OFFICE OF THE CORRECTIONAL INVESTIGATOR (OCI)

Final Assessment

Correctional Service of Canada's Response to Deaths in Custody

September 08, 2010

Introduction

This is the fourth (and final) quarterly assessment of the Correctional Service of Canada's (CSC) *Response* to the findings and recommendations of a series of internal and external (Office of the Correctional Investigator – OCI) reports, studies and investigations examining preventable deaths in federal custody. This final assessment focuses on CSC's response and commitments to date to prevent deaths in custody and details some areas of ongoing and immediate concern.

The factors that contribute to preventable deaths in custody, both individual and systemic, have been extensively documented:

- OCI *Deaths in Custody Study* (February 2007), an examination of 82 non-natural deaths (e.g. suicides, homicides and accidental deaths) occurring in federal correctional facilities between 2001 and 2005

- CSC *National Board of Investigation into the Death of an Inmate (Ashley Smith) at Grand Valley Institution for Women on October 19, 2007* (February 2008)

- CSC Incident Investigations Branch – *Significant Findings from National Investigations on Inmate Suicides* (April 2008)

- CSC *Annual Inmate Suicide Report(s)* (2002 and ongoing)

- OCI investigation – *A Failure to Respond: Report on the Circumstances Surrounding the Death of a Federal Inmate* (May 2008)

- OCI investigation – *A Preventable Death* (June 2008), OCI investigation into the death of Ashley Smith (report publicly released in March 2009)

- CSC Incident Investigations Branch – *Significant Findings from National Investigations into Deaths by Natural Cause* (January 2009)

- CSC Incident Investigations Branch – *Deaths in Custody: Highlights and Significant Findings* (Activity Report, May 2010 and ongoing)

My Office issued its *Initial Assessment* of CSC's *Response* to the issues raised in our deaths in custody investigative reports in September 2009. Since then, the Office has issued two other quarterly assessments – in December 2009 and again in March 2010. These documents – the Service's *Response* and OCI *Assessments* – are part of the public record and can be accessed at our website (www.oci-bec.gc.ca).

In this final assessment, the objective is not simply to reissue recommendations or repeat findings from previous reports. I believe the way forward is clear. It is critical that the Correctional Service translate findings, recommendations and lessons learned into demonstrable and sustainable progress on the ground. The preservation of life is an integral part of the mandate of the Correctional Service. I expect this principle to be embedded in policy, reflected in the culture of the organization and orient its day-to-day interactions with offenders. The preservation of life involves an integrative "continuum of care" perspective. It requires heightened and continued vigilance and it cannot be done in isolation, in a piecemeal or silo fashion. All sectors of the CSC – security, health services, case management, programming, staff training, research and education – must work together in a common purpose.

Assessment of Latest Initiatives

In the third quarter assessment, we noted a series of promising initiatives that had been launched in response to some of the recommendations made in the Office's deaths in custody reports. During this quarter, CSC's Verification Team, examining progress on key commitments relating to deaths in custody, concluded its audit of 11 select federal penitentiaries. The team made 18 recommendations in the areas of resources and communications, dynamic security, segregation and mental health.

In July 2010, my Office received three additional external reports that were commissioned by the Service in response to recommendations made in our Ashley Smith investigation, *A Preventable Death*. Considered together, these three independent reviews, which examine CSC`s complaints and grievance process as well as long-term segregation of inmates with mental health concerns, issue an additional 128 recommendations.

My Office endorses the findings and recommmendations of the internal verification audit and three external reports. In the public interest, the Service is encouraged to do the same, and release these reports along with its detailed response and action plans.

Other significant developments during this quarter include:

- Launch of an Independent Review Group that will assess, on an annual basis, the appropriateness and adequacy of corrective measures initiated by the Correctional Service in response to various deaths in custody reports.

- Annual meetings with provincial and territorial Chief Coroner and Medical Examiner's Offices to discuss and explore ways of improving CSC strategies to prevent deaths in custody.

- Promulgation of procedural *Guidelines* for the use of Automated External Defibrillators (AEDs) in federal correctional facilities.

- Dissemination of a *Security Bulletin* entitled “Infrastructure vulnerabilities – Points of suspension and suicide prevention.”

- Internal (Infonet) posting of *Deaths in Custody: Highlights and Significant Findings,* Bulletin 3 (Activity Report January – March 2010).

These are important activities. They reflect the Correctional Service’s commitment to improve its performance in relation to the prevention and reduction of deaths in federal correctional facilities. As before, I encourage the CSC to make public its efforts to reduce preventable deaths in custody.

Final Assessment

It has been nearly three years since Ashley Smith died in Grand Valley Institution for Women. Between October 2007 and August 2010, another 130 inmates have died in federal custody. I believe it is in the public interest to determine if the actions and efforts of the Correctional Service of Canada have adequately met the challenges set by the commitment to make preventable deaths a corporate priority.

This assessment presents nine case summaries of deaths in custody that occurred between April 2008 and April 2010. The cases were purposefully selected because they highlight significant, and, in many instances, recurring patterns and themes. Individually and collectively, the cases illustrate the complexity of the challenge facing CSC in preserving life in a correctional context. Each case yields important findings in its own right, but also points to the general need for more rigorous attention to certain preventative measures, particularly in cases involving more vulnerable, “at-risk” populations.

Five of the deaths were suicides, and one death resulted from medical complications arising from chronic self-injurious behaviour. In two of these deaths, the deceased was of Aboriginal descent. Another suicide was a young, first-time federal offender serving a two-year sentence. Some of the deaths involved offenders with mental health issues. Three cases were recorded as death by “natural” causes, although the cause of death in one case is “unknown.”

