DEATHS IN CUSTODY

Final Report

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February 28, 2007

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ACKNOWLEDGMENTS

The author would like to express his profound gratitude for the guidance and support of staff members at the Office of the Correctional Investigator. He is especially grateful for the efforts and support of Dr. Ivan Zinger, Mr. John Reid, and Mr. Ed McIsaac.

1.0 INTRODUCTION

The Office of the Correctional Investigator (OCI) investigates and attempts to resolve complaints from individual offenders under federal jurisdiction. In addition, it has a responsibility to review and make recommendations on the policies and procedures of Correctional Services Canada (CSC) that relate to individual complaints. In this way, systemic areas of concern can be identified and appropriately addressed.

Over the last decade, OCI has become increasingly concerned about the high number of deaths and self-inflicted injuries in federal institutions. In his last Annual Report (2005-06), Mr. Howard Sapers, Correctional Investigator of Canada, stated that his office was especially concerned about the number of similar recommendations made year after year by CSC's national investigations, provincial coroners, and medical examiners. He also expressed concern about the ability of the Correctional Service to implement these recommendations on a national level. In his report, the Correctional Investigator undertook to conduct a comprehensive review of reports and recommendations dealing with deaths in custody and other matters. Mr. Sapers noted that, in order to reduce the number of fatalities, a timely and systematic follow-up on corrective actions was required to ensure that preventive measures are implemented.

It is in this context that the present project was undertaken. Specifically, this project examined all reported deaths, due to other than natural causes, occurring over a five-year period in Canadian federal correctional institutions. Thus, all deaths determined by CSC to be homicides, suicides, and accidents have been included, with the aim of identifying areas in which improvements might enhance CSC's ability to prevent or respond to assaults and attempted self-injury in the future. The goal was to move from the analysis of incidents, on a case-by-case basis, to an overall assessment of trends and patterns.

Key questions posed by this study included:

1. Do the Boards of Investigation (BOIs) and Coroners' reports reveal a pattern of shortcomings on the part of CSC staff or policies?

2. Do more recent incidents indicate that CSC has improved its capacity to prevent and respond to assaults, acts of self-injury, and accidents?

3. How does CSC respond to the findings and recommendations of BOIs and Coroners?

4. How expeditiously does CSC respond to deaths in convening investigative boards and in acting upon their recommendations?

5. Could some of the fatalities have been foreseen and possibly prevented?

It is important to note that some investigative reports commend CSC staff for exemplary behaviour in highly stressful circumstances. These BOI reports occasionally note that the manner in which institutional personnel responded to an incident should constitute a "Best Practice" that should be emulated nationwide. The focus of this report, however, was on the identification of systemic issues that have compromised the prevention of, or response to, fatal assaults and acts of self-injury.

It is also important to acknowledge that a study confined to fatal incidents may possess an inherent bias. As this is a study of people who succeeded in ending their lives, in harming others, or who were victims of tragic accidents, this report does not include those incidents in which lives may have been saved through actions by CSC personnel that were in full compliance with existing policies and procedures. Thus, it may be that those cases resulting in deaths involve a disproportionate number of compliance issues.

Notwithstanding the possibility that incidents resulting in fatalities may reveal more issues with existing practices than non-fatal ones, the number of non-natural fatalities—which is far in excess of the rate in the civilian population--deserves attention in its own right. Institutional homicide and suicide rates, when combined, are calculated here to be nearly **eight** times the rates found in the population as a whole.[1] This situation underscores the urgency of identifying those areas in which actions have fallen short of the optimal across a variety of institutional settings.

[1] According to Statistics Canada, the national suicide rate for 2003 was 11.9 per 100,000 Canadians. In 2003-2005, the homicide rate in Canada was in the range of 2 incidents per 100,000, resulting in a combined rate of approximately 14 incidents per 100,000. The present study reveals an annual average of 13.6 homicides and suicides in federal institutions from 2001-2005. According to CSC's Research Branch, there were 12,561 men and women in custody in Canadian federal institutions on any given day in 2004/2005, yielding a rate of 108 deaths by suicide or homicide per 100,000 inmates—nearly 8 times the rate in the civilian population.

2.0 METHODOLOGY

This study examined 82 reported suicides, homicides, and accidental deaths in custody from 2001 to 2005 (inclusive). The cause of death in each case was determined by CSC; however, where a Coroner's Office subsequently concluded that a death was due to some other factor, this was then deemed to be the more definitive cause of death. The study reviewed Board of Investigation reports, CSC Action Plans, Coroner's Reports, correspondence between CSC and both OCI and Coroners'Offices, and other documents pertaining to each fatality. The cut-off date for inclusion of documents in the study was November 1, 2006. Incidents occurring during the study period were not included if BOI reports were not available by that date. Incidents were included, however, where Action Plans or Coroner's reports were unavailable.

