RELEASE DATE: December 17th, 2019

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***The Fatality Inquiries Act,*** **C.C.S.M. c. F52**

AND IN THE MATTER OF: **An Inquest into the Death of**

FREEMAN THOMAS GUSTAVE ZONG

Report on Inquest and Recommendations of
The Honourable Judge Christine V. Harapiak
Issued this 11th day of December, 2019

APPEARANCES:

Counsel to the Inquest: Alan Semchuk
Sean Boyd, Corrections Counsel
Jim Koch, Corrections Counsel
Danielle Barchyn, Counsel to Drs. Smith, DuToit and Kish

Manitoba

THE FATALITY INQUIRIES ACT, *C.C.S.M. c. F52*

REPORT BY PROVINCIAL JUDGE ON INQUEST
RESPECTING THE DEATH OF:

FREEMAN THOMAS GUSTAVE ZONG

Having held an inquest respecting the death of Freeman Thomas Gustave Zong on March 8th and April 1st – 5th, 8th – 12th, 29th, and June 26th and 27th, 2019 with final submissions being received August 16th, 2019 at the City of Dauphin in the Province of Manitoba I report as follows:

The deceased came to his death on the 14th day of July, 2016 at the City of Dauphin in the Province of Manitoba by asphyxiation by hanging.

This report contains my findings and recommendations after my review of evidence and submissions by Inquest Counsel and Counsel for Corrections.

Pursuant to the provisions of section 33(3) of *The Fatality Inquiries Act*, I am ordering all Exhibits deposited with the Exhibit Officer, Provincial Court of Manitoba, to be released only upon application with notice to any party with a privacy interest.

Dated at the City of Dauphin, in Manitoba, this 11th day of December, 2019.

"Original signed by"
Judge C. V. Harapiak

Copies to: ME
CJ
Minister
DM
ADAG
Inquest Counsel
Counsel for Corrections
Counsel for Doctors
Aimee Fortier, Executive Assistant and Media Relations, Provincial Court
Exhibit Coordinator, Provincial Court

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Inquest Report
Freeman Thomas Gustave Zong
Date of Death: July 14th, 2016

1.) INQUEST MANDATE AND PARTIES WITH STANDING

[1] This inquest is required by s. 19(5)(b)(ii) of *The Fatality Inquiries Act* because Mr. Zong's death occurred while he was resident in a custodial facility.

[2] On December 13th, 2017 Acting Chief Medical Examiner Dr. John K. Younes directed an inquest be held into the circumstances of Mr. Zong's death:

i) to fulfill the mandatory requirement;
ii) to determine the circumstances related to Mr. Zong's death; and
iii) to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[3] Pursuant to s. 28(1) of *The Fatality Inquiries Act,* people who are "substantially and directly interested in the inquest, may attend the inquest in person or by counsel and may question witnesses called at the inquest." Mr. Zong's family was notified of their right to apply for standing but chose not to participate in person. To meet the requirements of this section a standing hearing was held on July 25th, 2018 and the following parties were granted standing:

- Manitoba Corrections
- Dr. Riley Smith
- Manitoba Association of Rights and Liberties

[4] Standing was again addressed on March 8th, 2019. It came to the court's attention that when the individual seeking standing on behalf of MARL did so she did not have current authority. Although the individual sought, alternatively, standing as a private individual who had worked within the Corrections system, the Court found this did not constitute a substantial and direct interest in the inquest and the earlier standing granted was revoked.

[5] Standing was addressed on two more occasions – April 1st, 2019 and June 26th, 2019. Evidence related to interactions Mr. Zong had at the Dauphin Hospital with Dr. Linda Du Toit and Dr. Scott Kish arose. Both doctors were granted standing and Ms. Barchyn represented all three doctors.

2.) CAUSE, MANNER & CIRCUMSTANCES OF MR. ZONG`S DEATH

[6] Freeman Zong's family was worried about him on July 11th, 2016. He had been abusing drugs and alcohol and had been threatening self-harm. He discharged a gun at his girlfriend and pictures were posted to his Facebook page of a cut to his arm and a message suggesting he wanted to die. The police responded to a 911 call and were let into his home by his brother, Fraser Chartrand, who said Zong was threatening to shoot himself. The officers found Zong aggressive, armed with a knife and uncooperative. 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.

[7] After a hospital visit to stitch up his arm Mr. Zong was admitted to the Dauphin Correctional Institution – ("DCI"). Although Mr. Zong denied feeling suicidal, the admitting officer ranked him a medium risk (SUM) due to concerning information in the Prosecutors' Information Sheet. When he saw the nurse the next day, Mr. Zong told her that he did not want to live due to a Hep C diagnosis and the prospect of a potentially lengthy sentence, but assured her he would keep himself safe.

[8] Mr. Zong took the stitches out of his arm later that day and returned to the hospital on the 14th to have his wound treated again. None of the officers who had direct contact with him that day suspected he was at immediate risk of self-harm. He spoke about trying to be a better role model for his brother, and seemed future oriented.

[9] After a series of upsetting telephone calls subsequent to his return from the hospital Mr. Zong went into his cell, fashioned a ligature out of the bottom of a bedsheet, turned on the shower and, behind a blind corner in the washroom, hanged himself from a vent. It took 56 minutes for his body to be discovered.

[10] The risk of suicide in institutions is a grim reality and Manitoba Corrections, over the years, and partly in response to far too many deaths such as this one, has developed policies to minimize this risk by heightened supervision and communication – keeping careful watch and offering inmates hope that their situations will improve. This is achieved, in part, through suicide prevention training and compliance with very specific policies. There were multiple gaps in the implementation of these policies with Mr. Zong.

[11] The telephone calls Mr. Zong had with family members shortly before his death highlighted their concern for him. Although he specifically denied any acts or thoughts of self-harm his father's response to this denial was telling and a sad testament to the family's view of his mental health at the time - "at least you'll be safe there." My deepest regret and sympathies to all of them that this was not to be the case.

3.) EVIDENCE

[12] I will review the evidence received chronologically. This review is not exhaustive. For example, many correctional officers testified about Mr. Zong's time at the Dauphin Correctional Institution and the standard and emergency care he received there. There is some inevitable duplication in this evidence and I have not repeated it all here, but rather tried to focus on the unique perspectives different individuals had to offer the inquest to ensure a coherent narrative of Mr. Zong's final days.

Zong`s Recent Mental Health History

[13] Mr. Zong had multiple contacts with the medical system, the police and Corrections in the months leading up to his death. Dr. Riley Smith saw him at the Dauphin Medical Clinic November 2nd, 2015 for a complaint of depression. Mr. Zong was adamant that he was not suicidal at that time and agreed he had no plan to harm himself. He was referred to a psychiatrist but did not keep that appointment.

[14] In December, 2015 Mr. Zong was brought into hospital after cutting himself. He threatened further self-harm if sent back to jail. Dr. Smith referred him first to a mental health worker and then for a psychiatric assessment. The attending psychiatrist Dr. Omodunbi authorized his transfer to The Pas Hospital for a crisis mental health admission.

[15] Mr. Zong's most recent release from the Dauphin Correctional Centre was June 23rd, 2016.

