SUBMISSON

Annual Reviews for Death in Correctional Institutions

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About the John Howard Society of Ontario

For more than 90 years, we've worked to keep the humanity in justice.

Today we continue to build a safer Ontario by supporting the people and communities affected by the criminal justice system. Our 19 local offices deliver more than 80 evidence-based programs and services focused on prevention, intervention and re-integration across the province. These range from helping youth develop the life skills that will let them achieve their full potential, to helping families navigate issues of criminal justice, to providing job training for those leaving incarceration so they can contribute to their community in a meaningful way. We promote practical, equitable policies while raising awareness of the root causes of crime and calling on Ontarians to share responsibility for addressing them. Within the system itself, we advocate for the fair treatment of every individual. Each year, our work impacts the lives of more than 100,000 Ontarians.

Coroners' inquests are an important means of providing the public with transparency and, for families of those who have passed away within institutions, with clarity and closure. Inquests serve an important public purpose by generating recommendations to prevent future deaths. They also provide the opportunity for external scrutiny into the correctional system – a system that is largely concealed from public view. The Ministry of Solicitor General announced a proposal to replace the current system of mandatory Coroner's inquests for non-natural deaths in correctional institutions with a mandatory Coroner-led annual review of these deaths. The following submission outlines JHSO's responses to the stakeholder engagement questions provided by the Coroner's office and input on crucial considerations for the implementation of an annual review process.

The Current Inquest Process

John Howard Societies support individuals involved in the justice system, and JHS clients are sometimes the deceased in an inquest. JHS offices also support loved ones and families of individuals experiencing incarceration and participate directly in inquests through obtaining party standing.

The *Coroners Act* identifies three obligations for death investigations: scrutinize the circumstances of the death; answer five questions; and consider recommendations to prevent further deaths. Of the three obligations, although they are all important, JHSO believes that the most significant obligation is to consider recommendations to prevent further deaths. Understanding and scrutinizing the circumstances surrounding the death, and answering the five questions, are essential to determining what happened and informing a set of robust recommendations. Identifying systemic gaps and promoting well-thought-out improvements can reduce risks and enhance safety for incarcerated people and staff alike within institutions.

In addition to the above listed obligations, inquests also provide an important opportunity for public examination of the correctional system. Through parties with standing and media in attendance, the processes, procedures and circumstances of particular tragic events are reviewed. This transparency helps illuminate what often remains hidden from the public view.

Examining deaths at an institutional level allows light to be shed on operational challenges, local and institution-specific practices and policies that may have contributed to a death. Each facility has its own culture, staffing patterns, physical environment and resource constraints, and though across the province there may be similarities, individual institutional characteristics may be lost when deaths are grouped too broadly.

We also note that the current inquest process presents challenges; inquests can be resource-intensive and, as a result, may take place years after the death of the individual. We also acknowledge the emotional impact this process may have on families and loved ones. Revisiting the circumstances of a death can be deeply painful, and some may choose not to participate. At the same time, experience has shown that many families find inquests very important as they want information and transparency around their loved one's death.

Annual Review Proposal

Coroner-led annual reviews for deaths in correctional institutions have the potential to provide improved analysis on trends and systemic issues across the province. Reviewing deaths across multiple institutions would provide important comparisons and trends, identify reoccurring root causes and track repeat recommendations and their implementation progress.

Both individual inquests and systematic reviews have strong benefits for preventing deaths and promoting public safety. The greatest benefit would come from reviewing individual deaths within specific correctional institutions, while still drawing value from comparing findings across the province. JHSO would suggest the following considerations guide the creation of a Coroner-led annual review process for deaths in correctional institutions.

Parties with interest in the death, including family members, individuals and organizations, should have the ability to request a full inquest.

Families should receive clear, accessible information about the annual review process, and inquests to make an informed decision about whether they would like to request a full inquest for the deceased loved one. In addition to family members, other parties, including lawyers or organizations, should be able to request a full inquest. Not every deceased has family members but others with information or connection to their death may have good reason to request an inquest in the public interest. Individuals should be able to request an inquest within a reasonable timeframe, including following the release of the annual review report since that may be the first time they are alerted to the death. For the Construction Death Review process, individual inquests can be requested before or within a year after, the release of an annual review report. This timeline can be adopted for the annual deaths in corrections review process. Considerations for the approval or denial of requests for inquests should be made public for transparency. If an inquest request is denied, there should be reasons provided by the Coroner's office for the refusal, subject to judicial review.

The scope of the annual review should not be limited to non-natural deaths.

To ensure a comprehensive understanding of mortality in correctional institutions, reviews of deaths in corrections should include deaths from disease or internal failure. This broader approach will help provide a more accurate picture of systemic issues and health-related challenges within these facilities as gaps in access to healthcare or environmental conditions have been known to contribute to fatalities. A broader review of deaths including those deemed natural would provide a more accurate view of patterns and systemic issues.

The review should incorporate socio-demographic factors such as age, gender, ethnicity, health status, mental health status and any other pertinent factors.

Socio-economic data can help identify patterns and trends of vulnerability and inequities within the correctional system. The review should also include information on relevant health indicators while complying with privacy regulations. This level of transparency is essential for identifying disparities and ensuring informed, equitable, evidence-based recommendations.

The process should include multi-year tracking of recommendations, root causes and ministry responses.

The review should analyze recurring issues and recommendations and assess the progress in implementing recommendations over time. The review should also summarize key findings and recommendations from any inquests conducted during the year. Individual inquests can make it seem like there are isolated incidents or issues but a systemic review of trends in deaths and causes reveal underlying patterns leading to more informed recommendations. Furthermore, the report should consider the impact of broader societal health issues, such as pandemics or public health crises, that may have affected mortality rates in correctional settings.

There should be a mechanism for stakeholder participation.

In the present system, key stakeholder groups are able to request standing to participate in the process, put forward evidence, learn about internal operations and inform the recommendations. In order to preserve public transparency and oversight, organizations should have the opportunity to contribute feedback to the annual review process by providing evidence or submissions. Collaboration with such organizations allows for continued public input into the process and can strengthen the recommendations or the examination based on knowledge they may have about the individual case or systemic issues they have identified.

Structure of the Committee

The committee should include diverse expertise. The Coroner should consider including members with correctional health expertise like correctional physicians, mental health processionals, individuals with understanding of custodial operations, independent members without ties to the correctional system and people with lived experience. All committee members should have a strong understanding of the correctional and health systems and the social determinants of health. Since provincial and federal correctional institutions are different in many ways, committee members should differ for provincial and federal deaths in corrections to ensure each type of review is done with the requisite level of experience and understanding.

The final report must be published publicly and be easily accessible.

This should include proactive media outreach and a clear communications plan for the report launch. The annual review should be published and proactively shared with different audiences, including families, policymakers, practitioners, and the public. Clear and concise summaries should be made available to institutions so they can be reviewed by staff, and should also be posted on the website for ease of tracking recommendations. The Coroner's office should also explore mechanisms to share the annual reports with incarcerated populations.