RELEASE DATE: May 19, 2017

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: An Inquest into the death of:

MICHAEL WINSOR

(date of birth: June 3, 1991)
(date of death: September 10, 2013)

Report on Inquest and Recommendations of
Judge R.L. Pollack
Issued this 16th day of May, 2017

APPEARANCES:

Counsel to the Inquest: Patrice Miniely
Counsel for Winnipeg Police Service: Kimberly Carswell
Counsel to the Winnipeg Regional Health Authority: Daniel Ryall
Counsel to Dr. D. Schellenberg, Dr. M. Morrissette, Dr. L. Karvelas, Dr. C. Staniforth, Dr. S. Kelleher: Keith Ferbers and Curtis Parker

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THE FATALITY INQUIRIES ACT, C.C.S.M. c. F52

REPORT BY PROVINCIAL JUDGE ON AN INQUEST INTO THE DEATH OF:

MICHAEL WINSOR

Michael Winsor is the full name of the deceased. He was born on June 3, 1991 and came to his death on September 10, 2013 in the Health Sciences Centre, PsycHealth Unit PY3 South, in Winnipeg, Manitoba. At twenty-two years of age he was in poor mental health and had received recent care in Ontario, Saskatchewan and Manitoba.

Michael Winsor was an involuntary patient at PsycHealth, having just been admitted for an observation period pursuant to *The Mental Health Act, C.C.S.M. c. M110*. Using a wet towel as a ligature, he was able to partially suspend himself from a towel bar. By hanging himself in this way, this young man caused his own death by strangulation.

This report contains my essential findings and recommendations after having reviewed the evidence and submissions provided, on two occasions at my request, by Inquest counsel and counsel for the parties. On more than one occasion after adjournment, counsel provided supplementary information that was relevant and timely. I have included a list of witnesses who testified and a series of Exhibits that were admitted into evidence. The collaboration of counsel in addressing both the events leading to Mr. Winsor's demise as well as the potential for useful recommendations was helpful and productive. Although Mr. Winsor's family did not take part, they should know that his difficulties were treated with solemnity and his character with respect.

Pursuant to the provisions of subsection 33(3) of *The Fatality Inquiries Act*, I am ordering that all Exhibits be returned to the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application with notice to any party with a privacy interest.

Dated at the City of Winnipeg, in Manitoba, this 16th day of May, 2017.

"Original signed by"

Judge R.L. Pollack

Copies to: Dr. John Younes, A/Chief Medical Examiner
Chief Judge Margaret Wiebe, Provincial Court of Manitoba
The Honourable Heather Stefanson, Minister Responsible for *The Fatality Inquiries Act*
Ms. Julie Frederickson, Deputy Minister of Justice & Attorney General
Mr. Michael Mahon, Assistant Deputy Attorney General
Patrice Miniely, Counsel to the Inquest
Kimberly Carswell, Counsel for the Winnipeg Police Service
Daniel Ryall, Counsel for the Winnipeg Regional Health Authority
Keith Ferbers and Curtis Parker, Counsel for Dr. D. Schellenberg, Dr. M. Morrissette, Dr. L. Karvelas, Dr. C. Staniforth, Dr. S. Kelleher

BACKGROUND

[1] The Health Sciences Centre ("HSC") is a Winnipeg Regional Health Authority ("WRHA") hospital campus. It includes a building called PsycHealth Centre which includes locked units for the acutely ill. As such, it is a psychiatric facility for involuntary residents as defined by *The Mental Health Act*. It was there that Michael Winsor met his death.

[2] This Inquest is required by the provisions of subsection 19(3) of *The Fatality Inquiries Act,*:

> **Inquest mandatory**
>
> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe
>
> > (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in The Mental Health Act, or while a resident in a developmental centre as defined in The Vulnerable Persons Living with a Mental Disability Act, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
> >
> > (b) that a person died as a result of an act or omission of a peace officer in the course of duty;
>
> the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death. (*emphasis added*)

[3] On August 8, 2014 (then) Chief Medical Examiner Dr. Thambirajah Balachandra wrote to (then) Chief Judge Ken Champagne directing that an inquest be held:

1. to fulfill the statutory requirement (*cited above*);
2. to determine the circumstances of the death, including suicide assessment by the staff of the Health Sciences Centre;
3. to determine whether anything can be done to prevent similar deaths.

[4] After notice was given to the public, a hearing was held on April 10, 2015 to enable interested parties to apply for standing at the Inquest. Inquest counsel communicated with the father of Michael Winsor to advise him of the proceedings. Upon hearing representations from counsel for the

Winnipeg Police Service ("WPS"), WRHA and the five physicians under subpoena, I granted standing to all of the applicants as parties to the Inquest. Standing included the opportunity to present evidence, to examine or to cross-examine witnesses and to make submissions.

[5] Attached as "Appendix A" is a schedule of proceedings including witnesses and the dates upon which I heard their evidence in the Law Courts, 408 York Street, Winnipeg, Manitoba. Attached as "Appendix B" is a list of Exhibits that I admitted into evidence.

