RELEASE DATE: JUNE 11, 2019

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: BRADLEY ERROL GREENE, Deceased

Report on Inquest and Recommendations of Judge Heather Pullan
Issued this 6th day of June, 2019

APPEARANCES:

Keith Eyrikson (now The Honourable Judge Keith Eyrikson) and Bryton Moen, Inquest Counsel
Corey Shefman, Counsel for Rochelle Pranteau
Kimberly D. Carswell, Counsel for City of Winnipeg - Winnipeg Police Service and Winnipeg Fire Paramedic Service
Sean Boyd and Jim Koch, Counsel for Government of Manitoba (Department of Justice, Community Safety Division and Department of Health, Seniors and Active Living)
Daniel Ryall with Tim Lach and Ryan Kaita, Counsel for Winnipeg Regional Health Authority
John Hutton, Executive Director of the John Howard Society of Manitoba

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INTRODUCTION

The Circumstances of Bradley Errol Greene's Death

[1] Bradley Errol Greene was arrested and admitted to the Winnipeg Remand Centre March 12, 2016. He was interviewed by a nurse at 17:35, and despite the fact that he was an "intox" admission, clearly said he suffered from epilepsy, took the medication valproic acid 250 milligrams QID, last took his medication that morning, and his last seizure was two weeks prior. He was said he consumed no drugs prior to admission but had consumed alcohol. There is no indication he had been administered valproic acid at the Winnipeg Remand Centre from his admission until he suffered a seizure during discharge March 13, 2016 at 13:04 hours. The nursing decision was made to call EMS, and he was taken by ambulance to the Health Sciences Centre.

[2] Approximately seven weeks later, Mr. Greene was again admitted to the Winnipeg Remand Centre April 30, 2016 at 1:18 hours. He was seen by the same nurse, again advised he suffered from epilepsy, took valproic acid 250 milligrams, had consumed beer and THC, and his last seizure, not alcohol related, was when incarcerated two months prior. Again, despite the fact that he was an "intox" admission, the information he gave was clear.

[3] On May 1, 2016 at 13:53 hours, he had a seizure. He was restrained. A decision was made to observe him. Ultimately the restraints were removed. At 14:40 hours, he had a second seizure, was again restrained, and the nurse injected Ativan. Emergency medical services were called. While still restrained, and being assessed by EMS, Mr. Greene became unresponsive. EMS commenced resuscitative efforts. Mr. Greene was transported to the Health Sciences Centre. His pulse was ultimately restored approximately 45 minutes later, but he remained comatose and died at 20:27 hours. He received no seizure medication while held at the Winnipeg Remand Centre.

The Ordering of the Inquest

[4] On December 6, 2016 Acting Chief Medical Examiner Dr. John K. Younes wrote to The Honourable Chief Judge Margaret Wiebe advising of his direction that an Inquest be held into the death of Bradley Errol Greene, 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(3)(b) of *The Fatality Inquiries Act*:
>
> ---
>
> Inquest mandatory
> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe
>
> (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
> (b) that a person died as a result of an act or omission of a peace officer in the course of duty;
>
> the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.
>
> 2. to determine the circumstances relating to Mr. Greene'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, she must assign a Provincial Judge to conduct the Inquest. I was assigned to conduct this Inquest. Mr. Keith Eyrikson (now The Honourable Judge Keith Eyrikson) and Mr. Bryton Moen 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 March 15, 2017 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:

- Rochelle Pranteau
- Government of Manitoba (Department of Justice, Community Safety Division)
- John Howard Society of Manitoba
- Winnipeg Fire and Paramedic Service
- Winnipeg Police Service

[8] A further standing hearing was held to consider applications for standing by two additional parties, arising from evolution of the issues to be considered by the Inquest. As a consequence of the further standing hearing held October 23, 2017 the following parties were granted standing:

- Government of Manitoba (Department of Health, Seniors and Active Living)
- Winnipeg Regional Health Authority

[9] Another standing hearing was held, while the Inquest was in progress, as a result of the expression of interest by a citizen wishing to apply for standing. That standing hearing was held September 28, 2018. After hearing from the citizen, the Court was not satisfied the citizen was "substantially and directly interested in the Inquest" as required by section 28(1) of *The Fatality Inquires Act*, and the application was denied.

The Inquest Proceeding

[10] Evidence and submissions relating to the Inquest were heard for 23 days as follows:

January 29, 2018
January 30, 2018
January 31, 2018
February 1, 2018

February 2, 2018
February 5, 2018
February 7, 2018
February 9, 2018
February 20, 2018
February 21, 2018
February 22, 2018
February 23, 2018
February 27, 2018
February 28, 2018
October 4, 2018
October 5, 2018
October 9, 2018
October 10, 2018
October 24, 2018
October 25, 2018
October 26, 2018
October 30, 2018
October 31, 2018

[11] During the final days of the Inquest, a jurisdictional issue arose requiring further submissions by counsel. In an attempt to expedite the proceedings and not set further days for hearing I required submissions on the point be submitted in writing. The last of the written submissions by counsel in connection with the Inquest was filed December 6, 2018.

The Inquest Report

[12] 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.

[13] 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.

[14] 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

Bradley Errol Greene's Spouse

1. Rochelle Pranteau

[14] Ms. Pranteau was in a relationship with Bradley Errol Greene for almost 11 years. At the time of his passing they had three children and she was expecting a fourth. When her fourth child was born after Mr. Greene's passing, she named him Errol.

[15] They lived together at some points during that relationship. When they first started dating, she was unaware Mr. Greene had medical issues. Ultimately, she became aware that he had epilepsy, and had suffered from epilepsy for a long period of time. She witnessed Mr. Greene having seizures. During the last two years, he suffered seizures approximately twice per year that she was aware of. In addition, she believed he had seizures that she did not see that he told her about.

[16] She was concerned about this medical problem. During a seizure, Mr. Greene became disoriented, and did not know what he was doing, or who was around him. Mr. Greene's response to the seizures was consistent. She would observe his body shake, jerk, and he could not recognize familiar faces after the shaking.

[17] In the two years prior to his passing, they lived together. During that time, he took his seizure medication regularly. She recalled Mr. Greene took valproic acid three times a day, two tablets in the morning, one mid-day, and two tablets in the evening. Most of the time he was good at taking his medication, but there were times when he would only take three tablets a day when he was busy. There may be a day when he would go without medication, if not at home. There would be times when they simply did not have the medication.

[18] Ms. Pranteau assisted Mr. Greene in taking his medication by reminding him daily to take the medication and how important it was. If Ms. Pranteau did not remind Mr. Greene to take his medication, he would generally still take the medication because their 6 year old daughter would always assist in reminding her father to take his medication. Ms. Pranteau estimated the longest duration Mr. Greene might go without taking medication might be two days.

[19] There was a time when Mr. Greene did not take his medication, and he had a seizure. Mr. Greene regularly attended his appointments with Dr. Yankovsky at the hospital. Mr. Greene did not have a family doctor. He would go to walk-in clinics to obtain his prescriptions.

[20] Acknowledging that Mr. Greene did consume alcohol, Ms. Pranteau was not able to provide details of that consumption because she did not want to be around him when he was drinking and did not drink herself. She did not allow drinking in her home. This lead to friction between them.

[21] For the last two weeks of his life, Mr. Greene resided with Ms. Pranteau, but went back and forth between Ms. Pranteau's home and his mother's home. He would spend the night at his mother's from time to time. In the last week of his life, Ms. Pranteau was aware that Mr. Greene was taking his medication because he was home.

[22] In the last days before his passing, Mr. Greene left the home early on Friday and, consequently, missed some medication. She last saw Mr. Greene around lunchtime, when he left. He was going to his uncle's place, a friend's and then his mother's. He did not take his medication with him. He was planning to come home.

[23] Ms. Pranteau spoke to Mr. Greene in the evening on the telephone, and developed a plan to meet at Portage and Carlton at 10 p.m. to come home. He did not make that meeting.

[24] He called her the next morning from the Winnipeg Remand Centre. That was the first she knew of where he was. She had been worried about where he was.

[25] He told her he had been picked up by the police because he was under the influence. He told her he smelled of alcohol. The conversation was brief. Mr. Greene said he would call back. Ms. Pranteau was upset, but she knew he was somewhere safe. The subject of his medications came up. He was nervous because of what had occurred in March, and Ms. Pranteau asked him if he had put in a request for his meds. He said that he had. In March, when he was arrested for the first time, he had a seizure while waiting to be discharged from the Winnipeg Remand Centre. He was brought to the Health Sciences Centre, given medication, and treated.

[26] On Saturday, he called around lunchtime to see how the family was doing. Ms. Pranteau, again, asked Mr. Greene if he had taken his meds yet. He said no, he was still waiting for the nurse. Ms. Pranteau had difficulty recalling, however believed there was no further conversation Saturday after lunchtime.

[27] On Sunday May 1, Ms. Pranteau did not recall Mr. Greene calling in the morning. She did recall a telephone call about 1:30 in the afternoon. Mr. Greene said he wasn't feeling very well because they had pancakes at breakfast and his stomach was upset. Ms. Pranteau again asked Mr. Greene if he had taken his meds. He said had not, and was still waiting for the nurse. Ms. Pranteau's understanding was that the nurse was to come and see Mr. Greene. She did not know how many times he had asked for medication, and there was no mention of a doctor.

[28] Ms. Pranteau was very concerned about Mr. Greene's failure to see the nurse because of what had occurred in March. Mr. Greene told Ms. Pranteau he had a feeling something bad was going to happen in the Winnipeg Remand Centre if he did not get his meds.

[29] They talked on the phone for 15 - 20 minutes. Ms. Pranteau asked Mr. Greene to tell the guards he needed his medication. He responded that there was no point, because they would not listen.

[30] Towards the end of the conversation, he said he was getting the numbing feeling in his fingertips that is one of the signs that he was about to have a seizure when he was awake and aware of it. Ms. Pranteau was trying to tell Mr. Greene to

tell a guard if he could, so they would be ready for his seizure but he did not get the chance to. By the time he got up, he collapsed.

[31] Ms. Pranteau heard him hit the floor when she heard a thud. The phone fell and was hanging. She could hear what was going on. She could hear Mr. Greene jerking, and screaming, as he did when disoriented. Ms. Pranteau heard one of the inmates say that Mr. Greene was having a seizure and to put him on his side and watch his head. It was her impression that the inmates crowded him to keep him safe until the guards came.

[32] Ms. Pranteau was aware that Mr. Greene had told Stephen King how to deal with him should he have a seizure because of what had occurred in March.

[33] Ms. Pranteau did not hear Corrections officers right away. When she did hear them, they told the inmates to get to their rooms. Ms. Pranteau estimated there was a five minute gap between when she heard Mr. Greene fall to when she heard the Corrections Officers on the phone. The officers were telling Mr. Greene to get on his side and not resist. They told him to put his hands behind his back. Ms. Pranteau then heard the nurse finally appearing, and calling Mr. Greene "Dennis." The female voice told him to calm down. Ms. Pranteau heard individual voices continuing to address Mr. Greene as "Dennis." She could hear Mr. Greene gasping for air. Mr. Greene did not say anything during this time. Ms. Pranteau could hear him grunting. She heard the same sounds before when Mr. Greene had a seizure.

[34] Ms. Pranteau pushed buttons, screamed, and cursed on the phone in the hope of catching someone's attention. She hoped one of the Corrections Officers would talk to her. Instead, the phone was hung up. She could hear what was going on for a good 10 minutes. She timed it. Ms. Pranteau did not call the Winnipeg Remand Centre because she did not think they would release information.

[35] The next communication she received about Mr. Greene was later that night, around 9:30 p.m. The Remand Centre called her. She was given the terrible news that he had died.

[36] Mr. Greene hated taking his medication. He did not like taking pills. That is why he needed to be reminded to take his medication. When having a seizure, Mr. Greene would flail his arms. She came to expect that after every seizure. This concerned Ms. Pranteau as Mr. Greene did not know what he was doing.

[37] After a seizure, he would be disoriented, not know where he was, and behave in a random fashion, going room to room. He would roll around, and behave aggressively because he didn't like strangers around him. The disorientation phase after a seizure could last twenty to forty minutes, depending on the seizure. Ms. Pranteau was concerned he might hurt himself during this phase. She was not concerned he might hurt others. Mr. Greene did not remember this conduct afterwards.

[38] Ms. Pranteau clarified that Mr. Greene's last dose of medication was in the morning on the Friday he left. No one from the Remand Centre, she said, had ever called her to obtain medication information about Mr. Greene. She was unaware of a telephone number to call to speak to Remand Centre staff.

[39] Ms. Pranteau indicated there were times when Mr. Greene would have a seizure and not go to the hospital. Sometimes she would call an ambulance, and sometimes she would not. She said Mr. Greene had no alternate source of medication such as a doctor's sample, other than by prescription.

[40] Ms. Pranteau said Mr. Greene did not drink when he was home with her, but did drink when he stayed at his mother's place. During Friday night, before Mr. Greene's arrest, Ms. Pranteau could tell that Mr. Greene had been drinking but he was not blacked-out drunk.

[41] Mr. Greene told her the indicators that he was about to have a seizure were finger numbing, light-headedness, his jaw would lock, and his teeth grind. He had a pretty good sense of when he would have a seizure when awake.

[42] He would tell someone when he knew he was about to have a seizure. If told Mr. Greene were about to have a seizure, Ms. Pranteau would watch him, make sure he would not harm himself, removing the hard objects around him and putting a pillow under his head. She would make sure he did not put himself near something where would get hurt, like falling down the stairs.

[43] When Mr. Greene had his first seizure in Ms. Pranteau's presence, she did not know what to do. She learned steps to take from his mother. Mr. Greene's mother told her that Mr. Greene needed to be on his side during his seizure. During a seizure, he was not conscious.

[44] He did not have control over his behavior after his seizure. He told people in the Remand Center about his seizures because he was scared about what happened in March.

[45] His post-seizure situation was made worse if people crowded him.

[46] She eventually heard from someone from the Remand Centre who said they were sorry about Mr. Greene passing. They asked if Ms. Pranteau had any questions. When she asked what happened, they said they could not answer her questions and she would have to wait for the autopsy report. She was offered no moral support and no counselling. The phone call lasted two minutes. She did not recall whether the caller identified themselves. No one called her to advise that Mr. Greene was going to or at the hospital. She was told what hospital he was in, but was not told she could go there.

[47] She did go to the hospital. Mr. Greene could not be found on record because he was gone. She waited at the hospital for an hour for them to track him down. When he was finally located, a nurse took Ms. Pranteau to where Mr. Greene was. She was the only person allowed to go in the room to see him. She was not allowed to touch him. She wanted to kiss him goodbye and hug him.

[48] Ms. Pranteau found out what happened to Mr. Greene by requesting and ultimately receiving the autopsy report. At no time did she hear from anyone at Corrections. No one has offered her support or counseling.

[49] As an Indigenous person, Mr. Greene wanted to seek out Indigenous healing practices but it was difficult. Mr. Greene suffered from depression, which sometimes interfered with taking his pills.

[50] Ms. Pranteau said there were no occasions in which Mr. Greene refused to take his medication.

Expert Witnesses

2. Dr. Raymond Rivera

[51] Dr. Raymond Rivera testified as an expert in the field of Pathology.

[52] Dr. Rivera was given information that an autopsy was required to be performed on an individual who died suddenly on May 1, 2016 at 2027 hrs. His body had been brought to the Health Science Centre where he had been declared dead and the circumstances surrounding his death required the involvement of the Chief Medical Examiner. The information given to the Pathologist was provided by the Medical Investigator. The information provided related to what may have

happened to Mr. Greene in the 12 or 24 hours before his death. Dr. Rivera's autopsy report was filed as an exhibit in these proceedings.

[53] The external examination of Mr. Greene's body was unremarkable. There was evidence of medical intervention. Dr. Rivera noted a needle puncture in his right buttock consistent with the report received by Dr. Rivera that prior to Mr. Greene stopping breathing and moving, an attempt was made to give him medication by injection. Dr. Rivera was told the medication was Ativan.

[54] Dr. Rivera noted two injuries, a skin scrape over Mr. Greene's right lower cheek, and bruising secondary to bite marks on his tongue. The tongue had been bitten so hard it tore, to a small degree. These injuries were consistent with being sustained by seizure or shortly after.

[55] On the torso, at the top of the breastbone, was a small area of pinpoint bleeding into the skin, known as petechial hemorrhage, bruising in and around the belly button, as well as a faint bruise in the upper left quadrant of the abdomen. It is possible that these injuries occurred during the ictal or post-ictal phase. Eight areas of the extremities showed bruising, located over the right medial bicep, the distal left forearm and the several over the knuckles of the hand, the knees and the front of the shins. There were skin impressions with superficial scraping over the left wrist. This injury could have been caused by a handcuff. Dr. Rivera did not see any injuries consistent with a blow directed to Mr. Greene's body.

[56] Dr. Rivera's conclusion was the Mr. Greene died of acute hypoxic-ischemic encephalopathy, due to cardiorespiratory arrest, that Dr. Rivera believed was secondary to the complications of his seizure activity and chronic epilepsy. Another significant contributor to Mr. Greene's death was a subtherapeutic level of valproic acid.

[57] Dr. Rivera explained that acute hypoxic-ischemic encephalopathy is a lack of oxygen to the brain that causes brain damage, which was fatal in this case. Dr. Rivera opined that would have occurred at the time the Paramedics noted that Mr. Greene's heart had stopped beating, and his breathing stopped. It was Dr. Rivera's information that Mr. Greene's heart had stopped for a period of about 45 minutes. That is what caused the fatal brain damage. This circumstance can occur in someone who has had an acute seizure which can cause the heart to stop beating. It was his view this is what occurred with Mr. Greene. It is possible a third seizure occurred after Paramedics arrived.

[58] Dr. Rivera's opinion is best expressed by Dr. Rivera in his report:

> It is my opinion that the decedent, Bradley Green, died as a result of an acute electrical storm within his brain (i.e. seizure) that arose as a part of his chronic epilepsy. The seizure likely caused a disruption in his normal heartbeat and breathing (i.e. cardiorespiratory arrest due to automatic dysfunction), which then led to irreversible fatal brain damage from a lack of oxygen (i.e. hypoxic-ischemic encephalopathy). Toxicologic analysis of antemortem plasma taken prior to his death (i.e. May 1, 2016 at 1543 hrs) revealed a subtherapeutic level of valproic acid, which would have made him susceptible to having a seizure.

[59] Dr. Rivera was aware that attempts were made to revive Mr. Greene, resulting in reinstating his heartbeat after 45 minutes. Dr. Rivera testified that it was common to have fatal damage to the body after being deprived of oxygen for 45 minutes.

[60] In his opinion, Dr. Rivera also noted the following:

> Sudden death can also occur in the setting of extreme psychomotor agitation in people who have been physically restrained (i.e. excited delirium). Given the circumstances in this case (i.e. postictal aggression/agitation with the placement of handcuffs, leg shackles, and physical limb restraint by guards), the possibility of excited delirium having played a contributory role in causing a cardiac arrhythmia cannot be ruled out.

[61] Dr. Rivera was not certain what role this played in Mr. Greene's death except that he was in an agitated post-ictal state and had been restrained. His heart may have been a little more electrically unstable, which might also have then played a role in potentially a third seizure. This may have primed the heart to develop sudden fatal stoppage. He could not be certain that excited delirium had any role to play.

[62] The valproic acid level in Mr. Greene's blood at the time of admission to hospital was 6.9 micrograms per millilitre when the therapeutic dosage should be approximately 50-100 micrograms per millilitre. Dr. Rivera also relied on neuropathology diagnoses by Dr. S. Krawitz.

[63] Dr. Krawitz made the following diagnoses:

1. Acute hypoxic-ischemic neuronal injury, with sparse dying neurons widespread.
2. Developmental anomalies (see Comment), with:
   a. Focal dysplastic gyri;
   b. Periventricular neuronal heterotopia;
   c. Absent septum pellucidum;
   d. Dysmorphic left hippocampus;
   e. Clinical history of seizures.
3. Secondary reactive changes, non-specific, microscopic, widespread (see Comment).
4. Mild autolysis of the brain.

Comment:
2. See clinical history above including structural abnormalities reported on radiologic imaging. Post-mortem examination of the brain revealed structural abnormalities as described above. These are anomalies of nervous system development (dysgenesis or a disorder of migrating neurons in the developing brain; not destructive lesions). This correlates with a seizure disorder (epilepsy).
3. Microscopic reactive changes include gliosis (highlighted by immunoreactivity for glial fibrillary acidic protein, GFAP) and are non-specific. Subpial gliosis (described above) is seen in individuals with epilepsy.
Selected slides reviewed by Dr. M. Del Bigio who agrees with the diagnosis.

[64] Dr. Rivera said that taken together, this meant that Mr. Greene had an abnormal brain, a portion of his brain that was supposed to be there was not, and a portion of the brain that can be associated with epilepsy, contained abnormalities. Taken together, Mr. Greene had abnormalities of his brain that made him susceptible to developing seizures.

[65] Dr. Rivera indicated that reinstatement of heartbeat after 45 minutes is relatively uncommon. Mr. Greene did have a relatively healthy heart, and given the medications that had been administered, it was not impossible for the heart to restart.

[66] Dr. Rivera said there were no symptoms or signs of a third seizure reported to him. There is no way, through an autopsy, to determine whether Mr. Greene did or did not have a third seizure. Dr. Rivera said that he had previously seen injuries similar to those on Mr. Greene's wrist, which he attributed to handcuffs, on people who had been handcuffed. The bruises on the chest were as a result of force applied to that region, which broke the capillaries and could have occurred during the time of thrashing about on the ground.

3. Dr. Alexei Yankovsky

[67] Dr. Alexei Yankovsky was qualified to give expert evidence in the fields of neurology and epilepsy. He currently holds appointments as Assistant Professor of Medicine, Department of Internal Medicine, Neurology, University of Manitoba, and in the Department of Internal Medicine, in Neurology at the Winnipeg Health Sciences Centre. His Curriculum Vitae, reflecting his professional background and accomplishments, was filed as an exhibit in the proceedings. In addition, he was Bradley Errol Greene's physician, and gave evidence in that context as well.

[68] Dr. Yankovsky testified that Bradley Errol Greene suffered from epilepsy. Mr. Greene had been referred to Dr. Yankovsky because he suffered from epilepsy and seizures. Dr. Yankovsky began treating Mr. Greene in 2011, and last saw him September, 2015. Dr. Yankovsky saw Mr. Greene every several months, but Mr. Greene sometimes missed appointments. Dr. Yankovsky was concerned when Mr. Greene missed appointments, particularly because his seizures were not fully controlled and he had appeared at emergency rooms. Dr. Yankovsky thought that Mr. Greene's seizures were not fully controlled because he did not take his medications regularly, documented in charts that Dr. Yankovsky reviewed. The importance in taking medications regularly was discussed with Mr. Greene at appointments.

[69] Mr. Greene was prescribed valproic acid by Dr. Yankovsky. However, if he missed appointments, he got prescriptions from walk-in clinics and emergency rooms. The emergency room physician would recommend Mr. Greene see Dr. Yankovsky and sent a letter to Dr. Yankovsky about the visit. A walk-in physician prescribing valproic acid for Mr. Greene may or may not send a letter to Dr. Yankovsky. Dr. Yankovsky was not always aware of what was going on with Mr. Greene, when he was not coming in for his appointments.

[70] Valproic acid is an anti-seizure medication, usually controlling seizures, but not always. It is one of the common treatments for seizures. Valproic Acid is normally prescribed to be taken two or three times a day. The usual starting dose is 250-milligrams, three times a day. The general optimum therapeutic blood level is between 50-100 µg/mL. It is normally taken in pill form. Generally, it takes about three days to reach therapeutic levels in the blood. Physicians, however, regularly wait one week to determine if blood levels have reached a steady state.

[71] After one day's dosage, the blood level will generally be subtherapeutic, but will have some effect on seizures.

[72] A patient abruptly stopping valproic acid would result in a steeply dropping blood level until reaching zero, or close to it, within several days. Dr. Yankovsky described this as a dangerous situation. The blood level starts to drop even with one missed dose. The blood level can drop significantly within 24 hours. This circumstance would cause Dr. Yankovsky concern.

[73] The consumption of alcohol can affect medication absorption, and compliance with taking medication. If an excessive amount of alcohol is consumed, seizures can be activated. This is not as a consequence of the medication but a consequence of the alcohol consumption. In addition, a several day long consumption of alcohol with abrupt stoppage may cause a seizure. This is called "alcohol withdrawal seizures."

[74] The consumption of street drugs such as cocaine may activate seizures but Dr. Yankovsky did not believe that it affected valproic acid.

[75] When asked about the impact of physical restraint on seizures, Dr. Yankovsky said that being restrained can provoke an aggressive reaction. In hospital, initially an attempt is made not to restrain. Sometimes there is no alternative if there is aggression.

[76] The postictal phase is the phase that follows a generalized seizure, and is very common. It is a period of abnormal brain function. The person may be calm, sleepy, unconscious, or occasionally may become aggressive, but not know what he is doing. This period may last from minutes to hours.

[77] The postictal phase commences when the seizure activity stops. The individual would not recall what occurred during the postictal phase. The individual normally cannot control his or her behavior. Yelling, thrashing, making sounds, and behaving aggressively often occurs in the postictal phase. The individual cannot control themselves during this phase. Other individuals may be sleepy. The calmer postictal phase is more common.

[78] If an individual is restrained during the postictal phase, Dr. Yankovsky testified there is no harm to the brain. In the case of a significant seizure, every individual has a postictal state. In the case of a milder seizure, there is not necessarily a postictal state. A valproic acid blood level of 6.9-micrograms is very low. Dr. Yankovsky thought that at least one whole days dose would have been missed, or perhaps even more. It is difficult to say precisely because metabolisms differ. If it were known that the regular dosages caused a therapeutic level, 6.9-micrograms would suggest a gap in dosage of at least 24 hours if not more.

[79] Two seizures within 40 - 45 minutes, according to Dr. Yankovsky, is a significant major concern.

[80] Someone at a therapeutic level of valproic acid could still have a seizure, and require additional valproic acid and/or other medications. Alcohol can lower the threshold for a seizure. Ativan is used for cessation of seizures as valproic acid is used for prevention of seizure. In an emergency room environment, circumstances can arise where the medication is ineffective and an individual could potentially need to be restrained in the course of a seizure. Similarly, EMS might need to restrain an individual in the context of a seizure, although EMS personnel have intravenous Ativan, which generally is very effective.

[81] In September 2015, Mr. Greene was admitted to the Health Sciences Centre for one week for assessment. Dr. Yankovsky initiated a referral in August 2015, arising from concern that his condition needed to be better evaluated. He was released in September 2015, and received a scheduled appointment with Dr. Yankovsky in November 2015, which he missed. Dr. Yankovsky had not seen him since his hospital discharge in September.

[82] When referred to a print out from the Drug Prescription Information Network ("DPIN"), Dr. Yankovsky was asked about the medications reflected for Mr. Greene on the network. On October 13, 2015, roughly a month after Mr. Greene's discharge from the hospital assessment, a physician unknown to Dr. Yankovsky prescribed 150 250-milligram tablets of valproic acid as a 30-day supply. On March 20, 2016, a pharmacy dispensed another 30-day supply of valproic acid, as 90 tablets of 250-milligram valproic acid. Dr. Yankovsky noted his own prescribing history with Mr. Greene in 2013 of 375-milligram tablets, three times a day, based on valproic acid levels. The dosage is not fixed, but variable accordingly to measured levels and the patient.

[83] If Mr. Greene were fully compliant with his medication regime and stopped 48 hours prior to his death, that could be consistent with the 6.9-microgram (mcg) level in his blood. When an individual misses a few doses of valproic acid, it is very important they resume taking the medication as quickly as possible. Had Mr. Greene been given valproic acid in the 48 hours prior to his death, he likely would have had a higher blood level than the 6.9-micrograms at autopsy, and be better protected from seizure. Not giving an individual valproic acid, from Dr. Yankovsky's perspective, puts them at an increased risk of seizure.

[84] Dr. Yankovsky could not see a reason not to give a person known to have epilepsy valproic acid unless they were known to suffer dangerous side effects from it. Dangerous side effects from valproic acid are uncommon.

[85] Sudden unexplained death in epilepsy, Dr. Yankovsky indicated, is an issue under investigation. It appears to be more likely during an unobserved seizure, such as when an individual is sleeping. Insofar as the postictal phase is concerned, it is typical that an individual will exhibit confusion, discomfort, and, although the patient may not be aware of it, aggression. Memory loss can continue during the postictal period and longer. Individuals are usually disoriented, may not recognize familiar faces, and being surrounded by unfamiliar faces can result in fear. They may exhibit agitation, and behave in a way that might appear defensive.

[86] As one of the authors in a 2005 study on postictal rage and aggression, Dr. Yankovsky confirmed that this is a field of study and occurs in patients. If Dr. Yankovsky were training individuals in the care of persons with epilepsy, he would ensure that they knew that aggression could be present in a person in the postictal state.

[87] If an individual has one seizure, and low valproic acid levels, Dr. Yankovsky would administer Ativan to protect from a second seizure.

[88] If an individual does not have epilepsy, it is still possible to have a seizure, for example as a result of alcohol withdrawal. No one from the Medical Unit at the Winnipeg Remand Centre called Dr. Yankovsky for a consultation after Mr. Greene's March 2016 seizure at the Remand Centre. When Mr. Greene was readmitted to the Winnipeg Remand Centre at the end of April 2016, no one from the Medical Unit called him for consultation. Dr. Yankovsky reviewed his chart and found no notation of such an inquiry, and had no recollection of the Winnipeg Remand Centre calling him.

[89] Dr. Yankovsky was unequivocal that a patient who had epilepsy should receive valproic acid regardless of level of intoxication. There is no reason, in Dr. Yankovsky`s opinion, to delay starting or re-starting valproic acid at levels even higher than what normally would be given to better achieve a steady state. An aggressive response to someone in the postictal state could provoke more aggression. Training in how best to respond, and when restraint is necessary, could be very helpful.

[90] Dr. Yankovsky clarified why he would be particularly concerned about two seizures within a short period of time. He said that usually the brain knows how to recover after the first seizure. If the second seizure occurs quickly, there has been no recovery period. Particularly where the patient has epilepsy, and doesn`t have medication, concern is exacerbated. Generally, that is a clear sign one must treat with Ativan. Dr. Yankovsky testified that in an urgent situation where a patient has been non-compliant with medication, he would treat with valproic acid even prior to knowing the blood levels.

[91] When asked if Dr. Yankovsky had any recommendations to assist the Inquest in making recommendations to prevent a future death, Dr. Yankovsky said his main recommendation would be to have a system to quickly check the diagnosis of the patient, what kind of medication they are supposed to take, and to give the medication as soon as possible. In acute impending seizures, such as in the case of Mr. Greene, Dr. Yankovsky highlighted the importance of health care providers obtaining Ativan and knowing how to use it.

Winnipeg Remand Centre Inmates

4. Stephen Shae King

[92] At the time of his evidence, Mr. King indicated that he was still suffering from the trauma arising from the circumstances surrounding the death of Mr. Greene. He also took issue with some of the contents of the statement he gave to police, referring to them as a "fabrication." When given opportunity to review his statement in the privacy and quiet of the Victim Witness Room, he returned to court having declined to do so because of his feeling about the inaccuracies of the statement. When he earlier attended the Victim Witness Room several days before his evidence, he was extremely upset and said he was there because the government had killed his friend.

[93] In harmony with the writing on the shirt he was wearing at the time of his evidence, Mr. King said he wanted justice for Errol Greene. He frankly told the Court he was of the view that something terribly wrong had happened to cause the death of Mr. Greene. He feels the death was preventable. It should not have happened in the safest place in the world, referring to the Winnipeg Remand Centre.

[94] He was confident that Mr. Greene came into the Winnipeg Remand Centre on Friday evening, and that he spent two evenings with him. The events that occurred with Mr. Greene were very stressful and traumatic for Mr. King. He has

not had the opportunity to obtain counselling. He agreed that his memory would have been affected by the trauma occasioned by these events.

[95] Mr. Greene entered his cell late at night and they started talking the next day. During Saturday, they talked a lot, and played chess. They told each other their respective stories. Mr. Greene mentioned how fearful he was that he had epilepsy, and he had not been given his medication. Mr. King knew how to assist Mr. Greene with this problem and knew how to work the paperwork. Mr. King told Mr. Greene he had to make some noise. The nurse comes to the range three times a day, but there is a deterrent, which is the guard. The guard would tell individuals that they do not need anything. Mr. Greene was told by the guard on several occasions that he did not need anything. Mr. King became passionate. He intervened with the guard and told the guard that Mr. Greene was epileptic, needed his medication, and could not get high on it so there was no reason he not be given it. The guard just closed the door in his face.

[96] Although Mr. King did not know the names of the officers approached by Mr. Greene, Mr. Greene made many approaches which Mr. King better defined as six times at least, acknowledging the nurse would have been on the range three times a day. Mr. Greene put in three medical sheets requesting help. They attempted to talk to "Steamer" the Supervisor on Level 400, but their requests were rebuffed. Mr. King observed Mr. Greene approach officers at least six times over the two days.

[97] Mr. Greene took the form with Mr. King beside him at times to Correctional Officers, but Mr. King was unable to identify who the officers were. Mr. Greene also deposited completed request forms into the box for the Supervisor to retrieve and process. Mr. Greene spoke to officers through the DuKane System to request medication. The officers said they would look into it. Mr. Greene also used the DuKane System in front of the pod but the officers did not answer.

[98] Mr. King went to play chess with another inmate. He heard someone call out describing what he believed to be Mr. Greene having a seizure. Mr. King rushed to Mr. Greene. The phone was dangling and swinging, and Mr. Greene was on his back lying in front of their door of Room 462.

[99] No code had yet been called, and Mr. King told an inmate to push the button on the wall to advise staff. Mr. King rolled Mr. Greene on his side and his arms were bent at the elbows. He was in the fetal position. The other inmates were locked up, and the only one out was Mr. King, still with Mr. Greene. Mr. Greene

was not injured, he was just seizing. An officer arrived, and Mr. King went to lock up as directed by the officer.

[100] Mr. King was able to observe events, as they unfolded before him, once in his room 462. It took several minutes for officers to join the original officer. There was no nurse in sight, and Mr. Greene was experiencing a lengthy seizure. Mr. King advised he had taken first aid training in the context of industrial employment. In the two or three courses taken in British Columbia, the basics of seizures are covered. The courses included the effects coming off a seizure, cues for seizures, and protocols to place the person suffering the seizure in the fetal position to let them "ride it out". Mr. Greene was placed on his stomach, and cuffed behind his back mid-seizure. It was Mr. King's impression the way the Correctional Officers cuffed Mr. Greene behind his back, mid-seizure, his arms would be broken. The officers were being very rough with Mr. Greene. The officers did not know his name. Mr. Greene, when he woke up, started screaming when he realized he was in pain. When the nurse finally arrived, she stood back and was laughing. The officers did not use a pillow to assist Mr. Greene. Mr. King was shouting Mr. Greene's name to the officers but they disregarded it.

[101] Mr. King was moved from Room 462 down the hall to Room 471, all windows were blocked, and from that point on all the inmates on the range were listening.

[102] Mr. King could hear Mr. Greene screaming, and saying words such as mom, help, and why. There was much crying and yelling in pain. Mr. King heard Mr. Greene say "Why is this happening?" Mr. King could also hear the Correctional Officers and Paramedics come in, delivering CPR and electrical shock, and officers talking about their break.

[103] Mr. King was certain he could hear Mr. Greene's arms breaking. Mr. King said he could hear Mr. Greene speak on the DuKane System requesting his medication and water despite the distance between the cells and the fact the doors were closed. When placed in Room 471, Mr. King put his ear underneath the door in order to hear better. Mr. King heard a thud, and assumed Mr. Greene had a second seizure. After the thud, eventually Paramedics arrived and Mr. Greene was pulled out of the room. The Paramedics attempted to resuscitate him. Mr. King heard a nurse say to Mr. Green "Don't fake it, you are making it harder on yourself." He heard persons doing CPR on Mr. Greene.

[104] After the event was over, there was Indigenous singing on the range. Mr. King coordinated with the Elder to arrange ceremonies to help the passing of the spirit and for the grieving process of the inmates. Mr. King disagreed with many aspects of his police statement, but signed it anyway, knowing it to be inaccurate, because he believed that was the best way to finally testify as to the events concerning the death of Mr. Greene.

[105] Mr. King was certain he saw Mr. Greene fill out the appropriate yellow request form for medication, hand copies to various Correctional Officers, and also put a copy in the Request Form Box. Mr. King said that he and Mr. Greene both used the DuKane System to communicate with Correctional Officers requesting medication for Mr. Greene. Mr. King was confident he spent two nights with Mr. Greene, and that Mr. Greene was admitted to his room Saturday morning after midnight. When it was suggested to him that Winnipeg Remand Centre records and video show that Mr. Greene was not admitted to the 400 Level until afternoon on Saturday, he said those records were in error. He was certain officers had pushed Mr. Greene's head onto the floor while restraining him such that he bled onto the floor and other inmates had to clean it up. Mr. King was confident that one of the nurses was laughing during Mr. Greene's seizure, and he described that nurse. When it was suggested to Mr. King that video existed showing the Correctional Officers running to Mr. Greene in less than a minute, it was Mr. King's view that video could be "adjusted."

[106] Mr. King did indicate that after Mr. Greene's first seizure, when Mr. King was moved to Room 471, he could no longer see what was going on with Mr. Greene and some of his impressions of what had occurred were based on what others had told him.

5. Michael Redhead

[107] When Michael Redhead testified, he was a prisoner, in remand, at Headingly Correctional Institute. He previously had been an inmate at Milner Ridge Correctional Institute. He had called Inquest counsel Mr. Keith Eyrikson in December of 2017. At that time, Mr. Eyrikson told him he could not speak to him but may speak to him in the future. In fact, they had no further interaction prior to the day of his evidence.

[108] Mr. Redhead wrote a letter to Rochelle Pranteau dated May 14, 2016. On December 21, 2017, Mr. Redhead met with Jana Siepman, Assistant Superintendent of Operations at Milner Ridge Correctional Institute. Ms. Siepman

told Mr. Redhead that "Divisions wanted a statement," and that a lawyer had called wanting a statement.

[109] Mr. Redhead said that a Correctional Officer came to see him, reporting that "one of the higher-ups" wanted to see him and that he wasn't in trouble. During Mr. Redhead's evidence, a uniformed Correctional Officer entered the courtroom and sat in the gallery. Counsel for Corrections later explained the officer was there simply to observe and educate himself.

[110] Mr. Redhead's concerned reaction to the officer entering the courtroom was visible to the Court and counsel. He explained that since he was present during the incident with Mr. Greene, and it was known somehow that he had given a statement, he had been treated differently by officers including racial slurs.

[111] Mr. Redhead was on the phone beside Mr. Greene when Mr. Greene had a seizure. Mr. Redhead waved his arms to attract the attention of the Correctional Officers, but no one responded except for the inmates. Stephen King came immediately, and it took 2 - 4 minutes for the Correctional Officers to arrive. When the Correctional Officers did arrive, they called Mr. Greene by different names, including Darryl. Mr. Redhead locked up as directed, but could hear Mr. Greene calling for his mom. Mr. Greene called out the name of one his children and the Correctional Officers told him to stop faking it and kicked him in the chest. The officers flipped him around, handcuffed him, and also tied his ankles resulting in him being hogtied. Mr. Redhead and his roommate both saw it and were calling out that officers were not permitted to hogtie him. Mr. Greene was placed on his stomach, his hands were handcuffed to the back, his legs were up, and one guard had his knee on his back. Mr. Redhead did not see anyone touch Mr. Greene's head.

[112] During the first seizure, for fifteen minutes, no nurses came to check on him. Mr. Greene was dragged to his cell and was asking for water. The guard said, "You have fucking water in there." He was crying in agony, and then everything went to silence. The time from when he was placed in the cell until he went quiet, was less than 10 minutes.

[113] The Correctional Officers pulled him out again, unresponsive, and the officers did not do CPR or attempt to assist Mr. Green. All the inmates knew he was already gone. Stephen King began singing, and everyone started saying rest in peace. This was upsetting to everyone. The inmates were all mad at the guards.

He was asking for his medication. It was their job to get his medication. Mr. Redhead is still angry about this.

[114] The inmates all talked to the Elder, and there was a sharing circle the next day when people expressed their anger at the medical team and Corrections Officers.

[115] The officers did not rush the way they are supposed to and did not get his name right. Mr. Redhead later adopted the timelines reflected in his statement, including that it took 5 minutes for the officers to arrive. After the windows of the rooms were covered, he could look out under his door and see what was happening with Mr. Greene perfectly. The kick that Mr. Redhead observed being delivered by a Correctional Officer to Mr. Greene was when the officer was telling Mr. Greene to stop faking it.

