An Obligation to Prevent

Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody

January 2023

Foreword: Lost Lives that Must Matter to All of Us

Any death that occurs in the custody of a provincial correctional facility is one too many. The persons who enter custody do so for a wide range of reasons, and at their point of entry they surrender almost all autonomous control over their well-being. They have every reason to expect that those who assume control over so many aspects of their lives will at minimum protect them from harm and unwellness, while also continuously respecting their dignity and their human rights. These individuals matter to their families and friends. Moreover, their well-being and safe return is tied to our entire society's expectations for justice and public safety. Any failure to deliver on these basic promises undermines the confidence of every citizen of Ontario.

Our review examined lives lost between 2014 and 2021 while in the custody of Ontario correctional facilities. In all, there were 186 in-scope deaths during this period, and the trend line has risen dramatically over the period, from 19 deaths in 2014, to 25 in 2019, and 46 in 2021.

Our mandate was not to conduct in-depth inquiries into any specific death, but rather to examine evident patterns, systemic gaps and common factors that can and must be addressed toward improvements that will prevent further deaths in custody and restore healthier conditions for everyone. Nonetheless, each one of the individuals in this tragic sample remained with us throughout our studies and deliberations. We were privileged to learn their names and to get to know some of their personal stories. We met some of their families, we felt the poignancy of their losses and we listened to their enduring shock and disbelief. With very rare exception, almost every life lost in our sample could be deemed a preventable death.

We also met many of the individuals who staff and manage the 25 correctional facilities across the province. This included the policy makers who guide and oversee the provincial corrections mandate of the Ministry of the Solicitor General (SOLGEN), the professionals who interact with people in custody on a daily basis and the labour officials who represent staff interests and career ambitions. We learned of the traumatic impact these lost lives have had on everyone involved. We heard how their growing inability to protect the well-being of many others is undermining their own health, morale and well-being to alarming degrees.

Ultimately, we learned much about a criminal justice system that is struggling to deliver on the basic promises above, and an in-custody reality that in its current state is increasingly both ineffective and unsafe. The picture varies from opaque to astoundingly clear. The solutions range from simple to frustratingly complex.

The need for action is simply compelling and urgent.

Respectfully,
The Members of the Ontario Chief Coroner's Expert Panel on Deaths in Provincial Custody
December 2022

Glossary of Common Terms Used in this Report

Acute drug toxicity — An acute intoxication/toxicity death resulting from the direct contribution of consumed substance(s).

Agency-based nursing staff — Nursing staff who are employed by an external employer outside of the Ministry of the Solicitor General.

Cause of death — The medical cause of death as determined through the death investigation.

Coroner's Inquest — An inquest is a public hearing conducted by a coroner before a jury of five community members to inform the public about the circumstances of a death through an objective examination of facts. At the conclusion of an inquest, the five-person jury often makes recommendations aimed at helping to prevent further deaths.

Correctional Officer — Correctional Officers (COs) work in correctional facilities to ensure the security and custody of persons-in-custody in Ontario correctional centres, detention centres and jails.

Correctional Services — Headed by the Deputy Solicitor General, Correctional Services, Correctional Services establishes, maintains, operates and monitors adult correctional institutions and probation and parole offices.

Correctional Services Oversight and Investigations (CSOI) — Correctional Services Oversight and Investigations (CSOI) is the intelligence and investigative body of the Ontario Ministry of the Solicitor General. CSOI is responsible for providing intelligence support and conducting investigations, pursuant to section 22 of the *Ministry of Correctional Services Act*.

Death in custody/in-custody death — A death that has occurred within a provincial correctional facility, including deaths that have occurred outside of a facility (e.g., at a hospital) where the event or injury leading to death took place within a provincial institution.

Family Support Liaison — The Family Support Liaison (FSL) is a position within the Human Rights Unit of Correctional Services aimed at supporting families in the event of a death in custody.

Federal sentence — Sentences of two years or more, served in federal penitentiaries.

Fixed-term employee	An employee with a non-permanent employment contract that specifies an end date.
Lockdown	A term used to refer to situations where persons-in-custody are locked in their cells as a result of staffing shortages, administrative reasons, or emergency or other security purposes.
Manner of death	The category of death as determined by a coroner. The manner of death is provided as natural, accident, homicide, suicide or undetermined.
Maximum security	The highest level of security within Ontario Corrections. Maximum security correctional facilities and units are designed to house persons-in-custody who present a greater threat to the safety of the public and/or who require a higher degree of supervision while in custody.
Median	The median is the middle value of a data set. This means that 50% of data points have a value smaller or equal to the median, and 50% of data points have a value higher or equal to the median.
Ministry of the Solicitor General	The Ministry of the Solicitor General (SOLGEN) is one of the Ontario government's largest ministries, responsible for the areas of Community Safety, Correctional Services and the Ontario Provincial Police.
Native Inmate Liaison Officer (NILO)	Native Inmate Liaison Officers (NILOs) act to facilitate communication between Indigenous people in custody, their families, institutional staff and other community resources. They develop, organize and coordinate cultural and spiritual programming for persons-in-custody and act as a resource to assist with the admission and release of Indigenous persons-in-custody.
Opioid agonist therapy (OAT)	An evidence-based approach for treating opioid use disorder (OUD), involving the use of oral or injectable medications (i.e., methadone, buprenorphine, or slow-release oral morphine) to prevent withdrawal, cravings or other opioid use.
Opioid use disorder (OUD)	A medical condition associated with cravings for opioids that may lead to chronic use of opioids and behaviours that may interfere with the activities of daily life.

Provincial correctional facility	Provincial institutions that house adults who have been sentenced provincially to a maximum of two years less a day, adults on remand (awaiting trial or sentencing), adults being held for immigration hearings or deportation, and adults awaiting transfer to federal institutions to serve sentences of two years or more.
Provincial sentence	Terms of imprisonment of two years less a day, or conditional sentences of up to two years less a day. Provincial sentences are served in provincial correctional facilities (i.e., correctional centres, detention centres, intermittent centres, treatment centres or jails).
Remand	Individuals on remand are persons-in-custody who are awaiting trial, sentencing or other proceedings.
SAFER	The Security Assessment for Evaluating Risk (SAFER) is a classification tool for evaluating a person's risk for misconduct at the time of admission and throughout their term of incarceration.
Segregation	Any type of custody where an inmate is in highly restricted conditions for 22 to 24 hours or does not receive a minimum of two hours meaningful social interaction each day, excluding circumstances of an unscheduled lockdown.
Sergeant	Correctional Sergeants supervise correctional officers and manage the day-to-day operations within correctional facilities.

Executive Summary

The Province of Ontario currently operates 25 custodial facilities as part of a correctional system that also includes community parole and probation services. These facilities span the province and reflect considerable differences in size, capacity, age and design. For the most part, persons-in-custody are held in maximum security conditions. The average length of stay currently ranges from 48 days for unsentenced persons on court-ordered remand, and 60 days for sentenced individuals. Individuals on remand account for almost 70% of the people in custody on any given day.

During 2014, 19 persons died while in custody in Ontario facilities. In 2021, that number had risen to 46, and the cumulative number of deaths in that eight-year period had reached 192. In January 2022, the Chief Coroner for Ontario initiated the Correctional Services Death Review (CSDR) to examine the 186 of these tragedies where the manner of death was not deemed a homicide. With differences across age cohorts, deaths due to accidental drug toxicity and deaths by suicide featured heavily alongside accidental and natural causes.

The review process included considerable data analysis and research intended to reveal as much as possible about themes and patterns found across the system and in each facility that may have contributed to deaths, and those which may have interfered with or impeded their prevention. In turn, the results of that work were presented for interpretation by a diverse nine-member Expert Panel which convened in October and November. This report summarizes the work of the panel as the members sought to understand and identify practical and actionable improvements. The report includes 18 recommendations for action.

In Part I of the report, the panel sets a foundation for the reader by exploring several defining characteristics of correctional custody in Ontario, and by presenting a cumulative understanding of the in-scope deaths based on several dimensions revealed through the data analysis phase of the review. In Part II, the panel has organized a wide range of factors under five distinct themes. These factors emerged from the data, from additional and important insights gained from 21 contributing delegations and from the panel's own deliberations. Each of these action themes is examined in depth and supported by the available evidence. Informed by these actionable factors, and with a view to preventing further deaths and serious injuries in custody, Part III sets out specific recommendations, including proposed roles, responsibilities and timelines.

Central to these recommendations is the opening-up of a system that currently operates with very little transparency and in isolation from many important perspectives. A more open approach, including greater attention to the lived experience of persons-in-custody, front-line staff, family survivors and other justice and health care partners will better inform and support overall safety and guarantee more humane conditions in all facilities. It will also open more channels for seeking and promoting alternatives to current custody arrangements, with greater reliance on community-based and health care supports that may be more suitable to the complex needs of many of today's persons-in-custody.

Connected to this is a call for improvements in data quality and availability, as well as strengthened oversight and ongoing reviews of correctional practices. Importantly, there must be an enhanced ability to understand and respond to such practices not only as they are set out in policy, but also as they are actually occurring. There is a need to advance a learning culture at every level.

The prevention of further deaths requires the removal of barriers to health care and more reliable standards of quality care on an aggressive schedule. More insights and improvements to the training and competencies of correctional staff are also urgently needed. Taken together, and supported by other recommendations, an important goal is to balance the essential mission of all custody facilities to ensure that care becomes as dominant a priority as security and control.

The final recommendation confronts a hard reality and may call for hard decisions, in the near future. Capacity limitations sit at the core of the unsafe and unhealthy conditions that must be improved considerably if further deaths and serious harms are to be prevented. The frequency of lockdowns and general staffing deficiencies present ongoing barriers to effective care, humane conditions, meaningful programs and the connections to family that are all essential to well-being for those in custody. Security and control alone are inadequate to keeping people safe and to meeting their complex needs. Recovery, life skills and transitional supports must be equal parts in the equation if persons-in-custody are to return to healthier lives in the community.

The panel has determined that over recent years, these conditions have significantly decreased the safety for persons-in-custody. They have also led to alarming deteriorations in the safety, wellness and career satisfaction for the dedicated individuals who work within the current environment of custodial corrections.

The panel recognizes that the health, social and criminal justice evidence, as well as economic realities, may all argue against increasing capacity and infrastructure for custody in Ontario. Alternatives may exist for reducing demand on the system and for safely meeting the needs of individuals who come into conflict with the law in other ways. Within current correctional resources, adjustments to leadership practices, staffing models and new methods to promote system-wide learning might stimulate a range of operational improvements. In turn, such improvements may ultimately reveal greater capacity for supporting persons-in-custody, for operating healthier workplaces and for preventing further deaths.

Finding and mobilizing all such options is an urgent obligation.

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Part I: The Foundations for Our Review and Recommendations

A. Understanding the Current Realities of Provincial Custody in Ontario

For most Ontarians, the images we have formed about incarceration have likely derived from popular media, movies, television and books. Such depictions typically feature stories of hardened criminals serving lengthy sentences, many for unspeakable crimes. Some settle on themes of fear and conflict. Some manage to convey a sort of closed community, highlighting the long-term camaraderie among prisoners, and between prisoners and their familiar guards. Others might showcase institutional efforts to provide meaningful work programs, to support the development of new skills, to restore spiritual and emotional well-being, and to sustain hopes for a smooth transition to independent and crime-free lives.

The situation in our provincial correctional facilities is an entirely different reality. To begin with, the majority of residents have not been convicted of the crime or offense for which they are being held. Only about a quarter of the population on any given day may already be serving a court-determined sentence ranging from a few days to two years less a day, or they may ultimately be convicted of the crimes and provincial offences that brought them into custody. Many will not. Many will be in custody for less than a month.

