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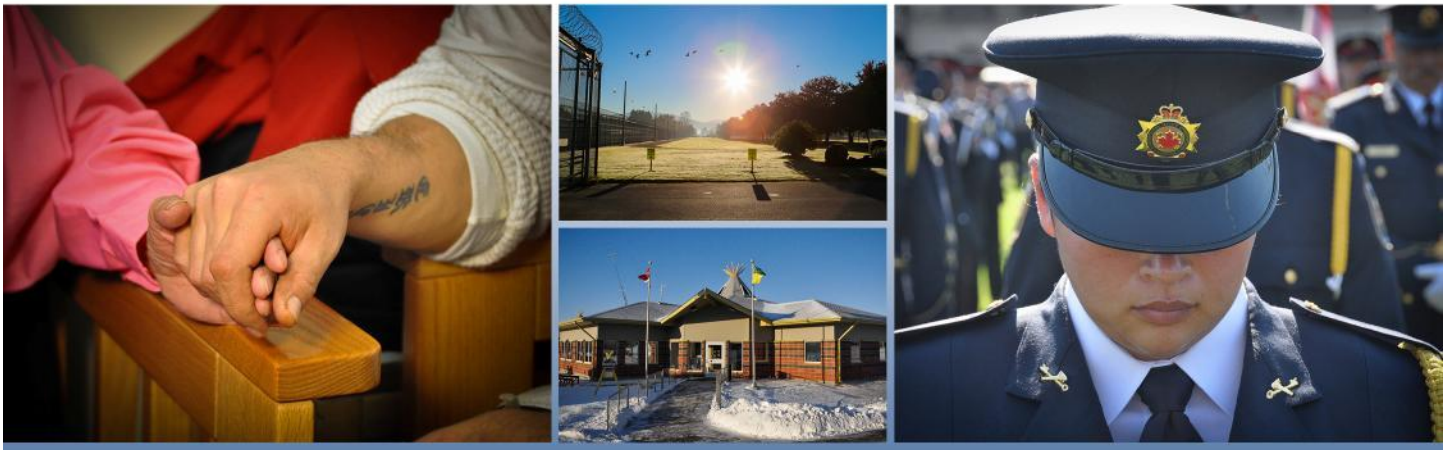

Annual Report on Deaths in Custody

2015/2016

NOVEMBER, 2017

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Executive Summary

The Correctional Service of Canada (CSC) takes seriously its obligation to ensure the safety and security of all offenders in its custody. Therefore reducing the number of deaths in custody, particularly non-natural deaths, is a fundamental priority of the organization. To better understand the circumstances surrounding deaths in custody, the 2015/2016 Annual Report contains an overview of deaths in custody that occurred in a CSC institution for the fiscal year 2015/2016, as well as a historical analysis to track patterns and trends in deaths in custody over time.

In 2015/2016, the majority (65%) of deaths were the result of natural causes. Of the remaining deaths, suicide was the most common manner of death, followed by overdose. Deaths by other manner, including homicide, accident and undetermined cause, were relatively rare. In general, this makeup of deaths in custody is consistent with trends over the last 15 years.

The characteristics of offenders who died in custody since 2000/2001 varied. However, offenders tended to be White or Indigenous, medium security offenders who were incarcerated for homicide-related offences, and serving indeterminate sentences. Those who died by natural cause tended to be aged 55 or older, while those who died by non-natural manner tended to be under the age of 45. As a proportion of all deaths, natural deaths were most common in the Quebec and Ontario regions, while suicides were most common in the Atlantic region.

Deaths in the 2009/2010 to 2015/2016 period[1] were examined more closely. Among natural deaths, cancer was the leading cause, followed by cardiovascular-related conditions. Chronic health issues were common among offenders who died by natural cause, with at least one chronic health condition unrelated to the cause of death identified in 96% of cases. Mental health issues, though not as common as chronic health conditions, were also quite prevalent, identified in 49% of cases. Other common elements in natural deaths included the presence of cigarette smoking as a contributing factor (identified in 51% of cases) and offender non-compliance with medication (identified in 34% of cases). Common institutional compliance issues noted in cases of natural death concerned search logs and reporting requirements, as well as the provision of support to staff and offenders.

