police were following him everywhere that he went.

[15] Angela Christine Stewart testified that in the months leading up to her brother's death he was both frustrated and depressed. His ability to see his son on a regular basis and his ongoing addiction were undoubtedly contributing faster to the decline of Mr. Stewart's mental state.

[16] Angela Christine Stewart made a number of recommendations for this Inquest to consider. She recommended training for the police in dealing with addicted persons, she also recommended that when police suspect someone has ingested drugs the police should take them to the hospital first before taking them to the police station.

[17] Angela Christine Stewart recommended that there should be recording equipment in police cars to capture what is taking place and what is being said by all parties. She also recommended that officers wear body cameras to record what interaction is taking place. She also recommended that all interviews and holding rooms be fitted with recording equipment.

[18] Angela Christine Stewart's testimony was very helpful to the Court. Hearing a vivid picture painted of the deceased was most helpful. In addition, the Court found her recommendations to be balanced and insightful.

b. Constable A. Parashar and Constable D. Mikawoz

[19] The next two witnesses were the arresting police officers from the WPS. As these witnesses were partners and their testimony was consistent and unchallenged, I will deal with their testimony together. Constable (Cst.) Prashar was the passenger and note taker as the interaction with Mr. Stewart's vehicle first began. Cst. Parashar testified that they observed a vehicle, a truck, parked in the back lane between 565 and 579 Washington Avenue and Ottawa Avenue. The officers decided to do a routine check of this motor vehicle.

[20] As the officers approached, the truck started to move away at a fast rate of speed. The truck turned west from the Washington/Ottawa back lane and then made a southbound turn on to Watt Street. As the officers were unable to catch up to read the licence plate number of the vehicle, Cst. Mikawoz turned on both the police car's emergency lights and the cruiser's siren and air horn. The truck began to slow but kept moving forward. The vehicle made another turn and stopped in the rear of 436 Talbot Avenue.

[21] The driver of the vehicle, Mr. Stewart was placed under arrest by both officers. He identified himself, was handcuffed and placed in the rear of the cruiser car. Cst. Mikawoz observed crack cocaine in Mr. Stewart's truck and accordingly he was placed under arrest for possession of crack cocaine. While in the cruiser car Mr. Stewart stated on numerous occasions that he just wanted to go home.

[22] A subsequent computer check revealed that Mr. Stewart's licence was suspended, and another check of his person revealed some cash in his jacket pocket. A further check of Mr. Stewart's truck revealed some drug paraphernalia. Mr. Stewart was then advised that he would be charged with the following offences:

- CDSA 5(2)
- Possess Proceeds of Crime
- Drive Suspend.

[23] The officers testified that Mr. Stewart was asked if he wished any medical attention to which he declined. Mr. Stewart did volunteer that he had ingested three to five rocks of crack cocaine. On the way to the Central Processing Unit (CPU) the officers called the CPU to advise them about Mr. Stewart, and the fact that he had ingested drugs.

[24] At some point in the drive to the CPU, Mr. Stewart became erratic and started banging his head against the silent keeper. This caused Mr. Stewart's head to start to bleed. He was told to stop this behavior, and he did.

[25] Mr. Stewart was taken to the CPU and seen by Patrol Sergeant Ryan. Mr. Stewart again advised that he had consumed three to five rocks of cocaine. Next, Mr. Stewart was taken to see the paramedic at the CPU. He advised the paramedic that he consumed three to four rocks of cocaine and four points of methamphetamine. The paramedic advised that she would keep a close eye on him. She also treated the cut on his forehead. The officer noted that Mr. Stewart was sweating profusely. Subsequently an officer advised that Mr. Stewart was in medical distress and subsequent to this the officers were advised that Mr. Stewart had been pronounced dead at the St. Boniface Hospital.

c. Janelle Paluck

[26] Ms. Paluck is a qualified paramedic with over 20 years of experience. On November 4, 2020, she was on duty as a paramedic with the Winnipeg Fire Paramedic Service.

[27] On November 4, 2020, Ms. Paluck was on duty as a paramedic in the CPU at the Winnipeg Police Station. Her responsibilities included viewing detainees giving them a short medical exam and taking their vital signs.

[28] In the early morning hours of November 4, 2020, she saw Mr. Stewart as a new detainee. She testified that he was of sound mind, he knew where he was and why he was there. He could recall some of the events leading up to the arrest. His vital signs were mostly within normal limits. He had a bit of an elevated heart rate. He was a little bit sweaty, which she attributed to being a little bit agitated and having struck his head while in the back of the police car.

