CANADIAN CIVIL LIBERTIES ASSOCIATION ASSOCIATION CANADIENNE DES LIBERTES CIVILES

Honourable Michael Kerzner, Solicitor General of Ontario
25 Grosvenor St, 18th Fl
Toronto, ON
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December 19, 2022

Dear Solicitor General Kerzner:

Re: Deaths in provincial prisons

We are writing on behalf of the Canadian Civil Liberties Association to express serious concern regarding the staggering rise in deaths occurring within Ontario provincial prisons. The Ministry of the Solicitor General must take immediate action act improve oversight, transparency and put in place trauma-informed supports after in-custody deaths.

A new report produced by *Tracking (In)Justice* shows that, despite a declining provincial prison population, there has been a sharp increase in the number of deaths in Ontario' provincial institutions; the full report, which will be publicly released tomorrow, is appended to this letter. The report notes that, compared to 2010, the rate of deaths in Ontario provincial custody in 2021 increased 173.3%. The number of annual reported deaths have risen from 15 in 2010, to 25 in 2019, to 41 in 2021. Preliminary numbers from the first 10 months of this year report 28 custodial deaths. In total, since 2010, there have been over 280 deaths in Ontario's provincial institutions.

As you know, Ontario's jails are disproportionately filled with racialized persons, and in particular Black and Indigenous people, individuals experiencing poverty, homelessness, mental health issues, and those criminalized for substance use. These deaths have had a significant impact on Ontarians whose families and community members are incarcerated within these institutions.

While these numbers are alarming, they are unsurprising to those who have come in contact with Ontario's jails and prisons. In the spring of this year, community groups wrote to the Solicitor General outlining their concerns about deaths in custody at institutions across the province.[1] Community members, including prisoners and their families, have also raised concerns. In February, for example, community advocates and family members of provincially incarcerated people heard that four people had died at Maplehurst Correctional Complex within a week and a half. Prisoners then began to report that there had been a very alarming number of deaths at

[1] Toronto Prisoners' Rights Project, Open Letter to Solicitor General Sylvia Jones, March 26 2022, available at https://www.torontoprisonersrightsproject.org/updates/open-letter-to-solicitor-general-sylvia-jones; Black Legal Action Centre, Open Letter about the Mistreatment of People in Provincial Prisons, April 14 2022, available at https://www.blacklegalactioncentre.ca/wp-content/uploads/2022/04/2022-04-14-Letter-to-Solicitor-General.docx.pdf.

Maplehurst in previous months. Little to no official information was available to prisoners or community advocates because the Ministry does not release information about deaths in custody in a timely manner. We understand that 11 prisoners from that institution died between December 2021 and April 2022; five more people have died since April. Two recent deaths at Elgin Middlesex Detention Centre have also prompted significant public concern; at least 21 individuals have died in connection with that institution since 2009.[2]

We are aware that the Office of the Chief Coroner: Ontario (OCC) is currently conducting a review examining deaths in custody from 2014 to 2021.[3] We commend the OCC for recognizing the rising number of deaths in custody and applying a systemic lens to this issue. However, there is no need to wait for the findings of this review to enact immediate and necessary changes to the Institutional Services' policies and procedures. This is not the first time that an oversight body has examined Ontario custodial deaths. Most notably, the 2017 *Independent Review of Ontario Corrections* thoroughly examined Ontario's policies and procedures for deaths in custody and made recommendations on death investigation oversight and response.[4] Many of these recommendations have remained unaddressed for the past five years. The Tracking (In)Justice report raises many of these longstanding issues first raised during the Independent Review of Ontario Corrections.

Immediate action must be taken to improve transparency, oversight and accountability in response to preventable deaths in custody. Ontario must ensure timely information and appropriate trauma-informed supports are made available to prisoners and their families in the aftermath of deaths within SOLGEN institutions. Further details about problems in each of these areas are set out below, followed by recommendations that must be acted upon without further delay.

