Office of the
Chief Coroner

Bureau du
coroner en chef

Verdict of Inquest Jury
Verdict de l'enquête

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de _____

_____ of / de _____

_____ of / de _____

_____ of / de _____

_____ of / de _____

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de:

Surname / Nom de famille	Given Names / Prénoms
Faqiri	Soleiman

aged / à l'âge de 30 held at / tenue à Via Video Conference, Ontario

from the / du November 20 to the / au December 12 20 23

By / Par Dr. / Dr David Cameron Presiding Officer for Ontario / président pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Soleiman Faqiri

Date and Time of Death / Date et heure du décès
December 15, 2016

Place of Death / Lieu du décès
Central East Correctional Centre, 541 Kawartha Lakes County Road 36, Lindsay, Ontario

Cause of Death / Cause du décès
Prone position restraint and musculocutaneous injuries sustained during struggle, exertion and pepper foam exposure in the setting of cardiomegaly and worsening symptoms of schizophrenia

By what means / Circonstances du décès
Homicide

Original confirmed by: Foreperson / Original confirmé par: Président du

_____

_____

_____
Original confirmed by jurors / Original confirmé par les jurés

The verdict was received on the / Ce verdict a été reçu le 12 (Day / Jour) day of / December (Month / Mois) 20 23

Presiding Officer's Name (Please print) / Nom du président (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. David Cameron	2023/12/12

Presiding Officer's Signature / Signature du président

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)

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Verdict de l'enquête

The *Coroners Act* – Province of Ontario
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Inquest into the death of:
L'enquête sur le décès de:

Soleiman FAQIRI

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

To the Government of Ontario:

The Government of Ontario, specifically the Ministry of the Solicitor General and, where applicable, the Ministry of Health and the Ministry of the Attorney General, should:

Oversight and Accountability

1. Develop and issue a public position statement within 60 days of this verdict recognizing that correctional facilities are not an appropriate environment for persons in custody experiencing significant mental health issues.

2. Take immediate steps to ensure that any person in custody experiencing an acute mental health crisis is admitted to hospital for assessment and, when appropriate, treatment, in a therapeutic setting that is suitable, secure, and safe.

3. Adopt, as Provincial Policy, the principle of equivalence, which requires that persons in custody receive the equivalent quality and standard of healthcare services as is available in the community.

4. Immediately institute a provincial implementation committee ("Implementation Committee") dedicated to ensuring that the recommendations from this Inquest are comprehensively considered, and any responses are fully reported and published. The committee should annually report to a Deputy Minister and include senior members of relevant ministries central to the issues raised by this case, representation from the Ontario Public Service Employees Union, and an equal number of community experts and people with lived experience. It should be chaired by an independent expert who could speak freely on progress made on implementation, including an annual public update on implementation.

5. Establish an Independent Provincial Correctional Inspectorate or equivalent body ("Correctional Inspectorate") led by a person appointed by Order in Council. This body's authority should include the authority to:

    a. Investigate individual and systemic complaints in correctional facilities with the necessary powers to summon and interview people with relevant information and examine people under affirmation,
    b. Initiate its own investigations,
    c. Review operations and identify non-compliance with any applicable legislation, regulations, correctional policies, and procedures,
    d. Review and report on the use of segregation and restrictive confinement,
    e. Direct that remedial or preventative actions be taken,
    f. Make recommendations that shall be considered by government,
    g. Directly engage the responsible Minister,
    h. Have a special report tabled in the Legislature, and
    i. Publicly and annually report on its investigations, collected data, and the correctional system.

6. Establish an Independent Advisory Committee (“Advisory Committee”) at all correctional facilities with members from all job groups and the community, including people with lived experience, representation from the Ontario Public Service Employees Union, and families of persons who have died in custody. The Advisory Committee should:

    a. Be co-chaired by a person with lived experience,
    b. Meet on an ongoing and regular basis to review the conditions of the facilities and the management of persons in custody with mental health issues,
    c. Receive and provide advice on issues raised by facility staff, persons in custody, families, and advocates,
    d. Provide advice on effective functioning with all elements of the correctional system, with the goal of enhancing workplace culture and communication,
    e. Consider and advise on recommendations from inquests and other review bodies,
    f. Prepare reports, as appropriate, which should be posted publicly.

7. Continue to take immediate steps to ensure that persons in custody experiencing significant mental health issues are identified, are not housed in conditions of confinement that constitute segregation, and that all segregation placements are properly tracked and reviewed.

8. Upgrade infrastructure to ensure adequate programming, interview space, and single cell accommodation are available at each correctional facility.

