Office of the Chief Coroner

Bureau du coroner en chef

1999 CanLII 20112 (ON OCCO)

GENTLES, Robert Wayne
Inquest

March 30th – June 24th, 1999

Key Words: Accident, Asphyxia, Freon 113, Restraint, Custody, Chest Compression, Suffocation

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Office of the Chief Coroner
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Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

1999 CanLII 20112 (ON OCCO)

We the undersigned / Nous soussignés,

_____ of / de _____

_____ of / de _____

_____ of / de _____

_____ of / de _____

_____ of / de _____

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
GENTLES	Robert Wayne

aged / à l'âge de 23 held at / tenue à Ontario Court (General Division), Kingston **, Ontario**

from the / du 30th March to the / Au 24th June 19 99

By / Par Dr. / Dr Benoit Bechard Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Robert Wayne GENTLES

Date and Time of Death / Date et heure du décès
October 24th, 1993 at approximately 1:25pm

Place of Death / Lieu du décès
3G, Kingston Penitentiary

Cause of Death / Cause du décès
Asphyxia associated with multiple factors including the effects of Freon 113, restraint in a prone position, chest compression and suffocation

By what means / Circonstances du décès
Accident

Original signed by: Foreman / Original signé par : Président du jury

Original signed by jurors / Original signé par les jurés

The verdict was received on the / Ce verdict a été reçu le 24th (Day / Jour) day of June (Month / Mois) 19 99

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. B. Bechard	1999/06/24

Coroner's Signature / Signature du coroner

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)

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Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

1999 CanLII 20112 (ON OCCO)

Inquest into the death of:
Enquête sur le décès de :

Robert Wayne GENTLES

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

A. Cell Extractions:

1. It is recommended that all alternatives be considered before a cell extraction is ordered.

2. It is recommended that all cell extractions be videotaped.

3. It is recommended that all cell extractions of non-compliant inmates, except for those in the most extreme situations, such as where actual risk of bodily harm or death may be imminent to any staff or inmate, be conducted by properly trained and equipped Institutional Emergency Response Teams.

4. It is recommended that a fully qualified nurse, doctor, or paramedic be present during all IERT and non-IERT cell extractions for non-compliant inmates. The attending health care professional must be adequately equipped to handle possible medical emergencies and must perform a health check of the inmate immediately following the restraint, and prior to removal.

5. It is recommended that esc maintain an Institutional Emergency Response Team on 24-hour standby in all medium and maximum security institutions. During lockdowns, the IERT should be on-site.

6. It is recommended that CSC continue to follow Regional Instruction 605 dated 23 June 1995 on Cell Extractions for all non-IERT cell extractions. The role of each member of the extraction team for non-IERT extractions must be determined by the Correctional Supervisor or his/her delegate before the cell is entered.

7. It is recommended that as soon as an inmate is securely restrained that he be placed in a sitting position provided that it can be done without risk of injury to inmate or staff.

8. It is recommended that a standard kit of equipment be assembled for non-IERT cell extractions. This kit should include leg irons, handcuffs, a chemical agent and a video camera and be made available to the team prior to the commencement of any extraction.

B. Chemical Agents and Inflammatory Sprays:

9. It is recommended that CSC only authorize for use those chemical agents, inflammatory sprays and their constituents, which meet Health Canada and Environment Canada standards. All chemical agents and inflammatory sprays in use by esc must be re-authorized annually.

10. It is recommended that, for each incident for which chemical agents/inflammatory sprays are to be used, they be used only upon the specific authority of the person who is in charge of the institution at that time. This will be done in accordance with the Commissioner's Directives and Standard Operating Procedures. The person in charge must make himself/herself aware of the reason for the request for chemical agent/inflammatory spray before authorizing its use.

11. It is recommended that, when time and circumstances permit, before a chemical agent/inflammatory spray is administered to an inmate that the medical authority at the institution be called to check the inmate's medical file for possible adverse effects to the chemical agent/inflammatory spray. If that is not possible, and when time and circumstances permit, a continually updated list of inmates with medical conditions that might be adversely affected by chemical agents/inflammatory sprays shall be available on each living unit and must be checked.

12. It is recommended that chemical agents/inflammatory sprays continue to be used only by properly trained staff.

13. It is recommended that after a chemical agent/inflammatory spray has been applied that officers wait the recommended time before a second application and/or before entering the cell.

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14. It is recommended that all written procedures concerning chemical agents and inflammatory sprays include the name commonly used in the workplace as well as the proper technical name.

C. Lockdowns:

15. It is recommended that a communications policy be implemented to ensure that all inmates are aware of the procedures to be followed during a lockdown, especially as they relate to meals and movement.

16. It is recommended that the communication of information during a lockdown should not rely exclusively on the communication of information by inmate representatives, as it is not possible to be certain what information is passed.

17. It is recommended that CSC investigate alternative ways of more efficiently providing meals to inmates during a lockdown at Kingston Penitentiary.

18. It is recommended that during a lockdown adequate meals be served at reasonable intervals. The first meal of the day should be served to all inmates no later than 11:00 am.

D. Segregation:

19. It is recommended that when administrative segregation is used, it is administered in compliance with institutional procedures and the law and appropriately monitored by senior management.

E. Training:

20. It is recommended that all correctional officers be recertified in CPR every year and in first aid every three years.

21. It is recommended that all correctional officers receive refresher training every three years in the following areas:

- CSC and the Law,
- Use of Force Management Model,
- Cell Extraction Procedures,
- Restraint Equipment,
- Arrest and Control,
- Use of Force, and
- Chemical Agents.

22. It is recommended that all employees of the Correctional Service of Canada continue to receive training in anti-racism, cultural awareness and harassment.

23. It is recommended that, for the safety of correctional officers and inmates, all correctional officers receive training in the cell extractions of non-compliant inmates.

24. It is recommended that new officers, after initial in-class training, be on-the-job trained on an ongoing basis during their first year of work. They should be brought back frequently for training during their first year with respect to ethical dilemmas experienced on the job.

25. It is recommended that the Commissioner appoint a consultant to study the effectiveness and recommend improvements regarding the course "CSC and the Law".

26. Recognizing the potential negative impact on correctional officers working in an institutional setting, CSC must continue to train new recruits and existing staff in accordance with the values expressed in the Mission of the Correctional Service of Canada.

27. It is recommended that the orientation program for all new officers include a module on "Officer Norms", outlining its beneficial and detrimental aspects.

28. It is recommended that CSC ensure that the Standard Operating Procedures (replacing the Security Manual) and the training in those procedures have been provided to all correctional officers within a year.

29. It is recommended that training be provided in how to lift and carry an uncooperative inmate.

30. It is recommended that training be provided in how to determine whether or not an inmate is "playing possum" or is in medical distress.

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F. The Correctional Officer and Stress:

31. It is recommended that esc evaluate psychological screening as a component of its officer recruitment process.

32. It is recommended that any officer who has inmate contact and who is out on stress leave go for a psychological evaluation prior to returning to work.

