Verdict Explanation

Inquest into the Death of
Justin Joseph (Mather) ST. AMOUR

Dr. Michael B. Wilson, Presiding Coroner
April 8 - 18, 2019
City Hall - Keefer Room
110 Laurier Ave W
Ottawa, Ontario

Opening comment:

This verdict explanation is intended to give the reader a brief overview of the circumstances surrounding the death of Justin Joseph (Mather) St. Amour, along with some context for the jury's recommendations. The synopsis of events and comments herein are based on my recollection of the evidence heard and the jury's findings of fact flowing from that evidence. This explanation has been written to assist recipient organizations, agencies and government ministries in understanding the intent of the various recommendations so that they may better consider implementation.

Participants:

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Court Reporter:	Mr. Robert Christie Gillespie Reporting Services 200-130 Slate Street Ottawa, ON K1P 6E2 613-238-8501
Parties with Standing / Permitted to Make Submissions at the Inquest:	**Represented by:**
Family of Mr. Justin St. Amour	Paul Champ, Counsel Champ Law 43 Florence Street | 43, rue Florence Ottawa, Ontario K2P 0W6 613-237-2441
Ministry of Community Safety and Correctional Services representing the Ottawa Carleton Detention Centre (OCDC)	Hera Evans, Counsel Erika Hodge, Counsel Legal Services Branch 439 University Ave., 4th Floor Toronto, Ontario M7A 1N3 416-212-2617
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Basis of the Inquest and Determination of Scope

Preparing for this inquest, initially anticipated to focus on the bare facts of the death of Mr. St. Amour, we identified issues which merited an expanded scope. These included: the treatability of Borderline Personality Disorder; involuntary hospital admissions under the *Mental Health Act* (use of a Form 1 by physicians); and challenges and risks faced by individuals with this condition who all too often come into conflict with the criminal justice system.

Summary of the Circumstances of the Death of Mr. St. Amour:

Mr. Justin St. Amour, also known as Justin Mather (his biological father's last name), aged 31 years, died on December 8, 2016, in the Intensive Care Unit of the Ottawa General Hospital, nine days after he had been found attempting to hang himself at the Ottawa Carleton Detention Centre (OCDC) on November 30. The cause of death was reported by the forensic pathologist who performed the post mortem examination as "Complications of Hanging".

Mr. St. Amour was known to the staff at OCDC and had made threats to suicide in the past. He had many previous incarcerations for relatively minor offences. His primary diagnosis was Antisocial and Borderline Personality Disorder. An inmate care plan was in place to attempt to deal with his frequent and ongoing problematic and disruptive behaviors at OCDC.

His final period in custody began on November 23, 2016, after he was accused of threatening to harm his community support worker. The week at OCDC leading up to his hanging was characterized by recurrent self-harming behavior, suicidal threats, being placed on and then subsequently removed from suicide watch, with his explanation that his behaviors were motivated by a desire to obtain more food or other special considerations.

These behaviors were in keeping with his previous periods at OCDC and were attributed to the underlying personality disorder. He was confrontational and non-compliant with the officers at OCDC and created disruption. He was described as causing "chaos" around him.

On the evening of November 30, 2016, he made further suicide threats. He showed an officer a noose that he had braided from a bed sheet. He demanded to see a "Sergeant" (senior supervisory Correctional Officer). The Correctional Officer went to get assistance. By the time he returned with the Sergeant, Mr. St. Amour was hanging from a pipe above the toilet in his cell. He was cut down and resuscitated and transported to the hospital where it became clear that he had suffered irreversible brain damage as a result of his hanging.

Investigation and Inquest

The coroner was contacted and, as part of the investigation, a post mortem examination was ordered. Due to the circumstances of this death, a mandatory inquest was ordered.

