

RELEASE DATE: September 12, 2024



**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 Jordan Timothy Sutherland

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**Report on Inquest and Recommendations of  
Judge Dave Mann  
Issued: September 9, 2024**

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**APPEARANCES:**

Carrie Ritchot, Inquest Counsel

Jim Koch and Erika Dolcetti, Counsel for the Government of Manitoba (Department of Justice, Community Safety Division)



## MANITOBA

### *THE FATALITY INQUIRIES ACT* REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: Jordan Timothy Sutherland

Having held an inquest respecting the said death on May 6, 7, 8, 9, 13 and 14, 2024, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: Jordan Timothy Sutherland.

I find the deceased came to his death while alone in his cell at Milner Ridge Correctional Centre between 11:30 p.m. and midnight on June 23, 2020. After unsuccessful attempts at CPR, he was pronounced deceased at approximately 1:38 a.m. on June 24, 2020, at the Beausejour General Hospital in Beausejour, Manitoba.

The cause of death was suicide by hanging.

Based on a review of the circumstances, I make recommendations as set out in the attached report. Attached as Exhibit A is a list of witnesses that were called, and Exhibit B lists the exhibits that were filed during the inquest.

Dated at the City of Winnipeg, Manitoba, this 9th day of September, 2024.

*Original signed by Judge Mann*

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Judge Dave Mann  
Provincial Court of Manitoba

**Copies to:**

1. Chief Judge Ryan Rolston, Provincial Court of Manitoba
2. Dr. John Younes, Chief Medical Examiner
3. Hon. 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. SMP Executive Assistants, Crown's Office
8. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba
9. Carrie Ritchot, Inquest Counsel
10. Jim Koch, Counsel for Manitoba Justice, Community Safety Division
11. Erika Dolcetti, Counsel for Manitoba Justice, Community Safety Division
12. Exhibit Coordinator, Provincial Court of Manitoba



Manitoba

*THE FATALITY INQUIRIES ACT*  
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: Jordan Timothy Sutherland

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## **I. INTRODUCTION**

### **The Circumstances of Jordan Sutherland’s Death**

[1] Jordan Sutherland was a 26-year-old Indigenous male, only a few weeks shy of his 27th birthday at the time of his death. Mr. Sutherland died while serving a custodial sentence for a number of offences. He appeared to have been struggling with addictions and homelessness for some time.

[2] Mr. Sutherland was described as a pleasant and cooperative person by staff at Milner Ridge Correctional Centre (“Milner Ridge”). He was noted to be non-aggressive, polite and respectful while serving his sentence. He appeared to have a good relationship with a number of the officers who testified during the inquest.

[3] It was clear that his death and the entire incident had an impact on many staff at Milner Ridge, some of whom went on leave following the tragic event. Mr. Sutherland’s death is no doubt painful for his family and friends. I express my condolences and sympathy to everyone touched by his tragic loss.

### **The Inquest Proceedings**

[4] The inquest was ordered by a letter from the Office of the Chief Medical Examiner on July 5, 2021. The inquest was mandatory under section 19(5)(b)(ii) of *The Fatality Inquiries Act* (“the Act”), *C.C.S.M. c. F52*, as Mr. Sutherland was in custody at the time of his death. The scope of the inquest was “to determine the

circumstances relating to Jordan’s death” and “to determine what, if anything, can be done to prevent similar deaths from occurring in the future”.

[5] Ms. Carrie Ritchot acted as counsel for the inquest. The Manitoba Justice, Community Safety Division was represented by Mr. Jim Koch and Ms. Erika Dolcetti. No other parties requested standing in this inquest.

[6] Given the pause in hearing inquests as a result of the Covid pandemic, the inquest did not proceed until May 6, 2024.

