The Devil's Playground: A Case Study of Elgin-Middlesex Detention Centre (EMDC) Demonstrating the Systemic Failings of the Ontario Corrections Regime

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ABSTRACT

Despite numerous calls to action from news outlets, prison activists, and incarcerated individuals themselves, the Ontario corrections regime continues to operate in an unlawful and inhumane manner. The last decade has seen the publication of several prison reform recommendations that are yet to be meaningfully implemented. This paper spotlights four serious issues that plague Ontario correctional institutions through the lens of one of the worst: Elgin-Middlesex Detention Centre. Through its discussion of death in custody, drugs in custody, inhumane conditions, and understaffing, this paper seeks to highlight the profound gap between our democratic aspirations and the lived reality of working and living in Ontario jails. This case study urges us to finally take action and implement the roadmap for reform that has already been provided.

I. INTRODUCTION

"Dignity. Respect. Legality. These values are integral to the delivery of correctional services."[1] Or at least theoretically these should be integral values in Ontario correctional institutions. Unfortunately, these values are not the reality for the lived experiences of many incarcerated individuals. News outlets, members of the public, and the Ontario Human Rights Commission (OHRC) have all decried the inhumane conditions of Ontario correctional institutions.[2] Despite this call for better treatment and living conditions, individuals incarcerated in Ontario correctional institutions continue to face terrible atrocities with limited avenues for relief.

An exploration of the issues at a specific Ontario jail, Elgin-Middlesex Detention Centre (EMDC), provides a concrete example of the disorder and corruption commonly experienced in Ontario correctional institutions. There have been sporadic reports about aspects of life at EMDC and more system-wide reports about the prison system in Ontario. This paper seeks to expose the magnitude of the needs of both prisoners and workers at EMDC by bringing those sporadic reports together into one case study. It reveals the profound gap between our democratic aspirations and the lived reality of Ontarians who work and live in EMDC. And it argues that the roadmap for reform has already been provided: this paper urges that we finally take action.

Before beginning this journey into the depths of EMDC, it is important to underscore that this paper does not advance a claim about whether EMDC is better or worse than other Ontario jails in terms of the

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1 Independent Review of Ontario Corrections, *Corrections in Ontario: Directions for Reform* (Toronto: Ministry of the Solicitor General, September 2017) at 1 [Ministry, *Directions for Reform*].

2 OHRC, *A bold voice: Annual report 2016-2017: Ending cruel and inhuman treatment in correction* (Toronto: OHRC, 23 June 2017), online: <www.ohrc.on.ca> [perma.cc/58Q6-JX9X]; Jacques Gallant, "'Inhumane' conditions at Toronto South Detention Centre amount to 'deliberate state misconduct,' judge says", *Toronto Star* (14 January 2020), online: <www.thestar.com> [perma.cc/28CS-S9T4] (last accessed 10 January 2021); CBC News, "About 100 inmates to stage hunger strike at Lindsay jail over inhumane conditions", *CBC News* (15 June 2020), online: <www.cbc.ca/news> [perma.cc/J95T-KKRA].

experiences of incarcerated people. Instead, this paper uses the EMDC case study to raise the kinds of questions we should be asking about all prison complexes, and it urges us to use this case study as a wake-up call for change.

This paper proceeds as follows: Part II describes the history of EMDC and the departure from its original purpose of housing up to 190 prisoners awaiting trial. Parts III to VI highlight four main aspects of EMDC that are in particular need of attention: death in custody, drugs in custody, inhumane conditions, and understaffing. Part VII concludes with a discussion on the lessons learned from the continuous scandal and corruption at EDMC and steps that should be taken to address the systemic failings of the Ontario corrections regime.

II. THE ESTABLISHMENT OF EMDC AS A LOWER CAPACITY REMAND CENTRE

In Canada, the prison system is divided between federal and provincial institutions, with individuals serving less than two years' imprisonment housed in provincial institutions.[3] Thus, remand centres fall under provincial jurisdiction. Provincial and territorial correctional institutions are not uniformly regulated, as each province and territory has its own corrections system and legislation. In Ontario, correctional services are governed by the Ministry of the Solicitor General (the "Ministry") and the *Ministry of Correctional Services Act*.[4]

EMDC is an Ontario detention centre for individuals on remand[5] that is located in London, Ontario. EMDC was built in 1977 with an original operational capacity of 190 individuals in single cells, but it now has a capacity of 452 prisoners.[6] EMDC houses both men and women who are admitted under a variety of warrants and detention orders. Sojourns at

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3 *Criminal Code*, RSC 1985, c C-46, s 743.1(3).

4 RSO 1990, c M 22, s 5 [*MCSA*].

5 Remand is the process of detaining a person who has been arrested and charged with an offence until their trial or sentencing. A person who is held on remand is legally innocent.

6 Note that there have not been any significant structural changes to EMDC to create this more than two-fold increase in capacity. Instead, inmates are double, triple, or quadruple bunked in these cells that were intended for single capacity. Ontario, Ministry of the Solicitor General, *Community Advisory Board Annual Report 2015* (Toronto: Ministry of the Solicitor General, 11 March 2016), online: <www.mcscs.jus.gov.on.ca> [perma.cc/3UB2-LZHP] [Ministry, *Community Advisory*].

EMDC range from hours to years.[7] There are ten detention units at EMDC, organized under seven main groupings: protective custody, general population, intermittent prisoners, women, workers, special needs, and segregation.[8] The facility does not have an infirmary, but it does have a "Health Care Unit" staffed by a health care manager and nurses.[9]

As a provincial remand centre that has been frequently criticized for its inhumane conditions,[10] EMDC is the perfect candidate for a case study on the systemic failings of the Ontario prison regime. The conditions at EMDC were pronounced as amongst the worst seen by the OHRC during their tours of Ontario jails.[11] "[O]vercrowded, unsanitary and dangerous" were the words used by the Chief Commissioner to describe the institution after her tour of the facility.[12]

There have been eighteen publicized deaths in EMDC in the past ten years, with the majority of these deaths attributed to suicide or drug overdoses.[13] EMDC has been plagued by violence, understaffing, overcrowding, drug abuse, and poor labour relations for decades, leading to its recurrent spotlight in the news by local media outlets.[14] Former prisoners

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7 *Johnson v Ontario*, 2016 ONSC 5314 at para 10 [*Johnson*].

8 *Ibid* at para 11.

9 *Ibid* at para 12.

10 *Ibid* at paras 3, 6, 47–67, 126–28. See also Marek Sutherland, "Another inmate death at EMDC, another plea for change", *CTV News* (29 November 2020), online: <london.ctvnews.ca> [perma.cc/P8R6-5A6J] (last accessed 25 January 2021); Letter from Renu Mandhane, Chief Commissioner OHRC to Solicitor General Jones (17 May 2019), online: *OHRC* <www.ohrc.on.ca> [perma.cc/M2CY-ZPCE] [OHRC, "Letter to Solicitor General Jones"].

11 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

12 *Ibid*.

13 Sebastian Bron, "'Outrageous': Inmate death makes 15 in past decade at London's troubled Elgin-Middlesex Detention Centre", *The London Free Press* (25 June 2019), online: <www.lfpress.com> [perma.cc/UPR9-R5ZJ]; Randy Richmond, "London man, 41, dies at Elgin-Middlesex Detention Centre", *The Londoner* (27 November 2020), online: <www.thelondoner.ca> [perma.cc/3ABT-429D]; Matthew Trevithick, "Second inmate death in three days reported at EMDC, ministry confirms", *Global News* (24 March 2021), online: <globalnews.ca> [perma.cc/9467-CK8L].

14 See e.g. Jess Brady, "Death of another inmate at Elgin-Middlesex Detention Centre under investigation", *Global News* (1 April 2019), online: <www.globalnews.ca> [perma.cc/JSB2-D9NJ]; Colin Butler, "What a guard's key and 'unknown pills' tell us about the Elgin Middlesex Detention Centre", *CBC News* (14 August 2018), online: <www.cbc.ca/news> [perma.cc/FSQ4-U6VC]; Randy Richmond, "Disturbing video

of EMDC have commenced dozens of actions against the Ministry asserting that EMDC is overridden with issues of overcrowding, understaffing, systemic negligence, assault, battery, and breaches of fiduciary duty.[15]

EMDC can be described as the devil's playground where the sinners are winners.[16] In the sections that follow, I will describe some of these common "sins" and how they are connected to the lack of meaningful Ministry policies and the serious corruption that exists within the facility. The next four sections (Parts III-VI) will discuss some of the most prevalent "sins" at EMDC, namely the issues surrounding avoidable deaths, the systemic drug problem, inhumane conditions, and understaffing.

III. EIGHTEEN DEATHS AT EMDC SINCE 2009

Over 150 people have died in Ontario's correctional institutions over the past decade, and the majority of these deaths have not been subjected to a thorough, fully arms-length review.[17] In 2018 alone, 26 individuals died while in the custody of Ontario correctional institutions, with only six dying from natural causes.[18] Of note, 18 of these incarcerated individuals were legally innocent.[19] It is statutorily mandated in Ontario that the death of any incarcerated individual be investigated by a coroner, and if the investigation determines the death was not by natural causes, an inquest must be held.[20] There have been 72 coroner's inquests into prisoner deaths in Ontario correctional facilities in the last five years alone.[21]

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released by court appears to show one cellmate killing another in London jail", *National Post* (12 October 2017), online: <nationalpost.com> [perma.cc/Q8FP-LD4X].

15 *Johnson*, *supra* note 7 at paras 4, 14.

16 Selena Zabian, "'The devil's playground': Elgin-Middlesex Detention Centre", *The Gazette* (7 December 2018), online: <westerngazette.ca> [perma.cc/9ARU-PUX9].