33. It is recommended that CSC provide a Stress Management course for staff with an option of professional counselling as needed.

34. It is recommended that CSC provide a 1-800 number to access counselling for staff who are reluctant to self-identify to local management when they are suffering the effects of job related stress.

35. It is recommended that the amount of overtime be reviewed on a monthly basis. Corrective action should be taken where an excessive number of hours are being worked by individual correctional officers. This will ensure that the stresses of the job are not made worse by lengthy exposure to the prison environment.

36. It is recommended that any record of stress related counselling should not be kept on employees' personnel files. This should encourage employees to feel comfortable to come forward and ask for help or stress counselling without reprisal.

G. Policy:

37. It is recommended that the Correctional Service review all Commissioner's Directives, Regional Instructions, Standing Orders and Standard Operating Procedures to ensure they are clear and in compliance with the law and policy and to avoid any duplication and conflicting information.

38. It is recommended that the Union of Solicitor General Employees, with the support of CSC, encourage its members to report any illegal acts or harassment, as their obligations as peace officers should take priority over labour solidarity.

39. It is recommended that all log book entries be read daily by unit managers and the IPSO so that action plans and necessary follow-up can be established when required. There must be feedback to the reporting officer.

40. It is recommended that staff conduct in breach of the CCRA, Commissioner's Directives, Regional Instructions, Standing Orders, Standard Operating Procedures or the CSC Code of Conduct be dealt with by management expeditiously, suitably and openly by any one or more of the following measures:

- counselling;
- re-training; and/or
- discipline.

41. It is recommended that all Standard Operating Procedures, Commissioner's Directives, Regional Instructions and Standard Orders contain a definition section to ensure that terminology used within is clearly understood by staff.

42. It is recommended that CSC continue to investigate the most appropriate device for transporting uncooperative inmates (i.e. chair used by ambulances).

43. It is recommended that CSC, with cooperation from the USGE, investigate the possibility of rotating staff among institutions on a regular basis in order to have a turnover of the majority of staff at Kingston Penitentiary.

44. It is recommended that there be formal steps to notify families of a death in the institution. Notification must be made in person.

45. It is recommended that there always be a staff member trained in crisis negotiation in the institution.

H. Reports:

46. It is recommended that all directives concerning report writing be strictly adhered to.

47. It is recommended that reports (i.e. Use of Force and Situation Reports) be filled out immediately following an incident. Appropriate disciplinary action should be taken if this is not done.

48. It is recommended that the Situation Report contain an attention box with a warning that officers fill out reports independently.

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49. It is recommended that a room be made available at the time of an incident within every institution (i.e. cafeteria, chapel, etc.) for the preparation of reports concerning serious incidents. This room must be supervised during the preparation of those reports by the institutional head or his designate. It is further recommended that a record be kept of those preparing and invigilating the reports.

I. Record Keeping:

50. It is recommended that CSC continue with the current audit of its filing and information system with the objective of improving that system.

J. Management Accountability:

51. It is recommended that all persons in the CSC with specific authority who are empowered or required to dispose of complaints, grievances or investigations be able to admit error on the part of, and on behalf of the Correctional Service.

52. It is recommended that CSC initiate a national program of statistical collection, analysis and reporting that will reflect the trends in the use of force, segregation, inmate discipline, inmate grievances, officer discipline and officer grievances. This would provide indicators to the management team of the performance of their institution.

53. It is recommended that press releases be accurate, precise and clear with no possibility of a misinterpretation of information (i.e. gilding the lily).

54. It is recommended that there be a top down commitment where management sets the appropriate example for staff in accordance with the Mission Statement and the five core values.

55. It is recommended that the Warden and Deputy Warden at Kingston Penitentiary be left in place for a minimum of a three year term. CSC should consider instituting a system of financial incentives for Wardens and Deputy Wardens to stay in their jobs at difficult posts like Kingston Penitentiary.

56. It is recommended that the salary classification of a Warden of a maximum security institution reflect the responsibilities of the position and be such that it will allow for his/her transfer back to the line operation after the completion of a staff assignment (Regional or National Headquarters) without a financial penalty.

57. It is recommended that special assignments that take the Warden away from the institution be limited.

58. It is recommended that all levels of management be held accountable for their actions or lack of same. Senior managers who are found to be ineffective should be provided with additional training, retrained, demoted or dismissed.

K. Discipline:

59. It is recommended that because of the nature of work performed by CSC peace officers, that CSC take forward to Treasury Board a proposal that the Master Agreement between the Public Service Alliance of Canada and the Treasury Board be amended to provide an exception to the general "sunset clause" which provides for the removal of any disciplinary action from a public service employee's file after two years. This exception to the "sunset clause" should be applied only in circumstances where a esc peace officer has received discipline relating to the use of force against an inmate.

60. It is recommended that when allegations of excessive force used against an inmate are proven, the staff member involved be dismissed from the Public Service.

61. It is recommended that any agreement with the applicable union concerning the appropriateness of discipline or the conduct of investigations should be in writing and should be permanently preserved by both parties.

62. It is recommended that the CSC take forward the proposal to Treasury Board that its current legislative and/or policy position be amended to provide for suspension with pay in certain circumstances. This would give CSC the option to suspend an employee with or without pay.

63. It is recommended that the Code of Discipline (CD 60) be amended to include procedures that must be followed whenever a staff member has committed an alleged infraction.

64. It is recommended that an officer who uses an unauthorized control hold be disciplined.

L. Citizens' Advisory Committee:

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65. The public accountability of each Citizens' Advisory Committee (CAC) should be strengthened. To achieve this it is recommended that the Regional Deputy Commissioner, at the beginning of each year, take steps to ensure that each CAC in the Region is at optimum levels of strength and performance. Each committee shall be comprised of at least 3 persons and no more than 7 who are reasonably representative of a cross-section of the community. Newspaper advertisements should be used as necessary to recruit new members. A selection committee made up of the head of the institution, the local union president and the chair of the local CAC shall select new members. The participation of the correctional officers is considered essential in the success of the committee's mandate.

66. It is recommended that each CAC prepare an annual report containing a review of the past year's activities, an assessment of the effectiveness of the committee's monitoring of crisis situations where the safety of staff and/or inmates was clearly at risk and a statement of the needs of the committee in order to carry out their duties in the coming year. The report would be submitted to the Regional Deputy Commissioner, the Correctional Investigator, the head of the institution and to community agencies and individuals involved in public policy relating to community safety and prisoner rehabilitation.

1999 CanLII 20112 (ON OCCO)

M. Pathology:

67. It is recommended that in situations involving the application of chemical agents/inflammatory sprays prior to death, blood and tissue samples be screened for concentrations of chemical agent constituents. In cases where the samples are being forwarded to the Centre for Forensic Sciences, it is recommended that they be provided in the amounts and containers specified by the Centre.

68. It is recommended that the post-mortem report and, if possible, the police report, be provided to the Centre for Forensic Sciences along with the Case Submission form (form CFS 69) when the samples are submitted.