[116] Mr. Redhead made multiple references in his evidence to no one attempting CPR on Mr. Greene prior to Paramedic arrival. When shown a portion in his May 14, 2016 letter to Rochelle Pranteau where he said the nurse did commence CPR, he indicated that he did not remember. Mr. Redhead was confident he had seen two Paramedics come in, attend to Mr. Greene, and leave with him on a stretcher after about five minutes. He was unable to explain how he was able to see this as the window of his cell was covered. When it was suggested that perhaps he had not seen the Paramedics, but had only heard them, he was adamant that in fact he had seen them.

[117] Mr. Redhead was adamant that Dr. Rivera's conclusions that Mr. Greene's injuries were as a result of thrashing on the floor were all a lie. Mr. Redhead thought Dr. Rivera had somehow made up his conclusions to cover up the incident, and Mr. Redhead confirmed his view Dr. Rivera's findings were all a lie. Mr. Redhead based his opinion on the Pathologist opinion from news media reports about what the Pathologist had said. Mr. Redhead emphasized he heard Mr. Greene ask for his medication multiple times. Mr. Redhead noted that when he asks for his own medication, it is provided right away. He did not know why Mr. Greene did not get his.

[118] Mr. Redhead grounded his evidence that there were two Correctional Officers posted outside Mr. Greene's door to observe him after the first seizure, on his general knowledge that there must always be two officers in case something occurs to the first officer. When it was suggested to him that, in fact, witnesses

have or would testify, including that officer, that he was the only officer posted, Mr. Redhead disagreed.

[119] Mr. Redhead, from media reports, has concluded that there is a scheme to cover up the true circumstances of Mr. Greene's death, and the Correctional Officers are in on the conspiracy.

Winnipeg Remand Centre Nurses

6. Roberta Brotherston

[120] Roberta Brotherston, a Registered Nurse for 31 years, attended Dalhousie University for the Outpost Nursing Program geared to nurses working in First Nations Communities. In addition, she is a certified Diabetes Educator and, for a number of years in both Ontario and Nunavut, was a Nurse Practitioner. She has in the past, and at the time of her evidence still did, work on First Nations Communities in Manitoba. Because of the remoteness of some of the communities in which Ms. Brotherston has worked, she has been called upon to make significant nursing decisions. As a result, she has vast experience in many situations.

[121] On April 30, 2016, Ms. Brotherston commenced a 12 hour nursing shift at the Winnipeg Remand Centre. Ms. Brotherston was new at the Winnipeg Remand Centre, and on April 30, 2016 was working her sixth shift. Ms. Brotherston did not yet have access to the Drug Programs Information Network ("DPIN"). As she explained, access to the network is restricted and an individual can only gain access once authorized. The network contains information about prescriptions dispensed in Manitoba.

[122] When working in a medical facility, nurses generally are granted access to DPIN but only once authorized. She had been advised by her manager that she would ultimately be given authorization but it would take some time.

[123] Ms. Brotherston testified that DPIN is important because it reflects which prescriptions an individual's doctor has prescribed in the past. Ms. Brotherston, at the time of her evidence, was no longer working at the Winnipeg Remand Centre. She has no memory of having met Bradley Errol Greene. The Winnipeg Remand Centre population is transient and turn over is high.

[124] When an inmate is admitted to the Remand Centre, he or she is assessed by the nurse. The assessment consists of a sheet of paper with questions, and the nurse documents the answers. If the nurse worked Monday to Friday, the doctor

would review the admission assessments, consult with nursing staff, and discuss any medical issues requiring medical attention. No doctor was available during the weekends. For a portion of her shift, Ms. Brotherston was not working alone. She believed the other nurse she was working with, for that portion of the shift, was Kathy Berens. Ms. Brotherston knew Kathy Berens quite well, as they had nursed together in Bloodvein, Manitoba. Not only nurses, but anyone in the health field, consults with other health care professionals. It is viewed as a safe practice to collaborate as a team. It was Ms. Brotherston's practice to always consult with another nurse. She would feel uncomfortable if she did not consult.

[125] Ms. Brotherston identified the Winnipeg Remand Centre Intox Admission Form, as the document a nurse would be called upon to complete upon arrival of an intoxicated individual. This form will give the nurse a preliminary picture of the inmate's health. Health conditions requiring immediate attention would be recorded. There are health concerns present with intoxicated individuals.

[126] In Mr. Greene's case the form was completed on April 30, 2016 at 1:22 a.m. by a different nurse. Ms. Brotherston did not recall seeing the Intox Admission Form completed for Errol Greene's admission. The medical assessment earlier described by Ms. Brotherston is different than the Intox Admission Form. Ms. Brotherston was not on duty April 30, 2016 at 1:22 a.m.

[127] Ms. Brotherston did start on shift at 6:00 or 7:00 a.m. When asked whether she would have that form with her when meeting with the patient, Ms. Brotherston responded, "Sometimes you do and sometimes you don't." When it was determined the inmate was ready to no longer be observed because of intoxication, the nurse was called to come down to the Lower Level and proceed with the Admissions Assessment. The nurse would not always have the Intox Admission Form, despite the fact that it had been earlier completed. The completed Intox Admission Form would be placed at a certain area on the nurses' desk. When the nurse was called downstairs, the nurse would not necessarily be advised that the individual she was being called to process included those subject to the Intox Admission Process. The nurses are only told that there are individuals to process.

[128] It would be better to have the Intox Admission Form at the time of processing of the admission. The Intox Admission Form includes a listing of medical problems. On Mr. Greene's form the word "epilepsy" was noted. That would have been of assistance to Ms. Brotherston to have seen. On the Medications portion of the form, it would have been of assistance to Ms.

Brotherston to know that Mr. Greene's form said "valproic acid 250 mg TID (last took 24 hours ago)."

[129] Ms. Brotherston did complete "The Health Care Assessment" form related to Mr. Greene on April 30, 2016 at 12:20 pm. The information on the form would come from the inmate. Under Current Medication, Ms. Brotherston wrote "valproic acid 250 mg TID" and beside Current Health Concerns she wrote "Seizure disorder." It would be important to confirm the inmate's report of medication by accessing DPIN. Ms. Brotherston did not have access. She did ask someone to check DPIN for her but could not recall who. She would have written on a square of paper, designated specifically to make note if DPIN is required. She would have put a tick mark and taped it to the front of the file. She would take Mr. Greene's chart, together with charts of other newly processed inmates, up to her colleague in the Nursing Office and request their assistance with DPIN access. In this case, that would have been the only way that Ms. Brotherston could have accessed DPIN. The Health Care Assessment Form says the Mr. Greene reported his last seizure was months ago.

[130] Ms. Brotherston recognized a note with various check marks on it with a left hand column listed "Action Required" as being completed by herself. This would be the form she taped to the front of the chart. She noted that Actions Required ticked off, included DPIN, Chart Only, and Meds to be Started. The completed vertical column had checked off, in a different color pen than her own, DPIN as completed. Beside Meds to be Started, words she did not write "(? valproic acid)" were on the form. The "Chart Only" that was ticked in a different color than the DPIN Required, means the chart is to be given to the doctor for review. Ms. Brotherston's impression was the reason the physician needs to see the chart was to sign off a prescription for valproic acid. The "Meds to be Started" check mark in a different color than Ms. Brotherston's DPIN check mark suggests to her that someone had checked DPIN and thought valproic acid should be started. Ms. Brotherston does not know if Mr. Greene were ever started on valproic acid, and she was not on shift the next day.

[131] Based on the documentation she has seen and her experience as a nurse, Ms. Brotherston would discuss the situation with a colleague. If she did not have a colleague, she would have elected to start valproic acid on her own. She would know what DPIN said and a physician, who would be there two days later to sign off the chart, would be in agreement. The presence of a doctor for consultation would have been helpful. Ms. Brotherston said she had mentioned to her Manager she was very surprised there was no access to a doctor to consult with.

[132] Ms. Brotherston identified a document "Major Medical Problem List", as a component of the Medical Chart. The Major Medical Problem List Form with Errol Greene's name on it, lists epilepsy in the column entitled "Chronic Problem". Ms. Brotherston thought the handwriting on that document was not hers. From her perspective it matched the handwriting on the Intox Admission Form. Ms. Brotherston said she would not have had the Major Medical Problem List when she completed her Health Care Assessment.

[133] A chart is opened at the time the Intox Admission Form is completed, on the understanding a nurse will later reassess at the next opportunity after the individual is no longer intoxicated. That is generally on a subsequent shift. On the next shift, the chart is made up and DPIN is pulled. If DPIN confirmed an individual had a prescription for valproic acid within the last 45 days, she would start him on it because epilepsy is treated generally with valproic acid. This individual told her he had a seizure disorder and reported a seizure two months ago. If an individual is non-compliant taking their medication, and not everyone is totally compliant with medication, in the case of valproic acid if doses are missed the likelihood of having a seizure is increased.

[134] Ms. Brotherston testified she did not feel there was sufficient nursing staff. There were times when she worked alone, a situation which could impact safety should there be an emergency. In the case of an emergency, one needs more than one nurse. It also means that, when working alone, one is overworked which is not good practice. If an Intox comes in, according Winnipeg Remand Centre rules, the nurse has to drop everything and deal with the Intox. If inmates are stacked up in Admissions in the Basement, so as not to hold up police, nurses must scramble to get the Admissions seen. If there are a lot of dressings needing to be changed, or if an officer calls from a floor saying an inmate has a question, the nurse must prioritize what needs to be done. Sometimes that means things get left behind. The situation is magnified when the nurse is working alone.

[135] Ms. Brotherston highlighted the helpfulness of having a physician available to consult all the time.

[136] Ms. Brotherston said she would be surprised if Mr. Greene did not get valproic acid while he was at the Winnipeg Remand Centre if everyone had done everything correctly. She elaborated that if the documentation were available promptly, if the person taking the information obtained correct information, if DPIN revealed he needed valproic acid, Ms. Brotherston would be surprised that he did not get his medication.

[137] She would not be surprised if all of the processes were not conducted in a timely manner given the nature of the work environment at the Winnipeg Remand Centre. Anything can happen where people might be stacked up in the basement needing to be processed, medications must be given, and an Intox presents requiring the nurse to drop everything. Sometimes it just gets so crazy the nurse must do her best to do things as fast as she can. Ms. Brotherston would not be surprised if things get missed, and she needed to develop her own checks and balances to ensure everything that needed to get done, was done. These safety checks and balances were not Remand Centre policy, but a protocol Ms. Brotherston developed for herself arising from her training and experience. She thought other nurses also had their own checks and balances.

[138] Acknowledging her job is one where decisions can result in an individual's life or death, Ms. Brotherston agreed having things missed can sometimes be fatal. The environment being what it is at the Winnipeg Remand Centre, Ms. Brotherston recognized that not everything that needed to be done could be done on a shift. By necessity, duties would have to be handed to the next shift. For example, one of the first things one learns as a nurse is that the only medication a nurse should administer is a medication she has poured herself. One does not expect a subsequent nurse to administer medications a colleague has prepared. It was a common expected practice at the Winnipeg Remand Centre, that night shift nurses prepare all of the medication for day nurses to dispense. As a consequence, Ms. Brotherston checked and double checked medications she was giving because someone else prepared them.

[139] From what Ms. Brotherston knew of the circumstances with Mr. Greene, the impediment to her ability to give him valproic acid was her lack of access to DPIN and not having a computer password. It upset Ms. Brotherston that she did not have DPIN access. It impaired her ability to do her job to the best of her ability. Ms. Brotherston recalled emailing her Nurse Manager Beverley Reeves once for certain, and perhaps one time subsequent with concern about DPIN access. Ms. Brotherston did not recall speaking to her in person as they did not commonly work the same shifts. In the end, it took about six months for Ms. Brotherston to obtain access.

[140] By way of recommendations, Ms. Brotherston suggested a doctor should always be on call, medications should be dispensed by the person who prepares them, nurses ought not work alone, sufficient staff be in place such that tasks are completed in a timely manner and nurses are not compelled to walk away from a task in process to complete another. One nurse should complete the chain of care

from beginning to end with respect to a task with a patient. This ensures that things that need to get done, get done.

[141] The current situation at the Winnipeg Remand Center is not nursing best practice. If DPIN suggested an individual were irregular in taking medication for a seizure disorder that might mean the individual needed it more urgently than one who took it regularly. Ms. Brotherston was clear that operational needs of the institution interfered with her ability to deliver care to the inmates at the Winnipeg Remand Centre. She said she learned quickly that if there is an Intox waiting in the basement, you drop everything. She recalled on one occasion being called from the basement and advised of an Intox being present for her attention. Her response was that the Intox would have to wait because she had meds to give on medication rounds. She received another call directing she come down to deal with the Intox. The supervisor for the shift told her that was how it is.

[142] Ms. Brotherston confirmed that, reviewing her Health Care Assessment completed April 30, 2016 at 12:20 pm, it is apparent that DPIN needed to be pulled so the medication can be confirmed and Mr. Greene can be started on it as soon as possible. It was not her intention to convey the idea that the administration of valproic acid should be deferred or delayed on account of other substances that may be in Mr. Greene's system. There is a balance. Sometimes a nurse may not know what it is in the individual's system, but needs to err on the side of safety. It would have been safer to give the valproic acid even if it were not known what was in his system. At the time of Mr. Greene's admission, Ms. Brotherston did not have the benefit of Dr. Yankovsky's opinion on this point.

[143] She was certain had she had the benefit of DPIN, she probably would have given Mr. Greene valproic acid, knowing that he told her he had a seizure disorder. Ms. Brotherston was 99% sure that when she worked at the Winnipeg Remand Centre valproic acid was on hand. She was confident, in this situation, she would have given him the medication because the worst outcome would be that he had a seizure in the Winnipeg Remand Centre. It would be worth risking giving him the medication not knowing what was in his system. The lesser of two evils would be to give him the medication to prevent a seizure in the Winnipeg Remand Centre.

[144] When it was suggested to Ms. Brotherston that opinion was easy given 20/20 hindsight, Ms. Brotherston said she knows her own practice and best practice. There would be no reason for her not to follow through with what she knows to be best practice.

[145] When questioned further about administering care to an intoxicated person who may not be fully able to consent to treatment, Ms. Brotherston said that if the treatment is something the individual cannot wait to have and harm caused as a consequence, the nurse needs to give the care provided to prevent the harm.

[146] Ms. Brotherston wished to clarify an answer previously given about the treatment of an intoxicated person. She said the nurse must always be mindful of the fact that the individual cannot consent. One also does not know the other substances on board, and even though the chance might be remote, there could be a reaction of some kind. While mindful of all of those factors, the nurse must perform what is the safest for the patient. To illustrate her point, Ms. Brotherston cited an example of an individual at the Winnipeg Remand Centre who reported consumption of a large amount of alcohol over a period of time. Ms. Brotherston knew that put him at risk of seizure, usually commencing within 24 – 36 hours after the drinking stopped. She was not certain what other substances he may have consumed other than alcohol. Ms. Brotherston elected to give him Diazepam to prevent seizure. She recalled the colleague she was working with being critical of her choice because Ms. Brotherston did not know what was in his system.

[147] As a consequence, Ms. Brotherston followed up with her Manager by telephone, and her Manager told her she did the right thing. Similarly, to Ms. Brotherston, a person with epilepsy who has not been taking their medication presents an urgent situation.

[148] As to the tension between medical and operational requirements in the work of a nurse at the Winnipeg Remand Centre, Ms. Brotherston felt when those in operations required she attend to operational matters when it was her best nursing judgement her medication be administered on time, her best medical judgement had been overridden.

[149] Her work at the Winnipeg Remand Centre, in her 31 year career, was the only time Ms. Brotherston did not have ready access to a physician when necessary. In her time up North, there had always been physician access when necessary 24/7 by telephone. When she worked for the Winnipeg Regional Health Authority, there were doctors there in person.

7. Paula Ewen

[150] Paula Ewen is a nurse with 34 years experience, employed as a nurse at the Winnipeg Remand Centre for the last six years. She has Advance Practice Nursing and has treated thousands of people over the course of her career, suffering a vast

array of medical conditions. She was working the night shift April 30, 2016 but does not recall interacting with Mr. Greene.

[151] She predominately worked night shift at the Winnipeg Remand Centre because she had a day job working with First Nations and Inuit Health Branch. She worked 11 ½ years full time up North, and she and her husband lived on First Nations in Ontario, Manitoba, The Northwest Territories, and she worked for 10 years at Stony Mountain Institution.

[152] Although the number of admissions is quite variable during nights at the Winnipeg Remand Centre, on weekends a higher number of intoxicated individuals are brought in by the Winnipeg Police Service. An average night may result in 5 – 10 admissions of intoxicated individuals, and 20 through the other process which does not relate to intoxicated individuals.

[153] Intoxicated persons are identified to insure their safety at the Winnipeg Remand Centre. In circumstances where an intoxicated person is presented for admission, a process ensues including the nurse completing the Intoxicated Admission Form with the individual to determine whether they are able to be admitted. Once the nurse completes the form, if admission is deemed appropriate, the nurse reports that to all concerned. If the individual is refused, there is a different form completed indicating why the individual was refused. The form relating to Mr. Greene was completed April 30, 2016 at 1:22 a.m. The previous medical file would not always be available to the nurse at this point, if, for example, the inmate were released by another institution or the Winnipeg Remand Centre file were upstairs at the time. In an ideal world, Ms. Ewen would always want the medical file. When the Health Assessment is completed, the nurse ensures he or she has the medical file. If the file is at another institution, the nurse must proceed blindly without access to the information contained in the other institutional file. The Standing Order requires the medical assessment be completed within 24 hours of the individual being taken into custody at the Winnipeg Remand Centre. Ms. Ewen was not concerned about the potential for the medical assessment being completed after that much time had passed.

[154] In the place on the form for Medical Problems, epilepsy is indicated. In the place for Medication, valproic acid, 250 mgs, three times a day is written. The form says that Mr. Greene last took valproic acid 24 hours ago. Intoxicants Consumed, as shown on the form, are beer and THC. On the portion of the form relating to Seizure History, his last seizure is shown as having been two months prior when incarcerated and not alcohol related. He was oriented to person, place,

and date, and demonstrated steady gait, clear speech, good eye contact, followed commands, and demonstrated appropriate responses. The information on the form came from Mr. Greene.

[155] Had Mr. Greene requested his medication at the time of the Intox Assessment, Ms. Ewen would not write that specifically on the form. She would have informed him Winnipeg Remand Centre nurses did not administer medication to a person while they are intoxicated, and the issue would be evaluated when he had a later assessment. When asked if an individual presented with the need for a life sustaining medication such as an insulin dependant diabetic, Ms. Ewen said she would refuse the individual and send them out for an order for insulin. The variable circumstances may direct different notating on the form. DPIN is not always checked, when this form is done, depending on how busy nurses are. In a case such as this, because Mr. Greene was intoxicated, Ms. Ewen would not have started medication, but would have deferred the issue to the nurse completing the assessment later on. When doing the Health Assessment, Ms. Ewen requires the Intox Admission Form at hand.

[156] The only way to ensure the Intox Form is married with the health care file, such that when the health assessment is preformed the Intox Form is available, is if the nurse performing the intox assessment retrieves the file and places it in that file. Ms. Ewen was confident that was her process and she always does that.

[157] The only way to ensure the medical file is with the nurse at the time the health assessment is completed, is if the nurse makes sure he or she has it.

[158] In terms of staffing, Ms. Ewen said it was not always as she would wish it to be. Sometimes she worked alone if another nurse called in sick. In a perfect world, there ought to be two nurses on at night and three in the day. When Ms. Ewen walks in when her shift commences, she has no idea if she will, or will not, have a partner. Ms. Ewen indicated that a doctor's advice was not always available when needed, but she relied on her very good connections and calls upon personal favours from doctors. That form of advice and support is not available to other nurses who did not have her degree of connections.

[159] The availability of a physician was one hour per day Monday through Friday. The only access otherwise that nurses at the Remand Centre had was to call the hospital and rely on the generosity of physicians if they were able. Some physicians at the hospital will suggest sending the patient to hospital if they did not wish to do a phone consult. Ms. Ewen did not think a doctor was necessarily

needed to see patients off hours, but there was value in having the physician available for consultation. In Indigenous communities, nurses had access to the Northern Medical Unit, Thompson General Hospital, and other opportunities to consult with physicians off hours. Nurse Practitioners have been added to some communities that nurses can consult if required. The average time spent with an intox admission is 3 – 5 minutes, depending on the level of intoxication.

[160] Ms. Ewen confirmed she has extensive experience working with First Nations people, and also worked in a correctional setting at Stony Mountain Institution, in the farm annex at Rockwood Institution. She was also seconded to Grande Cache, Alberta, to work for one year. This is a medium/minimum institution. She received no special training in the federal system relating to specialized care for inmates. Although clinically, Ms. Ewen thought her medical assessments and treatment do not change from community to correctional facility, her ability to deliver service sometimes is impacted by the correctional environment. This is especially the case affecting her ability to deliver service in a timely fashion. In custody, she sees more individuals with substance abuse and addictions, but she also saw a high proportion of alcohol abuse in remote communities when she worked there.

[161] At the Winnipeg Remand Centre, a significant number of individuals come in with seizure disorders, from alcohol abuse and other medical conditions. In custody, her experience is to see an individual with a seizure approximately once per month. In her breadth of experience, she has practiced in areas where seizures were even more common.

[162] In Ms. Ewen's experience, a Code Red has been called every time there has been a seizure. She was of the view that the nurses at the Winnipeg Remand Centre could benefit from additional training in the area of seizures.

[163] In terms of the administration of medication to an intoxicated person, Ms. Ewen referred to the standing order requiring a health assessment within 24 hours of admission. She said that is when an individual's medication needs are assessed. At that time, if an individual says they are on medication that must be confirmed either through DPIN or calling the pharmacy. It is also determined whether the individual has been compliant with the medication. This would all occur after the individual is no longer intoxicated.

[164] The correctional officer in charge makes the determination that an individual is no longer intoxicated and ready to proceed through the ordinary admission

process. Referring to the Intox Admission Form for Mr. Greene, Ms. Ewen estimated that on a scale of 1 to 10 relating to levels of intoxication, Mr. Greene would have placed towards the beginning to mid-range. Should an individual require medication prior to the Health Assessment, for example for a seizure, Ms. Ewen definitely would treat and in the case of a seizure, with Ativan. When asked if it would be better to prevent a seizure rather than treating one after it occurred, Ms. Ewen said she was in no position to predict who would have a seizure. She would not put herself or the patient at risk by giving medication when she does not know the whole story.

[165] Ms. Ewen agreed that on the face of the responses on the Intox Admission Form, where Mr. Greene reported last taking his medication 24 hours before, he was at risk for a seizure. Ms. Ewen did not give Mr. Greene valproic acid because of the requirements of the standing order and because she did not know the entire circumstances of what he had otherwise consumed. Ms. Ewen did not see sending Mr. Greene out to hospital as a matter of urgency, because he had missed two doses already and had not had a seizure. She said she sees very few seizures where individuals have not taken their medication under these circumstances. The Winnipeg Remand Centre does not send individuals out to hospital just because they have a seizure disorder and she relies on the standing order that gives nurses some flexibility. She emphasized the Remand Centre does not dictate they must be sent out. It is the practice that nursing staff do not send individuals out to hospital in these circumstances. Depending on a nurse's level of education and experience, a nurse could decide an issue differently. Ms. Ewen did not send Mr. Greene to hospital because she felt he could be managed by her during her shift within the institution.

[166] Every new admission is not reviewed at shift change with the incoming nurse. It is only those which involve risk. Ms. Ewen did not recall discussing Mr. Greene's case with the incoming nurse. Someone with a seizure disorder would normally be flagged by her to the incoming nurse but she did not recall if she did so in this case.

[167] In terms of recommendations to assist the Inquest, Ms. Ewen agreed that access to the previous medical files, whether electronic or hard copy, would be helpful. In addition, access to a doctor in addition to the then one hour Monday to Friday access would be of assistance. As Ms. Ewen worked nights, she was not at the Remand Centre when doctors held the one hour clinics. As a result, if she needed physician opinion, she called St. Boniface Hospital to try to access the doctors who normally conducted the clinics. Ms. Ewen believed the doctors took

those calls as favour, not as a function of their employment. She has never been directed by her supervisor on this issue.

[168] In commenting on whether access to a physician at all times would be helpful, Ms. Ewen said it would help her get orders in a more timely fashion. For example, if an individual were admitted on Friday night of a long weekend, it would sometimes take until Tuesday to have the order signed off.

[169] Ms. Ewen commented on the Intox Admission Form relating to Mr. Greene's admission March 12, 2016 completed by herself. It was noted that Mr. Greene had a seizure upon discharge March 13, 2016 at 12:58 p.m. The Intox Admission Form identifies that Mr. Greene had epilepsy, was taking valproic acid, and had a previous seizure two weeks prior to March 12, 2016. An individual in these circumstances could be put on the shift report to communicate the need for further attention to the issue to the next shift. At the end of every shift, a shift report with a written and verbal component, is completed. Even if nothing noteworthy has occurred, the previous shift report is noted to include the current one. The shift reports are kept in a large binder, and available for reference.

8. Beverly Reeves – Evidence as Health Services Manager

[170] At the time of the first component of her evidence, Ms. Reeves had been employed by Manitoba Corrections for nine years, and had been Health Services Manager at Milner Ridge Correctional Centre since November 2017. Previously, she was the acting Health Services Manager at the Winnipeg Remand Centre. She has been a nurse for 31 years. She worked for the Addictions Foundation of Manitoba for 15 years, at a private methadone clinic for six years, coming to Corrections after that.

[171] In Corrections, she was hired as a Correctional Psychiatric Nurse at the Winnipeg Remand Centre, worked as a General Duty Nurse at the Winnipeg Remand Centre, and when Chris Ainley went to the Directorship of Medical Services for Corrections in an acting capacity, Ms. Reeves assumed his role in an acting capacity as Health Services Manager at the Winnipeg Remand Centre.

[172] She is a Psychiatric Nurse by background and training. She remained in an acting position as Nurse Manager at the Winnipeg Remand Centre for three years. In the spring of 2016, as acting Health Services Manager, she was required to address staff management, hiring, ensuring adequate supplies, and the overall functioning of the Medical Unit. She was also required to fill in for nursing staff when they were short staffed. In March 2016, Winnipeg Remand Centre Medical

Unit was always looking to hire more staff. The regular complement of full time nurses was in place, but there were gaps in casual and part time staff. A bulletin recruiting part time staff to a 0.45 position resulted in the selection of two suitable candidates. Both candidates, however, went to other nursing positions. One indicated the process took too long and he needed a job more immediately. The other did not give a reason but simply withdrew. It was difficult to cover sick calls. Ms. Reeves often worked the floor. Ms. Reeves "bulletined to my staff verbally," that if they knew of anyone who might be interested in casual shifts they should connect with Ms. Reeves. There was no formal bulletin for a casual pool.

[173] Full staffing complement was comprised of two nurses working day shift, one working a day 8 shift and one working a day 12 shift, and another nurse would come in for a day/evening shift from 11:00 a.m. to 11:20 p.m. so that there would be overlap of a few hours with three nurses on. One night nurse came in at 7:00 p.m. and another night nurse came in at 11:00 p.m. Ideally, then, two nursing staff would be on at all times with, and during the busier part of the day, three nurses were on. This scheduling regimen was consistent weekdays and weekends. When asked whether Ms. Reeves would prefer to see more nurses on staff during a shift, she responded that for the most part the nurses were able to keep up. If there were a particular influx or a particularly chaotic day it would be helpful to have more staff available. Ms. Reeves thought two nurses on night shift sufficient, as nights tend to be a little less chaotic.

[174] When Ms. Reeves testified on the first occasion, the physician's schedule at the Winnipeg Remand Centre was one hour per day Monday to Friday. The doctor would often come in on statutory holidays. Ms. Reeves did not think not having more fulsome doctor availability was a problem as the nurses are competent and if physician intervention is necessary people would be sent to hospital. When asked if it would be better to have a doctor available Saturday and Sunday, Ms. Reeves reinforced the competency of the nursing staff and repeated individuals requiring physician attention would be sent to hospital.

[175] During the screening process for recruitment of nursing staff, Ms. Reeves said a good background in nursing is a requirement. She did not hire new grads. Emergency room experience and northern nursing experience were examples of the sort of good nursing experience she recruited. For training, the new recruits completed at least four or five shifts shadowing other nurses, orienting to evening and night shifts in addition to day. New recruits also did two weekend orientation shifts to acclimatize to the different procedures on the weekends. Ms. Reeves does not supervise new recruits on their orientation shifts. They are attached to

whomever is on shift that day. There is no specific requirement of duties to be accomplished or assessed during orientation shifts. Ms. Reeves said it was more a function of "watch, learn, and participate."

[176] Ms. Reeves emphasized this is a "learning through doing" process, and her means of assessing recruit performance was to ask for feedback from the supervising nurse and offer further orientation shifts should the recruit wish them. There is no formal assessment process.

[177] Ms. Reeves agreed nurses have different strengths and weakness, depending on their personal characteristics and nursing experience.

[178] In terms of requirements for Winnipeg Remand Centre nurses' completion of documentation, Ms. Reeves began by outlining the paperwork involved in the admissions process. Ms. Reeves gave a detailed description of the sort of information nurses must record on the Health Care Assessment and the blue Intox Form. The nurse must make a determination, when an inmate presents for admission, whether the individual is medically safe to admit. The Intox Form is placed in a file, and put in an "Intox Box" for people awaiting processing, when the person's condition was such that they were better able to answer questions. Once that occurs, the individual is subject to a more complete Health Care Assessment.

[179] On occasion, nurses have difficulty locating previous files for various reasons, as they are paper files so they can be simply misplaced. If an inmate is transferred to another institution, the Health Care file follows them and can be difficult to access quickly should the inmate then be re-admitted to a different institution. If an individual is presented for admission, and intoxication is not a factor, the Health Care Assessment is preformed at that time.

[180] A DPIN search should be done at the same time as the Health Care Assessment. If a DPIN search is not done, there are other ways to obtain the information. For example, the nurse could call the inmate's pharmacy, if the inmate knows the name, to determine their medication history. Nurses at the Winnipeg Remand Centre, in accordance with Ms. Reeves' evidence, use a combination of DPIN and pharmacy checks to determine an inmate's medication history.

[181] Winnipeg Remand Centre nurses have access to DPIN. The process by which nurses obtain access to DPIN begins with securing internet access. Once internet access is confirmed, Ms. Reeves arranges, on the nurse's behalf, for DPIN

access. The arrangement is through Chris Ainley, the Director. The length of time for this process is variable, up to several weeks. Once internet access is confirmed, it does not take long for Ms. Reeves to request DPIN and for Mr. Ainley to have it set up. An orienting nurse would be working towards obtaining DPIN access.

[182] If the originating form requesting internet access is not returned to Ms. Reeves for weeks, the entire process is delayed. Ms. Reeves does not have a timeline set up for establishing DPIN access. The expectation is that a nurse who does not have DPIN access would be working with a nurse who does have it. Some nurses do not know how to how to access DPIN and must be walked through the process and trained.

[183] If an inmate medical issue were identified for follow up, including seeing the physician, DPIN access, or other outstanding concern, it should be flagged on the file. The process is a small sticky note placed on the front of the file indicating the next step required. This process is designed to facilitate the nurse's quick appreciation of what the next step is to be and eliminating the need to read through the progress notes. A "major medical list" form identifies major or chronic medical problems the inmate may have which nursing staff ought to be aware of. The form should be filled out on admission when the Health Care Assessment is done. In Ms. Reeves' view, this is a "fluid form" that does not require a date on it. From looking at the document, it is impossible to say the date the document was created.

[184] The Medication Administrative Record document is a written record, containing a nurse's signature relating to each medication administration, and recording the medication history of the individual in the Winnipeg Remand Centre. In Mr. Greene's case, the document was prepared in anticipation of Mr. Greene seeing the doctor as a time saving measure. The time the doctor attends the Winnipeg Remand Centre is variable. Health Services Progress Notes contain an ongoing record of day-to-day health care issues. Another way to describe this is, according to Ms. Reeves, is Charting Notes. Ms. Reeves hoped the notes would be filled out "as soon as possible after the nurse has seen the inmate." It is Ms. Reeves' expectation that nurse charting notes be made as soon as possible after interaction with the patient or no later than end of that shift. It is important the record be left for oncoming nursing staff.

[185] A two hour delay for charting and interaction is not unreasonable at the Winnipeg Remand Centre, but certainly all charting must be done before leaving shift for the day. May 1, 2016 was an extremely busy day in a normally busy place.

[186] It was suggested to Ms. Reeves that DPIN was not done on Mr. Greene for about 26 hours after his admission. Ms. Reeves indicated she was not aware that was the timeline but she was supposed to have two nurses on that day and two nurses had called in sick. Roberta Brotherston was there for shadowing and Ms. Reeves was unaware she did not have DPIN access. Her response as to whether it caused her concern, was that it could have been done earlier had more nursing staff been on shift April 30, 2016.

[187] Ms. Reeves testified that had she had concern about an individual requiring medication, and DPIN were not able to be checked, she probably would have taken alternative measures by asking the individual if they had a pharmacy and calling that pharmacy. DPIN is a useful tool, but not the only tool. She would want the medication information.

[188] If nurses are involved in a Code, there is an expectation they put a brief note in the COMS system. This is not done by every nursing staff. If two nurses are on, it is acceptable to Ms. Reeves that only one nurse make the note in COMS.

[189] On May 1, 2016 Ms. Reeves came in to fill a shift for a colleague, assisting Bonny Weber who was left working alone. Ms. Reeves arrived at the Winnipeg Remand Centre shortly after the 7:00 a.m. usual start time, at around 8:00 or 9:00 a.m. Ms. Reeves was there to stay for as long as she was needed. It would have been impossible to review each of the files of the new admissions because of the number. The charts are flagged as to those needing attention. Ms. Reeves saw the diabetic patients, did med rounds on Level 300, poured medication, and responded to another Code Red relating to an inmate who had jumped off the second tier. Admissions and transfers were coming and going, and nurses were responsible for getting files, completing paperwork, and preparing medication. It was a chaotic morning.

[190] Ms. Reeves did not know Mr. Greene, and was unaware of him until the Code relating to him was called. Ms. Reeves grabbed the Code bag containing emergency medical supplies and went to the elevator. Code Red relates to an inmate requiring emergency medical attention. That is all the information Ms. Reeves had. Ms. Reeves heard yelling on the second tier of the fourth floor, and

heard and saw officers present. The yelling was coming from Mr. Greene. Ms. Reeves was told the inmate had a seizure but at the time she attended he was no longer seizing. He was on the floor by the phone area yelling and officers were trying to keep him calm and from hurting himself. He did not present a typical postictal phase. Ms. Reeves did not know his name and had been given a different name. She knelt down beside him, and tried to get his attention, calling him by the wrong name. Mr. Greene was resistant, combative, and trying to get away from the officers. Someone told Ms. Reeves the correct name, and Ms. Reeves had a discussion with Angie Banks, the SOM, and Bonny Weber. They realized this was an inmate they were on duty with during a previous admission who had a seizure and responded in a similar fashion after the seizure. They said he had been given a private cell and calmed down on his own.

[191] At the time he was in restraints. Ms. Reeves got him to sit up. She tried to instruct him to take slower, deeper breaths. He did once or twice, but reverted to the combative, agitated state. Through discussion, they decided to put him in his cell on a mattress to recover. Ms. Reeves asked Angie Banks if Mr. Greene's restraints could be removed to assist him in calming down She said that could be accommodated.

[192] In Ms. Reeves' view, it was not an option to bring Mr. Greene down to the Medical Unit on the third floor because he was too uncooperative. In the interest of safety, it was not a possibility. He needed to be monitored so Mr. Wiens was posted to observe him.

[193] Mr. Greene was yelling generally, but occasionally yelled "mommy." Based on Mr. Greene's conduct Ms. Reeves had concerns for the officers' safety but not for her own as she felt she was far enough back. Once Mr. Greene was in the room, Ms. Reeves was able to establish some communication with him. She told him who she was and that she wanted to help him. Ms. Reeves asked Mr. Greene if he could manage until she returned and keep himself calm enough so they could enter the cell and give him medication. She said he was agreeable. Because Mr. Greene came in as an Intox, and Ms. Reeves was unaware of his medical history, it was common to give Valium after a seizure. That was Ms. Reeves' intention. The purpose of the Valium, according to Ms. Reeves, was to calm him down so the seizures would not recur. Ms. Reeves advised that Corrections has a withdrawal policy protocol for people who could be experiencing withdrawal which is what Ms. Reeves thought Mr. Greene was experiencing at the time. Ms. Reeves had no understanding that Mr. Greene suffered from a seizure disorder.

[194] Ms. Reeves did not call an ambulance immediately for Mr. Greene because he had a good airway, was taking in oxygen well, and seizures are often handled "in-house." Unless the individual presents with a second seizure, they are not commonly sent out. A lot of people come into the Winnipeg Remand Centre intoxicated, and seizure is not an uncommon occurrence at the Winnipeg Remand Centre, so seizures are generally handled in-house and kept in the Remand Centre. Nurses then use the Standing Orders to assist.

[195] Particularly because she formally worked at the Addictions Foundation of Manitoba, Ms. Reeves has been exposed to hundreds of seizures.

[196] Injectable Ativan is used for treatment of seizures. Two milligrams is used to stop or reduce the threshold of seizures in people who have any kind of seizure activity. Ativan was not administered in this first incident, because Ms. Reeves did not have a Standing Order for the administration of Ativan during the first seizure. The Standing Order is specific that the individual must have two seizures before Ativan is administered. No matter what the seizure presents as in the first incident, Ativan is not administered until there is a second incident.

[197] Bonny Weber and Ms. Reeves were looking in the Medical Unit for Mr. Greene's file. It was not in the filing cabinet, it was not in the area where it would be placed awaiting DPIN, and was ultimately located in a box for "files needing attention." It was flagged for the office Medical Assistant to put before the doctor the next day. The file was taken in to the nursing office and reviewed for his previous history. The nurses reviewed the previous seizure he had when admitted in March, nursing notes, DPIN, and the decision was made to administer Valium.

[198] Ms. Reeves was either in the nursing office or the medication room when the second code was called. She grabbed the code bag, and recalled saying to Bonny Weber that it could be the same inmate. Ms. Reeves estimated 14 or 15 minutes had passed from when she left Mr. Greene until the second code was called. The medication locker, where medications are locked up in the Winnipeg Remand Centre contained, at the time, Valium, Ativan and valproic acid. Prior to Ms. Reeves' review of the file after the first seizure, she was unaware Mr. Greene had a seizure disorder and that the incident may not necessarily be withdrawal related. The previous discussion Ms. Reeves had with Bonny Weber about Mr. Greene having a seizure at the Winnipeg Remand Centre previously, did not include that he actually had a seizure disorder. Ms. Reeves asked Ms. Weber to grab the Ativan and a syringe in the chance that the Code Red was about Mr. Greene and Ativan may have to be administered.

[199] By the time Ms. Reeves reached Mr. Greene, he had a second seizure, and was again combative with officers. Ms. Reeves asked Ms. Weber to call Paramedics.

[200] As Ms. Reeves approached Mr. Greene's cell, she saw, through the open door, Mr. Greene on the mat yelling and thrashing about, and officers restraining him. He was trying to bite the officers. Officers had Mr. Greene in the recovery position facing away from her, in Ms. Reeves' view attempting to be accommodating to facilitate the injection. Ms. Reeves asked officers to flip Mr. Greene onto his stomach, so she could landmark where she was going to give the injection. The injection was given, and officers put Mr. Greene back on his side in the recovery position. The cell was crowded, with six to eight correctional officers inside. Ms. Reeves was anxious to get the syringe into a sharps container so she left the cell. She put the needle in the code bag, spoke with EMS on the phone, and learned the ambulance had already been dispatched. Mr. Greene continued to yell.

[201] Paramedics came quickly, and Ms. Reeves had the file retrieved and gave Paramedics a copy of Mr. Greene's DPIN. They entered the cell to do their own assessment. Mr. Greene's yelling ceased. One of the Paramedics advised Ms. Reeves that they were going and Mr. Greene had suffered cardiac arrest. Ms. Reeves was shocked.

[202] That handcuffs and leg restraints should have come off was not communicated to Ms. Reeves. The firefighters and Paramedics worked on Mr. Greene for quite a while in the cell, and Ms. Reeves did not recall how or when he was removed to the main level. She recalled him on a wheeled stretcher, and Paramedics performing CPR. A senior Paramedic wearing a white shirt attended the scene and was intubating Mr. Greene. They ultimately exited down the elevator with Mr. Greene, and that was the last contact Ms. Reeves had with him.

