January 15, 2026

To:

Dr. Dirk Huyer
Chief Coroner, Ontario

Ministry of the Solicitor General
Office of the Chief Coroner
Ontario Forensic Pathology Service

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Sent via email to:

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Re: Stakeholder Engagement on Proposed Legislative Change to End Mandatory Inquests for Non-Natural In Custody Deaths and Replace this Process with Annual Reviews for Deaths in Correctional Institutions in Ontario

This response is directed to the *Ministry of the Solicitor General for Ontario* (SOLGEN), in their request to the *Tracking (In)Justice: A law enforcement and criminal legal data and transparency project* team for stakeholder engagement. On December 16, 2025, our project received a request for feedback on the proposed legislative change to end mandatory inquests for non-natural in custody deaths and to replace this process with an annual review for deaths in correctional institutions across Ontario. We were provided with a timeline of January 15, 2026, to reply with feedback. In the following response, we address each of the 22 questions provided to us by SOLGEN in the request for feedback.

As per the letter from SOLGEN, the intended purpose of this stakeholder engagement process is to gather feedback on a proposed legislative change that would replace mandatory inquests into deaths in correctional institutions with annual coroner-led reviews. The engagement seeks to understand stakeholder concerns and expectations, identify operational requirements and implementation recommendations, assess any potential consequences of a coroner-led review in relation to transparency, accountability, and public confidence.

As we detail in our stakeholder response letter below, our team has the following concerns, which are that the proposed legislative change:

- **Will further undermine transparency**
  Annual reviews have the potential to lack public and transparent hearings, with juries, the testing of evidence, and cross-examination. Internal SOLGEN-controlled reviews risk obscuring evidence, shielding institutional wrongdoing, and misrepresenting facts. Relying exclusively on annual reports to summarize deaths risks reducing individuals to footnotes and rendering deaths invisible to the public, erasing their humanity.

- **Will cause harm to families & loved ones**
  Ending inquests will mean that families and loved ones will be denied answers, opportunities for meaningful participation, and closure. Reduced access to inquests will retraumatize families and loved ones, and risks further undermining trust, as well as limiting the availability of information on deaths, and opportunities for answers. Inquests also provide a critical forum for families to share information about their loved ones. These insights are a valuable and often overlooked source of information in the investigative process.

- **Will result in inadequate investigations & risks of misrepresentation**
  Without detailed and thorough, case-by-case investigations, findings on the cause and manner of death may be inaccurate. Important systemic issues, including violence, neglect, non-compliance by correctional staff, and institutional failures, may be unaccounted for in the process. As a result, any recommendations arising from such inadequate investigations will lack the relevance and strength required to prevent future deaths.

- **Is presented in a context of persistent systemic failures to implement recommendations & the absence of effective accountability mechanisms**
  Systemic issues identified in past inquests continue, due to lack of political will, enforceable follow-through, and eliminated oversight and accountability structures. Chronic underfunding, inquest backlogs, and opposition to evidence disclosures reduce the effectiveness of existing mechanisms. Without independent advisory input or evaluation mechanisms, reviews risk being even more ineffective in realizing accountability than the current system.

- **Is presented within an inadequate framework of "public safety"**
  A narrow "public safety" lens adopted by SOLGEN excludes incarcerated people from accessing justice and protection. It also obscures the structural contributors to preventable deaths, such as the denial of healthcare and mental health supports, the ongoing deadly conditions of confinement, and the use of force.

- **Is not in compliance with Canada's international human rights obligations**

Ending mandatory inquests conflicts with international human rights standards, including Canada's United Nations obligations to ensure independent and transparent investigations into deaths in custody.

About Tracking (In)Justice

Tracking (In)Justice is a law enforcement and criminal legal data and transparency project. We launched our initiative in 2021, housed at Carleton University, led by the *Data and Justice Criminology Lab*, at the *Institute of Criminology and Criminal Justice*.

One of our primary aims is documenting and analyzing deaths in custody across Canada. As a collaborative and community-engaged public criminology initiative, we bring together families and loved ones of people who have died in custody, and people with lived experience of incarceration, criminologists, computer scientists, social workers, and legal experts to collectively undertake the work of documenting deaths in custody. We engage with families and loved ones of people who have died in custody, and people with experience of incarceration on an ongoing basis to ensure our work is relevant, rigorous, and trauma and grief informed.

In 2023, we launched an online memorial for those who have died in custody, and in 2024, we launched a web-portal making data on deaths in custody searchable and accessible to the public. Our online database tracks deaths since the year 2000 and includes over 2309 deaths that have occurred in police, provincial, youth detention, immigration detention, forensic psychiatric detention, and federal custody.

