Investigation Report

Law on the investigation of the causes and circumstances of death

FOR THE PROTECTION OF HUMAN LIFE

concerning the death of

Joyce Echaquan

2020-00275

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INTRODUCTION

On September 28, 2020, Coroner André Cantin takes notice of the death of Mrs. Joyce Echaquan.

Mrs. Joyce Echaquan died at the Centre hospitalier de Lanaudière following unsuccessful resuscitation manoeuvres. Questions were raised about the quality of the care received by the patient and the inappropriate comments made about her.

On October 6, 2020, the Chief Coroner of Quebec, Me Pascale Descary, ordered a public enquiry into the death of Mrs. Joyce Echaquan, which occurred in Saint-Charles-Borromée on September 28, 2020. I have been appointed to preside over this enquiry, to shed light on the causes and circumstances surrounding this death, to identify the contributing factors and to make recommendations, if any.

On April 28, 2021, Dr. Jacques Ramsay, Coroner, was appointed to act as an assessor at this Inquest.

IDENTIFICATION OF THE DECEASED

Mrs. Joyce Echaquan was visually identified by a relative who was at her bedside at the hospital.

CIRCUMSTANCES OF DEATH

An investigation report from the Sûreté du Québec's Major Crime Section indicates that on September 26, 2020, Mrs. Joyce Echaquan was transported by paramedics to the Centre hospitalier de Lanaudière. Mrs. Echaquan had been suffering from stomach pains in the form of stabbing pain for a fortnight; episodically at first and then in a crescendo, for the past 24 hours.

During her hospitalisation on September 28, 2020, Mrs. Echaquan suffered a cardiorespiratory arrest and resuscitation manoeuvres were initiated by the medical staff, without result. She was pronounced dead at 12:44 p.m.

The Sûreté du Québec handled this case in assisting the coroner.

EXTERNAL EXAMINATION, AUTOPSY AND TOXICOLOGICAL ANALYSIS

An autopsy was performed on September 29, 2020 at the McGill University Health Centre. In his report, the pathologist notes the presence under microscopy of the heart, of characteristic cells, named Aschoff's cells, grouped in clusters forming Aschoff's bodies. This is a very suggestive (pathognomonic) sign of a rheumatic disease, in this case chronic and recurrent (active) rheumatic carditis. This diagnosis was confirmed by a cardiopathologist at the Centre hospitalier de l'Université de Montréal.

The heart is large and his ventricles are dilated, suggesting cardiac malfunction. This is consistent with Mrs. Echaquan's medical history, which includes episodes of heart failure that fluctuate over time. Finally, the pathologist notes engorged and very heavy lungs (over 2000 g),

suggesting that heart failure could be the cause of death. The presence of a defibrillator was noted.

The Laboratoire de sciences judiciaires et de médecine légale conducted the usual toxicological analyses on October 7, 2020. The tests revealed the presence of diphenhydramine, acetaminophen and morphine, all within a therapeutic threshold. Traces of lorazepam, cannabis, duloxetine and metoprolol were also detected.

On 7 January 2021, I requested an additional analysis to contextualize the intake of haloperidol (Haldol®) (an anti-agitation medication). Again, the concentration found in the blood was at a level considered as therapeutic.

ANALYSIS

The death of Mrs. Joyce Echaquan and the public enquiry that followed have caused deep distress to her family and to the Atikamekw community of Quebec. It also harshly confronted Quebec society as a whole.

In this regard, because of the very high emotional toll associated with this tragedy, it is imperative to mention that my analysis is in no way intended to determine the criminal or civil liability of the health care institution or of any individual. Rather, the entire process is intended to seek the truth about the circumstances surrounding Mrs. Echaquan's death and the factors that contributed to it.

The analysis of the events leading up to the death (the factual framework) can be divided into three factual segments: the conclusions of the Sûreté du Québec investigation, Mrs. Echaquan's medical history, and the treatment by the Centre hospitalier de Lanaudière (also known as the " Hôpital de Joliette").

THE FACTUAL OUTLINE

The Sûreté du Québec investigation

On September 30, 2020, Mrs. Echaquan's file at the Sûreté du Québec's Major Crime Investigation Service in Mascouche was seized from them, following the transfer of responsibility from the investigation office of the Joliette MRC.

During the investigation and based on the information obtained from the various witnesses, the Sûreté du Québec concluded that no criminal offence had been identified. Consequently, the file was not submitted to the Director of Criminal and Penal Prosecution.

Mrs. Joyce Echaquan

Mrs. Echaquan is a 37-year-old mother of seven children, of whom she was very proud. She is described by her partner and family as a loving mother, a religious person and a person dedicated to her community. She loved life and, had it not been for her health problems, would probably have had more children.

Mrs. Echaquan was known to have a significant medical history, including diabetes and severe non-ischaemic cardiomyopathy resulting in heart failure with an ejection fraction (EF)[1] fluctuating at very low values as monitored over the years, i.e. between 38% and 10%. An acetaminophen intolerance was also noted.

Care by the Centre hospitalier de Lanaudière

Mrs. Echaquan was hospitalised at the Centre hospitalier de Lanaudière between the evening of September 26, 2020 and the early afternoon of September 28, 2020, when she was pronounced dead.

I retained the services of Dr. Alain Vadeboncoeur, an emergency physician at the Montreal Heart Institute, as an expert. His expertise was not contested by the parties. Dr. Vadeboncoeur enabled us in particular, to determine the trajectory of the medical stay and to specify the cause of Mrs. Echaquan's death.

On September 26, 2020, at approximately 11:00 p.m., Mrs. Echaquan arrived by ambulance at the Centre hospitalier de Lanaudière. The triage nurse's initial assessment mentions in her progress note that Mrs. Echaquan had been complaining of intermittent stabbing epigastric pain, non-radiating, accompanied by palpitations and dyspnea (orthopnea) for the last two weeks. The pain is said to be constant at 10/10 since the previous afternoon. She also suffers from nausea and food vomiting after meals and has been eating and hydrating very little for the last two weeks.

Upon arrival, and in order to rule out a coronary syndrome, which can sometimes manifest itself as epigastric pain, an electrocardiogram and a cardiac enzyme test are ordered. These tests are normal. The presumptive diagnoses retained are therefore epigastric pain with a gastric appearance despite an unremarkable gastroscopy just a few weeks ago, and anaemia. Her admission diagnosis was a recently exacerbated microcytic (small red blood cells) iron deficiency anaemia (haemoglobin down from 107 to 81 g/L within a month) and epigastric pain of an unknown cause. A referral was made to the on-call gastroenterologist and Mrs. Echaquan was kept under observation. The gastroenterologist planned to do a colonoscopy the next day to ensure that the cause of the anaemia was not in the large intestine. To do this, the anticoagulant is stopped and a bowel preparation is given. For pain, the analgesia is adjusted.

On September 27, 2020, the gastroenterologist saw Mrs. Echaquan again, as she was showing signs of agitation. A possible withdrawal from narcotics and cannabis was mentioned, but no real use prior to the episode could be demonstrated.

Mrs. Echaquan reportedly said that she had taken medication and been prescribed morphine for similar pain in August of 2019. An antiemetic (Maxeran®), a benzodiazepine (Ativan®), acetaminophen and an opioid (morphine) were prescribed and administered to reduce nausea and symptoms associated with withdrawal and pain.

[1] The ejection fraction refers to the ability of the heart to eject a certain percentage of blood present in its cavity.