[203] After Mr. Greene's departure, there was work to catch up on, documentation to complete, and there was a further Code Red at about 4:00 p.m.

[204] Ms. Reeves commented on what she described as a "sticky note," a document placed on the front of the file to determine whether the doctor should start, in this case, valproic acid. This was a standard practice means of communication. It could reflect any form of medication, and the question mark relates to whether or not the doctor wishes to start or continue this medication. The words "chart only" is a direction for the doctor to review the chart without

seeing the inmate. The plain meaning of the note is that there is no need for the doctor to see the patient, and valproic acid should be started by the doctor. The Medication Administration Record shows valproic acid, a dosage of 750 milligrams once per day, and vitamin B1, administered at 100 milligrams. The time shown on the record is 8:00 a.m. for both medications. Ms. Reeves believed Ms. Weber filled out the form after Mr. Greene went to the hospital. The form is filled out in advance to save the nurse time the next day during Doctor's Clinic. In explaining why a time was already on the form, but not a date, Ms. Reeves said this reflected a standard time to give medication. If a doctor ordered the medication differently, it would be stroked through and amended on the sheet. When asked why the time on the medication administration form showed 8:00 a.m., when the doctor normally came between 10:00 a.m. and 1:00 p.m., Ms. Reeves said if the doctor ordered the medication when the doctor came in later, another small sticky note would be placed showing the medication start date and to administer at the time directed by the doctor. In subsequent days the medication would be administered at 8:00 a.m.

[205] Whether a nurse, knowing a patient had been treated by a physician for a seizure disorder with valproic acid, should continue the same treatment, Ms. Reeves thought was an oversimplification. She said that a nurse has an obligation to evaluate how long medication has been used, whether the patient has been consistent in their use, and ask "a bunch of other questions". If an inmate came in, and there was a consistent pattern of use, over a long period of time, a nurse would be correct in continuing that medication. When other questions come in play, however, such as sporadic use or noncompliant use, with no explanation as to why the use was inconsistent, the nurse must consider whether were there adverse effects, and whether they were followed consistently by a doctor who is prescribing the medication. In not continuing the medication, there are more considerations than simply looking at the DPIN.

[206] Some of the danger factors for inconsistent use of valproic acid, Ms. Reeves said, might be adverse effects. Was there stomach upset with valproic acid, migraines, was the patient trying an alternative therapy? In Mr. Greene's case there was no access to the other information from his neurologist. Ms. Reeves said the nurses at the Winnipeg Remand Centre did not know if Mr. Greene were followed by a neurologist. Was it he, or his doctor, who discontinued the use?

[207] Since Mr. Greene's passing, upon Ms. Reeves' review of his file, she was of the view that the course of conduct in his case by nursing staff was correct and the file should have gone before the doctor to address the issue of whether valproic

acid should be continued. In the same situation, again, Ms. Reeves said she would proceed in the same fashion as had been the case with Mr. Greene and put the file before the doctor for review. Nurses are not prescribers. They follow doctor's orders. Where there is some ambiguity relating to continuing a medication it becomes the doctor's decision.

[208] Manitoba Corrections does not require nurses to have a certain number of hours of professional development a year. Nurses are required to maintain the standards of their own professional organizations. Other requirements are to keep CPR up to date. Ms. Reeves received training about the care and management of seizures in her nursing training, but has received nothing since she has worked at the Winnipeg Remand Centre. The reason Ms. Reeves came into work on the day of Mr. Greene's passing, was because a nurse was working alone arising from sick calls, and Ms. Reeves did not want her working alone. At the time, a nurse might end up working alone because of staffing issues about once a week. One to three times per week she would fill a shift as a general duty nurse, rather than in her managerial capacity, to fill a staffing gap. She would often stay late after her regular shift if nursing coverage were inadequate, and, as here, she would come in specifically to cover shifts. Ms. Reeves accumulated significant extra time during that time. The outstanding casual positions Ms. Reeves attempted to fill by word of mouth through her own nurses. Casuals could be hired without having to go through the usual bulletin process. Part or full time positions, with an EFT assigned, would have to be posted. The two part time .45 EFT positions, to hire for weekends, were bulletined.

[209] The day of Mr. Greene's passing, including the four Code Reds, was a day unlike any other Ms. Reeves had in her career or since.

[210] Each admissions medical assessment takes between five and ten minutes. When admissions staff accumulate approximately four admissions or more, nursing staff are called to come down and perform the assessments.

[211] Ms. Reeves agreed seizures are a medical emergency, and someone with a seizure disorder requires immediate medical care. Not only are seizures life threatening, but an individual can die after a single seizure. Ms. Reeves agreed that any amount of valproic acid will lessen the likelihood that an individual will have a seizure. One dose may not prevent a seizure, but it may make the occurrence of a seizure less likely. Ms. Reeves indicated that getting Mr. Greene his valproic acid was a priority, and arrangements were made for the physician to review it as soon as possible. Mr. Greene was admitted Friday night, and there

would be no physician at the Winnipeg Remand Centre until Monday at perhaps 10:00 a.m. or 1:00 p.m.

[212] Ms. Reeves said there may be reasons why Mr. Greene was inconsistent in taking his medication, and so critical thinking must be applied by the nurse. The conclusion that Mr. Greene was inconsistent in taking his medication came from the DPIN evidence alone. Ms. Reeves agreed that the DPIN does not indicate exactly when the individual took their medication, and said that was a matter for a doctor to determine.

[213] Mr. Reeves was referred to the Intox Admission Form completed by Paula Ewen, indicating that Mr. Greene was on valproic acid TID, and last took it 24 hours ago. This was not in DPIN. It was information provided by Mr. Greene to Ms. Ewen. Ms. Reeves agreed she would have seen the form when she went back to review the file after the first seizure. When she saw the form, she had no reason to doubt that Mr. Greene last took medication 24 hours prior. When asked on what grounds Ms. Reeves denied Mr. Greene valproic acid, she responded there may be issues relating to whether he was developing toxicity quickly, whether the medication was causing stomach problems, migraines, or any other type of adverse reaction. A doctor would be the best one to assess that. There was no evidence of any of the negative outcomes of valproic acid in the admissions material.

[214] Ms. Reeves had never met Mr. Greene before and agreed she had no reason to consider him a liar. After Mr. Greene's first seizure, and after talking to him through the door, and learning from the officer that he was admitted as an intox, Ms. Reeves determined that the appropriate medication to give him was Valium.

[215] As the acting supervisor of the medical unit at the Winnipeg Remand Centre at the time of the events, Ms. Reeves indicated she did "ongoing evaluations", but never had the opportunity to do "regular nursing reviews" of the other nurses. She would, however, give nurses feedback on an ongoing basis. If there were a practice infraction that could be corrected, Ms. Reeves would address it. If the problem were an ethical issue, she may refer to the College. Ms. Reeves has not read the Code of Ethics for Colleges other than her own. Not all of the nurses under her supervision are psychiatric nurses. The majority are registered nurses. Ms. Reeves is not familiar with the code of ethics for registered nurses. She was confident she would recognize an ethics based problem in a registered nurse under her supervision because the standards would be similar "across the board".

[216] When asked by counsel about the concept in nursing of "power differential", Ms. Reeves was not familiar with it. She was unaware that the phrase was contained in the code of ethics for registered nurses to support compliance in her nurses with that part of the code. On May 1, 2016, if one of the nurses under Ms. Reeves' supervision were experiencing challenges relating to power differential in the ethical context, Ms. Reeves said she might recognize the conduct without associating it with a particular phrase.

[217] In terms of whether or not an ambulance should be called, if medical staff is present, the SOM will defer to the judgement of medical staff on site. Where medical staff are not present, the SOM makes a decision whether or not EMS is to be called. Ms. Reeves said she did not call EMS herself, because only the SOM has a cell phone. When Ms. Reeves arrived at Mr. Greene's cell in response to the second code, the door to the cell was open and officers were inside restraining him as during the first code. Mr. Greene was yelling and resistant to the officers. Ms. Reeves did note that Mr. Greene became less agitated once the restraints were removed after the first seizure.

[218] Once Ms. Reeves administered the Ativan, she removed herself from the cell leaving Mr. Greene with the officers in the cell. The officers did not close the door again before EMS arrived. When Ms. Reeves exited the cell, she stood just outside it beside the code bag. Because of the number of officers involved and surrounding Mr. Greene, he was not in the sightline of Ms. Reeves. When the First Responders arrived, some went into the room, and others remained outside to collect information. Ms. Reeves could not see, from her vantage point, what was going on in the room. She could not hear what was going on in the room generally, or what was going on between the first responders and the officers. She did not hear, she testified, first responders request Corrections Officers take off the restraints.

[219] Ms. Reeves testified that she did not call EMS after the first seizure because Mr. Greene had reoriented, responded verbally, responded to commands, and Ms. Reeves had a standing order for treatment. In response to a suggestion that the best chance of preserving Mr. Greene's life would have been to call EMS after the first seizure, Ms. Reeves said that would not have been "proper practice for us to do that". She added that to suggest that calling EMS after the first seizure might have changed the outcome is speculative. She agreed, in hindsight, that the best possible outcome of Mr. Greene's seizure would most likely result from EMS having been called after the first seizure.

[220] In terms of professional training, Ms. Reeves indicated that as a requirement of her employment with Corrections she is obliged to recertify CPR every two years. There is no other mandatory retraining mandated by Corrections. There are no other professional development opportunities offered through Corrections. In terms of training specific to provision of health services to Indigenous people, as a nurse Ms. Reeves attended Aboriginal Issues in Corrections when she first began her work with Corrections. The course did not relate to the provision of healthcare, but more to understanding cultural differences and possible differences in methods of communication.

[221] Ms. Reeves said she was familiar with nurses on duty at the Winnipeg Remand Centre calling doctors at their other place of work, including St. Boniface Hospital relating to patients in the Winnipeg Remand Centre. Doctors will say, if they are working, that they do not mind being called in these circumstances. Ms. Reeves has called doctors under these circumstances. If Ms. Reeves had been the nurse involved in the admission of Mr. Greene, and if what is recorded on the documentation to the nurse upon admission had been said to Ms. Reeves, she would not have made use of this informal arrangement in an attempt to try to get valproic acid ordered right away.

[222] When asked if there were any condition where she might reach out to the doctor as she had described, Ms. Reeves responded that a severe infection might be an example. Ms. Reeves explained that a severe infection is different because if it is not responding to the standing orders, the doctor may opt to change the antibiotic over the phone. The doctor may also opt to see the individual in hospital. Acknowledging that one seizure could be fatal, and the longer an individual is without seizure medication the greater the risk, when asked to describe how the infection scenario was different than the circumstance Mr. Greene was in justifying outreach to a physician, Ms. Reeves responded that apparent noncompliance with previous medication was a factor in her decision to not call a physician.

[223] Ms. Reeves agreed with the observation that some of the documents on Mr. Greene's medical file did not reflect dates and time. Ms. Reeves indicated this tended to happen when things were busy, but concurred this was not best practice and could result in errors. In fact, sometimes nurses on a later shift would go back to the chart and fill in missing demographic and other information relating to file documents that had been entered by a different nurse on a previous shift. She agreed this was not best practice, and could result in errors.

[224] If the nursing complement ever reached a level where specific deployment of tasks could be accommodated, Ms. Reeves felt it would be better if nurses were assigned to specific tasks such as admissions, or emergency response. She raised this as a possibility with nursing staff prior to her evidence. The nursing feedback was generally positive about this. It would be easier to focus on one task until completion, and not be torn in many directions. Ms. Reeves indicated that nurses are obliged to make notes on anything that could impact inmates' healthcare. Observations related to the inmate that could impact health should be contained in the notes. It is not Ms. Reeves' practice to document another individual's interaction with a patient, including that of Paramedics. If Ms. Reeves were present when the doctor was interacting with the patient, she would not make nurses notes in connection with her observations, but would leave it to the doctor to chart it him or herself. When more than one nurse attends to the same patient event, only one nurse would document. If more than one nurse provided treatment, a single nurse would document and comment on the treatment provided by others. If Ms. Reeves saw another person providing CPR to an inmate, she would document it only if it were another Winnipeg Remand Centre nurse. In Mr. Greene's case, at the time the Paramedics were performing their duties, it was Ms. Reeves' expectation that Mr. Greene would be returned to her care. She has no access to the Paramedics' records. Rather than document the Paramedics' treatment, Ms. Reeves said she would request a copy of the emergency records. When asked whether it would be important to have notes of Paramedic treatment, considering Mr. Greene would be returned to Winnipeg Remand Centre care, Ms. Reeves indicated she has never been in a position, such as she was being asked before in the Inquest, to evaluate whether the nurse charting requirements were sufficient. She agreed it prudent to make observational notes that CPR was done, an IV started, that the patient was intubated, etc. Ms. Reeves said she did not recall that an IV was started in Mr. Greene's case.

[225] Ms. Reeves was referred to staff reports of involvement in the first seizure, noted the report of each of the individuals involved, and observed there was no report from Medical. Ms. Reeves said there was not enough time between the first and the second incident. Ms. Reeves was referred to the report submitted in connection with the second seizure and noted Ms. Reeves' three line report. The entry refers to further information on the medical file. When referred to Health Service Progress Notes, prepared by nursing staff, the only notes written by Ms. Reeves reflect the second seizure.

[226] Ms. Reeves was interviewed July 16, 2016, in connection with Mr. Ed Klassen's Death In Custody Review of July 26, 2016. The interview was not recorded, although Mr. Klassen did take notes of what Ms. Reeves said. Ms. Reeves did not have an opportunity to review Mr. Klassen's notes to determine their accuracy.

[227] When asked why Ms. Reeves chose to stand in a position, outside Mr. Greene's room with no sightline that would have permitted observation of Mr. Greene or the work of the Paramedics after she had given him the injection, she indicated there were so many officers in the cell itself, even if she had stood right outside the cell she could not have seen. She preferred to get out of the way so everyone had room to work. Ms. Reeves had no recollection of firefighters arriving, and Paramedics arriving, and could not comment on Mr. Greene's condition or any change in it. Ms. Reeves' only observation was that Mr. Greene had stopped yelling, because she could not see him.

[228] One of the caregivers came out of the cell, in the process of retrieving equipment, and Ms. Reeves asked him how Mr. Greene was. He responded things were not going well and the inmate had suffered a cardiac arrest. Ms. Reeves did not know whether that individual was a Paramedic or a firefighter.

[229] Ms. Reeves' Health Service Progress Notes say that she overheard EMS state the inmate was unresponsive and had a possible myocardial infarction. The notes do not indicate any direct interaction with emergency personnel but only overhearing conversation from out in the hallway. Ms. Reeves was certain she had direct conversation and could not explain why her chart notes indicated she overheard. She agreed there was no indication in her notes that CPR was preformed by emergency personnel. There also is no indication that Mr. Greene was intubated. There was no indication of the time any treatment was applied because she could not see it from where she had positioned herself in the hallway. Ms. Reeves agreed she was unaware of any treatment applied to Mr. Greene in that cell.

[230] Ms. Reeves was certain she provided a copy of the DPIN to one of the EMS personnel but did not recall to whom. She did not recall having given them any other documentation. Ms. Reeves had no recollection of preparing a Transfer Summary, although that she did so and gave it to Winnipeg Fire and Paramedic Service is referred in Ed Klassen's report as a component of his interview with her. A Transfer Summary would have taken some time to prepare. Transfer Summaries are most often prepared during attendance at the code. Ms. Reeves could not hear

any interaction between Correctional Officers and EMS in the room, or on the range.

[231] Ms. Reeves said whether or not an inmate suffering a seizure in custody is sent to hospital is based on the clinical judgement of the nurse. There is no policy or other guideline to support that decision making process. Ms. Reeves indicated none of the documentation she had in connection with Mr. Greene's admission would have justified a trip to hospital. None of the factors in Mr. Greene's case including the Intox Admission Form where he indicated his medical problem as epilepsy, he was on valproic acid last taken 24 hours ago, his seizure history of a seizure most recently two months prior when incarcerated, not alcohol related, together with his healthcare assessment later done indicating similar information would have sufficiently grounded a decision to transfer to hospital for further assessment. Ms. Reeves said those factors would warrant a review by the doctor. One of the frailties of DPIN is that although it may show what is prescribed, it does not indicate what medication has been taken. Ms. Reeves estimated that one in 10 in custody seizures resulted in a trip to hospital.

[232] When asked to explain the medical rationale reflected in the Winnipeg Remand Centre policy relating to not calling EMS until a second seizure has occurred, Ms. Reeves responded that if an individual recovers well from a seizure, the individual would be retained at the Winnipeg Remand Centre and treated there. If the individual does not recover well EMS will be called.

[233] Ms. Reeves indicated that she would consider a transfer of care to EMS to have occurred, once she has given EMS a history of the patient and as much information as she possibly could, and they have assumed control of the situation and the patient. The information sharing, in Ms. Reeves' judgement, occurs when EMS first arrives. That, in her view, is when the transfer of care occurs. As a consequence, she would not be expected to document every aspect of medical care performed by EMS.

[234] Ms Reeves was asked whether it might have provided a better outcome to start Mr. Greene on valproic acid at the time of his intox admission April 30, 2016, given the information he provided to Nurse Ewen. Ms. Reeves responded that as a rule, nurses will not administer medication to an intoxicated individual even if they have been taking it consistently in the community for reasons of drug interaction, and not knowing specifically what an individual has in their system at that time. Nurses do not know if there is anything else that has been used in that period, and answers may change later on when the healthcare assessment is completed, so it

would not have been considered a safe practice to administer valproic acid at that time. In addition, the DPIN had not been pulled, so his compliance with his medication regime was not known.

[235] This is not a nursing rule. It is a practice that has been adopted by the nurses at the Winnipeg Remand Centre. When asked why DPIN is not pulled before the intox assessment, Ms. Reeves responded that sometimes that is done. Medication would not likely be started, in any event, until after that person is processed. There is no policy relating to when the DPIN information is printed off the computer for nurse use.

[236] Ms. Reeves wished to enhance the staff complement at the Winnipeg Remand Center for a period of time before the incident concerning Mr. Greene. In January of 2016, she identified two successful individuals for a .5 EFT, to work on the weekends, but she was not successful in filling either of those. She had often requested a bulletin for casual staff but management determined those causal shifts be better filled by a nurse working EFT's as opposed to casual staff. Ms. Reeves remained at the Winnipeg Remand Centre until November 2017. Because of changes in the RHA's Ms. Reeves managed to hire about 10 casual staff which drastically increased the complement of nurses. At the time of Ms. Reeves' departure from the Winnipeg Remand Centre in November 2017, she felt an adequate nursing complement was in place.

[237] Although Ms. Reeves only learned that Mr. Greene had epilepsy after the first seizure, had she learned of that before the first seizure, it would have made no difference. Her response to the first seizure would have been identical. She reviewed the chart after the first seizure to determine whether there was any contraindication to the administration of the Valium as planned. Had she the Valium in her code bag at the time of the first seizure, and had Mr. Greene indicated an absence of allergy to Valium, she probably would have administered it at the time of the first seizure. If Mr. Greene suffered only the first seizure, he would continue to be observed and hopefully moved down to the medical unit. His vital signs would be monitored, and if he became agitated or there were indications of an impending second seizure Ms. Reeves would have administered a second dose of Valium in accordance with the standing order continuing to manage the matter in house. Ms. Reeves would have administered further Valium and not valproic acid because valproic acid, in her view, must operate at a therapeutic level to prevent seizure. The Valium would have been more effective.

[238] Ms. Reeves described the medical unit as having two separate standing orders related to seizures – one standing order for withdrawal management which is the "Valium" order, and second "seizure management" standing order which speaks to multiple seizures speaking to the Ativan order. An individual having a single seizure is not part of the standing order, but part of, in accordance with Ms. Reeves' evidence, the "nursing function". It is only when a second seizure, or a seizure of more than five minutes duration occurs, the nurse moves to using Ativan and transporting to hospital. The "seizure standing order" is one in which a doctor has approved the use of Ativan for a second seizure. The authorization for the use of Ativan does not extend to a first seizure. Given the fact that most persons experiencing a first seizure will not have complications, a majority of the time seizures are handled in house. If an individual is not recovering well, remains in a postictal state for a long time, or any other complications, EMS may be called during a first seizure. Only in the case of multiple seizures, or a seizure exceeding five minutes, would a nurse use Ativan. Valproic acid is not used recreationally as a drug of abuse that Ms. Reeves is aware of.

[239] During the intox assessment, police are present, which has been explained by inmates as a reason for difference between answers to healthcare questions given on the intox admission form, and answers by the same inmates to questions in the context of the healthcare assessment where police are no longer present. Ms. Reeves explained the presence of the police proximate to the nurse and inmate, as a security issue relating to the fact that individual has not yet been accepted as an inmate. The individuals, during the intox assessment, are cuffed and shackled, and the nurse is behind a counter. The inmate sometimes can become belligerent or combative. The police officers can encourage the individual to cooperate with a nurse, so their presence is appreciated.

[240] Ms. Reeves said she did not have time to do performance reviews on the nurses at the Winnipeg Remand Centre. If she had time, which she did not, Ms. Reeves would have preferred to perform performance reviews on the nurses yearly. When Ms. Reeves was asked whether she could reach out to her supervisor, in view of the fact that she was nursing as much as she was supervising, could not get to performance reviews, DPIN processing and access was delayed, and she was short staffed. Ms. Reeves responded that she did send emails to her superiors and the superintendent about that. Often times, the response was that there were not additional funds for an immediate solution to the problems.

[241] When asked why the DPIN processing function could not have been handed off to her supervisor, Ms. Reeves responded that she did receive verbal support.

She had dual reporting at the Winnipeg Remand Centre, both to Mr. Ainley the Director of Health Services and also to Corrections**.** Both were aware of the understaffing issue, and workload issues. Ms. Reeves sent emails to both parties. Some issues had resolved over time such as staffing. She did feel she was getting some support in some ways. In other ways, Ms. Reeves very much felt like she was treading water. Mr. Ainley was in the position prior to Ms. Reeves and was aware of these issues.

[242] On the subject of DPIN access, once internet access is granted, Ms. Reeves submitted a DPIN request on behalf of the nurse to Mr. Ainley, and Mr. Ainley would submit the request to the DPIN program. Once DPIN access is granted, Mr. Ainley received the password, and sent the information to the nurse concerned. There is a long and layered process to becoming a nurse in Corrections, according to Ms. Reeves. At first, there is an interview. Documentation must be submitted such as nursing license and CPR certificate, and the candidate must undergo a physical. The nurse must go through security screening which could take from a month to six weeks and longer. Some nurses do express frustration going with the process. Corrections has lost nurses to that process. The time from interview to stepping into a shift at the Winnipeg Remand Centre can be from four to six months, and someone looking for work generally cannot wait that long.

9. Bonny Weber

[243] Ms. Weber, a psychiatric nurse, has been a nurse for about 20 years. She taught at the University of Manitoba supervising practicum students. She worked at Selkirk Mental Health Centre, and various other positions over the years. At the time of her evidence, Ms. Weber had worked at the Winnipeg Remand Centre for a little over three years. By March, April, and May 2016, she was comfortable and familiar with Winnipeg Remand Centre procedures.

[244] On March 12, 2016 Mr. Greene was in the process of being discharged from the Winnipeg Remand Centre just before the end of Ms. Weber's shift. A code was called in the basement, and the two nurses on shift attended in response. Ms. Weber went to assist. The other nurses arrived on scene prior to Ms. Weber. She has no notes of the incident.

[245] The incident occurred mid afternoon. Mr. Greene was in his cell in the admissions area downstairs and had just finished having a seizure. He was rolling on the floor, kicking, and calling out in a postictal phase at the end of the seizure. Ms. Weber had not seen anyone act in that fashion in the postictal phase before.

The nurses attempted to get him to sit up, to assess if he could follow direction. Mr. Greene was not able to follow direction and respond appropriately. Ms. Weber did not recall Mr. Greene in restraints.

[246] Mr. Greene was being released, so he was no longer able to be held in custody. In his best interest, nursing felt they could not just do nothing. The dilemma was they could not keep him, but felt they could not just release him. There was discussion about whether he would be transported to hospital by ambulance or Corrections.

[247] It took 15 minutes from when Ms. Weber arrived on scene for the ambulance to be called. Ms. Weber said that one of the other nurses made the decision to call the ambulance.

[248] Had Mr. Greene remained in custody, Ms. Weber would not have called an ambulance at that time because this was just a single seizure. He had a known seizure disorder. It is not protocol to call the ambulance after a first seizure. An ambulance did arrive, and care was transferred to them.

[249] Ms. Weber did not file a report of the incident, because she was only a passive observer. Her understanding is if she is the one providing care, notes or a report are required. If she is working with a fellow nurse, whatever she did in the case would be documented by herself. Nurses work as a team, and if another nurse provided the primary care and Ms. Weber's role was to provide assistance, the other nurse would make the note. If the other nurse made the note, Ms. Weber would not read it over or sign it. There may be consultation prior to writing the note.

[250] On May 1, 2016 Ms. Weber arrived at 6:30 a.m. for a 7:00 a.m. shift. Generally, she would receive a briefing from the night nurse about events from that shift. When asked whether any mention was made about Mr. Greene, Ms. Weber responded that on that date, there was no night nurse. When it was suggested in fact that there was night nurse the night before, Ms. Weber recalled nothing mentioned about Mr. Greene. It would be unusual for there not to be a briefing from the nightshift.

[251] Ms. Weber recalled working with Ms. Reeves and that she came in for the same time. When the first code was called in connection with Mr. Greene, Ms. Weber recalled both nurses were in the medical office. Prior to the code, Ms. Weber had no interaction with Mr. Greene. After the code was called, Ms. Reeves

and Ms. Weber grabbed the code bag, and went to the floor where the code was called. They were directed to the specific area.

[252] Ms. Weber recalled when she arrived on scene, Mr. Greene was already in his cell. He was restrained, and thrashing around yelling "mum mum mum". That triggered a memory for Ms. Weber and she asked who the inmate was. Ms. Weber remembered him from before as his conduct was the same. She was given his name. There were approximately 10 to 15 officers present. It was Ms. Weber's impression that Mr. Greene was in the postictal phase.

[253] Ms. Weber saw no untoward behaviour by the Correctional Officers towards Mr. Greene.

[254] Ms. Weber remembered talking with the duty officer who was involved in the case of the previous seizure by Mr. Greene in custody. Ms. Weber quickly reviewed her memory of the last event with the SOM and suggested that he just be left to recover in the cell. Mr. Greene was put in the cell, restraints taken off, and left on a mat in the cell.

[255] When observed by Ms. Weber in the cell, Mr. Greene was calming. Ms. Weber did not believe he fully understood what was going on around him. Nurses were trying to reassure him. He did not respond fully to them. The recovery phase can take minutes or hours. Ms. Reeves and Ms. Weber had other duties to perform. There was nothing more they could do for Mr. Greene at that time. Their decision was to have him monitored by Correctional Officers, quickly come back, offer him medication and reassess him.

[256] Ms. Weber did the med rounds that day. No one, officer or inmate, approached her about anything in connection with Mr. Greene's medical circumstances or medication. It is quite common for officers to tell a nurse an individual wishes to be seen but that did not occur on that day.

[257] Should an inmate complete a written request to see medical, when the nurse is on the floor the Correctional Officers give the forms to the nurse. When the nurse is back in the medical office, the nurse reviews the forms. Ms. Weber heard no inmates yelling from their cells about Mr. Greene's medical situation. Mr. Greene was "settling" and an officer was assigned to observe him. Ms. Weber did not know why Mr. Greene was not transferred to a medical area, but speculated that he was able to be monitored by Correctional Officer, had a known seizure disorder, and nothing would have been done differently with him on the third floor than what he was receiving on the fourth floor.

[258] An ambulance was not called after the first seizure because Ms. Weber was following protocol. An ambulance is not called for every seizure and nurses had no medical concerns.

[259] Nurses returned to the medical unit, and strategized the management of their responsibility to the rest of the institution for the rest of the shift. Ms. Weber recalled finding and reviewing Mr. Greene's medical file.

[260] When the second code was called in the same area as Mr. Greene's previous, Ms. Weber and Ms. Reeves speculated it may be Mr. Greene again and developed a plan. They determined that if it were Mr. Greene, and another seizure, he was definitely going out and would be administered Ativan. Ms. Weber recalled the cell door was open, and officers were waiting for the nurses. Some were already involved with Mr. Greene and Bev Reeves said she wanted the ambulance called. In Ms. Weber's view, the duty officer calls and she has never witnessed the phone being given to the nurse. From the time Ms. Weber arrived on scene until the time EMS arrived, Mr. Greene was held down. Ms. Reeves administered the injection, Ms. Weber was standing outside the cell and everyone waited for EMS. Until EMS arrived, Mr. Greene was settling. There was no evidence of seizure. Ativan calms a person, and it was being effective. There was nothing remarkable about Mr. Greene's recovery from the seizure until the time EMS arrived.

[261] At one point Ms. Weber went to the bottom tier, to brief EMS. Some EMS personnel went up to 4A, one remained behind to set up the stretcher and get whatever other equipment was needed, and retrieve information. Bev Reeves was still upstairs with the inmate. Ms. Weber removed herself from the scene because there were many people with Mr. Greene, a nurse was there, EMS was there, and the area was simply crowded. She thought she could meet EMS personnel on the mezzanine floor and impart what information she had. After seeing Mr. Greene receive the Ativan, and absenting herself from the area, she did not see Mr. Greene again. Ms. Weber has seen many seizures, but none that resulted in circumstances such as here. She said people don't usually die from a seizure.

[262] Ms. Weber heard nothing from EMS relating to how Mr. Greene was being treated or handled. Ms. Weber heard no expression of concern from anyone relating to Mr. Greene from inmates or Correctional staff. She was confident that nurses did everything they could to prevent the outcome here.

[263] When asked to comment on the sticky note that had fallen off Mr. Greene's chart, Ms. Weber said the note was just something the nurses had come up with to

meet what needed to be done for each chart. Ms. Weber explained the Medication Administration Record for Mr. Greene, showing valproic acid, 750 mg, once a day, and vitamin B1, 100 mg, both administered at 8:00 a.m. as a document prepared in anticipation of an order by the doctor. When asked if it would not be better to leave the medication and time on the form blank, and leave it to the doctor to assess the medication and time, Ms. Weber responded the form would be crossed out and corrected. She agreed that in order to have written the medications as she did on this form, she must have reviewed DPIN and the chart. Ms. Weber said she did not start Mr. Greene on valproic acid when she reviewed the chart, as that was not within her scope of practice. She said it looked as if he had been without medication for 10 days, and she had questions. When referred to the DPIN printout that Ms. Weber said she reviewed before preparing the Medication Administration Record, Ms. Weber agreed it was clear that Mr. Greene had been prescribed valproic acid 250 mg on two occasions during the time reflected in that dispensing history. DPIN goes back about six months.

[264] Ms. Weber said she would not offer medication to an individual who is intoxicated but was unable to indicate whether that direction was was a rule, practice, or a policy. She ultimately said it was just what she did. Had Ms. Weber access to a physician, she would have written the order as prescribed and followed it.

[265] Except for the one hour daily physician attendance Monday to Friday, Ms. Weber was unaware of a number to call to reach a doctor to assist with patient care. She was not aware of the informal practice of calling in favours from doctors to fill that gap. She has never done that.

[266] In Ms. Weber's experience, people do not normally die from seizures. Ms. Weber described the nurses that day working collaboratively, and one nurse charting for both. She was unaware of a rule requiring each nurse chart his or her own observation. When presented with the Corrections Division Charting Policy, Ms. Weber said she had never seen that document. Upon reflection, she said she may have seen it before, but could not recall. She agreed, when her attention was drawn to it, that the policy required each nurse chart his or her own observation. Ms. Weber acknowledged that in this case, she did not chart her own observations, and said it was practice at the Winnipeg Remand Centre not to do so. When her notes relating to the Code Red for the second seizure were reviewed with Ms. Weber, she had not used approved abbreviations and had not clearly indicated when she had made an error and stroked out an entry as required by the charting policy. She had seen variations from policy in the course of chart notes written by

her nursing colleagues as well as herself. Charting falls down the list of priority, she said, when inmates present with immediate needs.

[267] Ms. Weber has been given no training on charting policies at the Winnipeg Remand Centre and the training she received was shadowing for a few shifts as currently is the case. The senior nurse does not take the new nurse through various policies and procedures. The orientation shifts are more a function of "watch and learn". Ms. Weber agreed this form of training might promote bad habits being passed on. Ms. Weber has not been required to take, or offered the opportunity to take, any training relating to charting techniques at the Winnipeg Remand Centre. No other mandatory training is required other than recertification for CPR. Her chart notes, to her knowledge, had never been reviewed with a view to offering feedback.

[268] Ms. Weber recalled Mr. Greene was in handcuffs and shackles when she arrived in his room for the second code. Ms. Weber did not recall saying to SOM Banks that Mr. Greene's behaviour was a performance, and his audience should be taken away. It did not appear to Ms. Weber that Mr. Greene's postictal behaviour was intentional. In Ms. Weber's view, seizures are very common at the Winnipeg Remand Centre. She has never been given any specialized nursing training relating to seizures. As people don't normally die of seizures, it was not common practice to send someone out after a first seizure and there was a policy that addressed that in any event.

[269] There are different places a patient's chart can be found when one enters the nursing office. Some charts can be found on the nursing desk in the nursing unit, some charts can be found in filing cabinets, and some charts can be found on the nursing assistant's desk. Typically, the files on the nursing assistant's desk are those flagged for review by the doctor. In a case where a nurse comes in on a Sunday, and the chart is on the nursing assistant's desk, it would not be viewed by the incoming nurse but simply left for the doctor when the doctor came in.

10. Kathryn Berens

[270] Ms. Berens has been a nurse for almost 40 years and estimated having treated tens of thousands of patients over the course of her career. Ms. Berens has a Bachelor of Nursing degree, and is a Registered Nurse. The majority of her career has been working in isolated communities with First Nations people. There is no doctor on site the majority of the time in those communities so Mr. Berens is accustomed to working independently in serious situations.

[271] At the time of her evidence, she continued to work at Bloodvein. In addition, she picked up casual shifts at the Winnipeg Remand Centre. In April and May, 2016, Ms. Berens had been working casually at the Winnipeg Remand Centre for about eight years. Her Bloodvein employment required three weeks in the community, and three weeks out. Originally she would attempt to pick up two 12 hour shifts during her three weeks out, which later transitioned to 6 hour shifts.

[272] Every time she would attend for a shift, she would discover something had changed she did not know, because processes were not well documented. When asked about whether she ever had a course or learning session to address issues of policy and procedure, Ms. Berens responded that the general advice given was to use her best judgement.

[273] Ms. Berens said that the policies and guidelines for nursing at the Winnipeg Remand Centre were limited and could be greatly improved. She was never required to take training, or given direction related to requirements for nurses to do a particular form of documentation. There is a written list of main duties for each shift, and when she started a shift she would generally ensure the basement had been cleared out and noon hour meds, if any, prepared. The schedule for shift would be very much fluid, and "see what happens" sort of schedule. The duties would be based on what needed to be done that day.

[274] Ms. Berens indicated that because of her background, her expectation is to work with clinical guidelines. She is accustomed to go to manuals, so if she is not sure how to address a certain problem or issue there is some guidance as to what to do in the situation. There is a wide variety of nursing skill sets and experience employed at the Winnipeg Remand Centre and many do not have the same experience and expertise as northern nurses.

[275] In Ms. Berens' view, the number of guidelines that have been signed off by the physician is too limited. Most seizures are alcohol related, and for the most part it is not about people already on seizure medication. There is a guideline for persons withdrawing from street drugs, which if withdrawn abruptly can result in a seizure. Ms. Berens has a hard time with that guideline, because it is not specific and Ms. Berens is compelled to consult the regular nurses. The policies and procedures are neither clear nor user friendly.

[276] When asked if guidelines were the same thing in her mind as standing orders, Ms. Berens replied standing orders were difficult because one is always dealing with variations with human beings. One needs an assessment of the whole

patient to deliver appropriate care. Ms. Berens was firmly of the view that guidelines and standing orders required improvement. The guidelines were simply too general, and required greater specificity.

[277] This concern about deficiencies in the written directions to nurses at the Winnipeg Remand Centre, included seizure medications. There ought to be, in Ms. Berens' view, greater collaboration with the pharmacist and physicians to complete a list of medications nurses could initiate themselves under appropriate circumstances. It is already being done for some of the medication and not written down. For example, nurses can continue Ventolin for asthma or reactive airway disease. A Ventolin puffer will be provided in the pod without waiting for the physician on Monday. It is a rescue medication. If the nurse has a report an individual is on HIV medication and nurses have the DPIN, the nurse does not have to wait until Monday to ensure they are getting their medication. In Ms. Berens' mind, seizure medication could fall into the same category. Ms. Berens had not seen anything written about the initiation of seizure medications.

[278] If someone were to be admitted on a Friday night with a history of seizure disorder and taking seizure medication, the person is under a lot of stress during admission and may not recall all the medications they are on. They may remember the colour of the medication but not the dose. One need not depend on DPIN information. If the individual recalls the pharmacy they last obtained medication, the Winnipeg Remand Centre nurse can contact the pharmacy for further information. Ms. Berens notes that pharmacists are very, very helpful.

[279] Ms. Berens did not understand why all healthcare providers, including pharmacists and physicians do not collaborate to develop protocols that are safer for patients. Ms. Berens is concerned that nurses are always "picking up" for other professionals, where there are gaps either in the system, or the availability of other professionals. There is not the level of input from the other professionals that Ms. Berens thought important. She emphasized the importance of pharmacy input to inform and support nurse practice.

[280] In Bloodvein, Ms. Berens commonly phones the pharmacist having the contract with questions about, for example, side effects or drug interactions. There is no formalized relationship at the Winnipeg Remand Centre with a pharmacist. Ms. Berens, currently, when nursing at the Winnipeg Remand Centre, has to rely on the willingness of a particular pharmacist to assist her.

[281] In Bloodvein, the ability to consult with a physician is a 24 hour system. Physician support is provided through the Northern Medical Unit. There is a designated physician on call. At the Remand Centre, there is no such arrangement, and a nurse must make a judgement call as to which physician he or she wishes to talk to and there is no designated hospital for communication. For concerns about a potential cardiac issue, Ms. Berens would call St. Boniface Hospital. Ms. Berens thought dedicated access to a physician from the Winnipeg Remand Centre would be very helpful.

[282] The current arrangement where a doctor attends Monday to Friday for an hour is not enough. There can be operational impediments to moving patients within the institution to be seen by the doctor. They are not there long enough to provide a brief in-service on anything. There is no on going opportunity for real education. Weekends can be very busy, and not only is there no physician, but no clerical staff. Nurses are doing everything. It would be helpful to have a physician on call, particularly relating to starting or restarting medication.

[283] When asked about staffing levels and their sufficiency at the Winnipeg Remand Centre, Ms. Berens responded that is why she cut back some of her hours. She does not want to work alone there. It has occurred too many times that she works a 12 hour shift and she is working alone for the last half because someone has called in sick. The minimum staffing level is two, and as a casual there are often changes that a full time staff person would be better aware of. In addition, if there were a code called, Ms. Berens would be there alone unable to have other nursing support or deliver nursing service to anyone else except the individual concerned in the code. It does not feel safe, and in Ms. Berens' view, is wrong.

[284] Nurses do not have enough time to do proper charting. Ms. Berens attempts to chart all patient interactions including when an inmate asks a question, but she sometimes asks them to fill out the yellow request form so their concern is not lost in the busyness of the place. The guards will help them fill out the form if they have any difficulties. Ms. Berens identified a difficulty with medication distribution. She was certain a pharmacist would think the medication distribution system is a throwback to the 1960's. Nurses work with little medication cards and the medication administration manual. The card needs to match the medication administration manual. It can be so busy the nurse who has given out medication has not initialed confirming the medication was given. An inmate can refuse medication, resulting in a placement of the letter R, but there are no codes to explain, for example, if the inmate did not get the medication because they were away at court. In that instance, the inmate did not refuse the medication. They

also did not get the medication. On some occasions, individuals miss a dose of medication. Ms. Berens must set medication aside to determine where the individual is away at court and when they might be coming back. The medication distribution system could be a lot better.

[285] There should be a more refined coding system reflecting medication distribution. Ms. Berens has experienced having medication to distribute, and when she went to record it in the medication administration record there was no sheet. She has no idea how long the individual has been on the medication and she finds it very annoying. It can be very exasperating to work there.

[286] In any pharmacy, there is more than one pair of eyes looking at the pills. At the Winnipeg Remand Centre, there is one set of eyes filling the tray. Ms. Berens needs to be certain she has enough time to review the medication to ensure that her colleagues have filled out the "tickets" properly to ensure no meds have been missed.