N. Kingston Penitentiary:

69. It is recommended that a review of Kingston Penitentiary be conducted with respect to its appropriate use within the context of the Corrections and Conditional Release Act. This review should be conducted by a committee consisting of representatives from CSC, the Ministry of the Solicitor General and independent persons from the community.

0. Oversight:

70. It is recommended, with the issue of accountability a concern, that increased independent civilian oversight of CSC is required. An independent oversight committee shall be formed by the Ministry of the Solicitor General to conduct a study and report within 12 months to the Justice Committee of the Parliament of Canada. This committee shall determine what type of civilian oversight body should be established and the scope of its powers.

P. Additional:

71. It is recommended that CSC through the IPSOs conduct an annual review of stock in the armories to ensure that all security equipment meets the current standards and that any items not meeting the standards are removed.

72. It is recommended that esc investigate the possibility of requiring inmates in certain cell settings (ie open faced cells) to use headphones for their stereos and televisions.

Q. Implementation:

73. It is recommended that the Chief Coroner receive written reports from the Commissioner of Corrections and any other recipient of these recommendations with respect to their implementation. These reports shall include the status of this jury's recommendations as well as explanations as to why certain, if any recommendations were not implemented. These reports are due to the Chief Coroner within twelve months and will be made public.

74. It is recommended that the Chief Coroner receive a written report from the Solicitor General with respect to the implementation of these recommendations also within twelve months. This report will also be made public.

Personal information contained on this form is collected under the authority of the *Coroners Act*, R.S.O. 1990, C. C.37, as amended. Questions about this collection should be directed to the Chief Coroner, 26 Grenville St., Toronto ON M7A 2G9, Tel.: 416 314-4000 or Toll Free: 1 877 991-9959.

Les renseignements personnels contenus dans cette formule sont recueillis en vertu de la *Loi sur les coroners*, L.R.O. 1990, chap. C.37, telle que modifiée. Si vous avez des questions sur la collecte de ces renseignements, veuillez les adresser au coroner en chef, 26, rue Grenville, Toronto ON M7A 2G9, tél. : 416 314-4000 ou, sans frais : 1 877 991-9959.

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Verdict Explanation

Robert Wayne GENTLES
March 30th – June 24th, 1999
Ontario Court (General Division), Kingston

1999 CanLII 20112 (ON OCCO)

Opening Comment:

It is traditional for the Presiding Coroner at an inquest to provide a synopsis of the events leading to the inquest and also provide background information. This makes reading the Jury's Verdict easier to understand by putting the Findings and Recommendations into their proper context. This is based on my own understanding of the evidence and my interpretation of the Jury's Reasons. This is not to be considered actual evidence presented at the inquest. It is offered only to assist the reader. It is not intended in any way to replace the Jury's Verdict and it should be read in conjunction with the actual Verdict.

Participants:

Coroner's Counsel:	Mr. Ed Bradley, Crown Attorney, Lennox and Addington
Coroner's Constable:	Constable Robert Pringle, Kingston Police Force
Parties with Standing:	**Represented By:**
Family of Robert Wayne GENTLES	Mr. Julian Falconer Mr. Louis Sokolov Ms. Leslie Mondour
Correctional Services of Canada	Mr. Andre Chamberlain Mr. Richard Kramer
Mr. Desjardins, Ms. Hartwick, Mr. Gauvreau, Mr. Wylie, correctional officers	Mr. Angus MacLeod
Mr. Stacey, correctional officer,	Mr. Fred Delaney
Mr. Aitchison, correctional officer	Mr. Alan Gold
Mr. Richard McKee, correctional supervisor	Mr. Bruce Carr-Harris
Mr. Evans, correctional officer	Mr. Fergus O'Connor
Black Inmates and Friends Assembly	Mr. Julian Roy
Dr. Dagnone, Dr. Dexter, physicians	Ms. Laura Stewart

Summary of the Circumstances of Death:

Robert Wayne Gentles was born 30 November 1969, in the Hamilton, Ontario.

In 1992, Robert Gentles was sentenced to thirty months incarceration in a Federal Institution and was sent to Millhaven Assessment Unit on March 4, 1992. After initial assessment, he was transferred to Bath Institution (Minimum Security).

On September 18, 1992, it was decided that Robert Gentles required a more secure setting and was returned to Millhaven Transfer Unit involuntarily until he could be transferred to Warkworth Institution. In December 1992, Gentles was transferred to Warkworth Institution Medium Security.

On March 19, 1993 while Gentles was being counseled in the office of a Correctional Supervisor, he was advised to attend the Segregation Cells area; he refused - grabbed a chair and threatened correctional officers. He was warned MACE would be used, but ignored this and advanced on the officers. MACE was applied, he was restrained and taken to Segregation Cells. Upon arrival in segregation, Robert Gentles had calmed down; he was subsequently decontaminated and suffered no ill effects from being MACED.

Approximately March 26, 1993, a review of Gentles lack of progress and problems at the institution resulted in an involuntary transfer to Maximum Security at Kingston Penitentiary, arriving around April 22, 1993.

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On Sunday October 24, 1993, inmate Robert Gentles was housed in cell #9-3-G. The prison was, at the time, in a state of lock down due to an institution wide search under way, for drugs, weapons and contraband. During the lock down, prisoners were to be fed twice that day.

At approximately 13:20hrs, one of the search teams headed by CX6 McKee, was requested to attend Range G, to assist in the movement of inmates for feeding. This was about 19 hours after the inmates had had their last meal. This request had been made due to the agitated state of the inmates. Fires had been set and inmates on the range were noisy and threatening towards guards present on the range.

Inmates in cells 1 to 5 on 3-G were released and moved to get their lunches, and then returned to their cells. This went without problem.

The decision was made by CX6 McKee to remove Robert Gentles from his cell and place him in the Disassociation Cells, in an attempt to quiet down the ongoing problem of banging, yelling and general disorder on the range. Specifically CX6 McKee ordered Robert Gentles to turn down his radio.

Correctional Officer Wylie gave inmate Gentles three verbal warnings to exit his cell peacefully or a chemical agent would be used on him.

Inmate Gentles became abusive and threatening towards Correctional Officer Wylie, and at this time Mace was sprayed at the inmate. Gentles immediately splashed water on his face and covered his face with a cloth and Wylie again sprayed Mace at the inmate. The application of Mace did not appear to have any effect on the inmate. While the inmate was turned away, the cell door was opened and the following correctional staff entered: CO Wylie, CO Aitchison, CO Gauvreau, CO Desjardins, CO Hartwick. The inmate was pinned against the back wall of the cell in an attempt to gain control of the inmate. Inmate Gentles was placed face down on his bed, as he struggled against the guards who were attempting to restrain him. Handcuffs were placed on the inmate and a request was made for a set of leg irons to be brought to the cell. Correctional staff continued to restrain the inmate on the bed until the leg irons were placed on him, at which time the inmate was removed from his cell. Once outside the cell, the inmate, who was now lying on the floor, appeared to be limp and the correctional officers assumed that he was offering passive resistance. Correctional staff picked up Gentles by the arms and legs and carried him face down from the range downstairs to the Disassociation Cells.