Transparency

The attached report clearly demonstrates the ongoing deficiencies in Ontario's reporting and tracking of deaths in custody. As noted in the report from Tracking (In)Justice:

> There is no publicly available information breaking down deaths by institution or manner of death over an extended period […] SOLGEN is not required to inform the public of the death through news releases so there is no way for members of the public to keep track of decedents' names and demographic information. Ontario provincial institutions receive little direction regarding information sharing following an individual death in custody.
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> Due to lack of transparency and policy, determining with certainty how many people have died in provincial custody is a challenging process. During the Independent Review of Ontario Corrections, investigators attempted to obtain a concrete figure on deaths within

[2] Angela McInnes, "Man arrested in good health found dead 1 week later in London's Elgin-Middlesex Detention Centre", CBC News, November 18, 2022, available at https://www.cbc.ca/news/canada/london/man-arrested-in-good-health-found-dead-1-week-later-in-london-s-elgin-middlesex-detention-centre-1.6656117.
[3] CBC News, "More and more inmates are dying. Ontario's coroner wants to know why", July 8 2022, available at https://www.cbc.ca/news/canada/london/more-and-more-inmates-are-dying-ontario-s-coroner-wants-to-know-why-1.6514983.
[4] See Independent Review of Ontario Corrections, *Corrections in Ontario: Directions for Reform* (Toronto: Ministry of Community Safety and Correctional Services, 2017) at 62–97, 83–85.

> Ontario provincial institutions but were unable to do so, as the figures provided by different branches of government did not align. The problem was that different units tracking deaths in custody were not sharing a uniform definition of what "in custody" meant.

There are some public-facing Ministry reports that provide information on deaths in recent years, a welcome improvement to transprency. Unfortunately, the data is inadequate and unreliable. Currently, reporting is limited to three years – 2019, 2020 and 2021. Moreover, as noted by the authors of the Tracking (In)Justice report, the data provided is difficult to use for basic analysis:

> When our team attempted to access deaths in custody figures through the SOLGEN open data website, we found that the available data in the deaths in custody tables for 2019 and 2020 were categorized differently in each year that data was provided making data difficult to compare. The files for the past several years defined custody too widely for the purposes of this report. Beyond obtaining basic figures like those shared [in the Tracking (In)Justice report], accessing information on deaths in custody becomes more challenging and requires the use of data use agreements and Freedom of Information Requests which can be costly and time consuming.

The Ministry's reporting relies on a broad definition of custodial deaths, which includes "custodial deaths where an individual was under the ministry's supervision, as well as non-custodial deaths where an individual may have been on an unescorted temporary absence pass, on parole, in police custody, in custody of the Canada Border Security Agency, or had their charges stayed." It is appropriate and important for the Ministry to track and publicly report on a wide range of "custodial deaths". Nevertheless, the lack of detail in the Ministry information makes it impossible to distinguish between deaths with a substantial connection to a custodial setting and deaths resulting from events in the community. This significantly limits the ability of the public and researchers to adequately track and analyze deaths occurring within the custody of provincial institutions.

Ontario also needs to publicly report on individual deaths in a timely manner. As noted in the report, the Ministry does not provide any public notification or reporting of in-custody deaths when they occur. The overview reports currently available are typically released nearly a year after the relevant reporting period. In contrast, when a death occurs in the federal prison system the Correctional Service of Canada ("CSC") issues a news release a few days after the family has been notified. The public release, which is posted on CSC's website, typically includes basic information about the death including the name of the individual, the prison they were being held in, and age where available. This form of timely release helps facilitate real-time tracking of deaths, identification of emerging trends, and the maintenance of a clear and official channel of communication to the broader community which may otherwise only be hearing about deaths through rumours and unconfirmed sources.

Finally, there needs to be transparency and information sharing with families of individuals who have died in provincial custody. As outlined in the report, families have significant difficulties accessing information about what happened to their loved one in a timely manner, particularly if a death has been classified as natural and the coroner declines to call a discretionary inquest.