[287] As a final check, Ms. Berens will show the inmate the medication and have the inmate confirm that it is in fact the correct medication because inmates know their medications. It can also be an opportunity to reassure the inmate they are getting the right medication. This can be helpful in the case of a medication, for example, that comes in both pill and capsule form and the inmate is accustomed to receiving the alternate. Ms. Berens said she double and triple checks to ensure that not only is she giving the right medication but that she is giving it to the correct inmate as they do no have nametags.

[288] Ms. Berens wished to address issues related to the medication cart itself. The elevator doors do not close properly, and there is a trolley with trays of medication. Ms. Berens' practice is to squeeze off the top of the little medication cups because once the cart hits a bump the pills jump out. This is a significant safety concern for her.

[289] When invited to raise other issues relative to operations in the Winnipeg Remand Centre Medical Unit, Ms. Berens said that the nurses work in a very, very trying environment and that correctional officers do not understand the role of nursing staff there. For example, Ms. Berens has been downstairs processing admissions and it is time for medication tour. If there are still admissions needing to be seen when medication time comes, Ms. Berens believes her medication obligations come first, resulting in tension with Corrections staff. Ms. Berens has an expectation that if there an officer assigned to support medication dispensing,

the officer knows what time is required and that Ms. Berens does not have to go looking for the officer. She also should not have to wait for the officer because an intox could come in at any time and a nurse will have to go back downstairs. Ms. Berens keeps hoping that the work environment for nurses would be made better, and has spoken to the Manager Bev Reeves. There are so many casual nurses and the answers are there. One just needs to bring the nurses together to problem solve.

[290] The nurses at the Winnipeg Remand Centre have a broad range of experience, and there are also nursing units in remand centers across Canada. There must be a way, in Ms. Berens' view, to bring the nurses together to brainstorm solutions for these issues. Ms. Reeves was very receptive to Ms. Berens' suggestions, and asked her to put them in writing.

[291] On March 13, 2016 Ms. Berens responded to a Code Red at 1:04 p.m. Three nurses were working that day, and they grabbed the medical bag and proceeded to the basement where Mr. Greene was. Mr. Greene was handcuffed on the floor, and shackled. The correctional officers were holding him to the floor. He was breathing on his own, and agitated. As a nurse, Ms. Berens had a problem that Mr. Greene was shackled. To secure the airway, the individual must be rolled on their side, and the head protected so it does not bang on the floor. If the individual is postictal, secretions can develop and as a nurse, you want the patient on their side. When one is cuffed and shackled, it is challenging to put them on their side. Shackling will also contribute to the inmate being more panicked and confused. When one comes out of a seizure, according to Ms. Berens, the individual doesn't know where they are. If, when coming out of a seizure, one could not move arms and legs, it could contribute to panic. This could contribute to agitation, and increased breathing, making it harder to settle.

[292] It had been reported that Mr. Greene had a seizure. Ms. Berens was confident Mr. Greene was postictal because he was not answering questions directly and appeared agitated.

[293] As a nurse, Ms. Berens saw her role to protect Mr. Greene, not to be protected from him. She thought it best the environment be managed such that he would not hurt himself. In Ms. Berens' experience as a nurse, the thrashing is very tiring and generally the individual does not go on for too long in that condition.

[294] Ms. Berens recalled a senior nurse with her requesting correctional officers get off Mr. Greene's chest so he could breathe. As a nurse, Ms. Berens found the

manner in which Mr. Greene was dealt with by the correctional officers to be surprising. She was troubled by an individual who has had a seizure being restrained. It was evident to her an individual in that condition was not likely to hurt someone, and she felt it helpful if there would be fewer people in the room to allow Mr. Greene to breathe. The officers did loosen their grip on Mr. Greene, and the decision was made to put him in another room on camera. He was breathing fine, alert, but not answering questions.

[295] In the room, Mr. Greene continued to roll on the floor but it was directed behaviour. The nurses and duty officer decided to call an ambulance. This was the first time Ms. Berens had seen the process by which the institution responded to a seizure.

[296] On Saturday, April 30, 2016 Ms. Berens was not scheduled to work but she received a call that Ms. Brotherston was alone so she came in.

[297] Ms. Berens is well familiar with the DPIN system, but has no recollection of whether or not she checked it for Mr. Greene on that day. Although it can be a helpful tool, it is only as good as the information entered into it. Ms. Berens agreed with the suggestion that her DPIN access password had expired and, as a consequence, she could not have accessed DPIN on that day. This is why, in Ms. Berens' view, she does not like working alone. As a casual employee, she could come to work, find no DPIN access, and need to rely on the access of the other individual she was working with.

[298] Her alternative would be to get the inmate to sign a release, determine whether the inmate recalled his usual pharmacy, and fax the release to the pharmacy to obtain medication history. There were probably times where she was working with a nurse who also did not have DPIN access. Sometimes the shift is too busy to deal with issues relating to medication information access, and, to Ms. Berens' discomfort, she had to leave it for a colleague to access on the next shift.

[299] When asked about missing medical files and whether it happens often, Ms. Berens responded that it has happened to her and she only works casually. It happens at least once a shift that Ms. Berens has to hunt around for medical records, which is time consuming although the record is most often found.

[300] If an individual were admitted to the Winnipeg Remand Centre, and reported to her what his medication was and the dose, Ms. Berens would confirm the dose and give them the medication. Even if an individual showed sporadic compliance with medication taken in the case of valproic acid, Ms. Berens said that people on

seizure medication often don't take their medication. For some people, the side effects are unpleasant. It was clear Mr. Greene had a seizure disorder. A nurse must "go the nine yards" to find out what the dose is. The individual's sporadic compliance with medication would not be a bar for Ms. Berens to giving him the medication.

[301] Ms. Berens was clear that she would give the medication, and face the repercussions if she were wrong in doing so. Ms. Berens would also want to speak to the physician to determine whether supplementary medication should be included as he could be going through alcohol withdrawal as well. Ms. Berens needed to speak to a doctor before she would give the medication, and would find a doctor to do so. She said she would call an emergency department. The fact that Mr. Greene had been potentially noncompliant, in Ms. Berens' mind, had "nothing to do with it".

[302] Ms. Berens thought more clear and full clinical guidelines, together with a list of medications nurses could start on their own, and ready access to a physician would be most helpful. She said it all comes down to education. When a person is sent out to hospital there is not immediate feedback from the facility which would also be helpful to have to properly care for the inmate going forward.

[303] Ms. Berens reiterated her hope that had she been in that situation, she would have given Mr. Greene his medication. She would have the medical chart indicating he had had a previous seizure, Mr. Greene was articulating the correct dose, asking for his medication, and there would be no harm in giving it to him. The DPIN record, potentially showing medication noncompliance, suggested to Ms. Berens she would prefer to consult with a physician, but if she could not she would conclude there was no harm in giving him his medication.

[304] Ms. Berens emphasized that each seizure must be taken individually, considering all the circumstances of the seizure and the patient. She did not take the standing order with respect to medications as a direction an ambulance may not be called after a first seizure should the circumstances require it.

11. Marshall Lawrence

[305] Mr. Lawrence has been practicing nursing since 1985. He holds a Master of Nursing degree from the University of Manitoba. Mr. Lawrence taught intensive care nurses at St. Boniface Hospital for about seven years, but is not currently teaching. At the time of his evidence, his full time position was with the Winnipeg Regional Health Authority in the Department of Anesthesia. He works as a

Clinical Assistant in Anesthesia. In addition, he has worked part time through Manitoba Corrections at the Winnipeg Remand Centre for about 20 years. He worked the nightshift Saturday, April 30, 2016 into the morning of May 1, 2016. When presented with the hardcopy of a DPIN search for Mr. Greene in the early morning hours of May 1, 2016, Mr. Lawrence had no specific recollection of accessing that information, but agreed it was apparently his password used to access the information. It would not be unusual for him to have assisted a colleague by accessing DPIN in this fashion at their request.

[306] When Mr. Marshall is going through the admission process with an inmate himself, he will note in the chart that he requires DPIN and pull it himself. The yellow sticky note filed as exhibit 7, is an example of a process developed to address the issue of what to do next with a file. Prior to the creation of these particular notes, nurses would write on an ordinary Post-it note and it was not always clear what the next step requested was from the note. The notes are usually taped on the front of the file. As to whether the markings on this particular note were his, Mr. Lawrence said the writing was definitely not. As to the checkmarks, it is his clinical practice to initial rather than place a checkmark, so he doubted those markings were in fact his. The sticky notes are not kept but, but discarded. Had Mr. Lawrence pulled the DPIN, his clinical practice would have been to also review the file although he had no recollection of this incident. In a usual situation, if an individual came in intoxicated, Mr. Lawrence would expect to see an intox form in the file. Whether the healthcare assessment would also be in the file would depend on timing. One would also expect to find a major medical problem list and health service progress notes.

[307] In this case, Mr. Greene's DPIN was not pulled until approximately 24 hours after his admission. Mr. Marshall thought that could have been done sooner. He described other means, such as calling the individual's pharmacy, to get information about medication history and the inmate should DPIN access not be available.

[308] Mr. Marshall was asked about a hypothetical reflecting DPIN showing doctors prescribing valproic acid for Mr. Greene twice in six months, Mr. Greene may have requested valproic acid, was aware of the dosage, and had a seizure disorder. Mr. Lawrence was asked whether, in those circumstances, he would give the individual valproic acid in the Winnipeg Remand Centre prior to review by a doctor. Mr. Lawrence said he thought it would be appropriate to continue the valproic acid over the weekend because it is about interviewing the inmate, obtaining the DPIN, noting the apparent gaps in taking the medication on the part

of the inmate, and carefully considering that there was no reason not to give him the valproic acid. The doctor can review the decision on Monday. There is no downside to giving the medication so long as the nurse has done due diligence in interviewing the inmate. There have been cases where there are inconsistencies between the inmate's account and what is reflected on DPIN. Mr. Marshall would then go back and re-interview the inmate. There are certain medications that, historically, are not given out by the Winnipeg Remand Centre. Valproic acid is not one of those medications. It would not have been the clinical practice, at the Winnipeg Remand Centre, in the circumstances, to wake Mr. Greene up in the middle of the night to give him the medication.

[309] To assist the Court with recommendations, Mr. Lawrence was asked specifically about certain issues. In terms of the staffing level at the Winnipeg Remand Centre, Mr. Lawrence thought is was, at the time of his evidence, adequate. He noted that from time to time a sick call cannot be filled and the nurse must attempt to do their best to deal with the situation. He noted in terms of recruitment, the particular challenge in recruiting nurses who wished to work is that environment. The Winnipeg Remand Centre can be an unsettling environment for some people. Mr. Lawrence has tried to recruit individuals whom he thinks would be a good fit. When asked for his perspective on the staffing levels in March and April of 2016, Mr. Lawrence noted there were a few vacant full time positions. He thought, for the most part, shifts were being covered.

[310] When asked to describe the level of documentation in the medical unit at the Winnipeg Remand Centre, Mr. Lawrence explained the various levels of patient interaction. He described the "doorway consult" in which an individual may explain their problem as the nurse is in the area. Mr. Lawrence tells the individual to fill out a medical request form. These interactions are not documented in the file. Sometimes a Correctional Officer will call Mr. Lawrence in the medical unit, indicating an inmate has concerns and wishes to be seen. In that case, Mr. Lawrence pulls the file, reviews it, and reports back to the inmate including concerns about not receiving medication. Those interactions are documented.

[311] Mr. Lawrence described the chart documentation as adequate, noting that years ago the nurses spoke about improving the health assessment form to make it more inclusive, and enhance nurse consistency in filling out the form. As the form presently reads, much is left to the individual nurse's clinical practice. There is a continuum in terms of how each nurse fills out that form.

[312] Mr. Lawrence acknowledged that he is an "outlier" in terms of his clinic experience and his background. Experience and impression of the individual help guide his assessment of the individual's physical health. The other nurses do not necessarily think the same way. They come from a different continuum. The documentation is reflective of the differing backgrounds.

[313] When Mr. Lawrence first started work at the Remand Centre, it was not uncommon to see 15 individuals on a medication round. It is currently not uncommon to see 60 or 70 individuals, with a variety of medical problems. They are generally sicker and there are more individuals with mental health issues on medication. The current needs of the inmate population of the Winnipeg Remand Centre have evolved over time. The newer challenges include individuals affected by methamphetamines, fentanyl, and the Winnipeg Remand Centre medical unit is not a chemical withdrawal unit.

[314] When asked what changes could be made to provide better healthcare and health outcomes, Mr. Lawrence noted the limited access to eChart and the information that could be accessed. He thought for the most part, the Winnipeg Remand Centre medical unit does a good job but nurses are limited in how much of the whole picture they are able to determine. In terms of physician access over the weekend, Mr. Lawrence highlighted the situation where over the Easter weekend a chart may not be looked at by a physician for four days. Phone access to a physician would be helpful but the presence of a nurse practitioner on site everyday would also be helpful. A nurse practitioner might be beneficial in assessing many of the issues nurses are confronted with. Mr. Lawrence did not feel access to a pharmacist is necessarily a challenge, because in his experience he can always find a 24 hour pharmacy with a pharmacist willing to answer a question. A list of dedicated pharmacists willing to answer questions, with whom there is a formalized relationship, would enhance patient care.

[315] Diabetic individuals used to be all in one unit, but they are now scattered about the institution for reasons relating to Corrections. They used to be all on one floor where the nurses could see them. An individual on the locked unit requires three officers to be moved to the medical unit. Immediate access to inmates when necessary is not always as available as before.

[316] As to Mr. Lawrence's thoughts on the fact that it took 24 hours to pull Mr. Greene's DPIN, Mr. Lawrence said that the teacher in him, when he is training, emphasizes the necessity to take ownership of a task and finish it to completion. Don't leave work for someone else to try and sort out. Had there been someone on

site with DPIN access when Mr. Greene was admitted, the DPIN would have been pulled and it would not have been left for him to do 24 hours later at two in the morning.

[317] The card system used to dispense medication at the Winnipeg Remand Centre is a system that was used when Mr. Lawrence was in nursing school in the 1980's. Currently, in most places, dispensing is computerized. The turnover rate at the Winnipeg Remand Centre would make a computerized system impractical. Noting that dispensing safety is not Mr. Lawrence's area of expertise, it was his impression that a computerized system is safer. One noteworthy feature present at the Winnipeg Remand Centre is that the inmates do not wear wristbands as do patients in other medical settings. There is no ability to compare the medication ticket to the wristband to make sure the nurse is giving the medication to the right person.

[318] Demands from the admissions department to see people and move them through into the institution, versus the other clinical duties, balanced with people having to go to court can render the nursing environment hectic but not unmanageable. There can also be instances where multiple codes occur at the same time. Mr. Lawrence described his own training experience at the Winnipeg Remand Centre as being thrown in there to fend for himself, working a variety of shifts with a variety of other nurses.

[319] It is common to see individuals at the Winnipeg Remand Centre who have been inconsistent in taking their medication. In the case of Mr. Greene, having reviewed the DPIN, Mr. Lawrence would have interviewed him to obtain an explanation of how he was taking the medication. Valproic acid requires a drug level, so Mr. Lawrence would attempt to assess the circumstances.

[320] Mr. Lawrence considered that the Intox Admission Form for Mr. Greene in which he stated that he was on valproic acid at 250 milligrams three times a day, together with the healthcare assessment where he gave identical information, together with the DPIN showing the medications that had been dispensed would be sufficient, taken together, to enable Mr. Lawrence to give Mr. Greene valproic acid. Mr. Lawrence could not think of any reason why he should not have been given this medication, after speaking to Mr. Greene about the apparent inconsistency in taking it.

[321] Common practice, for the last 20 years, is that after interviewing inmates and gathering information looking for consistencies or inconsistencies in the

inmates' report of their medication taking behaviour, the nurse would decide whether the doctor needed to review the file. Standing Order no. 50.6 (inmate medication review) that came in to affect August 22, 2016 after Mr. Greene's passing, is clear in allowing the nurse to decide, using clinical judgement to make the decision whether to continue medication or not. The Standing Order does not contain guidelines to assist in making the decision. Based on Mr. Lawrence's experience, the criteria he would use to decide whether or not to continue medication included whether the inmate has a past history with Corrections, medication that has been previously prescribed for that medical problem, and generally other indicators of reliability. Mr. Lawrence does not start medication for anyone he has not interviewed.

[322] Mr. Lawrence agreed with counsel's suggestion that it would be helpful to have clear criteria to assist the nurse in making that decision. A jail is a unique nursing environment unto itself. Dealing with incarcerated individuals, and security issues results in some new nurses having no idea of the experience or the environment until they are there.

[323] Mr. Lawrence calls the hospital to speak to the Winnipeg Remand Centre physician or another emergency doctor if the Remand Centre doctor is not working or available, when a situation arises at the Winnipeg Remand Centre requiring a doctor consultation. He recognizes that, in doing so, the doctor is not within the scope of their contract and, in fact, doing a favour. Mr. Lawrence has also called pharmacists in the community at a pharmacy to obtain a pharmaceutical consult. In both instances, it was his view that access to a contract physician and contract pharmacist when needed could only enhance the safety of a nursing environment for both patients and the Winnipeg Remand Centre.

[324] In front of the medical pod, there are two isolation cells, a slightly larger cell where multiple inmates can be housed, and two other single cells. Mr. Lawrence's view was likely the initial intent was that this area was designed as a medical unit where medical staff can respond more quickly. In addition, where an inmate has a mobility issue like the use of a wheelchair, the individual has difficulty mobilizing because of multiple stairs and may be placed in the medical unit. Although this may be what the architect had in mind, prioritization of appropriate placement of individuals in the unit can be a challenge. The current utilization involves nurses having at least some say in who goes into those cells. In Mr. Lawrence's experience, those cells are always full.

[325] In terms of continuing nursing education through the Winnipeg Remand Centre, Mr. Lawrence noted that one's CPR could be recertified. Mr. Lawrence recalled being required to take an online course as an expectation of his work with Corrections related to the provision of healthcare to Indigenous people.

[326] For any seizure at the Winnipeg Remand Centre Mr. Lawrence would call EMS. Seizures are extremely variable in their presentation and duration, and in the course of his career Mr. Lawrence has seen hundreds of them. The typical seizure from alcohol withdrawal can demonstrate a usual presentation of seizure, postictal phase, and recovery. In over 20 years at the Winnipeg Remand Centre, Mr. Lawrence estimated he had observed 20 to 25 seizures. He sees one approximately every six months. On each occasion, Mr. Lawrence contacted EMS, and the inmate was taken to hospital. In Mr. Lawrence's experience, it has never been the case that EMS responded to a call about a seizure, and not taken the inmate to hospital.

[327] By the time EMS arrives, generally the individual is in the postictal phase. Although Mr. Lawrence did not see Mr. Greene's first seizure, his general clinical practice would have been to call EMS after the first seizure. Mr. Lawrence's practice arises from concern for the safety of the Correctional Officers, his own safety, but most importantly the individual. Mr. Lawrence had not had a situation where an individual had a seizure, he gave them valium, and then sat and watched them. He was firmly of the view that an individual suffering a seizure needs to be seen by a physician.

[328] Mr. Lawrence, when asked about processes related to the "doorway consults" previously referred in his evidence, emphasized the importance of instructions to the inmate, should the doorway consult result in concern, to fill out the yellow request form usually picked up from the unit on the next med rounds. Sometimes the officers bring the forms to the medical unit. The medical file is pulled, the request reflected on the form is evaluated in the context of the medical file, and a list is generated of individuals for the doctor to see or charts to review. All Corrections Officers are familiar with the form.

[329] When Mr. Lawrence was asked about his view that after a first seizure any inmate should be sent to hospital, he said the safest thing is to call an ambulance, have them go to the hospital, be examined by a doctor, and have clinical decisions made. The Winnipeg Remand Centre is not necessarily equipped to deal with multiple seizures. When Advanced Paramedics come, they are authorized to use different medication than that available through the Winnipeg Remand Centre.

[330] When referred to the Standing Medication Order, which appears to contemplate a second seizure before Paramedics are called, Mr. Lawrence said he does not read it that way. He said it does not seem to him reasonable to take out a stopwatch and time whether a seizure is four and a half minutes or five minutes referring to the provision where a single five minute seizure prompts a call to EMS. In describing the continuum of seizures that an individual could have, Mr. Lawrence emphasized he would not keep an inmate in custody if they have a seizure without having a doctor see them. Mr. Lawrence indicated that where his clinical practice may differ from an interpretation of the Standing Medication Order, his clinical practice will determine whether or not he calls an ambulance.

Director of Health Services – Community Safety Division

12. Christopher Ainley

[331] On the day of Mr. Ainley's testimony, he had been the Director of Health Services with Manitoba Corrections, recently retired in June of 2018. Prior to his retirement, he held the position for five years. He was the Health Services Manager at the Winnipeg Remand Centre from 1996 to 2013. He started his career with Manitoba Corrections in 1986 as a general duty nurse at the Winnipeg Remand Centre, and when the Remand Centre moved to its present facility in 1992, he became the first Corrections Psychiatric Nurse. He held that position until 1996, when he became the Health Services Manager. Mr. Ainley holds a Diploma in Nursing from 1984, from the Health Sciences Centre, and a certificate in Healthcare Management from the University of Manitoba in 1993. When he first started nursing, Mr. Ainley worked at the rehabilitation hospital with spinal cord injury patients, amputees, and individuals with diabetes.

[332] Mr. Ainley explained the Director of Health Services position he held from 2013 until June, 2018, was a difficult position to describe. He primarily acted as a resource to the Health Service Mangers in the nine correctional centres, liaison between custody and health service, and between health service in the correctional service and Manitoba governed health services. He was involved in policy, anything clinical, and generally anything to do with the care of inmates in custody. The Health Services Managers occupied a unique position, reporting to Mr. Ainley on matters clinical but operationally on custody issues directly to the Superintendents of the individual correction centres.

[333] At the time of the incidents relating to Errol Greene, the Health Services Manager was Bev Reeves. The responsibilities of the Health Services Manager are

very complex. Primarily, the responsibility of the Health Services Manager is to ensure that inmates, who become patients of the medical unit, receive the healthcare that they need. It is very much a working manager position, so they are often required to fill in shifts or add extra help during busy days. It is a close working relationship. Currently, the Director of Healthcare Services reports to the Executive Director of Rehabilitation Services. In the past, the position reported to the Executive Director of Custody. The change occurred in approximately 2015. The rationale behind the change in reporting is a desire to enhance prioritization of attention in an appropriate fashion to healthcare services and an attempt to enhance consistency in the clinical application of healthcare.

[334] The impact of this shift is that healthcare moved from the custody responsibility in Corrections to the rehabilitation area of Correctional Services. Healthcare tried to "ride the fence" between correctional operations and providing healthcare. Funding for health services comes from the general operating budget of each of the correctional centres. The result is pressure put on the Superintendents and their administrative groups to try to balance healthcare needs with custodial and security needs within the institution.

[335] The mandate of healthcare services within the organization is to provide the care required by inmate patients and ensure they leave healthier than when they came into custody.

[336] Some of the special challenges of providing health services in a custody environment include simple access to patients. It is difficult sometimes to see people when you want to arising from security issues. The inmates are locked up and separated from the healthcare providers. Resourcing is always a particular challenge. It is difficult to recruit nurses, and the process is very long for recruitment and hiring. The prioritization of the service itself within the centre can present challenges. The problems with the length of processing of successful applicants relates to government processes.

[337] The provision of health services in Corrections has changed significantly over Mr. Ainley's career. When he first started, 100 people in custody at the Remand Centre was a significant number. The health needs of the inmates were a little more predictable, and less acute and complex. The numbers of inmates has increased generally over the years. Currently, the needs are often lifestyle or substance abuse related, and, in particular, meth makes the issues more complex. When Mr. Ainley began, when people came in intoxicated, it was generally

alcohol. Now, nurses never know what someone is intoxicated by. That factor alone complicates everybody's health picture.

[338] When asked to compare the nursing environment with other nursing settings, Mr. Ainley noted that generally the patients are between 18 and 45. Mr. Ainley likened the nursing environment to a cross between a doctor's office and northern medical unit. Mr. Ainley estimated that 99% of the people that come in leave much healthier than when they arrived.

[339] Mr. Ainley said there were no accreditations or certifications required in relation to running a medical unit in a custodial facility. Mr. Ainley indicated that the nursing standards required are those of all nurses. He in particular is active in this area is serving the third year of a three year term on the council of the College of Registered Nurses of Manitoba. Standards for nurses are fairly broad, related to providing appropriate care within one's scope. A nurse must maintain competence and maintain one's license, acting ethically.

[340] Mr. Ainley said there are no specific standards that apply to charting but there are skills or duties a nurse is required to perform covered in training. From time to time the College will put out suggestions regarding the legalities of charting, soft directives to stop using contractions or abbreviations for example. The provision of medication to a patient is not specifically described in standards, but it is covered in training. Nursing standards would not apply, for example, to problems where pills might jump from one pill cup to another, and it is the nurse's responsibility to ensure that the medications given to the patient are the correct medications. The process would be for the nurse to go to the Health Service Manager, and raise the concern. It is not a requirement, according to Mr. Ainley, that nurses have DPIN access, and there are places where they do not. The contents of DPIN are also reflected as part of the eChart system. Correctional nurses do currently have access to eChart and had that access from 18 months prior to Mr. Ainley's evidence.

[341] Mr. Ainley has seen hundreds of seizures. Up until the time of Mr. Greene's death, very few inmates were sent out to hospital after a first seizure. They were managed in-house, following Standing Orders in existence. The threshold until Mr. Ainley's retirement in June of 2018 had lowered, and far more were being sent out. The decrease is, in part, a result of what had occurred with Mr. Greene. Mr. Ainley had conversation with the Health Sciences Centre as a result. Their emergency room is extremely busy, and bringing someone in for a seizure that has resolved and managed in-house seemed "a bit off" to them. They

have absorbed it, and it has become a non-issue. Of all the seizures Mr. Ainley has been involved with, there have been two deaths including Mr. Greene. The previous one was in 1986. It is part of nursing duty to prioritize who might require direct observation and there is a facility to place an individual in an area where they are more likely to be observed. There is a protocol for observation of intoxicated people.

[342] There is no protocol specific to the observation of someone who may have a seizure, but there is for monitoring intoxicated people.

[343] Correctional centres are not medical facilities. Medical care must be provided because inmates need it sometimes. The correctional pressures are great and healthcare needs are sometimes prioritized differently than they would be in a purely medical environment. A nurse could be in the middle of a medication round. If they are the only one on and an intoxicated person is brought in, the nurse would be called from the medication round and medications need to be secured and put away. The nurse would then go down to see the intoxicated prisoner. Mr. Ainley described this issue as a small example.

[344] Having police officers wait at the Remand Centre for an individual to be assessed upon admission keeps officers off the street while that process progresses. Often, there are lineups of individuals waiting to be processed for admission to the Winnipeg Remand Centre, and the officers must wait with them.

[345] Commenting on the possibility of a designated nurse dealing solely with admissions to address this issue, Mr. Ainley said the idea was "kind of utopian". They would have periods of hurried work, together with periods where they were sitting idle. Doing that would not be the best use of resources.

[346] Prior to Mr. Greene's death, Mr. Ainley had no contact with him. Whenever there is a death in custody, there is always an internal investigation. Mr. Ainley's role is to review the health record and speak to the nurse manager to get a sense of whether the care provided was appropriate. Mr. Klassen was conducting the review, and Mr. Ainley provided the health records to Mr. Klassen to be included in his report. Mr. Ainley reviewed the written documentation in the health record, and compared timelines to the COMS entries. His analysis also involved making a determination as to whether something could have been done differently and getting a sense of what the issues were at the time. Mr. Ainley could not recall speaking to anyone except Bev Reeves. He could have interviewed the nurses

involved had it been requested of him. The medical care appeared to be appropriate at that time.

[347] Staffing is an ongoing issue but Mr. Ainley was of the view that it was difficult to address unless one were to completely overstaff the unit. There was heavy reliance on part time and casual nurses, but if they do not have length of warning as to when they will be required they tend to find work elsewhere.

[348] Under the *Regulated Health Professions Act*, C.C.S.M. c. R117 (*RHPA*), as of May, 2018, nurses are no longer permitted to work from standing orders for medications that have not been prescribed for a specific patient and cannot be given. General standing orders are no longer permissible. According to Mr. Ainley, prior to the *RHPA* nurses were getting a little more worried about giving medication that had not been directly ordered for that patient. Now the physician attends the Winnipeg Remand Centre seven days a week in order to write prescriptions on the weekends.

[349] As to the conduct of the nurses, Mr. Ainley had no clinical concerns except the inability to assess Mr. Greene after the seizure because of his postictal response. Mr. Ainley had no concerns about the administration of Ativan to Mr. Greene after the second seizure, or how it was done. In Mr. Ainley's experience response to a code is a very cooperative enterprise. The role of a nurse in a Code Red is to direct and provide care required. The correctional role is to ensure that everyone is safe in that process. That Correctional Officer Wiens was left observing Mr. Greene was not a concern to Mr. Ainley. Correctional Officers are often the eyes for a small medical resource. The reoccurrence of a seizure is usually pretty visual. Having a medical person observing Mr. Greene would have been better, but again that is asking for a "utopian situation". That is just not possible in a custody centre.

[350] The recommendation in Mr. Klassen's report that unit medical logs be retained for a year, results from records normally kept in the unit of inmate requests for over the counter medication normally kept for a year reportedly destroyed in this case. Mr. Ainley believed it an error they were destroyed this time. Another recommendation was for Quality Assurance Processes for the medical unit. Before Mr. Ainley left in July of 2018, he developed a process for systematic review of charts so each Health Service Manager had to review a medical record once a week and document that review in detail so that if follow up were required with a specific nurse it was taken. Less detailed documentation was

to be sent to the Director that reviews were completed. As far as Mr. Ainley was aware, that was still in effect.

[351] When asked about whether any steps had been taken to address the challenges with DPIN access by nurses in this case, Mr. Ainley emphasized that this requires time. DPIN and eChart are both administered by Manitoba Health, and access to internet is an institutional process. Applications, when Mr. Ainley was Director, were sent to him but Mr. Ainley said the duty now sits with an administrative assistant so there is someone available every weekday to process.

[352] Where an inmate indicates being prescribed a certain medication, Mr. Ainley said Winnipeg Remand Centre medical unit staff try by any means available to verify that is the case. Now, the information goes before the physician. In the past, if verification that the medication had been prescribed were achieved, Winnipeg Remand Centre medical staff would continue the medication in most instances until reviewed by a physician.

[353] In terms of after hour physician contact, Mr. Ainley said he was aware that even though not contracted to do so the physician normally attending the Winnipeg Remand Centre would sometimes take calls. EMS is also far better able to respond to an emergent case, and is another resource. Currently, resources available to Winnipeg Remand Centre nursing staff are a doctor who may be called, the doctor who comes in next day, and EMS.

[354] As to the issue relative to the potential for healthcare services to be delivered at the Winnipeg Remand Centre by a Health Authority, as opposed to a Correctional Facility, knowing of the Inquest's interest in this area Mr. Ainley made some inquiries. His research determined Nova Scotia has correctional health services delivered by the Health Authority, Quebec is currently a hybrid moving toward health authority service delivery, Alberta was the first correctional service to transition to health services through Alberta Health, and British Columbia is moving towards healthcare by British Columbia Health. Alberta is the province with whom Mr. Ainley has had the greatest contact, and their Director of Health Services provided Mr. Ainley with insight into how the system is currently working. The Director of Healthcare provided in Alberta correctional facilities is actually a psychiatrist. Mr. Ainley, based on his research, was unsure of the details of the transition in each province, but indicated the transition involved a two year planning process and a two year implementation process for a total of four years in Alberta.

[355] The feedback on current operations provided by those provinces transitioning or transitioned, include that the positives are better continuity of care for inmates. It is more expensive to provide care in the institutional setting as more staff are required to deliver care, but in the long term there are savings as people do not escalate to an acute stage as they would otherwise. Long term, it is much better for the patients but costs more initially. One of the other downsides is staffing stability, as nurses can transfer more easily between corrections and community nursing, should they determine correctional nursing does not suite them. Currently, nurses working in Manitoba Corrections can enjoy long careers solely with Manitoba Corrections.

[356] Mr. Ainley thought all of the Winnipeg Remand Centre human resources issues are concerning. Often good people are lost because the hiring process takes so long. It is a stressful milieu to work in, and the retention of part time people is an ongoing challenge. Nurses are sometimes surprised by the breadth of knowledge and nursing skills required in the correctional setting. At the Remand Centre, in particular, the rate of admission is significant, and a high percentage are intoxicated to some degree. The interaction is difficult, in the sense that the nurse is not always receiving all the information necessary.

[357] Arising from the implementation of the *RHPA*, the former standing orders with respect to medications are no longer acceptable. Because nurses are no longer able to accept delegation to continue medication from physicians as a standing order, the nurses at the Winnipeg Remand Centre are currently developing protocols appropriate to the new medication distribution model. Medications that are non-prescription are still appropriately covered by the Standing Order for Medication. The Health Service Managers under the direction of Ms. Reeves, are developing protocols for emergency doses, rather than ongoing care.

[358] For example, in the instance of a seizure related to withdrawal, there would still be provision for one emergency dose, but all subsequent doses will need to be authorized by a physician.

[359] Nurse Practitioners are still able to prescribe medication, and the Nurse Prescriber designation permits prescribing after several years training. What can be prescribed by a Nurse Prescriber is limited.

[360] When asked about his view of the use of restraints in Mr. Greene's case, Mr. Ainley indicated he would always prefer not to have to restrain people. The decision to restrain in the milieu in which correctional nurses work is not that of

the nurse. Where Correctional Officers assess there is danger to either the inmate or other people as a result of their actions, they are generally restrained. Restraint can actually facilitate the provision of medication. If a person is lashing out, it is far safer for everyone if the individual is restrained while the medication is administered. Having read of Mr. Greene's postictal response, it made sense to Mr. Ainley that he was restrained. The syringe itself presents risk before, during, and after use.

[361] Mr. Ainley indicted seizures at the Winnipeg Remand Centre have historically been a problem, were a problem at the time of Mr. Greene's passing, and will always be a problem. The only training nurses received specific to seizures is in orientation, and ongoing experience at the Winnipeg Remand Centre. There is a checklist of tasks that must be completed, but there is no classroom training and the orientation is essentially job shadowing. Withdrawal seizures are more common than seizures from other causes at the Winnipeg Remand Centre. Access to the medical chart, at the time of a nursing Code Red, is dependent on where the nurse is at the time the code is called. The chart is sometimes brought to the nurse with the code bag. When asked how that could be if the name of the patient is not provided at the time the code is called, Mr. Ainley confirmed the nurse does not know who it is until the nurse gets there unless the nurse is in a position to call ahead of time. Electronic access by tablet or otherwise to a patient's medical file would be helpful**.**

[362] At the time surrounding Mr. Greene's death a single nurse was on duty sometimes. That continued to be the case until Mr. Ainley's retirement. In 2016, the Winnipeg Remand Centre was often over its 286 person capacity. Inmates had serious and acute medical problems, and were sometimes served by the presence of a single nurse. Mr. Ainley said if an individual needed to be in hospital, they would be. The single nurse would have to distribute medication, perform intake admission protocols, treat inmates with routine medical problems, update charts, pull DPIN records, make notes for the doctors and nurses on the next shift, and stop everything they were doing and respond to a Code Red whenever it was called. That would be a lot of work for two people. It is certainly a lot of work for one person. The nurse would have to prioritize tasks and time. Prioritization is a large part of the job. The nurse would be required to focus on what the nurse perceived the most urgent task. There were times when the nurse was unable to get to all of the tasks in the course of a shift.

[363] Although there are no particular requirements for how nurses dispense medication, there are best practices. Best practice would require the nurse who

prepares the medication, gives it to the patient. Mr. Ainley was aware that that best practice was not followed at the Winnipeg Remand Centre. Because of time pressures, generally the night nurse will prepare morning medications.

[364] Mr. Ainley recalled nurses expressing concern to him about working alone. To remedy that, Mr. Ainley said that one takes all steps possible. When he was a Nursing Manager, he often came in. Ms. Reeves often came in. You do what you can do, and sometimes there is nothing you can do.

[365] One tries to get as many part time and casual nurses as one can. The difficulties in the hiring process for nurses is well known, and Mr. Ainley had discussed it with his superiors. Hiring is a totally separate department, and their protocols are their protocols. Mr. Ainley is confident his concerns were expressed to the other department.

[366] In 2016, a nurse, in the absence of corroborating evidence confirming a patient was on a certain medication, could decline to continue it. The patient's report, standing alone, that the patient was taking that medication was insufficient to continue it.

[367] At the time of Mr. Greene's death, an inmate coming into the Winnipeg Remand Centre on Friday night would not have an opportunity to see a doctor until Monday, unless they went out on an emergency basis. Whether that occurred was at the discretion of the nurse.

[368] Nurses are required to maintain their competency through ongoing professional education, and on occasion there are courses offered by Manitoba Corrections to nurses but they are more related to the milieu and patients non-medically. Mr. Ainley referred to a gang awareness training, and suicide risk assessment, but nothing is offered relating to more prevalent medical conditions seen in corrections. Sometimes nurses are permitted to go to community programs such as programming at the Health Sciences Centre related to pathogens and infections for example, but that is only permissible should there otherwise be sufficient staffing.

[369] When asked for recommendations Mr. Ainley might have for this Inquest to consider, Mr. Ainley noted that for a period of time no one knew who Mr. Greene was. There is no way to know who anyone is with any degree of certainty unless they are known from before. Some form of inmate identification would be of assistance. Electronic medical records, easily available through tablet or some other form of electronic device, would also be helpful. To Mr. Ainley's

knowledge, there are no regulated requirements for the delivery of health services in a correctional institution in Manitoba. He thought some form of standards might be helpful because regulation would lend itself to consistency of service delivery, quality control, and could provide a means of assessing the needs of a particular institution. In addition, Mr. Ainley thought it important that every nurse working a shift at the Winnipeg Remand Centre have DPIN and eChart access. Mr. Ainley thought eChart of greater value than DPIN, because it contained information accessible through DPIN and, in addition, certain diagnostic information.

[370] When asked about accreditation providing a benefit to patients and the medical unit at the Winnipeg Remand Centre, the concern Mr. Ainley had was resourcing to be able to meet accreditation standards. Mr. Ainley was not optimistic about the possibility of obtaining new resources to meet standards that may be required through accreditation.

[371] Mr. Ainley noted medical services in provincial corrections are now under the supervision and direction of rehabilitation services rather than custody services as before, but funding for the medical unit at the Winnipeg Remand Centre remains under custody services. Ms. Ainley feels this model to be concerning. It remains difficult for prioritizations in health service delivery in the Remand Centre medical unit to be made in the way that health professionals would prefer.

[372] When asked about the potential for a physician medical director for medical services in provincial corrections, Mr. Ainley advised that there had been such a position. When Dr. Robertson, who held the position, retired the position was not filled and redeployed into the director of medical services nurse position as it currently exists.

[373] When asked about the cells dedicated to medical, Mr. Ainley indicated they were right across from the nursing desk and suitable for delivering immediate medical attention but are often occupied by people with mobility challenges. Every other unit in the Winnipeg Remand Centre has stairs which rendering them unsuitable for those with mobility problems.

13. Beverly Reeves – Evidence as Director of Health Services

[374] Ms. Reeves testified on a second occasion, after she was appointed Director of Health Services as a consequence of Mr. Ainley's retirement from the position. Her evidence on the second occasion was for the purpose of exploring operational and other changes at the medical unit of the Winnipeg Remand Centre as a

consequence of registered nurses being brought under the jurisdiction of the *RHPA.*

[375] Ms. Reeves advised that in addition to the previous practice of a physician attending the medical unit of the Winnipeg Remand Centre Monday to Friday, physicians now attend for chart review over the weekend. The change is a result of the *RHPA.* Recently, the College of Registered Nurses of Manitoba has developed regulations and practice expectations around the legislation nurses are bound by. Previously, physicians gave generalized standing orders for certain types of health issues. The nurses could take the standing order and apply it to the particular health issue where the physician has indicated certain appropriate medications. Currently, in accordance with the *RHPA* and College changes, physicians can no longer delegate that practice to nurses. Physicians' orders must be client specific. The physician must review each file and each incident individually and apply a prescription or doctor's order to that patient.

[376] Previously, on weekends, the nurse may, where appropriate, initiate an antibiotic, for example, but currently they must consult a physician. Physicians are currently coming into the Winnipeg Remand Centre on the weekend to look at health issues that might require prescriptions, and perform chart reviews as nurses are no longer able to continue medication. In addition, physicians are now available by telephone for any type of semi-urgent or non- emergent situation. If the nurse feels the situation warrants a call to the doctor, and the situation cannot wait until the doctor comes in for a chart review, the nurse has the option to call the doctor.