Since our launch, we have had over 40,000 unique visitors engage with the website. Our methodology for tracking and verifying deaths has been peer-reviewed,[1] and our project is funded by the Social Science and Humanities Research Council of Canada and the Law Foundation of Ontario.

Data on Ontario

There are serious data limitations on what is known on deaths in custody due to limited government and institutional transparency. Despite these limitations, data indicates that deaths in custody are on the rise, with many deaths being deemed unnatural. Based on coronial records, media reports, and access to information requests, our project has documented 763 deaths in custody in Ontario since the year 2000. These include 711 deaths in provincial and federal prisons, immigration, mental health, and youth detention facilities. However, between 2010 and 2024, we documented 371 deaths in provincial custody. During this period, deaths in SOLGEN facilities increased by 205%, from 10 in 2010 to a peak of 46 in 2021, a record matched again in 2024.

[1] Crosby A, McClelland A, Sharpe TL, et al. (2025). Tracking (In)Justice: Documenting Fatal Encounters with Police in Canada. *Canadian Journal of Law and Society / Revue Canadienne Droit et Société*; 40(1):23-47. doi:10.1017/cls.2025.1

This rise in deaths in custody far outpaces incarceration levels. In 2010, according to Statistics Canada, there were 8,731 people in provincial custody, corresponding to a death rate of 1.71 per 1,000. In 2021, with 6,409 incarcerated, the death rate rose to 7.17 per 1,000, and in 2023 it remained elevated at 4.15 per 1,000 with an average population of 7,943.

It is important to note that in other circumstances, where deaths are accidental, such as construction, an annual review for deaths may have great benefit. But in the context of deaths in custody, we are looking at a different picture. Many of the deaths we track occur due to deliberate medical neglect, acts of physical and psychological violence, denial of lifesaving healthcare, such as naloxone, or methadone, or due to lack of access to, or willful denial of, mental health services, such as suicide prevention supports. Among the 82% of cases in our database with a known coroner or inquest determination (the rest are unknown to our project due ongoing investigations, or lack of access to information), 35% were ruled as natural deaths, while 44.5% were attributed to unnatural preventable causes, including suicide, homicide, and accidents, such as drug toxicity poisoning.

While information is limited, greater understanding of these increases in deaths in custody can only come from transparency and engagement with public processes, through inquests, and will not come from their removal.

Context

The context in which this proposed legislative change is being brought forward matters. Over the past 15 years, there have been a range of both deliberate or passive policy decisions which have enabled the proliferation of death and the disappearing of incarcerated people's lives and bodies with impunity in this province. This proposed change continues this trajectory.

In 2010, the province changed the *Coroner's Act* to end mandatory inquests into custody deaths when the manner of death is deemed "natural". The outcome is that deaths due to medical neglect, conditions of confinement, or systemic issues can be covered up as "natural", with no inquest into the surrounding context. Notably, during our efforts, we have tracked a minimum of 6 deaths classified as "natural" which involved some form of use of force, including physical handling, chemical restraints, or an intermediate weapon- after the 2010 change, and therefore were not subject to inquests.

In 2017, the former *Independent Advisor on Corrections*, released the report titled, *Corrections in Ontario: Directions for Reform*, which called for the "*Government of Ontario to clearly articulate a commitment to transfer responsibility for provision of health care within correctional institutions to the*

Ministry of Health and Long-Term Care".[2] Furthermore, in 2017, the final report from *Ontario's Expert Advisory Committee on Health Care Transformation in Corrections* was also released, titled, *Transforming Healthcare in Our Ontario Provincial Prisons*,[3] which also called for the transfer of healthcare as a measure to realize the health and well-being of prisoners. Neither of the findings of these reports were implemented, and the latter has been deeply redacted and is no longer publicly available.

In 2018, the position of the *Independent Advisor on Corrections* was eliminated, meaning there is no longer an independent oversight body for any institution managed by SOLGEN. Additionally, in 2018, despite being previously passed in provincial parliament, the sitting government did not set into force the *Bill C6 Transformation of Corrections Act.* Had it been implemented, the Act would have aligned the use of segregation with the Mandela Rules, and would have required minimum standards for living conditions, implemented the office of an Inspector General, instituted independent review panels to ensure compliance with the new legislation and all policies, and created disciplinary hearings for officers with the authority to make decisions about sanctions for serious acts of misconduct towards prisoners.

In 2021, despite outcry from *the Ontario Human Rights Commission*,[4] the sitting government disbanded the 10 Community Advisory Boards overseeing SOLGEN institutions, which were in place to make sure facilities operated in a safe and respectful way that was aligned with the *Human Rights Code* and *Charter* rights of prisoners.