The facts reported in these cases are extracted from the Correctional Service’s own Board of Investigation reports. The contents of the summaries have been factually corroborated against the existing documentary record, including information received on staff disciplinary measures related to incidents involving the death of an inmate. In some instances, internal investigations may still be in process. Coroner inquiries into the cause or circumstances of the death may or may not have been initiated or available at time of writing.

In each case, a summary of the Office's concerns are noted. A sampling of these concerns include:

- Quality of care received
- Lack of appropriate or timely medical follow-up or intervention
- Critical information-sharing failures between clinical and front-line staff
- Improper or inadequate observation, surveillance and evaluation of suicide risk
- Quality of national board of investigation reports.

These are not, by any means, new issues for the federal correctional authority. All of the factors contributing to the deaths reviewed in this assessment have been identified in previous reports and investigations. Indeed, an internal (CSC) Activity Report summarizing highlights and significant findings from fifteen (15) deaths that occurred in federal custody between January and March 2010 identified the following compliance issues:

- Recording, reporting and sharing of information
- Inconsistencies in specific patrols and counts
- Concerns regarding timely responses by Health Care
- Location of cell alarms for physically handicapped inmates
- CPR performance
- Issues related to unprotected suspension points.[1]

According to the Activity Report, "corrective measures had been taken to address all the issues identified above."

As was concluded in the Office's 2007 *Deaths in Custody Study*, it is likely that some of the deaths currently under review could have been prevented through improved risk assessments, more vigorous preventive measures, and more competent and timely responses to medical emergencies by institutional staff. There clearly remains room for improvement.

[1] Incident Investigations Branch, *Deaths in Custody: Highlights and Significant Findings* (Activity Report, January – March 2010), May 10, 2010.

I do not dispute the activity, efforts and commitment of CSC toward the "preservation of life" principle. However, measurable progress, including a performance indicator framework to record improvement or deficits over time against well-defined criteria, is not yet where it should be. The latest numbers do not show a reduction in the rate of offender deaths by other than natural causes.[2]

Information-Sharing Concerns

Indeed, the suicide cases reviewed here reveal a recurring pattern of deficiencies insofar as the capacity to identify, recognize and piece together pre-indicators of suicide risk. CSC staff has received training with respect to identifying factors associated with a risk of self-harm or suicide. Many institutions make use of a color-coded notice system to inform front-line staff when an offender is placed on enhanced monitoring or suicide watch status. Yet, in a number of suicide cases summarized here, effective information sharing could have made a difference to the intervention and prevention efforts of both clinical and front-line staff. Being able to quickly ascertain, communicate and respond to a change in offender routine or behaviour is an essential component of a robust suicide prevention and situational awareness strategy.

We know that many suicide attempts have been interrupted by clinical interventions and alert officer responses. We will never know how many lives are saved by quality security patrols, enhanced monitoring or timely and responsive interventions of front-line staff, health care and clinical professionals. The cases reviewed here, unfortunately, reveal only the failures, not the successes. As the Service itself acknowledges (and we agree), it is extraordinarily difficult to stop a determined and resourceful offender from purposefully ending his/her life in a prison setting. The intent in presenting these case summaries is not to blame particular individuals, but rather illustrate the ongoing challenges that confront CSC in preserving life in a prison setting. We hope in so doing this will point the way towards enhanced life-saving practices.

Quality of Security Rounds and Patrols – Dynamic Security

In a number of recent deaths in custody, natural and otherwise, CSC's investigation reports reveal compliance issues regarding security patrols and emergency response protocols. In some cases, internal investigations reveal that patrols were not conducted according to policy. There is an obligation to ensure security rounds are completed on a random rather than routine, predictable or regular schedule.

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[2] Total number of overdoses resulting in death in 2008-09 was 2; in 2009-10 it was 1. Total number of murders in 2008-09 was 2; in 2009-10 it was 1. Total number of suicides for 2008-09 was 9; in 2009-10 it was also 9. Total number of deaths by unknown causes for 2008-09 was 4; in 2009-10 it was 7. (Deaths by unknown causes category refers to those unsuspicious deaths where the exact cause of death has yet to be determined by the Chief Coroner or Medical Examiner's office.) Source: CSC Performance Management.

However, it is not just the quantity or intervals between security rounds that will make the difference in reducing preventable deaths, but the quality and vigilance in which these patrols are conducted. Some patrols were found to be conducted so rapidly that officers did not take the time to ensure the presence of a live and well person in each cell.

Regular staff-offender interaction is a key component of effective dynamic security, which makes for safer and more positive living and working conditions for both groups. This point is illustrated in the case of the inmate who hanged himself in a standing position. Previous patrols had failed to report or notice that the inmate was suspended from a shelf.

Timely and Responsive Interventions

As referenced in the second and third quarter assessments, my Office is increasingly concerned with so-called “natural” cause deaths. Three deaths by natural causes – i.e. deaths deemed not to have been caused by suicide, homicide or accident – are included in the case summaries to highlight other challenges related to the “preservation of life” principle. In many circumstances, correctional officers are the first responders to medical emergencies. In these cases, officers must rely on their training, experience and instinct to preserve life in a situation where every second counts.

It is troubling, therefore, to find that some front-line officers are not carrying the required emergency equipment on their person (e.g. CPR mask, gloves) when confronted with a medical emergency. Although it is far less common than before to see cases where correctional officers equip themselves with protective and/or security gear (e.g. batons, shields, pepper spray) before entering a cell in a medical emergency, in one of the cases reported here the correctional officers did exactly that because it was deemed the proper practice on that particular unit, despite the local practice conflicting with national directives on medical emergency interventions.

