RELEASE DATE: March 24, 2023

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act* C.C.S.M. c. F52

AND IN THE MATTER OF: An Inquest into the Death of Jeffrey Owen Tait

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Report on Inquest and Recommendations of
Judge Stacy Cawley
Issued this March 21, 2023

APPEARANCES:

Paula Leslie, Inquest Counsel
Lisa Cupples and Sarah Zagozewski, Counsel for the Government of Manitoba (Department of Justice, Community Safety Division)
Zilla Jones, Counsel for Eugene Tait (father of deceased)
Nicole Watson, Counsel for Dr. J. Atwal

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: Jeffrey Owen Tait

Having held an Inquest respecting the said death beginning on September 19, 2022 and ending on October 7, 2022, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: Jeffrey Owen Tait

I find the deceased came to his death on January 29, 2019, at approximately 3:50 p.m. (pronounced deceased at 5:18 p.m.), in the R.M. of Headingley in the Province of Manitoba.

The cause of death was ligature strangulation due to suicide.

Based on a review of the circumstances I make recommendations as set out in the attached report.

Dated at the City of Winnipeg, in Manitoba, this March 21, 2023.

"Original signed by:"
Judge Stacy Cawley
Provincial Court of Manitoba

Copies to:

1. Dr. John Younes, Chief Medical Examiner (2 copies)
2. Chief Judge Margaret Wiebe, Provincial Court of Manitoba
3. Honourable Kelvin Goertzen, Minister Responsible for *The Fatality Inquiries Act.*
4. Jeremy Akerstream, Deputy Minister of Justice & Deputy Attorney General
5. Michael Conner, Assistant Deputy Attorney General
6. Paula Leslie, Counsel to the Inquest
7. Zilla Jones, Counsel for Eugene Tait (father of deceased)
8. Nicole Watson, Counsel for Dr. J. Atwal
9. Lisa Cupples and Sarah Zagozewski for the Government of Manitoba (Department of Justice, Community Safety Division)
10. Exhibit Officer, Provincial Court of Manitoba
11. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba

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THE FATALITY INQUIRIES ACT
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RESPECTING THE DEATH OF: Jeffrey Owen Tait

I. INTRODUCTION

The Circumstances of Jeffrey Tait's Death

[1] Mr. Jeffrey Tait (Tait) was an inmate housed in a segregation unit at Headingley Correctional Centre (HCC) on January 29, 2019. At 4:48 p.m. that day, he was found, alone in his cell, lying on the floor unresponsive with a piece of fabric wrapped around his neck. Both staff and paramedics attempted to resuscitate Tait but he was pronounced deceased at 5:18 p.m.

The Ordering of the Inquest

[2] By way of a letter dated January 8, 2020, Chief Medical Examiner, Dr. John K. Younes directed an Inquest be held into the death of Jeffrey Tait, fulfilling the requirement for an Inquest as defined in section 19(5)(b) of the *The Fatality Inquiries Act* (the Act), *C.C.S.M. c. F52*, to determine the circumstances relating to Tait's death and to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

> Presumption of inquest
>
> 19(5) Subject to subsections (6) and (7), an inquest into a death must be held if
>
> (b) At the time of death, the deceased person was
> (i) In the custody of a peace officer,
> (ii) **A resident in a custodial facility,** (emphasis added)
> (iii) An involuntary resident in a facility under *The Mental Health Act*, or
> (iv) A resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*.
>
> The purpose of the inquest is to establish the facts necessary to complete a report as required by s.26.2(1) of The *Fatality Inquiries Act.*

The Standing Hearing

[3] Ms. Paula Leslie was appointed as counsel for the Inquest. On May 18, 2021, a hearing was held to identify parties substantially and directly interested in the Inquest. As a result of the hearing, the following parties were granted standing:

Eugene Tait (father of deceased), represented by Ms. Zilla Jones;

Government of Manitoba (Department of Justice, Community Safety Division), represented by Ms. Lisa Cupples and Mr. Sean Boyd.

A further application for standing, limited in scope to the involvement of Dr. Jasdeep Atwal, was made by Ms. Nicole Watson, counsel for Dr. Jasdeep Atwal and granted on September 20, 2022.

The Inquest Proceeding

[4] The Inquest was held over thirteen days between September 19, 2022 and October 7, 2022. Twenty four witnesses testified. Two binders containing institutional documents relating to Tait's correctional history and medical information, photo and video surveillance evidence, HCC policies, and incident review/recommendations were tendered as exhibits.

The Inquest Report

[5] At the completion of an Inquest, the Inquest Judge must complete a report that complies with the requirements of s. 33(1) of the Act, which states:

> 33(1) After completion of an inquest, the presiding provincial judge must provide the minister with a written report that sets out his or her findings respecting the following:
>
> (a) the identity of the deceased;
> (b) the date, time and place of death;
> (c) the cause of death;
> (d) the manner of death;
> (e) the circumstances in which the death occurred.

[6] The report may contain recommendations but the Inquest Judge is prohibited from expressing an opinion or making findings such that any person could be identified as a culpable party in the death per s. 33(2)(b) of the Act. The recommendations are to be specific in scope and aimed at preventing future deaths in similar circumstances as required by s. 33(1.1) of the Act, which states:

> 33(1.1) The report under subsection (1) may contain recommendations on changes to provincial laws or the programs, policies and practices of the provincial government

or of public agencies or institutions to prevent deaths in similar circumstances.

II. SUMMARY OF THE EVIDENCE

Tait's Admission into Custody

[7] Tait was admitted into the Winnipeg Remand Centre (WRC) on November 3, 2018. He was assessed as presenting with no evidence of suicide risk. He was placed into a form of segregation due to his gang status and incompatibility with other inmates.

