REPORT FOR ACTION

Implementation of Coroner's Recommendations from the Faulkner and Chapman Inquests

Date: August 21, 2019
To: Economic and Community Development Committee
From: General Manager, Shelter, Support & Housing Administration
Wards: All

SUMMARY

This report is in response to City Council's direction at their meeting on June 18 and 19, 2019 that the General Manager, Shelter, Support and Housing Administration (SSHA), report on the actions taken by City divisions to respond to the recommendations from the Coroner's Inquests into the deaths of Grant Faulkner and Bradley Chapman.

The report outlines each of the recommendations from the two Coroner's Inquests directed to the City and notes the actions taken or planned for each division impacted by the recommendations.

RECOMMENDATIONS

The General Manager, Shelter, Support and Housing Administration, recommends that City Council receive this report for information.

FINANCIAL IMPACT

The financial implications are under review by the divisions impacted by the Coroner's recommendations. Many of the actions that respond to the recommendations are part of current administration activities and are being absorbed by existing budgets. However, there are a number of recommendations that require new and enhanced services such as the Streets to Homes street outreach services, distribution of survival equipment, and the Eviction Prevention in the Community (EPIC) program, for which funding implications will be referred to the 2020 budget.

The Chief Financial Officer and Treasurer has reviewed this report and agrees with the financial impact information.

DECISION HISTORY

At its meeting on June 18 and 19, 2019 City Council adopted MM8.2 "Coroner's Jury Inquest Recommendations for the Homeless" which stated:

1. City Council request the General Manager, Shelter, Support and Housing Administration, to report on the Coroner's Jury recommendations on the inquest of Bradley Chapman when reporting to the October 2, 2019 City Council meeting on the Coroner's Jury recommendations on the inquest into the death of Grant Faulkner.

http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2019.MM8.2

COMMENTS

Inquest into the Death of Mr. Faulkner

On June 11-15, 2018, the Office of the Chief Coroner held a discretionary inquest into the death of Mr. Grant Faulkner. Mr. Faulkner, aged 49, died on January 13, 2015 in a fire inside a wooden encampment on private property behind a cement plant near McCowan and Sheppard Ave East in Scarborough.

Mr. Faulkner had experienced episodic periods of homelessness leading up to the date of his death. Mr. Faulkner had previously used various homeless services available in the community such as the Out of the Cold program at Knox United Church and regularly accessed services at the Agincourt Community Services drop-in centre.

The focus of the inquest was on services provided in Scarborough to those who are homeless or precariously housed; specifically,

- availability of information and data about homelessness in Scarborough;
- services available to those who are homeless in Scarborough and do not use the overnight shelter system;
- responses to extreme cold weather situations for those that are homeless;
- availability of overnight services for those that are homeless in Scarborough; and
- awareness and handling of temporary encampments.

The City's Legal Services Division represented the City in the inquest and evidence on the City's behalf was presented by Shelter, Support and Housing Administration Division (SSHA).

The verdict from the Coroner's Inquest resulted in 35 recommendations aimed at assisting in the prevention of similar deaths in the future.

Of the 35 recommendations:

- 16 were directed exclusively to the City of Toronto;
- 6 were directed collectively to: (a) the Province of Ontario, (b) the City of Toronto; and (c) homelessness service providers in Scarborough:
- 7 were directed exclusively to the Province of Ontario;
- 3 were directed exclusively to Agincourt Community Services Association;
- 1 was directed exclusively to the TTC (and Metrolinx);
- 1 was directed exclusively to the Ontario Fire Marshal; and
- 1 was directed to all municipalities in Ontario.

Inquest into the Death of Mr. Chapman

Mr. Chapman died at the Toronto General Hospital on August 26, 2015 at the age of 43. In the early morning of August 18, 2015, Mr. Chapman was found by a security guard from the Delta Chelsea hotel slumped in the doorway of a retail storefront. The security guard called the non-emergency police number and police were dispatched on a non-emergency non-medical call.

Mr. Chapman was experiencing homelessness at the time of his death. He was not a regular user of the City's shelter system, but he made regular use of the services at the City's Street to Homes Assessment and Referral Center at 129 Peter St.

Mr. Chapman was also a client of the Works where he obtained harm reduction supplies, including Naloxone. His use of the services at the Works predated its offering supervised consumption services.