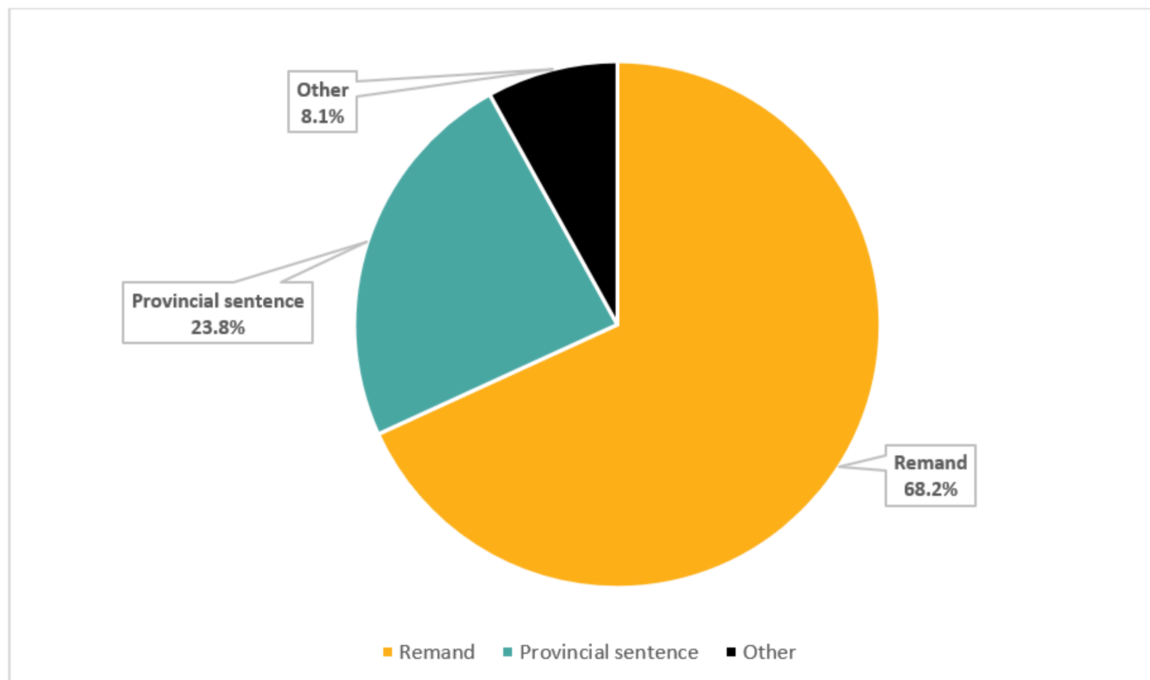

Figure 1 presents the percent of all persons-in-custody in Ontario, broken down by their hold status (see Glossary for definitions). The percentages presented are based on average daily counts and are presented for the combined period 2014 through 2021. Individuals on remand make up the largest proportion of the population (68.2%).

Almost all of them across Ontario will be held in maximum security. While in custody, they most commonly will be referred to as *offenders*.

There is no single prototype by which these individuals might be more accurately described. In this report, we have chosen to avoid the offender label. The residents can alternately be called persons-in-custody, but to be clear, for the duration of their stay, they are prisoners of the state. Their needs and their life experiences are complex and diverse. Many have ongoing substance use disorders. Many have been periodically or chronically unhoused or living in unstable circumstances. Many have suspected and/or diagnosed mental health conditions. Many have been victims of crime, abuse and trauma. Some have done terrible things. Some have exhibited erratic or unpleasant behaviours deemed to be a threat to public safety. Some have merely nowhere else to go. For the most part, all of them will be housed together, but some will spend long periods in isolation if they are deemed to be at risk from others, a threat to others, a threat to themselves, or at their own request.

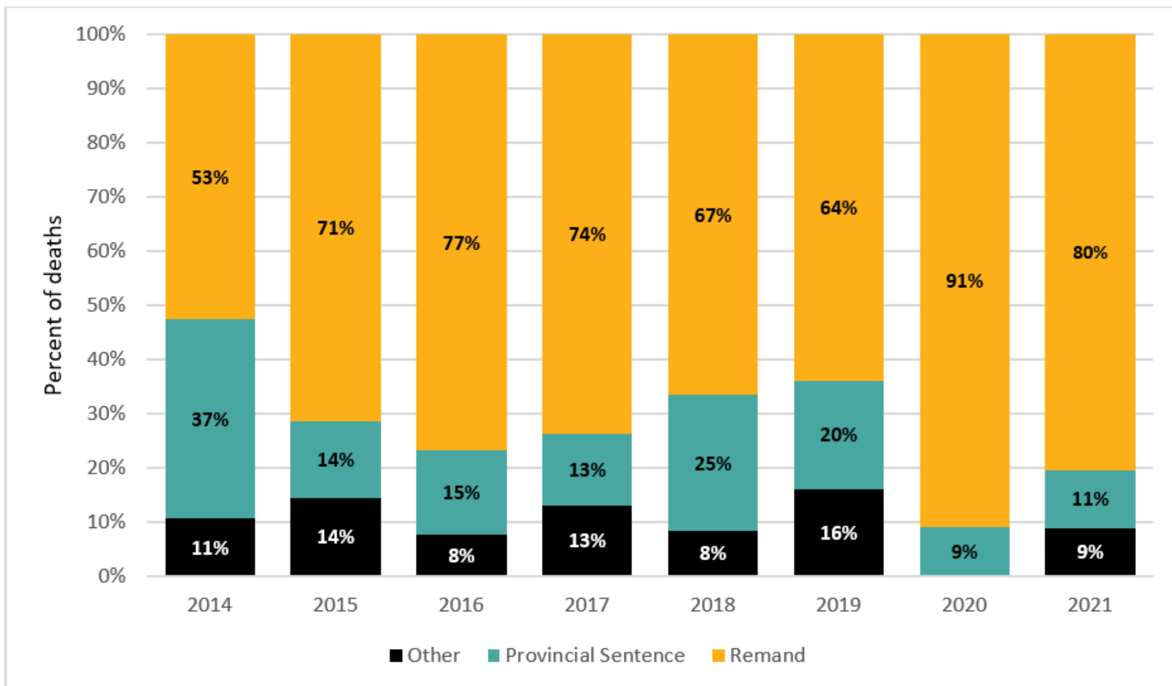

Figure 2 presents the proportion of deaths by hold status. In each year, individuals on remand made up the largest proportion of deaths among persons-in-custody, with the highest proportion in 2020 (91%).

Our panel learned that the catchphrase that is meant to define the duties and responsibilities for most of the staff is *care, custody and control*. By necessity, for the safety of everyone involved, it is control that will mostly define the in-custody experience. Under the current patterns of remand in the Ontario courts, it is care that most of these persons-in-custody require. Under current conditions in Ontario's facilities, we learned that it is care that remains the most elusive, despite the commitment, skills and best efforts of those who are meant to provide it.

We also learned that the dominant term that underpins this sad reality is the term *lockdown*. In those popular prison images we have come to know, lockdowns are usually depicted as an emergency response to unruly behaviour. Only a very small fraction of Ontario's lockdowns are triggered by such events. The vast majority of lockdowns are initiated in response to inadequate staffing. In recent years, the frequency of such events is alarming. The negative consequences are wide ranging for persons-in-custody and their families, and also for correctional officers, health care providers and the essential spiritual, cultural and community supports that are meant to bring care into the custody equation.

In Part II of this report, we will expand on these conditions and others as we outline actionable factors leading to the prevention of deaths and a safer and healthier environment in Ontario's custodial facilities. But we would be remiss if we did not first point out a fundamental misalignment that should be a critical concern to everyone in Ontario.
As it stands, our human services system has all but defaulted to the criminal justice system as the primary path of choice to address persons with complex needs. More specifically, when such individuals act out, or merely present in a manner that is deemed anti-social, disruptive to the public peace, or merely unpleasant to encounter, we expect the police to intervene for everybody's immediate safety. Too often, when other options do not exist, or may exist but in such limited capacity to be of no immediate assistance, the individual is charged and taken to court to answer for their offending behaviour, or in some effort to curtail that behaviour, or simply to remove their offending presence from the community. Very often, it is the same complexity of their needs that renders these individuals ineligible for immediate bail release conditions, and as result, an ever-increasing number are remanded into provincial custody. Many will be released back into the community within a few days, some a bit longer. But, as precluded by the current conditions in our facilities, most will depart with few supports provided in the interim that might have improved their ability to resume healthier and safer lives in the community. Many will return, again and again.

For more than two decades, remand has accounted for all growth in provincial custody numbers, and now represents almost 70% of the in-custody population. The dominant profile of the population has become one of complex needs that require health care, mental health care, addictions treatment and recovery, and transition supports that can facilitate continuity of care and success at living in the community. Almost none of these things can be provided to the required degree in any of our prisons, and most certainly not in a prison where lockdowns due to capacity limitations have become the norm.

It is beyond the scope of our review to resolve such systemic challenges. However, we would offer to those who can, to consider this question. If we are to continue using the criminal justice system to manage people in this manner, is it not incumbent on us all to at least do it well? Or, perhaps more to the point, if all evidence says we cannot do this well, we cannot do it economically and we cannot do this safely, then perhaps the entire system needs to stop thinking we can.

The increasing adoption across Ontario of collaborative models for community safety and well-being represent significant promise for alternative solutions. Such models routinely bring together both the available data and the qualified professionals from health, mental health, addictions support, housing, education, social services, community-based organizations and police working in a more supportive rather than enforcement manner. Under the demonstrated promise of such models, more individuals can be helped in the community and more equitable services can be made accessible and more effective. At the same time, collaborative and proactive solutions can also reduce risks to public and personal safety, clear backlogs in the courts and ultimately, achieve lasting reductions in the temporary custody arrangements that have grown to unmanageable levels in Ontario's prisons. We know that many practitioners in each of these sectors have embraced these opportunities to do things better. We encourage senior policy makers to continue to amplify the importance of these forms of systemic reform.

Within the scope of this review and in this report, our panel will address itself to how corrections officials at all levels can save lives and promote health, well-being and greater humanity to Ontario's correctional facilities, for the benefit of those in custody, and also for the deserving professionals charged with their care, custody and control.

B. Understanding the Deaths in Provincial Custody 2014-2021

This review was initiated in January 2022 by the Chief Coroner for Ontario, Dr. Dirk Huyer. Among the triggering factors was, of course, two years of the COVID-19 pandemic, and questions about how this may have contributed to in-custody deaths. At the same time, an initial analysis showed that the increasing pattern in death rates was already evident in the years before the pandemic struck, and very few of the deaths in 2020 and 2021 had any directly evident connection to the illness. Between January and September, the Correctional Services Death Review (CSDR) team framed out the study to span from 2014 to 2021, and they set out to source the necessary data that might provide insights into any patterns and evident contributing factors. This turned out to be a very difficult task, and that fact alone forms some of our findings and recommendations in Part II and Part III.

It is important to note that coroners across the province have already pronounced on the cause and manner of death in almost all cases in our sample. This review applies a collective lens and seeks answers to one very important question that remains. Why were these deaths not prevented?

Our diverse, nine-member Expert Panel was formed by late September, and we benefitted considerably from the information produced expertly by the CSDR team. Each member was presented with over 150-pages in a briefing package in advance of our working sessions, a package that included a wide variety of analysis dimensions and graphic illustrations, along with a rich narrative built upon seven themes as observed and interpreted by the research team.

The COVID-19 Effect

In the 2020-21 period, there were 66 deaths in custody in Ontario. Of these, two persons died as a direct result of acquiring COVID-19 disease. Our review has determined that these losses alone do not reveal the whole story of the effects that resulted from the pandemic. First, it is commendable that this number remained as low as it has. Like everyone else, corrections staff at every level were required to implement various prevention and response strategies in the context of rapidly changing public health guidance, and to balance community safety and the health and well-being of persons-in-custody and staff while sustaining a secure environment.

Many of these measures unfortunately exposed and worsened some of the most dangerous circumstances we describe throughout this report, including lockdown conditions, periods of isolation, strained staffing, restricted access to health care including psychological and spiritual supports, lack of personal and professional visits, and extreme limitations on supportive programming. It is not surprising that these unusual conditions may have contributed to an increase in the number of people who died in a system that was already operating under considerable strain.

The quantitative data components provided a comprehensive analysis of the 186 in-scope deaths across 25 institutions of varying size and character. The panel was able to examine such dimensions as age, length of custody before death, manner of death, proximity between each death and family visits, programming and health supports in place at the time, and the relative timing of lockdown conditions, among others. Some of the graphics and tables found most useful to the panel's work are recreated throughout this report.

The qualitative data and the resulting CSDR insights were derived from almost 70 interviews with survivors who had lost a loved one, SOLGEN officials, and correctional staff including correctional officers (COs) and health care providers. The panel greatly appreciated the inclusion of personalized commentaries in the briefing package, each highlighting available details of the individuals who lost their lives while in custody. This set the tone for our opening discussions. It became evident that the panel was not solely committed to the policy and procedural aspects of our analysis. Even more so, we pledged to re-humanize the persons who suffered and died as much as possible, to do the same for all current and future persons-in-custody, and to similarly respect the needs of COs, health professionals and others who have been traumatized by every loss.

