2024 CarswellOnt 5202
Ontario Coroner

Elliot, Re

2024 CarswellOnt 5202

Inquest into the Death of Jayson ELLIOT

Selwyn A. Pieters Presiding Officer

Heard: February 26, 2024; February 27, 2024; February 28, 2024; February 29, 2024; March 1, 2024
Judgment: April 10, 2024
Docket: None given.

Proceedings: additional reasons to *Elliot, Re* (2024), 2024 CarswellOnt 4699, Selwyn Pieters Presiding Officer (Ont. Coroner)

Counsel: Peter Napier — Inquest Counsel
Tiffany Elliot, Cathy McKnight — themselves
Larissa Easson, for Ontario Ministry of The Solicitor General

Subject: Civil Practice and Procedure
Related Abridgment Classifications
Judges and courts
VII Coroners
VII.2 Coroner's inquest
VII.2.b Practice and procedure
VII.2.b.ix Verdict or inquisition
VII.2.b.ix.B Explanation of verdict
Headnote
Judges and courts --- Coroners — Coroner's inquest — Practice and procedure — Verdict or inquisition — Explanation of verdict
Verdict explanation following inquest into death of person in custody.
Table of Authorities
Statutes considered:
Coroners Act, R.S.O. 1990, c. C.37
s. 10

s. 31(1)

***Selwyn A. Pieters Presiding Officer*:**

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OPENING COMMENT

1 This verdict explanation is intended to give the reader a brief overview of the circumstances surrounding the death of Jayson Elliot as well as some context for the recommendations made by the jury. The synopsis of events and comments are based on the evidence presented and written to assist in understanding the jury's basis for the recommendations.

PARTICIPANTS

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Parties with Standing:	**Represented by:**
The Ellliot Family - Tiffany Elliot (sister of the deceased) and Cathy McKnight (cousin of the deceased)	Self-Represented
Ontario Ministry of The Solicitor General	Larissa Easson, Counsel Ministry of the Solicitor General 655 Bay Street, Suite 501 Toronto, ON M7A 0A8 Larissa.easson@ontario.ca

SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

3 On May 11, 2021, Mr. Jayson Elliot was housed on a range in cell number 8 with one other cellmate, Mr. Shane Bullis, at the Ottawa-Carleton Detention Centre (OCDC). According to the written and verbal statements of Mr. Bullis that were admitted into evidence at this inquest, Mr. Bullis heard Mr. Elliot trying to clear his throat because he was choking on something. Mr. Bullis thought Mr. Elliot was choking on a muffin from his supper. Mr. Elliot started to bang on the cell door for help, stating that he couldn't breathe. Mr. Elliot collapsed, hitting his head off the bunk or the floor as he fell to the ground unconscious. Mr. Bullis then began to bang on the door to get a staff member's attention.

4 Sergeant Sylvana Baric was on duty that night at the OCDC when she heard banging on a cell door. Thinking it was coming from another cell, she went to that cell first but then went to the cell occupied by Mr. Bullis and Mr. Elliot. When she looked inside the cell, she saw Mr. Elliot lying on the ground, and called a medical emergency. Correctional officers and registered nurses attended the cell and found Mr. Elliot unresponsive.

5 Some of the events described above were captured on video footage from a camera on the range which recorded the area immediately outside cell 8. The door of cell 8 can be seen moving in a manner consistent with Mr. Elliot and then Mr. Bullis banging on the cell door. During the inquest the parties agreed that a timeline summary of pertinent events captured on the video surveillance could be filed as an exhibit. According to this agreement, the following events occurred at the following times:

8:16:44 p.m.	Cell door 8 seen shaking.
8:17:39 p.m.	Cell door 8 seen shaking a second time.
8:17:50 p.m.	Acting Sergeant Baric arrives at cell 8, looks inside the cell window, and walks out of camera view.
8:18:10 p.m.	Acting Sergeant Baric attends Cell 8 again with Correctional Officers O'Brien, Smith, and Aitken. Correctional Officer O'Brien uses his portable radio to request cell 8 door be opened.
8:18:20 p.m.	Cell 8 door opens, and Mr. Bullis exits the cell. Correctional Officers O'Brien, Smith, and Aitken, followed by Correctional Officer Thompson, enter cell 8.

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6 Following the entry into the cell by correctional officers O'Brien, Smith and Aitken, institutional nursing staff arrived at the cell. The first nurse arrived at 8:20:08, a second nurse at 8:20:57 another nurse at 8:21:08 followed by two other nurses at 8:21:23 and 8:21:45 respectively.

7 Emergency medical services were called by Sergeant Siroski through 911 at 8:21:01 according to the timestamp on the recording of the 911 call which was played at this inquest.

8 Both correctional officers and nursing staff provided first aid and medical care to Mr. Elliot, including the administration of back blows, chest compressions, CPR, air-way suctioning and bag mask-assisted ventilation. None of these efforts were successful. Mr. Elliot was removed from cell 8 at 8:30:31 and further efforts to resuscitate Mr. Elliot were made by paramedics. These efforts were also unsuccessful, and Mr. Elliot was declared deceased at 8:57 p.m.