[8] Tait was interviewed by WRC staff on November 5, 2018 but the meeting was terminated because Tait became confrontational and threatened staff. As a result of the incident, Tait was raised to "Red Flag" status which is a designation used by Corrections to alert staff that an inmate is potentially violent. As a result of this designation, Tait was moved to a different segregation level and received institutional charges.

[9] Tait requested a transfer to the Dauphin Correctional Centre (DCC) the next day. He remained housed in segregation at the WRC until his transfer to DCC on November 19, 2018. While waiting for this transfer Tait was checked daily by staff and he continuously denied having any suicidal thoughts. His "Red Flag" designation was reviewed on November 13, 2018 and lowered to "Special Handling". Tait remained in segregation.

[10] On November 19, 2018, Tait's status was reviewed again. Tait was emotional during the interview. He stated he did not want to be in segregation because of gang status at the WRC and would prefer to be at the HCC.

Tait's Transfer to Dauphin Correctional Centre

[11] Tait was transferred to the DCC on November 19, 2018. He was assessed as presenting with no evidence of suicide risk. He was housed in a regular custody placement where he remained until early January 2019.

[12] A new suicide risk assessment was completed on January 5, 2019 because staff observed Tait was keeping to himself. He denied any suicidal thoughts. Tait

requested a move to segregation on January 6, 2019 because he wanted to spend some time alone. He was observed to be in a good mood in segregation on the evening of January 6, 2019, however, the next day he smashed his cell window with a chair causing shards of glass to hit a member of staff. Tait spoke to medical personnel the next day and he admitted he was hearing voices. He requested a psychiatric assessment.

Tait's Transfer to Headingley Correctional Centre

[13] Tait was transferred to HCC on January 8, 2019 and housed in the Intensive Supervision Unit– Alpha (ISU). He was assessed as presenting no risk of suicide. He was noted as being in a good mood on January 9, 2019 when he was advised he was raised to "Red Flag" status and pending charges before the discipline board because he smashed his cell window in Dauphin.

[14] Between January 10 and 13, 2019, Tait's emotional status ranged from quiet to talkative. His suicide risk level was assessed as low risk, which was an elevation from his previous status, although staff testified that was an error. According to staff testimony, Tait should have remained designated as presenting no evidence of suicide risk. On January 14, 2019, staff conducted a segregation review and noted Tait appeared physically and mentally well.

[15] On January 15, 2019, Tait appeared before the discipline board concerning the incident in Dauphin. He pled guilty and received 15 days of disciplinary segregation plus $25 restitution as a consequence. Later that day, Tait was observed to be upset about the outcome at the discipline board but he reported he felt better after he spoke to an Elder. Tait also spoke to a psychiatric nurse about his January 7, 2019 request for a psychiatric assessment. He told the nurse he did not want to meet with a psychiatrist or psychologist. He indicated he preferred to deal with matters on his own. He denied hearing voices or having any suicidal thoughts, plan or intent. The nurse noted Tait was possibly suffering from a form of psychosis. Tait was reminded he could request mental health services at any time.

[16] On January 16, 2019, Tait provided staff with an appeal letter concerning the ruling of the discipline board. In the letter, Tait advised that he had mental health issues. In response, Tait was offered mental health services but he did not want to

access them. Later on January 16, 2019, Tait was observed acting in an irrational and aggressive manner. He believed the staff were "messing" with him. Tait refused his medication and all meals, stating he was fasting.

[17] Staff conducted a segregation review on Tait the next day, January 17, 2019. Tait reported he was doing well, however, the staff noted he was argumentative when interacting with others. Later that day, Tait was involved in an aggressive incident with a staff member but institutional charges were not recommended because it was recognized Tait's mental health was deteriorating. Tait's designation was raised to "Red Flag" status due to his unpredictable behavior. The staff spoke with an Elder about Tait's condition and agreed he could be provided with a medicine bag. Psychiatric services were advised of Tait's condition. They encouraged Tait to make an appointment with mental health staff but he refused.

[18] A correctional officer familiar with Tait noted his behavior was markedly different from past terms of imprisonment. Tait did not know why he was in segregation until staff reminded him of the cell window incident in Dauphin. The staff noted Tait's behavior as bizarre, angry and confused.

[19] On January 19, 2019, Tait was upset about his "Red Flag" status and claimed he was misunderstood by the staff. He was agitated and pacing in his cell. He was told his status would be reviewed the following week.

[20] On January 20, 2019, Tait was observed by the medical unit. He reported he was not suffering from any physical or mental distress. On January 21, 2019 he received spiritual care from an Elder and requested to be transferred to Milner Ridge or Brandon Correctional Centres. A nurse assessed Tait on January 22, 2019 and reported he was eating and sleeping well. Tait was advised he would be seeing the doctor the following week.

[21] On January 23, 2019, Tait's discipline board appeal was denied. Tait appeared to take the news well. He reported he was enjoying his meetings with the Elder. Over the next four days, Tait had regular contact with the Elder and they developed a spiritual care plan for when he was released from segregation. Correctional staff

noted Tait was generally positive and respectful. No mental health or behavioral issues were observed.

Tait's Removal from Segregation - January 28, 2019

[22] Tait's punitive segregation sentence, for smashing the cell window in the DCC was ending on January 30, 2019, however he was removed from segregation early because the staff noted his mental health was declining. During his segregation review on January 28, 2019, Tait told staff he was not doing well in segregation. He was emotional and observed rocking back and forth in his cell. Tait was referred to psychiatric services and moved to the Differential Needs Unit (DNU). Later that day, Tait met with the Elder and told him he was feeling better. They developed a plan to meet every day that week.

[23] Tait was also assessed by Dr. Atwal on January 28, 2019 at which time he denied any suicidal thoughts. Tait was prescribed medication for symptoms of mild psychosis. While Tait told Dr. Atwal he was willing to take the medication, he refused to take it later that night.