In 2023, the Chief Coroner of Ontario released the report from the Expert Panel on Deaths in Custody, *An Obligation to Prevent: A Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody.*[5] This vitally important report outlines 18 recommendations for preventing future death in Ontario's jails. To date, there is no reporting indicating whether SOLGEN has implemented any of these recommendations. Furthermore, based on a recent judicial review of 5 deaths at Elgin-Middlesex Detention Centre, SOLGEN representatives have worked to devalue and limit the

[2] Sapers, H. (2017). *Corrections in Ontario: Directions for Reform.* Independent Review of Ontario Corrections. https://files.ontario.ca/solgen-corrections_in_ontario_directions_for_reform.pdf

[3] Ontario Expert Advisory Committee on Health Care Transformation in Corrections. (2017). *Transforming Healthcare in Our Ontario Provincial Prisons.* Ontario Government.

[4] Chadha, E. (2021). Letter to the Solicitor General on the elimination of Community Advisory Boards. Ontario Human Rights Commission. https://www.ohrc.on.ca/en/news-center/letter-solicitor-general-elimination-community-advisory-boards

[5] Expert Panel on Deaths in Custody. (2023). *An Obligation to Prevent: A Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody.* Chief Coroner of Ontario. https://www.ontario.ca/document/obligation-prevent-report-ontario-chief-coroners-expert-panel-deaths-custody

credibility and usefulness of this report.[6]Furthermore, SOLGEN is legally not required to inform the public of a death in custody through news releases so there is no way for members of the public to keep track of decedents' names and demographic information. In this context, instead of being notified in a timely manner by SOLGEN about a death, our project is aware of families and loved ones who have found out that their loved one has died inside due to a Facebook post from the family of another prisoner. Furthermore, following a death, families of the deceased can request a copy of the investigation report, however SOLGEN has in the past not been required to provide it – and they may choose to redact the document considerably before providing it to the loved ones of the deceased.

Additionally, it is the current sitting government leader who, in 2025, despite the abolition of the death penalty in 1976 across Canada, made a reference to empowering judges to use the death penalty in the province, saying he wished they could "send 'em right to sparky".[7] The proposed legislative change by SOLGEN reflects this context of an ongoing erosion of rights and oversight mechanisms intended to protect the lives and safety of incarcerated people.

Obligation to United Nations standards on investigations into deaths in custody

The proposed legislative change is not consistent with Canada's obligations to international human rights standards and risks violating the *Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*,[8] the *Minnesota Protocol on the Investigation of Potentially Unlawful Death*,[9] and guidance issued by the *Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions*.[10]

As detailed in the above noted principles, guidance, and declarations - of which SOLGEN will be aware - there are a series of international standards for ensuring deaths in custody are

[6] His Majesty the King as Represented by the Ministry of the Solicitor General v. Dr. John Carlisle, 2025 ONSC 5878 (CanLII), https://canlii.ca/t/kg08d

[7] CBC News. (February 13, 2025). Doug Ford made 'poor-taste joke' about supporting death penalty, PCs say. https://www.cbc.ca/news/canada/toronto/doug-ford-death-penalty-crime-comments-1.7459051

[8] Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions Recommended by Economic and Social Council resolution 1989/65 of 24 May 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-effective-prevention-and-investigation-extra-legal

[9] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), Office of the United Nations High Commissioner for Human Rights, New York/Geneva, 2017. https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf

[10] Human Rights Council Fifty-third session. A/HRC/53/29: Deaths in prisons Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz. https://www.ohchr.org/en/documents/thematic-reports/ahrc5329-deaths-prisons-report-special-rapporteur-extrajudicial-summary

investigated appropriately to align with human rights obligations. These standards include that families of those who die in state custody must have access to justice that is adequate, prompt and reparative, and, as outlined in *Principle 11* of the *Minnesota Protocol*, families have the right to access to evidence, and "to obtain information on the causes of a killing and to learn the truth about the circumstances, events and causes that led to it".[11] Furthermore, investigations into deaths in custody, as per *Principle 17* of the *Minnesota Protocol*, must be investigated by a "competent authority that is independent of the detaining authority and mandated to conduct prompt, impartial and effective investigations into the circumstances and causes of such a death".[12] Furthermore, international guidance outlines that "governments shall maintain investigative offices and procedures to undertake such inquiries", which further notes, that deaths in custody investigations:

> "…shall be to determine the cause, manner and time of death, the person responsible, and any pattern or practice which may have brought about that death. It shall include an adequate autopsy, collection and analysis of all physical and documentary evidence and statements from witnesses. The investigation shall distinguish between natural death, accidental death, suicide and homicide."[13]

Furthermore, investigations, must, "at a minimum, have the legal power to compel witnesses and require the production of evidence, and must have sufficient financial and human resources, including qualified investigators and relevant experts."[14]

It is unlikely that a death review process producing only minimal summaries of deaths and limited investigations, will provide families, loved ones, the deceased, and the public with investigations that meet the rigorous and thorough standards required to ensure access to justice and compliance with international standards. As a result, we fear that none of these international human rights standards are reflected in the proposed legislative change.

