RELEASE DATE: JULY 15, 2024

Manitoba

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: An Inquest into the Death of Amanda Zygarliski

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Report on Inquest
Judge Kael McKenzie
Issued this 10th day of July 2024

APPEARANCES:

Jacqueline Briard, Inquest Counsel
Jim Koch and Tamara Edkins, Counsel for Manitoba Corrections
Kelly Zygarliski and Sandra Wollmann, family of Amanda Zygarliski

Manitoba

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

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

An Inquest into the death of Amanda Zygarliski (DOB: July 8, 1980) was held January 8-11, 2024, in Winnipeg, Manitoba.

This report contains my findings and observations. Attached is a list of witnesses who testified at the Inquest and a list of exhibits filed. Pursuant to the provisions of *The Fatality Inquiries Act*, I am ordering that all exhibits be returned to the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application with notice to any party with a privacy interest.

Dated at the City of Winnipeg, in Manitoba, this 10th day of July 2024.

Kael McKenzie Digitally signed by Kael McKenzie Date: 2024.07.10 10:22:00 -05'00'

Judge Kael McKenzie
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, Chief Medical Examiner (2 copies)
2. Chief Judge Ryan Rolston, Provincial Court of Manitoba
3. Honourable Matt Wiebe, Minister Responsible for *The Fatality Inquiries Act*
4. Mr. Jeremy Akerstream, Deputy Minister of Justice & Deputy Attorney General
5. Michele Jules, Executive Director of Manitoba Prosecution Service
6. Michael Conner, Assistant Deputy Attorney General (Copy Tina Fakes)
7. Jacqueline Briard, Counsel to the Inquest
8. Jim Koch and Tamara Edkins, Counsel for Manitoba Corrections
9. Kelly Zygarliski and Sandra Wollmann, Family of Amanda Zygarliski
10. Exhibit Coordinator, Provincial Court
11. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: AMANDA ZYGARLISKI

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6. Video surveillance of the Indigo Unit at Women's Correctional Centre from May 15, 2021
7. USB with surveillance video of Amanda Zygarliski's cell from May 15, 2021
8. Status of recommendations
9. Areas of recommendations

WITNESS LIST

1. Tara Hayden - Correctional Officer, CO4
2. Joseph Ogoms - Correctional Officer, CO1
3. Stephanie Corby - Correctional Officer, CO1
4. Arno Gutierrez - Correctional Officer, CO3
5. Laura Baker - Correctional Officer, CO1
6. Linda Bruce – Admissions Officer Women's Correctional Centre
7. Margo Lee – Superintendent Women's Correctional Centre

I. INTRODUCTION

[1] By way of letter dated October 6, 2021, the Chief Medical Examiner ordered that an inquest take place into the death of Amanda Zygarliski as her death occurred while she was in custody at the Women's Correctional Centre (WCC). The cause of death was a result of food being lodged in Ms. Zygarliski's airway causing her to choke.

Background of Amanda Zygarliski

[2] Ms. Zygarliski was 40 years of age at the time of her death. She grew up with her parents and siblings. From the time of her birth she struggled with a number of physical and mental illnesses. As a result she suffered socially which brought her into conflict with the law early in her life. Prior to her incarceration she was residing in a supportive living program run by an organization in Winnipeg known as "Turning Leaf".

[3] Ms. Zygarliski was a kind, loving and fun person and in return was loved despite her mental health struggles. Her siblings, Ms. Sandra Wollmann and Mr. Kelly Zygarliski, together with her two nephews miss her dearly.

II. ARREST AND INSTITUTIONAL PLACEMENT

[4] In the arrest report, on May 10, 2021, the police had been summonsed for a disturbance to Ms. Zygarliski's residence. They arrived at 7:05 P.M. and spoke with her. Ms. Zygarliski had calmed down and was doing okay so the police left without taking Ms. Zygarliski into their custody. At 7:49 P.M. that same day, the police learned that emergency medical services had been dispatched to assist Ms. Zygarliski as she was cutting herself and had become violent.

They attempted to take her into custody under *The Mental Health Act* when she assaulted the police officers. Ms. Zygarliski was pending on violent charges and had a related criminal record. As a result, she was taken into custody and transported to the Winnipeg Remand Centre (WRC). This was not Ms. Zygarliski's first time in custody and the institution was aware of her prior mental health issues. At the WRC she was assessed as an "acute" security risk and a medium suicide risk and was deemed a "red flag" status. Red flag status means that she was in segregation for the safety of herself, other inmates, and the correctional staff.

[5] On May 14, 2021, she was transferred to WCC due to overcrowding at the WRC. Her "red flag" status assessment from WRC was kept and was to be reviewed within the next week.

[6] In the meantime, Ms. Zygarliski was granted judicial interim release with a condition that she only be released to a representative from Turning Leaf. On May 15, 2021, representatives from Turning Leaf attended WCC to pick up Ms. Zygarliski, but the individuals did not have the proper authorization with them. They were therefore turned away and told to return with the appropriate paperwork.

