MANITOBA OMBUDSMAN

INQUEST RECOMMENDATION IMPLEMENTATION STATUS REPORT

Report on Compliance with Recommendations Made in the Inquest into the Death of Richard Kakish

Public Report by Manitoba Ombudsman

Case #MO-00309

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MANITOBA OMBUDSMAN ROLE: MONITORING INQUEST RECOMMENDATIONS

Since 1985, Manitoba Ombudsman has been responsible for following up with provincial public bodies that are the subject of inquest recommendations made under The Fatality Inquiries Act. This responsibility arises from an agreement between Manitoba Ombudsman, the Chief Medical Examiner, and the Chief Judge of the Provincial Court.

Manitoba Ombudsman monitors and reports publicly on the implementation of inquest recommendations when they relate to provincial public bodies subject to The Ombudsman Act. Through our follow-up, we determine what action has been taken to give effect to inquest recommendations and then report the outcome to the Chief Justice and the public. Our monitoring and reporting process supports transparency and promotes accountability in provincial public systems.

BACKGROUND

On July 9, 2021, the Honourable Judge Wanda Garreck released an inquest report into the death of Richard Kakish.

Mr. Kakish was detained at the Winnipeg Remand Centre when he collapsed and was transported to Health Sciences Centre. It was determined that he had suffered internal injuries from a ruptured spleen that resulted in his death on August 13, 2017, two days after he collapsed.

The report examined the circumstances leading to his death and found that Mr. Kakish had contact with multiple police officers, health-care providers, and correctional staff over a short period following his arrest on August 9, 2017. Throughout these interactions, important information about the force used during his arrest, his reported injuries, and his ongoing medical condition was not consistently communicated.

The inquest identified significant gaps in communication, information sharing, and continuity of care across the involved agencies. Judge Garreck concluded that these failures contributed to missed opportunities to recognize and respond to Mr. Kakish's deteriorating condition.

The inquest report can be found on The Provincial Court of Manitoba website.[1]

The following section summarizes the eight recommendations made by Judge Garrek and the responses provided to our office by the relevant public bodies.

RECOMMENDATIONS AND RESPONSES

Recommendation One

WPS develop policy on gathering available or reasonably obtainable information from officers who were involved, who witnessed, who have knowledge or received information about a police use of force and the injuries to the person in custody and for the sharing of that information with health care providers and the WRC if detained.

We have assessed this recommendation as implemented.

In June and July 2025, The Winnipeg Police Service provided the following response:

> As a result of this inquest, a General Order notifying WPS members about the change of practice was issued on June 5, 2025.
>
> The WPS has developed a policy which instructs members who are involved in an incident where an injury to a prisoner has occurred through the use of police force to provide notification to the health care provider when that person is taken for treatment at a health care facility.

In June 2026, WPS clarified the following:

> General Orders are issued by the office of the Chief of Police and provide notice of policy change to the WPS membership.
>
> The change of practice issued on June 5, 2025, was made specifically to address the recommendation from the inquest.

[1] https://www.manitobacourts.mb.ca/site/assets/files/1051/kakish_richard_inquest_july_6_2021_garreck_pj.pdf

Prior to issuance of the General Order, there was no formal process for notification to health care if there was a prisoner injury due to use of force, but the information would have been available to medical staff from the escorting policy officers who would have escorted the prisoner to the health care facility, if the officers were asked. In this case, as was evidence at the inquest, health care staff did not seek the information from police as Mr. Kakish was responsive to their requests for information.

The General Order indicates that a member must complete a Medical Notification of Prisoners Injury in order to provide the form to the health care provider when a prisoner is being transported to a medical facility.

Recommendation Two

That WPS and WRHA/SOGH/Shared Health Inc., work to develop policy on how such information referred to in recommendation number 1 will be shared, collected, and recorded.

We have assessed this recommendation as partially implemented.

In June and July 2025, The Winnipeg Police Service (WPS) provided the following response:

> The WPS has developed a paper form entitled Medical Notification of Prisoner Injury, after discussions with Shared Health to develop an electronic solution for the transfer of information was unsuccessful. This form, which is available to members in their vehicles, is to be completed and provided to the health care provider upon attendance to the health care facility. The form indicates the areas of the body to which force was applied as well as the type of force used. The form is signed by the health care provider upon receipt and a copy is then provided to them for their files.

An August 2025 update from Shared Health indicated a joint policy was not created; however, that Shared Health would reach out to the WPS as needed to ensure that the forms are provided and/or received, and the information included in a patient record to assist in providing health services, as needed. Shared Health has indicated that they will work with WPS to ensure the sharing of important personal health information.