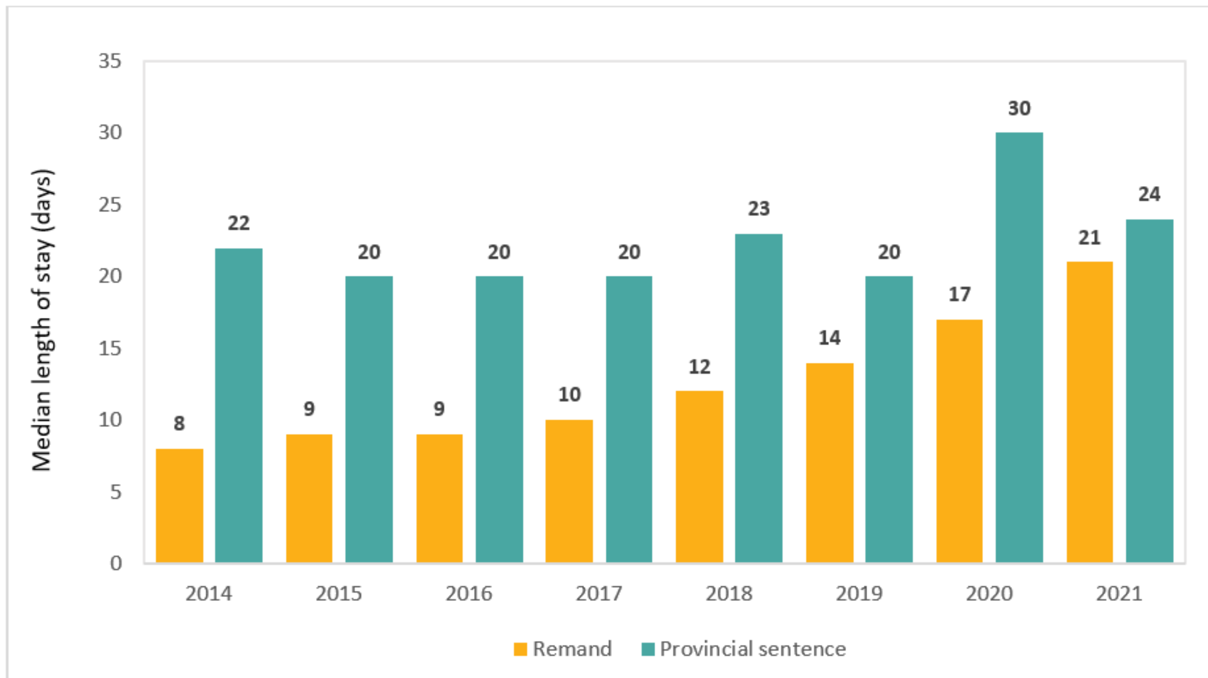

Figure 3 presents the median length of stay in custody (number of days), by hold status. In 2021, for example, the median provincial sentence served was 24 days, meaning that half of the persons-in-custody serving a provincial sentence stayed 24 days or less, and half stayed 24 days or more. The median length of stay for those on remand steadily increased from eight days in 2014 to 21 days in 2021. The median provincial sentence served was relatively stable over the eight-year period with the exception of 2020, when the median was notably higher (30 days).

To build upon the available data and deepen our insights, the panel moderator and the CSDR team worked together through the month of September to identify and schedule a total of 21 delegations who would be invited to provide their informed perspectives to the panel's deliberations. The delegations included (not presented in order of appearance):

- family survivors;
- prisoner advocates;
- ministry officials knowledgeable in health care, prisoner transfer, inquests, finance, information technologies and infrastructure;
- specialists in CO recruitment and training;
- policy specialists;
- investigators;
- health care providers;
- community-based service providers;
- human resource and labour officials;
- labour representatives; and,
- correctional officers.

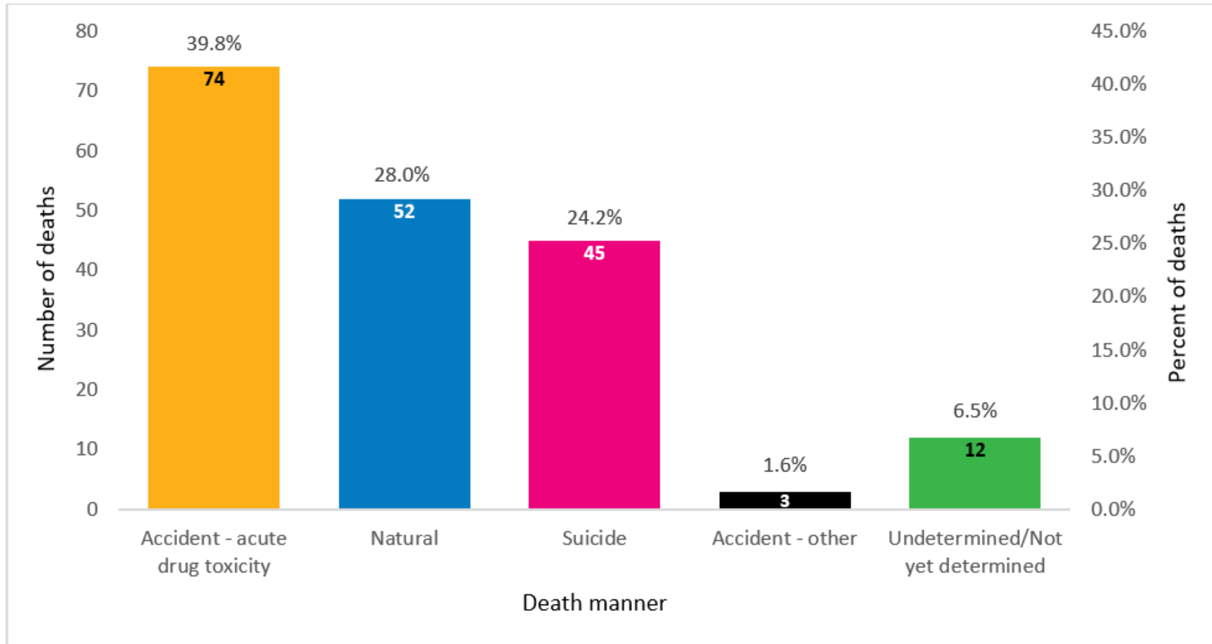

Figure 4 presents the number and percent of deaths, by death manner (see Glossary for definitions). Over the 2014-2021 period, acute drug toxicity deaths accounted for nearly 40% of deaths; natural deaths accounted for 28%, and suicides accounted for 24%.

We would not diminish the importance and value derived from every one of these contributors. However, the panel members all agree that the most impactful for us were the family survivors, and the correctional officers, for some notable reasons.

First, due to a continuing backlog in inquests – which are mandatory upon the death of a person in custody, with some exceptions in the case of natural deaths – and a host of other factors, some of which we bring forth in Part II, families and survivors have generally suffered through a vacuum of information since the deaths of their loved ones. In their conversations with the panel their emotions ran from hurt, to disbelief, to anger, and back. Said one, *"Some of Canada's worst criminals are still alive in prison after 30 years. Our son acted out from a drug problem, and he was deceased within 24 hours of being remanded to your facility. We still don't know how or why he died."* Said another, *"Everyone along the chain knew our daughter had expressed suicidal intentions right up to her transfer and admission. Why was she left alone and unwatched in a cell that included the ready means to end her own life?"*

A Note About Homicides:

In total, there were actually 192 deaths within custody in our study period. There were six deaths where the manner of death was homicide as determined by the coroner's investigations. For reasons related to criminal justice, these are excluded from the scope of the Correctional Services Death Review. However, the panel has addressed its considerations to all conditions that could contribute to unsafe conditions in the correctional facilities.

And one more said, *"Our loved one had been exonerated by the courts and scheduled for release within hours of his overdose death. How and why was he able to access these toxic drugs after several weeks in custody?"* Second, the many collateral impacts of the current conditions in most facilities were finely drawn by the COs with whom we met, who echoed and brought into sharper relief many similar observations provided in the earlier CSDR interviews. We learned of a work environment plagued by absenteeism, low morale, a competitive drive to avoid blame, a severely restricted ability to perform the most important and most career-gratifying aspects of the job, and a prevailing dark cloud of mistrust. Said one, *"I can take prisoner interactions all day long, they are why I still like the job. It is my interactions with my colleagues and managers that is destroying me."* Said all of them as their time with our panel ended, *"Help us, please."*

From our CSDR briefing materials and from our many hours of candid conversations with our delegations, something came very clearly into focus for us as a group. While the central purpose of our work remains focused on a review of the deaths that have occurred, and on the prevention of any further fatal tragedies, there is the potential for us to deliver a much wider scope of impact. The circumstances that have contributed to the in-scope deaths are the same circumstances that are placing every resident and every staff member in an unhealthy and unsafe environment every day. We submit that the extent of the harm from these enduring circumstances is much, much wider and it shows no sign of easing.

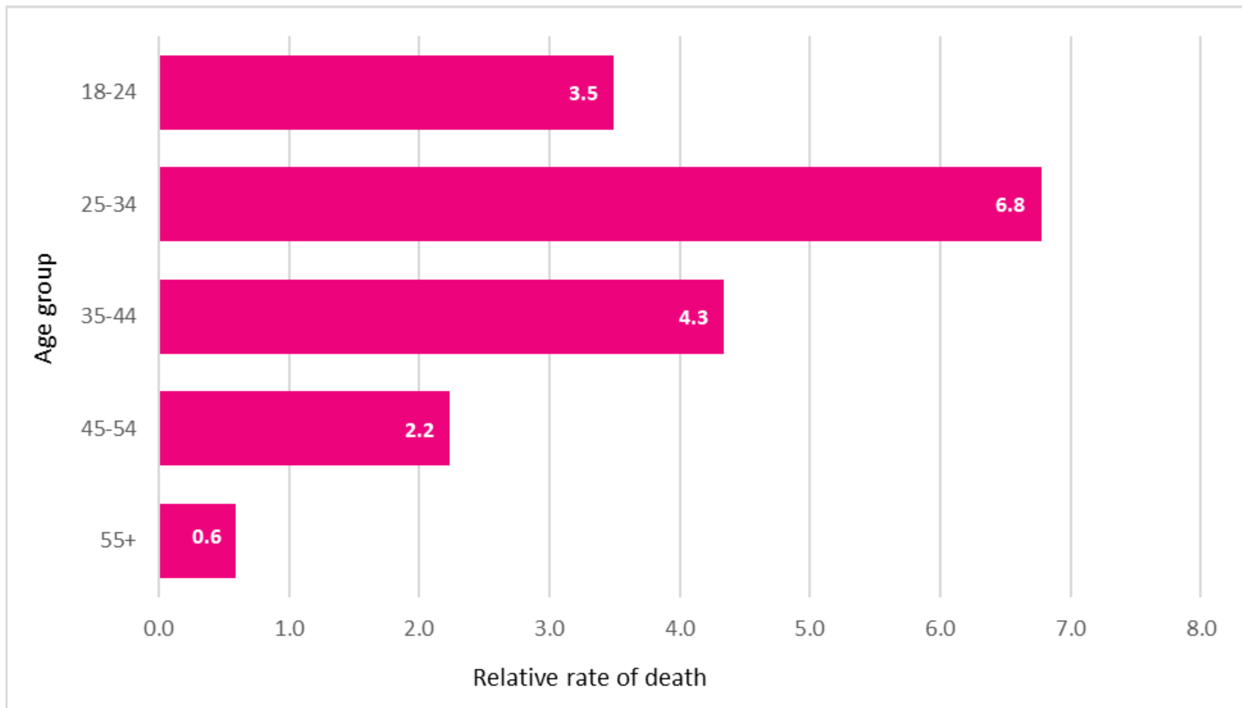

Figure 5 presents the relative rate of death among individuals in custody compared to the general Ontario population, by age group. Among individuals aged 25 to 34 years, those in custody are nearly seven times more likely to die; those 18 to 24 years are 3.5 times more likely to die in custody, and those aged 35 to 44 are 4.3 times more likely to die in custody.

On the other hand, this also means that the dividends and benefits that could derive from actionable solutions are significant and compelling. In Part II, we will discuss the key factors we identified as the most evident contributors to these circumstances. In Part III, we offer several direct recommendations for action. They are not all equal in their scope or complexity, but they are all equivalent in their urgency.

Part II: Actionable Factors Contributing to Unsafe Conditions in Ontario Corrections Custody Facilities

We have organized our observations into five themes as depicted in the illustration below. It is important to stress the interactive nature of these themes, and several of our resulting recommendations will address more than one. Collectively in our view, the conditions described in the following narratives have coalesced to create a corrections environment in Ontario that is fundamentally unsafe, outmoded and misaligned with the aims and modern needs it is intended to serve and support. By addressing each theme separately in the narrative, we hope to make specific actionable conditions clear to everyone with a role to play.