The Scope of this Inquest was set as:

Included in Scope:

1. *The facts and circumstances of the death of Mr. St. Amour/Mather to answer the mandatory five questions of this death, namely the identity, place, time, cause and manner of death.*

The following will be explored only to the extent relevant and material to the facts and circumstances of this death:

2. *Assessment, treatment and management of individuals incarcerated at the Ottawa Carleton Detention Centre (OCDC) who threaten suicide or engage in para-suicide, including:*

    a. *Initiation, cancellation and communication of orders for constant watch, suicide watch and enhanced supervision*

    b. *Custodial placement options*

    c. *Treatment options for self-harming inmates with a diagnosed mental disorder*

    d. *Determination, implementation and dissemination of "inmate care plans"*

    e. *Policies, procedures and training applicable to correctional officers and medical staff with respect to potentially suicidal inmates, including suicide awareness and response training.*

    f. *Communication between the Health Care Team and Corrections Staff.*

    g. *Live, real-time video monitoring of inmates*

3. *Assessment and Conclusions on November 22, 2016, at The Ottawa Hospital to determine admissibility under Mental Health Act*

Excluded from scope:

4. *Issues of legal responsibility or conclusions of law with respect to correctional officers*

The inquest was held in Ottawa and included seven days of testimony over the period from April 1-18, 2019. Four parties sought standing or status as a party to make submissions and I granted these. They are identified above.

The jury heard from 23 witnesses and received 33 exhibits.

Mr. St. Amour's mother described his early life and history of involvement with mental health professionals, foster care, and the criminal justice system. The Correctional Officers and the nursing staff and psychologists and physicians who had provided care to Mr. St. Amour described their roles and observations to the jury. A community physician who deals with individuals having challenges similar to those faced by Mr. St. Amour provided insights regarding potential treatment options. The jury heard from an expert witness who provided an overview of psychiatric care in custody and provided the basis for some recommendations.

Mr. St. Amour's condition was identified as being best managed in a setting with clearly defined limits, predictability of routine and order. Ironically, it was in this very setting that he ultimately took his life.

Evidence was heard that Mr. St. Amour had made many, many threats to suicide in previous periods of incarceration. It is quite possible, despite the absence of direct evidence on this point, that the frequency of these threats led to them being taken less seriously.

Upon conclusion of the evidence, parties with standing provided a joint slate of suggested recommendations to the jury. Additional recommendations were suggested by one of the parties. On April 18, 2019, after a day's deliberation, the jury arrived at a verdict. The jury answered the mandatory five questions (see below) and also made a total of 24 recommendations.

Verdict:

Name of Deceased:	Justin Joseph ST. AMOUR
Date and Time of Death:	December 8th, 2016 at 5:00 pm
Place of Death:	The Ottawa Hospital, 501 Smyth Rd., Ottawa, ON
Cause of Death:	Complications of Hanging
By What Means:	Suicide

Jury Recommendations

To The Ottawa Carleton Detention Centre (OCDC) and The Ministry of The Solicitor General:

1) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should ensure that there are no suspension or hanging points in any prisoner area. These efforts should include conducting an "annual suspension point audit" of The Ottawa Carleton Detention Centre with the results provided to senior managers.

   Coroner's Comment

   Evidence was heard that the sprinkler pipe above the toilet in Mr. St. Amour's cell was an ideal suspension point with a stepping off point below it. The Jury also heard that by removing this suspension point, the likelihood of a completed suicide would be lessened.

2) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should ensure that medical records at The Ottawa Carleton Detention Centre are in electronic form and easily accessible to all medical staff. These efforts should include exploring the use of voice dictation software for charting. In the interim, the Ministry of the Solicitor General and the Ottawa Carleton Detention Centre should develop a tracking system for medical charts which facilitates locating and access to the charts by health care staff at the jail.

   Coroner's Comment

   Accessibility to, and legibility of, medical records were identified as problems by medical staff. They testified that better information would lead to better decision-making surrounding suicide watch initiation and discontinuation, implementation of inmate care plans and adherence to these plans, and communication of concerns that various professional staff had regarding Mr. St. Amour. Medical charts were frequently not available to staff and at times when they may have been helpful.

3) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should increase the complement of health care staff, in particular nurses, mental health nurses, psychologists and physicians. Mental health staffing should be

available to inmates and Correctional Officers during the week, evenings, nights and weekends.

Coroner's Comment:

Many of the crises in Mr. St. Amour's life occurred after hours when there was limited access to specialized staff who were equipped to deal with the challenges he presented. Staff identified a lack of nurses and mental health nurses. They also noted that at the time of the inquest, there were no psychologists available on staff.

4) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should explore the possibility of including nursing and other medical staff as part of the regular formal debriefing ("muster") sessions for the Stabilization / Segregation and Health Care units.

Coroner's Comment:

Formal debriefing or "muster" is one identified very useful opportunity for sharing of information about challenges with inmates at OCDC. The jury heard that nursing and medical staff are not part of this regularly scheduled meeting.

5) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should use best efforts to ensure that a mental health nurse is present when admitting inmates to the jail. When possible, suicide screening conducted at Admission & Discharge should be completed in a private area.

Coroner's Comment:

The questions asked on admission relating to mental health are often very personal and private questions and need to be asked in a sensitive manner, ideally by someone trained to interpret the responses. At the time of Mr. St. Amour's admission to OCDC, there was no private space for these questions to be asked.

6) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should use best efforts to ensure that Correctional Officers do not have to continue their shifts after witnessing highly traumatic events. The institution will continue to consult the Critical Incident Stress Management (CISM) program after a major incident.

Coroner's Comment:

After finding Mr. St. Amour hanging, staff had to stay at work and finish their shift. This may be distinct to other responders who after having been involved in critical incidents that would not be part of their daily routine would be given the opportunity to leave work. Recognizing the risk for post traumatic stress disorder, CISM was recommended to be maintained as part of the toolbox for supporting Correctional Officers.

7) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should liaise with psychological experts and mental health resources to explore options and potential models for delivering treatment based on Dialectical Behaviour Therapy to inmates diagnosed with borderline personality disorder.

Coroner's Comment:

Dialectical Behaviour Therapy was the only therapy that was suggested to the jury that has some evidence of effectiveness in cases such as Mr. St. Amour's. Availability is quite limited in general and was nonexistent at the jail at the time of his death.

8) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should make best efforts to ensure only seasoned Correctional Officers staff inmates housed in the segregation area or the Health Care Unit. Correctional Officers assigned to the segregation area or Health Care Unit should be required to review the Inmate Care Plans for all inmates in those areas and encouraged to develop a rapport with and provide companionship to the inmates based on guidance from those plans.

Coroner's Comment:

The last Correctional Officer who dealt with Mr. St. Amour was a very new hire with little experience dealing with challenging or problematic behaviours. The officer did not consider the likelihood of Mr. St. Amour completing his suicidal threats. He and other Correctional Officers responsible for the area did not demonstrate familiarity with the Inmate Care Plan that was in place to address the very real risk Mr. St. Amour posed to himself.

9) The Ottawa Carleton Detention Centre should make best efforts to provide additional mental health training. This additional mental health training should be

delivered by experts as well as experienced Correctional Officers who could speak about scenarios that occurred at The Ottawa Carleton Detention Centre.

Coroner's Comment:

Several Correctional Officers testified about a lack of training regarding inmates' mental health challenges. Recurrent themes that are found at OCDC could be the basis for training, including the circumstances surrounding this death. A high proportion of inmates have mental health and addictions which Correctional Officers would be in a better position to deal with if they had more knowledge of these issues.

10) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should consider authorizing access to supervisory staff to view the live feed video and audio monitoring equipment in cells in the Health Care Unit and Segregation Units along with provision of video and audio monitoring of current management offices.

Coroner's Comment:

Although there is video recording of many areas of the institution, there is no live monitoring of many of these areas. Considering that the area where Mr. St. Amour was found hanging was not in view of the staff when they were in the pod office, a "live feed" from the cell in question may have provided some earlier opportunity to intervene in his hanging. The second part of this recommendation arises out of the fact that no audio recording occurs, only video. The jury asked witnesses why this was and the response they were provided was that it was because of the need to protect the privacy of the inmates and staff.

11) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should consider designating a Family Emergency Response Liaison, who would be responsible for facilitating communications from family members of inmates who have reported self-harming behaviour or threats of self-harm or suicide.

Coroner's Comment:

Two separate grounds for this recommendation arose in testimony: 1: Family involvement in a time of crisis can provide comfort and relieve anxiety experienced by inmates and 2: family understanding of what has happened in OCDC was limited in this case and their notification appeared to be delayed due to the absence of an identified person whose role it would be to convey such information.

12) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should take steps to ensure that any discharge planning done to prepare inmates with Borderline Personality Disorder for community re-entry include efforts to ensure continuity of care for those suffering from this chronic and debilitating disorder.