It is acknowledged that CSC faces extremely difficult challenges in preventing deaths in custody as the number of offenders with mental health issues increases. In one case, correctional officers sought to place an inmate outside the general population unit due to problematic behaviour. Health care staff attested the inmate could safely be placed in segregation, notwithstanding the possible mental health causes underlying the problematic behaviour. Basic levels of care, treatment and protection mandated by law and policy were simply not met in this case. In another case, health care staff thought an inmate was exhibiting symptoms of mental illness while in fact his behaviour was related to brain damage caused by an aneurysm. The inmate had no previous mental health diagnosis and his behaviour and attitude were simply noted as “odd.” A complete physical health care assessment may have accelerated an accurate diagnosis and life-saving intervention.

In yet another case, years of extreme and chronic self-injurious behaviour in prison eventually culminated in the death of a 28-year old male in an outside hospital. Given the extended duration and extreme nature of self-harming, and the fact that the Service had convened no less than eight investigations over the course of the offender's incarceration, my Office recommended that a National Board of Investigation be convened, chaired by an external health care professional. The Service has agreed to conduct a national investigation, albeit chaired by a CSC health professional. It may be found that even the most determined correctional and medical efforts, including extended periods of outside hospitalization, solicitation of external advice and different treatment interventions may not have made a difference in changing the extreme self-injurious behaviour of this offender while in a prison environment. Unfortunately, for this young man, there were no complex needs or intermediate care units in place to provide the level of intensive support and specialized care that would seem to have been necessary in this case.

Corrective Measures, Accountability and Lessons Learned

Separate staff disciplinary investigations were conducted as a result of four of the deaths. Some of the internal disciplinary investigations raised compliance and performance issues; three investigations resulted in formal staff disciplinary action ranging from a written reprimand to 12 day suspension without pay. In all other cases, staff response was not subject to disciplinary review.

With respect to corrective measures, the National Boards of Investigation (NBOI) that have reported to date have made recommendations in four separate cases. Where recommendations are made, they appear to us as being inconsistent with the seriousness of the deficiencies noted in the Board's own findings. The internal investigative reports typically provide no focus on issues of accountability. In terms of corrective measures, they tend to generically focus on the need for policy compliance, policy clarification or enhanced training. NBOI reports are not made public, nor are they automatically provided to family members.

According to CSC policy, the purpose of the internal investigative process is to ensure that:

1. Appropriate action is taken following an incident

2. Lessons learned from the review and analysis of reports are integrated into organizational practices

3. Responsibility, accountability and transparency are demonstrated.

Our review and corroboration of NBOI reports against the documentary record notes a series of common and ongoing deficiencies:

- Quality of the internal investigative process and reports (e.g. undue focus on chronology and background rather than critical analysis and commentary).

- Limited external, independent or expert representation on the board of investigation membership.

- Lack of demonstrable and sustained progress with respect to integrating lessons learned consistently across the Service's five regions of operations.

Findings and Summary Recommendations

The cases selected highlight significant and recurring compliance issues. Not surprisingly, the Service's own internal investigative process found common deficiencies, and both individual and systemic concerns. Lessons can be drawn, corrective measures identified and remedial actions implemented as a result of these findings. Mistakes and recommendations should not need to be repeated. Lessons learned from a single death should have lasting impact on the correctional environment.

There are significant weaknesses in the overall quality of the internal review and oversight mechanisms in place, resulting in reduced management focus and accountability for safe and effective custody practices. It is a constant challenge to balance professional duty of care and preservation of life obligations against operational imperatives. Security and clinical interventions need to be seen as complementary, not mutually exclusive activities. From a preventative standpoint, there are some particularly high risk areas that require a rigorous internal review and accountability framework – the use of segregation and solitary confinement to manage offenders at risk of suicide and the application of physical restraints to manage self-injurious offenders come immediately to mind. It also is clear that public reporting is a key accountability element in assessing the Service's progress and capacity to preserve life and prevent deaths in custody. Lessons learned must be translated into activities and measures that make a demonstrable and sustained difference.

The nine cases reviewed for this report found common deficiencies in the following areas:

1. Response to medical emergencies.

2. Sharing of information between clinical and front-line staff.

3. Monitoring of suicide pre-indicators.

4. Quality/frequency of security patrols, rounds and counts.

5. Management of mentally ill offenders.

6. Quality of internal investigative reports and processes.

As a result of the noted deficiencies, I make the following recommendations:

1. I recommend that the Service develop a comprehensive public accountability and performance framework to ensure sustained progress in addressing factors related to preventing deaths in custody.

2. I recommend that the Service provide 24 hour per day / 7 days per week health care coverage at all maximum, medium and multi-level institutions.

3. I recommend that basic information and instruction for managing offenders at risk of self-injury or suicide be shared with front-line staff so as to ensure effective monitoring, crisis response strategies and prevention protocols are easily and readily accessible.

4. I recommend that the quality of security patrols be enhanced by introducing audit and accountability measures to ensure rounds and counts are conducted in a manner consistent with preservation of life principles.

5. I recommend that the practice of placing mentally ill offenders at risk of suicide or serious self-injury in prolonged segregation be prohibited.

6. I recommend that the Service strengthen its national investigative framework to ensure principles of independence, accountability and transparency are entrenched in the review of lessons learned and implementation of corrective actions. To that end, National Boards of Investigation involving suicide and serious self-injury should be chaired by an external health care professional and their reports be made public.

7. I recommend that the Service create a senior management position exclusively responsible for promoting, monitoring and ensuring Safe Custody practices.

