

## **FOR IMPLEMENTATION:**

**Deputy Minister, Ministry of Community Safety and Correctional  
Services, 11<sup>th</sup> Floor, 25 Grosvenor Street, Toronto, Ontario M7A 1Y6  
(Recommendations – 1 and 2)**



Office of  
The Chief  
Coroner  
  
Bureau du  
coroner  
en chef

**Verdict of Coroner's Jury  
Verdict du jury du coroner**

We the undersigned / Now soussigné  
Heidi Takalo of Thunder Bay, Ontario  
 de  
Robyn Eady-Sitar of Thunder Bay, Ontario  
 de  
Peter Rzeszut of Thunder Bay, Ontario  
 de  
Jack Bisby of Thunder Bay, Ontario  
 &  
Karen Maa of Thunder Bay, Ontario  
 de

the jury sewing on the inquest into the death of **dément assermentés**, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famille **DUBOIS** | Given names / Prénom **Raymond**

aged / âgé(e) de held at The Ontario Government Building, 189 Red River Road. Thunder Bay, Ontario  
qui a été menée à

from the / du **9<sup>th</sup> of July** to the / a la **13<sup>th</sup> of July** 20 **07**

By / Par Dr. **D. Mutrie** Coroner for Ontario / coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following: / avons enquêté at avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e) **Raymond DUBOIS**
2. Date and time of death / Date et heure du décès **October 13, 2006 05:30 hours**
3. Place of Death / Lieu de décès **Thunder Bay Regional Health Sciences Centre  
Thunder Bay, Ontario**
4. Cause of death / Cause du décès **Mechanical Asphyxia due to Hanging**
5. By what means / Circonstances entourant le décès **Suicide**

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the / Ce verdict a été reçu par moi le **13<sup>th</sup>** day of **July** 20 **07**

Received by the Office of  
Dr. Bonita Porter  
Deputy Chief Coroner - Inquests  
JUL 19 2007

Original signed by Coroner

## Raymond DUBOIS Inquest

### JURY RECOMMENDATIONS

To the Thunder Bay District Jail:

1. Ensure that pertinent and **regulatory** documents, reports and **forms** be completed at the prescribed times and expedited to the appropriate levels of jurisdiction.
  
2. **In** consideration of the changing profile of the inmate population of the Thunder Bay District Jail, we recommend that:
  - a) The Thunder Bay District Jail should conduct **regular** assessments of the "Circle of Care" needs in order to ensure appropriate inmate care.
  
  - b) All **staff** are continuously provided the necessary training related to mental health issues which are relevant to their institution.
  
  - c) The delivery of Aboriginal Eastern Door **Program** be available and delivered to remanded inmates at the Thunder Bay District Jail.
  
  - d) Seek new **outside** partnerships within **the** local **communities** and **agencies** as a means to ~~meet~~ the Aboriginal program **needs** within the jail.



August 16,2007

Dr. B. Porter  
Deputy Chief Coroner for Inquests  
Office of the Chief Coroner  
26 Grenville St  
Toronto, ON  
M7A 2G9

Verdict Explanation:

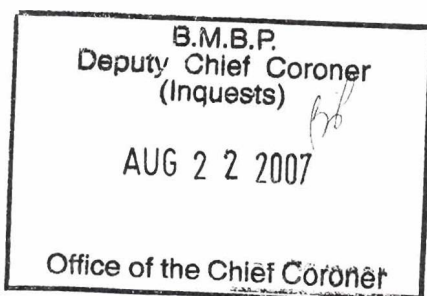
Raymond Dubois Inquest  
Ontario Government Building, 189 Red River Road, Thunder Bay  
July 9 to July 13,2007

Dear Dr. Porter:

I intend to give a brief synopsis of the issues presented and explain in some detail the reasons for the jury's recommendations. This explanation will be my interpretation of the evidence and the jury's reasons. The sole purpose of the explanation is to assist the potential reader to understand more fully the verdict and the recommendations. The reader should not consider the contents of this explanation as the actual evidence presented at the inquest, nor do I intend to replace the jury's verdict.