Tait's Return to Segregation - January 29, 2019

[24] The next morning January 29, 2019, Tait asked DNU staff if he could smudge. His request was denied because it was too cold outside but he was told he would be able to smudge later that day if the weather improved. In 2019, smudging was offered to the inmates in an outdoor space at HCC, but for safety reasons the policy did not permit outdoor access when the temperature was below -32 degrees Celsius.

[25] After his request was denied, Tait became argumentative and threatening toward the staff. He refused to return to his cell and asked to return to segregation. The DNU staff complied with his request to return to ISU in order to de-escalate the situation.

[26] Tait was noted as being a low risk for suicide when he was returned to the ISU. He was placed in a cell with a camera at 7:37 a.m. Within two minutes of entering the cell, Tait wet some toilet paper and covered the lens of the camera. The cell camera video surveillance confirms the view into Tait's cell was obstructed.

[27] At 10:26 a.m., a nurse checked on Tait and he indicated he had no concerns. At 12:59 p.m. a supervisor spoke to Tait about what happened in DNU earlier that day. Tait said DNU was not for him. The supervisor asked Tait to reconsider and they agreed they would talk about it further the next day.

[28] At 1:45 p.m. the toilet paper covering the camera started to dry and peeled back revealing a small portion of the cell. At 3:26 p.m., the paper had pulled away enough to show Tait sitting against the cell wall beside the desk with his blanket over his head. He got up to receive his meal tray delivery at 3:29 p.m. and joked with staff.

[29] After receiving his meal tray, Tait is visible sitting on the floor and leaning against the wall with a piece of white fabric tied around his neck. Within minutes, he fell to the right, out of view of the camera. The last perceptible movement by Tait was noted at 3:40 p.m. Correctional staff conducted security round checks at 4:11 p.m. and 4:28 p.m. but they did not notice that Tait was unresponsive. Officers testified it is not unusual to see inmates lying on the floor of their cells during security rounds, however, senior correctional management confirmed security rounds should confirm the inmate is alive and safe. Tait's status was not discovered by staff until 4:48 p.m.

[30] When Tait was discovered, multiple staff rushed to provide aid and immediately started resuscitation attempts until the medical personnel took over. Despite their efforts, Tait was pronounced deceased at 5:15 p.m.

Cause of Death

[31] An autopsy was conducted and the cause of death was determined to be ligature strangulation. The ligature wrapped around Tait's neck was very tight causing significant pressure. Tait's movements captured on the cell camera are consistent with the medical evidence. Dr. Younes, Chief Medical Examiner and Forensic Pathologist, testified, in such circumstances, death would occur within a ten minute period. Based on the evidence as a whole, I find Tait died before or at approximately 3:50 p.m. The manner of death was suicide.

III. JURISDICTION OF THE INQUEST JUDGE TO MAKE RECOMMENDATIONS

[32] Section 33(1.1) of the Act states that an Inquest report may contain recommendations to prevent deaths in similar circumstances.

[33] After Tait's death, an investigation was conducted by Manitoba Correctional Services which resulted in numerous recommended changes to HCC policies and protocols in order to avoid similar deaths in the future. HCC has been responsive and has implemented numerous changes to their Standing Orders and policies relating to segregation, access to spiritual care, security rounds and cell camera protocols, Control Pod (CCTV) Operations, and suicide risk assessments. The actions taken by HCC to date are summarized in Appendix A and address most of the concerns raised by the circumstances surrounding Tait's death.

[34] Inquest counsel and counsel for the family submit additional recommendations are warranted. Counsel for the Government of Manitoba (Department of Justice, Community Safety Division) argues some of the recommendations are outside the scope of s. 33(1.1) because they are not aimed at preventing deaths in similar circumstances. For example, counsel for the family recommends improvements to better support the family and staff after experiencing this type of traumatic event. Specifically, counsel recommends counselling for the family and additional leave for staff. Several witnesses were visibly upset during their testimony describing the discovery and attempts to resuscitate Tait. In addition to the family's trauma of losing a loved one, the staff involved were also traumatized. While I agree additional support in these circumstances is important and I am hopeful Manitoba Correctional Services will consider the suggestion, in my view a formal recommendation is outside the scope of s. 33(1.1).

[35] Similarly, suggested recommendations about how to conduct internal investigations when there is a death in an institution are outside the scope of this Inquest. I agree with counsel it was concerning that some staff members, such as those assigned to the control pod tasked with monitoring the cell cameras on January 29, 2019, were not interviewed in a timely manner causing the loss of evidence relating to whether the staff noticed Tait's camera was covered on January 29, 2019.

The subsequent creation of an independent investigative unit has alleviated these concerns. Again, a formal recommendation is outside the scope of s. 33(1.1).

[36] Inquest Counsel also made recommendations relating to the tracking and documentation of medical and psychiatric referrals. I am unable to conclude a formal recommendation is warranted given the circumstances of Tait's death and the evidence from the medical staff. While the evidence revealed an overall resourcing issue related to heavy nursing and physician workloads, in this case, the lack of resources did not prevent Tait from accessing medical and psychiatric services in a timely manner.

[37] After considering the submissions of counsel and reviewing the Inquest evidence as a whole, I am of the view seven recommendations are warranted to prevent future deaths in similar circumstances.

IV. RECOMMENDATIONS

Review the Use of Segregation

[38] The HCC Standing Orders define segregation as being secured alone in a cell for 18 hours or more each day. The Standing Orders also state that segregation is to be used as a last resort and only to the extent necessary. Segregated inmates are to be provided with a minimum of 30 minutes or more per day of out of cell exercise. The segregated inmates are offered regular breaks which provides an opportunity to interact with others.

