RELEASE DATE: October 9, 2025

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: DARREN MICHAEL WOOD, Deceased

Report on Inquest and Recommendations of Judge Heather Pullan
Issued this 6th day of October 2025

APPEARANCES:

Georgia Couturier & Noah Globerman, Inquest Counsel

Marc Kruse (Robson Hall, University of Manitoba Law School), assisted by Peter Frejek & Zachary Anderson (Robson Hall Law Students), Counsel for Sophie Harper (Family representative for the deceased, Darren Wood)

Erika Dolcetti & Coral Lang, Counsel for Manitoba Justice (Correctional Services Division)

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INTRODUCTION

The Circumstances of Darren Wood's Death

[1] Darren Wood (Mr. Wood) was arrested by the Winnipeg Police Service (WPS) May 29, 2021. He was lodged at the Winnipeg Remand Centre (WRC) on May 30, 2021, at 11:56 a.m. Upon admission to WRC, he told officers he had taken "down" and methamphetamine the evening prior to his arrest. He told Corrections and nursing staff about his recent opioid consumption and that he expected to go into withdrawal. On June 1, 2021, Mr. Wood was reported to be well, except for multiple episodes of vomiting.

[2] On June 2, 2021, he experienced more vomiting and complained of pain in his legs. He was moved to medical observation cells after an 11:00 a.m. episode of unwellness. Amongst other symptoms, he could not stand and was found seated on the fifth floor by the elevator. A "code" requiring urgent response by nursing and correctional staff was called and staff responded. After the code, at the direction of medical staff, Mr. Wood was placed in a medical observation cell and continually observed on camera. He was also checked intermittently by officers on rounds. Mr. Wood was found unresponsive on the floor of his room in the medical observation unit June 3, 2021, at 1:30 a.m. Emergency Medical Services were called. WRC medical staff attempted resuscitation.

[3] During Mr. Wood's time at WRC from May 30, 2021, until his death, as pronounced by the Winnipeg Fire and Paramedic Service at WRC June 3, 2021, at 1:55 a.m., he had been treated for opioid withdrawal in accordance with the protocols in place at WRC.

The Ordering of the Inquest

[4] On July 27, 2023, Chief Medical Examiner Dr. John K. Younes wrote to The Honourable Chief Judge Ryan Rolston advising of his direction that an Inquest be held into the death of Darren Wood, in accordance with the provisions of *The Fatality Inquiries Act*, for the following reasons:

> 1. to fulfill the requirement for an inquest, as defined in section 19(5)(b) of *The Fatality Inquiries Act*:
>
> **Presumption of inquest**
> 19(5) Subject to subsections (6) and (7), an inquest into a death must be held if
> (a) the chief medical examiner has reasonable grounds to believe that the deceased person died as the result of the use of force by a peace officer who was acting in the course of duty; or
> (b) at the time of death, the deceased person was
> (i) in the custody of a peace officer,
> (ii) a resident in a custodial facility,
> (iii) an involuntary resident in a facility under *The Mental Health Act*, or
> (iv) a resident in a developmental centre as defined in *The Adults Living with an Intellectual Disability Act*.
>
> 2. to determine the circumstances relating to Mr. Wood's death; and,
>
> 3. to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[5] According to s. 26(1) of *The Fatality Inquiries Act* C.C.S.M. c. F52 when the Chief Judge receives this instruction, he or she must assign a Provincial Judge to conduct the Inquest. I was assigned to conduct this Inquest. Georgia Couturier (Ms. Couturier) and Noah Globerman (Mr. Globerman) were appointed Inquest Counsel pursuant to s. 27 of *The Fatality Inquiries Act*.

[6] The purpose of the hearing is to establish the facts to complete a report as required by s. 26.2(1) of *The Fatality Inquiries Act*:

> 26.2(1) An inquest is a non-adversarial proceeding held for the sole purpose of establishing the facts necessary to enable the presiding provincial judge to prepare a report into the death under section 33.

Standing Hearing

[7] Pursuant to section 28(1) of *The Fatality Inquiries Act*, a hearing was held January 10, 2024, to identify parties substantially and directly interested in the Inquest, who may attend the Inquest and question witnesses called at the Inquest. As a result of this standing hearing, the following parties were granted standing:

- Sophie Harper, representing the family of Darren Wood
- Government of Manitoba (Correctional Services Division)
- Winnipeg Police Service

[8] The standing hearing occurred prior to the completion of disclosure, and before all the issues that may be the subject of the Inquest were fully considered. It was contemplated at the time WPS was granted standing, that once the focus of the Inquest became clearer, it may be that WPS may wish to withdraw their application should the issues explored at the inquest not include WPS. As the Inquest drew closer, it became apparent that, in fact, issues relating to WPS were not to be the focus of the Inquest. Accordingly, Kimberly Carswell (Ms. Carswell), counsel for WPS, appeared prior to the commencement of the Inquest and sought leave to withdraw her client's standing which was granted.

Accordingly, the only remaining parties with standing as the Inquest proceeded were Sophie Harper (Ms. Harper) for the family of Darren Wood, and the Government of Manitoba (Department of Justice, Community Safety Division).

The Inquest Proceeding

[9] I was assigned this Inquest on August 30, 2023. My first contact from original counsel assuming the role of Inquest counsel was September 27, 2023. In addition to the Standing Hearing, there were four meetings including counsel for the parties with standing, Inquest counsel, and myself. The dates originally set for the hearing of the Inquest were January 16 to January 31, 2025.

[10] Preparation for the inquest continued. On or about January the 10, 2025, I was advised that Inquest counsel had been appointed to the Provincial Court of Manitoba.

[11] On January 13, 2025, I was advised that Crown counsel Ms. Couturier and Mr. Globerman had been assigned conduct of this Inquest. Ms. Couturier indicated they had yet to receive the file from previous Inquest counsel and assured me they would attend to the matter as soon as the file was received. She acknowledged the matter was set to begin January 16, 2025, but anticipated they would be able to start the Inquest January 20, 2025.

[12] On January 16, 2025, Ms. Carswell, attended what was to have been day one of the hearing and WPS applied to withdraw their application for standing. The application was granted. Matthew Raffey (Mr. Raffey), then counsel for Ms. Harper, advised difficulties had arisen. Ms. Harper, having applied for contribution to funding for counsel at the Inquest in October 2024, was refused within the last week. The Inquest was adjourned to January 20, 2025, to commence the calling of evidence. The afternoon of January 16, 2025, was used as a Case Management Hearing (CMC) with counsel to organize the proceedings going forward.

[13] Evidence and submissions relating to the Inquest were heard for 16 days as follows:

January 16, 2025
January 20, 2025
January 21, 2025
January 22, 2025
January 23, 2025
January 24, 2025
January 27, 2025
January 28, 2025
January 29, 2025
January 30, 2025
January 31, 2025

March 4, 2025
March 10, 2025
March 11, 2025
March 12, 2025
April 4, 2025

The Inquest Report

[14] At the conclusion of an Inquest, the Inquest Judge must complete a report as required by s. 33(1) of *The Fatality Inquiries Act* as indicated below.

> 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.

[15] In accordance with the requirements of s. 33(1) of *The Fatality Inquiries Act* I make the following findings:

(a) The identity of the deceased is Darren Michael Wood.

(b) The date, time and place of death: Mr. Wood was pronounced deceased June 3, 2021, at 1:55 a.m. at the Winnipeg Remand Centre.

(c) The cause of death: Dr. J. Morin (Dr. Morin) performed a medical legal autopsy on June 4, 2021, and concluded the cause of death was undetermined. Dr. Morin's evidence disclosed that after the autopsy, he received further information from former Inquest counsel and collaborated with colleagues. His opinion in evidence was that the cause of death was probably withdrawal from opioids. Based on the evidence of Dr. Morin, and the evidence overall, it is the conclusion of this Inquest that Mr. Wood's cause of death was withdrawal from opioids.

(d) The manner of death: I have accepted and conclude the cause of death was related to opioid withdrawal in accordance with Dr. Morin's evidence. Dehydration, choking, asphyxiation in the context of vomiting, and Mr. Wood's positioning resulting in positional asphyxia may have been features. Dehydration causing heart arrhythmias, the possibility of seizure, and the decision not to transfer Mr. Wood to hospital were also factors considered. I am unable to definitively determine the manner of death.

(e) The circumstances in which the death occurred: Mr. Wood died in his monitored cell while on camera, under the supervision of Manitoba Corrections Officers and nurses in accordance with their protocols.

[16] The report the Inquest Judge completes may contain recommendations that are specific in scope according to s. 33(1.1) of *The Fatality Inquiries Act*:

> 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.

[17] In the report, the Inquest Judge is prohibited from expressing an opinion or making findings such that any person could be identified as a culpable party in the death, by s. 33(2)(b) of *The Fatality Inquiries Act*:

> 33(2) In a report made under subsection (1), a provincial 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.

THE WITNESSES

Darren Wood's Sister

1. Sophie Harper

[18] Ms. Harper told the story of her brother from the family perspective during a dialogue with her then counsel and the Inquest judge. Her commitment to tell the truth was not taken in view of the nature of the dialogue. She began by presenting the Inquest with a copy of the funeral brochure from her brother Darren Wood's service. She explained the funeral was at the Wasagamack First Nation and the wake was at her stepfather, Louie Wood's, residence. Darren is buried in the cemetery in Wasagamack.

[19] Ms. Harper explained she is the eldest of her 11 siblings, and the family is from Wasagamack. She and her brother Christopher were raised by their grandparents. Her mother, Aline, had the other children. Her mother and stepfather were in residential school and both struggled with alcohol. It took her mother many years to quit drinking. Her mother was sober for many years before Darren passed.

[20] Her mother left her stepfather when her stepfather abused a family member. She relocated to Winnipeg and lived on and off a crisis centre. Every time Aline found a nice place to live with the children, her stepfather ruined it for them. Ms. Harper, herself, also attended Day School, but did not really have much education. She is dyslexic.

[21] When the family moved to Winnipeg, the family members were separated. That is when she and her brother Christopher went to Wasagamack to live with their grandparents. Her parents were struggling with alcohol, and her stepfather always interrupted everything. Her younger brothers Graham, Donovan, and Darren went into care.

[22] When her brothers were in care they would run away to try and find their mother. On one occasion, not knowing where their mother resided, Darren asked for the mother's address, and kept running from the foster home to her. Ms. Harper was in hairdressing school at the time, looked through the window, and saw Darren who was about ten years of age. Darren had come to her school looking for her.

[23] Eventually, Child and Family Services (CFS) placed Darren with Sophie. At the time of the CFS placement, Darren would have been about twelve, and Sophie 30. Their mother was still struggling at that point. Ultimately the children were returned to her mother not long before they turned 18 because they were always running to her.

[24] When Darren resided with Sophie, he was a good boy and was not struggling. The only reason she had to give him back was because she was travelling back and forth to the Wasagamack community. At that time Sophie had a child of her own. Sophie's grandparents would pay for Sophie's son's fare but would not pay for Darren's fare, so she could not bring him back to the community with her.

[25] Ms. Harper said she is currently 49 years of age and has seven children. She had her first at age sixteen but never really parented her children. She struggled with alcohol and drug use and was on Birth Alert. She has only raised two of her children. She asked CFS how she was supposed to parent her children when they did not give her a chance.

[26] Ms. Harper has a book full of certificates from treatment and programming she has taken to prove she could parent her children, but her children were not returned to her. It was at that point that Darren came back into her life. She had sobered up and they gave her care of her brother. Her mother did not mind Darren living with her.

[27] The family has suffered incredible tragedy. It started with Donovan's death by suicide in Wasagamack. Donovan was the middle of the three brothers who were apprehended. That is when Darren began acting out. Their sister Louisa was the one that got Darren into down. Three of the siblings struggled the most with homelessness and substance misuse, Darren, Nancy, and Louisa.

[28] Ms. Harper's mother was in a wheelchair having suffered a stroke, unable to walk and had only one hand that functioned. She was always in her bed in the dining room.

[29] Darren, his friend, Louisa and her friends sat in the living room smoking drugs right in front of their mother. An altercation occurred between Darren and Louisa which lead to his arrest. It was a family dispute between two drug addicted people. On January 20, 2025, the date of her evidence, Ms. Harper said her sister Louisa continued to struggle with drug addiction. At the conclusion of the evidence in the Inquest, Ms. Harper informed, Louisa had passed away and she was now raising two of Louisa's children. Her sister Nancy was still struggling with drug addiction.

[30] Ms. Harper was extremely concerned about Darren prior to his last arrest and passing. She looked for him in the street. At one point he went missing for two weeks and she requested assistance from the Bear Clan to help find him. Nancy had seen him and talked to him and reported his drug provider was looking for him. If Darren were missing, Mr. Harper's mother asked the others to look for him. When Darren was missing, Ms. Harper also filed a missing person's report using the same photograph as on the program from his funeral. Their mother was glad sometimes when Darren was arrested because she worried he might freeze or pass out somewhere, and because his incarceration would take him off drugs.

[31] Darren's partner Felicia also had a drug addiction and passed away from drug use in February 2021, the same year Darren died. She passed away in her sleep at Ms. Harper's mother's residence. Darren slept beside Felicia all night not knowing

she had passed away. After that, Darren really struggled. He was using more, so much he didn't attend her funeral or the wake.

[32] Ms. Harper's mother Aline was the first one notified Darren had passed away in jail. Aline told the family she thought he was mistreated in jail by another inmate or Correctional Officer (CO). Once Ms. Harper reviewed the materials with Mr. Raffey, she formed the belief there were not enough steps taken to keep him healthy. She understood Darren likely died because of his addiction and wondered whether they were supposed to give him something for his withdrawal. She thought about how Darren must have felt when he was withdrawing and that he was alone.

[33] Ms. Harper's siblings appointed her to represent them at the Inquest which took a long time to be ordered. Although her siblings' motives may have been different, Ms. Harper wanted to understand how they let this happen. Her mother, who has passed away, would have wanted her to finish the Inquest for Darren despite Ms. Harper's own health problems. She wanted the Inquest to know that she feels so angry and frustrated about why they let this happen to him. The people who were supposed to look after him let him have all the pain and struggle.

[34] Ms. Harper was asked by the Inquest Judge about her plan moving forward, knowing she had standing at the Inquest but now had no counsel. She said she had wanted Mr. Raffey to be her lawyer because he has been there since day one, understands Ms. Harper, and explains things in a way she can understand. He has been working with her since before her mother passed away. If she had that kind of money, she said she would hire Mr. Raffey.

[35] At the time of her discussions directly with the Inquest Judge, she had not yet received the letter from Darrin Davis (Mr. Davis), Director, Legal Services Branch, refusing her application for funding contribution submitted in October. She only knew she had been refused because Mr. Raffey knew and told her. Ms. Harper indicated she had mobility issues. Ms. Couturier assured the Inquest taxi

arrangements could be made to transport Ms. Harper from home to the Inquest and return for every day of the Inquest.

[36] Ms. Harper explained that she has trouble with reading. When I asked her how she would manage reading the Inquest material she said her niece could help her. Ms. Harper further explained she had 12 people living in her house with her, but it is helpful because she is in pain all the time and they assist her.

[37] Reluctantly, Mr. Raffey made application for leave to withdraw from representing Ms. Harper at the Inquest. Leave to withdraw was granted.

[38] An issue arose and discussions were had with Ms. Harper about how to manage the disclosure, some of which came with trust conditions that could not be imposed on a non-lawyer. Mr. Raffey wished to return the materials so Ms. Harper could review them with her family. Additionally, there was a production order by consent relating to Corrections documents, indicating Ms. Harper could view the documents at Inquest counsel's office.

[39] Mr. Raffey noted Ms. Harper's first language is Oji-Cree and it would be an unfair expectation for her to navigate the documents. To ask meaningful questions to get to the bottom of how her brother died Ms. Harper requires great assistance. The challenge for Inquest counsel was that they simply, in the circumstances, did not have the time to review all the documents with Ms. Harper.

[40] The assistance of a file manager or articling student was considered but the language issue presented some difficulty. On the second day of the Inquest, Ms. Harper appeared with her niece Shayla Wood to support and assist her. Additionally, however, Marc Kruse (Mr. Kruse), Defence counsel, Director of Indigenous Legal Learning and Services, and Supervisor of the Indigenous Law Clinic at Robson Hall, the law school at the University of Manitoba, also appeared at the request of the Inquest judge to help. Mr. Kruse went on record for Ms. Harper,

and he and his students assisted her throughout the Inquest. More will be said about this later in this report.

Physicians

2. Doctor Jason Morin

[41] Dr. Morin is a forensic pathologist at the Health Sciences Centre in Winnipeg, having held the position since September 2018. Additionally, he is a medical examiner at the office of the Chief Medical Examiner and has been since September 2019. The following description of his background does not include all his credentials for the sake of brevity.

[42] He is the Program Director of the Forensic Pathology Residency Program at the University of Manitoba, holding that position for two years. Since December of 2018 he has been an assistant professor at the University of Manitoba in the department of pathology. He is a fellow of the Royal College of Physicians and Surgeons of Canada, and board certified in forensic and anatomical pathology. He graduated from medical school at the University of Calgary in 2009. He attended his residency at the University of British Columbia in anatomical pathology for five years. His fellowship training included a one-year fellowship in forensic pathology in New Mexico.

[43] Dr. Morin explained forensic pathology as the area of medicine dealing with extended postmortem examination. Forensic pathologists are doctors that conduct autopsies to try and figure out why someone has died.

[44] In the 1,200 to 1,300 autopsies Dr. Morin had performed at the time of Mr. Wood's autopsy, he had examined the bodies of deceased persons who overdosed on fentanyl and were fentanyl and methamphetamine users. He had also examined a variety of individuals with different heart issues, people who have died from seizures and deceased persons who were very dehydrated at the time of their deaths.

[45] The autopsy on Mr. Wood was performed June 4, 2021, starting at 9:25 a.m. After a thorough internal and external examination, together with a toxicology report, Dr. Morin concluded cause of death was undetermined and documented that conclusion in his report.

[46] The "undetermined' conclusion as to cause of death really means the pathologist does not know why someone died. This does not happen very often. In this case, the conclusion was reached, not because Dr. Morin did not have a good idea of why Mr. Wood died. It was more a convention of the autopsy report.

[47] Since the time of that report, Dr. Morin received a number of additional documents, more in-depth medical records, and expert reports. Taking the newer information into account Dr. Morin modified his opinion on the cause of death. Dr. Morin concluded, on holistic review, it was most likely Mr. Wood died in association with some sort of drug withdrawal, most probably an opioid withdrawal.

[48] When people die of drug withdrawal, it is often by a mechanism not easily identified at autopsy. In the end, the pathologist is left with no positive findings to assist in identifying why someone died.

[49] The other issue in this case is that death from opioid withdrawal is relatively rare. In the context of something relatively rare, that does not have positive findings, it is challenging to make it into a complication of drug withdrawal. Often the pathologist can rely on presenting history. In this case, there was a negative autopsy, but the pathologist could go back to the presenting history and conclude it was consistent with death from drug withdrawal.

[50] Mr. Wood's presentation was certainly consistent with going through withdrawal. It would have been helpful to have his clinical parameters closer to the time he died, but that information was not significantly present in this case. The likely causes of death in this instance are an association with dehydration, some low blood pressure sort of event, and he may have had some degree of decreased

consciousness and may have choked. The toxicology report does show trace amounts of fentanyl and methamphetamine, but those are likely associated with drugs consumed prior to admission at WRC and being cleared from his system at the time of his death. The most likely explanation for his cause of death, given the totality of the case, was withdrawal from opioids. It is a diagnosis of exclusion. Dr. Morin does not have an alternative explanation for Mr. Wood's death through the autopsy itself.

[51] As to time of death, Mr. Wood was last seen moving June 2, 2021, at around 11:30 p.m. He was seen at 1:40 a.m. June 3 in some stage of *rigor mortis*. *Rigor mortis* is the stiffening of the body after death; the muscles in the body become rigid. The usual onset of *rigor mortis* is one to two hours at onset, peaking around 12 hours after death.

[52] At 24 hours after death, for the most part *rigor mortis* is going away. This assessment is highly temperature dependant and a lot of it related to how fast the body is decomposing. Determining time of death in these circumstances is not an exact science.

[53] If someone is found at 1:40 a.m. in some degree of *rigor mortis,* this suggests they died hours before that. It is not possible to say exactly when. If some degree of *rigor mortis* is present, it is certainly hours as the time frame someone would have been dead for.

[54] The screen shot of Mr. Wood's cell at 11:42 p.m. on June 2 showed him laying on his back with his head up on the bunk. At 1:43 a.m., June 3, two hours later, Mr. Wood's head was upright, but his position was on the ground chin to chest. Commenting on that positioning, Dr. Morin said it would be much more difficult to breathe, and an individual could die from positional asphyxia. Mr. Wood was in a position where it is difficult to get air from the outside down into the lungs. It also raises concern, in the context of vomiting, where the position would make it relatively difficult to protect the airway. It may mean Mr. Wood was in a decreased

level of consciousness. He may not have woken up while vomiting, which could explain a possible failure to protect his airway while vomiting.

[55] In discussions with former Inquest counsel, the issue of cause of death was canvassed. In Manitoba there are eight forensic pathologists. They meet once a month in difficult case rounds where a pathologist may present cases where a group opinion could be helpful. Dr. Morin presented this case for discussion as to whether drug withdrawal as a cause of death should be included. The forensic pathologists agreed that there were no positive findings, considered that it is rare to die from opioid withdrawal, and in this case, there was a gap in clinical information to point to being opioid withdrawal because of the absence of corroborative information. From a legal point of view, the pathologists said they would still conclude the cause of death as undetermined. From an autopsy document point of view, all agreed that it is not unreasonable to assume this was a drug withdrawal death.

[56] At the time of the autopsy, Dr. Morin had performed about 1,200 autopsies. At the time of his evidence, the number was closer to 2,500. He recalled three or four deaths from opioid withdrawal in the 2,500 examinations he has done.

3. Doctor Travis Minish

[57] At the time of his evidence, Doctor Travis Minish (Dr. Minish) was the co-director of the Health Sciences Centre (HSC) Emergency Department in Winnipeg, having held that position since May 2023. Additionally, he has been an attending physician since 2005 at HSC in the emergency department. He has been a lecturer at the University of Manitoba, Faculty of Medicine in emergency medicine since 2003. He is Royal College of Physicians and Surgeons board certified in emergency medicine. He graduated from medical school at the University of Manitoba in 1998 and did his residency at the University of Manitoba, a five-year Royal College Emergency Fellowship.

[58] In 2021, his role as an emergency room physician at HSC was to see and assess patients throughout the department. Additionally, because of the affiliation with the University of Manitoba, he and his colleagues often have students with them. As an emergency room physician, Dr. Minish has treated patients who are IV fentanyl and opiate users, and patients withdrawing from those drugs. About 12% of the patients that come to the emergency room per day are presenting with a substance related complaint. They see approximately 170 patients per day.

[59] The dangers of opioid withdrawal, generally presenting as a flu like illness with significant nausea, vomiting, and often diarrhea, are related to the symptoms opiate withdrawal causes. Individuals have trouble eating and drinking, become sweaty, get goose flesh, which is little distended areas on the skin, yawn excessively and experience extreme tiredness. The symptoms generally last two to three days for the most part, in the usual circumstance. Because of the nausea, vomiting, and diarrhea and the inability to replace those fluids, patients are at risk of dehydration.

[60] Dehydration can cause heart arrhythmias, arising from electrolyte abnormalities. Some electrolyte abnormalities can lead to seizures.

[61] Dr. Minish did not see Mr. Wood at any time when he was alive. He has reviewed documents sent to him by Inquest counsel, including various historical reports from HSC and WRC, fire and paramedic reports, police reports, reports from the office of the Chief Medical Examiner and the Divisional Investigative Report. Dr. Minish's report identified seven issues warranting further discussion as listed below:

i. Camera monitoring equipment - The closed circuit tv camera through which officers observed Mr. Wood on a screen by video camera is problematic. The system was described by several individuals as presenting a grainy image with poor picture quality. It is, in fact, motion activated, so if the patient is not moving in a situation where they had stopped breathing or their heart had stopped, the camera would not turn on. Additionally, there

was no audio capability. To respond on the intercom, the inmate has to get up and press the button which is less than ideal. A motion activated camera that could be tracked around the room, zoom in on an individual, and transmit a colour image would be ideal.

ii. Vital sign documentation- Dr. Minish observed a paucity of vital signs documented in the chart. Vital signs were taken on intake, and on June 2nd there was a notation of VS, indicating vital signs stable but it does not document the numbers. When dealing with a patient in a medical unit, described as being quite unwell, regular documented vital signs are necessary. There are standard nursing protocols as to how often VS need to be done dependant on the patient's level of illness, severity, comorbid medical issues, and a history of abnormal vitals.

iii. Anti-nausea medication – the notes suggest Mr. Wood received two doses of diphenhydramine and the level of the medication at autopsy was elevated. There was only one dose documented in the pharmacy record. It is very important that medication administration is properly documented by nursing staff as it is the only way for subsequent medical staff to know what medication an individual has been given for alternative options for nausea.

iv. Diphenhydramine is generally considered a poor anti-nausea medication. The trademark name is Gravol. Gravol is generally not considered very potent, which is why it is available over the counter. For someone with severe nausea, more effective anti-nausea medications are generally used. Intravenous anti-nauseants are the ideal because the individual does not have to swallow the medication. There are more potent anti-nausea medications available that can be given sublingual or intramuscularly (IM).

v. Management of opioid withdrawal symptoms – It was Dr. Minish's impression from the review of the information he had been provided that Mr. Wood was suffering from severe opioid withdrawal. He was given an anti-nausea agent and Clonidine, which can be useful in reducing some of the symptoms of severe opioid withdrawal. It appeared Mr. Wood was repeatedly vomiting it up and it does not come in a preparation that can be administered any other way. The standard of care currently for someone with opioid withdrawal would be opioid replacement therapy. It is done frequently in hospital because medical personnel do not want patients leaving the hospital because they are craving opioids. They are sick and unwell. It is done in the emergency room and on medical wards. The mental

health program is started as well. Classic opioid replacement therapy from an addiction specialist is usually done with methadone or Suboxone. Other medications include Sublocade, a once monthly injectable. There is a specific pharmacy regulation that restricts opioid replacement therapy to a specialist who has obtained an opioid replacement therapy licence. In Manitoba, a physician needs a special licence to be able to prescribe methadone, Suboxone or Sublocade. A law was created to ensure the people prescribing this medication were experts and knew how to do it. The College of Physicians has more recently reduced some of the restrictions on getting a licence, so the process is faster, but a physician still must go through the process to get a licence to prescribe it.

To start someone on opioid replacement therapy the individual requires an assessment as to what type of opioids they are using, a set of vital signs done, and if starting Suboxone, a Clinical Opiate Withdrawal Scale (COWS) score needs to be calculated. Because of the opioid epidemic, there is a new evolution in Suboxone prescribing called micro-dosing of Suboxone.

Instead of letting someone go into significant withdrawal and then giving them higher doses, starting with very low doses of Suboxone and titrating it up over a period of three or four days prevents an individual from going into significant withdrawal and then requiring higher doses.

As to risk of diversion, Suboxone is probably the least prone to diversion. In Winnipeg, addiction specialists, including Doctor Erin Knight have used this specifically for patients in the emergency room being discharged out with a plan to follow up. The Rapid Access to Addictions Medicine Clinics get patients started on Suboxone, follow up, and see them daily at outpatient clinics.

When asked about micro-dosing at WRC, Dr. Minish said he would defer the ultimate answer to a specialist like Dr. Knight, because that is her area of expertise.

The detox unit available in Winnipeg is the Chemical Withdrawal Unit at HSC as the only in-patient medical detox in the province. Dr. Erin Knight is the Director there, and it is primarily for treatment of medically dangerous withdrawal.

vi. Choice of oral rehydration fluid – Dr. Minish took issue with Boost as an odd oral rehydration fluid that was provided to Mr. Wood. It is a meal replacement. It is creamy, so if one is nauseated and vomiting it rather hard to tolerate. Dr. Minish recommended commercial products available such as Pedialyte, Gastrolyte and even sports drinks like Gatorade or Powerade.

vii. Transfer to hospital – Dr. Minish said with a lens of retrospection that Mr. Wood obviously should have been transferred to hospital. He was most struck by the code red. Mr. Wood was described as having trouble walking and collapsed on the floor. Mr. Wood was described as confused and complaining of severe muscle cramps. At that point he had been vomiting for 36 hours. He'd been given a dose of Gravol and shortly after, continued to vomit. Although there was some view that Mr. Wood had recovered from that episode, it would be reasonable to send him to the hospital. Had he been taken to the emergency room, Dr. Minish would have instituted the following interventions:

- Lab work including electrolytes, complete blood count, liver function test, lipase. He would have been given an EKG given his history of endocarditis and the episode of pre-syncope. He would have been given intravenous fluids and anti-nausea medication. He would have been kept in hospital until he was no longer vomiting, tolerating oral fluids, and had stable vital signs.

[62] Dr. Minish was asked whether, if Mr. Wood had been transferred to hospital after the code red, Mr. Wood would have survived, if he had died of a cardiac arrhythmia because of an electrolyte abnormality. Dr. Minish said that if it had been identified 24 hours sooner, it could have been treated. Dr. Minish recommended the creation of guidelines for determining which inmates need to be transferred to a medical facility for assessment. He also recommended, in his evidence, the exploration of a process to try and institute opioid replacement therapy as a treatment option for patients.

[63] If a patient on methadone or Suboxone has been admitted to hospital, the medication is continued in hospital. Physicians are permitted to have a temporary waiver of the pharmacy prescribing laws that allow the physician to continue medication for a patient in hospital without a methadone licence because in hospital it is reviewed by a pharmacist. Adjustments to the dose cannot be made, but it can be continued. Dr. Minish said he did not have the ability to start a new prescription

for methadone, Sublocade, or Suboxone because he doesn't have a licence. If he needed to give treatment for opioid withdrawal, he would have to give the patient conventional opiate medication.

[64] A patient coming into the emergency room at HSC from WRC will be brought in by guards who have no knowledge as to the patient's medical history or why they are there. What is generally brought with the patient/inmate is a one-page, handwritten note by the medical officer which, for 20 years, had the wrong phone number to call the medical unit. That has recently been updated. The note is generally a one liner as to why the patient has been sent, what they are looking for, and what the issue is. In a minority of cases, medical records are sent from other hospitals. For example, if someone were going to a community IV program, WRC will frequently take patients for their daily IV to Misericordia Hospital. Those notes are sometimes sent along to HSC with a patient. Dr. Minish has never received a copy of the medical records from WRC in terms of nursing notes and vitals.