Upon arrival at the Disassociation Cells area inmate Gentles was placed in a shower cell to decontaminate him of the Mace that had been applied. The water from the shower was too hot, so guards applied water from a sink, using a pail. At this time correctional staff who had carried the inmate to that area noticed the inmate was in distress; they were unable to obtain a pulse.

The nurse arrived and the inmate was placed on a mattress on the floor outside the shower cell. The nurse made an assessment of his condition and immediately started resuscitation and CPR efforts continued using an Ambu-bag, oxygen and chest compressions until Regional Ambulance attendants arrived. Ambulance personnel attempted to defibrillate without success; the inmate was transported to Kingston General Hospital Emergency Department, with CPR continuing en route. Hospital Emergency Room staff attempted to revive the inmate without success; inmate Gentles being pronounced dead at 14: 13hrs

Verdict:

Name of Deceased:	**Robert Wayne GENTLES**
Date and Time of Death:	**October 24th, 1993 at approximately 1:25pm**
Place of Death:	**3G, Kingston Penitentiary**
Cause of Death:	**Asphyxia associated with multiple factors including the effects of Freon 113, restraint in a prone position, chest compression and suffocation**
By what means:	**Accident**

Recommendations:

Recommendation #1:

It is recommended that all alternatives be considered before a cell extraction is ordered.

Coroner's Comment:

Evidence was heard that extraction from cells and application of force to an inmate, are done fairly regularly, and obviously the jury thought, in this instance at least, other alternatives should have been considered. Such as: we heard testimony about cutting the electricity to the cell or the cell and adjoining cells and that would have dealt with the loud radio.

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Recommendation #2:

It is recommended that all cell extractions be videotaped.

Coroner's Comment:

The IERT (Institutional Emergency Response Team), when they are in action, videotape their actions as a form of recording what they do and obviously it would have been far easier to understand what happened to Mr. Gentles if the extraction had been videotaped.

Recommendation #3:

It is recommended that all cell extractions of non-compliant inmates, except for those in the most extreme situations, such as where actual risk of bodily harm or death may be imminent to any staff or inmate, be conducted by properly trained and equipped Institutional Emergency Response Teams.

Coroner's Comment:

We heard testimony that in the Ontario Region all cell extractions of all cell extractions of non-compliant inmates are now done by IERT and obviously the jury thought that this policy should apply at the national level.

Recommendation #4:

It is recommended that a fully qualified nurse, doctor, or paramedic be present during all IERT and non-IERT cell extractions for non-compliant inmates. The attending health care professional must be adequately equipped to handle possible medical emergencies and must perform a health check of the inmate immediately following the restraint, and prior to removal.

Coroner's Comment:

Testimony indicated that Mr. Gentles was in difficulty on the range, prior to being carried to the segregation area. The evidence also indicated that this was not recognised until he arrived in the Segregation Area. The jury must have felt that it would be useful to have somebody trained to identify any distress and apply corrective measures.

Recommendation #5:

It is recommended that CSC maintain an Institutional Emergency Response Team on 24-hour standby in all medium and maximum security institutions. During lockdowns, the IERT should be on-site.

Coroner's Comment:

We were told that one of the reasons why the IERT was not called in or not put in action when the extraction of Mr. Gentles was done was that their members were not all in the facility at the time and that it would have taken some time to gather them. The jury obviously thought that if this team is to respond to emergencies, it should be readily available and when an emergency can be anticipated such as the time of a lockdown, then that the IERT be on site.

Recommendation #6:

It is recommended that CSC continue to follow Regional Instruction 605 dated 23 June 1995 on Cell Extractions for all non-IERT cell extractions. The role of each member of the extraction team for non-IERT extractions must be determined by the Correctional Supervisor or his/her delegate before the cell is entered.

Coroner's Comment:

This recommendation follows the testimony that the extraction of Mr. Gentles was unplanned and unorganized and also by the testimony of the supervisor himself, unsupervised. There was no role definition, the individuals who went to the cells were self-selected and the extraction proceeded without having been scripted, even in the most general way.

Recommendation #7:

It is recommended that as soon as an inmate is securely restrained that he be placed in a sitting position provided that it can be done without risk of injury to inmate or staff.

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Coroner's Comment:

This follows testimony about the recommendation for "The Handling of Prisoners Restrained in the Prone Position", from the memo of Dr. Young to Police Forces and Correctional Institutions. The memo indicates that one way of minimizing the chance of problems is that as soon as restraint has been achieved and control of the individual achieved that then he be removed from the prone position and put in a sitting position.

Recommendation #8:

It is recommended that a standard kit of equipment be assembled for non-IERT cell extractions. This kit should include leg irons, handcuffs, a chemical agent and a video camera and be made available to the team prior to the commencement of any extraction.

Coroner's Comment:

We heard testimony that the correctional supervisor had secured a pair of handcuffs and a canister of Mace prior to entering the range to allow the inmates to go to the cafeteria. There was considerable delay after Mr. Gentles was put on the bed in order to get leg irons and that might have contributed to his distress. Also the fact that the extraction was not videotaped left a lot of questions unanswered. Obviously the jury thought that there should be a systematic approach if the IERT was not to conduct the cell extraction.

B. Chemical Agents and Inflammatory Sprays:

Recommendation #9:

It is recommended that esc only authorize for use those chemical agents, inflammatory sprays and their constituents, which meet Health Canada and Environment Canada standards. All chemical agents and inflammatory sprays in use by esc must be re-authorized annually.

Coroner's Comment:

Testimony was heard that mace, as formulated at the time of Mr. Gentles death, contained Freon 113 which is a halogenated compound with anesthetic-like properties and if given in sufficient quantity is able to provoke cardiac arrhythmias. It has been known for a number of years, that in low quantity, the breathing of Freon 113 can cause a confusion and loss of coordination. This type of product has been associated with the so called PAM deaths, where an individual would spray PAM into a bag and sniff the fumes to get a chemical high. It was apparent from the testimony, that the lacrimatory agent in the Mace had been passed as being safe but that little or no consideration had been given to the propellant; in this case Freon 113 and assorted other compounds, including Chloroform and Benzine, in determining whether this product was safe to use on humans.

It was also apparent from the testimony that there was a need for an inventory of these products, on a regular basis, to prevent the use of the product if they have been found to be dangerous after the fact.

Recommendation #10:

It is recommended that for each incident for which chemical agents/inflammatory sprays are to be used they be used only upon the specific authority of the person who is in charge of the institution at that time. This will be done in accordance with the Commissioner's Directives and Standard Operating Procedures. The person in charge must make himself/herself aware of the reason for the request for chemical agent/inflammatory spray before authorizing its use.