Importantly, 2026 is the year which Canada is being brought for its Seventh Periodic Report on compliance to the *International Covenant on Civil and Political Rights*, ratified in the Canadian parliament in 1976, which requires Canada to report to the United Nations and internationally on deaths in custody and related data. Notably, despite the shocking increase in deaths in custody in Ontario, there is no reporting on this in the current report to the United

[11] Minnesota Protocol, para. 11, pg. 4.

[12] Minnesota Protocol, para. 17, pg. 5

[13] Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions, para. 9.

[14] Minnesota Protocol, para. 27, pg. 8

Nations.[15] Our team will be making a detailed submission outlining Ontario's lack of adequate reporting, and concerns about for being in contravention of international human rights standards regarding investigations.

Response to request for stakeholder feedback questions re: legislative change

In the following response, we address each of the 22 questions provided to us by SOLGEN in the request for feedback. The first question to stakeholders is: *"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. What does your organization believe is the most significant obligation?"*

Our project believes the most significant obligation under the *Coroners Act* is the thorough scrutiny of the circumstances of death, as this process is foundational to accurately answering the five required questions and developing meaningful recommendations. This requires robust, mandatory public inquests for all deaths in custody, with juries, meaningful participation by families, and the ability to present evidence, and cross-examine witnesses; families should retain the option to opt-out.

Without rigorous investigation, findings on manner of death may be flawed and recommendations ineffective. The persistence of repeat recommendations reflects not their inadequacy, but their failure to be implemented, resulting in ongoing and worsening patterns of preventable deaths. Ultimately, all three obligations are interdependent and essential to transparency, accountability, and the prevention of future deaths.

Our project has serious concerns about the creation of a death review process if it is intended to replace or diminish the role of public inquests. Such a shift would likely reduce transparency, limit accountability, and undermine the dignity owed to individuals who die in custody. Public inquests have been critical in uncovering the true circumstances and manner of death, including findings of homicide that may not have been identified through internal review processes. Replacing inquests with non-public reviews risks re-traumatizing families by denying them answers and meaningful participation, while obscuring evidence and limiting scrutiny of institutional actions.

Ontario already has a mandatory and effective mechanism for reviewing deaths in custody: the public inquest. The core problem is not the process itself, but the backlog created by insufficient resourcing, persistent opposition to inquests, and continuous deaths happening due to recommendations not being implemented. Public funds would be better directed toward clearing

[15] See, CCPR - International Covenant on Civil and Political Rights, 145 (TBC) Session (02 Mar 2026 - 19 Mar 2026) https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/SessionDetails1.aspx?SessionID=2837&Lang=en

the inquest backlog and implementing existing recommendations, rather than creating parallel review structures. Any death review process must preserve the right to a public inquest, ensure independent oversight, and include enforceable mechanisms to address systemic failures in correctional practices, healthcare delivery, and staff conduct.

Benefits of a review of deaths in correctional institutions?

Stakeholders were asked a series of questions on the potential benefits of a review, including: *"Beyond the three obligations above, do you see any additional benefits that may result from a review of deaths in correctional institutions?" Does your organization believe greater benefit is derived from the review of individual deaths within a particular institution, or from deaths that may have resulted from similar circumstances within all institutions in the province? If so, why?"* And *"does your organization see a benefit to an annual review that analyzes deaths together with common characteristics, with a goal to identify and focus on underlying root causes and systemic issues that may be identified?"*

Our project sees value in an annual review that analyzes deaths together to identify common characteristics, root causes, and systemic issues. Such a review should be a complementary addition to, not a replacement for, individual public inquests.

A review of deaths in correctional institutions may offer limited additional benefits, but only if the review follows thorough and case-by-case investigations that are conducted by a truly independent oversight body. It is notable that the federal Correctional Investigator who conducted annual reviews of federal institutions, recently stepped down early due to his frustrations with the lack of implementation of recommendations.[16] Furthermore, as mentioned above, there is no such body in Ontario to oversee SOLGEN.

In that context, a review could help identify systemic patterns, recurring dangers, and institutional deficiencies contributing to preventable deaths. However, replacing mandatory inquests with government-led reviews risks obscuring the truth, particularly given documented concerns about altered reports, missing evidence, and misleading testimony by correctional authorities, coupled with an ongoing pattern of systemic injustice towards the health and well-being of incarcerated people.

Reviews controlled by the same ministry responsible for overseeing increasingly deadly institutions are in violation of international human rights standards, and are likely to be narrow, subjective, and shaped by political priorities rather than accountability. Without independence, transparency, and full evidentiary access, such reviews risk deflecting responsibility rather than preventing future deaths.