[65] As to the potential impact of a significant number of WRC presentations at HSC when the nurse is in doubt, sending the patient out, Dr. Minish said that if they are not sick there is not a great burden on the emergency room. If they are sick, it is important they be sent. He did not express concern over inappropriate presentations at hospital from WRC.

[66] The one system, according to Dr. Minish, that WRC does not have is adequate communication with HSC once patients are sent in. Every other hospital or nursing station that refers a patient to HSC emergency calls the emergency department. That gives HSC an option to refer the patient to a different level of care if indicated, for example to refer the patient to St. Boniface Hospital. Additionally, Dr. Minish can give advice over the phone if he is aware of the treatment history for the presenting problem. He can suggest what else to try while transport is being arranged. Sometimes, he can suggest better antibiotics. It gives HSC the ability to

intervene earlier in the process. When the patient does arrive, the information quality HSC will have is far better than the handwritten note as is presently the case. Dr. Minish emphasized that communication is key, especially when an institution is doing an interfacility transport.

[67] HSC is now receiving transport through Shared Health's Virtual Emergency Care and Transport Service (VECTRS), a one stop shop to arrange interfacility transport. The advantage to the use of VECTRS is the computerized note in the electronic patient record that stays as a permanent patient document. The critical information of where the patient is coming from, when they are expected to arrive, how they are coming, and what they are coming with is preserved and clear. Dr. Minish was unaware that WRC had ever called VECTRS, which at the time of his evidence had been running for a year and a half. Dr. Minish said he, and appropriate colleagues, would be willing to collaborate and develop protocols for the outreach and transfer of patients from WRC.

[68] Dr. Minish also recommended the WRC medical unit acquire a PYXIS machine, which operates a computerized way of dispensing medication. The machine logs medications dispensed, the name of the patient receiving them, a time stamp, and the amount of medication removed from the machine. The person retrieving the medication is only able to access the one drawer where that medication is held. It is restocked periodically by pharmacy staff.

[69] This is particularly useful because handwritten nursing records can be inaccurate. People forget, and with lack of staff it gets worse. The nurse can, after the fact, look at the machine and see exactly what the patient received.

4. Doctor Paul Doucet

[70] Doctor Paul Doucet (Dr. Doucet) has been the physician for the WRC medical clinic since 1996. Additionally, he has been a physician at the Minor Injury and Illness Clinic since 2023, an emergency physician at Misericordia Urgent Care from

2012 to 2017 and an emergency room physician at St. Boniface General Hospital for nearly 35 years from 1990 to 2023. He was a lecturer at the University of Manitoba for 20 years from 1987 to 2007 and an assistant professor from 2007 to 2023. He was also the Program Director for the Emergency Medicine Residency Program at the University of Manitoba until 2009. He has been a doctor for almost 40 years.

[71] His work at WRC is unlike a hospital emergency department, richly resourced with a nursing ratio of sometimes one to two. The emergency room has access to immediate diagnostic capacity and medication capabilities such as intravenous. The environments are completely different. In terms of monitoring equipment at WRC, one effectively relies on visual monitoring that cameras provide and just looking in the cells. Dr. Doucet described his role at WRC as contracted to provide clinic work. The nurses ask him to see a certain number of inmates the nurses believe require medical attention. They make up a list called doctor's parade, and the officers bring the inmates down.

[72] Dr. Doucet generally attends WRC in the morning, and the doctor's parade is usually from 8:00 to 9:00 a.m. The nurses find the mornings better. Sometimes Dr. Doucet has something to do in the morning, and he will come at 1:00 p.m. The nurses "moan and groan" because there is delay in ordering new medication and getting things organized. It works better for the nursing system if things get started in the morning. Dr. Doucet is involved in ordering all medications at WRC other than Opioid Agonist Therapy (OAT). People on Suboxone or methadone have prescriptions continued at WRC. Dr. Doucet does not prescribe those. Their medications are prescribed by their OAT doctor.

[73] Dr. Doucet does have the designation required to be a prescriber of OAT but prescribing that medication is usually dealt with in the community by the Rapid Access to Addictions Medicine (RAAM) clinics. The physicians involved in those clinics work in an enriched environment with social workers, nurse practitioners,

and people involved with a whole team approach to individuals with opiate use disorder. There are a lot of stumbling blocks to consider before OAT could be started successfully in the WRC environment.

[74] OAT is started at Stony Mountain Institution, a federal facility, and will be continued if transferred to WRC or another provincial institution. A factor that favours institutional commencement of OAT is a stable population.

[75] Dr. Doucet was unaware how an hour a day of service was determined sufficient to implement in the doctor's contract. The hour, according to Dr. Doucet, is roughly the time necessary. Sometimes he is there an hour and a half and sometimes 45 minutes. Something had to be put in the contract and that was roughly the time necessary.

[76] Dr. Doucet testified that the needs of the patient population are generally met within that time frame. It would be more important, from Dr. Doucet's perspective, to have more nursing time rather than more doctor time. Dr. Doucet supported the presence of a nurse practitioner at WRC, although it was his opinion the nurses at WRC had the enhanced skill set of a nurse practitioner although not the designation. The ability of a nurse practitioner to prescribe would take some of Dr. Doucet's workload, but his workload isn't too onerous in the first place. He would support an extra higher functioning nurse.

[77] Mr. Wood's medical chart comprised of about eight or nine pages was forwarded to Dr. Doucet. When asked when, in an hour a day, Dr. Doucet was able to read documents that are provided to him, he responded he wouldn't necessarily read those in detail because they relate to previous admissions. He would look at the diagnosis and treatment plan. He could spend more time with any patient if they have a complex history. If documents are sent to Dr. Doucet's attention, and he is not there, the nurse will review the documents but there is no formalized process for that.

[78] Individuals should not be at WRC, which is not medical facility, if the nurses feel the individual needs to see a physician and Dr. Doucet is not there. Typically, he is available from 7:00 a.m. to about 9:00 or 10:00 p.m. He goes to bed at 9:30 p.m. He has tried to get the nursing staff to primarily email him and not phone him. He looks at his email frequently. Some nurses still do call him.

[79] The communications he receives are principally for new admissions and someone in opiate withdrawal. Additionally, if an individual is transferred from hospital at 2:00 p.m. with eight medications for the nurses to continue, Dr. Doucet, knowing he is there at 8:00 a.m. the next day, will change one or two medications to start at the time so they don't have to wait until the next day.

[80] Nurses do call and ask whether an individual should be sent to hospital a couple of times a week. Typically, the nurses have been trained that when someone is acutely ill or has abnormal vitals, they should call 911 and not Dr. Doucet. If Dr. Doucet is not around, there are four physicians in total on the contract. Another physician can be contacted. There is typically not a physician available during the night.

[81] As to Mr. Wood, Dr. Doucet did not see him in June 2021. He was put on the doctor's list to see Dr. Doucet twice. Dr. Doucet had no idea why Mr. Wood did not see him. Some of the people put on the list refuse. The nurse manager goes to see the individual and they sign something, or they are encouraged to come.

[82] In reviewing Mr. Wood's chart, after his passing, Dr. Doucet concluded, after reading the forensic pathology report, that his death was completely unexpected and of undetermined cause. He was advised by Inquest counsel while he was testifying that Dr. Morin concluded Mr. Wood likely died from choking on his own vomit or an arrythmia from the withdrawal. Dr. Doucet was of the view Dr. Morin's report was unclear on cause of death, and said:

> …When people are forced to make -- give an opinion as to what happened, they

> make things up as much as they can think of what's likely or plausible, whether that's -- you know, he almost for sure had opiate withdrawal which he was being treated for, and he ended up dying. He -- like, he was vomiting and there was vomit in -- in his airways. So, like, whether that happened with CPR or happened before that, I don't think you can say conclusively. So I think it's fairly clear to me that it's not clear. Unfortunately.

(Inquest Transcript January 27, 2025, Page 25 Lines 22 – 28)

[83] When asked about whether enhanced monitoring may have made a difference in Mr. Wood's outcome, Dr. Doucet noted this is not a hospital. It is not a medical unit. It is a place where at night there is one nurse running around to care for three hundred people, and 10 to 15 people coming in during the night that are supposed to be seen. If people need constant monitoring, they are not in the right place. When asked about wireless monitoring, Dr. Doucet felt that if a patient needs wireless monitoring, they are in the wrong place.

[84] Dr. Doucet did feel that someone like Doctor Erin Knight (Dr. Knight) and a team could address the opiate use epidemic at WRC. It is not an ideal environment because people are there involuntarily and come and go quickly. However, Dr. Knight, with her expertise, may be able to help the population at WRC.

[85] As to microdosing Suboxone and related treatments, Dr. Doucet said he has raised the issue with the nursing staff for five to ten years, but they do not think it's feasible.

[86] As to any recommendations Dr. Doucet may have to prevent future deaths in these circumstances, Dr. Doucet did not know whether microdosing could have assisted in this case because he did not think it was clear what happened to Mr. Wood. He did say a recommendation related to microdosing is something that could be an outcome of this Inquest.

[87] As to WRC, when sending an inmate to hospital, Dr. Doucet said there was no impediment to the nurses giving the hospital notice but felt it redundant because the individual is coming by ambulance and the ambulance communicates with the emergency department. On occasion, an individual might be transported by WRC staff. In that case, notice should be given to the emergency department.

[88] Most inmates are dealing with mental health and addiction issues. There is often a combination of the two.

[89] Dr. Doucet does not determine which patients he sees in person, and which are subject to a chart review. The nurses determine that. Historically, his contract was five days a week. The contract did not include weekends or holidays. Nurses would simply continue medications if Dr. Doucet were not available. For example, if an individual came into WRC on a Friday evening, the nurses would continue their medication until Monday when Dr. Doucet would sign the order. Five years ago, the Nursing College determined that protocol to be prescribing, and WRC asked doctors to attend seven days a week.

[90] Winnipeg Remand Centre staffing does not allow adequate officers to move inmates around on holidays and weekends, so inmates aren't seen in person during those days. Sometimes there will be 30 charts to review and order medication for. On occasion, Dr. Doucet will see individuals on the weekend, for example where the nurse determines the individual cannot wait until Monday. Although there are other physicians involved in the contract, it is primarily Dr. Doucet who does the work. Dr. Doucet only receives phone calls until 9:00 p.m. Sometimes the communication is by email which continues until 9:30 to 10:00 at night.

[91] Typically, the nurses do not have access to Dr. Doucet overnight. Dr. Doucet prefers email communication with the nurses rather than telephone calls as a matter of convenience. A request for medication is not an immediate requirement, so if

Dr. Doucet is in the middle of something he does not have to stop what he is doing as he would if he were receiving a phone call.

5. Doctor Erin Knight

[92] Dr. Knight`s full list of credentials is edited here for brevity. Dr. Knight is an Associate Professor in the departments of Psychiatry and Family Medicine at the University of Manitoba. She is the president of the Canadian Society of Addiction Medicine. Having completed medical school in Manitoba and a residency at the University of British Columbia in the Aboriginal program, she completed a one-year fellowship in addiction medicine at St. Paul's Hospital in Vancouver. She holds certification from the Canadian Society of Addiction Medicine (CSAM) and a certificate of added competence, addiction medicine (CCFP(AM)) from the College of Family Physicians of Canada. She holds certification from the International Society of Addiction Medicine (ISAM).

[93] At the time of her evidence, she practiced family medicine at the Aboriginal Health and Wellness Centre in Winnipeg and addiction medicine at HSC and St. Boniface Hospital in Winnipeg. She is the medical director of the addiction services program at HSC and holds a position with Four Arrows Regional Health Authority as director of the addiction medicine program. The residency program at the University of Manitoba is a fellowship training program for family doctors involving an additional year of focussed residency in addiction medicine.

[94] Addiction medicine is a relatively new recognized speciality. A number of doctors practice some variety of addiction medicine. In Manitoba, there is a smaller number of physicians who have done formal training, approximately seven. Dr. Knight is the medical lead for the RAAM program in Manitoba. The idea of the program is low barrier walk-in addiction care. The first clinic opened in August 2018, and there are seven clinics across Manitoba, three in Winnipeg and four in rural areas. For the most part, the clinics are made up of a nurse, a counsellor,

a physician or nurse practitioner, and support staff. Individuals can walk into the clinic and be seen for any type of substance use disorders without an appointment or referral.

[95] Substance use disorders are more common in Manitoba than in other places across the country. Since 2020, opioid use has been tied with alcohol as the reason individuals present to RAAM clinics. The patients of RAAM clinics present from all walks of life. Assuming the clinic is not overcrowded, the time from walking in the door until seeing the doctor and the doctor's decision to put the individual on opiate replacement therapy is about an hour. The province funds the RAAM clinics. The medications prescribed at the clinic can be covered by various plans if individuals have private coverage, and First Nation Inuit Health Branch coverage, if the individual is covered by them. Once a patient hits their pharmacare deductible, they could be covered. The people who may struggle to pay for the medication, which is 20 to 30 dollars per day, are those who are working but do not have medical coverage.

[96] Individuals started on Suboxone may be asked to remain at the clinic for the rest of the day so their dose can be adjusted to get them comfortable and out of withdrawal. They would probably need to be seen the next day for reassessment as well. After the correct dose is determined, individuals are typically seen once a week for a period of time, and then gradually less often. People on methadone are dealt with differently. Doses are generally only increased every three to seven days, so they will be seen typically the following week.

[97] For Suboxone, it takes between three and five minutes to observe the dose because there is a wait while it dissolves entirely under the tongue. Ideally, the team would like to see the patient stay in the clinic for at least 30 to 45 minutes after a first dose to ensure they are tolerating the medication. The Aboriginal Health and

Wellness Centre, the most recently opened RAAM clinic, is Indigenous led, operating under the umbrella of Aboriginal Health and Wellness.

[98] After a first dose of Suboxone, an individual can start to feel some symptom relief within 30 minutes. The medication hits its peak in approximately 60 minutes. Patients are observed for around 45 to 60 minutes after that first dose because if they still have ongoing withdrawal, they can be given another dose. Generally, with Suboxone, the administration is not something that requires a great deal of medical observation, hospitalization, or emergency room involvement.

[99] One of the assets of this medication is that it decreases an individual's risk of overdose if they use other opioids. It blocks the potential for overdose in terms of respiratory depression but also blocks the euphoric effect from other opioids. If a person wants to stop using other drugs, it blocks the positive effect of those other opioids and discourages people from using them.

[100] Dr. Knight testified that research shows that using these medications engages people in care, makes them stay connected to care, decreases their illicit opioid use, and decreases their use of other drugs. There are also other positive health benefits. For example, there is a decrease in transmission of HIV and hepatitis C. Success rates for positive outcomes without opioid treatment are extremely low. Dr. Knight said that all the clinical practice guidelines recommend strongly against abstinence-based options. The risk of return to opioid use is incredibly high in a short period of time.

[101] When people go through a period of abstinence, then return to opioid use, they do so in a higher risk setting. They have lost their tolerance to opioids and now are at risk of fatal and non-fatal drug poisoning. Additionally, there is an elevated risk of using in less safe situations, so there are higher risks of HIV transmission.

[102] A person can lose their tolerance to opioids very quickly, so practice guidelines specifically recommend against opioid withdrawal management for

people with opioid use disorder. Rather than treating the withdrawal, the goal is to prevent the withdrawal from occurring.

[103] Opioid withdrawal is very distressing. People are extremely uncomfortable and difficult to talk to when in significant opiate withdrawal. People are much easier to work with if they are not in that situation. Once an individual experiences the benefits of the medication, the buy-in is often very quick.

[104] An individual is highly unlikely to address their opioid use disorder by going cold turkey and not using opioid replacement therapy. Studies have documented as high as 99% return to opioid use within three months of therapy by abstinence. With opioid replacement therapy, like any treatment for chronic disease, not everyone will get better. Medication is helpful in terms of retention and care, reduction in opioid use, reduction in overdose, and reduction in adverse effects. That data is very different when people who are receiving opiate agonist therapy are compared with those who are not.

[105] Although the monthly injectable, Sublocade, is helpful for individuals who do not have access to a pharmacy, for example in remote regions, there is no evidence that the monthly injectable is as good as the tablet. There is no diversion risk which is a consideration. For those who prefer the injection, they only come to the clinic once a month as opposed to daily medication. The process is to start an individual on the Suboxone tablet first, ensure that the individual can tolerate it and progress to Sublocade if that is the best option for that person.

[106] Currently for a physician to be able to prescribe buprenorphine, the requirements are they need to feel confident they know enough about it to safely prescribe it, and they need to identify themselves to the regulatory body as wanting to prescribe it. A letter comes back to the applying physician, usually within a couple days that puts them onto the approval list. The idea behind the simplicity of the

process is to encourage more physicians to prescribe this medication. A nurse practitioner would be able to prescribe it, given approval.

[107] In Manitoba an individual cannot be started on opioid replacement therapy in a provincial correctional institution unless they are already on opioid replacement therapy. In Dr. Knight's experience, Federal Corrections can start opioid replacement therapy. Although she did not know the detail across Canada, Dr. Knight was aware that in some jurisdictions there is the ability to start and titrate people's medications.

[108] Alberta has engaged in meetings with those who run their Virtual Opioid Dependency Program (VODP). They support opioid agonist therapy starts in Corrections in Alberta. It is Dr. Knight's understanding that when people enter Corrections in Alberta it is routine that they are asked to provide a urine drug screen on intake. They are also offered the opportunity to provide their drug use history on a video recording to be shared with VODP physician prescribers. The equivalent personnel necessary to affect this process would not be much different from what Dr. Knight described is done at the Manitoba RAAM clinics.

[109] Some work has been done in recent months to roll out a "digital front door" with the RAAM clinics. This is a virtual option for coming to the walk-in.

The current set-up is meeting with the nurse who will do the history intake as would typically be done at the RAAM clinic. If appropriate, the person can meet with a counsellor and be referred to treatment. If they need to see a physician, they will be booked a follow-up appointment with the physician. Any virtual care must follow standards of practice set by the College. Those at the RAAM Clinic have an interest in supporting developmental services within Corrections and think the digital front door could be a good tool for this. At WRC, one would need a computer to be able to access these individuals virtually, the urinalysis tests, and the ability to check vitals. Additionally, staff at WRC would need to have the medication on site or there

needs to be a partnership with a pharmacy who could provide the medication if they were to be prescribed because the doctors are not physically there.

[110] If medication were available on site at WRC, the physician could send a prescription or order to the nursing staff at WRC. It could be started immediately depending on the timing of the last use of an opioid prior to assessment.

[111] In terms of consumption of nursing resources to administer this treatment, Dr. Knight said treating severe opioid withdrawal systematically without OAT results in duration and severity of withdrawal that is substantially worse than treating with an OAT medication. Dr. Knight acknowledges that change is hard, and change management is hard.

[112] She also noted there remains a stigma around treatment of substance use disorder within our medical institutions and the public in general. As part of a roll out of expanding access to these medications, there is a need for targeted education including addressing the stigma.

[113] The RAAM hub has expressed this is an interest and would like to support and work with Corrections in identifying their educational needs and trying to support them. As to expression of concern in the Inquest by nursing staff and COs about keeping up with the constant changing landscape of drugs, Dr. Knight said it was easier to keep up with it when you provide people with treatment because you learn through them talking to you about it.

[114] Dr. Knight opined that one of the most critical things that needs to be done is the WRC policy on OAT needs to be updated and written based on evidence. The policy has been consistently referenced as the barrier. Dr. Knight has discussed this with nurses and nursing supervisors at WRC concerning patients of hers who are in WRC. She has spent many hours on the phone talking about this policy. In terms of developing or being part of a team developing policies relating to medicine at WRC, Dr. Knight thought it would make sense for those developing a

policy related to an area of specialty medicine to have engagement with people who provide that medicine. To her knowledge, there has been no involvement of any local opiate agonist therapy prescribers in policy development in Manitoba Corrections.

[115] Dr. Knight expressed her enthusiasm to become involved in supporting policy development at WRC in opiate agonist therapy. She has sent her ideas to Manitoba Justice Community Safety Division and had meetings. The updated policy came out the summer of 2023, that prompted a reopening of the discussion and trying to engage around it. The policy, in Dr. Knight's view, is not grounded in evidence. The most consistent message in response is that Corrections does not have enough staff.

[116] Dr. Knight was asked by original Inquest counsel to review the medical care Mr. Wood received at WRC. She concluded, based on the available documentation, that Mr. Wood was likely in significant opioid withdrawal. That it was consistent with fentanyl withdrawal appeared to be common knowledge amongst the medical team. The policy prohibits the use of the best treatment for opioid withdrawal. Nurses are forced to monitor people in serious withdrawal, and treat it with inadequate, less than gold standard, treatment. The nurses are basically just treating dehydration and symptoms without getting to the heart of the issue.

[117] The main treatment of Mr. Wood's symptoms was clonidine, but it did not appear there were updated vital signs done, in the context of providing clonidine which has a known impact of decreasing blood pressure. For someone already on the lower end in terms of blood pressure, they could be at risk of losing consciousness because of low blood pressure. In the context of significant dehydration, the potential for low blood pressure is enhanced.

[118] In the absence of OAT, the treatment for opioid withdrawal is an alpha agonist like clonidine in combination with symptomatic management. For example, Tylenol, ibuprofen, loperamide for diarrhea, anti-nauseants for nausea, all essentially treat the

symptoms. The blood pressure can be enhanced with hydration considering the nausea, vomiting and diarrhea, sometimes IV rehydration is required.

[119] It was difficult for Dr. Knight to comment on whether Mr. Wood should have been sent to hospital, because of the lack of documentation of vital signs. If he were vitally stable, and his symptoms could be managed, it might have been reasonable to maintain his treatment at WRC. For people who do go through opioid withdrawal, providing information about where they can get access to treatment on release, and harm-reduction measures to protect them against drug poisoning, including naloxone training and kits would be appropriate.

[120] When Dr. Knight was asked about the impact of the population being transient and short-term and whether that would present difficulties starting the program at WRC, Dr. Knight said there is strong evidence that even a single day's worth of buprenorphine provided in the emergency department is protective against repeat episodes of drug poisoning, repeat visits to the emergency department, and increases potential engagement in care after that single dose. It is still worth it, in Dr. Knight's opinion.

[121] Dr. Knight thought a RAAM clinic satellite office at WRC is something that should be considered. Dr. Knight's experience with her patients that have been in WRC and then released and go on medication is that when they are stabilized on medication there are improvements in all aspects of their lives. It could be reuniting with children, getting back to work, and not becoming incarcerated again. The literature supports the observation that medications improve the social situation of the individual.

[122] Dr. Knight oversees the addiction consult service which provides addiction medicine consultation to people admitted to medical, surgical, obstetrical, and psychiatric wards at HSC and St. Boniface Hospital. These are individuals who need to be in the hospital but who also have a substance use disorder. That presents an

opportunity to engage with someone who may not self-present to a clinic and ask for help but who is in a situation against their will, some in withdrawal and they are offered an opportunity to feel better.

[123] Dr. Knight noted this is a very quickly evolving area of medicine. It is relatively new. Dr. Knight would encourage Corrections and anyone else who provides service to look at the substance use disorder treatment as treatment of other chronic diseases. This is an opportunity to provide people who often have poor health care with health care.

Recovery Alberta

6. Angela Draude

[124] Angela Draude (Ms. Draude) testified remotely from Alberta. She is presently the Executive Director of Correctional Health Services with Recovery Alberta. This is the new mental health and addictions arm for the province. Ms. Draude deals with all the addictions and mental health services within provincial jails in the province of Alberta. This excludes federal correctional institutions and deals only with institutions run by Alberta. Formerly, this endeavour was run by Alberta Health Services but is now connected to Recovery Alberta. She has been the Executive Director for a little over two years. Previously, she was the Director of Health Services in the province of Alberta since 2019.

[125] Although still a registered nurse, she spent over 20 years with the Correctional Service of Canada, mostly in health. For seven of the 20 years, she was the warden at various institutions. She spent four years in British Columbia with Provincial Health Services Authority in their forensic system and the correctional system.

[126] Health services provided in Alberta Corrections fall under the control of Alberta Health, not Alberta Corrections. In 2010, Alberta was the first jurisdiction in Canada to recognize that health services in their correctional system, reporting to

or under the jurisdiction of Corrections, were not meeting the needs of the correctional population. The government of Alberta decided that all mental health and addictions accountability were the responsibility of Alberta Health Services. Legal accountability, budget, and all operations were moved to Alberta Health Services from Corrections.

[127] Since the change over, there have been significant changes. There is now a health authority overseeing delivery of health services with a different approach. Health Services works very closely with correctional colleagues through a master agreement, for the best interests of the shared population while still meeting the requirements of the *Corrections Act* for the province of Alberta. The nurses, doctors, and all the health-related professionals are employees of Alberta Health and not Alberta Corrections. Hiring, training, retention, and other issues are run by Health and not Corrections. Ms. Draude oversees the health services, including those at the Edmonton Remand Centre, the largest facility in the province. They have anywhere between 1300 to1600 inmates. The Edmonton Remand Centre, in addition to the other nine provincial correctional institutions, runs an OAT program.

[128] The Edmonton Remand Centre was the most difficult to implement, but nonetheless the program operates in that institution together with the others. The challenges at the Edmonton Remand Centre were the number of inmates, the fast turnover, the structure of the building, how it is set up with the Edmonton Police Service and the proximity of where the inmates are housed in order to be brought over to remand. There are many complexities involved. All the remand facilities in the province experience very quick turnaround of inmates. The average length of stay is increasing, currently up to a median length of 26 days. Back in 2019, when the OAT program was initiated, the median length of stay was seven days. Many individuals are in withdrawal or quite ill for the first five to seven days of their

incarceration. The problems involved trying to fit a health endeavour into a non-health system but still provide the best care and safest options for the inmates.

[129] The program first started in 2017. In Alberta, methadone had been used for quite some time, but methadone has a very risky safety profile. It is a difficult drug to administer within facilities for many reasons, but at that time the opioid crisis was escalating in multiple areas of the country including Alberta.

[130] In 2018, a small pilot project in a couple of facilities was started where any individual that came from the community on Suboxone could be accommodated. The preexisting methadone program continued, but there were myths and misunderstandings around Suboxone at the time and restrictions were put on Suboxone for both health and correctional reasons based on what was known about methadone. It was very restrictive at that time.

[131] Originally, no one was initiated on Suboxone even though it was known they would benefit from the program. Corrections wanted to closely monitor and observe patients after Suboxone was administered, and there were only so many COs. The concern was the impact on correctional operations.

[132] In 2018 and 2019, more people were admitted who could benefit from the program. They met the clinical criteria and were able to be diagnosed with opioid use disorder. A pilot project was started at a couple of facilities where treatment was initiated. There was very slow progress. There were caps on how many correctional colleagues were able to assist with operationalizing. Word got out to the patients that the program could be available. The patients did not want to be sick. Wait lists of people started requesting initiation on Suboxone or some kind of known therapy.

[133] In 2019, a government grant to expand the program was applied for and granted. Additionally, the focus was to decrease wait lists. They never dreamed they would get to a zero waitlist, get people started on OAT as soon as possible to help

them while they are in custody and hopefully transitioned to the community, which is where they are today.

[134] The Ministry of Mental Health and Addictions within the Government of Alberta supplied the grant. It was small, but enough to develop OAT coordinators to do assessments on admission as nurses do. Anyone that, on admission, endorsed using an opioid of any kind would be referred to an OAT coordinator who did a further in-depth assessment required by the physicians and prescribers. They did urine tests and anything that was needed to gather information from the community on their use. Any further collateral information that could be obtained to get them on OAT was secured.

[135] It was a lot of work. The people being assessed were not feeling well, so it was challenging getting the information required and having the patient sit through it. There was fear by Corrections about what the medication could do within the jail from a subculture perspective. A lot of education was done to address those concerns. The OAT grant allowed them to bring in additional nurses. The operation of the program must not impact correctional operations.

[136] Among the many things learned as the program was implemented, was the earlier the inmate could get on the program, the less risk it was to the institution. The individuals would be less likely to abuse the medication or use it for contraband if the program were instituted with them earlier. Inmates still do attempt to abuse the medication and use it for contraband, but they do the same thing with Tylenol and any other medication. For those that were actually drug sick, it was important to expedite being put on the program, so they weren't pressuring other individuals to get their meds.

[137] The program was successful in nine of ten correctional institutions in Alberta, getting the wait lists down to zero and everyone on the program within a couple of days of admission. The Edmonton Remand Centre was a special challenge because

of its size. Edmonton Remand Centre was partnered with an Alberta program called the Virtual Opioid Dependency Program (VODP), a community program intended for anybody in the province, except for the jails. Individuals could call a hotline and talk to a physician who then did an assessment virtually or by phone and could get the individual initiated on Suboxone or some kind of appropriate OAT therapy. The patient was videoed as the nurse went through the questions the physician needed answers to. With the patient's consent, they could get a synchronous assessment.

[138] In that way, the correctional operations were not impeded, inmates did not need to be escorted down to be assessed and the physicians and VOPD viewed the videos without impeding correctional operations. If more information were required, the program worked with the physicians to get them what they needed or get the patient in front of them. By mid 2022, all ten facilities across the province were where they are now. There are zero wait lists, and everyone that meets the criteria for opioid use disorder is initiated into the program, less then 24 hours after admission. The program and the inmates both know they are going to get sick. It is best to get them started with as much immediacy as possible. It is a proactive approach, not to let them get sick. There is consistency in every institution, such that, every individual gets the same type of order and practices. The doctors are all different, but they talk to each other.

[139] In Alberta, there are approximately 3,200 inmates in custody everyday. VODP, in collaboration with partners is providing service in the police holding cells. They have paramedics in the arrest processing units, and the paramedics call VODP and get them started within cells if appropriate. The inmate does not actually go into withdrawal depending on how long they have been waiting in the police cells. Arising from this collaboration, Corrections initiate fewer people because some are

getting started earlier while still in police custody. In Ms. Draude's view, the key to all of this is to get people on the program as early as possible so they don't get sick.