[6] It is important to note that this Inquest was neither intended nor designed to determine wrongdoing or fault; it is convened to respond to the issues put by the Chief Medical Examiner in this mandatory proceeding. Indeed, subsection 33(2) of *The Fatality Inquiries Act* states that the Inquest Judge:

> (b) shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest. (*emphasis added*)

MICHAEL WINSOR'S ARRIVAL IN WINNIPEG

[7] In the early morning hours of September 8, 2013 Michael Winsor, a 22 year old apprentice electrician, arrived at the Winnipeg Bus Depot which is located at the airport. He had been discharged the previous day from the Battlefords Mental Health Centre ("BMHC") in North Battleford, Saskatchewan after an involuntary admission.

[8] Mr. Winsor had been hospitalized in St. Thomas, Ontario the previous year. He was thought to have suffered a brief psychosis when he presented with paranoia symptoms; for this Seroquel therapy was prescribed. Mr. Winsor then went back to work in Lloydminster, Alberta. He discontinued the drug until symptoms like paranoia and hallucinations began and he found himself hospitalized again. His path to BMHC admission began on August 29, 2013. While at home, Mr. Winsor attempted to take his own life by ingesting an overdose of Seroquel. After intensive care treatment in Lloydminster, he was transferred to BMHC where Seroquel was prescribed again.

[9] The discharge summary from BMHC indicated that he believed that biker gangs were after him. A senior psychiatrist told him that he wished to

assess him again on Saturday, September 7, 2013 but Mr. Winsor wished to be discharged. He had a bus ticket to Ontario which he had already purchased and, against medical advice, he was discharged to begin his bus trip.

MICHAEL WINSOR'S 911 CALL AND THE POLICE RESPONSE

[10] Departing the Bus Depot, Mr. Winsor walked across to the airport terminal and made a 911 call from a pay phone. It was just before 1:08 a.m. on Sunday, September 8, 2013 when he told the call recipient that he needed advice about what to do because "angels" were after him. Much later in the call it became clear that he was referring to the notorious outlaw gang and not biblical angels. In a rambling conversation with the call taker, all of which was recorded, Mr. Winsor made a number of statements demonstrating paranoia about harm coming to him and his family because he had previously alienated those "angels". He believed that they had the ability to follow him and to track his telephone calls and credit card use; he was also sure that no one believed him. He spoke freely about his recent hospitalization and previous suicide attempt. When the call taker asked him if he was still thinking about hurting himself he answered in the negative.

[11] At 1:15 a.m. WPS Constables David Karsin and Gurvinder Chakal were dispatched to look into Mr. Winsor's situation. About fifteen minutes later Mr. Winsor can be heard telling the call taker that he saw them arrive in their marked police car. At 1:50 a.m. Constable Chakal began speaking to Mr. Winsor while Constable Karsin stood back. For a police officer with just three and one-half years of experience, Constable Chakal demonstrated a remarkable understanding that day of how best to approach and to speak to someone in Mr. Winsor's circumstances. The officer chatted with him for a few minutes and learned all about his hospitalization in Saskatchewan. He told the officer that he was diagnosed with an "acute psychosis". He also told them that he had no thoughts about harming himself.

[12] Section 12 of *The Mental Health Act* provided this authority to the Constables:

> 12(1) A peace officer may take a person into custody and then promptly to a place to be examined involuntarily by a physician if

> (a) the peace officer believes on reasonable grounds that the person
>
> > (i) has threatened or attempted to cause bodily harm to himself or herself,
> >
> > (ii) has behaved violently towards another person or caused another person to fear bodily harm from him or her, or
> >
> > (iii) has shown a lack of competence to care for himself or herself;
>
> (b) the peace officer is of the opinion that the person is apparently suffering from a mental disorder of a nature that will likely result in serious harm to the person or to another person, or in the person's substantial mental or physical deterioration; and
>
> (c) the urgency of the situation does not allow for an order for an examination under section 11. (*i.e. ordered by the Court*)

[13] The officers explained their interest in his well being and told him that he had to come with them to HSC. Both officers described him as cooperative and, although he was searched for officer safety reasons, he was not handcuffed when placed in the rear seat of the police car. In the car they provided him with the required notice under the *The Mental Health Act* ("Form 3" entitled "Notice to a Person in Custody"*)* that he was being taken involuntarily for examination and that he had the right to contact a lawyer.

IN THE HSC EMERGENCY DEPARTMENT ("ER")

[14] Constable Karsin parked just outside the HSC and, when Mr. Winsor was let out of the car by Constable Chakal, he turned to leave the officers behind. Constable Chakal reached out to take his arm to keep him there and he did so with no difficulty. At that point, however, his hands were cuffed behind his back. They approached a triage nurse and Constable Chakal briefed her on what had taken place, providing her with a copy of their Form 3. They were given a private waiting room, described to me as a makeshift room because of some renovations that were taking place. It had a lockable door and a window enabling Mr. Winsor to be watched from outside the room. The cuffs were removed.

