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

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
BEAVER	Moses

aged / à l'âge de 56 held at / tenue à 189 Red River Road, Thunder Bay, Ontario

from the / Du 17th April to the / Au 12th May 20 23

By / Par Dr. / Dr Louise McNaughton-Filion 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 :

Moses BEAVER
Name of Deceased / Nom du défunt

February 13, 2017 2201 h
Date and Time of Death / Date et heure du décès

Thunder Bay Regional Health Sciences Centre
Place of Death / Lieu du décès

Hanging
Cause of Death / Cause du décès

Undetermined
By what means / Circonstances du déc

[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 12th (Day / Jour) day of May (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. Louise McNaughton-Filion	2023/05/12

Presiding Officer's Signature / Signature du president

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
Loi sur les coroners – Province de l'Ontario

Inquest into the death of:
L'enquête sur le décès de:

Moses BEAVER (AMIK)

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

To the Governments of Canada and Ontario:

1. In order to support Moses' vision of preserving cultural knowledge through art, Canada and Ontario should provide annual funding. This funding will be directed to the Nibinamik Education Centre as well as one additional NAN community, rotating annually, to support a program each school year for an artist to work with students to create art reflecting traditional knowledge.
2. Ensure equitable funding, resources, and adequate policing services in Indigenous communities. Indigenous police services must be deemed an essential service under the Police Services Act (PSA). The PSA should be amended with Indigenous consultation to include an Indigenous specific section to address the unique cultural and geographical issues.

To the Ministry of the Solicitor General, the Ontario Ministry of Health, Indigenous Services Canada, Nishnawbe Aski Nation, Nishnawbe-Aski Police Service, Ontario Provincial Police, Sioux Lookout First Nations Health Authority, Ornge, and the Ministry of the Attorney General:

3. In moving forward with any initiatives that respond to the following inquest recommendations, the recipients of these recommendations should be guided by the principle that funded supports and services are provided to meet the acute mental health needs in NAN communities on a substantively equal basis with non-Indigenous people.
4. A regional review committee should be assembled to review cases on a regular basis where there is an adverse outcome of a treatment plan for a mental health emergency in a remote community. The committee should include representatives from local healthcare providers, non-healthcare providers as well as community members as appropriate. In each case reviewed, the committee should work to identify root causes of adverse events as well as lessons learned and opportunities for improvement. Committee findings, recommendations and/or actions should be shared amongst nursing stations in the interests of continuous quality improvement.
5. All stakeholders working with members of remote First Nations should be required to fulfill informed trauma training inclusive of burnout awareness and prevention strategies.

To Indigenous Services Canada (ISC), Nishnawbe Aski Nation (NAN) and the Ontario Ministry of Health (MOH):

6. A mobile mental health and addictions clinic should be created in consultation with Nishnawbe Aski Nation, and funded by Indigenous Services Canada and the Ontario Ministry of Health with the following goals:

   a) to provide early intervention care in a culturally appropriate and safe manner;

b) to address mental health challenges before they become more significant and debilitating;

c) to offer a variety of services together under one roof close to home, including but not limited to case management of wrap-around services for the individual and to assist in sustained and continuous access to a therapeutic relationship;

d) to reduce the need for clients to travel to access healthcare services;

e) to ensure individuals receive the care and support they need when and where they need it; and

f) if individual communities deem it appropriate, persons with lived experience should be integrated into the planning and implementation of service.

7. NAN should be funded to develop an integrated, culturally safe mental health care plan for remote First Nations in Northwestern Ontario. This plan, through accessible, effective interventions, will reduce psychiatric emergencies, and provide aftercare services including patient education for the patient and their family to assist with healthy reintegration into the community upon discharge from a psychiatric facility.

To the MOH and NAN:

8. A public health campaign should be created by Nishnawbe Aski Nation in consultation with, and funded by the Ontario Ministry of Health, to reduce stigma surrounding mental illness including bipolar disorder, and to enhance understanding of the role of psychiatric medication in the treatment of mental illness. The campaign should address mistrust of the colonial health care system amongst First Nations people.

To the Ministry of the Solicitor General and NAN:

9. Representatives of NAN should create and annually present regional and community specific information to all frontline staff in the Thunder Bay district jail and the Thunder Bay Correctional facility. This will ensure all staff are trained in cultural awareness of Northern communities.

To ISC and NAN:

10. ISC should work with NAN to fund the development and delivery of land-based and culture-based programs for persons with acute mental health crises in NAN territory.

To ISC:

11. ISC should engage with First Nations communities on the construction of secure/safe rooms as well as similar options such as comfort rooms or safe houses. If a First Nation community wants a secure/safe room or similar option in the nursing station, ISC and the community should explore options to build physical space attached to or in proximity to the nursing station or elsewhere in the community. ISC and the community should explore options for funding, hiring and training attendants, developing appropriate protocols for the use of the secure/safe room and determining the specifications of the space. ISC nurses should not be expected to guard people in the secure/safe room or to otherwise operate the facility.