[140] From the Alberta correctional nursing staff, there was initial resistance because it was a lot of work, not enough staff and there were correctional operations, deadlines and other things involved. The reality is, extra nurses have been brought in to administer the OAT program, and correctional operations have been impacted as little as possible. Suboxone films are used that are put inside the cheek and dissolve immediately. There is a decrease in medical engagement by altering the mode of medication. It did cost more, but it was a resource shift by reducing staff who were no longer running around responding to codes four times a day. There are fewer codes, and poisonings, both fatal and non-fatal that need to be responded to consuming resources. The impact on correctional staff has shifted as well, as they are no longer running to codes regularly through the day arising from opioid withdrawal.

[141] There is a monthly national meeting relating to correctional concerns about opioid withdrawal around the country. Ms. Draude emphasized that having accountability for healthcare separated from Corrections is very important. It does cost more money from a health perspective. The correctional approach to healthcare in an institution is different than the overall healthcare system which looks at a bigger picture. The monthly meetings are virtual, and someone from Manitoba is involved. There is a mix of Corrections and healthcare individuals in the group called the Federal Provincial Territorial Heads of Corrections Committee. All the Wardens, Correctional Services of Canada, and heads of Corrections from a correctional perspective meet. There is a subcommittee of Health and Mental Health Ms. Draude sits on. The participants share outcomes, learn and participate in different projects together. Currently, the subcommittee is working on a virtual health project, with the goal of decreasing medical escorts.

[142] For Manitoba, Natalie Horne, acting Director of Health Services for Corrections is on the distribution list for the committee.

[143] Ms. Draude is willing to collaborate with Manitoba in developing or advising in the development of an OAT program for WRC. She participates in this way with other provinces and was meeting with Saskatchewan later in the week she testified. She is always happy to share, meet, and learn together.

Manitoba Talent Acquisition

7. Travis Hoemsen

[144] Travis Hoemsen (Mr. Hoemsen) is the Director of Talent Acquisition, for the Province of Manitoba. He has been involved in human resources (HR) for over 20 years. He went through a certificate program at Red River College, graduating with honours. He was a member of the Chartered Professionals in Human Resources (CPHR) until last year when he let his registration lapse. He was an HR manager for a private security firm for five or six years. He came to work with the province in February 2009 as a HR consultant. After a few years, he became an HR manager, ultimately becoming HR director in and around 2015, working with most departments.

[145] Around 2020, he assumed a role in a transformation office within the public sector, looking at reorganization within the public service commission. He moved into the role of Director of Talent Acquisition around October 2022. Talent Acquisition is a new department within government. The Talent Acquisition Branch centralized all recruitment to enable better focus of resources on recruitment. Currently, Talent Acquisition is responsible for all competitive hires in the Government of Manitoba. Once a department determines a position is to be filled, it comes to Talent Acquisition who will look at identifying candidates. A large portion of the work is specific recruitment, posting ads, screening candidates, and assessing

candidates with the hiring managers for specific jobs. There is a group within the office that looks at outreach, promotion, and continuous improvements.

[146] His evidence was called to assist the Inquest with understanding the process and protocols related to hiring nurses at WRC. There is a hiring manager for this purpose within Corrections, and that person interacts with Talent Acquisition.

[147] Once a staffing approval document, outlining the position, terms of work, and location comes into Talent Acquisition, they reach out to the hiring manager as the point of contact. A discussion relating to strategy to recruit as far as outreach potential takes place. Consideration is given to whether there are internal candidates who could satisfy the need, or whether to advertise to the broader open market.

[148] Specific to nursing, there is an ongoing intake for nurses within a Corrections setting, recruiting on an ongoing basis. There are regular interviews with staff at WRC. There is an outreach group within Talent Acquisition assigned portfolios relating to which part of government they are recruiting for. Others represent government as an entire entity. There are a couple of staff looking primarily at nursing recruitment.

[149] The advertisements are sent to broad lists of universities, colleges, and registration bodies, all for nursing. There is also more general outreach with attendance at postsecondary institutions and community organizations where Talent Acquisition is promoting itself as an employer.

[150] Beyond Talent Acquisition efforts, Justice is very engaged in recruitment. They are actively promoting Corrections as well. Mr. Hoemsen did not know if the active promotion of Corrections included Correctional nursing. Candidates are also promoted through LinkedIn. The job is also posted on the government website. Job sites mine Talent Acquisition’s information, so the adds can be picked up by sites like Workopolis, Indeed, or others. Talent Acquisition staff also regularly engage with hiring managers.

[151] Mr. Hoemsen was unaware a previous Inquest recommended that a strategic plan be developed for nursing retention and recruitment. He was not aware of any strategic plan Talent Acquisition is involved in with Corrections for the recruitment of nurses. If there were such a strategic plan, Mr. Hoemsen thought he would know of it. If Corrections did reach out for assistance in creating a strategic plan for this position, Talent Acquisition would be willing to assist. Applicants have an opportunity to visit WRC and are shown around by one of the nursing supervisors and nurse managers.

[152] Based on the timelines for all the processing involved in considering a nursing applicant, including background checks, there is a range of 11 to 20 weeks to process from the time the application is received to the time a successful applicant receives an offer. Mr. Hoemsen did not see a way to try to speed this process up. Currently, considering the 20 open nursing positions at WRC, at the time of his evidence, Mr. Hoemsen said there were ten candidates in the background check phase.

[153] Another issue relates to attrition of candidates offered interviews. In a recent competition in 2024, 47 applications were submitted. Of those, 36 were screened-in, meaning they met the threshold to be invited for further assessment. There were 24 candidates interviewed, 15 of whom were successful. Four withdrew post interview. Overall, 12 individuals withdrew or declined interviews.

[154] Mr. Hoemsen attributed the number of nurses dropping out after applying for a job to the competitive market. A Correctional setting is not something that may be top of mind for people exploring career options. The compensation, said Mr. Hoemsen, is comparable, although a little below some other organizations. At the time of his evidence, Mr. Hoemsen said there had been a new pay structure agreement between the parties, but the new numbers were not yet able to be posted. Once the new agreement is fully implemented, anticipated to be May 2025, position

advertising will be at the current rates. Mr. Hoemsen said that the Correctional nurses' wages will be comparable to Winnipeg hospitals.

[155] As to nursing position turnover, in 2025 Justice had an attrition rate of about ten percent. Talent Acquisition attempts to achieve an attrition rate of seven to ten percent as an indicator of healthy turn-over. A retirement would not be included in the attrition rate. Mr. Hoemsen was unable to determine the attrition rate within WRC.

[156] Exit interviews are not done in the case of resignation, although tools to do so exist. As to the issues of addressing retention issues, Mr. Hoemsen said there is mixed success in exit interviews. There is a survey available, individuals are provided in their exit documents, but uptake is very low. In an exit interview, individuals are often not able to provide a full picture, so they are not a reliable tool. It is much more effective to consider engagement levels while people are still employed. There are regular engagement surveys for all employees with the province. Data that does come in is shared with the departments. Management with support from HR would explore the reasons behind the indicators and discuss what action could take place to explore them. That structure is already in place. Individuals are not banging down the door for these jobs. Considering, for example, a position that has been posted for several months, there are a few dozen applicants which is not a high level.

[157] Mr. Hoemsen said his team is looking at building a focused event specifically targeting nurses to bring candidates in to talk about the different roles which could address some of the delay in timelines between application and offer. He emphasised that Talent Acquisition was still in the building out phases of that. There is also some exploration of the thought of having practicum students do their practicums in the centres. Further, once there is a sustainable level of staffing within a centre, one

strategy that could be considered is staff picking up shifts at other centres if there is a need. Mr. Hoemsen has not had extensive discussions with Corrections about that.

[158] Mr. Hoemsen testified that any nurses that work in Corrections may also work in personal care homes or wherever outside of Corrections they wish. That is a reason some nurses might prefer a part time over a fulltime position. Mr. Hoemsen indicated there is a nursing shortage everywhere in all sectors. He clarified that if a nurse transferred to a different institution, that would be a loss to WRC staffing but would not be reflected in attrition rates.

[159] In so far as the delay requiring child abuse registry, vulnerable persons registry, and a criminal record check to be hired in correctional nursing, Mr. Hoemsen said it was his understanding that outside of the correctional centres other centres wouldn't require these checks because it is a requirement of nursing registration. It is his understanding that other centres do not necessarily have the same requirements that Manitoba Corrections does for the security check. The checks are not required in other centres because they do not have the same security requirements.

[160] Mr. Hoemsen began working with Justice in Talent Acquisition in November of 2023, so he was unaware of any previous Inquest recommendations made. There is no specific, active plan for nursing recruitment Talent Acquisition is currently engaged with.

[161] Moving forward, Mr. Hoemsen recommended maintaining efforts for a continual intake process, so recruitment is not sporadic as it has been. Introducing nurses to the concept of correctional nursing while they are still in school is a plan Talent Acquisition has been working towards. When the Manitoba Developmental Centre shut down, Talent Acquisition did look at possibly transitioning of those staff, but they were not able to attract anyone to the correctional setting.

[162] There is no single recommendation Mr. Hoemsen could make to assist the Inquest with the recruitment and retention nursing issue in Corrections, but it is an ongoing effort utilizing continued focus and continued prioritization.

Winnipeg Remand Centre Nurses

8. Murray Olafson

[163] Murray Olafson (Nurse Olafson) is a Licenced Practical Nurse (LPN), having worked at the WRC since 2017. Prior to his work at the WRC, Nurse Olafson worked at the Winnipeg Health Sciences Centre (HSC) in the neurosurgical department for about seven years. Prior to his employment in neurosurgery, he worked in orthopedics. He began working at HSC in 1988, where he started in the laundry, and transitioned into the orthopedic technology department. There was an opportunity to go into nursing, so he took a leave from work and took his nursing training. WRC is the only correctional facility he has worked in.

[164] The largest difference observed by Nurse Olafson between the hospital setting and correctional setting is that the nurse has a team in the hospital setting to draw on in the work environment should support or collaboration be required. In WRC, the nurse is the person who makes those decisions. The medical unit at WRC is not equipped like a hospital so the nurses are restricted in therapies available to support patients. For example, there is no intravenous (IV). Should a patient require hydration, oral ingestion is the number one method for hydration. Intramuscular injection permitting a medication to go into the muscle tissue and be absorbed as opposed to taking it orally could assist when an individual is vomiting out oral medications. There is no injectable medication available to the nurse that treats nausea and rehydrates. In June 2021, the instruments available to monitor patients were the blood pressure machine, Accu-Chek monitor, a stethoscope, the eyes of the nurse, and their knowledge of recovery from alcohol and drug

withdrawal. The blood pressure machine can monitor oxygen saturation. There is a pulse rate monitor which measures whether the heart is working hard by rapidly beating and blood pressure.

[165] The most beneficial assistance would be access to blood work, chemistry and IV, because those are the things that restore the nutritional requirements during withdrawal. Blood can be drawn at WRC, but it requires a turn around of twelve hours to much longer to get the results. If a particular lab is used, results could be obtained within eight hours.

[166] In terms of individuals withdrawing from drugs, Nurse Olafson's observation was the severity of symptoms has increased significantly over the last five years. In his role, he can tell when there is a bad batch of drugs on the street because of the increase in the number of individuals having more problems in their withdrawal. The withdrawal process is variable depending on the drug the individual is addicted to. For example, when benzodiazepine is a component of the drug, the addict is withdrawing from both the drug and the benzodiazepine. Those drugs stay in the body longer and create more havoc during withdrawal. Nurses do try to stay on top of new drugs to be prepared but the drugs are constantly changing. It is very difficult to keep up. The police have presented on the drugs in Winnipeg to the nurses and that is helpful because the nurse can be better prepared for the unexpected. It would be extremely beneficial to have information of drugs and their side effects as they evolve.

[167] Nurse Olafson estimated he has treated individuals withdrawing from opioids in the thousands. At WRC, there are 20 to 24 intakes a day; at least 50% are using drugs of some sort. In terms of the treatment of opioid withdrawal, considering the limitations of equipment and concerning impact of opioid withdrawal on the inmates, Nurse Olafson relies on his personal mantra which he described as "when in doubt, send them out". He sticks by that rule. If uncertain the treatment taken is

producing results, Nurse Olafson sends the patient out to hospital. He learned the mantra from another nurse, and he is reasonably certain all the nurses hear that kind of slogan because it makes a lot of sense.

[168] His treatment for an inmate undergoing withdrawal is to start with an injection of Gravol if the individual is vomiting. There is no point in administering an oral medication if the individual is vomiting it out. One is better to proceed with intramuscular injection. If the individual is responding and not vomiting, Nurse Olafson may offer Pedialyte to get electrolytes back in their system. It is very important to get the vomiting under control. At WRC, Clonidine can be administered two or three times daily, most often two times daily. Imodium is used for diarrhea, one of the side effects of opioid withdrawal. The combination of diarrhea, vomiting and sweating results in a loss of electrolytes.

[169] In 2021, Pedialyte was not in use at WRC. Prior to the opioid crisis, Nurse Olafson recalled lots of alcohol withdrawal. Alcohol became the least of his concerns because of the escalating opioid concern.

[170] The dangers of not treating an individual's symptoms of withdrawal are particularly electrolyte imbalance that can lead to heart arrhythmia and seizures. The electrolyte imbalance leads to instability resulting in the person in more acute condition requiring more monitoring. Nurse Olafson has been involved in the administration of opiates as part of opiate replacement therapy or opiate agonist therapy at WRC. The types of treatment that could be administered include methadone, Suboxone and Sublocade. Nurse Olafson has seen people suffering from withdrawal. Methadone or Suboxone are not started at WRC because they don't have oxygen and IVs. Administration of an initial dose requires monitoring and having extra supplies for situations where things go awry. Not everyone responds to a new medication the same way. If the individual is prescribed methadone or Suboxone prior to incarceration, they can continue treatment in the facility.

[171] If an individual is not on those medications and having a challenging time and not improving as they go through withdrawal, they are sent to hospital. Hospitals can start methadone or Suboxone. When the inmate returns from hospital the medications have been prescribed and the initial dose administered so they can then continue receiving those medications at WRC. This is a more frequent occurrence now than it was in 2021.

[172] More individuals have mixes of drugs and are less able to respond well to the therapies WRC can administer. They must be sent to hospital and have the methadone or Suboxone started.

[173] Nurse Olafson has seen a lot of diversion, when individuals given a medication stow it in their cheek and pretend they have taken it. When no one is looking, they hide it in their hand and sell it to other inmates. This is a big concern. If the medication is tucked in underneath the cheek, when a mouth check is done it may not be evident the medication is tucked away. Generally, with a liquid form of medication, it is very rare an individual can conceal it.

[174] Nurse Olafson was confident COs are briefed by nursing staff for observable criteria to watch for in inmates housed in medical. The information is not written down but verbally communicated. Nurse Olafson believed there was a general awareness of withdrawal signs and symptoms which are clear. He was unaware of training COs may receive on withdrawal symptoms. There is an inadequate number of camera cells, and it becomes an issue when a cell observable by camera is needed but unavailable.

[175] The cameras have been upgraded but the picture is still poor. Sometimes people damage the camera. The camera is one of the best tools for knowing what is going on with the individual. There are more inmates going through withdrawal who are unpredictable. A nurse does not have the ability to walk around and into someone's cell to ask how the individual is making out. Everyone is in a

locked cell, and an officer must be present to open the door. Winnipeg Remand Centre houses 400 people. One can only tell so much by looking through the window on the cell door.

[176] Much of the time the nurse is unable to have the chart at hand when assessing an individual, considering the nurse travels throughout the institution and can't take all the charts with them. Computerised charting would be extremely useful.

[177] Nurse Olafson said Dr. Doucet has a four-hour block of time when he comes in. He sees people on what is called doctor's parade. There is a list of individuals who have concerns, and they are presented to the doctor daily one at a time. The day prior to Nurse Olafson's evidence, there were 12 individuals on the doctor's parade. If an individual requires a long time with the doctor, it becomes difficult. People are seen based on how acute their condition is if the doctor's parade is tight for time. The two nurses who are the medical managers go through the doctor's list every morning and make determinations as to who gets to see the doctor and in what priority. Sometimes a non-manager nurse completes this task.

[178] In describing his duties, Nurse Olafson said more time could be spent assessing patients and less doing administrative tasks if there were more staff. The ratio is two nurses to 400 inmates, leaving 200 individuals per nurse to look after. It is impossible to be able to look at everyone of them and make a judgement as to whether they are going to be okay. The nursing managers do not see patients but have other things to deal with. The inmates have a lot of complaints and valid issues. There are no health care aides.

[179] Nurse Olafson described the WRC staff as fantastic, and much information flows from counsellors and COs to assist. Nurse Olafson referred to the various urgent items concurrently occurring during his shift as wildfires. The Corrections nursing experience is far different from the hospital experience Nurse Olafson has worked in. Although a health care aide rarely has come in to assist someone who is

elderly and not mobile, it becomes a security issue to make that person safe in a cell with someone potentially violent.

[180] Transcribing orders is one of Nurse Olafson's favoured duties and he takes a lot of pride in it. The tasks are done on a need basis. Nurses communicate issues or observations about patients at shift change by verbal report. There is also a report book that covers individuals in the medical unit and those receiving special attention outside of the medical unit. The matters transitioned in shift change are not placed in the inmate's physical chart but in the centralized binder.

[181] Nurse Olafson's shift on June 2, 2021, started at 7:00 a.m. He responded to a code red call on the fifth floor. He was not involved with Mr. Wood prior to the code red. In a video of the fifth-floor code red response, he identified the medical team responding as his unit manager Karen Chrabaszcz (Ms. Chrabaszcz), Nurse Oliver Maglaqui (Nurse Maglaqui) and Nurse Malgorzata Koscian (Nurse Koscian). He observed the scene on video to show the nurses assessing Mr. Wood and talking to him. He did not recall whether he was the nurse to take the vital signs, but he is the one who brought the machine because he is one of the larger nurses.

[182] He recalled the vital signs as being stable, nothing outlandish or way outside of normal parameters. Nurse Olafson acknowledged it would have been preferable to have the data relating to the vital signs documented in numbers rather that the observation simply that it was stable. Mr. Wood was alert, responding, and speaking clearly. He was on his way to see a lawyer. Nurse Olafson also noted CO Rob Pollok (CO Pollok) as present. Nurse Olafson recalled understanding Mr. Wood's speech completely. On reflection, although Nurse Olafson was not designated to document the information, he felt he should have documented something because he would have particularized the vital signs.

[183] In terms of code response by nursing staff, there is no predetermined designation of responsibilities. Nurse Olafson would prefer assigned responsibilities in emergency responses. Nurse Olafson observed Mr. Wood able to keep himself upright while seated on the floor, speaking clearly, fatigued and said he was feeling a little bit weak. Other than that, he appeared to be alright. Although Nurse Olafson could not recall the vital signs, he recalled they were stable. He got up and was able to walk. He was not vomiting or tremulous.

[184] Nurse Olafson did consider that perhaps he should be sent to hospital. This was, however, his first encounter with Mr. Wood and his overall impression was that he was stable enough to be treated in WRC, perhaps with injectable Gravol. Often individuals in withdrawal have normal vital signs. When Mr. Wood was walking, he knew where he was going and was alert. The usual procedure is when an inmate is transferred to the medical unit, his chart is then reviewed by a nurse. It appeared on video review at the Inquest that Mr. Wood seemed be stable, able to get up and move, and he went to see his lawyer. Nurse Olafson interpreted all these features as positive.

[185] Winnipeg Remand Centre documentation referred to Mr. Wood previously having suffered seizures with withdrawal from opiates. Nurse Olafson was unaware of this at the time he treated Mr. Wood. It would have influenced his decision making and possibly changed how he treated Mr. Wood. It also would have been useful to know that from previous attendances at HSC, Mr. Wood had received methadone and become stable at 35 milligrams of methadone daily.

[186] Nurse Olafson thought there needed to be a realistic assessment of who gets sent out to be started on methadone or Suboxone, rather than a policy that says we don’t start methadone and Suboxone.

[187] Nurse Olafson’s shift ended at 2:30 p.m. He did not learn Mr. Wood had passed away until the next morning. Nurse Olafson felt horrible about Mr. Wood’s

passing. Nurse Olafson wonders if he should have sent Mr. Wood out to hospital. He continues to think about it. When asked if he had any recommendations he wished to share with the Inquest, Nurse Olafson said he would do whatever it takes to never have this happen again.

[188] Nurse Olafson estimated that approximately one percentage of inmates going through withdrawal are sent to hospital and most are handled successfully in WRC. Some are sent to hospital and returned with little intervention. That does not change Nurse Olafson's perspective on sending inmates out to hospital when he feels they need to be sent.

[189] Nurse Olafson was aware Mr. Wood had been given Boost as a means of rehydration. Nurse Olafson agreed that Pedialyte or Gatorade might be a better alternative. The nurses do not have regular scheduled meetings to discuss matters of common concern specific to their work environment. Nurse Olafson said meetings would be helpful, but the biggest impediment to not having meetings is staffing shortage. It has been bad for a long time. A lot of the nurses have been working overtime resulting in burnout and stress.

[190] The change in drug use in the last five years has been the biggest problem, according to Nurse Olafson. In that period, nurses have seen 80% of inmate intoxication from alcohol and some drugs go to 95% drugs, if not higher. The type of drugs being used changes everyday. A group of individuals will be admitted all doing poorly. Intuition tells Nurse Olafson there is something different on the street, but nurses are challenged in rectifying it, limited in staff, time and resources. On some night shifts there are no nurses.

[191] Nurse Olafson might come in at 4:00 a.m. to see 15 inmates brought in over night. He must see those inmates before 6:00 a.m. because the doctor comes in at 8:00 a.m. and they need to be assessed before the doctor gets there. Sometimes the new admissions sitting in the basement waiting to be seen cannot be seen until the

doctor comes and goes. When they are seen after the doctor goes, it becomes a challenge for them to get medication. As a result, Nurse Olafson comes in at 4:00 a.m. to get medications ordered for them at the 8:00 a.m. time when the doctor comes. The nurses are doing the best they can, but it is a losing battle.

[192] When asked about nurse recruitment and what could be done to improve it, Nurse Olafson said the following:

> I don't know. That -- that's such a hard question because, I'll tell you, I love this job, and I know that my license is at risk every time I go into work because of the numbers, because of the lack of resources, and that this type of horrible event could happen, but I choose to do it because I love it, and I feel I'm making a difference, and I'll continue to do it. But try and lure somebody else in with that type of statement. Come on, 400 to two. Come on. It's a good place. It's a hard sell. It's a hard sell. And a lot of people do not want to come into an environment where you're dealing with people who are incarcerated.
>
> They are fearful of that, so it creates an issue. I find I feel safer there than anywhere. Like, I'm with officers, I'm with good people. The officers are incredible. It's a good place, but just some more staff would be really helpful.

(Inquest Transcript January 22, 2025, Page 80 Lines 1 – 13)

[193] In terms of sending individuals out to hospital, sometimes Nurse Olafson is asked, when he has determined an individual must go out to hospital, if it can wait until new staff come in. He does feel pressure, but he is tough and will say they cannot wait. The WRC nurse must be strong in their knowledge base and what they believe in.

[194] When asked about a role for nurse practitioners to supplement the nurse component, Nurse Olafson could not see how they could help given the absence of lab access, IV's, oxygen, and other features. A nurse practitioner does not have the ability to do what a nurse practitioner is trained to do. They would likely end up sending the individual out, so the result would be the same.

9. Karen Chrabaszcz

[195] Ms. Chrabaszcz has been the Acting Health Services Manager at WRC since the spring of 2022. She is responsible for overall services including managing staff, hiring, ensuring the staff meet guidelines, and delivering the best possible patient care. Prior to that, she was a nurse supervisor, a newly created position. At the time of Mr. Wood's passing in June 2021 she held the position of nurse supervisor. She commenced her career as an LPN in 1981 and went back to train as a registered nurse in 1984. She has been a nurse for 40 years. She worked in hospitals starting in 1981 and ultimately worked on casual status in the hospitals concurrent with her work in Corrections. Her work as a nurse at WRC began in 2005.

[196] The Supervising nurse responsibilities include preparing for the doctor's medical parade. The doctor comes in early, so Ms. Chrabaszcz's role at that time was to review all incoming charts from the night. The doctor must sign off on things he has reviewed, information that came off the fax machine, lab results, or other incoming information. She reviewed all the information, matching it with the paper chart, and checking the chart is complete.

[197] There has been discussion about the time of day for the doctor's parade, as the early presence of the doctor is sometimes not compatible with the needs of the patients who wish to sleep in. In Ms. Chrabaszcz's view, it is better for the doctor's parade to be early, because this allows ample time for things to be done as the patients' needs require.

[198] Dr. Doucet is present for one hour, seven days a week. Ms. Chrabaszcz reviews all the documents and flags, sticky notes and places arrows on them to review with the doctor. If she does not review all the incoming documents in this way to discuss with the doctor, he has only one hour of time and he otherwise would not be able to accomplish all the requirements.

[199] The nurses in WRC currently utilize the Clinical Opiate Withdrawal Scale (COWS) to determine an individual's level of dependence and guide the treatment approach. Back in 2021, there was an alcohol withdrawal checklist but not an opiate withdrawal checklist.

[200] Ms. Chrabaszcz said there is no standard in terms of how often a person withdrawing from opiates should have their vital signs taken because people are fluid. Some might need it every half hour and some, every four hours. In terms of time given for the nurse to ensure awareness of policies and emails pertinent to the execution of their duties, Ms. Chrabaszcz said it is very difficult to ensure time to read those materials based on lack of resources and staff. When asked what she could recommend to improve that, she said "more staff".

[201] Ms. Chrabaszcz explained WRC is critically short of nurses and has been for many years. In most rooms there is linkage to screens in the officer's pod area from the inmate's rooms. The officers are the nurses "eyes and ears" according to Ms. Chrabaszcz, and officers let the nurses know if there are problems. Every inmate placed on the medical floor is there for a reason.

[202] The medical observation form, revised in 2020, requires the nurse place on the form what the medical observation needs are and the observations that are to be reported to a nurse. The nurse would not tell an officer to look for withdrawal, because withdrawal is too vague. The officer needs specifics to understand what is to be reported to the nurse. The form is to be filled out either at the nurses' station or during intake in the basement. The officers do not write on the form. The form goes in the inmate file. The information is then written in the Corrections Offender Management System (COMS). Nurses do not write in COMS themselves.

[203] Vomiting is extremely common in WRC and is something nurses would like observed and communicated to them. The requirements of the *Personal Health Information Act* (*PHIA*) can be a barrier to communication relating to information

nurses can disclose about an inmate to COs. It is challenging for a nurse to rely on officers' observation, but their hands are tied as to what information they can provide about the patient. Ms. Chrabaszcz thought officers should be aware of what is necessary so they can do their job properly, and if they have had a *PHIA* training course Ms. Chrabaszcz does not know what the barrier would be to disclosure.

[204] As to when an individual withdrawing from opiates should be sent to hospital, many things are taken into consideration including resources. Generally, treatment would be attempted inside the institution and if things are not improving, they should be transferred out.

[205] Specific to Mr. Wood, Ms. Chrabaszcz was working at WRC June 2, 2021. As supervisor at the time, her shift would run from 6:45 a.m. to 1430. She has no recollection of responding to the code in the case of Mr. Wood. It was a very busy day. There were a lot of opiate-related issues.

[206] Ms. Chrabaszcz thought enforcing that people who are not managing well in withdrawal should be sent out to hospital would be helpful. Addressing opioid replacement therapy at WRC, Ms. Chrabaszcz said the methadone/Suboxone policy was in place before she started at WRC. She has seen inmates provided methadone, Suboxone, and the newest drug Sublocade in WRC. Ms. Chrabaszcz described Sublocade as an injectable form of opioid replacement given once a month. As the other drugs, Sublocade requires a fair bit of monitoring, outside agencies to start inmates on it, a prescription, obtaining the medication from a pharmacy, a nurse to administer it, and someone to ensure it is not being diverted. Ensuring inmate compliance is always a concern, and nurses do what they can to negate diversion, a very worrisome concern.

[207] The injectable form was developed, as indicated in presentations on the medication, to address the issue of diversion but it is not foolproof. Individuals have been known to attempt to squeeze Sublocade out of their abdomen and share it in

some way. One must be on the pill before they can switch to Sublocade. It must build up in the blood stream and then switched to needle form. At WRC, they do not start Sublocade or any medication in remand generally. There is a policy regarding that.

[208] The WRC medical unit does not do medication starts for several reasons, including that it is time consuming and difficult to navigate. Should an inmate incoming advise they are on methadone, Suboxone or Sublocade the nurse must check to see where the medication came from in the first place.

[209] The Drug Program Information Network (DPIN) is an electronic, on-line, drug system in Manitoba. A DPIN report is retrieved to check the medication history. The individual may be from some other institution and their DPIN history does not register. Manitoba is not connected with Alberta, Saskatchewan or anywhere else outside of Manitoba, so the information may not be readily available.

[210] The next step is to determine how long ago the individual last received one of these medications. The nurse must ensure the individual is administered the medication within three days of the next ingestion. If one comes in on a Friday, the nurse must confirm with the pharmacist who administered it and observed the consumption, as a witnessed dose only, that it occurred within the previous three days or five days in the case of Suboxone. Should the individual be given medication that need not be consumed in front of a pharmacist, or for many reasons including the nurse may not be able to reach the pharmacy particularly on a weekend to confirm what the status of the individual is, it creates certain challenges.

[211] Inmates have been known to sell or divert the doses, so WRC only counts doses that have been witnessed. Suboxone lasts for five days in the blood stream, and again only witnessed doses can be accepted and relied upon.

[212] Sometimes inmates don`t know the name of the doctor and nurses must research who the doctor is. The nurse will phone to try and find out the last witnessed dose. They never give it without a prescription. Sometimes the prescriptions that

come in through the fax machine have run out. Ms. Chrabaszcz described many other factors that present barriers administering opioid replacement therapy to inmates in the WRC.

[213] Generally, nurses are doing all the outside checks. There is a clerk but sometimes they are sick. The clerk starts the process of getting the pharmacy involved, determining who the doctor is, and confirming the dose. But in the end, it is the nurse responsibility to check everything.

[214] The nurse must also consider when the individual`s court date is and whether they might be released from custody. Manitoba Corrections has moved to a particular drug logistics company that supplies correctional facilities so if they are transferred to a different institution, the prescription must be dealt with by them to get the medication to the inmate. Some pharmacists will only send one day at a time and not provide five days worth of medication when asked for it. In these cases, the nurses must phone everyday and request more doses. Sometimes it is lapsed when the courier doesn`t come.