Coroner's Comment:

Recognizing the seriousness of Borderline Personality Disorder, and the benefits of consistency, continuity of care, and management of the relationship for people with this disorder, the jury heard of prior admissions and discharges from various facilities where discharge was undertaken with no follow-up plan in place. This was felt to put individuals at increased risk and be unprepared for release from jail.

13) Suicide Prevention Refresher training of all correctional officers, sergeants and supervisors by The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should be mandatory and annually monitored for compliance with non-compliance reported to supervisors for immediate follow-up. This training should apply to everyone and incorporate examples and scenarios from recent suicides and /or serious suicide attempts within the facility.

Coroner's Comment:

Suicides remain a serious risk for inmates in all custodial institutions including OCDC. Some of the staff testified that they had directly worked with suicidal inmates in the past. However, personal experience with serious attempts and completed suicides is only one way for Correctional Officers to become familiar with the risks. The jury also heard about the benefits of scenario-based training for staff.

14) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should enhance the mentoring program and develop an incentive plan for the continuation of this successful program to ensure adequate staffing.

Coroner's Comment:

As indicated above in response to recommendation #8, the last Correctional Officer to have dealings with Mr. St. Amour was a recent hire who had little experience with individuals exhibiting the challenges that Mr. St. Amour did. There were descriptions of various models of mentoring where more experienced officers would provide guidance for such new hires.

15) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre, in order to break up the cycle of “revolving doors” and reduce the “silo effect” after numerous suicide attempts, an inmate should be automatically considered for admission to a long-term facility to provide a stable environment for treatment.

Coroner’s Comment:

Mr. St. Amour had been at OCDC many previous times with frequent threats and attempts to suicide or self harm. Prior to his most recent arrest he had indicated an intention to freeze to death in a graveyard and expressed a wish to be in OCDC so that he could have a warm place to sleep. Alternate facilities expressly for the purpose of addressing mental health and homelessness where suicide risk is identified might prevent the cost and risk associated with custody as happened in this circumstance.

16) The Ministry of The Solicitor General and The Ottawa Carleton Detention Centre should direct that during inmate rounds, at the scheduled inspection times, all guards will rotate their inspections to provide “another set of eyes” and perspective on the inmates’ behaviour.

Coroner’s Comment:

The Correctional Officers at OCDC do rounds on a regular schedule. Generally, the same guard does these rounds on a specific area for the duration of their shift. There may be advantages of this practice in that they may be able to see when things change for a particular inmate; a disadvantage as in this case, and the basis for this recommendation, exists where a relatively inexperienced guard did not appreciate the rapid deterioration and the imminent risk of harm in an individual in his cell.

To The Ottawa Carleton Detention Centre:

17) The Ottawa Carleton Detention Centre should prepare, with the help of psychologists, social workers and community agencies, discharge plans designed to reduce and prevent the “revolving door” experiences of many mentally ill persons. This includes persons with Borderline Personality Disorder, in an effort to secure proper housing and care for inmates with mental health problems once they are returned to the community.

Coroner's Comment:

See recommendation #15. This recommendation focusses on individuals who are identified to have Borderline Personality Disorder and the need to have plans in place upon their release from custody, otherwise they very frequently deteriorate after discharge and are back in short order.

18) The Ottawa Carleton Detention Centre should ensure that every Correctional Officer working in an area with inmates is equipped with a two-way radio.

Coroner's Comment:

Several of the officers reported that there was an insufficient number of radios for each to have one. In this incident, the initial officer felt that he could not stay with the inmate at the cell but had to go for help.

19) The superintendent at The Ottawa Carleton Detention Centre should issue a memo to reinforce that Correctional Officers are expected to familiarize themselves with any inmate care plans that exist for the inmates they are supervising, as required by existing policy.

Coroner's Comment:

As noted above, Correctional Officers were not aware of the inmate care plan which had been produced by the Jail Psychologist and was intended to help address Mr. St. Amour's problematic and disruptive behaviours. By making this care plan available and required reading for the Correctional Officers, it is hoped that they will be aware of specific challenges with inmates they are supervising and be better prepared to deal with them.