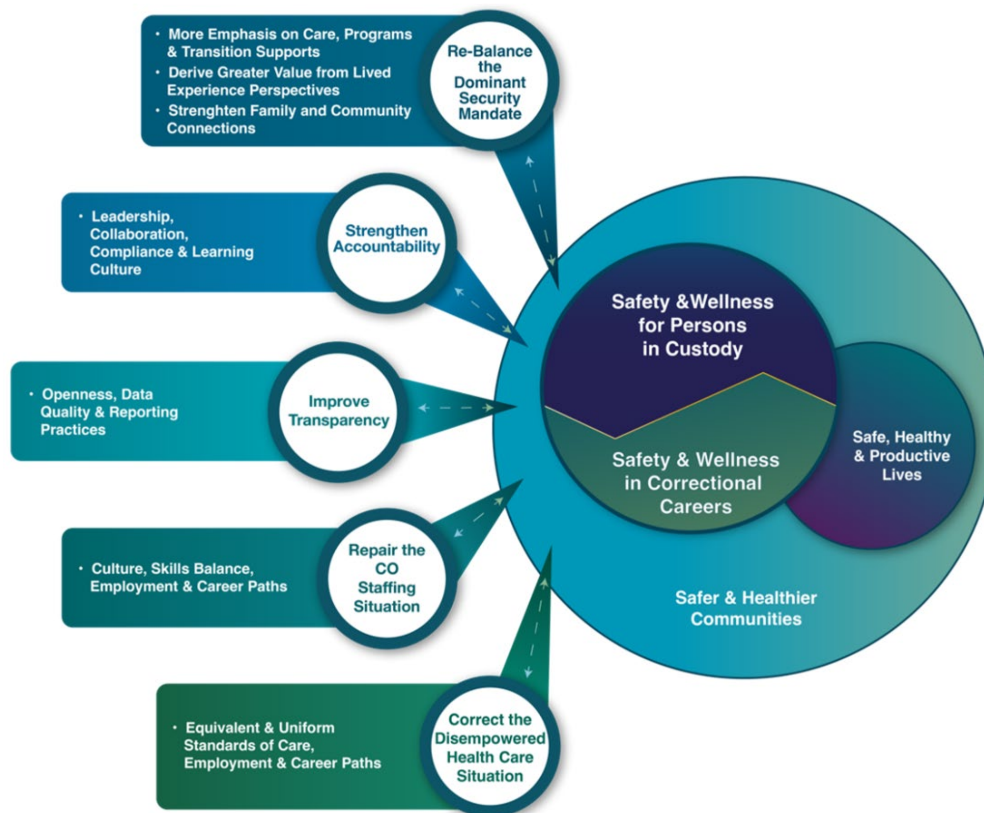

Figure 6 depicts a range of factors currently contributing to reduced safety in Ontario custodial facilities, where key opportunities exist to prevent deaths and serious injuries to persons-in-custody, to improve the safety and well-being of correctional staff, and to support better outcomes across the criminal justice system.

We believe that action is urgently required in every area we have identified. We are grateful to the CSDR team and to all of our contributing delegations for the candor and constructive suggestions that have brought this urgency into clear focus. Among staff and stakeholders, we encountered a common willingness to learn and a shared commitment to act. As such, we are optimistic that with greater clarity and illumination of these issues and concerns, actionable remedies exist and are realistically achievable in the short and medium term.

A. The Mission: An Urgent Need to Re-Balance the Apparent Mandate for Security and Control

As is the case with many of our long-standing institutions, today's public service professionals have effectively inherited systems and workplace cultures with long and deep origins. Such cultures can be reflected in everything from decades-old infrastructure, prevailing language and the myths that help to shape everyday interactions. In turn, they can manifest in the decision-making reflexes of everyone in the system. In corrections practice, Ontario has long pursued more progressive policies, new structural choices and corporate-level decisions designed to reflect evidence-based correctional practice, as has our entire criminal justice apparatus to a large degree. Much progress has been achieved, and this was clearly reflected in the knowledge and attitudes our panel encountered. However, it also appears that too many artifacts of the past continue to dominate the day-to-day reality in Ontario's 25 correctional facilities.

In many ways, fully embracing modern practices is a luxury that can be easily denied to any system that is operating at a breaking point. With little capacity available to managers and staff, systems will often default to a more apparent and so-called mission-critical mandate. This appears to be the case for Ontario corrections, and that apparent historical mandate for custody and control is all but silencing the alternative: a progressive emphasis on care, wellness, supportive programs and effective transitions to living in the community. Unfortunately, this is occurring at a time in our society where these more progressive practices are required more than ever before, and if applied fully, they would be much more compatible with the realities and needs of today's prison population.

We found clear and repetitive evidence of this phenomenon revealed in many ways, just some of which are highlighted below:

- The Default to Maximum Security

  The facilities in Ontario are almost completely configured for maximum security custody, despite the fact that only a small percentage of persons-in-custody have been charged with crimes of violence. This alone transmits a culture where control is the apparent and dominant priority. We were encouraged to learn of the Security Assessment for Evaluating Risk (SAFER), an innovative tool for evaluating a person's risk for misconduct at the time of admission and throughout their term of incarceration. This tool supports staff in

anticipating and mitigating improper behaviour. Some noted the risks of inequities in its applications, and this is an area deserving of attention and improvement.

- Isolation and De Facto Segregation

We understand the infrastructure challenges in changing facility design in short order. But we were deeply concerned to learn that it is actually front-line decisions that can often override even the best attempts to provide the most risk-commensurate environments. Undoubtedly for a host of reasons, the CO staffing levels have fallen to such a critical state that frequent lockdowns are the routine response. When lockdowns occur, programming cannot take place, and health care and spiritual supports as well visitations may also be canceled or interrupted. In addition, capacity limitations often require isolation simply due to over-crowding, for example, when there is no alternate safe space for women or gender diverse individuals introduced into a facility with a general population dominated by men. As noted in the sidebar above, the COVID-19 situation certainly accounted for a sharp increase in similar conditions out of public health necessity. We also learned that the recently updated segregation policy is often circumvented by lockdowns and other short-term operational reasons. This policy is designed to limit and track placements of persons-in-custody in highly restricted conditions for 22 to 24 hours or persons-in-custody that do not receive a minimum of two hours of meaningful social interaction each day.

- An Imbalance in CO Training Priorities

To the extent that we were able to learn about curriculum, it was evident that the dominant language tends strongly toward control. Certainly, COs and others fully deserve to put safety at the top, and to acquire the necessary knowledge, skills and abilities (KSAs) required for the management of the most risky and dangerous circumstances. But, absent a broader competency model, and with insufficient capacity and rigour in achieving in-service training compliance, it appears that most COs have only cursory development in the aspects of emergency care, mental health, trauma and violence-informed practices, and other supportive aspects of their modern role requirements. Alarmingly, there also seemed to be little appetite to date to address these learning gaps, and training appeared to us to merit a generally low priority across the system. For unknown reasons, there is little transparency to the entire staff development processes that currently exist, and very little opportunity for others to engage outside of those with direct responsibility for the current training regimes.

- A Consistent Devaluation of Lived Experience, Family and Community Perspectives

When our panel inquired about the active involvement of individuals with lived experience in the scenario-based components of CO training, it appeared we were speaking a foreign language. This occurred again and again in our discussions with delegations and revealed a prevailing attitude that places low priority on including anyone outside of the officials who operate the system. It was evident again in the long information gaps that have frustrated and isolated family survivors, although we were very encouraged by the recent introduction

of the Family Support Liaison position (we offer more on that below). It was evident in the lack of feedback provided from investigations, beyond that which is obligatory and typically restricted to superintendents and their regional directors. It was also evident in the denial of any form of spiritual commemoration of lost lives, inside or outside of the facilities.

- The Unofficial Abandonment of Supportive Programming

It would be unfair for us to assert that programming does not exist. We learned of many valiant efforts to bring supportive programs to persons-in-custody, often in creative and adaptive ways. Much of this programming is delivered by community-based agencies with strong reputations and metrics that validate the quality of their services. However, interruptions to access due to lockdowns, general staff unavailability, fiercely competitive access to suitable gathering spaces, have conspired to reduce program consistency in the extreme. We learned from lived experience contributors that this results in a prevailing experience of boredom. We also learned of a direct connection between that dispiriting monotony and the growing and unrelenting demand for potentially toxic substance use, and we know that the connections between isolation and suicide are already well documented. This extends to include the all-important transition planning that can connect departing persons-in-custody with appropriate community supports and health care continuity. Again, due to capacity limits, these vital connections are routinely sacrificed.

- Punishing Disconnections from Family, Community and Professional Supports

Collectively, the policies, facility designs and current capacity limits have limited both inside and temporary absence visitation and humane family and social connections to a degree that is completely out of step with the expectations of a modern and caring approach to incarceration. While the reasons may be complex, the message this sends to everyone involved is that social interactions and connected relationships simply do not matter. Again, the evidence with respect to suicide, accidental deaths by toxicity and the general unwellness that can lead to early natural deaths overwhelmingly says that this matters a lot. Connections to family, friends and supports are well documented factors that can protect against exacerbating mental health conditions while promoting greater wellness and supporting reintegration. When these connections are as tenuous as they have become in our prisons, health conditions can worsen, and the lack of connection can play into the boredom cycle with tragic results.

In our recommendations in Part III, we identify several immediate steps that if taken together, could solidly establish a new concept-of-operations for Ontario corrections, one that will both improve individual and community outcomes and save many lives in the process. In turn, the broad enculturation of this renewed and re-balanced concept will drive different decisions at every level, from the micro to the macro. As evidenced in other systems and business sectors, this can spur a new level of innovation and creative adaptation, both of which will be required to ensure that long established infrastructure does not remain the sole defining symbol of what matters to us in 21st century Ontario.

B. Accountability: An Urgent Need for More Assertive and Collaborative Leadership, Rigorous Policy Compliance and a Learning Culture

It is always challenging to direct specific observations toward any identified sub-set of the system. We acknowledge from the outset that the individuals who occupy the positions of greatest influence are themselves committed to achieving the best outcomes, and often find themselves restricted by history, by bureaucratic inertia and by the more complex interconnections between their own span of control and other parts of the broader system. It is our hope that our observations and recommendations under this theme might grant greater license to those executives and managers, and perhaps amplify and accelerate the improvements and innovations they have already attempted to advance.

For reasons unknown to the panel, the current model of corrections in Ontario appears to have been left in a somewhat isolated state, where almost all evident accountability is internally focused. While the system accounts for a significant portion of the provincial public service, it seems fair to observe that it receives from senior government only a small fraction of the attention it requires. We view this Coroner's review, as unfortunate as it is, as an opportunity to ensure these lost lives receive the response from the full system that they deserve.

We have identified many aspects of accountability that can and must be strengthened, just some of which are as follows:

- Policy and Practice Gaps

  The isolated state of the corrections system within government as described above appears to be replicated within, much like a set of those decorative nesting dolls, at the ministry level, the regional level, by single institution, and all the way to the level of the range. The data from Correctional Services Oversight and Investigations (CSOI) on deaths and other critical incident investigations reveals astonishing levels of non-compliance with long-established and well documented policies. We were left to wonder if this points to an epidemic of 'going rogue', or if perhaps too many of the policies cited are out of step with operational realities. We also discovered an interesting dichotomy, in which senior executives cite local and regional autonomy as an explanation for non-compliance, or at least varied interpretations of compliance, while local and regional managers commonly cite strict system-wide uniformity as a reason for not implementing creative and innovative solutions. At the front-line levels, this has contributed to a prevailing atmosphere of fear, where no CO wants to be the last doll to be unpacked, the one to whom a policy or standing order breach can be attached, and thus the one left to take sole career responsibility for a long chain of uncertainty and confusion. It would appear that such consequences at the front line can often be immediately career limiting ones. Further up the line, we were unable to detect any notable pattern of consequence, even amid the disturbing pattern of deaths being experienced in recent years. We can only conclude that this is largely due to the diffuse state of accountability that exists.

- Learning Gaps

Among a number of concerns with the foregoing, perhaps the most troubling is the lost opportunity to learn. Within a prevailing fear of blame at the front line, and a prevailing deference to regional and local autonomy at the top, it appears that rarely is anyone engaging in the collaborative deconstructions of critically important events sufficiently to discover and apply valuable learning across the system. We note that, to the extent that learning is being considered, there appears to be a pattern of independent analysis at the Superintendent level, or at most, some accountability at each Regional Director's scope of responsibility. From our consultations, we did not discover any real pattern of system-wide learning, including in the face of CSOI investigations and even Coroner's Inquest results. It does appear that periodically, institutions of similar size and character might share experiences and outcomes, but this also appears to be ad hoc and at the discretion of those managers involved. Ultimately, there is no doubt that important opportunities to improve the safety, care and support to persons-in-custody are being lost. Conversely, a deliberate and coordinated pattern of collaboration across the 25 institutions could unleash a continuous improvement environment, and likely reveal the most intractable barriers to change that are being experienced by the staff and managers in every facility.