The gastroenterologist scheduled the colonoscopy for the next day. In order to determine whether there was indeed a possible disorder related to drug use or withdrawal, a request for a consultation was sent to the Joliette Addiction Rehabilitation Centre. This evaluation, as reported to the doctor on September 28, 2020, concluded that the symptoms described by Mrs. Echaquan were not related to physical withdrawal from opioids or stimulants.

Also on the afternoon of September 27, 2020, instead of a nurse, a candidate for the practice of nursing (CPNP) was in charge of Mrs. Echaquan. Although the diagnosis was uncertain at best, the nursing staff presented Mrs. Echaquan as a patient in withdrawal.

At about 8:00 p.m., the gastroenterologist saw Mrs. Echaquan again , as she was agitated and complained of generalized pain. Despite the medication, the agitation was not controlled. Four-limb restraints and a lap belt were applied. Close monitoring was prescribed. At 10:10 p.m., Mrs. Echaquan was calmer and the restraints were removed. She remained calm until the morning.

On September 28, 2020, at about 7:40 a.m., a patient who is on a neighbouring stretcher asks Mrs. Echaquan if she can borrow her mobile phone to reach her son's school. Mrs. Echaquan is cordial and the two women talk for a while.

At 9:53 a.m., Mrs. Echaquan exhibits agitation and generalized discomfort. She was given 1 mg of Ativan®. At 10:10 a.m., Mrs. Echaquan screams and falls, initially described as intentional by the nursing staff with probable cranial impact. This fall, according to the testimony heard, was more likely to be accidental, due to a sudden movement of Mrs. Echaquan on his stretcher. The doctor was informed of the situation. She prescribed a dose of Haldol ® 5 mg intramuscularly and, if the Haldol ® was not effective, restraints would be used. Mrs. Echaquan was moved from the stretcher to a cubicle with an anteroom and toilet. The Haldol® is administered at 10:25. Sometime between 10:35 and 10:45 a.m., Mrs. Echaquan films herself with her mobile phone and posts the video in real time on the Facebook social network. Two members of the nursing staff were with Mrs. Echaquan at the time. It is understood from the video that Mrs. Echaquan fell off her stretcher again. Denigrating words are spoken by the nursing staff. She was put back on the bed, the intravenous infusion was reinstalled, and then restraints were applied, first to all four limbs, before the abdominal belt was installed. The video is made without the knowledge of the staff on site, except at the very end, and lasts 7 minutes and 12 seconds.

At 11:22 a.m., close monitoring was ordered. However, despite several requests to do so by the CPNP, who had been given responsibility for patient Echaquan, the orderlies were unable to carry out this monitoring. The CPNP therefore carried out visual surveillance through the cubicle window until 11:35 a.m., at which time Mrs. Echaquan's condition deteriorated. The CPNP admitted that there was a discrepancy between the notes in the file and the actual surveillance, as it was completely overwhelmed by the events, which were compounded by a particularly busy day and several other users under its responsibility requiring significant surveillance.

At this point, Mrs. Echaquan is unresponsive and her pulse is barely perceptible at best, despite the fact that the medical record shows 70 beats per minute. She is hardly awake, her pulse is reportedly present and her breathing is regular. What is certain, however, is that from 11:39 and onwards, there is no longer anything regular about her breathing, as evidenced by a second video broadcast in real time on Facebook by her daughter when she arrives at her mother's bedside. This broadcast lasts 10 minutes and 49 seconds and is recorded between 11:39 and 11:49.

At 11:49 a.m., the CPNP belatedly notes that Mrs. Echaquan is unresponsive to pain and notifies the doctor. At 11:45 a.m., the vital signs indicated were "blood pressure 57/35, heart rate 77 beats per minute, oxygen saturation 90% on room air. A transfer to the resuscitation room is requested by the CPNP and the doctor is notified. The room where Mrs. Echaquan is located is equipped to perform resuscitation. There was a delay before the transfer because the room had to be cleaned according to the rules applicable in the context of the health crisis related to COVID-19. At 11:56 a.m., she was transferred to the resuscitation room: Her breathing was shallow, with six breaths per minute, and there was no verbal response. The doctor was at the bedside and the four-limb restraints and lap belt would be removed. At 11:58 a.m., the cardiac monitor indicated an asystole. Resuscitation is initiated. Resuscitation was carried out according to the established procedures, but to no avail, since death was declared by the doctor at 12:44 p.m.

MY FINDINGS

I have listened carefully to all the evidence and, although my investigation must focus on detailing the cause of death and establishing the circumstances, I cannot ignore the context in which the death occurred.

More than 44 factual witnesses were heard. During the testimony of the nursing staff, divergent and sometimes contradictory versions were told. It is in this particular context that I had to base my observations.

As soon as she arrived at the Centre hospitalier de Lanaudière, Mrs. Echaquan was quickly labelled as a narcotics addict and, based on this prejudice, her calls for help were unfortunately not taken seriously. For example, during her stay at the same hospital in August of 2020, Mrs. Echaquan cries a lot and complains that she is not believed when she expresses her pain. The doctor's note is eloquent as it states "she is dissatisfied and has a tendency to manipulate".

When she was hospitalised in September of 2020, once again, this label of drug dependence followed her throughout her stay and guided the actions of the nursing staff until her death. The medical staff even referred to alcohol withdrawal, which constitutes erroneous information. The evidence heard during the hearing also showed that Mrs. Echaquan only consumed narcotics that were duly prescribed and in quantities insufficient to create a dependence. At the time of her admission to the emergency room, no Medication Reconciliation (MedRec) indicating the medications that had been prescribed to Mrs. Echaquan was completed. A completed MedRec would have been an essential working tool to enable the treatment team to properly document Mrs. Echaquan's pharmacology and to act accordingly.

When questioned in turn during the hearings, no doctor or staff member of the Centre intégré de santé et de services sociaux (CISSS) de Lanaudière was able to tell us what Mrs. Echaquan's diagnosis of narcotics dependency was based on. Nor will they be able to inform us of the clinical basis on which this diagnosis is established (apart from the notes in the previous medical file, which date back a few years and have not been reassessed). In the testimony of the gastroenterologist, he will admit that the term narcotics addiction may induce a bias in people's minds. A conversation also allegedly took place between Mrs. Echaquan and another doctor at the hospital. This conversation is poorly documented in the medical file and leads us to believe that Mrs. Echaquan was uncomfortable being relieved with morphine. Indeed, Mrs. Echaquan criticized the health care providers for never resolving her pain and simply sending

her home with painkillers. This is the most likely theory, given the side effects of her last hospitalizations.

When discussing the various diagnoses, the doctor usually uses the question mark when raising an untested hypothesis. It is therefore important, especially for other doctors and nursing staff, to avoid jumping to conclusions, as seems to have been the case with Mrs. Echaquan. A hypothesis must remain a hypothesis until it is validated.

This is the case when the gastroenterologist reports withdrawal due to lack of medication or cannabis use. Mrs. Echaquan reportedly said she had taken medication. During the day, he prescribes morphine and Ativan® and requests that she undergo a colonoscopy the next day. He indicated that she could be discharged afterwards.

In this sense, the consultation with the Addiction Rehabilitation Centre on September 28, 2020, is indicated since it aims to confirm or refute the diagnostic hypothesis. It should be recalled that this evaluation concluded that the symptoms described by Mrs. Echaquan are not related to physical withdrawal from opioids or stimulants.