[39] A review of Tait's housing placement during his final term of incarceration confirms he was housed in a form of segregation for a substantial amount of time between his admission into the WRC on November 3, 2018 and his death on January 29, 2019. Tait was initially housed in segregation because there were limited suitable housing options available in the WRC given his incompatibility with other inmates. Tait spent approximately 15 days in segregation in the WRC. Later, at HCC he was placed in segregation for behavioral and punitive reasons for approximately 23 days. I note the 15 days of punitive segregation he received from the discipline board, for the incident in Dauphin, is the maximum disciplinary segregation sentence an inmate can receive per incident, according to the HCC Standing Orders.

[40] By January 28, 2019, after 23 days in segregation since his self-admission on January 6, 2019, Tait's mental health was suffering. Correctional staff observed obvious changes in his behavior. He demonstrated emotional distress that was attributed to his placement in the segregation unit.

[41] Since his death, HCC has addressed the communication issue that lead to his return to segregation the next day. HCC has made changes to their segregation policy confirming an inmate cannot be returned to segregation within 72 hours of their release without approval from senior management. HCC has also improved practices for maintaining segregation observation logs and conducting segregation reviews. While these are positive steps, they do not address how frequently segregation continues to be used within the institution. The various justifications for Tait's placement in segregation and the overall length of time he spent there cannot be overlooked. The decline of his mental health and death occurred while he was housed in segregation for an extended period of time.

I therefore recommend: that the Government of Manitoba retain an independent, third party agency with no relationship to Manitoba Correctional Services, to conduct a full and comprehensive review of the use of segregation in Manitoba correctional institutions with a mandate to: investigate whether segregation is actually being used as a last resort and only to the extent necessary, to reduce the amount of time inmates spend in segregation, to protect the mental health of inmates housed in forms of segregation and to make recommendations for alternatives to segregation.

Create Additional Specialized Housing Placements

[42] One of the reasons Tait spent a significant amount of time in segregation was because there were limited housing options available for inmates with special needs. Given Tait's personal circumstances and history, placement with the general population was not appropriate. The DNU was the only option available in HCC, outside of segregation in ISU. After the behavioural incident in the DNU on January 29, 2019, Tait requested a return to ISU but his request must be assessed in context; there were no other medical units or special housing options available to him.

[43] HCC Senior Management are working on a DNU reconfiguration proposal to offer additional options to inmates with specialized needs, but to date no improvements have been made. The Inquest evidence confirms mental health concerns within the inmate population are on the rise, specifically in the area of methamphetamine psychosis. Tait struggled with methamphetamine use and was displaying symptoms of mild psychosis the day before his death. He needed specialized housing capable of supporting his needs.

I therefore recommend: that the Government of Manitoba invest additional resources to support the mental health of inmates including the creation of additional specialized housing placement options.

Provide Further Training - Cell Camera Monitoring Standards

[44] The camera inside Tait's cell was not monitored on January 29, 2019. Tait covered the camera almost immediately upon entering the cell and it remained covered for over nine hours.

[45] The Court heard from multiple witnesses who described varying degrees of tolerance with respect to inmates covering their cell cameras for privacy reasons. This practice of allowing inmates to cover their cameras was inconsistent with existing policy. Since Tait's death, HCC has taken steps to ensure staff are aware that immediate action is required should an inmate cover their cell camera. However, there was evidence presented at the Inquest that confusion still exists amongst staff about whether cell cameras can be covered for short periods of time.

I therefore recommend: that Manitoba Correctional Services conduct further training to educate all staff tasked with cell camera monitoring of the relevant Standing Orders to ensure a consistent response should an inmate tamper with a cell camera.

Increase Staff for Cell Camera Monitoring

[46] The control pod is the location where institutional cameras are monitored. The control pod is designed to monitor four stations in different areas of the institution. Several correctional officers testified the control pod is busy and regularly understaffed, making effective camera monitoring difficult. Witnesses testified

about the visual fatigue they experience when monitoring cameras for a twelve hour shift. Further, because the control pod does not have access to the Corrections Offender Management System (COMS), officers are required to leave the pod if they need to complete a COMS report, leaving fewer staff in the pod for monitoring. In my view, improvements to the staffing and operations of the control pod are necessary to ensure cell cameras are properly monitored.

I therefore recommend: that Senior Management at HCC conduct a comprehensive review of their control pod operations to ensure effective monitoring.

Modify Infrastructure - Improve Monitored Cell Design

[47] Tait was able to quickly and easily cover the camera in his cell.

I therefore recommend: that the Government of Manitoba invest in improvements to the cell design for monitored cells in order to minimize/eliminate an inmate's ability to tamper with cell cameras.

Increase Access to Indigenous Spiritual Care and Practices

[48] The Court heard evidence from Elder Edwards that smudging is available at HCC, with prior approval, when in the presence of an Indigenous spiritual care provider. Elder Edwards testified the practice of smudging helps calm the inmates. In his view, requests to smudge should not be delayed if possible.

[49] The overrepresentation of Indigenous persons in custody at HCC is an important contextual consideration. Tait was one of over 72% Indigenous inmates incarcerated at HCC. While not all Indigenous inmates wish to access spiritual care, according to Elder Edwards the demand for Indigenous spiritual care services is very high and requires additional resources. Senior Management at HCC is currently addressing this issue by adding additional Indigenous spiritual care provider positions at HCC. Hopefully with increased resources, inmates will have access to Indigenous spiritual care seven days per week.

[50] The circumstances surrounding Tait's death did not relate to the unavailability of Indigenous spiritual care. Based on the record, I am satisfied Tait had frequent

access to Indigenous spiritual care while he was incarcerated. On the day of his death, his request to smudge was denied for safety reasons because it was too cold outside.

[51] After Tait's request to smudge was denied he acted out, which resulted in his return to segregation. While safety must remain the paramount consideration in an institutional setting, access to spiritual care which includes the ability to engage in cultural and spiritual practices is important.