[15] It was now about 3:00 a.m. and the officers were relieved for an hour by Constables Leishman and Tucker while they went for (what the night shift calls) lunch. After he was placed in that room there was no

indication that he was going to present any problem and Mr. Winsor's handcuffs were removed.

[16] At 5:05 a.m. Constables Leishman and Tucker were briefing Constables Karsin and Chakal about what had just transpired. An ER physician, Dr. Schellenberg, had seen Mr. Winsor at about 4:30 a.m. and told them that, in all likelihood, Mr. Winsor would be admitted and seen by a psychiatrist. Constable Chakal then looked through the window and saw Mr. Winsor bent over with something white over his head; Mr. Winsor was attempting to use the drawstring of his hoodie to choke himself. This caused some marks on his neck and some vomiting. He was restrained and Dr. Schellenberg was called back. Mr. Winsor was not injured.

[17] Having used their powers to detain Mr. Winsor and to bring him to HSC with a Form 3, the police were then bound by section 15 of *The Mental Health Act* to keep him in custody:

> 15(1) A peace officer who takes a person into custody for an involuntary medical examination under section 11 or 12 or an involuntary psychiatric assessment under section 9 shall remain with the person and retain custody of them, or arrange for another peace officer to do so, until the examination or assessment is completed or the person is admitted to the facility.
>
> Exception
>
> 15(2) Subsection (1) does not apply if the physician conducting the examination or assessment advises the peace officer that continuing custody is not required.

[18] Constables Karsin and Chakal remained with Mr. Winsor until 7:20 in the morning of September 8, 2013. At that time peace officers, who were employed as HSC security staff, took custody of the patient while he waited for the psychiatric assessment which Dr. Schellenberg had requested.

[19] Earlier Constable Karsin had contacted Mr. Winsor's father to let him know about the conversation at the airport and to obtain some background information. His father confirmed information about the previous hospitalization and suicide attempt and also indicated that his son was a marihuana user. As they were leaving the HSC they contacted him again to let him know that his son was being hospitalized.

[20] It was after his initial examination that Dr. Schellenberg ordered a psychiatric consultation. This witness has no independent recollection of Mr. Winsor and had to rely upon the patient chart for his testimony; I hasten to point out that he has thirty years of experience in emergency medicine and his use of the chart assisted me. It is not clear precisely when he saw Mr. Winsor but it must have been in the early morning hours of September 8, 2013 because his shift ended at 8:00 a.m.

[21] The HSC ER does not always have a psychiatric emergency nurse ("PEN") on duty. The first PEN who saw Mr. Winsor was Heather Bell. Her thirty years of experience includes being involved in the opening of PsycHealth. Nurse Bell testified that she could not recall when she came on duty on September 8, 2013 but her first charting of Mr. Winsor was at noon; she was his PEN until his transfer to PsycHealth early in the afternoon of Monday, September 9, 2013.

[22] I digress to point out that this witness received her subpoena about three weeks before she was called upon to testify. At no time before that was she told by anyone in authority that the death of Mr. Winsor in hospital would prompt an inquest and that she would be on the witness list. Not only did this dedicated caregiver accompany Mr. Winsor to his eventual hospital bed to make sure that the staff were briefed but later she phoned to check on how he was doing. Had she known that she would probably be testifying, I am sure that she would have prepared herself then with the necessary detailed notes in contemplation of a later court proceeding.

[23] Dr. Morrissette began his residency in psychiatry at HSC a few months before he found himself on call with a request to examine Mr. Winsor. He took the opportunity to speak to the patient's father to obtain some of the background information about the previous hospitalization, suicide attempt and use of street drugs. This information assisted him in determining that Mr. Winsor was suffering paranoid ideation similar to that which was diagnosed in Saskatchewan.

[24] Dr. Morrissette charted his findings at 11:50 a.m. on Sunday, September 8, 2013. He described Mr. Winsor as very frightened and very guarded. Although he denied being concerned about others out to get him, his verbal responses were slow in coming and there were questions that he just did not want to answer. In consultation with the attending psychiatrist, Dr. Morrissette completed *The Mental Health Act* "Form 4" entitled "Application by Physician for Involuntary Psychiatric Assessment".

Unfortunately no beds were available and it was necessary to hold Mr. Winsor in the ER until there was a bed opening. Dr. Morrissette started Mr. Winsor on Seroquel with a total of 200 milligrams that day and increased to 400 milligrams for the following day. He also ordered Cogentin as needed for possible side effects.

[25] I digress again, this time to explain what no bed being available really means. In Unit PY3 South, on the third floor of PsycHealth, there are fourteen beds. This is the area dedicated to mental health patients whose illness is of the highest acuity; it is the mental health intensive care unit. There were empty psychiatric beds but they were reserved for patients brought in from the Crisis Response Centre. Nurse Bell explained that the ER is busy with mental health patients and it is not unusual for them to handle ten at a time. Only two beds exist in the ER for those patients; some are brought in by ambulance or by police and some just walk in the door. The allocation of these beds is subject to the approval of a manager who contemporaneously controls all of the beds in all of the hospitals in Manitoba.