17 Ministry, *Directions for Reform*, *supra* note 1 at 4.

18 "2019 Data release: Review of all inmate deaths within all facilities during 2018" (last modified 12 November 2019), online: *Ministry of the Solicitor General* <www.mcscs.jus.gov.on.ca> [perma.cc/NK8P-LZ9R].

19 *Ibid*.

20 *Coroners Act*, RSO 1990, c C-37, s 10(4.3).

21 The Ministry's website identifies 69 coroner's inquests involving "custody" between 2014 and 2020, 64 of which concerned Ontario jails. In addition, there were 8 inquests into the deaths of Timothy Lloyd Elliott, Jeffrey Kellar, Dexter Robert Laface, Louis Unelli, William Acheson, Trevor Burke, Martin Tykoliz, Stephen Neeson, David Gillan, Julien Walton, Peter McNelis, Paul Stevens, Jeffrey Sutton, Diane Lisle, Jamie High, and Jonathan Dew which occurred in Ontario correctional facilities but were not

The next section of this paper highlights all of the coroner's inquests in the last decade that have arisen from a prisoner's death at EMDC. This section will be followed by a discussion of the circumstances surrounding another incarcerated individual's death that did not result in an inquest, yet significantly impacted the lives of all who witnessed it. In comparing these differing circumstances, this paper hopes to highlight the inconsistencies in how deaths are addressed and the avoidable circumstances under which many occur.

A. Coroner's Inquests into Deaths at EMDC

Of the 18 publicized deaths at EMDC in the past decade, five inquests have been held for the deaths of prisoners from non-natural causes: Laura Straughan, Kenneth Randall Drysdale, Jamie High, Michael Fall, Floyd Sinclair Deleary, and Justin William Thompson. Laura Straughan died of bacterial pneumonia overnight, as there was no on-site health care available between 11:00 p.m. and 7:00 a.m.[22] Kenneth Randall Drysdale died from blunt trauma that resulted from seizures caused by methadone withdrawal when he was refused treatment by EMDC nurses.[23] Jamie High died from alcohol withdrawal when he was placed in segregation on suicide watch.[24] Michael Fall, Floyd Sinclair Deleary, and Justin William Thompson died from fentanyl toxicity in separate incidents (with the inquests for the latter held together).[25] The causes of death for the other twelve publicized EMDC deaths in the past decade include homicide, suicide, delirium, overdoses, medical conditions, and unknown causes.[26]

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identified as "custody" deaths. "Office of the Chief Coroner: Verdicts and Recommendations" (last modified 8 January 2021), online: *Ministry of the Solicitor General* <www.mcscs.jus.gov.on.ca> [perma.cc/YV98-49B4].

22 *Re Straughan*, 2011 CarswellOnt 19311 at paras 8, 10 (WL Can) [*Coroner's Verdict – Straughan*].

23 *Re Drysdale*, 2011 CarswellOnt 19340 at paras 4-9 (WL Can) [*Coroner's Verdict – Drysdale*].

24 *Re High*, 2016 CarswellOnt 22010 at paras 6, 9 (WL Can) [*Coroner's Verdict – High*].

25 *Re Fall*, 2019 CarswellOnt 22370 at para 8 (WL Can) [*Coroner's Verdict – Fall*]; *Re Deleary*, 2020 CarswellOnt 7982 at paras 3, 5 (WL Can) [*Coroner's Verdict – Deleary & Thompson*].

26 Trevithick, *supra* note 13; London Free Press Staff, "Coroner's inquest into 2017 London jailhouse death of inmate Michael Fall begins", *The London Free Press* (23 September 2019), online: <www.lfpress.com> [perma.cc/GMA5-4J8F] [Free Press Staff, "Coroner's inquest"].

While these inquests took place over ten years, there are many similarities in the juries' recommendations. Each inquest recommended implementing a comprehensive communications policy for correctional officers to ensure open communication between different shifts and staff. The inquests were also concerned with the lack of an infirmary at EMDC: the 2011 inquests recommended that an infirmary be opened, and the same recommendation was repeated nine years later.[27] Many of the inquests commented on the lack of training and emergency equipment available for correctional staff,[28] and the juries recommended equipping correctional officers and nurses with naloxone and first aid kits.[29]

Of particular note is a jury recommendation from the most recent inquest: the jury recommended that EMDC be torn down and a new facility be "designed to adequately accommodate, with dignity, the inmate population and to provide an environment with suitable space in which inmates may achieve rehabilitation and reintegration."[30] This recommendation implies that the concerns surrounding EMDC run so deep that the Ministry would be better off starting from scratch with an entirely new infrastructure.

These inquests highlighted issues that plague most Ontario correctional institutions (e.g., understaffing, lack of medical equipment, deficient policies, inadequate monitoring, etc.)[31] and provided meaningful recommendations on how to best address these issues at EMDC.

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27 *Coroner's Verdict – Straughan, supra* note 22 at paras 11–12; *Coroner's Verdict – Drysdale, supra* note 23 at paras 13–14; Coroner's *Verdict – Deleary & Thompson, supra* note 25 at paras 33–34.

28 *Coroner's Verdict – Straughan, supra* note 22 at paras 13–14, 21–30; *Coroner's Verdict – Drysdale, supra* note 23 at paras 16–27; *Coroner's Verdict – High, supra* note 24 at paras 25–51.

29 *Coroner's Verdict – Fall, supra* note 25 at paras 38–40, 44–46; *Coroner's Verdict – Deleary & Thompson, supra* note 25 at paras 85–101.

30 *Coroner's Verdict – Deleary & Thompson, supra* note 25 at para 31.

31 "Independent Review of Ontario Corrections" (last modified 5 February 2020), online: *Ministry of the Solicitor General* <www.mcscs.jus.gov.on.ca> [perma.cc/9FYP-GWBC] [Ministry, "Independent Review"]; Justice David P Cole, *Final Report of the Independent Reviewer on the Ontario Ministry of the Solicitor General's Compliance with the 2013 "Jahn Settlement Agreement" and the Terms of the Consent Order of January 16, 2018 Issued by the Human Rights Tribunal of Ontario* (Toronto: Ministry of the Solicitor General, 25 February 2020), online: *Ministry of the Solicitor General* <www.mcscs.jus.gov.on.ca> [perma.cc/SR6W-UMYM] [Justice Cole, *Final Report*].

Unfortunately, the Ministry is slow to act and selective in the recommendations it attempts to implement.

As an example, it took 18 months for the Ministry to address the recommendations from the 2014 inquest into Jamie High's death and, even then, the policies it implemented fell short of the jury's directions.[32] After receiving the same recommendation from multiple inquests, the Ministry has still not installed real-time monitoring in all segregation cells, a very basic request that could save the lives of many individuals.

The Ministry is also slow to react on recommendations made by its own advisors. On February 28, 2019, Justice David P. Cole, the appointed Independent Reviewer for the Ministry's compliance with the Jahn Settlement,[33] delivered an interim report with recommendations for the Ministry on institutional discipline and improving linkages between courts and corrections.[34] One year later, Justice Cole delivered his final report, in which he noted that the Ministry had failed to operationalize any of his recommendations and had only committed to considering implementing some of them.[35]

The recommendations prepared by Howard Sapers, the appointed Independent Advisor on Corrections Reform, received a similar fate. Sapers prepared three interim reports and two final reports, including the detailed outline in the *Directions for Reform* for the Ministry in 2017 and 2018.[36] As a response to these reports, Ontario passed the *Correctional Services and Reintegration Act*[37] in May 2018, which was intended to improve conditions,

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32 *High, Re,* 2018 CarswellOnt 23060. A London Free Press article highlighted many lawyer's criticisms of the Ministry's lacklustre response: Randy Richmond, "Pain and hope: Province finally responds to jail inquest", *The London Free Press* (2 June 2018), online: <lfpress.com> [perma.cc/2GAJ-CCJV].

33 The Jahn settlement was reached between the Ministry and OHRC in 2013 to implement ten public interest remedies in Ontario correctional institutions, targeted at the use of segregation and treatment of prisoners: "Segregation and mental health in Ontario's prisons: Jahn v. Ministry of Community Safety and Correctional Services", online: *OHRC* <www.ohrc.on.ca> [perma.cc/B4TZ-JR99].

34 Justice David P Cole, *Interim Report of the Independent Reviewer of the Ontario Ministry of Correctional Services' Compliance with the 2013 Jahn Settlement Agreement and the Terms of the Consent Order of January 16, 2018, Issued by the Human Rights Tribunal of Ontario* (Toronto, Ministry of the Solicitor General, 28 February 2019), online: <www3.ohrc.on.ca> [perma.cc/TE4N-999C].

35 Justice Cole, *Final Report, supra* note 31.

36 Ministry, *Directions for Reform, supra* note 1.

37 SO 2018, c 6, Sched 2.

increase transparency, and promote the rehabilitation and reintegration of individuals in custody.[38] Despite receiving royal assent on May 7, 2018, this new legislation never came into force and Sapers was not reappointed.[39]

The Ministry has consistently, and almost without exception, failed to meaningfully and adequately implement recommendations for reform. Many of these recommendations are not controversial and require minimum effort on the Ministry's part.[40] The Ministry's lacklustre response to recommendations made by its appointed advisors and Coroner's inquest juries is quite disappointing. What is of even more concern is the Ministry's failure to address or respond to other shocking events that have occurred in Ontario correctional institutions, such as the murder of Adam Kargus.[41]

B. The Murder of Adam Kargus at EMDC

At 7:56 p.m. on October 31, 2013, Adam Kargus was choked, punched, kicked, and stomped on by his cellmate, Anthony George, and was murdered at approximately 8:53 p.m. in their shared cell. Between this time and 9:50 a.m. on November 1, correctional officers conducted regular security rounds without taking notice of what had happened in their cell. At 8:16 a.m., Anthony George dragged Adam Kargus' body, wrapped in bloody sheets, from their cell, across the unit, and into the shower area. Anthony George then engaged in various activities, attempting to clean up and dispose of the evidence related to the murder, with the assistance of other individuals. At 9:50 a.m., a correctional officer conducting regular rounds discovered Adam Kargus' body in the shower area. All of these events were captured by a security camera whose field of view captured the inside of their shared cell.[42]

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38 Ministry of the Community Safety and Correctional Services, *Ontario Passes Legislation to Transform Adult Correctional System: Improving Conditions and Increasing Transparency to Create Better Outcomes* (News Release) (Ottawa: Ministry of the Solicitor General, 3 May 2018), online: <www.news.ontario.ca> [perma.cc/3QR2-UU7Z].