Suicide was the most common type of non-natural death between 2009/2010 and 2015/2016, accounting for 67 deaths. Most suicide deaths occurred by hanging. Mental health and substance misuse issues were common among offenders who died in custody by suicide and other non-natural manners. For example, 71% of offenders had an identified mental health disorder and 76% had a history of substance misuse. For suicide deaths, changes in mental health medication regimens appeared in 35% of cases. In most of these

[1] Prior to 2009/2010, a different reporting system was in place to record deaths in custody. Earlier reports did not record information in the same way or contain the same information as current reports do. Thus, most analyses in this report start with data from 2009/2010.

cases, the change had occurred within 4 weeks prior to the death. Common institutional compliance issues noted in cases of non-natural death concerned search logs and reporting requirements. Finally, many of the recommendations listed in the Board of Investigation reports for non-natural deaths pertained to the improvement of overall care of individuals with mental health or substance misuse issues in order to prevent similar situations from occurring, whether through policy changes, more effective training for staff or improved communication between services and departments.

Overall, the number of suicide deaths is decreasing as a proportion of all non-natural deaths. While suicides accounted for around 64% of non-natural deaths in 2012/2013, they accounted for 39% in 2015/2016. Unfortunately, this decline has corresponded with a relative increase in the number of overdose deaths. While accounting for less than 10% of non-natural deaths in 2012/2013, overdose deaths accounted for 30% of non-natural deaths in 2015/2016. Overdose deaths outnumbered suicide deaths in the Prairie and Pacific regions in 2015/2016. Fentanyl has become more common in overdose deaths, particularly in the last two fiscal years when it was identified as a standalone or contributing substance in nearly 69% (9) of overdoses.

CSC is committed to learning from these deaths in custody and preventing future non-natural deaths. The investigations and reviews conducted following deaths in custody allow for the identification of areas of need in the service. CSC works proactively to implement recommendations and consider policy and practice in light of findings, thereby contributing to the safety and well-being of offenders, as well as staff and the public.

Table of Contents

List of Tables

Introduction

The reduction and prevention of offender deaths in custody is a challenge for all correctional jurisdictions. Deaths in custody serve as one of the primary indicators of concern in custodial situations and are directly related to the Correctional Service of Canada's (CSC) strategic priority of "Safety and security of members of the public, victims, staff and offenders in our institutions and in the community".

This current Annual Report contains an overview of deaths in custody that occurred in a Correctional Service of Canada (CSC) institution during the fiscal year 2015/2016, as well as a historical analysis in order to further understand the issue. This report is a significant expansion of content compared to previous reports. Drawing upon recommendations of the Third Independent Review Committee on Deaths in Custody and previous inquiries, the report highlights results at both a national and regional level and looks at trends over previous years.

This report explores deaths in custody in a variety of ways. First, consideration is given to deaths in custody as a whole and contrasting non-natural and natural deaths where appropriate. Next, natural deaths are examined more closely at both a national and regional level. This is followed by an overview of non-natural deaths in custody and an analysis of each sub-type of non-natural death. Each section examines the deaths that occurred in 2015/2016 and then compares them to previous years. Periods of comparison vary depending on the availability of reliable information.

CSC has policies in place concerning the review and investigation of deaths in custody. These policies ensure responsibility, accountability, and transparency, as well as

the enhanced ability to prevent or better respond to similar incidents in the future through the identification of areas of need. As per Commissioner's Directive (CD) 041, *Incident Investigations*[2], CSC's Incident Investigation Branch investigates all non-natural deaths and CSC's Health Services Sector conducts a Mortality Review for all natural deaths, except in the rare instances where the circumstances warrant no further investigation. The Research Branch (Policy Sector) utilized information from these investigations and reviews, as well as other contextual information, to produce this report. The findings in this report will be used to inform organizational policy and practices, thereby contributing to the safety and well-being of the public, staff, and offenders.

Deaths in custody remain a complex and difficult issue and CSC recognizes that it is imperative to continuously work to enhance its relevant prevention and intervention strategies. Ultimately, all efforts around deaths in custody are designed with the goal of attaining the objective of zero non-natural offender deaths in custody, as well as the best possible physical health outcomes for offenders. This third Annual Report on Deaths in Custody provides information in order to enhance accountability and transparency, and to inform prevention and intervention strategies. This report also creates an important opportunity for information sharing, which facilitates the ability of correctional jurisdictions to learn from each other regarding the most effective methods to reduce and prevent deaths in custody.