Recommendation Three

That Shared Health Inc. and WRHA take steps to ensure that emergency department summaries and discharge instructions from Winnipeg hospitals are included on e-Chart to allow the WRC to have timely access in respect to individuals in police custody then detained at WRC.

We have assessed this recommendation as implemented.

In July 2022, Shared Health provided the following response:

> As a result of this inquest, emergency department discharge summaries from WRHA and Shared Health are now included in eChart and WRC has access to these reports. Our office was told this was implemented in the first half of 2022. In addition to this, through education and record auditing, WRHA and Shared Health are also working with the emergency departments and urgent care centers to encourage the timely completion of the summaries in eChart.

In June 2026, Manitoba Justice confirmed that only nurses and medical office assistants have access to eChart within WRC, and that the access is view-only.

Recommendation Four

WRC review and improve the WRC Standing Order, Documenting Injuries On New Arrivals with a view to improving the space, manner and training for recording the details of injuries from the person, from anyone escorting them, and of the observations or disclosures of physical symptoms and the communication of this information to the medical unit or incoming nurse responsible for completing the Health Care Assessment form.

We have assessed this recommendation as implemented.

In November 2021, Manitoba Justice provided the following response:

> The Documenting Injuries to New Arrivals standing order has been revised (since its 2013 release) as of September 13, 2021. Any injuries that are noted on arresting agency documents, disclosed by the inmate or observed by officers are recorded on the "New Admission Injury Documentation Form" during admission. Admissions staff complete the "Medical Intake Checklist – No Nurse on Duty" form if no nurse is on duty. If necessary and possible injuries are assessed and treated

by a nurse on admission. The Admissions Supervisor ensures that injuries are recorded on the "New Admission Injury Documentation Form" when notified of observed or disclosed injuries. The New Admission Injury Documentation Form was created as a result of this inquest and includes space to document any injury as it was documented by the arresting agency. The New Admission Injury Documentation Form also includes space for staff to document observed or possible injuries or injuries reported by Prisoners. The New Admission Injury Documentation Form also states that staff are to complete the "Medical Intake Checklist – No Nurse on Duty" form if injuries are reported and there is no nurse on duty.

In follow up to questions from our office, Manitoba Justice clarified in July 2026 that Documenting Injuries on New Arrival form is used by correctional officers to document injuries if nursing staff is not present to do an initial intake assessment. The form is part of the admissions training package and staff who will work in admissions are trained to use the form which has straightforward instructions. In response to our January 2026 queries related to staff training on Documenting injuries on New Arrivals, Manitoba Justice provided the following response:

> When the new document for reporting injuries was created due to this recommendation, training for all intake staff was completed. New staff as they enter the admissions department also receive training on this document.
>
> Additionally, a new training course has been developed to improve education in urgent healthcare situations in correctional nursing. The Correctional Nursing Emergency Healthcare Response Training, scheduled to start in January 2026. This specialized course—delivered by the Canadian Red Cross—will equip correctional nurses with the skills to effectively assess, respond to, and treat medical emergencies within correctional settings. The training emphasizes trauma response, including comprehensive injury assessment and evidence-based treatment protocols, ensuring nurses are prepared for urgent and complex healthcare situations.

Recommendation Five

WRC review and develop a practice for dealing with and documenting the situation where an inmate refuses to see the doctor after referral, to improve communication of potentially relevant health care information.

We have assessed this recommendation as implemented.

In June 2022, Manitoba Justice provided the following response:

> WRC has developed a process for dealing with and documenting situations where an inmate refuses to attend any type of medical event. Where there is a refusal [by an inmate to see the doctor] or attend any type of medical event, an Officer attends the inmate's cell and speaks to them, advises Officers assigned to the inmate's Pod and managing the [doctors appointments] of the refusal, and documents the refusal which includes recording details of the discussion with the inmate and any reason for refusing that's provided in a COMS Running Record as well as completing a "Refusal of Medical Treatment or Therapy" form that is provided to either the Health Services Manager or the Nursing Supervisor. Medical staff review refusals for priority needs. Inmates who request to see the doctor but refuse to attend [an appointment with the doctor when they are available] are seen by a Nurse. Nurses attend the cell and try to find out why the inmate asked to see the doctor and determine any need for immediate medical attention as soon as practicable. They also document the visit as per established nursing documentation requirements.

Recommendation Six

WRC review and improve the policy and practice of documenting and sharing health care information between the WRC medical personnel and the medical record to ensure proper compliance and training is in place. This would include review of the Health Care Assessment form to include an area for documenting injuries from inmate/police assault interactions, and a review of the purpose and proper use of the Major Medical Problems document.