Pre-Arrest

[16] On July 11th, 2016 Freeman Zong's Facebook account showed several entries suggesting he was going to harm himself; a message of self-harm at 9:19 p.m. and a picture of a man's forearm with a laceration and blood drops on the floor beneath it at 9:20 p.m. His brother Fraser Chartrand advised the police that Mr. Zong had been cutting himself and threatening to shoot himself. Taylor Mancheese, Zong's girlfriend at the time, testified he also fired a sawed off shotgun at her that night, leaving a bullet hole in the couch and the wall, missing her by about 6 – 8 inches; leaving her shaken and with ringing ears. Ms. Mancheese remembered Fraser Chartrand trying to take the weapon away from Mr. Zong and claimed that Mr. Zong was "always using" drugs at the time, including by intravenous injection.

Response to 911 Call

[17] Constable Dale Hamm responded to the 911 call. He arrived at 9:41 p.m. along with Corporal Dewar and Constables Ultra and Mellor, meeting Fraser Chartrand outside. Chartrand allowed the officers access to the house. Hamm watched Corporal Dewar enter the residence and call out for Mr. Zong, who began walking down the hallway with his hands behind his back. Hamm could see a knife and yelled out a warning "knife knife knife!" Hamm drew his weapon and kept it at the low ready position. The officers retreated when Mr. Zong refused to comply with the direction to show his hands. At this point Hamm holstered his weapon and took out his taser. While the officers regrouped Zong fled through a window leading to a foot chase. Upon arrest Hamm noticed Mr. Zong had a cut on his arm.

[18] Corporal Dewar took the lead in dealing with Mr. Zong, stepping into the residence. He called out for him, saying that Fraser said he needed help and that the police were there to help. Mr. Zong told him to get a warrant. Dewar saw the knife behind Mr. Zong's back when he started down the hall as well and called out "knife!" The Corporal drew his pistol and directed Mr. Zong to drop his knife. He did not, but kept advancing. Corporal Dewar's impression was that "he wanted me to shoot him." The officers retreated from this escalating situation and Mr. Zong slammed the door shut. The officers moved to reposition themselves in order to contain the residence but before they could Mr. Zong fled and was quickly apprehended.

Investigating the Scene

[19] Corporal Dewar immediately recognized this situation as mental health related and moved to ensure medical review of Mr. Zong as to his fitness for incarceration. He had further discussions with Mr. Chartrand, who took him through the house and pointed out the droplets of blood from Mr. Zong's self-inflicted wound, a blood-stained knife in the sink that Mr. Zong had used to cut himself, and the hole in the couch and the wall caused by Mr. Zong firing the sawed off shotgun.

[20] Constable Ultra was part of the team that responded to the 911 call. He observed Zong approach the door with his hands behind his back and refuse to comply with police commands. When Hamm yelled "knife knife knife" Ultra drew his service pistol and kept it in the down low position – not pointed at anyone. He saw drops of blood on the deck, leading into the house and throughout the interior. A few minutes after Zong slammed the door on the officers Ultra noticed him running away. He called for him to stop and gave chase when he did not comply.

[21] Once Mr. Zong was in custody and enroute to the hospital Constable Ultra searched for the knife with Corporal Dewar. After advice from Mr. Chartrand that Mr. Zong liked to

hide the gun in the garbage can a sawed off shotgun, wrapped in duct tape, was found underneath the plastic bag in the kitchen garbage can.

At the Hospital on July 11th

[22] Constable Hamm**,** meanwhile, had transported Mr. Zong to the hospital for assessment and treatment of his mental health and injuries. He stayed with Mr. Zong when he saw the doctor and received several stitches to his arm. During treatment Mr. Zong refused to say how he got the injuries and denied ever having a knife. He told Hamm that he had put his arms through a window.

[23] Dr. Kish treated Mr. Zong during a 20 minute visit. The Nursing notes show that Mr. Zong "made cut to right arm today." The emergency record indicates that Mr. Zong had three knife wounds to his right forearm, the largest being a 5 cm laceration. The cuts were cleaned, sutured or glued and Mr. Zong was sent on his way with the RCMP. Dr. Kish noted, in testimony, that if Mr. Zong had been noted as a suicide risk he would have still been sent with the RCMP due to his intoxicated state and then brought back in the morning for a mental health consult when sober. No suicide risk was noted so these steps were not taken.

At the Detachment July 11 – 12th

[24] Mr. Zong then traveled to the RCMP detachment in Dauphin where he was fingerprinted and processed and remanded to the care of DCI. Constable Hamm noted that if the Prosecutors' Information Sheet ("P.I.S.") is completed when a prisoner is transferred they will send it over with the person.

Admission to DCI July 12th

[25] Corrections Officer ("CO") Max Jordan was working the day shift on July 12th when Mr. Zong arrived along with a P.I.S. detailing his attempts at self-harm the day before. There was concerning material in the P.I.S. It bears repeating at length:

> On July 11th, 2016 at 9:35 pm, Dauphin RCMP received a report through 911 from B.S. that the people living at X were shooting and cutting themselves.
>
> At 9:41 pm, police attended the location. A male identified as Fraser CHARTAND, as he is known to police, came to the residence and advised that his brother, Freeman ZONG, has been cutting himself and was going to shoot himself. ZONG is familiar to police as he is a known offender. CHARTRAND was concerned for his brother and wanted police to check his wellbeing. Drips of blood can be observed on the

> back patio heading towards that back door. CHARTRAND advised that no one else was in the residence except ZONG.
>
> CHARTRAND opened the back to let the police in and ZONG approached the back door. ZONG had his hands behind his back as he faced the police while in the house. ZONG was asked to show his hands and to exit the house but he was not compliant. Police saw ZONG holding a knife in his hands. Police told ZONG to drop the knife and to put his hands where the police could see them. ZONG again refused to comply and kept advancing towards the police with the knife in his possession. Police told him that he was under arrest and again told to drop the knife. ZONG kept advancing towards the police eventually making it to the door. ZONG then slammed the door, locking himself in.
>
> A few minutes after shutting the back door, ZONG was seen ducking inside a neighbour's fence and running away from the police to avoid being arrested. A foot pursuit ensued south bound through the yards of residences. ZONG was then arrested for possession of weapon dangerous for public and handcuffed. He was read his *Charter of Rights* and police warning while in the back of a police vehicle. He indicated he understood and wished to call a lawyer. ZONG was transported by police to the Dauphin Hospital to receive medical attention for his cuts, injuries on his forearm, and mental health.
>
> Other police members stayed to speak with CHARTRAND. He let police in the house. Drips of blood [were] observed in the hallways, kitchen, living room, bedrooms and basement of the house. CHARTRAND advised police that ZONG was going to shoot himself with a sawed-off shotgun. He showed the police a couch in the living room that has a bullet hole from the firearm. CHARTRAND wanted the firearm out of the residence as he is concerned that ZONG may use it. He guided the police to possible places where ZONG may have stored the firearm. CHARTRAND pointed out the garbage bin and was insisting it was there. Police searched the garbage bin and found the sawed-off shotgun. It was wrapped with aluminum tape and had an empty shotgun shell in the chamber. It was seized and taken back to the RCMP detachment. Police also seized a knife that CHARTRAND believed ZONG used to cut himself. It was located in the kitchen sink with blood on the blade.