### **The Inquest Report**

[7] At the completion of an inquest, the Inquest Judge must complete a report in compliance with the requirements of section 33(1) of the *Act*, which states:

33(1) After completion of an inquest, the presiding provincial judge must provide the minister with a written report that sets out his or her findings respecting the following:

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

[8] The Inquest Judge is prohibited from expressing an opinion or making findings in its report such that any person could be identified as a culpable party in the death per section 33(2)(b) of the *Act*. The Inquest Judge may make recommendations in the report that are to be specific in scope and aimed at preventing future deaths in similar circumstances as required by section 33(1.1) of the *Act*, which states:

33(1.1) The report under subsection (1) may contain recommendations on changes to provincial laws or the programs, policies and practices of the provincial government or of public agencies or institutions to prevent deaths in similar circumstances.

## **II. SUMMARY OF THE EVIDENCE**

### **Jordan Sutherland's Incarceration at Milner Ridge**

[9] Mr. Sutherland was transferred to Milner Ridge from Brandon Correctional Centre ("BCC") on April 24, 2020. He was exhibiting self-harming behaviour, such as hitting his head against the wall during his pre-trial detention at BCC. Upon arrival at Milner Ridge, Mr. Sutherland was placed in the segregation unit on his request, as he did not feel comfortable going into a regular unit.

[10] On April 27, 2020, Mr. Sutherland was assessed by a three-person Suicide Risk Assessment Team and determined to be at Suicide Risk Low. The team was led by Psychiatric Nurse Greenaway and included Correctional Officer Sass and Correctional Officer Oyugi. Nurse Greenaway met separately with Mr. Sutherland and then collectively with the other officers in making the determination. She testified that a group approach gives different perspectives and sometimes inmates share things with one staff they may not tell another. The evidence was that Mr. Sutherland was not expressing any self-harm ideation or planning. He was assessed as being more hopeful and feeling better at Milner Ridge.

[11] On April 28, 2020, Mr. Sutherland was sentenced on a number of charges to a go-forward sentence of about 14 and a half months of custody.

[12] On May 5, 2020, Mr. Sutherland was seen via video by psychiatrist Dr. Graham. All psychiatric appointments took place over video at that time because of the Covid pandemic. During that appointment, Dr. Graham indicated that Mr. Sutherland was doing well and made an adjustment to his medication, decreasing the amount of Olanzapine. Mr. Sutherland was not seen again by Dr. Graham after that appointment. Dr. Graham indicated that there would generally be a couple of months between appointments, unless he was referred as a result of the symptoms reoccurring. There was no re-referral made.

[13] Mr. Sutherland remained in the segregation unit until June 8, 2020, but participated in case work and did not attempt any self-harm or express any suicidal thoughts. Officer Reske testified that he had built up what he thought was a good rapport with Mr. Sutherland and that Mr. Sutherland was encouraged to move to a regular unit, but that he was anxious being around other people and having a roommate.

[14] On June 8, 2020, Mr. Sutherland agreed to move off the segregation range. He was moved onto the Foxtrot unit. Officer Reske advised that Mr. Sutherland told him he would try the regular unit, but Officer Reske also told Mr. Sutherland that if he was feeling too uncomfortable and could not handle it, he would be moved back into segregation upon his request.

[15] On June 22, 2020, Mr. Sutherland told Officer Weigelt that he wanted to move back to segregation, so that he had his own cell and area to workout. Officer Reske met with Mr. Sutherland who indicated he was not having any thoughts of self-harm or issues with his roommate, but that he just wanted to move back. Mr. Sutherland was advised per the agreement that he would be moved back if necessary, but after further discussion with Officer Reske, he agreed to stay in Foxtrot a little longer.

[16] Mr. Sutherland transferred back to segregation the next evening, which would have been about eight hours before his death. Mr. Sutherland told officers that he needed a rest from the Foxtrot unit and may return later. He denied any thoughts of suicide at that time.