- The Role of Leaders in Setting the Tone

Several of the recommendations that are principally connected to our first theme also have direct relevance here. If the system is to embrace and reflect a re-balanced mandate, it will be incumbent on every leader, at each successive level of responsibility, to ensure that this is reflected in their everyday interactions with those who report to them. If a new set of framing principles can be developed, with the benefit of an inclusive approach as we propose in Recommendation # 1 below, then those principles should remain top of mind in every decision and interaction that occurs in the normal operations of each facility.

C. The Data Situation: An Urgent Need for Greater Transparency with Consistent, Open and Reliable Reporting Throughout

Our review's insights into this theme emerged well before our panel began its work. The CSDR research team struggled to access, interpret and apply data sources that ranged from archaic paper methods, to incomplete electronic records, and often illogical reporting patterns. They also encountered organizational units whose responses to their information requests ranged from eagerly cooperative to only tacitly willing. Our visiting delegations helped to further illuminate why some of this might occur. The data quality across the system is well below modern expectations, and it appears that just about everyone involved is aware of this condition.

Beyond the availability and application of quality information, it also became very clear to the panel that across the entire system, there is an evident reluctance to share information.

For the most part, we detected simply a self-protecting or system-protecting *need-to-know* culture, coupled with an evident attitude that very few deserve to know. Again, this appears to extend from senior policy maker levels, to regional and facility mid-managers, and to the front line where COs can serve as open or closed gateways of information, however they might choose. Unfortunately for persons-in-custody, this is a dangerous environment where it has been demonstrated far too many times that what other people don't know, can kill them.

Jointly with the CSDR team, our panel has identified several of the most urgent opportunities for improvement in transparency, data quality and general reporting behaviours, highlighted as follows:

- The Acute Vulnerability of Silenced Individuals

For disempowered individuals, the difference between being heard or silenced rests with others in positions of power and control. In addition, the ability to be heard without fear of retribution, including sometimes violent retribution, is similarly in the control of others. The most cynical reasons we heard for blocking voices from the range is that control and order might necessitate tempering complainers and disrupters. Fair enough, we understand that such situations can apply. But there is still only one gateway available to most, and what if the information being silenced at that gate could contribute to deteriorating health or safety, for the individual and/or for others? Under the current information regimes, it is impossible for us or anyone to provide empirical evidence that blocked information has contributed to deaths, or to what specific degree a more open flow might have saved a life. We can offer with certainty that we encountered a striking gap between what is said to occur on the range, in official records or notes when available, and what is actually happening, based on insights gained from our lived experience and family or advocate sources. To avoid further harm, this gap demands the immediate design and adoption of more reliable and failsafe systems and practices to support the safe flow of information from persons-in-custody to those who need to hear their voices, and those with the ability to act in protection of their health and well-being.

Potential Expansion of the Promising Family Support Liaison (FSL) Role

Our panel was encouraged to learn about the Family Support Liaison position introduced earlier this year. We were impressed by its lead and by the early indications of the unit's value in better serving the needs of grieving survivors and providing much-needed improvement in the flow of information and supports. We also note that the single position is currently tentative, and should it be extended as we would hope, questions remain about the capacity and reach this office alone can attain. We note that opportunities may exist to position the FSL at the centre of a wider network of available resources who can be partially repurposed and deployed to further support these important tasks.

An expanded liaison network could include chaplains, Native Inmate Liaison Officers (NILOs), and community-based organizations already working in the areas of supportive programming and prisoner advocacy.

- Information Gaps at Time and Place of Transfer

With a high proportion of the in-scope deaths occurring within hours or days of admission, it is essential that the hand-off from courts to prisoner transport, and onward to the Admissions and Discharge (A&D) units be both seamless and as free from human error as much as possible. Current systems do not rise to these standards. We learned of free-form paper notes which may or may not be sufficiently complete or accurate, which may or may not survive the transfer process, and which may or may not be read on receipt with sufficient diligence.

- Investigations and the Application of Outcomes and Intelligence

Our panel was encouraged by the continuing investments in the Correctional Services Oversight and Investigations (CSOI) division over the past several years. This is a vitally important function. To date CSOI, which also includes the Ontario Corrections Intelligence Unit (OCIU), has yet to achieve the capacity and scope required. The combined units currently lack sufficient ability to provide data-based evidence to identify trends and deliver analysis, to address gaps in policy and identify training needs, and to provide strategic support to management to mitigate identified risks to safety and security in the 25 institutional settings. Limited CSOI resources are spread thin as they must currently serve both the custodial facilities and the community parole and probation operations of the correctional system. In addition, CSOI does not currently have the necessary access to all relevant corrections databases to support efficient and relevant intelligence dissemination, or to ensure the broadest depth and application of investigative outcomes.

CSOI reports a growing reliance among operational leaders on its findings and data related to such urgent issues as deaths in custody, contraband trafficking, prisoner on prisoner assaults and use-of-force situations. However, the unit requires expanded analytic capabilities and updated technology and information systems to ensure that investigations and intelligence outcomes will lead to improved application of policy and practice in real time and across all facilities. Given the alarming patterns of harm identified through this review, our panel believes that priority consideration should be given to expanding these capacities, and perhaps raising CSOI to the level of a full Inspectorate identity and functionality as recently adopted in the provincial policing system.

- Expanded Capability in the Offender Tracking Information System (OTIS)

It is a reasonable expectation that once an individual enters a provincial correctional facility, at minimum, records of their institutional location, placement and experience in custody will be adequately kept and recorded. Although this is currently viable through the Offender Tracking Information System (OTIS) – the main electronic database used by Ontario Corrections to track individuals in custody – our panel learned from the review team and the delegations that this is not always how it is applied in practice. Due to a mix of issues stemming from technological limitations to operational and procedural barriers,

including a lack of access to OTIS for institutional staff and an absence of quality standards guiding data inputs, information is often incomplete, unverified or otherwise omitted in the electronic database. This jeopardizes the integrity of the information collected and unnecessarily contributes to unsafe situations, for both staff and persons-in-custody.

One gap that was particularly concerning to our panel, raised repeatedly by institutional staff, was the lack of access to OTIS for all staff involved in a person's care (e.g., NILO's, chaplains, etc.) and the alarming level of data that is carelessly omitted as a result. Without consistent access to OTIS to accurately record all provider interactions and program delivery, the benefits and opportunities of OTIS as an information management system are not being sufficiently leveraged. Without a complete picture or understanding of a person's unique situation, it is almost impossible to adequately meet and address their needs. A database such as OTIS can only be an effective information tool if all necessary staff are able to access it consistently and reliably.

For those who do have access to the electronic system, the panel also heard concerns not just regarding the limited information that is available in OTIS, but also regarding the quality of the data that is captured. Quoting one interviewee, *"The suicide flag can be pretty vague. It might say '2001 previous attempt', but it won't have any details. It depends on who is admitting the person, the documents or updates in OTIS, and whether they have more experience with the individual as far as their charges or their medical history."* Our visiting delegations further echoed this by describing an environment in which staff are pressured to adopt a *'less is more'* approach when inputting data into the system, and where information sharing among staff is often determined by rank within the institution.

As the main electronic data source for Ontario Corrections, there is an expectation that this system should be as reliable and free from human error to the greatest extent possible. However, much like the information gaps noted above during transfers, the current electronic database does not rise to the level of quality record-keeping or data standards required for reliable information sharing, analysis or operational management.

It would be beneficial to expand access to OTIS for all front-line staff so that data currently recorded in physical logs can be archived digitally. While there may be issues around data protection to be resolved, OTIS could be utilized to record medical records, with access given to staff under strict confidentiality protocols. In addition, the panel believes that this primary data system must also reflect the balanced mission discussed above, and in that regard, the term *'offender'* should be removed from use in its title.

- Open Access Performance Metrics

Our panel was surprised by the lack of openly available metrics and basic performance and incident data, as discovered throughout the research phase and as further revealed in our deliberations. We note that this apparent bias to not disclose information appears to be out of alignment with the open data philosophies and practices adopted across the Ontario

Public Service. An evident reluctance for transparency, whether by policy, implicit policy, or simply out of historical habit, risks undermining both public trust and employee confidence in the correctional system.

Conversely, as is being exhibited in other spheres including health, public health, education and policing, public-facing information can drive system improvement and innovation in response to concerns and opportunities raised by more widely informed voices. A full analysis of how a more open data posture, and the degrees to which openness can be applied, is beyond the scope of our panel. However, we believe the contributing factors outlined in each of our identified themes would benefit from higher degrees of visibility and from the corresponding drivers for change that such information can generate, and we strongly encourage Ministry action in this direction.

D. Correctional Officer Staffing and Employment: An Urgent Need to Restore Capacity and Advance a Culture for Safety, Care and Employee Wellness

We begin our observations in this section with an acknowledgement that no report of this nature could ever do justice to the complexity and diversity of daily and career-long workplace experience for correctional employees across 25 different institutions. These are careers that require courage, compassion and dedication, attributes that were consistently identified in CSDR interviews, in questionnaires, and in our panel discussions with COs, their labour representatives and the Ministry officials most informed about staffing, training, labour relations and human resources management. Further evidence from the tenure patterns of current officers reveals that many spend the majority if not all of their career within the Corrections system. This indicates their commitment to the mandate and the importance they see in their role in the justice system.

Collectively, they described a lot of positive change that is underway and made it clear that staff are generally proud of their careers and the work they do. As one delegate phrased it, *"There is a lot of work left to be done, but we are on a good road by acknowledging the importance of focusing on opportunities, not deficiencies."* To quote another, *"Systemically, it is hard to do the job to the level we would like to. Correctional officers have the same goals as this Expert Panel: to address the unsafe environment and aspects of harm involved in the system. We would like to see recommendations that can address these concerns."*

Our panel learned again and again that it is impossible to separate the tragic impacts of in-custody deaths. They are tragedies for individuals and their families, and every such event is another traumatic experience for the employees, sadly punctuating their everyday awareness of the risks faced by persons-in-custody and staff in these environments.

For the purpose of this review, we have identified what the panel regards as the most apparent and urgent areas related to staffing, employment and workplace culture, areas where opportunities for greater safety and well-being can be pursued for the benefit of everyone involved. These include:

- Ongoing Short-staffed Conditions are Undermining Morale, Staff Wellness and Safety, Staff Effectiveness and Safety for Those in Custody

Our panel encountered a litany of causes and potential remedies related to the chronic inadequate staffing conditions, but ultimately, the message was that this pattern represents a clear and present danger to everyone, and it is likely among the primary contributing factors to the alarming rise in deaths in custody.

Lockdown type	2014	2015	2016	2017	2018	2019	2020	2021
Staff shortage	75.0%	95.8%	88.6%	81.0%	64.9%	82.1%	82.4%	92.9%
Search	25.0%	3.2%	5.8%	10.6%	20.3%	11.4%	8.2%	3.1%
Health care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	1.2%
Administrative maintenance	0.0%	1.0%	4.4%	8.2%	12.4%	6.5%	6.8%	2.2%
Inmate behaviour	0.0%	0.3%	1.1%	1.4%	2.4%	0.7%	0.9%	0.6%
Local investigation	0.0%	0.0%	0.6%	1.0%	2.7%	0.2%	0.7%	0.4%

*Data are incomplete for 2014 and 2021. Incidents are self-reported, and results should be interpreted with caution. Variations may be the result of incomplete reporting.

Figure 7 shows the various causes that have triggered lockdown conditions across all custodial facilities in Ontario. In the eight years studied, the percentage of lockdowns due to staffing shortages has averaged above 82%.

We note that there are two levers available to senior decision makers, and by extension, to their partners across the criminal justice system and in senior government. One or both of these levers will need to be acted upon, or the unsafe conditions in Ontario custody facilities will most certainly continue, with a high potential to worsen in the years ahead.

The most directly actionable of these levers for the Ministry alone would be to increase staffing levels. There are a host of barriers and counter-indications to relying solely or even primarily on this option. It is already difficult to manage adequate attraction, recruitment, training and deployment at current staffing levels. At the same time, most of the physical environments are similarly stretched beyond capacity. There are few if any indications of an appetite for increasing the correctional services capital or operating budgets. Perhaps most importantly, adding further custodial infrastructure would run counter to emerging best practices in criminal justice and community safety and well-being.

The much more promising option is to act on the demand side of the equation. The second lever would be to systematically reduce the reliance on correctional custody as an over-used solution to those persons who present with complex needs but who also represent minimal and/or otherwise manageable risk to the community.