[2] Correctional Service Canada (2010). *Commissioner's Directive (CD) Number 041: Incident Investigations.*

Data Source and Methodology

The information used to conduct the analysis presented in this report was gathered from a variety of sources. The Offender Management System was used to gather demographic and other information about the deceased offender, as well as to retrieve incident reports on the death. Coroner's reports, toxicology reports and Warden's situation reports (where available) were systematically examined and information extracted. For all deaths from fiscal year 2009/2010 onwards[3], either a Mortality Review (for natural cause deaths) or Board of Investigation (for non-natural deaths) was obtained and systematically coded to extract available information. Once coded, each death was entered into a database maintained using survey software. In order to analyze the information, data files were extracted and analysis was done with a statistical software program. In order to ensure the quality and consistency of the information gathered, each death was audited by a different coder and any discrepancies were reconciled. Data entry into the survey software was also independently checked. The database developed will be maintained for future deaths and used for analysis in subsequent annual reports and other research projects.

In regards to the extraction of information from Board of Investigation reports and Mortality Reviews, coding forms were developed, tested, revised and used by multiple coders to capture information in a reliable manner. Coding decision logs were maintained to maximize data quality. Copies of blank coding sheets and decision logs are available from the Research Branch upon request.

[3] Prior to 2009/2010, a different reporting system was in place to record deaths in custody. Earlier reports did not record information in the same way or contain the same information as current reports do. Thus, most analyses in this report start with data from 2009/2010.

Information to be extracted from reports was broad based and wide reaching. There were some types of information that were not found consistently in all reports. It was impossible to ascertain whether the information had simply not been recorded or whether non-reporting indicated the term was irrelevant or non-applicable. In these cases, the item was coded as not indicated. When information was not available for 25% or more of cases, items were not included in the analyses. For example, in coding for the item 'Primary source of support in year prior to death,' information was not available in 54% of non-natural deaths; hence, this item was not included in the report for non-natural deaths.

Looking at trends over low-base rate phenomenon, such as deaths in custody, can be challenging. To overcome the natural fluctuations that can occur year-to-year, comparisons were normally done by comparing 2015/2016 to an amalgamation of previous years.

Not all percentage totals in the tables will add to 100% due to rounding. This phenomenon is more pronounced due to the small numbers in some tables.

The Research Branch gratefully acknowledges the assistance of the Incident Investigation Branch and Health Services in gathering and assisting with the interpretation of the varied documents and reports used in the analysis. This report would not have been possible without their assistance and co-operation.

Overview of Deaths in Federal Custody

Deaths in Custody over a 16-year period: Manner of Death and Regional Differences

Between 2000/2001 and 2015/2016, there were a total of 857 deaths in federal custody[4]. Of these deaths, 34% were non-natural deaths (see Table 1). The proportion of non-natural deaths fluctuated over the 16 year period, ranging from a low of 25% in 2007/2008, to a high of 44% in 2002/2003. In 2015/2016, there were 23 non-natural deaths, accounting for 35% of all deaths in that time period. This was similar to the proportion of natural and non-natural deaths that occurred in the previous fiscal year.

In 2015/2016, more natural deaths occurred in the Quebec region and fewer occurred in the Atlantic Region (i.e., 91% versus 33%; see Table 2). Suicide deaths were more likely to occur in the Atlantic region (44%), while both overdoses and homicides were more likely to occur in the Prairie region (i.e., 25% and 13%). Despite the normal fluctuation that will occur each year, these proportional distributions across the regions are similar when compared to the last 15 years (i.e., 2000/2001 to 2014/2015).

Across the previous 15-year period, natural deaths were, on average, most likely to occur in the Quebec region and least likely to occur in the Prairie region (i.e., 72% versus 56%). Suicide deaths were most likely to occur in the Atlantic and the Prairie regions (i.e., 25% and 23%, respectively) and least likely to occur in the Ontario region (14%).

[4] Death in custody refers to any death where the originating incident occurred in a Federal institution, not including community residential facilities (e.g., Community Correctional Centre or Community-Based Residential Facilities) or deaths that occurred during an unescorted temporary absence.

The proportion of overdose deaths that occurred in the Ontario, Prairie and Pacific regions were similar (i.e., 9%, 8% and 7%), while overdose deaths were least likely to occur in the Atlantic region (4%). Finally, homicide deaths were most common in the Prairie region (10%) in comparison to the other regions.