### **June 24, 2020 Incident**

[17] On the night of June 23, 2020, Officer Jonski was conducting the punch rounds that included the cells in the Golf unit (segregation). As part of the rounds, she would look into each cell and ensure that the inmates were okay and that everything seemed fine. The rounds are made approximately every half-hour but are deliberately staggered a little before or after the half-hour so that inmates do not know exactly when they will be checked. The officer doing the rounds is required to take a wand with them and punch a sensor on each range as the checks are made, so that it can be assured the checks were done.

[18] Officer Jonski completed the 11:30 p.m. rounds and everything was fine. During the next round, Officer Jonski attended to Mr. Sutherland's cell at 12:05 a.m. and observed him hanging with a bed sheet around his neck. It was later established that two bedsheets had been tied together and looped around the top bunk of the bed to allow Mr. Sutherland to hang himself.

[19] Upon observing Mr. Sutherland hanging, Officer Jonski immediately called a Code Red to alert other officers that there was a medical emergency. Several officers then attended. The shift leader, Officer Vincent, arrived first. As Officers Vincent and Jonski were entering the cell, Acting Supervising Officer Herzog and Officer Kirby arrived. The officers supported Mr. Sutherland's weight, while Officer Herzog was able to quickly remove the bedsheets from around his neck, at which time Mr. Sutherland was placed on the floor.

[20] Officers attempted to get a response from Mr. Sutherland, who showed no signs of a pulse or indication that he was breathing. Officer Vincent called 911 and the officers immediately began CPR while waiting for the Automated External Defibrillator ("AED") to arrive. Officer Herzog performed mouth-to-mouth, while Officers Kirby and Penner were rotating chest compressions. The CPR was stopped briefly to administer the AED when it arrived, but the AED indicated not to shock Mr. Sutherland, so CPR was continued until around 1:00 a.m.

[21] The ambulance and paramedics arrived during the CPR at about 12:25 a.m., but the Corrections officers continued to administer chest compressions along with and under the paramedics' direction for most of that time.

[22] Upon the Code Red initially being called, Officer Huynh attended to Cell G23 with the video camera. She remained in the doorway outside of the cell and filmed the entire interaction that was occurring inside the cell until Mr. Sutherland was taken by paramedics to the ambulance.

[23] While there are some recommendations around both training and equipment that will come later in this report, I find that the officers responded quickly and professionally in a very traumatic situation. Sadly, Mr. Sutherland was not responding at all when officers arrived and despite the efforts of Corrections staff and paramedics, he remained unresponsive.

### **Internal Reviews Completed by Manitoba Corrections**

[24] Following Mr. Sutherland's death there were two internal investigations and reports completed. A divisional report was completed by Cam Unrau, Lalaine Holder and Reanna Brockman in November of 2020. The Milner Ridge Correctional Centre also conducted a serious/critical incident review. That report was authored by Officer L. Scott.

[25] I am not going to summarize those reports. Both reports were filed as exhibits in the proceedings. However, I specifically acknowledge both reports as they were

helpful for a few reasons. First, they conducted interviews with a number of the staff involved. Second, they included a review of existing policies as well as level of compliance with those policies. Third, they considered areas that should be improved, and each report included their own list of recommendations.

[26] The recommendations in those reports have now been implemented. There is no need to include any recommendations that are now implemented in my recommendations. However, I am summarizing the more significant areas below as they were raised in the inquest and are relevant to the scope of this inquest, which is examining the circumstances of Mr. Sutherland's death and preventing similar deaths in the future.

#### Gap Between the Bed and the Window

[27] The most immediate and direct recommendation to prevent a similar death from occurring in the future was closing the gap between the upper concrete bunk and the cell window. Mr. Sutherland's cell had a concrete bunk bed that was attached to the wall. In the middle of that wall was a tall narrow window that extended above and below the upper bunk. The small gap between the bunk and the window allowed for Mr. Sutherland to get two bedsheets tied together all the way around the top bunk.

[28] This same cell design was present in all the cells in the west wing. Following the internal review, a metal plate was welded into that space in all the cells with a

similar design. I accept from the witnesses and photographs shown that this should prevent another person from doing this same thing in the future.