[215] When asked whether electronic monitoring of some sort might be of assistance, Ms. Chrabaszcz's concern was creating a false sense of security. Over the years, she has learned the primary means of monitoring the patient is to check the patient. One cannot rely simply on a machine. If the pod officers are to monitor the machine, and need to call the nurse, and there is no nurse available, there is no purpose to it.

[216] She said "How is that fair to a nurse and her licence to know that there is something beeping or maybe amiss, that you are -- you are tied up for the next half hour. Is that right?" (Inquest Transcript January 23, 2025, Page 87 Lines 24 – 26)

[217] Ms. Chrabaszcz said at intake the nurse asks about drug consumption. Most people are somewhat honest with the nurse, and the majority are still doing drugs. A gadget maybe helpful for monitoring, although if there were one or two

nurses in the building and they are busy the nurse may not be able to respond in a circumstance of a ratio of one nurse to 200 people. In her role as Nurse Manager, Ms. Chrabaszcz recommended more staff and retention of staff as a priority. A monitoring device might be helpful, but she was unsure about electronic charting. She felt the medical staff is a close group and extremely supportive of each other. They do the best they can given the resources.

[218] Ms. Chrabaszcz has attempted several in-service training sessions, but they can always use more, and it comes down to a time crunch. The training is left "…at the back end of the burner." (Inquest Transcript January 23, 2025, Page 88 Line 32) Ms. Chrabaszcz has been attempting for two years to get more programs for the nursing staff that would add to the value of the work they do.

[219] One of the issues impacting nurse recruitment relates to compensation. Nurses start at a lower rate than those in hospitals. Working in a jail is a "tough gig". (Inquest Transcript January 23, 2025, Page 89 Line 35) Some people believe it to be scary, creating a barrier. When a nurse is eventually identified, the lengthy hiring process is a problem. Recently, the wage has improved slightly but is still less than at the hospitals. Additionally, the weekend and evening premiums are also better at the hospitals. At the time of her evidence, Ms. Chrabaszcz identified 20 open nursing positions including casuals at WRC.

[220] As to how the decision is made as to which inmate gets to see Dr. Doucet when he comes in, the nurse who does the parade makes the list for the parade. The nurse also decides if the inmate physically sees the physician or is just eligible for chart review. Those individuals who see Dr. Doucet are not decided by the physician. When the physician comes in the list has already been determined. As to whether the physician can spend enough time at WRC during the day to see everyone and meet their needs properly, Ms. Chrabaszcz said the physician will stay longer than the one hour he is contracted for if it is needed. If he is not going to stay longer, the individual is

not seen, and they are put over to the next day. The doctor would be utilized if he were there for longer then an hour, but it is not always necessary.

[221] What would be particularly helpful is if all health facilities in Manitoba were linked so the correctional nurses have access to medical information about inmates. Should a WRC nurse require a chart from another Manitoba correctional institution, a request is made, and the hard copy chart must be brought in when escorts bring inmates in from the other institution. The charts are ultimately stored at WRC after an individual is discharged, but sometimes the individual is readmitted to WRC before his chart returns.

[222] Ms. Chrabaszcz, as the acting Health Services Manager, is currently responsible for retention and recruitment of nurses. Nursing is linked with Human Resources and a new process called Talent Acquisition. This is a new employment strategy in the province of Manitoba. They are responsible for placing the ad, receiving the incoming resumes, and reviewing the applicants to ensure they are appropriately licenced nurses. The resumes are shared with Ms. Chrabaszcz, and she reviews them with the HR employee and schedules a date for interview. After the interview, she does the reference checks, and the security persons start screening. The time gap from offer to when the nurse can commence employment at WRC is, according to Ms. Chrabaszcz, dismal. Her recent experience is, for example, a review of applications in July, interview in August and a single fulltime nurse started in December. The delay is the security clearance not from the acting nurse manager protocols.

[223] Ms. Chrabaszcz said she had no recollection of the incident with Mr. Wood, despite her presence at the first code red, and was not interviewed for the purpose of the divisional investigation report.

10. Paula Ewen

[224] Paula Ewen (Nurse Ewen) is a registered nurse who, at the time of her evidence, had worked at WRC for almost 13 years. Prior to that she worked for Indigenous Services Canada on First Nations communities for 11 years. She then worked at Stony Mountain and Rockwood Institutions for 10 years. After that, she was asked to complete some investigations into narcotics being diverted from nursing stations. She then returned to First Nations and Inuit Health Branch as a supervisor for nurses in the north. Ultimately, she retired after 38 years with the federal government. She was working at WRC part-time as a casual nurse doing nights and weekends. When she retired two years ago, she became a full-time night nurse at WRC. At one point she was seconded to Grande Cache, Alberta to organize their healthcare system within the prison organization and recruit nurses.

[225] Despite her past involvement in nurse recruitment, she has not been involved in that endeavour at WRC. On an informal basis, she tries to encourage nurses to work in Corrections. For example, she went to an appointment related to her own health and recruited one of the nurses to work for WRC on a casual basis.

[226] Apart from Nurse Ewen's private recruitment, her impression of WRC and Corrections' recruitment endeavours is to put advertisements out. They are not going to the nursing schools or recruitment fairs. In her 38 years as a nurse, Nurse Ewen has never seen a Corrections representative at a recruitment fair. There are massive recruitment fairs all over Canada. She would be pleased to attend these recruitment fairs on behalf of Manitoba Corrections if asked to do so.

[227] Comparing her nursing experience in other venues to Manitoba Corrections, in the federal system Nurse Ewen observed there is better physician availability and services. The Manitoba Corrections doctor comes in briefly in the morning and is not on call after hours, so he is not really available. She has not been able to reach him after 9:00 at night, and for an urgent request she does not hear a response until

7:00 a.m. In terms of psychiatric services, physicians were always available in the federal system if needed.

[228] In terms of the current outreach to WRC physicians, Nurse Ewen said that she sent an email to the physician, she tried phoning, and there was no answer. If she does send an email, she usually gets a response at about 6:45 a.m. She leaves at 7:00 a.m., so if she sent a message at 9:30 p.m., she does not hear back until the morning. That may mean she sends the individual out to hospital or the individual is put on the list for the doctor in the morning. When asked whether Nurse Ewen would simply reach out to another physician for advice or opinion if Dr. Doucet is not available, she said there is no other physician available to WRC nurses. Historically, because of her personal connection with physicians she would call a doctor she knew unrelated to WRC, or the hospital emergency department. The problem with calling another doctor or the hospital is they do not have the patient right in front of them and they are reluctant to take responsibility, which Nurse Ewen understands.

[229] She felt strongly there was a role for a nurse practitioner. At the time of her evidence, she had sent an email two days before to one she worked with up north, asking her to consider applying to Manitoba Corrections. The benefit would be someone available after hours for advice and the ability to prescribe. A list of physicians she could ask for advice or information if Dr. Doucet were not available would be extremely helpful, but there is no formal guideline for nurses at WRC in that regard.

[230] Because Nurse Ewen works nights, her duties include making up files, because the clerical staff don't do that, filing, paperwork, and taking stickers off old files so they can make up new files. The night nurse must sort inmate request forms to determine which of the medical resources the inmate should be accessing. There are clerks during the day but no clerks evenings, weekends or at night. Much of the clerical duties fall to the night nurse. Chart notes are done as they can

be. When Nurse Ewen is distributing medication, often inmates will discuss concerns. She makes notes on little pieces of paper as she goes. When she returns to the nursing office, Nurse Ewen would then pull their file and make notes in the files after she signs off on her meds.

[231] She could be called to a code, or needed in the basement admissions area, so she charts when and as she can. The ideal would be to make the chart notes as soon as she sees the individual, but that is not the reality working alone at WRC. If she can, and is called to see a particular inmate, she will attempt to pull and quickly review their file to prepare but the reality of doing that is challenging. Nurse Ewen may not get to a chart until 5:00 in the morning relating to an incident that occurred at 11:00 p.m. the night before.

[232] A paramedic to assist the nurse in the WRC would be extremely helpful to do vital signs and observation. They are *PHIA* trained. They could not replace a nurse but would be an excellent teammate.

[233] Any encounter with an inmate is supposed to be documented. Officers are forced to monitor inmates for medical concerns because of the lack of medical staff. The officers are very astute, and the medical unit is fortunate to have their support. The nurses vary with the type of information they share with the officers because everyone looks at what is acceptable to share differently. Nurse Ewen works nights alone. The officers are her eyes and ears. It is her view she is more forthcoming than some of the others. There is always the fear if a nurse discloses something she feels she must, that somebody will go after their licence for inappropriately disclosing information. Nurse Ewen described this discrepancy as a major issue of the WRC.

[234] She has gone to the Ombudsman, to the College and the Canadian Nurses Association because of her concern regarding white boards that are in the medical unit displaying personal health information when there are contractors that come and go through the unit. However, when it comes to the health and safety of inmates

entrusted into staff care at the WRC, there is a reluctance to share the same information with those who could use it to better serve the well-being of the inmates.

[235] The information nurses were given about the treatment of withdrawal was limited. The nurses generally had exposure to a lot of alcohol withdrawal, crystal meth, and fentanyl. However, at the time of Mr. Wood's death, opiate withdrawal was new. There was not a lot of formal education given to the nurses at the time, and so there was much self-learning.

[236] In October 2022 the COWS form was implemented for opiate withdrawal monitoring. It is a rating scale to determine the level of withdrawal. The incident with Mr. Wood has made many of the nurses more aware. They do not want a repeat. They are learning from the trauma of the experience. Nurses come to work at WRC with varying nursing backgrounds, and a standardized and consistent objective assessment such as the Canadian Triage and Acuity Scale (CTAS) score would be very helpful in assisting the nurse to determine when an inmate should be sent out to hospital.

[237] On June 2, 2021, Nurse Ewen was working the night shift, generally starting at 11:20 p.m. She came in early, however, because Nurse Koscian was working evenings alone. Nurse Ewen recalled coming in at about 9:00 p.m. Nurse Koscian had not yet been able to distribute the medications on the third floor, so Nurse Ewen went to distribute them, resulting in her first encounter with Mr. Wood. When she went to give him his Clonidine, she noticed a lot of vomit on the floor so she gave him oral Gravol. He was a bit unsteady when he stood up and Nurse Ewen told him to hold on to the wall so he wouldn't fall. She was concerned he might slip and fall on the vomit on the floor.

[238] Mr. Wood proceeded to vomit up the Gravol, so she got another one and handed it to him through the slot and he dropped it. He went to pick it up out of the vomit and Nurse Ewen told him not to do that and just to sit back down.

She consulted with Nurse Koscian, who said they had a stat order for IM Gravol. She went back to give him the IM Gravol and asked the officer accompanying her for a mop and pail. She wanted to clean the room because it was full of vomit. The officer offered to clean the floor, so Nurse Ewen cleaned and changed Mr. Wood. She told Mr. Wood she would come back in a little bit, once his stomach settled down, and bring him some Boost to attempt to get some nutrient into him. There were massive amounts of drying vomit on the floor. It appeared the vomit had been there for some time, and no one had cleaned it. She was concerned if he went to the bathroom he would slip on it and hurt himself. She needed to know if he was still vomiting and couldn't tell with all the substance on the floor. She also wanted to give him a sense of dignity.

[239] She was in the cell with Mr. Wood for about five minutes. He was able to converse. He was quiet but did speak to her. He mentioned he felt sick. He told her he hadn't eaten anything, which is why she said she would get him the Boost.

[240] When Nurse Ewen later checked the shift report book, she saw there had been a code and Mr. Wood had been transferred from the fifth floor to the third floor. He had been complaining of cramping and lots of vomiting. When Nurse Ewen went to chart the Gravol for him, she found out he had already had the IM Gravol. Nurse Ewen was very busy and had many people to see in admissions in the basement.

[241] At the time Nurse Ewen was treating Mr. Wood, she did not know how long he had been vomiting for. Looking back, she would have wanted to know that. Nurse Even was unaware Mr. Wood had pressed the Dukane system at 2219, about 20 minutes after she saw him. Nurse Koscian ended her shift at 2300 hours. At that time Nurse Ewen was in the basement in admitting, so Nurse Koscian was gone when Nurse Ewen came back up. She was unable to have a conversation with

Nurse Koscian before she left. Mr. Wood was not reassessed after Nurse Ewen's interaction with him. She was the only nurse on shift.

[242] She gave him Boost to try and get nutrients back into him. He was not taking solids. She thought once the Gravol settled his stomach they could get some nutrition into him. Pedialyte was not available to the nurses at that time.

[243] At the time the Boost was provided, it was not in Nurse Ewen's mind to contact Dr. Doucet or send Mr. Wood to hospital. She thought she was dealing with fentanyl withdrawal, that Mr. Wood was vomiting and probably dehydrated and likely needed some fluids. She was hoping the Gravol and Boost was going to turn things around for him.

[244] Later on, Nurse Ewen was in the back medical office working on files. The Duty Officer asked her to look at Mr. Wood. She came around the corner and the Duty Officer said he was not breathing. Nurse Ewen commenced cardiopulmonary resuscitation (CPR) while someone got the Automated External Defibrillator (AED) and brought it in. Nurse Ewen asked them to call 911. She had a difficult time putting in the airway, so she was aware he had likely been deceased for some time already. The officers were doing CPR, and the ambulance came. In these circumstances, Nurse Ewen is not permitted to say he is deceased and must wait for the ambulance or a doctor. It can be extremely traumatic knowing the individual is deceased and exposing a lot of officers to having to continue with the CPR when you know it is not going to be successful. There was a debrief after the event, but Nurse Ewen did not receive any information that she did not already know.

[245] In discussions with her fellow nurses the following day, she received a lot of information she did not know that would have changed the way she managed Mr. Wood's care if she had. She learned he was having contractures, not cramps and his blood sugar was elevated. That was not documented in the file. That would have sent off red flags to Nurse Ewen that there was more going on than she was aware

of. She thought the indication to her, would have been at the time, that Mr. Wood was probably was in ketoacidosis and electrolyte imbalance. Had she known all that, she would have sent him to hospital.

[246] After her discussion with the other nurses, she was called in for another debriefing. Nurse Ewen thought this unusual, because nurses involved in a code were not involved in a second debriefing. Usually, it is staff from another institution. Ms. Chrabaszcz was involved in the earlier code and Ms. Mueller had done the intake. Nurse Ewen has had conversations with Ms. Chrabaszcz about Mr. Wood over the last four years since it occurred. Nurse Ewen did not know why certain nurses were selected to be interviewed for the Divisional Investigation Report and others were not.

[247] As to expanding opioid treatment at WRC, Nurse Ewen noted her experience working at Stony Mountain. There was a methadone program there when she worked there. It is her view changes to addiction treatment is not about handing out a pill. WRC doesn't have the programs and counselling in place for addictions. WRC has a lot of short-term inmates, but some are there for the long term. Handing out Suboxone or methadone, in her view, is not the answer to changing human behaviour. She also worries about divergence. It is her opinion that Sublocade, an injectable, is probably the best medication because it is difficult for the inmates to divert. It is not always the case that an inmate wants to divert the medication. Sometimes they are pressured or threatened.

[248] In terms of her recommendations to assist the Inquest, Nurse Ewen thought more education is needed for staff and an observation area for inmates in high intensity withdrawal. They are spread out all over the institution, and the nurse is pulled in all directions. The other important issue is more medical staff, so the existing staff are not pulled in multiple directions at the same time.

[249] In describing the stresses and competing priorities WRC nurses must contend with, Nurse Ewen described the tension as follows:

> And you go home at the end of the day and you think, you know what, thank God they're all alive today, I - I did my job. And the day that they're not, it's like, what failed? Was it me? What was it? So it's always tough.

(Inquest Transcript January 28, 2025, Page 48 Lines 13 – 15)

[250] In describing the infrastructure at WRC for observing inmates, she described the screens that had been moved down and replaced as terrible and that one can't see on them. The Dukanes are terrible, and she did not know how the officers could understand anything the inmates say because of the poor quality or lack of sound.

[251] In terms of recruitment or retention of nurses, Nurse Ewen noted a dearth of ongoing education and observed to bring in a new graduate is not a good fit. It is her belief that one must come to Corrections nursing with "tools in your toolbelt." At WRC as a nurse, you're going to be on your own. There is not an opportunity for advancement in Corrections nursing at WRC. If a nurse wants to move up, vertical movement is slow if at all because individuals hold positions for long periods of time. Other nurses are much better paid than WRC nurses and have incentives. The hiring time is "excruciating". People will not wait six months to be hired, and they find another job.

[252] At WRC, Suboxone is administered by pill; they do not use the sublingual film. The entire process, including observation of the inmate, takes about 45 minutes plus the time to bring them from their location and return them. On any given day, WRC probably has between 15 and 20 individuals in varying stages of withdrawal. The amount of Clonidine administered in the institution currently is "phenomenal". Mr. Wood's passing from withdrawal was the first Nurse Ewen had experienced. There was another one after. In 2021 and 2022, in Nurse Ewen's recollection, there were a lot of individuals withdrawing from alcohol and methamphetamine. They did not see at lot of opioid withdrawal at that time. Two out of every 100, are sent out to

hospital. There are a lot of inmates who will not admit they are in withdrawal. Several days later they are very, very sick.

[253] In terms of Dr. Doucet's availability, Nurse Ewen thought Dr. Doucet chose not to see patients on weekends. She did not agree that not seeing patients on weekends had anything to do with staffing levels. On the weekends, he quickly does the charts and is out the door. Some mornings on the weekend he stays 15 or 20 minutes. During the week, he is there a bit longer because of the doctor's parade. The supervising nurses pick and choose which of the individuals they think Dr. Doucet should see. Nurse Ewen did not know why he is not able to see them all. He stays about two hours during the week.

[254] When asked how Nurse Ewen manages on the night shift with no access to a physician and multiple admissions and various issues, she responded "with a lot of prayer". Additionally, if she is in doubt she will send the individual to hospital. Sometimes, in Nurse Ewen's view they are not fit for admission medically, and the police then take them to the hospital. Nurse Ewen's process for communication with Dr. Doucet is to first call his cell phone. She has gotten an answer from him once. The other physicians on contract, if she calls late at night, answer the phone. She has never had to email them because they pick up the phone. If she cannot reach Dr. Doucet by phone, she sends an email. The response comes back between 6:30 and 7:00 in the morning.

[255] Communicating by telephone is better for the nurse, because it occurs in real time. It is an opportunity to dialogue about the issue, and for the nurse to receive advice.

[256] An email from one of the supervising nurses advising nursing staff not to communicate with Dr. Doucet after a certain time because he needed to sleep was filed as an exhibit in the Inquest.

11. Malgorzata Koscian

[257] At the time of her evidence, Nurse Koscian a registered nurse, has been a nurse at WRC since 2011. She worked at the HSC from 2008 until 2012 and 2017 until 2019. She has also participated in immunization clinics and worked in a nursing home. While at HSC she was primarily a surgical nurse. She graduated from nursing school in 2008 and has been a nurse for 17 years.

[258] At the time of her evidence, Nurse Koscian acknowledged WRC currently has more tools at a nurse's disposal to treat opioid withdrawal than in 2021. Starting an individual on Clonidine is very helpful as are Suboxone and methadone.

[259] Starting a patient on methadone or Suboxone is nursing intensive and a lengthy process. They need to be heavily monitored, and WRC simply does not have the staff. The individuals also must be watched carefully for diversion at WRC. The Sublocade injection has been administered at WRC. Suboxone is highly diverted at WRC, and Nurse Koscian preferred administering methadone. Individuals starting the medications need to be monitored closely, optimally every four to six hours for any signs of medical distress. In June of 2021, COs observed inmates in the medical unit, watching for signs of distress, movement, certain behaviours, fluid and fluid intake.

[260] It is Nurse Koscian's practice to communicate with officers if there is something specific to watch for. For example, a cardiac patient will be different than someone in withdrawal, and also different from someone who suffers seizures. A nurse wants to be respectful of the privacy of a patient's medical information, but when one wishes the best possible outcome for them certain information needs to be disclosed to the officers. Nurses walk a fine line in this regard.

[261] In Mr. Wood's case, there was no medical observation form completed for him. If completed, the form can indicate whether a camera cell is required on the medical unit or whether the individual can be observed in the tower in a camera cell.

The form is typically completed after a code red or during the admissions process. should an admit be identified as benefitting from camera observation.

[262] Nurse Koscian, as one of the nurse responders to Mr. Wood's first code red, assumed everyone else completed the form. A code protocol would be helpful to assist in determining who does what in responding to a code, so nothing is missed.

[263] As to the doctor's parade, it is typically the supervisor who decides which inmate will see the doctor. Nurse Koscian's experience and understanding is that Dr. Doucet is required to be at WRC for one hour to see patients and review charts. He is not typically there for one hour. Nurse Koscian does not clock him, but it is her view he is there for much less than one hour. The time he is there is insufficient for the needs of the inmates. In her opinion, it would be nice if the physician would stay to finish the patients and not "clock out" because the hour is over and put patients over to the next day. She felt he was very committed to his contract and when the hour was up, he leaves.

[264] If the physician leaves before the patients are seen, there is not much the nurse can do. If a nurse calls Dr. Doucet past 7:00 p.m., often there is no answer. An email sent after 9:00 p.m. is not responded to until the following morning. There is no alternate list of physicians, which would be helpful. The odd time, a nurse has called emergency centres. It was Nurse Koscian's view the nurse is not legally permitted to take an order from a physician not employed at her centre. You can ask for advice, but you can't take a medication order or any other kind of order. She has only called an emergency centre less than a handful of times, and only when she is truly uncertain. If something is not looking good, the nurses typically send individuals out to the hospital.

[265] On the day in question, Nurse Koscian was working 11:00 a.m. to 11:00 p.m. There are no designated duties at WRC, which can be challenging. If nurses don't communicate with the next nurse about what has or hasn't been done, things can get

missed. She supports assigning designated duties, which is difficult because they are so short staffed. When there is a single nurse on, they do it all.

[266] The mid-shift, the 11 to 11 shift, is extremely busy with medication rounds, doctor's parade, dressing changes, and admissions. To orient herself, Nurse Koscian looks at the white boards in the back office to see who is in the medical cells and why. There is also a book specifically for withdrawal clients. The public health nurse, working Monday to Friday 8:00 a.m. to 4:00 p.m., addresses needs relating most specifically to sexually transmitted infections.

[267] On her shift, there was a code red called relating to Mr. Wood. Nurses Murray, Oliver, Ms. Chrabaszcz and herself responded on level 500. This occurred about an hour into Nurse Koscian's shift. As the incident unfolded by the elevator, Nurse Koscian was standing off to the side. At the time, it did not appear to Nurse Koscian Mr. Wood needed to be sent out by ambulance. She does not recall the specifics of his vitals but does recall the vitals were stable. Blood sugar was good, and the pulse did not indicate he was tachycardic. Mr. Wood spoke in full sentences with clear speech. There was no indication he was in major medical distress. No one was charting what was going on. Nurse Koscian made no notes in Mr. Wood's medical chart. She was not involved in any medication to be given to him at the time. She did recall phoning Dr. Doucet for an order for injectable Gravol later.

[268] Around 5:00 or 6:00 p.m. Nurse Oliver thought medication was warranted, and Nurse Koscian must have called Dr. Doucet for an IM Gravol order, but she does not recall it. Such conversations are usually very quick.

[269] Nurse Koscian did not learn Mr. Wood had passed away until the next day. She did not recall a meeting with other nurses or management. When asked what would be useful to improve patient care, Nurse Koscian responded:

> So, knowing what we know about the Remand Centre, what else do you think would be useful to improve patient care?
> More staff. More staff, more staff. We've been preaching that for years.

(Inquest Transcript January 29, 2025, Page 30 Lines 22 – 28)

[270] In the absence of more staff, Nurse Koscian suggested better cameras for officers to watch clients. The existing cameras are black and white and very small. They can see fluid on the floor, but one can't tell if it is urine, blood or emesis. One can't tell if it's spilled soup or a carton of milk.

[271] Nurse Koscian also supported the presence of a nurse practitioner, who could prescribe, assess patients on the spot, and determine what dressing changes clients need. Wound care can be a problem at WRC. Clients often decline to have their dressings done, but from a nurse training perspective it is not a requirement to have a wound care course prior to being hired. COs are tasked with observing inmates for medical safety, but they require training in withdrawal, cardiac events, strokes, and other major things to look for.

[272] Nurse Koscian was shown a video of Mr. Wood in cell 341 starting at 2245. She was asked to focus on the way Mr. Wood was holding his hands and arms in a rigid manner. His wrists appeared flexed outward, and his hands were clenched into fists. Nurse Koscian said that is not uncommonly seen in psychiatric patients, but without knowing Mr. Wood's medical history it was difficult for her to comment. Assuming no pertinent psychiatric history, and that he is withdrawing from opiates, Nurse Koscian speculated that kind of clenching might be indicative of cramps which could mean dehydration. Had she seen Mr. Wood's presentation as depicted in the video, she would have considered sending him out for rehydration in hospital because WRC does not have the means to do so.

[273] Nurse Koscian's recommendations related primarily to staffing levels and education. In addition to appropriate responses to persons withdrawing from opiates, Nurse Koscian thought that education was required for everything in general. There had been a suggestion historically that the nurses and other staff participate in mock code reds. There has been one such drill in the past two years.

[274] Concerning staff meetings, the last was in May or November of 2023, so Nurse Koscian thought that for practical purposes there really were no staff meetings. Of the staff meetings that are held, nothing gets resolved. Ideas are presented and nothing implemented. Nurse Koscian has found courses for herself, such as International Trauma Nursing, and she wanted also to attend a cardiac seminar. Both were denied as irrelevant to her work at WRC. Other courses have been offered with irrelevant content. The latest course offering was on colostomy bags and ostomies. Generally, there is one ostomy client per year in WRC.

[275] For a nurse to function at WRC, the nurse must be very independent. There are no healthcare aides or any kind of assistants. Ms. Kocian wants to learn about strokes, cardiac issues, wound care, and other necessities that are more prevalent. A course was to be offered on sexually transmitted infections, about two months after Nurse Koscian's evidence. She noted that there are public health nurses five days a week to deal with that specialised issue and she does not need that training. The training is determined by the manager.

[276] Nurse Koscian believed the nurses need more opiate withdrawal training, and to stay more current on drugs currently on the street because they change. It is not that sexually transmitted infection is not important. It is, but not in the context of the resources already in place, the population at WRC, and the other more pressing demands for education.

[277] Nurse Koscian thought an electrolyte monitor would be of assistance, as it is not only vital signs that can indicate dehydration. In treating patients in opiate withdrawal, Nurse Koscian said caring for patients is really difficult because the nurses are fighting the unknown. In Mr. Wood's case, his dehydration may have led to hypovolemic shock. The heart is working harder to push the fluids through the body, and Mr. Wood was also vomiting, resulting in fewer fluids in the body. There seems to be no true requirement for training for nurses at WRC. If you have a

nursing licence, and pass the interview, you are hired but there is no mandatory training of any sort. Nurse Koscian would urge mandatory training, particularly for wound care which is a significant problem at WRC. Training in cardiac disease is helpful, to assist a nurse, for example, in being able to sort out whether the nurse is dealing with an anxiety attack or an acute cardiac event. Other training should be offered in strokes and withdrawal. In terms of the recruitment process, the biggest problem is that it takes four to six months to hire a nurse at WRC. Nurse Koscian estimated 70% of people coming into WRC have disclosed opiate use, whether by IV or in some other way.

[278] Dr. Doucet is available on the weekends. He comes in to do charts but does not see patients because he says it is not in his contract. Nurse Koscian did not think the physician not seeing patients had anything to do with officer availability. In addition to reviewing the charts, he orders medications. He is there for 15 minutes both on Saturday and Sunday.

[279] Sometimes the doctor leaves and the patients are not all seen. Assuming the patient has not, in the interim, gone out on a code red there is already a reserve of patients now that haven't been seen. More people arrive who also need to be seen. Sometimes the needs are simply not appropriately addressed. Sometimes the person is released or transferred. Sometimes the issue resolves because it has been so long. Sometimes individuals wait for days. This has been an ongoing issue.

[280] Nurse Koscian thought WRC does not have great physician support which is why she suggested to perhaps hire a nurse practitioner. Nurse Koscian expressed the hope that the Inquest would produce meaningful recommendations for change.

12. Oliver Maglaqui

[281] Nurse Maglaqui started as a CO at WRC in 2013. He was a nurse in California from 2008 until 2010. He has held the designation here of licenced practical nurse since 2019. In California, he was a licenced psychiatric technician, which is a registered psych nurse here. He worked in a hospital which was a facility for developmentally disabled individuals. He has also worked as an LPN at a personal care home. Originally, starting in 2019, Nurse Maglaqui's designation was transfer nurse. He oversaw transferring inmates healthy enough to be transferred to other correctional institutions. He is also capable of being a medical nurse, and because of staffing shortages he can be a general duty nurse. His shift is Monday to Friday 6:45 a.m. to 2:30 p.m., involved in transfers from WRC to other Manitoba institutions. He is to assess them and ensure they are healthy enough to be transferred.

[282] In 2021, when Mr. Wood passed away, Nurse Maglaqui was performing the responsibilities of a medical nurse. As the transfer nurse, Nurse Maglaqui prepares files for transfer, and if there is medication, if the individual needs a colostomy bag, or any other specialised supplies, including methadone or Suboxone, he prepares all those materials for the next institution. When Nurse Maglaqui sees a patient, he generally does not have their chart with him. The interaction takes place, and then subsequently he makes the chart entry. He finds he is forgetting to chart because of that process.

[283] Nurse Maglaqui said they are so short staffed, nurses are pulled in every direction. As one tends to one patient, there are multiple requests for the nurse from others. It is overwhelming at times. Nurse Maglaqui writes things down as best he can and tries to remember to chart the issue. If there is a code or something else happens, he must immediately go to address that. Because of the chaos, sometimes

a chart is misfiled. Sometimes the psych department has it. Sometimes the public health nurse has it. It is difficult to go looking for charts on a regular basis.

[284] If Nurse Maglaqui determines medication is required that is not over the counter and requires a doctor's attention, his practice is to write a note into the chart and then put a sticky note saying the patient should see the doctor. Nurse Maglaqui has no role in determining who gets seen by Dr. Doucet. It is not up to him. It is up to whomever is doing the charts for the day, usually the manager or supervisor.