39 Patrick White, "Ford government to dismiss Ontario's prison reformer Howard Sapers", *The Globe and Mail* (17 December 2018), online: <www.theglobeandmail.com> [perma.cc/X4WX-E4CH].

40 See e.g. Justice Cole, *Final Report, supra* note 31 at "Ministry responses to Independent Reviewer's Interim Report" where he outlines the Ministry's response to all of his recommendations and outlines the steps required to implement them.

41 A Coroner's inquest was not held for Adam Kargus.

42 *Ontario Public Service Employees Union (Langford et al) v Ontario (Community Safety and Correctional Services)*, 2017 CanLII 30327 (ON GSB) at paras 4–7 [*Langford et al*].

Not surprisingly, these horrific events at EMDC resulted in multiple lawsuits. Anthony George was charged with second-degree murder and ultimately pled guilty.[43] Prisoners David Cake and Bradley Mielke were charged with being accessories to murder after the fact for helping Anthony George attempt to cover up the murder. Cake pled guilty to obstruction of justice,[44] and the charges against Mielke were withdrawn in September 2015.[45] Two correctional officers, Leslie Lonsbary and Greg Langford, were charged with failing to provide the necessaries of life, along with EMDC operational manager Stephen Jurkus. The charges against Langford were withdrawn and he was subsequently called as a witness in the trial against Lonsbary and Jurkus.[46] Ultimately, Jurkus was declared not guilty and a mistrial was declared for Lonsbary.[47]

1. Correctional Officers' Grievance Against the Ministry for Reprimands Related to Adam Kargus' Death

Outside of these court battles, EMDC terminated five correctional officers (including Lonsbary and Langford) and gave written reprimands to two correctional officers for their various failures in performance on the evening and morning in question. These seven correctional officers filed grievances against the discipline imposed, which were heard by the Ontario Grievance Settlement Board (the "Board"). To resolve this dispute, the Board conducted an intensive review of the policies and procedures at EMDC as a result of the Ministry's assertion that the correctional officers had failed to perform many fundamental and core requirements of their jobs.

The Ministry argued that the correctional officers had violated specific employer policies and it was irrelevant that the correctional officers had performed their jobs in the way they "always had."[48] The union representing the disciplined correctional officers responded to these allegations with

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43 *R v Jurkus and Lonsbary*, 2018 ONSC 4766 at para 2 [*Jurkus and Lonsbary*].

44 *R v Cake & Mielke & George & Sun Media*, 2014 ONSC 3413 at paras 2–3.

45 London Free Press Staff, "Correctional officer and manager at London's jail face trial in death of inmate Adam Kargus", *The London Free Press* (11 January 2016), online: <lfpress.com> [perma.cc/93UH-BZ2R].

46 *Jurkus and Lonsbary*, *supra* note 43 at para 3.

47 CBC News, "Jury delivers mixed decisions in trial of former EMDC employees", *CBC News* (6 February 2019), online: <www.cbc.ca/news> [perma.cc/US6Z-BC63].

48 *Langford et al*, *supra* note 42 at para 17.

conclusive evidence that the Ministry's written policies had been "universally ignored for decades at EMDC," and several tenures of superintendents and managers were fully aware of these improper practices.[49]

After reviewing EMDC's policies and procedures, the Board held it was indisputable that EMDC's supervisors knew about the improper practices, yet had not brought a disciplinary action against correctional officers for these discrepancies before Adam Kargus' death.[50] Some of these improper practices included correctional officers refraining from performing tours at certain hours, irregular shift changeover policies, conducting poor quality tours at rapid paces, allowing individuals to cover the lights in their cells, and failing to check for live bodies.[51]

The evidence demonstrated that the typical tour was 40–60 seconds, with the correctional officers walking at a medium to brisk walking pace, not pausing in front of cells, and sometimes even failing to turn their heads during the tours.[52] While the Board's conclusions on the quality of work performed at EMDC were alarming, the Ministry had no justification for reprimanding these correctional officers as there was no evidence that their job performance was different in quality than the accepted practices at EMDC.

The Board's investigation and ultimate findings on the standard operating procedures at EMDC provide a perfect example of the inadequate policies and enforcement measures at the facility. The Ministry has policies in place that were specifically developed to ensure prisoner safety and structure at Ontario correctional institutions. These policies are blatantly ignored at EMDC with the absence of reprimands and accompanied by a failure to provide basic equipment (such as "mandatory" flashlights that were not available at EMDC on October 31, 2013), with the full knowledge of managers who review the logbooks/security footage.[53]

This lack of direct supervision and enforcement of policies is not an EMDC-specific issue. In the Toronto South Detention Centre, incarcerated individuals raised concerns about the unlawful use of "sanctions" by correctional officers that were unpredictable and inconsistent in practice as

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49 *Ibid* at para 21.

50 *Ibid* at para 31.

51 *Ibid* at paras 35–36, 47–49, 56–60, 66–71.

52 *Ibid* at para 70.

53 *Ibid* at para 61.

"every guard has their own rules."[54] The OHRC followed up with the Ministry on the legal authority for these sanctions and learned that the policy governing sanctions stated, "if you break a rule, the Unit Officer will determine the consequences."[55] There are no due process protections for incarcerated individuals and correctional officers are encouraged to "be creative" in determining punishments.

This is not a new phenomenon that the Ministry is slow or even absent in addressing complaints and concerns about questionable practices in its correctional facilities. In 2013, the Ontario Ombudsman released a report on the overuse of force and violence by correctional officers in Ontario correctional institutions.[56] In this report, the Ombudsman criticized the Ministry for denying the Ombudsman's findings until there was incontrovertible evidence of wrongdoing, and even then, enacting slow-moving policies that did little to hold correctional officers accountable.[57]

To address some of these concerns about the lack of oversight, Howard Sapers' *Directions for Reform* include establishing a fair and expeditious inmate complaints process and aligning policy and operational practices with the presumption of innocence.[58] Similarly, Justice Cole's final report recommended the establishment of a unit or branch within the Ministry that was exclusively focused on ensuring province-wide operational compliance with the Ministry's obligations under the Jahn settlement.[59] Implementation of either or both of these recommendations would surely improve the Ministry's ability to ensure the on-the-ground compliance and enforcement of its policies.

2. Incarcerated Individuals' Response to Adam Kargus' Death

The Ministry's (unsuccessful) attempt to reprimand correctional officers for the events surrounding Adam Kargus' death is a prime example of the

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54 OHRC, *Report on conditions of confinement at Toronto South Detention Centre* (Toronto: OHRC, 30 March 2020), online: <www.ohrc.on.ca> [perma.cc/Q7DL-RSM6].

55 *Ibid*.

56 Ombudsman Ontario, *The Code: Investigation into the Ministry of Community Safety and Correctional Services' response to allegations of excessive use of force against inmates* (Toronto: Office of the Ombudsman of Ontario, June 2013), online: <www.ombudsman.on.ca> [perma.cc/BCU3-9E2E].

57 *Ibid* at 6.

58 Ministry, *Directions for Reform*, *supra* note 1 at 80–81, 97.

59 Justice Cole, *Final Report*, *supra* note 31, Recommendation 3.2.

Ministry's problematic prioritization of its public appearance rather than on making meaningful changes inside correctional facilities. It is apparent that the Ministry was more concerned with disciplining its correctional officers than reviewing the practices at EMDC that allowed this horrific murder to occur and the effect witnessing such events had on the surrounding prisoners.

At Jurkus' and Lonsbary's criminal trial, a nearby prisoner testified that he could hear "excessive banging" from the floor below and that Adam Kargus had repeatedly screamed for help, but no correctional officers came to investigate.[60] During the wrongful dismissal grievance, Lonsbary admitted that he closed the office door to "dull the sound" coming from Adam Kargus' unit as he assumed the excessive noise was caused by a sporting event.[61] The prisoners in the unit were not as fortunate and had nothing to muffle the horrendous sounds coming from the cell.

As a result of these events, six prisoners filed a $15-million lawsuit against the Ministry for being trapped in their cells while they were forced to helplessly watch and listen to Adam Kargus' brutal torture and murder. In their claim, the prisoners recounted seeing the look of terror on Adam's face and hearing his cries for help for an hour. Not only were these individuals forced to witness these horrific events, but they also had to endure George's boasting about the murder and see the bloody evidence as the body was dragged to the shower the following morning.

Some of these individuals were locked in their cells for two weeks or more after witnessing the murder. None of these individuals were offered or received adequate counselling, and they continue to suffer from psychological damage and post-traumatic stress, including lasting nervous shock with difficulty sleeping, continued depression, anxiety, and panic attacks. In their statement of defence, the Ministry denied liability for any problems the prisoners experienced and stated that Adam Kargus' death did not result in any psychological or psychiatric illnesses for any incarcerated individuals.[62]

One of these individuals, James Pigeau, was 27-years old at the time of this murder and suffered from bipolar disorder. Following Adam Kargus'

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60 *R v Jurkus*, 2018 ONCA 489 at para 1.