The day before, on September 27, 2020, at 2.17 a.m., the nurse notes: "advised [*sic*] patient to calm down and wait for medication to take effect [*sic*] [...] agitated on stretcher, crying +++, lyre". When questioned about her choice of words, the nurse told us that we should rather translate this as : "I understand your pain, Madam". The rest of the night was particularly calm.

At 2:18 p.m., Mrs. Echaquan was questioned by the nursing staff about her consumption. It is stated: "Says she uses pot 3 times a day and more, says she has never had withdrawal symptoms. Blames nausea again".

At about 5 p.m., the gastroenterologist is called on his pager by the nurse. The nurse's note states: "...patient has had an episode of palpitations and wants to know if he can prescribe a drug for withdrawal". Although the electrocardiogram taken earlier showed a sinus rhythm which turned out to be normal, her palpitations should probably have prompted greater caution in taking care of Mrs. Echaquan. The medication prescription was also transmitted.

At 7.20pm, Mrs. Echaquan said that she felt unwell, that she was having palpitations again and that she did not want to die.

At around 7.45 p.m., Mrs. Echaquan got up from her stretcher and found herself on the ground. She mentions feeling dizzy. She got up with the help of three staff members. However, no incident or accident report was completed at that time, and no assessment of the pain was made following the fall.

At 19:55, it is noted that Mrs. Echaquan is "cooperating but [is] very theatrical". The words set the tone of the care.

At 20:39, Mrs. Echaquan is agitated. She is placed in restraints. A private orderly service was present at her bedside. At 9:39 p.m., still in restraints, the fluid intake protocol for the colonoscopy was started. At 10:10 p.m., the restraints were removed.

Staff also weighed Mrs. Echaquan when she arrived at the hospital. She was weighed again on September 28, 2020. She weighed 92.2 kg, which is surprising since the day before she

weighed 87.09 kg. She would have gained 5.2 kg in a few hours. The doctor in charge of hospitalizations in family medicine, justified this error by a reference weight recorded the day before, and therefore not real, which is questionable at the very least.

On September 28, 2020, at 8:45 a.m., the gastroenterology resident also saw Mrs. Echaquan, who had tremors, but these did not necessarily seem credible. When questioned about her medical notes, including the fact that she indicated that the patient was narcotics dependent according to the patient's partner to whom she had not spoken to, and the fact that she had taken the trouble to indicate that Mrs. Echaquan had seven children, the resident was not very forthcoming. There is every reason to believe that the resident also drew on the previous notes and also jumped to conclusions too quickly.

In the testimony of the doctor in charge of hospitalizations in family medicine, they explained that the restraint measures were applied at Mrs. Echaquan's request because she starts screaming and getting agitated when she is in withdrawal and no longer feels like herself. I would like to express my doubts concerning this allegation, as it seems absurd to me to imagine a patient asking for restraints.

It should be recalled that the policy on the exceptional application of control measures (restraints, seclusion and chemical substances), adopted on January 28, 2019 by the institution, provides, among other things, that chemical substances, restraints and seclusion must be considered only as a control measure and only as a last resort. In Mrs. Echaquan's case, we note that she was mechanically and chemically restrained and isolated without constant supervision. Moreover, the same policy requires that a record be kept of the use of control measures. This restraint was not documented on the form provided. At no time were alternative measures offered to alleviate Mrs. Echaquan's fears, such as the obvious and simple option of having a member of the Atikamekw community stay at Mrs. Echaquan's bedside. However, this idea of cultural accompaniment never crossed the mind of any member of the hospital's caregiving community, despite the availability and presence in due form of an Aboriginal liaison officer. In doing so, the choice of restraint, supposedly required by Mrs. Echaquan herself, was certainly not an optimal solution in the circumstances.

At around 9:50 a.m., Mrs. Echaquan becomes agitated, screams and moans. The justification for withdrawal was again mentioned. Shortly afterwards, she fell, which a witness first described as intentional, but then changed their mind; the fall could have been accidental. The notes in the medical file still state that "she is theatrical". A few witnesses admitted that colleagues thought she was acting at times during the morning. Mrs. Echaquan has clearly been labelled a difficult patient. It is a prejudice that will remain ingrained in the minds of many staff. For her part, Mrs. Echaquan's stretcher neighbour said she had a front row seat to the lack of humanity of some of the attendants and nurses, telling us that she heard one of them say to her colleagues, "She threw herself to the ground, you know. According to this witness, Mrs. Echaquan screamed that she was afraid of dying. A nurse reportedly said: "Stop shouting, you're disturbing everyone here. We're not in a daycare centre here, we don't manage babies. For this witness, the care is simply devoid of empathy and she doesn't understand why the nurses make fun of Mrs. Echaquan. During the hearings, this testimony provided a clear picture of how care can be provided with a double standard depending on where a patient comes from and with the label they are characterized with.

At around 10:16 a.m., Mrs. Echaquan was still shouting, but she was not struggling and was somewhat calmer. The doctor in charge of consultations and hospitalisations in family medicine

then stated that she had been alerted on her mobile phone. She understood that the patient's screams were due to agitation and not to any pain.

However, without having seen Mrs. Echaquan, she then prescribed chemical restraint with 5 mg of Haldol® and, if necessary, physical restraint with close monitoring. A witness told us that the doctor had initially prescribed a dose of 3 mg, but then changed her mind and told the CPNP: "We'll give her 5 mg to calm her down as much as she needs. Although the dose is not strictly inappropriate, since it is the same dose suggested in the manufacturer's monograph, what we believe to be true is that it is at least questionable. The doctor, by not taking the opportunity to see the patient in crisis in person, also missed a great opportunity to better understand what was causing her patient's erratic behaviour. Instead, she endorsed the judgement of her colleagues and supported a diagnosis of withdrawal that was not supported by any evidence.

Then came the time for the Haldol® injection, at around 10:20. Mrs. Echaquan is calm and even exposes her buttocks to receive the injection. Just before the transfer, Mrs. Echaquan's attitude varied, according to the witnesses. She seems absent. In turn, she is seen repeatedly banging her occiput against the wall, then cradling herself on the stretcher with her legs crossed. She asks for her mobile phone. She no longer screams, but is obviously agitated, possibly suffering.

According to the staff heard during the hearings, this behaviour is worrisome, even frightening to the other patients in the vicinity. Shortly after 10:25 a.m., it was therefore decided to transfer her to alcove 10 and isolate her. At about the same time, Mrs. Echaquan's cousin, who was also under observation in the emergency room reported hearing Mrs. Echaquan say her partner’s name and calling for help.

At around 10:27a.m. after her transfer, Mrs. Echaquan posted her video live on Facebook. The comments speak for themselves. The translation was provided by the Sûreté du Québec:

"Ni cta ni akohikon: It hurts me
Carol pe ntamici : Carol, come see me
Ni taci sa micta mackikikatakoiin: They are overdosing me with drugs
Wipatc tca: Make it quick [...]
3 min 59 s: We'll leave it on the ground for a while, eh.
4 min 21 s: We'll look after you. I think you're having a hard time taking care of yourself right now. But we'll do it for you, OK?
Asti of a thick tabarnouche.
This is better off dead [...].
5 min 25 s: *Patient starts moaning loudly.*
Are you done messing around! Are you done with that... piss off.
Joyce: If you were in my shoes right now.
Hey, you're thick in the head
Joyce: I don't like it when people tell me I'm being silly about it.
Well, you made some bad choices, baby
What would your children think, seeing you like this?
Joyce: That's why I came yesterday.
Well, it's better for stuffing than other things... eh
Especially since it's us who pay for it...
6 min 9 s : *Joyce moans loudly.*
His damn cell phone is there. "

When the nurse realises that the conversations between her and her colleague are being recorded, she grabs the mobile phone and hurries to erase the recording, which is not possible because it has already been broadcast. As for the beneficiary attendant, according to her, her comments should only be seen as benevolent. During her testimony, she defended herself by saying that she had been taught to provoke patients to make them react. In fact, according to her, these were not condescending or reductive remarks, but rather a way to make Mrs. Echaquan feel proud so that she could take charge of her life.