Coroner's Comment:

The testimony indicated that the authorization to use mace on an individual, except in the case of extreme emergency, should involve the person in charge of the institution. This would also allow a safeguard so that the individual, who is involved in the confrontation, does not become the sole decision maker but has to refer to a superior officer to confirm his intention to use mace.

Recommendation #11:

It is recommended that, when time and circumstances permit, before a chemical agent/inflammatory spray is administered to an inmate that the medical authority at the institution be called to check the inmate's medical file for possible adverse effects to the chemical agent/inflammatory spray. If that is not possible, and when time and circumstances permit, a continually updated list of inmates with medical conditions that might be adversely affected by chemical agents/inflammatory sprays shall be available on each living unit and must be checked.

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Coroner's Comment:

Service be contacted to ensure that the inmate was not allergic to Mace and this was not done in this case although there was ample time to do it.

Recommendation #12:

It is recommended that chemical agents/inflammatory sprays continue to be used only by properly trained staff.

Coroner's Comment:

Testimony was heard that officer who discharged the mace had been trained as a member of the IERT. But it was also quite apparent from his use of the mace that he did not allow for the product to take effect before applying a second and third dose of the chemical, as is required in the training that he received.

Recommendation #13:

It is recommended that after a chemical agent/inflammatory spray has been applied that officers wait the recommended time before a second application and/or before entering the cell.

Coroner's Comment:

Again, it refers to the same concern that mace was applied and action was taken immediately, without allowing mace to have an effect.

Recommendation #14:

It is recommended that all written procedures concerning chemical agents and inflammatory sprays include the name commonly used in the workplace as well as the proper technical name.

Coroner's Comment:

There was a number of conflicting testimonies where witnesses appeared to take the position since mace is not a gas, the rules concerning gas did not apply. It was quite apparent also, and it is a fact, that the active chemical in mace, the lacrimatory agent is the same as the agent in certain tear gases, and that the distinction being made between mace and gas is a convenient way to explain the non-adherence to the rules.

C. Lockdowns:

Recommendation #15:

It is recommended that a communications policy be implemented to ensure that all inmates are aware of the procedures to be followed during a lockdown, especially as they relate to meals and movement.

Coroner's Comment:

Testimony was heard that the inmates were informed, by the use of the inmate representatives, of the lockdown and of the approximate time when food would be provided for them. The jury obviously thought that this form of communication is not adequate since it is not possible for the staff to know exactly what each inmate is being informed of.

Recommendation #16:

It is recommended that the communication of information during a lockdown should not rely exclusively on the communication of information inmate representatives, as it is not possible to be certain what information is passed passed.

Coroner's Comment:

Same as 15.

Recommendation #17:

It is recommended that CSC investigate alternative ways of more efficiently providing meals to inmates during a lockdown at Kingston Penitentiary.

1999 CanLII 20112 (ON OCCO)

Coroner's Comment:

Testimony was heard that at the time of Mr. Gentles' extraction from his cell, the inmates had not received food for over 19 hours and obviously the jury thought this was not adequate, which led to recommendation 17 and 18.

Recommendation #18:

It is recommended that during a lockdown adequate meals be served at reasonable intervals. The first meal of the day should be served to all inmates no later than 11:00 am.

Coroner's Comment:

Same as 17.

D. Segregation:

Recommendation #19:

It is recommended that when administrative segregation is used, it is administered in compliance with institutional procedures and the law and appropriately monitored by senior management.

Coroner's Comment:

Testimony was heard that administrative segregation can be used without charges being laid. The decision is then reviewed by a senior staff member the day after the inmate is put in segregation. Testimony was heard also that when an inmate is charged with an institutional offence, the punishment that he receives by being placed in segregation is reviewed by an outside independent arbiter. We heard that this allows staff to use segregation in situations where charges cannot be laid and without having their actions scrutinized

E. Training:

Recommendation #20:

It is recommended that all correctional officers be recertified in CPR every year and in first aid every three years.

Coroner's Comment:

Testimony was heard that some of the officers had received CPR but it would appear that once they had received their initial training that there was no re-training offered by the CSC. Again, the First Aid Course is a requirement of employment or is given at the time of the basic training but again there is no obvious training program in place.

Recommendation #21:

It is recommended that all correctional officers receive refresher training every three years in the following areas:

- CSC and the Law,
- Use of Force Management Model,
- Cell Extraction Procedures,
- Restraint Equipment,
- Arrest and Control,
- Use of Force, and
- Chemical Agents.

Coroner's Comment:

The officers receive training at the time of their entry into the CSC in the various items listed in the recommendations but because this relates to the use of force on an inmate that the jury also believed that periodic refreshers would be necessary.

Recommendation #22:

It is recommended that all employees of the Correctional Service of Canada continue to receive training in anti-racism, cultural awareness and harassment.

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Coroner's Comment:

Same as 21.

Recommendation #23:

It is recommended that, for the safety of correctional officers and inmates, all correctional officers receive training in the cell extractions of non-compliant inmates.

Coroner's Comment:

The jury obviously thought that sending five officers, not trained as a team, into a cell to extract an inmate, could be dangerous to not only the inmate but also to members of the staff.

Recommendation #24:

It is recommended that new officers, after initial in-class training, be on- the-job trained on an ongoing basis during their first year of work. They should be brought back frequently for training during their first year with respect to ethical dilemmas experienced on the job.

Coroner's Comment:

This stems from the discussion from the officer's code or officer's norms. This was the subject of a scientific study leading to a doctoral thesis by a doctor who testified at the inquest. This Code is also the subject of teaching, by Dr. Jones at Trent University. These norms would tend to conflict with normal behaviour where one would report people who would behave aberrantly, but given the norms, there is strong pressure for the officers to protect one another.

Recommendation #25:

It is recommended that the Commissioner appoint a consultant to study the effectiveness and recommend improvements regarding the course "CSC and the Law".

Recommendation #26:

Recognizing the potential negative impact on correctional officers working in an institutional setting, CSC must continue to train new recruits and existing staff in accordance with the values expressed in the Mission of the Correctional Service of Canada.

Coroner's Comment:

We heard testimony that working in a prison can have a negative impact on workers and tend to generate a feeling of 'us against them' amidst the staff so that they become more custodial than correctional.

Recommendation #27:

It is recommended that the orientation program for all new officers include a module on "Officer Norms", outlining its beneficial and detrimental aspects.

Coroner's Comment:

The concept of the officer's norms is not well recognized either in the community or within the correctional officer's groups. It is now well established as to its existence and the jury thought that officers need to be aware of its existence and its positive as well as negative effects.

Recommendation #28:

It is recommended that CSC ensure that the Standard Operating Procedures (replacing the Security Manual) and the training in those procedures have been provided to all correctional officers within a year.