A coding instrument was developed to guide the process of recording information from each file (see Appendix A). Information drawn from each file included:

- The cause of death;
- The institution in which the incident occurred;
- Basic information about the victim (age, gender, Aboriginal status);
- Current offences and criminal history;
- Relevant dates, including those of the incident, admission to institution, parole eligibility, completion of the BOI report, and CSC's national or regional response to the report;
- Pre-indicators of the incident and risk factors (e.g., substance abuse, previous suicide attempts, mental health issues, family support, institutional history); and,
- Relevant findings and recommendations contained in BOI and Coroners' Reports, as well as CSC's response to these.

The issues raised in the findings and recommendations of BOI and Coroners' Reports were placed in one of 15 categories (Appendix B). These categories included: 1) post-incident emergency care and resources; 2) counts and patrols; 3) mental health issues, programming, and suicide prevention; and 4) security issues. The categories were developed on the basis of a preliminary review of 15 files and through consultation with OCI personnel. The study also noted whether a recommendation was directed to CSC Headquarters, regional authorities, or institutional officials. CSC's responses to findings of non-compliance and recommendations were placed in one of five categories:

1. Agree: No Action
2. Agree: Action Consistent
3. Agree: Action Inconsistent
4. Disagree
5. Recommendation Ignored

Some interpretation was required in those instances in which CSC Action Plans did not explicitly state whether the Service agreed or disagreed with a finding of non-compliance or with a recommendation.

3.0 BASIC VICTIM AND INCIDENT CHARACTERISTICS

Table 1 shows that over 60 percent of the deaths in custody examined in this project were suicides and that the remainder was almost equally split among homicides and accidents. Almost nine of every ten suicides were by hanging, whereas stabbings accounted for over half of all homicides and drug overdoses accounted for 80 percent of the unintentional deaths. All but one incident involved men and three of every ten victims were under 30 years of age. Aboriginal persons accounted for more than a fifth of the victims.

Inmates who had been involuntarily transferred seemed to be especially at risk. In fact, one-fifth of the victims had spent less than 30 days at the institution at which their death occurred. There were other cases in which an impending transfer, the denial of parole, an unsuccessful appeal, or the loss of a significant other played a role, reinforcing the idea that transitions and other critical events in their lives can elevate the risk of self-injury and other types of harm.

More than 90 percent of the victims possessed a criminal record for a prior offence as an adult and/or juvenile, and over 90 percent were serving their last sentence for violent crimes. Almost a third of the victims were serving a life sentence and over half had passed their full parole eligibility date at the time of their death.

TABLE 1 – Key Characteristics of the Victims and Incidents (N=82)

VICTIM/INCIDENT CHARACTERISTIC	% OF ALL CASES
Homicides	20.7
Suicides	61.0
Accidents	18.3
Males	98.8
Under 30 years of age	29.3
Aboriginal descent	22.0
Incident occurred within 30 days of admission to that institution	20.7
Possessed a criminal record prior to most recent offence(s)	93.9
Most recent offence involved violence	92.7
Was serving life sentence	32.9
Passed full parole eligibility date	51.2

4.0 FINDINGS

Finding #1 - Several Concerns Are Raised Repeatedly by Investigative Boards and Coroners in a Significant Number of Death in Custody Cases

Table 2 displays the number and proportion of cases in which various concerns have been raised by BOIs or Coroners in their findings of non-compliance with existing practices or policies, or in their recommendations.

a) Post-Incident Medical/Emergency Care, Resources, & Decontamination

In almost two-thirds of the cases, some shortcoming was noted by a BOI or Coroner in the response of personnel to the emergency, in the adequacy of emergency resources, and/or in the decontamination of the area surrounding the victim in the immediate aftermath of the incident.

The concern that was perhaps raised in the largest number of cases related to the failure of officers to perform Cardio-Pulmonary Resuscitation (CPR), or a delay in so doing, upon the discovery of an inmate without any apparent vital signs. Delays in taking other actions (e.g., notifying health personnel or emergency responders) were also noted in a number of cases. Questions were raised about the adequacy of the training of officers in the administration of CPR and in the prevention of contamination through body fluids during its administration. In many cases, for example, officers did not wear protective masks. Overall, officers often appeared uncertain as to what to do when a body was discovered.

Additional shortcomings noted in the post-incident emergency response included:

- The inadequate decontamination of cells or other areas in which fatalities occurred;
- The absence of on-site defibrillators;
- Concerns about the quality of emergency care and nursing staff in several institutions, especially on the night shift;
- The inaccessibility of emergency supplies in institutions.