61 *Langford et al*, *supra* note 42 at paras 174–80.

62 London Free Press Staff, "Inmates at London jail sue province for $15M after seeing, hearing fellow prisoner killed", *The London Free Press* (1 December 2017), online: <lfpress.com> [perma.cc/9PRY-PRBM].

death, he was diagnosed with post-traumatic stress disorder and treated at a correctional psychiatric centre. James Pigeau became an activist for improving the terrible conditions at EMDC. He kept track of the frequent lockdowns and wrote letters to local news outlets describing the horrific conditions he experienced. In August 2017, he informed the London Free Press that he was attacked by a correctional officer, and, in fall 2017, he was jumped by multiple prisoners.[63] James Pigeau was beaten so badly that he was left in a wheelchair.[64] On January 7, 2018, he died of a suspected fentanyl overdose while on remand at EMDC. James Pigeau is one of many people whose deaths could have been prevented with the implementation of well-known, recommended, better practices at EMDC.[65]

C. Final Thoughts on Deaths in Ontario Correctional Institutions

The deaths of Laura Straughan, Kenneth Randall Drysdale, Jamie High, Michael Fall, Floyd Sinclair Deleary, Justin William Thompson, Adam Kargus, James Pigeau, and the other eight individuals who died at EMDC in the last decade were likely avoidable. With a proper infirmary, Laura Straughan's bacterial pneumonia could have been properly diagnosed and Kenneth Randall Drysdale's seizures could have been properly treated. Sufficient training of staff for treating individuals with addictions likely could have prevented the deaths of Jamie High, Michael Fall, Floyd Sinclair Deleary, Justin William Thompson, and James Pigeau's substance abuse-caused deaths. Adam Kargus' death may have also been avoidable, as it is suspected that Anthony George was intoxicated that evening and had been refused medical treatment by a nurse earlier that day.[66]

While correctional officers are provided with basic mental health training, it is insufficient to equip them to appropriately respond to

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63 *Ibid.* See also Paula Duhatschek, "EMDC inmate who died Sunday had been assaulted before", *CBC News* (8 January 2019), online: <www.cbc.ca/news/canada/london/emdc-inmate-who-died-sunday-had-been-assaulted-before-1.4477981>.

64 Maryam Mirza, "Did a corrections system in crisis turn jail time into a death sentence for James Pigeau?", *Brampton Guardian* (25 June 2019), online: <www.bramptonguardian.com> [perma.cc/K8C4-TBNG].

65 Also note that the Ministry did not perform an inquest into James Pigeau's death despite the fact that he clearly did not die of natural causes.

66 *Langford et al, supra* note 42 at para 5.

individuals with mental health disabilities and provide sufficient assistance.[67] With the proper training, staffing, funding, and oversight of correctional officers, these terrible events could have been avoided. With more than 150 deaths in Ontario correctional institutions in the last decade, it is imperative that the Ministry amend its policies, provide counselling for incarcerated individuals and correctional officers alike, and take responsibility for so many of these avoidable deaths.

IV. SYSTEMIC PREVALENCE OF DRUGS IN CUSTODY

Studies in Canada have consistently connected high rates of overall drug use and injection drug use to incarceration in provincial and federal institutions. For instance, one study found that 68% of 597 prisoners surveyed in an Ontario correctional institution had used drugs, with 51% of prisoners admitting to using drugs other than cannabis, and 17% admitting to injecting drugs before incarceration.[68] Another study of 500 prisoners in an Ontario correctional facility reported that more than half of prisoners had used opioids, crack, cocaine, or methamphetamine in the previous year, and 12.2% had injected drugs.[69] Substance abuse issues do not end when an individual enters prison, and there are numerous ways for drugs to end up in Ontario correctional institutions.

The Ontario *Ministry of Correctional Services Act* ("MCSA") allows the superintendent of a jail to authorize searches of any person or prisoner in correctional institutions, as well as the property of any person on the institution's premises.[70] The MCSA also permits the seizure and disposal of any contraband found during a search.[71] Contraband includes anything a prisoner is not authorized to have, or anything a prisoner is authorized to have but is not authorized to have in the place, quantity, or for the purpose it is being used.[72] Contraband searches are a routine aspect of prison life, and incarcerated individuals have found creative ways to protect their

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67 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

68 Liviana M. Calzavara et al, "Prior opiate injection and incarceration history predict injection drug use among inmates" (2003) 98:9 Addiction 1257 at 1259.

69 Fiona G. Kouyoumdjian et al, "Drug use prior to incarceration and associated socio-behavioural factors among males in a provincial correctional facility in Ontario, Canada" (2014) 105:3 Can J Pub Health e198 at e199–20.

70 MCSA, *supra* note 4, s 23.1(1).

71 *Ibid*, s 23.1(2).

72 *Ibid*, ss 23.1(3)(a)–(d).

contraband. The consequences of being caught are severe, and disputes over the ownership of contraband can lead to conflict between individuals.[73]

There is an undeniable systemic drug problem in Ontario correctional facilities, and the frequent overdoses at EMDC highlight some of these concerns. Overdoses at EMDC are reported in the news all too often. In March 2018, four female prisoners overdosed in one night.[74] On August 9th, 2018, seven individuals simultaneously overdosed on opioids and were rushed to the hospital.[75] On July 26, 2020, during a global pandemic when access to drugs is more difficult, an incarcerated individual was rushed to the hospital for a suspected overdose.[76]

Fortunately, no prisoner died in any of these instances. Unfortunately, this is not the case for all individuals who overdose at EMDC, as demonstrated by the deaths of Michael Fall, Floyd Sinclair Deleary, Justin William Thompson, and James Pigeau (as discussed above). The inquests into these deaths illustrate the need for better training and equipment for personnel to ensure they are prepared to recognize and react to overdoses. Based on the continuous and recent reports of overdoses at EMDC, it seems unlikely that these recommendations have been implemented in an effective manner.

A. Prisoners Smuggling Narcotics into EMDC

The quantity and types of black-market drugs available in EMDC are shocking. Between 2015 and 2016, EMDC guards found "unknown pills" 70 times, while the next most common contraband seized was disposable lighters (found 64 times) and extra laundry (found 57 times).[77] Other drugs found during this time period included: known pills such as anti-psychotics and opioids (found 20 times), unknown powders (found 8 times), marijuana (found 21 times), the butts of marijuana cigarettes known as roaches (found 12 times), and crystal meth (found once).[78]

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73 *Langford et al*, *supra* note 42 at para 115.

74 Dan Brown & Randy Richmond, "Seven inmate drug overdoses found simultaneously at London's jail", *The London Free Press* (10 August 2018), online: <lfpress.com> [perma.cc/PVL7-2XSW].

75 *Ibid*.

76 Justin Zadorsky, "Woman taken to hospital after suspected overdose at EMDC", *CTV News* (27 July 2020), online: <london.ctvnews.ca> [perma.cc/Y6QR-3AQ2].

77 Butler, *supra* note 14.

78 *Ibid*.

In 2012, an individual serving an intermittent sentence at EMDC was caught smuggling in prescription drugs on six occasions and was given a misconduct by staff on each occasion.[79] On one such occasion, this individual was caught sneaking in 213 OxyNeo and 7 Cesamet pills located in the collar of her coat and tucked in her underwear.[80] It is reassuring that EMDC staff were able to stop these 220 pills from entering EMDC, but it is apparent that many other incarcerated individuals have been more cunning and successful with their smuggling techniques.

Aside from voluntary drug smuggling concerns, there are also concerns about the blackmail used against incarcerated individuals to smuggle in drugs. One such individual testified that she was approached by thugs before her drug treatment court attendance and was threatened with violence against herself and her daughter if she did not sneak drugs into EMDC.[81] She was charged with possession of hydromorphone during a search at EMDC and testified that she was told she would "get her face punched and head kicked" and stated they were "going to get me and my daughter."[82] Other prisoners at EMDC informed OHRC of similar experiences, and these incarcerated individuals who fail to smuggle in contraband drugs face serious threats or actual violence.[83]

In early 2018, EMDC installed a full-body scanner to search for external and internal contraband as an attempt to fight the systemic drug problem.[84] EMDC also has a canine unit to "serve as a deterrent to contraband" and is hoping to get new ion scanners that can identify trace elements of drugs on individuals' mail.[85] On February 8th, 2018, a prisoner was caught attempting to smuggle in 20 matches, rolling papers, 167 grams of marijuana, 1 gram of marijuana shatter, 1 gram of cocaine, 2 grams of crystal methamphetamine, and 3 grams of fentanyl into EMDC by the electronic

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79 *R v Fitzsimmons*, 2016 ONCA 107 at para 2.

80 *Ibid* at para 3.

81 *R v Kynock*, 2014 ONCJ 251 at para 25.

82 *Ibid*.

83 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

84 "Elgin-Middlesex Detention Centre Enhancement Initiative" (last modified 2 May 2018), online: *Ministry of the Solicitor General* <www.mcscs.jus.gov.on.ca> [perma.cc/MT8P-FT78] [Ministry, "EMDC"].

85 "Another tense weekend at EMDC after multiple drug overdoses", *CBC News* (23 April 2019), online: <www.cbc.ca/news> [perma.cc/P7QZ-85UQ] [CBC News, "Another tense weekend"].

body scanning device.[86] This prisoner's story highlights the sheer volume of drugs being smuggled in by one person and raises concerns about other similar quantities of drugs that are not caught by the full-body scanner.

