Aupaluk, QC
J0M 1X0

REPORT TO THE COMMISSION D'ENQUETTE SUR LES RELATIONS ENTRE LES AUTOCHTONES ET CERTAINS SERVICES PUBLICS

From: Martin Scott /Expert Witness
Administrator of the Tumiapiit Justice Committee of Aupaluk

Hello,

I was encouraged to write this report due to my involvement with the Justice Committee of Aupaluk since 2001 and having been a resident and member of several other committees since 1989.

I will begin with two very significant files that I have been involved with. I have already submitted coroner report documents to the Commission team in late August relating to the deaths of two Inuit men in Aupaluk, both involving the police services at the time.

EVENT (two separate incidents of local Inuit men dying due to police action):

The first man, Jimmy Akpahatak, died on October 17, 1992 after Jimmy barricaded himself in the family home and began an armed stand-off, finally involving the SQ SWAT team that was flown in. It is my understanding the stand-off ended when the Mayor gave the SQ permission to shoot Jimmy (his own son) as Jimmy was out of his mind after sniffing and was shooting at random within the community from his house windows. Jimmy was fatally shot as he exited the house while still threatening with his gun. I believe this was the first fatality of a Nunavik resident at the hands of the Surete Quebec police force.

The community is still waiting for some kind of report from the investigating police agency, which I believe was the Montreal Police force. The Coroner's report (# A-60476) signed and dated 1993-05-15 was received after being requested after the following incident.

Secondly, on April 31, 2004, Sandy Salowatseak, died after an armed confrontation with the lone Kativik Regional Police Force (KRPF) officer in town. Sandy was drunk and angry about his wife and children staying somewhere in town due to Social Services placing them for safety reasons. He had threatened to shut off the community power and then to kill people in the dark when the KRPF officer confronted him in the middle of town. Sandy threatened the officer with his gun and they chased each other around the police truck until the officer shot Sandy once and then again fatally when Sandy would not drop his weapon and pointed it at the officer.

At the funeral, the Chairperson of the Kativik Regional Government promised an enquiry as this was the first fatality at the hands of the newly formed KRPF, the regional police force meant to serve and protect the Inuit of Nunavik. Despite my efforts over some years, (as evidenced by a 2008 letter from Sergent [redacted] from Rouyn-Noranda, responsible for District 08, saying the file had been sent to the attention of Capitaine [redacted] in Montreal) the investigative report for this death (I believe to have been done by the SQ) has never been presented to the family, nor the community. The Coroner's report (# A-153479) signed and dated 2006-06-14 was received after being requested sometime earlier.

RECOMMENDATIONS:

In both cases there is still a need for closure for the families and this has been agreed to by different Social Workers over the years, even preparing a plan to support the families before and after such reports would have been presented.

It should be noted that the KRPF did soon after send a resource to interview the community members how they felt about relations with the police and perhaps due to this the KRPF increased the number of officers in the smallest towns from one to two at first and then at least 3 officers for some time now.

The full Coroner's reports (even with disturbing photos perhaps being necessary for the family to be fully aware of the cause of death) along with the findings of the independent police investigations of the incidents, need to be released and presented to the families and community with full support by Social Services providing extra mental health support /counseling resources before-hand to prepare the families, and for as long as needed after the presentations to ensure the health and safety of the families and community members.

EVENT (young woman dying one week after police arrest with subsequent coroner's report # A-184626 / 168406 and Deontology investigation 15-0314):

I am aware that some family members have approached the visiting agents in different communities about the sudden death of Annie Angutinguak. I personally created the deontology complaint at the request of the family after Annie herself approached me just before she died that she wanted to make an official complaint, but we did not get it started before she died suddenly at home after visiting the nursing station in the evening of November 11, 2014.

Annie was arrested and forcefully pulled off an ATV by the police a week earlier on November 4, 2014. She was being driven home by her young teenage son and some witnesses were upset she was not allowed to go home and was obviously hurt by the arresting officers, since she was very overweight and was pulled hard to the ground off of the ATV, landing hard on her back. Another witness claims Annie was physically hurt

again in the police station while being processed before being put into a cell from what he could hear around the corner. Over the next few days Annie was in a lot of pain and eventually was flown to the Kuujjuaq hospital but returned soon after. I also worked at the airport at the time and Annie required a wheel chair as soon as she was helped off the plane because she was in too much pain to walk. It was that day or the next that Annie called me to ask for help to make the official complaint because she was in so much pain and believed it was due to her violent arrest. She then died in her home a day or so later after visiting the nursing station for the pain.

