

Most Negative Treatment: Recently added (treatment not yet designated)

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2024 CarswellOnt 16129

Ontario Coroner

Mussa, Re

2024 CarswellOnt 16129

Inquest into the death of: Abdurazak MUSSA

Selwyn Pieters Presiding Officer

Heard: October 7, 2024; October 8, 2024; October 9, 2024; October 10, 2024; October 11, 2024

Judgment: October 11, 2024

Docket: None given.

Counsel: Counsel — not provided

Subject: Civil Practice and Procedure

Headnote

Judges and courts

Selwyn Pieters Presiding Officer:

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JURY RECOMMENDATIONS

To the Ministry of the Solicitor General ('SOLGEN'):

1 Initiate an immediate review for the purposes of determining the potential need at the TEDC (Toronto East Detention Centre) for provision for 24 hours per day, 7 days per week, on-site mental health nursing. For greater clarity, immediately assess the possible benefits of having a mental health nurse physically present on-site at the TEDC 24 hours per day, 7 days per week, to ensure adequate coverage during overnight hours and ensure that a minimum of two nurses are on-site at all times.

a) We the jury strongly recommend a TEDC Correctional Officer and TEDC Registered Nurse be involved in the review and decision making process.

2 Within the next 12 months, all correctional officers, sergeants, and supervisors at the TEDC be registered for enhanced or additional training to what is currently in place for suicide prevention training. Mandatory suicide prevention refresher training should be delivered to all correctional staff annually thereafter.

3 Immediately review and explore the implementation of the Columbia-Suicide Severity Rating Scale (C-SSRS) at the TEDC to support correctional staff in identifying persons in custody who may be at elevated risk of suicide or self-harm. Informal and regular screening should be conducted throughout an individual's time in custody to help identify those who may be at high risk.

4 Reinforce the Ministry policies and TEDC Standing Orders requiring correctional officers to conduct night shift rounds of living units at irregular and 'sporadic' intervals to prevent predictability by persons in custody.

5 Conduct a quality review of the Ministry-issued flashlights currently provided to correctional officers, especially those working evening/overnight shifts, to explore whether upgrades are necessary to improve the quality of visual night inspections.

a) Amend the relevant Standing Orders at TEDC to make mandatory the use of flashlights by correctional officers when conducting evening/overnight security rounds.

6 Provide cellular telephones to on-duty correctional officers at the Sergeant level and above, at all Provincial Correctional Facilities and Detention Centres, for the use in notifying Emergency Medical Services (EMS) and reducing the need for a 'runner' to convey information between correctional staff during a medical emergency.

a) Ensure that appropriate policy and compliance controls are in place to monitor and govern their use.

7 Continue to prioritize and expedite the implementation of the Ministry-wide Electronic Medical Record (EMR) system to ensure it is available and functional in all provincial institutions as soon as possible.

8 In addition to the implementation of the Electronic Medical Record (EMR) system, the Ministry should continue to improve its record management capabilities in provincial institutions to implement an electronic record system for logbooks and documentation made by correctional staff during patrols.

9 To ensure compliance with Ministry policies and TEDC Standing Orders related to record keeping and documentation.

a) The Ministry should ensure that all correctional staff receive regular, mandatory refresher training on record keeping and documentation.

b) All logging should be entered in a timely fashion and include date and time, and to whom the referral was submitted, especially verbal requests made for mental health support.

c) Regular audits should be conducted by management at the TEDC to identify any deficiencies in logbooks, security checks, and record keeping by correctional staff, and implement corrective measures as identified.

10 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.

11 Consideration should be given to procure an artificial manual breathing unit - supplying such a device so that it may be used in events where CPR administration is necessary. This device should be readily accessible to all staff in cases where CPR is necessitated.