Conclusion

Preventing deaths in custody is challenging work. There are no shortcuts. Even the slightest of errors or omissions – failure to record or communicate a change in an offender's behaviour, for example – can lead to tragic if unintended

consequences. Despite appropriate policy, a legal duty of care and the best efforts of staff, a prison is not a hospital. Security is always a factor. Managing health care emergencies is complex, precarious and demanding even in the most technologically sophisticated and advanced emergency departments. In a custodial setting, it is all the more complicated by the constant necessity to balance security concerns against a legal duty of care.

There is no denying the initiative and direction that the Service has taken to address factors related to preventable deaths in custody. From the very highest levels, it is clear that the organization is seized of the issue and is determined to improve both its capacity and performance in this area of corrections. While this commitment deserves recognition and commendation, my Office calls for sustained progress and transparency.

In the final analysis, I return to issues of accountability and governance. In concluding the quarterly assessment exercise, I note that the Service has not moved on some key issues that have the potential to significantly impact on preventable deaths in custody. Disturbingly, the same governance and accountability structures and gaps in mental health services that failed young Ashley Smith are still largely in place. Security concerns still largely tend to trump clinical interventions. Wardens of women's institutions still do not report to a central, national authority. Mentally ill prisoners being held in long-term segregation (beyond 60 days) still are not independently and expertly monitored. Chronic self-harming offenders with serious mental health issues are still subject to a disproportionate number of involuntary placements in segregation. Intermediate mental health care and specialized units for managing chronic self-harmers still need to be created. And finally, policy regarding National Boards of Investigation involving incidents of suicide and serious self-injury still does not require the investigations to be chaired by independent mental health professionals or be released to the public.

ANNEXES

CASE SUMMARY NO. 1

SUICIDE BY HANGING OF A 41 YEAR OLD INMATE

Background:

An inmate was found hanging in his cell in the Fall of 2008. He was 41 years old. He was serving a two-year sentence.

The deceased was of Inuit descent; his mother was from a community that was displaced in the late 1950s. Historically, this community has had serious problems with very high rates of substance abuse, violence and foetal alcohol spectrum disorder.

The deceased had serious alcoholism and dependency problems and a lengthy criminal history consisting of convictions for assault, many of which involved incidents with members of his family. The sentence that he was serving at the time of his death was his first conviction for sexual assault.

Indicators/Events preceding Death:

On the date of the incident, at 05:00, a correctional officer conducted a security patrol of the inmate's unit. He reported that he saw the inmate standing up, with the lights off, leaning against the far wall on the right side of the cell. Another patrol was conducted at 07:03.

Response:

At 08:45, officers noticed that the inmate appeared unconscious and had something tied around his neck. A call was made immediately. The officers present reported that the inmate was hanging from a shelf, at the far end of the cell, on the right-hand side.

Additional officers arrived at 08:48, and the officers entered the cell at 08:51. The officers who responded did not have the necessary CPR equipment with them, as required by the Commissioner's Directive on Health Services[3], so one of them had to go back to the security post to obtain a CPR mask.

The nursing staff called to respond to the incident noted that there was already significant rigor mortis when they arrived on the scene. The inmate's arms stayed raised, and the nurse was unable to insert the necessary equipment into his mouth because his jaw was already too rigid. It was obvious that the inmate had been deceased for a few hours prior to any concern being raised.

[3] Commissioner's Directive 800, par. 5(*b*)

The institutional physician arrived at 08:57 and pronounced the death. It was noted that the body showed rigor mortis and lividity in the extremities at the time the emergency response was initiated.

National Board of Investigation (NBOI) Findings:

The NBOI report outlined the various assessments conducted since the inmate entered the correctional system. Suicide risk assessments were conducted at various times, but at no point did he reveal any psychological distress.

The NBOI consulted the patrol records from 22:00 on the night before the incident up to 10:00 on the day of the incident, but only had video recording from 05:00 to 10:00. The earlier video recordings had been destroyed.

The NBOI reported that the count patrols were not carried out in accordance with CSC policies. The patrols were not conducted at the required intervals and the time between the patrols usually exceeded the maximum time set out in the Commissioner's Directive.[4] The patrols were conducted so quickly that the officers clearly did not take the time to verify that the inmates were in their cells and alive, as set out in CSC policy.[5]

The video showed one officer who did not take the time to look into the cell. This is especially concerning because night patrols require increased attention since most of the inmates are sleeping and it is more difficult to determine whether they are breathing. Furthermore, the NBOI found that a number of the patrols were carried out by a single officer, which is also not in compliance with CSC policy and directives.

The officer who conducted the 05:00 patrol reported that the inmate was standing in the same position in which he was found dead. The officer did not seem to have considered whether the inmate was simply standing or whether he needed help. The NBOI therefore found that the inmate might have already been dead during the 05:00 patrol. However, the emergency response was not initiated until 08:48. None of the officers on patrol noticed that the deceased was standing in the same position between these times.

The NBOI indicates that the inmate was not previously identified as being at risk of suicide. During past sentences, he did talk about a suicide attempt when he was a teenager; however this information was not included in the institutional files. Issues related to effective information sharing were identified as a concern in this case.

[4] Commissioner's Directive 566-4, par. 3
[5] Op. cit., par 23

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Summary of Concerns:

- retention of evidence (surveillance videos)
- quality of security rounds and patrols
- quality of suicide risk assessments
- delayed response to medical emergency
- absence of video record
- compliance with Commissioner's Directives regarding first aid

CASE SUMMARY NO. 2

DEATH BY NATURAL CAUSES OF A 58 YEAR OLD INMATE

Background:

An inmate died on in Fall 2009. He was 58 years old. By all indications, he died of natural causes. As of end of August 2010, the Coroner's report is still not available.

