Rapport d'enquête du coroner

Québec

Bureau du coroner
Québec

Report of inquest

Act respecting the determination of the causes and circumstances of death

FOR the protection of human LIFE

Concerning the deaths of

Charles Junior Grégoire-Vollant, #169386
Marie-Marthe Grégoire, #171086
Alicia Grace Sandy, #171081
Céline Michel-Rock, #171818
Nadeige Guanish, #172855

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INTRODUCTION

Between February 10 and October 31, 2015, five suicides occurred in the Aboriginal community of Uashat Mak Mani-Utenam, which has approximately 3400 inhabitants and is located within the limits of Ville de Sept-Îles. Charles Junior Grégoire-Vollant, Marie-Marthe Grégoire, Alicia Grace Sandy, Céline Michel-Rock and Nadeige Guanish took their lives during that short period of time.

Given the context of Aboriginal communities and the circumstances surrounding that wave of suicides in only a few months, on January 28, 2016, at the request of the Minister of Public Security, the Chief Coroner ordered a public inquiry into those five deaths.

I was appointed to conduct the inquiry, with the goal of examining all of the evidence available in order to determine the causes and circumstances of those deaths, as well as to better understand the motives and life experiences in the community of the persons involved, with a view to making recommendations to avoid other deaths from occurring in similar circumstances.

In addition to analyzing each death on a case-by-case basis, one of the main objectives of the inquiry was to try to find common threads connecting the five suicides, in order to better understand the problems associated with suicide in Aboriginal communities and, more particularly, the communities of Uashat Mak Mani-Utenam and Kawawachikamach.[1]

Thus, I will first determine the causes and circumstances of the deaths, then analyze each of the cases and draw the appropriate conclusions. Following that, I will conduct an overall analysis and make joint recommendations on all five of the cases that were the subject of the inquiry.

[1] Appendix 3, p. 47.

DEATH OF CHARLES JUNIOR GRÉGOIRE-VOLLANT
(NOTICE A-184169 - Death: February 10, 2015)

IDENTIFICATION OF THE DECEASED

Charles Junior Grégoire-Vollant (24 years old) was identified by his brother.

CIRCUMSTANCES OF THE DEATH

The day before his death, Charles Junior Grégoire-Vollant was seen intoxicated. He was not doing well and said that life was hard. On February 10, 2015, he told one of his aunts that he wanted to do like his father, kill himself. The aunt tried to reason with him. After that, he returned home. He went down to the basement; the others in the house believed that he was sleeping.

On February 11, 2015, at around 1:30 a.m., Charles Junior Grégoire-Vollant's mother, concerned that it had been some time since she had seen her son, asked another of her sons to go check in the basement of the house. So Charles Junior Grégoire-Vollant's brother went down to the basement and found him hanging from a rope tied to a beam.

Emergency services were called at 1:42 a.m.

At 1:47 a.m., the ambulance technicians arrived at the scene, before the police, who arrived at 1:53 a.m. The victim's body was laid on the ground and CPR was attempted. He was cyanotic and in asystole. The ambulance technicians were unable to open his airway to perform CPR because he was in rigour.

At 2:12 a.m., the ambulance technicians left for the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles (North shore integrated health and social services centre - Sept-Îles section), arriving there at 2:25 a.m.

The emergency personnel took charge of Charles Junior Grégoire-Vollant, but all they could do was pronounce him dead at 2:45 a.m. on February 11, 2015.

EXTERNAL EXAMINATION, AUTOPSY AND TOXICOLOGICAL ANALYSES

Given the circumstances, there was no autopsy or toxicological analyses. The police examined the body. Apart from the hanging furrow on the victim's neck, there were no signs of violence on the body.

ANALYSIS

Charles Junior Grégoire-Vollant, a fragile individual because of his past, was struggling with his recent breakup with his girlfriend. In particular, he had difficulty accepting that he did not see his son. He resumed drinking and using drugs abusively, which made him more emotional and more depressed.

Mr. Grégoire-Vollant made suicidal comments. Certain persons close to him tried to dissuade him, and to encourage him, to lift his spirits.

His father committed suicide in 1996 at 24 years of age (same age as Charles Junior Grégoire-Vollant at the time of his death). Like his son, he hung himself in the basement of the house.

The inquest revealed that those around Mr. Grégoire-Vollant did not offer any concrete assistance. No one suggested professional support or the services of the suicide prevention centre either. His immediate family and friends did not know what to do. During his crisis or period of distress, it seems that no preventive or assistance service was provided him; he himself did ask for any help.

The protocol was implemented after Charles Junior Grégoire-Vollant's suicide (that is, level 1), but, before that, he was not taken in charge and there was no preventive intervention (level 2 or 3). And yet, at the inquest I was told that he had been identified as a person at risk of suicide, but it was also stated that there was a shortage of personnel to do follow-up or prevention. Therefore, there are shortfalls in taking persons in charge.

Family members who testified at the inquest described Charles Junior Grégoire-Vollant as timid and withdrawn, someone who drank and used speed a lot and regularly. When he used, he became depressed. It was reported that he had a troubled adolescence, living in foster families. He had been hospitalized for suicide attempts, among others. His father committed suicide in 1996, when he was six years old.

Charles Junior Grégoire-Vollant had separated recently from his spouse, with whom he had a little boy. They lived in Kawawachikamach, and Charles Junior did not see his son often because of the distance. He had resumed using substances, as the separation had been difficult for him. His son was to come to visit him in Sept-Îles in February 2015, but the trip had been canceled, which had affected him.

On January 29, 2015, he posted on Facebook that he wanted to do a [TRANSLATION] "crazy thing like his father".[2] There was no intervention following that cry for help.

After Charles Junior Grégoire-Vollant's death, the protocol was implemented and a report by the coordinator was filed.[3] That will be discussed in the recommendations.

CONCLUSION

Charles Junior Grégoire-Vollant died of asphyxia by hanging.

It was a suicide.

[2] Facebook comments by Charles Junior Grégoire-Vollant (January 29, 2015), Exhibit C-2, p. 43.

[3] Coordination report by Danielle Descent, Exhibit C-7, p. 43.

DEATH OF MARIE-MARTHE GRÉGOIRE
(NOTICE A-184187 - Death: June 21, 2015)

IDENTIFICATION OF THE DECEASED

Marie-Marthe Grégoire (46 years old) was identified by her son.

CIRCUMSTANCES OF THE DEATH

Marie-Marthe Grégoire was Charles Junior Grégoire-Vollant's mother, who committed suicide on February 10, 2015 (A-184169). She had six children.

Following her son's death, Ms. Grégoire was followed by Aboriginal social services, as she was considered to be at risk under the crisis intervention protocol for the community of Uashat Mak Mani-Utenam.

Ms. Grégoire drank and used speed regularly and abusively. Her son's death did not lessen that abuse, to the contrary. She cooperated well in the assistance provided, but she did not confide very much, and made no changes to her behaviours or substance abuse. She often said that she wanted to die.

On June 19, 2015, one of her daughters saw her at her home at around 2:00 p.m. She was intoxicated, crying and yelling further to an altercation with another person. Ms. Grégoire's daughter left the premises with her children.

The morning of Sunday, June 21, 2015, Ms. Grégoire's daughter returned to her mother's home. She did not see her, but saw that her shoes were there. She spent part of the day at the home.

She returned again at around 10:00 p.m.; the shoes were still there, but she still did not see her mother. She went to bed and slept. She did not dare go down to the basement for fear of finding her mother dead.

On Monday June 22, 2015, at around 11:00 a.m., one of Ms. Grégoire's sons arrived at the home and asked his sister where their mother was. She said that she had not seen her mother the entire weekend. He went down to the basement and found her hanging by the neck from an electric cable, dead.

Emergency services were called at 11:43 a.m. by Ms. Grégoire's daughter. At 11:47 a.m., the ambulance technicians arrived. Given the state of the body, they were not able to perform CPR. They prepared a remote attestation of death. Ms. Grégoire was pronounced dead on June 22, 2015, at 11:52 a.m.

Subsequently, police officers arrived at the scene and began their investigation. There were no signs of violence in the home.

The body was taken to the morgue at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles.

EXTERNAL EXAMINATION, AUTOPSY AND TOXICOLOGICAL ANALYSES

Given the circumstances, there was no autopsy or toxicological analyses. The police did an external examination of the body. They noted a 9 mm hanging furrow on Ms. Grégoire's neck, and her lower extremities were in rigour. There were no signs of violence. The officers found a photo of a young child in Ms. Grégoire's clothing; it was of a brother of Ms. Grégoire, who also committed suicide.

ANALYSIS

Marie-Marthe Grégoire had gone through very many difficult situations in her life. Her children were placed in foster families. Her husband, Charles Junior Grégoire-Vollant's father, committed suicide, along with her brother. After her husband's death, she was the victim of conjugal violence. She sought refuge in drinking and drugs. Her son's suicide, on February 10, 2015, greatly affected her.

From the evidence adduced at the inquest, I learned that Ms. Grégoire was known to the police, who had had to intervene in her respect on certain occasions. The events of the weekend of June 20 and 21, 2015 were not isolated.

On May 14, 2015, while intoxicated and in crisis, Ms. Grégoire was taken by the police to the emergency department of the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles to be treated by the physicians.

On June 13, 2015, another police intervention was necessary in a public place, where Ms. Grégoire was intoxicated, in crisis and injured. She was again transported to the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles.

The weekend of June 20 and 21, 2015, Ms. Grégoire hung herself in the same spot as her son Charles Junior had, four months earlier, in the basement of the house.

There is no doubt that Ms. Grégoire was suffering, but she had not decided to make changes to her lifestyle. Witnesses who tried to help her said that it was difficult to meet with her, as she was often intoxicated. She received help, or at least it was offered. Was it enough?

She was followed under the protocol mentioned earlier because she was Charles Junior Grégoire-Vollant's mother, but the protocol ends after 30 days. Follow-up seems to slacken after that, due to a shortage of personnel and resources. She needed much closer follow-up, even if she herself did not ask for it. I will return to that in the recommendations.

CONCLUSION

Marie-Marthe Grégoire died of asphyxia by hanging.