Both would deny having any racial prejudice, one responding that she would have reacted the same way to "a woman on welfare with lots of children". We did hear the apology that the nurse and the orderly made to the family during the investigation. The treatment of Mrs. Echaquan is nonetheless unacceptable. Moreover, the fact that neither of these individuals admitted to having a racist bias raises doubts about whether their introspection was sufficient. The very fact that they did not admit to having a bias is even more distressing, as it illustrates this lack of compassion for a human being.

In the meantime, another beneficiary attendant, who had been made aware of the video, immediately notified the manager that Mrs. Echaquan had filmed employees. The manager then inquired about the situation, but did not fully appreciate it until late in the evening when she was sent the second video, which was recorded by Mrs. Echaquan's daughter. Yet she had also told the nurse earlier in the day not to worry, even though she had seen the video taken by Mrs. Echaquan. The social worker had also informed her of a call from the clinic referring to insults to Mrs. Echaquan, including calling her "thick". She did not seek to investigate the situation with the seriousness required when the events were related to her. When asked about alleged derogatory remarks by staff, the head of the department said that this certainly existed, but that she had not witnessed it. However, a nurse reported that she had informed the head of department in the past that derogatory remarks had been made to a Syrian family who needed

an interpreter, expressing the desire "not to waste too much time with them, [as] they are not from here". No sanctions or investigations were carried out as a result of this denunciation.

In the case of Mrs. Echaquan, had it not been for the video footage, it is likely that this event would never have come to public attention. When the system withdraws defensively into itself, that is the very definition of systemic racism. Systemic racism is insidious. The Commission des droits de la personne et de la jeunesse (CDPDJ) defines [1]it "as the sum total of disproportionate exclusionary effects that result from the combined effect of prejudiced and stereotypical attitudes, often unconscious, and policies and practices that are generally adopted without regard to the characteristics of members of groups prohibited from discrimination. " Although sometimes unintentional, this form of racism has the effect of perpetuating the inequalities experienced by people of indigenous origin. Unfortunately, Mrs. Echaquan is not alone in her experience. Members of the community, including Mrs. Echaquan's brother, have expressed similar fears because of past experiences that were similar. When Mrs. Echaquan's daughter arrives, she films her mother. Mrs. Echaquan is in a five-point restraint. To her eyes, she looks dead. Her testimony is heartbreaking, she tells us: "I will regret all my life that I did not untie her". The video recording allows us to see that Mrs. Echaquan's respiratory amplitude is not perceptible. About a minute into the video, CPNP is seen going to Mrs. Echaquan's bedside. The CPNP tries to get a response from Mrs. Echaquan by calling out to her and gently shaking her shoulder. She takes the vital signs and obviously does not get the expected values, as she tells Mrs. Echaquan's daughter that she needs to make a call to transfer her to the resuscitation room. The CPNP returns two minutes later and takes the vital signs. The CPNP explained, without appearing very convincing, that Mrs. Echaquan's lack of response was due to the medication. In fact, and the expert also concurs, Mrs. Echaquan was in an advanced coma at the time, which required immediate and vigorous treatment.

At about the same time, around 11:35, the gastroenterology resident sees Mrs. Echaquan and her assessment is surprising. The resident introduced herself, as the patient had mentioned that she wanted to leave the hospital before the procedure scheduled for early afternoon. She therefore had to validate Mrs. Echaquan's wishes and, if necessary, have him sign a refusal of treatment. This refusal was of course not signed given Mrs. Echaquan's condition. The doctor's notes indicate: "calm, attached to all 4 limbs, difficult to wake up".

When asked about her assessment, the resident explained that, as she was not the attending physician, her assessment had been cursory. Mrs. Echaquan's daughter had hoped for more, certainly that the doctor would detect her mother's critical condition. In the end, the resident's visit was a blip. She found the atmosphere unpleasant and sought to leave the room quickly. The daughter wanted the mother to be taken care of, and a family member said that they had asked that the situation be taken seriously. The resident translated this conversation as threats from them. When questioned about the threats, the resident was also less than forthcoming, as she had no recollection of what had been said. She did not call the doctor who was responsible for Mrs. Echaquan.
Simultaneously, at about 11:35 a.m., a nurse went to her department head to request a transfer to the intensive care unit for Mrs. +Echaquan. In the meantime, the CPNP called the doctor several times and, when she did not receive an answer, requested her urgently via the central intercom. Several witnesses heard the CPNP's repeated calls to the microphone for medical assistance. The doctor's version that she moved on the first call is simply not credible. The

[1] *Brief to the Office de consultation publique de Montréal as part of the public consultation on systemic racism and discrimination*. November 2019.

evidence showed that the doctor had arrived slightly before or at the same time as the transfer to intensive care. This situation unfortunately shows how the CPNP was left to its own devices and how Mrs. Echaquan's chances of survival were diminishing by the minute. In the end, it was an experienced orderly who took the initiative to force the transfer to the resuscitation room. In her eyes, Mrs. Echaquan was in a critical situation.

Once her death was confirmed, civilian witnesses heard the nursing staff express relief that this patient was no longer an inconvenience. They said that they heard: "Indian women like to complain about nothing, to get stuffed and have children. And it's us who pay for it. At last she is dead."

On October 9, 2020, the head of the department sends an email to the health care team stating that: "...from now on, when you use a 4 limb restraint you must notify the NCA (Nursing Care Assistant). A private service will be requested and to the extent that it cannot be provided, the patient will have to be transferred to intensive care. … Monitoring should be at least every 15 minutes if all 4 limbs are restrained. " This note essentially repeats what was already provided for in the establishment's protocol on restraint measures. It should be remembered that Mrs. Echaquan was not entitled to this monitoring and that her condition was not reassessed by a doctor. Although intramuscular injections in themselves do not require special monitoring, in this case, in the presence of a patient with a well-documented heart failure status, the injection of the antipsychotic drug, combined with the additional physical restraint, required the utmost caution. It is even more surprising to learn that prior to this death, the staff was not familiar with the restraint protocol that was in place at the institution.

The CPNP probably did not have enough clinical experience to understand the risks involved. This was not the case, however, with the experienced nurse who gave the injection. She did not show more caution. Could it be that Mrs. Echaquan's behaviour had clouded her judgement? Without doubt, the comments heard on the recording suggest that this may have been the case. As soon as the injection was given and the restraints were applied, she left for her lunch break without worrying about any possible complications.

The CPNP admitted that the medical notes indicating Mrs. Echaquan's condition were entered late, that they were confusing, and that monitoring was done through the glass of the cubicle because of time constraints. The CPNP was the only one to admit of this major shortcoming in record keeping, while throughout the hearings we witnessed inconsistency between the testimony and what was actually recorded in the file.