Table 2: Issues Raised in the Findings and Recommendations of Boards of Investigation and Coroners Following Deaths in Custody (N=82)

ISSUE	# OF CASES	% OF CASES
Post-Incident Medical/Emergency Care, Resources, & Decontamination	54	65.9
Recordkeeping and Information Sharing Among Staff Within Institutions	43	52.4
Security Practices, Video Surveillance, and Evidence Gathering	42	51.2
Patrols, Counts, and Live Body Verification	36	43.9
Mental Health Issues, Programming, and Suicide Prevention	36	43.9
Availability of Illicit Drugs & Paraphernalia, & Monitoring of Prescription Drugs	21	25.6
Post-Incident Stress Management Services for Staff & Inmates	18	22.0
Post-Incident Family Concerns—Notification, Personal Effects, Funeral Arrangements	11	13.4
Information Sharing Between Institutions	8	9.8
Inmates' Institutional Placement and Security Classification	6	7.3
Pre-Incident Medical Care and Resources	3	3.7
Private Family Visits—Screening of Visitors and Security Procedures	3	3.7
Expeditious Resolution of High Priority Grievances	3	3.7
Prevention of and Response to Prison Disturbances	3	3.7
Other Issues	21	25.6

b) Recordkeeping and Information Sharing Within Institutions

In more than half the cases, issues were raised about the failure of institutional staff to record relevant medical or mental health information on the inmate's file or to otherwise share such information with others working with an inmate. In a number of files, BOIs and Coroners noted that poor communications existed between health care or psychological personnel and those involved daily with inmates (correctional officers, members of the case management team). Information on stresses experienced by the inmates or threats against them often were not shared with other personnel. Mental health interventions and previous suicide attempts, which might have resulted in closer monitoring, were sometimes not noted in the inmate's file. In one case, the failure of an inmate who committed suicide to pick up his anti-depressant medication for three days was not shared with his case management team. In another case in which an inmate committed suicide following an unsuccessful appeal of his conviction, there was no alert in the Offender Management System (OMS) despite a history of self-harm, suicide attempts (including one following a previous unsuccessful appeal), and a history of substance abuse.

Recordkeeping issues also arose in relation to officers' rounds. The recording of these rounds appeared to be inconsistent, making it difficult to ascertain their precise timing and frequency in the post-incident investigation. In one homicide, officers sensed that an incident was going to occur and that they were being observed by inmates; however, they failed to record this in the log book. With regard to contraband, there was no alert in one case that a deceased inmate's wife had previously triggered a drug detection device. In a subsequent visit, the inmate choked on a bag of drugs he had swallowed to avoid detection. In addition, health care personnel were not always informed when searches of an inmate's cell revealed substantial quantities of prescription drugs that had been dispensed by health staff.

c) Security Practices, Video Surveillance, and Evidence Gathering

In over half the cases, BOIs and/or Coroners raised some security concern(s) or issue(s) pertaining to the collection or preservation of evidence. Concerns were raised repeatedly about the quality and coverage provided by video cameras. Evidence was sometimes lost or of low quality and video surveillance often was found to be inadequate in ranges, living units, and recreational areas. In a number of cases, cells were obscured by privacy panels, curtains, and mesh, making it more difficult to verify the condition of an inmate during patrols.

Inmate movements were sometimes found to be poorly controlled, especially during recreational activities. A number of homicides occurred in a gym area and, in one case, a metal bar was removed from a weight room and used as the murder weapon. In another case, an inmate was so intoxicated he fell to his death over a railing. The Coroner's report noted that closer supervision during free time was required so that a state of intoxication of such severity could not go unnoticed.

A number of killings and suicides were gang-related. Killings could be due to inter-gang rivalries or to discipline within a gang. Suicides had occurred due to gang-related pressures on inmates. The lack of anti-gang strategies or of trained security intelligence analysts was mentioned in several files.

d) Patrols, Counts, and Live Body Verification

In just under half the cases, issues were raised regarding some aspect of patrols or counts, including the failure of correctional officers to ensure that inmates were still alive in their cells. The main concerns related to range walks that may not have been done or counts that were done improperly. In several cases, questions were raised as to whether national protocols were needed with regard to rounds and counts in Native centers. Issues concerning the proper functioning of the Silverguard guard monitoring system were also mentioned in several files.

e) Mental Health Issues, Programming, and Suicide Prevention

In nearly half the cases, BOIs and/or Coroners raised concerns about the services available to inmates with mental health issues and to those with a history of self-injury. In a number of cases, there were suggestions that more could have been done to assist individuals with well documented records of self-harm and suicide attempts. In a number of files, questions were asked about the competence of clinical personnel and about the quality of assessments as to the mental state of an inmate or the degree to which he was at risk of committing suicide. In several cases, psychologists or psychiatrists wrongfully believed that suicide threats, suicidal ideation reported by the inmate, or abnormal behaviour were nothing more than malingering or manipulation on the part of the inmate. In one case, previous suicide attempts, declining mental health, and knowledge that the inmate was giving away his possessions did not lead the psychologist who assessed him to view the inmate as one at an elevated risk to commit suicide.