Present:

Coroners Counsel:	Ms. Deb Kinsella
Coroners Constable:	Det/Cst Greg Forbes
Investigating Officer:	Det/Cst John Fredborg
Court Reporter(s):	Ms. Karen Irving (For the Record) (807) 343-0109



**Standing Granted to:**

Ministry of Community Safety & Correctional Services (Thunder Bay Jail):

Mr. B. Whitehead  
Ministry of Community Safety & Correctional Services  
Legal Services Branch, 8<sup>th</sup> Floor  
77 Grenville Street  
Toronto, ON M5S 1B3

Dubois Family

Ms. Jackie Esmonde, Ms. Mandy Eason  
Aboriginal Legal Services of Toronto  
Suite 803  
415 Yonge Street  
Toronto, ON M5B 2E7

Dr. P. J. Schubert:

Mr. Daniel Boivin  
Gowlings Canada Inc.  
Suite 2600  
160 Elgin Street  
Ottawa, ON K1P 1C3

**The Verdict:**

The jury heard evidence over 5 days from 20 witnesses and were provided with 42 exhibits.

The jury deliberated for 4 hrs.

1. Name of deceased: Raymond Dubois
2. Date and time of death: October 13, 2006 05:30 hours
3. Place of death: Thunder Bay Regional Health Sciences Centre
4. Cause of death: Mechanical asphyxia due to hanging
5. By what means: Suicide

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### **Summary of Circumstances:**

Mr. Dubois was a 23-year-old man who was arrested on August 16, 2006 and charged with the offence of aggravated sexual assault regarding an incident on August 15, 2006. He was remanded by the courts with a seven-day Psychiatric assessment being ordered on August 21<sup>st</sup> and a further thirty day Psychiatric assessment ordered by the courts on September 21, 2006.

Mr. Dubois had an extensive past forensic Psychiatric history as well as a past criminal record.

In the Thunder Bay Jail Mr. Dubois was placed on "constant" and "suicide" watch on a number of **occasions**, due to intermittent episodes of self-harming behaviour with fluctuating levels of self-harm risk, based on repeated assessments by various members of the Jail staff.

Several days prior to his death, when Mr. Dubois was moved from one cell to another, a noose type ligature was found in his cell. The communication of this finding appears to have been lost in the system.

In the two days prior to his death, Mr. Dubois, who was an articulate and communicative individual, had actively engaged and been assessed by several members of the **Jail** staff (Nursing, Social Work and Corrections Officer). During this time the staff noted that he was depressed and angry at having to wait for his transfer out for his 30 day Psychiatry assessment, however it was uniformly felt by the staff that he displayed forward looking thoughts and that he was felt to be of relatively **low** risk for self-harm. At the time of his death Mr. Dubois was not on any type of "constant or suicide watch" but was in an area that required every 15 minute visual checks of inmates by the correction officers.

The early morning of October 13, 2006 Mr. Dubois was found suspended from the end of his bunk by a noose made of torn bed sheet material. His roommate was asleep and entrance to the cell was impeded by what appeared to be pencil fragments jammed into the cell door lock mechanism. Attempts at revival with CPR and **timely** 911- response were **unsuccessful** and Mr. Dubois was pronounced dead in the local Emergency Department.

### **Issues Explored:**

1. Constant and Suicide Watch Process: The issue of how an inmate is assessed, placed on and taken off of these types of enhanced watches was discussed in depth. The availability of staff training for this type of assessment and the mechanism to ensure compliance with organizational policy were explored.

