Office of the Chief Coroner
Bureau du coroner en chef

FOR INFORMATION ONLY
NOT OFFICIAL
VERDICT/RECOMMENDATIONS

Verdict of Coroner's Jury
Verdict du jury du coroner

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

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
FALL	Michael

aged / à l'âge de 47 held at / tenue à 4 Wellington St, St. Thomas, **Ontario**

from the / du 23rd of September to the / au 27th of September 20 19

By / Par Dr. / Dr Elizabeth Urbantke 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
Michael Fall

Date and Time of Death / Date et heure du décès
11:13pm on July 30, 2017

Place of Death / Lieu du décès
Elgin Middlesex Detention Centre, 711 Exeter Road, London, Ontario

Cause of Death / Cause du décès
Fentanyl Toxicity

By what means / Circonstances du décès
Accidental

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 27th (Day / Jour) day of September (Month / Mois) 20 19

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

Michael FALL

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

To the Ministry of the Solicitor General:

1. Implement an electronic health record system to:
    a. Facilitate continuity of care through improved communications among professionals and enable safe clinical decision making;
    b. Improve the ability to monitor health status, including substance use disorders and outcomes over time;
    c. Enhance appropriate utilization of services, including health-related programs
    d. Collect data for future resource program planning, research or education;
    e. Conduct quality of care reviews;
    f. Develop an alert and notification system to ensure compliance with provincial standards of care; and
    g. Enhance communication with community health providers

2. Review the current counselling services and therapy offered to correctional officers and nursing staff who witness a death at a detention or correctional centre and implement the necessary changes to ensure it is providing access to adequate counselling services.

To the Elgin Middlesex Detention Centre:

3. Implement a Direct Observation model in all other units at EMDC, as piloted in Unit #4.

4. Reinforce the policy requiring correctional officers to conduct night shift rounds of living units at "staggered" or irregular intervals.

5. Ensure that at the beginning of every shift, a Sergeant or other designated person informs correctional staff about inmates recently found in possession of contraband drugs or suspected to be under the influence of contraband drugs. This should be done by written log sheet or document and read and initialed by each correctional officer on that shift.

6. Develop a local policy to ensure that a social worker, counsellor or other appropriate staff member speaks to inmates who have witnessed a death at the institution as soon as practical following the death. Such inmates shall be offered trauma-informed services and, when requested, efforts will be made to find an outside service provider.

7. Discontinue the practice assigning correctional officers to living units on "rotating" schedules. Replace this with a "platoon" model in which correctional officers are assigned to living units in teams and for periods of no less than six months at a time.

8. Increase the number of correctional officers on night shifts to ensure that at least one officer is present on each unit at all times.

9. Implement a policy that nursing staff responding to an emergency must be equipped with a radio and portable first response kit.