### Increase in Pod Staff

[29] As this incident occurred around midnight, there was only one staff member assigned to the pod. The staff member assigned to the pod has a number of responsibilities in a short period of time during a Code emergency. This includes manning the computer to monitor the situation and ensuring doors are unlocked for staff rushing to emergencies. However, there are also responsibilities that take the staff member away from the computer such as handing out equipment and turning on the range lights on the wall.

[30] Milner Ridge now has two officers assigned to all pods on a 24-hour basis. There are also clear directions to have one staff turn on lights before officers enter a cell so that the other officer does not need to leave the monitors.

### 911 Knife in the Code Red Bag

[31] When a Code Red is called, an officer is assigned to attend with the Code Red Bag. In this case, the officer assigned to the Code Red Bag grabbed the bag and attended to Mr. Sutherland's cell. However, in his rush to attend he did not retrieve the knife and had to return to get it. Not having the knife in the Code Red Bag caused delay in getting it there and unnecessary additional steps being required by an officer in a time of crisis.

[32] The knife not being initially present did not however, negatively impact this matter. Given the way Mr. Sutherland was hanging leaning forward and low to the ground, the officers were able to immediately lift him up allowing the sheets to be removed from around his neck in seconds. While the knife was not required in this situation, it is an important tool, and extra time to retrieve it could potentially be very significant in other cases.

[33] The evidence is that there is a rescue knife in the pods and escort vehicles, but there is also a standing order that one is inside all the Code Red Bags. The camera and AED are also kept with each Code Red Bag in each pod so they are all together should a crisis arise.

### **III. RECOMMENDATIONS**

[34] I now turn to my recommendations.

#### **Psychiatric/Psychological Services**

[35] The most significant area of concern raised in this inquest is the need for more psychiatric services. Several correctional officers noted the challenges of dealing with mental health issues and the assistance it would be to both the inmates and officers for them to have more psychiatric nursing staff available to assist those in custody at Milner Ridge.

[36] The Court heard from Ms. Greenaway, who has been a psychiatric nurse for more than 20 years and worked at Milner Ridge for 13 of those years. She testified

that there are currently more inmates with mental illnesses, and the mental health issues are more severe than ever before. She felt that many of the inmates in segregation should be in the psychiatric hospitals.

[37] There is currently a psychiatrist available one half-day a week. At the time of Mr. Sutherland's death, Dr. Graham was seeing patients by Zoom as a result of Covid. However, he is now back to seeing patients in person and currently attends to Milner Ridge for three and a half hours, one day a week.

[38] Dr. Graham testified that the three and half hours is not enough time for him to see all the patients he would like to see. Dr. Graham advised that the wait time to see him is not necessarily longer than for someone out of custody; and in fact, it is often shorter. However, the concern is that when he does see patients, the visits are generally shorter given the number of patients he needs to see. He testified that he often sees 10 or 11 inmates in an afternoon, which he acknowledged was a lot. He further reviews the paperwork and signs off on medication for another 14 or 15 people that he does not see personally.

[39] Dr. Graham, Ms. Greenaway and a number of the correctional officers, including Mr. Shewchuk, acknowledged that Milner Ridge requires a psychiatrist at least one full day a week at a minimum. I agree.

[40] *Recommendation #1: It is recommended that Milner Ridge increase the hours of attendance of the psychiatrist to a minimum of one full day a week.*

[41] There is similarly a need for more psychiatric nursing hours. The psychiatric nursing staff are currently seeing all patients on admission into Milner Ridge as well as any inmates who are referred to or request to see them. It was evident that more nursing staff are required to meet the complex demands of the individuals housed at Milner Ridge.

[42] The lack of psychiatric nursing resources was evident in the case of Mr. Sutherland. Mr. Sutherland was seen by Dr. Graham on May 5, 2020, and the decision was made to reduce his medication. That decision was made by Dr. Graham, but as acknowledged by Ms. Greenaway, best practices would have been to have a psychiatric professional follow up with him a couple of days after the medication was removed. This did not happen, which appears to have been largely a resource issue.