The clinical situation could have been reversible if there was :

- Increased monitoring by an experienced nurse was put in place or, failing that, a more rapid transfer to the resuscitation room was made;
- An assessment by the doctor responsible for inpatient admissions in family medicine, had been made using a different approach before authorizing a new sedative;
- Monitoring of the control measure (restraint) had been implemented as prescribed;
- Early recognition of her precarious condition had been detected;
- A protocol for the early launch of a Code Blue existed;
- Early correction of sources of instability had been considered (hypoglycemia, hypotension, pulmonary edema);
- Cardiac *monitoring* and saturometry had been installed.

The autopsy and the expert's report suggest that Mrs. Echaquan died of pulmonary edema. No arrhythmogenic event (which would have been observed on the pacemaker worn by Mrs. Echaquan) was involved. Moreover, no ischaemic event was observed at the autopsy. Therefore, cardiomyopathy must be referred to as the cause of death. Other factors could have been involved, including the hypotension caused by the injection of Haldol® and the restraints that kept Mrs. Echaquan pinned against her stretcher without the possibility of straightening up, a natural gesture when there is an accumulation of water on the lungs. The presence of fluid in the pulmonary alveoli can be responsible for a decrease in the quality of gas exchange, leading to significant breathing difficulties.

Overworked staff

During the hearings, several employees described the work overload, particularly the disparity between the emergency room at the Centre hospitalier de Lanaudière and the emergency room at Hôpital Pierre-Le Gardeur. This disparity is real and well documented. It is therefore not uncommon for employees to have to take time off from their breaks and lunches to provide care. On August 12, 2020, an email from a nurse was forwarded to the head of the department reporting great difficulties for the care staff, including the fact that they do not have time to adequately supervise the CPNPs and that, at this rate, without the necessary staffing, the health of the patients could be compromised. This nurse also informed him that, under these conditions, she no longer wished to do replacement work as an ASI.

On October 29, 2020, the union representatives (FIQ-SIL) once again sounded the alarm by reiterating that the care professional/patient ratios in the ED are inadequate: CPNPs working in the emergency department are placed in situations that do not comply with the *Regulation respecting professional activities that may be performed by persons other than nurses*, the dyads between nurses and nursing assistants are not adequately defined and the care team has expressed to its department head the need for clinical support by having access to clinical monitors. These requests went unheeded under the former president and director general.

Furthermore, on the day of Mrs. Echaquan's death, the occupancy rate at 8 a.m. was 37 stretchers at observation. At 11:00, 42 stretchers were occupied. The ED occupancy rate was

therefore at 112% at 8:00 a.m. and at 127% at 11:00 a.m., which is not unusual for Quebec EDs.

The issue of CPNPs was widely discussed during the hearings. According to the *nursing rule* of the Centre intégré de santé et de services sociaux de Lanaudière (CISSS de Lanaudière), adopted in July 2018, college-trained CPNPs cannot practice in the emergency department. It also notes that, for all levels of education (college or university training), "CPNPs are not authorized to practice in triage, in the shock room and in the ambulatory sector of the emergency department." Management has agreed to bring CPNPs back to the ED in 2019, relying on experienced nurses to support and train their younger colleagues. However, the CPNPs are considered full nurses in the staff planning of this department, which frequently sees unstable patients. In other words, this solution was created to deal with staff shortages, but it also created significant risks for patients in the Centre hospitalier de Lanaudière emergency department. According to a senior management official, the Ordre des infirmières et infirmiers du Québec has endorsed this practice. However, there is no written confirmation of this. This situation alone was a harbinger of things to come.

When the CPNP requested assistance from the assistant head-nurse to provide close supervision of Mrs. Echaquan, the assistant head nurse told the CPNP to find an orderly herself, which the CPNP attempted to do, but without success. The assistant head-nurse never visited Mrs. Echaquan to assess the situation, nor did she offer any support to the CPNP, who had just under four months' experience.

Training and meeting the other

Some of the witnesses heard from the hospital centre, stated that their work environment was free of racism or even derogatory comments. A few ventured towards the opposite, claiming to have heard clear prejudices against the Atikamekw community.

When asked about the mandatory three-hour training they all have to attend, which started after Mrs. Echaquan's death, the employees said that they did not learn anything in particular and that it was not helpful in their daily practice. This is worrying as, since Mrs. Echaquan's death, all testified that the bridges between the two communities had been eroded. On one hand, the Atikamekw community is even more afraid of going to the hospital to obtain necessary care and on the other hand, the caregiving staff is afraid of not being up to the task or that their words will be misinterpreted by Atikamekw patients.

I have not personally viewed the training, but I have had access to the details of the offer of training. I note that the desire expressed by staff for ultra-targeted, concise training relevant to their practice, while legitimate, also reflects a certain paternalism that would like racism to be a simple concept, that can be addressed in the form of capsules before moving on to the next topic. To be detected, racism must be understood as camouflaged in the dominant culture. Saying *Kwei* (greetings) is good, but it is not enough.

In fact, fighting racism and prejudice starts with opening up to the other community. I believe that this was the basis of the three-hour training offered to employees. Perhaps this training could be improved, but looking for shortcuts to sustain the attention of the staff is perhaps indicative of their lack of interest even after they have, individually and collectively, had to deal with the devastating effects of Mrs. Echaquan's death.

Nevertheless, several witnesses asked for awareness training concerning problems faced by Aboriginal women in particular, which would be carried out in collaboration with Aboriginal communities. The Centre hospitalier de Lanaudière had also offered its employees training on cultural safety in 2019, but barely 3% of those invited, mainly nurses, had participated. Surprisingly, the CISSS sends the information to employees at their personal email address. This raises legitimate questions about whether employees are receiving the communications intended for them and whether the associated privacy settings are being respected. This situation is not part of my investigative mandate, but it is nonetheless noteworthy.

An Aboriginal liaison officer from the Atikamekw Nation was also employed by the hospital at the time of the events. Surprisingly, very few employees knew her and no one within the institution had taken her under their wing to help integrate her. With no designated office, she wandered the corridors or waited for requests for support from home. On the day of Mrs. Echaquan's death, despite her hospital card identifying her as a liaison officer, she was denied access to the emergency room even though she was made aware of the situation by a community member. She tried several times to enter the emergency room to be at his bedside. However, since her ID card is not a real employee card, she is denied access. When she tries to make calls to understand the situation, she is told that there is no time to talk to her, and then the discussion is ended, despite the fact that she was the available and appropriate resource under the circumstances. I would even dare to say that she was the only resource that could have made a difference in terms of cultural safety for Mrs. Echaquan.

It must be admitted that this position has given the CISSS a good conscience, but has definitely not been used to its full potential. In reality, the liaison officer is at best an ornament placed on a shelf for show. If more attention had been paid to the fact that Mrs. Echaquan was Atikamekw, not only would the Aboriginal liaison officer have been called in, but her medical file could have been assessed with the cultural dimension associated to the situation. This would have allowed health professionals to better consider the possible implications of her medical condition.

The CISSS recognized that the liaison officer had been left aside and committed to hiring two cultural safety liaison officers. One of these positions has already been filled and the other is still to be filled. This second position will be filled by a person from the Manawan community in order to offer a 24/7 service. The real challenge will be to involve these liaison officers and to make room for them within the institution. Real accountability will be required to reassure the Atikamekw community about the reconciliation process.