I happened to be in Kuujjuaq just days later and went to the KRPF to explain I would be making a complaint on Annie's behalf. They directed me to the SQ since the KRPF might be under investigation for the incident. My statement (#173-141114-001) to SQ Sargent ██████████ (Badge # ████ was taken on November 14, 3 days after Annie's passing. What is important to note is that the Deontology report (see below) states that my submission of the complaint was months after the incident so the video evidence from the police station was already recorded over and lost, but shouldn't both the KRPF and the SQ have requested a copy of any video evidence when they knew I would be making a complaint or even just because a detainee that had just been in their cell a week earlier had died and it was sure an investigation would take place?

Also to note is that when I mentioned to the KRPF supervisors in Kuujjuaq that time, that Annie had been injured and was in such pain that she had wanted to make a complaint, they seemed to imply that she could have been injured after she was released and might have gotten drunk either in Aupaluk or while she was in Kuujjuaq. This is something they must have already discussed with the officers in Aupaluk for them to try to find other reasons Annie would have been in such pain. For her part, Annie's mother insisted that once she was home the next day, Annie was in too much pain to drink after that either in Aupaluk or Kuujjuaq.

As the Administrator of the local Tumiapiit Justice Committee, I proceeded to make the complaint to the Deontology office on behalf of Annie and her family. As the Secretary-Treasurer of the local Health/Wellness Committee, I was also involved as the family requested an investigation of the nursing station and hospital actions to explain how a young woman in the care of the nursing staff was sent home and died just hours later, after also being sent home from the hospital in Kuujjuaq just days earlier. Other questions involved the fact that witnesses remarked that Annie had too much difficulty getting up and down the stairs to her second floor room at the hospital transit house and that is one of the reasons she requested to go home early. It seems Annie left the hospital without going to her appointment or seeing anyone for a preliminary assessment despite being there overnight. Why wasn't she put in an emergency room bed or on the first floor?

I was present to read the Deontology report (File # 15-0314) to the family. I was also with them earlier in the year during the video-conference with the hospital staff to share the findings of the Coroner's report (# A-184626 / 168406). It seems no internal review at the hospital or health board was ever initiated. In both instances the family was not convinced of the results and I was asked if a second opinion could be sought for both

investigations. I had approached lawyers at Makivik Corporation to help give advice or to lead the process of requesting at least a review of the coroner's findings but they seem to have been too busy to look into this for the past few years now.

RECOMMENDATIONS:

Such serious, tragic events should have more official resources readily available in case the family wishes to challenge the results of a coroner's report. Follow up by Social Services with Inuit counselors for the families should also be standard practice.

Cultural safety practices need to be established in the police force and the health sector, so that drunken behaviour is not assumed to be the norm. Community policing practices could be encouraged where an individual might be allowed to be taken home by a family member instead of being forcibly arrested.

Also some apparent issues in the Deontology report, specifically the lack of video surveillance footage from the police station during Annie Angutinguak's arrest and processing (despite the KRPF and the SQ being officially notified of the request for an inquiry within a few days of the arrest date), need to be addressed. Do all Nunavik police stations have functioning video surveillance that can be accessed up to some months or at least one month after a certain event needs to be reviewed? I believe we were also told the video recorder was not working at the time. These must be functional in every police station.

In the Coroner's report and the hospital and CLSC staff's review of the incident, there seemed to be a defensive attitude by the doctor during the video-conference in response to the family's questions. Should an independent full review of the incident at the hospital and CLSC level have been undertaken instead of just relying on the Coroner's report, so that the hospital and nursing practices might have been reviewed and potentially changed? One suggestion is that if one blood sample had been taken any time during the week that Annie was in pain it should have shown some sign of the infection that led to full sepsis that caused Annie's death and she might have been saved with anti-biotic medication.

