Ontario Deaths in Custody on the Rise

December 2022

TRACKING (IN) JUSTICE

Tracking (In)Justice: A Law Enforcement & Criminal Justice Data & Transparency Project

Scope of report

This report from the Tracking (In)Justice, a law enforcement and criminal justice data and transparency project, focuses specifically on the deaths of individuals incarcerated within Ontario provincial jails and prisons.

In Canada, people sentenced to less than two years of incarceration, and those detained pre-trial, are held in the custody of the provincial and territorial governments. The figures provided in this report refer exclusively to deaths of individuals in the custody of Ontario provincial jails and prisons from 2010-2021.

In this report, a **death in custody** is defined as any death directly occurring while in the legal custody of Ministry of the Solicitor General (SOLGEN). The death must have resulted directly from events within an Ontario provincial jail or prison. To be defined as a death in custody, both of these criteria would have to have been met:

- The event leading to the death occurred within an provincial jail or prison;
- While the actual death might have not occurred within the institution the person was still legally in SOLGEN custody at the time of the event.

Deaths of people under community supervision or released on a temporary absence are not included in the data in this report. As a result, the numbers in this report may differ from figures provided in the SOLGEN open data portal, which include deaths on temporary absence, provincial parole, police custody, and after charges have been stayed. In contrast, data in this report focuses specifically on deaths which both occurred in SOLGEN custody and resulted from event occurring within a SOLGEN institution.

Data for this report were obtained through requests to the Ministry of the Solicitor General (SOLGEN). Complementing these data are qualitative interview findings with lawyers who have represented bereaved families following a death in custody, and transcripts from testimony at inquests into deaths in custody in Ontario collected by doctoral candidate Sarah Speight, University of Ottawa.

Responding to public concern about deaths in custody

Deaths in custody in Ontario are on the rise. Due to a systemic lack of transparency, information about deaths in custody is hard to come by, and inconsistently released to the public and families of those who have died.

The Ontario Coroner's Office is currently conducting a review of deaths that took place at Ontario provincial institutions between 2014 and 2021. In the meantime, however, deaths have continued to mount. Bereaved families, activists, and people with lived experience of incarceration have worked tirelessly to focus public attention on this issue, calling for transparency, oversight, and accountability on the part of the provincial government.

Those impacted by deaths in custody have held protests at Ontario provincial institutions and government buildings, organized public education events, and supported each other through systems navigation following the loss of loved ones.

The purpose of this report is to contribute to informed public and policy discussion on in-custody deaths in Ontario's provincial jails and prisons by:

- Releasing existing Ontario government data confirming that deaths in Ontario provincial institutions are increasing despite a decreasing custodial population.
- Providing background on the deaths in custody reporting practices and their impact on bereaved families.
- Identifying policy issues behind access to information barriers following a death in custody.

280

Since 2010 there have been over 280 deaths in Ontario provincial jails & prisons

28

28 reported deaths in Ontario custody in the first 10 months of 2022

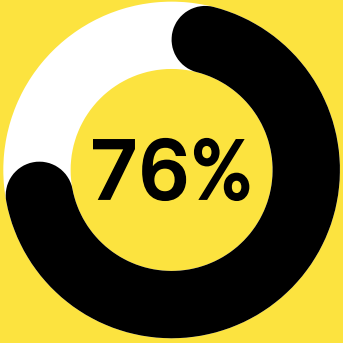
41

41 reported deaths in Ontario custody in 2021

23

23 reported deaths in Ontario custody in 2020

Key trends



In 2021, 76% of the Ontario provincially incarcerated population was on remand.

What is remand?

Remand is custody for people who are held while waiting for a court appearance or who are waiting for a bail hearing. A small portion of people on remand have been tried, found guilty, and are awaiting sentencing. The vast majority of people held in remand are held in custody before their trial because they have been denied bail.