The panel also recognizes that individuals successfully diverted from incarceration will require adequate community supports and sufficient human service investments across the social determinants of health and well-being. The panel is confident that the literature and

experience indicates that such supports can offer significantly more efficiency and effectiveness, wherever the operating criminogenic factors are minimal enough to ensure safe living in the community.

- Permanent versus Fixed-Term Employment Arrangement Fosters Competitive Dynamics and Increased Turnover

Even without increasing staffing levels, there are additional conditions that can be addressed to increase safety. Notable among these is to place greater urgency on restoring a healthy workplace environment for all employees. The panel determined that the current stratified employment model is contributing to a stressful and unhealthy work environment, and thus heightening operational gaps that can translate to unsafe conditions for persons-in-custody.

We learned of an evident hierarchy and power imbalance that exists at the front-line between permanent employees and fixed-term employees, the latter often existing in a precarious state for several years, and far more vulnerable to punitive action by management as a result. In addition, we learned that the mixing of these two classes of employees on the same range raises risks of inconsistent practice and a significant blame-avoidance scenario where opportunities for important learning are suppressed.

Some Things to Know about Corrections Careers

There are currently just over 7,000 people employed or under contract to the Institutional Services (IS) division of Ontario Correctional Services. IS staff represent the second largest division in the Ministry with 35% of SOLGEN staff. 98% of these employees work at the front lines of 24/7 service delivery. 88% of staff are represented by collective bargaining agreements.

The largest categories of correctional employees are:

- Correctional Officers – 63%
- Correctional Sergeants and Staff Sergeants – 7%
- Nurses – 8%

Additional front-line staff and contract positions include:

- Mental Health Nurses
- Health Care Managers and Coordinators
- Chaplains
- Native Inmate Liaison Officers
- Social Workers
- Psychologists

We heard from employees, labour and human resources representatives that unravelling this staffing model is a complex challenge. But at the same time, all of them indicated it is a defining negative factor in the current CO culture.

- Employee and Labour Perspectives (among others) are Excluded from Active Partnership in Systemic Improvements

Our panel found that from our own experience, when compared to other public service sectors, the custodial corrections system appears to be out of step with cooperative management models that have emerged in the past few decades. First, two separate domains appear to exist, with one representing 'corporate' functional units, and the other being the vast operational environment where the bulk of employees are. There is a sense that these domains often act in isolation from one another. Secondly, within that operational domain, we discovered little evidence of structured engagement arrangements, other than the joint health and safety committee that is a mandated practice in Ontario. Employees and their labour representatives described being isolated from decisions, from information about critical incidents from which learning could derive, and from opportunities to contribute their direct front-line experience to systemic improvements and innovations. Labour representatives have concerns they are viewed by management almost exclusively as a barrier, and not as a willing partner, despite their assertion that any systemic improvements that could benefit the effectiveness and wellness of their members are among their highest priorities.

This is not a universal problem, as we also heard from executives and front-line COs of managers who are open to trying new approaches and who exemplify highly engaged and empowering practices. On a systemic level, however, one employee may have summed it up best, with, *"There is almost never a teaching moment."*

- Training Models Defy Constructive Review

Our panel was not provided with sufficient information about the current training regimes to offer conclusions with any degree of confidence about their scope, effectiveness or appropriateness to the roles of all employees and managers. We have described the general prevailing lack of transparency elsewhere in this report. Nowhere was this more evident than in our attempts to decipher current training and staff development practices. In the research phase of the review, the CSDR team struggled to access and understand the fragmented records that exist, but at best, they were able to determine that significant gaps appear to exist in the compliance and completion levels for in-service learning programs.

In discussions with our delegations, the panel learned that there is a shared awareness of the need for an increased emphasis on mental health, crisis prevention and informed responses to substance use situations. However, it seems that little traction has been achieved to date. As well, we learned of a system that appears to operate without much evaluation of outcomes, feedback loops from the workplace realities, or simple debriefs in the course of learning completion. There is currently no lived experience that we could identify, including in the design and execution of new experiential and simulation components being recently introduced. Moreover, while the ministry retains responsibility

for applied learning in the basic training for COs, theoretical aspects of training have been outsourced to a third-party provider with some oversight provided by the ministry.

Throughout the foregoing section, we have avoided commenting on the routine operational behaviour and practices of COs and other corrections employees. We recognize that toxic attitudes and errant behaviours can and do arise in any workplace. When they arise in the context of a significant power imbalance, there is no doubt that the consequences for persons-in-custody can be inhumane and dangerous. However, we also learned that many COs and their representatives are committed to addressing unprofessional behaviour in the workplace. They are indeed proud of their work, and their commitment and endurance are reflected in an above-normal retention and tenure in corrections careers, as compared to many other sectors. We found the balance of care and security to be genuine in their self-concept, combined with a self-awareness that has staff eager to benefit from higher degrees of training in all aspects of care and harm reduction on the range. In our view, and for the most part at least, staff are trying to do all of these things to the best of their abilities under the very difficult circumstances that surround them.

E. The Health Care Situation: An Urgent Need to Correct the Disempowerment and Establish Stronger Connections to Uniform Standards of Care

This theme is presented last in our report, certainly not because it is the least important, but because in many ways it flips the script on our discussion thus far. Much of the foregoing has examined how custody and control can be managed with greater care. In this section, we examine how that all important care might be better managed within the unique context of provincial custody.

The citizens of Ontario benefit from one of the most progressive and available health care systems in the world. Like all systems it has its imperfections, but most of us have come to recognize and expect a consistently high standard of care. For decades in Canada, this presumptive expectation has become an enduring source of national pride. Persons entering provincial custody do not forfeit their right to health care. Especially today, amid the varied reasons for which we are placing many of these persons into custody, they and their families have every reason to expect that they will continue to have access to excellent, and equitable, health care in custody.

Within the broader scope of this care discussion are the nurses, doctors, psychiatrists, psychologists and social workers, as well as the spiritual and cultural advisors, who collectively represent more than eight percent of correctional staffing and contractual employment. Each of these professionals brings to their work the same standards of practice, ethical guidelines and personal commitment to excellence that they share with their counterparts working in hospitals, clinics, offices and places of worship elsewhere in Ontario. When working inside, their professional roles and effectiveness may be compromised due to the peculiarities and unique challenges of operating in an environment where security and control are usually the dominant considerations.

Our panel heard evidence of many such challenges which have undoubtedly contributed to tragic outcomes, and on which action must be taken if further tragedies are to be prevented. We feature below some of the most apparent and critical opportunities that have shaped our recommendations for action:

- Health Care is an Imperative Too Often Denied

We have discussed the significant impact of lockdowns earlier in this report, and lockdowns are not the only situations that are impeding health care workers from doing their jobs. Often, due to staffing shortages in a particular range, or the emergence of an unsafe incident that has yet to be resolved to everyone's satisfaction, or simply procedural delays in the admissions process, COs may make decisions that restrict access to treatment and supports. These resulting access restrictions can extend to hours, or even to several days. They may also extend to restrictions on off-site medical and professional visits, which may be frequently denied due to similar decisions.

Across our varying delegations, our panel was dismayed to learn of an alarming culture of mistrust between correctional officers and health care staff. Captured succinctly by one delegation, "*We all have one common goal to provide care, but everyone is against each other. We need to be one team. Staff need to be aware of each other's roles and how we work together."* While disentangling this culture is certainly complex, it is a priority that cannot be ignored.

The risk of confusion stemming from mistrust argues strongly for a review of decision-making authorities. Such authorities may be essential to providing expedient health care, more comprehensive and appropriate health assessments at intake, attention to health and well-being challenges for those in isolation, and early access to essential mental health supports. The panel recognizes that some situations may always require decisions in favour of security for the safety of everyone involved, but the evidence suggests that the line between safety and operational convenience is currently difficult to discern, and undoubtedly difficult to navigate. The situations that have resulted in tragedies cry out for much greater clarity in this regard.

- The Nursing Employment Problem

Not unlike the stratified employment problem amongst fixed-term and permanent correctional officers, similar difficulties in retention, recruitment and compensation are contributing to significant staff shortages within correctional health care. Time and again from our delegations and the CSDR team's interviews with staff, health care staffing vacancies and a lack of institutionally based staff were cited as common issues impeding the delivery of health care within provincial institutions. This is a critical issue for a multitude of reasons. Without adequate staffing levels to maintain optimal operations, it is not uncommon for persons-in-custody to experience longer wait times to see health care providers, delays in prescription medication access while awaiting assessment, and an

overall level of deteriorating care for people in custody due to large staff caseloads. Correctional health care staff are being stretched thin beyond their institutional capacity.

Nurses have long been in high demand across the entire health care system in Ontario, contributing to a highly competitive market for hiring and retention. Rates of pay, benefits and working conditions differ across the many workplaces that employ nurses. Employment practices range from full-length careers to often-precarious contract terms and agency-based engagements; the latter nonetheless sometimes preferred by nurses for professional and personal reasons.

When both employment and contract arrangements are mixed within a single organizational environment, this can lead to inconsistencies in practice, challenge reliability in staffing levels and introduce unforeseen consequences in the quality and safety of everyone involved – this is the case in Ontario's custodial facilities. Our panel learned of variations in the level of training between employed and agency-based nursing staff, variations in their real and perceived authorities to make health care decisions, and a continuing challenge to maintain the required complement of the most qualified nurses, including those with adequate knowledge in mental health nursing, in each facility and across the full system.

When asked to consider what might be contributing to the lack of health care staff, we received the same answer, without hesitation, every time: a lack of competitive wages between corrections-based positions and other health environments. Quite simply, compensation and employment conditions within corrections are failing to compete with other health care environments outside of the corrections sphere. Until this competitive disadvantage is resolved, it is reasonable to expect that the issue of health care staffing is unlikely to improve.

- The Misalignment with Provincial Health Practices and Standards of Care

Health care in provincial correctional facilities is overseen and delivered by the Ministry of the Solicitor General. Rather than a model in which health care in provincial custodial facilities is fully integrated with health care in the community, health care in provincial correctional facilities operates in a separate silo. Progressive provincial and local health care initiatives often fail to include correctional facilities in their planning and implementation. Correctional facilities bear their own burden of establishing relationships and procedures with community practitioners and organizations. As a result, health care quality and accessibility are often substandard, and there is a lack of continuity of care for people entering incarceration and upon release.

Like all others across Ontario, persons-in-custody should reasonably expect:

- timely evaluation of medical and/or psychiatric concerns;

- prompt institution of treatment and continuity of care at the currently accepted, evidence-based standards for this province;
- regular and appropriate monitoring for identified conditions – noting that in particular, mental health problems are almost universally chronic and often demanding of care in perpetuity;
- that referrals be made when outside expertise is necessary;
- assistance with anticipated transition to the community (i.e., continuity of care).

Explicit attention is urgently needed to achieve and sustain equity in health care and to align standards of care in custody with community standards. To prevent further tragedies, the mandate of custody and control must never be allowed to diminish or interfere with standards of care, or to undermine the professional obligations and independence of health care providers. There is no provision in any professional regulatory body that allows for, or in any way tolerates, the provision of differing levels of quality or adequacy of health care.

The Pernicious Threat from Toxic Substances

Acute drug toxicity is the most frequently identified manner of death for those who died in custody between 2014 and 2021, accounting for 74 deaths, or approximately 40% of all deaths in the period of study. Our panel has chosen to highlight here two among many complex and actionable factors to prevent further such tragedies.

Achieve Zero Tolerance on Contraband Trafficking

Many procedures have been put in place in attempts to stop the supply of illicit street and prescription drugs from reaching the highly vulnerable prison population. Our review revealed that drugs continue to enter facilities at an alarming pace, transported by persons entering custody, visitors, lawyers and other visiting professionals, drones and by corrupt or compromised staff. Body scanners and other search methods are in wide use, but questions continue as to their effectiveness, their susceptibility to concealment methods and the training that supports their effective use. The panel was shocked to discover that even with the evident frequency of overdose deaths, staff were still exempt from scanning. We have recently learned that randomized screening for staff has been implemented. This must surely be expanded to all staff to the extent possible. Not only are staff the most frequent in-bound path, permitting their exemption from screening places them at great risk as ideal targets for extortion and duress. To borrow a hospital term, we strongly recommend that any death that could potentially result from any unregulated drug supply must be regarded by everyone as a 'never event' in Ontario correctional facilities.

Broad-based Emergency Intervention in Overdose Situations

Since 2017, coroner data when available reveals that naloxone was used much less frequently in overdose events where there was an absence of prior knowledge of an opioid use disorder or in the absence of a prior non-fatal overdose. Staff have reported some uncertainty in their ability to use naloxone, and some concerns about its general availability. Recognizing that opioids are present in custody, both as contraband and prescriptions, we recommend wide access to naloxone and the removal of barriers to its use. We also recommend expanded capacity to overcome barriers to the timely provision of opioid agonist therapy (OAT).