[377] A Clinical Decision Tool is developed in collaboration with nursing staff, the physician, and the pharmacist at certain institutions for emergent situations where there is no time to call a doctor to administer lifesaving medication. It is similar to a previous Standing Order. It identifies specific symptoms, and a course of action to be embarked upon approved by the physician and developed in collaboration with the physician.

[378] Generally, under the *RHPA*, the administration of medication would be considered outside the scope of the nurse, but because the Decision Tool is developed in collaboration with a doctor a nurse could administer lifesaving medication. The nurse would then advise the doctor after it has been done. At the Winnipeg Remand Centre, those matters that would have been the subject of a Standing Order, in emergent circumstances are being developed into a Clinical Decision Tool.

[379] Non emergent matters cannot be dealt with in this way. They must be subject to a physician visit or telephone call consult.

[380] The Clinical Decision Tools have been developed collaboratively. The Health Services Managers of all nine correctional centre medical units in Manitoba have gotten together to examine best practices, internet research on best practice, and collaboration with pharmacist and physician. The Clinical Decision Tool must be approved by the physician, and in the case of medication administration, the pharmacist. The tool development was also in collaboration with the College.

[381] One aspect of the Clinical Decision Tool is descriptive of the symptoms and discussion of best practice as to what is recommended as best practice. The second part of the Clinical Decision Tool includes the form the nurse uses, directing step by step how the nurse proceeds forward.

[382] Each individual institution may have different parameters for physician on call. Nurses at the Winnipeg Remand Centre, according to Ms. Reeves, would be aware they have the ability to consult with a physician 24/7, and "should have" the on call names posted. Ms. Reeves said she would have to check that to be sure. She was confident the nurses know they could call a physician whenever needed. She was not aware of any limits on what time a nurse may call a physician. She was not aware of any guidelines with respect to this practice.

[383] When asked whether there had been any discussion about how the process of the physician weekend attendance, and new on call expectations was going, Ms. Reeves indicated that normally she would only hear about complaints. She had received no complaints, and said "I am thinking that it is probably going quite well". Having more resource and physician coverage is a good thing, and she can confirm that she was not receiving complaints. There are no restrictions relating to when an ambulance may be called.

[384] There is no restriction on medications that may be prescribed except for "huge ticket items" where there is further examination on need.

[385] Ms. Reeves is not currently involved in any discussion with respect to the movement of Winnipeg Remand Centre health services from Corrections to operations by the Health Authority. She has just a basic knowledge of accreditation for health service facilities, and that it provides guidelines, best practice standards, and involves health facilities being reviewed to ensure compliance with certain guidelines. She is aware that Accreditation Canada has an accreditation package for provincial correctional institution healthcare facilities.

Ms. Reeves is aware the medical units in federal facilities operated by Correctional Service Canada (CSC) are accredited. She believes accreditation was instituted within the last year. Any knowledge Ms. Reeves has about the process involved or how long it might take to achieve accreditation was only through numerous friends who work for CSC. It is her impression the process is resource intensive. When asked about the intersection between movement of the Winnipeg Remand Centre medical unit to operation by the Health Department, and the process of Accreditation, Ms. Reeves observed that both processes are very labour intensive and lengthy. Ms. Reeves was unsure whether if operations of the Winnipeg Remand Centre medical unit transitioned to operation by a Health Authority, whether accreditation would be required.

[386] When asked about the potential helpfulness of increasing physician clinics at the Winnipeg Remand Centre from one per day to two, Ms. Reeves had not heard the existing one hour a day clinic model was inadequate. Nurses do a really good job of triaging, so the most acute inmates are seen for urgent issues first. Physicians will sometimes stay if there is an urgent case that needs to be seen before they leave.

[387] In terms of continuing education for correctional nurses, Ms. Reeves indicated she would like to see more education for nurses. However, correctional nurses do have the opportunity to access educational workshops, webinars, and other modes of education. Part of nurses accessing these educational resources is compliance with licensing requirements. A fund, entitled The Nurses Recruitment and Retention Fund, is a $450 sum per nurse to be used towards education to be directed to whatever educational endeavour the nurse chooses to pursue. Ms. Reeves is in the process of attempting to secure additional funding for education to standardize training for correctional nurses to standard training officers receive specific to working in an institution. As a previous manager, Ms. Reeves would encourage her staff to identify areas where they might need further education such as mental health, suicide prevention, schizophrenia, or any similar area.

[388] The Winnipeg Remand Centre would provide salary for the day for the nurse to attend a specific educational program. When asked more specifically how much time would be permitted for attendance for educational purposes, Ms. Reeves indicated there was no set amount. Historically, not many nurses have put in requests to access the fund for reimbursement for fees and salary for educational programs.

[389] Ms. Reeves testified that to her knowledge there has been no change to any of the forms used in relation to nursing documentation since Mr. Greene's passing in May 2016, or since she earlier testified in February of 2018 until her later evidence October 2018. There have also been no changes in instructions to nurses with respect to charting. Ms. Reeves indicated that nursing charting is standard practice as set out by the College of Registered Nurses.

[390] Some of the forms might require revision arising from the requirements of the *RHPA*, and those are "going to be looked at in future". She indicated she was new to the position of Director, so there are certain things that are going to be coming up with the Health Services Managers. Looking at documentation is one of the issues they will be reviewing in terms of wording and how it applies to the *RHPA*.

[391] Despite the apparent arrangement with Winnipeg Remand Centre physicians that clinics occur Monday through Friday, and only a chart review on Saturday and Sunday, Ms. Reeves thought doctors may be open to see a patient if required during the weekend. Doctor attendance time at the Winnipeg Remand Centre is variable, generally scheduled around their other work hours. Ms. Reeves indicated it could be 10 o'clock in the morning or 4 o'clock in the afternoon. The files given to the physician for review would be those in which a Healthcare Assessment had been undertaken. Someone admitted intoxicated, not yet seen for Healthcare Assessment, would not have their file submitted for physician review.

[392] Ms. Reeves said someone undergoing a Healthcare Assessment after physician departure and potentially requiring seizure medication, could have the issue addressed by the nurse calling the physician. The doctor could authorize the prescription over the phone, and the medication could start. The next time the doctor was in, the doctor would confirm those instructions and authorizations in writing.

[393] The physician, as earlier indicated, is on call 24 hours a day and seven days a week, in addition to five clinics and two days of on site chart review per week. Ms. Reeves has had no concerns expressed to her, in her new position, about nurse reluctance to call the doctor considering the physician's workload otherwise. She has had no concerns expressed to her about physician reluctance to receive a call.

[394] Ms. Reeves testified that valproic acid would not be considered emergent medication, such as to engage the Clinical Decision Tool as it is not administered in an emergency. The Clinical Decision Tool would not apply to an individual at

risk of having a seizure. The physician would decide how to manage that situation. Asked about whether there were medical staff meetings, to discuss the impact of the *RHPA* and other issues, Ms. Reeves responded the Health Services Managers had a meeting the week previous to her evidence. No concerns were raised with respect to the *RHPA* changes, or availability of the doctor, and there were agenda items relating to the Clinical Decision Tool and processes relating to it. Ms. Reeves indicated she sent an email to the Managers asking them to solicit issues from their staff to be discussed at the meeting. Ms. Reeves was not aware of whether the managers actually solicited expressions of concern from staff.

[395] Ms. Reeves thought it helpful for nurses to have additional training specific to issues relative to working in corrections. Ms. Reeves said there will always be a pull between what is operationally required and what is medically required. She declined to characterize it as tension. Nurses, she said, do a really good job of navigating and prioritizing what is needed to be done in terms of operations.

[396] When Ms. Reeves was working at the Winnipeg Remand Centre, she said nurse priorities were codes, administration of medication, and the admission of intoxicated persons with Winnipeg Police Service. Anything other than that, can be prioritized and worked around. Medical emergencies always take priority. As to the other two priorities, Ms. Reeves was of the view that if a nurse were called down to deal with a Winnipeg Police Service admission thought to be intoxicated, the nurse might elect to complete medication before responding to that. The nurse may choose to make the Winnipeg Police Service officers wait.

[397] Ms. Reeves said she did not know why this would be called a tension, when it was simply a matter of assigning priority. Whether or not the nurse left medication distribution, would depend on what the circumstances were surrounding the admission call.

[398] Management of the pull between operations and medical operations is currently, in Ms. Reeves' view, part of orientation as the nurse shadows a more experienced nurse for several days. It many not be formalized but the knowledge is acquired through shadowing. Ms. Reeves was of the opinion that nurses were already well equipped to prioritize their duties based on their training from nursing college, and there was nothing to be expanded upon by orientation or training in the Winnipeg Remand Centre beyond what nurses are already trained to do. Ms. Reeves did not see any value in a more formalized approach to training and orientation, as nurses come to the position at the Winnipeg Remand Centre with much training relating to prioritizing duties.

[399] When asked how a nurse would decide under what circumstances to call the doctor, Ms. Reeves responded that if the situation were outside of the scope of practice of the nurse, and not patently emergent such that an ambulance should be called, it would be appropriate to call the doctor. A nurse would phone the doctor to receive instruction and advice on how to proceed. When asked if there were any guidance to assist the nurse in determining whether the issue were one outside scope of practice that could wait until the doctor next came in, Ms. Reeves said that is part of nursing training and continuing competence through the College. It is basically clinical judgement. This is not something one can, or would want to, regulate. There are so many different variables and factors involved.

[400] Ms. Reeves was unaware of what, if any, instructions were given to Winnipeg Remand Centre nurses about calling the physician when 24 hour on call became available. She did not think instructions need to be given, as that decision making process is another component of clinical judgement. Acknowledging that the nurse triages patients and assigns priority to see the doctor, when asked if the doctor at the Winnipeg Remand Centre always sees all the patients on the list, Ms. Reeves responded that the doctor makes every effort to see everyone on the list. There are times when a patient is bumped to the next day. Under these circumstances, the patient likely would go to the top of the next day's list, unless there was something quite urgent that would preclude the bumped patient from being seen that day, or being seen first that day.

[401] Noting Ms. Reeves' indication that no changes had been made to charting policy and protocol, she was referred to Documentation Guidelines for Registered Nurses as published by the College of Registered Nurses of Manitoba. She said no changes had been made because current protocols were compliant with the requirements of the College of Registered Nurses. Best practices can dictate charting practice. It is important to stay on top of best practice changes as they happen.

[402] She indicated the majority of her time since she took the Director position had been consumed by ensuring the *RHPA* requirements are complied with. Reviewing documentation guidelines and other College of Registered Nurses of Manitoba directions and a review to ensure compliance is also a priority but not currently the highest priority. Ms. Reeves said she had worked with the College to draft Clinical Decision Tools but has not brought them in to consult on other practice issues except medication distribution.

[403] Ms. Reeves had consulted with the College in relation to medication distribution by Correctional Officers. So long as medication distribution was clearly documented, the inmate is permitted to administer it themselves under correctional officer supervision. She clarified that at the Winnipeg Remand Centre correctional officers do not distribute prescription medication. Only over the counter medication is distributed.

[404] When asked what steps she was taking, as Director, to ensure nurses were maintaining competence, Ms. Reeves responded that so long as nurses maintain licensure through the College, they are considered competent. There are staff reviews, performance management reviews, managers meet with staff regularly to review problem areas, and managers perform chart audits all designed to ensure maintenance of standards. There are a number of practices in place to ensure competence and nurses are aware of that oversight. If a nurse has a problem, the nurse knows he or she can approach a Manager.

[405] There is no formal curriculum for the orientation job shadowing, and no means of establishing consistency in information transfer from the person being shadowed to the new employee. The person shadowing is not formally evaluated, but feedback is solicited from the mentor. If the individual feels they need more time to orient, they can request additional days. Ms. Reeves highlighted the orientation is not limited to seven days. There is continual evaluation. The evaluation is based on feedback from the mentor and the person being evaluated. There has been no formal assessment of the number of calls to the physician since the *RHPA* protocols came in place.

[406] As to online learning, and whether work time could be afforded to support that form of learning, Ms. Reeves said that had not been requested and would have to be further considered. She did not think that during the day, there would be time to engage in online learning. The nightshift might be the only possible available timeslot to facilitate this form of learning. If a nurse wished to attend a learning opportunity on a day off, the nurse would have to submit a discretionary spending request, and the decision would be at the discretion of the employing authority. Despite her position as Director of Health Services for Manitoba Corrections, Ms. Reeves said she would not have the authority to grant this request. As to the sufficiency of the $450 sum to enable appropriate learning for Winnipeg Remand Centre nurses, Ms. Reeves said in reality, in the last year, she has only submitted three funding applications, two from Milner Ridge and one from the Winnipeg Remand Centre. One request was for a Wound Care Course, and another for

Anxiety Management. The rest of the nurses did not submit requests for any funding.

[407] When asked if she were concerned so few nurses were seeking educational opportunities, Ms. Reeves responded that she is an advocate of education so she would like to see them use it more. As a Nurse Manager, she would always encourage staff to avail themselves of educational opportunities. The uptake has not been great. The nurses are expected to maintain competency through the College of Registered Nurses of Manitoba. Some will submit courses as support for compliance with the ongoing educational requirement that have not required funding. This would include reading articles, or an online webinar that may not have a fee attached. Ms. Reeves was not certain of all the educational pieces nurses may have completed.

[408] When asked if there were value to the Winnipeg Remand Centre, perhaps even in combination with other correctional institution medical unit staff, holding internal education seminars, on an issue critical to their employment, such as seizures, Ms. Reeves said that at one point correctional nurses held a two day nurses' conference where a number of corrections related topics were addressed. The last one Ms. Reeves attended herself was about 10 years ago. The funding for those conferences was cut. Ms. Reeves was of the view there was a need for further funding to support corrections specific nursing training endeavours.

[409] When asked how she would see the potential of nurses training correctional officers on the identification of various issues like seizures, Ms. Reeves responded that staff education is a part of that, but she would be reluctant to make correctional officers responsible for interpreting seizures. They present in such a variable manner that a little education could be dangerous. She would never want a correctional officer to assume that a seizure is not a medical emergency based on what they were seeing. She would rather have them call medical staff. When further queried about whether there might be some value in correctional officers understanding the varying manifestations of the postictal phase so they can be adequately managed by correctional officers, Ms. Reeves thought that would be good education for them.

[410] When asked about credentials required to be employed as a nurse at the Winnipeg Remand Centre, Ms. Reeves said Licensed Practical Nurses, Psychiatric Nurses, as well as Registered Nurses could be employed. As of October 26, 2018, Ms. Reeves' second occasion testifying, Ms. Reeves said all Winnipeg Remand Centre full time positions were full, and they were looking for casual staff. The

staffing complement, at its optimal, is four full time nurses. There is an open position for a correctional psychiatric nurse, which could be filled by a registered psychiatric nurse or a registered nurse depending on experience. Four full time nurses work 12 hour shifts, including one position called a full time position shared between two nurses, one working .7 and the other working .3. The rest of the time required to be filled is by part time and casual staff. Shifts not covered by full time, are filled by the Health Services Manager bulletining to fill. The part time staff may have a .2 or .4 equivalent full time (EFT), and their shifts would be filled based on EFT. The rest would go to part time staff wishing to pick up extra shifts, and casual staff. Ms. Reeves was unaware how many part time and casual staff were currently employed at the Winnipeg Remand Centre. Relying on her previous experience there were six to eight part time staff that had an EFT, and five or six causal staff that would pick up shifts as, if, and when needed.

[411] Recruitment is extremely difficult, and candidates are usually attracted through word of mouth. There is some hesitancy on the part of senior management to have a lot of casual staff on board. They preferred seeing nurses in EFT positions. It was however, difficult, to recruit nurses into the part time positions as they would often be working elsewhere full time and resistant to the commitment required by an EFT position. The Correctional nursing approach is different than that of Correctional Officers who often work towards a full time position.

[412] If some of the part time and casual positions were redirected to full time positons, Ms. Reeves thought attraction of candidates might be better facilitated. Attraction of candidates for nursing positons can be complicated because qualified nurses are not always attracted to nursing at a correctional institution. They see the work as dangerous, and "debunking some of those myths might go long way" to recruiting candidates. Wage levels are an ongoing concern. As far as the collective agreement is concerned, nurses were at parity with WRHA nurses, but two years behind. Although a minimum of two nurses is, from Ms. Reeves' perspective, necessary, a minimum of three nurses on shift per day would be better. From a resource perspective, Ms. Reeves would like to see healthcare revamped, so nurses could complete tasks at hand. For example, it would be better if one nurse processed admissions in the admissions department, one nurse were in charge of medications, one nurse were in charge of doctors' parade and processing medication orders, and one nurse in charge of treatment. Resources could be refocused to permit nurse task oriented work.

[413] Ms. Reeves agreed with the suggestion that the Winnipeg Remand Centre medical unit can be somewhat of an island, cut off from the general medical

community. There is difficulty getting information to, or from, other healthcare institutions. Nursing staff can feel isolated. The other component may be perception. Corrections, itself, is viewed as a silo, as is the operation of the medical unit within each institution. Ms. Reeves, through her community involvement and connections, is attempting to engage those working with individuals in the community to determine whether there is opportunity to continue care of the individual from the Winnipeg Remand Centre to the Community by way of treatment, placement, etc.

[414] As to the isolation experienced by individual nursing staff, Ms. Reeves thought many staff members already operate in the more general nursing community. She said collaborative participation in education sessions with outside nurses would be helpful.

[415] Ms. Reeves is aware that other jurisdictions have transferred correctional healthcare administration to the health authorities. She felt there were patient benefits to that transition and that it was a "good way to go".

[416] Ms. Reeves said, with respect to performance reviews, there is a Correctional Healthcare Worker Form, but Health Services Managers do not routinely perform performance appraisals due to time constraints. In Ms. Reeves' time at the Winnipeg Remand Centre, performance appraisals were never done. She was not aware of anyone on nursing staff at the Winnipeg Remand Centre receiving a performance appraisal.

[417] Of all the correctional institution medical units, Winnipeg Remand Centre utilizes eChart the most because it offers accessibility to information about hospital visits prior to admission at the Remand Centre. Lab and other report accessibility makes it an extremely helpful tool.

[418] DPIN is sometimes the preferred choice by Winnipeg Remand Centre nurses, because the medications are listed chronologically with all of the information required evident. On eChart, one must click on each individual prescription to access the information about it. There are no current problems, according to Ms. Reeves, with nurse access to DPIN. Managers do not receive a report about who is accessing DPIN as they do with eChart. Someone's DPIN might still lapse due to lack of use, and the Manager would be unaware, which is not the case with eChart. Ms. Reeves also thought some correctional officer like training would be helpful to nurses. For example, sometimes nurses are handed a radio with no instruction on how to use it. Gang related information would also be

useful to nurses. General information about how the institution is run would also be of assistance to nurses in the discharge of their duties. Non violent crisis intervention, fire training in the context of the entire operation during a fire drill and not merely restricted to the nursing unit, knowing what the radio is used for, and mental health first aid, are all training pieces offered to correctional officers but not nurses.

Winnipeg Remand Centre Correctional Officers

14. Angela Banks

[419] At the time of her evidence, Angela Banks was a CO4 Correctional Officer rank at the Winnipeg Remand Centre, designated managerial. As Shift Operations Manager (SOM), Ms. Banks said she was responsible for one of the four shifts within the institution, and day-to-day operation including responding to codes, dealing with staff, and scheduling. Above her in level is the Assistant Superintendent and Superintendent. At times, she is the most senior person working at the Winnipeg Remand Centre. Ms. Banks has been employed with Corrections for 23 years, starting in Brandon as a CO1, and moving to the Winnipeg Remand Centre as a CO1. She became an acting CO3, a permanent CO3, which involved supervision, and became a CO4 two years prior to her evidence.

[420] The SOM responds to all codes within the institution, including Code Reds, which deal with medical emergencies. The staff, seeing the Code Red incident, would call Code Red, and the location of the Code Red over the radio. The code is acknowledged by Master Control, and Medical and SOM attends. All COs carry radios. Cell phones are not permitted. When a Code Red is called, the institution is locked down, meaning no inmate movement and inmates are locked in cells. All staff available must respond to the location of the Code Red.

[421] The Winnipeg Remand Centre is comprised of nine floors, dedicated as follows: Admissions in the basement; Main Floor is public entry, including visits, lawyer access, and the Main Control Pod; the second level is the Gym and Staff Lounge; the third floor is Medical and Intoxicated Persons Area; the fourth and fifth floors are General Population; the sixth floor is Special Needs and General Population and the seventh and eighth floors are Segregation. Movement by elevator is not controlled by the elevator occupant - all movements by elevator are controlled by Master Control.

[422] On March 13, 2016 at 13:04, Ms. Banks was working a twelve hour shift as the SOM, and a Code Red was called. Ms. Banks was in the Duty Office on the Main Floor, and proceeded downstairs to the Admissions area where the code was called. The nurse was on scene, and Ms. Banks could hear an inmate screaming. It appeared the inmate was having a seizure. The inmate was Mr. Greene, and he was in the process of being released. Mr. Greene was clothed and fighting with staff. This was the first time Ms. Banks had ever seen Errol Greene. She knew nothing about him. Mr. Greene was flailing and staff were trying to get hold of him. He was trying to punch and kick staff. Mr. Greene was positioned on his back on the ground. A Code during release is unusual. Normally, during a seizure, the inmate does not fight. Ms. Banks dismissed some staff who responded to the Code, but had to call them back because Mr. Greene was fighting so hard staff on scene needed relief. Mr. Greene called for his mother on a couple of occasions and said nothing more. He did not respond to staff verbal direction and continued to fight. Mr. Greene was handcuffed and shackled, not responding, and continuing to fight. Staff carried him to a cell that could lock. He was placed down on a mattress.

[423] Ms. Banks did not recall whether handcuffs and shackles were removed, but presumed they must have been because she recalled Mr. Greene getting up and flailing against the walls of the cell. Mr. Greene almost fell down, laid down on the mat, got up again and kicked the door.

[424] Ms. Banks described the nature of the decision making as collaborative with nurses on scene. Ms. Banks did not think this behaviour had anything to do with a seizure. One of the nurses decided an ambulance should be called, and Ms. Banks dialed the number and handed the phone to the nurse. The SOM is the only staff permitted to the carry a cell phone.

[425] Because Mr. Greene had been released, he was in his personal clothes at the time of the incident. At 13:44, Winnipeg Fire and Paramedics Service arrived and took him to the hospital, and Ms. Banks ultimately called “All Clear” at 14:00hrs.

[426] At the Winnipeg Remand Centre, medical staff are on the unit three times a day, distributing medication. In addition, on General Population floors, Correctional Officers go into the Units at least every half hour, making rounds and interacting with inmates. Every cell is checked to make sure all is well. Inmates are free to press a button on the DuKane System anytime, giving access through the speaker to the Correctional Officers in the pod. In Admissions, inmates are given an orientation pamphlet explaining general information they need to know

during their stay at the Winnipeg Remand Centre. It includes an explanation of access to communication with officers on the system. The orientation pamphlet contains the medication policy that nurses come through the Unit three times a day to dispense medication and inmates can put in a request form to see the nurse or the doctor. The request forms are in the Units.

[427] On May 1, 2016, Ms. Banks experienced a busy shift. There were two Codes with Mr. Greene, another inmate jumped off a top tier, a staff member passed out, and an inmate barricaded himself in his cell.

[428] A Code was called on the fourth floor. Ms. Banks proceeded there and saw an inmate on the floor whom she was told was having a seizure. Staff members were congregated in front of a door. Ms. Banks could hear screaming, sounding as if it were coming from the top tier. Staff were trying to get the inmates locked up. Ms. Banks proceeded upstairs. She recalled inmate Stephen King expressing concern about accessing his canteen, and obtaining a mattress. Ms. Banks saw four Correctional Officers attempting to calm Errol Greene who was fighting and kicking. Mr. Greene was on the ground in front of the telephones. Staff continued to try to soothe Mr. Greene, who was kicking and fighting with staff. One staff person held his head, attempting to reassure him Medical was on the way. Staff were calling him by a name other than Errol. Ms. Banks and the Medical Manager decided to move Mr. Greene, as he was fighting too hard and staff could not give him any medication. One of the medical staff recognized him from the Code back in March. Mr. Greene was cuffed, shackled, and placed in a cell. The nurses responding were Bonny Weber and Medical Manager Bev Reeves. Stephen King had been housed with Mr. Greene but was moved to accommodate Mr. Greene in a cell alone, giving rise to Mr. King's concern about his canteen and being given a mattress for the cell he was being moved to. Mr. King was moved to Cell 467.

[429] Ms. Banks estimated that in her Corrections career she had witnessed over 200 seizures. It was her decision Mr. Greene be handcuffed and shackled for staff safety. She was, at that point, unaware of the reason for Mr. Greene's continual fighting. She was also concerned for his safety, indicating he could fall down the stairs. Mr. Greene was screaming incoherently. The behaviour she observed was similar to what she had previously observed with Mr. Greene. Between the last seizure she observed Mr. Greene suffering, and this occasion, Ms. Banks asked nurse Giles if this were normal behaviour for someone coming out of a seizure, as she had not seen it before. The nurse explained some people behave in this fashion when coming out of a seizure, but the nurse had not seen this sort of behaviour to this extent.

[430] Staff were calling Mr. Greene by a name other than Errol, and he did not appear able to focus and take direction. The other nurse who recognized Mr. Greene immediately from the other event in March retrieved his file.

[431] Ms. Banks said Mr. Greene was moved into a cell for containment, and noted when moved into a cell in the March episode he seemed to calm down. It was Ms. Banks' impression that when people were watching Mr. Greene he seemed to act out more. When placed in a cell during the March episode, and watched on camera, he seemed to calm down. Handcuffs and leg irons were removed. He was carried into the cell, thrashing his arms and legs, and attempting to hit. Ms. Reeves said she would like to enter the cell and give Mr. Greene medication, but could not because he was still fighting so badly. There was no discussion with or from Medical about giving Mr. Greene medication by injection, or calling an ambulance. Mr. Greene seemed to calm down in the cell, but as a precaution Ms. Banks assigned CO Wiens to observe Mr. Greene.

[432] Cell 462, in which Mr. Greene was placed, had a large window facilitating easier observation by CO Wiens. Ms. Banks then held a de-brief with staff, to assess how they were doing, whether anyone was hurt, and whether things could have been done differently. All staff, including nurses, should file an Incident Report after an event of this nature. Ms. Banks testified that it would surprise her to find out that Incident Reports were not filed. Nurses must file reports by policy and have had to be reminded before.

[433] The incident with Mr. Greene was cleared at 14:17. CO Wiens called a Code Red at 14:37. Mr. Greene was having another seizure in Cell 462. Ms. Banks directed staff enter the cell. Mr. Greene was thrashing around, and Medical decided to inject him with medication. Ms. Banks directed staff to handcuff and shackle Mr. Greene to facilitate medical assessment. The traditional seizure-like behaviour Ms. Banks was accustomed to, shaking and twitching, was not exhibited by Mr. Greene at that time. He was thrashing, and attempting to bite and hit. Medical Manager Reeves instructed staff to place Mr. Greene on his stomach so she could inject him. Once Mr. Greene was placed on his stomach and contained by staff, Ms. Reeves injected him quickly. Even after the injection, he was still fighting and resisting staff. Mr. Greene was not saying discernable words but was incoherently yelling. The injection occurred approximately 10 minutes after Ms. Banks heard the Code called.

[434] As soon as Nurse Reeves discovered it was Mr. Greene having a seizure, she requested an ambulance be called. When Paramedics arrived, Mr. Greene was still

cuffed, shackled and thrashing. Ms. Banks told Paramedics she wished staff to go in with them because Mr. Greene was still cuffed and shackled. Ms. Reeves also spoke with them. Ms. Banks recalled the two Paramedics entered the room. Four staff entered the room with Paramedics and Ms. Banks could hear one staff saying "stop trying to bite me." Ms. Banks testified that there was no comment about the restraints being inappropriate, or request to remove the restraints. Mr. Greene's thrashing behaviour stopped and the Paramedic Supervisor advised the Paramedics would commence CPR. Ms. Banks was outside the room and could not see beyond the four Corrections staff and two Paramedics in the room with Mr. Greene. Paramedics began CPR at 14:55. Paramedics advised the room was too crowded, and they wished to move Mr. Greene out of the room. The restraints were removed so Paramedics could do their job.

[435] Mr. Greene looked like he was sleeping. When CPR commenced, Ms. Banks testified she directed staff take the handcuffs and shackles off. CPR continued as Mr. Greene was removed from the Remand Centre to the ambulance. Two Correctional Officers went to the hospital with Mr. Greene, one in the ambulance and one in a car.

[436] Ms. Banks took staff involved to the back office, and spoke to them about Employee Assistance, and what had happened. Staff expressed concern about having cuffed and shackled Mr. Greene. Ms. Banks told them she directed them to take that action, and it had been her decision. Ms. Banks is absolutely certain she made the correct decision to cuff and shackle Mr. Greene on both occasions.

[437] Ms. Banks has received training on how to write Incident Reports. At the time her reports were written in connection with these incidents, Ms. Banks thought the reports sufficient. Two years later, during her evidence, she has a different view, saying that she thought her report should have been more detailed. In addition, she now knows that reports from staff should have been more detailed.

[438] Some staff were significantly affected by Mr. Greene's passing, and at the time of Ms. Banks evidence, January 31, 2018, some staff were still off work as a consequence.

[439] Paramedics requested Mr. Greene be moved into the hallway. Ms. Banks said Mr. Greene was moved after the first request was made. She could not hear all of the conversation going on in the room. She did not hear the Paramedics request Mr. Greene's shackles and handcuffs be removed. She saw CPR being commenced in the cell. Ms. Banks did not recall if, once CPR had been

commenced by the Paramedics, it was stopped at any time. Ms. Banks did indicate this incident was extremely traumatic for herself. Ms. Banks did not observe the Paramedics insert an intravenous into Mr. Greene or intubate him. Ms Banks instructed the Correctional Officers who went in the room with the Paramedics, to be there just in case something happened. Ms. Banks testified the Supervisor of the Paramedics, who was on scene, told her they were initiating CPR when Mr. Greene was still in the room.

[440] At the time of her evidence, Ms. Banks thought that Correctional Officer staffing was greater than generally would be required for the number of inmates in the Institution. Sometimes there are occasions where there are more inmates than beds, and some inmates have to sleep on a mattress on the floor.

[441] If an inmate wished medication, the inmate could fill out a request form, push the DuKane button and speak to staff, and also could speak to the Nurse on one of the rounds that occur three times a day. The inmate could also speak to staff on rounds, and staff will contact the nurse on their behalf. Upon admission, an inmate must speak to a Nurse and part of the discussion is about what medication that inmate might be taking. Ms. Banks would expect that if an inmate reported, on admission, the requirement for medication it would be recorded. An inmate is able to request Tylenol and Motrin from the pod. There is a medication log kept by the Correctional Officers for Tylenol and Motrin. Policy requires such logs be retained. It would surprise Ms. Banks to hear that the medication log in this case was destroyed. That would not be following proper procedure.

[442] Ms. Banks recalled being interviewed by Ed Klassen for the purpose of his Death in Custody review. Ms. Banks was referred to a comment attributed to her in the Klassen Report that Nurse Reeves offered Mr. Greene medication but he was not cooperative. Ms. Banks didn't recall the words used by Ms. Reeves, and did not know what medication Ms. Reeves was speaking about. Ms. Banks did not take the necessity for administration of this medication to be urgent, because Ms. Reeves was prepared to wait to administer it. Ms. Reeves did not say anything about how she intended to ultimately administer the medication, or what her plan was for it. Ms. Banks offered to have Mr. Greene moved to the Medical Unit for monitoring. Ms. Reeves declined the offer. She said there was no bed space to move him to. Nurse Reeves said she would come back, but did not indicate when.

[443] The Medical Unit is specifically designed for inmates requiring medical supervision. Medical staff are on hand at all times, except when they need to

respond to a situation. Inadequacy of beds for patients requiring medical supervision is a common problem.

[444] Ms. Banks was asked about a portion of her report for the March, 2016 seizure in which she referred to Mr. Greene's behavior as "falling strategically" and "it looked like he was acting or performing", and noted that when staff withdrew, Mr. Greene would settle and was fine. Ms. Banks understood Mr. Greene's behaviour to be similar after the first seizure May 1, 2016. When asked if she meant Mr. Greene could have been faking his symptoms, Ms. Banks emphasized her view that his falling was strategic and similarly noted in the May 1, 2016 first seizure that he appeared more agitated when staff was around. In May, Ms. Banks said she thought the same thing was happening again as it did in March. She said that in the May incident, she decided to move people away to take Mr. Greene's audience away. She still considered him to be acting or performing. Ms. Banks said it was Nurse Bonny Weber who brought to her attention that Mr. Greene, in May, was the same inmate as in the incident in March. They shared the same impression in March that Mr. Greene had been performing.

[445] Ms. Banks said that what she meant by performing was that Mr. Greene was behaving erratically. Had Ms. Banks known that a person coming out of a seizure may not be able to control their behaviour that would not have changed her impression. After Mr. Greene was medicated for the second seizure, staff left the room, closed the door tightly, observed him and awaited arrival of Paramedics.

[446] As to whether specialized seizure training would be of assistance to Ms. Banks, the other Operations Managers, and those who report to them, Ms. Banks did not feel that would be helpful because she relies heavily on medical staff to get through these incidents. Ms. Banks did not call an ambulance after Mr. Greene's first seizure on May 1, 2016, despite the ambulance called for him and her knowledge of it after the March seizure, because Medical did not see the need for it. She described their relationship as lateral, and medical staff had the final decision making power on matters related to medical issues.

[447] In May, Mr. Greene could still be monitored in the institution, while in March he was being released. Ms. Banks was of the view that training in seizures would not be helpful because she could not distinguish between an individual faking a seizure and requiring actual help. When asked if training could give Ms. Banks tools to determine between a genuine seizure and acting out, if such training would be helpful. Ms. Banks said she would not change what she did. Having a

better understanding, unless she could be assured 100 percent that Mr. Greene was having a genuine seizure, would not change her behaviour because she was still responsible for security.

15. Ashlee Griffin

[448] At the time of her evidence, Ms. Griffin had worked as a Correctional Officer at the Winnipeg Remand Centre, at the CO1 level, for approximately four years. On May 1, 2016, she was working in the Level 400 Control Pod, working the 7:00 a.m. to 7:00 p.m. shift. Pod duties on each shift are rotated through the officers working on that floor on that day. That morning, Ms. Griffin conducted a Custody Release Plan with Mr. Greene, a case management tool that enables officers to get to know inmates. It is solely based on information the inmate wishes to provide to the officer. A basic list of questions is asked, and the inmate can elect to answer or not. The interview was conducted in the 400 Level back office. In the context of the interview, an inmate could bring up a problem the person was having on the range, if they chose. Mr. Greene did not mention medication or medical issues he was having. There were no requests made by Mr. Greene at any time. Mr. Greene was coherent, and understood the conversation between Ms. Griffin and himself. The meeting was about 10 minutes in length, the usual duration for meetings of this kind.

[449] Ms. Griffin said no employee of the Winnipeg Remand Centre had brought to her attention that Mr. Greene had medical issues, or that he had requested medication. On 400 Level, a written log is kept as a communication tool between officers. An inmate requesting medications at the pod would not be included in the writings in the log. Ms. Griffin was not aware that Mr. Greene, or anyone on his behalf, had come to the pod to request medication for him.

[450] Ms. Griffin was located in the pod, and she saw Mr. Greene on the phone. She saw the phone cord drop, and shoot back up. She immediately stood up to see what was going on. She thought that to be odd. She saw Mr. Greene on the ground shaking, and called a Code Red. It was only a matter of seconds between when Ms. Griffin saw that phone drop to when she called the Code Red. The Code was acknowledged by Master Control, confirming everyone in the building heard the Code. Other inmates on the range were directed to lock up, and await the arrival of Code Responders and the SOM. Ms. Griffin used the DuKane System to direct inmates to lock up. Mr. Stephen King was the only inmate slow to lock up. Ms. Griffin had interacted with Mr. King before, on the main floor when she was stationed as a Court Officer, and Mr. King had gone to court. Mr. King went up

the stairs, and all Ms. Griffin could see was Mr. King bent over Mr. Greene. When a Code is called, the officer must wait for direction from the SOM before anyone is admitted in response to the Code. Ms. Griffin estimated a duration of 1 - 2 minutes before other officers arrived. SOM Angie Banks directed the door be opened, and she entered with a group of officers. Ms. Griffin could see Mr. Greene shaking on the floor, and officers tending to him.

[451] By that point, Mr. Greene was thrashing on the ground more than shaking. Ms. Griffin's view was obstructed by the four responding COs, and Ms. Banks. There was at least one nurse present, entering the door after Ms. Banks although Ms. Griffin could not determine whether the nursing staff in fact had arrived prior to Ms. Banks. Mr. Greene was placed in Cell 462 for recovery, under constant watch. Mr. Greene's roommate, Mr. King, was internally transferred to Room 471. Officer Wiens was assigned to constant watch on Mr. Greene. The Code Red was called at 13:55. All officers are required to carry handcuffs, but leg shackles are held at the pod. An officer attended to the pod requesting leg shackles, which Ms. Griffin provided. Ms. Griffin could not see Mr. Greene inside Cell 462, but she could see Officer Wiens standing outside Cell 462. Ms. Griffin remained in the pod.

[452] At 14:40 hours, 45 minutes after the previous incident, Officer Wiens called a Code Red, officers arrived, and Ms. Griffin was asked to provide shackles and handcuffs. As before, Ms. Banks, other officers, and Medical appeared and were let onto the range at Ms. Banks' direction. Mr. Greene was in Cell 462 when that Code was called. Ms. Griffin opened Cell 462 under direction. First Responders arrived, were admitted, and Ms. Griffin ultimately saw Mr. Greene leave with First Responders who were performing CPR on him. Ms. Griffin was not interviewed for the purpose of Mr. Klassen's review of the incident.

[453] Ms. Griffin did witness the phone Mr. Greene had been on at the time of the first seizure being hung up by an officer, but she was not able to say how long the phone had been off the hook dangling. Officers are permitted to give inmates Tylenol and Motrin, and during that shift no one made a request that Ms. Griffin was aware of. Requests for those medications are logged by officers in the pod. Inmates fill out a form to request other medication, and Ms. Griffin said she forwards the forms onto Medical when she has them. She had no such request forms from that day. The forms are placed in a box on the range. The boxes are emptied every night. She would not have distributed forms on that day because she was a day shift officer, and they are distributed by the night shift officer.

[454] Ms. Griffin said she did not receive any calls on the DuKane System that day from any inmates requesting anything. There is no process for recording incoming calls from inmates on that system. Ms. Griffin has called Code Reds in the past, but Mr. Greene's circumstances were unusual. He was violently thrashing, and Ms. Griffin had not seen that before. Ordinarily, persons having a seizure that she has observed are shaking, placed in the recovery positon, Medical attends and the situation is over.

16. Albert Wiens

[455] Mr. Wiens has been employed by Manitoba Corrections at the Winnipeg Remand Centre for 11 years. On May 1, 2016 Mr. Wiens was not scheduled to work. He had been called by the SOM to come in for an overtime shift arising from another incident in the institution. Mr. Wiens is a CO1, and being called in for an unscheduled shift was not an unusual occurrence. The duration of the unscheduled shift was defined as "open ended", as Mr. Wiens was to escort an inmate to hospital and it was not known at what time he might be discharged if at all. Whenever possible, restraints are used on an inmate during transport to hospital, to preserve safety for the inmate and the officers, and prevent escape.

[456] When Mr. Wiens arrived on shift, at approximately 2:00 p.m., he reported to the SOM office and was advised the plan had changed. Instead of escorting an inmate to hospital, he was now being assigned to another incident that had just occurred. The issues relating to Mr. Greene had been prioritized as being more urgent. Mr. Wiens did not recall having met Mr. Greene before, but there may have been incidental contact. Mr. Wiens was advised Mr. Greene had a seizure, was in his cell, agitated, and staff were waiting for him to calm down. Medical wanted to see him. Mr. Wiens observed Mr. Greene's roommate being removed from the cell and moved, and Mr. Greene being placed in the cell alone. Mr. Wiens was directed, for the time being, to act as a constant watch over Mr. Greene in the cell. There is a large glass window on the door, and the whole room is clearly visible from the outside. If Mr. Greene were to calm down and be able to communicate, Mr. Wiens was instructed to let them know so Medical could attend. Mr. Wiens replaced numerous officers who were still on the floor as a consequence of the Code, watching him.

