MANITOBA OMBUDSMAN

INQUEST RECOMMENDATION MONITORING REPORT

Report on Recommendations Made in the Inquest into the Death of Bradley Errol Greene

Issue Date:
March 10, 2026

FILE # MO-00337 | Public Report | Available in alternate formats upon request.

MANITOBA OMBUDSMAN
300 - 5 Donald Street, Winnipeg, MB R3L 2T4
204-982-9130 | 1-800-665-0531 | ombudsman@ombudsman.mb.ca
www.ombudsman.mb.ca

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. Recommendation monitoring occurs over a period of years, providing the public body with time to make changes. 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. This report reflects our office's monitoring activity between 2019-2025.

BACKGROUND

The Honourable Judge Heather Pullan issued an inquest report into the death of Bradley Errol Greene on June 11, 2019. Her report included eleven recommendations to prevent a death in similar circumstances.

At the time of his death, Bradley Errol Greene was a father of three children; his partner was expecting their fourth child who was born after Mr. Greene's passing. His partner testified at the inquest that in the two years prior to his death, Mr. Greene took prescribed seizure medication three times a day. In the last days before his passing on May 1, 2016, Mr. Greene left home early on Friday and, consequently, missed some medication. She last saw Mr. Greene around lunchtime, when he left to visit family and friends. He did not take his medication with him because he was planning to come home.

Mr. Greene's partner spoke to him in the evening on the telephone, and they planned to meet at 10 p.m. for him to come home; he did not make that meeting. Mr. Greene called his partner the next morning to let her know he had been picked up by the police for being under the influence, and that he was being held at the Winnipeg Remand Centre. In conversation, Mr. Greene's partner asked him if he had put in a request for his epilepsy medications, and Mr. Green stated he had. Mr. Greene shared that he was nervous about this as he had a seizure while waiting to be released from custody approximately two months prior. Mr. Greene had shared with his partner that during his previous incarceration he had advised the nurse on duty of his history of epilepsy, and asked for, but had not received medication while in custody.

The circumstances surrounding Mr. Greene's death began on April 30, 2016, when Mr. Greene was admitted to the Winnipeg Remand Centre. He advised staff that he suffered from epilepsy and took medication and that his last seizure was when he was incarcerated two months prior. The following day, on May 1, 2016, Mr. Greene suffered two seizures, and each time he was restrained. Following the second seizure he became unresponsive, resuscitative efforts commenced, and he was transported to the Health Sciences Centre and died later that evening. He received no seizure medication while being held at the Winnipeg Remand Centre.

RECOMMENDATIONS AND RESPONSES

Recommendation One

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.

We have assessed this recommendation as implemented.

Manitoba Justice confirmed to our office it had implemented this recommendation effective January 2020. Seizure specific training was developed in 2019 with Dr. Yankovsky. The training is now delivered to all nursing staff at the Winnipeg Remand Centre in conjunction with their First Aid/CPR certification and renewals.

Recommendation Two

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.

We have assessed this recommendation as implemented.

Manitoba Justice advised our office that by December 2019, new correctional officer recruits were receiving an orientation to seizure disorders. At that time, an additional training module was under development. In June 2022, the department confirmed the new module was developed and is being delivered as part of core training and as an addition to First Aid/CPR certification or recertification.

Recommendation Three

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.

We have assessed this recommendation as implemented.

Manitoba Justice advised our office that the Crisis Management Policy was revised to include a directive for maintaining nurse presence. The revised policy was approved August 24, 2021. Additionally, senior managers went throughout the province to talk to correctional facility managers about this revised policy, and other policies.

Recommendation Four

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.

We have assessed this recommendation as implemented.

Manitoba Justice advised our office in December 2019 of actions taken to implement this recommendation and improve physician services to inmates at the Winnipeg Remand Centre. An 'on-call' clause was added to the physician contract to allow for consultations outside of regular clinic schedules. Physician coverage was also expanded to include

weekend file and prescription reviews. No other changes were determined to be necessary.

The department advised us that some of these changes were underway at the time of the inquest in response to changes to The Regulated Health Professions Act.

Recommendation Five

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.

We have assessed this recommendation as not implemented – declined by the Department.

In 2019 and 2020, the department reviewed several identification technologies and conducted inter-jurisdictional consultations with those who use the technology. The department reported to us that they found suicide risks associated with the wristband technology used in some other jurisdictions, and logistical challenges that outweigh the potential benefits of adopting the new technology.

Manitoba Justice further advised our office in June 2022 that this recommendation was studied but is not being implemented due to inmate safety and logistical challenges posed by existing inmate identification technologies.

