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,

[redacted] of / de Toronto
[redacted] of / de Toronto
[redacted] of / de Toronto
[redacted] of / de Toronto
[redacted] of / de Toronto

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
Hassan	Abdurahman

aged / à l'âge de 39 held at / tenue à Virtual Office of the Chief Coroner, Ontario

from the / du 16th of January to the / au 10th of February 20 23

By / Par Dr. / Dr David Eden, 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
Hassan, Abdurahman

Date and Time of Death / Date et heure du décès
June 11th, 2015 at 1:28am

Place of Death / Lieu du décès
Peterborough Regional Health Centre

Cause of Death / Cause du décès
Sudden death during struggle/restraint with a towel placed on the mouth, under the nose in the setting of schizophrenia and hypertensive heart disease

By what means / Circonstances du décès
Undetermined

[redacted] [redacted]
Original confirmed by: Foreperson / Original confirmé par: Président du jury

[redacted]
[redacted]
[redacted]
Original confirmed by jurors / Original confirmé par les jurés

The verdict was received on the / Ce verdict a été reçu le 10 (Day / Jour) day of / February (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)

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

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

To Government of Canada

1. Seek and allocate resources to develop and implement a plan to end the practice of housing immigration detainees in provincial correctional facilities in Ontario.

2. Redefine the purposes of immigration detention to include rehabilitation and when appropriate to the detainee's circumstances, reintegration into the community. This should include resources and facilities to:
    a. Stabilize detainees with acute mental health symptoms,
    b. Develop care plans for detainees with mental illnesses, and
    c. Assist with discharge planning.

3. Amend the agreement between Canada and Ontario to prohibit placing immigration detainees in conditions of segregation and to require immediate notification if this prohibition is violated.

4. Establish an independent oversight body to:
    a. Review and investigate conditions of detention for immigration detainees,
    b. Receive complaints about the conditions of detention, and
    c. Investigate critical incidents and fatalities involving immigration detainees.

5. Collect data on conditions of detention and consider this data when determining whether to continue housing an immigration detainee in a provincial correctional facility, including:
    a. Whether the detainee was in conditions of segregation,
    b. Whether the detainee was triple-bunked,
    c. The number of days in lockdown and the impact of lockdown on access to health care, and
    d. Whether a serious mental illness alert has been issued for the detainee.

6. Seek and allocate resources to expand access to alternatives to detention for individuals with a serious mental illness.

7. Consult with the Province of Ontario about the possibility of funding beds at the St. Lawrence Valley Correctional and Treatment Centre for immigration detainees.

8. Train Canada Border Services Agency (CBSA) employees operating in the detention continuum on the impacts of detention on mental health.

To Government of Ontario

9. Consider withdrawing from the immigration detention agreement between Ontario and Canada.

10. Review the existing ombudsman process to determine whether immigration detainees have reasonable access to put forth complaints that result in timely remedies to conditions of detention.

To Ontario Ministry of the Solicitor General

Segregation – Interpretation and Tracking

11. Re-assess how the Ministry interprets the term "highly restricted conditions" in *Ontario Regulation 778*. In particular, the Ministry should adopt an interpretation designed to ensure that inmates are taken out of confined physical spaces for at least two hours per day.

12. Develop and implement a plan to ensure that "meaningful social interaction" is clarified and operationalized in a manner that reflects the plain meaning of the phrase and that it allows for sustained social interaction with other individuals.

13. Consider developing and implementing a new definition for "meaningful activities" that occurs when an inmate is alone and engaged in meaningful activities, to avoid confusion and facilitate public reporting.

14. In the interim, when tracking and reporting "meaningful social interaction", correctional staff should record solitary activities separately from social interaction involving other individuals.

15. Update the Ministry's publicly released data on the use of segregation to clearly indicate that the reported number of inmates held in conditions of segregation is likely inaccurate because of how "meaningful social interaction" has been interpreted by correctional staff.

16. The Ministry's future public reporting on the use of segregation should provide separate statistics for meaningful activities that occurs when an inmate is alone and meaningful social interaction that involves interaction with other individuals.

17. Monitor how often racialized inmates with serious mental illnesses are held in conditions of segregation. Make this information available to correctional and health care staff and report disaggregated data publicly.

Central East Correctional Centre (CECC) Segregation Review

18. Conduct a comprehensive review of compliance with segregation regulations at the CECC. The methodology for the review should include:
    a) An audit of a meaningful selection of segregation records,
    b) Interviews with correctional staff, management and affected inmates about how the terms "highly restrictive conditions" and "meaningful social interaction" are being interpreted and implemented, and
    c) An assessment of the infrastructure, staffing and operational resources required to comply with all segregation regulations, including the prohibition against placing inmates with serious mental illnesses in conditions of segregation.
    d) Share findings and best practices with other correctional centers.

19. The Ministry should seek and allocate funds to complete and implement an Action Plan to address and support the results of the CECC Segregation Review. This should include a plan to upgrade the physical infrastructure at the CECC to ensure compliance with the prohibition against placing inmates with Serious Mental Illnesses in conditions of segregation.

20. The CECC Segregation Review and Action Plan should be made a high priority.

Hospitalization

21. Develop clear policies about alerting family members when an inmate has been hospitalized.

Health Care at CECC

22. Prioritize implementation of the planned Electronic Medical Records system at the CECC.

23. Prioritize implementing the Action Plan that resulted from the CECC Health Care Review.

24. Seek and allocate resources to recruit and retain adequate health care staff to meet the needs of the inmate population at the CECC.