[52] Since Tait's death, policy changes now allow for greater access to spiritual care even for inmates housed in segregation. These are positive changes but the weather continues to dictate whether inmates will be able to engage in certain forms of practice such as smudging. Our northern climate may prevent inmates from smudging for extended periods of time. In my view, inmates must have consistent access to spiritual care and cultural practices even during the winter season.

I therefore recommend: That HCC create a space that is accessible year-round for inmates to engage in cultural and spiritual practices such as smudging.

Provide Further Training – Suicide Risk Assessments, Impact of Segregation on Mental Health

[53] Tait's death was a shock to the medical and correctional staff who worked with him. He repeatedly denied any suicidal ideation and was regularly assessed as presenting no evidence of suicide risk. Based on staff training and experience at the time, his suicide was not predictable. Since Tait's death, changes have been made to the suicide risk assessment process, however it continues to rely heavily on inmate self-reporting.

[54] Many of the correctional officers who testified indicated they needed further training on how to conduct a suicide risk assessment. Currently staff receive two days of training during their orientation and refresher courses. The evidence confirms the two day training offered has not been updated in years. Further, the evidence indicates that training is not consistent amongst full and part-time staff.

[55] In order to properly conduct suicide risk assessments, the staff must be trained on the impact of segregation on an inmate's mental health. While I appreciate there has been some effort to offer mental health training to the staff since Tait's death, based on the Inquest evidence, I find that training is inadequate because it does not include information about the impact of segregation on mental health. In my view, further training is required in order to ensure suicide risk assessments are completed properly and with appreciation for the limits of inmate self-reporting.

I therefore recommend: that the Government of Manitoba invest resources to update and improve current training offered at HCC in the area of suicide risk assessment including specialized training on the impact of segregation on the mental health of segregated inmates.

List of Recommendations

1. That the Government of Manitoba retain an independent, third party agency with no relationship to Manitoba Correctional Services, to conduct a full and comprehensive review of the use of segregation in Manitoba correctional institutions with a mandate to: investigate whether segregation is actually being used as a last resort and only to the extent necessary, to reduce the amount of time inmates spend in segregation, to protect the mental health of inmates housed in forms of segregation and to make recommendations for alternatives to segregation.

2. That the Government of Manitoba invest additional resources to support the mental health of inmates including the creation of additional specialized housing placement options.

3. That Manitoba Correctional Services conduct further training to educate all staff tasked with cell camera monitoring of the relevant Standing Orders to ensure a consistent response should an inmate tamper with a cell camera.

4. That Senior Management at HCC conduct a comprehensive review of their control pod operations to ensure effective monitoring.

5. That the Government of Manitoba invest in improvements to the cell design for monitored cells in order to minimize/eliminate an inmate's ability to tamper with cell cameras.

6. That HCC create a space that is accessible year-round for inmates to engage in cultural and spiritual practices such as smudging.

7. That the Government of Manitoba invest resources to update and improve current training offered at HCC in the area of suicide risk assessment including specialized training on the impact of segregation on the mental health of segregated inmates.

V. ACKNOWLEDGMENTS AND FINAL NOTES

[56] Jeffrey Tait was 31 years of age when he died. He is much loved and greatly missed by his four children, his partner Shandy Kakekayash, and his parents Eugene Tait and Lillian Abraham. I extend my sincere condolences to his family for their loss. My hope is that the recommendations in this report will prevent deaths in similar circumstances.

[57] I wish to extend my gratitude to all counsel for their diligent and thoughtful approach during the Inquest.

[58] I respectfully conclude and submit this Report on this 21st day of March, 2023, at the City of Winnipeg, in the Province of Manitoba.

"Original signed by:"
Judge Stacy Cawley
Provincial Court of Manitoba

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: Jeffrey Owen Tait

Appendix A: Status of Recommendations Related to the HCC – Jeffrey Tait Review

Status of Recommendations Related to the Headingley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
COMS # 96965- Death In Custody January 2019			
1. HCC Orders	a. Segregation: (i) Include the Manager's ability to remove an inmate from Preventive or Disciplinary Segregation for cause, as exists in the Transitional Confinement section;	E-mail (Sept 23,2019) to the Standing Orders Officer to review the Segregation Policy and work the UM ability to modify an inmates placement based on mental health needs- (Section 14.4) Being added to Segregation standing order. Emailed to all Managers reminding them they can remove inmates from segregation for cause.	Appendix A Completed January 24, 2020 January 16, 2020 Appendix L January 24, 2020
	(ii) Note that if an inmate is removed from segregation as a result of a concern for well-being, with or without a referral to the Superintendent, that placement back into segregation requires approval of Senior Management;	Segregation policy to be updated to reflect; a) if an inmate returns to segregation within 72 hours, this requires authorization by the on call Manager and an email forwarded to the Superintendent or designate. Email sent to	

1
February 2020

Status of Recommendations Related to the H[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
		Standing orders Officer Sept 19, 2019.(Section 14.4.1) b) Once Mental Health concerns have been identified, for segregated inmates, reference to placement review to be added to cautions tab - Do not place in segregation without SMT authorization (section 14.4.2 Add this to section 14 of the Seg policy – UM responsibilities and Section 13 SMT Responsibilities. Email to Bsmt, ISU, DNU and Medical Unit Managers and all SOMS.	January 16, 2020 Appendix L January 24, 2020
	(iii) Formalize a process that allows staff to refer inmates to mental health services which requires an appropriate medical assessment within a specified time frame;	Practice in place already to address concerning mental health related behaviours and they are considered and communicated during segregation reviews; but formal process to be documented in the segregation policy and communicated...a COMS Running Record, email to Medical	September 24, 2019 Appendix G