[26] Mr. Zong's Running Record (which documents all events pertaining to an inmate) has an entry on July 12th at 3:21 p.m. documenting his admission and noting he had court on July 13th. Eighteen minutes later CO Jordan made another entry with the following noted under Urgent Offender/Community Concerns: to see medical re mental health, noting required separation from another inmate, and a no contact requirement for certain people in the community. The Running Record notes he was a 10 Medium Security Classification and a Medium (or SUM) suicide risk level.

[27] CO Jordan explained the process of security and suicide assessment. The Inmate Security Assessment requires the CO to assess the inmate's file and current charges. Depending on the current charges, history, past institutional behavior and history of

escape a security risk classification will occur. The officer has the discretion to over-ride that classification. In this case the risk was a medium and CO Jordan saw no need to interfere with that.

Suicide Risk Assessment

[28] Mr. Zong's suicide risk assessment was a combination of file review (*eg* was there confirmation of history of suicide attempts by himself or attempts or completions by significant others?) and interview. In order to be helpful, interviews require forthrightness. Mr. Zong made good eye contact, and denied any suicidal thoughts. Despite his assertions and the file contents which resulted in a low suicide risk rating, CO Jordan upgraded Mr. Zong's risk to Medium due to the concerning material in the P.I.S.

Standing Orders – Adult Suicide Prevention

[29] The Standing Orders on adult suicide prevention at the time directed that "all offenders assessed as medium and high risk of suicide will have an individualized safe plan. The plan should work with the strengths of the offender and offer hope that things can change for the better." This was not done with Mr. Zong. CO Jordan testified that high risk inmates have the added protection of a segregated room with more direct observation every 15 minutes and special clothing that is tear-resistant. He would not generally categorize someone high risk without visible depression or emotion, recent attempt in custody or expressed suicidal ideation.

[30] Part of the suicide policy requires direct personal observation and corresponding records to be made. These forms are kept convenient to the inmate's cell to ensure ease of recording checks. SUM designated inmates are to be checked every 30 minutes and each shift is to make fuller observations about meals, emotional status, social interaction, sleep and hygiene. These fuller observations for the shift from 6:30 a.m. to 6:30 p.m. on July 14th were not made for Mr. Zong. CO Helash, one of the Remand B day shift officers on July 14th, testified that there was no designated person responsible for completing these observations in July of 2016.

[31] One of the Correctional Officers' designated tasks in the Standing Orders is to "communicate the need for peer support with other offenders who may be housed in the same unit." The attached appendix suggests the following briefing points –

> * Watch for risk behavior and if, for an unexplained reason, his mood dramatically changes, especially if he no longer seems worried, concerned or cares.
> * Listen to what he says and the way he says it and let him talk about what is bothering him.

* Report anything that makes you feel uncomfortable and immediately if you believe his safety is at risk.

[32] Mr. Zong`s roommates were not briefed pursuant to the "peer support" system.

[33] The Standing Orders set out, as an appendix, Adult Minimum Standards of Intervention and Supervision for inmates with an assessed suicide risk. This document is attached as Appendix A to this report. For SUM inmates this includes a Safety Plan, a Keep Safe Card, a suicide prevention contact at least daily, Direct Personal Observation Records every 30 minutes and Suicide Prevention Reports every 12 hour shift. A suicide prevention contact is defined as an "interpersonal verbal communication/meeting with an offender to explore their current suicide risk." This was not done in Mr. Zong's case. I will return to the idea of minimum standards and how to operationalize them later in this report.

[34] Mr. Zong's admission process continued. By 3:57 p.m. on July 12th his Personal Identification Number ("PIN") for phone access had been approved with a single number on his list – his sister Frieda Chartrand's. The following morning a note was added that Mr. Zong slept most of the evening on July 12th other than to take some medication and talk on the phone for a few minutes. Although his voice was rough and he was apparently moving slowly when he walked he is noted as responding politely with short sentences when spoken to.

DCC Nursing Assessment July 13th

[35] Mr. Zong was taken to see Nurse Hancharyk as part of his admission process on Wednesday, July 13th around 9 a.m. Nursing staff were mandated to see SUM inmates every Monday, Wednesday and Friday. Hancharyk reviewed his SUM status and asked Mr. Zong if he had any current thoughts of wanting to hurt or kill himself. The health care assessment form notes that he had "no thoughts of suicide but doesn't want to live because of Hep C" and that he had "drank continuously since last release from custody." The Health Service Progress Notes expand on this - saying he felt depressed because of his Hep C diagnosis and his expectation that he would be in jail for some time, and requesting Wellbutrin, an anti-depressant he had been on in the past.

[36] This request, including reference to recent extensive drug use including heroin, morphine and oxycontin, was reviewed by the Corrections' Contract Physician Dr. Bretecher. Dr. Bretecher testified that, apart from the concerns about Mr. Zong's improper use of Wellbutrin in custody and resulting discontinuance, adding Wellbutrin to the mix of medications and drugs that Mr. Zong had in his body could have been quite dangerous for him. Wellbutrin, apparently, taken at higher than therapeutic levels, can act as a stimulant with a similar effect to cocaine. Dr. Bretecher advised that Mr. Zong had

refused other anti-depressants when offered drugs with less concerning properties in the past. Dr. Bretecher denied the request for Wellbutrin.

[37] Nurse Hancharyk recalled Mr. Zong contracting to safety – effectively agreeing not to harm himself. She took some time to educate him, in light of his concerns about Hep C being a death sentence, saying that "it is a curable illness." He responded that he would not take any pills for treatment because he knew people who had and had then developed liver cancer.

[38] The process, according to Nurse Hancharyk, for raising suicide risk level, is quite simple. If an officer has a concern the inmate can be moved up to a higher level of risk and supervision. Downgrading the status is more complex. She testified this is a collaborative process involving the nursing staff and the SOM. Hancharyk advised that she receives a 2 day ASSIST (Applied Suicide Intervention Skills Training Course) and a refresher course every 2 years.

[39] After his appointment with the nurse Mr. Zong was returned to Remand B. His suicide risk level remained SUM.

30 Minute Observations on SUM Inmates

[40] Every 30 minutes or so a security round is made of the building and the required check on SUM inmates is completed. Officers are required to electronically check (or "punch") in at certain points. One officer enters the inmate area and the other stands outside with keys. One of these electronic checkpoints is located inside the Remand B common area just outside the cell Mr. Zong was assigned.

Zong Pulls Out Stitches

[41] During the 8 p.m. "punch" on July 13th, 2016 CO Mark Wendling was the officer standing outside the cell area. He could see Mr. Zong from his vantage point and asked him how he was doing. He replied, "okay, but I just took my stitches out." CO Wendling noted that inmates sometimes take stitches out when "they think…the stitches have been in long enough." This, however, was a fresh wound. CO Wendling took Mr. Zong into the hallway and pointed out that it looked like he was trying to hurt himself. "Was there something else going on?" he queried. Mr. Zong laughed it off and said no, he simply didn't like the way the stitches looked.

[42] Mr. Zong was brought up to the Main Floor and Nurse Hancharyk was contacted about the stitches. She gave basic first aid direction and CO Colin Fisher put steri-strips on the wound to prevent deterioration before reassessing the wound in the morning. Mr.

Zong agreed not to pick at the wound. Fisher thought Mr. Zong appeared to be in good spirits that night.