Recommendation Six

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.

We have assessed this recommendation as implemented.

Manitoba Justice advised our office that by December 2019, this recommendation was partially completed, with full implementation confirmed to us in June 2022.

By December 2019, the Clinical Decision Tool for Status Epilepticus (medical emergency involving a seizure lasting longer than five minutes or more than one seizure within a five-minute time frame) had been reviewed with Dr. Yankovsky who found the process used to be accurate and in compliance with best practice. At that time, Dr. Yankovsky identified some wording changes. The department noted that these changes were

specific to wording of the document and did not involve a change to the response or procedure.

By June 2022, the amended Clinical Decision Tool for Status Epilepticus had been approved collaboratively and signed by the contract physician and pharmacist.

Recommendation Seven

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.

We have assessed this recommendation as partially implemented with the Department of Justice providing alternative solutions with ongoing progress.

We were not provided with a strategic plan document as specified in the recommendation. Manitoba Justice responded with an alternate solution to the recommendation and described various activities to differently support recruitment and retention.

In a December 2019 response, the department advised us that the Winnipeg Remand Centre's medical staffing complement had changed significantly since Mr. Greene's death in custody, and that these changes support recruitment and retention efforts. Key changes included the addition of a Nurse Supervisor, creation of a Transfer Nurse position, and greater autonomy for the Health Services Manager in the hiring process. We were advised these new positions were created after the Winnipeg Remand Centre received one and a half full-time equivalent nurse positions from two other correctional centres.

Manitoba Justice advised us that recruitment and retention of nurses is being supported through creative redesign of the Winnipeg Remand Centre's medical staffing complement, and through the development of a new Corrections Nurses website and social media campaign to attract new recruits.

In their response, the department noted that retention is less of a problem for the Winnipeg Remand Centre than recruitment, and that recruitment and retention of nurses is an ongoing challenge across the country for all who hire nurse professionals. The department noted that these labour market challenges in the health-care sector have only increased since the COVID-19 pandemic.

In July 2025, the department reaffirmed its position provided in 2019. It further advised that nurse recruitment, retention and vacancies continue to be an ongoing issue. The department shared that they continue to actively recruit and hire nurses with a job bulletin always posted. The department advised that in addition to this, they have been given a dedicated recruiter and have been accepting nursing student practicum placements within the correctional centres, as well as actively recruiting at colleges and career fairs. In September 2025, the Government of Manitoba job opportunities website had a posting for Nurse 1/Northern Nurse 1 from 09/16/25 to 09/30/25. Additionally, sometime in late September 2025, a notice about nursing information sessions with both correctional and northern nursing was posted on the website homepage. These sessions were scheduled for October 9 and 16, 2025, to be held virtually, to share information, career opportunities, and recruitment programs about both correctional and northern nursing.

Recommendation Eight

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.

We have assessed this recommendation as partially implemented with an alternate solution.

Manitoba Justice advised us in December 2019 that the then-Community Safety Division's Quality Assurance Unit had reviewed training and ongoing development opportunities for medical staff. Following this review, Learning Fund[1] resources were accessed to cover the costs of additional training for 27 staff members.

In addition to orientation and seizure-specific training, mandatory courses include online training offered through the Canadian Standards Association called Medical Device

[1] The Learning Fund was created in May 2019 by the Province of Manitoba to help public servants access training to develop and upgrade skills and enhance their ability to provide quality services.

Reprocessing in Community Settings[2] , free seminars through Organizational and Staff Development, Health Sciences Bug Day (infection control), Addictions Foundation of Manitoba webinars (Street drugs and medication interactions, Prescription and over-the-counter abuse, Trends in Youth Drug use, Methamphetamine: What's old is new again, Cannabis: It's legal ...Now what?, Rapid Access to Addictions Medicine (RAAM), etc.), and other online webinars as offered through Canadian Nurses Protective Society.

The department also developed a policy and procedure manual for Medical Device Reprocessing. As of June 2022, nursing staff either have received or are receiving training in the areas of Medical Device Reprocessing, Immunization Administration and Wound Care Management.

In September 2025, the department told us that they continue to look for educational opportunities as appropriate and relevant to nursing in a correctional facility setting, and current training is regularly reviewed, and individualized. The department shared that they normally hold review meetings in spring and fall of each year, there were reviews in October 2024, June 2025, and one scheduled for October 2025. The department also advised us that on-the-job training and experience complements formal orientation and mandatory training sessions.