At the time of his death, the deceased was serving a sentence of two years for assault. It was his fourth sentence in a federal penitentiary. He was mentally disordered and had been homeless in the community. The inmate's bizarre behaviour and lack of personal hygiene during his most recent term of federal custody presented difficulties in integrating him into the general population.

Indicators/ Events preceding Death:

Upon his admission, staff members referred the inmate to the psychologist. He was subsequently referred to the psychiatrist, who met with him twelve days after his admission.

Two days before his death, the officers noted that the inmate was exhibiting incoherent behaviour. Near the end of the day prior to his death, the inmate collapsed on the floor of the unit. He was escorted in a wheelchair to the institutional health care unit. He was conscious at the time and evaluated by the nurse before being returned to his cell. In the evening, he collapsed while trying to go down the stairs. A fellow inmate caught him. A correctional officer noted that the inmate seemed to be suffering from an "obvious cognitive impairment" and that the physical layout of the facility posed a danger to his safety.

Later that night, the officers on duty were contacted by the man who shared the inmate's cell. The inmate had urinated on his chair and seemed unable to care for himself. He was again brought to the health care unit in a wheelchair.

The inmate appeared to have a greenish tone to his skin and was continuing to suffer from apparent cognitive impairment. A more thorough medical examination was not conducted at this time. The inmate was placed in the segregation unit.

During the night, the official count report indicated that at the midnight, 1:00 a.m., 2:00 a.m. and 3:52 a.m. counts, the inmate was alive. The officers' reports indicated that, at 2:00 a.m., the inmate activated the alarm in his cell to request a shower. The CSC Board of Investigation report contains reference to comments from inmates in neighbouring cells that state the inmate asked to see the nursing staff because he was not feeling well. In these accounts, the officers allegedly told the inmate that he would have to wait for the nursing staff to arrive at 05:00.

The night reports also showed that the inmate sounded the alarm in his cell at 03:25 to ask to clean up his cell.

Response:

At approximately 05:03, the officers on patrol stopped in front of the inmate's cell. They proceeded to record the visit on the time clock before returning to his cell. They noted that he was lying on the floor and did not appear to be breathing. They contacted the correctional manager at 05:06, then collected their baton, shield and gas, and waited for the correctional manager. The officers entered the cell at 05:09 accompanied by the correctional manager.

After failing to find the inmate's vital signs, the correctional manager ordered the officers to begin CPR and requested that an ambulance be called. The ambulance attendants arrived at the institution at 05:20, and after the vehicle was searched, paramedics arrived at the scene at 05:38.

CPR was performed until the ambulance attendants arrived. The inmate was pronounced dead at the hospital an hour later.

National Board of Investigation (NBOI) Findings:

The NBOI showed that the inmate's care was insufficient and the medical evaluation and emergency intervention were inappropriate. The NBOI also stated that the institutional staff did not comply with the directives on evidence management and preservation.

According to the NBOI, the correctional officers working in the segregation area were not informed of the inmate's precarious state. The nurse on duty told the NBOI that he thought the inmate was nearing the end of his life, but he did not expect him to die that night. He did not deem it necessary to request medical attention.

The NBOI report includes a critical judgment of the examination performed by the nurse on duty and the examination conducted earlier that day, given that the facts reported should have led to immediate medical attention. The NBOI also notes a number of other inconsistencies, particularly in terms of the initial medical evaluation reports that should have been previously completed.

The NBOI report revealed a number of additional deficiencies. For example, patrols in the segregation unit were conducted at set times and could therefore be anticipated, contrary to policy. Policy also stipulates that inmates must be seen at least every 60 minutes as part of patrols. The NBOI found that, in this case, more than one hour had elapsed between the time the inmate was last confirmed alive and the time he was found lying on the floor.

With regard to the contradictions noted in the various accounts of the events of that night, the NBOI found that the institution did not preserve all of the evidence that could have helped them clarify events. Also, the cell alarm tracking system was defective and the NBOI was unable to review the calls the inmate made during the early morning hours.

The officers' intervention after discovering the inmate lying on the floor of his cell clearly did not meet the prescribed rules. Rather than conducting a risk analysis, the officers armed themselves and waited until the correctional manager arrived to enter the cell, more than six minutes after he was discovered in a state of medical distress. The NBOI noted the existence of an unwritten rule whereby any intervention in this unit requires safety equipment, because a number of the inmates in this unit have been previously housed at the Special Handling Unit. It is understood, however, that the inmate was never considered a security risk, and was not in segregation for security reasons.

Summary of Concerns:

- preservation of evidence
- inappropriate use of segregation
- quality of security rounds and patrols
- delayed response to medical emergency
- quality of physical health care evaluations
- role of the correctional manager

CASE SUMMARY NO. 3

DEATH BY NATURAL CAUSES OF A 47 YEAR OLD INMATE

Background:

An inmate died on in the Fall of 2008. He was 47 years old. He was serving a life sentence for second degree murder.

The Coroner's report concluded that the cause of death was spontaneous cardiac arrhythmia.

Indicators / Events preceding the death:

The unit where the inmate was incarcerated on the night of his death had four ranges. The inmate's cell was in the first range that was checked during count patrol.

The NBOI report stated that at 02:46, when the officer on patrol passed by the inmate's cell, he noticed that "something was not right." He called out to the inmate and scanned the cell with his flashlight through the window. He said that he thought the inmate was breathing, but he was not sure.

The Officer finished patrolling that range and returned to the cell. He knocked on the door again and called out to the inmate. The Officer looked at the inmate's ribcage and did not see it moving. After a minute of observation, the officer went to finish his patrol in the other three ranges.

It was not until he completed his rounds that the officer returned to the Operations Office to contact the correctional manager and inform him of a potential medical emergency. It was 02:56.