In September of 2019, the report of the Viens Commission, the *Public Inquiry Commission on Relations between Indigenous Peoples and Certain Public Services*, was tabled. This report set out some calls to action directed at the CISSS de Lanaudière, including the lack of emergency ambulatory service for Manawan. As indicated by Chief Paul-Émile Ottawa in his testimony, the pandemic occurred a few months after the Viens Commission report, so the community and the CISSS de Lanaudière did not have the opportunity to implement solutions to respond to the report's calls for action. However, the CISSS de Lanaudière had already responded to some of the Viens Commission's calls to action, even before the report was tabled. In fact, pre-hospital transportation (ambulances) for Manawan was put in place, which was a priority for the community.

The hospital's leadership is aware of the gap that has been created. The new president, director - general herself has acknowledged that the gaps between what is conveyed and what is experienced are different worlds unto themselves. It was noted that the CISSS de Lanaudière must take steps to deconstruct prejudice and eradicate discrimination. As stated by some of the factual witnesses and by witnesses from the recommendations component, prejudices and biases towards Aboriginal communities exist at the Centre hospitalier de Lanaudière. These biases can be manifested implicitly through prejudices associated with Aboriginal communities

(drug addiction, alcoholism, large families, unhealthy lifestyles, etc.) or explicitly through inappropriate comments about Aboriginal communities. Unfortunately, these prejudices do not seem to be exclusive to this hospital. They seem to exist everywhere in the Quebec health and social services network, as testified to by Dr. Stanley Vollant and Mrs. Michèle Audette.

Each individual therefore has a personal responsibility and has to question his or her own actions. The staff of the hospital is dedicated and this involvement is felt and recognised. Acknowledging prejudice does not diminish the professionalism of employees. On the contrary, it is when the problem is not recognised that professionalism is called into question.

The hiring of an Atikamekw person as vice-president or deputy director-general, is an important first step towards this reconciliation. The new president and director-general's open-minded approach is an undeniable source of hope for the Atikamekw community and the Lanaudière population in general.

Dr. Stanley Vollant has highlighted the disparities in treatment between Aboriginal communities and native Quebecers. He himself had to fight these prejudices for a long time. He used the image of the red apple on the outside, as the Innu that he is, but white on the inside, as the doctor obeying his caste of affiliation, to illustrate how he sought to deny his own cultural history in order to gain acceptance in the health system. This call to break down the walls of misunderstanding, to train liaison officers, to hold facility management accountable for follow-ups, to increase the number of health care workers in the communities, and to rebuild trust in the health care system resonated during the hearings.

Cultural safety was one of the lines of thought provided by many witnesses, including Dr. Stanley Vollant. However, he felt that it was necessary to go beyond this concept, i.e. to respect culture and differences, but also to learn to communicate and understand the other, independently of their culture and origin.

The Director of Aboriginal Affairs at the Ministry of Health and Social Services (MHSS) indicated during the hearings that cultural safety is clearly a government and a sectoral priority. She also presented the global plan for the implementation of this concept in the health network for 2020-2025, a plan that tentatively started in 2018, but whose work has been more significant since November 2020. During the hearings, we learned that, within the MHSS, individuals are designated to be responsible for Aboriginal issues throughout Quebec. When we consulted the list of these people produced for the public enquiry, we found that, in the vast majority of cases, they are senior executives or their deputies who are responsible for the Aboriginal file among several other files under their responsibility, the exceptions being Nunavik, James Bay Cree Lands and the Naskapi CLSC. Moreover, no plan, however laudable, can succeed without the active participation of Aboriginal communities in its design and implementation. I note that both the MHSS and the CISSS are still largely in the hands of white people. Should we be concerned about this? In 2021, it is obvious and redundant to say that the presence of Aboriginal communities is a prerequisite in the development of all policies and programs that concern them.

That being said, the work of the MHSS is necessarily a sign of hope. This plan shows several similarities to the *Joyce's Principle* proposed by the Atikamekw Nation, without naming or adopting the principle. *Joyce's Principle* aims to ensure that all Aboriginal people have the right to equitable access, without discrimination, to all health and social services and the right to enjoy the highest attainable standard of physical, mental, emotional and spiritual health. In doing so, the MHSS plan aims to put in place a plan with $15 million in funding to implement cultural safety by 2025 in all healthcare settings. The five actions planned between now and 2025 are the implementation of continuous training, the accompaniment of the network's

establishments, the creation of liaison officer positions, services browsers and the overhaul of the complaints review system.

With respect to the complaints process in particular, it needs to be rethought. We understood during the hearings that mistrust of institutions makes it difficult for a person of Aboriginal origin to initiate the complaint process and then to pursue it in a system in which that person does not recognize themselves. In this regard, we should be remember that in recent years, only about ten complaints from people of Aboriginal origin have been recorded at the CISSS de Lanaudière.

In this regard, the MHSS's advisory commissioner for the complaints examination system came to present the law aimed at strengthening the complaints examination system in the health and social services network, which came into force on June 1, 2021. The establishment of an advisory commissioner for Aboriginal issues within the MHSS is one of the interesting avenues put in place to guide local commissioners.

The aim is to continuously improve the quality of services in a non-punitive way. Knowing that written communication is not a common vehicle for Aboriginal communities, the possibility of formulating a verbal complaint is considered. In addition, a position has also been created for an assistant commissioner for complaints and the quality of services offered to the Aboriginal communities of Lanaudière. This person will be responsible for collecting and processing complaints from Aboriginal users in the region and making recommendations to correct problematic situations. This is a significant step forward.

During the hearings, we noted that a certain consensus was emerging both among the experts who came to present the bases of a real social pact and among the chiefs and grand chiefs of the indigenous communities.

Professional orders have come out in favour of the *Joyce Principle*, including the Collège des médecins du Québec. The delegation from the Fédération interprofessionnelle de la santé du Québec also adopted *Joyce's Principle* at its congress, which was held on June 7, 9 and 10 in 2021.

According to Professor Browne, who is a Distinguished University Professor and Scholar at the *University of British Columbia (UBC) School of Nursing* in Vancouver, the literature clearly indicates that the population in any province or territory is affected by racism. Because the health care system is often a focal point, there are many instances of racism, both individual and systemic. This discrimination is documented and it is time to demand strong leadership to put strategies and policies in place in a constructive, non-accusatory manner.

In his testimony, Dr. Samir Shaheen-Hussain went further to say that inaction is the biggest problem in our society and that medical colonialism, which he has already denounced several times, contributed to Mrs. Echaquan's death.

For Mrs. Viviane Michel, President of Quebec Native Women, racism and discrimination kill, as Mrs. Echaquan received poor care because of racist and misogynistic prejudices. In this context, and since this has been noted on a few occasions, if the words did not kill her literally, I can only agree that they were hurtful and humiliating.

The social pact

In the days following Mrs. Echaquan's death, the notion of systemic racism was raised on several occasions and was brought to the National Assembly. This shows how uncomfortable

the population is with the care that is being administered to the Atikamekw community. It is therefore my duty, as coroner, to do everything in my power to prevent a member of the Aboriginal community or of any other origin from receiving care such as that offered to Mrs. Echaquan.

It is no longer time to take stock. We have witnessed an unacceptable death, and we must ensure that it is not in vain and that we have learned as a society from this tragic event. It is no longer acceptable for the greater part of our society to deny such a well-documented reality.