[16] See: https://www.cbc.ca/news/politics/zinger-leaving-prison-post-early-9.6976313

Focus of reviews?

Stakeholders were asked a series of questions regarding the scope and focus of the proposed review. Regarding individual and institutional specific reviews, both institution-specific inquiries and province-wide reviews provide important and complementary benefits. Individual public inquests remain essential because each institution has distinct cultures, practices, and conditions that can contribute to deaths in custody. These inquests ensure accountability, prevent individual deaths from being reduced to statistics, and allow for recommendations tailored to specific facilities.

At the same time, a province-wide review that analyzes patterns and shared circumstances across institutions would help identify systemic policy gaps and recurring risks. The primary challenge is not the inquest process itself, but the lack of implementation of recommendations. A coordinated, annual review of inquest findings could support meaningful change while preserving the importance of individual inquests.

An annual review that summarizes causes of death, institutional contexts, recurring circumstances, and inquest recommendations could support system-wide learning and prevention. However, its effectiveness depends on the existence of clear mechanisms to ensure that identified recommendations are acted upon, including the political will from government officials to enforce recommendations and hold institutions and correctional staff accountable for negligence and noncompliance of policies and procedures that contribute to deaths.

Many systemic issues have already been identified through existing inquests, yet deaths continue to increase due to a lack of implementation and accountability. The central issue is not the absence of review processes, but the absence of political will and enforceable mechanisms to ensure follow-through. Any annual review must therefore be paired with accountability measures that require transparent responses and concrete action from responsible institutions.

Public Safety for whom?

Stakeholders were also asked: *"How does your organization believe individual deaths should be reviewed if recommendations that enhance public safety are the goal?"*

Our project questions the use of a narrow "public safety" framework to guide investigations into deaths in custody. Many people currently warehoused in jails in Ontario are not considered the *public* in how the current government conceives of "public safety". Yet, the coroner's role is to speak for the dead to protect the living This includes those who are incarcerated and not considered part of the "public". Framing custodial death reviews primarily through "public safety" risks obscuring the many systemic factors—such as conditions of confinement, access to healthcare and mental health supports, use of force, and institutional neglect and decision-making—that

contribute to preventable deaths. If we focused on true public safety for all, our society would want to keep all people alive, and we would value human life and dignity.

A meaningful approach to safety requires clarity about whose safety is being prioritized. If safety is truly intended for all, death investigations must lead to enforceable changes in correctional practices, supported by independent oversight and adequate institutional and community-based supports. Investigations should therefore be grounded in accountability, prevention, and human dignity, rather than a limited conception of "public safety" that risks excluding those most directly affected.

Impact of legislative change to end mandatory inquests into non-natural deaths in custody in Ontario

Stakeholders were asked questions about the impacts of the proposed legislative change, including: *How might the populations that your organization represents be impacted by a shift to an annual review? Is there anything that your organization believes is critical for the legislative review process to consider? What does your organization believe will be the impact (positive or negative) of the creation of a mandatory death review process for deaths in correctional institutions? Are there any processes that could be included in the death review that would address potential negative consequences?* and, *What impact (if any) do you foresee a shift to an annual review will have on families who have experienced the death of a loved one in a provincial or federal correctional institution?*

We asked families and loved ones who have lost someone to answer the above questions, as the stakeholder engagement process failed to involve those most impacted - families. We include the responses we collected below:

- "If the inquest for my loved one were not done, my family and I would be left without answers and closure, making it much harder to grieve and process the loss. We would not fully understand the circumstances surrounding their death, and important lessons that could prevent similar tragedies might be missed. Without a formal examination, there would be no accountability, and systemic issues or risks could go unaddressed. This would leave us with lingering questions and a profound sense of injustice, affecting both our emotional well-being and trust in the system" - *Melissa Dooley, loved one to Jennifer (Jamie) Dooley, died 5/28/2024, Hamilton Wentworth Detention Centre*

- "I wouldn't have been able to get the proof out there that they, as in the nurses and doctors, killed my son by medically neglecting him for 3 months!" - *Cathy Hardy, loved one to Robert George Hardy, died 1/17/2020 Central North Correctional Centre*

- "I am currently still awaiting a copy of the autopsy. It is really bothering me. I know that I need the inquest in order to understand why and how her death could occur. She was scanned when she entered the detention centre so they would have seen the drugs bagged inside of her.