In the weeks prior to his death, Mr. Chapman was incarcerated in a provincial facility, specifically the Toronto South Detention Centre, and received little discharge planning upon his release.

The focus of the inquest, as set out by the Coroner, covered a range of areas which included:

- Recognition, awareness and handling of Mr. Chapman's drug addiction during his incarceration in 2015;
- Transition services offered through the Ministry of Community Safety and Correctional Services;
- Discovery of Mr. Chapman and response to his medical situation. In particular, the assessment, observation and intervention by the police officers who attended Mr. Chapman;
- Training and responsibility of police officers in administering first aid, including administering Naloxone. In particular, identification and management of an individual in potential cardiorespiratory arrest (e.g. monitoring tight next to individual, checking pulse, counting breaths, placing in recovery position);
- Assistive measures available to people experiencing homeless with drug addictions; and

- Identification of Mr. Chapman and communication with his family, following admission to the hospital in August 2015.

The City's Legal Services Division represented the City in the inquest and coordinated between and worked with teams from Toronto Paramedic Services, the Shelter, Support and Housing Administration and Toronto Public Health, as well as the Toronto Police Services Board.

A significant amount of testimony during the inquest was focused on the increased use of opioids in Toronto and across Canada. Toronto Public Health has been consulting with Shelter, Support & Housing Administration and health care providers and researchers in the field to explore ways to improve access to opioid substitution treatments. This has included current treatments, as well as examining expanding what is currently offered to include managed opioid programs for people experiencing homelessness. As noted in the *"Expanding Opioid Substitution Treatment with Managed Opioid Programs*" staff report (see link below) to the Board of Health in February 2019, there continues to be system and funding challenges to implementing a managed opioid program in Toronto.

https://www.toronto.ca/legdocs/mmis/2019/hl/bgrd/backgroundfile-126527.pdf

The verdict from the Coroner's Inquest resulted in 55 recommendations aimed at assisting in the prevention of similar deaths in the future.

Of the 55 recommendations:

- 7 were directed exclusively to the City of Toronto
- 1 was directed collectively to: (a) the Toronto Police Services Board, (b) The Chief of the Toronto Police Services and (c) Toronto Public Health;
- 11 were directed exclusively to the Chief of the Toronto Police Service;
- 27 were directed exclusively to the Government of Ontario;
- 2 were directed exclusively to the Government of Canada;
- 2 were directed collectively to: (a) the Government of Canada and (b) the Government of Ontario;
- 1 was directed exclusively to the Registered Nurses' Association of Ontario;
- 1 was directed to Providers of First Aid Training in Ontario including St. John Ambulance, Canadian Red Cross, and Heart and Stroke Foundation of Canada;
- 1 was directed to the Office of the Chief Coroner, Ontario Forensic Pathology Service and the Centre for Forensic Sciences; and
- 2 were directed collectively to all recipients of the recommendations.

Coroner's Jury Recommendations and City Actions

Attached are all the recommendations directed to the City along with actions currently underway by the appropriate division(s) for both the Faulkner and Chapman inquests (*Attachment 1: Coroner's Jury Recommendations and City Actions for Faulkner* and *Attachment 3: Coroner's Jury Recommendations and City Actions for Chapman*). The

reference numbers in the charts in Attachments 1 and 3 are those of the enumerated recommendations as listed in the Jury Recommendations section of the Verdict for each Inquest *(Attachment 2: Verdict of Coroner's Jury Faulkner* and *Attachment 4: Verdict of Coroner's Jury Chapman)*.

CONCLUSION

The verdict from the inquests into the deaths of Mr. Grant Faulkner and Mr. Bradley Chapman provide valuable recommendations to all parties to help address important issues in Toronto. The City of Toronto, and its partners, play an essential role in responding to critical and urgent issues such as housing, homelessness and opioid use. Action is being taken by SSHA, Toronto Public Health and many other City divisions, to respond to the recommendations and make improvements to policies, practices and support services to help prevent future deaths similar to those of Mr. Faulkner and Mr. Chapman.

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ATTACHMENTS

Attachment 1: Coroner's Jury Recommendations and City Actions for Faulkner
Attachment 2: Verdict of Coroner's Jury - Faulkner
Attachment 3: Coroner's Jury Recommendations and City Actions for Chapman
Attachment 4: Verdict of Coroner's Jury - Chapman