EVENT (postponement of files of accused that must travel to court to Kuujjuaq):

The stress that individuals, families, and the community of Aupaluk must endure cannot be underestimated every time the itinerant court requires accused and witnesses to travel to Kuujjuaq for court.

Usually after months of delays, court cases are finally heard that require the presence of community members to travel to Kuujjuaq as no facility able to hold court sessions is recognized yet in Aupaluk. Usually the travel for the court week takes place on Sunday when lawyers are not available to confirm if the clients really need to travel or not.

The majority of cases are postponed and the individuals that travelled to Kuujjuaq on court tickets are sent back home, but not before staying at least one or two nights often without money or food or even a safe place to stay. Many times the clients miss their flights not having any transportation to the airport, or not being sure of their flights and face the hardship of needing to buy their own tickets back home, an average of $250 one way.

Each time someone travels to court they may relive the trauma of the incident or the stress of going to court and facing their charges. Accused must find a place to stay, find food and transportation (while these are provided to witnesses) and all of them must leave their families behind and miss work for the time they are gone from Aupaluk, also stressing the community that may not find replacement workers, disrupting the organization now lacking workers: municipal services, daycare, school, nursing, etc.

Most frustrating is that the vast majority of files are postponed after the people arrive in Kuujjuaq. Accused must pay the lawyer each time they are represented even for postponements and witnesses must usually travel on the same flights as the offenders.

For the individuals that are seen in court and then must return to Aupaluk, they often are rushed in their time with the lawyers, and with the probation officers or clerks that get them to sign the paperwork, indicating that they have understood the conditions and sentences applied to them. When we meet these individuals as a Justice Committee they most often say that they signed the documents in a rush to get out of the court building and have a limited understanding of what they signed. The lack of real time and consideration of their files by the lawyers the clients pay to represent them is a real frustration especially considering the fees that are charged for the very little amount of time that is spent in the lawyer's office and usually without interpretation for clients that have a functional command of English or French but are not really fluent especially in legal or technical terms.

RECOMMENDATIONS:

No one should travel to court from Aupaluk (or Tasiujaq) to Kuujjuaq until their file is confirmed. The court docket for out of town files should be reviewed first thing on Monday with postponements being determined before clients must travel, so that an updated list can be provided to the airline that evening or next day with only confirmed files needing to travel. Or have the week to determine who really needs to travel from Aupaluk and have their court date set for the Thursday or Friday of each court week. This would save hundreds of thousands of dollars on tickets and the reduction in suffering and stress would be noteworthy as it often leads to more incidents by individuals either in Kuujjuaq or before or after the repeated unnecessary travel dates.

In the case of Aupaluk, the previous Municipal office is now available for court hearings and has been offered to the court organizers to consider using it but no-one has responded to this offer sent to Justice Quebec nearly a year ago now. This is an absolute necessity for the court to come to Aupaluk instead of our community members travelling to

Kuujjuaq if at all possible. Some response from Quebec should have been directed to our Justice Committee or our Municipal Council that also wrote a letter to request the court be held in Aupaluk from now on.

If court could be held in Aupaluk, Tasiujaq clients might also be more comfortable coming to Aupaluk for court with many relatives to stay with as well as less chance of getting into trouble in Aupaluk compared to Kuujjuaq.

Also of great importance, time with lawyers and probation officers must be increased for meaningful discussion and understanding of the situations leading to the file and with adequate translation so that clients understand everything they are about to plead guilty or not-guilty to before they appear in court, as well as before signing to indicate they understand their sentence and/or conditions.

EVENT (common incidents for detainees):

There are numerous incidents of detainees having their personal effects lost during transit, especially wallets with ID cards and cash, but also clothing, hearing aids, and other essential items.
The issue of spending weekends or longer in the cell in Aupaluk is concerning due to the lack of resources, the ability to have access to fresh air and exercise, and the lack of good food. Families that want to bring country food or just to visit their loved ones before they are flown away for who knows how long are denied any visits and must see them as they leave at the airport.

Many detainees are forced to wait much longer than the 72 hours maximum before a bail hearing must be heard. A lawyer, [redacted] was to take this to superior court in the file of an individual from Aupaluk on behalf of all Nunavik Inuit but he passed away before completing this effort. In the file, the detainee spent days in the cell in Aupaluk before being transported to the south where she also waited several days in Amos before her bail hearing could be held during the Christmas holidays.