Deaths in custody are increasing despite a declining prisoner population

Since 2010, there have been over 280 deaths within Ontario provincial jails and prisons.[1] In 2021, the number of people who have died in Ontario provincial custody almost doubled, from 23 deaths reported in 2020, to 41 reported last year (Figure 1). This far surpasses a marked increase in deaths starting in 2017, which saw a rise from 17 deaths in 2016 to 24 deaths the following year. Compared to 2010, the rate of deaths in Ontario provincial custody in 2021 increased 173.3%. Preliminary numbers for 2022 report 28 custodial deaths, already surpassing numbers from 2020.

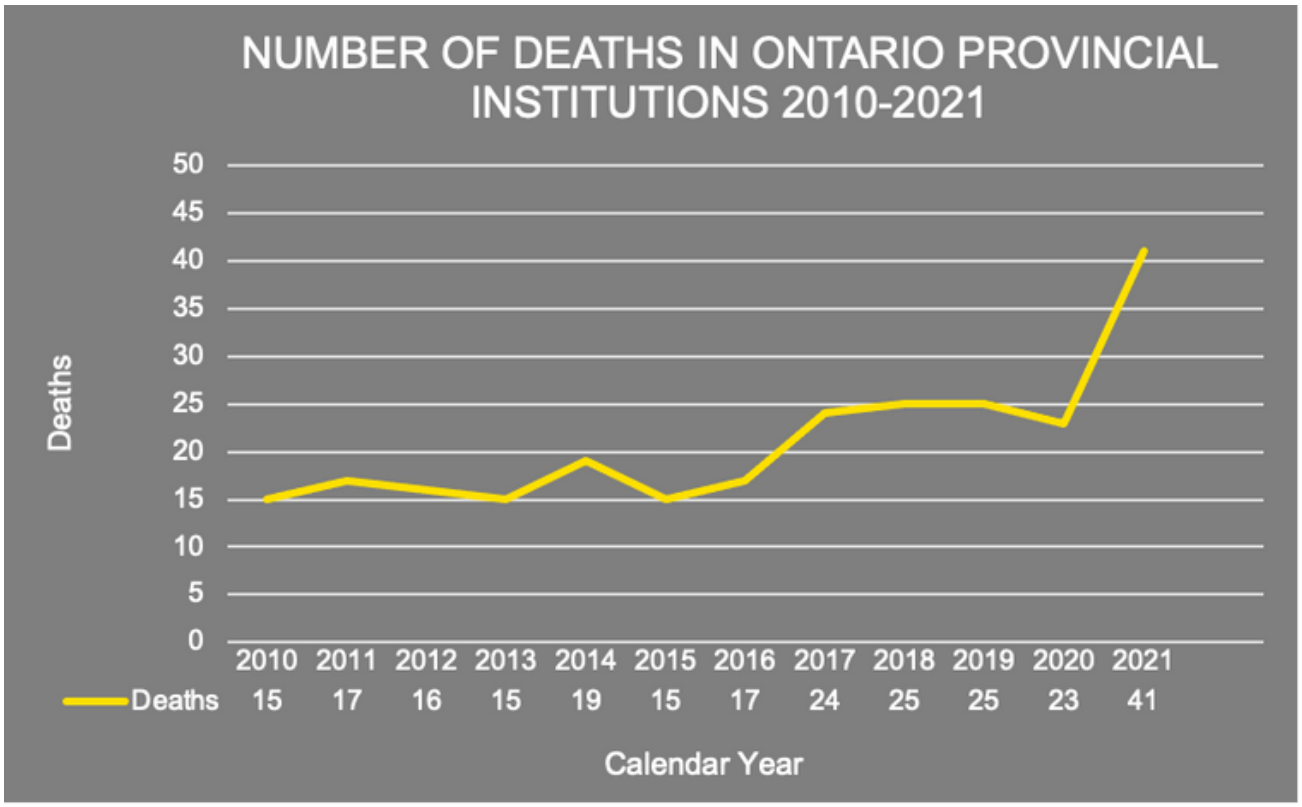


Figure 1: Deaths in Ontario Provincial Institutions 2010-2021

Most provincially-incarcerated people are in pre-trial custody rather than in the community on bail