It was a suicide.

DEATH OF ALICIA GRACE SANDY
(NOTICE A-184186 - Death: June 22, 2015)

IDENTIFICATION OF THE DECEASED

Alicia Grace Sandy (21 years old) was identified by her spouse.

CIRCUMSTANCES OF THE DEATH

On June 21, 2015, Ms. Sandy spent the morning in Mani-Utenam with her new spouse, and then left for Uashat to meet a friend. That evening and night, she was with a number of persons around a fire on the beach behind the building for the Uashat Mak Mani-Utenam Band Council. She drank and took speed. She seemed depressed, but did not talk about suicide. Her friends attempted to make her laugh.

She left the group at around 4 a.m., and her friends did not see her again. In turn, the friends left the beach an hour later.

Several hours later, at around 7:15 a.m., a man walking along a path near the water saw someone who appeared to be sleeping near a bush. When he approached, he saw that the person had the straps of a backpack tied around her neck; the backpack itself was secured to a bush. Shortly after, the passer-by saw a police officer and reported what he had seen.

Police officers and ambulance technicians arrived at the scene at around 7:40 a.m. CPR was attempted, but was unsuccessful. A remote attestation of death was prepared, and the death was pronounced at 7:45 a.m. on June 22, 2015.

The place where the body was found was approximately 75 feet from the fire where Ms. Sandy had spent the evening. The victim's body was on sloping ground, which allowed the straps of the backpack to tighten around Ms. Sandy's neck. There were no signs of violence at the scene.

EXTERNAL EXAMINATION, AUTOPSY AND TOXICOLOGICAL ANALYSES

The external examination and autopsy were performed on June 23, 2015 at the Centre intégré de santé et de services sociaux du Bas-Saint-Laurent - section de Rimouski-Neigette (Lower St. Lawrence integrated health and social services centre - Rimouski-Neigette section).

The external examination did not reveal any particularities about the death, except the hanging furrow on the victim's neck.

The autopsy concluded that the cause of death was strangulation by hanging. Other elements were observed, such as mild hepatic steatosis, a single serous cyst on the left ovary and thyroid nodular hyperplasia, but with no link to the death. There were no signs of violence on the body.

Toxicological analyses were done at the Centre de toxicologie de l'Institut national de santé publique (National institute for public health toxicology centre), with the results that follow.

Ethanol levels were at 230 mg/dl in the blood and 270 mg/dl in the ocular fluid. For informational purposes, the legal limit allowed to drive a vehicle is 80 mg/dl. The level in question is more than three times the legal limit and exceeds the toxic threshold. There was 160 ng/ml of methamphetamine and 200 µmol/l of salicylic acid in the blood; 130 ng/ml of amphetamine and 2400 ng/ml of methamphetamine were found in the urine.

ANALYSIS

According to the evidence heard, Ms. Sandy began to experience instability and personal problems after a miscarriage in 2011. She began to have drinking and drug problems, and was believed to have borderline personality disorder. Already in 2011, she had made suicidal comments. In 2013, she received therapy, but it was suspended due to her lack of cooperation.

On February 12, 2015, Ms. Sandy, originally from Kawawachikamach, made suicidal comments, then, on May 4, 2015, Naskapi police officers intervened with her because of her perturbed mental state. She was intoxicated and had not slept for two days, and was threatening to take her life. As the police did not dispose of more adequate resources at Kawawachikamach, they put her in a cell for her own safety, to allow the substances ingested to leave her system and for Ms. Sandy to sober up.

On May 18, 2015, the Kawawachikamach police were again called to intervene with Ms. Sandy. She once again wanted to end her life. She was intoxicated and aggressive, so she was again put in a cell. However, steps were taken to transfer her to the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles, to be seen by the medical personnel, mainly in psychiatry.

On May 19, 2015, at around 7:00 p.m., she arrived at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles for a mental health assessment and treatment. Ms. Sandy refused to cooperate and to undergo a psychiatric assessment. The professionals at the institution then drew up a motion to institute proceedings to place her under temporary confinement at a resource for a psychiatric assessment. They believed that Ms. Sandy was a danger to her health and safety and those of others, as she was aggressive and refused to cooperate, so much so that she had to be restrained. The motion was signed and filed on May 21, 2015.

On May 22, 2015, the hearing on the motion was postponed to Monday, May 25, 2015 by the Court.

On May 24, 2015, seeing that Ms. Sandy had decided to cooperate, that she was no longer a danger to herself or others, and that she wanted to return to Kawawachikamach and begin therapy, the psychiatrist discharged her. Her father was there to accompany her when she left the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles. The psychiatrist prescribed 500 mg of Seroquel, four times a day. The motion was never heard, as it was discontinued. When Ms. Sandy left the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles on May 24,

2015, she never returned to Kawawachikamach. She never went for a psychiatric assessment or began therapy either.

That leads me to ask questions. I can understand that someone may progress and change their attitude, but it is difficult to explain why a person who was in a suicidal crisis would suddenly no longer need psychiatric services, when two days earlier the professionals wanted a judge to force her to submit to hospitalization and tests.

On June 8, 2015, Aboriginal officers from Uashat Mak Mani-Utenam intervened with Ms. Sandy, who this time was a complainant. She filed a sexual assault complaint: someone allegedly assaulted her while she was unconscious. She was taken to the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles for a forensic examination, but she left the institution of her own volition without having the tests.

Ms. Sandy did not return to her community between May 24, 2015 and June 22, 2015, the day of her death; she stayed in Uashat Mak Mani-Utenam and Sept-Îles. No evidence was adduced at the inquest showing that Ms. Sandy received assistance measures during that period. No follow-up was ensured following her discharge from the hospital centre.

Of course, when she was discharged from the hospital centre on May 24, 2015, Ms. Sandy was no longer in crisis, but she had not resolved her personal problems or her substance abuse problems which, in turn, resulted in suicidal crises. She did not ask for help and no resources contacted her. The crisis intervention protocol was implemented in Ms. Sandy's case only when she was dead. And yet, the protocol should have been initiated after her suicidal crisis, and prevention measures should have been put in place. However, the fact that Ms. Sandy was not part of the Innu community of Uashat Mak Mani-Utenam must be taken into account. No one notified the persons in charge of implementing the protocol of Ms. Sandy's situation. Once Ms. Sandy was discharged from the hospital centre, there was no longer anyone taking charge of her. Even when she returned to the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles on June 8, 2015, further to alleged sexual abuse, the psychiatrist who treated her between May 19 and 24, 2015 was not informed. However, it was an aggravating factor for a person at risk of suicide.

Therefore, it was only a question of time before Ms. Sandy had another suicidal crisis, as she did not receive any help and continued to abuse substances. Furthermore, Ms. Sandy did not live in her community after May 19, 2015, and it is possible that she did not know where to go to get help. However, she was in crisis in her community on May 4, 2015, and it does not seem that she received further help or support once the crisis was over.

Persons who are at risk of suicide often have mental health problems. Family and friends do not always know what to do or when to do it. Frequently, persons who have mental health problems do not ask for support and do not call on assistance resources. Mechanisms must be put in place so that resources get to those persons to support them. When a type of help is provided, there must be follow-up so that persons do not find themselves on their own again with their problems. Resources must also communicate together to coordinate interventions, so a person who is in need of help is not left without a safety net or in a socio-psychological vacuum left by various resources due to lack of coordination.

All of that was noted in Ms. Sandy's situation, and I will get back to it when I make my recommendations.

Although the night preceding her death on June 21 to 22, 2015, according to friends who were with her, Ms. Sandy did not appear to be in a suicidal crisis–as she had been previously and that had required intervention to control her–she committed suicide by hanging herself by the neck from a bush not far from the spot where her friends were.

That clearly demonstrates that her problems were far from resolved, even after a crisis situation, and also shows that some persons may commit suicide, but not be in an apparent state of crisis or have made suicide threats. In addition, it also indicates that friends and family of persons who are at risk of suicide must be better informed and aware of what they must or must not do to help the person. I will get back to that as well in my recommendations.

CONCLUSION

Alicia Grace Sandy died of asphyxia by hanging.

It was a suicide.

DEATH OF CÉLINE MICHEL-ROCK
(NOTICE A-184191 - Death: August 13, 2015)

IDENTIFICATION OF THE DECEASED

Céline Michel-Rock (30 years old) was identified by a police officer, as she was well known to the police force.

CIRCUMSTANCES OF THE DEATH

Céline Michel-Rock had a number of personal and social problems, and had a drinking and drug problem (speed and marijuana).

During the day of August 12, 2015, she carried out various activities, such as doing her laundry at a friend's house. Toward the end of the afternoon, Ms. Michel-Rock began drinking. She went to a friend's home and continued drinking. She talked about her many problems and seemed discouraged, but did not make suicidal comments. A little later, she had an exchange on Facebook with a friend, saying, in particular, that she was [TRANSLATION] "fed up". She also exchanged texts with her father, who tried to encourage her, and advised her to go for treatment.

On August 12, 2015, she also talked to the father of her twins (who had custody of the children since July 31, 2015), saying that she wanted to go for treatment with the help of her addiction counsellor, in order to resolve her problems.

At around 11:00 p.m., she went to the home of her ex-boyfriend while intoxicated. He refused to speak to her and asked her to leave the premises. She left, shouting that she was going to hang herself at the neighbour's. The ex-boyfriend did not think anything of it, as it was not the first time she made such comments. The two broke up on July 31, 2015, further to a crisis while Ms. Michel-Rock was intoxicated. A complaint was lodged against her with the police. It was at that time that she lost custody of her twins.

During the week, Ms. Michel-Rock had told her ex-boyfriend that she wanted to go for treatment, but that everything was closed.

The next morning, the ex-boyfriend noticed that the fishing net in his yard had been moved, and that one end of the net extended into the woods behind. At around 7:45 a.m., his brother arrived and suggested they go check in the woods. That was when the former spouse saw Ms. Michel-Rock's body hanging from a tree. Emergency services were called at 7:49 a.m. Police officers arrived at the scene at 7:55 a.m. The ambulance technicians arrived at 8:07 a.m.