[26] As Dr. Morrissette described him, Mr. Winsor was left in the ER with thought processes and presumptions of reality that were very disturbed. He was required to remain there with a sitter until a bed became available in PY3 South. In his case, of course, “sitter” meant peace officer.

[27] Mr. Winsor demonstrated the same symptoms throughout his thirty-four-hour stay in the ER: he was fearful, not ready to trust anyone and increasingly interested in leaving. The noon-hour note from Nurse Bell includes his bolting from the room in which he was kept, wearing only underwear, and making it outside before being brought to the ground by a security guard. In that encounter Mr. Winsor suffered some scrapes to his forehead and knee which were summarily treated by Ms Bell. He was given a conservative dose of Seroquel to manage that behaviour.

[28] All day long the noises of power tools, including jack hammers, were heard in the ER. Patients like Mr. Winsor do not respond well to that sort of thing. At one point he complained that he felt the walls were going to cave in on him. While Mr. Winsor was not subjected to what has become known as hallway medicine, he certainly was unable to escape the cacophony.

[29] Because Mr. Winsor was in the ER for over twenty-four hours a reassessment was required. Dr. Karvelas has been providing ER psychiatric consultation since 2004 at the Critical Response Centre and St. Boniface Hospital as well as HSC. She, too, has no independent recollection of Mr. Winsor and testified that she certainly would have made more notes to refresh her memory had she been aware of the likelihood of an Inquest subpoena. The charts are clear that it was she who assessed him on the morning of September 9, 2013. Her assessment on the HSC consultation form indicated that Mr. Winsor was seriously ill and required hospitalization in PsycHealth. His condition was considered critical and, upon admission, he would certainly require suicide observation.

[30] Dr. Karvelas provided the Inquest with information about an additional resource for accommodating ER psychiatric patients. In October, 2014 the HSC established a Reassessment and Observation Unit ("ROU") in PsycHealth. It would have been a better place for Mr. Winsor to wait pending the availability of a hospital bed than a makeshift room amid the construction and other chaos in a major hospital ER. That said, she indicated that Mr. Winsor would not have qualified for a transfer to that unit because he was an involuntary examination patient brought in by police and there were concerns about his behaviour when agitated.

IN PSYCHEALTH PY3 SOUTH

[31] At 1:45 p.m. on Monday, September 9, 2013 Mr. Winsor was handcuffed and placed in a wheelchair. Accompanied by Nurse Bell, he was taken to PY3 South in PsycHealth. There he was under the care of Dr. Kelleher, who had just become the medical director of PY3, and Dr. Staniforth, a first year resident in psychiatry.

[32] Dr. Kelleher met Mr. Winsor that day at 2:50 p.m. in an examination room known as "the fishbowl" because of its glass wall. Dr. Staniforth sat in as she began her assessment. She, too, observed the man's manifest paranoia and recalled specifically his concern that, because of something he must have done, his family had been killed. Knowing this to be untrue (from the charts), she found it difficult to assure him and even offered a phone so that he could call them. On the basis of her diagnosed psychosis, the information from BMHC and the HSC charts, she completed *The Mental Health Act "*Form 6" entitled "Involuntary Admission Certificate", indicating

> "persecutory delusions regarding devils, believes people are chasing him, suicidal thoughts".

[33] Late that evening Dr. Staniforth was called by nursing staff and told that Mr. Winsor had attacked another patient. The staff requested an order for seclusion and restraint. Dr. Staniforth (and the other professionals) explained that patients like Mr. Winsor should be treated in a manner that restricts their freedom as little as possible. That is, of course, subject to concerns for the safety of others. When someone suffering a psychotic illness becomes paranoid then seclusion is a very frightening experience. Dr. Staniforth ordered that Mr. Winsor be secluded and retrained as necessary. He was to be put in a seclusion room and checked every fifteen minutes. Furthermore, the need for seclusion would be reassessed every two hours and each additional seclusion request required his authorization. Mr. Winsor fell asleep and continued sleeping through several authorizations for continued seclusion.

[34] Lawrence Stratton is a psychiatric nurse with over thirty years of experience at HSC. He has worked at PsycHealth since the building opened in 1992 and spent twenty-two years on PY3. He described the ward as one for patients who were "highly charged or active" and at a high risk for leaving the ward on their own. This witness was a fund of information about the use of seclusion in treating psychiatric patients, starting with the basic proposition that resort to seclusion is an indication of failure. When he was required to take a year off as a result of an injury after restraining a patient, he looked for a better solution than seclusion and, on his own initiative, did research, obtained funding and organized continuing education.

[35] With expertise drawn from centres in the United States, a new program to reduce seclusion was started. PsycHealth PY3 had been averaging twelve seclusions a month requiring sixteen hundred hours of seclusion room annually. Seclusion is now so rare that the annual average is now just seventy-five hours so what Nurse Stratton called a failure rate requiring seclusion has been reduced by ninety-five per cent.