[29] Ms. Paluck noted a laceration in the middle of Mr. Stewart's forehead which she treated with a dressing and clean up. According to Ms. Paluck, Mr. Stewart admitted that his injury was caused by him striking his head on the plexiglass divider in the cruiser car.

[30] Mr. Stewart admitted to swallowing up to three rocks of cocaine prior to his arrest and that he was a frequent user of drugs. According to Ms. Paluck, Mr. Stewart

did not complain of any medical issues. She felt it was safe to keep him at the CPU at the time.

[31] Mr. Stewart was detained in a cell at the CPU, and she advised the officer she would check on him within 30 minutes. Within 15 minutes she was advised that Mr. Stewart was having a seizure. She attended his cell to assess him. She found him only slightly responsive. While his vital signs were only slightly changed, his level of consciousness was greatly changed. She said she walked to her office to call for an ambulance.

[32] After calling for an ambulance she returned to Mr. Stewart's cell and inserted an intravenous (IV) into him just in case they needed to give him further medication. She testified that Mr. Stewart started to fade and went into an agonal rhythm. At this point she checked to find that Mr. Stewart had no pulse. At this point Cardiopulmonary Resuscitation (CPR) was started on Mr. Stewart. CPR was continued until the ambulance arrived 10-15 minutes later. Mr. Stewart was then transported to the hospital.

d. Patrol Sergeant Ryan Fuerst

[33] Patrol Sergeant (P/Sgt.) Fuerst was the final witness called by the Crown at the inquest. P/Sgt. Fuerst testified that at about 1:30 a.m. on November 4, 2020, he received a call from a general patrol unit to bring a prisoner to the CPU. He was advised that the individual was under the influence of drugs or alcohol. The unit arrived at 1:53 a.m. Immediately the officers conducted a strip search while he (P/Sgt. Fuerst) completed the prisoner log sheet. After this he conducted the risk assessment document on Mr. Stewart personally. Mr. Stewart advised P/Sgt. Fuerst that he had suffered from seizures but more recently. Mr. Stewart did not respond when he was asked if he consumed any methamphetamine or crack within the previous 24 hours. P/Sgt. Fuerst noted a laceration on Mr. Stewart's forehead and when asked about this he indicated he had hit his head on the shield. Sgt. Fuerst assigned Mr. Stewart a cell and told him he would have to see the paramedic.

[34] At approximately 3:00 a.m., P/Sgt. Fuerst was advised that Mr. Stewart was having a seizure and that the paramedic had attended to see him. P/Sgt. Fuerst attended to Mr. Stewart's cell where a couple of his officers were conducting CPR on Mr. Stewart, and the paramedic was providing medical assistance to him.

Subsequently an ambulance attended and Mr. Stewart was taken from the CPU to the hospital.

[35] The investigation unit of the WPS took a number of other statements, both oral and written, from a number of other potential witnesses to this Inquest. By consent none of those additional witnesses were called to testify. Their statements were filed by Inquest counsel and do form part of the record of proceedings into the Inquest of the death of Mr. Stewart.

IV. RECOMMENDATIONS

[36] At the conclusion of this Inquest, I am making three recommendations as a result of the evidence heard at this hearing.

[37] The first recommendation has already been implemented. As a matter of fact it was implemented a short time after Mr. Stewart's tragic death. I am attaching for the purposes of this recommendation a copy of the WPS routine order which sets out the following:

[38] I made mention at the beginning of this Inquest that on behalf of the family Mr. Cramer had made a request to government to have his expenses covered as it pertained to representing the interests of the family. That request was denied.

[39] I appreciate that the government's position is that counsel at the Inquest is present to represent the interests of the family. Ms. Logan as counsel to Mr. Stewart's Inquest conducted her responsibilities admirably. The Court greatly appreciated her assistance in addition to all counsel to this inquest.

[40] However, Ms. Logan was not the family's lawyer. Her primary responsibility is to ensure that the proper administration of justice be carried out throughout this Inquest. It is not to advocate on behalf of the Stewart family; as Mr. Cramer had the responsibility to do.

[41] The second recommendation is that I am not recommending that counsel for all families at Inquests be afforded counsel compensated by the government. However, I would recommend that some greater latitude be exercised by government and its officials as to whether an Inquest Judge could be better served by having counsel appointed and properly funded to represent families left behind by such tragedies as the death of Mr. Stewart.

[42] The third recommendation is that the testimony of Angela Christine Stewart reminds the Court of the horrible tragedies the abuse of drugs has caused in our community. Cocaine, crack cocaine, methamphetamine, fentanyl separately and in total are having a devastating impact on individuals, families, and communities. Every day the criminal dockets are jammed with those suffering from severe addiction. The problem continues to get worse. Government cannot allow these drugs to run our communities. Strategies need to be developed by our best experts in all fields working together at the highest level and supported completely by government to deal with the ongoing problems caused by this epidemic. A multi level empowered task force is not only ideal, it is necessary.