12. ISC should provide funding to remote communities to support the employment of properly trained security guards. Training for security personnel should include, but not be limited to non-violent de-escalation, mental health and cultural safety training. Security personnel at nursing stations in remote communities will assist in maintaining safety and security for patients and healthcare staff in cases of psychiatric emergency, and police be available to assist in situations where guards aren’t present or need further support.

13. Nurse practitioners should be authorized to assess and complete form 1 under the Mental Health Act.

To the MOH and Sioux Lookout First Nations Health Authority (SLFNHA):

14. Nursing stations in First Nations communities, as well as their physicians, should have access to the "Connecting Ontario Clinical Viewer", Meditech, SLFNHA's emergency medical record (i.e. OSCAR), or any other relevant electronic medical records.

To the MOH:

15. MOH should expand the mandate of Criticall to include acute mental health crisis calls and investigate the need for a dedicated mental health branch.

16. MOH should designate Meno Ya Win Health Centre in Sioux Lookout as a Schedule 1 facility under the *Mental Health Act*.

17. MOH should ensure that medical assessments of patients from a remote fly-in nursing station are effected at a Schedule 1 facility, as determined by the patient's treatment team in consultation with the patient and his or her family. Patients who are to be transported to a Schedule 1 facility for definitive care should not be required to be medically assessed at a non-Schedule 1 facility, absent exigent circumstances.

18. MOH should ensure that when a patient is in a psychiatric crisis, the wishes of the patient and family be considered first when searching for a schedule 1 facility, and if not feasible, then the closest geographical facility should be the receiving facility.

19. A protocol/clinical pathway should be developed to guide decision-making and prioritize the delivery of health care services when an acute psychiatric emergency arises in remote First Nation communities.

    a. This protocol/clinical pathway should be developed in consultation with First Nation communities and all relevant stakeholders, and should be made available publicly as well as available to a member of the public upon request.

    b. This clinical pathway should have a checklist which considers:

        i) whether a safe or secure room would be required for a violent/aggressive patient. This would include consideration of the patient's experience with residential schools, the criminal justice system and other factors which might impact the choice of restraint;

        ii) an emergency assessment by a physician arranged in a timely manner by videoconference to assess the patient regarding Section 15 of the *Mental Health Act*;

        iii) the security needs for the patient;

        iv) contact to Criticall under the proposed "Life or Limb" policy for mental health crises;

        v) the need for police escort and escalation of this request for police escort if air ambulance transfer in a dedicated mental health aircraft is not possible;

        vi) the compilation of medical information and a transfer note to accompany the patient whether at a hospital or correctional facility.

20. MOH should develop culturally specific public health education related to bipolar disorder and its many presentations.

21. The MOH should amend the provincial "Life or Limb" policy to include acute mental health crises in geographically remote areas as emergent risks to life or limb.

22. The MOH should fund Ornge to continue and expand its Mental Health Transport Team Program. Expansion should include, at minimum, two dedicated Standing Agreement aircraft to support no less than two dedicated teams comprised of one mental health nurse, one primary care paramedic and one security officer. Expansion should result in at least two full shifts of the Mental Health Transport Team capable of providing 24/7 emergency transportation and care for mental health patients in remote communities in Ontario. Evaluation of need should occur on an annual basis and be adjusted according to the relevant statistics.

23. The MOH in consultation with the Ministry of the Solicitor General should consider amendments to Sections 18 and 33 of the *Mental Health Act*, to make clear where an examination by a physician under section 16 or 17 should occur, and the duties of a police officer once a person is brought to a nursing station or non-Schedule 1 facility.

To Nishnawbe-Aski Police Service (NAPS), Ontario Provincial Police (OPP) and the Ministry of the Solicitor General:

24. Restorative justice should remain at the forefront of all planning and implementation of decisions made regarding corrections including but not limited to accountability, restitution and reconciliation, authentic communication, and community engagement.

To Nishnawbe-Aski Police Service (NAPS) and Ontario Provincial Police (OPP):

25. NAPS and the OPP should consider pre-charge diversion of those with recognized or declared mental health issues for persons in First Nations communities.

26. NAPS and OPP should each create written procedures in consultation with ORNGE, ISC, and SLFNHA for external circulation to healthcare partners and stakeholders setting out the circumstances in which OPP or NAPS may assist ORNGE in transportation security of an individual suffering a mental health crisis in a remote community by providing an escort officer. Such escort officers shall only be made available upon special request and in exigent circumstances. The procedures shall expressly consider, among other things, the following issues:

    a. A contact path within each of OPP and NAPS for requests to be made;

    b. A direction or specification from each of OPP and NAPS explaining what medical assessments external providers must first complete before making requests under the procedure; and

    c. A protocol for repatriation of any police officer escorts authorized under the procedure.