[285] Nurse Maglaqui's experience with the doctor, is that he comes in at about 8:15 or 8:30 a.m. until about 9:00 or 9:30 a.m. He stays about 30 minutes to one hour Monday to Friday. On Saturday and Sunday, he just does a chart review and is there for 30 minutes tops. The odd time, he will see someone but that is very unusual. This coverage is insufficient. In terms of phone calls, sometimes Dr. Doucet answers right away, sometimes he answers after a while, and sometimes he does not answer. Email is the best practice but even then, there is sometimes delay. Nurse Maglaqui would prefer a phone call. The interaction is immediate, and more information can be exchanged at the time.

[286] For communication any time past 9:00 p.m. if a nurse phones the doctor, he usually does not return calls. He also does not return emails in the middle of the night. When Nurse Maglaqui needs advice from a physician and cannot get an answer from Dr. Doucet, he has called the emergency room for advice on one occasion. Most of the time, he sends them out to the hospital if he is unsure. A nurse practitioner would be extremely helpful. Having a doctor see the inmates on the weekend would also be very helpful so they don't get lumped into Mondays because Monday has a great number of patients that need to be seen generally. Inmates get pushed over to the next day if they are not seen on the original day until they are eventually seen.

[287] On the medical observation unit, the officers are supposed to look at a screen and if a person looks like they are in danger, notify an officer who is to do the round. In terms of *PHIA* concern about sharing information with the COs to assist them in what to look for, the reality is, that when a nurse sees an inmate, the officer will always be there. After administration of methadone, the period of observation by the nurse is 30 minutes, and after Suboxone, the period is 45 minutes. Nurse Maglaqui did not know how that period of time was determined and by whom. As of June 2021, there was no opioid specific training at WRC. After, there was a session for opioid training conducted by WPS in the boardroom.

[288] Nurse Maglaqui worked June 1 and 2, 2021. Mr. Wood was on the fifth floor, and Nurse Maglaqui gave him his medication. Nurse Maglaqui's note of June 1, 2021, at 9:00, indicated his interaction with Mr. Wood at that time. Mr. Wood stated he was withdrawing from fentanyl and meth and had been a daily IV user. He complained of projectile vomiting, diarrhea and weakness. He said his daily use of fentanyl had been for the last two years. There was liquid vomit on the cell floor and Nurse Maglaqui noted he would put him on the doctor's list. He was given 50 milligrams of Gravol, and four milligrams of Imodium. Nurse Maglaqui also surmised that he gave Mr. Wood his Clonidine. Nurse Maglaqui recalled that Mr. Wood was walking, alert, oriented and was talking.

[289] The sticker Nurse Maglaqui placed on the chart was for Mr. Wood to see the doctor tomorrow for opiate withdrawal. He did not see the doctor, and Nurse Maglaqui did not know why. Nurse Maglaqui completed a follow up of vital signs on June 1 at 1:30 p.m., and his data was placed in the chart. Nurse Maglaqui noted the inmate was ambulatory, walked upstairs, was alert and oriented, and complained of vomiting ten times. He had no more diarrhea. He repeated that he was withdrawing from fentanyl.

[290] The notes Nurse Maglaqui made were standard. He saw Mr. Wood again because it was about four and a half hours later than the previous interaction. He could not get vitals earlier on, so he needed to get a set of vitals and did so at 1:30 p.m. No further interaction is charted on June 1.

[291] On June 2, Nurse Maglaqui could recall there was a code red, and he went to the fifth floor with a group of nurses and helped. Nurse Maglaqui went to retrieve Mr. Wood's chart and noticed no one had charted. The vital signs had been erased from the machine, so he had nothing. The vital signs are recorded as simply stable with no numerical data. If they had been unstable, Nurse Maglaqui was confident Mr. Wood would be sent out. His charted note was at 12:00 p.m. indicating the inmate was on the floor, lying on his back. He was alert, oriented and exhibited weakness. The inmate complained of cramps to bilateral legs and right hand. He complained of generalized weakness and constant vomiting. His vital signs were stable; he was given 50 milligrams of Gravol.

[292] There is a further chart note, although the time is not clear, that the inmate was noted as lying down in bed. The cell was filled with Gravol and vomit. A note said, "will place to see MD tomorrow". Nurse Maglaqui noticed Mr. Wood had not been seen by the doctor as Nurse Maglaqui had requested because there was no chart note from the doctor. Nurse Maglaqui recalled asking Nurse Koscian to get an order for IM Gravol and she was able to get a response from Dr. Doucet. Nurse Maglaqui was carrying a suppository and IM Gravol and asked Mr. Wood for his preference of administration. Mr. Wood chuckled and said no suppository for him, and he would prefer the injection. Nurse Maglaqui then administered the IM Gravol medication.

[293] Although Nurse Maglaqui noted the vital signs had been deleted from the machine, he has since learned they can be retained by simply pressing "save". This training gap resulted in the loss of the only record of the data relating to the vital signs taken as stable. Nurse Maglaqui did not know why the medical

observation form was not completed when Mr. Wood was brought to medical. No one was specifically tasked with that responsibility. Nurse Maglaqui was of the view that Mr. Wood was doing better. When Nurse Maglaqui's shift ended at about 1:30 p.m., there was no discussion with other nurses about what to expect.

[294] After this incident, the use of the COWS scale was implemented. People suffering from opiate withdrawal are placed on medical observation and seen four times a day to twice a day depending on the severity. The tool is helpful. The CTAS scale, used in hospitals for triage, and the assignment of a scale from one to five in priority might be useful for determining whether to send people out.

[295] Often, the institution is short staffed with nurses and officers. In situations where three people need to go out to hospital there needs to be an assessment about who gets to go first, which is particularly challenging. There was consensus amongst the nurses that since Mr. Wood stood up, was alert, and oriented and went to see his lawyer, he was well enough. The determination was he would be placed on medical observation just to make sure he was fine, and nurses would continue medicating him.

[296] Nurse Maglaqui was asked about the use of a device to measure electrolyte imbalance. He felt it would be useful, so long as proper training was offered for the use of the equipment. When asked if he had any further recommendations for medical equipment or devices that could be of assistance, Nurse Maglaqui was clear he was concerned about staffing. More staff would result in better care. In addition to Mr. Wood, there can be other inmates in opiate withdrawal, alcohol withdrawal, and benzodiazepine withdrawal. He is just one nurse among many patients sometimes and it is a bit overwhelming, particularly when the nurse is working alone or even if there are two nurses attending to 400 patients. There had been a previous attempt to supplement care with a paramedic overnights, but it did not help.

[297] Nurse Maglaqui noted that, when he works nights, he makes files. He felt that task would be better suited to a clerical person. There are no clerks on the weekends, which doesn't make sense to Nurse Maglaqui. All the clerical work takes time away from patient care.

[298] In Nurse Maglaqui's estimation, 80 to 90% of the inmates are coming down off some sort of substance at any time.

Winnipeg Remand Centre Administration Staff

13. Allyson Mueller

[299] Allyson Mueller (Ms. Mueller) holds a Bachelor of Science degree in psychiatric nursing from Brandon University achieved in 2010. She has been employed by Manitoba Corrections since 2011. She has also worked at HSC, St. Boniface Hospital and Victoria Hospital in psychiatric nursing. Additionally, she was a medical clerk from 2004 to 2010. When she started work at WRC, she was in the role of psych nurse. She was involved in medical nursing when they were short staffed. She was the Health Services Manager from 2017.

[300] Reviewing Mr. Wood's health care assessment completed on his admission to WRC, the form indicates Mr. Wood was a drug user, last consuming down and crystal meth. The vital signs reflected on the form completed at admission were that Mr. Wood's blood pressure was 143/94, pulse 73, temperature 36.5, and oxygen saturation 99. From Ms. Mueller's perspective, these were normal vitals. The form goes in the medical chart.

[301] Ms. Mueller was the Health Service Manager at WRC until 2023, when she moved to the Manitoba Youth Centre (MYC) where she is currently the Health Service Manager. While at WRC, she was involved in the creation of the opioid withdrawal clinical decision tool to be used whenever the nurse felt it appropriate. The use of the tool is at a nurse's discretion. If Admissions advise nursing that an

individual is incoming, the nurse will pull his chart from medical files, and print a DPIN or see if he had been in hospital lately from an e-chart print. The DPIN shows any prescriptions in the last six months, and e-chart access can determine whether he was in hospital in the last 24 hours or would have all the hospital admissions listed. The information available is limited to discharge summaries, lab work and similar information. It is the expectation the nurse reviews all the information if aware ahead of time the inmate is coming. Whether the chart can be reviewed simply depends on time available.

[302] In Mr. Wood's case, in his Corrections running record concerning this admission, notes were made by the COs. In the section relating to substance abuse, it states, "Refer to medical. States he expects to withdraw from down." (Inquest Transcript January 31, 2025, Page 12 Lines 30 – 31) An officer can refer an inmate to medical via phone call. Additionally, an inmate can self-refer.

[303] In the healthcare assessment there is nothing indicating that Mr. Wood expects to withdraw. When asked, in her managerial position, whether that should have been noted, Ms. Mueller responded that if it had been herself, she would have noted that. However, that notation would not change how he was monitored or cared for. Nurses generally respond to how the inmate is presenting in the moment. An inmate might expect to withdraw but have no real effects, but others may not feel well. Withdrawing inmates are encouraged to drink water, eat something and rest. They are also provided Advil or Tylenol from the officers if it is required. Any further requirement should result in a contact to medical.

[304] In the case of every inmate upon admission, the DPIN is printed, and all are signed by the doctor the day after admission. Should there be a concern, nursing would sometimes put a sticky note on the front of the chart or make another note indicating the doctor should review something specific. This could happen at any time, depending on the concern. Who sees the doctor in the morning and who waits

is triaged by the nurse on duty. The nursing supervisor would normally go through the list, or Ms. Mueller in the absence of the nursing supervisor and determine who is seen. More urgent situations are seen first. There is a cap on how many individuals are seen during the doctor's parade. Generally, ten individuals would be the higher end of the number of people seen in the hour. In Ms. Mueller's view, ten individuals, is enough to be seen in the most urgent cases. The lesser concerns would be pushed off to the next day if not urgent.

[305] There is no limit on the number of days an individual can be bumped from the list. Realistically, people are seen the following day or the day after. If the ten people on the list were not seen within the physician's allocated hour, they would be bumped to the next day. On occasion, if required, the doctor will stay longer. The parade is Monday to Friday, and on weekends Dr. Doucet does chart reviews. The reason for the chart review protocol only on weekends is, according to Ms. Mueller, that the doctor's parade is run more like a clinic which would be open only Monday to Friday. Anything urgent over the weekend would be sent out to the hospital. The chart reviews Dr. Doucet does on the weekend are the same chart reviews he does Monday to Friday.

[306] Ms. Mueller thought the one hour a day was sufficient for the doctor to treat the inmates. She said everyone at WRC is supposed to be stable when they are admitted. She highlighted this is a Correctional facility, not a healthcare facility.

[307] Ms. Mueller was asked about an email she sent to nursing staff concerning expectations nurses may have regarding communication with the physician. The email directs communication during normal hours, not overnight. If it is an emergency, the email directs the nurse to send the patient to the hospital or wait for the doctor's next day clinic.

[308] Ms. Mueller explained that Dr. Doucet had received several phone calls to start antibiotics at 2 or 3:00 a.m. which, in her opinion, could wait. She noted that if one were at home, they would not go to an emergency room. They would likely wait for a walk-in clinic the next day. She felt the expectation should be the same. When asked about another email indicating there were discussions with the superintendent and the Director of Health Services about the direction Dr. Doucet was on call for consultation 24 hours a day, Ms. Mueller did not recall. Her speculation was that there was a point where he was not on call so it could be that this was the discussion about payment for him to be on call. Ms. Mueller did think it was helpful to have a doctor on call for nurse consultation 24 hours a day but reiterated that if anything is urgent the individual should be sent to hospital. She said the standard was if a nurse is concerned about anything, the individual should be sent to hospital.

[309] Ms. Mueller moved to a different correctional healthcare facility in April 2023. She was unaware of any change to Dr. Doucet's availability. She had not heard anything about that. At the time she worked at WRC, there was no other way for nursing staff to consult a physician other than contacting the physician on call. Although a nurse may call an emergency room, in her view, if the nurse is calling an emergency room, and is that concerned, the patient should be going out.

[310] Ms. Mueller was unaware of the VECTRS call system created to receive indication from institutions when somebody is being transferred to an emergency room. Ms. Mueller was advised Dr. Minish from HSC testified there was room in the system to provide consultation with an emergency room doctor. Ms. Mueller thought that would be helpful but reiterated that if the nurse is that concerned, the individual should be transferred to hospital.

[311] When it was suggested to her that some of the nurses testified that they liked open dialogue with the physician, because sometimes it isn't clear cut that an inmate should be transferred to hospital. Ms. Mueller responded that if a nurse is concerned that is a possibility, the individual should be sent out and seen by a doctor in hospital. She thought telephone conversations were of minimal value because the information given by a nurse over the phone, from the limited scope of a nurse, is not being evaluated by a doctor. The doctor is working off whatever the nurse is telling him.

[312] When asked about the value in consultation with Dr. Doucet, who is in the same situation, Ms. Mueller said it was difficult to quantify the value in that consultation. She noted WRC is a correctional facility, not a healthcare facility. When asked about the potential for virtual consultation with a physician who could see the patient, Ms. Mueller thought in person hands on assessment is best so the individual should be sent out to be seen by a doctor. In terms of adequacy of resourcing to send an inmate out, Ms. Mueller said on occasion there may be a slight delay. Ms. Mueller was supportive of a clerk in the medical unit 24/7 to deal with administrative tasks.

[313] In discussion about the amount of time WRC nurses dedicate to preparing and administering medication, Ms. Mueller thought a pharmacist or pharmacist technician would be helpful. Ms. Mueller did see some benefit in electronic charting, particularly considering that the physical charts could be in another area of WRC for nursing purposes and not in the medical unit at the time they are required. She was particularly supportive of electronic charting, acknowledging that sometimes the nurses are so busy they must chart later, and things could be missed. Charting contemporaneously with the treatment electronically might be of assistance.

[314] When asked, considering that Ms. Mueller reviewed the symptoms and care Mr. Wood received after the fact, whether anything should have been done differently, she responded that he should have been sent out to the hospital. When asked when he should have been sent out to the hospital, Ms. Mueller indicated that was always a clinical decision by the nurse who was on, but when Mr. Wood was moved down to the medical unit he likely should have gone instead to the hospital for assessment at the time of the first code red around noon.

[315] When asked whether there were tools or procedures Ms. Mueller, in retrospect, thought might have resulted in possibly better care or observation of Mr. Wood, Ms. Mueller said she would love to have more nurses. Recruitment of nurses has always been an issue and is significant. As to communication with officers of what they should be watching for relating to inmates in medical observation, Ms. Mueller said an observation form has been developed to give officers guidance on what to look for. The officers are generally told to report changes in anything to a nurse. Prior to the form, the nurse would tell the officers if they had a concern and if the concern was specific, what it was. To the best of Ms. Mueller's knowledge, this was occurring. As to *PHIA*, Ms. Mueller's understanding was that a nurse could only share what was necessary. In a case like Mr. Wood's, the communication would be that the nurse was concerned about withdrawal and to advise medical if anything changed with the existing symptoms. For Ms. Mueller, what was shared would be dependent on the officer.

[316] Ms. Mueller was clear that WRC did not have the resources to start someone on an OAT program. Winnipeg Remand Centre is not a withdrawal facility. Resources she referred to included nursing and monitoring. The dose starts smaller and needs to be increased, and that can be dangerous. She also mentioned a significant issue with diversion. Winnipeg Remand Centre medical unit maintains what medication an individual was on in the community. They will not increase a

methadone dose but can decrease. There was a discussion between Health Services Managers and the Director of Health, and it was their collaborative opinion that it was safer to do maintenance and not increase or start an OAT program. Ms. Mueller said there was a Health Services Managers meeting in The Pas where an addictions specialist did a presentation, but she did not recall the name of the person. She believed the individual to be from the RAAM clinic. She was unaware of the program in the Alberta Corrections that does starts for OAT programming for inmates. She was unaware of any group or working group for cross-provincial information sharing about best practices within Corrections facilities health care.

[317] Ms. Mueller could not recall any opioid specific withdrawal training for staff prior to June 2021. She referred to an article she had cut from the newspaper about a particular drug she sent around so staff were aware there was a new drug and to be cautious about that deadly drug. There is no formal communication with the RAAM clinic. The police did come to talk to WRC staff on a single occasion relating to drugs in the community sometime between 2021 and 2023. There was no additional training related to symptoms of dehydration or anything related arising from Mr. Wood's death.

[318] Ms. Mueller thought the challenges with nurse recruitment related to pay, perception of danger working in a correctional institution, and an overall shortage of nurses in the province. Ms. Mueller did observe, in the context of nurse safety in the correctional environment, that in hospital, the nurse may be the one getting hit because the nurse is the only person around. In Corrections, the officers take over should there be a problem. In her view, Corrections nursing is actually safer.

[319] At the time of her evidence, Ms. Mueller was working at MYC. She has Red River College nursing students attend which can result in students interested enough to apply. It is also helpful when nursing students have a favourable impression of the workplace from a site visit and spread the word to other nurses.

The decision about who can be employed from a security screening perspective is made by the Preventive Security Office. Ms. Mueller said she has not had a problem with timeline delays for students coming in. Before they start, she has their clearance. Ms. Mueller acknowledged that for new hires who were not students the process takes a long time from interview to a nurse actually starting. Ms. Mueller hired two casuals on her own who were recommended, and she did all the paperwork, sent it out, received all the checks and sent it in. She is not a human resource specialist, but it seemed to speed up the process. With Ms. Mueller becoming engaged in the process, it took four months. If HR is going through the process, it is generally much longer.

[320] Ms. Mueller was involved in the implementation of some of the recommendations from the Errol Greene Inquest. A review of the then current physician contract for service delivery reflected expansion of coverage in 2019 to seven days a week. At that time, there was no coverage on the weekend. Ms. Mueller was unaware there had been a change to overnight access to Dr. Doucet. At MYC, nurses have access to a physician 24 hours a day.

[321] As to the Errol Greene Inquest recommendation for an effective strategic plan for the recruitment and retention of nurses, there is an indication a plan was subsequently developed and in place, and there was a continuation of work on the strategic plan for optimal staffing. Additional shifts were added. Ms. Mueller is unaware of a formal strategic plan to retain and recruit nurses. Ms. Mueller was aware of the Errol Greene Inquest recommendation for an independent third-party agency review of clinical areas and to make recommendations for change but did not recall any steps taken for that objective assessment.

[322] At MYC, there is a physician two mornings a week from 9:00 to 11:00 a.m. on Tuesdays and Fridays. The physicians see patients, do chart reviews as they would at WRC. The access to an on-call physician is done differently than at WRC.

The nurse at MYC calls Children's Emergency and gets the on-call doctor to call back. It is not necessarily the MYC doctor. Dr. Lane has the contract at MYC, but the physician to call is the one at Children's Emergency. The available physician assists the youth patient. It is not always the same doctor. For example, when Dr. Doucet at WRC is on holidays or unavailable, one of the other doctors from St. Boniface Emergency will fill in, similar to procedure at MYC. There are risks to starting someone on Suboxone, methadone, etc when you do not know how they are going to react. That is why those medications are started at a small dose and gradually increased.

[323] Most inmates at WRC have both a chronic illness and are likely going through withdrawal. Clonidine can be used on doctor's order. A clinical decision tool was developed. If they fail, the nurse does the COWS scale for opiate withdrawal and the nurse can administer, if appropriate, Clonidine and have the doctor sign after. Although it appeared best practice is to follow up with vitals after the administration of Clonidine, that probably does not happen in WRC. Nurses have never been specifically told to do that. If the DPIN showed that the individual was on Suboxone or methadone, the WRC nurse must obtain the actual prescription before they can administer anything. They would also have to provide the doses. It is a significant process and takes a while to get it all done. It is more complicated if the individual is not from Manitoba and the information must be acquired from other out of Province facility. If seven doses of methadone have been missed, it is not safe to restart. Similarly, if the requisite number of missed doses of Suboxone have occurred, it is not safe to restart.

14. Christine Reimer

[324] Chrisine Reimer (Ms. Reimer) has worked in Corrections for 26 years, currently in the role of Assistant Superintendent of Security at WRC. She began her career as a parttime CO in 1988, escalated in various positions and has held her current position for the last seven years. Her immediate report is Tim Matson, Superintendent. She holds a Bachelor of Arts degree with a major in criminology from the University of Manitoba. As the Assistant Superintendent of Security, she is responsible for the overall security of the institution.

[325] Ms. Reimer reviews new policy that comes out. If the Superintendent directs a new policy be created, she is part of the review process before it is sent to staff and finalized. The process is the same with updates.

[326] She is not involved in updating medical unit policies but would be involved in operational pieces to those policies. Ms. Reimer described the various types of directions and policies, including divisional policies which are directions from the division. Sometimes there is a need to take the divisional policy and make a standing order or post order to refine the specificity for the particular centre. A standing order within a centre is a generalized policy outlining policies, rules, and regulations within the centre. A post order is more specific in terms of how something is to be done, more process related.

[327] There may be a need identified by the Superintendent or Deputy Superintendent to create an order to allow for standardized process, so everyone knows what is expected. Standing orders are signed off by the Superintendent, and a post order is signed off by the Deputy Superintendent. There is not a schedule when policies are reviewed at WRC. At the time of her evidence, Ms. Reimer testified that all the policies, standing orders and post orders were under review at the direction of the Superintendent. She was unaware of why that direction was given. Some of them go back to when WRC first opened, so there is a need to

go back and ensure that each order and direction is updated and accurate so staff can reference it as required. If a staff member had an idea for a new policy or suggestion for change, they would speak to their supervisor. The supervisor would speak to the Correctional Manager. The Correctional Manager would sort out the details and speak to the Assistant Superintendent of Operations, Ms. Reimer, or the Superintendent about it. The Superintendent or Deputy would be the final decision maker if whatever the issue is warrants a policy change. Ms. Reimer was unaware of whether there is much involvement from staff with new ideas or recognizing areas that needed to be addressed.

[328] Correctional Officer training is a program called Central Training. Officers go through comprehensive training in relation to being a CO. Once they pass and graduate, they come to centre specific training at WRC. The centre specific training is a week of boardroom training. In the boardroom training, new recruits review specific institutional policy and directives specific to WRC. Included in the review is fire training, code call reviews, emergency restraint chair training, payroll, scheduling, and other similar matters. In addition to the boardroom training, new employees are placed on the floor and shadow other officers for 120 hours. If successful, the new employee is considered trained and ready to go. If an individual requires additional coaching or mentorship, additional shadow shifts can be arranged.

[329] After the shadow shifts, the new employee must complete a 30-day period where they can only work on their assigned floor until the manager, in collaboration with the supervisor, terminates floor restrictions.

[330] The 300 medical floor (3M) does not require any additional training, unlike other areas considered to be specialized, including admissions, master control, stores, and canteen. The means by which WRC ensures an officer knows the specific policies related to 3M, is that the standing and post orders are all available to staff

to reference on the computers and on the floor. New staff shadowing should have had the opportunity to review all the standing orders and post orders to learn centre specific or 300 specific policies and procedures. Should a new employee end up being assigned to 3M and they have not reviewed the specific orders and policies, the supervisor or manager is responsible to ensure they know the policies for medical observation.

[331] There is no written schedule of what has been reviewed with individuals when they come on to that unit. Ms. Reimer was unaware whether the hard copies of the policies are available in that pod. As to when an officer would have the time to be at a computer reviewing the policies, there is an expectation that within the shift the employee has an opportunity to get on the computer to review policies, procedures, check email, and other related endeavours. If the staff member does not have that opportunity, a supervisor or manager would be available to speak to about that. There is no fixed schedule. Once an individual is on the job, there is no refresh training or anything that happens in relation to policies in 3M.

[332] When a policy changes, it is attached to an email sent out globally from the Superintendent or the Deputy Superintendent and the change is highlighted for staff to note the update. Additionally, Monday through Friday there is a daily muster with the manager and unit staff, which provides the opportunity to let staff know there has been a policy update.

[333] The Shift Operations Manager will assign staff to 3M, and the actual staff deployment, once assigned to level 300, is the responsibility of the manager and supervisor.

[334] The post order titled Local Control Pod #12 revised June 2022 at page 77 relates to an indication of additional local control pod responsibilities for officers staffing the 24-hour pods. This would apply to the 3M pod. As indicated in the Post Order, visual observation of inmates deemed to be at risk on camera cells is

maintained. Ms. Reimer said the officers observing on camera would receive an explanation about who the inmates on camera were and why they were in the medical unit, emphasizing the importance of maintaining supervision of the cameras. The kind of information, according to Ms. Reimer, that is relayed to the officers who must observe is whether the inmate is suicidal, or on other medical observation. There is a prohibition about reading or involvement in other activities not related to security observation. The previous policy had the no reading condition as well. The reading issue is unchanged.

[335] When asked why several officers, who testified they were reading while on surveillance duty of the 3M pod, did not know they were not allowed to read, Ms. Reimer did not know why that would be. Ms. Reimer thought the policy could be circulated twice a year or quarterly to ensure everyone was up to date.

[336] From a review of the Post Order in place relating to inmate supervision of 3M inmates, and the application of the *PHIA*, Ms. Reimer said that nurses ought to be allowed to share medical information with COs if required for the security or medical wellbeing of the inmate. She said if nurses are not aware of that, there needs to be updated training. The policy further requires nursing staff to communicate with the unit manager or supervisor, and document in COMS what observable criteria staff need to watch for, including seizures, vomiting, etc.

[337] Ms. Reimer was advised that communication is not happening. Because Ms. Reimer did not have any part in the supervision of medical staff, it was her view that the issue needed to be reviewed by a level higher than her own. Policy indicates that upon placement in the medical observation unit, a nurse is to complete the Medical Observation Form. It is to be put in the inmate's file and a COMS entry in limited scope is to be made. Ms. Reimer agreed there is a discrepancy between the two policies, but the current practice is that there is a COMS entry saying the

inmate is in 3M for medical observation but not to enter what the officer should be looking for to properly supervise the inmate.

[338] Ms. Reimer said the criteria for observation should be relayed to the COs in that pod by the nurse giving the information to the unit manager or supervisor who would verbally brief the staff working in the pod and those working in the unit. It is the supervisor's or manager's responsibility to make sure that everything listed, as far as observation criteria, makes its way to each person working in the pod. There is no access to COMS for officers sitting at the pod. If the information is not verbally relayed to the officers, they do not have access to it. Further, if Corrections staff has contact with nursing staff because of medical concerns, it should similarly be documented in the COMS running record. If it is a code red, there is a different policy for documentation. Ms. Reimer did not know if the information does make it into the pod running record.

[339] In the case of Mr. Wood, an officer was observing him. Mr. Wood made comments to the officer, and nurses were called in. There is no record of that in the running record. Ms. Reimer said she knew nothing of it.

[340] Ms. Reimer agreed that adding a requirement to the duties of officers, that written documentation of each inmate's needs is provided to the people tasked with observing them, would be helpful. As to the logbook, in the policy there is no requirement for logbook notations for inmates in medical observation about their status, condition, or things to observe. Ms. Reimer thought there is a need for a new policy or a subsection to existing policy about the use of the logbook in 3M in particular for additional documentation related to medical observation inmates. Ms. Reimer saw no issue with *PHIA* documenting this information in 3M's logbook, because it relates to the CO's care for the inmate.

[341] Ms. Reimer thought the global email updates and muster were sufficient to ensure everyone understood documentation responsibilities in the logbook.

[342] Ms. Reimer testified that in November of 2023, the WRC began staffing all pods 24-7 and there is a new fulltime workforce pilot. That has created the opportunity to make sure pods not previously staffed 24-7, now are. The benefit is that officers normally assigned to the unit do the punch rounds. They know the inmates and have a better sense of how the inmates are doing that day. It allows more time to complete the punch round because it is an only unit-based punch round that is being done by those officers.

[343] A change from the old policy to the new is inclusion of verifying signs of life in the punch round. To Ms. Reimer, verification of signs of life means they are breathing, have some form of movement, and don't appear in distress. Should the inmate be sleeping, the officer should use a flashlight to see in the room. The officer could knock on the door and rouse the inmate, require the inmate speak to the officer, or simply observe movement if there is no other way to verify signs of life. If these steps are insufficient, a manager can be called for assistance or a code called depending on the situation.

[344] In terms of changes since Mr. Wood's death, the monitors are brand new, with higher resolution, and have been moved for more effective viewing. A video refresh of the entire CCTV system has been approved. This will see all cameras in the centre updated. The cameras will be better quality, with higher resolution. There will be no ability, with the new cameras and screens, to zoom in. The screens will be in colour. The new cameras will only record based on movement, as in the previous system.

[345] In Ms. Reimer's view, the logbook is the first thing an officer entering the pod should look at to see what has been going on during the day. If more information were recorded in the logbook, like medical observation information, Ms. Reimer thought that would be helpful to the officers.

[346] Ms. Reimer also thought culture was good for change within WRC. She believed morale was good, and officers know that if they have ideas for change, managers and supervisors are open to their feedback. Similarly, Ms. Reimer was of the view that upper management is also open to change.

[347] Ms. Reimer indicated that in the case of a critical and urgent medical concern, if there is any doubt, the inmate would be sent to hospital despite resourcing issues relating to escort availability. In a case, however, where a concern is considered less urgent and there are operational challenges, the shift operations manager will ask the nurse if it is possible to wait until a new escort team is called in or shift change when enhanced resources are available.

[348] On average, WRC admits 20 to 30 new arrivals per day. There are up to 10 to 20 releases per day. In addition, there are daily multiple transfers to other institutions. An average inmate stay at WRC is seven days. There are no plans for the implementation of a stabilization unit at WRC. From an operational perspective, it is not possible to house all inmates requiring medical attention in the same area. Some camera cells are used for segregation.

[349] If nurses in WRC were to carry iPads or tablets to chart electronically, there is a security concern the device could get lost. The issue is if the information got into the wrong hands. It could also be fashioned into a weapon. The potential for inmates to communicate with the outside via the device is multifaceted. The resistance to administer intravenous in WRC relates to the metal IV pole being used as a weapon and the long plastic IV tube also being used as a weapon or for self harm.

[350] Ms. Reimer was asked about the possibility of WRC implementing a program to start opioid agonist therapies. She responded in detail about what is involved in administering Suboxone or methadone to inmates. After the comprehensive description, Ms. Reimer indicated that if multiple inmates were on these OAT

programs in WRC at the same time, it is possible it could take a nurse's entire shift to administer methadone or Suboxone. Ms. Reimer also addressed the concern with inmates attempting to divert methadone and Suboxone and sell it on the unit. She described the diversionary techniques.