Some institutions reportedly do not have a multidisciplinary mental health team to assess inmates during intake, to deal with suicidal inmates, and to provide input into placements into, and releases from, mental health ranges. In several cases, it was noted that suicide watch was *de facto* segregation and did little to respond to the inmate's mental health needs. There were also many references to structural modifications in cells and shower rooms that would make it more difficult for inmates to commit suicide by hanging, the suicide method in close to 90 percent of the cases.

f) Availability of Contraband

In a quarter of the cases, BOIs and/or Coroners expressed concerns about the availability of illicit drugs and related paraphernalia, as well as about the administration of prescription drugs. References were made to the ease of bringing drugs into institutions and, in several cases, to the role played by spouses and girlfriends during family visits. It was noted in several files that an inmate had played a role in the institutional drug trade or "culture". The diversion of

methadone, following administration, was mentioned as one problem. Several victims had been found to be in possession of a large quantity of illegal substances, prescription drugs, and drug paraphernalia. One individual was reported to have consumed $1,000 worth of heroin daily. One Coroner lamented that it is difficult to talk about the rehabilitation of inmates when inmates have access to illicit substances.

g) Post-Incident Stress Management

Following more than a fifth of the incidents, officers and/or inmates were not offered services to deal with the stresses associated with a death in their midst. In some of these cases, stress management services were offered but they were not offered promptly.

h) Other Issues

A smaller number of cases involved such issues as post-incident family concerns, the failure to transfer critical information about an inmate who was transferring to another institution, the inappropriate placement of an inmate, pre-incident medical care, security procedures during private family visits, the failure to resolve an inmate's grievance in a timely fashion, and issues in the prevention of, and response to, prison disturbances.

<u>Finding #2</u> – There is No Evidence that Correctional Services Canada has Improved its Overall Capacity to Prevent or Respond to Deaths in Custody During the Five-Year Study Period

Finding #1 indicates that some issues continue to surface in death in custody cases. It is plausible that CSC has improved its capacity to prevent and respond to these cases over time. Two indicators were used to determine whether this was the case.

First, the number of non-natural deaths was compared over the five-year study period. Table 3 shows that there was a spike in deaths in 2003. This spike was followed by a number of fatalities in the final two years of the study period (2004-2005) that actually exceeded the number of deaths in the first two years (2001-2002). Furthermore, there was at least one additional case in 2005 that was excluded from the study, as the BOI report was unavailable as of November 1, 2006, the present study's cut-off date for including documents.

Table 3 – Deaths in Federal Institutions, 2001-2005 (N=82)

YEAR	# OF DEATHS
2001	15
2002	14
2003	23
2004	14
2005	16

A second measure of whether CSC's responses to deaths in custody were becoming more effective over time involved a comparison of incidents occurring in the last two years of the study period, with those taking place during the entire study period. Thus, did the BOI and Coroners' Reports raise fewer concerns following the incidents in 2004-2005 than from 2001-2003?

Table 4 indicates that there is no reason to believe that these concerns have diminished over the five-year study period. In fact, five of the six main categories of concerns were raised more often in the last two years of the study period than in the entire study period. Thus, in 2004 and 2005, post-incident emergency care and related issues were raised in three-quarters of the cases. Concerns with security practices were raised in 60 percent of the cases, while recordkeeping and information sharing, as well as patrols and counts, were mentioned as concerns in over half the cases. Issues relating to the availability of contraband were raised in a third of the cases in 2004-2005, as opposed to a quarter of the cases over the entire study period. It was only in relation to mental health issues that concerns were not raised more frequently in the last two years than in the study period as a whole.

Therefore, neither the analysis of the number of deaths from 2001-2005, nor the study of concerns raised by BOIs and Coroners, supports the assertion that fatalities have diminished over time or that CSC has responded more effectively, in 2004-2005, in the core areas frequently identified by BOIs and Coroners.

Table 4 – A Comparison of Issues Raised by Boards of Investigation and Coroners in Fatalities Occurring in 2004-2005 with Cases Occurring During the Entire Study Period

ISSUE	% OF CASES (2004-2005)	% OF CASES (2001-2005)
Post-Incident Medical/Emergency Care, Resources, and Decontamination	76.7	65.9
Security Practices, Video Surveillance, and Evidence Gathering	60.0	51.2
Recordkeeping and Information Sharing Among Staff Within Institutions	56.7	52.4
Patrols, Counts, and Live Body Verification	53.3	43.9
Mental Health Issues, Programming, and Suicide Prevention	43.3	43.9
Availability of Illicit Drugs & Paraphernalia, & Monitoring of Prescription Drugs	33.3	25.6