To NAPS:

27. NAPS should continue to review and operationalize training to recognize acute mental health crises, and have their officers approach an apprehension under the Mental Health Act as a first alternative to arrest with criminal charges in the case of a person in crisis in a remote First Nations community.

28. When NAPS officers are removing a member of the community through arrest or apprehension, they should ask the person being transported for consent to contact the nursing station regarding medications, medical records or health conditions, and follow up where consent is given with the nursing station as required.

29. NAPS should develop the equivalent of Police Order 2.20 of the Ontario Provincial Police Service, respecting their structure and available resources. This should include the completion by police officers of the Brief Mental Health Screener, or equivalent, for all occurrences involving a person in crisis where mental health-related issues are known or suspected, regardless of whether an apprehension is made under the *Mental Health Act*. The police officer should then provide a copy

of this document to health facility staff during police-hospital transition, and to any correctional facility where deemed necessary.

To the Ministry of the Solicitor General (the Ministry) and the Ministry of Health:

30. The Ministry and the Ministry of Health should both have representatives sit on the Community Reintegration Table to help inform policy and practice and encourage a close liaison with the provincial healthcare system.

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

31. The Ministry should establish a patient-centred model of care that promotes consistent, integrated, and team-based care, and that enhances continuity of care and successful transitions to and from the community.

32. A Provincial Agency under the Ministry of Health and in liaison with the Ministry of the Solicitor General, should directly deliver and oversee healthcare services in correctional facilities, including responsibility for quality improvement, capacity-building, and system planning.

33. The Ministry should conduct training to reinforce understanding of the policy requiring a nurse completing a health assessment upon admission to ask the individual about prior engagement with healthcare providers concerning the individual's mental health. The training should include direction with respect to obtaining written consents from the individual to obtain records from those providers when, in their clinical judgement, such records would assist in meeting the health care needs of the individual.

34. When a family member or outside medical professional contacts a correctional facility with medical information regarding an individual, this information should be shared with a healthcare professional, documented and flagged to the most responsible practitioner.

35. When a care plan is formulated for an individual with a mental illness at a correctional facility, all inter professional team supports and community participants in care plan formulation should be identified and contacted directly, with the request and their response regarding input into the care plan recorded in the individual's file. This would include the patient's participation and input.

36. The Ministry should ensure that inmates who are at elevated risk of suicide are placed in cells where the risks associated with tie-off points are mitigated.

37. An individual's medical record at a correctional facility should have up to date information related to next of kin and the primary healthcare providers in the community.

38. The next of kin and primary healthcare provider should be advised of the individual's discharge into the community, with the consent of the individual being collected upon admission. Where consent is given, relevant medical information should be transmitted to the healthcare provider to allow for timely and appropriate follow up.

39. The Ministry should develop key performance indicators in provincial correctional facilities, related to:

    a. success in integrating individuals back into their community, evaluated with the care plan goals as a guideline

    b. tracking the number of individuals with mental health alerts returning to a correctional environment and,

    c. worker and patient experience survey within correctional institutions.

Key performance indicators should be available to correctional workers, individuals housed in the jail and the public and should be evaluated on an annual basis, to guide further decision making in provincial corrections.

40. The Ministry should ensure that all health professionals employed or contracted by the Ministry have access to Connecting Ontario.

41. The Ministry should continue to implement its own province-wide electronic medical records system.

42. The Ministry should explore whether the Intake Unit, which is now being used for COVID/infectious disease observation before direct admission to a correctional facility, should also be used as a tool for obtaining medical information and identifying mental health behaviours which may require psychiatric intervention. As part of this process, consideration should be given to:

    a. obtaining pertinent past medical records for an individual;

    b. observing for signs of acute mental illness, and thereafter recording and reporting such observations, particularly when the individual is on a form of enhanced watch;

    c. employing Correctional officers with enhanced mental health training and professional interest in mental health issues, subject to collective bargaining requirements;

    d. conducting daily debriefing sessions to ensure quick access to mental health professional assistance, and

    e. determining the housing required and the initial treatment plan (if required) for an arriving individual.

43. A mental health unit should be created in the new Thunder Bay correctional institution, where residents experiencing mental health symptoms, or those being assessed for a mental illness diagnosis, can be housed, assessed and treated. Consideration should be given to:

    a. Correctional officers, health care staff, NILO (Native Inmate Liaison Officer) and other service providers sharing information regarding individuals in this unit, sharing any observations made and needs for the day, according to their care plan;

    b. Correctional officers, health care staff, NILO and other service providers working together on this unit to provide a therapeutic environment and,

    c. ensuring that there is a focus on mental health treatment, assessment, and activities promoting optimal mental health both inside the institution and at the time of discharge into the community.