[36] Jeffrey Schellenberg was also a full time psychiatric nurse at PY3 South. Earlier that year he graduated from Brandon University and began working part time at PsycHealth. About two weeks before Mr. Winsor's admission, he became part of the full time day shift on the unit.

[37] Nurses Stratton and Schellenberg woke Mr. Winsor on Tuesday, September 10, 2013 at 8:45 a.m. They reviewed with him the sequence of events that led Dr. Staniforth to order his seclusion. Mr. Winsor described "being 'paranoid' and thus acting out physically" against another patient; this acting out consisted of grasping a patient in a headlock. He accepted their encouragement to talk to the staff if he felt paranoid again and seemed to understand the safety needs of all patients. Having taken his 100 milligrams of Seroquel, Mr. Winsor told the nurses that he felt calm and was ready to come out of seclusion. He was escorted to the breakfast area.

[38] After breakfast Nurse Stratton recalled seeing Mr. Winsor watching television for about half an hour. Later he noticed that he was not in his room so he began a routine check of the unit. When they left the interview with Mr. Winsor, the nurses had no concerns about the patient's safety, noting that "he was well-settled and appropriate to be on the ward, receiving treatment and to be amongst other patients". It is important to note that, in addition to the patient chart which detailed all or Mr. Winsor's conduct and care since he left the police car, the nurses had access to an audio recording made by staff on the previous shift as to patient observations. Their determination that he was not a self-harm risk therefore included consideration of his intake history as well as what happened overnight.

[39] Patients on PY3 South receive care from an organized staff that includes unit assistants. Mr. Bushra was one of those assistants on the night shift commencing at 11:30 P.M. on September 9, 2013 and ending at 7:45 a.m. the following day. Upon the completion of his shift he was asked if he would take an extra shift as someone had called in sick and he agreed. Therefore he stayed on duty until 3:45 P.M. on Tuesday, September 10, 2013. For reasons that will become apparent, Mr. Bushra has a recollection of a pleasant looking young man having breakfast that morning in the kitchen area of his unit. Because Mr. Winsor was classified as requiring suicide observation, a unit assistant had to check on him every fifteen minutes. Mr. Bushra's initials appear on several occasions on the record of rounds made to check on him, particularly at 8:45 and 9:00 a.m. after Mr. Winsor woke up.

[40] Mr. Bushra took a coffee break, with the approval of the unit clerk, at about 9:15 a.m. in a lounge outside the locked unit. There has been a change in the protocol concerning staff breaks as a result of this fatality.

The unit clerk used to keep track of who was taking a break. The clerk could have denied a break if it was sought at a bad time but the nurse(s), who shared rounds with the assistants, would not necessarily know who, or how many, were on a break at any given time. Now responsibility for breaks is given to the nurse in charge and there is an electronic board displaying who is away from the unit.

THE SHOWER ROOM

[41] Still looking for Mr. Winsor, Nurse Stratton had checked the television area, an activity room and a series of alcoves and utility rooms down a hallway that led to a shower room. Although he could have checked other places such as a nearby washroom, he heard water running and walked to the shower. Having knocked loudly, he entered the room asking who was in there but he heard no response. Opening the shower curtain he found Mr. Winsor partially suspended by a wet towel that was affixed to a towel bar and tied around his neck. The towel bar was thirty-two inches above the floor; Mr. Winsor was about sixty-six inches in height.

[42] After removing the towel he stepped out and called “Medical 25”. “Medical 25” (or “Code 25”) is a medical emergency alarm and it was heard by Nurse Schellenberg who happened to be at the nursing station holding Mr. Winsor’s chart. After confirming the alarm he took the necessary steps to page it and to call for security assistance. He saw Nurse Stratton performing compressions and returned to the desk to give information to the staff and incoming security people.

[43] The Code 25 broadcast interrupted Mr. Bushra’s morning coffee. He ran back to the unit and found staff attempting to resuscitate Mr. Winsor. Before a medical emergency team from HSC arrived, Mr. Bushra took a turn applying compressions to Mr. Winsor. When the emergency medical team arrived, Mr. Bushra assisted in moving Mr. Winsor by stretcher to the Intensive Care Unit in the HSC building.

[44] It was only ten or fifteen seconds before Nurse Stratton realized that Mr. Winsor had no pulse and he changed his alarm to “Code Blue” - for a patient not breathing - to summon the HSC emergency team. Compression continued with others taking turns trying to save Mr. Winsor’s life. The autopsy report of Dr. Charles Littman indicates evidence of a series of measures taken by the medical team to assist in breathing and circulation but Mr. Winsor died at 10:45 that evening.

[45] There is simply no evidence of how or precisely when Mr. Winsor entered the shower room. While the observation logs indicate that other patients at other times were showering, no such indication is found in Mr. Winsor's case. The last notation of his whereabouts is at 9:15 a.m. and the initials appear to be those of Nurse Stratton who, as I indicated, was with him at the time. There is no entry of an observation at 9:30 a.m. and it was 9:45 a.m. when Nurse Stratton set out to look for Mr. Winsor.