During this and subsequent detentions for the same client, her specific case was also of concern because the client in question was on her period and did not receive her clothes for several days on two separate occassions. On the second time when the husband asked for help from the local Justice Committee and we did approach our contacts at Makivik Corporation Justice Department, the prison workers at Leclerc must have been questioned because they then seemed to deliberately keep the clothing an extra day while they handed out clothing to the other inmates that had travelled the same day as the Aupaluk client. She was told not to complain when they finally gave her the clothes a day later than the others. This same client has indicated that she and other Inuit were treated very badly when they spoke in Inuktitut and even in English, being told that they lived in Quebec and should speak French. This is not the first time we have heard this complaint

from other individuals as a Justice Committee. The client and her husband hope to bring these incidents to the attention of a lawyer if possible.

Other detainees have shared that they do not feel they have proper service from detention center workers, even after writing memos and waiting weeks for medical attention or a response to their other needs. Many facing parole feel they did not have any or enough support before their hearings. In general, programs are not offered in English so the clients have little opportunity to access programs that might otherwise help them learn and improve their personal condition.

RECOMMENDATIONS:

Bail hearings must happen within 72 hours.

Personal effects must be better supervised and assured of arriving the same time as the detainees. The disappearance of ID cards needs to be investigated as it happens often while other personal effects are not lost at the same time.

The language of detainees must be respected, especially English and hopefully Inuktitut can be offered by translators or Inuit case workers in the south.

EVENT (miscommunication due to lack of translation):

This happens so often it must be addressed. Even during the visit of the commission, I received a call for help from the spouse of a detained client, saying someone had called that morning but she did not understand them and she was worried they did not understand her. Sure enough, when I called the number of the parole officer that had called her, the officer was very surprised to hear that the spouse had tried to say that she wanted to be able to speak to her husband and that she wanted him back home as soon as possible. Instead the officer had understood that the husband was calling and threatening her and that she did not want him home, so he had already begun to activate the process of charging the detainee with uttering threats and ensuring he would not be able to call home any more. If I had not been approached or had not called the parole officer in the institution, that detainee would have faced more charges and been cut off from speaking with his family.

RECOMMENDATIONS:

All communications with family members by officials must have access to translation in Inuktitut, especially if they are calling for a routine check on the situation, but even and especially in urgent cases, there must be translation available or the consequences could be drastic due to misunderstanding. This should apply to all communications with detainees as well -even if they have a good use of English or French, it is not certain they will understand or express themselves correctly while they are in a stressful situation.

EVENT (Police officers are young and inexperienced and lack sensitization and orientation to the Inuit community and values)

In Aupaluk we seem to always get the newest, most inexperienced police officer recruits as they are trained in our smallest community first before being transferred to larger towns. These police officers seem eager to prove themselves by making as many arrests and doing as many interventions as possible (stopping youth for trivial things, arresting a man for the possession of one gram of marijuana after using a search warrant for another man staying at his house suspected of having large quantities of alcohol which were not found, etc.) These inexperienced officers seem to use excessive force in their interactions with suspects instead of using family and other resources to help calm and detain the accused. Response times are sometimes slow when situations are urgent and callers' fears are not taken seriously. Victim's needs of getting counseling or medical care are not considered as important as taking statements in some cases.

Also after some police officers stay in Aupaluk for several months and want to stay after becoming familiar with the community members, they are almost always transferred away to larger communities and the orientation process starts over. These officers that chose to stay for 2 or more contracts in Aupaluk become good at community policing and the trust and respect for them is very high, resulting in better involvement in the community and a safer environment than the confrontations that arise with new unknown officers.

This very much applies to nurses, social workers, and YP agents as well.

RECOMMENDATIONS:

All police and other front line workers (nurses, Social Services and YP workers) should have much more extensive orientation and sensitization to Inuit values and community realities before they are placed in Nunavik communities. They should have workshops and exposure to becoming Trauma Informed with a clear awareness of the effects of Multi-Generational Trauma. The concept of community policing should be strived for with officers and front line workers being encouraged to stay in one community for as long as possible to gain the trust of the community and to improve the services that will come with that trust, respect and familiarization with these southern workers and officers.