The average daily counts of people in custody have decreased in Ontario, pre-trial detention rates have risen 137% over the past 30 years. [2] In 2010, the average daily count for the provincial population was 8,761 (62.3% on remand). In 2021, the average daily count for the provincially incarcerated population was 7,162 (78.6% on remand). The increase in remand rate affects deaths in custody as individuals on remand face heightened suicide [3] and drug overdose risk [4] compared to those serving sentences. Suicide risk for people on remand is four times that of the sentenced population [5] due to the challenges of adjustment, uncertainty, drug or alcohol withdrawal, disrupted personal relationships, isolation, restrictive conditions, and first time incarceration. Drug toxicity risk in pre-trial detention is heightened due to reduced drug tolerance and high turnover of people rotating through facilities, which facilitates the entry of drugs into institutions. [6]

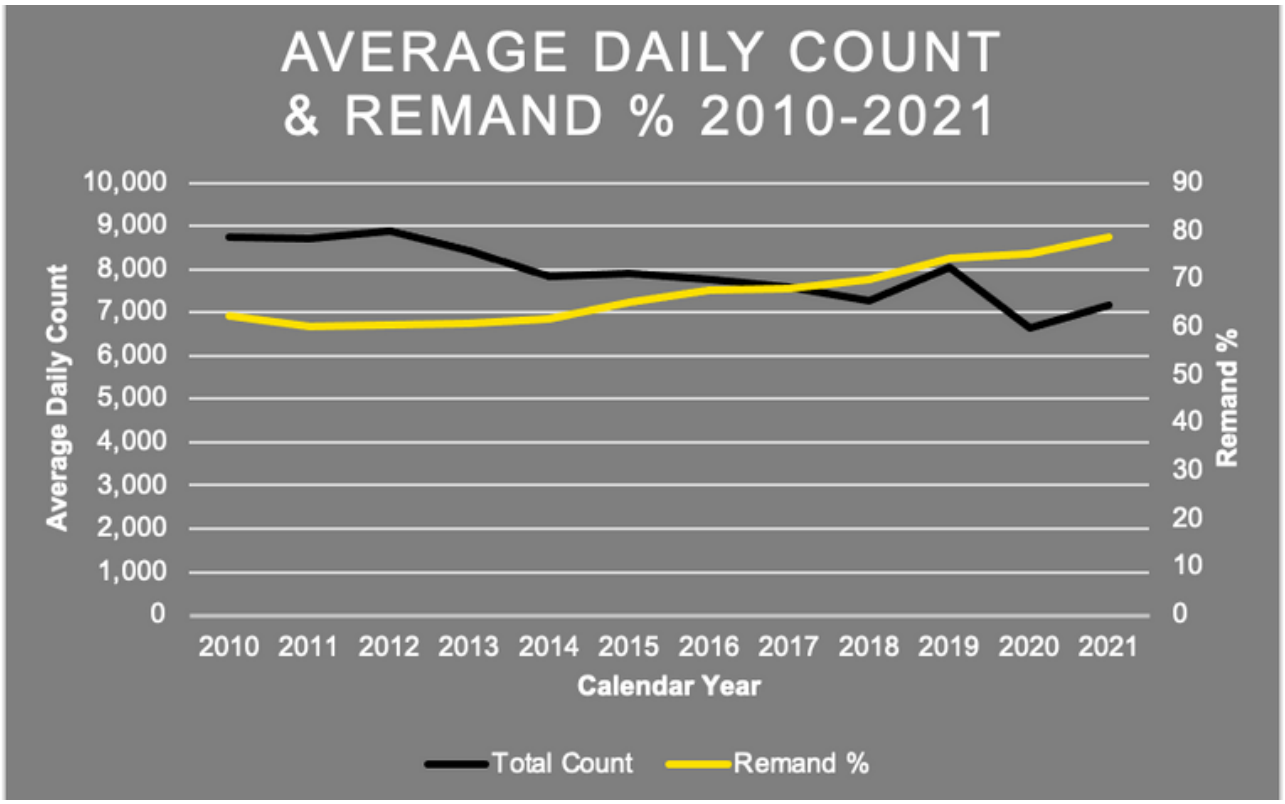


Figure 2: Average daily count and remand percentage in Ontario provincial institutions