This applies equally to general health care, mental health care and addiction services for persons-in-custody.

As with the previous section, we did not elect to focus this health care discussion on the specific performance and behaviours of health care staff as they undertake their roles to the best of their abilities. The evidence available to our panel raised no concerns with the professional knowledge, skills or personal attributes with which correctional health care staff endeavor to perform their duties. With other career options available to them, there can be no question of the dedication, commitment and compassion that inspires them to choose to apply their expertise in service of persons-in-custody, and to work in environments with such unique and often frustrating challenges.

Summary of Part II: Distinguishing Prevention from Cause

Throughout this section we have sought to distill and present a broad range of factors on which our panel believes action can and must be taken. They are presented in five distinct themes for ease of understanding, but it is important to note that none of these themes stands in isolation of the others. Our recommendations, which follow in Part III, are designed to guide a system-wide response on several fronts.

We also believe it is important to note that no single factor, nor any specific combination of these factors, can be said to have *caused* any specific death, nor any group of deaths. In this, our mandate differs from an inquest. Our mandate is to help us all to understand how these factors contributed, collectively, to an overall custodial environment in which these deaths were not avoided. In this, our shared obligation is to prevent.

Part III: Our Recommendations

In total, we offer 18 recommendations below, and several are related to more than one of the actionable themes (A to E) that are described above in Part II. See Reference indicators for each.

1. The Deputy Solicitor General, Correctional Services (DSG), will establish an Intersectoral Custody Advisory Committee (ICAC) that will meet on an ongoing quarterly basis under the leadership of an Assistant Deputy Minister (ADM). *(Reference Themes A, B, C, D & E)*

    a. In addition to select officials from the Ministry, including a representative selection of operational leaders as determined by the ADM, the ICAC will include at least two or more members from each of the following representative groups:

    - persons with prior lived experience in Ontario custody facilities, family survivors and/or advocates;
    - experienced front-line and supervisory correctional officers (COs);
    - experienced front-line nursing staff or nursing managers;
    - an executive member of the OPSEU provincial bargaining unit;
    - senior representation from the Ministry of the Attorney General (MAG) prosecution services.

    b. Among other agenda items to be jointly determined on a continuing basis, the ICAC will include periodically:

    - a review of deaths and serious injuries in custody facilities, and the status of investigation progress and results, including postvention insights gained in the case of deaths by suicide, and contraband insights gained in the case of accidental drug toxicity deaths;
    - a review of policy compliance and non-compliance as identified in investigations and custody complaints, and responses implemented;
    - an objective review of safety improvements implemented across all facilities;
    - a review of community-based alternatives, diversion programs and harm reduction practices that have resulted from Ontario court decisions as alternatives to incarceration, their demonstrated outcomes and missed opportunities where such alternatives were not applied;
    - a review of CO competency models and recruit training practices, evaluation methods and the state of compliance with prescribed in-service training requirements;
    - a review of the efficacy of custody complaint processes and facility visitation practices;
    - a review of the frequency, duration and causes of lockdowns in all facilities.

c. Within the first six months of operation, the ICAC will establish and publish a renewed mission, vision and guiding principles statement for the Ministry of the Solicitor General, Correctional Services, establishing a clear balance between security and care considerations in custody.

2. Appropriately assigned staff in the Ministry of the Solicitor General (SOLGEN staff), in cooperation with the ICAC and the custody operations management team, will develop, implement and report on new resources and procedures for enhancing the informed intake of people entering custody, including: *(Reference Themes A, C & E)*

    - transportation and admission processes that ensure the reliable transfer of all pertinent health information;
    - methods to ensure a full orientation and understanding by new persons-in-custody of their rights and responsibilities, available spiritual and health care resources, and methods of recourse for unmet concerns about their health and wellness, with attention to literacy, language, culture and other considerations;
    - the application of evidence-based admission screening processes and practices to reflect and mitigate unique needs of people entering custody, including health intake practices to reflect important morbidity and mortality risks that could impact correctional stay, and SAFER and other methods for achieving risk-commensurate placements to the extent possible;
    - additional screening processes required to increase identification and response to traumatic brain injuries (on entry and after critical incident experiences in custody), fetal alcohol spectrum disorders and physical and developmental disabilities.

3. In cooperation among the Family Support Liaison (FSL), Correctional Services Oversight and Investigations (CSOI), and operational management, SOLGEN staff will develop, implement and report on an expanded family-centered approach for continuous information flows and compassionate support for survivors of deaths in custody, including engagement with chaplains, NILO's, social workers and select community-based supports. *(Reference Themes A, C & E)*

4. Within one year, the DSG will assign a project team working in cooperation with family survivors, cultural advisors and operational management to examine, determine and report on appropriate and available means for memorializing deaths in custody, and to track plans for their implementation at each institution and across the custody system. *(Reference Theme A)*

5. Within one year, the DSG will assign a project team to identify, implement and report on improvements and removal of barriers in all facilities for access to community supports, including in-person family visits and available hours, access to legal advice, costs of

telephone and mail, and access to peer support programs and community organizations that can assist with transition planning. *(Reference Theme A)*

6. Within six months, the DSG will initiate a project in collaboration with the Deputy Attorney General (DAG) to conduct research and provide an updated report to the DSG and DAG on available strategies for reducing the number of people remanded into institutions. The scope of the joint project will include: *(Reference Theme A & B)*

    - enhanced risk-assessment methods for informing courts of available alternatives;
    - consideration to barriers limiting community-based alternatives;
    - enhancing access to multi-agency support resources, including housing, Ontario Disability Support Program (ODSP) and substance use treatment;
    - culturally specific and gender-specific considerations for over-represented groups.

7. Within one year, the DSG will receive an initial, comprehensive report from the Superintendents and Regional Directors Committee (SRDC; see #10 below), developed in cooperation with Ministry program design and implementation staff, which outlines strategies implemented, successes achieved and ongoing evaluation models for expanding the effective operation and more consistent availability of all forms of programming in each facility, including: *(Reference Themes A, B, D & E)*

    - strategies for increasing reliable cooperation with available community-based supports;
    - expanding available and suitable spaces to accommodate programming;
    - reducing barriers to accommodate internally and externally provided programs;
    - increasing program support related to employment and transferrable skills, including education, books and literacy, including for remanded persons-in-custody;
    - increasing access and uptake of meaningful activities by all persons-in-custody;
    - applying gender and cultural lenses to achieve equitable access and participation in programming and skill-building;
    - achieving consistency across institutions to ensure continuous learning and best practices in program quality and efficacy;
    - establishing ongoing reporting requirements beyond this initial report.

8. Within six months, the DSG will initiate a project team to assess and report on the current progress and future planning with regard to achieving inclusive practices, anti-racism, culture and gender considerations, and LGBTQ2S+ inclusivity in all facilities, including attention to: *(Reference Themes A, B, C & D)*

    - zero-tolerance policies;
    - sensitivity training for correctional staff;

- collection, reporting and use of race-based data;
- culturally specific product availability within canteens and facilities;
- means for safely and appropriately accommodating women and gender diverse individuals without a continuing reliance on segregation conditions.

9. Upon receipt by the DSG, the reports generated by the project teams identified in Recommendations #2 through #8 above will be provided to ICAC for their consideration and review in the next available quarterly meeting, where the scope of each report's distribution will be determined by consensus of ICAC, and unless otherwise restricted by Ontario Public Service policy, consideration will be given to extending distribution to persons-in-custody, families, correctional staff, OPSEU and the general public. *(Reference Theme A)*

10. The Assistant Deputy Minister (ADM) of Institutional Services will establish an ongoing Superintendents and Regional Directors Committee (SRDC) that will meet quarterly to establish a robust community of practice (CoP) model for the sharing of experiences, concerns, innovations and applicable metrics for cross-institutional collaboration and learning. *(Reference Themes B & C)*

    a. Within the first year of operation, the SRDC will initiate and report to the ADM on a review of policy compliance and non-compliance across all 25 facilities. Included in the report will be recommendations for amending policies deemed to be inappropriate to current conditions, new policies required to better align with current and future conditions, and any measures implemented or required for achieving more reliable and consistent compliance for policies that continue to apply.

    b. Within the first six months of operation, the SRDC will initiate and report to the ADM on strategies to strengthen the quality, reliability and necessary management supports in the supervision of correctional officers and other staff in general, and in specific areas to include:

        - applications of isolation conditions, when applied explicitly in accordance with segregation policy, when applied for other reasons outside of those policy guidelines, and when inappropriate to health and wellness conditions;
        - the identification of systemic barriers to reducing the use of isolation and lockdown conditions;
        - interferences with complaints and concerns from persons-in-custody;
        - staff rotation practices that ensure variability of care is balanced with appropriate connections with persons-in-custody;
        - the reliable application of all CO competencies and best practices;
        - surveillance techniques including electronic options and the viability and potential scope of body-worn cameras to enhance safety.

11. Within the next six months, the ADM of Institutional Services will initiate a project in cooperation with Ministry partners, including Justice Technology Services (JTS), to deliver within two years of this report a comprehensive Corrections Transparency and Data Quality (CTDQ) strategy that will improve the quality, reliability, completeness and availability of all data collected and applied within custody operations, with emphasis on the following priority areas: *(Reference Themes B & C)*

    - develop an inventory of the barriers to the collection of all applicable, relevant and available corrections data (e.g., non-mandatory fields, Wi-Fi capabilities);
    - capture all health information in an electronic system;
    - capture information on medications, visits with care providers (including general practitioners, mental health care and specialists) and visits to health care facilities outside of the institution;
    - ensure accessibility of relevant health information to internal staff, staff at other institutions (e.g., in the case of transfers) and by staff within SOLGEN, including a review of real and/or perceived information sharing barriers due to privacy or other considerations;
    - assess and remedy gaps in data collection, particularly where reporting to SOLGEN is optional;
    - develop and document standards for how data are collected and captured (e.g., minimum data fields and time between event and reporting to the Ministry);
    - improve accountability and general transparency in all data collection and reporting;
    - raise the numeracy and data literacy of institution and ministry staff;
    - where data are currently collected via telephone or email or are paper-based, set out a realistic timeline for transition to fully electronic data collection and transfer (e.g., prisoner transfer, program cancellations, use of force, visits and mail received);
    - share this comprehensive strategy with the SRDC and the ICAC for comment.

12. Within one year of this report, the DSG will commission a report from the correctional services senior management team and other SOLGEN partners as required to determine the viability of seeking Cabinet approval for establishing the current CSOI unit as an Inspectorate of Corrections (IOC). *(Reference Themes A, B & C)*

    a. Within the next two years, CSOI (or the IOC if approved and implemented) will implement specific improvements to the transparency and accountability of custody operations, including:

        - introduce public reporting on all deaths in custody with an annual report structure, including facility and manner of death;

- prioritize investigations into incidents and behaviours that may have improperly interrupted the flow of information, requests and complaints from persons-in-custody, and provide a timely report on each incident to the ADM, the SRDC and the ICAC on actions taken as a result;
- increase access to rights and information pathways for persons-in-custody (e.g., CSOI contact numbers, hotline booth);
- ensure access to CSOI investigators to conduct proactive safety audits and reviews, periodically in all correctional facilities;
- expand analytic and reporting capacities to support more timely and wider access to the outcomes from all investigations, audits and reviews.

13. Within one year of this report, the Director of the Human Resources Strategic Business Unit (SBU) will develop a report to the DSG outlining viable pathways to, timelines and budget requirements for aligning the compensation rate for all professional service staff and contracted providers in custody facilities, including physicians, nurses, mental health physicians, mental health nurses, social workers, chaplains and other spiritual advisors at levels commensurate with positions outside of the Ministry, to attract and retain the numbers and quality of staff required to serve the needs of persons-in-custody. *(Reference Themes B & E)*

14. Within one year of this report, and in cooperation with OPSEU, the Director of the Human Resources Strategic Business Unit (SBU) will develop a report to the DSG outlining viable pathways to and realistic timelines for eliminating the widespread use of fixed-term correctional officers, including a plan, budget requirements and collective bargaining considerations for normalizing a full-time permanent staffing model to the extent achievable over the next three to five years. *(Reference Themes B & D)*

15. Within 18 months of this report, the ADM of Operational Support will establish, complete and report to the DSG, the SRDC, and the ICAC a review of the core competencies and an evaluation of the effectiveness of delivery for all correctional officer training, including basic and in-service, with an emphasis on the following considerations: *(Reference Themes A, D & E)*

    - engagement of people with lived experiences and experienced front-line and supervisory CO perspectives in training curriculum and design;
    - engagement of people with lived experiences and experienced front-line and supervisory CO perspectives in the design and use of experiential and scenario-based learning models;
    - balanced emphasis on prevention, support and security;
    - ongoing mental health and substance use training;
    - mandatory trauma and violence-informed training;
    - compliance and completion levels in all facilities.

