MANITOBA OMBUDSMAN

Ombudsman Act:

Inquest Recommendation Monitoring Report

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Available in alternate formats upon request

Mailing address:	Manitoba Ombudsman 5 – 300 Donald Street Winnipeg, MB R3L 2T4
Phone:	204-982-9130
Toll-free phone:	1-800-665-0531
Email:	ombudsman@ombudsman.mb.ca
Website:	www.ombudsman.mb.ca

INQUEST RECOMMENDATION MONITORING REPORT UNDER

THE OMBUDSMAN ACT

FILE #MO-00605 / 2019-0622

MANITOBA JUSTICE – CORRECTIONS DIVISION

BACKGROUND

The Honourable Judge Christine V. Harapiak issued an inquest report into the death of Freeman Zong on December 11, 2019. Judge Harapiak's report describes how Mr. Zong had multiple contacts with the medical system, police and corrections in the months leading up to his death. He had been diagnosed with post-traumatic stress disorder and told his assessor he was using substances to cope with the death of his mother.

Police responded to a 911 call on July 11, 2016 after a family member called because Mr. Zong had discharged a firearm and threatened to harm himself. As one officer suspected he was trying to provoke a fatal confrontation they backed off at which time Mr. Zong fled and was taken into custody after a foot chase.

After receiving medical attention for a self-inflicted injury, Mr. Zong was admitted to the Dauphin Correctional Centre and ranked at medium suicide risk. When he saw the nurse the next day, Mr. Zong told her that he did not want to live but assured her he would keep himself safe. Three days later, on July 14, 2016, Mr. Zong was found deceased in a shower area of the Dauphin Correctional Centre. After a series of upsetting telephone calls Mr. Zong hanged himself from a vent in a blind corner of the washroom. It took 56 minutes for his body to be discovered.

Judge Harapiak's report notes that over time, Manitoba Corrections developed policies to minimize suicide risk through heightened supervision and ongoing interaction and communication. This is achieved, in part, through suicide prevention training and compliance with specific policies. The inquest found multiple gaps in implementation of these policies when Mr. Zong died.

At the time of Mr. Zong's death, Dauphin Correctional Centre was the oldest correctional centre in Manitoba. In her report, Judge Harapiak noted correctional officers could not always visually observe persons held at the centre because of the building's design, which was outdated compared to the other provincially run correctional centers. The Government of Manitoba closed this facility on May 26, 2020. At the time of its closure, the responsible minister indicated the building was in poor condition and the ageing infrastructure did not meet modern standards.

Some of the responses to the recommendations reflect that the facility is no longer in operation.

MANITOBA OMBUDSMAN ROLE

It is the role of Manitoba Ombudsman to monitor and report on the implementation of inquest recommendations when they relate to a provincial public body subject of the Ombudsman Act. Our monitoring and reporting process supports transparency and promotes accountability in provincial public systems. Following an inquest, we help bridge the gap between public service providers, affected families, and the public.

RECOMMENDATIONS AND RESPONSES

The Honourable Judge Harapiak's recommendations, Manitoba Justice's responses provided to us, and our assessment of the implementation status of each recommendation, are provided below.

Recommendation One
Assign Case Manager who will be on shift within 24 hours of admission.

We assessed this recommendation as implemented.

Manitoba Justice provided the following response to this recommendation:

> This recommendation is accepted and was implemented on January 3, 2020. Excerpt from Standing Orders address this recommendation below:
> Revised Standing Order – 5.1 – Case Management - Management & Supervision
> 11. The case contact process is supervised by the Shift Operations Manager (SOM) and/or Assistant Superintendent of Programs;
>
> 11.1 All inmates shall be assigned a Case Management Officer (CMO) ***that will be on shift within 24 hours upon admission*** by the SOM / Top Floor Supervisor or designate;
>
> Shift Operations Manager Review
> 17. The shift operations manager (SOM) will be responsible for completing a thorough file review within 24 hours of admission and ensure correct placement and urgent concerns

have been addressed. The SOM should also ensure that supervision is correctly identified according to the tier system. If an LS/CMI has not been completed, the inmate is to be supervised at a tier 3 level;

17.1 The SOM and Top Floor Supervisor will ensure assigned CMOs are completing case contacts in a timely fashion according to the tier that has been assigned to the inmate. Any CMOs that are not making the case contacts according to the tier system will need to be addressed. A second incident will require the SOM to refer the CMO to the Assistant Superintendent of Programs and direction will be given.

17.2. The SOM will consult with the Assistant Superintendent of Programs /Designate to discuss changing the supervision level of an offender.

Recommendation Two

Immediately move to change the remaining vents to security grade vents.

We assessed this recommendation as implemented.

Manitoba Justice provided the following response to this recommendation:

> This recommendation is accepted and implemented. The project was completed on October 17, 2019.

Recommendation Three

Revise both the title of the *Security Punch Round Reference* and everyday usage to include reference to well-being of inmates (and examples of how to query this) rather than punches to routinely remind officers of the most important core purpose of the rounds. A possible example might be *Well-being and Security Round Reference*. The physical act of punching in should be designated as a task, not stand in as the purpose of the round.

We assessed this recommendation as implemented.

Manitoba Justice provided the following response to this recommendation:

> This recommendation is accepted and implemented on January 3, 2020. Revised Standing Order 10.7 to reflect "Inmate Wellness and Security Round Inspections" – language changed throughout standing order to include reference to the well-being of inmates.

Recommendation Four

Revise the Adult Suicide Prevention Standing Order to clarify and specifically identify position responsible for ensuring Safe Plan and Keep Safe cards are completed for SUM [medium suicide risk] and SUH [high suicide risk] inmates.