25. Increase number of hours for primary care physicians and psychiatrists at the CECC.

Race-based Data Collection and Reporting

26. Collect and publicly report on the race and ethnicity of all people who are detained in provincial

correctional facilities. Include characteristics such as reasons for detention, length of stay, age and sex distribution.

Policing

27. The Ontario Police College should review current police training with respect to the use of the term “excited delirium” to ensure that it is consistent with the latest medical and scientific research concerning the risk of sudden death in cases of police restraint of persons experiencing extreme agitation. In particular, the term “excited delirium” should no longer be used to describe the risks associated with restraining an agitated individual.

28. The Ontario Police College should review, and if appropriate, amend training policies and procedures respecting de-escalation tactics, crisis intervention, anti-racism, and mental health.

29. All Ontario police services should seek and allocate resources to create and maintain advisory committees on mental health, addictions, and anti-racism, and that these committees include members of these communities, as well as organizations that advocate on behalf of these communities.

30. Review the current Use of Force Model (2004) and related regulations and training.

31. All Ontario Police services should consider requiring or encouraging officers to:

    a. Communicate a concern when there is excessive use of force.

    b. Document all observed Use of Force and de-escalation strategies attempted.

To Ontario Provincial Police (OPP)

32. The OPP should implement a policy in the Ontario Provincial Police Orders with respect to the use of “additional means of restraint” that applies to OPP officers using such restraints at a facility that is not an OPP lockup, courthouse, or lockup of another police service.

33. The policy with respect to “additional means of restraint” should apply to OPP officers on both regular and paid duties.

34. The policy with respect to “additional means of restraint” should apply to both restraints that are authorized by the OPP and to improvised restraints.

35. The policy with respect to “additional means of restraint” should require that prior authorization be obtained from a supervisor for the use of additional means of restraint. Where exigent circumstances do not permit prior authorization, the policy should require that the use of additional means of restraint be reported to a supervisor as soon as practicable.

36. The OPP should amend the current Ontario Provincial Police Orders relating to Spit Hoods to clarify that it applies to any item that is improvised to be used as a spit hood.

37. The OPP should immediately notify all frontline officers that the use of any restraints in a manner that obstructs or partially obstructs an airway imposes a significant risk of sudden death. Information concerning the risk of sudden death from the obstruction or partial obstruction of a person’s airway should be incorporated into Use of Force training.

38. The OPP should alert other police services in Ontario to the potential need to clarify policies concerning the use of improvised restraints.

To OPP, Peterborough Police Service (PPS), CECC and Peterborough Regional Health Centre (PRHC)

39. PRHC, the OPP, PPS, and CECC should collaborate on developing a protocol to clarify the roles, responsibilities and interactions of hospital personnel, police, correctional officers, and special constables in situations where they are assigned to guard patients in custody.

40. The protocol should require that hospital personnel and resources, including multi-disciplinary staff, be considered before police officers or correctional officers are requested to restrain a patient in custody for the provision of healthcare.

41. The OPP, PPS, CECC and PRHC should develop and implement the necessary policies and training to support the protocol.

42. PRHC and the CECC health unit should collaborate on developing a protocol that provides for the sharing of relevant patient information (subject to applicable law) necessary to provide trauma-informed care to patients and to improve safety. PHRC should support input from relevant community organizations and people with lived experiences in the development of the protocol.

43. Where feasible, the CECC should ensure that patients in CECC custody are accompanied at all times by Correctional Officers.

44. The OPP, PPS, and CECC should collaborate on developing a protocol for the sharing of information necessary for the safety of the patient, the public, hospital personnel and police or correctional officers assigned to guard the patient.

To Peterborough Regional Health Centre

45. PRHC should update their procedures/policies to state that hospital personnel should not apply or assist anyone in applying a non-hospital approved restraint. After the update, ensure that the policy is circulated to relevant hospital personnel.

46. PRHC should update their procedures/policies to state that no form of restraint should be applied in a manner that may obstruct or partially obstruct a patient's airway. After the update, ensure that the policy is circulated to relevant hospital personnel.

47. PRHC should review their workplace violence prevention program and consider training updates with a focus on restraints and supports for de-escalation, using a trauma-informed, intersectional lens.

48. The PRHC Health, Equity, Diversity and Inclusion Committee should include in its mandate the development and deployment of training in the areas of trauma informed care, anti-racism, equity, and implicit bias in clinical settings. People with lived experience should be involved in the development, deployment and review of such training.

49. The PRHC Health, Equity, Diversity and Inclusion Committee should review what steps may be taken to facilitate and promote data collection practices to obtain meaningful information, including the collection of disaggregated socio-demographic data from all areas of the hospital, to inform the development and deployment of ongoing training.

50. The PRHC should implement a process to provide adequate access to counseling and confidential debriefs when traumatic events occur.

To the Office of the Chief Coroner / Ontario Forensic Pathology Service

51. Consider conducting inquests in a timelier manner from the date of the incident.

To the Special Investigations Unit (SIU)

52. Provide direct notification in a timely manner to individuals involved in an SIU investigation that the investigation has concluded and confidentiality is no longer necessary.

53. Inform civilians involved in an SIU investigation of their rights and responsibilities and allow them access to confidential counseling services for the duration of the investigation.