9 The death was investigated by the Coroner and the Ministry of the Solicitor-General, which manages OCDC, conducted an internal review through its Correctional Service Oversight and Investigations unit ("CSOI").

THE INQUEST

10 Dr. Louise McNaughton-Filion, Regional Supervising Coroner, East Region, Ottawa Office, called a mandatory inquest into the death of Jayson Elliot pursuant to section 10 of the *Coroners Act*.

11 The document outlining the scope of this inquest is attached as an Appendix to this verdict explanation.

12 The inquest was conducted in a virtual manner, with remote participation by parties with standing and remote testimony from all witnesses. In keeping with the open court principle, the inquest was streamed live.

13 The jury sat for five days, heard evidence from 10 witnesses, reviewed 10 exhibits and deliberated for five hours in reaching a verdict.

VERDICT

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Name of Deceased:	Jayson Elliot
Date and Time of Death:	May 11, 2021, at 8:57 p.m.
Place of Death:	Ottawa-Carleton Detention Centre 2244 Innes Road, Ottawa, Ontario
Cause of Death:	Choking on food
By What Means:	Accident

RECOMMENDATIONS

To the Ottawa-Carleton Detention Centre (OCDC):

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1. Provide cellular telephones to on-duty correctional officers at the Sergeant level and above for use in notifying Emergency Medical Services (EMS).

Comment:

Evidence was heard from a Deputy Superintendent at OCDC that he was frustrated that he was not able to provide real-time information to the 911 operator as he had to speak to her from his office rather than from on the range where the incident was unfolding. This witness held the rank of a Sergeant on May 11, 2021. He testified that it would have saved

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time and would have been more efficacious for him to have had a cellular telephone and requested that the jury make that recommendation. There was no at the inquest to suggest that providing cellular telephones to on duty correctional officers at the Sergeant Level and above at the OCDC was unreasonable.

2. Enhance current scenario-based training provided to nursing staff and correctional officers. This training should:

a) Be done on a recurring basis and should be mandatory for nursing staff and correctional officers,

b) When possible, utilize external entities such as such as the Ottawa Hospital or other local hospitals and external medical staff,

c) Include realistic scenarios involving persons in custody where the person is unresponsive and/or is suffering from an obstructed or damaged airway,

d) When possible, be conducted in a facility or environment that can accommodate training scenarios and/or simulate the environment of a correctional institution, and;

e) Include training on coordination, cooperation, and communication between correction officers and nursing staff during a medical emergency, including training on "closed loop" communication when appropriate.

Comment:

The jury heard evidence that scenario-based training had been provided at the institution. Correctional and medical staff felt that this training should be recurring, and that attendance should be mandatory for all correctional and medical staff.

Additionally, a number of witnesses testified that external medical entities such as the Ottawa Hospital and their medical staff had participated in scenario-based training at the institution and that this participation was beneficial.

Witnesses also testified that the use of scenario-based training involving persons in custody who are unresponsive due to an unobstructed airway or otherwise would be useful. There was evidence that it was preferable for this training to be conducted in a facility or an environment that is similar to a correctional institution and that the training scenarios be based on events that occur in correctional settings.

Evidence was heard by the jury that a person experiencing an obstructed airway has a matter of minutes to be attended to in order to have the airway cleared. Training, coordination, and communication is important as delayed resuscitation efforts, particularly if a person in custody suffers a cardiac arrest, can negatively affect a successful outcome.

Correctional officers and nurses testified that unified training on a joint response to a medical emergency in the institution has not been a regular feature of their training, even though they both respond to and must manage these situations together. This recommendation would allow them to coordinate, cooperate, communicate, and critique their response and refine best practices in an effort to save lives.

The jury also felt that it would be useful for staff to be trained on "closed loop" communication — a communication technique in which the person receiving instruction or information repeats the message back to make sure the message is received and understood correctly.

To the Ottawa-Carleton Detention Centre (OCDC), the Ministry of the Solicitor General, and the Government of Ontario:

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3. Conduct regular audits of on-site medical equipment at the OCDC and at all provincial correctional facilities to:

a) Ensure that all available medical equipment is up to date,

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b) Review and add to medical equipment as necessary to be consistent with the needs of medical/nursing staff,

c) Ensure that medical/nursing staff is properly trained on the use of all medical equipment,

d) Assess and determine whether medical "crash carts" can be made available at correctional institutions, and;

e) Explore options for new, more compartmentalized medical bags to be made available at correctional institutions.

Comment:

Based on the evidence presented at the inquest, the jury felt that regular audits should be conducted at all provincial correctional facilities to ensure that all available medical equipment was up to date, was consistent with the needs of medical and nursing staff and that all medical/nursing staff were properly trained on the use of this equipment.

The jury heard evidence from nursing staff that medical "crash carts" and compartmentalized medical bags would be helpful in providing emergency medical care to persons in custody.

4. Consider providing enhanced Basic Life Skills (BLS) training to nursing staff similar to that provided to first responders and advanced cardiac care providers.