Ms. Michel-Rock was found in the woods bordering the former spouse's residence, hanging from a tree with a rope that was near the fishing net around her neck. The officers took down Ms. Michel-Rock at around 8:03 a.m. The body was in rigour and without vital signs. CPR was not performed, given the state of the body. A remote attestation of death was drawn up, establishing the death at 8:15 a.m. on August 13, 2015. The police officers did not find any signs of violence.

EXTERNAL EXAMINATION, AUTOPSY AND TOXICOLOGICAL ANALYSES

Given the circumstances, there was no autopsy or toxicological analyses. The police examined the body. They found a 9-mm-wide hanging furrow on Ms. Michel-Rock's neck, corresponding to the size of the rope found with the body. The body was in rigour. No other sign of violence was noted, nor any indication of intervention by a third party.

ANALYSIS

According to the evidence gathered at the inquest, Ms. Michel-Rock had serious problems with drinking and drug abuse, as well as family problems. She had a stormy adolescence, which had required her placement.

There were a number of events in her life that may have been aggravating factors to her situation. There were breakups, the loss of her children, sexual assault and mental illness. In October 2014, she consulted the emergency department of the hospital centre for detox treatment. She discussed that with her family physician in May 2015.

According to health worker, Ms. Michel-Rock had an appointment with an addiction counsellor on August 13, 2015. She had made the request at the Uauitshitun centre on August 7, 2015. According to that request, her substance abuse had deteriorated following her crisis with her spouse on July 31, 2015. That was also the same day that she lost contact with her children because youth protection authorities intervened.

Ms. Michel-Rock was described as an impulsive person. Things became more dramatic for her when she drank or took drugs. When she didn't sleep, she was said to be difficult to put up with. Her use of speed (an amphetamine) is noteworthy, as it is a stimulant that combats sleep and fatigue.

According to some, she made suicidal comments, others, no. That may depend on whether or not she was intoxicated or who she was talking to.

Ms. Michel-Rock had taken steps to get help, especially for her substance abuse. Although her problems surfaced particularly when she was intoxicated, she also needed help in other areas. She knew that, she was aware of it, but, like many people in that situation, she was conflicted, and took a lot of time to decide to take concrete action.

The crisis intervention protocol in effect in the community of Uashat Mak Mani-Utenam was implemented after the death of Ms. Michel-Rock (level 1). According to what was reported at the inquest, nothing indicates that level 3, for a suicidal crisis, which is implemented as a preventive measure when there is a personnel shortage, was actually initiated in Ms. Michel-Rock's case before she took her life. I will get back to that in my recommendations.

Ms. Michel-Rock asked for help. She received it. Did she get enough help and was it in time? It does not seem so, as she committed suicide before that help materialized.

Persons in that situation often take much time to decide to take steps. And, unfortunately as well, when the decision is taken, the assistance measures or the resources are not always available or accessible. Given that she was considered suicidal, Ms. Michel-Rock needed to be supported more closely while awaiting treatment.

CONCLUSION

Céline Michel-Rock died of asphyxia by hanging.

It was a suicide.

DEATH OF NADEIGE GUANISH
(NOTICE A-184205 - Death: October 31, 2015)

IDENTIFICATION OF THE DECEASED

Nadeige Guanish (18 years old) was identified by a police officer who knew her because he had met her in the course of his work.

CIRCUMSTANCES OF THE DEATH

The afternoon of October 30, 2015, Nadeige Guanish went to the home of her great-grandmother, who lives in Uashat, to get some clothes. She was happy and in a good mood.

At around 22:30 p.m., Ms. Guanish went to the home of her aunt, who lives on the same reserve, for a Halloween costume party. She arrived with her sister, both accompanied by their stepfather. The atmosphere was festive. Nadeige Guanish drank and used cannabis.

When Ms. Guanish's sister left the party at around 12:30 a.m. on October 31, 2015, Nadeige Guanish was fine. At around 2:00 a.m., she and others left the premises to go to a bar, where the party continued. Ms. Guanish danced and drank some more, then she and the others returned to the house of Ms. Guanish's aunt to continue partying the rest of the night. Ms. Guanish seemed happy, talked a lot and danced.

At around 7:30 a.m., Ms. Guanish spoke with a young man who asked her to take him to Mani-Utenam. She was very intoxicated by then, and the party was about to end. As it was cold, the young man leant her his coat. Nadeige Guanish, along with two of her friends, drove the young man to Mani-Utenam. The three girls then returned to Uashat and drove around for a while, then went to the home of one of the girls. A little later, one of the friends saw Ms. Guanish in a room drinking beer and crying. Ms. Guanish spoke to her friend about suicide. She said that she had wanted to commit suicide ever since she was sexually assaulted in January 2015.

At around 10 a.m., Nadeige Guanish called her mother. A little later, at around 11 a.m., she contacted her sister to have her find a babysitter for her little girl, two years old, as she did not want her daughter to see her intoxicated. Ms. Guanish's sister suggested that she come home and eat something. Ms. Guanish refused, and did not want to say where she was, contending that everyone believed that she wanted to commit suicide when all she wanted was to find a babysitter. However, she was crying. Using her cell phone, Nadeige sent photos and texts and made calls to a number of persons.

At around 11:50 a.m., Nadeige Guanish exchanged texts with one of her aunts. Seeing that she was not doing well, the aunt told her that drinking was not good for her, and that she was worrying everyone. She told Ms. Guanish to go to bed, that things would be better after, and she would make good decisions.

At around 11:55 a.m., the three girls left in the car to go to the hair salon, where the two other girls had appointments. Nadeige Guanish was to wait for them, lying in the back seat of the car, but, a short time later, the girls realized that she was gone. They texted her several times, but received no answer.

At around 12:00 p.m., Nadeige Guanish texted her mother, saying that she was suicidal. Her mother found the texts worrisome and scolded her trying to find a babysitter instead of coming home to take care of her daughter; it was the mother who was caring for Ms. Guanish's daughter.

At around 12:54 p.m., Nadeige Guanish sent three texts to an officer with the Aboriginal police force. The messages said that she needed help, wanted to kill herself and that it was necessary for a police officer to know it. The officer was at an arena and was not on duty. According to his testimony, he did not read the texts at that time.

At around 1:00 p.m., Ms. Guanish's mother called the police. At around 1:07 p.m., the police used technology called triangulation to find Ms. Guanish by locating her cell phone. When the officers arrived at the location indicated by triangulation, she was no longer there.

At 2:24 p.m., Nadeige Guanish called 911. At that time, she said that she was in the woods about to hang herself. The operator asked her where she was. Ms. Guanish did not answer. A new triangulation was done at 2:32 p.m.

At 2:36 p.m., her phone was located. She was in the woods near the Sept-Îles cemetery.

At around 2:50 p.m., two police officers found her in the woods. She was hanging from a tree by a rubber strap. Her knees were touching the ground and she was lifeless. The officers cut her loose and began CPR.

At 2:54 p.m., the ambulance technicians arrived and took over CPR. They took her to the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles, where further unsuccessful attempts were made to save her life.

At 4:15 p.m., she was pronounced dead by the emergency physician.

Nadeige had posted a photo on Snapchat with her phone. She also made a video of herself for her daughter.

EXTERNAL EXAMINATION, AUTOPSY AND TOXICOLOGICAL ANALYSES

Given the circumstances, there was no autopsy or toxicological analyses. The police did an external examination of the body. It was not yet in rigour. There was redness at the front of the neck, approximately two inches in width. The police noted contact areas on the knees. There were no signs of violence or intervention by a third party.

ANALYSIS

The evidence gathered at the inquest indicates that Nadeige Guanish had serious problems despite her young age. On the other hand, she had a large, caring family, and quite a wide circle of friends. She was not isolated at all. Therefore, she had help to care for her two-year-old daughter.

She had just turned 18 on April 25, 2015. Thus she was only 16 years old when her daughter was born. Nadeige Guanish reportedly had two miscarriages after the baby was born in December 2013, and those affected her.

Her hospital record indicates that on November 25, 2014, she talked about suicide at school. The comments were worrisome enough that the authorities called the ambulance technicians. They took Ms. Guanish to the emergency at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles, where she was treated and received care. While hospitalized, she said that she wanted to commit suicide and hang herself. She said that she had not been herself for several weeks, and that many ideas were going through her head. She cooperated and wanted to get help. She met with a psychiatrist and spent the day and the night at the hospital centre under observation. The hospital staff had her complete a document entitled *Protocole d'analyse en comportement suicidaire ou parasuicidaire*. (Assessment protocol for suicidal or parasuicidal behaviour)

In that document, she said that she was at her home at 3 or 4 in the morning, and that she put a wire around her neck. Then she thought about her daughter and, because of her, she did not go further. She said she had written a letter stating that she had decided to take her life. Instead of hanging herself, she self-mutilated. She also stated in the document that suicide was not the right solution, and that her daughter and family would never have forgiven her. She said that, instead of taking her life, she should talk about it, find help or see a psychologist.

During her stay, her family visited her. She was her old self again, smiling, and did not have other suicidal ideas. She was discharged on November 27, 2014, at around 6:20 p.m., and had psychiatric follow-up in December 2014 as well as follow-up with a specialized educator.

On January 31, 2015, Nadeige Guanish filed a complaint for sexual assault, which allegedly took place the previous night. Charges were brought against an individual. Legal proceedings were instituted and she received services from the Centre d'aide aux victimes d'actes criminels (Crime Victims Assistance Centre (CAVAC). Out-patient psychiatric follow-up began, as the assault made her feel awful and she blamed herself for being intoxicated during the incident.

Some persons close to Nadeige Guanish testified that her drinking and use of drugs increased after the assault.

On February 19, 2015, Nadeige Guanish was again hospitalized for emergency treatment for suicidal ideation. She was considered to be in a state of [TRANSLATION] "acute stress", and was abusing drugs (speed and THC) and drinking. When sober, she said that she did not want to die, but as soon as she used, the dark ideas returned and the loss of inhibitions made it easier to go through with it. Her psychiatrist directed her to the emergency, and saw her during her stay. She was not diagnosed with PTS. She was discharged the next day, with a prescription for Seroquel (quetiapine), an antipsychotic. Out-patient psychiatric follow-up continued.