[351] A brochure is now given to inmates, on release, containing information about addiction services in the community. This is something new, implemented in the last few years. Another new development is the video recording of code responses from beginning to end, implemented in 2022. The intercom system permitting inmates to communicate with staff is no longer the Dukane system. It is now the CareHawk system. Inmates have been tampering with the system by squeezing toothpaste, bits of paper, jam, peanut butter, etc. to obstruct the speakers or the microphone hole. This could be so that officers can't hear when they buzz into the cell or to compromise the system overall. Additionally, inmates may tamper with the system because they believe someone can listen to them.

[352] The most frequent drugs seen diverted are Suboxone and methadone. There are others, but they are more infrequent.

[353] Based on her 26 years of experience as a CO, Ms. Reimer did not think, despite evidence that most inmates at WRC are at risk of withdrawal or going through it at the time of admission, that if everyone had ready access to OAT programming, it would decrease diversion. That opinion, according to Ms. Reimer's evidence, was based on the ongoing diversion she has seen. It is currently at the highest level she has observed. In her role, Ms. Reimer does not have contact with anyone outside of Manitoba, so experience in the implementation of OAT therapy in Corrections is beyond her experience. Ms. Reimer's employment portfolio and responsibility is Security.

[354] When asked if there were an alternative way of delivering information to COs about changes in policy, standing orders, or post orders, besides sending an email, which has apparently not been as effective as planned and apparently not working well, Ms. Reimer said that was an issue for senior management. Her suggestion, from a recommendation perspective, was to repeat sending emails to update staff on policy and order changes. She agreed that some of the issues in the policies, relating to the Inquest, could be matters of life and death.

[355] The camera refresh had been approved within the last several months prior to Ms. Reimer's evidence. The safety meeting had been held a couple of weeks prior to her evidence, and the equipment was starting to roll in. Ms. Reimer's evidence was that full completion of the project was still one to two years off, because it was an overhaul of the entire system.

Winnipeg Remand Centre Correctional Officers

15. Evan Ramage

[356] Evan Ramage (CO Ramage) started working at WRC in 2012 as a CO1, as a frontline CO. He was called as a witness to describe the layout of the 300 level of WRC, what various shifts do, what the pod unit is, and to provide a description of punch rounds. In addition, CO Ramage was called to testify about his interaction with Mr. Wood. In June 2021 CO Ramage was the Central Supervisor whose role, during the day, was to oversee operations in master control. Master control operates the elevators and the doors for the entire facility. Central services, also under his supervision, coordinates movements for court, meetings with lawyers, visits, and programming.

[357] Additionally, CO Ramage assisted the Shift Operations Manager (SOM) in staffing the building and responding to emergencies. He described the various functions of the areas in WRC, and of note in this Inquest, the cells designed for

people under medical observation or with mobility issues. Inmates are housed in the medical cells at the medical department's discretion because they have determined the person is suffering from a medical situation that requires closer medical attention and observation. This area is in closer proximity to nursing staff and their offices. If a CO notes an individual in need of medical assessment by a nurse, the officer can request the nurse attend and assess the inmate to determine if further medical attention is required. The individual may need to go to hospital or be better placed into one of the medical observation cells. A camera oversees the medical pod depicting the control pod desk and a lit screen that has red and green colours.

[358] That control panel deals with all the barrier doors as well as all the cell doors for the entire area. At the time of the occurrence that is the subject of this Inquest, the desk contained silver boxes that are elevated housing tube TVs providing CCTV live views of the camera cells. The desk area also contains a filing cabinet against the wall containing inmate medical files for easy nurse access as they work from that desk periodically. During the day the area is used for medical office assistants.

[359] When an officer is sitting at the pod desk, they can see the cell doors. As to the view of cell 347 and 342, they are unable to see the actual cell doors from their positioning. The doors are opened by the pod officers. During the daytime, officers are permitted to open cell doors to permit inmates into the contained area for breaks from their cell. At night, after 2300 the only time an officer can open a door of a cell of their own accord, other than placing a new arrival into a cell, is if a person of rank is present. In case of a life-threatening emergency, the doors can be opened to offer life saving support. If the emergency is not life threatening, officers have to wait for the person of rank to attend.

[360] After Mr. Wood's passing, the screens have changed, as has their positioning. The new screens are on the desk, at eye level, facing the officer who is monitoring

them. A single officer monitors eleven cell images. A second officer is present during the daytime to monitor inmate movement.

[361] The newer screens are larger, with modernized technology. The video is clearer, and the camera shots themselves are larger. The previous tube TV screens were much smaller and divided into multiple shots. The individual cell feed was about four to five inches by four to five inches at most. The new screen images are approximately seven to eight inches by six inches. The pod officer cannot change the view in a cell, nor can the cameras zoom in. Although the screens have been replaced, the camera system itself has not been changed or upgraded since 2021. The video quality is the same today.

[362] Even today, some of the images can be blurry or distorted due to the feed from the camera, camera damage or scuffing by inmates. The video quality from the medical cells is the same as other videoed cells.

[363] The Dukane system is a two-way intercom system used to speak to inmates in their cell or to make an announcement to the entire unit. It is a two-way system, so the officer can call a specific cell, and inmates have speakers with buttons in every cell. If they press the button, the Dukane system rings and the officer can answer and speak to the inmate.

[364] Should an inmate be speaking to the pod officer and someone else engages the system from their cell, the second person communicating goes into call-waiting. The officer becomes aware there is someone waiting and when finished with the first person, they can take the call from the second person.

[365] The pod is staffed 24/7, around-the-clock. The officer duties in that pod consist of monitoring the cameras, opening barrier doors for movement, opening cell doors, answering the Dukane system and making announcements on it. Officers must record occurrences in the logbook. Any releases or admissions are noted in the movement log together with updating a room log to reflect any changes

in prisoner occupancy. Behind the officer is a white board with a picture of each inmate on that unit. There are little tabs that indicate cautions associated with the unit, such as high suicide risk, medical observation or mobility issues. Additionally, the officer must answer telephone calls from the main floor requesting an inmate attend, calls from the back office, and general questions from other officers.

[366] During daytime, it is up to individual staff to work out how long they wish to sit at and rotate through the stations. On a nighttime schedule, the maximum time an officer would be stationed in that pod is two hours. The purpose of monitoring the screens is to identify and monitor inmate safety. Officers are required to verify signs of life, identifying if the individual appears to be in any kind of medical distress. However, the screen would not be sufficient to accurately verify sign of life. A sleeping individual would produce little more than a general image. The pod officer is given general information relating to those under medical observation such as why they are being observed. Reasons for observation could include withdrawal symptoms or severe seizure disorders. Occasionally, an individual has sleep apnea and has machines in their rooms to address it.

[367] In the case of withdrawal symptoms, the officer would look for any changes in the inmate's behaviour, declining health as far as may be observed including vomiting, diarrhea, lethargy, inability to move, or soiling oneself as they are unable to get to the toilet. The information is transferred officer to officer as they change stations. Should a pod officer have concern about an inmate in medical cells, during the day an officer must contact additional officers as well as medical so the nurse can assess. Extra officers are required because the medical nurse must have officers with them for all inmate interactions.

[368] The officers do not have the medical chart. The officers have access to COMS only if it has been printed. In Mr. Wood's case, the COMS running report would be printed to highlight special information beyond basic medical information. It may

indicate severe allergies but most commonly the running record indicates special handling procedures for the inmate. Should the running record not be printed, and it is not general practice for the pod officer to look at it, a pod officer would become aware of the running record through looking at a computer in the 300-level office, or by word of mouth from other officers verbally. It is uncommon for the pod officer to search out extra information about an inmate.

[369] Even the updated screens, in CO Ramage's opinion, are insufficient to verify signs of life or allow an officer to properly view an inmate as they should. A technology update, including camera replacement, digital video recording device storage improvement, and updating the monitors themselves to higher quality and resolution, would enhance inmate observation and allow pod officers to better do their duty. A zoom function on the camera would be extremely helpful.

[370] The video is live streamed to the screens but only recorded if there is movement in the cell. Continuous recording would be beneficial, as absence of movement can be a concern not properly documented without recorded video.

[371] If the video were better quality, the officer would have a much better chance of identifying any types of medical distress. Further, it would be beneficial to have a dedicated officer monitor the cameras but there are many other cameras operational in the institution. Given the number of duties an officer must perform in addition to monitoring, and considering the quality of the images, camera glances are inadequate to determine whether an individual is in medical distress. Better quality video would not address the concern but may give the officer a better opportunity to identify medical distress.

[372] Punch rounds are rounds conducted by officers cell to cell to check on the wellbeing of an inmate including monitoring for signs of life and medical distress. They involve inserting a wand carried by the officer against a specialised tab on the wall recording the time and location of the presence of the officer with the wand.

During the day, these rounds are conducted every 30 minutes. Individuals at high risk for suicide are monitored every 15 minutes.

[373] In 2021, in the third-floor medical cell area, the officer was required to look in the cell checking for signs of life including movement and chest rising and falling. In some instances, this is next to impossible because of large amounts of clothing and bedding piled on top the individual. In that case, the officer will verify there does not appear to be any kind of medical distress. Currently, the practice and priorities of observation are the same. An officer would not wake up an individual to verify signs of life in a medical cell or any other cell. Additional steps to confirm life may be taken should the officer observe discoloration of an individual's skin, any blood in the area of the individual, and any obvious sign of suicide attempt if the individual does appear to be in some form of medical distress.

[374] In the assessment of skin colouration, the observation is done in variable lighting. Inmates do cover the lights in their cells because it is hard to sleep with the lights on, leaving the only option to use the flashlight on the officer's duty belt. Officers do not take notes or write reports about observations during punch rounds unless something is significant. The punch officers know nothing about the inmate's medical conditions or why inmates have been housed in a medical cell. They have less information than the pod officer about the inmates housed there.

[375] As to whether pod officers are permitted to read while posted to the desk, they are permitted to read Corrections-related materials including running records that have been printed, standing orders, or emergency code procedure.

[376] On the evening of June 2 to 3, 2021, CO Ramage worked as a supervisor. The 12:30 a.m. punch round was completed by the central supervisor because inmates who are medium or high risk of suicide have direct personal observation records posted outside their cell where the officer must write down what the inmate is doing at the time of the check. At 12:30 a.m., the central supervisor performing

the checks must sign the sheets to verify the checks have been done and that officers recorded what the inmates were doing. Based on CO Ramage's role that night, he was assigned the 12:30 a.m. punch round together with CO Benjamin Anaele (CO Anaele). CO Ramage assumed, according to routine practice, that CO Anaele had already completed the punch round of the medical unit and was exiting to wait in the hall for CO Ramage.

[377] The records show that at cell 341, containing Mr. Wood, the punch wand never struck the sensor outside of cell 341 at 12:30 a.m. as it should have. Similarly, cell 342 records show the officer did not complete that punch either. That suggests that CO Anaele did not enter the area shared by cells 341 and 342, the bubble. The other records suggest he went into the second bubble next door, but not the area containing the two cells 341 and 342. CO Ramage was later contacted by acting Shift Operations Manager (SOM) Wasslen to attend back to the third floor to check on the inmate in cell 341. The inmate was reported unresponsive to the punch team at 1:30 a.m.

[378] After donning personal protective equipment (PPE) and recruiting other officers and the nurse to assist, he entered cell 341 and observed Mr. Wood laying on the floor with his head propped against the bunk. He initially made this observation through the window on the cell and entered attempting to rouse Mr. Wood by calling his name and tapping his foot. He realized Mr. Wood's body was rigid and called a code red for medical emergency. He couldn't find a pulse, and Mr. Wood's skin at that time was already below normal body temperature. Mr. Wood's skin colouring was greyish, but that is also common with individuals going through severe withdrawal. From the window, he could not tell if Mr. Wood's eyes were open because of the angle of his head. Only when he entered the cell and checked for a pulse could he observe Mr. Wood's eyes were slightly open.

[379] Acting SOM Wasslen and Nurse Ewen entered the cell. Nurse Ewen began CPR chest compressions, relieved by CO Ramage so she could work on establishing an airway. CO Ramage switched off chest compressions with CO Ziya at two-minute intervals. Code responders from within the institution arrived. CO Ramage was provided the automated external defibrillator (AED) which was applied to Mr. Wood. The AED indicated "no shock advised" indicating to CO Ramage there is a heart rhythm not capable of correcting, or no heart rhythm at all.

[380] In addition to his correction duties, CO Ramage is also a volunteer firefighter well experienced in providing life saving treatment, including the use of an AED. Chest compressions were continued until paramedics arrived. The paramedics directed ceasing any further life saving efforts and declared Mr. Wood was deceased. EMS was called at 1:44 a.m. and CPR discontinued at 1:53 a.m. CO Ramage continued with the multiple duties required in the case of a critical incident such as this.

[381] In reviewing all the reports necessary, CO Ramage noted CO Anaele had not documented anything about his punch round at 12:30 a.m. so CO Ramage spoke to him and requested he put in a report about the 12:30 a.m. punch round. CO Anaele asked CO Ramage what he should be writing and was directed to write whatever he recalled to the best of his recollection.

[382] Inmates experiencing withdrawal symptoms from drugs or opioids has become extremely common in WRC. It was common in 2021. A CO, in the case of an inmate going through withdrawal symptoms, may observe many different symptoms dictated by the type of street drug consumed. The symptoms may include hallucinations, psychosis, severe aggression, vomiting, diarrhea, severe confusion, extreme lethargy or something as minor as flu-like symptoms or minimal withdrawal symptoms even though the individual is going through withdrawal. Every inmate

experiencing withdrawal is not put in medical cells. Inmates placed in the medical cells are experiencing serious medical withdrawal.

[383] CO Ramage indicated that approximately 80% of inmates at the WRC are Indigenous, and Elders are on staff typically Monday through Friday. Inmates can request a visit with an Elder by submitting a request form.

[384] When CO Ramage has done punch rounds, in his experience, an inmate sleeping on the floor is not unusual. Some inmates are going through withdrawal, some have mental health issues, and some sleep on the floor because the vent by the door provides cooler air. CO Ramage has seen an inmate on the floor for many reasons including that some inmates simply like to sleep on the floor. Although officers look for signs of life, they don't always see them in every inmate. An inmate lying on their side or covered in a heavy layer of blankets might obstruct the officer's view of their chest rising and falling. Waking inmates in the night is an unhelpful approach as the inmates would become agitated.

[385] In 2021, two COs attend every floor in the building to perform the punch rounds. That has changed. Currently there is a minimum of two officers on each floor so one officer can remain in the pod while the other officer does the 30-minute, or 15-minute punch rounds as required.

[386] When CO Ramage first saw Mr. Wood lying on the floor through the cell window, he did not look dead to CO Ramage. As he was positioned, he may just have appeared to be sleeping. His right arm was raised above his head slightly, and CO Ramage would have expected, should he have been deceased, his arm would have fallen to the ground.

[387] CO Ramage estimated that 75 to 80% of the inmates coming into WRC are going through some level of withdrawal. Withdrawal from various mixtures of opioids is common, and methamphetamine is also a common substance from which inmates withdraw. Because of the general symptoms of withdrawal, an inmate

vomiting or losing control of their bowels is not uncommon in WRC. It is the case that an inmate may appear alright at admission, but because of delayed onset of withdrawal symptoms, particularly in the case of methamphetamine, days later the inmate may start to exhibit symptoms of withdrawal.

[388] Duration of withdrawal symptoms is variable by factors specific to the individual, including body size, type of drug consumed, and level of withdrawal. Some individuals, in CO Ramage's experience, exhibit flu-like symptoms gone within a day or two. In others, individuals have gone well over a week through a very difficult withdrawal. Although it can be common for inmates to be sent to hospital while experiencing withdrawal symptoms, in any given population the numbers are variable.

[389] It would not be possible to send every inmate experiencing severe withdrawal symptoms to hospital because it requires a significant number of officers for escorts and staffing levels simply do not permit this. Generally, the inmate must wait in the emergency room for a long time and eventually receive an IV for rehydration. Then they are discharged. They return to WRC, but the IV typically exits their system long before the withdrawal symptoms and they revert to the state they were in before. For a regular inmate, a minimum of two officers per inmate is required for a hospital escort and must remain with the inmate. For other inmates, who are acute security, three officers are required to attend the hospital.

[390] When CO Ramage viewed Mr. Wood and his positioning through his cell door, were the situation a regular punch round, he would have inquired further and attempted to gain a response from him. Had he not received a response he would have entered the cell with an additional officer to check on him. His positioning, laying on the hard floor with his head propped up, is an unusual position. It is not completely out of the realm of what is normally seen, but when CO Ramage views

individuals in a position that seems unnatural, as this one was to him, he will try to gain a response.

[391] CO Ramage had no recommendations to make punch rounds more effective to achieve their desired purpose. He did note that there has only been one other person than Mr. Wood found deceased in their cell in an apparent sleeping position. Very often, officers can identify people in medical distress and respond accordingly.

16. Ehizokhae Arikhan

[392] In June of 2021, Ehizokhae Arikhan (CO Arikhan) was entering his sixth month working at WRC. He was scheduled for the night shift punch round. When an officer does a punch round, the first priority is the well-being of the inmate, to be sure they are alive and determine whether there is anything unusual in the cell. In 2021, CO Arikhan had a partner to do the punch round with. His partner was just arriving.

[393] On a punch round, if an inmate is sleeping and you can't see breathing or movement CO Arikhan said he would do something to get the inmate's attention like knock on the door to make noise. The officer on the night shift is not given information about why the inmate is in the cell.

[394] On June 3, 2021, CO Arikhan started his shift at 7:00 p.m. and was to work overnight until 7:00 a.m. He was assigned a punch round at 1:30 a.m. He got to cell 341 and saw an inmate lying there. The way the inmate was positioned, caught his attention because his head was tilted towards the toilet bowl. CO Arikhan tried to make a sound, but the inmate didn't respond. Mr. Arikhan spoke to the pod officer and told him about the inmate in 341 who did not respond. The officer told him to return to the cell and hit the door harder, and the officer called the inmate through the Dukane. The inmate still did not respond. CO Arikhan returned to the pod officer who called the SOM and CO Arikhan continued with his punch round.

[395] The lighting in the cell was bright enough to see the inmate in 341. Had it not been, CO Arikhan would have used his flashlight. To see an inmate on the floor is not unusual. However, in this instance, the position on the floor was unusual. After CO Arikhan completed his punch round, he saw the SOM, medical team, and lots of people in room 341. He heard a code red being called. The punch round had taken 30 to 45 minutes before his return to the area of cell 341.

[396] The punch round protocol has changed since 2021. Previously, two COs would do a punch round on the entire building. Currently, the staff on each floor complete the punch rounds of their own floor. In CO Arikhan's opinion, it is better because the officers are more familiar with the inmates and how they like to sleep. From the four years experience CO Arikhan has had working at WRC, he has seen many people go through withdrawal. He has observed different symptoms like constant vomiting, the inmate experiencing pain and loss of bowel control. The onset of different symptoms is variable, in some cases delayed a day or two after admission and in others the onset of symptoms is immediate. Most inmates eventually come out of the withdrawal symptoms.

17. Robert Pollok

[397] Robert Pollok (CO Pollok) started working at WRC on July 10, 2000. He has been involved in a wide variety of positions. On June 2, 2021, he was a CO, working as the acting supervisor on the floor that day. He worked the day shift, from 11:00 a.m. to 11:00 p.m. At 12:35 p.m., he was in the elevator area and came in to contact with Darren Wood. CO Pollok came out of the back office and noticed Mr. Wood laying on the floor in the hallway. He had pressed the button on the elevator to go to the main floor and proceeded to lie down. CO Pollok came out of the back office to find Mr. Wood sitting on the floor slumped against the wall. He appeared unwell. CO Pollok noted Mr. Wood looked in distress, sweaty, and

uncomposed. He was drooling all over himself, and when CO Pollock spoke to him, he did not make sense. CO Pollok concluded Mr. Wood to be in medical distress. CO Pollok called a code red indicating a medical emergency. Calling a code red results in a response by other officers and the nurse to attend.

[398] While waiting for responders, CO Pollok continued to talk to Mr. Wood to ensure he stayed awake and alert. CO Pollok briefed the responders in a muster exchange of information. Care of Mr. Wood began even before CO Pollok began the muster. It was a medical emergency. Although he had been trained in CPR, at that point CO Pollok did not feel it was necessary to administer it. He recalled medical staff taking Mr. Wood's vitals but did not recall who it was.

[399] When the medical team started dealing with Mr. Wood, CO Pollok returned to the back office to initiate the report of the circumstances of the code. Based on his 25 years of experience, it was CO Pollok's impression that Mr. Wood was withdrawing from drugs.

[400] In his 25-year career, CO Pollok described the problem with people withdrawing from drugs in the institutional environment as disastrous. He said it is horrible to watch young people come into the institution on the stuff that is on the street, and it is hurting them. He has seen a lot of individuals looking very, very sick. They could be vomiting, their skin is very clammy and sweaty, they are thin, and their heads appear bigger than their bodies. They do not seem to comprehend a lot of what is being said, and often what they say does not make sense.

[401] His experience is that there can be a phenomenon like a secondary or delayed withdrawal. The individual starts to go into a drug induced psychosis at around the seven-to-ten-day mark. CO Pollok estimated that the percentage of individuals coming into WRC withdrawing from some form of opiate as 90%.

[402] CO Pollok was of the view that the training given to assist understanding about the drugs inmates have consumed to assist staff being on the cutting edge as not adequate. He believed officers should have more training in new street drugs, and what to expect from individuals who may be coming off those drugs.

[403] The only experience CO Pollok had with training of this kind was a drug information seminar held through his work in probation and delivered by WPS that CO Pollok thought was very well done.

18. Eric Teixeira

[404] At the time of his evidence, Constable Eric Teixeira (Cst. Teixeira) was a WPS officer. At the time of the events here, he worked for Manitoba Corrections beginning in 2021 at WRC for approximately ten months. While working at WRC, Cst. Teixeira's primary duties were working in the pod or conducting punch rounds. His understanding of a punch round was to check on the wellbeing of inmates within the cell including signs of distress. He looked for anything that would stand out requiring his attention including checking for signs of life.

[405] If an inmate were sleeping, he would not disturb them. He could not see if their chest were moving on every occasion. If something looked concerning, he would check for chest movements. He had access to inmate information through the COMS system but did not read up on every inmate in custody at the time. His duties included checking inmates in the entire building.

[406] The third level included camera cells where inmates were housed for medical observation or other reasons. He did not recall that he was aware of anyone specifically going in or out of withdrawal symptoms. If an inmate were sleeping, he did not do anything differently to assess signs of life. Had he known specifically why the individual were in the medical unit, he would look for symptoms related to that issue. Similarly, when working as a pod officer, it would be helpful to know

why the inmate was in the medical unit. He could not recall ever being given information by a nursing staff member about a particular inmate.

[407] In his experience, inmates would communicate that they were feeling unwell, for whatever reason, either through walking up to the window during a punch round to speak to him or call on the Dukane system.

[408] The night of June 2 to June 3, 2021, Cst. Teixeira worked the night shift from 7:00 p.m. to 7:00 a.m. He did not recall the punch rounds of cell 341 specifically. It was not usual to take notes or make reports of a punch round unless something unusual had occurred. A code was called around 1:35 a.m. on June 3. He immediately went to the site of the code call. Medical aid was already being administered to Mr. Wood, so there was no further need for his assistance. He was directed to go to the eighth-floor pod to relieve someone to go out on an escort and then redirected to come back to the third floor. He was later instructed to retrieve Mr. Wood's files and properties from the third floor. If Cst. Teixeira were to see someone who was vomiting during a punch round or vomit in their cell he would verbally check in with them.

19. Benjamin Anaele

[409] At the time of his evidence, CO Anaele was employed at Stony Mountain Institution where he had worked for the previous one year and one month. Prior to that, he was employed at WRC with Manitoba Corrections. He started working at WRC in March 2021.

[410] When CO Anaele worked at WRC on the night shift, he described his responsibility including a security walk with a partner requiring they walk the whole institution, from the bottom up, to ensure all the inmates are alive and breathing. He described this protocol as the same as a punch round. Punch rounds occurred every 30 minutes for the whole building. Some cells would be subject to punch

rounds every 15 minutes. In addition to checking if the inmate is alive and breathing, officers also check if they are in distress.

[411] If the officer is unsure about the status of an inmate, the officer must engage with the individual by talking to them. If the individual were asleep the officer would flash the flashlight on the chest area to determine if it is going up and down. If the officer still could not see properly, the officer would tap on the window to see if the individual moves. One can also escalate response by calling the supervisor or others for their attention. On the medical level, these checks are called medical observation. The individuals are on camera, and an officer observes from the desk.

[412] If the individual does not respond as anticipated, the punch round officer can go to the pod officer to find information on the inmate. When CO Anaele worked at the pod desk on the third floor, he was told which individuals are on medical observation and that an individual is withdrawing or any other specific challenge. Someone laying on the ground would not be able to reach the Dukane system.

[413] CO Anaele worked June 3, 2021. He was assigned a punch round at 12:30 a.m. The actual video runs contrary to his recollection. He was assigned to do the punch round at 12:30 a.m. with CO Ramage. CO Anaele recalled part of the 12:30 a.m. punch round on June 3, 2021. He recalled the two of them going into the area to punch but could not remember everything.

[414] The fact is he did not start the round with CO Ramage. They met up later. CO Anaele could not recall conversation between them about which cells had been punched. Usually, partners do have that discussion. CO Anaele recalled responding to the code red from the break room. He followed direction from the supervisor. He was requested to retrieve the responder's bag and asked by the nurse to get some items. CO Anaele remained at the door of the cell, because there were a lot of other officers in it and the cell was small. He saw the nurse attempting to resuscitate Mr. Wood.

[415] CO Anaele was requested to write a report, which he did. In his report, he indicated that he checked Mr. Wood in 341 and he appeared to be laying on the floor sleeping. This was CO Anaele's first time responding to an incident of this kind. He could not remember the details. He has no independent recollection of checking on Mr. Wood during the punch round at 12:30 a.m. at all. After the incident, he was contacted by Christine Reimer, in management at WRC, and informed that his supplementary report was inconsistent with the surveillance and that he did not enter the 341-cell area. He responded that he thought CO Ramage had already done it.

[416] He did receive training about serious signs of withdrawal that should lead an officer to take steps. If he saw one of the signs, he would call a member of the medical team. In terms of training about drugs potentially impacting inmates, CO Anaele said there was no training, but he did recall an email about Fentanyl telling him some of the signs of inmates on Fentanyl.

20. Katherine Sullivan

[417] Katherine Sullivan (Ms. Sullivan) testified she worked at WRC for three and a half years from 2019 until November 2022. She is currently employed as a probation officer with Manitoba Justice (Community Corrections). When she worked at WRC, she was a CO there.

[418] The role of the pod officer on the third floor where she worked, is to open cell doors as necessary for the movement of inmates ensuring they are secured when they need to be. She was also responsible for maintaining population count accuracy on that unit, updating the logbook, answering the phone, and responding to inmate inquiries if they had pressed the button. Additionally, she was to observe them on camera.

[419] In June 2021, when observing the screens above the pod desk, Ms. Sullivan would look for obvious signs of medical distress, particularly since it was the medical observation unit, or incidents of self harm. An obvious sign of medical distress to her would be a seizure, bleeding, or circumstances of that nature. She would advise a nurse if she had seen vomiting or speak to the inmate and ask if they were alright. She regularly checked the screens at an interval of a few minutes at a time. She tried to be as conscientious as possible.

[420] There was a chart with the inmate population on the unit, and sometimes "withdrawal" would be written next to the picture of the inmate. That information, however, was not always provided.

[421] The pod officer is not consistently looking at the camera, because they are potentially engaged in other duties. She would be aware if an officer were going into the bubble area of the cell because she would be the one opening the door. No one else would be responsible for opening that door. Ms. Sullivan said she did many punch rounds as part of her role.

[422] She would look for signs of life when she did punch rounds like what she would observe on the surveillance video. She looked for blood or an extreme amount of bodily fluid. If there were an absence of blood and nothing seemed amiss, she would consider that a sign of life. A general rule of thumb was that if one could see the inmate's head and neck exposed and nothing appeared evidently wrong, that also would be considered a sign of life. If she could see the inmate's head and neck and nothing seemed amiss, she was satisfied and moved on. She would wake up an inmate if concerned. If the blanket were over their entire head, that would be concerning. An inmate lying on the floor is not unusual. The light is dimmer overnight. A flashlight would not be shone unless the officer felt it necessary to do so. Ms. Sullivan would not wait to see if there were movement or breathing.

[423] On June 2, 2021, Ms. Sullivan worked the night shift from 7:00 p.m. to 7:00 a.m. From 11:30 p.m. until 12:30 a.m. she was posted to the medical pod desk. She also did a punch round at 1:00 a.m. She recalled that next to Darren Wood's picture was a note indicating that he was in withdrawal. To her that meant he was on medical observation likely due to symptoms of withdrawal.

[424] She recalled her observation of Mr. Wood such that it appeared he was sleeping when she arrived. She opened the door to his cell at some point during her hour-long shift for officers to give him some sort of meal replacement drink. He groaned and shifted position when they did that. She did not recall him throwing up. She did not think Mr. Wood throwing up would have shown up on camera.

[425] Her impression of Mr. Wood was that he likely wasn't feeling well but that he was okay. She did not see him in person until she did the punch round. The last time she saw him move was when he groaned and shifted position. She recalled his feet towards the door and his head away from the door, laying on the ground. That did not seem odd to her, and she could see his head.

[426] In evidence. Ms. Sullivan was advised that the video of her time at the pod desk showed that for a significant period she was reading a book. She thought she looked up to monitor the video every one or two minutes. She was advised that a review by the Divisional Investigator calculated 3.3 minutes as the duration when she looked up from her book. She was aware a pod officer was not to read personal materials, something not institutionally related. She was reading institutional related materials because it was permitted. When asked whether pod officers should pay more attention, knowing what happened to Mr. Wood, Ms. Sullivan responded she did not know. When asked about the 12:30 a.m. punch round missed by CO Anaele in cells 341 and 342, Ms. Sullivan acknowledged she would have overseen opening the door into the area. She said she was being relieved by another officer and did not note CO Anaele had missed the first punch round. She did not recall any change in

policy about a regular set sequence directing which cells should be punched in which order that would help ensure punch rounds being properly completed.