Oversight

As outlined in the Tracking (In)Justice report, there are significant gaps in Ontario's post-death investigations mechanisms:

> An inquest is mandatory under the *Coroners Act* only if the death is determined to be unnatural. Discretionary inquests into natural deaths in custody are rare, leaving a significant gap in arms length oversight of custodial deaths presumed to be natural.
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> […]
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> From 2012 to 2017, the most reported means of death in Ontario provincial institutions was "natural." This is a classification of death reflecting an underlying medical cause. However, deaths classified as natural may still raise serious concerns regarding medication dispensing, medical documentation practices, or conditions of confinement.

The 2017 *Independent Review of Ontario Corrections* also found that the Ministry lacked adequate policies and procedures to prevent, track, and learn from deaths in Ontario's provincial institutions. Correctional Services Oversight & Investigations (CSOI) investigations were focused on staff compliance, not prevention, Corporate Health Care reviews were ad-hoc and informal, and the Ministry's response to Coroner's Inquests were neither adopted nor communicated on a system-wide basis. Although Coroners' recommendations are available online, there is still no publicly-available repository of Ministry responses to these recommendations.

Even when a Coroner's Inquest is called, there are significant backlogs resulting in delay between a death in custody and an inquest. Most inquests do not start until years after the death has occurred, which results in missed opportunities to address conditions of confinement which continue to pose serious risks to prisoners in the interim. Delays in inquest scheduling have significant impacts both on the timing of important policy recommendations and changes, as well as families' ability to find out crucial information regarding the death of their loved ones.

Trauma-informed support and timely information for prisoners and families

Prisoners and families do not receive an adequate amount of information and support after an individual has died in custody. As a result, prisoners are frequently left in a state of fear and trauma, and families whose loved ones have died struggle to navigate a complex and slow system. As noted in the Tracking (In)Justice report:

> Detailed information on deaths in custody is only available to the public after an inquest, which often occurs years after a death. In the time that families are waiting for an inquest, they may obtain some access to information through the review of CSOI or coroner's reports, but there is no guarantee that these documents will be provided, and they may be heavily redacted. In such cases, families wait years for answers regarding the death of their loved one. Institutions must ensure that each institution has a staff member appointed to liaise and share information with bereaved families in the aftermath of a death in custody.

There is no easily-identifiable central liaison person a family can contact for information or support, we continue to receive reports that counselling services or referrals are not provided families who have lost a loved one or prisoners who have witnessed a death. According to a media report, at least one institution has a family liaison officer, whose job is to support families following a death in custody.[5] We could find no publicly available information on the Ministry's website regarding how to contact this person or the scope of their role. We understand that when Community Advisory Boards ("CABs") were active, they sometimes acted as a liaison between the family and the institution or the Ministry to get answers to questions and arrange meetings; with the dissolution of CABs even that informal support mechanism is gone.

It is understandable that while investigations are ongoing, not all details can be shared with families or other impacted communities, including other prisoners. It is deeply harmful, however, to leave these individuals with no supports or clear communication channels during this time. It must be a priority to establish effective, trauma-informed mechanisms to proactively share as much information as possible and provide a single point of contact that impacted individuals can access to receive updates and send inquiries.

Particular concerns have also been raised about the interactions between Ministry staff and family members after deaths occur. We have been informed, for example, that memorial crosses located near Maplehurst Correctional Complex that were not located on provincial government property were thrown into the garbage by Ministry staff. Community members have also reported a lack of communication with families and compassionate accommodation after the memorial removal at Elgin Middlesex Detention Centre. We note that any government actions to remove memorials constitutes an infringement on individuals' constitutional rights to freedom of expression. It is the government's obligation to demonstrate that such infringements are reasonable limits on *Charter* rights.

Recommendations

Several recommendations for improving Ontario's tracking, oversight, and response to deaths in custody were issued in the 2017 report from the Independent Review of Ontario Corrections. These recommendations included:

- Relevant legislation should be amended to include a broader definition of death in custody that captures inmates who die after being transferred to a community health care setting regardless of whether they were under direct ministry supervision at the time of their death.
- The Ministry should amend the *Coroners Act* to require a coroner-led review process for all in-custody natural deaths.
- Legislation governing provincial incarceration should include provisions that:
    - Require the body of a deceased inmate to be treated with respect and dignity, and require that the body be returned to next of kin or other contacts as soon as legally and reasonably possible, in a respectful manner;

[5] Kathleen Saylors, "Design of mental health unit questioned", Windsor Star, June 30 2022.