B. Correctional Officers Smuggling Narcotics into EMDC

Incarcerated individuals are not the only drug mules smuggling narcotics into EMDC. On the morning of February 14th, 2015, prisoner Nelson Moran called Tanya Zavitz (a correctional officer at EMDC) and asked her to pick up and deliver some items to the jail. Zavitz arrived at EMDC at 8:30 a.m. and went straight to Moran's unit. Video surveillance showed Zavitz passing Moran two white envelopes and Moran tucking these envelopes in his pants. Moran then went to the shower area where there were no cameras.[87]

A "veritable conga line" of prisoners headed in and out of the shower area, and sometime later correctional officers testified that they could smell marijuana. Between 12:45 and 1:15 p.m., three cells in Moran's unit were searched, and the following narcotics were confiscated: 17 grams of marijuana, 1 gram of hash, and 28 grams of hash oil. Zavitz was charged with three counts of drug trafficking, and Moran was charged with three counts of trafficking and three counts of possession.[88]

At trial, the Honourable Justice John Skowronski held that because drugs were so prevalent at EMDC and searches were so sporadic, there was no way of proving that the suspicious transaction between Zavitz and Moran had led to the treasure trove of narcotics found.[89] Justice Skowronski also noted that "[t]he existence of drugs in EMDC is seemingly epidemic," and searches that might locate contraband are sometimes not carried out for weeks. Ultimately, Zavitz and Moran were acquitted of all counts.

It is interesting to note that Tanya Zavitz was one of the correctional officers who received a written reprimand for Adam Kargus' murder. She witnessed Anthony George choking Adam Kargus earlier on the day of the murder, after she complimented Anthony George on his shirt, and failed to

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86 *R v Doxtator,* 2019 ONCJ 26 at paras 8–10.

87 "Officer, inmate cleared of trafficking weed because drug use in their jail is 'seemingly epidemic,' says judge", *National Post* (14 June 2016), online: <www.nationalpost.com> [perma.cc/JSR9-GYCS].

88 *Ibid.*

89 *Ibid.*

address and report the altercation properly.[90] It may be a coincidence that one correctional officer was involved in two highly publicized incidents in such a short period of time, or it may be an indication of the numerous horrifying incidents that regularly occur at EMDC. While Zavitz's behaviour may seem questionable at best from an outside perspective, questionable conduct is the best way, if not the only way, to survive the constant threats and corruption at EMDC.

C. Contraband Alcoholic Beverages at EMDC

Another major substance-related issue in Ontario correctional institutions is contraband alcoholic beverages. "Brew" is an improvised alcoholic concoction made by incarcerated individuals by using sugar and fermented fruit. In 2003, a total of 8,732 litres of alcohol/brew were seized in Canadian federal prisons.[91] While it is clear that drug overdoses are an ongoing concern at EMDC, one correctional officer acknowledged that there is an even greater risk of alcohol poisoning.[92] Between 2015 and 2016, correctional officers reported finding brew 42 times at EMDC.[93] Brew is known to have dangerous impacts on individuals, causing mood swings, depression, aggression, and suicidal thoughts.[94] Anthony George was believed to be drunk on brew the day that he murdered Adam Kargus.[95]

D. Final Thoughts on the Drug Problem at Ontario Correctional Institutions

In 2018, Ontario's Chief Coroner held an inquest into the overdose of eight men in custody between March 2012 and 2016 at another Ontario correctional institution for individuals on remand.[96] The jury recommendations included requiring weekly audits of prisoner admissions by the Ministry, designating a liaison officer from the local police department to meet with representatives at the detention centre, and

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90 *Langford et al*, *supra* note 42 at para 96.

91 "Substance Abuse in Corrections FAQs" (2004) at 4, online (pdf): *Canadian Centre on Substance Use and Addiction* <www.ccsa.ca/substance-abuse-corrections-faqs> [perma.cc/5ZR5-ME72].

92 *Langford et al*, *supra* note 42 at para 115.

93 Butler, *supra* note 14.

94 *Langford et al*, *supra* note 42 at para 115.

95 *Ibid* at para 116.

96 *Unelli Re*, 2018 CarswellOnt 23166 at para 3 (WL Can).

creating a working group to further improve health care services to individuals at the detention centre.[97]

Implementation of any or all of these oversight mechanisms at EMDC and other Ontario correctional institutions would be a game-changer for fighting the systemic drug problem. Similarly, implementation of some of the recommendations from EMDC-related inquests would be of great assistance. These recommendations included improving communication policies between correctional officers at shift changes to ensure there is awareness of individuals who have recently been found in possession of contraband and equipping staff with naloxone kits.[98] As discussed above, the Ministry is slow to act on any of these recommendations and very selective on the recommendations they do choose to implement.

While this paper is primarily concerned with reform recommendations targeting prison infrastructures, it is also important to consider other avenues of reform for combatting the drug crisis. One such avenue is the decriminalization of personal-use drug offences and the implementation of non-criminal penalties (e.g., fines).[99] The decriminalization of these offences could decrease the drug-using prison population, unsafe drug consumption practices, and the stigma associated with drug use.[100]

As decriminalization requires legislative action on behalf of the federal government, it is outside the Ministry's jurisdiction. As such, the remaining discussion will focus on drug reform mechanisms that are within the Ministry's capabilities, namely harm reduction mechanisms that target the health, social, and economic consequences of the drug crisis. These interventions include opioid substitution therapy, needle and syringe programs, overdose prevention and reversal, and testing for treatment of HIV and Hepatitis C.[101]

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97 *Ibid* at paras 41, 59, 121.

98 See e.g. *Coroner's Verdict – Fall*, *supra* note 25 at paras 26–28, 38–40.

99 Rebecca Jesseman & Doris Payer, "Decriminalization: Options and Evidence" (June 2018) at 1, online (pdf): *Canadian Centre on Substance Use and Addiction* <www.ccsa.ca> [perma.cc/FB23-TMFN].

100 Matthew Bonn et al, "Addressing the Syndemic of HIV, Hepatitis C, Overdose, and COVID-19 Among People Who Use Drugs: The Potential Roles for Decriminalization and Safe Supply" (2020) 81:5 J Stud Alcohol & Drugs 556 at 557.

101 Gen Sander, Sam Shirley-Beavan & Katie Stone, "The Global State of Harm Reduction in Prisons" (2019) 25:2 J Correct Health Care 105 at 107.

Harm reduction measures have been endorsed by the World Health Organization ("WHO") and United Nations ("UN") as essential public health measures both in the community and prison environment.[102] They are widely recognized as a legally binding human rights obligation[103] and captured under *Mandela Rule* 24, which requires that prisoners have access to equivalent health care to that in the community.[104] The Ministry has failed to implement many of these measures meaningfully.

EMDC does not have equivalent health care to that in the community. It still does not have an infirmary, despite the numerous calls for action and the overdoses and deaths that continue to occur. It is clear that the Health Care Unit is not sufficient for meeting incarcerated individuals' needs. Even when nurses or social workers are available at EMDC, there is an inadequate space for them to meet with their patients confidentially.[105]

While EMDC has methadone and suboxone programs available, the programs are realistically inaccessible to individuals unless they were already prescribed methadone before their arrest. It is also not reassuring that naloxone kits are only sometimes available and, even then, only sometimes successfully administered.[106] There have been at least seven deaths reportedly caused by overdose in the past decade,[107] with four of these deaths occurring since June 2017, and at least sixteen individuals rushed to hospitals for fentanyl overdose in 2018 alone.[108]

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102 "Policy Brief: HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions" (Austria: UNODC, June 2013) at 1, online: <www.who.int> [perma.cc/HFB7-539V].

103 Dainius Pūras, "Open Letter by the Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health, Dainius Pūras, in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which will take place in New York in April 2016" (Geneva: OHCHR, 7 December 2015) at 5, online: <www.ohchr.org> [perma.cc/Z6H6-JFZF].

104 *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, GA Res 70/175, UNGAOR, 70th Sess, UN Doc A/RES/70/175 (2015) 12 [*Mandela Rules*].

105 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

106 *Ibid*.

107 Free Press Staff, "Coroner's inquest", *supra* note 26.

108 Brown & Richmond, *supra* note 74; Solicitor General, "News Release: Enhancing Security Measures and Improving Safety at Elgin-Middlesex Detention Centre," *Ontario* (28 September 2018), online: <news.ontario.ca/en/release/50110/enhancing-security-measures-and-improving-safety-at-elgin-middlesex-detention-centre>.

When questioned about the drug epidemic, Greg Flood, the spokesperson for EMDC, stated that "[s]taff are trained to be vigilant" for drugs, including "frequent and thorough searches of any suspected contraband."[109] These statements were made after three individuals overdosed one weekend in April 2019, causing correctional officers to administer naloxone and hurriedly transport the individuals to a hospital.[110] It is obvious that these "vigilant" efforts are insufficient, and there will continue to be frequent drug-related deaths and overdoses until the Ministry makes drastic changes.

Harm reduction mechanisms are not captured by the Ministry's current approach to the systemic drug issues as it continues to be punitive rather than targeted at risk management. Incarcerated individuals do not immediately master their addictions, and the challenges associated with drug and alcohol addictions continue to endure while in prison.[111] Implementing prison needle and syringe programs can help reduce many of the associated risks with drug use and reduce drug overdoses.[112] While the federal prison system has started to roll out safe injection programs,[113] the Ontario correctional system has not followed suit.

V. Inhumane and Unsanitary Conditions at EMDC

It is well established that incarcerated individuals in Ontario correctional institutions are subjected to inhumane and unsanitary conditions.[114] Some of these unacceptable conditions interfere with

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109 CBC News, "Another tense weekend", *supra* note 85.

110 *Ibid.*

111 James Gacek & Rosemary Ricciardelli, "Constructing, Assessing, and Managing the Risk Posed by Intoxicants within Federal Prisons" (2020) 43:3 Man LJ 273 at 288.