[43] Presently, psychiatric nursing staff are only available during the day. As noted by Ms. Greenaway, if there are any issues that occur after 4:30 p.m., the correctional officers are expected to carry out the crisis intervention. While I appreciate there may be challenges with hiring sufficient staff to work evenings, a psychiatric nurse working evenings would be extremely beneficial.

[44] Additional psychiatric nurses would also allow for them to facilitate some mental health groups and training, which is discussed in more detail below under Group Cognitive Behavioural Therapy (“CBT”) Training.

[45] *Recommendation #2: It is recommended that the complement of psychiatric nurses at Milner Ridge be increased significantly to at least five full-time equivalent positions.*

[46] For many of the reasons already stated above, it became apparent that Milner Ridge would benefit from the presence of a psychologist, at least part of the time. The evidence was that there is one psychologist at Headingley Correctional Centre, but there does not appear to be one available at the other provincial institutions. There is definitely not one at Milner Ridge.

[47] The need for a psychologist was echoed by some of the staff at Milner Ridge. This inquest did not explore the resources at the other institutions, but the need is no doubt present in those institutions as well. There is a recognized increase in mental health issues amongst incarcerated individuals in Canada and it is appropriate that all inmates have access to this resource as needed.

[48] In recognizing the cost of a psychologist and the needs of the various institutions, it may be that a full-time psychologist could work between a few of the provincial institutions that do not currently have one. Manitoba Corrections is in the best place to determine how it is implemented, but there is a significant need for psychological services at Milner Ridge.

[49] *Recommendation #3: It is recommended that an in-house psychologist be hired at Milner Ridge, at least on a part-time basis.*

## **Mental Health Group Programming**

[50] There are a number of programs currently being offered for offenders at Milner Ridge to address offenders' underlying criminogenic factors, but none of the programs are specifically aimed at offenders' mental health. The evidence was that some of the core programs, such as Coming to Terms, End of Aggression, Reclaiming our Identity, and the individual CBT workbooks may assist with mental health. However, none of the programs are specifically aimed at mental health issues and none of the programming is carried out by mental health professionals.

[51] All programming at Milner Ridge, including the programs listed above, are completed by Corrections officers. Those officers are trained and designated as Resource Facilitators, and I have no reason to believe are not well suited to deliver the programming that is currently being offered. That was not the subject or focus of this inquest, nor is it the additional programming being recommended.

[52] Dr. Graham and Ms. Greenaway testified about several benefits to small groups of individuals with similar identifiable diagnoses, such as mood disorders or anxiety engaging in CBT together with a psychiatric nurse or psychiatrist. Dr. Graham was not aware of any such groups in custody but indicated that there are groups like this in the community and it can be very helpful.

[53] Groups of 8 or 10 people working together with a mental health professional as a facilitator has benefits well beyond lowering their risk of self-harm. It gives

them tools to address their mental health, which will lower their risk in the community once released. Presently, without that assistance, Dr. Graham noted that most people self-regulate on their own with street drugs or alcohol.

[54] *Recommendation #4: Milner Ridge explore the implementation of mental health group programming facilitated by mental health nurses and/or a psychologist.*

### **Correctional Staff Training**

[55] Another area of concern was that training was not up to date for a number of the correctional officers who testified. A review of the training records for the institution confirms this is a broader problem. The officers at Milner Ridge receive training in a wide variety of areas, including areas such as use of force, fire safety, and crisis management. However, the two specific areas of concern that were highlighted relating to suicides, are CPR Training and Applied Suicide Intervention and Skills Training (“ASIST”).

[56] All correctional staff receive the training in both CPR and ASIST as part of their initial eight-week orientation training. The Corrections policy is that all staff receive refresher training in both areas every two years. At the time of the incident, the vast majority of officers were overdue for their refresher training. In 2021, about 90 percent of officers were overdue for their training.