On June 28, 2015, Nadeige Guanish was again taken to the emergency at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles for a suicidal crisis and intoxication. She reportedly drank in a bar and [TRANSLATION] "blacked out" after. She had injured one of her hands. Initially, she cooperated little, but she changed her attitude subsequently. She was hospitalized for five days. She met with her psychiatrist again. Ms. Guanish repeated that she became suicidal when she drank or used drugs, and that she should no longer use. A plan to reduce her use of substances was developed. Steps were taken for her to go for detox treatment, and she was to start therapy in July 2015, but it was postponed. Out-patient psychiatric follow-up continued.

On July 23, 2015, the police intervened, as she threw herself into the water to drown. She was intoxicated when she arrived at the emergency of the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles. She had been at a party the night before. Her psychiatrist saw her when she had sobered up, and discharged her because she felt that Ms. Guanish was adequately supervised by her family. Psychiatric follow-up and follow-up with the specialised educator continued.

In August 2015, Nadeige Guanish went for rehab treatment, which lasted 28 days. She was doing very well after the therapy; she no longer used, she took care of her daughter, and had even found work.

On October 16, 2015, Ms. Guanish met with her psychiatrist and told her that she was doing [TRANSLATION] “super well”. However, Nadeige Guanish’s mother testified that she had gradually resumed substance use in early October 2015. And yet she knew that she could not touch alcohol or drugs. It seems that no one notified the health workers, such as her treating psychiatrist, when she resumed using substances.

On October 30, 2015, during the day, Nadeige Guanish learned that the case involving her sexual assault had been postponed. The CAVAC representative who contacted her by phone testified that Ms. Guanish did not react badly to the news. In addition, the evidence shows that it was not the trial that was postponed, as Nadeige Guanish was not scheduled to be in court that day. Thus, the postponement was a formality. I am making that clarification, as at the inquest certain witnesses reported that they believed she was so affected by the trial postponement that she took her life. On the other hand, Nadeige Guanish’s family and friends reported that she found the judicial process difficult and that she was anxious to get it over with. At the inquest, some said that she was not suicidal before she was assaulted. We now know that this is not exact.

Additionally, Nadeige often stated that the assault made her feel dirty. Did she talk about it enough with the various persons who were working with her? The evidence as a whole indicates that Nadeige Guanish was suicidal before the assault. However, it is clear that the assault in January 2015 aggravated her condition and her situation. She became more suicidal and had problems with substance abuse.

Rehab treatment helped Nadeige Guanish very much. She herself knew that she did not have suicidal ideation when she did not use substances. She was doing much better after rehab treatment, up until the night of October 30 to 31, 2015, when she relapsed and used substances, which plunged her into a suicidal crisis.

She got lots of support from her family and friends. However, mechanisms must be found to better raise the awareness of and better equip the family and friends of persons who cannot drink or take drugs. Most people at a party have fun, except those with substance abuse problems. Family and friends must be able to adapt accordingly, so they do not submit a fragile person to temptation.

Although the evidence has shown that Nadeige Guanish needed to be pushed to get help, when it comes to quantity, it certainly cannot be said that she failed to receive services or assistance measures. However, despite all of that support, when each one works separately, a suicidal person’s needs may not be met due to lack of cooperation or agreement.

Once again, after Nadeige Guanish's death, level 1 of the intervention protocol was implemented. A great number of people reacted to Ms. Guanish's suicide, and health workers had to redouble their efforts to eliminate the crises.

However, before Nadeige took her life, there should have been an intervention and the level 2 or 3 protocol implemented, so that follow-up was exercised. The prior suicide attempts should have triggered the implementation of the protocol. In that case as well, a shortage of personnel and resources was reported, with the result that levels 2 and 3 are too often not implemented.

Last, I am puzzled that an officer received texts making suicidal comments, but did not read them because he was not on duty. As Nadeige Guanish had his number, the two must have known each other. She turned to him because he was a police officer, and asked for his assistance. Her cry for help, which could have prevented her death, was ignored.

I will get back to that during the recommendations.

CONCLUSION

Nadeige Guanish died of asphyxia by hanging.

It was a suicide.

ANALYSIS

The five suicides studied by the inquest involved persons of Aboriginal heritage. Four were from Uashat Mak Mani-Utenam (Innu community), and one was from Kawawachikamach (Naskapi community).

Overall, I believe that these five suicides were avoidable. In four cases, the deaths occurred on the territory of Uashat Mak Mani-Utenam, while the last case was a death within the city limits of Ville de Sept-Îles.

Each person who died had a personal history and life trajectory that was unique. However, the five had their Aboriginal heritage in common. That fact raises the issue of living conditions in these communities even though, when each death is considered individually, each person may have had a different reason for ending his or her life.

The witnesses heard, the exhibits filed in evidence and the documents submitted have established that these five suicides had a common backdrop.

In almost all of the cases, at the time of the suicide there was a sort of profound personal discontent; most of the time the person did not want to die, but to put an end to his or her suffering. The person did not see any solutions, and only death appeared to be a means to put an end to that suffering.

When a person receives help, most of the time they manage to see that there are ways to attenuate or eliminate suffering other than suicide. On the other hand, without help, the person may drink and use drugs, or even abuse medication in order to dull the suffering, but that only lasts while the substance has an effect. Afterward, there are side effects, which may leave the person in emotional overload and depressed, which solves nothing.

Besides the profound personal discontent of the five persons considered by this inquest, there is the backdrop of profound collective discontent experienced by the community as a whole or by a group of individuals belonging to the community.

One of the purposes of this inquest is to recommend means or measures to avoid other deaths from occurring in similar circumstances. The inquest has demonstrated that, to do so, it is indispensable to review the living conditions, life experience and future prospects of Aboriginal peoples, more specifically, those in Kawawachikamach and Uashat Mak Mani-Utenam.

It is necessary to identify and understand the various individual and collective factors that may have caused the five persons in question to commit suicide, but it is also necessary to note the shortage of means to overcome difficulties, which are often called [TRANSLATION] “protective factors”.

In general, most of the factors associated with suicide are the following:

- presence of a mental disorder;
- abuse and addiction to alcohol and drugs, or other addictions;
- suicidal ideation or prior suicide attempts;
- conjugal problems or family break-up;
- exposure to the suicide of a relative or friend;
- violent, aggressive or impulsive behaviour;
- financial problems, loss of employment;

- problems with the law;
- exposure to abuse and neglect, dysfunctional family;
- social problems, rejection, intimidation.

These factors may be categorized:

- predisposing factors: elements from a person's past that contribute to vulnerability;
- contributing factors: elements that accentuate a person's vulnerability;
- precipitating factors: elements that act as triggers for suicidal ideation;
- aggravating factors: events or elements that reinforce existing fragility and vulnerability.

In all five cases, it can be said that these five categories of factors came into play.

The inquest shows that Aboriginals in general are more affected by unemployment, poverty, drinking and drugs, crime, conjugal violence, dropping out of school, children in foster care and suicide than other communities. The inhabitants of Uashat Mak Mani-Utenam and Kawawachikamach are no exception.

Following are some numbers that were obtained during the inquest.

Generally speaking, it is known that the suicide rate for the Aboriginal population is twice that of the national average.

Between 2000 and 2011, there were 152 suicides among Aboriginals living in their communities. Uashat Mak Mani-Utenam has approximately 3400 inhabitants. The Naskapi in Kawawachikamach are approximately 650.

Between May 1994 and November 2015, there were 44 suicides in the community of Uashat Mak Mani-Utenam. Still in this community, 66% of persons 15 years old and over have no diploma, and 66% of persons old enough to work are unemployed. Most of the persons who are employed work for the Band Council and many of the jobs are seasonal.

Despite its population of 3400, the community of Uashat Mak Mani-Utenam offers services that are not found in much larger localities. The community has its **own police force, social services, three Innu schools, health service points**, an arena, an outdoor pool, therapy centre for inmates, a number of shelters and rehabilitation centres, a shopping centre, a museum, etc. In addition, there are no premises licenced to serve alcohol on the reserve.

In spite of all of those resources and services offered, a profound personal discontent and profound collective discontent are still present among the population.

THE RESERVE SYSTEM

The Aboriginal issue is complex. I was able to see that on reading the many documents and in light of the testimony heard. To correct the problem of suicide in Aboriginal communities, living conditions in those communities must improve, which includes economic, cultural, social and community conditions.

Despite all of the funds and efforts invested in recent decades, despite the treaties and agreements signed and the numerous discussions and negotiations, little has changed.

In Aboriginal communities there are still as many social problems, as many persons struggling with substance abuse and addiction, as many children in need of protection, as many persons incarcerated and as many jobless, and the ratios or proportions exceed those of non-Aboriginal communities.

Some believe that, if government authorities invested more money in Aboriginal communities, many of the problems would be resolved. Perhaps, but unfortunately, despite more public funds being allocated than in the past, the social issues, the identity and cultural problems and the underlying difficulties remain.

Uashat Mak Mani-Utenam is an Aboriginal community twinned with Ville de Sept-Îles. It enjoys all of the services, and is not an isolated community like some others. Its budget is substantial, with multiple cash inflows. That has not alleviated the profound collective discontent, and has not prevented the wave of suicides studied by this inquest or the too numerous attempts that followed the suicides.

I believe that as long as the viewpoint from which the problems are approached and the solutions are proposed does not change, things will not really improve.

I believe and see evidence that the great fundamental problem lies with the “apartheid” system into which Aboriginals have been thrust for 150 years or more.

The *Indian Act* is an ancient and outdated law that establishes two kinds of citizens, Aboriginals and non-Aboriginals. The Aboriginal is a ward of the State, someone considered incapable and unfit.

These citizens, who are under a separate system, have been stuck in reserves where they cannot progress or become emancipated. The message that is constantly sent to Aboriginals is: [TRANSLATION] “you are different and incapable”.

Here is not the place to analyze the details of the Act. Any observer is able to see its effects. Note that the Naskapi in Kawawachikamach are governed by an agreement, the *Northeastern Québec Agreement*, and not the *Indian Act*; however, to the average observer, a reserve remains a reserve, even if it is not called that.