Response:

At 03:02, sixteen minutes after a possible situation of medical distress was first noticed, the correctional manager and two officers asked the control post to open the door to the inmate's cell. They entered the cell and found the inmate unconscious. The correctional manager said that he thought that the inmate was dead and told the officers not to move him so as not to destroy any evidence.

At 03:06, the correctional manager called the duty nurse and asked her to contact a second nurse for backup. (There is no nursing staff at the institution during the night). At 03:10, an officer in the range contacted the correctional manager by radio and asked what he should do. The manager told him not to move the inmate and said that a nurse was on her way.

The nurse arrived at the institution at 03:17 and went straight to the Operations Office. When she discovered that no ambulance had been called, she asked the manager to call one. She then went to the Health Services Unit, but it was locked and it was obvious that the inmate had not been taken there. From there, she ran to the inmate's range.

An officer called 911 at 03:18, and CPR was started at 03:23, which was 37 minutes after the medical emergency was first discovered. When the nurse arrived on the scene, she examined the inmate and found that he was warm, with a weak but detectable radial pulse.

The inmate was placed on a stretcher and transported to the Health Care Unit, where CPR resumed, but the nurse noticed that the inmate's lips were blue and that his sphincter had relaxed. An automatic defibrillator was used, but the inmate had no pulse.

The paramedics, who were travelling from another city, arrived at the institution at 03:57. They relieved the officers who were performing CPR. The paramedics stopped CPR at 04:10. The inmate was pronounced dead at outside hospital at 04:40.

National Board of Investigation (NBOI) Findings:

The NBOI found that the medical treatment provided to the inmate in the four weeks prior to his death did not meet professionally accepted standards. The NBOI also found that the blood tests and blood pressure readings ordered for the inmate by the physician in the summer of 2008 were never performed.

The NBOI report highlighted certain similarities between this case and the findings made in a special report on the death of another inmate at the same institution six years earlier.

Summary of Concerns:

- delayed response to a medical emergency
- lack of sustained application of lessons learned (striking similarities between the two cases, although occurring six years apart)
- impact of a remote location on emergency response times
- lack of nursing coverage during night hours

CASE SUMMARY NO. 4

DEATH BY NATURAL CAUSES OF A 40 YEARS OLD INMATE

Background:

An inmate died in the Spring of 2008, at an outside hospital. He was serving a life sentence.

The inmate was 40 years old at the time of his death. He suffered a cerebral aneurysm caused by a brain tumour.

The CSC's National Board of Investigation indicated that fellow inmates and staff members found that the inmate had a "peculiar" personality. In the past, he had been assessed as having some characteristics of a schizoid personality, but did not require any medical intervention in that respect. Aside from what some referred to as a "strange" attitude, he had no specific identified mental health issues.

Indicators / Events preceding the death:

At the end of Spring 2008, the inmate met with the institutional physician who referred him for psychological follow-up. A note was left for the unit's correctional officers asking them to pay special attention to him, given his strange behaviour.

A day later staff in the inmate's unit called the Health Care Unit, indicating that the inmate was ill. He was complaining of a pulsating pain beneath his left ear. He was offered anti-inflammatory medication.

One day later a disciplinary report indicated that the inmate did not stand during the count, as set out in the directives.

On the following weekend, generalized cell confinement was ordered by the institution to conduct an exceptional search for a missing screwdriver. During these two days, there is no indication of special attention provided by the health care staff to the inmate.

On the day before his death, at about 8:30 a.m., staff members on the range asked the Health Care Unit to send a nurse to examine the inmate. He was seated on his bed, seemed absent, did not respond to prompting, and was incontinent. An appointment was made with the psychiatrist.

After being cleaned up, he was transported in a wheelchair to his appointment with the psychiatrist who recommended a transfer to the Regional Treatment Centre for a more extensive examination.

Response:

At 12:15, the officers again escorted the inmate to the Health Care Unit in a wheelchair where he was placed in an observation cell. His vital signs were normal, but he did not respond to prompting. At 12:45, he was found lying down with his face against his pillow.

The emergency response protocol was only initiated at 15:45 – three hours after he was found unresponsive to verbal commands. Attempts were made to reposition the inmate. Eventually an ambulance was called. The inmate was first transported to a local hospital at about 16:00, and then he was transported by air in the evening to a regional hospital. He was pronounced dead the next morning.

National Board of Investigation (NBOI) Findings:

The NBOI found that the nursing staff incorrectly attributed the inmate's symptoms to a mental health issue, and did not fully consider physical health issues.

The NBOI also indicated, with no special emphasis, that a medical follow-up was not conducted during the weekend before his death.

Summary of Concerns:

- quality of physical health care assessment
- medical follow-up
- delayed response to medical emergency
- lockdown inhibiting timely and effective delivery of clinical services
- quality of NBOI report

CASE SUMMARY NO.5

SUICIDE BY HANGING OF A 43 YEAR OLD INMATE

Background:

An inmate died in the Fall of 2009. He was 43 years old, having committed suicide one week short of his 44th birthday.

A first time federal offender serving a life sentence, the inmate died in his medium security cell.

The inmate had a documented history of mental health issues. He demonstrated behaviour that appeared out of context and he refused most interactions with mental health professionals.

Indicators / Events preceding the death:

At 07:55 on the date of his death, the inmate was behaving in a manner that was noted to be "odd" as reported by other offenders to the security staff on shift. When staff approached him, he demanded to see his Parole Officer and his Correctional Manager. During this exchange, he provided evidence of paranoid and distorted thinking and seemed much more agitated than usual. Later that morning, staff noted that the inmate was fashioning something out of strips of bed sheets. The inmate reported that it was a belt, just like the one he was already wearing. This item was confiscated as it could be used as a ligature.