[43] Early on July 14th the Running Record notes indicate that Mr. Zong requested a phone call, was observed interacting with other inmates and overall seemed in a decent mood.

[44] On July 14th Mr. Zong had breakfast at 7:30 a.m. Between the 10:30 and 10:45 checks he saw the nurse. Nurse Ogryzlo noted in Zong's Health Service Progress Report at 10:45 a.m. that he had "removed 5-6 stitches from right forearm" and would be sent to Outpatients to have the stitches re-stitched as she was concerned about possible infection. The nurse testified that it was unusual for inmates with fresh wounds to remove their own stitches and that best practice, in light of his suicide risk rating, would have been to ask him "if he was trying to self-harm." Although she does not recall asking that question, she testified that Mr. Zong told her that he had cut himself by putting his hand through a window. Ogryzlo found him to be quiet, very cooperative and not presenting as depressed.

Transport to Hospital

[45] After breakfast and his visit to the nurse Mr. Zong stayed in his cell until the scheduled medical escort at 11:30 a.m. Correctional Officers Mike Jestin and Trenton Beaulieu were tasked with this escort. CO Jestin was one of the officers assigned to Remand B on the 14th. He explained that Officers are to keep the escorted prisoner in view throughout treatment. He thought Mr. Zong was calm and passive during the escort and observed nothing that raised concerns about his mental health or would warrant a reclassification of his suicide risk.

Case Manager Assignment

[46] Each inmate is assigned a Case Manager and a backup Case Manager. CO Jestin was assigned to be Mr. Zong's case manager on July 13th, 2016 while he was on days off. He was unaware of this fact until after he initially testified at the inquest. Jestin testified that casework is usually done on night shifts as day shifts can be very busy with tasks such as remand, transport and medical escorts. Jestin testified that as many as six days can go by without discovering you have a new charge or being in a position to meet the person. In fact, he finds that "a lot of times…the inmate will notify you that he's on your caseload because he's asked, and other officers have gone and looked it up for him and tell him." The inmate will know before the responsible officer has been notified.

[47] Officer Joey Christianson was the assigned backup. He was scheduled for the 13th but the shift was cancelled for reasons unknown. The Shift Operations Manager ("SOM")

is to notify officers when they have a new inmate on their caseload by email, orally and on COMS. The Case Manager is to complete an Urgent Concern/Release Planning Document *as soon as possible* after admission. DCI Acting Superintendent Shewchuk indicated this is expected to be within a week but that this often happens with a couple of days. He conceded that the time frame could be clearer and that *as soon as possible* was open to multiple interpretations. Assisting an inmate to not lose hope is a complex and nebulous task. Having an officer take a particular interest in an inmate as soon as possible could result in the individual feeling more connected.

RECOMMENDATION: Assign Case Manager who will be on shift within 24 hours of admission.

[48] The SOM is required to complete "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 their tier system. If an LS/CMI has not been completed, the inmate is to be supervised at a tier 3 level." The LSI/CMI is a level of service/case management inventory which "measures the risk and need factors of offenders. It is also a case management tool that provides the information needed to aid professionals in the planning and management of offenders."

[49] Mr. Zong's most recent LSI/CMI was completed on May 11th, 2016, just months before his death. The assessment determined he had a 61% chance of being re-incarcerated within the year and touched, briefly, on self-harm. Mr. Zong told the assessor that "[s]ince the passing of his mother, [he] ha[d] taken to frequent abuse of prescription drugs mixed with alcohol. He explain[ed] it as a giving up type of attitude. At one point he stated that he wanted to end it all, but ended up self-harming instead." He had also been diagnosed with PTSD and been a victim of physical and emotional abuse and neglect in his childhood. He was recommended to be supervised at a Tier 5 level.

[50] CO Jestin testified that the Tier scale reflects the extent of programming that the case manager would be setting for the inmate. On a scale of 1 – 5, the lower end of the scale is usually reserved for first time offenders, who "you could reach the most" and the higher end of the scale would be reserved for inmates who had been in and out of custody for years and "would not require as much." The default position to supervise at Tier 3 would be followed unless the earlier LS/CMI was still valid; having been completed in the past year.

[51] There was a comparative report completed during Mr. Zong's May assessment which compared LS/CMI scores in 2012, 2014 and 2016. Although his score steadily climbed (32 – 37 – 40) he remained in the same risk category with an identical possibility of recidivism – 61%.

Second CO on Medical Transport

[52] CO Beaulieu said he had "watched Freeman grow up" in custody and had seen him mature since his mother's 2014 passing. Beaulieu recalled the conversation he had with Mr. Zong during the transport to be future oriented – he wanted to be there for his brother Fraser and show him a better way to live. He also commented that he expected to do "some big time this time around." Beaulieu testified that when he was told that Mr. Zong had committed suicide that "it changed [him] and [he] believes [it changed] every officer that was there that day." He spoke to the very heart of the inquest's mandate when he expressed a desire to "[t]ry to do something different to prevent [suicides]."

[53] Beaulieu elaborated on the ASSIST training and the importance of inmates having a future focused orientation. "[A]t Corrections", he testified, "…we have safe plans, safe cards and with a safe plan you talk about stuff like that with them. What – what kind of plans do you have for the future? Do you have plans for the future? And when they start talking about their families and their friends and jobs and stuff like that, that – that gives us reason to believe that they want to live."

Hospital Visit July 14th

[54] Dr. Linda Du Toit was the emergency room doctor the afternoon of July 14th at the Dauphin Regional Health Centre. Dr. Du Toit sees many patients in her medical practice encompassing patient clinic, walk-in clinic, ER clinic and obstetrics. This short interaction with Mr. Zong nearly three years earlier did not stand out in her mind leaving her to rely on the emergency room records.

[55] Dr. Du Toit's emergency room notes indicate that Mr. Zong had a previously sutured large gaping wound that he had pulled stitches out of and then pulled off the steri-strips (affixed by Corrections Staff the night before). Dr. Du Toit had concerns about infection and gave direction about wound care and prescribed an antibiotic. She explained that new wounds less than 12 – 24 hours old can be stitched together but older wounds can't be due to risk of infection. In this case the wound was left partially open to drain in the event of infection.

[56] Just before 2:00 p.m. the Running Record confirms this escort from DCI of inmate Zong to the Dauphin Regional Health Centre from noon until 1:30 p.m. having been completed without incident.

Telephone Calls

[57] From 1:30 until 3:30 p.m. on July 14th Mr. Zong is noted, on his Direct Personal Observation Record, to be watching television. At the 4:00 p.m. check he was given his

antibiotic and at 4:30 p.m. he was at supper. He rested for awhile after supper, being noted to be lying on his left side, and was seen talking at 6:00 p.m. At 6:30 p.m. he was on the phone.

[58] The Running Record notes that Mr. Zong's request to add Taylor Mancheese to his approved phone list was approved by 4:15 p.m. on July 14th.

[59] Telephone calls Mr. Zong made the day of his death were downloaded and provided to the court. He spoke to his father and, when questioned about possible self-harm, denied cutting himself and repeated his assertion that he had cut his arm on a window. He also asked his father to pass a message on to his landlord that he wanted a few personal items brought to DCI.

[60] Mr. Zong tried to get in touch with his sister to find out if his brother Fraser had been released from custody.