112 "A Public Health Failure: Former Prisoner and HIV Groups in Court Suing the Government of Canada for Failing to Provide Access to Effective Prison Needle and Syringe Program" (9 December 2019), online: *HIV/AIDS Legal Network* <www.hivlegalnetwork.ca> [perma.cc/YAE4-HQK8].

113 "The Prison Needle Exchange Program" (last modified 28 August 2019), online: *Correctional Services Canada* <www.csc-scc.gc.ca> [perma.cc/8WU2-WVFJ].

114 "Joint submission to Ontario's consultation on the 2020 budget: Necessary investments in Ontario's correctional system" (21 January 2020), online: *OHRC* <www.ohrc.on.ca> [perma.cc/6UV4-22TZ]; Office of the Auditor General of Ontario, *2019 Annual Report*, vol 3, ch 1, "Adult Correctional Institutions" (Toronto: Office of the Auditor General,

prisoners' freedom of movement and right to meaningful contact through the inappropriate and excessive use of lockdowns and segregation. Other conditions fail to comport with basic standards of human decency, such as forcing prisoners to use the toilet in full view of other prisoners and preventing access to telephones, showers, and fresh air for up to a week.[115] Incarcerated individuals are given clothing, bedding and towels that are stained with urine, blood and feces, suffer through bedbug infestations, and are forced to use unclean shared nail clippers that may result in untreatable fungal infections.[116]

In 2019–2020, the Ontario Office of the Ombudsman received 6,000 complaints about correctional facilities, with many of them signalling systemic issues involving lack of access to services, persistent lockdowns, or overcrowding.[117] Of these complaints, 2,429 were health-related, 186 related to methadone, 78 related to prisoner-on-prisoner assaults, 75 related to the lack of Indigenous services, 118 related to excessive use of force by correctional officers, and 162 related to segregation.[118] These 162 complaints were a decrease from the previous year (266 in 2018–2019)[119] as a result of the Ministry's attempts to reform its use of administrative segregation. Despite this attempt at reform, the Ministry's use of segregation remains habitual, continual, and the Ministry "has fallen short in fulfilling the promises or undertakings it made, to do better."[120]

Unsurprisingly, the conditions at EMDC are just as unacceptable as other Ontario correctional institutions. In early 2019, OHRC visited

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4 December 2019), online: <www.auditor.on.ca> [perma.cc/C8FR-H8HX] [Auditor General, *2019 Annual Report*].

115 *R v Persad*, 2020 ONSC 188 at para 9 [*Persad*]. This case was concerned with conditions at the Toronto South Detention Centre but is reflective of the experiences of incarcerated individuals at every Ontario correctional institution.

116 *Ibid* at para 12.

117 Ombudsman Ontario, *2019–2020 Annual Report* (Toronto, Office of the Ombudsman of Ontario, 30 June 2020) at 33, online (pdf): <www.ombudsman.on.ca> [perma.cc/U9LX-QHRC] [Ontario Ombudsman, *2019-2020*].

118 *Ibid* at 33–36.

119 Ombudsman Ontario, *2018–2019 Annual Report* (Toronto: Office of the Ombudsman of Ontario, 25 June 2019) at 24, online (pdf): <www.ombudsman.on.ca> [perma.cc/T9TX-G5RB] [Ontario Ombudsman, *2018–2019*].

120 *Francis v Ontario*, 2020 ONSC 1644 at para 581 [*Francis*]. See also Ministry, "Independent Review", *supra* note 31; Justice Cole, *Final Report, supra* note 31.

EMDC as part of their monitoring of the Jahn settlement.[121] Although the institution was cleaned for OHRC's visit, there was still a "noticeable smell" throughout the institution coupled with poor air quality and concerns of mould.[122] OHRC described the conditions as "dehumanizing, antithetical to rehabilitation and reintegration, and pose a serious risk to the health and safety of prisoners and correctional officers."[123] The plethora of safety concerns observed at EMDC violates numerous international human rights conventions, including *Mandela Rules* 12, 14, 15, 17, 23 and 35, which provide minimum standards for the sanitation, maintenance, hygiene, clothing, pre/postnatal care, and information made available for incarcerated individuals.[124]

The following sections will highlight some of the worrisome conditions at EMDC as a representation of the systemic issues surrounding the living conditions in Ontario correctional institutions.

A. Overcrowding of Individuals at EMDC

When it was built in 1977, EMDC had a capacity of 190 individuals in single cells.[125] These original sleeping accommodations were compliant with the *Mandela Rules*, which state that it is "not desirable to have two prisoners in a cell or room," even where administration must make an exception to single-occupancy cells.[126] The institution now hosts four to five individuals per cell, and the program rooms in the units have been converted into cells.[127] Not only does this create limitations on the rehabilitative programming that can be offered to incarcerated individuals,[128] but these converted rooms also fall outside the visibility of correctional officers and security cameras, creating considerable security concerns.[129]

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121 "Jahn Settlement: Special Advisors Appointed for Adult Corrections" (24 October 2019), online: *Ministry of the Solicitor General* <www.mcsc.jus.gov.on.ca> [perma.cc/TN9T-V3TK].

122 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

123 *Ibid.*

124 *Mandela Rules*, *supra* note 104 at 10–12 (Rules 12, 14, 15, 17, 23 and 25).

125 Ministry, *Community Advisory*, *supra* note 6.

126 *Mandela Rules*, *supra* note 104 at 10 (Rule 12).

127 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

128 Ministry, *Directions for Reform*, *supra* note 1 at 7.

129 Mirza, *supra* note 64.

An incarcerated individual who had been in EMDC on remand illustrated exactly what it was like to live in such conditions. He described his cell as very small, dirty, and suffering from a bed bug infestation.[130] He was the third man in the cell and was required to sleep on a mattress on the floor in the two-and-a-half-foot space between the two beds.[131] Not only are these living conditions uncomfortable, but this overcrowding of cells creates increased stress and anxiety for vulnerable individuals, especially those with mental health disabilities or youthful individuals. This increased level of stress and anxiety can lead to "voluntary" admissions to segregation, use of intoxicants, violence, or other harmful behaviours.[132] It is also the prime environment for the uncontrollable spread of disease and infections.

B. Overuse of Segregation as "Treatment" for Incarcerated Individuals

EMDC has two segregation units known as the "Special Needs Unit" and "Special Care Unit." When asked how they differ from segregation, the management and staff at EMDC were unable to clearly identify how the conditions differed. [133] As there is no infirmary at EMDC, ill individuals are placed in segregation cells in proximity to the Health Care Unit. These cells are not dedicated to ill individuals.[134] For example, when Kenneth Randall Drysdale was discovered having a seizure in the washroom/shower area, he was assessed by nurses and placed in segregation for observation.[135]

Only half of the segregation cells have continuous video monitors, causing incarcerated individuals to prioritize which cells they are placed in.[136] During the OHRC tour of EMDC, one correctional officer casually mentioned that an individual had been kept in segregation for "a couple of years" and that there was no significant plan to address this long-term placement problem.[137]

This systemic use of segregation is not limited to EMDC. In 2017, Howard Sapers reported that 1,300 men and women spent 60 or more

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130 *R v Sabatine*, 2012 ONCJ 310 at paras 11–12 [*Sabatine*].

131 *Ibid.*

132 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

133 *Ibid.*

134 *Coroner's Verdict – Straughan*, *supra* note 22 at para 12.

135 *Coroner's Verdict – Drysdale*, *supra* note 23 at paras 4–6.

136 *Coroner's Verdict – High*, *supra* note 24 at para 51.

137 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

aggregate days inside an Ontario correctional services segregation cell.[138] While the Ministry policy states that segregation is "an area designated for the placement of inmates who are to be housed separate from the general population,"[139] segregation is realistically used as a place to house individuals with special needs. The fact that some of these cells do not have security monitoring and that prisoners can be housed there "for a couple of years" without a plan to fix the problem is a serious concern.

A group of incarcerated individuals successfully brought a class action against the Ministry for its excessive use of segregation and were awarded $30 million in aggregate *Charter* damages in April 2020. Justice Paul Perell of the Ontario Superior Court of Justice described the Ministry's justifications as embarrassing and stated that "neither television, books, magazines, radio, telephones, or computers, negates the effects of being confined in a small cell for twenty-two to twenty-four hours a day without meaningful human contact and without adequate health care."[140]

One would hope that the significant monetary consequence of this action would motivate the Ministry to take action. At EMDC specifically, the Ministry's *EMDC Enhancement Initiative* is increasing the hours and numbers of medical staff available and completing a health care review to determine other areas of improvement for health care at EMDC.[141] Hopefully, similar changes will be made at other correctional institutions, resulting in a decrease in the use of segregation as a form of medical treatment.

C. Inappropriate Use of Lockdowns due to Understaffing

The Ministry defines lockdowns as "strict limitation on the movement of inmates in all or part of an institution," with the Ontario Office of the Ombudsman receiving 483 complaints about lockdowns in 2018–2019.[142] These numbers increased to 668 in 2019–2020, an increase to about 10%

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138 Independent Review of Ontario Corrections, *Segregation in Ontario* (Toronto: Ministry of the Solicitor General, March 2017) at 1, online: <www.mcscs.jus.gov.on.ca> [perma.cc/Q5C6-P8QL] [Ministry, *Segregation in Ontario*].

139 Ontario, Ministry of Community Safety and Correctional Services, *Institutional Services Policy and Procedures Manual: Placement of Special Management Inmates* (Toronto: Ministry of Community Safety and Correctional Services, 6 December 2016), s 4.1.

140 *Francis*, *supra* note 120 at para 589.