It is time to put an end to this apartheid system, and for all of the authorities concerned to confront that challenge.

At the inquest, a number of witnesses spoke of the personal, social and family wounds that some suffered during the period of Indian residential schools. Others spoke of trauma from that period, handed down from generation to generation.

Of course the residential schools may have caused personal and social problems in the communities. Residential schools were done away with a long time ago, but the problems remain. None of the five persons concerned by the inquest went to a residential school. Their parents or grandparents perhaps went, but I believe residential schools were only one product, one beast among many others, of the apartheid system that was introduced by our ancestors and that has been preserved to our day.

This inquest was held because these were suicides of Aboriginal persons. Therefore, I cannot ignore the Aboriginal issue, which is at the root of social and personal problems, a profound discontent and, ultimately, suicides. A person ends his or her life because they do not see a solution to their problems, and no longer has any hope for the future. What future do Aboriginals have with the present apartheid system?

Of course, they can leave the reserves, even permanently. A number do it. Some are successful, many suffer failure. If they leave, they may lose their identity.

Some witnesses reported at the inquest that, if they went to study outside the reserve, got diplomas and acquired skills, they were not welcomed when they returned to the reserve. They were told that they were no longer Aboriginal. How can someone anticipate a better future and social improvements in that context? Aboriginals are at the centre of a vicious circle.

Once again, these are the effects of the ancient apartheid system. Abolishing that system would allow Aboriginals to be better able to define themselves and strengthen their identity, to preserve their culture and to move forward into the 21st century. Additionally, there are the tensions the system creates, which, because of irritants resulting from the *Indian Act*, can lead to racism between Aboriginals and non-Aboriginals.

In Sept-Îles, Innu and non-Innu coexist on a daily basis in a certain harmony. There is cooperation on some occasions because both communities flout the apartheid system. For example, the garbage collection contract for Ville de Sept-Îles was given to an Innu business. Fishing boats and shellfish treatment plants are also operated by Innu. Some cruise ships stop in Sept-Îles to allow the cruise ship passengers to meet Aboriginals. Recently, the Aboriginal festival Innu Nikamu, which relies on a well-structured resource, accomplished the feat of inviting the internationally renowned group Simple Plan, attracting several thousand persons.

Those successes, which benefit both communities, are possible through partnerships that could better be reached without the current exceptional regime. Abolishing such a system could only benefit both communities. The political authorities and decision makers, both Aboriginal and non-Aboriginal, have the task of reassessing the purpose of the reserve system. Doing so would at the very least confront the profound collective discontent of Aboriginal communities, and the suicide rate could decrease.

In the meantime, I will look into recommendations that could improve the problem of suicide and suicidal crises in the communities of Uashat Mak Mani-Utenam and Kawawachikamach.

Professionals who participated in the inquest submitted several dozen suggestions as recommendations. My recommendations will attempt to propose measures to reduce the number of suicides in the short term, with the view that a suicide is always one suicide too many.

RESOURCES

At the inquest, I received information about the resources offered by the community of Kawawachikamach. There is a Naskapi police force, which acts as first responder. However, it seems that the police cannot provide service 24 hours a day, 7 days a week, due to lack of funding at the federal and Québec levels.

It appears that the CLSC (local community service centre) plays an important role when it comes to health problems in general. However, shortcomings were observed with regard to mental health issues. The CLSC does not have a psychologist on site or any residential facilities.

The case of Alicia Grace Sandy raises the issue of resources. When Ms. Sandy was in suicidal crisis and intoxicated the first time, only police station cells were available to ensure her safety while waiting for the crisis to pass.

When the second crisis took place, Ms. Sandy was transferred by plane to the Centre intégré de santé et de services sociaux de la Côte-Nord - section Sept-Îles to be taken in charge by the psychiatrist. When the crisis was over, Ms. Sandy was discharged. She did not return to Kawawachikamach, and she did not have follow-up. She was left on her own, hoping that she would take charge of herself, alone, in a community that was not hers. There was no follow-up and not sufficient communication between the Naskapi CLSC and the psychiatric service at the Centre intégré de santé et de services sociaux de la Côte-Nord - section Sept-Îles.

And yet Ms. Sandy's situation was serious enough to request a transfer to Sept-Îles, and warranted going to court to seek psychiatric assessments against her will. However, no one appears to have ensured follow-up after her discharge from the hospital, as the Uashat social services felt little concerned by a non-Innu, their mandate being to provide care to the Innu.

There are no residential facilities in Kawawachikamach for persons who are struggling with drinking and substance abuse problems. The Naskapi must go to Montréal for treatment or therapy services, in particular because the Naskapi speak only Naskapi and English.

Ms. Sandy had integrated a centre in Montréal, but had terminated her treatment before it was completed. Unfortunately, that is the case for many Aboriginals, who do not feel they fit in at resources poorly adapted to them and far from their reality.

Therefore, my recommendations attempt to address those shortfalls as regards resources.

The services in Uashat Mak Mani-Utenam are numerous, in particular, as that they are provided to a population of just over 3000 persons. The social services organization chart is impressive.[4] Numerous problems are addressed, but when the issue of suicide or persons in suicidal crisis is raised, it becomes difficult to understand who does what and how.

There is a crisis intervention protocol. It was reviewed recently and should be again, in my opinion. It is very well implemented after a suicide. Front-line services at the Uauitshitun centre are called on. The staff meet with the deceased's friends and family, and offers a great deal of support.

In the case of Nadeige Guanish, that service proved essential, and the staff worked tirelessly for several weeks, as her suicide triggered numerous suicidal crises. In the months that followed her death, nine suicide attempts and 24 emotional crises with

[4] Exhibit R-13, Appendix 3, p. 48.

suicidal ideation were reported, including a number involving youths from 12 to 30 years of age.

However, the protocol is not effective with regard to postvention, as it ceases to be implemented after one month, or in the case of suicidal crises, that is, the support to be given persons who make suicidal comments or suicide attempts. Unfortunately, some of those who died did not receive much help or support while alive because the support was not provided adequately or they were simply not taken in charge, due to lack of cooperation. Too often, everyone believes that others are taking care of things.

And that is how our five persons fell through the cracks of the system, which should have been their safety net. Persons who ask for help generally receive services, but those who don't ask for any are given minimum attention.

My recommendations are to set up a resource to take charge of persons who are at risk of suicide.

In addition, despite a cooperation agreement entered into by the Uauitshitun centre, the Uashat Mak Mani-Utenam police force and the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles,[5] there are serious communication problems among the resources.

Persons come and go at the psychiatric service of the hospital centre without notifying social services so that follow-up can be done. Even the family is not always notified, given the rules of confidentiality for health centres. In short, the problems with communication or the exchange of information may result in a person who is at risk of suicide not receiving any follow-up after a crisis.

My recommendations will attempt to correct that shortcoming.

The inquest also emphasized the lack of human resources for front-line services at the Uauitshitun centre, in particular social workers and psychologists. Vacant positions are not filled or care providers on leave are not replaced. Budgets for crisis situations are not maintained once the crisis is over.

There are numerous resources in Sept-Îles and Uashat Mak Mani-Utenam. That was seen in our five cases. The hospital centre, social services, front-line services, police, CAVAC, the suicide prevention centre, the justice system, community resources, rehabilitation and therapy centres, etc.

Despite that, there are deaths because certain persons fall through the cracks or are forgotten due to a lack of sufficient human resources or cooperation.

Thus, I believe a specialized resource is needed to fill those gaps.

PREVENTION

In addition to the primary and secondary prevention services offered by the front-line community services at the Uauitshitun centre, there are other prevention services, but the

[5] Exhibit R-13, Appendix 4, p. 48.

Centre de prévention du suicide de la Côte-Nord (North shore suicide prevention centre) is used very little by Aboriginals. There are no responders who speak Innu or Naskapi.

At the inquest, it was noted that that shortcoming at the Centre de prévention du suicide deprived the Aboriginal clientele of the possibility of receiving services. On the other hand, the Centre de prévention du suicide, despite its good will, has limited budgets.

A person in distress does not always know who to turn to or which resource to use. The Centre de prévention du suicide has put a lot of effort into making itself known, including to Aboriginals. However, it must be said those efforts have yielded very little results, given the reticence of Aboriginals to use the service, where they do not feel they fit in.

Therefore, I will recommend measures to remedy that problem.

Sometimes the police also offer prevention services. The Uashat Mak Mani-Utenam police force (SPUM) has a community officer who appears to work especially with youth. I did not receive a request to increase personnel for this service. However, I can suggest that the issue of suicide prevention be one of the subjects the community officer discusses with young persons.

At the inquest, the importance of prioritizing suicide prevention was discussed, given the goal of social services to reduce the suicide rate. In particular, this includes interventions with the clientele that is most at risk, namely, young persons. In fact, Aboriginal adolescents are five to six times more likely to die from suicide than the average Canadian adolescent.

Since persons who have been exposed to the suicide of a family member are at increased risk, special attention must also be paid to children who are grieving the loss of a parent. This was seen in the case of Charles Junior Grégoire-Vollant.

Thus, I specifically recommend that the Uauitshitun centre focus on prevention among young persons. In that regard, special attention must be given to the Internet and the possibilities that social networks can offer.

Young persons communicate a lot on social networks. In 2016, that is where they send out messages of all types, which may be cries of alarm or for help.

These days, when a person under 30 leaves a suicide note or a farewell letter, they do it on a social network using a computer or a cell phone (as did Nadeige Guanish).

Simultaneously, it is necessary to intervene at school, including at college level. Social services must also see that gatekeepers are trained, in collaboration with the Centre de prévention du suicide. That should be done each year. In addition, there could be training for informal helpers or peer helpers. Each Aboriginal school could have a specialized educator who would implement prevention strategies and supervise the teams of gatekeepers, among others, in addition to their role in the event of a suicidal crisis.

ALCOHOL AND DRUGS

Intoxicating substances played a prime role in the deaths of the five persons concerned by the inquest, that is, each one had a substance abuse problem related to other

difficulties, which led them to commit suicide, or they were in an intoxicated state when they ended their life.

I mentioned earlier that, since 1994, 44 persons have committed suicide in the community of Uashat Mak Mani-Utenam, 40 of whom were addicted to alcohol or drugs.