[57] To be fair, those numbers are from the middle of the Covid pandemic when it was difficult and sometimes not possible to do things such as CPR training. However, the vast majority of the officers requiring refresher training in both CPR and ASIST were over two years past their refresher date. Further, while the current levels have improved somewhat, still over half of the officers are behind on CPR training, with about a third being two years overdue. For ASIST, the numbers are worse, with most officers being overdue and over half of them being two years overdue.

[58] The Court was advised that there is a training co-ordinator who is assigned to schedule the training. The backlog in training, arising out of Covid, was exacerbated by the fact that Corrections was unable to recruit new employees as they could not take part in the orientation training program. This lack of new recruits meant there were not the additional staff needed to cover shifts for existing staff to be trained. I acknowledge there are a few challenges in getting everyone trained. There are also a number of different training programs, all of which require trainers to be available, and also require resources to remove large numbers of staff from their duties for training. However, the training in these areas is important.

[59] On the evidence before me, I do not find that any deficiencies in the CPR training played a role in this incident. As noted, the officers initiated CPR quickly and continued with the assistance of the paramedics for a lengthy period of time,

without any concerns. However, people lose skills and forget things over time when the skills they have learned are not used. The refresher training needs to be a priority.

[60] With respect to the ASIST training, Mr. Sutherland was asked about suicidal thoughts by various individuals during his stay at Milner Ridge. These individuals range from officers who did not know him at all, to officers who appeared to have a good rapport with him. The evidence was that Mr. Sutherland was forward-thinking and denied suicidal thoughts. I also accept, as Dr. Graham testified, that suicide can often be very difficult to predict. However, this also highlights why it is so important that everyone's training is up to date on what to look for and how to assist.

[61] *Recommendation #5: Milner Ridge prioritize ensuring all staff are up to date on their CPR and ASIST training. This may include training more facilitators and bringing in training facilitators from outside Milner Ridge to address the shortages.*

[62] As noted, correctional staff conducted CPR for an extended period of time. They testified that the breath part of the CPR was made easier when the paramedics arrived and provided them with air bags. These air bags allowed the officers, under the direction of the paramedics, to administer breaths by squeezing the bag.

[63] The use of air bags was described as an improved way to continue CPR. There was no evidence on its effectiveness but given the air bags are utilized by the paramedics and are included in the Code Red Bag utilized by the medical unit, it would appear to be an appropriate tool. There is an air bag in the Code Red Bag in

the medical unit, but not in the bag for the rest of the units, as the other officers are not trained on its use.

[64] I recognize the backlog in training noted above, so Corrections would have to investigate the impact adding air bag training would have to the CPR course. However, the air bags were described as effective and easy to use. They did not appear to be very expensive nor require extensive training.

[65] *Recommendation #6: Milner Ridge investigate the training requirements and feasibility of adding air bags in all of the Code Red Bags.*

### **Communication of Information**

[66] It became apparent that a lot of information is shared with staff through e-mail that is only accessible while on a work computer. Most staff are working in the units and doing rounds and do not have regular access to a work computer, although there is a computer in each pod and lounge in each of the four wings. The computer in the lounge can be used by staff to check work e-mails and review shared information. This information includes updates to procedures that are often changing. Several changes were made after this incident for example.

[67] While the changes are also temporarily posted on the board, staff work different shifts and may also be away from work for periods of time. Several staff noted that with just one computer in each lounge, it is often difficult to get on to check for any updates or information. In giving evidence, it was evident staff were

not always aware of policy changes. One extra computer in the lounge would assist with this. It is of course, essential that staff utilize the computers and review all correspondence and policies on a regular basis.

[68] *Recommendation #7: That a second computer be added to each staff lounge at Milner Ridge to ensure that all staff are able to access and review all policies and procedures as changes are made.*

[69] Mr. Sutherland had been recently transferred back to segregation when this incident occurred. However, he had previously been in segregation from April 24, 2020 to June 8, 2020, and during that time a 30-day segregation assessment was not completed as required.