The Viens Commission, well before this death, had called for reconciliation and had warned about the fears expressed by the Atikamekw community regarding the Centre hospitalier de Lanaudière. The Grand Chief of the Atikamekw Nation Council, Constant Awashish, the Chief of the Atikamekw Council of Manawan, Paul-Émile Ottawa and the Chief of the Assembly of First Nations of Quebec and Labrador, Ghislain Picard, reminded us of the importance of cultivating fertile ground in order to build lasting bridges. Although actions have been taken by the government to re-establish this necessary communication, the recognition of a disparity in treatment is fundamental, even vital, to working within a spirit of trust.

It is clear that the road to reconciliation is a long and arduous one. Efforts are all the more necessary, as the findings of this enquiry indicate that Mrs. Echaquan was indeed ostracised, and that her death was directly related to the care that she received during her hospitalisation in September of 2020, and that her death could have been avoided.

The courage in the words aiming at pacifying our relationships with others is crucial. We must have a firm will to name, but without having a cosmetic intent regarding a principle that is so clear: The right of all to goodwill and to living in a free and democratic society, in the hope that every human being deserves the same services with dignity and respect and who above all, deserves to live.

CONCLUSION

Mrs. Joyce Echaquan died as a result of pulmonary edema caused by cardiogenic shock in the context of a diseased heart (pre-existing cardiomyopathy, probably rheumatic) associated with possibly deleterious effect manoeuvres, such as the supine restraint without adequate supervision.

The racism and prejudice that Mrs. Echaquan faced was certainly a contributing factor to her death.

This was an accidental death.

RECOMMENDATIONS

To prevent such a situation from happening again and to protect human life, I recommend :

That the **Quebec government** :

- Acknowledge the existence of systemic racism within our institutions and commit to helping eliminate it.

That the **Centre intégré de santé et de services sociaux de Lanaudière** :

- Ensures that the Manawan liaison officer is effectively integrated into the institution, particularly by involving him/her in the care teams;
- Ensures a collaborative mechanism between the Manawan clinic and the Centre hospitalier de Lanaudière emergency room so that medical information concerning the patient is transmitted in real time;
- Ensures that the notes in the medical record reflect the reality of a patient's care;
- Reviews its nursing and orderly ratios in accordance with provincially recognized standards in order to offer safe services to the population;
- Applies an emergency management model based on the guiding principles of the Emergency Management Guide;
- Maintains periodic training in the facility's code of ethics, restraint measures, monitoring of patients following a fall, and record keeping;
- Rapidly implements training and activities for the inclusion of Aboriginal culture in cooperation with the Manawan community;
- Refines the model of the nurse/practical nurse dyads and ensures that each understands their role.

That the **Collège des médecins du Québec** reviews the quality of the medical acts of the physician responsible for hospitalizations in family medicine and the gastrology resident who provided care to Mrs. Echaquan during her hospitalization in September of 2020.

That the **Ordre des infirmières et infirmiers du Québec**:

- Reviews the quality of the services of the nurses who provided care to Mrs. Echaquan during her hospitalisation from September 26 to 28, 2020;

- Reviews the integration practices of college candidates for nursing practice (CPNPs) in hospital emergency departments across the province.

That the **Ministry of Higher Education** for its educational institutions (colleges and universities) that train doctors, nurses and nursing assistants:

- Includes training in the care of indigenous patients that takes into account the realities of indigenous communities within the school curriculum;

- Establishes along with Aboriginal communities a greater number of internships for both nurses and medical residents.

Montreal, September 8, 2021.

Me Géhane Kamel, Coroner

ANNEX I

THE PROCEDURE

On October 6, 2020, the Chief Coroner of Quebec ordered a public enquiry to clarify the causes and circumstances of the death of Mrs. Joyce Echaquan, which occurred on September 28, 2020 at the Centre hospitalier de Lanaudière.

I was mandated to chair this public enquiry. Dr. Jacques Ramsay, coroner, assisted me as assessor.

From the beginning of the hearings, I recognised as interested persons those who had asked me to do so, namely :

- **Mr. Carol Dubé,** Mrs. Joyce Echaquan's eldest daughter, **Mrs. Maria Wasianna Echaquan Dubé**, her brother, **Mr. Stéphane Echaquan**, her parents, **Diane and Michel Echaquan,** as well as other members of the extended family, who are represented by **M^e^ Patrick Martin-Ménard (Ménard Martin, Attorneys)**;
- Centre intégré de santé et de services sociaux de Lanaudière, represented by **M^e^ Anne Bélanger** (Lavery, lawyers);
- The Fédération interprofessionnelle de la santé du Québec - FIQ, represented by **M^e^ Émilie Gauthier and M^e^ Audrey Limoges-Gobeil**;
- The Syndicat des travailleuses et travailleurs du CISSS de Lanaudière - CSN, represented by **M^e^ Franccesca Cancino** (Laroche Martin, Service juridique de la CSN);
- The Atikamekw Nation Council and the Conseil des Atikamekw de Manawan, both represented by **M^e^ Jean-François Arteau** (Kesserwan Arteau, lawyers);
- Quebec Native Women, represented by **M^e^ Rainbow Miller**.

I was assisted throughout the preparation and the public enquiry by M^e^ Dave Kimpton and M^e^ Julie Roberge, public enquiry prosecutors of the Coroner's Office.

The public hearings took place from May 13, 2021 to June 2, 2021.

I heard 44 factual witnesses and 115 exhibits were produced. The exhibits are public except for those that are prohibited from publication or broadcast under *The Causes and Circumstances of Death Inquiry Act* (preceded by an asterisk in the list of exhibits in Appendix II).

ANNEX II

LIST OF EXHIBITS

Code	Description
C-1	Investigation order
***C-2**	Toxicology expert report
***C-3**	Addendum to the Toxicology Expert Report
***C-4**	Final autopsy report MUHC
***C-5**	Report Dr. Charles Leduc (pathology - CHUM)
***C-6**	Analysis report of the pacemaker-defibrillator
***C-7**	Medical file of the Centre hospitalier de Lanaudière
***C-8**	Medical file Montreal Heart Institute
***C-9**	Medical file - Last hospitalisation before death
***C-10**	Outpatient and Emergency 2020
***C-11**	Hospitalizations April 2020
***C-12**	Hospitalizations January 2020
***C-13**	Consultations summary examinations hospitalizations 2014 to 2019
C-14	Cellular messages (JE) to be translated (SQ report)
C-15	Atikamewk-French translation of text messages
C-16	JE cell extraction ratio (SQ)
C-17	1st live video by Joyce Echaquan
C-18	Atikamewk-French translation 1st video (SQ)
***C-19**	2nd live video (Marie-Wasianna Echaquan-Dubé)
C-20	Facebook Video Recovery Report (SQ)
C-21	List of emergency staff (September 26-28, 2020)
C-22	List of emergency physicians (September 26-28, 2020)
C-23	Hospital sketch (witness Paméla Dubé)