141 Ministry, *EMDC*, *supra* note 84.

142 Ontario Ombudsman, *2018–2019*, *supra* note 119 at 23.

of the total number of complaints made by incarcerated individuals.[143] Lockdowns may occur as a result of a violent incident at EMDC, such as the murder of Adam Kargus, but more often than not, they occur as a result of staff shortages. This means that lockdowns are, for the most part, avoidable.

An individual on remand at EMDC from September 26, 2011, to February 17, 2012, was on lockdown on approximately five occasions during this time period.[144] During these lockdowns, individuals were confined to their cells 24 hours a day, and all privileges were suspended, including the usual 20 minutes allowed outside in the yard. The only exception was a shower and a 20-minute phone call that was permitted every third day. Each "lockdown" lasted four to seven days, with the longest lockdown lasting approximately 20 days. This particular individual's behaviour was never the cause of the lockdown, and he had no behaviour issues at EMDC.[145] Long periods of lockdown are harmful to the mental health of prisoners, as they are deprived of basic necessities and the ability to contact loved ones and lawyers.[146]

The conditions of lockdown are the same as segregation or solitary confinement. Segregation is not determined by where an inmate is confined or what the unit is called; rather it is how they are confined. Lockdowns involve individuals being locked in their cells for 24 hours a day, with the periods of confinement being entirely arbitrary and unpredictable. The Ministry's use of sustained periods of frequent, unpredictable lockdowns due to staff shortages violates s. 12 of the *Charter*.[147] The Ministry has been aware of the issues arising out of understaffing since at least 2002, and it is entirely within their control to ensure sufficient staff is available.[148]

Studies have shown the negative effects of segregation include psychological distress, anxiety, insomnia, hallucinations, depression, suicide, self-harm, violent ruminations, institutional violence, and increased

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143 Ontario Ombudsman, *2019–2020*, *supra* note 117 at 33.

144 *Sabatine*, *supra* note 130 at para 13.

145 *Ibid.*

146 Ontario Ombudsman, *2018–2019*, *supra* note 119 at 23; Auditor General, *2019 Annual Report*, *supra* note 114 at 48-50; OHRC, "Letter to Solicitor General Jones", *supra* note 10.

147 *Ogiamien v Ontario*, 2016 ONSC 3080 at para 269 [*Ogiamien*].

148 *Ibid* at paras 253–54.

reoffending.[149] Further, particular individuals and groups are differentially impacted by segregation, such as the young and elderly, individuals with mental illness, women, racialized, and Indigenous persons.[150] Individuals confined in lockdowns are likely to experience the same consequences and have no control over the frequency, length, or timing of their isolation.

D. The Violent Environment at EMDC

Prisoner-on-prisoner violence and excessive use of force by correctional officers are a routine aspect of living in Ontario correctional institutions. This constant fear of violence, combined with a lack of adequate medical equipment and staff, causes individuals to live in a state of hyper-vigilance.[151] This culture of violence feeds directly into the lawlessness and corruption of the prison atmosphere, and it creates a social order where the strong prey on the weak (or where the sinners are winners).

Violent events are so common at EMDC that they are rarely appropriately identified or addressed. For example, when Anthony George put Adam Kargus in a chokehold in front of multiple correctional officers, it was described as "horseplay."[152] A misconduct/sanction was not issued against Anthony George. Despite the situation clearly being an act of bullying where a strong individual engaged in a one-sided physical exchange, one correctional officer felt that "if [Kargus] did not say he was in fear, how was I supposed to know."[153] It is up to the correctional officer's discretion whether or not to file an Occurrence Report following a violent incident, and these reports are rarely filed.

The number of weapons available in EMDC is also of concern. Between 2015 and 2016, contraband or improvised weapons were found 33 times, including a sharpened tile, metal wire, razors, screws, nunchucks, a four-inch jack knife, and many more weapons.[154] Prisoners speak of the "near constant threat of violence" and how a "prison subculture has taken root where more dangerous prisoners are able to control the range and prey on

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149 Ellie Brown, "A systematic review of the effects of prison segregation" (2020) 52 Aggress Violent Behav 1 at 1–2.

150 Ministry, *Segregation in Ontario*, *supra* note 138 at 3.

151 *Persad*, *supra* note 115 at para 11.

152 *Langford et al*, *supra* note 42 at para 96.

153 *Ibid* at para 104.

154 Butler, *supra* note 14.

weaker individuals."[155] This high level of violence also has negative impacts on the mental health of correctional officers. Correctional officers report high levels of violence and abuse from prisoners, which the Ministry has done nothing to address.[156] Correctional officers describe their work as stressful and EMDC as a violent jail.[157]

A former correctional officer, Don Roman, experienced PTSD and had to take off work for an extended period after having a breakdown while working at EMDC.[158] During his leave from work, Roman was "very angry, full of rage, and he expressed thoughts of suicide and homicide."[159] His rage was mostly associated with his interactions with prisoners at EMDC, and his wife stated that "if he saw an inmate driving or at the park, he didn't know what he would do to him."[160] Roman himself stated that he associated his PTSD with prisoners at the jail and that his mental health made him "think of harming people, including inmates at the jail."[161] The violent acts and dangerous conditions occurring at EMDC negatively affect all individuals involved: incarcerated individuals, correctional officers, and staff.

The stressful conditions associated with working in correctional institutions are not a new phenomenon. In a 2011 survey of 200 correctional officers in British Columbia, it was determined that in the previous year, 90% of correctional officers had been exposed to blood, more than 75% had been exposed to feces, spit and urine, and 90% had responded to requests for staff assistance and medical emergencies.[162] Numerous studies have demonstrated that correctional officers frequently experience traumatic stressors, demanding social interactions, low

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155 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

156 "Human Rights Commissioner slams EMDC as 'overcrowded, unsanitary and dangerous'", *CBC News* (21 May 2019), online: <www.cbc.ca/news> [perma.cc/E2L4-A5X7].

157 *R v Roman*, 2018 ONCJ 344 at para 31.

158 *Ibid* at para 16.

159 *Ibid* at para 17.

160 *Ibid*.

161 *Ibid* at para 42.

162 Ministry, *Directions for Reform*, *supra* note 1 at 18, citing Neil Boyd, *Correctional Officers in British Columbia, 2011: Abnormal Working Conditions* (Burnaby, BC: Simon Fraser University, November 2011) at i.

organizational support, harsh physical environments, and repeated direct and indirect exposures to violence, injury, and death events.[163]

There is no excuse for the Ministry's failure to improve the conditions at Ontario correctional institutions, for prisoners and correctional officers alike.

VI. The Effect of Understaffing on Correctional Officers and Prisoners

Understaffing is another major issue in Ontario correctional institutions, as reflected in the discussion about deaths in custody, drugs in custody, lockdowns, and segregation. There have been specific incidents at EMDC that highlight this issue, such as the situation in January 2016 where 50 staff called in sick on the same day.[164] EMDC remained operational through the assistance of management, but the correctional officers who did arrive at work that day stated that there was insufficient staff to operate the institution safely.[165]

These understaffing issues result from a lack of funding from the Ministry, as well as the terrible working conditions that staff are forced to face. There is an elevated use of sick leave amongst staff at EMDC, which creates a vicious cycle of persistent understaffing at the institution. It ultimately makes the job more difficult for on-duty staff due to lockdowns and increased security threats in the prison environment.[166]

The first things to be cancelled due to staffing shortages are life skills, education, and rehabilitative programs at Ontario correctional institutions.[167] Correctional officers observed that EMDC houses a particularly dangerous population, and there is a lack of meaningful access to programming to address their criminogenic factors or meaningful tools to engage individuals proactively.[168]

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163 *Ibid*, citing Michael D Denhof, Caterina G Spinaris & Gregory R Morton, *Occupational Stressors in Corrections Organizations: Types, Effects and Solutions* (Washington DC: Department of Justice, National Institute of Corrections, July 2014) at 7–8.

164 *Lynda Kathleen Gough v Elgin-Middlesex Detention Centre*, 2016 CanLII 74661 (OLRB) at paras 3–4.

165 *Ibid*.

166 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

167 Ministry, *Directions for Reform*, *supra* note 1 at 125.

168 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

Those correctional officers that do show up do not have adequate training or support.[169] These systemic issues with understaffing also cause institutions to rely primarily on indirect supervision of prisoners and static security. Studies have shown that direct supervision is preferable in detention centres, as it maintains personal contact with prisoners, tends to offer prisoners more physical amenities, and can allow trained staff to detect and defuse potential problems.[170]

There are also understaffing issues with the health services at EMDC, which result in the misuse of segregation as a means to protect vulnerable and ill individuals. In 2010, the Ontario Public Services Employees Union came to an agreement with the Ministry to increase staffing and funding in the EMDC Health Care Unit.[171] Despite these apparent increases, at least six individuals have died due to inadequate health care at EMDC (Laura Straughan, Kenneth Randall Drysdale, Jamie High, Michael Fall, Floyd Sinclair Deleary, and Justin William Thompson). It is clear that promises by the Ministry to increase funding and staffing are not enough to solve these systemic issues.

VII. CONCLUSION

This paper has highlighted specific issues at Ontario correctional institutions that are in drastic need of attention and care from the Ministry. These issues include the concerning number of deaths, overdoses, and violent incidents in custody, as well as the overall unsanitary and inhumane conditions of detention centres. These are not new issues. These same complaints can be traced back to 1835, when the first penitentiary was built in Canada.[172] At EMDC, complaints were made shortly after it was built

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169 *Ibid.*

170 "FORUM on Corrections Research: Direct versus Indirect Supervision in Correctional Institutions" (last modified 5 March 2015), online: *Correctional Services Canada* <www.csc-scc.gc.ca> [perma.cc/8G9W-5V93].