[43] I respectfully conclude and submit this Report on this 9th day of April 2026, at the City of Winnipeg, in the Province of Manitoba.

“Original signed by”

Judge R. Finlayson
Provincial Court of Manitoba



Manitoba

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

RESPECTING THE DEATH OF: JAMES STEWART

EXHIBIT LIST

<u>Exhibit No.</u>	<u>Description</u>
1	<p>Binder of Inquest Materials Winnipeg Police Service</p> <ol style="list-style-type: none">Constable D. Mikawoz<ul style="list-style-type: none">• Transcript of Statement• Officer Notes• Narrative ReportConstable A. Prashar<ul style="list-style-type: none">• Transcript of Statement• Officer Notes• Narrative NotesPatrol Sargent Marlene Hyde<ul style="list-style-type: none">• Transcript of Statement• Officer Notes• Narrative NotesPatrol Sergeant Ryan Fuerst<ul style="list-style-type: none">• Transcript of Statement• Narrative ReportConstable David Daher<ul style="list-style-type: none">• Transcript of interview• Officer Notes• Narrative Report

6. Constable Jordan Doherty
 - Transcript of Statement
 - Officer Notes
7. Patrol Sergeant David Aitken
 - Transcript of Statement
 - Officer Notes
8. Constable Ashton Bartley
 - Transcript of Statement
 - Narrative Report
9. Constable Jason Dee
 - Forensic Identification Report
10. Prisoner Log Sheet
11. Time Checks Sheet
12. Video Surveillance of Arrest

Winnipeg Police Central Procession Officers

13. Giovanna Wickett
 - Transcript of Statement
 - Narrative Support
14. T. Concalves
 - Narrative Report
15. Braden Biggar
 - Narrative Report
16. Daniel Popel
 - Narrative Report

Civilian Witnesses Statements and Transcripts

17. Jennifer McKay
 - Transcript of Statement
18. Adam Harris
 - Transcript of Statement
19. Zachary Mondor
 - Transcript of Statement

Winnipeg Fire Paramedic Service

20. WFPS Intake Assessment - November 4, 2020

21. WFPS Patient Care Report
Office of the Chief Medical Examiner
22. Autopsy Report

2 Email from Doctor John Younes

3 Winnipeg Police Service Changed Policy



WINNIPEG POLICE SERVICE

ROUTINE ORDER

DIRECTIVE NUMBER: 280

DATE: 20 12 04

RE: MEDICAL EMERGENCY OF PERSONS IN POLICE CUSTODY:

A person in police custody must be taken to hospital for medical clearance when;

- The prisoner admits to having orally consumed or ingested either legal or illicit drugs for concealment purposes.
- Police members / Central Processing Officers observed the prisoner orally consume or ingest either legal or illicit drugs for concealment purposes.
- Circumstances give rise to Police Members / Central Processing Officers having a reasonable belief that the prisoner has orally consumed or ingested either legal or illicit drugs for concealment purposes.

At any time, should a person in police custody become unresponsive members shall render first aid immediately and request an ambulance. This first aid shall include the administering of Narcan nasal spray, regardless of whether or not a drug overdose is suspected.

If a person in custody at a police facility experiences a medical emergency, call 911 and request an ambulance. Provide the operator the building address, location of the prisoner, details of the medical emergency and person's present condition.

If the person is in a police facility other than CPU:

1. Stay on the phone with the WFPS 911 operator and provide constant updates about the prisoner's condition. Be prepared to receive and follow first aid instructions from the WFPS 911 operator until the WFPS arrives.
2. Appoint a member to:
 - a) Attend the main public entrance to meet WFPS.
 - b) Escort WFPS to the prisoner's location.

If the person is in the Central Processing Unit (ensure the address is provided as 245 Smith Street, Central Processing Unit):

1. Immediately notify the CPU Paramedic of the medical emergency.

2. In the absence of the CPU Paramedic, stay on the phone with the WFPS 911 operator and provide constant updates about the prisoner's condition. Be prepared to receive and follow first aid instructions from the WFPS 911 operator until the WFPS arrives.
3. CPU will appoint a member to:
 - a) Attend the CPU prisoner release corridor to meet WFPS.
 - b) Escort WFPS to the prisoner's location.

An update to the procedure manual topic [Death Or Injury Non-Member / In-Custody Death / Firearm Discharge](#) will follow.

* * * * *

DANNY G. SMYTH
CHIEF OF POLICE

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