The KRPF should stop its practice of transferring police officers that prefer to work in a community rather than moving them often before they can become known and respected in a community. The Health Board should encourage the same thing with incentives for workers to stay for as long as possible.

EVENT (family of deaf son feel the need to make a walk for fundraising so they can access better services in the south instead of what is offered locally or in the region):

There is little documentation for this file except that as a member of the Health/Wellness committee, it came to our attention in the winter of 2017 that [redacted], the father of [redacted] who is deaf (born in 1993) was requesting donations from organizations in Aupaluk and Kangirsuk as he was about to embark on a walk between Aupaluk and Kangirsuk (90km) in winter time to raise funds so that he and his wife could take [redacted] to Montreal to get services to help them with their son's situation. The real needs or services were not clearly outlined but the family was obviously frustrated. Their son was beginning to have issues with the law in up-coming court cases and [redacted] did not seem to be able to continue to work with the municipality as a truck driver's assistant.

[redacted] declined to attend, when approached by the Health committee for a meeting. We planned to meet with the family due to the fact that neither of the parents, nor [redacted], had even approached the CLSC Nursing or Social Services staff to request help or services in the past year. When asked why they had not even tried to get help before going on the walk, [redacted] replied that no one could or would help them anyway.

Perhaps this is the result of a complete lack of trust in the services provided by the transient nurses and social workers to the Indigenous residents of Aupaluk?

RECOMMENDATIONS:

Handicapped and special needs patients should be given extra attention for regular or personalized follow-ups instead of potentially falling through the cracks without their needs being met. Designated resources with regular visits for special needs clients must be adequate and available even in our remote region. Trust building must become part of the mandate of the CLSC staff.

EVENT (no women's shelter or drop-in center for youth at risk):

Even the smallest of towns needs a women's emergency shelter as well as a drop-in center for youth that usually walk the streets all night when their home environment is not safe. These resources would greatly reduce the trauma that women and children experience on a regular basis. Counselors at these centers could provide immediate help and also long term follow-up for families of the children that regularly stay over if necessary and to individuals that also use the facilities for shelter when in need.

Men could also benefit from a shelter if they are in need of somewhere to stay that is safer for them and/or their families than for them to stay home.

Perhaps with these resources, most of the YP cases might be avoided.

RECOMMENDATIONS:

Women's shelters, Youth drop-in (overnight) centers, and Men's shelters must all be available in every community, staffed by trained counselors who can offer services on a 24/7 basis. Follow up for families of children that frequent these centers could provide prevention of YP placement of these children.

Programs for men and women, either together or separately for conjugal violence and healthy relationship workshops must become available in every community and would be offered in these shelter/centers by trained professionals that would mentor Inuit to eventually replace them. These specific programs must be offered to Inuit.

EVENT (Youth Protection placement and then adoption of children):

This is the most serious, wide-spread issue in Nunavik, discussed at every regional meeting no matter which organization is at work.

Too many children are being removed from their families and communities into foster homes that then adopt them in a very short period of time. These fostered and adopted children are lost to their family and community until they are 18, at which time they often return as broken youth that have no connection to their own parents or community and have difficulty re-integrating due to little self-identity.

There is not nearly enough effort or resources to help the parents of these children become healthier families before the youth are permanently removed. Non-family and foster homes are given much more resources to help them raise the youth than the families are given.

RECOMMENDATIONS:

Youth Protection must consider all other options and provide more resources to families before removing children from the community.

Parents and families must be given help and counseling, to improve their situation and to allow them to keep access to their children.

Immediate and extended family should be offered the same compensation for taking care of the children as non-family members are given.

This situation is bigger than the 60's scoop and the government must recognize the potential for lawsuits in the future and should spend the money now to reverse this situation before they will have to pay more as compensation.

Thank you for your attention to my notes and comments of my experiences over the years in Aupaluk. Please let me know what other information or details you would need to have from me before the hearings in November.

Sincerely,

Martin Scott

Administrator, Tumiapiit Justice Committee of Aupaluk

Secretary-Treasurer of the Aupaluk Health/Wellness Committee