Finding #3 – Correctional Services Canada Tended to Act on the Findings and Recommendations of Boards of Investigation, but Often Disagreed With, or Took No Action on, Coroners' Recommendations

Table 5 illustrates that, in nearly three-quarters of the cases in which a finding of non-compliance or recommendation was made by an investigative board, CSC, either nationally or at the regional level, responded in a manner consistent with that finding or recommendation. Thus, it can be said that BOI findings and recommendations were treated seriously. In some cases, an Action Plan reported that the appropriate action had already been taken, while in other cases it was reported that a directive had or would be issued. It is beyond the scope of this project to verify whether concrete actions, consistent with a finding or recommendation, had actually been taken and whether such actions were sustained over time and applied regionally or nationally, when the recommendation urged that this be done. This analysis is based on the assumption that statements made on CSC Action Plans and regional responses are accurate.

In another 8 percent of the cases, the Service agreed with a BOI finding or recommendation but either took no action or, in a few rare cases, took an action that was inconsistent with a finding or recommendation. CSC ignored 11 percent and disagreed with 8 percent of BOI findings and recommendations.

CSC was more likely to resist or to fail to act on Coroners' recommendations. The Service complied with just over a third of the recommendations. CSC asserted that it disagreed with nearly another third of the recommendations. The Service agreed with, but took no action on, another 27 percent of the Coroners' recommendations.

When BOI and Coroners' findings and recommendations are combined, CSC agreed with and acted consistently on these in over two-thirds of the cases. This finding begs the question as to why similar issues continue to arise in fatal incidents in federal institutions if, in most instances, the Service takes concrete measures to improve its capacity to prevent and respond to acts of self-injury and assaults. Further investigation is required to assess the implementation of BOI and Coroners' recommendations.

Table 5 - Correctional Services Canada's Responses to Boards of Investigation and Coroners' Findings and Recommendations Following Deaths in Custody

RESPONSE	TO BOI REPORT	%	TO CORONERS' REPORTS	%	ALL RESPONSES	%
Agree: No Action	24	6.5	18	27.3	42	9.6
Agree: Action Consistent	270	72.6	25	37.9	295	67.4
Agree: Action Inconsistent	7	1.9	0	0	7	1.6
Disagree	30	8.1	21	31.8	51	11.6
Finding/Re-commendation Ignored	41	11.0	2	3.0	43	9.8
Total	372	100.1*	66	100.0	438	100.0

***** Column does not equal 100% due to rounding error

<u>Finding #4</u> – Typically, A Significant Period of Time Elapses Between An Institutional Fatality and the Adoption, by Correctional Services Canada, of Formal Measures to Address Issues Arising From It

Table 6 displays the amount of time elapsing from the date a fatality occurred to the completion of the BOI Report and the formal approval of remedies at the national or regional level. A small number of cases were excluded from these analyses where the inmate's file was unclear as to the date of the submission of a BOI report or the date of the adoption of an Action Plan by CSC's Executive Committee.

The table shows that an average of 165 days (over 5 months) elapsed between an incident and the completion of the BOI report. An average of another 10 months elapsed between the completion of the BOI report and the review of remedies by CSC's Executive Committee or at the regional level. Thus, it took an average of nearly 16 months following fatalities to formally adopt measures to address issues arising from the incidents. The 16-month figure underestimates the true length of time. As there was no Action Plan in 14 of the 75 cases in which clear dates were available from the files, the study cut-off date of November 1, 2006 was used to calculate the promptness of the Service's response. It is possible that, in some of these 14 cases, it may be many additional months before an Action Plan is drawn up and approved.

Averages are deceptive in that they may obscure extreme values. In 15 of the 75 cases with clear dates available in the files, Action Plans were approved within six months of the incident. However, on the other extreme, 10 cases were not resolved until at least two years after the incident and 7 of these cases did not receive the approbation of senior officials for at least three years following the incident.

Table 6 – Average Number of Days Elapsing Between Deaths in Custody and Key Phases of Correctional Services Canada's Responses

FROM INCIDENT TO SIGN-OFF OF THE BOI REPORT	FROM BOI REPORT TO APROVAL OF ACTION PLANS	FROM INCIDENT TO APPROVAL OF ACTION PLANS
165 days	310 days	475 days

<u>Finding #5</u> – It is Likely that Some of the Deaths in Custody Could Have Been Averted Through Improved Risk Assessments, More Vigorous Preventive Measures, and More Competent and Timely Responses by Institutional Staff

It is difficult to say, with any certainty, that a particular fatality could have been prevented had institutional staff performed some action differently. The life of an inmate bent on suicide, for example, may be saved as a result of the actions of vigilant and competent staff, only to be extinguished in subsequent attempts. Thus, in some cases, staff acting in an optimal manner and in compliance with all existing procedures, cannot avert that which appears to be inevitable.