[61] He placed multiple phone calls to his girlfriend. She told him, in an early call, that in light of his having fired a gun at her that they were through. He also had heated exchanges with a man who was at her house. At the end of the final phone call Mr. Zong tells the young woman "I love you." She responds, in reference to being shot at, "that's not love." He hangs up and goes into his cell.

[62] A security round was completed at 6:24 pm, shortly before this phone call ended.

Time In Cell Prior to Shower

[63] Upon entering the cell Mr. Zong laid down. In the video we see him lying on his bunk with his leg blocking the camera's view of his hands. He seems to be fiddling with a blue sheet. After awhile he gets up, grabs a fresh change of clothes and heads into the bathroom. The quality of the surveillance images are extremely poor – there is video but no audio. Facial expressions are very difficult to make out.

[64] There is a camera in the individual cell area and in the common room area. There is no washroom camera. Once Mr. Zong passes briskly through the common area at 6:37 p.m., where two other inmates are watching television, he is lost to sight.

Muster

[65] The inquest heard that shift change (or "muster") is an opportunity for information to be shared from one shift to another. Shift logs are reviewed and pertinent information is passed along. CO Chartrand testified that shift starts at 6:30 p.m. but shift change is 10 minutes earlier, to allow for exchange of information. The incoming shift will review

running records and get up to speed on what has happened during the last 12 hours in the institution.

[66] During this meeting, suicide and medical watches are noted as well as any incidents and details about new admissions. The Direct Personal Observation Records for the shift ending at 6:30 p.m. should have been reviewed with the new shift but they had not been completed, an unusual gap in record-keeping according to CO Chartrand.

[67] CO Chartrand testified that Mr. Zong had a reputation for being street-tough and that any unit he was put in he ran. She viewed all three of his cell mates as being more passive than him.

Inside Remand B

[68] These other inmates were Albert Chartrand, Jeremy Cook and Lawrence Beaulieu. As muster was taking place Albert Chartrand was shuffling cards, watching television and talking to Jeremy Cook. Mr. Lawrence Beaulieu was initially napping. All three provided written statements which were filed and both Mr. Chartrand and Mr. Beaulieu testified.

[69] Mr. Chartrand shared a sub-cell with Jeremy Cook and Mr. Zong shared with Lawrence Beaulieu. According to Mr. Chartrand, Mr. Zong stayed in his room mostly unless he was getting coffee or using the phone.

[70] Jeremy Cook told Corrections Staff that when Mr. Zong was first placed in Remand B he shook everyone's hand except his. He tried to leave him alone as a result of this. Cook remembered July 14th starting off uneventfully. "Everything was okay" until Mr. Zong "pulled his bandage off." He heard Mr. Zong tell the staff he needed another bandage.

[71] The officers arrived at some point and gave Mr. Zong his PIN to use the phone. Mr. Chartrand said when Mr. Zong was on the phone that Chartrand would turn the volume up on the television to try to give him some privacy as the calls were "supposed to be private."

[72] Mr. Cook observed Mr. Zong calling someone who "hung up on him" about five times. He also overheard Mr. Zong talking to his Dad and asking him to have some items brought to DCI for him. The final call Cook overheard ended with Mr. Zong saying "well then it's over" and retreating to his room. When he came out, with towel and fresh clothes in hand, Mr. Cook remembered him looking at him "really mean" and going into the washroom. The video shows Mr. Zong entering the washroom at 6:37 p.m. Cook went to his room to rest. Lawrence Beaulieu continued resting in the sub-cell.

[73] Within four minutes of Mr. Zong entering the washroom both Chartrand and Cook heard a gagging sound. In the video we see Chartrand jump up and go to the washroom opening and bang on the wall. There was no response. Chartrand speaks to Cook who also listens. Both men suspected Mr. Zong was vomiting. Neither man intruded on him. They heard continued movement inside the washroom as the shower ran throughout and Mr. Chartrand thought Mr. Zong simply didn't want to talk to anyone.

[74] When Mr. Beaulieu entered the common room at 6:59 p.m. both men told him that Mr. Zong had been in the shower for quite awhile. Beaulieu thought this was not unusual – that Mr. Zong liked to "sit in the shower." Beaulieu went to the washroom and called out "Freeman are you okay?" When Mr. Zong did not respond he agreed to give him his space.

[75] Thirty-one minutes after Mr. Zong went into the shower a "punch" round was done – at 7:05 p.m. by CO Mikael Dzyuba. The hallway video shows COs Dustin Dawson and Allyson Warkentin in the hall outside Remand B. Warkentin holds keys while Dawson speaks with an inmate. Dzyuba testified that he knew Mr. Zong was classified as a medium suicide risk. Cook told Dzyuba that Mr. Zong had finished a phone call and gone into the shower. No direct communication took place between Mr. Zong and the officer during this security round. His name wasn't called and he was not observed. Dzyuba had no independent memory of the 7:00 p.m. check.

Code Red

[76] It was 55 minutes after Mr. Zong went into the shower with his bundle of clothes and towel that the next security round took place by the same officer at 7:32 p.m.

[77] CO Chartrand was shift leader on the July 14th night shift and accompanied CO Dyzuba on this round. As required by policy Chartrand waited at the door with the keys while Dyzuba checked the inmates. There were only three inmates visible. Chartrand could hear the water running and the shower curtain moving. She called out "Freeman Zong!" Getting no response she asked another inmate "how long has he been in there?" When told "quite awhile" she directed CO Dyzuba to check on him.

[78] Dzuyba entered the shower area at 7:33 p.m. to find Mr. Zong hanging by his neck from the vent above the toilet. This image (and event) was a shocking one and it spurred Dzyuba into immediate action. He ushered the other inmates into a cell as he called a Code Red Remand B (twice as per policy) on his radio and immediately requested and was provided the secured knife to cut Mr. Zong down.

[79] CO Dzyuba cut through the sheet that Mr. Zong had used as a ligature and quickly removed him, with assistance, from the shower area and placed him on the floor of the common area for medical assistance.

[80] The other inmates were immediately locked in one cell and were auditory witnesses to the emergency and medical interventions that followed. Cell video was provided of the three men waiting to be moved from that cell – they were all visibly shaken by the incident.

[81] CO Chartrand began chest compressions on Mr. Zong, switching off occasionally with CO Zeilor, CO Warkentin and EMS staff as each of them tired. Warkentin also started mouth to mouth resuscitation. Warkentin used her sealed CPR protective shield from her belt to provide breath to Mr. Zong. As it didn't seem to be functioning properly she used CO Zeilor's protective shield.

[82] CO Dawson responded to the Code Red immediately. He then ran back and forth to the main floor to get the Code Red bag, pass messages, obtain the AED equipment and liaise with the 911 operator. There was no landline to use in Remand B. He did not broadcast over the radio to ensure other inmates were not listening in as the crisis unfolded. CO Zeilor cut Mr. Zong's shirt to allow the AED device to be used prior to EMS arrival. No shock was recommended and CPR resumed.