2. 30 day Psychiatric Wait Times: The variability of wait times for inmate access to 30 day assessments, depending of the availability of local space, was discussed as was the potential for accessing other Psychiatric resources at different centres within the provincial system. The recent enhancement of the court ordered Psychiatric assessment resources within the Province was presented to the jury.
3. Availability of an Aboriginal Inmate Liaison Officer (NILO) and Aboriginal specific programming at the Thunder Bay Jail: The fact that it is estimated that 80% of the Thunder Bay Jail inmate population is aboriginal (Mr. Dubois was of aboriginal decent) raised the concern that, while Mr. Dubois expressed no sense of a lack of access, there did appear to be the potential for other members of the Aboriginal inmate population to have unmet cultural needs. The current aboriginal programming, as well as the plans for the future expansion of Aboriginal specific programming at the Jail was reviewed. The propriety of the blending of the NILO (part-time funding) with the part-time Chaplain positions (2) at the Thunder Bay Jail and the Thunder Bay Correctional Centre to create two full-time Chaplain positions, currently staffed by individuals of Métis and Aboriginal origin, was also discussed.
4. Communication Processes within the Jail: The issues around the fact that the report regarding the finding of the noose like ligature in Mr. Dubois's cell several days before his death were explored. As well, the fact that medication dispensing forms were completed prior to the medication actually being dispensed was raised and discussed. In addition the fact that not all parties involved in the "circle of care" of an inmate (social work, nursing, psychiatry, operations manager, native court worker, etc.) are recipients of internal Jail memos sent regarding the status of an inmate was explored, as it became apparent that with a psychiatrically complex individual such as Mr. Dubois there were a number of concerning behaviours identified by staff that collectively may have provided some warning of a negative shift in his mental status.

**Explanation of Recommendations:** (coroner's comments in italics)

**To the Thunder Bay District Jail:**

1. *Ensure that pertinent and regulatory documents, reports and forms be completed at the prescribed times and expedited to the appropriate levels of jurisdiction.*

*The jury heard evidence concerning the practice of issuing memos and specifically in this case the issuance of a memo regarding the finding of a bed sheet noose in Mr. Dubois's cell several days before his death. The memo seems to have been lost in the system and the potential upgrading of his watch status did not occur.*

**2. In consideration of the changing profile of the inmate population of the Thunder Bay District Jail, we recommend that:**

**a) The Thunder Bay District Jail should conduct regular assessments of the "Circle of Care" needs in order to ensure appropriate inmate care.**

*The "circle of care" referred to involves both employees of the Jail and other support staff working part-time in the Jail but employed by other organizations ie Native Court Worker. The current level of integration at the Jail appears to be very effective but there is still the potential to improve overall communication within this group.*

**b) All staff are continuously provided the necessary training related to mental health issues which are relevant to their institution.**

*The jury heard evidence that the Jail inmate population is high risk for a variety of mental health issues and that ongoing training regarding mental health training and specifically self-harm risk assessment should receive priority status.*

**c) The delivery of Aboriginal Eastern Door Program be available and delivered to remanded inmates at the Thunder Bay District Jail.**

*The jury heard evidence of the success of this program at the Thunder Bay Correctional Centre and was supportive of the proposal to bring this same type of programming to the jail population.*

**d) Seek new outside partnerships within the local communities and agencies as a means to meet the Aboriginal program needs within the jail**

*The failure of the previous NLO (Native Inmate Liaison Officer) position due to specific delivery issues should not prevent the ongoing expansion of the Jail's current community partnerships with local Aboriginal agencies in the provision of enhanced Aboriginal programming and supports to the inmate population.*

In closing, I would like to stress once again that I prepared this document solely to assist interested parties to understand the jury's verdict. It is not the verdict. Likewise, my comments about evidence are my personal recollections and are not put forth as the actual evidence. If anyone feels that I have made a gross error in my recollection or in a conclusion drawn by the jury I would be most appreciative if my error could be brought to my attention and I will correct it.

D. E. Mutrie MD, CCFP (EM), MA, FCFP  
Inquest Coroner, Northwest Region