Why was she not sent to the hospital for removal? It was noted in her chart that she should be on suicide watch from the police and her family. During an inquest I worried about being able to have these questions answered. I have had difficulty sleeping since her death and her two sisters are also having difficulties. We need answers. Maybe then, we will be able to accept what happened" - *Tangie Gagnon, loved one to Jennifer Dooley, died 5/28/2024, Hamilton Detention Center*

- "Coroners' inquiries are extremely important not only for the families but to also help identify issues within the correctional system and implement change or update old policies. Good recommendations came out of my son's inquest such as mandatory training for correctional officers including, dealing with persons in crisis, mental health, illicit drug use, de-escalation techniques" - *Angela Case, loved one to Jordan Case, died 12/1/2018, Niagara Detention Centre*

- "I would be devastated and it has me depressed, sad, stressed, and is a hold on my life making so hard for me to move on. It makes me feel as if I have let him down" -*Shanika Spaulding, loved on to Shawn Spaulding, died 3/3/2019, Maplehurst Correctional Complex*

- "If an inquest wasn't carried out, it would very much have been another insult to injury. It would be accepting to fail. To fail to recognise the systemic failures, to fail those who they have a duty of care. To fail the loved ones of each and every person that has been devastated by the loss of a loved one. To fail to treat human beings with dignity and respect. To fail to provide basic human rights. To fail, where cost is king and cutting corners is not only the norm, but encouraged. Under the aegis of rehabilitation, these institutions exist, yet individuals more often than not go without the most very basic human rights, such as medical care. Institutions need to be held accountable, there are criminals working in the prison system. Committing the most horrendous acts. Institutions can and do neglect the rights and duty of care to those they are meant to protect. They can turn a blind eye , not comply with policy and procedures and when the inevitable happens they pass the buck , make excuses, lie whatever they need to do so they are not held accountable and they can continue day to day operations as if the loss of human life is something to be treated with such little regard" - *Rachael Oliveira Graca, loved one to Robert Gorge Hardy, died 1/17/2020, Central North Correctional Centre*

As these families and loved ones outline, a change to end inquests risks further marginalizing and erasing the individuals who die in custody by reducing their lives and deaths to brief summaries rather than subjecting them to meaningful public scrutiny. This change will make it more difficult for families to access public inquests and obtain full disclosure of evidence surrounding their loved one's death, particularly in a context where there is no legal obligation for provincial authorities to publicly acknowledge deaths in custody.

Any legislative review must therefore safeguard the right to individual public inquests, ensure transparency, and be directly linked to enforceable mechanisms that require implementation of identified systemic reforms. Without these protections, an annual review risks diminishing accountability rather than enhancing it.

Families and loved ones risk being denied answers about the deaths of those in custody, and without thorough, transparent investigations, they may justifiably question the accuracy of information provided by state actors, whose interests can conflict with accountability. Furthermore, due to the evidentiary requirements of inquests, some have resulted in the changing or overturning of initial death classifications, such as the death of Shannon Sargeant at the Ottawa-Carleton Detention Centre, which was not initially attributed to any cause until a public inquest determined it to be a homicide. Similarly, the death of Zackary Rogers, was initially noted as unascertained and later found to be a natural death during the inquest. Without the inquest's evidentiary process—including expert testimony and cross-examination—the true manner of death may not have been identified.

Furthermore, experiences in federal corrections illustrate that annual reviews alone do not ensure implementation of recommendations or prevent future deaths; in fact, the federal system is currently holding a major inquest into multiple deaths at Collins Bay Institution, demonstrating the continued need for inquests.[17] An annual review alone does not enhance accountability or scrutiny for deaths from unnatural causes.

Committee Composition & Roles

Stakeholders were asked: *What recommendations would you make to the Office of the Chief Coroner to assist with the process of identifying appropriate sector stakeholders when developing a review process and/or experts to participate and provide advice to the coroner leading the review process?*, and, *Are there any specific practices or processes that your organization believes could be included in the annual review?*

An annual review should occur only in conjunction with the inquest process and should not replace this essential investigative safeguard. An annual review should incorporate all information from completed inquests and highlight patterns identified across these investigations. There must be a mechanism to ensure that recommendations arising from such a review can be binding and enforceable, with clear consequences for non-compliance, to ensure accountability and meaningful systemic change.

Review Process

[17] See: https://www.kingstonist.com/news/inquest-into-five-deaths-at-collins-bay-institution-will-begin-in-january/

Stakeholders were additionally asked questions about what the review process could entail, including questions focused on information sharing and privacy, recommendations and reporting, qualifications for review members, differences for the review process by jurisdiction (federal institutions/provincial institutions), and mechanisms to improve the review process.

Any annual death review must operate alongside, not in place of, the coroner's inquest, which remains essential to serving the public interest. Ensuring adequate resourcing of inquests, avoiding unnecessary procedural opposition, and allowing full disclosure of relevant evidence would improve efficiency and reduce costs. Streamlining government participation—rather than limiting investigative scope—would better support timely, transparent, and accountable outcomes.