[7] Ms. Zygarliski was advised that Turning Leaf had attended, but did not have the appropriate paperwork, but was reassured that she would be released soon.

Women's Correctional Centre Secure Unit

[8] At WCC, there are separate units for different security risks of inmates. Ms. Zygarliski was in a secure wing because of her red flag status. The secure wing consists of two units, Indigo, and Juliet. Ms. Zygarliski was housed in Indigo unit in cell number two.

[9] All cells in Indigo and Juliet are video monitored by a correctional officer in what is known as a "pod". The pod is a secure area in that inmates do not have access. The supervisors and other officers sometimes are required to attend the pod to sign a log sheet, review information on prisoners, or relieve the pod officer for breaks. The pod officer's job is to monitor two screens. The first is a screen with multiple images from the cells in Indigo and Juliet. The second is to monitor access points into the unit wherein the pod officer controls the movement in and out of the units. This is done via a two-way intercom system known as the "Dukane system". In addition to access control, the Dukane system is installed in all the cells to allow inmates to speak with the pod officer or vice versa. When someone depresses a button on the Dukane system, the screen flashes on one of the monitors in the Pod.

[10] All video cameras in the institution are recorded. The pod officer does not have the ability to review or rewind these cameras for inmate privacy, but senior correctional staff have the capacity to review these recordings at any time.

[11] In addition to video monitoring of cells, correctional staff in the secure units are required to do a physical check of inmates housed in segregation to ensure their wellbeing.

III. CIRCUMSTANCES OF AMANDA ZYGARLISKI'S DEATH

[12] On May 15, 2021, after being informed that her release was delayed, Ms. Zygarliski was upset, but initially seemed fine. When Ms. Zygarliski was brought her dinner tray at 4:09 P.M., she was reluctant to take it. Correctional Officer (CO) Ogums convinced her to take her meal. Ms. Zygarliski threw her food on her bed, but eventually did pick it up and begin to eat her chicken wrap. She took a bite of food and then took another before she was done chewing the previous bite. She began showing signs she was choking at 4:13 P.M.

She was trying to throw up or cough, she was holding her throat, and waving at the security camera for help. She appears to have pushed the Dukane button and remained at the button for approximately 20 seconds. Ms. Zygarliski continued to show signs of distress until she ultimately fell to the ground face down and stopped moving at approximately 4:17 P.M.

[13] CO Ogums, checked in on Ms. Zygarliski at 4:30 P.M. where he saw her lying face down with her feet towards the door of the cell. He noted that her pants were part way down exposing a portion of her buttocks. He shook his head and walked away. He returned a few moments later and saw she was still lying in the same spot. Not wanting to look at her because she had her pants partially down, CO Ogums asked the pod officer at 4:37 P.M. if there had been any recent communication with Ms. Zygarliski. The pod officer indicated there had not been any recent communication and immediately attempted to speak to her via the Dukane system with no response.

[14] Policy dictates that to open the cell door in the secure area that at least three officers are present. Similarly, they cannot open the meal slot on the door unless two officers are present. CO Corby, a female officer, attended the cell at 4:42 P.M. and once a second officer attended, she opened the slot on the door. She did not see any obvious signs of life, but also did not see any signs of trauma either. She yelled at Ms. Zygarliski and kicked at the door to get her to move. Ms. Zygarliski did not move. At 4:48 P.M., CO Corby went and got a glass of water with the intention of throwing it on Ms. Zygarliski but did not do so at the suggestion of CO Ogums. At 4:50 P.M. acting senior officer M. Koersvelt attended Indigo Unit, he kicked the cell door and called out to Ms. Zygarliski. Seeing no movement at 4:51 P.M. he ordered a “code red” which is a medical emergency code that sets into action a response team amongst other actions within the institution.

[15] The cell door was finally breached at 4:53 P.M. and Ms. Zygarliski was obviously deceased. Resuscitation was attempted by the nurses but was unsuccessful. Notably, when an oxygen tank was brought to the cell it was empty and another had to be retrieved.

[16] Emergency medical services were summonsed to the institution. As Ms. Zygarliski had died the RCMP were notified. Ultimately, Ms. Zygarliski's body was transported to the coroner at Health Sciences Centre in Winnipeg and the cause of death was determined to be accidental choking on food.

Calling of the Inquest and Proceedings

[17] As Ms. Zygarliski was a resident of a custodial facility, the Chief Medical Examiner ordered that an inquest be conducted pursuant to s.19(5) of *The Fatality Inquiries Act*. The purpose of the inquest is to determine the circumstances relating to the death of Amanda Zygarliski, and to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[18] Because of the COVID-19 pandemic the Chief Judge of the Provincial Court ordered that all pending inquests be postponed until after October 2022. Accordingly, this inquest was postponed. A standing hearing was held on June 7, 2022, at which time standing was granted to the Province of Manitoba represented by legal counsel Mr. J. Koch and Ms. T. Edkin, and also to the family, Ms. Sandra Wollmann and Mr. Kelly Zygarliski.