9. Establish an independent Rights Advisor and Prisoner Advocate (“Advocate”) at all correctional facilities for all persons in custody, regardless of security classification, status, or placement. The Advocate should be responsible for providing advice, advocacy, and support to persons in custody, including regarding corrections policy and practice, appropriate use of force, segregation, seclusion, and the right to proper healthcare. The Advocate must be notified immediately upon any increased restrictions on the person in custody’s conditions of confinement.

10. Take immediate steps at all correctional facilities, including Central East Correctional Centre (“CECC”), to create special needs units with appropriate and consistent staffing levels and specialized staff to support the needs of people with mental health issues who cannot be housed in the general population. The Rights Advisor and Prisoner Advocate should be readily accessible to persons in the special needs units.

11. Implement all recommendations from the Report from the Expert Panel on Deaths in Custody issued by the Office of the Chief Coroner in January 2023.

12. Regularly review the existing accountability process pertaining to correctional management, including institutional and regional management, to ensure fair, transparent, and equitable consequences for work-related conduct. Following the review, share a report with all correctional employees setting out the review process, information gathered, conclusions, and any resulting changes.

<u>Correctional Healthcare Governance and Healthcare Capacity</u>

13. Take immediate and urgent steps to establish a Provincial Agency within the mandate of the Ministry of Health and in liaison with the Ministry of the Solicitor General to directly deliver and oversee healthcare services in correctional facilities, including responsibility for quality improvement, capacity-building, and system planning. The establishment of a Provincial Agency should have, at minimum, a net neutral impact on Ontario Public Service employment. Any other recommendation regarding healthcare and governance is in addition to, and not in place of, a Provincial Agency.

14. Establish formalized partnerships among all provincial correctional facilities and appropriate specialized psychiatric hospitals, with forensic psychiatry units, ensuring access to services equivalent to the Acute Stabilization Unit provided at St. Joseph’s Health Care in partnership with the Hamilton Wentworth Detention Centre.

15. Require and establish standardized practices, consistent with best practices in community mental health care, in the treatment and care of persons in custody with mental health issues across all correctional facilities, including the consistent use of screening and assessment tools by trained mental health professionals.

16. Implement a quality assurance cycle to continuously identify problems with respect to healthcare provided to persons in custody and develop and test solutions.

17. Improve the effectiveness of healthcare at correctional facilities through:

    a. A targeted recruitment strategy for doctors, nurses, nurse practitioners, social workers, and healthcare staff in correctional facilities, focusing on specialized training in correctional healthcare,
    b. A protocol for all correctional facilities defining the role and responsibilities of the Most Responsible Provider, which should provide clarity on who is responsible for a patient in custody, and make such assignment clear and obvious with instructions on whom to contact during off-hours,
    c. Increase the salary and benefits for physicians, psychiatrists, psychologists, nurses, social workers, and other healthcare staff to ensure their compensation is equal to the compensation paid to healthcare workers in the community. This is to attract and increase staffing to ensure services equivalent to those received in the community,
    d. An increase in the number of hours for primary care physicians and psychiatrists at correctional facilities, and
    e. Requiring all healthcare managers and administrators to have appropriate healthcare education and experience.

18. Ensure that persons in custody have a mechanism to raise complaints to the Correctional Inspectorate or other oversight body about their healthcare while in custody.

19. Ensure that healthcare and operations staff and management are made aware of their authority to take persons in custody with mental health issues to the hospital.

20. Ensure that all correctional facilities obtain and maintain accreditation through Accreditation Canada and make public the reports and results of their most recent accreditation reviews.

21. Provide the necessary leadership, coordination, and resources to local hospitals relied upon by correctional facilities for the healthcare of persons in custody experiencing an acute mental health crisis, including Ross Memorial Hospital, to allow for:

    a. A clear understanding that hospitals and correctional facilities must engage in effective communication and coordination to ensure appropriate and responsive healthcare of persons in custody experiencing acute mental health crises,
    b. Hospitals having sufficient capacity to admit people who require hospitalization for inpatient mental health care, without having a negative effect on the hospital's budget or the hospital's capacity to serve its community,
    c. Better coordination and effectiveness of transfers from the correctional facility to local hospitals, and
    d. An improved working relationship between hospital and correctional facilities.

22. Ensure that all physicians and nurse practitioners in correctional facilities are registered users of eConsult Ontario and able to access the service from within correctional facilities to ensure quick access to an external roster of psychiatrists and other medical specialists.

23. Require that eConsult Ontario implement a triage process that would categorize incoming requests by level of urgency and provide a service commitment for urgent requests that would ensure a response within 12 hours of receipt.