[427] She did a punch round at cell 341 at 1:00 a.m. She did have an independent recollection of looking into that cell. She recalled she placed her hands up to the window on either side of her face so she could get close to the glass to see him. She recalled looking at him for a few seconds. She saw that he was laying on the floor, thinking to herself that he must be feeling better if he is sleeping. It was her impression he was asleep. She recalled seeing movement in his chest.

[428] She recalled the code red, responding, and being directed to be the recorder of events. She took notes of times that events were occurring. Ms. Sullivan, at the time of the 1:00 a.m. punch round was able to see Mr. Wood's head and his chin upturned because he was laying on his back flat out.

21. Charles Isaacs

[429] Charles Isaacs (CO Isaacs) is a CO, employed by Manitoba Corrections for the last 19 years. His career has been exclusively at WRC.

[430] On the third floor, the officer monitoring the screens watched five screens for cells from the medical side, and approximately five more cells the officer is monitoring at the same time. Each of those cells has the Dukane audio contact, and the officer responds to those cells and more.

[431] When the officer is sitting in the pod tasked with monitoring the individuals in the medical observation cells, the officer is not looking for something specific but rather watching general movement. CO Isaacs, when asked about looking for signs of medical distress, did not know what a sign of medical distress was and how he was to know an individual was in medical distress. His understanding is that when he is monitoring the medical cell screens, he is there for medical observation.

Medical observation meant he is looking to see if someone is not doing well, and signs of life.

[432] He receives no communication from nursing staff about what to look for in a particular individual. He is aware of the medical observation form, which requires he document what the individual is doing at the time. CO Isaacs further advised that related to suicide watch. He is not aware of something similar for medical observation unrelated to suicide watch. CO Isaacs' understanding of an individual not doing well would be, as an example, someone who gets up quickly and runs to the toilet. If an individual is observed not to be doing well, the officer can buzz them on the Dukane system and ask if they are alright. Depending on the response, staff is called, and a check takes place. If they say they are fine, there is no intervention.

[433] The new screens with their enhanced image quality are sufficient to properly monitor inmates. The ability to zoom in might be helpful. On a punch round, if there is some movement, CO Isaacs is satisfied. If he doesn't see movement, or hear any noise, he takes extra steps like waking or stirring the inmate somehow.

[434] On June 2, 2021, CO Isaacs was working from 7:00 p.m. to 7:00 a.m. as a pod officer. He entered cell 341 with Nurse Ewen at approximately 9:00 p.m. to check on Mr. Wood, who was unable to get up. CO Isaacs got him some water. He had vomited on the floor, and CO Isaacs cleaned it up. Additionally, he had soiled himself. He thought Mr. Wood could possibly be sent to the hospital, and informed Nurse Ewen of that. She had given him something to help, so CO Isaacs assumed that was sufficient. He assumed what Nurse Ewen gave would help him. He was assigned to the 3M pod at 2300 and did not have any further dealings with Mr. Wood between entering the cell with Nurse Ewen to 2300. When CO Isaacs came onto the pod shift, Mr. Wood was just lying on his bunk.

[435] He did not recall buzzing Mr. Wood on the Dukane. CO Isaacs was at the pod from 2300 to 2330, and again at 1:00 a.m. He was contacted by CO Arikhan at

1:30 a.m. CO Arikhan was doing the punch round and went to cell 341. CO Arikhan told CO Isaacs that Mr. Wood did not look good. CO Isaacs buzzed him and got no response. He called the duty officer who came up with staff and he let them into the cell. A code was called.

[436] It is quite common for individuals admitted to WRC to be experiencing withdrawal symptoms. In fact, it is often the case an inmate admitted would be experiencing withdrawal. He has received no training on how to recognize or manage someone going through opioid withdrawal. A lot of the individuals are out in general population at WRC. He thought it could possibly be helpful for COs to understand withdrawal symptoms and current drug trends. CO Isaacs noted everyone reacts differently to withdrawal.

22. Harrison Giles

[437] On June 2 and 3, 2021, Harrison Giles (CO Giles) worked a 7:00 p.m. to 7:00 a.m. shift as a CO at WRC. On that date, he was assigned, in addition to other duties, to work on the 3M floor and to do punch rounds later. He relieved the daytime pod officer in the 3M pod from approximately 1900 to 2130.

[438] At the start of the shift, he observed Darren Wood in cell 341. He did look quite sick. There was a significant amount of bile and vomit in the room. CO Giles was aware Mr. Wood had a medical incident somewhere else in WRC earlier that day and had been placed in 3M to be observed. He spoke to Mr. Wood through the Dukane system. Mr. Wood said he was having trouble breathing and felt he was going to die. CO Giles called Million Mehari (CO Mehari) who was the 300 supervisor at that time. CO Mehari got Nurse Koscian and they attended cell 341 to check on Mr. Wood. CO Giles did not witness the medical care Mr. Wood received but understood it was a Gravol injection. Mr. Wood was back in cell 341 after that interaction. At 2130 CO Giles was relieved in the control pod to go on break and did

not return to the pod until after lock up. He could not recall whether it was 2300 or midnight when he returned to the pod for his assigned period.

[439] When he returned to the pod and saw Mr. Wood through the camera, he noted Mr. Wood's room had been cleaned. He saw Mr. Wood lying on the floor of the cell. He thought that perhaps Mr. Wood had been talking through the vent system under the bunk. CO Giles was relieved by another officer after one half hour in accordance with normal operations. The security round arriving to start the next punch round had seen Mr. Wood. They asked what the situation was with Mr. Wood. CO Giles reported he had been in an incident in the day and medical staff were aware.

[440] CO Giles recalled he said he would track down a nurse, but the elevator opened, and Nurse Ewen got off. CO Giles was about to let her know an officer was looking for her to check on Mr. Wood. It is CO Giles' understanding they did go in and check on Mr. Wood. That was CO Giles' last interaction, making sure the nurse talked to the officer on the security round to ensure they were heading in the direction to check up on Mr. Wood.

[441] CO Giles could not remember exactly where he was assigned until he heard the code red called on three medical. He responded. He recalled officers doing CPR. He recalled a request for other staff and officers to clear the area to give them space to work. CO Giles let CO3 Ramage know he was going to begin a continuous punch round. That continued until they were relieved.

[442] CO Giles was invited to offer any recommendations he wished the Inquest to be aware of.

[443] CO Giles highlighted in the course of his work as a CO, he never felt he had the tools to properly understand his place as a non-medically trained individual observing an inmate under medical observation. It was less challenging to see in some circumstances when an individual was in duress. However, it was extremely difficult to make judgement calls when the symptoms were less evident. CO Giles

wished to speak of the number of incidents he has seen observing individuals in really, really poor health when he has wanted to contact nurses to have the health concerns addressed. To exercise the judgement as to when intervention was required was extremely difficult without the appropriate information and training.

[444] CO Giles expressed a heartfelt address to Mr. Wood's family and conveyed his hope things would move in the right direction so something like this did not happen again. CO Giles emphasized that being a CO is a huge responsibility that isn't always recognized. There are multiple people relying on the officer, including the people in Corrections' care, and CO Giles wanted a better future for everyone. He felt the pressure of his responsibilities considerably.

Counsel

23. Matthew Raffey

[445] Mr. Raffey, a practicing lawyer, testified that he assisted other members of Sophie Harper's family over the years. After Darren Wood passed away, Sophie Harper, Darren Wood's sister, and Darren Wood's mother, Aline Wood, called him in the summer of 2021. Aline Wood requested Mr. Raffey's assistance finding out what happened to her son Darren. She knew he had passed away in Corrections' custody, where he had been for at least several days. She initially thought it was as the result of foul play and somebody else had done this to her son. She wanted Mr. Raffey to try to figure it out for her. She was unaware that her son's death would be the subject of an Inquest.

[446] Mr. Raffey reached out to Mark Lafreniere, senior counsel with Manitoba Prosecutions, to ensure he was one of those notified when a decision was made about what was going to happen, and whether there were charges to be laid or an Inquest to be called. Mr. Raffey and Aline Wood waited for information.

[447] They didn't hear much for several years. Mr. Raffey would follow up, check in, and try to see if there was any information about the progress of this available. Ultimately, Sophie Harper was granted standing at the Inquest during the standing hearing on January 10, 2024. Prior to that, tragically, Aline Wood passed away in May of 2023.

[448] Previous Inquest counsel reached out to Mr. Raffey requesting assistance in tracking down the family. Mr. Raffey met with members of the family to compile a family history. He wanted to stay in touch with the family because he was worried about losing contact and, as a consequence, the family not being able to participate in the Inquest which he knew was something Aline Wood would have wanted.

[449] Once standing was granted, Mr. Raffey was alive to the fact that an application for funding may be a bigger hurdle than he had anticipated. He was urged to contact another counsel who had involvement with an Inquest who gave him some advice and templates that he worked from. He spoke to the other counsel January 17, 2024.

[450] Mr. Raffey met with Ms. Harper and provided her the information sheet the Province of Manitoba had on their website related to applications for funding for counsel. Mr. Raffey knew the family was not likely to be able to provide funding in any other way.

[451] Ms. Harper has a lot of family obligations raising children and grandchildren simultaneously and always had a full house. Mr. Raffey didn't hear from her again until the summer of 2024. She was still planning to write the letter to apply for funding.

[452] In September or October 2024, there was a Case Management Hearing in this matter. Ms. Harper came into Mr. Raffey's office in September to start working on the application letter. Ultimately, the letter was drafted and signed by Ms. Harper on October 28, 2024. Mr. Raffey reviewed the criteria for funding as indicated in the document from the government website.

[453] Of note to Mr. Raffey, is that the underlying offence that led to Mr. Wood's detention was an allegation by his sister claiming Mr. Wood had robbed her. Sophie Harper was very concerned about the veracity of the allegations. She noted that the sister and Darren Wood were both street affected people with long standing addiction issues. Sophie Harper felt that had Darren Wood and his complainant sister been in more stable positions, he likely would not have been in jail and consequently would not have died, at least not at that point.

[454] Sophie Harper speaks English as a second language, as is the situation with all her family. Arising from their preparations, it became apparent to Mr. Raffey that Sophie Harper was not a confident English reader. The policy relating to contribution to funding for counsel indicates the factors to be considered, but beyond that there is no indication of which of the factors are critical and what other factors might be relevant. How a lay person would interpret the criteria is a real challenge.

[455] Mr. Raffey noted the absence of an appeal process. When one applies for Legal Aid through the application process, there is a whole booklet explaining the parameters and terms of representation. It describes under what circumstances representation can be offered and when it cannot. The application for funding contribution to counsel for an Inquest offers an explanation on how and when support will be offered and offers points that are considered. There is no indication of how the factors are considered and under what circumstances support will not be offered.

[456] This was also the process in Sophie Harper's case. Mr. Raffey has absolutely no idea how the decision of refusing her support was made. To Mr. Raffey, he and his client were told to write a letter, send it off, and the response ultimately came back with no explanation at all.

[457] It needs to be understood, from Mr. Raffey's perspective, that it feels extremely paternalistic for someone like the Harper/Wood family to lose somebody

in custody. The family has lost a loved one, asked the government for help after their family member died in the custody of the government, and are simply told that the province is going to take care of it for them by having Inquest counsel address their concerns.

[458] In Mr. Raffey's view, this position is unfair to the family, paternalistic, and unfair to other families going through the same experience. The concept that a family, in circumstances like these is able to understand and read the disclosure provided to prepare themselves for participation in the Inquest without counsel is totally unrealistic. The disclosure is designed for interpretation by legally trained individuals, not lay people. Even the concept of the scope of an Inquest is something difficult for lay people to struggle with.

[459] The notion of attendance at a standing hearing to determine whether the Harper/Wood family would be given standing at the Inquest is problematic. From Mr. Raffey's viewpoint, it is self-evident that if a family member dies in Corrections or police custody, the family should be included in the process and should have standing. In this instance, on the eve of the hearing, the family was told they still had standing, a right to be present, and question witnesses, but the very means by which they can fully participate in the process was eliminated by not supporting counsel. Mr. Raffey's view is the presumption should be that the family gets a lawyer, and the family should participate in the Inquest. Someone like Sophie Harper, being subjected to the kind of trauma the week before the Inquest, being told she would have to find an alternative situation or figure out the boxes and binders of disclosure on her own, is unacceptable.

[460] As to the process in Ms. Harper's case, as earlier indicated, the application for funding was hand delivered October 28, 2024. Mr. Raffey walked it over to the Legal Services Branch in the Woodsworth Building. He could not recall if Ms. Harper, who used an electric scooter, came with him or not. The application was

presented to someone there and Mr. Raffey explained that it was an application for Inquest funding.

[461] The Inquest was coming up, scheduled to begin the middle of January and Mr. Raffey was concerned the application receive the earliest attention possible. He recalled asking, in the Legal Services Branch office, whether there was someone to present his application to rather than reception. He received assurance from the individual he does not recall that they would take care of it.

[462] From that point on, Mr. Raffey said he heard nothing back. Neither Ms. Harper nor Mr. Raffey received any response. Mr. Raffey began phoning the Legal Services Branch on January 8. The first day of this Inquest was scheduled for January 16, 2025. Mr. Raffey asked to speak to any lawyer. He asked for help, explaining that his client had not heard a response. He followed that conversation up with an email. On January 9, 2025, his support person received a call from Darrin Davis, Director, Legal Services Branch, indicating he wished to speak to Mr. Raffey. Mr. Raffey tried to call him back twice on January 10, the following day, and left voice messages. He received a call back from Mr. Davis on Friday, January 10, 2025, at 4:30 p.m. Mr. Davis indicated he was intending to deny Ms. Harper's application for contribution.

[463] Inquest counsel had just been appointed to the Provincial Court. Mr. Raffey asked to follow up with Mr. Davis once more information was available considering the anticipated change in Inquest counsel. Mr. Davis indicated he would always consider more information.

[464] Mr. Raffey had a telephone conversation with former Inquest counsel on Saturday January 11, confirming she had been appointed. Mr. Raffey called Mr. Davis again on Monday January 13. Mr. Davis advised nothing had changed. Mr. Davis's office sent out a letter denying coverage to Ms. Harper by mail on Monday, January 13, three days before the Inquest was scheduled to begin. The letter

only got to Ms. Harper because Mr. Raffey printed a copy for her, having been sent the letter by email January 13. The letter, itself, was dated January 6. Mr. Raffey sent an email back to Mr. Davis's support person because he observed it had been back dated a week. On January 14 new Inquest counsel was confirmed.

[465] Mr. Raffey's conversation with Mr. Davis included the observation that original Inquest counsel was not employed by the Crown's office but a member of the private bar as a factor in the refusal. Mr. Raffey observed that newly appointed Inquest counsel are, in fact, two members of the Crown's office. The refusal letter contained no reference to the fact that Inquest counsel was a member of the private bar. Mr. Raffey recalled that feature from the conversation he had with Mr. Davis on January 10.

[466] The impact on Ms. Harper of being refused contribution to counsel costs was significant. She was told she was not allowed to review disclosure in her home. She lost Mr. Raffey's ability to review disclosure at his office with her because he could no longer continue as her counsel. She lost Mr. Raffey as a resource to review the disclosure with and guide her through the information and review the relevance with her.

[467] She was told that if she wanted to review the disclosure, she had to go to the Crown's office, a place she was inexperienced with and had no support. There was no system in place designed to protect Ms. Harper or her family. The only support she had for the Inquest ultimately was because people stepped up, saw a need, and filled it for which Ms. Harper is very fortunate.

[468] Despite being denied coverage, Mr. Raffey spent the weekend in his office with Ms. Harper preparing for her explanation and remembrances of her brother to be explained to the Inquest. Mr. Raffey tried to give Ms. Harper a crash course in the disclosure and what to look for. He did not withdraw from her case until she had completed her remarks to the Inquest.

[469] Mr. Raffey indicated he heard from Ms. Harper, and Mr. Wood's brother Cliff, several times over the course of the Inquest. He wished Mr. Raffey to advise the Inquest that Darren Wood had claustrophobia, and it would have been very challenging for him to be alone in a cell because of a childhood traumatic experience.

[470] Mr. Raffey recommended deadlines for a response to an application for contribution to funding, and the funding decision ought not to be made by a branch of government that could be liable for the death depending on the facts. Mr. Raffey urged the Inquest to consider an arms length decision maker like Legal Aid Manitoba. Legal Aid regularly appoints counsel; it is what they do.

[471] Legal Aid is much clearer, and provides more certainty and clarity to litigants, unlike the current model which requires an individual to drop off a letter and the responding party will get back to them at some point.

[472] Mr. Raffey would recommend an appeal process in addition to timelines. Mr. Raffey is unaware, when the decision to deny funding was made, whether the decision maker had any information about the case. Legal Aid, when a decision is made, has particulars. Additionally, there is an informal appeal process and a formal appeal process. An intake officer will advise if there is information missing from the application, and an explanation for why the application may result in counsel for some aspect but not others, of the case.

[473] All Ms. Harper and Mr. Raffey got was a phone call four business days before the Inquest was supposed to start saying the application would be denied.

[474] Mr. Raffey highlighted his perception that a conflict is engaged where the decision maker is a branch of government through Civil Legal Services. Considering the principles of Truth and Reconciliation, Mr. Raffey emphasised there should be a presumption that the family of the deceased have counsel especially in the case of an Indigenous family. A denial of counsel is tantamount to delivering a message that the government does not want the family to participate in the process for this family.

[475] Mr. Raffey described his preparation hours for this then three-week Inquest. He said he did not know any lawyer that would not have completed preparation by a week prior to a three-week hearing. The Legal Services Branch did not consider that. A lot of the challenge could have been avoided by a timely response to the letter application.

[476] Without the assistance of Mr. Kruse, Ms. Harper's voice would have been silenced in this hearing. Lawyers are disincentivized from representing families at Inquests because of the process relating to funding issues. It is nonsense to say to a family that their participation is wanted in an Inquest and tell them to go and get resources themselves. In this case, the family is largely supported by social assistance and in crisis. Another piece of support for the family in the context of an Inquest should be consideration of the sophistication of the family and their ability to even read English when it is their second language.

24. Peter Kingsley K.C.

[477] Peter Kingsley K.C. (Mr. Kingsley) is a lawyer. He was appointed Executive Director of Legal Aid Manitoba in 2021 and still occupies the position. Prior to that, he was the Senior Area Director, a member of senior management of Legal Aid, from 2011 until his current appointment. Originally, he was the acting Area Director for Dauphin, Acting Supervising Attorney, and held various roles, including staff attorney for Legal Aid for most of his career.

[478] Legal Aid Manitoba is an arm's length organization of Manitoba Justice. Although there is a working relationship with Manitoba Justice, the policy and direction of Legal Aid Manitoba is set by a management council, and the Executive Director puts the policies into effect. Ultimately, his day-to-day responsibility is to ensure that policy direction as set by management council is implemented, together with the Legislation that empowers Legal Aid Manitoba to do its function. Legal Aid Manitoba covers adult criminal matters, youth criminal matters and those going

through marital breakdowns. Additionally, Legal Aid Manitoba covers the child protection area. There are other areas such as some residential tenancy, social assistance appeals, immigration matters, and other related matters that are governed by the regulations and policies of Legal Aid Manitoba.

[479] The Public Interest area empowers Legal Aid Manitoba to take on cases that would be in the public interest. Examples of this include areas of consumer law including public utility board hearings, and other areas that have significant impact on all Manitobans. The Public Interest section may also involve an issue such as hunting rights engaging the intersection of Indigenous law and other laws.

[480] The funding for Legal Aid Manitoba comes from, generally, three sources: the Province of Manitoba, the Federal Government, and The Manitoba Law Foundation. If Legal Aid does not have enough funds to cover the needs in Manitoba, unlike other government departments their cheques bounce.

[481] Legal Aid has been involved in Inquests in the past through the Public Interest Law Centre. Legal Aid became involved in those Inquests because they were significant Indigenous issues. The Public Interest Centre is particularly interested in public interest issues, not simply a matter of representing a particular client. It is a matter of considering whether the outcome of the Inquest can change things. In the cases Legal Aid involves itself, it can participate as counsel to the family or a fusion of two or three groups who have come together.

[482] From a staffing perspective, Legal Aid has about 18 people who process applications on a regular basis. Matters can be prioritized for processing depending on whether there is an individual in custody or where the matter is urgent. For Public Interest applications, there is typically a legal opinion generally provided by someone from the Public Interest Law Centre and the decision whether to participate is generally referred to the Executive Director. Historically, Legal Aid Manitoba's involvement in Inquests has been because of a recommendation by the Public

Interest Law Centre who had been contacted to assist. In one case, Mr. Kingsley was approached directly and in another the family made application to Legal Aid.

[483] Generally, Legal Aid Manitoba did not deal with Inquests because there is a funding option available through government. Legal Aid tries to not duplicate services provided elsewhere, or elsewhere available.

[484] Mr. Kingsley commented on the current Inquest Legal Fee Funding Policy. The funding process appears to be set up for individuals who have money and can access legal services, familiar with how to do that and how to access the legal system. The reality is that Inquests are often held for individuals not in that situation and the families not in that circumstance. There is no appeal process, or process of review.

[485] The guidelines are not particularly user friendly or realistic. The policy invites someone who has already lost a family member, already at a disadvantage, to go out, find a lawyer who is willing to assist them, and that lawyer then be able to provide the service at some sort of rate. Only then can the applicant apply for up to 90 thousand dollars of funding based on the current Legal Aid rate of 100 dollars per hour to reimburse them. There is no deadline for a decision to be made, so even though an individual may have standing, they may not receive funding at all.

[486] Legal Aid's assumption is generally two to three hours of preparation time per hour in court for senior counsel, which is a significant investment to ask counsel to become involved in without a response on the issue of contribution. Mr. Kingsley said the following on the issue of the connection between standing and funding:

"If you have standing and no funding you don't have standing." (Inquest Transcript March 10, 2025, Page 11 Line 36)

[487] This is the system that excludes the family from the opportunity for meaningful input.

[488] While the general process for considering Legal Aid applications is not perfect, it is set up to provide a quick, clear answer with an appeal process.

The individual is given a clear, written decision explaining why, or why not, funding has been approved. The current government policy for contribution of funding at Inquests does not operate in that way.

[489] Additionally, by setting a maximum contribution cap, the policy does not consider what would be a reasonable matter. It assumes that every Inquest is the same. Legal Aid has a process, meets with counsel, reviews the case with counsel, and assesses what resources are required.

[490] While the current contribution to funding policy controls funding, it is not a good way to address the legal needs. It does not consider that for a number of families, the Crown's office may not be seen as the friendliest environment. It may be, in certain circumstances, that having counsel for the family for even a short period of time to assist through certain aspects of the process may contribute to relationship and trust building. Legal Aid has had to familiarise themselves with the type of circumstances a lot of Manitobans live in and has learned that one size does not fit all. Legal Aid has tried to move their own policies towards the recognition that for most of the time, the policies work but in some instances, they need to carefully consider a case in its entirety to properly resource it.

[491] Legal Aid Manitoba has the infrastructure, knowledge, and experience to work with different groups and individuals to properly assess what sort of legal support they require and determine how to best supply those legal services. This is a system that works across the province.

[492] Assuming approximately 50 Inquests in the past ten years, decisions would have to be made, should Legal Aid become involved in administering whatever the infrastructure properly becomes, for how this process could work. It is possible for Legal Aid to administer such a program depending on how it is created.

[493] Legal Aid can definitely not become involved in this issue in its current budget. Legal Aid has fixed funding. Ballparking, Mr. Kingsley estimated a 1.8-

million-dollar investment over a ten-year period assuming the number and nature of Inquests remain the same. Legal Aid would require a funding scheme to support this.

[494] Whatever the decision might be, Legal Aid cannot become involved if the plan is to impact current funding for mandated functions. Additionally, it ought not take away funding from the discretionary programs Legal Aid operates as these are necessary for Manitobans. Of note, Legal Aid Manitoba's independent decision-making process, in the public interest, is what they already do. Manitobans can be comforted knowing the decision is made on the factors presented and not something else. Legal Aid has a policy of transparency.

[495] The guidelines are published. Reasons for decisions are sent by letter to clients. The financial guidelines are on the website. Even how counsel is paid is transparent. Mr. Kingsley, himself, routinely holds seminars for private bar and staff counsel explaining the billing process. There is no mystery, and there is no magic. The current existing contribution to funding model through Legal Services Branch does not seem to address whether a decision is made for budgetary purposes, or other reasons. This is particularly problematic for individuals who may already have mistrust of the system.

[496] A meeting with counsel already familiar with the Inquest process, is of assistance in making a funding decision. Additionally, Inquest counsel could be consulted to receive a clear understanding of what is involved in this Inquest and what the focus is. Mr. Kingsley also thought working with the family initially, and whoever the applicant is, to determine what they hope to get out of the process that a lawyer could bring, would be helpful. Mr. Kingsley also touched on the necessity of an appeal process and how that might be implemented.

[497] As to whether Legal Aid could take over the process of family funding from the Government of Manitoba Legal Services Branch where it currently sits, Mr. Kingsley said that at the end of the day, management council would make the

decision. However, management council has already made it clear it is the job of Legal Aid to expand services that could be offered, and this plainly is an area that is something Legal Aid would be uniquely suited to assist with. When asked by the Inquest, whether Legal Aid would be willing to take over this area, Mr. Kingsley said: “If it helps people, I'm willing, and I think this will make a difference.
(Inquest Transcript March 10, 2025, Page 18 Line 34)

[498] Regarding the participation of university students, Mr. Kingsley highlighted that a university student is not the same thing as a lawyer. He would want to ensure people have the best possible legal resource available. He would also not wish to put a student in a position where Legal Aid should be putting a lawyer, but he does see students being able to take part and learn to develop their capabilities. Mr. Kingsley was asked by counsel for the Harper/Wood family whether an understanding of the specialised needs and traumas relating to the Indigenous community would be included in any intake and public interest process potentially developed by Legal Aid. Mr. Kinglsey said: “It absolutely. We like to think that our consideration of reconciliation is part of every decision we make.”
(Inquest Transcript March 10, 2025, Page 34 Lines 5-6)

RECOMMENDATIONS

Recommendations in Inquest Report

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.

[499] In making these recommendations, I was greatly assisted by the fulsome submissions by the parties granted standing to this Inquest, and Inquest counsel, to assist in formulating the recommendations below. The parties and Inquest counsel submitted many recommendations for my consideration, some similar to each other. All counsel are to be commended for their thoughtful reflection and thoroughness in presenting the Inquest with suggestions to assist in this process. In addition to oral submissions, I had the benefit of a written submission presented by counsel for Sophie Harper on behalf of the family of Darren Wood written by Marc Kruse and Robson Hall law students Peter Frejek and Zachary Anderson.

[500] Not all their suggestions are integrated into my recommendations. Some of their suggestions are included in a different fashion than suggested. Adopted or not, each of the suggestions, together with the submissions of the parties and the written brief were extremely helpful in coming to the conclusions I have. In formulating my recommendations, I have attempted to follow the directions in the *Fatality Inquiries Act*. It is my anticipation the recommendations are sufficiently practical to be operationally viable for implementation.

[501] I sincerely hope the recommendations made in this Inquest report into the death of Darren Wood will prevent future deaths in similar circumstances.

[502] The legislation directing operation of correctional services in Manitoba, outlined below, applies to the WRC. It requires the WRC to consider the safe and humane accommodation of persons in custody and offer programs and services to

assist them in leading law-abiding and useful lives. Additionally, WRC, according to the legislation, must address the needs of offenders relating to their offending behaviour.

[503] There is little room for debate that opioid addiction is directly related to offending behaviour. The options for opioid addiction treatment explored in this Inquest as implemented by Alberta Corrections and available in the community in Manitoba are directly linked to the humane treatment of offenders experiencing opioid withdrawal.

[504] The *Correctional Services Act*, C.C.S.M. c.C230 at Section 2 of the *Act* focuses attention on the important purposes of the *Act*:

> Purpose
>
> 2(1) The purpose of this Act is to contribute to a safe, just and peaceful society by providing for
>
> …….
> (b) the safe, secure and humane accommodation of persons who are in lawful custody; and
> (c) appropriate programs, services and encouragement to assist offenders to lead law-abiding and useful lives.

[505] Additionally, the *Act* general principles assist in interpreting how the purpose of the *Act* is to be achieved. Included in general principles is the following:

> General principles
> 2(2) The purpose of this Act is to be achieved, and this Act and the regulations are to be construed and administered, in a manner consistent with the following principles:
>
> (a) The protection of society and the accountability and responsibility of offenders shall be given paramount consideration in all decisions to be made in the administration of this Act…
>
> (c) The safety of the community will be enhanced by addressing, as far as possible, those needs and circumstances of offenders that are related to their offending behaviour.

[506] Most of the recommendations to follow likely will engage the expenditure of public funds. They may also involve a refocus of priorities and thinking outside the box to implement them. It is my hope that, when considering the acceptance or not

of these recommendations, that the priority placed by the Legislation on the safe, secure, and humane accommodation of persons in custody and its inevitable linkage to the protection of society and safety of the community as directed by the *Correctional Services Act* will be considered. The inmates in WRC are entitled to the same level of medical care as their fellow Manitobans.

[507] Counsel for the Correctional Services Division urged the Inquest Judge to appreciate the Department of Corrections does take the treatment and death of Mr. Wood and all fatalities very seriously. Corrections have already conducted their own investigation and identified, from their perspective, what could be improved. The Department takes the position that what they are doing right now is really all they can manage based on their current resources.

[508] Resourcing recommendations are beyond the scope of this Inquest. However, the challenges providing appropriate medical care to the inmates at WRC is not a new concern. The frailties of the current delivery of medical care, and the significant negative impact on the inmates, diligent nurses and conscientious Corrections staff is self-evident from and made clear by the evidence.

[509] The retelling of the story of the circumstances of the death of Darren Wood in WRC affected each one of them in a substantial way, and each witness is to be commended for their courage and resilience in assisting with this Inquest in the hope of contributing to meaningful change in ensuring the wellbeing of the inmates of WRC.

[510] The recommendations are made pursuant to section 33(1.1) of the *The Fatality Inquiries Act* as follows:

1. **Government of Manitoba financial support for a lawyer to represent the family of the deceased whose death is the subject of an Inquest**

[511] The current "Inquest Legal Fee Funding Policy" of the Manitoba Government operates as consideration for reimbursement of legal fees, as a:

> …contribution to help pay for legal fees for a lawyer to represent the family of the subject of an Inquest in extraordinary cases where the circumstances of the death and the family make it such that it is in the interests of justice for the family to have independent counsel.