It is well known that alcohol and certain drugs decrease inhibitions and increase impulsiveness or exacerbate emotions, particularly those considered negative. It is known that regular use of alcohol and drugs over a long period can lead to depression, hopelessness, and judgment or perception problems.

A few years ago, many suicides on the north shore were related to the use of PCP. Now, amphetamines, or speed, have replaced PCP. These are stimulants and, in particular, they prevent sleep. A person who is on speed may not sleep for several days. The lack of sleep often results in a depressive state and dark thoughts. When that is mixed with alcohol, it is enough to put a person who is already fragile and has suicidal tendencies at great risk.

Alcohol and speed are often taken for their euphoric effect, but after that phase there is a depressive state, triggering a resumption of use to combat that state, and so on.

Among the Aboriginal population, alcohol and drugs are also a source of social problems. Whether violence, crime or youth protection, intoxicating substances are almost always part of the picture.

The SPUM chief of police was present at the inquest, and spoke of the scourge of drugs, in particular, speed. Given the community's proximity to Ville de Sept-Îles, which he described as the north shore's central hub for trafficking, he would like to create a regional task force to fight the drug problem.

I am ready to make a recommendation in that regard, if it can reduce the suicide rate.

Several years ago, certain young Aboriginals were using solvents to get high; however, those products were completely legal.

Alcohol is legal as well, but that does not prevent it from wreaking havoc among those who abuse it. In addition, paradoxically, there are no premises licenced to serve alcoholic beverages (bars) on the territory of Uashat Mak Mani-Utenam. That does not prevent people from drinking.

Instead, I would advocate that authorities, such as the Band Council, be more proactive in raising peoples' awareness of the problems related to drinking and drug use.

We know that some Aboriginal communities go so far as to prohibit alcohol on the territory of the reserve. Without going that far, it would not hurt if the Band Council adopted a clear policy on alcohol and drugs on the reserve and put more emphasis on prevention.

I am aware that most Innu do not drink any alcohol or drugs when they spend extended periods in the woods. The Band Council could, for example, promote and finance more therapy or rehabilitation programs focussed on extended stays in nature so that the community could benefit. Programs of this type can also prove beneficial for persons who are at risk of suicide.

There were similar programs in the past but, unfortunately, they were not renewed. The Band Council could make more effort in that regard. But federal authorities should also participate more in funding such programs, as those same federal authorities have recognized or should better recognize that these programs are beneficial. They can help Aboriginals to preserve their identity, culture, and physical and mental health, which have been altered by the reserve system. Too many persons have tried to compensate for that failure by drinking and taking drugs.

RECOMMENDATIONS FOR THE RESIDENTS OF UASHAT MAK MANI-UTENAM AND OTHER COMMUNITIES

In order to remedy the lack of specialized residential facilities and follow-up for persons who are at risk of suicide;

For the purpose of reassessing or reorganizing the crisis intervention protocol;

With the goal of reorganizing the tasks of front-line community services at the Uauitshitun centre;

Whereas the creation of a central specialized resource may better ensure that a person who is in need does not go without services;

Also, to avoid the hospitalization of suicidal persons as much as possible, and to reduce the subsequent risks related to discharge after hospitalization;

Whereas many residents are struggling with difficulties that result in a suicidal crisis or a suicide attempt because of the social situation in the reserves, more specifically, in Uashat Mak Mani-Utenam;

Whereas the inquest has demonstrated that Aboriginals rarely use non-Aboriginal resources, and that it is important for the Innu of Uashat Mak Mani-Utenam to have their own resources;

I RECOMMEND:

- That the Uashat Mak Mani-Utenam Band Council and the Government of Canada see to the creation of a specialized resource for suicidal crises. That resource could have specialized personnel in its service, such as educators and caseworkers trained to deal with suicidal crises, and a psychologist to ensure close follow-up of suicidal persons. The resource should also provide short-term lodging, in particular, for the [TRANSLATION] “sobering up” of suicidal persons who are intoxicated.

  The resource could also take charge of suicidal persons on their discharge from the hospital and provide residential facilities, if necessary. The service should be available 24/7.

I RECOMMEND:

- That the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles and, more particularly, the psychiatric service, direct all Aboriginal patients hospitalized for a suicidal crisis to the resource set up on my recommendation on their discharge or, failing that, to the Uauitshitun centre, after obtaining the person’s authorization, if needed.

Whereas psychiatric services at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles seem to have been provided differently in the case of the persons concerned by the inquest who used this service;

Whereas for the same person, for example Ms. Sandy, psychiatric services do not appear to have been coherent, at least not from the viewpoint of the user or the observer;

I RECOMMEND:

- That the Centre intégré de santé et de services sociaux de la Côte-Nord - section Sept-Îles and, more specifically, the psychiatric service, review hospitalization, treatment and discharge policies, particularly if new resources are set up.

I do not claim to have the ideal solutions; however, the inquest has shown that the crisis intervention protocol was a useful tool when implemented after a suicide (level 1), but that it neglected persons in a suicidal crisis or who attempted suicide, as levels 2 and 3 of the protocol were implemented rarely or not at all due to lack of resources.

I believe that the crisis intervention protocol should be reviewed and reworked, and that its implementation should not be the responsibility of front-line social services at the Uauitshitun centre only.

Thus, I believe that levels 2 and 3 of the protocol would be implemented better if they were the responsibility of the resource I recommended, in order to intervene when there are suicide attempts and suicidal crises.

Front-line services could continue to provide intervention at level 1 of the protocol.

In that way, by sharing implementation of the protocol, the health workers would be less likely to be overloaded.

I RECOMMEND:

- That the Uauitshitun centre review the intervention protocol, given the new resource I recommended and, as needed, share implementation of the protocol by the resources;

- That the Uauitshitun centre not have a predetermined duration for protocol implementation, which must at all times be provided according to individual needs;

- That front-line community services at the Uauitshitun centre pay particular attention, when implementing level 1 of the protocol, to children and adolescents directly or indirectly affected by a suicide.

With the creation of the specialized resource for persons in a suicidal crisis in mind;

I RECOMMEND:

- That front-line community services at the Uauitshitun centre concentrate their energy on primary prevention and implementation of the intervention protocol after a suicide (level 1);

- That the Uauitshitun centre task the newly created resource to implement levels 2 and 3 of the intervention protocol in situations of suicidal crises, ensuring that the resource is available at all times, that is, 24 hours a day, 7 days a week.

Whereas the inquest has shown that front-line services personnel at the Uauitshitun centre are in insufficient number for various reasons;

I RECOMMEND:

- That the Band Council of Uashat Mak Mani-Utenam and the Government of Canada prioritize the hiring of the necessary personnel for the front-line services at the Uauitshitun centre to fulfil their mission.

As the multipartite cooperation agreement[6] signed in November 2006 seems more or less applied, and needs to be more detailed and precise;

Since close cooperation between the various resources is necessary to prevent a suicidal person from going without follow-up or services in the future;

I RECOMMEND:

- That the Uauitshitun centre, the Uashat Mak Mani-Utenam police force and the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles negotiate a new cooperation agreement enabling, in particular, the exchange of information between the stakeholders at the resources or the creation of mechanisms for a better exchange of information, given the obligations of confidentiality;

- That each time someone is taken to the emergency service at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles for a suicidal crisis or a suicide attempt, the Uashat Mak Mani-Utenam police force notify the resource to be created, which will take charge of persons in suicidal crisis at the same time as the social services at the Uauitshitun centre, so that follow-up is ensured during the person's stay at the hospital centre and upon their discharge.

As there is no responder who speaks Innu at the Centre de prévention du suicide de la Côte-Nord;

Since the services offered are used very little by the Aboriginal population, because they do not feel they fit in;

[6] Exhibit R-13, Appendix 4, p. 48.

I RECOMMEND:

- That the Government of Canada create an Aboriginal suicide prevention centre that would offer services to all of the Aboriginal communities on the North Shore, and employ Aboriginal responders who are specialized in assistance relations and speak the language of the persons in need of help;

- That the suicide prevention centre in question or, failing that, social services at the Uauitshitun centre, set up a telephone line with text message capabilities and a website, offering services 24 hours a day exclusively to Aboriginals who are in need;

- That the Government of Canada see to the creation of the said Aboriginal suicide prevention centre and negotiate the terms and funding with other authorities, as needed.

Given the verbal communication problems with non-Aboriginal services;

Given the importance of optimal communication between professionals and a beneficiary during a suicidal crisis;

Since the forms and questionnaires used by the professionals are in French only, from what I learned at the inquest and from what I saw on reading the cases;

Whereas, for example, during Alicia Grace Sandy's hospitalization, understanding and communication problems were observed between the patient and the health professionals;

I RECOMMEND:

- That the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles and, more specifically, the psychiatric service, ensure there is an interpreter, so that the needs of the hospitalized patient are properly understood and the patient properly understands;

- That the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles translate the forms and questionnaires used into Innu, English and Naskapi.

So that the new proposed resource to help persons in a suicidal crisis can broaden its services;

So that Aboriginals (Naskapi and Innu) can receive services before or after they are taken in charge by the psychiatric service at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles;

Whereas Aboriginals from all of the communities on the North Shore located east and north of Sept-Îles—including Mingan, Natashquan, La Romaine, Pakuashipi, Matimekosh

and Kawawachikamach—may, in a crisis situation, be hospitalized at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles;

So that there is follow-up for Aboriginals from the North Shore hospitalized at the psychiatric service at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles;

I RECOMMEND:

- That the Band Council of Uashat Mak Mani-Utenam enter into cooperation and service agreements with the band councils of the other Aboriginal communities on the North Shore so that all Aboriginals can receive services from the new resource I recommended;

- That the Government of Canada promote the said agreements between the different bands on the North Shore, and respond favourably to the various requests for additional funding that the said agreements may require.

So that all persons in the community of Uashat Mak Mani-Utenam can have access to services after a professional has discharged them from the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles and, more specifically, from the psychiatric service;

I RECOMMEND:

- That the psychiatric service at the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles have all hospitalized Aboriginal patients sign, or attempt to have them sign, a form consenting to communicate all relevant information to the Uauitshitun centre for post-hospitalization follow-up or, if needed, to the new resource I recommended, which will provide the patient services when he or she is discharged.