[46] The shower room door is locked on the outside when closed; a person in the room can always open a closed door from the inside. If he found the door closed, Mr. Winsor would have to have been let into the shower room by a staff person with a key.

[47] A patient requiring a towel would ask for one at the nursing desk and, in this way, a staff member would know that someone was about to shower. But shower requests and times were not logged and there was no strict control of towels. Sometimes used towels were left in the shower room. And the towels, a sample of which I was shown, are so thin that, when soaked, they can have the texture of a rope.

[48] A completed suicide like this has never taken place at HSC. Some witnesses did not think that it was possible for a patient to strangle himself using a normal towel bar mounted so low that only Mr. Winsor's torso was suspended. There are solutions to address this as well as other potential opportunities for self harm.

SUICIDE ASSESSMENT BY HSC STAFF

[49] In my opinion, the HSC staff suicide assessments in the ER and at PY3 South were carried out in accordance with established protocols and criteria. That Mr. Winsor used a suicide opportunity to completion is not an indication that their assessments were deficient. And those assessments were continuously charted; no personnel were without access to those assessments. Therefore I have no recommendation in this regard.

WHETHER ANYTHING CAN BE DONE TO PREVENT SIMILAR DEATHS

[50] I interpret this category broadly. While neither can possibly be considered a cause, both the towel bar and the police were part of a chain of events that led to Mr. Winsor's death.

[51] While no one foresaw the way in which this death occurred, there exists an expertise in the area of safe architecture. Recently the Grace General Hospital ("Grace") accessed such expertise in developing new space. Ms Omar is the program director with responsibility for special services at Grace. She was involved in the recent development of a new psychiatric unit.

[52] Ms Omar provided photographs of a series of design features in that new facility that display a merger of experience, interior design and common sense. Rails that protrude from walls at Grace, whether towel bars or handrails, have no open spaces between the rail and the wall like the one that enabled Mr. Winsor to tie an end of his towel to the towel bar.

[53] There are no ligature points at Grace. Protrusions like coat hooks or toilet paper dispensers are rounded and will simply break away under stress. Doors have continuous hinges leaving no gap through which a ligature can be fed and even the top edges of cubicle doors are angled downward. Light fixtures are made flush with the walls without any protrusion.

[54] WRHA has a working group on mental health bathroom safety. Its May 20, 2015 report indicates that its purpose is to review ligature points in patient bathrooms and

> "to provide an analysis and recommendations related to the priorities to be addressed".

Regardless of the progress made by the working group, the shower room in which Mr. Winsor was able to complete his suicide is still in the same state as he found it.

[55] All of the testimony that I heard touched upon the need to be aware of how important it was for staff to be aware of the privacy needs – indeed the privacy rights – of mental health patients. Toilet and shower facilities are where patient observation usually ends and they provide opportunities for self-harm. It may well be that the aforementioned working group will address this recommendation but my Inquest report cannot fail to include it:

Recommendation #1:

It is recommended that all Manitoba health authorities carry out the necessary renovations to remove ligature points and other protrusions that enable self-harm in facilities where mental health patients require privacy.

ESCORTING INVOLUNTARY MENTAL HEALTH PATIENTS TO ASSESSMENT POINTS

[56] Dr. Enns has been the Medical Director of the WRHA Mental Health Program for ten years. He described the roles of police and hospitals in relation to people like Mr. Winsor as "a little bit of an uncomfortable alliance" where "there is an intersection between law enforcement and health care". The police, performing their sworn duties in compliance with *The Mental Health Act*, see the need to remain with patients as interference with their normal duties on the street; health care professionals would rather see the patient being taken over by health care staff as soon as possible but, as will be seen, that isn't always immediately available and sometimes only a police officer can provide security.

[57] Ms Clarke is the WRHA's Chief Operating Officer for Emergency Response and Patient Transport. She and Dr. Enns described a Joint Operating Committee of WRHA and WPS which was created in 2010, part of the alliance referred to by Dr. Enns. That committee has derived and implemented a strategy for lessening the tension and it has four main components:

1. All mental health patients in police custody are brought to HSC;
2. The PsycHealth ROU takes some of the pressure off ER resources and custodians;
3. PEN nurses and a unit assistant are available around the clock;
4. Security staff is available around the clock.

It is clear, however, that the fourth prong also presents a weakness in the strategy.

[58] The police treated Mr. Winsor as someone who needed care and they did so with kindness. It struck me, however, that detached observers unfamiliar with *The Mental Health Act* could have come to a different conclusion about Mr. Winsor had they watched a silent video of him from his first encounter with WPS at the airport through being turned over to HSC security staff.

[59] Having been approached by police in uniform and engaged in conversation with one of them, he was led to a marked police car, searched, placed in the rear seat and driven away. At the first opportunity, when the car stopped at a large building (HSC), he attempted to walk away but was guided back, handcuffed and taken inside. Just as if the building was a police station, he was brought before the official in charge – not a sergeant but, in this case, a triage nurse.