Deaths in custody trends are shifting

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. In an interview, a lawyer representing the family of a young man who died unexpectedly in provincial custody described the challenge with natural death classification:

> ***“It was clear that the way this death occurred was anything but natural. The severe dehydration, the video imagery of [him] the day that he was picked up while riding his bicycle. He was well enough to be riding his bicycle, and you can see him joking around when he’s getting [processed] and then you see after him five days [in custody] presenting with gross emaciation. He looked like a character from the walking dead. It was just horrific. So to see that and to say hmm natural causes – it may have been a natural process that he died from but it was a very unnatural course in prison that led him to die from. That was our theory and I think that it was established.” - Lawyer***

This example illustrates that the proportion of deaths in provincial custody classified as natural over the past decade should not immediately be taken at face value as such deaths may have arisen out of questionable circumstances.

Although deaths in custody have risen across the province, means of death trends have changed. According to a SOLGEN prisoner data release, “The increase in deaths between 2017 and 2018 are a result of a rise in suspected overdose as the reason for death.” [7] The ongoing drug policy crisis has resulted in a highly toxic drug supply and a dramatic increase in drug-related death across Canada. This already-high risk of drug toxicity prior to incarceration is amplified in custodial settings and following release. [8]

Due to lack of transparency, we do not yet know the reasons for the current increase in deaths between 2020 and 2021. There is anecdotal evidence that in the general population, the COVID-19 epidemic, has amplified risks associated with drug toxicity and access to supports, which could increase risk of drug related deaths. [9] Similarly, the level of isolation imposed on Ontario provincial prisoners, and uncertainty during the COVID-19 pandemic may have contributed to a rise in suicide deaths.

Reporting deaths in custody in Ontario

There is no publicly available information breaking down deaths by institution or manner of death over an extended period. Ministry policies are absent of sufficient direction regarding the notification of next of kin, the transfer of belongings, and access to official reports. 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.[10]

Due to lack of transparency and policy, determining with certainty how many people have died in provincial custody is a challenging process.[11] During the Independent Review of Ontario Corrections, investigators attempted to obtain a concrete figure on deaths within 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.

Following a death, families of the deceased can request a copy of the investigation report, however SOLGEN is not required to provide it – and they may choose to redact the document considerably before providing it to loved ones. At a recent inquest into a suicide death in custody, a mother described her experience with the death in custody notification process at the provincial detention center where her son died, where she stated:

"I am still waiting for them to call me back regarding my son being in a psychosis [before his death]. I did call them after [he] had passed and this was about three, possibly four days after. I asked to speak with the superintendent and I am still waiting for him to call me back. [H]is receptionist had asked me why I wanted to speak with the superintendent, and I said, "Well, because my son just died in your facility" and she said "oh really we didn't hear about this". I thought well, this is strange because the whole [prisoner] population knew and five or six of them called me at my home to let me know that they knew what happened to [my son]." ***- Parent***

The failure of SOLGEN employees to communicate with this young man's mother – both before and after his suicide – is commonplace. In this case, there was a three-year gap between the death in custody and the inquest. In that period, a mother waited years for answers regarding the circumstances of her son's death.

Correctional Service Canada (CSC) and reporting deaths in custody

In contrast, federal penitentiaries operated under the authority of Correctional Service Canada have a more systematic approach to tracking and reporting deaths in custody. Following a death in federal custody, CSC is required to contact a Coroner and the Office of the Correctional Investigator (OCI), and to conduct an internal review of the death. The OCI tracks deaths in federal custody and conducts additional investigation where they feel it is required. The number of deaths in custody each fiscal year is included in the OCI's annual reports.