Status of Recommendations Related to the He[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
	(iv) Establish a review process to ensure that segregation timetables are being met for Segregation Observation Logs and Segregation Reviews;	Manager and Medical Supervisor, and impacted Unit Manager.A phone call if there are urgent circumstances. Section 14.4 UM/SOM; Section 15.5 SUO; Section 16.3 CO1	September 24, 2019 Appendix C
		Email to Medical Manager to discuss.	Completed : ISU – September 27, 2019 - Appendix J2 Completed DNU – September 26, 2019 – Appendix J1
		Reminder to Unit Managers to ensure established timelines for segregation reviews are met as per policy and all follow ups are documented and completed.	October 25, 2019 Appendix J4
			August 26, 2019 Appendix J3
		Email reminder to staff managing segregated inmates in ISU and DNU as per policy, of the need for 2 segregation logs in a 24 hour period for all segregated inmates.	January 22, 2020 Appendix K
		Global email sent from Superintendent.	January 16, 2020 Appendix M
		Global email sent from CCO - reminder	
		Segregation Tracker Check List to be	Completed: September 24, 2019

Status of Recommendations Related to the He[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
	(v) Note that Segregation Reviews should not take place in the inmate's cell.	Implemented (7 day tracking back) and added to the Segregation standing order as (a. policy Appendix E Section 14.3) Email update to all CO4s, CO3s, all CCOs, Deputy and Superintendent. Direction to Unit Managers facilitating Segregation Reviews regarding ensuring where possible, meeting location is external to the cell. Add to Seg Policy after sec 14.4 NOTE BOX.	Appendix C January 24, 2020
	b. Security Rounds: (i) Under Purpose, establish that the assurance of inmate life safety is one of, if not the primary purpose;	Direction to be Sent to HCC Staff in a global to address purpose of security rounds as related to life safety. Add to Security Round standing order Purpose Section 1 – life safety. UM ISU also had sent out a communication in this regard on February	Completed: September 27, 2019 Appendix D1 January 24, 2020 February 7, 2019 UM ISU Appendix D2

Incident #	Recommendation	Action	Date Completed
	(ii) Require the use of the Guard One pipe 24/7;	7, 2019. Policy already in place.	
		In Segregation and TC 24/7 punch rounds with guard one Pipe placed back into effect consistent with policy (ISA, ISB, DNF)	Completed January 31, 2019 for both ISU and DNU staff. Appendix D3
	(iii) Staff are not to carry personal items such as beverage containers with them when conducting security rounds;	Policy already in place	ISU reminder Feb 21, 2019 Appendix D4
		Direction on punch round expectation to be sent out Global.	Completed – September 27, 2019 Appendix D1(#6)
		Note Box added to Security Rounds policy Section 4	January 24, 2020
	(iv) If the intent is to have activities such as cell inspections, meal delivery, daily manager segregation contacts, etc., to count as security rounds, note this in documentation, however it is recommended that these activities exist separate and apart from security rounds and that orders state this;	Direction to be sent that operational contact is separate and apart from security rounds. Global to be sent.	Completed Sept 27, 2019 See Appendix D1 (#5)
			January 24, 2020

Incident #	Recommendation	Action	Date Completed
		Security Round standing order Section 8 NOTE BOX	
	(v) Include a requirement for Supervisors to regularly review staff performance of security rounds to ensure that quality rounds are being performed;	E-mail to ISU & DNU UM's to meet, discuss and come up with a plan for the supervisors and email for direction to their staff. Link to the HCC Learning Key that demonstrates effective punch rounds. ISU and DNU UMs to establish a process with their Supervisors ensuring they are participating and monitoring appropriate security rounds.	Completed Sept 23, 2019 See Appendix B1 DNU UM – Appendix B2 completed September 27, 2019 ISU UM – Appendix B3 completed January 15, 2020
	(vi) Consideration should be given to having Supervisors perform a certain number of security rounds per shift in their units. This would not only allow the Supervisor to ensure that nothing is being missed from a safety or security perspective, but allow Supervisors to visibly display the performance of quality rounds for staff to observe	We will not incorporate into operational policy but will address through staff performance management. Email to UMs, ISU, DNU, BSMT confirming Supervisory responsibility to ensure policy compliance with security rounds.	September 23, 2019 Appendix B1

Status of Recommendations Related to the He[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
	C. Control Pod Operations (CCTV):	Action for C (i),(ii),(iii),(v)	
	(i) Ambiguity was evident in staff perception of expectations when an inmate covered his camera:	Direction sent to DNU and ISU UMs to ensure their staff are aware of expectations where inmates have covered camera. Specifically cameras should never be covered.	Completed September 23, 2019 Appendix F1
	(ii) Some staff felt it was acceptable for an inmate to temporarily cover the camera when using the toilet.		
	(iii) Some staff expressed that if the inmate didn't need to be in a camera-equipped cell but was placed into one as no non-camera cells were available, it was acceptable for the inmate to cover the camera.	Direction sent to UMs and SUOs in DNU and ISU and SOMS by CCO for process of having cell camera uncovered safely.	Completed: March 12, 2019 Appendix F2
		Direction to be sent out to Staff by Unit Manger ISU / DNU UM's	Complete Sept 26th, 2019 (DNU) Appendix F3 Completed Sept 27, 2019 (ISU) See Appendix F4
	(iv) If an inmate does not need to be under camera but is placed in a camera-equipped cell because no non-camera cells are available, if the ability to turn off the camera shot to the cell exists, this should take place. That is, only inmates who need to be observed via	Rejected. If a cell is equipted with a camera it should be not be taken out of service. i.e. Tait did not require a cell with a camera at the time of his move to ISU as there was no indication of a	N/A