EMS Arrives at DCI

[83] Paramedic Jordon McCrimmon (then Pasloski) was in the first ambulance, which responded to the 911 call, arriving on scene at 7:43 p.m. and at the patient a minute later. The second ambulance staff later brought in a backboard to transport Mr. Zong out of the institution. The paramedics confirmed Mr. Zong was in cardiac arrest and then worked through their Cardiac Arrest Protocol - starting with CPR, putting pads on him to defibrillate if appropriate and starting an airway to provide oxygen, starting an IV and giving him epinephrine. No shock was administered as he was asystole – his heart was not beating at all. Once the required 25 minutes of CPR had passed without success the decision was made by Paramedic T. James Borock, at 8:06 p.m., to move Mr. Zong up to the ambulance.

[84] Borock testified about the care he provided to Mr. Zong. After twenty-five minutes of unsuccessful CPR, four rounds of ineffective epinephrine and electrodes showing no activity he formally declared Mr. Zong deceased at 8:11 p.m. prior to the problems exiting the locked compound, outlined below, were brought to his attention.

RCMP Arrive

[85] Three RCMP officers also attended in response to the 911 call, assisting with CPR and transport of Mr. Zong as needed, and starting an investigation into his death.

Leaving the Grounds – Gate Problems

[86] Shift Leader Chartrand testified that once Mr. Zong was loaded into the ambulance, the camera and door system crashed, leaving emergency services unable to leave the property. CO Warkentin, who had been tasked with accompanying Mr. Zong to the hospital, exited the ambulance, advising others that EMS had declared Mr. Zong deceased at 8:11 p.m. Chartrand returned to the Centre to obtain the key to manually open the gate. She and CO Waldack struggled removing the box to allow the gate to be opened manually and failed - they were forced to wait for the system reboot which took approximately 20 minutes.

Autopsy

[87] The Inquest heard from pathologist Dr. Raymond Rivera who performed the autopsy on Mr. Zong's body on July 15th, 2016 at St. Boniface Hospital. After examination of Mr. Zong's body he concluded that cause of death was asphyxiation (due to lack of oxygenated blood flowing to the brain) by hanging. He estimated it would take from a matter of seconds to a couple of minutes before a person's heart would stop beating in this type of situation.

4.) CORRECTIONS' PROCEDURES & INVESTIGATIONS

Evidence From Corrections Administration

[88] Three witnesses gave more evidence about Manitoba Corrections' policies and procedures and the internal investigation that occurred after Mr. Zong's death. The Inquest heard from Acting Superintendent David Shewchuk, Assistant Superintendent of Operations Dean Erlendson and Executive Director Adult Corrections Gregory Skelly.

[89] E.D. Skelly gave a broader view of the correctional system DCI operates within. He has responsibility for management of seven adult and two youth provincially run correctional institutions in the Province of Manitoba – Dauphin is the oldest of these by decades.

[90] Correctional design has shifted over the years. E.D. Skelly spoke about the recent builds, which were structured to ensure direct supervision of inmates. He contrasted that with Dauphin, where there is linear surveillance, which he explained as being "an intermittent ability to view what's going on in the units."

[91] He testified about guiding institutions with divisional policies. Divisional policies, apparently, "are intentionally written fairly wide in terms of a particular topic. And it's…to alert the individual institutions in terms of the direction that the…Division would like to go

in terms of a particular topic. …[i]nstitutions will then take those divisional policies and distill them down to make them operational …for their own centre."

[92] Most of the distinctions between centres arise out of differing physical plants. As Dauphin is a smaller centre, according to E.D. Skelly, staff may have different methods of achieving divisional policies than a larger centre such as Headingley.

[93] Each correctional officer has to complete unpaid training prior to starting work at an institution. Skelly spoke about the two day suicide prevention training (ASIST) that is part of that program and the refresher that is given to staff every two years.

[94] There are tasks outlined in Standing Orders that were not completed in this case. Skelly was asked what strategies are used to ensure staff do the tasks assigned to them. His answer was three-fold: Refresher training reminds staff of tasks required; managers have an oversight duty and, finally, ongoing coaching is done to help staff understand the purpose of assigned tasks to ensure they understand the value in performing the tasks.

[95] When questioned about the wisdom of designating all inmates with any suicide risk a medium or high suicide risk as an initial default position, Skelly wondered whether the real inmates at risk would get appropriate attention in such a system. He testified "if everybody's a high suicide risk, then we're not going to pay as much attention to those who have that real designation." He later noted that "if we make everything the same, then…my strong concern is that staff would be doing this by rote. They would be doing it just to get the work done, as opposed to doing it to pay particular attention to someone with a particular issue raised." I share his concern about rote attention to assigned tasks and will return to it later in this report.

Manitoba Corrections' Internal Investigation

[96] Corrections undertook its own internal review as a result of Mr. Zong's suicide. Investigators Jodi Chubaty & Bob Alm reviewed the file, interviewed staff, reviewed relevant policies, staff understanding and compliance with policy, and recommended changes to minimize risk of further incidents.

[97] Their recommendations include items respecting managing staff and inmates after an inmate suicide, which are outside the inquest mandate and are not included below.

[98] The Standing Order respecting *Security Rounds and Daily Inspections* is quite specific, according to the writers, with respect to checking property and security equipment but gives no direction other than "check on well-being of offenders" for ensuring offender safety.

[99] We cannot know Mr. Zong's reasons for taking his own life. After witness interviews and file review the report writers considered the following to be likely contributing factors – the phone calls he had just prior to entering the washroom, his recent arrest with expectation of lengthy sentence, his Hep C diagnosis along with his belief he would die from this disease, heavy use of alcohol and drugs along with possible withdrawal from it and the ongoing impact of the death of his mother.

[100] The November 4th, 2016 Corrections' report recommended or noted –

a) The addition of a constant officer presence in the secure remand area be continued;
b) The Standing Order on Security Rounds be amended to ensure inmate safety when they are out of sight during a security round;
c) The requirements for completing and documenting Suicide Prevention Contact and Safe Plans be reviewed with staff. The writers noted with favour the new requirement in the DCC *Adult Suicide Prevention* Standing Order to review the suicide risk status of all SUM and SUH inmates on a daily basis by committee including medical staff;
d) New CO specific medical kits have been created and staff have been trained to use them. Use of rescue knife and manual operation of gate is to be reviewed as part of regular fire training with staff; and
e) Remand bathrooms have been renovated to be open concept and bathroom vents have been replaced with new security vents.

Assistant Superintendent Operations – Changes Already Made

[101] A.S.O. Erlendson outlined some of the changes that have been made to DCI as a result of this incident and the recommendations received as a result of the internal review. It was helpful to have the institutional level perspective on the outside review.

Lack of Direct Supervision in Remand B

[102] A landline was installed outside Remand B, along with a new desk and CCTV monitor which allows the permanently stationed officer to view the remand units at any time.

Blocked Gate

[103] The systems failure that impacted the operation of the gates was addressed. This had occasionally been a problem during general power outages where the power would flicker off before the backup generator kicked in. Rebooting the system should take

minutes. To address what had been an occasional glitch DCI installed an uninterrupted power supply which runs off battery at all times and should guarantee a constant source of power for the computer system. There is now a quick reference guide for rebooting the system located underneath the main keyboard.

[104] The inability of staff to manually open the gate when the system crashed has also been addressed. As the lid is heavy and difficult to move handles were added to facilitate that task. During annual fire training, the process of manually opening the gate is reviewed and staff are required to demonstrate their ability to complete this vital task.