According to the department, a standardized curriculum for nurses would not be helpful, and thus is not in development. Nurses are hired with a wide breath of experience and practice background, so individual needs and knowledge gaps can vary greatly. We heard that some nurses have prior correctional services experience, whereas other may come from other backgrounds such as emergency room or other non-correctional nursing settings. Because of this, nurse training is individualized and commensurate with a particular nurse's prior training, education, and experience. The department's response also highlighted that nurses come to correctional centres as trained nurses and therefore already have a certain baseline of training and knowledge that applies to their role as nurses in correctional settings.

A July 9, 2025, update from Manitoba Justice advised that in addition to the information previously provided, nurses have also been taking the Winnipeg Regional Health Authority's Sexually Transmitted and Blood Borne Infections online course and completing Basic Life Saving certification or recertification. Manitoba Justice has advised

[2] Medical device reprocessing refers to the disinfection and sterilization of reusable medical devices. Depending on the classification of the device, reprocessing may include point-of-use treatment, cleaning, packaging, high level disinfection and sterilization, among other steps. This is essential to ensuring that medical devices and instruments do not transmit infectious pathogens.

that they are working towards having all nurses completed the Trauma Nursing course in 2026.

Recommendation Nine

That the Department of Justice (Community Safety Division) explore and potentially implement accreditation for the Winnipeg Remand Centre Medical Unit on an expedited basis.

We have assessed this recommendation as not implemented.

In December 2019, Manitoba Justice advised our office that their assessment of this recommendation was pending and would depend on Manitoba Health's responses to recommendations ten and eleven below. Around 2022, Manitoba Justice had declined to implement this recommendation as there was a previous commitment to transfer responsibility for inmate health services to Shared Health. In May 2025 the department advised discussions about transferring responsibility for medical services from Justice to Health are ongoing.

Recommendation Ten

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.

We have assessed this recommendation as partially implemented and with a plan to transition responsibility to health in progress.

In 2021, a change to support the intent of this recommendation occurred after Shared Health contracted a vendor to support Manitoba Justice in purchasing and distributing pharmaceutical services in correctional facilities. In May 2022, Manitoba Health acknowledged the health system had been restructured, with Shared Health established as a provincial health authority responsible for the delivery of provincial health services. With this change, the department determined Shared Health is the most appropriate health-care service delivery organization to effect the change recommended by Judge Heather Pullan.

In the same year, we were advised this recommendation would be addressed by transferring responsibility for inmate health care from Justice to Shared Health.

In a May 2025 we requested further updates and were told that the departments of Justice and Manitoba Health had reached an agreement to transfer psychiatry services

for inmates from Justice to Health (Shared Health), and this transfer of responsibility is in process. The department was unable to provide us with a clear implementation timeline. The department advised us they are also in discussion about plans for the transfer of the remaining health services and anticipate this will take some time.

A July 2025 update from Manitoba Justice confirmed the information from the department of Health. Justice shared that the discussions regarding transfer were ongoing and psychiatry services is under a contract with Shared Health for three years ending March 31, 2028. Justice also indicated that a committee was formed to help identify what is needed to complete the transfer of the remaining health services. The timeline for this transfer remains undetermined. This will be an action of the committee.

Recommendation Eleven

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.

We have assessed this recommendation as not implemented.

Manitoba Justice confirmed that it does not plan to act on this recommendation as worded.

Manitoba Health provided the following response to this recommendation in April 2022:

The Government of Manitoba is achieving the intent of this recommendation through the transfer of responsibility for inmate healthcare services from Manitoba Justice to Shared Health. In preparation for the transition of healthcare service delivery to inmates from Manitoba Justice to Shared Health, Shared Health will conduct a thorough assessment of operational and clinical needs across the corrections sector. Shared Health is a corporate entity with no prior relationship with Manitoba Corrections.

As of July 2025, Shared Health did not have a comprehensive update on its implementation of this recommendation. As shared in Recommendation 10, Shared Health indicated that the plans for transfer of services continue to develop.

CONCLUSION

The recommendations made following the inquest into the death of Mr. Bradley Errol Greene marked a turning point for change in how medical services are delivered in correctional centers. However, the resulting changes have been slow. Of the eleven recommendations, one has been declined by the department as not feasible, five are implemented, two not implemented and three partially implemented with ongoing progress.

It is noted that recommendations specifying the implementation of accreditation and a comprehensive review of the Winnipeg Remand Center medical unit, as well as the transition of health services from Manitoba Justice to Manitoba Health, have not yet materialized.

We will continue to monitor the plan for transitioning inmate medical services to Shared Health and may issue a further public statement on this work.

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