[457] Constant watch is a common assignment. At the time of Mr. Wiens' attendance, Mr. Greene was not wearing handcuffs and leg shackles. When Mr. Wiens commenced his constant watch, Mr. Greene was walking around and pacing in the room. Mr. Greene said he was thirsty and needed water. Mr. Wiens

instructed him to drink from the sink. Mr. Greene did not respond. Mr. Greene never verbally responded acknowledging the information but did drink from the sink. He was pacing, and on occasion came up to the glass window in the door and placed his hands on it, pushing off from the glass. Mr. Wiens interpreted this behaviour as "somewhat" aggressive.

[458] When not pacing, on occasion, Mr. Greene dropped onto the mattress, rolled around on the mattress from one wall to the other, got up again, drank water, and repeated the cycle. To Mr. Wiens, the behavior reflected frustration, agitation, or something was going on that caused this conduct. Mr. Wiens never received any form of communication indicating Mr. Greene understood what Mr. Wiens had been saying to him. He did drink the water in the sink, but that is something he would have known from before. Mr. Greene suddenly became very calm, stopped pacing, stood there, and, within seconds, lay on his back on his mattress.

[459] Mr. Wiens was not certain how to interpret the change in conduct. He has no medical training. He was, however, concerned enough to take his radio off his belt thinking this may be the beginning of a second seizure.

[460] Mr. Wiens, in the course of his employment, has received CPR training but has received no training in dealing with seizures. Mr. Wiens estimated he responds to seizure related Codes weekly or monthly depending on the time of the year. It is frequent. He thought he had seen over 100 seizures since working at the Winnipeg Remand Centre.

[461] When Mr. Wiens saw Mr. Greene exhibiting what Mr. Wiens thought to be the typical sign of a seizure, shaking, he called a Code Red. Mr. Greene's breathing was raspy or gurgly, because he was lying on his back. There was bubbling and foam coming out of his mouth but he was still breathing. Officers present decided to roll him on his side, but because of instructions required more officers than were currently present to enter the room. Part of the explanation given at muster, was that Mr. Greene had a seizure in March which is why the constant watch was ordered. Instructions were given that officers not enter alone. The SOM was present, but before the decision to enter could be made, Mr. Greene rolled himself on his side. What was in his mouth came out, and his breathing cleared. By that time, Medical had responded, the SOM was present, and SOM Banks gave direction to enter the room and shackle and cuff Mr. Greene. The seizure itself was over, and he had been laying still for 3 or 4 minutes. He was not responsive. He was looking and moving, but no longer showing what Mr. Wiens thought was a physical sign of seizure. When officers entered the room, Mr.

Greene attempted to jump up. Mr. Wiens and another officer applied leg irons. There was much resistance. It took some effort to prevent his legs from kicking and flailing. Legs were kept in control. Mr. Greene was cuffed in front. He remained on his left side as the plan was to deliver the injection to the right hip. The nurse administered the injection.

[462] Because of the resistance Mr. Greene was exhibiting, SOM Banks directed officers back out of the room, leaving him in restraints. SOM Banks hoped the meds would take effect. A constant watch was assigned to Mr. Greene, but it was two officers other than Mr. Wiens.

[463] Paramedics had been called. SOM Banks directed Mr. Wiens accompany Mr. Greene to the hospital. Mr. Wiens went to retrieve a different sort of restraints used for outside escorts.

[464] When Mr. Wiens returned to Mr. Greene's room, he saw Mr. Greene had been taken out of the room, handcuffs removed and leg irons left on. Paramedics were present, and commenced CPR. Mr. Wiens accompanied Mr. Greene to the hospital.

[465] Mr. Wiens did not get the impression Mr. Greene was faking it, or exaggerating his condition. Although he has had first aid training, he has not had training specific to seizures. Prior to May 1, 2016 Mr. Wiens was aware that seizures can be life threatening.

[466] Mr. Wiens confirmed restraints were applied to Mr. Greene. He clearly recalled that for transport to hospital Mr. Greene had shackles on, and that he had been assured by Paramedics they would not be an issue. Mr. Wiens said the hospital approached him for contact information for next of kin, as the data they had on file so far was not helpful. Mr. Wiens called the SOM, and learned the Winnipeg Remand Centre was attempting to reach next of kin as well, also unsuccessfully. The hospital and Remand Centre decided to share contact information and both would try all names in the hope that a successful notification could take place.

[467] At 15:45 the pulse was established and at 20:27 Mr. Greene passed away. Mr. Wiens and a colleague observed him in hospital during that time. When directed to do so, Mr. Wiens returned to the Winnipeg Remand Center to complete his reports.

17. Million Mehari

[468] Mr. Mehari, currently a Correctional Officer 1 has been with Manitoba Corrections for nine years. On May 1, 2016 Mr. Mehari was working on level 800. At approximately 14:40, he heard a Code Red, and responded to the fourth floor, on the A side. Upon arrival, Mr. Mehari observed numerous officers, medical staff, and SOM Angela Banks. The officers were congregated on the upper tier around cell 462. Mr. Mehari reported to the upper tier, in case they needed assistance. He observed Mr. Greene being restrained by officers, and thrashing around. Officers were telling Mr. Greene to stop resisting. Mr. Mehari had not seen a seizure before this event, and has not seen a seizure since. When Mr. Mehari arrived on scene, he recalled handcuffs already on Mr. Greene, but did not recall leg restraints. Mr. Mehari believed he recalled an injection was given, but did not remember how that occurred.

[469] After the injection, the nurse left the cell. SOM Banks ordered officers to leave the cell as safely as possible, and they did so. The cell door was secured after the officers left. Mr. Mehari recalled two nurses outside the cell, Bonny whose last name he did not know, and a second nurse. After Mr. Mehari left the cell, he recalled Mr. Greene lying on the cell floor, thrashing around and moving his body. He was not saying anything.

[470] When Paramedics arrived, officers returned to the cell including Mr. Mehari because Paramedics had to do an assessment, and Mr. Greene had been combative. Mr. Mehari was able to go to Mr. Greene's left side, and maintain control of his arm and part of his upper body. Mr. Greene continued to thrash and move around. Mr. Greene did attempt to bite Mr. Mehari, but Mr. Mehari was able to maintain control and move out of the way. After Mr. Greene's blood was drawn for testing by the Paramedics, he "went unresponsive all of a sudden".

[471] The Paramedics said they needed to turn him over. Mr. Greene was face down. He was turned over. The Paramedics began CPR. Mr. Mehari recalled that Mr. Greene was taken out of the cell at some point, but he could not recall when. Mr. Mehari stood there waiting for direction. Mr. Greene was taken to the upper tier, just outside of his cell.

[472] Mr. Mehari recalled Paramedics telling the officers to remove the restraints. He believed CPR would be better without the handcuffs. Mr. Greene's hands had been handcuffed in front of him. Mr. Mehari said that when the Paramedics asked that the handcuffs be removed, they were.

[473] It was Mr. Mehari's perception that EMS personnel were content with the way Mr. Greene was positioned, including when he was being restrained face down and EMS personnel were taking his blood pressure. They did not request officers turn Mr. Greene over to be face up while he was still conscious.

[474] When Mr. Greene became unconscious, Mr. Mehari said it was apparent something was different. At that point, Mr. Greene stopped resisting. To maintain safety, officers' hands were still on Mr. Greene, but not pushing down anymore.

[475] Mr. Mehari recalled that at some point Paramedics asked that Mr. Greene be turned over, and officers did so without delay. Paramedics began CPR immediately. Paramedics did ask that restraints be taken off Mr. Greene, but Mr. Mehari did not recall the request being made more than once. Mr. Mehari did not recall officers were reluctant to comply with the request, but did recall the handcuffs came off quickly. When it was suggested some COs protested removing restraints, and disagreed, Mr. Mehari said that he could not recall. Mr. Mehari did not recall EMS personnel expressing concern they could not get near Mr. Greene to assess him because of the number of correctional officers in the room. Mr. Mehari recalled officers removing Mr. Greene from the cell when he was unconscious, but did not recall whether he participated. That is when he left the cell.

[476] If Paramedic personnel had requested removal of restraints, Mr. Mehari said the decision would not have been his - it would have been that of SOM Angela Banks.

18. Richard Pow

[477] On May 1, 2016 Mr. Pow had been employed at the Winnipeg Remand Centre as a Correctional Officer for one month. Mr. Greene's seizure was the first he had seen in the context of his employment, but he had observed ten seizures prior to his employment. He was working level 400 at the time the code was called at 13:56. At the time of the code, he was in the back office writing a report so had to enter level 400A through a locked door. He was directed to something on the tier. He saw Mr. Greene having a seizure, and Stephen King attempting to assist him. Other inmates were around, but Stephen King was the only one assisting by holding Mr. Greene's head. Mr. Pow directed the inmate to lock up. Stephen King went to a different cell, and Mr. Pow assisted Mr. Greene by holding his head. Stephen King explained quickly what had happened, and went to his cell as directed.

[478] Stephen King said Mr. Greene needed his meds, and had started to have a seizure while on the phone. Mr. Greene's seizure went on for several minutes more. Mr. Greene started thrashing around and was confused. Mr. Pow attempted to reassure him. Mr. Greene did not appear to understand what was being said to him. The decision was made that he be put in handcuffs and shackles so he could be examined by the nurse and not hurt anyone. Mr. Pow was one of the individuals who applied the restraints. Mr. Pow understood restraints were applied because Mr. Greene was fighting and not following direction. The nurses arrived but were reluctant to come close to him because he was thrashing around, so they were unable to administer medical attention. The nurses stood there and said "we can't come close to him right now because of the way he is acting". He was nonresponsive when officers attempted to speak to him, and would not answer when the medical professionals were present. He was confused, and the decision was made to put him in a cell and supervise him until he calmed down.

[479] Mr. Greene, while seizing, hit his head several times so Mr. Pow asked Angie Banks, the SOM, to pass him a blanket to put under Mr. Greene's head so he would not hit it anymore. Mr. Greene was foaming a little bit in the mouth after his seizure. The color of the foam was white mixed with blood.

[480] Mr. Greene was placed in his cell on a mattress on the floor. Restraints were removed, and everyone exited the cell.

[481] Correctional Officer Wiens was assigned to observe Mr. Greene in the cell. Mr. Pow was in the pod for Mr. Greene's second seizure. Mr. Pow could see, once Paramedics arrived, Mr. Greene being removed from the cell and Paramedics working on him. He was put on a stretcher and taken to hospital. By the time SOM Banks arrived, Mr. Greene's seizure was finished.

[482] Mr. Pow explained he had taken a first aid course in the community before becoming employed by Corrections and had also received information from his mother who was a nurse about how to deal with seizures over the years. This assisted him in knowing what to do when presented with Mr. Greene having a seizure. He thought it would be helpful, as a Correctional Officer, to receive more training related to the immediate care of someone suffering a seizure. He has seen seizures since that of Mr. Greene and agreed seizures were not uncommon in the Winnipeg Remand Centre.

[483] Mr. Pow's shift on May 1, 2016 was 7:00 a.m. to 7:00 p.m. He was confident he would have completed security rounds of level 400 during that time.

He had no recollection of Mr. Greene approaching and asking about his medication, or anyone on Mr. Greene's behalf. Similarly, he was not approached by Stephen King to make that inquiry. He had no recollection of Mr. Green or anyone on his behalf approaching the pod about Mr. Greene and medication, or communicating with the pod on the DuKane System for that purpose. If someone were not getting medication, his first response would be to call the medical unit and inform them of the inmate who is not getting medication and needed it. Medical unit staff would take it from there. In those circumstances, either the nurse brings the medication up, or checks on it and relays the message through the officer to the inmate about what is going on with it.

Winnipeg Fire Paramedic Service

19. Michael Kaul – Paramedic

[484] At the time of his evidence, Mr. Kaul had been with Winnipeg Fire Paramedic Service for over 18 years. He started as a Paramedic in Gimli in 1997 or 1998, attended the Southern Alberta Institute of Technology, returned to Manitoba and challenged the provincial licensing exams. He started working in Pine Falls and was hired on at the City of Winnipeg in June of 2000. In his career, he has been exposed to a broad range of experiences and environments. He has treated many people for seizures.

[485] May 1, 2016 was his first experience responding to a call at the Winnipeg Remand Centre. Together with his partner Sabrina Labossiere, Mr. Kaul arrived at the Winnipeg Remand Centre and went to where Mr. Greene was. Mr. Greene was in his cell and was eventually brought out. When Mr. Greene was brought out of the cell, Mr. Kaul did not see him moving or responding. Mr. Kaul could not feel a pulse, and Mr. Kaul was not able to see any respiration. He was unconscious. Mr. Greene was cuffed at the wrists and ankles. Mr. Kaul was the senior Paramedic, and Ms. Labossiere was assisting him. Mr. Greene was handcuffed in front, affecting the Paramedics' ability to effectively perform CPR, a potentially life saving procedure where someone's heart has stopped. The handcuffs also interfered with the ability to give Mr. Greene drugs intravenously. Mr. Greene was not violent or aggressive, because he was unconscious. Mr. Kaul could not recall whether Ms. Labossiere asked as well, but he recalled asking at least twice for the cuffs to be removed.

[486] Not only did Mr. Kaul have to request the cuffs be removed but also had to provide an explanation to the officers as to the necessity of handcuff removal. Mr.

Kaul recalled this as a very challenging situation. Uncharacteristically, Mr. Kaul had to speak more loudly and clearly than he normally would to attempt to get his message across with the correctional officers. At the time, Mr. Kaul's notes reflect Mr. Greene's condition as "vital signs absent". Mr. Kaul was very unhappy that he had to twice request handcuffs be taken off an unconscious individual in these circumstances. Mr. Kaul agreed the situation was ridiculous.

[487] Once the cuffs were removed, Paramedics were better able to perform their duties. Mr. Greene was ultimately transported to the Health Sciences Centre. Mr. Kaul and Ms. Labossiere were never able to detect a pulse in Mr. Greene.

[488] As a Paramedic for 20 years, Mr. Kaul has had other circumstances where he wished restraints removed from a patient he was attempting to treat, in particular with the police. His requests are complied with. He has never, in his career, had a circumstance such as the one he experienced with Mr. Greene where he had to make multiple requests and then explain himself before the request was complied with.

[489] Although Mr. Kaul recalls correctional officers present, and his interactions with them, he has no recollection of interaction with a nurse, or a nurse even being present.

20. Sabrina Laboissiere – Paramedic

[490] At the time of her evidence, Ms. Laboissiere was approaching five years service with the Winnipeg Fire Paramedic Service as a Paramedic. On May 1, 2016 she was on duty partnered with Michael Kaul, assigned to station 1, 65 Ellen Street. On May 1, 2016 she and Mr. Kaul were dispatched to the Winnipeg Remand Centre at approximately 2:45 p.m. They were met by a correctional officer who guided them in to where the patient was. The ambulance was parked outside the Winnipeg Remand Centre, at the rear. The only information the team had at that time was that they were dispatched to a male with seizures. This call was Ms. Labossiere's first to the Winnipeg Remand Centre.

[491] Upon their arrival, Mr. Greene was in a cell behind the door. Correctional officers were in the cell with him, a fire fighter was in there, and Paramedics could not have contact with Mr. Greene right away because the room was so packed with people. Mr. Kaul initiated contact first. Ms. Labossiere did not have contact until Mr. Greene was pulled out of the cell. Mr. Kaul has more experience than Ms. Labossiere, and it would not be unusual for him to initiate contact first. It took one or two minutes for Mr. Greene to be removed from the cell. During that time the

firefighter was giving them a report. Mr. Kaul could not get into the room either, and poked his head in to receive the report. When Mr. Greene was removed from the cell, he was placed on his back with handcuffs on his arms and feet. Mr. Greene was not breathing, and did not have a pulse. His cuffed hands impeded the ability of the Paramedics to do CPR, start an IV and deal with other issues related to Mr. Greene's care.

[492] Paramedics asked the officers present to remove the cuffs, and the officers refused to remove them initially. Paramedics made the same request multiple times and had to explain to the officers that he did not have a pulse, was not breathing, and Paramedics needed the cuffs off. Eventually they did remove the handcuffs but not the leg cuffs. Ms. Labossiere found the officers' reluctance to remove the cuffs extremely frustrating. She felt it uncalled for from a medical perspective, as Mr. Greene was not moving, not breathing, and did not have a pulse. Ms. Labossiere could not perceive any safety reason Mr. Greene should be required to retain his handcuffs. It was obvious he was unconscious. Paramedics had to raise their voices to get correctional officers to remove the handcuffs. They were yelling at them to remove the cuffs. Paramedics were becoming angry as this should not be happening. In addition to the challenges with performing CPR adequately, when hands are cuffed, it is difficult to get an IV started as the inner arm is normally used to introduce potentially life saving drugs.

[493] In addition, Mr. Kaul inserted a tube down his throat to assist in breathing. There was no change in Mr. Greene's condition. CPR was continued all the time Mr. Greene was in Paramedics' care, except when he was being carried down the stairs because it was not possible. Ms. Labossiere indicated that from the time of her arrival at the Winnipeg Remand Centre to the time she was able to start providing care to Mr. Greene, who did not have a pulse, was eight to 12 minutes.

Community Safety Division-Administration

21. Shauna Appleyard – Executive Director of Rehabilitation Services

[494] Ms. Appleyard commenced employment with Manitoba Justice in 2007, and since February 2017 has been the Executive Director of Rehabilitation Services. Rehabilitation Services, a component of the Community Safety Division, was created to be more active toward reducing recidivism rates, reintegration planning, and looking to best assist individuals with reconnecting to the community in a positive way. It focuses on looking at factors individuals need both in custody and under community supervision, and includes individuals not subject to a court order

at all. This stream was designed to effect change in this area, and includes medical services, correctional based programming, Indigenous Spiritual Care, Chaplaincy Services, new programs for reintegration services.

[495] Historically, Health Services were housed within the custody department. As a consequence of the evolution of Rehabilitation Services, Health Services was moved to Rehabilitation Services. The opportunities provided by this migration include Ms. Appleyard working closely with the Health Services Director, to begin meeting with each centre and each manager and discuss what the unique needs of each centre are. This will assist in ensuring operational items are attended to, which they are in the centre, but to be able to discuss in a more fulsome way issues like hiring, and beginning to imagine the transition into the community.

[496] It involves beginning to work with community and probation to share health information with the individual's consent, to plan for that person as they transition. It involves looking at needs for detox, treatment, focusing on the care required in custody as well as bridging a continuum of care into the community. Specifically, in the case of Health Services, the transition is fairly new. Consideration is given to looking at other provinces, and research, observing that other provinces have moved to either a shared responsibility with Health, or service delivery provided by the provincial health system. In every area in rehabilitation, Ms. Appleyard is looking at what are we doing now, and how can we improve

[497] In terms of timing, there has been recent approval from Treasury Board on medical contracts so now it is time to move. This is a very large project. Currently, nurses are provincial correctional employees, and all other services are delivered by contract. Psychiatrists, dentists, doctors, pharmacists etc. are all contract delivered. Experience in other provinces, would suggest the primary focus should be on maintaining patient care. The transition in many provinces took a couple of years. The idea is to engage with health and develop work plans.

[498] As to the issue of accreditation, although Ms. Appleyard was not overly familiar with it, accreditation would be a small change and what government is looking for is a broad system change. The Department is very much looking for a whole government approach in continuum of care, and moving towards the broader change would be the best place to put time and research efforts. Ms. Appleyard indicated that her knowledge of accreditation is "almost nothing", but it is government's intention to go "broader".

[499] A Request for Proposals, dated July 24, 2017, went out asking for physicians to bid on providing service in correctional institutions. Physicians can choose to submit a proposal. This is designed to replace or update existing contracts. Contracts flowing from this Request for Proposals have not yet been finalized. Treasury Board approval had been granted the week prior to Ms. Appleyard's evidence October 24, 2018 permitting acting on the proposals. A few steps were in progress at the time of her evidence.

[500] Recently, physicians have changed over to visiting the Remand Centre seven days per week. That was not reflected in the RFP. The only reason the doctor attends on the weekend, according to Ms. Appleyard, is to review files. The volume at the Winnipeg Remand Centre is sufficiently high to justify the decision that a physician would actually attend on site at the Winnipeg Remand Centre rather than receiving phone calls.

[501] Bringing nurses under the *RHPA* occurred after the RFP, and after physicians would have responded. Some doctors would have included an additional amount in response to the RFP, and that amount would be paid when they are called. If adjustments need to be made to the contracts, they will be. Regarding telephone consultation, in practice and in draft contract, the position offers 24/7 on call telephone availability.

[502] Currently, medical professionals at the Winnipeg Remand Centre have available to them not only the DPIN system, but also eChart. EChart is a more advanced tool. Individuals like using it, as it provides an overview of nurse access and permits supervisors to ensure access to the tool has not lapsed.

[503] In terms of attracting physicians to work at the Remand Centre, Ms. Appleyard noted Corrections is a challenging environment to attract physicians to. She speculated that is because of their understanding or misunderstanding of the environment. Corrections has been fortunate to have mostly longstanding physicians. The reason for the new contracts was because of government process requirements. There were not a large number of individuals applying in response to the RFP. At least five years experience is required, based on the complex needs of the patient body.

[504] Accreditation for the medical unit at the Winnipeg Remand Centre was not something they had spent a lot of time on, because they were moving towards something more system wide, related to the integration of Health and Corrections. Ms. Appleyard is aware that Correctional Service of Canada (CSC) is accredited,

but noted CSC is not looking to integrate with Health. When asked if she were aware that Accreditation Canada has a document called Provincial Correctional Health Services Standards, Ms. Appleyard indicated that she was not aware. Ms. Appleyard was aware that Accreditation Canada's functions included inspections of healthcare centres including correctional centres and accreditation of them.

[505] Ms. Appleyard has not had a conversation with Correctional Service Canada about the accreditation procedure. From Ms. Appleyard's perspective, accreditation will provide little change, and the Department is looking to effect broad change for the individual.

[506] When asked whether it would take a long time, perhaps years, to make the transition, Ms. Appleyard responded the Department is interested in it but is not able yet to place a timeline on transition. Conversations need to happen to create the work plan. Other provinces' transitions have been lengthy, but we do have the benefit of learning from their experience. Ms. Appleyard's Department has been given a mandate to work on this transition, and the mandate is to meet and collaborate on the issue. Ms. Appleyard was unable to say that transition will happen.

[507] Ms. Appleyard acknowledged that she is the head of the team for this project. Information is being gathered to present to the final decision makers.

[508] Ambulance fees come out of the correctional centre's budget, but there is no cap placed on this budget line. There are no limits on an ambulance. If an ambulance is needed, it is called. Staff are not directed to consider the financial implications of calling an ambulance when one is needed.

[509] Ms. Appleyard has scanned Mr. Klassen's review report, but has not read it in detail because she does not wish to be biased by it. She prefers to wait for the outcome of the Inquest. She made a conscious decision to focus on resourcing, how to work with doctors, and getting contracts signed. What happened in this case certainly has been a topic of conversation. In conversation with many people involved, the detail of what occurred has been the conversation taking place. It had been sometime since she read Mr. Klassen's report. Most of her moving forward has been on the basis of the conversations she has had.

[510] It has been some time since the report was done. The document is dated, and more has occurred that she has learned of through the conversation she has had. Ms. Appleyard has, at her right hand, individuals either involved in the

process or moving forward on it. The majority of time and effort has been devoted to what is done next.

[511] The Department is looking to improve things in every regard. Ms. Appleyard was asked, considering the conversations she has engaged in, who she has spoken to about the Errol Greene matter. She responded she has spoken to Chris Ainley in great detail, Bev Reeves, Ed Klassen, Greg Skelly, and Greg Graceffo. She is confident she understands what happened based on these conversations.

[512] Ms. Appleyard was asked about physician attendance at the Remand Centre noting evidence that the physician has a clinic seeing patients five days a week for an hour a day, and chart review on the weekends for an hour a day. She clarified the weekday clinic is a variable that would allow for the physician to see patients. The physician may not actually see patients subject to the needs. The agreement does not provide that weekend chart review time includes seeing patients.

[513] When asked whether it would make any sense to have the doctor simply see patients seven days a week to deliver healthcare more comprehensively, Ms. Appleyard said she did not think anyone would oppose that idea. There would have to be adjustments to the physician contract and funding. Medical consultation for nurses on a 24 hour basis with physicians is taking place as needed, although the contract has not yet been signed to accommodate that service delivery.

[514] Ms. Appleyard said for delivery of health services in the Winnipeg Remand Centre going forward, there are multiple endeavours proceeding at the same time. There have been changes to contracts, changes to the *RHPA* that happened along the way, and the Department is looking to improve services ongoing in every aspect. Recommendations from an Inquest are something that the Department is required to consider, and is looking forward to. On an ongoing national level, research based, the Department has to consider best practice associated with the issues. In this situation, the approach is three fold. Globally, there is a desire to ensure individuals are complying with policy and practice, that communication is more robust, and that people are discussing the issue learning from what occurred.

[515] The availability of a physician for nurse consultation all the time has changed since June 1, 2018 and the implementation of the provisions of the *RHPA*. Ms. Appleyard believed the new system has been working effectively since that time. Although the new physician contract had not been signed at the time of her

evidence, Ms. Appleyard thought services are being delivered and those concerned are tracking their time for appropriate compensation.

[516] The budget for medical services is within the individual custodial centres. With the creation of rehabilitation services the budget for medical services was not realigned. Ms. Appleyard was asked why she did not view accreditation of the medical unit at the Winnipeg Remand Centre as helpful to maintain optimal standards, whether or not the discussions about having correctional health services under the umbrella of Health bear any fruit. She said she was not opposed to looking at anything but is looking more broadly. If accreditation is built into a correctional health system separate from Health that would not be going far enough. Rehabilitation services is about trying to work together as a system to support the individual to never enter, or stay out of, custody.

22. Ed Klassen – Director of Operations – Custody

[517] Mr. Klassen is the Director of Operations for Custody, Community Safety Division, Province of Manitoba. His responsibilities include operations of the Winnipeg Remand Centre. Relying on operational videos from Winnipeg Remand Centre installed cameras, Mr. Klassen commented on the timing of various events relevant to the Inquest. He confirmed there is a single camera installed in the ceiling of the level 400 range that offers recording of the events concerned here. The camera does not move. The camera only records when there is movement to save storage space.

[518] The events with Mr. Greene occurred the furthest distance away from the camera on the range. Mr. Klassen was unsure of the sensitivity of the detector based on distance. This is not an optimal situation. Attempts to have the video recorded of the events in the Winnipeg Remand Centre enhanced in quality to better aid seeing the images were not successful. The copy relied on in these proceedings is the best available.

[519] In addition to challenges with the quality and clarity of the video, the timestamp is consistent, but not necessarily accurate. The times are not well calibrated but generally consistent across the system. They assist in understanding distance between events, but may not necessarily be relied on for absolute times.

[520] Mr. Klassen has been with the Community Safety Division for 23 years. He is currently working on his Doctorate in Sociology. He is involved in strategic planning, policy development, legislation work, project management, sentence administration, and overseeing investigations involving staff. Health Services in

the Community Safety Division reports to the Executive Director of Rehabilitation Services. Rehabilitation Services is a position developed in early 2017 with a view to consolidating any rehabilitation focused services under that umbrella. For example, chaplaincy, case management, medical services, are all under that new position. Mr. Klassen's involvement with policy setting in medical services is restricted to areas where operationalizing medical services involved, for example, anything involving correctional officers. If correctional officers were required to participate, on occasion, in medication delivery, for example, that would engage Mr. Klassen's involvement.

[521] Medical services do, at times, conflict with operational goals. A common example where that might occur is escorting the inmate into the community for medical services. There may be differences in when restraints should or should not be applied. Mr. Klassen thought any differences between corrections and medical staff were easily resolvable with good communication. Mr. Klassen did not see a concern with financial allocation for medical services continuing to be housed with Corrections, as those line items specific to medical could easily be isolated and identified.

[522] Mr. Klassen was asked to do a review of the circumstances of Mr. Greene's death by the Associate Deputy Minister a day or two after the incident. The purpose of a review, in this particular case, was initially unclear to Mr. Klassen. Mr. Klassen thought the Associate Deputy Minister wished a review on the exploratory side to determine what was occurring. There were generalized concerns regarding restraints, medication administration, and related issues. In this particular case Mr. Klassen did not receive terms of reference which would be typical for a formal review.

[523] Almost every incident that occurs in custody flows through different levels of review at the centre level, and sometimes at the divisional level. As that progresses a more in depth review can be ordered. In this case, Mr. Klassen collected as much existing evidence as possible including incident reports, log entries, and video. Mr. Klassen engaged in consultation with managers about their review of the incident reports. Firstly, Mr. Klassen looked for obvious issues like policy breach. Mr. Klassen also reviews for poor process, and completes a veracity assessment of the reports. A key component is to attempt to determine whether the managers on scene were actually managing the incident. There were problems with individual reports, but when reviewing the reports overall Mr. Klassen was able to develop a picture of the incident that he was comfortable with.

[524] Mr. Klassen was impressed that SOM Banks exercised very strong control of the incident, managed the incident very effectively, and her ability to multitask was noteworthy. Decision making regarding the application and removal of restraints was atypical. Usually, in a crisis, once restraints are applied they are not removed. Her management of this crisis was highly sensitive. She was careful to adapt to information as it presented itself to her during the incident.

[525] In his review, Mr. Klassen did not see that staff thought this was other than a medical incident and that Mr. Greene was faking. Mr. Klassen's impression of Ms. Reeves' interview was that she was not withholding information and was clearly traumatized.

[526] In his report, Mr. Klassen made only three recommendations all of which were addressed by the time the report was written. He could have added a fourth related to direct supervision of the inmates on the unit, but chose not to.

[527] In terms of the potential for greater seizure training, Mr. Klassen explained that officers are trained to respond to behaviours, not diagnoses. To develop specialized response protocols reliant on an assessment that an officer may not be qualified to make, is problematic. Mr. Klassen does not wish to place officers in a position where they need to make a diagnosis before they determine how to respond. There is a health topics folder on the internet site, which all employees have access to that may assist in the dissemination of helpful information. As to a policy with respect to response to seizures, most officers, and even medical staff, have some difficulty determining one has occurred until after the fact. Mr. Klassen would be reluctant to place officers in that position.

[528] As to the intoxicated person's admissions protocols, province wide approximately 20,000 people per year are admitted into custody provincially. Only three of the centres are designated to receive intoxicated prisoners. Winnipeg Remand Centre receives two-thirds of the admissions of the entire province, and is by far the busiest of the provincial centres. Twenty to thirty percent of those admissions are related to persons who are intoxicated. The importation of intoxicated persons results in circumstances more likely to reflect medical risk for the first 36 hours after admission. Consideration is being given to diverting those individuals to another form of facility, but that is still in the discussion stage.

[529] Manitoba is one of the only jurisdictions in Canada that receives an intoxicated person. Work needs to be done to find alternatives. Mr. Klassen said: "this is not a question of saying no. It is a question of finding something that

would be better. Custody centres are not particularly effective as detoxification centres".

[530] As to the transfer of administration of health services in provincial correctional institutions from Corrections to Health, Mr. Klassen said that he has already had discussions on this topic with Alberta and Saskatchewan, the jurisdictions he feels most comparable to our own. Alberta has made a more fulsome transition, and Saskatchewan is currently operating as a bit of a hybrid. Those discussions have been occurring within the division for at least five years, off and on. At this point it is just a prospect.

[531] Mr. Klassen requested the medication logs from level 400, to determine which inmates had requested medication. Medication Logs reflect all inmate requests for medication of Corrections Officers. They are normally held in the level 400 pod. Mr. Klassen requested the medication logs to assist in the production of his Death In Custody Report and discovered the medication logs missing. He was advised that they had been inadvertently recycled. Initially in his evidence, he said the absence of availability of these logs was a rare occurrence. He later clarified that to his knowledge the logs had not disappeared in any other case but this one.

23. Alan Peacock – Acting Associate Director Operations – Custody

[532] Mr. Peacock is the Acting Associate Director, Operations, Community Safety Division, Custody Branch. He is responsible for operations of the seven adult and two youth correctional institutions in the Province of Manitoba. Previously, he was the Assistant Superintendent of Security at the Winnipeg Remand Centre. Mr. Peacock was in his 29th year working in Manitoba Corrections at the time of his evidence.

[533] Mr. Peacock directed and facilitated the production of a very helpful video of portions of the interior of the Winnipeg Remand Centre relevant to the Inquest, filed as an exhibit. In the course of his evidence, narration was provided of what was depicted in the video. Mr. Peacock supplied a spreadsheet with a brief description of the various scenes depicted in the video.

[534] Mr. Peacock confirmed there is one static camera on the range. The housing unit for that camera is the same as when Mr. Peacock began his work at the Winnipeg Remand Centre. The camera, itself, has been upgraded twice. It is an analogue CCTV recording system. The original camera burnt out after five or six years so a second generation analogue camera was installed. In approximately

2007 to 2008, when more bunks were introduced into the jail, the most advanced camera that could be purchased was installed. It is a digital camera. The problem is all of the digital features are not available because it is a digital camera on an analogue system. It is better than the original, but all features are not available.

College of Registered Nurses of Manitoba

24. Deb Elias – Chief of Quality Practice

[535] Ms. Deb Elias is currently Chief of Quality Practice with the College of Registered Nurses of Manitoba. The title of her position changed in August, 2018 from its former title of Director of Practice and Standards. She is a nurse with 30 years experience. For the last 18 years, she has worked in the area of nursing standards. She began with a role as Investigator in complaints and investigations regarding registered nurses and has escalated through the years to one of the senior positions in the College of Registered Nurses of Manitoba. All registered nurses in Manitoba are governed by the College. The College is responsible, among other duties, for implementing and enforcing professional standards for registered nurses in Manitoba. There are 26 standards contained in the Standards of Practice for Registered Nurses that a registered nurse, at a minimum, must attain. Other documents provide greater specificity, but the generality reflected in the Standards of Practice for Registered Nurses arises from the breadth of nursing practice contexts. The standards need to be of universal application. Employers generally have further policies and protocols, and clinical practice guidelines registered nurses are required to follow as well. In the absence of specific workplace policies, the registered nurse would apply best practices. There are, for example, guidelines for wound care, available nationally and recognized as a best practice. Other resources for nurses include Documentation Guidelines for Registered Nurses published by the College of Registered Nurses of Manitoba. This is a detailed document replete with examples and scenarios to support registered nurses in adherence to professional standards. Documentation is a critical part of nursing practice in that it communicates all nurses do.

[536] If a nurse is deviating significantly from best practices, it is a concern for the College. It reflects lack of continuity of care and is a patient safety issue. In the case of documentation in particular, if one nurse follows another and cannot determine what kind of care had occurred it puts the patient at risk. For example a yellow sticky note put on the outside of a chart that may fall off, is not adequate documentation. The note needs to be permanent. Each entry must be initialed or signed off. As part of continuing competence, the Annual Professional

Development Requirement, the documentation component is an aspect of the online learning model that all nurses are required to know.

[537] There is no document similar to Documentation Guidelines for medication administration. Medication administration is learned in basic entry of practice. There are a lot of employer policies that go into specifics of medication administration and nurses are required to use best clinical judgment.

[538] It is important for nurses to work in the limits of their knowledge. If care exceeds that, they need to reach out to other members of their team to work collaboratively. A client may even have needs beyond nursing scope of practice. The collaborative team approach is very important.

[539] Nurses who work in fairly isolated nursing environments, such as a correctional centre, could certainly benefit from collaboration with other nursing and medical professionals who do not work in the same environment. Ongoing training, and maintenance of training, is an important issue for the College. Maintaining competence, and learning new practices and procedures, is one of the focuses of the College. There is a requirement that registered nurses annually complete a self assessment based on the Standards of Practice, determine a learning goal, learn towards that goal and document it. The nurse must complete the jurisprudence online learning module, which is developed each year. In the past several years, in the jurisprudence module, topics such as documentation, professionalism, reserved acts and practice, have been included. Registered nurses must work 1,125 hours in a five year period and failure to do so would attract the attention of the College.

[540] Each year, the College performs a review to assess what nurses are recording as their learning goals, and takes a sampling of nurse responses to submit to the College which reviews it. Nurses are also required to go through a multi source feedback exercise where questionnaires are given to colleagues and patients, and responses are collated. The nurses are given a report of the final numbers for the survey results. Nurses are expected to utilize that information for further professional development.

[541] The audit is comprised of five percent of the 13,500 to 14,000 registered nurses in the province under the jurisdiction of the College. The sources for nurse continuing education include employer education delivered on site which is a primary source. The Colleges and Universities in the City of Winnipeg have some

courses a nurse could take. The College does offer educational opportunities, but more related to standards than clinical practice.

[542] If nurses do not have employer based learning opportunities, the expectation is the nurse will access online resources in Ms. Elias' experience. The Regional Health Authorities are willing to include nurses not in their employ, in nursing educational opportunities they offer for their employees. Learning and education should fit the client need of the population the nurse is engaged with.

[543] Legislative change on May 31, 2018 created a reserved acts model. The legislation reflects a list of 21 reserved acts, and registered nurses have 15 reserved acts of the list of 21. Some of the reserved acts are broken down into multiple points. For example, one of the reserved acts relates to doing things under the dermis. Starting an IV, doing wound care, and those types of things are all under the dermis or skin. The legislation has not changed the way nurses practice day to day. It has more changed how the College regulates. The legislation also shows that no single profession "owns" the practice, but there are overlapping scopes of practice.

[544] Ms. Elias said that the College has done what it can to address issues in the legislation to date. Some system changes need to occur. For example, the legislation allows registered nurses to initiate ordering of lab tests. There is some work that still needs to be done to permit that to occur.

[545] When asked about accreditation, Ms. Elias said Accreditation Canada assesses facilities, regions, or programs to determine whether they meet standards based on patient safety principles. The region or facility going through the accreditation process does the work to meet the framework set out in the accreditation piece. The process is designed to bring a facility up to a certain standard. There is a certain look at the facility to ensure they are maintaining the standards and are accredited for a certain period of time after which they must go through a review again to ensure they are maintaining the standards.

[546] Accreditation provides a certain comfort to the College, knowing that a facility has been accredited and maintains the accreditation. Best practices would suggest, and the College would prefer, that the correctional facility medical units in the Province currently not accredited, become so. This would support similar if not the same standards in all facilities. This makes the medical facility more easily governed, but also enables it to provide more consistent healthcare.

[547] Ms. Elias saw more value in an accreditation process, than moving operation of correctional centre medical units to the Department of Health. The value of devolution to Health was not evident to Ms. Elias.

[548] When referred to the Standing Medication Order in place at the time of Mr. Greene's passing, Ms. Elias said she would prefer a document with more guidance contained in it. The College produces Clinical Decision Tools outlining what is involved in and should be present in a Clinical Decision Tool. It should be developed by the team including physician, pharmacist, and nurse and have direction to the person applying it as far as assessment, interaction, and evaluation. If medications are involved, there should be a maximum dose.

[549] The College would have no difficulty consulting on the development of a tool. That is the majority of the work that Ms. Elias' team does. Some of the medications in the standing medication order could be purchased over the counter. With that, the legislation allows for registered nurses to administer those medications without an order. They would not need to be part of a document such as the standing medication order. They could be part of a policy in the facility. Standing orders such as the standing medication order, generally do not display any form of guidance and is a risk to patient safety. The ability for nurses to administer medication on a short term basis in emergent situations has not changed if a clinical decision tool is in place.

[550] From Ms. Elias' perspective, accreditation would improve the type of policies and systems in place and ensure that issues regarding quality would be addressed during established staff meetings so the whole communication process is clearly documented. Accreditation also speaks to orientation process and a clearly documented means of accomplishing that process. Orientation would be standardized for each individual hired. Accreditation would have the effect of bringing about more standardized practices, establishing what is ideal for practices, and establishes a checklist for facilities going through the process to achieve the desired goals.

[551] Ms. Elias identified one of the special challenges for nurses working in a correctional environment as ethical. The tension between security and providing healthcare could create specialized challenges for nurses.

[552] Ms. Elias thought cultural safety as defined in Entry Level Competencies for Registered Nurses, a publication of the College of Registered Nurses of Manitoba, ought to be a component in both the orientation, training, and practices of nurses in

the medical unit of the Winnipeg Remand Centre. This component of Healthcare Planning is an expectation of nursing practice in Manitoba. The College of Registered Nurses of Manitoba specifically turned its mind to the significant proportion of Indigenous people in the Manitoba population, when drafting cultural safety as a component of nursing practice. The College wishes to provide safe nursing care for all Manitobans.