Mental Healthcare Approach in Corrections

24. Require that healthcare staff and operations staff create an individualized care plan for all persons in custody with mental health issues, as early as possible after admission or upon detection, which should include:

    a. A case-management, individualized approach to the care of persons with mental health issues from the point of admission to discharge,
    b. Inter-disciplinary staff engagement in understanding and addressing the healthcare of persons with mental health issues,
    c. Discharge planning with appropriate community agencies, and
    d. Culturally safe, respectful engagement that ensures a safe environment free of racism and accommodates religious expression.

25. Require that healthcare staff develop a healthcare plan, integrating information from community mental health providers, if applicable and available.

26. Require that appropriate operations staff and healthcare staff hold regular inter-disciplinary team meetings to discuss the ongoing care of persons in custody with mental health issues and their care plan, which should include a written guideline articulating a person-centered approach to care decisions. This guideline should include:

    a. The circumstances that would require consultation with healthcare staff and management, corporate healthcare, other medical specialists, community-based mental health services, and family,
    b. The need to reduce the use of a single gatekeeper in making decisions about taking a person in custody to hospital, which should instead be the result of a comprehensive and collaborative healthcare process,
    c. When this guideline would not apply. For example, when there is a risk to delaying care such as an emergency requiring immediate hospitalization, and
    d. The guideline being shared with all correctional staff.

Coordination between Sectors

27. Implement evidenced-based integrated mental healthcare pathways between hospitals, correctional facilities, and community-based mental health services to ensure timely transfer, communication, information-sharing, and continuity of care for persons with mental health issues who may come into contact with the law.

28. Develop and make public educational materials for community healthcare providers concerning their authority to share medical records regarding people in custody with health care professionals working in correctional facilities. This should include engaging relevant healthcare entities, such as the Ontario Hospital Association, the Human Services & Justice Coordinating Committee, and healthcare professional associations, in developing these materials.

29. Increase resources to support consistent implementation, evaluation, and standardization of best practices in community-based mental healthcare, such as assertive community treatment and/or case management, supportive housing, mental health court support, and prison in-reach teams to provide ongoing support to persons with mental health issues who are involved in the justice system.

30. Establish formalized partnerships with community mental health agencies to be able to provide mental health services and resources within correctional facilities after appropriate training.

31. Explore the possibility of using video recordings to enhance accountability in correctional facilities. This should include engaging appropriate expertise to understand human rights and privacy interests.

Courts and Mental Health Assessments

32. Fund and appropriately resource mental health support programs and develop best practice guidelines and standards for supporting and accommodating persons with serious mental health issues who come before the criminal courts, including those who are not referred to mental health diversion.

33. When the court makes an order for a fitness assessment when someone is charged with a criminal offence, strive toward a best practice of having such assessment occur within 24 hours.

34. Expand the Forensic Early Intervention Service, currently available in Toronto, throughout the province.

35. Develop standardized protocols and pathways, when a court makes an order for a mental health assessment, for a direct transfer of the person to a hospital rather than awaiting such assessment in a correctional facility.

36. Ensure access to mental health assessments by a mental health professional for persons in custody with serious acute mental health issues within 24 hours of a court order or remand. This could include engaging in partnerships with mental health providers who are funded to deliver such care.

37. Consider expanding access to mental health courts throughout the province and eligibility for such courts based on a person's mental health needs, rather than the nature of the alleged criminal offence. This should include:

    a. Monitoring ongoing appropriateness of these courts, ensuring cultural competency and outcomes, and being led by an advisory group including persons with lived experience, and
    b. In jurisdictions without mental health courts, implement an informal mental health strategy based on a mental health court's therapeutic goals for accused persons, where appropriate.

38. Educate justice system participants, including judges, justices of the peace, and lawyers, and hospital administrators regarding the availability of assessments and options under the *Mental Health Act* beyond assessments for fitness and criminal responsibility.

39. Strongly consider establishing special designated beds in psychiatric facilities for court-ordered assessments under the *Mental Health Act* beyond assessments for fitness and criminal responsibility.

Training and Education

40. Provide correctional staff and management with mandatory, specific, and regular training on understanding mental health issues to better equip them to manage persons in custody presenting with mental health issues. Such training should be evidence-based, approved by, and delivered by experts in mental health. The training should include the participation of persons with lived experience who are appropriately supported such that they can participate safely and effectively. The training should include:

    a. Understanding when mental health issues require immediate attention,
    b. Regular seminars featuring mental health and psychiatric experts, and persons with lived experience, to educate correctional staff about the experiences of people in crisis, and the importance of effectively communicating with such persons and treating them with empathy and respect,
    c. Trauma-informed de-escalation and disengagement strategies and techniques, with mandatory emphasis on de-escalation or disengagement as the first intervention before any use of force,
    d. The respectful care of persons with mental health issues,
    e. Scenario-based training specific to interacting with persons in crisis, including de-escalating situations in use of force training,

f. Reviewing scenarios specific to their job duties, including one involving the circumstances surrounding the death of Soleiman Faqiri, and
g. Understanding of legislation that intersects with professional responsibilities, including the *Mental Health Act* and the *Personal Health Information Protection Act*.