People in the custody of CSC are required to provide a designated contact in the event of an emergency. Some people have different designated contacts for different situations in which case the appropriate contact for death notification will be informed of the death. If this person is unreachable, CSC consults the decedent's visitors list in order to identify next of kin. Following family notification, CSC's institutional family liaison follows up with the appropriate person to answer remaining questions and facilitate access to information. The family liaison provides next of kin with information on claiming their loved one's body and reclaiming their belongings.

Within a few days after CSC has notified the family of a death a news release informs the public of a death. This typically includes basic information about the death including the name of the individual, [12] their institution, and age, where available. News releases via the CSC website facilitate real-time tracking of deaths, which helps to identify important trends.

All deaths in federal custody that occur within the province of Ontario are subject to inquests held by the OCC in cases where the death is determined to have occurred unnaturally. However, when a death appears to have occurred by natural means CSC conducts a "Mortality Review". This is a medical review of the decedent's medical and institutional files to examine medical treatment prior to death. These reports are internal and may include recommendations to improve the delivery of medical services within CSC institutions. Family members are required to file an Access to Information request to obtain access to this document.

How are deaths in-custody investigated?

In Ontario, three separate bodies conduct in-custody death investigations, 1) the Office of the Chief Coroner (OCC), 2) SOLGEN's Correctional Services Oversight and Investigations (CSOI) office, and, 3) SOLGEN Corporate Healthcare.

1) The Office of the Chief Coroner

Following a death in custody, the institution is required to notify a Coroner who will conduct their own investigation into the death. An inquest is mandatory under the *Coroners Act* only if the death is determined to be unnatural. [13] Discretionary inquests into natural deaths in custody are rare, leaving a significant gap in arms-length oversight of custodial deaths presumed to be natural.

What is an inquest?

The purpose of an inquest is to determine the circumstances of a death [14] and produce recommendations to prevent similar deaths in the future. If the investigating Coroner determines that a death in custody occurred by "natural" means, an inquest is not mandatory but may go forward as a discretionary inquest if it is determined that doing so would serve the public interest.

In an interview, a lawyer who has represented both families and public interest organizations at inquests into deaths in custody described the challenges of accessing information when a death has been classified as natural and it becomes clear an inquest will not be held:

> ***"If someone dies in the hospital – or someone is hit by a car, there are all kinds of opportunities to ask questions, and to sit down. Even in a natural death that happens at a hospital… if you are a grieving spouse and you say to a doctor "I just want to sit down and have you explain your notes" – they will make that time because people recognize that someone died and this is a serious thing. The black box of a death in custody is hard to penetrate… [Families] have good reason to believe that if they go knocking on the police door or the prison door saying, "I've got some questions about my son's death" that they're not going to get very good answers… If someone dies of a heart attack in jail and their family says, "I feel like he's been poisoned" and you never get that result, you have a grieving family with questions. Also, it's no one's job in a jail to deal with a grieving family, to answer their questions, to get them their belongings, just addressing that human piece is one thing." – Lawyer***

Despite a reduced number of mandatory inquests now that natural death inquests are no longer required, the OCC continues to face significant inquest backlogs. During an interview, one lawyer with experience in representing families at inquests into deaths in custody described challenges of waiting five years for an inquest into an overdose death:

> ***"I think it is just terrible if the purpose of an inquest is to prevent similar deaths in the future… Waiting two years while more and more deaths are occurring is counterproductive. I can understand it when there are criminal charges pending or something like that but that has not been the case in most of these [deaths]. It's not only counterproductive to wait that period of time, but it's very difficult for the families because they're basically left in the dark about what happened to their loved one for years. – I mean look at, [my client's son], we are coming up on five years without an inquest."***
> ***– Lawyer***

If and when an inquest is eventually held, there is no systemic funding routinely available for families to obtain counsel to represent their interests at the inquest unless it is determined that the death resulted from a crime, or the Legal Aid Test Case Fund approves costs.