Primarily non-state actors should be part of the review process, analyzing deaths, interpreting patterns, and identifying adequate recommendations. The review process should include stakeholders with demonstrated expertise and lived experience, including members of the Expert Advisory Committee that contributed the Death Review Panel for the development of An *Obligation to Prevent* report, as well as formerly incarcerated individuals, family members, witnesses, and relevant nonprofit organizations.

Our project does not see a need to introduce additional qualifications for coroner's inquest jurors. The public jury system has functioned effectively for decades in determining the statutory questions related to deaths and should not be altered without clear justification. Requiring qualifications beyond those traditionally applied to public jurors, risks excluding community members, including those with relevant lived experience, while similar requirements are not imposed on other participants in the correctional system. Questions about qualifications should be applied consistently and transparently, particularly where other oversight bodies include public members without prescribed credentials. Any reform must ensure continued public participation rather than narrowing access or diminishing accountability.

Effective feedback mechanisms should include independent oversight bodies, community advisory structures, and meaningful engagement with families, people with lived experience, and civil society organizations. However, as we outlined above, many such mechanisms have been eliminated or weakened, limiting opportunities for evaluation and continuous improvement. Without restoring independent oversight and committing to transparent program evaluation and follow-up, there is a significant risk that review findings will not translate into meaningful change or prevention.

Respect for the deceased and their families requires that next of kin or designated representatives have meaningful decision-making authority over what personal information is disclosed in any public review. While individual narratives can support transparency, there are significant risks if deaths are summarized without thorough investigation. Incomplete or

premature accounts may rely on inaccurate information or omit critical context, potentially misrepresenting causes or suggesting misleading patterns. We have seen this regularly with our tracking project and access to information requests.

Any publicly accessible reporting must therefore be grounded in fully investigated findings and preserve the distinct circumstances of each death. Involved parties should be consulted throughout the review process.

Finally, this legislative amendment is presented by SOLGEN as an either/or scenario, where inquests must be dispensed with, in favour of annual reviews. This does not need to be the case. An annual review would differ significantly from an inquest in its ability to generate credible recommendations for death prevention and public safety outcomes. Without the transparency of a public hearing, participation of family representatives, and a judicial process that includes evidence, witness testimony, and cross-examination, an annual review would lack the depth, accuracy, and credibility of an inquest. This absence of rigorous investigation risks misrepresenting facts, producing inadequate recommendations, and denying families meaningful answers and closure. Replacing inquests with an annual review would ultimately undermine public confidence in the coroner's office and weaken human rights protections within correctional institutions.

We welcome this opportunity for stakeholder engagement in the process initiated by SOLGEN. While we have little confidence that our sincere, evidenced, and justified concern about this proposed legislative change will be heard by SOLGEN, we put this on the record in this letter, so that those in charge will know that this change will violate international human rights standards, will violate the needs and dignity of families and loved ones, will violate the rights of the public to have a robust understanding this issue, and most importantly it will violate the rights of those who have died in their custody. This change would make it impossible for the coroner to fulfill their oath to speak for the dead to protect the living.

Sincerely,

Alexander McClelland, PhD.
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Tracking (In)Justice
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Ministry of the Solicitor General

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December 16, 2025

Alexander McClelland
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Lead Researcher, Tracking (In)Justice
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Re: Request for Feedback on Proposed Legislative Change – Annual Reviews for Deaths in Correctional Institutions

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Dear Dr. McClelland,

The Ministry of the Solicitor General (SOLGEN) is proposing amendments to the *Coroners Act* to transition from the current practice of mandatory inquests into all non-natural deaths in a correctional institution to mandatory coroner-led annual reviews. The proposed legislative change is intended to preserve the effective and objective examination of individual in-custody deaths while enhancing the identification of systemic issues underlying deaths in correctional institutions across Ontario.

As you know, currently, under subsections 10 (4.3) and (4.5) of the *Coroners Act*, deaths from non-natural causes that occur while a person is in custody at either a provincial or federal correctional institution are subject to a mandatory inquest. Inquests follow strict legal procedures, bringing all parties with a direct interest in the death together to examine the circumstances of the death before a jury of five community members. While occasionally inquests inquire into multiple deaths in similar circumstances, the inquest process is limited in its ability to inquire into systemic issues that challenge public safety across the sector.

Under an annual review, deaths in correctional facilities would be reviewed by one or more coroners appointed by the Chief Coroner and supported by an advisory committee composed of experts and various stakeholders from the sector. This committee would assist the coroner(s) with the examination of the circumstances of all non-natural correctional deaths that occurred within the previous calendar year and explore systemic issues to make recommendations that may help improve health and safety and prevent further deaths within and connected to the corrections sector.

Over the next two months, the Office of the Chief Coroner (OCC) will be inviting individuals and organizations with connections to or expertise in the corrections sector

to provide feedback on the proposed amendments. The OCC seeks to better understand potential benefits and risks of reviewing in-custody deaths through a review process, as well as identifying ways to ensure that transparency, accountability, and public confidence are maintained.