Poor Quality CCTV System

[105] The CCTV system has been upgraded with a new digital system, which the Court observed while taking a view at the facility to have image clarity far superior to that which was in use at the time, allowing much clearer view of facial expressions.

Medical Bags vs First Aid Kits

[106] The Code Red medical bag was a source of confusion for many staff and is, according to Erlendson, specifically designed for trained medical staff. Finding the right materials was a bit of a challenge on the day in question. DCI addressed this by creating five new first aid kits designed specifically for emergencies and use by front line correctional officers. They are located throughout the building – including one in the Remand area. These kits are checked monthly to ensure all required materials are at hand.

[107] The protective mouth shields issued to each officer for CPR purposes are sealed single use units with an expiry date. It is up to the individual officer to keep track of the expiry date and come to Erlendson for a new unit at that time.

Grates used as Ligature Point

[108] The grate on the vent in the washroom that Mr. Zong used as a ligature point has been changed and replaced with security grate vents. These vents are 8 – 10" thick and weaved back and forth in such a manner that it is apparently impossible to thread something through them. Not all of the vents have been changed but there is an ongoing project to complete this transition. Priority was given to vents that are more difficult to observe or where there is a greater perceived risk – where there are, as Erlendson testified, "no visuals".

[109] It is clear from the evidence of Dr. Rivera that hanging can lead to death in a matter of seconds and that merely having a visual may not allow sufficient time to respond with life-saving measures.

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

Acting Superintendent David Shewchuk – Operational Review

[110] While Erlendson gave an operational review of the changes, A.S. Shewchuk offered a managerial perspective. He had oversight of the recommended corresponding changes to the Standing Orders. Shewchuk was grateful for the input of the internal review committee and emphasized the importance of such a review to allow DCI to address any shortcomings as soon as possible. He outlined some of the resulting changes that have been made or that might be advisable.

[111] The Review recommended the Security Round Guide be revised to ensure offenders who are out of sight during security rounds are confirmed to be well. Shewchuk chose to go further than recommended, in a manner that ensured some privacy to individuals using a washroom and prioritized earlier confirmation of physical well-being.

[112] The revised standing order requires the following:

> 6.1 In the event an inmate cannot be visibly seen due to their presence in a washroom facility, Officers must confirm the inmate's presence and wellbeing verbally; and
> a) Follow up within a 15 minute time frame, until such time that an officer can visually confirm the inmate's presence and well-being.

[113] The appendix attached to the Security Round Standing Order is titled *Security Punch Round Reference*. The focus on "punching" in to prove attendance at a certain location focuses on the narrowest aspect of this task – proof of completion. As was seen here, a perfunctory attendance to punch in glosses over one of the most important purposes of the visit. The punch round items listed as a guide to assist the officers include, in the general section, 28 points with detailed direction on physical areas to check – the floor, the ceiling and the walls are all examples. Although offenders' well-being is the first item listed it is not detailed with the same specificity. "Completion of suicide/security watch observation forms" is the last item listed.

RECOMMENDATION: 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.

[114] Changes were made to the Adult Suicide Prevention Policy to require a daily review/assessment by a suicide risk team of direct personal observation records, suicide observation reports and safe plans for all offenders designated SUM or SUH.

[115] A.S. Shewchuk conceded that the responsibility for developing a safe plan (being a safety agreement discussed with the inmate) is not specifically noted as being the responsibility of anyone in particular and that this may be a helpful addition to the Adult Suicide Prevention Standing Order. He said if there is time, the admissions staff will do it, or the shift leader may designate it to someone specific in the unit. As noted, this task was missed - no Safe Plan or Keep Safe Card was created with or for Mr. Zong.

RECOMMENDATION: 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 and SUH inmates.

[116] A.S. Shewchuk testified about the process for approving names on an inmate's telephone call list. He was asked if DCI had known that Mr. Zong had shot at his girlfriend whether she would have been an approved name on his list. The process, apparently, where there is reason to be concerned about a name, is to call ahead to see if it is okay to put the person on the list. It is not automatic. DCI will also remove a person from an approved list if they call and request it.

[117] The Adult Suicide Prevention Standing Orders remind officers that '[i]t is important for Corrections Staff to continually interact and provide support to offenders. Ongoing assessments may include a review of…telephone monitoring (threats of suicide-depression)." In light of the unsupervised access to telephones that inmates have it would be helpful to develop a protocol to consider what contacts should be approved for the at risk inmate's phone list.

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

5.) ANALYSIS

[118] Mr. Zong's death was a shocking event for the staff and inmates at the Dauphin Correctional Institution. The emotional impact was still obvious with a number of people even three years later. Many staff testified about their heightened vigilance respecting their duties as a direct result of this incident. The desire to avoid similar events in the

future by management and front line workers alike was clear. I was particularly impressed with A.S. Shewchuk's unblinking assessment of areas where further changes could be made and openness to suggestions for improvement.

[119] Corrections, with its internal review, also already asked its people some of the hard questions - What could be done differently? What could be done better?

[120] The work of a correctional officer can be hectic. That was clear throughout the evidence. There are court appearances, medical appointments, transfers between institutions, fresh air, exercise, running records and casework to complete. There are standing orders and divisional policies to keep track of, and ongoing review of training.

[121] This work takes place in a highly regulated environment. There are chains of command and a clear hierarchy of responsibility. There is much to keep track of.

[122] *The Fatality Inquiries Act* requires that I determine what, if anything, can be done to prevent deaths in similar circumstances from happening in the future. Some of my concerns have already been addressed by the internal review.

[123] Counsel argued that the existing systems are adequate – it is a question of execution of the appropriate steps. People just need to maintain good habits and to be more vigilant – to try harder, to do better. In the sea of requirements that Correctional Officers are compelled to comply with this seems to be an inadequate response to the failure to meet so many of the minimum standards required for an SUM inmate.

[124] Corrections' Adult Suicide Prevention Policy has, of course, been created over years of experience and with ongoing consultation and review. Its purpose is to assist staff in preventing inmates from attempting or committing suicide. There can be no guarantees when it comes to human behavior but the policy is designed to help reduce risk.

[125] The special tasks required when processing and housing an at-risk inmate are not endless. Correctional Officers, through regular review of standing orders and policies, must keep them in mind while completing all their other tasks and interacting with the inmate population. Why not have a simple checklist which follows the inmate that makes it clear to every staff person who interacts with the inmate, what has and has not yet been done?

[126] In his 2009 book The Checklist Manifesto surgeon Dr. Atul Gawande writes about the explosion of knowledge in modern society and the risk of error that accompanies such information overload. He argues in favour of the simple checklist. He writes that a good checklist should "not try to spell out everything – a checklist cannot fly a plane. Instead, they provide reminders of only the most critical and important steps – the ones that even the highly skilled professionals using them could miss. Good checklists are, above all, practical."

[127] Gawande urges clear pause points where such checklists would be utilized. He describes this as either a "Do-Confirm Checklist or a Read-Do Checklist. With a Do-Confirm checklist … team members perform their jobs from memory and experience, often separately. But then they stop. They pause to run the checklist and confirm that everything that was supposed to be done was done. With a Read-Do checklist, on the other hand, people carry out the tasks as they check them off – it's more like a recipe."