[553] When referred to Documentation Guidelines for Registered Nurses, Ms. Elias noted the publication emphasizes that clarity of communication is critical for healthcare providers and ultimately patient safety. Among other things, the document emphasizes that opinionated documentation can interfere with continuity of care and misrepresent assessment findings. Vague or opinionated documentation is unhelpful and inadequate. When asked whether describing patient behaviour as "combative" is acceptable, or not, Ms. Elias opined a descriptor referring to behaviour as being combative is insufficient and unclear.

[554] In the context of ongoing professional education provided by employers, Ms. Elias noted that healthcare in corrections presents unique challenges. One of the benefits of employer delivered professional education is that the education can be tailored to the specific needs of the healthcare environment and patient group.

[555] There are three nursing colleges in Manitoba; the College of Licensed Practical Nurses of Manitoba , the College of Registered Psychiatric Nurses of Manitoba, and the College of Registered Nurses of Manitoba. The three Colleges often work collaboratively to develop nursing standards. Standards for Documentation, for example, was not worked on together with the other Colleges, but their principles are very similar to those of the College of Registered Nurses of Manitoba. Where a document has been worked on collaboratively, the logos of all the participating Colleges are reflected on the document. Unlike the College of Registered Nurses of Manitoba integrated into the *RHPA*, the other two Colleges have not yet had their regulations proclaimed and, as a consequence, are still operating under their own legislation.

[556] For the purpose of documentation identification, commonly a reconciliation form is placed in the document, containing the signatures of all those who have participated in charting, together with the name of the individual, so there is a clear reference identifying the author of the charting.

[557] The Winnipeg Regional Health Authority has resources for training, and the majority of nurses employed in the City of Winnipeg are in some way connected to

the Winnipeg Regional Health Authority. Nurses employed with temporary placement agencies would have to comply with the standards of the Winnipeg Regional Health facilities they are placed in.

[558] The largest group of nurses working in the Winnipeg Health Authority region not connected to the Winnipeg Regional Health Authority and its educational resources, is nurses employed by provincial correctional centres in Winnipeg.

THE JURISDICTION OF THE INQUEST JUDGE TO MAKE RECOMMENDATIONS IN AN INQUEST REPORT PURSUANT TO SECTION 33(1.1) OF *THE FATALITY INQUIRIES ACT*

[559] At the conclusion of the evidence presented at the Inquest, Inquest counsel and some of the parties with standing submitted proposed recommendations for the court's consideration. Parties also commented on the proposed recommendations as submitted by the other parties. Counsel for Manitoba took issue with the Court's jurisdiction to make some of the recommendations submitted by Ms. Pranteau. A difference arose between the parties as to the proper scope of permissible recommendations in the Inquest report pursuant to section 33(1.1) of the *FIA*. In addition, Ms. Pranteau invited the Court to consider whether the 2018 amendments to the *FIA* altered the scope of recommendations as permitted by the legislation.

[560] As the issue related to jurisdiction arose at the conclusion of the time scheduled for the Inquest, rather than protracting the hearing, I invited counsel for Ms. Pranteau, and the Government of Manitoba, to make written submissions on this issue. The other parties took no position. Fulsome and helpful submissions were provided, and the following is my analysis.

[561] The wording of section 33(1) of the *FIA*, at the time of the decision in r*e: McDougall* 2016 MBPC 28 was as follows:

> 33(1) After completion of an inquest, the presiding provincial judge shall
>
> (a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
>
> (b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and

> (c) send a copy of the report to the medical examiner who examined the body of the deceased person;
>
> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

[562] The current section 33(1) of the *FIA* reads as follows:

> Inquest report
>
> 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.
>
> 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.

[563] Ms. Pranteau suggests that the change in wording from the obligation on the Inquest Judge to report on the "material circumstances of the death" to the potentially less limiting wording "the circumstances in which the death occurred" broadens the power of the Inquest Judge to make recommendations. Ms. Pranteau submits the removal of the word "material" is not restricted to simply clarity enhancement, but is a substantive change directing a broader mandate.

[564] Referencing the recommendation power in section 33(1.1) of the *FIA*, she says **that** in order to properly assess what recommendations ought to be made to prevent deaths in "similar circumstances", the Inquest must approach the section 33(1)(e) determination of "the circumstances in which the death occurred" including a broad range of facts beyond the who, where, what, when, and how of the death. Previous Inquests have considered circumstances corollary to the cause of death, although not the direct cause of death, and, as a consequence, a material circumstance. As a result, Ms. Pranteau suggests I find the circumstances of Mr.

Greene's death included events not directly connected to his death such as the investigation into his death, the practice of nursing and operation of health services in the Winnipeg Remand Centre generally, implicit bias and/or systemic racism in Manitoba Corrections and the proper training of nurses and correctional officers.

[565] The function of an Inquest should include a public interest component such as checking public imagination by identifying the exact circumstances surrounding a death, enabling the community to be aware of the factors that put human life at risk, and reassurance to the public that the government is acting to ensure that guarantees relating to human life are respected.

[566] Ms. Pranteau suggests Inquest Judges are directed to engage in comprehensive fact finding, resulting in broader recommendations resulting from all of the evidence collected.

[567] Ms. Pranteau urges the Inquest Judge to adopt Krahn ACJ's conclusion in *McDougall*:

> "'material circumstances' must be more than simply the 'who, what, where, when and how' of the death, so too must Circumstances as used in the recommendations power bear sufficient meaning so as to empower the Inquest Judge to make recommendations arising out of the evidence." (Pranteau submission)

[568] The Government of Manitoba, in their submission, suggests that Ms. Pranteau mischaracterises Manitoba's position, and acknowledges that an Inquest Judge's scope of jurisdiction in making Inquest recommendations is not limited to addressing circumstances identical to the circumstances of the death that is the subject of the Inquest. Manitoba agrees the Inquest Judge could make recommendations that could address categories of concern that naturally arise from the circumstances of the death.

[569] Manitoba highlights that recommendations from an Inquest must have the necessary connection to the statutory requirement that, in some way, "prevent deaths in similar circumstances." Specifically, in the case here, Manitoba agrees that this Inquest need not restrict itself to dealing with measures specifically relating to inmates with a seizure disorder. Manitoba concurs that the Inquest may consider making recommendations directed at the prevention of death of inmates arising from serious medical needs. However, Manitoba suggests the jurisdiction to make recommendations is not sufficiently expansive to include issues related to events after the death that do not have a direct nexus to the prevention of deaths in similar circumstances, or are not supported by the evidence.

[570] Manitoba agrees that this Inquest has the authority to make recommendations, assuming they are supported by the evidence, related to responses to seizures and administration of seizure medications within the Winnipeg Remand Centre. In addition, Manitoba concurs that the broader circumstances in which Mr. Greene's death occurred might include recommendations regarding care provided to individuals entering a correctional facility with serious medical conditions, or the improvement of medical services for persons with serious medical needs. This may result in further recommendations relating to the transfer of health services in corrections facilities to Manitoba Health, or accreditation. Although these recommendations would not directly flow from Mr. Greene's death, they could be engaged by similar circumstances, permitting the authority to make them.

[571] Manitoba highlights that, in the absence of an evidentiary foundation, such as Ms. Pranteau's suggested recommendations relating to systemic racism, such recommendations would be beyond the jurisdiction of the Court.

[572] Manitoba submits that a third category of proposed recommendations, reflecting an absence of nexus to the circumstances of Mr. Greene's passing, are beyond this Court's jurisdiction. Examples arising from counsel's submissions, of this form of improper recommendation as submitted by Manitoba, would include issues after Mr. Greene's death including apologies to the family of the deceased, recommendations relating to the divisional investigation into Mr. Greene's death, and changes to the *FIA*. Manitoba suggests such recommendations are out of scope.

[573] Manitoba suggests that reference must be had to the purpose of an Inquest as reflected in section 26.2(1) of the *FIA*:

> 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.

[574] Manitoba suggests that Joyal CJ Q.B. in *Awasis Agency of Northern Manitoba v. Allen* 2013 MBQB 47 directs the recommendation duty of an Inquest Judge to provide a meaningful investigation of facts and recommendations flowing from those facts, without becoming a forum to address broader public concerns. Heed must be had to the direction of the Chief Medical Examiner directing an Inquest be held. The caution is to avoid, in recommendations made at this Inquest, treading into areas so broad as to be unconnected to preventing deaths in similar circumstances, and are so broad as to be "a roving investigation into general public

concerns". (Awasis v. Allen supra). Inquests are narrower in scope than a public inquiry held pursuant to *The Manitoba Evidence Act* C.C.S.M. c. E150.

[575] Manitoba agrees with Ms. Pranteau's submission that the fact finding duty of an Inquest Judge is the primary goal of an Inquest, but disagrees this interpretation favours broader recommendations. The broad investigative mandate, submits Manitoba, is of assistance to the Inquest Judge in developing recommendations, as it is only by this means that the Inquest Judge can determine the circumstances of the death. Manitoba submits this, however, does not change the scope of recommendations to be made under the *FIA*.

[576] The specific provisions of the *FIA*, submits Manitoba, address the Inquest Judge's scope of jurisdiction. The core duties of an Inquest Judge are as prescribed by section 33(1) and (1.1) of the *FIA*:

> Inquest report
>
> 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.
>
> 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.

[577] In addition, the Chief Medical Examiner directs an Inquest be held by letter to the Chief Judge of the Provincial Court setting out the specific terms of reference to guide the Inquest. In this case, Dr. John Younes, in his December 6, 2016 letter, explains his reason for directing the Inquest as follows:

> "Thus, in accordance with The Fatality Inquiries Act, I direct that an inquest be held into the death of Bradley Errol Greene for the following reasons:
>
> 1. to fulfill the requirement for an inquest, as defined in section 19(3)(b) of *The Fatality Inquiries Act*:

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

2. to determine the circumstances relating to Mr. Greene's death; and,

3. to determine what, if anything, can be done to prevent similar deaths from occurring in the future."

[578] Manitoba submits that the previous wording related to scope of recommendations of "to reduce the likelihood of deaths in circumstances similar to those that resulted in the death" to the current direction in section 33(1) (1.1) of the *FIA* "to prevent deaths in similar circumstances" does not change the latitude of recommendation jurisdiction to include broader circumstances which did not arise from the death. If the Legislature intended to broaden the circumstances, the wording in the amendment would have explicitly addressed the change.

[579] In considering the former language in section 33(1)(a) of the *FIA*, requiring the Inquest Judge consider "material circumstances of the death", and the current language at section 33(1)(d) of the *FIA* requiring the Inquest Judge to determine the "circumstances in which the death occurred", Manitoba suggests that no substantive change was intended to the Inquest Judge's obligations. The change was most likely a drafting modernization and deployment of plain language. This, suggests Manitoba, accords with the obligation to make recommendations that "prevent deaths in similar circumstances". Manitoba says this wording appropriately focuses on events leading up to the death and recommendations to prevent something similar from happening again. This does not engage jurisdiction for recommendations related to apologies, subsequent investigations, etc. as there are not circumstances in which Mr. Greene's death occurred.

[580] Manitoba submits that the pattern followed by Inquest Judges in Manitoba is to adopt the similar circumstances test in formulating recommendations flowing from an Inquest. The case law and legislation support this approach.

[581] In considering the respective positions of the parties on the scope of jurisdiction of the nature of recommendations which may be permissibly made in an Inquest Report pursuant to section 33(1.1), I acknowledge and consider the helpful and complete submissions made by the parties. It is not my intention here to comprehensively review all of the relevant authorities submitted by counsel in support of their respective positions. I recognize the more expansive jurisdiction urged by Ms. Pranteau.

[582] It is critical to keep in mind that the mandatory, statutory directed, end goal of an Inquest is to, if grounded by evidence presented at the Inquest, present recommendations that "prevent deaths in similar circumstances". Clearly, a component of presenting those recommendations, is a determination in of the circumstances in which the death occurred.

[583] This focus is highlighted by the purpose of an Inquest which, pursuant to section 26.2(1) of the *FIA*, is for the "**sole** purpose" of establishing the facts necessary to prepare the report into the death required pursuant to section 33 of the *FIA*.

[584] Joyal CJ QB in *Awasis v. Allen* 2013 MBQB 47 highlighted the critical nature of the focus of an Inquest as being prescribed by statute and the direction of the Chief Medical Examiner.

> In other words, unlike criminal or civil proceedings, the scope of the Inquest is not defined by "parties" or even by appointed Crown counsel, or the interested "persons" who have been granted standing under s. 28 of the Act. Rather, what Freedman J.A. referred to as the comparatively more narrow question that has to be answered, is given meaning by what the inquest judge reasonably understands is necessary for the purpose of doing his or her duty as prescribed by s. 33(1) (c) and in accordance with the terms of reference contained in the directing letter of the Chief Medical Examiner. While the scope of the Inquest cannot, as Awasis rightly states, become a "roving investigation into general public concerns", neither should it be reduced to the point where the Inquest Judge's duty to make meaningful recommendations is supplanted by what is often and understandably an "interested person's" desire to shape and even limit those recommendations. (At para. 34)

[585] The scope of an Inquest, as a consequence, is by its nature narrower than a public inquiry. There are specific circumstances giving rise to the death as determined by the Inquest Judge, that are the underpinning of the achievement of the requisite goal of the Inquest, to make recommendations to prevent deaths in similar circumstances. The broad investigative mandate afforded the Inquest Judge

in the discharge of duties under the *FIA*, enables the judge to examine the circumstances in which the death occurred in a fulsome fashion with a view to making recommendations, if appropriate, which will meet the required goal of preventing deaths in similar circumstances. The investigative mandate does not, by its nature, enhance the scope of permissible recommendations beyond that supported by an evidentiary nexus to the death that is the subject of the Inquest.

[586] In commenting on this issue, Dvorak PJ, in *An Inquest into the Death of Craig Kucher* (April 7, 2016), considering the recommendation jurisdiction of an Inquest Judge, said:

> 23. I do not see this section as limiting an inquest judge's jurisdiction to make recommendations to only those circumstances that had a direct causal connection to the death that is the subject of the inquest. An inquest judge is entitled to consider circumstances leading to the death that, though not causally connected to the death, disclose a foreseeable issue that might lead to death under similar circumstances.
>
> 24. That being said, the provision is not so broad as to permit recommendations that are not supported by the evidence or are unrelated to the circumstances surrounding the person's death.

(At para. 23 to 24)

[587] The deletion of the word "material" in section 33(1) of the *FIA*, when referring to the Inquest Judge's obligation to report the circumstances of the death, I find, is not a substantive change giving the Inquest Judge a broader mandate to inquire into a more comprehensive range of circumstances. The change in recommendation obligation from "reduce the likelihood of deaths in circumstances similar to those that resulted in the death" to "prevent deaths in similar circumstances", I find, has not meaningfully changed the focus and obligation of the Inquest Judge.

[588] The newer wording is clearer, and more succinct. A review of the legislation as a whole, including section 26.2(1) of the *FIA*, confirms the well understood and clear role of an Inquest Judge - to determine the events leading up to the death, the cause, manner, and circumstances of the death, and make recommendations to prevent deaths in similar circumstances. Although other areas of concern may come to light as a result of the evidence, the recommendation obligation and power flows directly from the authority given and directed by *The Fatality Inquiries Act* itself, together with judicial decisions interpreting that power. It is clear there must be a nexus, in recommendations made pursuant to

section 33(1.1) of the *FIA*, between the prevention of deaths in similar circumstances and the recommendation. The Fatality Inquiries Act does not permit recommendations beyond that authority.

[589] An Inquest Judge is prohibited from making recommendations unrelated to the death that is the subject of the Inquest, or unsupported by the evidence presented at the Inquest. A balance must be achieved in considering whether proposed recommendations arising from an Inquest are within the permissible scope of the Inquest as articulated by Krahn A.C.J. in *An Inquest into the Death of Craig Vincent McDougall* (May 9, 2017) as follows:

> "[259] I recognize that there is a need for an Inquest Judge to carefully monitor the scope of the Inquest and the recommendations that arise from the circumstances of death so that it does not become a roving inquiry into matters of general public concern. But at the same time, there must be sufficient jurisdiction to meaningfully deal with all of the circumstances surrounding the death to "check public imagination" to ensure that government policies are developed that respect human life. This is a context specific inquiry into those matters which are implicated in the death before the Court."

(At para. 259)

[590] As were the recommendations made by Krahn A.C.J. in *McDougall*, the recommendations to follow here in this report are intended to prevent deaths in similar circumstances and address issues which arose naturally out of the material circumstances of the death.

[591] I am unable to, and precluded from, making recommendations unrelated to the death, and on matters for which sufficient evidence was not heard at the Inquest.

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.

[592] In making these recommendations, I had the benefit of fulsome submissions by the parties granted standing to this Inquest, and Inquest Counsel, to assist in

formulating the recommendations to follow. The parties and Inquest Counsel submitted, in total, 91 recommendations for my consideration. All are to be commended for their thoughtful reflection and thoroughness in presenting the Court with suggestions to assist in this process.

[593] Not all of their suggestions are integrated into my recommendations. Some of their suggestions are included in my recommendations in a different fashion than suggested. Adopted or not, each of the suggestions, together with the submissions of all the parties, 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* and the applicable law as referenced earlier in this report. It is my anticipation that the recommendations are sufficiently practical to be operationally viable for the Manitoba Government to implement. I hope the recommendations made as a consequence of this Inquest into the death of Bradley Errol Greene will prevent deaths in similar circumstances.

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

1. Nursing Assessment of Mr. Greene's Medical Circumstances Upon Admission

[595] Roberta Brotherston is a well qualified, well experienced nurse. At the time of the incident with Mr. Greene, she was working her sixth shift at the Winnipeg Remand Centre. Her nursing experience is primarily working in First Nations. At the time of her evidence she continued to do so. Her work at the Winnipeg Remand Centre was part time.

[596] On the Intox Admission Form, completed by a different nurse, Ms. Brotherston noted Mr. Greene said he suffered from epilepsy, and that his medication was valproic acid 250 milligrams TID (last taken 24 hours ago). It would have been of assistance to her to have that information when she completed the Healthcare Assessment Form on April 30, 2016 at 12:20 p.m. She did not recall if she had the Intox Admission Form when she completed the Healthcare Assessment.

[597] On the form she completed, she noted Mr. Greene's current medication as valproic acid 250 miligrams TID, and beside the space on the form for current healthcare concerns, she wrote seizure disorder. She considered the importance of confirming the inmate's report of medication by accessing DPIN, but she did not have access. She asked someone else to check it for her.

[598] Ms. Brotherston recognized a person with epilepsy who has not been taking his medication as an urgent situation. She was clear had she the benefit of DPIN, she would have given Mr. Greene valproic acid knowing that he had a seizure disorder. Acknowledging a nurse must be cautious not knowing what substances an individual may have consumed, she would have given him the medication nonetheless balancing the risk with a focus on doing all she could to prevent a seizure occurring for Mr. Greene in the Winnipeg Remand Centre.

[599] Paula Ewen is a nurse with 34 years experience. She worked with First Nations and Inuit Health Branch, and also worked at the Winnipeg Remand Centre. She had experience working in the medical unit at Stony Mountain Institution, and also in various First Nations. Had Mr. Greene requested his medication at the time of his intox assessment, Ms. Ewen would have informed Mr. Greene that Winnipeg Remand Centre nurses did not administer medication to a person while they were intoxicated. Ms. Ewen would not have started Mr. Greene on valproic acid, but would have deferred the issue to the nurse completing the healthcare assessment later on.

[600] When asked if it would be better to prevent a seizure by offering medication, rather than treating it with Ativan after it occurred as she testified, Ms. Ewen said she was not in a position to predict who would have a seizure. She would not put herself or the patient at risk by giving medication when she does not know the whole story. In Mr. Greene's case, Ms. Ewen did not give Mr. Greene his valproic acid, recognizing that because of his self report of last taking medication 24 hours before he was at risk of seizure. It was her perception administering medication must be deferred until the healthcare assessment. She made this decision because of his intoxication and she did not know what he had otherwise consumed. She did not consider sending Mr. Greene to hospital as a matter of urgency, because he had already missed two doses and had not had a seizure. Every new admission is not reviewed at shift change, only those which involve risk. Ms. Ewen did not recall discussing Mr. Greene's case with the incoming nurse.

[601] At the time she testified for the first time at the Inquest, Beverley Reeves had been employed by Manitoba Corrections for nine years, and was the Health Services Manager at Milner Ridge Correctional Centre. Previously, she had been the acting Health Services Manager at the Winnipeg Remand Centre and was working there in April and May of 2016. As a nurse for 31 years, she had worked in addictions. At the time she responded to Mr. Greene's first seizure, Ms. Reeves had no understanding that Mr. Greene suffered from a seizure disorder and was unaware of his medical history. Unless an individual presents with a second

seizure, they are not commonly sent out of the Winnipeg Remand Centre for treatment. Although Ativan is used to stop or reduce the threshold for a seizure, it was not administered by Ms. Reeves after Mr. Greene's first seizure because she did not have a standing order for the administration of Ativan after a first seizure. The standing order only permitted two seizures before Ativan is administered.

[602] In commenting on whether a nurse should continue valproic acid for a seizure disorder, Ms. Reeves thought the issue presented was an oversimplification. She said a nurse has an obligation to evaluate how long a medication had been used, whether the patient had been consistent in their use, and ask a number of other questions. A consistent pattern of use, over a long period of time, would result in a nurse being correct continuing the medication. If other questions come into play, including sporadic use with no explanation for inconsistency, the nurse must consider whether there were adverse effects or whether the patient was trying an alternative therapy.

[603] Having reviewed Mr. Greene's file since his passing, Ms. Reeves thought the nurse conduct in this case correct. The file should have gone before the doctor to address the issue of whether valproic acid should continue, and waiting for the Monday doctor clinic appropriate. Ms. Reeves acknowledged seizures are a medical emergency, that any amount of valproic acid could lessen the likelihood that an individual could have a seizure, and that obtaining valproic acid for Mr. Greene was a priority.

[604] She did not request EMS be called after his first seizure because he had reoriented, was responding verbally and to commands, and Ms. Reeves had a standing order for treatment. Mr. Greene's apparent noncompliance with his medication was a factor in her decision whether a physician should be contacted before regular Monday attendance at the Winnipeg Remand Centre. Ms. Reeves said whether an inmate suffering a seizure in custody is sent to hospital is based on the clinical judgement of the nurse.

[605] Bonny Weber has been a nurse for about 20 years. She taught at the University of Manitoba, worked at Selkirk Mental Health Centre and in various other positions. At the time of her evidence, she had worked at the Winnipeg Remand Centre for a little over three years. She was present, and assisted with Mr. Greene's seizure while being discharged from the Winnipeg Remand Centre March 13, 2016. Had Mr. Greene remained in custody, an ambulance would not have been called, despite his known seizure disorder, because this was just a single seizure and it was not protocol. Her memory was triggered by Mr. Greene's

conduct during his first seizure May 1, 2016. After that seizure it was decided he be left in his cell and observed. Nurses had no medical concerns, and an ambulance was not called after that first seizure because it was not protocol. It was only after his second seizure that a plan to administer Ativan and send Mr. Greene out was developed in consultation with Ms. Reeves.

[606] Ms. Weber said she did not start Mr. Greene on valproic acid when she reviewed his chart because it was not within her scope of practice. She had questions. She would not offer medication to an individual who was intoxicated.

[607] Kathryn Berens has been a nurse for almost 40 years. She has a Bachelor of Nursing degree, and is a Registered Nurse. The majority of her nursing career has been in isolated communities with First Nations people. At the time of her evidence, she continued to work at Bloodvein. In addition, she picked up casual shifts at the Winnipeg Remand Centre. Ms. Berens responded to the Code Red related to Mr. Greene's seizure March 13, 2016.

[608] When asked about continuing valproic acid prior to physician authorization, Mr. Berens said if an individual were admitted to the Winnipeg Remand Centre, and reported what the medication was and the dose, she would confirm the dose and give them medication. In the case of an individual showing sporadic compliance with medication in the case of valproic acid, Ms. Berens said people on seizure medication often do not take their medication. It was clear Mr. Greene had a seizure disorder. Sporadic compliance with medication was not a bar to Ms. Berens continuing the medication. She was quite clear that she would embark on this course of action, and face the repercussions if she were wrong in doing so.

[609] She hoped that, had she been the nurse confronted with Mr. Greene's seizures May 1, 2016, she would have given him his medication. She would attempt DPIN confirmation, although at the time she did not have DPIN access, and prefer to consult with a physician. In the end if she were unable, she would have given him the medication. She did not take the Standing Order with respect to medications as direction an ambulance may not be called after a first seizure should circumstances require it.

[610] Marshall Lawrence has been practicing as a nurse since 1985. He holds a Master's Degree in Nursing from the University of Manitoba, has taught intensive care nurses at St. Boniface Hospital, and at the time of his evidence was in a full time position with the Winnipeg Regional Health Authority in the Department of Anesthesia as a clinical assistant in anesthesia.

[611] In addition he has worked part time through Manitoba Corrections at the Winnipeg Remand Centre for about 20 years. He confirmed it was his password used in the DPIN search for Mr. Greene in the early morning hours of May 1, 2016. Although he had no specific recollection of it, it would not have been unusual for him to assist a colleague by accessing DPIN at their request. Mr. Lawrence thought it appropriate to continue valproic acid over the weekend prior to physician consult, based on the information available interviewing the inmate, consulting DPIN, Mr. Greene having a seizure disorder, and being aware of his dosage. A doctor can review the decision on Monday.

[612] There is no downside to giving the medication so long as the nurse has done due diligence in interviewing the inmate. Mr. Lawrence said that he would call EMS for any inmate experiencing a seizure in the Winnipeg Remand Centre. Seizures are extremely variable in their presentation and duration. In his career, Mr. Lawrence has seen hundreds of them. On each occasion when Mr. Lawrence has called EMS for an inmate having a seizure at the Winnipeg Remand Centre, the inmate was taken to hospital.

[613] When referred to the Standing Medication Order, which has been interpreted by others to require a second seizure before Paramedics are called, Mr. Lawrence said he does not read it that way. It is not reasonable, to him, to take out a stopwatch and time whether a seizure is four and a half minutes or five minutes in duration, referring to the provision where a single five minute seizure prompts a call to EMS. He would not keep an inmate in custody if they have had a seizure, without having a doctor see them. Generally, in circumstances where his clinical practice differs from his interpretation of the standing medication order, his clinical practice will determine whether or not he calls an ambulance.

[614] Dr. Alexei Yankovsky, an expert in neurology and epilepsy, testified that two seizures within 40 to 45 minutes is a significant major medical concern. When an individual misses a few doses of valproic acid, it is very important they resume taking the medication as quickly as possible. Had that occurred in this case, Mr. Greene would likely have been better protected from seizure and would have had a higher blood level of valproic acid. Dr. Yankovsky was clear that a patient who had epilepsy should receive valproic acid regardless of level of intoxication.

[615] There is no reason, in Dr. Yankovsky's opinion, to delay starting or restarting valproic acid at levels even higher than normally would be given to better achieve a steady state. In an urgent situation, where a patient has been noncompliant with medication, Dr. Yankovsky said he would treat with valproic

acid even prior to knowing blood levels. In acute impending seizures, such as in the case of Mr. Greene, Dr. Yankovsky highlighted the importance of healthcare providers obtaining Ativan and knowing how to use it.

[616] Ms. Reeves, now Director of Health Services for all provincial institution medical units was clear that a particular response to an inmate, having had a seizure or with a known seizure disorder having not had their medication, is an exercise in nursing clinical judgement. As indicated by the evidence of the nurse witnesses in this Inquest opining about what they would or should not do in case such as Mr. Greene's, the exercise of nursing judgement here, varied widely. Ms. Reeves, having personal involvement in Mr. Greene's seizures May 1, 2016, having been the acting Health Services Manager at the Winnipeg Remand Centre at the time of Mr. Greene's death, was confident the nursing judgement in Mr. Greene's case was exercised appropriately. Should the same circumstances occur, the same decision making and action should be taken. Her view varies from that of some of the nurses referred to, and that of Dr. Yankovsky.

[617] Clinical judgement can only be exercised where the circumstances presented are appropriately evaluated. It is only then that judgement relating to the course of conduct to be taken can be exercised. Seizures are a common occurrence at the Winnipeg Remand Centre. To prevent a death in circumstances similar to that of Mr. Greene, it is critical that nurses not only have the experience, but the training, to properly recognize and evaluate the urgency of an individual suffering from a seizure disorder, or who has suffered a seizure, before clinical judgement can be exercised. The evidence at the Inquest is that in the three years since Mr. Greene's passing, there has been no training specific to seizures for nurses at the Winnipeg Remand Centre.

I therefore recommend: that seizure specific training be developed for all nurses employed at the Winnipeg Remand Centre in consultation with Dr. Alexei Yankovsky or another expert in seizures, and that taking this training be a mandatory requirement for all nurses.

2. Correctional Officer Seizure Knowledge and Training

[618] Correctional Officer Albert Wiens, when assigned to oversee Mr. Greene, was advised that he had had a seizure and was in his cell, agitated. His role was to act as a "constant watch" over Mr. Greene in his cell. It was left to Mr. Wiens to interpret the behaviour he observed, and exercise judgement as to when other resources ought to be deployed. Mr. Wiens noted a sudden change of behaviour,

during the time of his surveillance of Mr. Greene, from agitation to sudden calm, and lying on his back on his mattress.

[619] Although Mr. Wiens has no medical training, he was concerned enough to take his radio off his belt thinking this may be the beginning of a second seizure. In the course of his employment, Mr. Wiens has received no training in dealing with seizures. Seizures, in accordance with his evidence, are a frequent occurrence and he has been involved in over 100 seizures since working at the Winnipeg Remand Centre.

[620] When Mr. Wiens ultimately saw Mr. Greene exhibiting what Mr. Wiens thought, absent any training, to be the typical signs of a seizure, he called a Code Red. After Mr. Greene received an injection from the nurse, a "constant watch" was again assigned to Mr. Greene by two officers other than Mr. Wiens.

[621] Correctional Officer Million Mehari has been with Corrections for nine years. On May 1, 2016 he responded to the second Code Red in connection with Mr. Greene. He had never seen a seizure before this event. Mr. Mehari was directed to enter the cell containing Mr. Greene again when Paramedics attended to do an assessment. Mr. Mehari maintained control of Mr. Greene's left arm and part of his upper body. Mr. Mehari recalled Paramedics telling officers to remove restraints from Mr. Greene. It was his belief the Paramedics' request was connected to the provision of CPR. If Paramedics had requested the removal of restraints, Mr. Mehari said the decision to do so would not have been his – it would have been that of SOM Angela Banks.

[622] At the time of his involvement with Mr. Greene, Richard Pow had only been employed by Corrections as a Correctional Officer for one month. Although he had previously observed ten seizures, Mr. Greene's seizure was the first he had seen in the context of his employment. Mr. Pow was the first Correctional Officer on scene. Mr. Greene was having a seizure and inmate Stephen King was attempting to assist him. Mr. Pow attempted to reassure Mr. Greene. Mr. Pow noted Mr. Greene, while seizing, hit his head several times. He asked SOM Angela Banks for a blanket to put under Mr. Greene's head so he would not hit it. By the time SOM Banks had arrived on scene, Mr. Greene's seizure was finished.

[623] Mr. Pow had taken a first aid course in the community before becoming employed by Corrections. Mr. Pow also had information about dealing with seizures from his personal life. His mother was a nurse, and had given him information about how to deal with seizures over the years. This assisted him in

knowing what to do when presented with Mr. Greene having a seizure. He thought it would be helpful, as a Correctional Officer, to receive more training related to the immediate care of someone suffering seizures. He had seen seizures since his experience with Mr. Greene working in the Remand Centre, and agreed seizures were not uncommon in the Winnipeg Remand Centre.

[624] Angela Banks was the senior correctional officer at the Winnipeg Remand Centre at the time of Mr. Greene's seizures, as the Shift Operations Manager (SOM). She was responsible for day- to -day operation during the time of her shift. She is a 23 year employee with Corrections.

[625] She was working on March 13, 2016, as the SOM, when Mr. Greene had a seizure while being discharged from the Remand Centre. Mr. Greene was flailing, and screaming. It was her view that normally, during a seizure, the inmate does not fight. It was Ms. Banks' opinion the behaviour she observed had nothing to do with a seizure. One of the nurses decided an ambulance should be called, and as the only cell phone carrying staff person, Ms. Banks facilitated the call.

[626] At the time of Mr. Greene's first seizure May 1, 2016, one of the nurses recognized him from the Code back in March. In the course of her Corrections career, Ms. Banks estimated she had witnessed over 200 seizures. The behaviour she observed May 1 was similar to what she observed in March. Ms. Banks had not seen behaviour such as Mr. Greene was exhibiting, and she asked the nurse if it were normal.

[627] In the March episode, it was Ms. Banks' impression that when people were watching Mr. Greene, he seemed to act out more. When watched on camera, he seemed to calm down. She was present during Mr. Greene's second seizure on May 1, 2016. Again, the behaviour he exhibited was not what she was accustomed to relating to seizures.

[628] Ms. Banks was, however, confident that arising out of her first aid training from her employment, she would know what to do if confronted with someone having a seizure in the absence of medical personnel. Ms. Banks testified that seizures were one of the most common medical episodes occurring in the Winnipeg Remand Centre. She has not received specialized training relating to seizures, she said, because she is not part of the medical personnel. In referring to Mr. Greene's conduct during the Code Red March of 2016, in reports, Ms. Banks observed that Mr. Greene would fall "strategically" onto his mattress and that "it looked like he was acting or performing". She further noted that when staff

withdrew, Mr. Greene would settle and was fine. These impressions of Ms. Banks' clearly suggest his conduct was not involuntary arising from a medical episode, but rather strategic and deliberate.

[629] When asked if Ms. Banks thought people in her position, as well as Correctional Officers, might benefit from specialized seizure training, Ms. Banks responded she relied heavily on medical to inform her and felt such training might be akin to the SOM asking medical for suggestions on security.

[630] Even when asked if there were room for training related to seizures, noting the distinction between the role medical plays and the obligation on Corrections to manage the behaviour, Ms. Banks was firm that she did not believe there to be a role for such training. She does not know if the inmate is faking or having a real seizure. When it was suggested that perhaps training might assist those in her role to determine that issue, she advised she could not speak to that issue.

[631] When pressed by counsel if training could assist her with the tools to distinguish a genuine or feigned seizure, her response was as follows:

> "and you can guarantee me it's 100%?... I wouldn't change what I did so I can't say even with better understanding because unless you are going to guarantee me 100% that he's having that seizure or that he which I don't know if we can do I wouldn't change it because I am still responsible for the security of staff and inmates in the institution"

[632] In response to a similar line of questioning, Ms. Reeves responded as follows:

> "don't want to make COs responsible for interpreting seizures. They present in such a different manner that I don't – what is the term "a little education can be dangerous sometimes." I would never want a CO to assume that a seizure is not a medical emergency based on what they are seeing. I would rather have them call medical staff or EMS and have them interpret the result".

[633] Ms. Reeves did indicate that an understanding of postictal behaviour potentially being driven by a medical episode rather than something else would be good education for Correctional Officers to have.

[634] It is clear Correctional Officers are on the frontline of inmate behaviour. They are confronted daily by a myriad of various types of human conduct. Some of the behaviour can be evidence of a medical challenge. Much of the behaviour is driven by other issues. Nonetheless, they are required to make quick judgement

calls, in the absence of medical staff, and in the absence of the SOM who has not yet arrived, as to how that behaviour ought to be appropriately responded to. This kind of judgement can best be exercised based on experience, and good training.

[635] The Correctional Officer first on scene at the first of Mr. Greene's May 1, 2016 seizures, was Richard Pow. Mr. Pow was the most junior officer, at one month's service, of all Corrections witnesses personally involved in the matter. He knew what to do because of training and information he had external to his Corrections training. Ironically, so did inmate Stephen King because of training he received in the course of his employment. Of interest, the most senior decision maker on scene, Ms. Banks, at the time of all Mr. Greene's seizures was resistant to a recommendation relating to seizure specific training for Corrections personnel unless it could guarantee 100% assistance with determining whether behaviour exhibited by an inmate was a genuine seizure.

[636] Seizure specific training for Correctional Officers would assist in appropriately responding to unusual behaviour which may be seizure related, and recognizing when the behaviour they are observing may, in fact, be seizure related. Of interest, Albert Wiens and others were assigned to the "constant watch" over Mr. Greene. It was left to Mr. Wiens to determine when the behaviour was such that a Code Red ought to be called. It is clear that officers are placed in the position of "constant watch" when the issue is potentially medical, in the absence of adequate education to perform such a function. The intention here is not to substitute Correctional Officer decision making for that of nursing staff. It is a recognition of the reality of the role Correctional Officers play in the day to day operation of the Winnipeg Remand Centre when confronted with unusual behaviour that could be medically, or, as in this case, specifically seizure driven.

I therefore recommend: recognizing the specific role Correctional Officers play in the Winnipeg Remand Centre, that seizure specific training, including recognition of behaviour that could be seizure related and appropriate response to it while awaiting the arrival of medical staff, be developed and delivered to all Corrections staff working directly with inmates including Shift Operations Managers, and that taking such training be mandatory.

3. On Scene Nurse Support to Paramedics

[637] Michael Kaul and Sabrina Labossiere, Paramedics, responded to a call from the Winnipeg Remand Centre regarding Mr. Greene's second seizure on May 1, 2016. In the course of attempting to treat Mr. Greene, they were confronted with a

situation they had not experienced before. Mr. Greene was unconscious, not breathing, and they could not detect a pulse. He was handcuffed in front of him, and had ankle cuffs. These restraints impeded Paramedics' ability to effectively treat Mr. Greene. They could not perform CPR, a potentially lifesaving procedure, could not give him lifesaving drugs intravenously, or deal effectively with other issues related to his care. Mr. Kaul, who presented as a very soft-spoken individual on the witness stand, testified that he had to speak more loudly and clearly than he normally would in an attempt to get his message across with the Correctional Officers that the cuffs needed to be removed.

[638] In his 20 years of experience as a Paramedic, Mr. Kaul has had other situations where he requested restraints removed to facilitate treatment, particularly with police. He has never, in his career, had an experience such as this where he had to make multiple requests, explain himself, and raise his voice before the request was ultimately complied with. He had no recollection of interaction with a nurse, or a nurse even being present.

[639] Paramedic Sabrina Labossiere recalled multiple requests to remove the cuffs, officers declining to do so, and Paramedics explaining to the Officers he did not have a pulse, and was not breathing. Ms. Labossiere could perceive no safety reason Mr. Greene should need to retain his handcuffs, as he was unconscious. From her perspective, it was obvious he was unconscious. Paramedics were yelling at the Officers to remove the cuffs. Million Mehari, Correctional Officer, recalled Paramedics requesting the cuffs be removed. The cuffs ultimately were removed, and appropriate treatment commenced. These Paramedics were so concerned about the challenging interaction with Corrections, it was noted in their report.

[640] This situation is a striking example of tension that can develop between the need for security, the responsibility of Corrections staff, and the need for medical treatment, the purview of medical staff. What the Paramedics did not know, at the time were desperately yelling at Corrections staff to remove the restraints from the unconscious and not breathing Mr. Greene, is that, in accordance with the evidence of Mr. Mehari, the Officers themselves did not have the authority. The person with authority to direct removal of the restraints would be the SOM. At some point the SOM must have intervened, because the restraints were ultimately, after some delay, removed.

[641] The individual on scene best positioned to resolve this obvious tension between Corrections priorities and medical treatment, is the nurse. The

Correctional nurse is well experienced in addressing these issues, and the presence of the nurse on scene to ensure medical and correctional priorities do not conflict would do much to facilitate speedy resolution of the conflict, and quicker deployment of lifesaving treatment. The nurse is uniquely positioned to recognize the medical urgency of restraint removal, communicate with the SOM, and have the situation resolved.

[642] The challenge in the circumstances here was that Ms. Weber attended to other duties after Paramedics arrived, and Ms. Reeves was present somewhere on scene but apparently not close enough to recognize the problem and offer support to Paramedics. The evidence suggests that, generally, nursing staff turn over care of the patient to Paramedics, and although remaining on scene, are not engaged with the treatment process such as to be available as an active support to Paramedics in resolving such difficulties.

I therefore recommend: that the Winnipeg Remand Centre Medical Unit develop a practice requiring a nurse remain on scene and engaged with the treatment process at all times Paramedics are in the Winnipeg Remand Centre. The nurse on scene should act in a supportive role to Paramedics when circumstances require, and when appropriate, act to facilitate resolution of challenges Paramedics are experiencing carrying out their duties.

4. Physician Availability and Accessibility

[643] At the time of Errol Greene's passing May 1, 2016, Manitoba Corrections contracted a physician to attend at the Winnipeg Remand Centre Monday through Friday, to address the medical needs of inmates. There was no arrangement for on call nurse access by telephone or otherwise. Nonetheless, depending on the nurse, and his or her experience or connections in the medical community, the nurse might reach out for advice to either the contract physician when he or she was working at the hospital, other physicians in the emergency department who might be generous enough to respond to questions, or other physicians in the community with whom the nurse had a connection.