Incident #	Recommendation	Action	Date Completed
	CCTV should be observed via CCTV.	suicide concern but he still completed a suicide in a cell with a camera that was covered. As a preventative tool we would use a cell with a camera for its purpose no different than if a camera is covered moving forward.	
	(v) Regardless whether an inmate is in a camera-equipped cell by design or because of resource availability, orders should require intervention if an inmate covers his camera.	As noted above in (i), (ii), (iii) response	Completed: as noted above in (i), (ii), (iii) response
	D. Sudden Death of an Offender (i) While staff who witnessed or were involved with the management of the incident all received appropriate debriefings and support, the staff who directly worked with Tait yet were not there for the incident felt that some sort of follow-up support may have been beneficial for them. Consideration should be given to including this in relevant orders.	The Superintendent sent out a global on January 30, 2019 as per standard practise based on an incident of this nature. Informal practice in place. Superintendent met with Elder who had been working with him post incident. Additionally all Major incidents at HCC have	See Appendix I

Status of Recommendations Related to the He[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
		operational debriefings that cover critical incident stress, EFAP and referrals to R2MR There was also additional follow up with the (3) staff that performed CPR on Mr. Tait. Review for further follow up for post incident staff care- to **include any staff that worked directly with the inmate even if they were not present for the incident.** i.e **case worker**; Sudden Death in Custody Standing Order section 11.1	January 24, 2020
2. Staff Follow up	Segregation (i) Reinforce that segregation reviews must occur within 7 days of either the primary placement in segregation or the last completed segregation review;	Direction and clarification to Managers…currently in place with Segregation Standing Order and reinforcement.	Completed Sept 24th, 2019 See Appendix C
	(ii) Reinforce that one Segregation Observation Log must be completed for each 12 hour period;	Direction to staff given for expectations post incident by UMS of ISU/DNU based on their meeting Email Sept 23rd.	Completed Sept 26, 2019 DNU Appendix J1 Sept 27, 2019 ISU

Incident #	Recommendation	Action	Date Completed
			Appendix J2
	Suicide (i) Follow-up with those staff who incorrectly identified Tait's suicide status as SUL and ensure that there is no confusion as to the distinction between NE and SUL;	CCO of Operations Josh Cooney to meet with the staff involved and complete file notes.	Completed October 28, 2019 See Appendix E
	Security Rounds (i) Either specifically with involved staff, generally with all staff or both, reinforce expectations regarding the performance of quality security rounds;	Direction sent out global to all staff. A global Email sent out to all staff on expectations.	Completed Sept 27, 2019 Appendix D1 Completed Sept 27, 2019 Appendix D1
	(ii) Follow up with staff who were carrying beverage containers during punch rounds	Staff identified on camera as not doing appropriate security rounds, will be interviewed. (4 staff)	Completed: December 11, 2019
	(iii) Follow up with staff regarding missed security rounds;	Reports to be submitted for Superintendent review. Determination of culpability and	

Status of Recommendations Related to the He[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
		corrective action/disciplinary consideration Behaviours to be managed consistent with performance management principals.	Jan 20/20) Received. Reviewed the week of January 27-31, 2020. Completed in February 2020.
	Control Pod Operations (CCTV) (i) As it did not appear to have taken place, reinforce with Pod Officers the need to alert Unit Officers when cameras are covered	See section C above: Control Pod Operations (CCTV):	Appendix F1, F2, F3, F4 Completed September 23, 2019 Appendix F1 Completed: Sept 26, 2019 Appendix F2 Complete Sept 25th, 2019 (DNU) Appendix F3 Completed Sept 27, 2019 (ISU) See Appendix F4
3. Miscellaneous	a. Segregation Impact Recognition (i) Divisionally, some sort of orientation or training should be considered to inform staff how to recognize that time in segregation is affecting an inmate's mental health;	Divisional Review HCC Mental Health Training Package Appendix H1 and Mental health Information	January 24, 2020 Completed

Status of Recommendations Related to the He[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #:	Recommendation	Action	Date Completed
		Sheets Appendix H2(a)(b) to be forwarded to Division. H2(a) for staff H2(b) for staff and inmate awareness. To be forwarded to Division by Supt.	
		Local Facility specific training:	Sept 25th, 2019 See Appendix G
		HCC Medical Management, HCC Psycologist Ash Fleming & Psyche Nurses met on Sept 25th.	Training Package completed November, 2019 Appendix H1
		Educate staff on signs of mental health to assistant in referral process. HCC psychologist Ash Fleming has developed a presentation related to identification of deteriorating mental health and is rolling out to staff via unit meetings and lunch and learns.	Completed pilot (at WR1 Unit Meeting): November 21, 2019 January 29, 2020
		Unit Meetings and some Lunch time learning meetings. Pilot to be completed.	February 27, 2020 November 28, 2017

Status of Recommendations Related to the He[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
		Pilot successful so the HCC Training package and Information sheets to be sent out global. Previous related information related to identification of signs of deteriorating mental health sent out global by Superintendent. W;drive folder Segregation and Mental Health Awareness Information Sheets. Appendix H2(a)(b)	Appendix H2(a)(b) November 28, 2017
	b. Access to Spiritual Care Activities for Segregated Inmates (i) Elder Edwards was of the opinion that it would be beneficial to segregated inmates' mental and spiritual health to allow them to participate in ceremonies – this concept should be explored with him;	Meeting to discuss recommendations on Sept 23rd, 19. Met with the Elders and decisions were made in relation to ceremony access. Reinforce and establish the following: Smudging options already exist; Bull pens, fresh air space. Other ceremony access is based on an assessment of risk i.e. acute and non-acute inmates in segregation.	Sept 23rd, 2019 Appendix N

Status of Recommendations Related to the He[illegible]ngley Correctional Centre-Jeffrey Tait Review

Incident #	Recommendation	Action	Date Completed
		Individual assessments to be made based on inmate needs, safety needs for other inmates and staff. Provisions to facilitate will be made and consistent with staffing and security/safety protocols. Segregation policy section 7.11 Indigenous Spiritual Care Giver Policy Section 75.02	January 22, 2020 January 24, 2020

Comments:

