

Amending the *Coroners Act* to Enable Annual Reviews of Non-natural Deaths in Correctional Institutions

Comment by the HIV Legal Network and HIV & AIDS Legal Clinic Ontario (HALCO)

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Introduction

The HIV Legal Network (Legal Network) promotes the human rights of people living with, at risk of, or affected by HIV, both in Canada and internationally, through research and analysis, litigation and other advocacy, public education, and community mobilization. Our work recognizes that fulfilling the right to health requires a firm commitment to human rights, particularly for populations disproportionately affected by punitive laws and criminalization. The HIV & AIDS Legal Clinic Ontario (HALCO) is a community-based legal clinic serving low-income people living with HIV. As the only such legal clinic in the country, HALCO has extensive experience addressing the day-to-day legal issues faced by this population, including human rights, health law, and prison issues.

Together, our organizations have a long history of advocating for the health and dignity of people in custody, recognizing that they do not surrender their fundamental rights upon incarceration. We have both participated in coroner's inquests exploring drug toxicity deaths in Ontario jails, advocating for evidence-based harm reduction and the principle of equivalency, i.e. the legal obligation to ensure people in custody have access to a standard of healthcare equivalent to that available in the community.

The Legal Network and HALCO oppose the proposed amendment to the *Coroners Act* that seeks to replace mandatory inquests for non-natural deaths in provincial and federal correctional institutions with mandatory coroner-led annual reviews. This proposal represents a significant erosion of transparency and government accountability. While the Ministry frames this change as an efficiency measure, it ultimately serves to further obscure deaths in custody and increases the risk of future preventable harms.

The Ministry's Stated Objectives

The Ministry of the Solicitor General (the "Ministry") justifies this legislative shift by citing several intended benefits. However, we contend that these objectives are either currently achievable or based on a mischaracterization of the systemic failures within the correctional system, which the proposed amendment will not correct.

I. Identification of Systemic Issues

The Ministry claims the annual review approach will better identify systemic issues underlying deaths in provincial and federal institutions. However, this function is already the core mandate of the mandatory inquest process, which brings all interested parties together to examine the circumstances of a death and

answer critical factual questions.¹ As the Appendix below confirms, systemic recommendations have been made in the context of numerous inquests, including those in which we have participated. If systemic issues remain unresolved, it is due to the opacity of the correctional system, which consistently masks contributing factors to a death, rather than a failure of the current inquest model itself. Moving to a review-led committee model risks further concealing systemic harms. Furthermore, an annual review process could always be established as a supplement to — rather than a replacement for — mandatory inquests. Such a review would be significantly more effective if informed by the robust, public-facing evidence currently available through the mandatory inquest process.

II. Timeliness and Repetitive Recommendations

The Ministry asserts that annual reviews will provide "timely, practical and implementable recommendations" while reducing the likelihood of repetitive recommendations. We submit that the repetitive nature of jury recommendations is a symptom of the Ministry's failure to act. Between 2018 and 2024, several inquest juries were forced to repeat numerous life-saving recommendations — such as the broader application of Good Samaritan principles, because the Ministry systematically ignored previous recommendations detailed in the Appendix below. If recommendations were actually implemented, the administrative "burden" of repetition would be naturally resolved. Moreover, the government already possesses the tools to avoid redundancy through joint inquests, when multiple deaths at the same institution are examined together, when they "appear to have occurred in the same event or from a common cause."²

III. Addressing Participant Challenges

The Ministry cites the re-traumatization of participants and the negative impact of time on witness recall as reasons for the shift. While these are valid concerns, the proposed remedy of an annual review diminishes the rights of the deceased and their families. Replacing a public, independent inquest with an internal review process reduces the ability to establish a clear, public record of the facts. Furthermore, the proposal places the onus on grieving families to request an inquest if they are dissatisfied with the review, creating an additional administrative and emotional burden. The most effective and humane way to address participant challenges would be to implement existing inquest recommendations to reduce the overall frequency of deaths in custody, thereby preventing harm and trauma at its source.

Enforceability and Public Confidence

The shift to an annual review process modelled on the Construction Death Review lacks the weight and transparency of a public inquest. Inquests serve the public interest by scrutinizing individual deaths, in a transparent forum, yielding findings that serve as a vital guide for correctional authorities. The proposed

¹ See, *Coroners Act*, RSO 1990, c C.37, s. 4(b).

² *Ibid*, s. 25(2).

annual reviews risk becoming a closed-door administrative exercise with recommendations that the Ministry continues to ignore with impunity. It remains unclear how public interest organizations, such as the Legal Network or HALCO, could be meaningfully engaged in an internal annual review to ensure accountability. Without the pressure of a public jury verdict, the systemic factors currently causing toxic drug deaths and suicides in prison will only persist.

Conclusion

The Legal Network and HALCO urge the Ministry to abandon the proposed amendment and focus instead on the immediate implementation of existing inquest recommendations. True reform requires prioritizing life, health, and dignity above the streamlining of administrative burdens.

Appendix: Systemic Implementation Failures across Four Inquests (2018-2024)

The following table tracks some key recommendations that have been issued repeatedly by different juries because the underlying systemic failures remain unaddressed by the Ministry.

Priority Area	Hamilton-Wentworth Detention Centre Inquest (2018)	Elgin-Middlesex Detention Centre Inquest (2020)	Niagara Detention Centre Inquest (2024)	Hamilton-Wentworth Detention Centre (2024)
Principle of Equivalency	Establish care plans compatible with community health services.	Review all policies to ensure adherence to the principle of equivalency.	Inform healthcare recruitment with community-equivalent training standards.	Adopt the collaborative, multi-disciplinary model of care used in the community.
Zero-Tolerance Policy	Prioritize medical response over security for suspected overdoses.	Abandon zero-tolerance policies as they stigmatize medical issues.	Abandon zero-tolerance policies for substance use and simple possession.	Amend the "Zero Tolerance" policy to provide immunity for life-saving disclosures.
"Good Samaritan" Principles	Include Good Samaritan principles in Information Guides for people in custody.	Adopt principles so people calling for help are not subjected to misconduct.	Adopt and be guided by Good Samaritan principles in all operational policies.	Adopt principles and provide immunity against institutional charges for life-saving disclosures.
Non-Punitive Harm Reduction	N/A	Take a non-punitive, harm reduction approach to substance misuse.	Review enforcement to ensure it does not deter access to harm reduction.	Discourage punitive consequences in favour of treatment options.
Direct Naloxone Access	N/A	N/A	Provide direct access to naloxone for people in custody, including in cells.	Equip all officers with naloxone kits to carry on their person; make naloxone directly accessible to people in custody.
Healthcare Privacy	Assessments should occur in the absence of correctional staff.	Ensure space permits private interactions with nurses/counsellors.	Admission assessments must be conducted in a manner that maintains confidentiality.	Amend policy to require patients be advised of their right to privacy.