Coroner's Comment:

It was apparent from the testimony that the numerous written communication between management of esc and its staff starting with commissioner's directives, regional directives, standard operating orders and standing orders in the institution were often conflicting in their language, subject to misinterpretation and largely not known by the staff. We were told that this was being simplified; to both simplify the language and simplify the number of references that an officer has to know in order to operate properly. Obviously the jury thought that

1999 CanLII 20112 (ON OCCO)

not only should the staff be aware of these directives but also should be given a refresher course from time to time since these directives are subject to change and there is no assurance that an officer will know that a new order has been put in place.

Recommendation #29:

It is recommended that training be provided in how to lift and carry an uncooperative inmate.

Coroner's Comment:

The testimony was that Mr. Gentles was held by the shoulders and the hip area by four officers with a fifth one holding onto his belt and carried in the prone position to segregation. The testimony was that this position with his bead down, resting on his chest would further impair breathing ability. The jury obviously thought a way of transporting an inmate that would not impair his breathing would be beneficial.

Recommendation #30:

It is recommended that training be provided in how to determine whether or not an inmate is "playing possum" or is in medical distress.

Coroner's Comment:

We've heard a number of correctional officers testify that they thought that Mr. Gentles was playing "possum" when they brought him out of his cell and he was not helping himself There was no attempt to determine whether or not this was actual distress or whether Mr. Gentles was in fact being uncooperative.

F. The Correctional Officer and Stress:

Recommendation #31:

It is recommended that CSC evaluate psychological screening as a component of its officer recruitment process.

Recommendation #32:

It is recommended that any officer who has inmate contact and who is out on stress leave go for a psychological evaluation prior to returning to work.

Recommendation #33:

It is recommended that CSC provide a Stress Management course for staff with an option of professional counselling as needed.

Recommendation #34:

It is recommended that esc provide a 1-800 number to access counselling for staff who are reluctant to self-identify to local management when they are suffering the effects of job related stress.

Coroner's Comment:

We heard testimony that being involved in incidents such as Mr. Gentles death, takes a toll on the officers involved and in fact some of the officers have not returned to work because of physiological stress caused by the incident. I believe all these recommendations are in response to these facts as a way of helping the officers and Correctional Services in minimizing the ill effects of such stressful incidents. There was testimony that there is no structured program to help these officers re-enter the work place.

Recommendation #35:

It is recommended that the amount of overtime be reviewed on a monthly basis. Corrective action should be taken where an excessive number of hours are being worked by individual correctional officers. This will ensure that the stresses of the job are not made worse by lengthy exposure to the prison environment.

Coroner's Comment:

There was some testimony of officers working overtime and obviously the jury thought if too much overtime is being worked, this can have a negative effect on the mental health of the officers.

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Recommendation #36:

It is recommended that any record of stress related counselling should not be kept on employees' personnel files. This should encourage employees to feel comfortable to come forward and ask for help or stress counselling without reprisal.

Coroner's Comment:

Once again, a way of making the officers more free to consult and request help for job induced stresses.

G. Policy:

Recommendation #37:

It is recommended that the Correctional Service review all Commissioner's Directives, Regional Instructions, Standing Orders and Standard Operating Procedures to ensure they are clear and in compliance with the law and policy and to avoid any duplication and conflicting information.

Coroner's Comment:

There was clear evidence that the plethora of rules and regulations and directives issued by different levels of management at esc were at times conflicting, at times unclear in their language or their intent, and at times so detailed as to make them almost impossible to implement. This recommendation is to encourage the Correctional Services to continue their work of simplification and clarification of their policies and orders.

Recommendation #38:

It is recommended that the Union of Solicitor General Employees, with the support of CSC, encourage its members to report any illegal acts or harassment, as their obligations as peace officers should take priority over labour solidarity.

Coroner's Comment:

This recommendation flows from the testimony of the Union President who said that harassment of one employee by another employee was something that relates to management responsibilities and the Union is not responsible for that. This is contradictory to some of the policies of the Union and also reinforced at a formal level, the officers' norm of not ratting on a colleague. It could be, that if the Union was prepared to help or protect some of their members which are being harassed by other members, that the ratting norm might be weakened.

Recommendation #39:

It is recommended that all log book entries be read daily by unit managers and the IPSO so that action plans and necessary follow-up can be established when required. There must be feedback to the reporting officer.

Coroner's Comment:

This flowed from evidence that range G, from the month of August until the month of October when Mr. Gentles died, had become more and more volatile and there were notes to that effect in the daily log but this did not appear to have generated any kind of action.

Recommendation #40:

It is recommended that staff conduct in breach of the CCRA, Commissioner's Directives, Regional Instructions, Standing Orders, Standard Operating Procedures or the CSC Code of Conduct be dealt with by management expeditiously, suitably and openly by any one or more of the following measures:

- counselling;
- re-training; and/or
- discipline.

Coroner's Comment:

We heard evidence that none of the staff involved in the extraction and the subsequent death of Mr. Gentles were subject to any form of corrective action, although it is quite obvious that a number of directives had been breached. The reason given was that there had been an arrangement with the Union that as long as there were proceedings underway that this would be inappropriate. It appeared that the arrangement with the Union was something arrived at over the telephone and there was no written confirmation of that decision or the reasons for it. We were left, six years later, with only speculation as to why this was done.

1999 CanLII 20112 (ON OCCO)

Recommendation #41:

It is recommended that all Standard Operating Procedures, Commissioner's Directives, Regional Instructions and Standard Orders contain a definition section to ensure that terminology used within is clearly understood by staff.

Coroner's Comment:

There was testimony that the meaning of words in the different directives issued by CSC's management, for the staff, took different meanings, depending on context. The jury obviously thought because of the uncertainty and confusion that this can create that the critical words in the document should be defined in a definition section at the beginning of the document.

Recommendation #42:

It is recommended that CSC continue to investigate the most appropriate device for transporting uncooperative inmates (i.e. chair used by ambulances).

Coroner's Comment:

This deals with the method used to transport Mr. Gentles to Segregation. We learned that six years after his death that there is still not a suitable appliance that would allow staff to carry a non-compliant inmate downstairs and over to segregation, if the inmate was refusing to walk.

Recommendation #43:

It is recommended that CSC, with cooperation from the USGE, investigate the possibility of rotating staff among institutions on a regular basis in order to have a turnover of the majority of staff at Kingston Penitentiary.

Recommendation #44:

It is recommended that there be formal steps to notify families of a death in the institution. Notification must be made in person.

Coroner's Comment:

Testimony was heard that Mrs. Gentles was informed of her son's death by telephone without any arrangement being made to have somebody with her at the time that would give her support and help her to cope with the grief at the time of learning the news.

Recommendation #45:

It is recommended that there always be a staff member trained in crisis negotiation in the institution.

Coroner's Comment:

The testimony that we heard was that part of extracting an inmate from his cell involved a period of negotiation to try and convince the inmate to comply. The evidence was also that the conversation with Mr. Gentles and the short time span used to arrive at the decision to extract him from his cell would not lead to a negotiated defusing of the situation.

H. Reports:

Recommendation #46:

It is recommended that all directives concerning report writing be strictly adhered to.