At the conclusion of an inquest, a jury of five members of the public render a verdict, which may include risk regulatory recommendations. Parties in receipt of recommendations must provide a response within six months indicating whether they intend to implement inquest recommendations and providing justifications for their decision. Responses to recommendations are not publicly available, but are available upon request. Out of the twenty-one lawyers interviewed as part of Sarah Speight's doctoral work, only three reported that they had followed up to check the responses to inquest recommendations submitted by the Ministry of the Solicitor General. One lawyer who represented medical professionals at inquests explained that, "my retainers are done at that point so I don't think I reviewed them with any kind of professional hat on." There is a lack of systemic tracking and follow up on responses to recommendations resulting from inquests into deaths in provincial custody.

2) Correctional Services Oversight and Investigations Office (CSOI)

The CSOI investigation functions parallel to the initial Coroners investigation into a death and is required to report on each death. From the outside, the purpose or role of these investigations is not stated to the public, although based on a review of these reports, they tend to focus on procedural issues like the performance of security rounds, record keeping practices, and emergency response. [15] To initiate an investigation, regional SOLGEN offices contact CSOI to request a "level 1 investigation." [16] An inspector acting on behalf of CSOI interviews witnesses, reviews documentary and video evidence, and examines the healthcare file of the deceased person.

The OCC provides the CSOI investigator with the cause of death. Once the investigation is complete, a report is forwarded to SOLGEN legal services and the appropriate regional director. There is no requirement to share CSOI report findings beyond this, but families of the deceased and Coroners may request copies. If there are concerns that the file contains sensitive human resources information, the report may be redacted.

After the report is finalized, regional directors are required to report action taken because of the findings of the report. CSOI is required to produce annual reports but does not release them.

3) SOLGEN Corporate Healthcare

SOLGEN Corporate Healthcare is a small unit within SOLGEN that works on strategic planning for medical services within Ontario provincial institutions. Following a death, members of the team conduct a medical file review to identify any healthcare delivery issues connected to the death. This could include medication dispensing issues, unanswered requests for medical services, or communication issues between healthcare and institutional staff.

Conclusion

Deaths in custody in Ontario are increasing at an alarming rate despite a declining provincial custody population.

As bereaved families continue to call for increased transparency and accountability in the aftermath of deaths in custody, SOLGEN poses significant barriers to accessing consistent, reliable data. Greater transparency is required, including the provision of real-time reporting on deaths in Ontario provincial custody through the news release format utilized by Correctional Service Canada - excluding any information related to sentencing. Data reported on deaths in custody need to be made public, in consistent formats, ensuring that information reported over multiple years is comparable.

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.

What is the Tracking (In)Justice project?

Tracking (In)Justice is a law enforcement and criminal justice data and transparency project that tracks and analyzes police-involved and carceral deaths across Canada.

We believe that accurate and verified data is one way to support communities advocating for justice, accountability, and transparency from police and corrections officials, and oversight bodies.

At the core of Tracking (In)Justice is a public, living database that provides information on police-involved deaths when force is used, from the year 2000 to the present. We are working to expand our database to include all police-involved deaths and deaths in custody across Canada. We will be making our data publicly accessible via an online database going live in 2023.

We are currently comprised of the Data and Justice Criminology Lab at the Institute of Criminology and Criminal Justice at Carleton University, the Canadian Civil Liberties Association (CCLA), Center for Research and Innovation for Black Survivors of Homicide Victims (CRIB), the Empowerment Council, the Ethics and Technology Lab at Queen's University JusticeTrans, Women's Health in Women's Hands Community Health Centre, and Maggie's Toronto Sex Work Action Project.

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[5] Supra, Note 3 p. 168.

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[10] Supra, Note 2.

[11] Note: 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 above accessing information on deaths in custody becomes more challenging and requires the use of data use agreements and Freedom of Information Requests.

[12] Unless subject to publication ban.

[13] Coroners Act, R.S.O. 1990, c. C.37 s.10(4.3)

[14] Coroners Act, R.S.O. 1990, c. C.37 s.31

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Cover image: Rennison, John. Hamilton Wentworth Corrections Centre. From the Hamilton Spectator, retrieved November 15 2022: https://www.therecord.com/ths/news/hamilton-region/2019/04/13/family-wants-answers-after-krystle-catherwood-dies-of-suspected-overdose-at-barton-jail.html

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