Notwithstanding this point, to suggest that none of the deaths could have been prevented would reflect a fatalism that would be an enormous impediment to an improvement of practices in any system. It would also ignore the fact that many people may have a history of suicide attempts and eventually desist from actions that are self-injurious. Also, the fatalistic notion that nothing can be done to prevent suicides and homicides ignores the impulsive nature of many of these acts. There is much evidence in the behavioural sciences that rage and despair leading to these extreme acts are often transient and may quickly dissipate following unsuccessful suicide or homicide attempts. Therefore, those responsible for the care of individuals at high risk of harm ought to strive to prevent as many incidents as possible, to analyze them, and to implement constructive remedies.

It is beyond the scope of this project to arrive at a figure representing the number of incidents that might have been prevented had institutional staff, in each case, responded in an exemplary manner, had all resources been in place, and had all preventive actions possible been undertaken. In many cases, however, it is clear that the Service fell short in implementing its own policies and practices, and in doing everything possible to avert a fatality. Table 2 indicates that BOIs and Coroners raised a number of concerns in the majority of cases. One might infer from this that a number of deaths might not have occurred had CPR been administered more

promptly, had officers received better training in First Aid, rounds and counts been done properly and on time, crucial information shared with mental health or front-line staff, mental health assessments and placements done more prudently, and so on.

In fact, in a few cases, a BOI or Coroner/Medical Examiner indicated that a particular action or omission on the part of institutional staff may well have contributed to a fatality. In one suicide case, the Board noted that there was no evidence the inmate should have remained in segregation after the fifth day review and noted that this may have contributed to the suicide. The inmate had a history of suicidal behaviour, substance abuse, impulsivity, and had no stable emotional relationships. At the time of his suicide, he was hearing voices, behaving strangely, and pacing in his cell. Segregation was thought to exacerbate his condition.

In a case involving a drug overdose, the BOI noted that the staff did not ensure that a live body was counted during the 12:30 and 4:30 counts. The Board further asserted that if the proper live body verification had been done, the outcome might have been different.

In one homicide case, the institution was at heightened readiness for a disturbance due to escalating tension. The disturbance nevertheless ensued and the murder, which was enabled by the disturbance, occurred. In another homicide, staff viewed the assault but failed to intervene effectively. A spray (likely pepper spray) was used to neutralize the assailant but was ineffective. The BOI noted that there is no standard national training in managing these types of situations. It further noted that there was also a delay in calling the ambulance as none of the staff on duty at the time knew the emergency number.

In a number of suicide and drug overdose cases, Boards and Coroners have commented on the ease with which inmates can access drugs and alcohol. In several files, it was mentioned that the diversion of methadone and prescription drugs was a chronic issue at some institutions. One Coroner's report dealing with an inquest into a methadone overdose mentioned that inmates were adept at transferring contraband to one another, even in segregation. In addition, several accidental deaths were related to the smuggling and trafficking of contraband. Two inmates choked to death on a bag of drugs brought in during a family visit. In one of these cases, the spouse had previously triggered a drug detection device, yet no alerts were present on the Offender Management System. One highly intoxicated inmate fell to his death over a railing. Several other suicides and homicides were linked to the institutional drug trade and the accumulation of drug-related debts.

A number of inmates who committed suicide were deemed to be malingering or, for other reasons, were not viewed as being at risk, despite previous attempts, substance abuse problems, and mental health issues. In one case, the inmate had this profile, in addition to giving away some of his possessions. Nevertheless, the psychologist who assessed him did not recommend that monitoring of the inmate be increased. In other cases, inmates with a history of self-injury made statements about their intention to commit suicide or were distraught about some matter and no additional monitoring was ordered. In several suicide cases, BOIs and Coroners commented on structural elements in cells that may have facilitated a suicide.

Several cases were marked by a virtual comedy of errors. In one case, an inmate who died of an accidental overdose was known to have overdosed on two previous occasions. His death was discovered slowly due to the failure of officers to conduct a proper count and the failure of staff to notify officers that he did not report to work. Upon discovery of the body, officers did not conduct CPR. In another example, this time a homicide case, officers sensed something was wrong and that they were being observed by inmates, while conducting their rounds. They took no action and made no record of this event. The homicide ensued and there was a delay in discovering the body and in notifying the police. In another homicide case, outdated health care facilities precluded the treatment of an inmate who had been assaulted. The inmate did not appear to have life-threatening injuries. In addition, officers failed to call an ambulance promptly and also did not deliver first aid.

Gang activities were considered to have played a role in a number of homicides and suicides. In eleven of the cases (13.4%) and close to half of the homicides, the file clearly indicated that the incident was gang-related. Several gang-related killings occurred just hours after a transfer to an institution with obvious incompatibles. In one case of a gang member who was murdered within hours of an institutional transfer, there were no notes on the transfer documents to the effect that there were two incompatible inmates in the receiving institution.