Opportunities to provide feedback will include written submissions and virtual engagement sessions to allow the OCC and identified and interested partners to discuss important issues related to the proposed legislative change. Your organization has been identified as a key interest holder in this work, and we hope that you will be willing to participate.

As a first step, please find enclosed a series of questions upon which the OCC is interested in receiving your input. While we would appreciate responses to the questions, we understand that time and resource restrictions may make that difficult. Please feel free to answer only those questions that touch on the issues of interest to your organization.

The deadline for the submission of written proposals to the OCC is **January 15, 2025.** Submissions can be made via email to Stephen Moore (Stephen.Moore2@ontario.ca) and Kim Motyl (Kim.Motyl@ontario.ca).

Following the receipt and analysis of the submissions, virtual engagement sessions will be scheduled in early February to discuss further elements of the proposal and regulatory amendments.

We look forward to receiving your feedback and meeting with you to help inform the development of this proposed legislative change.

Sincerely,

Dirk Huyer, MD
Chief Coroner for Ontario

Annual Reviews for Deaths in Correctional Institutions
Stakeholder Engagement Questions

Purpose of Engagement

To seek stakeholder feedback on a proposed legislative change replacing the mandatory requirement for inquests into deaths in correctional institutions with mandatory annual coroner-led reviews for such deaths to:

- Understand potential concerns and expectations
- Identify operational requirements and recommendations for implementation
- Capture the benefits that could be realized from a coroner-led review
- Ensure transparency, accountability, and public confidence in a review process

Proposed Questions

A. General
1. 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. What does your organization believe is the most significant obligation? 2. Beyond the three obligations above, do you see any additional benefits that may result from a review of deaths in correctional institutions? 3. How does your organization believe individual deaths should be reviewed if recommendations that enhance public safety are the goal? 4. Does your organization believe greater benefit is derived from the review of individual deaths within a particular institution, or from deaths that may have resulted from similar circumstances within all institutions in the province? If so, why? 5. Does your organization see a benefit to an annual review that analyzes deaths together with common characteristics, with a goal to identify and focus on underlying root causes and systemic issues that may be identified?
B. Impact of Legislative Change
6. How might the populations that your organization represents be impacted by a shift to an annual review? Is there anything that your organization believes is critical for the legislative review process to consider? 7. What does your organization believe will be the impact (positive or negative) of the creation of a mandatory death review process for deaths in correctional institutions? Are there any processes that could be included in the death review that would address potential negative consequences? 8. What impact (if any) do you foresee a shift to an annual review will have on families who have experienced the death of a loved one in a provincial or federal correctional institution?
C. Committee Composition and Roles
9. What recommendations would you make to the Office of the Chief Coroner to assist with the process of identifying appropriate sector stakeholders when developing a review process and/or experts to participate and provide advice to the coroner leading the review process?

10. Are there any specific practices or processes that your organization believes could be included in the annual review process to ensure that it is trauma informed and sensitive to the experiences of others?

D. Review Process

11. Are there any processes that could be included in an annual death review that your organization believes are necessary to ensure that the reviews continue to serve the public interest?
12. What are ways that the death review process can ensure that families, public interest organizations, and the public remain informed while a review is underway?
13. Are there any factors that your organization believes should be considered when the coroner is determining the structure of the review process? For example, should the review be led by a coroner with one broadly focused committee, or several focused subcommittees?
14. What does your organization believe are the key necessary qualifications for an individual involved in assisting the coroner with the review process? What expectations should the OCC have of individuals involved with assisting the coroner with the review process?
15. What types of data and information does your organization believe is necessary for the coroner to collect to ensure a comprehensive review process? What methods would best be used to analyze this information and data?
16. Are there any differences to be aware of when concurrently reviewing deaths that occur in a provincial correctional institution and deaths that occur in a federal correctional institution? How might these differences be addressed in a concurrent review?
17. What types of mechanisms might assist to gather feedback on the review process and identify improvements for future reviews?

E. Information Sharing and Privacy

18. Are there any factors that your organization believes should be considered with respect to confidentiality and respect for the deceased individuals who are subjects of the review process?
19. Does your organization see a benefit or risk to outlining the circumstances of each death individually in narrative form in a publicly accessible report?

F. Recommendations and Reporting

20. What format of final report for the annual review does your organization believe would be most beneficial and why?
21. How might an annual review differ from an inquest in terms of recommendations for death prevention and public safety outcomes?
22. How should findings from annual reviews be communicated to the public and involved parties (e.g., where should an annual report be published? What information should it include? Should additional anonymization or redactions beyond those legally required be applied to published reports)?