*******Recommendations Completed February 28, 2020*******

Updated Segregation Policy – Appendix O – January 22, 2020
Updated Security Rounds Policy – Appendix P – January 22, 2020/February 28, 2020
Updated Indigenous Spiritual Care Giver Policy – Appendix Q – January 23, 2020
Updated Sudden Death in Custody Policy – Appendix R - January 22, 2020
Global Email on Updated Policies (Segregation; Security Rounds; Indigenous Spiritual Care Giver; Sudden Death in Custody) – Appendix S – January 24, 2020

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: Jeffrey Owen Tait

Appendix B: Witness List

1. **Dr. John Younes** – Chief Medical Examiner/Pathologist
2. **Wayne Baker** – EMS, Paramedic
3. **Corporal Brian Gulay** – R.C.M.P. Officer
4. **Dr. Jasdeep Atwal** – Attending Physician at HCC
5. **Natalie Horne, R.N.** – Supervisor, HCC Medical Unit
6. **James Angus** – Superintendent WRC
7. **Brian Moore** – Correctional Officer
8. **Michael Delorme** – Correctional Officer
9. **Gary McLeod** – Correctional Officer
10. **Todd Schreyer** – Acting Superintendent of Security (Chief Correctional Officer) at HCC in 2019
11. **Edwin Edwards** – Elder and Spiritual Care Provider
12. **Steve Vanderzalm** – Unit Manager, ISU
13. **Lance Manweiller** – Correctional Officer
14. **Shawn Mollons** – DNU Foxtrot Supervisor
15. **Josh Cooney** – Assistant Superintendent
16. **Allan Brownrigg** – Unit Manager of DNU Foxtrot
17. **David Burt** – Acting Senior Unit Officer, ISU
18. **Cole Gibb** – Correctional Officer
19. **Michelle Duncan** – Superintendent at HCC in 2019
20. **Bayne Proctor** – Correctional Officer
21. **Eduardo Hernandez** – Correctional Officer
22. **Chantal Chepil** – Correctional Officer
23. **Keith Armstrong** – Correctional Officer
24. **Andy Williams** – Correctional Officer 3 - Supervisor

Manitoba

THE FATALITY INQUIRIES ACT
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RESPECTING THE DEATH OF: Jeffrey Owen Tait

Appendix C: Exhibit List

Exhibit No. Description

Standing Hearing

1. Letter Dated January 8, 2020 by the Chief Medical Examiner Dr. John Younes

Inquest Hearing

1. Inquest Documents

Initiation of Inquest – OCME & OCE File and Court Documentation

- Tab 1: Inquest Review Form
- Tab 2: Protocol – Provision of PCME File to Crown Counsel
- Tab 3: File Status – Medical Examiner Cases
- Tab 4: Preliminary Report of Death
- Tab 5: Fatality Inquiries Act Autopsy Authority
- Tab 6: Chief Medical Examiner "Pink Notes"
- Tab 7: Preliminary Autopsy Report
- Tab 8: Medical Certificate of Death
- Tab 9: Final Autopsy Report/Toxicology Report
- Tab 10: Report of the Medical Examiner
- Tab 11: Letter to the Honourable Chief Judge Margaret Wiebe
- Tab 11.1: Curriculum Vitae – Dr. John Younes, Chief Medical Examiner
- Tab 11.2: Autopsy Photos: Disc and Contact Sheet

Date of Incident

- Tab 12: Incident Report (Case #96965)
- Tab 13: HCC Shift Logs
- Tab 14: ISA Observations
- Tab 15: First Responders
- Tab 15.1: RCMP Notes and Reports
- Tab 15.2: Sudden Death Checklist

Medical

- Tab 16: Hospital Records
- Tab 17: Dispensing History
- Tab 18: HCC Medical Documentation
- Tab 19: HCC Summary of Medical Care
- Tab 20: eChart – Medication List

Inmate Correctional History

- Tab 21: Running Record Report
- Tab 22: WPS Prisoner Log Sheet
- Tab 23: Suicide Risk Assessment
- Tab 24: Appeal Disciple Board Decision

HCC Videos, Photographs and Blueprints

- Tab 25: Video #1 – Example Round
- Tab 26: Measurement Photographs
- Tab 26.1: Photographs of ISU Control Centre
- Tab 26.2: Blueprints of ISU Control Centre
- Tab 27: HCC Video
    - Disc 1: (1) DNU – Foxtrot; (2) ISU Alpha, cell #3 – 7:35 a.m. to 3:35 p.m.
    - Disc 2: ISU Alpha, cell #3 – 3:36 p.m. to 9:36 p.m.
    - Disc 3: ISU Alpha unit – 7:35 a.m. to 3:29 p.m.
    - Disc 4: ISU Alpha unit – 3:36 p.m. to 9:35 p.m.
- Tab 28: N/A
- Tab 29: N/A
- Tab 30: Video #5 – Handheld
- Tab 31: Incident Date RCMP Photos

HCC Policies in Force at Time of Death

- Tab 32: Divisional – Adult Suicide Prevention Policy
- Tab 32.1: Standing Order – Suicide Prevention
- Tab 33: Post Order – Control Pods
- Tab 34: Standing Order – Security Rounds
- Tab 35: Standing Order – Sudden Death of Offender
- Tab 36: Divisional – Segregation
- Tab 37: Divisional – Inmate/Youth Person Death Policy
- Tab 38: Standing Order – Segregation

HCC Policies in Force After Death

- Tab 39: Standing Order – Segregation
- Tab 40: Standing Order – Indigenous Spiritual Caregivers
- Tab 41: Standing Order – Security Rounds
- Tab 42: Standing Order – Sudden Death of an Inmate
- Tab 43: Standing Order – Security Rounds

HCC Review & Recommendations

- Tab 44: Terms of Reference for Death in Custody Review
- Tab 45: Interview Preambles
- Tab 46: Death in Custody Reviews
- Tab 47: Status of Recommendations (*found at Appendix A*)

2. Hand Drawing of the POD Stations