IV. WOMEN'S CORRECTIONAL CENTRE INTERNAL REVIEW AND ACTIONS

[19] The Women's Correctional Centre reviewed the institutional policies and procedures following the death of Ms. Zygarliski. As a result, they identified several areas where they could improve their practices and took the following actions:

1. Release to outside agencies:
    a. WCC amended their policy to allow agencies to submit documentation electronically when picking up inmates who have been granted judicial interim release; in the event officials do not have proper documentation with them. This is a simple process that requires an email.
        i. If staff have any issues with release they are to contact the duty office supervisory group.
    b. Staff were directed to conduct release plans pending release.

2. Calling of Codes:
    a. WCC received some indication that staff had a hesitancy to call codes. As a result, the WCC sent communications to all staff regarding the policies, practices, and support for calling codes.

3. Cross-gender staffing standing orders:
    a. WCC found that some male staff had a hesitancy to become involved in situations with the inmates as a result of this policy. The policy was clarified within a global communication to all staff.

4. Medical:
    a. WCC reviewed the tracking of the code red medical bags and their preparation with the health services manager; and
    b. They reviewed the placement of oxygen tanks with the health services manager.

[20] The only recommendation found in their review where no actions were taken involved a review of the functionality of the cameras in the cells and facility. Ms. Margo Lee, the Chief Superintendent, of the facility testified that the process of obtaining technology and upgrades is a lengthy process given government funding and the procurement process. This is an ongoing goal of the institution.

[21] The WCC identified other areas in their review that were not relevant for the purposes of this inquest.

V. FINDINGS AND RECOMMENDATIONS

Finding One

[22] While the cause of this tragic death was accidental and may not have been preventable, had Ms. Zygarliski's gestures for help been noticed and acted upon immediately, at a minimum there may have been a chance to save her life. This is not an assignment of fault, but rather an acknowledgment that there appeared from the evidence that the officer monitoring the pod did not observe Ms. Zygarliski for nearly five minutes while she was in medical distress. The control centre duties and disruptions could distract the officer from viewing the inmates long enough for a tragic accident to happen. At the time when Ms. Zygarliski was choking there were several other things happening. First, there were several officers going to and coming from their meal breaks. Secondly, meals were being delivered and picked up from the cells as it was the inmates' meal hour. This meant there was a lot of movement within the institution that required the pod officer to attend to the monitor for the access points rather than the monitor for the cells. In addition, it appears that around this time, a shift supervisor may have attended the pod to sign a logbook. However, Ms. Zygarliski was lying motionless on the floor for 34 minutes before a code was called.

Recommendation One

[23] A review should be conducted of the duties of the pod officer monitoring the inmates' cells. While an officer may have time to complete additional tasks or duties these should be minimal to maintain visual contact with the inmates. It is tempting to use an officer in this role for other staffing assignments, but this should be resisted given that accidents happen in an instant. This is especially so given that it takes a few minutes to breach a cell door once a code red is called in the secure units.

Finding Two

[24] As with all work environments, a culture develops outside of policy based on the nature of the work. The evidence demonstrated that there was a reluctance to call the code red, reluctance for male officers to check on the wellbeing of the inmates due to the Cross-Gender policy, and reluctance to believe that an inmate needs assistance rather than "acting".

[25] The WCC has already addressed most of this finding within their internal review following Ms. Zygarliski's death. The calling of a code would also never result in formal discipline. However, this does not address the culture. The culture of the institution is very difficult to manage because it is based on personalities of staff, and the reality of working inside of a correctional centre where some of the inmates are difficult to deal with, including issues with mental health, addictions, and others in need of attention. There are also male correctional officers dealing with female identifying inmates. These officers must strike a balance between their duties and ensuring that women are given appropriate privacy. As for the reluctance to believe an inmate is not acting, these are very situational. There were examples of an inmate intentionally hiding under a bed, or under the covers. These are obviously intentional as opposed to potentially life-threatening situations.

Recommendation Two

[26] All training and education of correctional officers should reinforce the safety and well-being of inmates as a priority. The inconvenience of attending a code and shutting down the facility is negligible in comparison to a loss of life.

Senior officers and supervisors should be trained to influence the culture by demonstrating tolerance for codes, respectful, but necessary interactions between male officers and inmates, and providing feedback on negative attitudes towards inmate behaviours.

Finding Three

[27] The circumstances of Ms. Zygarliski's death would not have arisen had she been released from custody when "Turning Leaf" representatives attended the institution. The WCC has already revamped their policy to be permissive of alternate forms of authorization so that inmates are released on a timelier basis. As a result of the actions taken by WCC, there are no additional recommendations.

All of which I respectfully submit this 10th day of July 2024.

Kael McKenzie

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Judge Kael McKenzie