[60] Then he was placed in a room with a window on a door, not unlike a locked interrogation room. He was handcuffed again, as a result of his trying to tighten his sweat shirt drawstring around his neck, and kept in that room. For five hours he was always in the company of two uniformed armed police officers. How different from a person under arrest would Mr. Winsor have appeared in that video? And this took place in a busy ER where hospital staff and other citizens come and go all the time.

[61] During those five hours the community was paying for, and was deprived of, the services of two fully trained and equipped WPS officers and their vehicle. While they were being relieved for lunch two more officers were occupied at HSC and two patrol cars were parked.

[62] Where it has been determined that someone requires mental health assessment and care, and that person is not charged with an offence but is in police custody, the public and the detainee are best served by changing custody from police to hospital staff as soon as possible. The public is better served when the police are paying undivided attention to public safety and they are better served when mental health patients are seen through healing lenses and not those of a jailer.

[63] Dr. Jeffrey Wyman is with the organizational development and support division of WPS. He is the WPS workload analyst and he provided the Inquest with some interesting information about the impact of mental health patient calls to WPS. Dr. Wyman looked at the ten years between 2005 and 2015 and reported that police units (a unit being two police

officers) spent about 7,000 hours in 2005 on dispatched calls for mental health and suicide threat events; by 2015 that number was doubled to 14,000 unit hours.

[64] From 2011 to 2015 police responded to 18,202 suicide threat calls and 2,166 calls concerning a mental health issue. The average time spent on a suicide threat was over three and one half hours and the other mental health calls averaged over seven hours. During the same period, an average commercial robbery call only took five hours.

PEACE OFFICER ATTRITION

[65] To understand why the situational tension persists, some more law must be added to the narrative. Section 2 of the *Criminal Code, R.S.C. 1985, c. C-46* includes in its definition of "peace officer":

> (c) a police officer, police constable, bailiff, constable, or other person employed for the preservation and maintenance of the public peace or for the service or execution of civil process (*emphasis added*)

In Manitoba, Part 8 of *The Police Services Act, C.C.S.M. c. P94.5* enables the "Director of Policing" (essentially a Department of Justice official) to appoint special constables for particular purposes, an example of which is the security officers who relieved the WPS by taking over custody of Mr. Winsor. There are regulations setting out the minimum requirements for appointment as a special constable that they had to meet and the WRHA was required to provide a bond of indemnity for any liability.

[66] Although two special constables in HSC uniforms were available to take custody of Mr. Winsor, HSC cannot always have them available and that is not just because its ER is a busy place. (And it is a busy place because ER physicians like Dr. Schellenberg are also responsible for assessing trauma and cardiac patients whose situations are acute.) Based upon government legal opinion, the appointment of special constables has stopped.[1] Attrition has resulted in fewer HSC staff being available to cover shifts and therefore the last prong of the Joint Operating Committee's

[1] WRHA, citing the qualification regulations and indemnity requirements, disagrees with any concern about the validity of continuing the appointment process. I was not provided with the government legal opinion or any factual antecedents. It should also be noted that, after the hearings closed, WRHA brought to my attention Bill 17 – *The Court Security Amendment Act* – granting certain powers to court security staff. Not having heard the Bill addressed by counsel, I am not in a position to comment upon its relevance to escorting mental health patients.

strategy has been weakened. To continue applying police resources to tasks best suited for hospital resources is to reject the logic of the Joint Operating Committee.

> Recommendation #2:
>
> It is recommended that Manitoba legislative and law reform authorities examine *The Mental Health Act* and *The Police Services Act* and take all necessary steps, to introduce law amendments if necessary, to permit a police officer who has brought an involuntary mental health patient to a health care facility to transfer custody of the patient to a peace officer employed by that health care facility.

MANDATORY INQUESTS

[67] Although the shower room where the death occurred remains as it was in 2013, neither the HSC nor its partners in care have stood still awaiting this inquiry. Clearly they have reacted to this critical incident: there is now better contemporaneous control over staff at work in PY3; information about architectural safety is being studied and shared; WRHA has a plan to retrofit higher risk areas; an ROU now enables some patients to be moved from the ER to PsycHealth. The intervention of an Inquest Judge wasn't required for Mr. Winsor's demise to prompt a critical look at safety, and the Court can hardly react as quickly as a health facility (or a police department).

[68] The steady increase in police officers and prosecutors adds continuously to the Court's intake of prosecution cases. As the number of cases increases, the complement of Provincial Court Judges remains the same. In each prosecution case is an accused who has the constitutional right to be tried within a reasonable time. Therefore it will be a rare Inquest that displaces a case of sexual assault or drug trafficking in the Court's timetable. Because there are some mandatory Inquests in Manitoba, and because the Chief Medical Examiner has the authority to direct a Judge of the Provincial Court to hold an Inquest, Inquests like this one may be delayed for years after the death under examination.[2]

[2] Bill 16 - *The Fatality Inquiries Amendment Act* – is presently before the Manitoba Legislature. It would amend section 19 to give the Chief Medical Examiner the discretion not to require an inquest where the public interest does not require an inquest and, in the case of an involuntary resident as defined by *The Mental Health Act*, "where there was no meaningful connection between the death and the nature or quality of supervision or care provided".