16. Within six months of this report, the Chief Administrative Officer/Assistant Deputy Minister (CAO/ADM) of Corporate Services will initiate a project that within one year will develop, implement and report on new quality standards for correctional health care services, in alignment with best practices from relevant professional colleges and organizations (including the College of Nurses of Ontario, the Registered Nurses Association of Ontario and the College of Physicians and Surgeons of Ontario) and with the following additional considerations applied: *(Reference Theme E)*

    - ensure minimum standards are met (or exceeded) across provincial correctional facilities;
    - build a framework for ongoing monitoring and reporting on quality standards;
    - ensure equivalence for health care in custody with health care in the community, with integration of care with programs funded and delivered by other institutions with expertise, such as Ministry of Health or Ontario Health;
    - empower health care staff to function in accordance within professional standards of practice and support strategies to identify and remedy conflicts;
    - hold Superintendents accountable to ensure no operational barriers exist to the delivery of health care that meets professional standards;
    - align adequate resourcing for equitable application of public health best practices;
    - implement best practices for treatment of substance use disorders, and remove barriers to opioid agonist therapy (OAT);
    - implement best practices for harm reduction, including naloxone access, and explore opportunities for supervised consumption and safe supply.

17. Within one year of this report, the DSG will receive from the SRDC a comprehensive report on best practices implemented, those requiring further Ministry support and ongoing evaluation methods for eliminating the trafficking of contraband in all facilities, with immediate emphasis on: *(Reference Themes B, C, D & E)*

    - all facility access will be dependent upon reliable forms of contraband screening, with the inclusion of corrections staff in all scanning and inspection procedures;
    - in cooperation with CSOI (or the IOC), improved intelligence and surveillance methods, including wider deployment of canine units, will be developed and applied for the recognition and interdiction of contraband;
    - in cooperation with the ICAC, the establishment and roll-out of an effective 'never event' strategy to eliminate toxic substance deaths across all institutions.

18. Within six months of this report, the DSG will establish and announce an updated Capacity Threshold Policy for Ontario Custody Facilities (CTP-OCF) that will declare any facility temporarily closed for in-bound transfers of persons-in-custody either until capacity can be restored or occupancy can be reduced sufficiently to comply with the following criteria,

and/or other criteria to be determined by the DSG, and will develop system wide metrics and a reporting regime to track all such determinations: *(Reference Themes A, B, C, D & E)*

- staffing levels and attendance patterns are sufficient to support full and adequate operations with due safety for COs and without lockdown conditions;
- staffing levels and attendance patterns are adequate to support optimal health care access and functioning, access for spiritual and psychological support personnel, and access for community-based program providers;
- staffing levels and attendance patterns are adequate to ensure uninterrupted family and legal advisory visitation access within established policies;
- staffing levels and attendance patterns are adequate to enable resources in support of approved external appointments for persons-in-custody;
- staffing levels and attendance patterns are adequate to enable emergency response procedures, when and as required.

Appendix: Members of the Chief Coroner's Expert Panel on Deaths in Custody

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The nine members of the panel brought diverse perspectives and provided their unique insights to inform our deliberations based upon their own life and career experiences and professional qualifications. All members contributed to the interpretation of the data, to the interactions and learning from our delegations and to the conceptual frameworks that shaped this report. However, the report as it is expressed should be regarded as a collective synthesis of those individual contributions.

Norman E. Taylor, M.Ed (D)

Mr. Norm Taylor, M.Ed (D), is the Panel Moderator and Lead Writer for the Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody. Mr. Taylor has served Canada's policing and criminal justice community for almost 30 years in his combined roles as an independent policy advisor, educator, researcher and author. Since 2014, he has organized and executed three national conferences on mental health issues in partnership with the Canadian Association of Chiefs of Police (CACP) and the Mental Health Commission of Canada. In his capacity as co-founder and Program Director of the CACP Executive Global Studies Program, he has led global research studies on criminal justice interfaces with the mental health system.

Mr. Taylor also provides strategic advisory and educational services to many police services, communities and at all government levels across Canada and in the USA, and since 2016 he has served as the founding Editor-in-Chief of the Journal of Community Safety and Well-Being.

Mr. Taylor is a recipient of the Queen Elizabeth Diamond Jubilee Medal on nomination by the CACP, the Premier of Saskatchewan's Award for Excellence in Public Service: Innovation, and in 2018 he was proud to be named an Honourary Commissioned Officer in the Ontario Provincial Police.

Jane Albright, M.P.A., CHRE

Jane Albright, M.P.A., CHRE, is a leader with more than 30 years of experience in corporate and senior human resources roles. Having worked in both the public and private sector, Jane has been a trusted advisor to leaders and public officials in both provincial and municipal government. In addition, she has held interim roles in the manufacturing sector and client service roles in the Insurance industry.

Jane has an extensive recruitment background across all levels of the organization from C-Suite leaders in various industries to Executive Directors in the non-profit sector and for associations. She provides strategic, practical and thoughtful advice to ensure that risk and action are

balanced for results and has an extensive network of contacts across a variety of sectors including rural and urban municipalities, ministries, charitable and professional organizations.

Jane has a Master of Public Administration from Queen's University, a Certified Human Resource Executive designation from the Human Resources Professional Association, a Lean Six Sigma Greenbelt in process improvement, a Certificate in Indigenous Studies from the University of Alberta, an Honours Arts degree from Western University, and she studied at Harvard Law School in their Certificate program in Leadership and Negotiation.

Jane has been President and Member-at-large of a number of organizations including the Ontario Municipal Human Resources Association, the Emergency Services Steering Committee and United Way Waterloo Region Communities.

Tricia Brunk, R.N.

Tricia Brunk, R.N., is a Nurse Supervisor at a provincial correctional facility. Since 2016, she has worked as a Health Care Assistant Manager, a Health Care Manager and a Health Care Supervisor. Over the past 14 years, Tricia has experience working in several small, large and mega institutions including Brantford Jail, Stratford Jail, Elgin Middlesex Detention Centre and Central North Correctional Centre.

Tricia studied nursing at Conestoga College, where she was also a clinical instructor in the Nursing and Personal Support Workers (PSWs) programs. She obtained her nursing licence in 1994. Prior to corrections, Tricia's previous experience includes working in Urgent Care Clinics, doctor's offices and industrial settings. Tricia also holds a post-secondary diploma in Occupational Health and Safety.

Her current study interests are focused on concurrent disorders within primary care.

Stephen Ellis

Stephen Ellis is a person with lived experience of the provincial and federal correctional systems. After a troubled early start in life led him to spending much of his lifetime involved with the criminal justice system, Steve now takes considerable pride in his work as an AIDS Committee worker, helping persons with addictions in the North Bay community.

Following his own recovery, Steve started a program for people post-incarceration to help increase their perceptions of their self-worth. He enjoys helping people who were in jail to discover that they can stay out and stay safe. Steve credits his own spiritual and cultural connections as important steps on his path to success.

Lindsay Jennings

Lindsay Jennings is a person who survived the correctional system. She is the current Co-Chair of the Transition from Custody Network, led by SOLGEN and Provincial HSJCC, working to address gaps in discharge planning and to increase continuity of care for people moving in and out of the correctional system.

Lindsay also chairs the Expert Advisory Committee for the Fresh Start Coalition, which is advocating for an automatic record suspension regime. Lindsay is a passionate and professional advocate for the Human and Health Care Rights of currently incarcerated individuals. Over the past seven years she has been dedicated to addressing the preventable deaths in custody, and a more ethical, supportive and compassionate process for the families of the loved ones who have died.

Dr. Fiona Kouyoumdjian, M.D., MPH, PhD., FCFP, FRCPC

Dr. Fiona Kouyoumdjian, M.D., MPH, PhD., FCFP, FRCPC, is a Public Health and Preventive Medicine Physician, Family Physician, Epidemiologist and an Associate Chief Medical Officer of Health in the Ontario Ministry of Health. She completed residencies in Family Medicine and in Public Health and Preventive Medicine at the University of Toronto, a Master of Public Health at the Johns Hopkins Bloomberg School of Public Health and a PhD in Epidemiology at the Dalla Lana School of Public Health at the University of Toronto.

Dr. Kouyoumdjian has expertise in prison health and in health equity. She worked part-time for more than a decade as a Family Physician in a provincial correctional facility in Ontario, and she has conducted research focused on the health and health care of people who experience incarceration.

Dr. Derek Pallandi, MSc, M.D., FRCPC

Dr. Derek Pallandi, MSc, M.D., FRCPC, is currently employed as a contract psychiatrist at the Ontario Correctional Institute (OCI) in Brampton and the Riverdale (Toronto), Keswick and Newmarket Probation and Parole offices, as well as serving as a staff psychiatrist at the Ontario Shores Centre for Mental Health Sciences in Whitby. Additionally, he maintains a private practice in psychiatry in civil, regulatory and criminal (forensic) matters. Between 2008 and 2020, he was an Investigating Coroner in the City of Toronto. He holds the rank of Lecturer in the Department of Psychiatry at the University of Toronto.

Dr. Pallandi has been licensed to practice medicine in Ontario as a psychiatrist since 2000 after he completed his Doctor of Medicine at McMaster University in 1995 and completed psychiatry residency training at the University of Toronto in 2000.

His interests are in serious and persistent mental illness and the recovery from it; correctional mental health; addictions, trauma and the evaluation and management of sexual and violent offenders.

Cory Roslyn, M.A.

Cory Roslyn, M.A., is the Executive Director of the Elizabeth Fry Society of Northeastern Ontario. She has held this position for the last six years. Cory has worked with criminalized women and gender diverse people for most of her career.

Cory completed her Master's degree in Criminology at the University of Ottawa, focusing in forensic mental health and the criminalization of individuals with mental illnesses. In 2009, she accepted a position working for the Elizabeth Fry Society of Ottawa in a women's Community Residential Facility and quickly recognized her inclination to advocate for the women who were residing there.

Cory's areas of focus have included the Bail Verification and Supervision Program, the development and facilitation of life skills and restorative justice programming, and release planning and advocacy for women incarcerated and in the community. Cory shares her insights in her capacity as President of the Council of Elizabeth Fry Societies of Ontario (CEFSO), with CEFSO's mandate to conduct annual provincial advocacy visits in every Ontario institution that incarcerates women. Cory served two years as a Regional Advocate for women at Grand Valley Institution for Women through the Canadian Association of Elizabeth Fry Societies and also currently volunteers her time in the role of Treasurer for the Ontario Association of Bail Verification and Supervision Services, as well as the role of Secretary for the board of the Canadian Association of Elizabeth Fry Societies.

Reverend Neil Stewart, M.A., D.Min.

Reverend Neil Stewart, M.A., D.Min., serves as Chaplain at Hamilton Wentworth Detention Centre (HWDC). He has served in Christian ministry for 30 years both in the United Kingdom (UK) and Canada, teaching for many years in Eastern Europe, running National Youth Camps, serving on Nation Committees and a National Trust Board. During the 1990s, Rev. Stewart worked within the UK criminal justice system as a member of a Youth Offending Team – a multi-agency team working to reduce remands into custody, piloting the use of GPS monitoring, and addressing social, educational, health and employment needs of young people in the justice system. During this time Rev. Stewart worked closely with Magistrates in the Youth Courts to establish confidence in community-based programmes as alternatives to custodial remands for young people.

Both life experience and work experience has brought him into contact with people working within and caught up in the criminal justice system and their families.

Dr. Rachelle Larocque, PhD.

Dr. Rachelle Larocque, PhD., is the Manager of the Correctional Services Death Review (CSDR). Since joining the Ontario Public Service (OPS) in 2017, Dr. Larocque has worked in various roles across several ministries leading and supporting justice and corrections transformation. Prior to the OPS, Dr. Larocque lent her expertise to the Independent Review of Ontario Corrections (IROC), writing a literature review on segregation, which helped build the foundation of the Segregation in Ontario Report.

Dr. Larocque's research has always been interdisciplinary in nature. Prior to studying penology, she focused primarily on serial murder, and its interpretation and intersection with culture and media. Dr. Larocque obtained her Doctorate from the University of Cambridge through a prestigious Commonwealth Scholarship where she explored the prison culture and prison experience in Ontario prisons. Dr. Larocque's doctoral dissertation continues to be leveraged in several IROC reports.

Dr. Larocque cares deeply about people and enjoys volunteering with community organizations focused on community reintegration, homelessness, poverty, and food insecurity. She is proud to have led the Correctional Services Death Review.