171 *Ontario Public Services Employees Union v Ontario (Community Safety and Correctional Services)*, 2010 CanLII 38786 (ON GSB) at para 2.

172 "History of the Canadian Correctional System" (25 April 2019) at 2, online (pdf): *Correctional Services Canada* <www.csc-scc.gc.ca > [perma.cc/2GLP-4ZK3].

regarding the verbal and physical abuse of incarcerated individuals[173] as well as the unacceptable working conditions for correctional officers.[174]

The issues highlighted in this paper are just one small snapshot of the horrific conditions that prisoners and staff are forced to endure. They must work and live in this unsanitary, unconscionable, and unforgiving environment where survival of the fittest is a prisoner's bible. "Correctional institutions control the most basic aspects of an individual's life."[175] This environment can also dictate the rest of their lives. This phenomenon is experienced by prisoners and correctional officers alike, such as James Pigeau, who never recovered from witnessing Adam Kargus' murder and Don Roman, who still lives with PTSD from his experiences working at EMDC.

It is unacceptable that in Canada, a free and democratic country known for its high quality of living, individuals are forced to live and work in conditions like this. It is absurd that in a country that recognizes the rule of law as the foundation of our society, there are government-run facilities in Ontario that operate entirely outside its bounds. As discovered during the investigations into deaths at EMDC, there are very few rules in Ontario correctional institutions and no one to enforce their compliance.

The Ministry needs to take meaningful action and actively work to implement the numerous recommendations from coroner's verdicts and

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173 See *Simpson v Ontario*, 2010 ONSC 2119. In February 1996, 40 youth were transferred to EMDC during a riot at the Bluewater Youth Centre in Goderich, Ontario. These youth were "subjected to excessive force and intimidation under a number of circumstances: during the admission process, they were verbally and physically intimidated, prodded, struck, kicked, humiliated, many of them sustaining injuries" (*ibid* at 326). The Chief Advocate in the Office of Child and Family Advocacy for Ontario conducted a report on the experiences of the youth and released a report describing the youth's treatment. Rather than dealing with the underlying issues at the facility, the Ministry successfully sued for defamation for releasing the report to the media. Fifteen years later, the Ministry provided a similar response in their response to the death of Adam Kargus.

174 *Elgin Middlesex Detention Centre v Ontario (Ministry of Labour)*, 1995 CarswellOnt 5124 at paras 6–7. An Occupational Health and Safety Officer was called to EMDC to investigate a work refusal by a correctional officer. During this hearing, it was determined that the chairs that EMDC staff were expected to use were broken, soiled or very worn, and the superintendent ordered new chairs that caused back pain for this correctional officer. Also of note is that even in the 1990s, EMDC was stated to have an inmate capacity of 500.

175 Ministry, *Directions for Reform*, *supra* note 1 at 2.

academic scholars writing on prison reform. How many fires does the Ministry need to put out before it realizes its errors? How many more avoidable prisoner deaths must occur before the Ministry finally begins its work for change? The Ontario government made the first steps towards addressing some of these issues when they hired an independent advisor on corrections reform.[176] Yet, his reports sit on shelves collecting dust, and the legislation they inspired will never come into force.[177]

There are many practices at Ontario correctional institutions that violate international conventions, the *Charter,* and the *Human Rights Code*[178]. The Ministry's use of prolonged segregation or placement of individuals with mental illness in segregation is a cruel and unusual punishment contrary to s. 12 of the *Charter*.[179] The frequency and duration of lockdowns due to staff shortages similarly violate s. 12.[180] The overcrowding, unsanitary/dangerous conditions, failure to accommodate individuals with mental health concerns, and overuse of segregation and lockdowns violate the *Mandela Rules*.[181] The Ministry's failure to accommodate the unique needs of prisoners with mental health disabilities or addictions, as well as religious and cultural practices, are human rights violations.[182] The Ministry is aware of these violations, yet it has failed to take meaningful steps towards addressing them.

The first essential steps for reform were clearly laid out by the independent review team on Ontario corrections in September 2017.[183] This report included 62 recommendations that focused on five themes: human rights and correctional operations; corrections and the presumption of innocence; evidence-based correctional practice; Indigenous people and Ontario corrections; and health care services and governance in corrections.[184] Overall, these recommendations were focused on the

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176 Ministry, *Independent Review*, *supra* note 31.

177 The PC Government dismissed Howard Sapers in December 2018, and the *Correctional Services and Reintegration Act, 2018,* SO 2018, c 6 received royal assent, but the Lieutenant Governor never declared the day for it to come into force. See White, *supra* note 39.

178 RSO 1990, c H.19.

179 *Francis*, *supra* note 120 at paras 327–47.

180 *Ogiamien*, *supra* note 147 at para 245.

181 OHRC, "Letter to Solicitor General Jones", *supra* note 10.

182 *Ibid*.

183 Ministry, *Directions for Reform*, *supra* note 1.

184 *Ibid* at 2.

Ministry devoting financing, hiring, and training to create policies and programs to improve the quality of life and care of Ontario's prison population.[185] While providing rights in Ontario correctional institutions is "an essential component of a healthy and safe Ontario,"[186] the Ministry has made very few efforts to act on these recommendations.

The same can be said about the Ministry's apathetic attempts to act on juries' recommendations for reform at EMDC. In March 2020, a coroner's verdict clearly laid out the steps that need to be taken.[187] First, EMDC needs to be replaced with a modern facility with its own infirmary and adequate space for incarcerated individuals to achieve rehabilitation and reintegration.[188] Next, the Ministry should install electronic monitoring devices[189] and ensure that correctional officers comply with the Ministry's operational procedures.[190] Finally, to assist in the battle against drugs in custody, the Ministry should install more scanning equipment, ensure officers perform both regular and thorough searches for contraband, and create policies to restrict staff from bringing anything but essential items into EMDC.[191] The Ministry has not responded to this verdict.

While the creation of a modern facility would be a drastic improvement for the lived experience of incarcerated individuals and EMDC staff, it will not be enough to sustain Ontario's ever-growing prison population. As briefly discussed above in the "Final Thoughts on the Drug Problem in Ontario Correctional Institutions" section, Ontario's policy reform should be focused on implementing and funding community-based alternatives to incarceration.

As Ontario's remand population comprises approximately 63% of all incarcerated individuals,[192] decreasing this population is imperative for addressing the overcrowding, double-bunking, and understaffing that plague Ontario correctional facilities. Parliament's introduction of Bill C-

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185 *Ibid* at 219–20.

186 *Ibid* at 220.

187 *Coroner's Verdict –Deleary & Thompson, supra* note 25.

188 *Ibid* at paras 31–34.

189 *Ibid* at paras 37–38.

190 *Ibid* at para 57.

191 *Ibid* at paras 39, 53–56.

192 Statistics Canada, *Adult admissions to correctional services*, Table 35-10-0014-01 (Ottawa: Statistics Canada, last modified 16 May 2021), online: <www150.statcan.gc.ca> [perma.cc/JYR7-S42V].

75 attempted to address some of these concerns with its amendment of the *Criminal Code* bail provisions and affirmation of the ladder principle.[193] While these amendments are an important step in depopulating Ontario jails, they are but one of many steps required to address the systemic failings of Ontario correctional institutions.

Until the Ministry begins its work towards meaningful change, prisoners of Ontario correctional institutions will be forced to rely on litigation and class actions to receive compensation for their horrible experiences. One such class action has been filed by a group of prisoners at EMDC, alleging they endured threats, assaults, inadequate medical attention, and overcrowding and that their experiences were shared by a host of other individuals.[194] Another former-EMDC prisoner reached an out-of-court settlement with the Ministry after being beaten within inches of his life during his 40-day sentence at EMDC in 2004.[195]

While it is hopeful that class actions and civil litigation will provide a form of justice for some incarcerated individuals, there are still many other incarcerated individuals that deserve retribution. As a free and democratic society, Canada has a duty to protect the rights of all citizens, whether or not they are incarcerated. Correctional institutions are secluded by their very nature and are not accessible to the public eye. Therefore, it is up to the state to protect the rights of incarcerated individuals.

There is little hope that the rule of law will implement itself without assistance from Parliament and courts,[196] and one cannot simply wait for corrections' oversight mechanisms to transform.[197] Meaningful changes need to happen in both the development of Ontario corrections policies, as

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193 Department of Justice, "Legislative Background: *An Act to amend the Criminal Code, the Youth Criminal Justice Act and other Acts and to make consequential amendments to other Acts*, as enacted (Bill C-75 in the 42nd Parliament)" (Ottawa: DOJ, 9 September 2019), online: <www.justice.gc.ca> [perma.cc/4GLM-8D8P].

194 "The EMDC Class Proceeding – Update" (2 December 2019), online: *McKenzie Lake Lawyers* <www.mckenzielake.com> [perma.cc/RUS7-BXZ6].

195 Bryan Bicknell, "Former EMDC inmate reaches settlement over jailhouse beating", *CTV London* (22 November 2019), online: <london.ctvnews.ca> [perma.cc/S9SW-ZEZV].

196 Canada, *Commission of inquiry into certain events at the Prison for Women in Kingston* (Report), Catalogue No JS42-73/1996E (Ottawa: Public Works and Government Services of Canada, 1996) (Louise Arbour, Commissioner), online: <publications.gc.ca/pub?id=9.831714&sl=1> [perma.cc/KF3J-LECZ].

197 Adelina Iftene, *Punished for Aging: Vulnerability, Rights, and Access to Justice in Canadian Penitentiaries* (Toronto: University of Toronto Press, 2019) at 144.

well as the correct and meaningful implementation of these policies. This paper demonstrates, through the prism of one institutional setting, why change is so vitally needed and that the roadmap for that change is so readily available.