44. The new correctional facility being built in Thunder Bay should ensure that there be a dedicated outdoor cultural space available and the construction and use will be in consultation with Indigenous representation.

45. All front-line staff working within a correctional institution should have ongoing mental health and suicide prevention education and learning opportunities. Recognition of acute behavioural changes related to mental illness, non-violent de-escalation techniques, the risk and recognition of psychosis and lessons learned from critical events which may occur in the institution (for example suicides or near suicides) should be part of this ongoing learning.

46. Investigate how incentive pay be made available for correctional officers who choose to work in the special handling unit (SHU) and fulfill extra mental health training.

47. The Ministry should conduct an information and outreach campaign to individuals housed within the correctional facility to educate them as to the signs and risk of mental health crisis to facilitate prompt reporting of such crises to health care staff.

48. Correctional facilities should work with Indigenous communities and the NILO, to ensure there are Elders and/or Indigenous service providers able to serve the needs of those in custody. There should be an approach to correctional healthcare for Indigenous people in custody that is Indigenous designed, developed and delivered, in keeping with self-determination and self-government.

49. The Ministry should expedite Indigenous cultural safety training for all frontline correctional staff, including healthcare staff.

50. The Ministry should establish an Indigenous Advisory Committee comprised of regional Indigenous representation from across the province to provide advice on the provision of health services and correctional services to Indigenous individuals housed in correctional facilities.

51. When critical incidents occur in a correctional facility, such as a death or an attempted suicide, a quality of care review should be conducted within a week, with all involved staff participating. The quality of care review should account for any privacy and/or legal privileges.

52. The Ministry should implement the following changes with regard to the reports produced by the Correctional Services Oversight and Investigations office (CSOI) following a death in custody:

    a) The investigation be conducted independent from the Ministry;

    b) The investigator should have access to the review of the health record conducted by Corporate Health and Corporate Health should be provided with a copy of the report to provide comment before it is finalized;

    c) The report should be provided to the relevant health care manager, superintendent, regional director, and Assistant Deputy Minister;

    d) The family of the deceased should be advised that they may request a copy of the report; and

    e) The report should be made available to the public with special attention to the following:

        i) any non-pertinent medical information should be redacted to allow for privacy, and

        ii) all names should be redacted.

53. The Ministry should pursue health accreditation with Accreditation Canada, or other comparable body. The Ministry should support the development of standards focused on ensuring culturally safe care for Indigenous individuals housed in correctional facilities.

54. The Ministry should conduct a workforce assessment to determine the appropriate staffing levels for health professionals (e.g. psychologists, psychiatrists, mental health nurses) and program staff for the Thunder Bay District Jail and its population. The number of individuals housed in the facility will be reflective of this assessment and accommodated in appropriate and humane living conditions.

55. The Ministry should ensure that all staff with direct clinical care responsibilities report to the correctional institution’s healthcare manager.

56. The Ministry should ensure all physicians or psychiatrists working within the correctional system in Ontario update their knowledge of Bipolar Disorders as part of their annual required continuing professional development.

57. The Ministry should supply laptops or equivalent technology for correctional officer posts to ease in the documentation process and the sharing of information.

58. The Ministry should install cameras that can monitor each individual cell in the special handling unit.

59. Individuals housed at a correctional facility who are being transported to a courthouse should have a 2-3 days supply worth of any current medication as well as their personal belongings in case of discharge. The ‘red bag’ initiative could be of reference. Upon discharge, individuals should also receive a city bus ticket.

60. The Ministry should provide a minimum of 5 hours daily of stimulating activity for individuals housed in the correctional facility. This should include a mix of programming, education, rigorous physical activity, and no less than 1 hour of outdoor time being offered.

To the Crown Attorneys and criminal defense lawyers in Thunder Bay:

61. Best efforts should be made to provide as much relevant information as possible regarding the circumstances that led to an arrest to the forensic court support nurse at the Thunder Bay court when seeking a *Criminal Code* mental health assessment. This may include information from family members or health care providers who were engaged with the individual prior to their arrest.

To the Ministry of the Attorney General (MAG):

62. MAG should consider implementing a Mental Health Court in Thunder Bay.

To the Office of the Chief Coroner for Ontario:

63. The Office of the Chief Coroner should conduct an annual review of recommendations from past Ontario inquests dealing with mental illness and addiction issues experienced by First Nations persons. This examination should take place to determine whether such recommendations have been implemented, and to identify any patterns in the implementation of recommendations and common obstacles in the non-implementation of recommendations. The results should be reviewed with political territorial organizations, such as NAN, to evaluate the ongoing need.

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