41. Enhance awareness of the importance and significance of psychological health and safety for all those working in correctional facilities.

42. Review and evaluate the effectiveness of all mental health-related training, which could include using multiple assessment methods, such as performance reviews, simulation exercises, and pre- and post-assessments.

43. Provide correctional staff and management with mandatory annual training on human rights, anti-racism, anti-bias and stereotyping, cultural safety, and intersectional barriers. Training on these matters should also be integrated into other areas including de-escalation, use of force, and scenario-based training.

<u>Use of Force</u>

44. Raise awareness of the mandatory bystander intervention policy that directs all correctional staff and management to intervene, which could include stopping, in a situation involving an excessive use of force and report such use of force. This should be accompanied by:

    a. Mandatory scenario-based training and mandatory annual refresher courses for all correctional staff, and
    b. Educating staff that there will not be repercussions for intervening, stopping, or reporting such conduct, but that there will be accountability for failing to intervene or report with potential repercussions up to and including dismissal.

45. Monitoring and evaluating the effectiveness of the bystander intervention policy, which should include collecting and publicly reporting disaggregated data on the number of times correctional staff and correctional management report that they have intervened and circumstances that warranted such interventions.

46. Ensure that healthcare staff receive mandatory bystander intervention training, which requires them to intervene and report on excessive use of force, to help them understand their own roles and responsibilities in this regard.

47. Review, evaluate, and improve policies and training related to use of force, including the risk of the use of pepper foam, spit hoods, and restraint, with an emphasis on the specific danger of positional or restraint asphyxia. Training must include the differential impact of using any form of force on a person in mental health crisis with mandatory and annual regular refresher training. Revisions to spit hood policies and training should include a requirement that a correctional officer be continuously present with any person on whom a spit hood is applied.

48. Review and refresh current de-escalation training in consultation with people with lived experience. The renewed de-escalation training should be mandatory for all correctional staff and should be subject to recertification every two years.

49. The Use of Force Report should include a means of noting whether the force was used on a person with mental health issues and disaggregated data, including demographic information, should be collected, and publicly reported.

50. Require that a use of force on a person with mental health issues be reported to and reviewed by the correctional facility's superintendent and corporate healthcare, and that senior management conduct a comprehensive debrief with affected and involved staff and persons in custody, focusing on the event's details, responses, outcomes, and learning points.

51. Provide trauma-informed mental health support for persons in custody and correctional staff directly or indirectly affected by a use of force to assist them to effectively manage and recover from any resulting impact.

52. Ensure that healthcare staff receive mandatory use of force training to help them understand the roles and responsibilities of operations staff.

53. Review current use of force policies and training, and revise to ensure clarity on the designation of the highest-ranking officer on scene during an emergency (code blue) situation, how and when the Institutional Crisis Intervention Team ("ICIT") is engaged, planned use of force, and defensive and offensive techniques. Provide mandatory and repeated training following appropriate revisions that should include ICIT-level team co-ordination tactics.

54. Consider developing a community-based crisis intervention alternative to an Institutional Crisis Intervention Team to address mental health crises, with staff specifically trained in de-escalation and disengagement.

55. Review and update the Inmate Handbook. The handbook should include the use of force policies. This handbook should be provided to persons in custody upon request and inmates should be made aware that it is available to them during the admission process.

<u>Family Support</u>

56. Implement a family-centered approach for continuous information flow and provide compassionate support for family members of persons in custody with mental issues. This should include:

    a. Designating a family liaison as a direct line of contact for a family that is responsible for keeping the family informed of any developments in the person in custody's care and well-being,
    b. Eliminating unnecessary barriers to family visitation,
    c. Virtual communication options when in-person visits are not possible or appropriate,
    d. Considerations for appropriate cultural and religious burial practices of the person in custody who has died, and
    e. Dignified notification approaches when the person in custody has died, which should ensure the presence of a person who is able to provide information regarding the circumstances of the death.

<u>Implementation</u>

57. Seek and allocate funding and resources adequate to implement the above recommendations with no negative impact on Ontario Public Service employment and resources. This funding should be sought in the 2025 provincial budget or before.