    - Require that the ministry facilitate the respectful and appropriate disposition of remains in accordance with applicable laws, if there is no other party willing or able to do so; and
    - Require that reports related to deaths in custody be proactively shared with the Office of the Chief Coroner, next of kin and other contacts of the deceased, and any other relevant oversight bodies as early as possible.
- The Ministry should establish policy regarding deaths in custody that provides for:
    - Defined procedures and protocols to inform and facilitate access by next of kin when an inmate is taken to a community hospital due to a medical emergency;
    - Establishing a family liaison position in each region to coordinate with institutions and ministry leadership in order to provide information to the next of kin from the point of notification until the completion of all investigative processes; and
    - An immediate letter of condolence to be sent to the next of kin.
- Staff and management responsible for speaking with family members after a death in custody receive the necessary training and support.
- The ministry should develop a guide for families on Ontario's Correctional Services policy, responsibilities and investigative process following a death in custody.
- The ministry should centralize data collection of deaths in custody and publicly post all inquest verdicts, verdict explanations, and ministry responses to allow for appropriate trend analysis and follow up regarding the implementation of coroner's inquest jury and other relevant recommendations.
- Ontario should champion the establishment of a national Canadian roundtable on the prevention of deaths in custody.

In 2018, the government passed the *Correctional Services Transformation Act*, which would have partially addressed these concerns, but to date, this Act has not been called into force.[6]

Even absent legislative changes, however, many of these recommendations can be implemented through policy and regulatory changes. The fact that the number of in-custody deaths has risen

[6] The Act, which is not in force, included the following important changes to legislation:

- Requiring the Minister to notify next of kin immediately after becoming aware of a death in custody, if notification had not already been provided. *Sch. 2, s. 106(1)*
- Requiring superintendents to prepare a report for the Minister, including a description of the circumstances surrounding the death. *Sch. 2, s. 106(3)*
- Giving next of kin the right to request a copy of the superintendent's report. *Sch. 2, s. 106(6)*
- Requiring that the Ministry maintain records and statistics regarding deaths in custody. *Sch. 2, s. 106(9)*
- Enabling the Ministry to pay a compassionate allowance to the estate of a person who died in custody to assist with the disposition of the person's remains. *Sch. 2, s. 107(c)*
- Creating an Inspector General of Correctional Services with authority to monitory, inspect, investigate, and audit the Ministry to ensure compliance with the Act, including legislation on deaths in custody. *Sch. 2, s. 122(2)(a)*
- Expanding the definition of deaths relating to correctional institutions by including those which occur at a hospital after a person was transferred there by a correctional institution (regardless of whether they were under the direct supervision of the ministry at the time of death). *Sch. 3, s. 6(1)*

significantly since the publication of these recommendations makes action in this area all the more urgent.

In addition to the above recommendations, we would also urge the Ministry to clarify that staff are not to unilaterally remove or otherwise interfere with any community memorials.[7]

We urge you to take immediate steps to implement the above recommendations.

Sincerely,

Abby Deshman
Director, Criminal Justice Program

Noa Medelsohn Aviv
Executive Director and General Counsel

Encl.: Tracking (In)Justice, "Ontario Death in Custody on the Rise", December 2022

Cc: Peter Copeland, Senior Policy and Stakeholder Relations Advisor

[7] A process through which staff can raise concerns about the impact of memorials, and the Ministry can appropriately and compassionately consult with families about the memorial, should be established. If the families decide not to remove or alter the memorial, staff may seek to file a grievance through their Union. This Ministry should be required to notify the impacted families and/or community organizations if any grievance is received to ensure that all views are adequately represented and taken into account in any subsequent agreement or arbitration ruling.