[644] Not all nurses had these personal connections, or were aware of the possibility of phoning the contract physician when that individual was working at the hospital. This ad hoc physician access was a significant feature in Mr. Greene's case, because the nursing decision made was to wait until Monday to have the doctor see him to review medication or start it. Mr. Greene was admitted to the Winnipeg Remand Centre on Saturday, and passed way on Sunday.

[645] When Bev Reeves testified on the first occasion, she was the Health Services Manager at Milner Ridge Correctional Centre and had been since November of 2017. Previously, she was the acting Health Services Manager at the Winnipeg Remand Centre, where she worked at the time of Mr. Greene's passing. When asked, at that time, whether it would be better to have a physician available Saturday and Sunday at the Winnipeg Remand Centre, she reinforced the competency of nursing staff and repeated that individuals requiring physician attention would be sent to hospital.

[646] Despite the incident with Mr. Greene, she confirmed that, in similar circumstances, she would proceed in the same fashion as had been the case with Mr. Greene and put the file before the physician for review. She did acknowledge that an on call physician would have been helpful.

[647] Chris Ainley, at the time of his evidence, had recently retired in June of 2018 as Director of Health Services with Manitoba Corrections. Prior to his retirement he held the position for five years.

[648] In terms of after hours physician contact, Mr. Ainley said he was aware that even though the contract physician was not normally obliged to take calls, that physician would sometimes do so. Mr. Ainley sits on council of the College of Registered Nurses, and was involved in discussions, planning, and implementation of bringing registered nurses under the jurisdiction of the *RHPA*. Nurses are no longer able to accept delegation to continue medications by way of standing order, but must have physician authorization to continue medications.

[649] Beverly Reeves testified on a second occasion to address issues related to changes in health service delivery impacted by the *RHPA*. At the time of her second appearance at the Inquest, about eight months after the first, she was no longer the Manager of Health Services at Milner Ridge Correctional Centre, but was in the position formerly occupied by Mr. Ainley as Director of Health Services with Manitoba Corrections. In her new capacity, she oversees all correctional medical units in the Province. She explained that currently, in addition to the previous practice of a physician coming in to the medical unit Monday to Friday, physicians also attend the Winnipeg Remand Centre on Saturday and Sunday for chart review only. The weekend engagement is not for the purpose of seeing patients, but solely for the purpose of reviewing charts to determine whether any medication authorizations are required. Of interest, the seven day physician access was implemented not as a result of the circumstances of Mr. Greene's passing, but arising from the requirements of the *RHPA*.

[650] In addition to the seven day attendance at the Winnipeg Remand Centre, Monday to Friday for clinic, and Saturday and Sunday for chart review, the physician is also on call at all times to consult with nurses at the Winnipeg Remand Centre by telephone. The evidence suggested the contracted physician also had employment in a hospital emergency room.

[651] When asked about the current functioning of the new system, Ms. Reeves said the Winnipeg Remand Centre should have the on call doctor names posted. She had not personally checked to determine whether this is the case, but she would check on it. She was not aware of any guidelines to assist nurses in determining whether the doctor should be called. She had received no complaints about how the system was functioning, so she assumed it is going quite well. She said the decision to call the doctor is the exercise of clinical judgement, obtained as part of nursing training, and continuing competence through the College of Registered Nurses.

[652] To Ms. Reeves' knowledge, the time of attendance of the physician is flexible, so from time to time more than 24 hours can elapse between physician visits, both for chart review and clinic attendances. If patient needs exceed the allotted time permissible by contract, generally the doctors are accommodating enough to see a patient if need be even if it required stay beyond that provided by contract. In the alternative, the patients are triaged and those not assessed as urgent would be seen on the next doctor visit.

[653] Even with the new system of weekend chart review, depending on when the physician attended, Mr. Greene's chart may not have been reviewed over the weekend. Acknowledging Ms. Reeves' observation that whether or not the situation is one that should engage a call to a physician is an exercise of nurse clinical judgement, the evidence is clear that at the Winnipeg Remand Centre the exercise of nurse clinical judgement in the case of an inmate with epilepsy is divergent.

[654] It is not clear from the evidence the reason why weekend physician attendance is restricted to chart review and does not contain a clinic component on Saturday and Sunday. The circumstances that give rise to the need to see a physician, including an evaluation of an inmate with epilepsy, do not cease to exist on the weekend. If inmates need to see a doctor Monday through Friday to have their conditions assessed and treated, the evidence did not disclose why those same circumstances do not exist on Saturday and Sunday.

[655] There was some suggestion that, despite the restriction to chart review over the weekend, a physician might see a patient if requested. Similarly, a physician might stay longer than contemplated to see a patient if need be. Adequate medical treatment for inmates at the Winnipeg Remand Centre should not rely on favours from doctors.

[656] The arrangement with the physician must provide for the doctor to remain in attendance at the Winnipeg Remand Centre for so long as the tasks generated by the medical needs of the inmates require. Every inmate reporting a diagnosis of epilepsy, such as Mr. Greene who clearly made that report on each of his admissions and to each nurse who assessed him, should have their chart reviewed, or be seen by the physician on the physician's next attendance at the Winnipeg Remand Centre regardless of intoxication or other factor.

I therefore recommend: that the Community Safety Division of the Department of Justice review the current physician contract for service delivery at the Winnipeg Remand Centre to determine whether the contract provisions adequately provide for the medical needs of the inmates.

5. Identification of Inmates

[657] At the time of Mr. Greene's first seizure May 1, 2016, Correctional Officers called him by the wrong name. When the nurses attended, having heard or been told of this name by Corrections Officers, he was similarly addressed by the wrong name. Inmate Stephen King knew Mr. Greene's name, and ultimately his correct name was identified.

[658] It was not clear, from the evidence, how Corrections staff are able to identify who is who for operational reasons, except by relying on inmate self-identification and, if necessary and time permits, confirming the inmate's identity with admissions identification information on file.

[659] In medical emergencies, such as what occurred with Mr. Greene, the ability to link an individual's identity with the correct medical history and information can be of critical importance.

[660] Chris Ainley assisted the Inquest with suggested recommendations to be considered. Included in them, was his recognition and acknowledgment that no one knew who Mr. Greene was for a period of time. Some form of inmate identification would be of assistance. There is no way to know who anyone is with any degree of certainty unless they are known from before.

[661] Ed Klassen acknowledged this significant challenge, and said some products have been considered but discarded as unworkable. In addition, he has consulted with colleagues in other provinces to try to source an appropriate mechanism for inmate identification that would be viable in the Winnipeg Remand Centre.

[662] From the perspective of the Inquest, it is self evident one cannot access medical background information if you do not know who you are dealing with. It is difficult to comfort, support, and assess the responses of an inmate in medical distress if the nurse is calling him by the wrong name.

I therefore recommend: that the Department of Justice (Community Safety Division) acquire and deploy an appropriate inmate identification system to be used by both Correctional Officers and medical staff for the purpose of immediately ascertaining the identity of a particular inmate.

6. Winnipeg Remand Centre Medical Unit Clinical Decision Tool relating to "Status Epilepticus"

[663] In evidence, when describing the protocol related to inmate seizure and when a call to EMS should be made, repeated nursing reference was made to the "Seizure Standing Order" which purported to direct EMS not be called until a second seizure has occurred. Upon inquiry by the Inquest, it was determined that what was referred to as the Seizure Standing Order did not exist.

[664] What did exist, in fact, was the "Standing Medication Orders" document. The document, filed as an exhibit in the Inquest, relates to various medical issues, and medication authorized by a physician to be administered in the medical circumstances described, and directs the chart be "placed as a "chart only" for the next medical parade". It also highlights "initiating treatment does not preclude placing an inmate on medical parade at first opportunity or arranging for transportation to a hospital should the situation require it". This is the document some of the nurses relied on as support for the position that the institutional policy directs EMS call only after a second seizure. That is why they believed correct practice was followed when Mr. Greene was not the subject of an EMS call before his second seizure.

[665] In the section relating to seizures, the Standing Medication Orders says:

> "For Status Epilepticus (a seizure lasting longer than 5 minutes or more than one seizure occurring within 5 minutes) call 911 and administer:…"

[666] This document purports to authorize, prior to registered nurses being brought under the umbrella of the *RHPA*, the utilization of certain medications. It would appear it was interpreted as a direction that 911 ought not be called unless the seizure lasted more than five minutes, or there was more than one seizure occurring within five minutes.

[667] Pursuant to nursing scope under the *RHPA*, the operative document, rather than the previous Standing Order, is now a Clinical Decision Tool. Counsel for the Community Safety Division assisted the Inquest by obtaining the Clinical Decision Tool, purporting to be in final draft subject to signature by the contract physician, contract pharmacist, and director of health services. Epilepsy was not listed in the document amongst the 12 Causative Factors for Status Epilepticus.

[668] When this apparent gap was brought to the attention of the drafters through counsel for Community Safety Division, another draft was presented to the Inquest. The only change from the first final draft to the second final draft was that epilepsy was now included as a causative factor to Status Epilepticus, increasing the list to 13 potential Causative Factors.

[669] The precipitating incident, in the Clinical Decision Tool is the same as in the previous Standing Medication Order: "seizure lasting longer than 5 minutes or more than one seizure occurring within 5 minutes". The Clinical Decision Tool, as did the Standing Medical Order before it, directs a call to EMS and Ativan injection.

[670] It appears from the evidence that some nurses directly involved with Mr. Greene's seizures believed from the standing medication order in place at the time that in order to engage EMS a seizure must last longer than five minutes, or there must be more than one seizure occurring within five minutes.

[671] Marshall Lawrence, a well-experienced nurse, did not interpret the medication standing order in that fashion. He was clear that, had he been presented with Mr. Greene's situation, he would have called 911 after the first seizure.

[672] Ms. Reeves was confident that the appropriate protocols had been complied with, and if the same situation were to reoccur, the same decision should be made. EMS would not be called until after a second seizure.

[673] It is not clear from the evidence that rote reliance on stopwatch timing of seizures as a foundation to decide to call EMS is the most medically appropriate. It is to be noted that Mr. Greene's seizures were approximately 42 minutes apart.

I therefore recommend: that the Department of Justice (Community Safety Division) review the Status Epilepticus Clinical Decision Tool in its entirety with Dr. Alexei Yankovsky, or some other expert in epilepsy, to determine its accuracy, and compliance with best clinical practice.

7. Recruitment and Retention of Nurses

[674] Challenges with nursing recruitment, retention, and the maintenance of adequate staffing levels was a consistent theme throughout the evidence relating to the death of Mr. Greene. From time to time, nurses must work alone. It is not uncommon for the Health Services Manager to come in to work to cover a shift when she was not normally scheduled. Her ability to attend to her administrative duties is compromised by the requirement that she work nursing shifts to cover them. Once appropriate candidates are identified, the actual process to commence employment is lengthy and cumbersome, resulting in the loss of otherwise suitable candidates to other opportunities because the wait is simply too long. Correctional nursing is not seen as an attractive opportunity by many in the nursing community. These are but some of the issues flowing from the evidence at the Inquest resulting in nurse staffing challenges.

[675] The strategy to address this challenge, has been essentially ad hoc. The Health Service Manager has attempted recruitment by word of mouth, and attempts to enhance the image of opportunities through correctional nursing in general social conversation, in the hope nurses can be attracted to apply. The generalized environment in nursing employment, resulting in more or fewer nurses interested in positions, is variable. The delays occasioned by the process from identification of a successful candidate to a first shift on the nursing floor has been seen as a regrettable, but almost insurmountable, obstacle to change.

[676] In the absence of a strategic plan to recruit and retain appropriate candidates for nursing positions at the Winnipeg Remand Centre, the challenge is unlikely to be addressed.

I therefore recommend: that the Community Safety Division of the Department of Justice develop and implement an effective strategic plan for the recruitment and retention of nurses at the Winnipeg Remand Centre.

8. Nurse Orientation, Training, and Ongoing Professional Development at the Winnipeg Remand Centre

[677] Nurses newly hired for work at the Winnipeg Remand Centre are trained for the unique responsibilities of their position through an informal process of job shadowing. The new nurse is assigned to follow a more experienced nurse at the Winnipeg Remand Centre in the hope the various requirements and protocols of the position are learned by the new nurse. There is no formalized assessment or testing of the new nurse to determine whether the recruit has been orientated to all requirements, has absorbed them, and is able to deliver service in an appropriate fashion. Informal feedback is obtained from the nurse mentor. If necessary, further shadowing shifts beyond the usual are assigned.

[678] The nurse orientation can be variable, depending on the demands of the shift, the nature of the medical issues presenting, and the special features of any Code Reds that may be called during the shadowing phase. The special challenges of correctional nursing, unique in dynamic between security and correctional needs, and the role of the nurse, is not specifically addressed but intended to be absorbed by the new nurse in addition to the other requirements of nursing at the Winnipeg Remand Centre.

[679] The evidence does not suggest that new nurses are required to have obtained DPIN or eChart access by the time they work the floor independently, as demonstrated by the circumstance nurse Roberta Brotherston found herself in.

[680] As to continuing education, correctional nurses do have the opportunity to access educational workshops, webinars, and other education modalities. There is an annual licensing requirement for continued annual education monitored and required by the College of Registered Nurses. There is no continuing education offered the Winnipeg Remand Centre nurse by the employer.

[681] The Nurses Recruitment and Retention Fund, according Ms. Reeves, offers a $450 sum to be used towards education directed to whichever educational endeavour the nurse chooses. When Ms. Reeves was the Health Services Manager, she would encourage staff to identify areas where they might need further education including mental health, suicide prevention, schizophrenia, or another area. She indicated that historically, not many nurses have submitted requests to access the fund to support educational opportunities.

[682] When asked about the sufficiency of the $450 sum to enable appropriate learning for Winnipeg Remand Centre nurses, Ms. Reeves said in the past year she

has received only one application from a nurse at the Winnipeg Remand Centre and two from Milner Ridge requesting funding. When she was Nurse Manager, she would always encourage staff to avail themselves of educational opportunities, but the uptake has been limited.

[683] Historically, Correctional nurses held a two day nurses' conference where corrections related topics were discussed. Because funding was cut, that conference no longer exists. The last one Ms. Reeves attended was 10 years ago. It was Ms. Reeves' view there was a need for further funding to support corrections specific nurse training endeavours.

[684] Ms. Reeves acknowledged the Winnipeg Remand Centre medical unit can be somewhat of an island, cut off from the general medical community. There is difficulty getting information to, or from, other healthcare institutions. Collaborative participation with nurses from other nursing settings in educational sessions may be helpful in mitigating the "silo" reality of correctional nursing.

[685] Deb Elias, of the College of Registered Nurses of Manitoba, noted that nurses who work in isolated nursing environments, such as a correctional centre, would benefit from collaboration with other nursing and medical professionals who do not work in the same environment. Ongoing training, and maintenance of training, is an important issue for the College. There is an annual review by the College of each nurse. The audit of the form the nurse must submit relating to their assessment, is restricted to 5% of the approximately 14,000 registered nurses under the jurisdiction of the College.

[686] The College relies on the employer for continuing education delivered on site. The employer in this matter does not deliver professional education and relies on College requirements to maintain assurance of clinical competence. There is an apparent gap here between College expectation and employer education support.

I therefore recommend: that in addition to seizure specific training for nurses and Correctional Officers, the Department of Justice (Community Safety Division), conduct a full and comprehensive review of current new employee training and ongoing professional development offerings for medical staff. It is further recommended that the Department develop a strategic plan for appropriate training for newly employed nurses together with formalized assessment, and a curriculum for ongoing professional development specific to clinical skills required of a correctional nurse, together with provision for adequate funding to support this education.

9. Accreditation

Definition of accreditation:

Health care accreditation is an ongoing process of assessing health care and social services organizations against standards of excellence to identify what is being done well and what needs to be improved.

(Accreditation Patients & Families, online: Accreditation Canada https://accreditation.ca/patients-families/)

[687] The medical unit at the Winnipeg Remand Centre is not accredited. It is not clear from the evidence why this is the case. If the focus on healthcare delivery in an institution is on quality and excellence, surely being held to an objective standard, assessed externally, is the best means by which excellence can be achieved and maintained. The Inquest was advised that the medical unit at Stony Mountain Institution, a federal institution operated by Correctional Service of Canada in Manitoba, is accredited.

[688] The Inquest did not hear direct evidence from an accreditor such as Accreditation Canada. Of interest, as indicated on its website, Accreditation Canada offers accreditation to Provincial Correctional Health Services. Provincial Correctional Health Services standards are offered for purchase online. Debra Elias from the College of Registered Nurses of Manitoba, when asked about accreditation, indicated accreditation provides a certain comfort to the College, knowing a facility has been accredited and maintains accreditation. Best practices would suggest, and the College would prefer, that the correctional facility medical units in the Province currently not accredited, become so. This enables the medical facility to be more easily governed, and to provide more consistent healthcare.

[689] Shauna Appleyard, Executive Director of Rehabilitation Services, to whom medical services in Provincial correctional institutions report, was not overly familiar with accreditation. She said that government was looking for broad systemic change, and from her perspective accreditation would be a small change. Government is very much looking for a whole government approach to a continuum of care, and it was her view that moving towards the broader change would be the best place to put time and research efforts. She was aware that the Correctional Service of Canada Medical Unit in Manitoba is accredited, but from her perspective federal corrections is not looking to integrate with Health Canada.

[690] It was her view the model integrating correctional health services with the Department of Health was the better way to go forward. Accreditation only exists

within the centre, and considering the length of time individuals are in provincial custody as opposed to federal custody, accreditation would provide little change. There was no timeline available for transition for corrections medical services to the Provincial Department of Health, and Ms. Appleyard was unable to say that, in fact, such a transition would ever take place.

[691] Bev Reeves, Director of Health Services, was not currently involved in any discussion with respect to the movement of Winnipeg Remand Centre health services from Corrections to the Department of Health. She had just a basic knowledge of accreditation for health service facilities. She is aware that Accreditation Canada has an accreditation package for provincial correctional institution healthcare facilities. Ms. Reeves is also aware that the medical units in federal facilities operated by Correctional Service of Canada are accredited. Any knowledge Ms. Reeves had about that process or how long it might take was only through numerous friends who work for CSC. It is her impression the process is resource intensive.

[692] Chris Ainley, former Director of Health Services, expressed concern about the Winnipeg Remand Centre medical unit being provided with adequate resources to meet accreditation standards. He was pessimistic about the possibility of obtaining new resources to meet standards that may be required through accreditation.

[693] A number of issues related to the operation of the medical unit at the Winnipeg Remand Centre were disclosed in the evidence presented at this Inquest and surrounded the circumstances of Mr. Greene's death. They include adequacy of staffing levels, recruitment and retention of nurses, continuing education, charting practices, maintenance of health records, medication distribution practices, clinical practice standards including recognition of the urgency of the medical situation of an inmate with epilepsy, deciding when a doctor should be consulted, and when a patient's medical situation ought to engage the calling of EMS. Regular nurse performance reviews, nurse performance reviews at all, on going professional education, the ability to identify who a patient is, storage and treatment of nursing charts, were but some of the issues involved in the situation surrounding Errol Greene's death.

[694] Being held to an objective standard, with scheduled reassessment, could only enhance the quality of care provided to inmates at the Winnipeg Remand Centre and contribute to preventing a death in similar circumstances to that of Mr. Greene. I appreciate that bringing the medical unit at the Winnipeg Remand

Centre up to accreditation standard may be resource and labour intensive. That would only be the case should the current operations of the medical unit at the Winnipeg Remand Centre fall far short of standards required. If that is the case, it enhances the need for accreditation. On the other hand, if operations are currently to an acceptable standard, clearly less work and more limited resourcing will be required.

[695] From the perspective of the Inquest, the upside to the accreditation process being applied to the medical unit at the Winnipeg Remand Centre far outweighs the potential downside of cost and extra work.

I therefore recommend: that the Department of Justice (Community Safety Division) explore and potentially implement accreditation for the Winnipeg Remand Centre Medical Unit on an expedited basis.

10. Transition of Operation of the Medical Unit at the Winnipeg Remand Centre from the Government of Manitoba (Department of Justice, Community Safety Division) to the Manitoba Department of Health

[696] Every inmate entering the Winnipeg Remand Centre experiences disconnect with their community healthcare, and enters a silo of correctional healthcare. Existing diagnoses are revisited, existing prescriptions re-evaluated, and community resources well engaged with the inmate are not integrated into their correctional healthcare plan. In Errol Greene's case, his self report April 30, 2016, upon admission, that he suffered from epilepsy and required valproic acid, was not able to be accepted at face value and deferred for physician consult two days later. This was the case despite Mr. Greene suffering a seizure upon discharge March 13, 2016, when Corrections called EMS and Mr. Greene was taken to hospital. The medical unit at the Winnipeg Remand Centre did not have records of what occurred medically with Mr. Greene at hospital, and in the community after discharge. When he suffered seizures at the Winnipeg Remand Centre May 1, 2016, by luck some of the same staff were present, remembered the incident and that it was connected to him.

[697] There has been much research and writing on the issue of the integration of correctional medical and public healthcare, and the benefits to be achieved as a consequence. Included in the discussion is the "dual loyalty" experienced by medical staff when the duty to serve patients conflicts with the duty to accommodate correctional priorities.

[698] It is not my intention to review the literature submitted by the John Howard Society to assist in considering this issue, as the evidence of Shauna Appleyard was that Manitoba intends to explore following the lead of Nova Scotia, Alberta, and British Columbia in transitioning inmate medical care from being operated by Corrections to the Provincial Health Authority.

[699] The evidence of Chris Ainley noted the correctional pressures are great, and healthcare needs are sometimes prioritized differently than they would be in a purely medical environment. He noted, as did other witnesses, the pressure for a nurse to attend immediately to the admissions area to facilitate admissions and, as a consequence, allow police officers to be released, interrupting nurses' other duties including medication distribution.

[700] When in his position as Director of Health Services with Manitoba Corrections, Mr. Ainley was well connected with colleagues nationally. The feedback he received from provinces transitioned or transitioning included better continuity of care for inmates that it was more expensive to provide care in the institutional setting than before transition, but in the long term savings were achieved as individuals did not escalate to an acute stage as they might otherwise. Long term, it was much better for the patients but more expensive initially.

[701] Bev Reeves, the current Director of Health Services, was aware that other jurisdictions have transferred correctional healthcare administration to the health authorities, and she acknowledged the potential health benefits to patients and that it was a positive move.

[702] Shauna Appleyard, the Executive Director of Rehabilitation Services, although acknowledging that she knew little about accreditation, thought that rather than pursing the accreditation process, the model integrating correctional health services through the Department of Health was a much broader systemic way to move forward. From Ms. Appleyard's perspective, accreditation will provide little change, and the Department is looking to effect broad change.

[703] Ms. Appleyard said she has been given a broad mandate to work on this transition, to meet and collaborate. She was unable to say what the timeline might be.

[704] Manitoba does have the benefit of learning from the experience of other provinces in this area, which may shorten timelines. Ms. Appleyard is the head of the team for this project, and information is currently being gathered to present to the final decision makers.

[705] Mr. Ed Klassen, Director of Operations – Custody, has already engaged in discussions on this topic with Alberta and Saskatchewan, the jurisdictions he feels most comparable to our own. Alberta has made a more fulsome transition, and Saskatchewan is currently operating a system that is a hybrid of both. For Mr. Klassen, discussions have been ongoing within the division for at least five years off and on, on this topic. From his perspective, at this point, Manitoba effecting such a transition is just a prospect.

[706] It is most positive that such a transition has been under discussion by Manitoba for a number of years. It is particularly helpful that Ms. Appleyard has already been charged with the responsibility to collaborate and study with a view to move the endeavour forward.

[707] Without question, much work and resources will be invested in planning and implementation of the transition of correctional healthcare to the administration of the Department of Health. However, based on the research and experience of other provinces in Canada that have effected this transition, it is evident that long term gains in quality of healthcare for Manitobans who have experienced time in a provincial correctional institution will be much enhanced.

I therefore recommend: that the Government of Manitoba further study transitioning health responsibility for inmates from Manitoba Corrections to Manitoba Health, and prioritize the development of a plan for this transition with a view to effecting the transition.

11. Full and Comprehensive Review of the Functioning of the Medical Unit of the Winnipeg Remand Centre by an Independent, Third Party Agency with No Relationship with Manitoba Corrections, with a Mandate to Recommend Changes

[708] A number of critical issues relative to effective functioning of the medical unit at the Winnipeg Remand Centre came to light in the evidence presented in this Inquest. Unlike most of Winnipeg institutions delivering healthcare within the geographical jurisdiction of the Winnipeg Regional Health Authority, the medical unit at the Winnipeg Remand Centre is operated by and accountable to the Department of Justice. Operations are not required to rise to standards of accreditation, or any external assessment of functioning. Some of the areas that raise concern, arising from the evidence of the Inquest relating to Mr. Greene's death, are as follows:

- Physician availability and accessibility – At the time of Mr. Greene's death, the physician contract apparently contemplated one hour clinics five

days a week, the time of the clinic to be scheduled at the convenience of the physician. Because of changes in nurse ability to continue medication brought about by registered nurses now being under the umbrella of the *RHPA*, approximately two years after Mr. Greene's passing, a one hour chart review only on Saturday and Sunday was added, to address medication concerns. In addition, the component of 24 hour doctor availability on call by telephone for nurse consultation was added to supplement physician on site attendance. The evidence suggests it is the same physician or physicians carrying out all of the on site service and responding to all the on call telephone consults. There was no evidence as to how well this system is functioning, or by what means an hour a day of clinical time during the week, and an hour a day of chart review only on weekends, was determined sufficient. It is self evident that physician access, both by direct service to patients, and as a resource for nurses, is a critical piece of appropriate healthcare delivery especially in a patient population rife with complex needs.

- Nurse training – Heavy reliance is placed by Winnipeg Remand Centre Medical Unit administration on the requirements of the Manitoba Association of Registered Nurses for ongoing professional education for nurses to maintain licensure and for nurse competence. The medical unit at the Winnipeg Remand Centre offers no professional nursing education to its nurses. Although there are conferences and educational opportunities in the community, it does not appear corrections nurses are accessing them, or, at least, seeking financial support and/or time off work to accommodate accessing these opportunities. The Manitoba Association of Registered Nurses, in part, relies on employers to provide ongoing professional education to nurses. In the Inquest evidence, the difference in nurse understanding of seizures, and difference in clinical judgement relating to seizures as described by the nurses at the Winnipeg Remand Centre was highly variable. This is but one example of an area that would benefit from ongoing professional education for nurses.

- Training of new nurses – New nurses at the Winnipeg Remand Centre become oriented and trained with respect to their job responsibilities, by an informal shadowing experience with a more experienced nurse. There is no assessment of the effectiveness of the shadow, no goals to meet, and the exposure gained in the shadowing is as variable as the skillset and experience of the nurse mentor and various situations that arise in the course of the shadowing shift.

- Nurse recruitment and retention – There is no strategy to address this important issue, apparently relying on word of mouth and hopeful job posting. It is an on going issue.

- Nursing staffing levels – It is not clear from the evidence on what basis the current staffing levels were determined. Whether they are objectively adequate, overstaffed, understaffed or whether staffing challenges could be met by different utilization of the nurse during his or her shift is a concerning unknown.

- Nurse utilization during a shift –Much mention was made, in the course of the Inquest, of the challenge experienced in executing nursing duties, particularly medication distribution, when police arrive with an intox admission to be processed. It is not clear why a nurse could not be dedicated to processing intox admissions, together with other nursing duties compatible with completion in the admissions area during down time in admissions were there to be any.

- Charting – Quality of chart recording by nurses, storage of charts so that they are readily retrievable particularly in urgent circumstances, the affixing of a sticky note that falls off on the front of a chart as a prompt to someone doing something with the chart, and the potential for transition to electronic charting were some of the issues relative to charting.

- Nurse online access to patient information – DPIN and eChart, accessibility of all nurses to these resources, ensuring accessibility is in place before the nurse commences employment, and continuity of access were areas of concern in the circumstances related to Mr. Greene.

- Nursing staff meetings – these apparently currently do not take place.

- Nursing performance reviews – these currently do not take place.

- Bed usage in the medical unit – There currently are beds in the medical unit which could be used for inmates with conditions such as epilepsy requiring nurse observation. Instead, the Inquest heard these beds are used for inmates with mobility issues. The nature of the design of the Winnipeg Remand Centre is challenging to those with mobility impairments because of the prevalence of stairs in the Remand Centre design. The Medical Unit is the most suitable place to house mobility challenged because

of the absence of stairs at the expense of direct medical supervision of others who might need it.

[709] The issues listed above are but some of those disclosed by the Inquest arising from the operations of the medical unit in the Winnipeg Remand Centre. It is not the role of an Inquest to micromanage the operation of a government department. It is, however, the role of an Inquest to make recommendations to prevent deaths in similar circumstances. The generalized functioning of the medical unit in the Winnipeg Remand Centre, according to the evidence presented, reflected concerning issues including those above noted. In addition, the evidence disclosed resistance by senior corrections management to accreditation as not effecting the broad change envisioned and prioritized by the Government of Manitoba.

[710] Although helpful suggestions were made by the parties to inform recommendations from this Inquest including particularization of numbers of nurses during specified shifts, number of hours between doctor attendances, and other specifics, the evidence did not disclose a foundation related to operational details. What was evident, however, was that there were significant challenges that would benefit from assessment by an outside expert eye with a view to making recommendations that would result in a more effective vehicle for inmate medical assessment and treatment.

I therefore recommend: that the Government of Manitoba retain an independent, third party agency with no relationship with Manitoba Corrections, with a mandate to recommend change in all operational and clinical areas, to perform a full and comprehensive review of the medical unit at the Winnipeg Remand Centre.

ACKNOWLEDGEMENTS AND FINAL NOTES

[711] The management of the proceedings related to this Inquest into the death of Bradley Errol Greene gave rise to some unique challenges. As the evidence developed, unanticipated issues arose requiring the setting of further dates for hearing, and unpredicted evidence to be called. Everyone involved in these proceedings, including the parties, counsel, the witnesses, and court staff contributed, in significant fashion, to assisting me in producing a report that is intended to achieve the goals of *The Fatality Inquiries Act*.

[712] Inquest counsel fulfilled their role in a remarkable fashion, assisting in the presentation of evidence, management of logistical issues as they arose, and facilitated discussions amongst counsel to enhance the productivity of the

proceedings. Counsel for the parties, including John Hutton, Executive Director of the John Howard Society who is not a lawyer, each represented their clients in an exemplary fashion. While these proceedings are non-adversarial, there certainly were divergent perspectives on some of the issues. Counsel and Mr. Hutton well managed the balance between representing the interest of their client while not deflecting focus from the non-adversarial nature of the proceedings.

[713] Court clerks Rachel Brooker and Rowan Greger were of great assistance in keeping proceedings running smoothly, managing the exhibits, the court recording system, and all other Clerk duties with efficiency and skill. The Sheriffs' Officers ensured the safety and security of the proceedings for those participating, and members of the public.

[714] Rochelle Pranteau's quiet and dignified strength is noteworthy, evident from her testimony as the first witness in the Inquest, through her consistent attendance in the courtroom gallery as the Inquest proceeded over nine months. In addition to being Errol Greene's spouse and mother of their four children, as disclosed in the evidence she had compelling personal involvement in the events of May 1, 2016. She was joined, in the courtroom gallery, by Errol Greene's mother Donna Greene who attended the proceedings as she could.

[715] This report contains my review of the evidence, findings, and recommendations after hearing the evidence and considering the submissions of the parties. Bradley Errol Greene was a son, spouse, and father, and 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.

I respectfully conclude and submit this report on this 6th day of June, 2019, at the City of Winnipeg, in the Province of Manitoba.

"Original signed by Judge Heather Pullan"

Judge Heather Pullan

LIST OF RECOMMENDATIONS

1. That seizure specific training be developed for all nurses employed at the Winnipeg Remand Centre in consultation with Dr. Alexei Yankovsky or another expert in seizures, and that taking this training be a mandatory requirement for all nurses.

2. Recognizing the specific role Correctional Officers play in the Winnipeg Remand Centre, that seizure specific training, including recognition of behaviour that could be seizure related and appropriate response to it while awaiting the arrival of medical staff, be developed and delivered to all Corrections staff working directly with inmates including Shift Operations Managers, and that taking such training be mandatory.

3. That the Winnipeg Remand Centre Medical Unit develop a practice requiring a nurse remain on scene and engaged with the treatment process at all times Paramedics are in the Winnipeg Remand Centre. The nurse on scene should act in a supportive role to Paramedics when circumstances require, and when appropriate, act to facilitate resolution of challenges Paramedics are experiencing carrying out their duties.

4. That the Community Safety Division of the Department of Justice review the current physician contract for service delivery at the Winnipeg Remand Centre to determine whether the contract provisions adequately provide for the medical needs of the inmates.

5. That the Department of Justice (Community Safety Division) acquire and deploy an appropriate inmate identification system to be used by both Correctional Officers and medical staff for the purpose of immediately ascertaining the identity of a particular inmate.

6. That the Department of Justice (Community Safety Division) review the Status Epilepticus Clinical Decision Tool in its entirety with Dr. Alexei Yankovsky, or some other expert in epilepsy, to determine its accuracy, and compliance with best clinical practice.

7. That the Community Safety Division of the Department of Justice develop and implement an effective strategic plan for the recruitment and retention of nurses at the Winnipeg Remand Centre.

8. That in addition to seizure specific training for nurses and Correctional Officers, the Department of Justice (Community Safety Division), conduct a full and comprehensive review of current new employee training and ongoing professional development offerings for medical staff. It is further recommended that the Department develop a strategic plan for appropriate training for newly employed nurses together with formalized assessment, and a curriculum for ongoing professional development specific to clinical skills required of a correctional nurse, together with provision for adequate funding to support this education.

9. That the Department of Justice (Community Safety Division) explore and potentially implement accreditation for the Winnipeg Remand Centre Medical Unit on an expedited basis.

10. That the Government of Manitoba further study transitioning health responsibility for inmates from Manitoba Corrections to Manitoba Health, and prioritize the development of a plan for this transition with a view to effecting the transition.

11. That the Government of Manitoba retain an independent, third party agency with no relationship with Manitoba Corrections, with a mandate to recommend change in all operational and clinical areas, to perform a full and comprehensive review of the medical unit at the Winnipeg Remand Centre.

WITNESS LIST

Bradley Errol Greene's Spouse
Rochelle Pranteau

Expert Witnesses
Dr. Raymond Rivera
Dr. Alexei Yankovsky

Winnipeg Remand Centre Inmates
Stephen Shae King
Michael Redhead

Winnipeg Remand Centre Nurses
Roberta Brotherston
Paula Ewen
Beverly Reeves
Bonny Weber
Kathryn Berens
Marshall Lawrence

Director of Health Services – Community Safety Division
Christopher Ainley
Beverly Reeves

Winnipeg Remand Centre Correctional Officers
Angela Banks
Ashlee Griffin
Albert Wiens
Million Mehari
Richard Pow

Winnipeg Fire Paramedic Service
Michael Kaul – Paramedic
Sabrina Laboissiere – Paramedic

Community Safety Division – Administration
Shauna Appleyard – Executive Director of Rehabilitation Services
Ed Klassen-Director of Operations – Custody
Alan Peacock – Acting Associate Director Operations – Custody

College of Registered Nurses of Manitoba
Deb Elias – Chief of Quality Practice

EXHIBIT LIST

P.C.# 556-26739 **Q.B.#**

BETWEEN:

(Crown **/** Plaintiff / Applicant / Petitioner**)**

QUEEN **COUNSEL: (P.C.)** K. Eyrikson, B. Moen

COUNSEL: (Q.B.)

VS/AND:

(Defence **/** Defendant / Appellant / Respondent**)**

INQUEST OF GREENE, BRADLEY ERROL

COUNSEL: (P.C.) S. Boyd, J. Koch, D. Ryall, T. Lach, C. Shefman, J. Hutton, K. Carswell,

COUNSEL: (Q.B.)

PROV. JUDGE: PCJ PULLAN **CLERK:RBROOKER/RGREGER** **HEARING DATE: Jan 29-31, Feb 1,2,5,7,**

Q.B. JUDGE: **CLERK:** **9,20-23,27,28, Oct 4,5,9,10,24-26,30,31**

CHARGE (if applicable) INQUEST **STORAGE LOC.:**

P.C. EX. I.D.	P.C. EX. NO.	EXHIBIT DESCRIPTION	Q.B. EX. I.D.	Q.B. EX. NO.	FILED BY	RETURN TO
		Day 1- January 29 2018 Clerk: RBROOKER				
	1	Curriculum vitae of Dr. Rivera			**Cr**	
	2	Autopsy Report Form of Bradley Greene dated September 9 2016 from St Boniface General Hospital			**Cr**	
		Day 2 - January 30 2018 Clerk: RBROOKER				
	3	Greene Inquest Binder "Volume Three" **(SEALED)**			**Cr**	
	4	Curriculum vitae of Dr. Yankovsky			**Cr**	
	5	Drug prescription information network (DPIN) chart			**Cr**	
		Day 3 - January 31 2018 Clerk: RGREGER				
	6	Floor Map of Winnipeg Remand Centre			**Cr**	
	33	Greene Inquest Binder "Volume One"			**Cr**	
		Day 4 - February 1 2018 Clerk RBROOKER				
	7	Colored Chart (with headings: action required, require, complete)			**Cr**	

	8	Greene Inquest Binder "Volume Two"			**Cr**	
		Day 7 – February 7 2018 Clerk: RBROOKER			**Cr**	
	9	Letter from Michael Redhead to Rochelle Pranteau, Dated May 14, 2016			**Cr**	
	10	Statement from Michael Redhead from December 21, 2017			**Cr**	
		Day 10 – February 21 2018 Clerk: RBROOKER				
	11	Map of Winnipeg Remand Center – marked by Beverly Reeves			**K Carswell**	
	12A	Divisional policy and appendix A – Dated August 2017			**J. Hutton**	
	12B	Standing/Post order from Winnipeg Remand Centre – Admission of intoxicated persons – Dated June 2004			**J. Hutton**	
	12C	Standing/Post order from Winnipeg Remand Centre – Admission of intoxicated persons – Dated November 2017			**J. Hutton**	
	13	Nursing Documentation – guidelines for charting			**J. Hutton**	
	14	Standing Medication Orders			**S. Boyd**	
		Day 13 – February 27 2018 Clerk: RBROOKER				
	15	HSC Documents dated April 15 2014 **(SEALED)**			**D. Ryall**	
	16	HSC Documents dated December 9 2013 **(SEALED)**			**D. Ryall**	
		Day 14 – February 28 2018 Clerk: RBROOKER				
	17	Standing/Post Order from Winnipeg Remand Centre – Inmate Medication Review (number 50.6)			**C. Shefman**	
		Day 16 – October 05 2018 Clerk: RGREGER				
	18	Video Footage Shot Description of Winnipeg Remand Centre			**Cr**	
	19	Video Tour of the Winnipeg Remand Centre **(SEALED)**			**Cr**	
	20	Video Surveillance of Winnipeg Remand Centre (SEALED)			**Cr**	
	21	Email from Christina Deda to James Angus			**C. Shefman**	
		Day 18 – October 10 2018 Clerk: RGREGER				
	22	Redacted Death in Custody Review **(SEALED)**			**Cr**	
		Day 19 – October 24 2018 Clerk: RBROOKER				
	23	Police Evidence booklet, three tabs			**Cr**	
	24	Excerpt of request for proposal - July 24 2017			**Cr**	
	25	Manitoba Correction Formulary / Pharmacy Policies and Procedures			**Cr**	
	26	Community Safety Division Organizational chart			**S. Boyd**	
		Day 20 – October 25, 2018 Clerk: RBROOKER				

	27	Administration of medication to offenders - Corrections Division Custodial Policy			**Cr**	
	28	Resume of Judith Elias			**Cr**	
	29	Standards of Practice of Registered Nurses			**Cr**	
	30	Docufmentation Guidelines for Registered Nurses			**Cr**	
	31	Entry Level Competencies for Registered Nurses			**C Shefman**	
	32A	Documents from MB Justice Inmates Health Services; Clinical deicision tool re: Status Epilepticus			**S. Boyd**	
	32B	Documents from MB Justice Inmates Health Services; Clinical decision tool re: Status Epilepticus, more recent version with highliting (colored document)			**S. Boyd**	
		Day 22 – October 31, 2018 **Clerk: RBROOKER**				
	33	Exhibit “A” becomes Exhibit 33 **(Contents of Tabs 9 and 43 are SEALED)**				