Apart from the case material discussed above, there is additional evidence that the victims of homicides, suicides, and fatal accidents in custody may constitute a high-risk sub-population within the federal correctional system. Overall, more than half of the files indicated that there were proximal or more long-term pre-indicators of the event.

Although the information on federal inmates available to this project is limited, some comparisons and observations can be made in relation to the largest group, the suicide victims. The vast majority of suicide victims displayed a history of substance abuse (91.8%); had previously attempted suicide (82.2%); and had previous institution infractions, escapes or violations of conditional releases (68.0%).

In addition, mental health issues pertaining to suicide victims were discussed in almost all files reviewed. A complete breakdown and assessment of the types of mental health issues was not undertaken in this study, as the files reviewed consisted of a combination of observations, symptoms, and/or mental health diagnoses. The CSC conceded in its recent Mental Health Strategy that its intake assessment of the mental health of offenders upon admission is inadequate (e.g., it consists of a few questions on such matters as previously psychiatric hospitalizations and prescriptions for psychotropic medications). Only offenders with evident, very serious mental health issues or symptoms are referred for a more comprehensive psychological assessment by either a psychologist or a psychiatrist.

The lack of comprehensive mental health assessment at intake hinders the ability of CSC to better identify those at risk of committing suicide, as well as those at risk of attempted suicide or self-injury. A sound and comprehensive mental health intake assessment is required for CSC to implement a more effective suicide and self-injury prevention strategy. The CSC's Mental Health Strategy also calls for significant investments in the care, treatment and support of offenders in custody with mental health issues. Without a comprehensive intake assessment and adequate mental health services, care and support, some offenders will continue to fall through the cracks.

5.0 SUMMARY AND CONCLUSIONS

This project reviewed *all* deaths from 2001-2005, occurring in federal custody and deemed to be due to other than natural causes. During that period, all cases in which a Board of Investigation had been convened and submitted its report were included. Therefore, in statistical terms, this was a study of a "population" rather than a "sample". Just over 60 percent of the 82 cases examined were suicides. Homicides and accidents (usually drug overdoses) each accounted for approximately one-fifth of the total. All but one of the cases involved men. Many of the victims were young men—30 percent were under the age of 30—and over a fifth was of Aboriginal descent. A disproportionate number of incidents occurred following an institutional transfer. Over 90 percent of the victims had a criminal record prior to the offence for which they were incarcerated at the time of their death. Over nine out of ten were serving sentences for violent offences. Close to a third were serving life sentences and more than half were past their full parole eligibility dates.

The present study provides strong support for the belief that certain issues continue to arise in fatalities occurring in federal institutions. Concerns relating to post-incident emergency care, recordkeeping and information sharing within institutions, and various security matters were raised by BOIs and/or Coroners in more than half the cases. Concerns relating to mental health programming and suicide prevention, as well as with counts or patrols, were raised in over 40 percent of the cases. Issues relating to the control of illicit or prescription drugs and those dealing with post-incident stress management also surfaced in a significant number of cases. There was no indication that these problems have abated over time. Specifically, this analysis showed that they arose as frequently, and sometimes more so, over the past two years. In addition, the annual number of fatalities is not declining.

These findings support the concern that, overall, Correctional Services Canada is not incorporating into current practices, the lessons that can be learned from previous incidents. Further investigation is needed to understand the impediments to reform in order to minimize the number of fatalities occurring in custody.

A review of CSC's Action Plans, the Service's formal response to Board of Investigation findings and recommendations, does suggest that BOI reports are taken seriously, as CSC's Executive Committee and Regional officials usually agree with and issue directives that are consistent with BOI recommendations. However, further investigation is required to determine whether corrective action is actually implemented nationally or regionally and whether it is sustained, as similar problems continue to persist.

The analysis of CSC's responses to Coroners' recommendations suggested that the Service disagreed with, ignored, or failed to take any action in relation to more than 60 percent of these recommendations. Further investigation is required to understand the rejection of such a high proportion of Coroners' recommendations. The development of a dialogue between CSC and Coroners' offices appears to be warranted. It should be noted that Coroners' reports often do not contain recommendations and, when recommendations are made, they are usually few in number. Therefore, these offices cannot be accused of dispensing an excessive amount of advice to correctional officials.

The present study also found that the time elapsing between a fatality and the formal response of the correctional system is considerable. On average, this figure is 16 months, although some cases take more than three years to resolve. This matter has been the subject of many correspondences between the Service and the Office of the Correctional Investigator. Every effort needs to be made to expedite the investigation of incidents and the response to them.