[512] The model presumes counsel in place, the family can retain counsel including financially, is able to articulate why their case is extraordinary and that the interests of justice for the family require the family to have their own independent counsel. The policy outlines the contribution does not exceed 90 thousand dollars including fees and disbursements including how the amount of contribution will be calculated. The request process is in writing to the Director of Legal Services as soon as possible after standing at the Inquest is received. The family member will be informed in writing, if approved, including detailed information on how to make their claim.

[513] The outcome of this process in the case of Sophie Harper's application makes it clear why there needs to be change. The evidence of lawyer Matthew Raffey, together with the statement made by Sophie Harper in the Inquest, explained how Mr. Raffey was already connected to the family at the time of Darren Wood's passing. Mr. Raffey was first contacted by Sophie Harper's mother, Aline Wood, in the summer of 2021 asking for assistance. Mr. Raffey reached out to Mark Lafreniere of Manitoba Prosecutions, requesting to be put on the list to be notified when the Inquest was called.

[514] Tragically, Aline Wood passed away in May of 2023, and Sophie Harper on behalf of her late mother and family sought standing to represent her mother and family on January 10, 2024. Standing was granted. Mr. Raffey was aware of the funding policy, and Ms. Harper knew she had to make application in accordance with the policy.

[515] Disclosure was made to Mr. Raffey and all counsel involved in the Inquest, and he began his preparation. Ultimately Sophie Harper's letter, which was her application for funding, was signed October 28, 2024.

[516] In the interim, disclosure continued, and Mr. Raffey continued to prepare. Inquest counsel sought Ms. Harper's consent to disclose certain information about Mr. Wood. Mr. Raffey, in his role as counsel for the family, assisted Ms. Harper in understanding the request and assisted her with her decision to consent to Inquest counsel's request.

[517] The situation was complicated by the fact that the reason for Mr. Wood's detention was an allegation by his sister claiming he robbed her. Ms. Harper was concerned about the reliability of the allegations. Ms. Harper was aware that both Darren and his sister Louisa, who complained to the police about Darren, were both street affected people with long- standing addiction issues. Sophie Harper struggled with her concern that had Darren and Louisa been more stable he may not have been in jail in the first place.

[518] Mr. Raffey walked Ms. Harper's application for funding contribution letter over to the Legal Services Branch and explained to the individual who received it that it was an application for Inquest funding, and the Inquest was coming up quickly. Mr. Raffey requested to present the letter to someone other than reception. His request was declined but he was assured it would be taken care of.

[519] Mr. Raffey heard nothing further, and, knowing the Inquest was to begin January 16, started calling Legal Services Branch on January 8. He spoke to a lawyer he knew there, explaining the impending Inquest, the lack of response, and sent her a follow up email. On January 9, 2024, Mr. Raffey received a call from Darrin Davis, Director of Civil Legal Services, indicating Mr. Davis wished to speak to him. Mr. Raffey tried twice to call him back on January 10, leaving several voice messages.

[520] Mr. Davis responded at 4:30 p.m. on January 10. Mr. Raffey was informed Mr. Davis was intending to deny the application. At that point, the Inquest was to begin in six days. There were new developments to be taken into consideration, and Mr. Raffey requested to follow up with Mr. Davis once he had more information. Mr. Davis said he would always consider more information. Mr. Raffey called him back on Monday, January 13 with further information. Mr. Davis confirmed the application would be denied. Three days prior to what was to have been the commencement of the Inquest, his office sent a letter denying coverage to Ms. Harper by regular mail. The only reason Ms. Harper was aware of the decision was that Mr. Raffey had received a copy of the letter of denial by email. By that time, Mr. Raffey had been working on the file for a year.

[521] The circumstances of Darren Wood's family, and the treatment of Sophie Harper's application, highlight the inadequacies of the existing policy. It is still unclear, from the statement of Sophie Harper, the evidence of Matthew Raffey, and the evidence of Peter Kingsley, Executive Director of Legal Aid Manitoba why this application was refused. Many other features exacerbate the need for a change in process.

[522] The lack of transparency of the application process, the absence of an appeal process in the Legal Services Branch, the complexity of this Inquest, the fact that Darren Wood died in the custody of the Government of Manitoba and the decision not to fund counsel was made by the Legal Services Branch of the Government of Manitoba are features.

[523] Additionally, the Department of Corrections in whose custody Darren Wood died was represented by two counsel employed by the Government of Manitoba, and Inquest Counsel were two Crown Attorneys employed by the Government of Manitoba. The result of the decision made by the Legal Services Branch was that Sophie Harper, who endured the trauma of losing her brother in the circumstances

that she did, an unsophisticated individual who struggled with English literacy, representing a family riddled with the effects of colonization, was left with no counsel or representation days before the Inquest started.

[524] Peter Kingley's and Matthew Raffey's evidence "if you have standing and no counsel, you don't have standing." is echoed by this Inquest.

[525] This situation was unacceptable to the Inquest Judge. I reached out to community contacts to forge some sort of solution to resolve the inequities in this situation as they affected the proper functioning of the Inquest.

[526] I am extremely fortunate that Marc Kruse's name was suggested. Mr. Kruse responded immediately to my email requesting assistance and appeared on what would have been the first day of the Inquest to be placed on the record. Mr. Kruse is a practicing lawyer, and also the Director of Indigenous Law Learning and Services at Robson Hall, the Faculty of Law at the University of Manitoba. Mr. Kruse indicated he would appear as he could, to be assisted by third year law students Peter Frejek and Zachary Anderson from the Indigenous Externship and the Criminal Law Clinic at Robson Hall who would appear with Sophie Harper when Mr. Kruse could not and assist as necessary.

[527] Of note, counsel (other than Inquest counsel) had been preparing for the Inquest for a year. Mr. Kruse received disclosure after the Inquest began. Nonetheless, Mr. Kruse and the students played an invaluable role in the Inquest. Despite the assistance of Mr. Kruse and the students who played a critical role under very challenging circumstances, and that they stepped up where other systems did not, is not to be seen as an adequate replacement for properly funded counsel with adequate time to prepare for an Inquest.

[528] The evidence of Peter Kingsley K.C. made it quite clear Legal Aid Manitoba is well positioned to develop an appropriate funding policy, receive and consider the applications, provide a transparent and supported response to the application in a

timely fashion, and deliver the service to Manitobans. Legal Aid Manitoba according to Mr. Kingsley's evidence, could take over this process assuming they are given adequate funding and resources to support this new endeavour. Mr. Kingsley was clear that Legal Aid has both the infrastructure and expertise to undertake this program so long as it does not detract from the important work they have been doing serving Manitobans for years.

[529] *I therefore recommend: that the Government of Manitoba conduct a comprehensive review of the current policy for funding contribution to families with standing at an inquest to address the shortcomings of the current policy and procedure. The Government of Manitoba should consider transferring the adjudication of funding applications to Legal Aid Manitoba.*

2. Physician Availability to Inmates at the Winnipeg Remand Centre

[530] According to the evidence, the physician attending to WRC is not an employee but engaged by a Request for Proposals by the Government of Manitoba as represented by the Minister of Justice as a prospective Vendor of medical services. In accordance with the request for proposals, the physician at WRC is to provide seven clinics per week at one hour per day, total clinic hours not to exceed 260. Telephone consultation is required.

[531] Dr. Doucet is one of the physicians currently under contract to deliver this service. Mr. Wood was placed on a list to see Dr. Doucet on two occasions, but he did not end up being seen by Dr. Doucet at all. The evidence did not disclose why. Dr. Doucet testified that there is no formalized criteria for nurses to determine who goes on the list to see him, and how priority is assessed. Nurse Koscian testified that there were times when a patient is on the list but the doctor leaves without seeing the patient. This causes a backlog and sometimes issues remain unaddressed and wait for days. It is an ongoing issue.

[532] There was evidence there is no limit to how many times someone can be bumped from the list. Several nurses felt contact with the physician, when he was not there, was difficult and increased physician accessibility would improve patient care at WRC. Nurses were in receipt of an email directing nurses not to call Dr. Doucet during nighttime hours, and to send an email. The nursing evidence was such that this was unhelpful to them in meeting the needs of their patients.

[533] Dr. Doucet testified that he was one of four different physicians on contract with WRC. When he is away, one of his colleagues fills in. If a nurse requires advice from a physician overnight, and if the patient has an acute medical deterioration, it was Dr. Doucet's view they should be sent to the emergency department.

[534] Dr. Doucet testified that originally, when he started seeing patients at the WRC, it was just five days a week. Holidays and weekends were not included. About five years ago, WRC asked physicians to come in seven days a week so there was no gap on holidays and weekends without physician attendance.

[535] It was his view that WRC staffing did not allow adequate officers to move inmates around on holidays and weekends, so inmates are not seen in person on the weekend. Sometimes there are 30 charts in a morning to review and order medications. Occasionally, Dr. Doucet does see people on the weekend.

[536] Dr. Doucet's reference to the staffing impediment to actually seeing patients on the weekend is inconsistent with other evidence that indicated there are no staffing impediments to the physician seeing patients over the weekend.

[537] The other physicians on contract to attend WRC are Dr. Ron Steigerwald, Dr. Friesen and Dr. Erik Smith. However, Dr. Doucet is the physician most commonly attending WRC. Although the physician engagement requires the physician take phone calls, Dr. Doucet said most often he receives email until about 9:30 or 10:00 p.m. Dr. Doucet prefers emails because if he is in the middle of

something and someone phones him, he is interrupted. If someone emails him, he can respond later. It is all a matter of his convenience.

[538] *I therefore recommend: that the Correctional Services Division of Manitoba Justice formalize the process by which inmates at the Winnipeg Remand Centre are seen by a physician, to ensure reasonable and ready access to a physician when it is necessary. The Correctional Services Division of Manitoba Justice should review the current physician contract for service delivery at WRC to determine whether its provisions adequately provide for the medical needs of the inmates, and whether the implementation of the contract provisions facilitating nurse access to physician input is being appropriately applied to best meet the needs of the inmates at WRC.*

3. Monitoring of inmates on 3M

[539] The evidence was clear that pod officers on 3M use screens to monitor the inmates. Even with currently modified relocation and upgrading of the screens, many of the officers testified they were still not sufficient for proper observation. The responsibility of the officers observing inmates in this heightened environment of monitoring for health-related issues, is demanding. The current screens are not sufficient, according to the evidence, to verify signs of life and properly visualize the person. Technology and camera updates with zoom functions, and the ability to monitor for movement would assist. The current camera system only records movement. Where there is no movement, there is no recording.

[540] Caroline Reimer testified about an upcoming update to enhance the quality and resolution and provide colour display. There will be no audio or continuous recording. Nurses rely heavily on COs to monitor inmate status on 3M. The COs are not medical professionals. The officers are focused on the particular inmates, as they ought to be, but their understanding is variable concerning exactly what it is they are looking for.

[541] The evidence of the officers indicated different understandings of what they were supposed to monitor, and what conditions should cause them to act. For example, the position that Mr. Wood was lying in his cell seemed unusual and

of concern to officers Ramage and Arikhan. This was not a concern to officers Sullivan and Teixeira. Some officers said they wake a sleeping inmate to confirm signs of life, while others said they would not. Officer Sullivan, the pod officer, said if there was no blood and nothing amiss, she would consider that a sign of life. Additionally, if she could see the head and neck exposed but nothing wrong, this would also be a sign of life. Other officers would need to see the chest moving up and down to confirm a sign of life. Officers do receive training upon joining Corrections, but there are no refreshers or policy review according to Caroline Reimer, except for emailed policies and discussion at muster.

[542] There was also variable understanding between nurses about what information may be shared with a CO about a medical condition, and universal concern about the potential for infringement by information sharing offending *PHIA*.

[543] Allyson Mueller, Health Services Manager at the time, did not know if COs were trained in *PHIA*, and would restrict her information sharing about what she considered to be necessary. For example, in the case of Mr. Wood, she would say she was concerned about withdrawal and might have shared he was vomiting and had nausea. Officers had different views of what was required of them relating to medical observation. Nursing documentation with respect to what to look out for in the case of a particular inmate was inconsistent, and the practice relating to the use of the logbook as a communication mechanism was not consistent.

[544] More effective and consistent communication from nursing staff as to why an inmate is in medical observation is necessary to assist COs in the discharge of their duties relating to medical observation. Concern in this area arising from the evidence from both officers and nurses leads to the following recommendations:

[545] *I therefore recommend: that the Correctional Services Division of Manitoba Justice:*

- *obtain video equipment for medical observation cells that enhances the ability of the pod officers to effectively monitor 3M cells.*

- *review responsibilities and procedures related to CO's responsibilities for medical observation, documentation related to medical observation, and when action should be taken by the officer.*
- *develop ongoing training requirements for all COs and nurses to ensure that all are up to date on current policies and protocols, in particular, training specifically on PHIA as it applies to their respective roles and what information can be shared by nurses with COs about an inmate's medical condition.*
- *review policies related to medical observation, duties in the pod, and requirements for unit logbook documentation or other communication mechanisms to ensure proper communication and documentation occurs between all staff caring for and monitoring an inmate in 3M.*
- *review CO education on policies related to punch round duties on an ongoing and regular basis.*

4. Nurse Understaffing at WRC

[546] Nurse understaffing was a clear and persistent theme throughout the evidence of the nurses. All were strongly committed to the appropriate discharge of their professional responsibilities but often overwhelmed by the demands placed upon them because there simply were not enough of them to go around. When things become busy, which is the norm not the exception, nurses are occupied meeting the needs of the inmates. One of the items that tends to slip under these circumstances and in this instance, is charting. Not everything that should have been charted in Mr. Wood's case was, and this is a sadly common occurrence. The nurses understand their obligations, but sometimes discharging the charting requirement slips between the cracks in the face of other demands. Clearly, the ability to take notes contemporaneously with completing the task may assist to mitigate charting gaps and errors.

[547] *I therefore recommend: that the Correctional Service Division of Manitoba Justice review the heavy reliance on paper charting and consider the feasibility of electronic charting at WRC.*

5. Recruitment and Retention of Nurses at WRC

[548] Travis Hoemsen is the Director of Talent Acquisition for the Province of Manitoba. He has been involved in human resources for over 20 years. He started work in this area in February 2009 for the Province of Manitoba. The Talent Acquisition Branch, a new department within government, was created to centralize recruitment and refocus resources. Mr. Hoemsen was unaware a previous Inquest recommended a strategic plan be developed in terms of nurse recruitment and retention. He was unaware of any strategic plan in Talent Acquisition involved with Corrections for the recruitment of nurses.

[549] At the time of Mr. Hoemsen's evidence, there were 20 open nursing positions at WRC. He said there were candidates identified for 10 of those positions going through the process and involved in various checks. Mr. Hoemsen identified the competition for nurses as a factor in recruitment. In the case of a resignation from the nursing staff at WRC, although the tools exist to facilitate an exit interview, it is not commonly done.

[550] Although Mr. Hoemsen had some ideas about how to deal with the nursing shortage at WRC, there is still no strategic plan.

[551] There are some nurses who, through their own commendable initiatives, have tried to reach out to attempt to recruit fellow nurses, and use their own skills and experience to sell correctional nursing to new grads and other nurses who may be interested. It appears there is no systemic uptake to utilize the creativity and talent of the existing nurses to attempt to recruit others. Although nursing shortage is not unique to the Correctional Services Division, the clear evidence of the nurse witnesses was that the nursing shortage at WRC is in crisis.

[552] *I therefore recommend: The Correctional Services Division of Manitoba Justice, working collaboratively with Talent Acquisition, develop and implement an effective strategic plan for the recruitment and retention of nurses at WRC.*

6. Transition of operation of the Medical Unit at WRC from the Government of Manitoba Department of Justice to the Manitoba Department of Health

[553] Inmates entering WRC are disconnected from community healthcare, entering the silo of correctional healthcare. Existing diagnoses are revisited, existing prescriptions re-evaluated, and existing community resources connected to the inmate are not integrated into their correctional healthcare plan. This issue was the subject of a recommendation in the Inquest into the death of Errol Greene, Provincial Court of Manitoba, (June 6, 2019). In 2019, Shauna Appleyard, then Executive Director of Rehabilitation Services for the Province of Manitoba, testified that Manitoba intended to explore following the lead of Nova Scotia, Alberta, and British Columbia in transitioning inmate health medical care from being operated by Corrections to the Provincial Health Authority. At that time, Ms. Appleyard indicated that she had been given a broad mandate to work on the transition and was unable to say what the timeline might be. Mr. Ed Klassen, then Director of Operations - Custody, had already engaged in discussion with Alberta and Saskatchewan.

[554] There was no evidence called on this point in the Inquest, but it was abundantly clear, from the evidence overall, that from an operational perspective there has been limited progress in this area. Counsel for the Correctional Services Division, in submission, advised the Inquest Judge that the department is aware of this recommendation in the Errol Greene Inquest, and the department is in regular meetings with Manitoba Health regarding a gradual transition of Correctional Health Services to Manitoba Health over time. That these discussions are ongoing is encouraging, but the continuing challenges experienced by the nurses and COs in WRC to meet the day-to-day health care needs of a high needs population is compelling.

[555] That there are two major hospitals in reasonable proximity to WRC is not the answer to addressing the ongoing health care needs of this population in an appropriate fashion.

[556] There is no doubt, that this transition in the short term will be resource intensive. Based on the experience of other provinces, it is evident that long term gains in the quality of healthcare for inmates at WRC will be much enhanced.

[557] The evidence of Angela Draude, Executive Director of Correctional Health Services, with Recovery Alberta, described how the transition from Correctional Health Services to under the auspices of Alberta Health benefitted and improved medical and health care for inmates in Alberta.

[558] The inmates of WRC are entitled to the same level of healthcare as every other citizen of Manitoba.

[559] *I therefore recommend: that the Government of Manitoba move forward to transition health responsibility for inmates of the Winnipeg Remand Centre from Manitoba Corrections to Manitoba Health, and prioritize the development of a plan for this transition with a view to effecting the transition.*

7. Treatment of Opioid Use Disorder Generally and Opioid Withdrawal in the Winnipeg Remand Centre

[560] Dr. Erin Knight's expertise, particularly in addictions medicine, is significant and broad. Her lengthy list of credentials, especially in addictions medicine, is abbreviated here. At the time of her evidence, she was an Associate Professor, Department of Psychiatry, Rady Faculty of Health Sciences at the University of Manitoba, the President of the Canadian Society of Addiction Medicine, and the Medical Lead for the seven Rapid Access to Addictions Medicine (RAAM) clinics across Manitoba. The physicians who testified deferred to her expertise in the area of addictions medicine during their evidence.

[561] Although the exact number of Manitobans struggling with opioid addiction is not clear, Dr. Knight testified that substance use disorders are more common in Manitoba than other places in the country. Substance use disorders affect a broad range of Manitobans.

[562] Dr. Knight was aware that within Federal Corrections, opioid replacement therapy can be started for the inmate population. Similarly, in the province of Alberta, opioid agonist therapy is started in provincial correctional institutions. Dr. Knight is particularly aware of the circumstances in Alberta, because she has had meetings with the individuals who run their Virtual Opioid Dependency Program in Alberta Corrections. She described her vision for how a similar program might work at WRC.

[563] Dr. Knight is committed to providing education to a variety of different areas within the health sector around substance use disorder. The RAAM group has already expressed interest in working with Corrections in terms of identifying their educational needs and trying to support them. Similarly, they could provide training on new and emerging drugs on the street, an area of particular interest to Corrections nursing staff and officers alike, to keep up with the constant changing landscape of drugs affecting the inmates.

[564] Dr. Knight has engaged with her patients who were in WRC and has spent hours on the phone with nurses and nursing supervisors about the WRC opioid policy, which she urges be updated and written based on evidence. She has offered to assist in updating the policy and tried to engage around it unsuccessfully. To Dr. Knight, it makes sense for a policy related to an area of specialty medicine to have some engagement with people who provide that medicine. To her knowledge, there has been no involvement of any local OAT prescribers in WRC policy. Through the RAAM hub, there has been an attempt to build relationships with

Corrections to support the use of evidence-based treatment in Corrections. The most consistent message and response relates to inadequate resources.

[565] Angela Draude, the Executive Director of Correctional Health Services, with Recovery Alberta, testified that Alberta has been running an OAT program in all the correctional institutions in Alberta, including the Edmonton Remand Centre. Implementation in the Edmonton Remand Centre was the most challenging of their ten correctional facilities, for reasons much like those expressed in the Manitoba context in this Inquest, including fast inmate turnover, the number of inmates, and the structure of the building.

[566] She attends monthly meetings of the Federal Provincial Territorial Heads of Corrections Committee, and there is a subcommittee of health and mental health Ms. Draude attends. Manitoba is represented at the subcommittee by Natalie Horne. Manitoba, it appears, is already engaged in this area by virtue of participation in the group, and Ms. Draude said she assists other provinces, meeting with Saskatchewan later in the same week she testified, and she is always happy to collaborate with Manitoba as she does with other provinces.

[567] Although it is encouraging that WRC now discharges inmates with a pamphlet, in English only, about RAAM clinics, Manitoba has a long way to go to bring the level of treatment for opioid withdrawal in custody to the level of other provinces, and the gold standard of medical treatment.

[568] In submission, counsel for Corrections said the following:

> And finally, I'm leaving it to the end because I think it's really one of the cruxes of this case and certainly one of the most complicated and that is the issue of opiate agonist therapy. Dr. Knight and the witness from Alberta Corrections, presented evidence to you regarding some of the recommendations and what's being done and these are wonderful ideas. The issue is resourcing and priorities and not just -- not just priorities within the Remand Centre but priorities government wide and implementing these ideas obviously takes significant money, significant staffing resources.

(Inquest Transcript April 4, 2025, Page 26 Lines 4 - 11)

Corrections counsel also stated the following:

> So those are all challenges that result in the department taking the view that what they're doing right now is really all they can manage based on their current resources. However, the department is committed to the idea of consulting with experts and doing a jurisdictional scan to find out what other provinces are doing in this area.

(Inquest Transcript April 4, 2025, Page 28 Lines 4 - 8)

[569] The ability to treat individuals in WRC at risk of or withdrawing from opioids, in a medically appropriate and evidence- based fashion, is most likely to prevent a future death in circumstances such as that of Darren Wood, reduce inmate suffering as a result of withdrawal, and best support the management of the addiction in custody and transitioned into the community which is the best outcome for the individual concerned and all Manitobans.

[570] *I therefore recommend: that the Correctional Services Division of Manitoba Justice, in consultation with Dr. Erin Knight, develop and implement appropriate evidence- based policies and protocols, including opioid agonist therapy, with respect to the treatment of inmates in WRC for opioid addiction and withdrawal.*

ACKNOWLEDGEMENTS AND FINAL NOTES

[571] The management of the proceedings related to this Inquest into the death of Darren Wood presented unique challenges. The original Inquest counsel, appointed in September 2023, was appointed as a judge of the Provincial Court of Manitoba days prior to the scheduled day one of the Inquest, January 16, 2025, leaving the Inquest Judge without Inquest counsel. The challenging nature of the circumstances was exacerbated by the information that the Legal Services Branch of the Province of Manitoba, again days prior to the first day of the Inquest, notified then counsel for Darren Wood's family the decision had been made not to contribute to funding for counsel to represent Sophie Harper on behalf of the family. This left the family without counsel.

[572] On January 13, 2025, I received notice from newly appointed Inquest counsel, Georgia Couturier, that she and Noah Globerman had been assigned to replace previous Inquest counsel on the Inquest. At the time, she indicated she and Mr. Globerman expected to be able to start the Inquest, with only a few days delay, on Monday, January 20, 2025. As may be self- evident from the contents of this report, the volume of evidence involved in this matter was significant, and counsel involved in this matter and myself had been preparing for this Inquest for over a year. I really do not know how Ms. Couturier and Mr. Globerman managed to prepare themselves, interview the witnesses, and present the evidence in the exemplary fashion that they did in the circumstances I have described. They fulfilled their role in a remarkable fashion, particularly considering the unusual way this Inquest developed and all the exigencies along the way. They were of great assistance to me in the presentation of the evidence, and as unexpected issues arose in sourcing and preparing for unexpected witnesses.

[573] The issue of counsel for Sophie Harper, with standing at the Inquest on behalf of her family of the deceased, Darren Wood, was a significant and late development immediately prior to the beginning of the Inquest. My thoughts on the issue and connected recommendation is addressed earlier on in this report. As I earlier indicated, I felt I could not proceed with this Inquest leaving the family unrepresented. As I reached out to contacts in the community, in my role as Inquest Judge, to attempt to address what I perceived to be an unacceptable situation, the immediate and unrestrained response of Mr. Marc Kruse is worthy of significant mention.

[574] Mr. Kruse, in addition to being a practicing lawyer, is also the Director of Indigenous Legal Learning and Services at Robson Hall, the Law School at the University of Manitoba. On very little notice, after a brief discussion with Ms. Harper, he agreed to act for her and her family in this Inquest. Mr. Kruse had

short notice of the need for his assistance in these circumstances but nonetheless agreed to take on this task. Because he has many responsibilities that require he attend personally, he arranged for then third year law students Peter Frejek and Zachary Anderson, participants in the Indigenous Community Legal Clinic Externship, to assist him and represent Ms. Harper and her family when Mr. Kruse could not be present in person. Mr. Frejek and Mr. Anderson appeared under the supervision of Mr. Kruse. I am grateful to Mr. Kruse, Mr. Frejek, and Mr. Anderson for their participation, and Faculty of Law Dean Richard Jochelson for permitting their involvement in the Inquest. The students, under the supervision of Mr. Kruse, stepped up to assist without hesitation. I frankly don't know how this Inquest could have proceeded in a fair and appropriate fashion without their assistance.

[575] While these proceedings are non-adversarial, there were divergent perspectives on some of the issues. Counsel well managed the balance between representing the interests of their client while not deflecting focus from the non-adversarial nature of the proceedings.

[576] Court Clerk Symone Bartley-Nova was of great assistance in keeping the proceedings running smoothly, managing the exhibits, the court recording system, and all other Clerk duties with efficiency and skill.

[577] Sophie Harper, assisted and supported by her niece, Shayla Wood, attended the Inquest daily, exhibiting dignified strength, representing the family of Darren Wood as her late mother Aline Wood would have wanted her to do. She experienced the very late rejection of her application for contribution to funding for counsel for the Inquest, leaving her confused and upset that the assistance of her counsel who had been involved with her family since her brother's death since its occurrence was no longer able to proceed. Until Mr. Kruse's involvement, she was bewildered, wondering how she was to deal with all the issues she could not understand without the assistance of counsel.

[578] She remained in the courtroom exposed to the very difficult evidence of her brother's death as she carried out her responsibility to her family. She told the story of her family, and particularly her brother Darren, with quiet dignity despite the painful nature of some of the detail. She presented the Inquest Judge with a copy of the program from Darren Wood's funeral, a cherished item.

[579] This report contains my review of the evidence, findings, and recommendations after hearing the evidence and considering the submissions of the parties. Darren Wood was a son, brother, and uncle. His untimely tragic death is a terrible loss to those who loved him. I sincerely hope that the recommendations contained in this report will serve to prevent deaths in similar circumstances.

[580] I respectfully conclude and submit this report on this 6th day of October 2025, at the City of Winnipeg, in the Province of Manitoba.

"Original Signed By"
Judge Heather Pullan

LIST OF RECOMMENDATIONS

1. That the Government of Manitoba conduct a comprehensive review of the current policy for funding contribution to families with standing at an inquest to address the shortcomings of the current policy and procedure. The Government of Manitoba should consider transferring the adjudication of funding applications to Legal Aid Manitoba.

2. That the Correctional Services Division of Manitoba Justice formalize the process by which inmates at WRC are seen by a physician, to ensure reasonable and ready access to a physician when it is necessary. The Correctional Services Division of Manitoba Justice should review the current physician contract for service delivery at WRC to determine whether its provisions adequately provide for the medical needs of the inmates, and whether the implementation of the contract provisions facilitating nurse access to physician input is being appropriately applied to best meet the needs of the inmates at WRC.

3. That the Correctional Services Division of Manitoba Justice:

- obtain video equipment for medical observation cells that enhances the ability of the pod officers to effectively monitor 3M cells.
- review responsibilities and procedures related to CO's responsibilities for medical observation, documentation related to medical observation, and when action should be taken by the officer.
- develop ongoing training requirements for all COs and nurses to ensure that all are up to date on current policies and protocols, in particular, training specifically on PHIA as it applies to their respective roles and what information can be shared by nurses with COs about an inmate's medical condition.
- review policies related to medical observation, duties in the pod, and requirements for unit logbook documentation or other communication mechanisms to ensure proper communication and documentation occurs between all staff caring for and monitoring an inmate in 3M.
- review CO education on policies related to punch round duties on an ongoing and regular basis.

4. That the Correctional Service Division of Manitoba Justice review the heavy reliance on paper charting and consider the feasibility of electronic charting at WRC.

5. That the Correctional Services Division of Manitoba Justice, working collaboratively with Talent Acquisition, develop and implement an effective strategic plan for the recruitment and retention of nurses at WRC.

6. That the Government of Manitoba move forward to transition health responsibility for inmates of WRC from Manitoba Corrections to Manitoba Health and prioritize the development of a plan for this transition with a view to affecting the transition.

7. That the Correctional Services Division of Manitoba Justice, in consultation with Dr. Erin Knight, develop and implement appropriate evidence- based policies and protocols, including opioid agonist therapy, with respect to the treatment of inmates in WRC for opioid addiction and withdrawal.

WITNESS LIST

Darren Wood's Sister
Sophie Harper

Physicians
Doctor Jason Morin
Doctor Travis Minish
Doctor Paul Doucet
Doctor Erin Knight

Recovery Alberta
Angela Draude

Manitoba Talent Acquisition
Travis Hoemsen

Winnipeg Remand Centre Nurses
Murray Olafson
Karen Chrabaszcz
Paula Ewen
Malgorzata Koscian
Oliver Maglaqui

Winnipeg Remand Centre Administration Staff
Allyson Mueller
Christine Reimer

Winnipeg Remand Centre Correctional Officers
Evan Ramage
Ehizokhae Arikhan
Robert Pollok
Eric Teixeira
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Katherine Sullivan
Charles Isaacs
Harrison Giles

Counsel
Matthew Raffey
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