Coroner's Comment:

The evidence was that a number of the reports mandated by the Service had never been completed.

Recommendation #47:

It is recommended that reports (i.e. Use of Force and Situation Reports) be filled out immediately following an incident. Appropriate disciplinary action should be taken if this is not done.

1999 CanLII 20112 (ON OCCO)

Coroner's Comment:

The evidence was that mandatory Use of Force reports were not filled out and the supervisory staff who must co-sign those reports did not take any action to ensure that they would be completed. The testimony was that no disciplinary action was taken in this respect.

Recommendation #48:

It is recommended that the Situation Report contain an attention box with a warning that officers fill out reports independently.

Coroner's Comment:

This flows from testimony that officers were able to talk to one another prior to writing the situation reports where they described their actions in the cell with Mr. Gentles. There was at the time a directive requiring that these be written independently. The evidence showed that this had been instituted following the 1991 inquest into the death of Gordon Henry Taylor. A copy of this directive was produced in the last week of the inquest, just prior to the testimony of the Commissioner.

Recommendation #49:

It is recommended that a room be made available at the time of an incident within every institution (ie. cafeteria, chapel, etc.) for the preparation of reports concerning serious incidents. This room must be supervised during the preparation of those reports by the institutional head or his designate. It is further recommended that a record be kept of those preparing and invigilating the reports.

Coroner's Comment:

Again, the jury describes how one of the methods by which CSC could ensure that there be proper and dependent writing of situation reports, with proper insurance that this is done independently and that there is appropriate supervisors to ensure that in fact there is no collusion.

I. Record Keeping:

Recommendation #50:

It is recommended that CSC continue with the current audit of its filing and information system with the objective of improving that system.

Coroner's Comment:

It was obvious during the inquest that there's a great difficulty in retrieving documents such as would be necessary to look at the circumstances of the death of Mr. Gentles. We heard that Madame Justice Arbour had similar experience when conducting an inquiry into Events at the Prison for Women. Testimony was heard that this is being audited and the jury encourages the Correctional Services to look at this important aspect of their operation since every time the documents are not forthcoming then the accusation of cover-up is not very far behind.

J. Management Accountability:

Recommendation #51:

It is recommended that all persons in the CSC with specific authority who are empowered or required to dispose of complaints, grievances or investigations be able to admit error on the part of, and on behalf of the Correctional Service.

Recommendation #52:

It is recommended that CSC initiate a national program of statistical collection, analysis and reporting that will reflect the trends in the use of force, segregation, inmate discipline, inmate grievances, officer discipline and officer grievances. This would provide indicators to the management team of the performance of their institution.

1999 CanLII 20112 (ON OCCO)

Coroner's Comment:

We saw some statistical analysis relating to morale of staff and inmates at Kingston Penitentiary and also similar statistics for the Ontario region and eventually National-wide. It would seem that the jury thought that the use of force being a major producer of critical incidents should be the subject of such surveys.

Recommendation #53:

It is recommended that press releases be accurate, precise and clear with no possibility of misinterpretation of information. (i.e. gilding the lily)

Coroner's Comment:

We received an exhibit showing the press releases that were made at the time of the death of Mr. Gentles and the argument was made that they could be interpreted as Mr. Gentles being extracted from his cell because of drug use or contraband. The evidence was that the extraction of Mr. Gentles had nothing to do with drug use or contraband but with a loud radio, disturbance on the Range during a lockdown.

Recommendation #54:

It is recommended that there be a top down commitment where management sets the appropriate example for staff in accordance with the Mission Statement and the five core values.

Recommendation #55:

It is recommended that the Warden and Deputy Warden at Kingston Penitentiary be left in place for a minimum of a three year term. CSC should consider instituting a system of financial incentives for Wardens and Deputy Wardens to stay in their jobs at difficult posts like Kingston Penitentiary.

Coroner's Comment:

There was testimony of changes in wardens and deputy wardens at Kingston Penitentiary which did little to ensure continuity and to get a handle on the management of the institution. There was also testimony that a senior manager, for instance at regional headquarters, when they are asked to go back to take the wardenship of an institution sees that as a demotion and in fact there might be some financial disincentive to accepting such a move.

Recommendation #56:

It is recommended that the salary classification of a Warden of a maximum security institution reflect the responsibilities of the position and be such that it will allow for his/her transfer back to the line operation after the completion of a staff assignment (Regional or National Headquarters) without a financial penalty.

Coroner's Comment:

Reflects the same consideration.

Recommendation #57:

It is recommended that special assignments that take the Warden away from the institution be limited.

Coroner's Comment:

Testimony was heard that the Warden of Kingston Penitentiary would be assigned projects at Regional Headquarters or at National Headquarters. This would take him away from the day to day running of the institution, leaving the job to the Deputy Warden and not providing the leadership that appeared to have been very necessary at that institution.

Recommendation #58:

It is recommended that all levels of management be held accountable for their actions or lack of same. Senior managers who are found to be ineffective should be provided with additional training, retrained, demoted or dismissed.

Coroner's Comment:

This I believe stems from the behaviour of the Senior Manager at the institution at the time of the death of Mr. Gentles who, instead of taking charge of the crisis, went and held the door open for the ambulance attendants

1999 CanLII 20112 (ON OCCO)

and stayed away from where Mr. Gentles was. This apparent lack of will to supervise was not an isolated incident.

K. Discipline:

Recommendation #59:

It is recommended that because of the nature of work performed by CSC peace officers, that CSC take forward to Treasury Board a proposal that the Master Agreement between the Public Service Alliance of Canada and the Treasury Board be amended to provide an exception to the general "sunset clause" which provides for the removal of any disciplinary action from a public service employee's file after two years. This exception to the "sunset clause" should be applied only in circumstances where a CSC peace officer has received discipline relating to the use of force against an inmate.

Coroner's Comment:

We learned that, as part of a master agreement between the Federal Government and the Civil Service, once a complaint, grievance or discipline process is two years old and there has been no further problem, this is deleted from the employee's personal file. This meant it was impossible to verify whether any corrective action had been taken at the time of Mr. Gentles death or whether any of the officers involved in Mr. Gentles death had previously been subject to complaints or disciplinary action because of use of excessive force against inmates. The jury obviously thought, because the Correctional Officers are Peace Officers and are allowed legally to use force, that this provision with respect to the use of force should not apply to them. If excessive force is found to have been used by a Correctional Officer, this should be a permanent notation on his personal file.

Recommendation #60:

It is recommended that when allegations of excessive force used against an inmate are proven, the staff member involved be dismissed from the Public Service.

Coroner's Comment:

This stems from the testimony that one of the officers in the extraction of Mr. Gentles had been found to have used excessive force on an inmate in the past and had been dismissed but later reinstated by an Arbitration Tribunal because the penalty was too severe.

Recommendation #61:

It is recommended that any agreement with the applicable union concerning the appropriateness of discipline or the conduct of investigations should be in writing and should be permanently preserved by both parties.