We assessed this recommendation as implemented.

Manitoba Justice provided the following response to this recommendation:

> This recommendation is accepted and implemented on June 3, 2019.
>
> Standing Order 3.1 - Adult Suicide Prevention Section 3.5 - Admissions Officer – responsible for completing the initial safe plan for all inmates classified as SUM / SUH. Advise the SOM of Suicide Risk Level.

Recommendation Five

Have Correctional staff communicate with all phone contacts requested by inmates with noted suicide risk before placing these contacts on an approved telephone list.

We assessed this recommendation as implemented with an alternate solution.

Unsupervised access to the telephone was an important factor in the chronology of events leading up to Mr. Zong's death. Immediately prior to his suicide, it was reported that he had a series of upsetting phone calls. Judge Harapiak noted it would be helpful to develop a protocol to consider what contacts should be approved for the at-risk inmate's phone list considering the unsupervised access to telephones that inmates have.

The department noted the recommendation as written could not be implemented because the current inmate telephone system does not allow contact lists, like the previous system in place at the time of Mr. Zong's death. The department pointed to technological and logistical limitations of the current inmate telephone system.

Manitoba Justice provided the following response to this recommendation:

> This recommendation could not be implemented. The current Synergy phone system does not have the capacity to create an approved phone list or otherwise restrict who an inmate can call, except where a specific phone number is restricted/blocked. Unless a specific [phone] number is restricted, the inmate can call anyone. The phone call is prefaced by the system identifying the inmate and the Correctional Centre where the call is originating from, to the receiver of the call.
>
> Our previous inmate phone system (during the time of Mr. Zong's incarceration at Dauphin Correctional Centre) had an approved telephone list where staff would verify

> that the caller wanted to receive a call from the inmate. In theory, subject to verification of privacy concerns, staff could have identified suicide concerns.

Despite these limitations of the current inmate telephone system, in July 2023, the Department advised us there is an ongoing assessment process to monitor the well-being of inmates on suicide watch. Divisional policy requires Corrections staff to continually interact and provide support to inmates and observe and report their behaviour.

We heard staff are expected to provide close monitoring during and after a phone call and are in direct contact and line of sight when the inmate is on the phone. Staff are trained to monitor demeanor and any change in behaviour. Correctional centres use observation logs where officers make entries throughout the day, including documenting phone calls. Ongoing assessments can also include telephone monitoring in cases where inmates have threatened suicide.

Recommendation Six

Develop a simple checklist listing the key components of the Suicide Prevention Policy to be reviewed at least daily by all staff who interact with the at-risk inmate.

We assessed this recommendation as not implemented.

Manitoba Justice provided the following response to this recommendation:

> This recommendation is accepted however was not implemented before the closure of Dauphin Correctional Centre.

The Corrections Division implemented a revised Adult Suicide Prevention Policy in March 2024. We heard the divisional policies act as operational reference guides for correctional centres, and could be used as a checklist, but a checklist is not a directive from the division.

Our review noted the Division's revised suicide prevention policy includes an appendix with an easy-to-read chart outlining the minimum standards of interventions and supervision by suicide risk level. It lists the key interventions and the intervals at which they are required.

Recommendation Seven

Amend the Suicide Prevention Policy to require a recorded decision on whether the Peer Support Policy has been utilized before placing a SUM [medium suicide risk] or SUH [high suicide risk] inmate with other prisoners.

We assessed this recommendation as implemented with an alternate solution.

Manitoba Justice provided the following response to this recommendation:

> This recommendation is partially accepted however was not implemented before the closure of Dauphin Correctional Centre. Note that SUH inmates are not housed with other prisoners. The Division added language to the Adult Suicide Prevention Policy providing guidance on when it may be appropriate to consider establishing peer support for inmates assessed as medium suicide risk.

The Dauphin Correctional Centre's local, centre-specific suicide prevention policies included a peer support component. The policy was not revised prior to the centre's closure to require a recorded decision on whether the peer support policy had been used. For reasons outlined below, the department's Correctional Services Division-level policies did not include peer supports to inmates requiring suicide prevention supports.

The department highlighted that many inmates are struggling to manage their own mental health challenges. Officials expressed genuine concern about briefing inmates on the mental health status of a peer and asking them to provide peer support for suicide prevention when they themselves are living with various challenges of their own.

The department shared with us that with the elimination of direct lock-up (that is, eliminating intake of inmates to correctional centres without a remand warrant), combined with restorative justice and other measures to reduce the number of inmates in correctional centres, has resulted in a higher concentration of inmates with more complex needs and multiple diagnoses. The department identified that inmate peers are not always able to offer suicide prevention monitoring and supports to other inmates. The department identified a need for more professional supports to assist inmates who are at risk of suicide or self-harm versus a peer support model.

In June 2022, the department told us that the suicide prevention policy was under review as part of a regular review of all policies. The revised policy was finalized and implemented in March 2024.

CONCLUSION

Freeman Zong's death was a traumatic event for the other inmates and staff and resulted in several important changes at the Dauphin Correctional Centre prior to its closure, and to the Corrections Division adult suicide prevention policy. Physical changes were made to the vents in Dauphin Correctional Centre before. The Corrections Division reviewed its adult suicide prevention policy and changed how case managers are assigned to inmates assessed under the suicide prevention policy, and clarified who is responsible for developing the initial safety plan and communicating the assessed risk level and plan to others. Mr. Zong's death was also cited when the Dauphin Correctional Centre permanently closed.

We conclude our report by acknowledging that more work is needed to prevent suicides in correctional centres in Manitoba.

This report concludes our review of the matter.

Manitoba Ombudsman