To The Ministry of The Solicitor General:

20) The Ministry of The Solicitor General should continue to revise and expand on its mental health training both at the Correctional Officer Training and Assessment program (COTA) and in refresher training.

Coroner's Comment:

A witness testifying about training of Correctional Officers described the limited amount of training on mental health that is offered to students in preparation for their

work, and as part of ongoing education through the Correctional Officer Training and Assessment programme. As many witnesses testified, mental and behavioural challenges are a common feature in people who are in custody, and the Correctional Officers advised that they often feel underprepared to deal with these matters.

To the Correctional Officer Training and Assessment Program and The Ministry of The Solicitor General:

21) When The Correctional Officer Training and Assessment Program and the Ministry of the Solicitor General consider new correctional officer and refresher correctional officer training, they should continue to use scenarios based on real events, including coroner's inquests and their recommendations. This should re-enforce, with real stories (including using the specific facts of this inquest) the importance of the learning taking place.

Coroner's Comment:

When Correctional Officers described their own training, they identified minimal realistic scenarios that would provide a basis for their understanding of workplace challenges such as those posed by Mr. St. Amour.

To the Ministry of The Solicitor General, The Ottawa Carleton Detention Centre and The Correctional Officer Training and Assessment Program:

22) The Ministry of The Solicitor General, the Ottawa Carleton Detention Centre, and The Correctional Officer Training and Assessment Program should ensure that Correctional Officers receive initial and ongoing training in the modalities of suicide, suicide response, Borderline Personality Disorder and Inmate Care Plans.

Coroner's Comment:

See also # 20 (above). Several witnesses testified that they were aware through their work at OCDC of other deaths due to hanging. They suggested that they did not feel sufficiently prepared by their education to identify how suicides happen in jails, how to respond to a threatened suicide, the challenges created by those with Borderline Personality Disorders, or the value in adhering to Inmate Care Plans. Some witnesses spoke about the risk of seeing Mr. St. Amour's behaviours as simply stirring up trouble rather than a pattern of disordered relationships that

created chaos around him and contained a very real risk that he could come to harm.

To The Ministry of The Solicitor General, The Ottawa Carleton Detention Centre and The Ottawa Hospital:

23) The Ministry of The Solicitor General, The Ottawa Hospital and The Ottawa Carleton Detention Centre should liaise in order to ensure that critical mental health information is shared with The Ottawa Carleton Detention Centre. This information sharing shall be in accordance with privacy legislation.

Coroner's Comment:

There is no formal shared information between the hospital and OCDC. Mental Health Staff at OCDC had minimal access to the information available in the medical records at the hospital and this reduced their understanding and ability to deal with Mr. St. Amour's challenges. Additionally, although the sharing of medical records within the "circle of care" for an individual is a generally accepted rule, the jury heard that privacy concerns might preclude full access to the information.

To The Ontario Ministry of Health and Long-Term Care:

24) The Ontario Ministry of Health and Long-Term Care should take steps to increase awareness of Borderline Personality Disorders among people suffering from this disorder, their families, mental health professionals and the general public by promoting education, research, funding, early detection, and effective treatments.

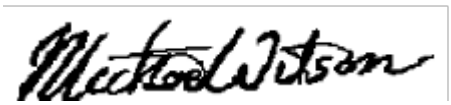
Coroner's Comment:

It was clear that there was a widespread lack of knowledge and understanding about Borderline Personality Disorder. The lack of public profile and significant limitations in any effective treatment were highlighted throughout the course of the inquest.

There was even disagreement among various professionals whether Borderline Personality Disorder is best described as a "mental illness", a "condition" or a personality or character trait. The jury was made aware of the current lack of effective treatment in many cases. The jury clearly felt that if the public were more aware, increased resources might be found to address this situation.

Closing comment:

In closing, I reiterate that this document has been prepared solely for the purpose of assisting interested parties in understanding the jury's verdict and providing some context for its recommendations so that their intent might be better understood. The comments are based on my personal recollection of the evidence, and on what I believe to be the jury's findings of fact. Should the reader contest any of my recollection of the evidence, I would defer to the official record maintained by the court reporter.



Michael B. Wilson, B.ArtsSc, MD, CCFP, FCFP
Presiding Coroner

August 7, 2019