Verdict of Coroner’s Jury
Office of the Chief Coroner
The Coroners Act – Province of Ontario

Surname: Patterson
Given names: Keith
Aged: 30

Held at: 399 Ridout Street North, London
From the: 2nd of November, 2015
To the: 6th of November, 2015
By: Dr. G. Rick Mann, Coroner for Ontario
having been duly sworn/affirmed, have inquired into and determined the following:

Name of Deceased: Mr. Keith Wayne James Patterson
Date and Time of Death: September 30, 2014 at 1427hrs
Place of Death: London Health Sciences Centre - Victoria Campus, London Ontario
Cause of Death: Complications of hypoxic-ischemic encephalopathy due to, or as a consequence of, hanging
By what means: Suicide

This verdict was received on the 6th of November, 2015
Coroner's Name: Dr. G. Rick Mann
(original signed by Foreman and Jurors)

We, the jury, wish to make the following recommendations:

Inquest into the death of:
Keith Patterson
Jury Recommendations

1. That the Ministry of Community Safety and Correctional Services explore the design, fabric and colour coordination of the security blankets that are used at provincial correctional institutions and take all appropriate corrective measures.

2. That the Ministry of Community Safety and Correctional Services review the cleaning, maintenance and inspection processes of the security blankets in use at provincial correctional institutions and take all appropriate corrective measures.

3. That the Ministry of Community Safety and Correctional Services explore the design, locking mechanism and colour coordination of the hatches as potential anchor points on the cell doors in use at provincial correctional institutions and take all appropriate corrective measures.

4. That Elgin Middlesex Detention Centre conduct a compliance review of the regular mandatory training requirements of the Ministry of Community Safety and Correctional Services for all front line staff in the area of suicide prevention and take all appropriate corrective measures.

5. That the Ministry of Community Safety and Correctional Services commit to deliver the developed mandatory mental health training to all front line correctional staff at provincial correctional institutions.

6. That the Ministry of Community Safety and Correctional Services review the effectiveness of the developed mandatory mental health training to all front line correctional staff at provincial correctional institutions and take all appropriate corrective measures.

7. That the Ministry of Community Safety and Correctional Services review the effectiveness of the mental health training and suicide prevention programs that are currently delivered at the Ontario Correctional Services College and take all appropriate corrective measures.

8. That the Ministry of Community Safety and Correctional Services review the effectiveness of the current information flow system that would allow for crisis information on inmates to be provided to and reviewed by the necessary parties in a timely manner and take all appropriate corrective measures.

9. That Elgin Middlesex Detention Centre explore an alternate method of identifying the reason for an inmate to be in segregation other than the magnets as they are currently used.

10. That Elgin Middlesex Detention Centre explore solutions to mitigate the opportunity for flooding and to facilitate clean up or drainage and take all appropriate corrective measures.

11. That the Ministry of Community Safety and Correctional Services undertake a study to identify stress-related issues and their effects specifically on inmates of provincial correctional institutions, especially those with mental health concerns, and to develop, identify and implement strategies to mitigate the effects.

12. That Elgin Middlesex Detention Centre review the effectiveness of its monitoring equipment to ensure all areas of the institution are proficiently monitored by appropriately trained staff.