[128] It seems that the most important aspects of the Suicide Prevention Policy have already been determined in the Adult Minimum Standards of Intervention and Supervision Chart and could be developed into a very brief checklist. Ensuring various staff pause and review the checklist at prescribed points would keep suicide risk management top of mind and not continue to rely on overtaxed officers to successfully complete important steps in the process from memory.

RECOMMENDATION: 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.

[129] It is unclear to me why the Peer Support System was not utilized. It is possible that the three inmates were deemed unsuitable for sharing of such information. We don't know. The only people who had a chance of raising an alarm early enough to make a difference were in the cell with Mr. Zong. I note this reluctantly, as this was a traumatic incident for all of them and this comment should not be interpreted as criticism of them. Mr. Zong kept his plans and his state of mind from them and they did their best based on the information they had. They banged on the wall and asked him if he was okay. Looking forward, and trying to put in place systems to lessen the risk of this happening again the importance of their proximity must be addressed.

RECOMMENDATION: Amend the Suicide Prevention Policy to require a recorded decision on whether the Peer Support Policy has been utilized before placing an SUM or SUH inmate with other prisoners.

6.) SUMMARY OF RECOMMENDATIONS

RECOMMENDATION: Assign Case Manager who will be on shift within 24 hours of admission.

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

RECOMMENDATION: 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.

RECOMMENDATION: 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 and SUH inmates.

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

RECOMMENDATION: 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.

RECOMMENDATION: Amend the Suicide Prevention Policy to require a recorded decision on whether the Peer Support Policy has been utilized before placing an SUM or SUH inmate with other prisoners.

7.) ACKNOWLEDGEMENTS AND CONCLUSION

[130] This inquest was a major undertaking and a difficult and emotional task for those charged with the care of Mr. Zong and for his loved ones who lost him as a father, son, brother, uncle and friend on July 14th, 2016.

[131] Mr. Zong's death in custody is a harsh reminder of the importance of ongoing vigilance with at risk inmates and strict compliance with existing suicide prevention policies. It is my hope that with the added vigilance evident at DCI and the completed and proposed changes to procedures the risk of another inmate suicide in the future will be minimized.

[132] My thanks to counsel for their compassion and care with all witnesses and their responsiveness to the court's many requests. I have considered the advice given on appropriate recommendations and have incorporated much of it above.

[133] I hereby respectfully conclude and submit my report on Wednesday, the 11th of December, 2019, at the City of Dauphin in the Province of Manitoba.

"Original signed by"

Judge C. V. Harapiak
Provincial Court of Manitoba

8.) EXHIBIT LIST

1. Shift sheet signed by DZYUBA, M.
2. DCC Standing Orders Document
3. Incident Report – Author DZYUBA, M. – July 15, 2016
4. Unused Number
5. Court Transcript of Proceedings – March 8, 2019
6. DVD and Photo List – Tour of Jail – SEALED
7. Floor Plan of Jail and Courthouse Map – SEALED
8. DVD Video Tour of Jail – SEALED
9. Incident 42394 – July 14th – CCTV Remand B, Common Area
10. CCTV DVD of Common Area – July 14, 2016
11. Prosecutors Information Sheet – Occurrence No. 201685509
12. July 13 – Direct Personal Observation records
13. July 14 – Direct personal Observation records
14. Inmate Security Assessment and Suicide Risk Assessment
15. Dauphin Regional Health Centre outpatient/emergency record – Dec 9, 2015
16. Dauphin Medical Records – Patient Record
17. Dauphin Regional Health Centre Out Patient Emergency Record – July 14, 2016
18. Health Care assessment – July 13, 2016
19. Health Service Progress Notes – April to July 2016
20. Health Service Progress Notes 'Appendix C' February to July 2016
21. DPIN Dispensing History – Adult Immunization Record Form
22. Escort briefing July 14, 2016
23. Running record report – July 14, 2016
24. Medical Consultation/Referral – July 14, 2016
25. Parkland Regional Health Authority Wound Care of Sutures /Stitches
26. Incident Report – DAWSON, D – July 15, 2016
27. Incident Report – CHARTRAND, C – July 15, 2016
28. Standing Orders – Policy and procedures – Adult Suicide Prevention – Revised 2015-09-21
29. Running record report – Manitoba Corrections
30. Incident Report – WARKENTIN, A – July 15, 2016
31. Incident Report – ZEILER, J – July 15, 2016
32. Activity Report – July 15/16 – Page 236/237
33. General Rules and Regulations – page 578
34. Divisional Suicide Prevention Policy
35. Incident Report – Prepared by POAST, P.
36. General Report – Prepared by FISHER, C.
37. Shift Log
38. Shift Log
39. Incident Report – Prepared by TKACHYK, K.
40. Dauphin RCMP File: FREEMAN ZONG
41. CST. THOMPSON'S Notebook – Copies

42. General Report – CST. ULTRA
43. Medical Incident Report – FISHER/WENDLING
44. Health Service Progress Notes
45. Transcription of Zong's phone calls from common area
46. DVD Fraser Chartrand – Visiting Room Call – 2016/07/15
47. BEAULIEU Statement
48. Disc - RCMP photos of Zong's cuts on arms
49. Autopsy Report
50. Incident Report – ANDRES, V.
51. Status of Recommendations – March 2017
52. Standing Orders – Security Round and Daily Inspection
53. Standing Orders – Security Punch Round Reference – Appendix B
54. Standing Orders –Adult Suicide Prevention
55. Manitoba Corrections Investigation Report re: Death in Custody
56. Health Service Progress Notes
57. Standing Orders Case Management – Old Policy
58. Standing Orders Case Management – Current Policy
59. Level of Service/Case Management Inventory Profile Report May/16 F. Zong
60. Facebook Photo from FREEMAN ZONG account – bandaged arm
61. Facebook Status Screenshot July 11/2016 FREEMAN ZONG account
62. DCI Shift Schedule July 9-15
63. Dauphin Regional Health Centre Emerg Record – July 11/2016
64. Nursing Triage Assessment July 11/2016
65. Ambulance Patient Care Report July 14/2016
66. Second Ambulance Patient Care Report July 14/2016
67. Paramedic BOROCK'S Personal Notes July 14/2016

Dauphin Correctional Institution
STANDING ORDERS

Manitoba
Justice

Subject: ADULT MINIMUM STANDARDS OF INTERVENTION AND SUPERVISION | Appendix A | Page 1 of 1

Intervention	Suicide Risk Level		
	Low SUL	Medium SUM	High SUH
Safety Plan	n/a	Required – document in Running Records	Required - document in Running Records
Keep Safe Card *Appendix D*	Optional	Required	Required
Suicide Prevention Contact	Periodic – Document in Case Management Plan	Daily – at minimum Document in Running Record	Daily – at minimum Document in Running Record
Direct Personal Observation Record *Appendix B*	n/a	Complete check and document every 30 minutes	Where EM is utilized: complete check and record details every 15 minutes. No EM: complete check and record details 4x/hour and at irregular intervals
Suicide Observation Report *Appendix C*	n/a	Complete report every 12 hour shift	Complete report every 12 hour shift
Isolation/ Observation Unit	n/a	n/a	For short periods of time
Safety Clothing	n/a	n/a	For short periods of time while in isolation/ observation unit