The inquest has shown that Innu youths between 15 and 30 years of age were most likely to commit suicide, and that prevention and screening were necessary for that group;

To ensure that the best communication media to target youths are used;

To ensure intervention in the environments where youths are found;

I RECOMMEND:

- That the Uauitshitun centre, the Band Council of Uashat Mak Mani-Utenam and the Government of Canada implement new specialized resources whose task would be to use social networks such as Facebook and Twitter to identify youth who are at risk of suicide and to better develop prevention programs;

- That the Band Council of Uashat Mak Mani-Utenam provide each school on the reserve with one or two specialized educators, whose task, among others, would

be to prevent youth suicide, to train and coordinate teams of gatekeepers and to intervene during suicidal crises.

In order to raise youths' awareness of the problem of suicide and to involve them in detecting the risk;

I RECOMMEND:

- That front-line services at the Uauitshitun centre offer training and refresher training each year for persons who act as [TRANSLATION] "gatekeepers, informal helpers or peer helpers".

In order to raise the awareness of family and friends of a suicidal person to the risks of drinking or using drugs, and to involve them in assistance measures;

I RECOMMEND:

- That front-line services at the Uauitshitun centre provide an information and training program for family and friends of a suicidal person that addresses drinking and the use of so-called social drugs.

So that the population of Uashat Mak Mani-Utenam will give the problem of drinking and drugs on the territory of the community primary importance;

Given that, in the five cases examined, drinking or the use of drugs was involved before or at the time of the suicide;

I RECOMMEND:

- That the Band Council of Uashat Mak Mani-Utenam adopt a policy regarding alcohol and drugs on its territory.

Whereas the inquest revealed a particular situation of trafficking and use of speed on the territory of Uashat Mak Mani-Utenam;

Given the role that speed plays in the onset of depressive states and emotional disorders that can lead to suicide or a suicide attempt;

Given the low cost and availability of speed on the territory;

Whereas any new drug on the market could contribute to increase the suicide rate or the number of unintentional deaths due to intoxication;

Whereas the Uashat Mak Mani-Utenam police force cannot, on its own, effectively fight drugs on its territory, as the problem and the solutions involve regional intervention, according to what was reported at the inquest;

I RECOMMEND:

- That Québec's ministère de la Sécurité publique (ministry of public security) and Public Safety Canada, along with other concerned resources, such as the Royal Canadian Mounted Police (RCMP) and the Sûreté du Québec (Québec provincial police), work to create a regional task force, which would include the Aboriginal police service of Uashat Mak Mani-Utenam, to fight the drug trade on the North Shore.

The inquest has identified social and psychological problems experienced by a good portion of the population on the Uashat Mak Mani-Utenam reserve, caused by the system of reserves that affects both the individual and the identity, development and culture of a community.

Whereas this problem includes, in particular, risks of suicidal crises;

Whereas it is important and necessary to act in a preventive measure, before a suicidal crisis occurs;

Whereas programs were implemented in the past that yielded positive results;

I RECOMMEND:

- That the Uauitshitun centre reinstate and enhance therapy and rehabilitation programs focussed on extended stays in nature, as well as family therapy programs;

- That the Band Council of Uashat Mak Mani-Utenam and the Government of Canada ensure the implementation of and funding for such programs.

Given the recommendations made to officers of the Uashat Mak Mani-Utenam police force, for them to play an increased role at the time of a suicidal crisis;

As the inquest brought to light the lack of information and training of certain SPUM officers as regards suicide, suicidal crises and good practices in that field;

I RECOMMEND:

- That the Band Council of Uashat Mak Mani-Utenam and the Uashat Mak Mani-Utenam police force, in collaboration with Québec's ministère de la Sécurité publique, see that the officers on the reserve receive adapted and relevant training to better intervene in suicidal crises;

- That the Uashat Mak Mani-Utenam police force assign its community police service the additional task of preventing youth suicides during its interventions.

With a view to reworking the crisis intervention protocol, and given my recommendations;

Given the impact of a suicide in the community and the need for rapid intervention by the staff at the Uauitshitun centre;

I RECOMMEND:

- That the Uauitshitun centre and the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles, more specifically, the physicians and psychiatrists at the hospital centre in Sept-Îles, enter into an agreement providing rapid access to medical consultations and medication, as needed, in the case of a crisis caused by the suicide of a friend, relative or member of the community.

In order to improve services to persons who are struggling with a suicidal dynamic and who receive services from the CAVAC as victims of crimes against persons;

So that the CAVAC caseworker can better assess the emotional state of the person using the services;

I RECOMMEND:

- That the Centre d'aide aux victimes d'actes criminels de la Côte-Nord (CAVAC) always convey information directly to the victim in person, and avoid phone or email communication, particularly when it is [TRANSLATION] "sensitive" information;

- That the Centre d'aide aux victimes d'actes criminels de la Côte-Nord obtain as much information as possible on the crime victim in order to better understand that person's risk of committing suicide;

- That the Centre d'aide aux victimes d'actes criminels de la Côte-Nord have the crime victim who consults the Centre sign an authorization to share information with the Uauitshitun centre or the Centre intégré de santé et de services sociaux de la Côte-Nord - section de Sept-Îles, particularly the psychiatric services, if needed.

Whereas the CAVAC de la Côte-Nord employs Innu, which promotes better communication;

I RECOMMEND:

- That the Centre d'aide aux victimes d'actes criminels ensure that its service points in Aboriginal communities employ persons who speak the language of the Aboriginal beneficiaries.

For residents of Kawawachikamach in particular

So that the community of Kawawachikamach can provide the necessary services to its population during crisis situations, and avoid transferring persons outside the community due to a lack of services;

To prevent police station cells from being used for persons other than those incarcerated for crimes;

I RECOMMEND:

- That the Naskapi CLSC in Kawawachikamach build or set up within the CLSC a soundproof and secure room for persons who are in a crisis situation or in need of sobering up when intoxicated.

The inquest showed that Ms. Sandy, who was staying in the Montréal area, did not finish her treatment because she felt far from familiar reference points, both in distance and with regard to the personnel and the other beneficiaries, with whom she shared only the language. She returned to her community without getting the services she needed.

To prevent members of the Naskapi community who require residential services for mental health reasons, for addiction or for detox treatment from being transferred outside the community to receive those services;

So that a person who is at risk of suicide can be treated in the community;

So that follow-up for person who is at risk of suicide can take place nearby, and family and friends can be involved in the follow-up;

I RECOMMEND:

- That the Naskapi nation of Kawawachikamach set up a resource capable of meeting the needs of persons with mental health or addiction problems, and hire the necessary personnel;

- That the ministère de la Santé et des Services sociaux (ministry of health and social services) negotiate the terms for funding the above-mentioned resource with the Naskapi nation.

If it is not possible to create the above-mentioned mental health and addiction resource in Kawawachikamach;

So that Anglophone Aboriginals, including the Naskapi, can receive services adapted to their needs without being mixed with Anglophone Aboriginals from big cities like Montréal, who have nothing in common with those from outlying regions;

I RECOMMEND:

- That the Québec government collaborate with the Government of Canada to create such a regional Anglophone resource, which could provide all of the Anglophone Aboriginal clientele (Cree, Naskapi, Inuit and Micmac) with residential facilities and addiction treatment services.

It was reported at the inquest that the Naskapi police force in Kawawachikamach does not operate 24 hours a day or 7 days a week due to an insufficient budget or staff.

It was also reported that, between May 2015 and May 2016, there were 64 situations in Kawawachikamach that involved suicide threats or attempts. The officers were called to intervene 64 times.

Whereas the police are the first responders for all emergency calls in the community of Kawawachikamach, whether for criminal offences or crisis situations;

Whereas a community must have first responders on duty at all times;

I RECOMMEND:

- That the Québec government and the Government of Canada see that the Naskapi nation of Kawawachikamach has police service 24 hours a day, 7 days a week.

- That the Naskapi nation of Kawawachikamach take the necessary measures for its police force to operate 24 hours a day, 7 days a week.

- That the Québec's ministère de la Sécurité publique and Public Safety Canada grant the Naskapi nation of Kawawachikamach all of the support required for that purpose.

APPENDIX 1 - THE PROCEEDING

The hearings on the deaths of Charles Junior Grégoire-Vollant, Marie-Marthe Grégoire, Alicia Grace Sandy, Céline Michel-Rock and Nadeige Guanish took place over nine days, that is, from June 13 to 17 and June 27 to 30, 2016, at the courthouse in Sept-Îles.

An Innu interpreter provided assistance during the hearings.

Throughout the inquest, I was assisted by Mtre. Dave Kimpton from the Bureau du coroner (coroner's office).

The status of [TRANSLATION] "interested person at the inquest" was granted to the members of the families of Charles Junior Grégoire-Vollant, Marie-Marthe Grégoire, Céline Michel-Rock and Nadeige Guanish, as well as to the members of the Uashat Mak Mani-Utenam Band Council, who were all represented by Mtre. Jean-François Bertrand.

The status of [TRANSLATION] "interested person" was also granted to the ministère de la Justice (department of justice), represented by Mtre. Alexandre Ouellet, and the Director of Criminal and Penal Prosecutions, represented by Mtre. Robin Tremblay.

In addition, Mtre. Caroline Neveu represented the family of Alicia Grace Sandy.

Thirty-six witnesses were heard regarding the causes and circumstances of the deaths, and 18 persons were heard on the recommendations.

Seventy-seven exhibits were filed regarding the causes and circumstances of the deaths, and 38 were filed on the recommendations, the list of which is in Appendix I.