[69] In his report of the *Inquest into the Death of Robert Wood* (May 26, 2014), Judge Colli noted:

> Inquests make heavy demands on judicial and court resources. When I was a Crown Attorney in the 1980's, longer inquests tended to last no more than a week and most were completed in one or two days. That is no longer the case. Hardly any inquest is set for less than one week and some go on for weeks and weeks. When an inquest of more than one day, which means practically any inquest, is to be set in this part of the Province, it forms part of a queue awaiting the assignment of hearing dates along with multi-day preliminary inquiries and trials of criminal charges. Sometimes, to accommodate an inquest, in-custody days in Thompson or docket days in the fifteen communities outside of Thompson where regional provincial judges sit are cancelled. In other words to hold an inquest costs resources that could easily be used on other matters, including regular circuit courts. It does not surprise me, therefore, that it has taken more than two years since the chief medical examiner directed an inquest into this death to finally complete it.

[70] An Inquest subpoena ought not to take a witness like Nurse Bell by surprise. While not every potential witness can be identified at the time of a fatality, certainly in this case the police and hospital witnesses who testified were obvious witnesses for a mandatory inquest. Indeed, counsel for WRHA was able to identify several at the time but too many testified without independent recollection.

Recommendation #3:

When a death occurs and it is clear that an inquest will take place, either because of the mandatory requirements of *The Fatality Inquiries Act* or the obvious need for an inquest because of the circumstances of the death, it is recommended that all Manitoba health authorities involved make their staff members aware that an inquest will be held at some time in the future and that it is desirable for them to make and to keep an account of their connection with the death to enable them to provide testimony.

Dated at the City of Winnipeg, in Manitoba, this 16th day of May, 2017.

"Original signed by"

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Judge R.L. Pollack

Appendix "A"
To the Inquest Report into the Death of Michael Winsor
dated the 16th day of May, 2017

SCHEDULE OF PROCEEDINGS

Date	Action	Witnesses
August 8, 2014	Inquest directed by CME	
January 7, 2015	Inquest judge assigned	
March 13, 2015	Inquest news release issued	
April 10, 2015	Inquest standing hearing	
January 18, 2016	evidence taken	Karsin, Constable David John
		Chakal, Constable Gurinder Singh
January 19, 2016	evidence taken	Bell, Heather, RPN
		Staniforth, Dr. Christopher
		Morrissette, Dr. Matthew
January 20, 2016	evidence taken	Schellenberg, Dr. Donald
January 21, 2016	evidence taken	Bushra, Ahmed
January 22, 2016	evidence taken	Kelleher, Dr. Samantha
January 27, 2016	evidence taken	Stratton, Lawrence, RPN
		McDougall, Annette, RPN
		Schellenberg, Jeffrey, RPN
May 3, 2016	evidence taken	Clarke, Helen
		Wyman, Dr. Jeffrey
		Enns, Dr. Murray
		Omar, Eve
May 11, 2016	oral submissions received	
June 27, 2016	further submissions requested	
November 21, 2016	further oral submissions received	
March 13, 2017	information re *The Court Securities Act* amendments submitted by counsel	

Appendix "B"
To the Inquest Report into the Death of Michael Winsor
dated the 16th day of May, 2017

EXHIBIT LIST

Exhibit No.	Exhibit Description
1	Two page letter from counsel dated December 1, 2015 re: standing for physician witness
2	Book of documents
3	Audio of 911 call
4	Medical Examiner Report of Dr. Balachandra
5	Map of PY3 South
6	Agreed Statement of Facts: ER
7	Agreed Statement of Facts: Post Asphyxiation
8	Medication Schedule (MAR) or Medication Administration Record
9	Book of photographs of PY3 shower room
10	Memo of HSC: Break Policy
11	Towel (for comparison)
12	Dimensions of towel, shower rod and camera
13	Bond of Indemnity signed by Arlene Wilgosh February 26, 2014
14	Manitoba Justice Appointment Form November 25, 2014
15	Police and Special Constables Qualifications Regulation
16	WPS Dispatched calls for Service 2011 through 2015
17	WPS Dispatched calls for Service January to March 2016
18	WPS Dispatched calls for service 2005-2015 Frequency of Events in the mental Health Type
19	Unit Hours On Scene for Mental Health Related Events 2011-2015
20	Mental Health Bathroom Safety Working Group Recommendations
21	Regional Mental Health Patient Safety Retrofit Concepts Report to Lori Ulrich
22	Memorandum from Susan Chipperfield and Dr. Murray Enns July 17, 2015 re: Bathroom Safety Review
23	Eight photographs of retro-fitting
24	Photo of HSC security staff in uniform
25	Autopsy Report by Dr. Littman and Medical Certificate of Death by Dr. Balachandra