There are indications that some of the fatalities occurring in the past five years might have been prevented. Some BOI reports suggest that the outcome of several cases may have been different had institutional staff discharged their duties as required. In some cases, staff failed to comply at a number of levels. There were serious errors made in assessing the suicide risk of several victims and gross errors on the part of medical staff in responding to emergencies. First responders (often correctional officers) often did not know what was expected of them and frequently failed to administer first aid. Emergency medical resources were often unavailable, especially at night. One major concern has been the absence of Automatic External Defibrillators as standard equipment in institutions. Vital information pertaining to an inmate's propensity to self-injure or risk of assault often went unrecorded or unshared, both within and among institutions. More than half the files indicated that there were pre-indicators to the incident. Furthermore, many of the victims appeared to be at higher risk than the norm by virtue of their mental health issues and previous suicide attempts.

Further study is required as to how risk assessments can be undertaken on a more routine basis. Ideally, this should be the work of a multidisciplinary team, rather than the responsibility of one professional. There should be more attention to the recording and sharing of information on the risks to which inmates are exposed and careful monitoring to ensure that a comprehensive risk management strategy is implemented across the federal system. Such a strategy might include a more formal examination of all suicide attempts, as these are often harbingers of successful suicides.

APPENDIX A

CODING FORM

OCI FILE #		
INSTITUTION		**FPS #**

Name		Sex	Age	Cause of Death
D.O.B.		Aboriginal Yes _____ No ____		

Date of Incident	
Date of CSC's Investigation Report	
Date of EXCOM's Response or Region's 1st Re	
Length of Sentence	
Sentence Commencement	
Admission to Institution	
Day Parole Eligibility (passed or date)	
Full Parole Eligibility (passed or date)	
Statutory Release Date	
Warrant Expiry Date	

CRIMINAL HISTORY

None ____ Juvenile ____ Adult ____ Juvenile & Adult ____

OFFENCES	VIOL	VSEX	SEX	PROP	DRUG	WEAP	OTH
Previous Offences							
Index Offences							

Viol = violent i.e. (murder, manslaughter, robbery, assault, kidnapping, hostage , threats)
Vsex = violent sex offences (i.e. sexual assault levels 1-3)
Sex = non violent sex offences (i.e. exhibitionism, invitation to sexual touching, exploitation)
Prop =property (i.e. break & enter, theft, forgery, possession of stolen goods)
Drug =drugs (i.e. possession or trafficking of illegal or scheduled substance)
Weap =weapons (i.e. possession of prohibited / restricted weapon)
Oth =other (i.e. prostitution)

RISK FACTORS	YES	NO	DK/ NA
Proximal Pre-Indicators			
Long-Term Pre-Indicators			
Substance Abuse			
Previous Suicide Attempts			
Mental Health Issues			
Active Intervention for Mental Health Issues			
Family Support			
Conditional Release Violations			
Institutional History			
• **Cooperative**			
• **Program Participation**			
• **Violations / Escapes**			

(dk=don't know, n/a=not applicable)

ISSUES RAISED IN THE FINDINGS AND RECOMMENDATIONS IN CSC'S AND CORONER'S INVESTIGATIONS

CSC Board of Investigation Recommendations:

Recom. #	Code #	Directed To			CSC Response				
		Inst.	Region	National	Agree: No Action	Agree: Action Consistent	Agree: Action Inconsist.	Disagree	Recom. Ignored
1									
2									
3									
4									

Other_____

CSC Board of Investigation's Key Findings Not Appearing in Recommendations:

Finding #	Code #	CSC Response				
		Agree: No Action	Agree: Action Consistent	Agree: Action Inconsistent	Disagree	Finding Ignored
1						
2						
3						
4						

Other_____

Coroner's Recommendations:

Recom. #	Code #	CSC Response				
		Agree: No Action	Agree: Action Consistent	Agree: Action Inconsistent	Disagree	Recom. Ignored
1						
2						
3						
4						

Other_____

Noteworthy Quotes and Source:

Appendix B
Issued Raised in the Recommendations and Findings of CSC and Coroners

1. Patrols, Counts, and Live Body Verification

2. Pre-Incident Medical Care and Resources

3. Post-Incident Medical/Emergency Care and Resources, as well as Decontamination

4. Mental Health Issues, Programming, and Suicide Prevention

5. Security Practices, Video Surveillance, and Evidence Gathering

6. Custody and Care Issues--Availability of Illicit Drugs, Drug Paraphernalia, Weapons, and Monitoring of Prescription Drugs

7. Inmate's Institutional Placement and Security Classification

8. Private Family Visits—Screening of Visitors and Security Procedures

9. Sensitivity to Family Concerns (Post-Incident)—Notification, Personal Effects, Arranging Funerals

10. Provision of Post-Incident Stress Management Services to Staff and Inmates

11. Expeditious Resolution of High Priority Grievances

12. Prevention of and Response to Prison Disturbances

13. Information Sharing Between Institutions

14. Recordkeeping and Information Sharing Among Staff Inside Institutions

15. Other_____