We have assessed this recommendation as implemented.

In June 2022, Manitoba Justice provided the following response:

> To address this recommendation WRC has revised the nursing documentation policy including charting guidelines and requirements for the Major Medical Problem List.
>
> The nursing documentation policy requires neat and legible focus charting to be completed immediately after assessment. Dates and times of events must be

listed, and progress notes are chronological with most recent on top using only approved abbreviations. Errors and late entries must be clearly marked.

Requirements for the Major Medical Problem List are that each problem be numbered, the list be updated during intake, and resolution of problems be clearly marked. The Major Medical Problem List is to be included in every inmate medical file.

The purpose of this document is to identify "need to know" information based on what has been shared by the inmate during the new arrival medical assessment, or what becomes known through their medical care/treatment while at WRC. This is a fast access process for information that may be crucial to know information during a medical emergency.

A June 2025 update shared from Manitoba Justice indicated that training on the Major Medical Problems document occurred, and all new nurses continue to receive training as a part of their orientation. There is an audit process in place where files are randomly audited for quality and feedback/coaching provided where deemed to be appropriate.

A July 2026 update from Manitoba Justice shared additional information on training received by nurses and medical staff which takes place during initial orientation. The orientation includes how to properly use the form and signing off that they have read and understand the instruction as part of their position description. Staff also receive reminder emails about the use of the form. Information shared includes adding to the list, how to document when a medical issue has been validated and when to document when the information has been received by an inmate but not yet verified.

Recommendation Seven

WRC review and improve availability and access to the medical chart by medical personnel. It is encouraged the review consider an electronic format for the health records for improving mobile access to the medical chart by medical personnel, throughout the WRC.

We have assessed this recommendation as partially implemented and in progress.

In June 2022 and July 2025, Manitoba Justice provided the following response:

> As outlined in WRC's report on recommendation six, WRC has reviewed the nursing documentation policy and improved availability and access to the medical

> chart by medical personnel. Additional computers were added to the medical unit for the nurses, and additional storage for medical files was identified such that only active files are maintained on the medical unit.

Manitoba Justice advised our office that it studied the possibility of moving to an electronic format for health records, but it has not yet been implemented due to technical and funding impediments. Justice advised that they continue to meet with Shared Health to address this need and a transition to electronic charting was under review as of summer 2025.

In July 2026, Manitoba Justice shared that electronic charting has not yet been implemented and that their access was read only. We heard there is a current review of the transfer of Corrections Health to Shared Health which may then allow for electronic charting in Correctional Centres.

Recommendation Eight

WRC review and update policy on accessing e-Chart to obtain the discharge summaries from health care providers who assessed the person prior to admission to WRC.

We have assessed this recommendation as implemented

In June 2022, Manitoba Justice provided the following response:

> This recommendation was accepted and implemented through a revision to the nursing documentation policy to include eChart as an electronic medium available to nurses to refer to as part of care planning.

Manitoba Justice provided further information on the implementation of this recommendation in June 2025 and January 2026. Manitoba Justice shared it updated its Nursing Documentation policy to explain eChart, the information that can be viewed and its importance in understanding an inmate's health care circumstance. Nurses determine whether checking eChart is appropriate to the situation. When a nurse does check eChart the information is noted on the medical file, and any notable significant information would also be added to the Major Medical Problems document. Discharge summaries are referenced, when they exist in eChart. If a discharge summary is not clear or not available, that correctional staff contact the appropriate health care site where an individual was seen by medical staff. Shared Health conducts eChart audits and collaborates with the WRC Medical manager for any follow up required.

In January 2026, Shared Health confirmed Manitoba Justice has ability to obtain discharge summaries from health providers who assessed the person prior to admission to WRC. Shared Health provided the following information:

The hospital/emergency visit summaries are sent to eChart once the physician providing care at discharge signs off on it. If a visit summary is not in eChart, correctional staff can make a request to Health Information Services at the appropriate health care site to obtain a copy of the summary. Health Information Services has advised that they have seen and processed these requests for patients as they are received.

CONCLUSION

Judge Garreck's inquest report and recommendations are intended to promote administrative changes to reduce the likelihood of death in a similar circumstance.

The recommendations made following the inquest into the death of Mr. Richard Kakish have resulted in Manitoba Justice and the Winnipeg Remand Centre, the Winnipeg Police, and health-care providers taking steps towards improving communication when responsible for individuals who are injured and in custody in the City of Winnipeg.

This report concludes Manitoba Ombudsman's review of this matter.

Please note, an electronic copy of this report will be posted on the Manitoba Ombudsman website: www.ombudsman.mb.ca.

This report is available in alternate formats upon request.

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