The inmate twice refused to speak with the nurse from psychology when she attempted to interview him. An interview with the institutional psychologist was to take place later that day.

Despite noted concerns and peculiar behaviour, he was returned to his cell while waiting for a meeting with other professionals. No enhanced monitoring was put in place. The correctional manager made a verbal contract with the inmate not to self harm, but the inmate was not placed in an observation cell.

The inmate was discovered hanging in his cell at 12:37. The ligature used to hang himself was made of strips from his bed sheet. The Psychologist who was to interview the inmate arrived on the unit a minute after the inmate was discovered.

National Board of Investigation (NBOI) Findings:

There were no significant findings or recommendations noted.

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Summary of Concerns:

- assessment of suicide risk pre-indicators
- access to psychological care
- lack of mental health training
- quality of NBOI report

CASE SUMMARY NO. 6

SUICIDE BY HANGING OF A 24 YEAR OLD INMATE

Background:

An inmate died in the first quarter of 2010. He committed suicide by hanging.

He was 24 years of age. He was sentenced six months earlier to a two-year term.

The inmate had reported that his family doctor had diagnosed attention-deficit hyperactivity disorder, anti-social personality disorder and obsessive compulsive disorder. He also had a significant history of alcohol and substance abuse. Need assessments conducted in the summer of 2009 indicated that he stated no concerns regarding suicide risk and that no suicide attempts had been reported in the last five years.

Indicators / Events preceding the death:

On the day of his death, the inmate attended a planned follow-up interview with his psychologist at the institutional Psychology Department. The interview was stressful as the inmate reported having nightmares and waking-up in state of panic.

During the same session, he related, for the very first time, some deeply traumatic experiences from his youth. He talked about his fears, his speculations on what would appear in the newspaper and what people would think of him. He began to cry. He was reassured by the psychologist and explanations were given as to what steps may be taken to deal with his concerns.

He was given an opportunity to wash his face so he would not appear to have been crying, before he left the Psychology Department. Despite the disclosure of traumatic events, the psychologist did not request any special measures, such as closer monitoring. The psychologist was reassured by the fact that the inmate was projecting himself in the future, inclusive of promising to bring papers on the next session.

Later that night, the inmate was seen alive by officers at the 22:30 stand-up count.

Response:

The inmate was found hanging by a bed sheet from the ceiling light fixture in his cell by an officer conducting his routine patrol at 23:23. The officer notified the duty correctional manager (CM). The CM immediately requested officer assistance and called an ambulance.

Two responding correctional officers retrieved a 911 knife and cut the sheet and carried the inmate to the vestibule area. They began CPR and an AED was retrieved and applied. No shock was advised from the AED and the officers continued to perform CPR as the AED instructed.

At 23:38, the ambulance arrived at the institution. The paramedics attended the scene at approximately 23:45. The inmate was placed on a stretcher and taken to the ambulance while officers continued CPR. Additional paramedics arrived and took over CPR in the ambulance.

The ambulance left the Institution at 00:03. An order from a doctor was received to cease CPR while en route to the hospital and the inmate was pronounced dead at approximately 00:29.

National Board of Investigation (NBOI) Findings:

One staff member who was working the midnight shift had a lapsed CPR and First Aid Certificate.

Summary of Concerns:

- enhanced monitoring of younger offenders, especially those serving their first federal sentence
- information-sharing between clinical and front-line staff
- removal of anchor/suspension points in cells (suicide-proof cells)
- quality of the National Board of Investigation reports

CASE SUMMARY NO. 7

SUICIDE OF A 50 YEAR OLD INMATE

Background:

An inmate committed suicide by use of a ligature during the last month of 2009. He was 50 years old.

The inmate had attempted suicide once in the past, during a prior period of incarceration, at 18 years of age. He was of Aboriginal origin. He was afflicted by substance addiction. He also had numerous health issues and met regularly with health care staff.

During prior incarceration, he had numerous consultations for mental health issues. Historical file information showed that those issues were influenced by drug addiction.

Indicators / Events preceding the death:

The inmate's father and one of his brothers were murdered in 1977 and 2002 respectively. Two of his sisters died of natural causes during the preceding ten years. His older brother committed suicide in the late seventies. The suicide note found in the inmate's cell directly referred to his brother's death, which had deeply affected him.

The inmate had been on a methadone maintenance program for seven years.

Less than a month before his death, he had been the victim of an assault by other inmates. The assault resulted in a short period of hospitalization. The inmate was subsequently placed on voluntary segregation status for his own protection. He committed suicide in his segregation cell.

Four days before his death, he asked to quit his methadone program. A medical and psychological follow-up had been requested by one of the nurses to monitor his state during withdrawal.

On the day preceding his death, a Friday, the Aboriginal Elder shared with correctional and health care staff his concerns that the inmate was not doing well. At 16:55, a mental health nurse met with the inmate. A note was placed in the health care register to ensure that the inmate would be seen by health care staff on the weekend. This information was not shared with the segregation unit staff.

On the morning of his death, the inmate asked permission to give away his canteen to other inmates on the range, as a gift. This unusual request was granted and an officer escorted the inmate on the range while he left a part of his

canteen in front of every cell door. The officer will later note that the inmate seemed cheerful and in a good mood.

Later that day, a nurse distributed the medication to the inmates on the range and talked with the inmate who said that everything was fine.

Response:

The Service's NBOI stated that, at 20:07, an officer started patrolling the range. He passed in front of the inmate's cell without looking in. He noted a strong odour of feces and attributed it to the inmate in the facing cell.

At 20:38, another officer started her patrol. She looked into the inmate's cell but did not see him as the lights were out. Presuming that he may have been on the toilet, she decided to give him some privacy and to come back at the end of her round.