Code	Description
C-24	Sketch of the site (witness M. B.)
C-25	Sketch of the site (witness P. R.)
C-26	Sketch of the resuscitation room (witness C. S.)
C-27	Emergency observation sketch (witness M.-D. F.)
C-28	Sketch (witness Josiane Ulrich)
C-29	Letter (witness Annie Desroches)
***C-30**	Nursing Practice Report 12 January 2021
***C-31**	Management Practices Analysis Report 18 November 2020
***C-32**	Summary report administrative enquiry 12 January 2021
C-33	FIQ-SIL union observation report (Marie-Chantale Bédard)
C-34	Policy Application of control measures 2019-01-28
C-35	Protocol Applications control measures 2019-01-28
C-36	Protocol for the practical supervision of CPNPs
C-37	Regulation on professional acts
C-38	Expert report by Dr. Alain Vadeboncoeur (March 11, 2021)
***C-38.1**	Extracts from the ICM file - Dr. Alain Vadeboncoeur
C-38.2	CV Dr. Alain Vadeboncoeur
C-38.3	Presentation of the expert report
***C-39**	Digoxin analysis report (April 13, 2021)
C-40	Access to care for First Nations - Discussion Paper (AFNQL)
C-41	Emergency Plan - CHDL
C-42	Emergency management guide MHSS and AQESSS
C-43	Presentation of the MHSS
C-44	Testimony and presentation by Mrs. Viviane Michel (FAQ)
C-45	Presentation and testimony of Dr. Annette Browne

Code	Description
C-46	Summary of presentation (Witness Samir Shaheen-Hussain)
C-47	Full text message extraction report
C-48	Complementary text vs. audio messages by SE Martin Pichette #11310
C-49	Order appointing Jacques Ramsay Assessor
*** C-50**	Family meeting on 29 September 2020 (Dr. Thanh)
C-51	Statement by Karine Echaquan
C-52	Commitment 3 CISSS-LAN internal communiqués (October 13 and 14, 2020)
C-53	Commitment 2 Emergency plan by sections
C-54	Emergency plan - Identification of the various areas (white circles for zones C-10 and C-14.2 and black circles for zones C11 and R-4)
C-55	Cultural Security at Atikamekw Nehirowisiw CIUSSS (202010-13-)
C-56	Requests received at the Office of the Service Quality and Complaints Commissioner CISSS-LAN (2017-2021)
C-57	Audio statement (Witness Josiane Ulrich)
C-58	Audio statement (Witness Stéphane Guilbault)
C-59	Mandate as liaison officer (Barbara Flamand)
C-60	Organisational issues - email to manager
C-61	New procedure on restraints
C-62	Recommendations from a health professional witness (Joliette ER)
C-63	Commitment 1: Chronology of Mrs. Echaquan's medical care (September 26-28, 2020)
C-64	Alexandre St-Jean: Training on Atikamekw cultural competencies and security for the CISSS-LAN
C-65	Alexandre St-Jean: Clinical report on Atikamekw cultural competencies and security for the CISSS-LAN
C-66	Specific service agreement between CISSS-LAN and Services de santé Masko-Siwin
C-67	Action plan for service trajectories of the Centre de santé Masko Siwin and CISSS-LAN
C-68	Letter of request for an ambulance in Manawan

Code	Description
C-69	Letter concerning the termination of the Atikamekw interpreting agreement
C-70	Follow-up on the termination of the Atikamekw interpreting agreement
C-71	CISSS-LAN presentation plan
C-72	Translation of the Facebook video by Marie Wasianna Dubé Echaquan (September 28, 2020)
***C-73**	Screenshot of Marie Wasianna Dubé Echaquan's Facebook video (September 28, 2020)
C-74	Presentation of the Advisory Commissioner Mrs. Dominique Charland to the Complaints Review System of the Ministry of Health and Social Services
C-75	Good practices identified by the AFNQL
C-76	Presentation by Dr. Stanley Vollant
C-77	Joyce's Principle - Exhibit filed at the request of the Atikamekw Nation Council and in support of the testimony of Grand Chief / President Constant Awashish
C-78	Presentation Mrs. Michèle Audette (recommendations)
C-79	Presentation Mr. Samir Shaheen-Hussain (SJS Collective)
C-80	Presentation of the Fédération interprofessionnelle de la santé du Québec - FIQ
C-81	Plan for the testimony of Grand Chief Constant Awashich
C-82	Chief Paul-Émile Ottawa's recommendations for the Manawan Atikamekw Council
***C-83**	Commitment 11: Alternative approaches to September 28, 2020
***C-84**	Undertaking 5: Requests for narcotics by Mrs. Echaquan (Extracts from medical file)
C-85	Commitment 19: List of persons responsible for the Aboriginal file at the MHSS
***C-86**	Undertaking 16: Reason for departure of a nurse from the Joliette Hospital
C-87	Commitment 6: Heavy users' binder (Joliette emergency)
***C-88**	Undertaking 14: Form H-223 for the death of Joyce Echaquan
***C-89**	Commitment 15: Letter of employment for a CPNP (Joliette Emergency)
C-90	Joliette Hospital's internal press release on the event of 28 September 2020

Code	Description
C-91	Press release concerning the cancellation of the population forum for the population of Haute-Matawinie
C-92	Press release on CISSS-LAN's invitation to the population of the Haute-Matawinie to a population forum
C-93	Correspondence between the President and CEO of CISSS-LAN and the Chief of the Atikamekw Council of Manawan concerning the death of Joyce Echaquan
C-94	Presentation of CISSS-LAN for Mrs. Maryse Poupart
C-95	Presentation by Mr. Samir Shaheen-Hussain (SJS Collective)
C-96	Joyce Echaquan's family's recommendations to the Coroner
***C-97**	Commitments 7 & 8 (FIQ): Correspondence between a nurse and the manager of the Joliette emergency room and analysis documents on the situation in the emergency room on September 28, 2020.
***C-98**	Commitment 10: Proposed mentoring by a nurse from the Joliette emergency room
C-99	Commitment 17: Letter of invitation to the CISSSLAN population forum -to the Chief of the Atikamekw Council of Manawan (February 28, 2020)
C-100	Commitment 20: Extract from the minutes of the 82^{e} meeting of the CISSS-LAN Board of Directors (March 8, 2021)
C-101	Commitment 20: Press release on the union of the CISSS-LAN and the Atikamekw Council concerning cultural security and the reconciliation committee
C-102	Commitment 20: Press release on CISSS-LAN's commitment to the cultural safety of Aboriginal communities (March 10, 2021)
C-103	Commitment 19 (MHSS): List of persons who have held the position of person responsible for indigenous issues
C-104	Email from the Fédération interprofessionnelle de la santé du Québec - FIQ confirming the non-filing of a brief (June 25, 2021)
C-105	CSN email regarding representations (July 1, 2021)
C-106	CISSS-LAN written submissions (July 2, 2021)
C-107	Written submissions from Quebec Native Women (July 2, 2021)
C-108	Written representations of the Manawan Atikamekw Council (July 2, 2021)
C-109	Written submissions from the Echaquan family prosecutors (2 July 2021)

Code	Description
C-110	Corrected translation of the testimony of Mrs. Marie Wasianna Echaquan (May 13, 2021)
C-111	Corrected translation of the testimony of Mrs. Pamela Dubé (May 14, 2021)
C-112	Email confirming that the FIQ will not file a brief in support of the representations made at the June 2, 2021 hearing
***C-113**	Commitment 12 (CISSS-LAN): Break schedules for nurses and orderlies (September 28, 2020)
***C-114**	Commitment 9 (CISSS-LAN): Extraction and logging in the "Médurge" system for Joyce Echaquan's stay (September 26 to 28, 2020)
***C-115**	Commitment 18 (CISSS-LAN): Minutes of the Joliette Hospital Management Committee (September 4, 2018)