[70] To ensure that important checkpoints like this are not missed, there needs to be an effective reminder system. At a minimum, there needs to be a flag in the computer system to act as a reminder, which appeared from the evidence to be a fairly simple thing to add.

[71] *Recommendation #8: A flag be put into the system to ensure that assessments, such as the 30-day assessment for individuals in segregation, are not missed.*

[72] In summary:

### **List of Recommendations**

1. It is recommended that Milner Ridge increase the hours of attendance of the psychiatrist to a minimum of one full day a week.
2. It is recommended that the complement of psychiatric nurses at Milner Ridge be increased significantly to at least five full-time equivalent positions.
3. It is recommended that an in-house psychologist be hired at Milner Ridge, at least on a part-time basis.
4. It is recommended that Milner Ridge explore the implementation of mental health group programming facilitated by mental health nurses and/or a psychologist.
5. It is recommended that Milner Ridge prioritize ensuring all staff are up to date on their CPR and ASIST training. This may include training more facilitators and bringing in training facilitators from outside Milner Ridge to address the shortages.
6. It is recommended that Milner Ridge investigate the training requirements and feasibility of putting air bags in all of the Code Red Bags.
7. It is recommended that a second computer be added to each staff lounge at Milner Ridge to ensure that all staff are able to access and review all policies and procedures as changes are made.

8. It is recommended that a flag be put into the system to ensure that assessments, such as the 30-day assessment for individuals in segregation, are not missed.

#### **IV. FINAL COMMENTS**

[73] I thank all counsel for the diligent and helpful approach during the inquest. It was truly appreciated.

[74] I again express my condolences to the family and friends of Jordan Sutherland. The passing of this young Indigenous male is both sad and tragic.

[75] I respectfully conclude this report on September 9, 2024, at the City of Winnipeg, in the Province of Manitoba.

*Original signed by Judge Mann*

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**MANN, P.J.**



**MANITOBA**

*THE FATALITY INQUIRIES ACT*

REPORTED BY PROVINCIAL COURT JUDGE ON INQUEST

RESPECTING THE DEATH OF: Jordan Timothy Sutherland

**APPENDIX "A" – WITNESS LIST**

1. Liane Weigelt
2. Bradley Reske
3. Dr. Roger Graham
4. Sukhdev Singh Brar
5. Corissa Jonski
6. Cory Herzog
7. Gregory Donald Vincent
8. Jacob Alexander Penner
9. Randy Kirby
10. Anh Ly Huynh
11. Renee Sass
12. Jodine Macey-Nolan
13. Nancy Greenaway
14. Jeremey Duval
15. Dave Shewchuk

**MANITOBA***THE FATALITY INQUIRIES ACT*

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RESPECTING THE DEATH OF: Jordan Timothy Sutherland

**APPENDIX "B" – EXHIBIT LIST**

Exhibit No.	Description
1.	Medical Examiner Letter Dated July 5, 2021
2.	Larger Binder with Correctional Records
3.	Thumb Drive, including video and pictures taken by Corrections
4.	Supplemental Booklet of Correctional Records
5.	Milner Ridge Correctional Centre – Organizational Chart
6.	Milner Ridge Correctional Centre – Daily Projection List
7.	Correctional Officer Code Red Bag Checklist
8.	Nurses Code Red Bag Checklist
9.	Time Sheet for Punch Checks
9A.	Detailed Time Sheet for Punch Checks (West Unit)
10.	Present Pictures of West Golf Unit (4 photos, 1 page)
11.	Photo of the Cell in Question on the Night in Question (1 photo)
12.	Milner Ridge Correctional – Training Projections (2021-22)
13.	Training Levels of Milner Ridge Staff with Graph
14.	Updated Status of Internal Recommendations Related to Death in Custody
15.	Autopsy Report