APPENDIX 2 - LIST OF EXHIBITS

CORONER'S PUBLIC INQUEST

CHARLES JUNIOR GRÉGOIRE-VOLLANT
MARIE-MARTHE GRÉGOIRE
ALICIA GRACE SANDY
CÉLINE MICHEL-ROCK
NADEIGE GUANISH

1. DEATH OF CHARLES JUNIOR GRÉGOIRE-VOLLANT

C-1	Order for an inquest
C-2	Facebook comments by Charles Junior Grégoire-Vollant (January 29, 2015)
C-3*	Information concerning insured medical services (from 2013-01-01 to 2015-02-11)
C-4	Certificate of death
C-5*	Medical record (from 2014-01-01 to 2015-02-11)
C-6	Crisis intervention protocol for the community of Uashat Mak Mani-Utenam
C-7*	Coordination report by Danielle Descent (application of the crisis intervention protocol)
C-8	Genogram

***** Subject to an order not to publish or protected by section 143 of the *Act respecting the determination of the causes and circumstances of death*.

** Where applicable, interested parties will receive, at the earliest opportunity, any updates resulting from the addition or modification of exhibits.*

2. DEATH OF MARIE-MARTHE GRÉGOIRE

C-1	Order for an inquest
C-2	Expert report on the crime scene
C-3	Sketch (expert report on the crime scene)
C-4	Remote attestation of death
C-5*	Information concerning insured medical services (from 2015-01-01 to 2015-06-22)
C-6*	Information concerning insured medical services and insured pharmaceutical services (from 2014-01-01 to 2015-06-21)
C-7*	Medical record of Marie-Marthe Grégoire (from 2012-01-01 to 2015-06-22)
C-8*	Statement of user transportation and prehospital intervention report
C-9*	Genogram for Charles Junior Grégoire-Vollant, by Danielle Descent
C-10	Steps taken by the investigator Guy Olivier to meet Angello Pinette
C-11	Incident reports
C-12	Coordination report by Danielle Descent (application of the crisis intervention protocol)
C-13	Statement by Caroline Grégoire-Vollant

***** Subject to an order not to publish or protected by section 143 of the *Act respecting the determination of the causes and circumstances of death*.

* *Where applicable, interested parties will receive, at the earliest opportunity, any updates resulting from the addition or modification of exhibits.*

3. DEATH OF ALICIA GRACE SANDY

C-1	Order for an inquest
C-2	Expert report on the crime scene
C-3	Sketch (expert report on the crime scene)
C-4*	Prehospital intervention report
C-5*	Statement of user transportation
C-6	Remote attestation of death
C-7*	Toxicology expertise
C-8*	Final autopsy report
C-9*	Pharmacological profile
C-10*	Information concerning insured medical services (from 2010-01-01 to 2015-07-01)
C-11*	Medical record (from 2015-01-01 to 2916-06-22)
C-12	Attempts to meet Ingrid Katsimoko
C-13*	Incident report
C-14	Statement by Adrien Tshirnish
C-15	Statement by Betty-Ann Sandy
C-16	Statement by Jenny Gabriel
C-17	Statement by Nicolas Joseph
C-18	Statement by Lucy Sandy
C-19	Statement by Sébastien Vollant
C-20	Coordination report by Danielle Descent (application of the crisis intervention protocol)

***** Subject to an order not to publish or protected by section 143 of the *Act respecting the determination of the causes and circumstances of death*.

** Where applicable, interested parties will receive, at the earliest opportunity, any updates resulting from the addition or modification of exhibits.*

4. DEATH OF CÉLINE MICHEL-ROCK

C-1	Order for an inquest
C-2	Expert report on the crime scene
C-3	Sketch (expert report on the crime scene)
C-4	Remote attestation of death
C-5*	Information concerning insured medical services and insured pharmaceutical services (from 2014-01-01 to 2015-08-12)
C-6*	Medical record of Céline Michel-Rock (from 2014-01-01 to 2015-08-15)
C-7*	Statement of user transportation and prehospital intervention report
C-8	Text message
C-9	Statement by Joachim St-Onge
C-10	Statement by Carole-Anne Hervieux-Jourdain
C-11	Statement by Gino Wapistan
C-12	Affidavit by Marie-Claude Lévesque (CAVAC)
C-13	Email exchanges with Tenina André
C-14	Statement by Dominique St-Onge
C-15	Coordination report on the protocol (application of the crisis intervention protocol)

***** Subject to an order not to publish or protected by section 143 of the *Act respecting the determination of the causes and circumstances of death*.

** Where applicable, interested parties will receive, at the earliest opportunity, any updates resulting from the addition or modification of exhibits.*

5. DEATH OF NADEIGE GUANISH

C-1	Order for an inquest
C-2	Expert report on the crime scene
C-3	Plan (expert report on the crime scene)
C-4	Sketch (expert report on the crime scene)
C-5*	Prehospital intervention report
C-6*	Statement of user transportation
C-7	Certificate of death for Nadeige Guanish
C-8*	Information concerning insured medical services (from 2015-01-01 to 2015-11-01)
C-9*	Medical record of Nadeige Guanish (from 2013-12-01 to 2016-10-31)
C-10*	911 call
C-11	Photos from Nadeige Guanish's cell phone
C-12	Statement by Lyne Fontaine
C-13	Statement by Jean-Philippe Sandy-Vollant
C-14*	Information sheet (CAVAC)
C-15*	Fact sheet (CAVAC)
C-16 *	Police reference sheet (CAVAC)
C-17	Criminal and penal plumitif
C-18	Coordination report by Danielle Descent (application of the crisis intervention protocol)
C-19	Statement by Jeff St-Onge
C-20	Minutes of the criminal trial
C-21	Statement by Jordan Roch
C-22	Quarterly statistics for the crisis intervention protocol

***** Subject to an order not to publish or protected by section 143 of the *Act respecting the determination of the causes and circumstances of death*.

** Where applicable, interested parties will receive, at the earliest opportunity, any updates resulting from the addition or modification of exhibits.*

RECOMMENDATIONS SECTION

R-1	Paper on suicide recommendations, CPS Côte-Nord
R-2	L'Aide aux personnes autochtones victimes d'actes criminels au Québec (help for Aboriginals who are victims of crime in Québec)
R-3	Centre d'aide aux victimes d'actes criminels de la Côte-Nord
R-4	Paper CIUSSS Estrie and AQPS
R-5	Presentation by Normand D'Aragon (1)
R-6	Presentation by Normand D'Aragon (2)
R-7	Presentation by Raynald Malec (1)
R-8	Presentation by Raynald Malec (2)
R-9	Documents in support of the presentation by Danielle Descent
R-10	Final report of the summit on addictions
R-11	Paper by Marcel Lortie (Alicia Grace Sandy)
R-12	State of the situation on suicide in communities PN 2016-06-23
R-13	Summary document by Carynne Guillemette
R-14	Documents in support of representations by Mtre. Jean-François Bertrand (R-14.1 to R 14.15)
R-15	2016-2021 strategic plan, social services sector of the Uauitshitun centre
R-15.1	Improved approach to prevention, child and family services (2015-2016)
R-16	Document in support of representations by Mtre. Caroline Neveu
R-16.1	May 21, 2016 article from the National Post

** Where applicable, interested parties will receive, at the earliest opportunity, any updates done further to the addition or modification of exhibits.*

APPENDIX 3

This section was prepared to help situate the reader geographically and demographically, and to qualify certain terms and expressions used in the report.

There are nine Aboriginal communities in the region known as the Côte-Nord (North Shore), which are also called “reserves”. They are described here in relation to Ville de Sept-Îles.

To the extreme west is Essipit (208 inhabitants), located near the town of Escoumins. Approximately 284 kilometres west of Sept-Îles is Pessamit, an Innu community of 2900 inhabitants.

Uashat Mak Mani-Utenam is located within the limits of Ville de Sept-Îles, and is an Innu community of approximately 3400 inhabitants. The reserve is divided into two parts: Uashat, in the western section of Sept-Îles, and Mani-Utenam (Maliotenam), located 16 kilometres to the east of Sept-Îles. Both are governed by the same Band Council.

Continuing east, Mingan, an Innu community of 470 inhabitants, is 200 kilometres from Sept-Îles, then there is Natashquan, an Innu community of 850 inhabitants, which is 369 kilometres from Sept-Îles. On the Basse-Côte-Nord (Lower North Shore), there is La Romaine, approximately 465 kilometres east of Sept-Îles, an Innu community of 1050 inhabitants, and last, Pakuashipi, an Innu community of 350 inhabitants located approximately 550 kilometres east of Sept-Îles. There is no overland road to the two last reserves, so it is necessary to go by plane or boat.

Matimekosh, an Innu community located near Schefferville, is 500 kilometres north of Sept-Îles. A little further north is Kawawachikamach, a Naskapi community of approximately 640 inhabitants who speak Naskapi, with English as their second language. The only way to get to Matimekosh or Kawawachikamach is to travel by plane or train (the railroad is used to transport iron ore).

This report concerns the Innu community of Uashat Mak Mani-Utenam in particular, where four of the suicides studied by the inquest occurred, and the Naskapi community of Kawawachikamach, concerned by one of the suicides.

The term “Uauitshitun” is used, which is the Innu word to refer to the Aboriginal social services of Uashat Mak Mani-Utenam, services provided by Innu caseworkers and supervised by the Band Council.

As well, the acronym “SPUM” is used to indicate the public safety services of Uashat Mak Mani-Utenam; it is in fact the community’s Aboriginal police force.

The term “protocol” is also used. It refers to the intervention plan adopted by the community of Uashat Mak Mani-Utenam when it must intervene in crisis situations, which include a suicidal crisis and a suicide itself. This protocol, which has been in effect since 2012, was developed by the front-line services at the Uauitshitun centre. The protocol has

three levels: level 1 when there is a suicide, level 2 when there is a suicide attempt, and level 3, for a suicidal crisis (suicidal comments made by one or more persons).

Levels 2 and 3 provide for preventive follow-up and assistance measures for persons who have made suicide attempts or suicidal comments. Level 1 applies to the family members and friends of a person who committed suicide.

In principle, the protocol applies to the Innu population of Uashat Mak Mani-Utenam only. It was filed in evidence[7] in the case of Charles Junior Grégoire-Vollant, and in its revised version of March 2016.[8]

[7] Crisis intervention protocol for the community of Uashat Mak Mani-Utenam, Exhibit C-6, p. 43.

[8] Summary document by Carynne Guillemette, Exhibit R-13, p. 48.

Pour la vie !

Bureau
du coroner
Québec