Comment:

Nursing staff testified that they were not provided with this training and that such training would be appropriate in an institutional setting where nurses encounter medical emergencies requiring a level of care similar to that provided by first responder paramedics and advanced cardiac care providers.

5. Review and revise nursing emergency response protocols to include:

a) Nurses responding to a medical emergency, when reasonably possible, should bring with them a fully equipped portable medical response bag or crash cart.

Comment:

Evidence was heard that nurses can be in any part of the institution when a medical emergency is called. They may be dispensing medications and would have to secure their medication cart in order to respond. One nurse testified she did not have a medical bag with her when she responded and she would have had to return to the medical unit to obtain one, which could result in delay. The jury felt that nursing staff should, when reasonably possible, bring a fully equipped portable medical response bag or crash cart with them to a medical emergency.

6. Conduct a review of current peer support and other support offered to nursing staff, correctional staff and witnesses following a critical incident to ensure that it is consistent across the province and consistent with other peer support programs provided to first responders which is trauma-informed, and which includes voluntary debriefings when appropriate.

Comment:

Mr. Elliot's sudden and unexpected death was very stressful and traumatic for correctional officers and nurses involved in his care. Some of them were still visibly upset when they gave their evidence at the inquest and many witnesses emphasized that they did all that they could to save Mr. Elliot but could not revive him. The jury strongly felt that peer support programs provided to staff should be reviewed to ensure that staff involved in a critical incident are provided with support programs that are similar to other support programs provided to first responders, are offered province-wide, and are both trauma-informed and voluntary.

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7. Should consider providing access to the same radio communication tools that correctional officers use for nurses.

Comment:

The jury heard that nurses do not currently have radio sets and the first they knew of the emergency was when the medical alert was communicated over the public address system. The jury felt that providing radio sets to the nurses could enhance two-way communication between the first responders in medically urgent situations.

8. Provide institutional nursing staff with motorized suction devices for use in clearing a patient's obstructed airway.

Comment:

The jury heard that nursing staff at OCDC did not have a motorized suction device available to them for use on May 11, 2021, and only had access to a less powerful and manually operated suction device. Since the death of Mr. Elliot, the OCDC has acquired a motorized suction device; however, it was unknown whether all correctional institutions possess same. The jury felt that all nursing staff in all provincial institutions should have access to a motorized suction device.

To the Government of Ontario and the Ministry of the Solicitor General:

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9. Should consider annual meetings of medical/nursing leads across institutions in Ontario to review critical events for the purpose of identifying opportunities for improvement.

Comment:

The Ministry currently does not conduct systematic province-wide education and training in response to critical medical and health care events that occur in an institution. The jury felt that regular and provincially led meetings of medical/ nursing leads could identify opportunities for improvement in institutional responses to critical incidents.

10. Seek and allocate adequate funding and resources to implement these recommendations.

Comment

There are costs associated with the recommendations made by the jury. This final recommendation was made so that adequate funding will be secured to implement the recommendations made by the jury at this inquest.

CLOSING COMMENT

18 In closing, I would like to again express my condolences to the family and friends of Jayson Elliot for their profound loss.

19 I would also like to acknowledge the vicarious trauma of the correctional officers and nurses that was acknowledged and felt by the jury and that is reflected in their recommendations. It was clear from the evidence that sudden and unexpected deaths can cause significant suffering to first responders in correctional institutions. As noted in this verdict explanation, the jury recommended that appropriate and trauma-informed voluntary supports be provided to correctional officers and nurses.

20 I would like to thank the witnesses and parties to the inquest for their thoughtful participation, and to thank the inquest counsel, investigator, and constable for their hard work and expertise. I would also like to thank the members of the jury for their commitment to the inquest.

21 One purpose of an inquest is to make, where appropriate, recommendations to help prevent further deaths. Recommendations are sent to the named recipients for implementation and responses are expected within six months of receipt.

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22 I hope that this verdict explanation helps interested parties understand the context for the jury's verdict and recommendations, with the goal of keeping Ontarians safer.

Appendix

STATEMENT OF SCOPE

Inquest into the Death of Jayson ELLIOT

This inquest will look into the circumstances of the death of Jayson Elliot and examine the events of his death on May 11, 2021, to assist the jury in answering the five mandatory questions set out in s. 31(1) of the *Coroners Act* and to help the jury make recommendations to prevent further deaths, should the jury decide to make recommendations. The following are the five mandatory questions for the jury:

(a) who the deceased was;

(b) how the deceased came to his or her death;

(c) when the deceased came to his or her death;

(d) where the deceased came to his or her death; and

(e) by what means the deceased came to his or her death

Specifically, beyond the facts required to accurately answer the five questions and understand the circumstances of the death, we will be addressing the following issues to the extent that these issues may have relevance to potential recommendations:

1. The circumstances surrounding the death of Mr. Jayson Elliot.

The following are excluded from scope, except insofar as necessary to answer the five questions cited above, or otherwise ruled necessary by the Presiding Officer in order to inform jury recommendations:

1. Medical care provided by paramedics.

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