When she returned, she observed that the inmate was lying on the floor and he was unresponsive to her calls.

At 20:39, she requested another officer's attendance. The officer immediately informed the Correctional Manager of the situation. At 20:41, the cell door was opened. Officers noted a strong odour of feces.

As soon as they noticed that there was a ligature attached to a chair, they lifted the inmate's shoulders. The ligature was cut a minute later, after an officer had retrieved the necessary tool from the unit front desk. Resuscitation measures were started immediately.

At 20:42, the Correctional Manager was advised the situation was a medical emergency. Once the Correctional Manager arrived at the scene, an order to call 9-1-1 was made. At 20:48, an automatic defibrillator was brought on the scene, but did not detect any pulse. CPR was administered by the officers until the arrival of the paramedics at 20:52. Resuscitation measures were then taken over by the paramedics.

Resuscitation efforts were pursued until 21:14, when ambulance workers received recommendations by the duty physician of the regional hospital's emergency department.

The death of the inmate was officially declared at 21:15.

National Board of Investigation (NBOI) Findings:

A subsequent search of the inmate's cell discovered five uneaten meals, and that he was no longer taking his medication.

The Service's NBOI concluded that the incident could not have been prevented, since the inmate had consistently and repeatedly denied having any suicidal thoughts. The NBOI underlined the number of meetings the inmate had with health care staff, the attention provided to him by health care, the regular assessments since his admission in the institution and to the segregation unit.

Summary of Concerns:

- monitoring of inmate behaviour
- assessment/communication of suicide risk pre-indicators
- information sharing failures
- staff training re: range walks, suicide prevention
- use of segregation for mentally ill offenders
- quality of NBOI

CASE SUMMARY NO. 8

DEATH RESULTING FROM CUMULATIVE SELF-INJURY BEHAVIOURS OF A 28 YEAR OLD INMATE

Background:

An inmate died in the Spring of 2010, at a regional hospital, while in custody of the Service. He died as a result of years of self injurious behaviour, more precisely from cumulative medical complications resulting from multiple self-inflicted injuries. He was 28 years old.

The inmate was serving a 12 year sentence, but he had been in hospital since January 2009 as a result of his condition. In 2003, at 22 years old, he was admitted directly to the Regional Treatment center due to his known history of self injurious behaviour.

Indicators / Events preceding the death:

During his incarceration, the inmate was regularly transported to outside hospitals. He was transferred for one year to another region's Regional Treatment Center, in an attempt to change his chronic self-injurious behaviour and treatment patterns, but to no avail.

The only period of relative stability took place in 2006, prior to a statutory release. He was placed in a transition unit. After suspension of his statutory release, though, his self harming behaviour resumed.

Response:

The management of this inmate's behaviour proved extremely challenging for the CSC's health care and correctional staff. During his incarceration, no less than eight investigation reports were convened by CSC regarding incidents of self-inflicted injuries or periods of intensive self-injurious behaviour. Three of those reports were convened at the national level.

The Service took the extraordinary step of requesting the assistance of an ethicist regarding the medical and correctional interventions that could be used to better manage the inmate's behaviours. Over the years, many of the recommendations made by various CSC investigative reports called for similar corrective actions, including the development of a responsive clinical management plan that would better integrate security, programming and clinical interventions.

National Board of Investigation (NBOI) Findings:

Following the death of this inmate, the Office recommended that the Service conduct a national investigation on his entire incarceration period and not only the months following the last investigation convened. The OCI also recommended that the NBOI be chaired by an external health care professional. CSC has accepted to convene a national investigation, but did not mandate an external chairperson.

Summary of Concerns:

- options for managing extreme forms of self-injurious behaviour in prison
- external and professional chairing of National Boards of Investigation involving suicide or serious self-injury
- consistent/sustained course of clinical treatment

CASE SUMMARY N. 9

SUICIDE BY HANGING OF A 54 YEAR OLD INMATE

Background:

An inmate died in hospital in the Spring of 2010 as a result of a suicide attempt three days earlier. He was 54 years old. He had been found hanging from pipes on the ceiling of his cell.

The inmate was serving a 2 years sentence. It was his first custodial sentence.

Response:

Four days prior to his death, at approximately 15:43, an inmate at the institution advised the correctional staff that another inmate on the range had hanged himself. Staff immediately proceeded to the cell and found the inmate hanging from a belt attached to the ceiling pipes.

CPR efforts were initiated as soon as possible and an ambulance arrived on site 13 minutes later. The inmate was transported to hospital and remained unconscious until his death.

Indicators / Events preceding death

OCI's *Deaths in Custody Report* (June 2007) reported that suspension points remained a concern. The Report noted *limited modifications of infrastructure to make it more difficult for inmate to commit suicide by hanging*.

There had been several projects undertaken to transform some cells in order to render them suicide-proof in the institution since 2006.

In January of 2010, a Security Bulletin had been published by CSC, indicating:

> «It is critical that all potential points of suspension, both removable (i.e. furniture, shelving) and non-removable (i.e. electrical outlets, air vents), and other cell vulnerabilities (i.e. protective covers that have been tampered with or removed) are systematically and consistently identified, inspected, repaired, replaced, repositioned or removed»

In 2009, a business plan to remove suspension points from almost a hundred cells had been prepared by the institution where the inmate hanged himself. However, National Headquarters decided not to take action immediately on this business plan.

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National Board of Investigation (NBOI) Findings:

The National Board of Investigation Report was not completed on time for it to be taken into account in this Assessment.

Summary of Concerns:

- Removal of anchor/suspension points in cells
- Sustained application of lessons learned