Coroner's Comment:

We heard testimony that an arrangement was made between Management and the Union not to proceed with any disciplinary or other action with regard to the death of Mr. Gentles until all proceedings were completed. This was oral testimony and there were no contemporaneous writings to support it.

Recommendation #62:

It is recommended that the CSC take forward the proposal to Treasury Board that its current legislative and/or policy position be amended to provide for suspension with pay in certain circumstances. This would give CSC the option to suspend an employee with or without pay.

Coroner's Comment:

We heard testimony that if a manager wanted to send an employee home, he had no option but to send him home without pay, which is a severe penalty when no charge has been laid or no investigation has been completed. The jury obviously thought that it was necessary that managers have the ability to send somebody home, without penalizing the individual, until they feel confident that either they have the necessary reasons for imposing a penalty or that there is no penalty to be imposed.

Recommendation #63:

It is recommended that the Code of Discipline (CD 60) be amended to include procedures that must be followed whenever a staff member has committed an alleged infraction.

1999 CanLII 20112 (ON OCCO)

Coroner's Comment:

The code of discipline is not clear, at least that is the impression we gained from listening to the testimony; about the procedure that must be followed to lay charges against staff.

Recommendation #64:

It is recommended that an officer who uses an unauthorized control hold be disciplined.

Coroner's Comment:

One of the guards who went into the cell to subdue Mr. Gentles testified that he used a "half-nelson" on Mr. Gentles. The use of force trainer testified that this hold is not taught and is not approved for use since it can put the staff member in jeopardy.

L. Citizens' Advisory Committee:

Recommendation #65:

The public accountability of each Citizens' Advisory Committee (CAC) should be strengthened. To achieve this it is recommended that the Regional Deputy Commissioner, at the beginning of each year, take steps to ensure that each CAC in the Region is at optimum levels of strength and performance. Each committee shall be comprised of at least 3 persons and no more than 7 who are reasonably representative of a cross-section of the community. Newspaper advertisements should be used as necessary to recruit new members. A selection committee made up of the head of the institution, the local union president and the chair of the local CAC shall select new members. The participation of the correctional officers is considered essential in the success of the committee's mandate.

Coroner's Comment:

We heard testimony that there were variable standards used in the way that the Citizen's Advisory Committees were employed in each institution. We also heard testimony that the front line staff regards the Citizen's Advisory Committee as an instrument of management and/or the inmates. It was testified that the services of the Citizen's Advisory Committee should be also available to help with concerns that the front line staff might have.

Recommendation #66:

It is recommended that each CAC prepare an annual report containing a review of the past year's activities, an assessment of the effectiveness of the committee's monitoring of crisis situations where the safety of staff and/or inmates was clearly at risk and a statement of the needs of the committee in order to carry out their duties in the coming year. The report would be submitted to the Regional Deputy Commissioner, the Correctional Investigator, the head of the institution and to community agencies and individuals involved in public policy relating to community safety and prisoner rehabilitation.

Coroner's Comment:

Same as #65.

M. Pathology:

Recommendation #67:

It is recommended that in situations involving the application of chemical agents/inflammatory sprays prior to death, blood and tissue samples be screened for concentrations of chemical agent constituents. In cases where the samples are being forwarded to the Centre for Forensic Sciences, it is recommended that they be provided in the amounts and containers specified by the Centre.

Coroner's Comment:

This stems from the fact that the mace and components of mace were not analysed at the time of Mr. Gentles death. It also stems from the fact that less than optimal quantities of blood was provided to the Centre of Forensic Sciences for analysis.

Recommendation #68:

It is recommended that the post-mortem report and, if possible, the police report, be provided to the Centre for Forensic Sciences along with the Case Submission form (form CFS 69) when the samples are submitted.

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Coroner's Comment:

We heard testimony that the information provided to the Centre of Forensic Sciences should be more complete than just the submission form.

N. Kingston Penitentiary:

Recommendation #69:

It is recommended that a review of Kingston Penitentiary be conducted with respect to its appropriate use within the context of the Corrections and Conditional Release Act. This review should be conducted by a committee consisting of representatives from CSC, the Ministry of the Solicitor General and independent persons from the community.

Coroner's Comment:

This stems from the fact that there are serious concerns expressed both by management and the staff about the working environment at Kingston Penitentiary. In particular, because of its austere and ancient architecture, we were told that Kingston Penitentiary is not conducive to good correctional practices. It was recommended, in fact, that the utilization of the Penitentiary be reviewed.

O. Oversight:

Recommendation #70:

It is recommended that with the issue of accountability a concern, that increased independent civilian oversight of CSC is required. An independent oversight committee shall be formed by the Ministry of the Solicitor General to conduct a study and report within 12 months to the Justice Committee of the Parliament of Canada. This committee shall determine what type of civilian oversight body should be established and the scope of its powers.

Coroner's Comment:

This reflects a recommendation of the Arbour Report which had been turned down by the then Solicitor General. Testimony and exhibit indicated that the Solicitor General was not in favor of such an overseer.

P. Additional:

Recommendation #71:

It is recommended that CSC through the IPSOs conduct an annual review of stock in the armories to ensure that all security equipment meets the current standards and that any items not meeting the standards are removed.

Coroner's Comment:

This stems from the fact that the mace used for Mr. Gentles' extraction, contained FREON which had been banned by the Government of Canada because of environmental concerns. Two years after the ban, it was still in the inventory, in the armory of the prison and still being used on inmates.

Recommendation #72:

It is recommended that CSC investigate the possibility of requiring inmates in certain cell settings (i.e. open faced cells) to use headphones for their stereos and televisions.

Coroner's Comment:

There is no doubt that the environment on the ranges at Kingston Penitentiary is very loud and that if a number of inmates are playing stereos, using loud speakers, etc., that they would in fact create a very stressful environment.

Q. Implementation:

Recommendation #73:

It is recommended that the Chief Coroner receive written reports from the Commissioner of Corrections and any other recipient of these recommendations with respect to their implementation. These reports shall include the status of this jury's recommendations as well as explanations as to why certain, if any recommendations

1999 CanLII 20112 (ON OCCO)

were not implemented. These reports are due to the Chief Coroner within twelve months and will be made public.

Coroner's Comment:

This follows a recognised need for accountability and obviously the jury wanted to set a timetable for this accountability to be obvious.

Recommendation #74:

It is recommended that the Chief Coroner receive a written report from the Solicitor General with respect to the implementation of these recommendations also within twelve months. This report will also be made public.

Closing Comment:

In closing, I would like to stress once again that this document was prepared solely to assist interested parties in understanding the Jury Verdict. It is not the Verdict nor should it be read separately from the Verdict. Likewise any comments regarding the evidence are my personal recollection and should not be seen as actual evidence. If I have made any gross errors I apologize and if this is brought to my attention, I will gladly correct the error.

Benoit Bechard MD
Regional Coroner, Eastern Ontario
Presiding Coroner

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