Table 1

Number of Deaths in Custody by Manner of Death over a 16-year period (2000/2001 – 2015/2016).

Fiscal Year	Manner of Death							*Total*
	Natural	Non-natural						
		Suicide	Overdose	Homicide	Accident	Staff Intervention	Undetermined	
2000/2001	25	8	7	-	-	-	1	*41*
2001/2002	33	13	3	1	1	-	2	*53*
2002/2003	27	12	7	2	-	-	-	*48*
2003/2004	40	10	3	8	1	-	3	*65*
2004/2005	33	9	2	3	-	-	1	*48*
2005/2006	33	10	2	3	1	-	-	*49*
2006/2007	42	11	5	3	-	-	-	*61*
2007/2008	30	5	3	2	-	-	-	*40*
2008/2009	48	9	2	2	-	-	4	*65*
2009/2010	30	10	4	2	1	-	2	*49*
2010/2011	35	4	4	5	-	1[a]	1	*50*
2011/2012	35	8	5	3	1	-	1	*53*
2012/2013	34	14	2	1	2	-	3	*56*
2013/2014	33	9	2	2	1	-	-	*47*
2014/2015	45	13	6	1	2	-	-	*67*
2015/2016	42	9	7	3	2	-	2[b]	*65*
Total	*66% (565)*	*18% (154)*	*7% (64)*	*5% (41)*	*1% (12)*	*>1% (1)*	*2% (20)*	*100% (857)*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] This death by staff intervention is excluded from subsequent analysis because it is a singular case.
[b] These deaths are currently under investigation and are thus not included in subsequent analyses.

Table 2

Regional Distribution of the Number of Deaths in Custody by Manner of Death for Fiscal Year 2015/2016.

Manner of Death	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Natural	3	10	14	4	11	*65% (42)*
Non-natural						
Suicide	4	-	3	1	1	*14% (9)*
Overdose	-	-	3	2	2	*11% (7)*
Homicide	-	1	1	1	-	*5% (3)*
Accident	1	-	-	-	1	*3% (2)*
Staff intervention	-	-	-	-	-	-
Undetermined[a]	1	-	1	-	-	*3% (2)*
Total	*14% (9)*	*17% (11)*	*34% (22)*	*12% (8)*	*23% (15)*	*65*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] These deaths are currently under investigation and are thus not included in subsequent analyses.

Table 3

Regional Distribution of the Number of Deaths in Custody over a 15-year period (2000/2001 - 2014/2015).

Manner of Death	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Natural	44	154	152	87	86	*66% (523)*
Non-natural						
Suicide	18	35	31	35	26	*18% (145)*
Overdose	3	13	20	12	9	*7% (57)*
Homicide	5	4	7	16	6	*5% (38)*
Accident	-	2	5	1	2	*1% (10)*
Staff intervention	-	-	1	-	-	*> 1% (1)*
Undetermined	2	6	6	3	1	*2% (18)*
Total	*9% (72)*	*27% (214)*	*28% (222)*	*19% (154)*	*16% (130)*	*100% (792)*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Profiles of Offenders Who Died in Custody

The overall rate of deaths in custody in 2015/2016 was 4.45 per 1000 offenders. The rate of natural deaths in 2015/2016 was 2.87 per 1000 offenders, while the rate of non-natural deaths in 2015/2016 was 1.58 per 1000 offenders. Offenders who died in custody varied considerably, but were typically White, 55 years of age or older and were often serving indeterminate sentences. Two of the deaths that occurred in 2015/2016 were

women and seven of the deaths that occurred in the previous six-years were women. As a result, analyses by gender were unable to be conducted.

Similar to the overall population of offenders who died in custody, offenders who died of natural deaths in 2015/2016 were more likely to be White, 55 years of age or older and were typically serving indeterminate sentences. These offenders were also more likely to have a medium or minimum security level and have a homicide-related index offence. The majority of characteristics did not differ by sub-type of natural deaths across the previous six years (i.e., 2009/2010 to 2014/2015).

Certain characteristics of offenders differed by natural and non-natural deaths over the six-year period. Among Indigenous offenders, a greater number of deaths were natural (52%) compared to non-natural (48%). Those who died of natural causes were most likely to be White (i.e., 70% natural versus 30% non-natural). Offenders whose manner of death was natural were more likely to be older. In terms of age, 8% of offenders who died from natural causes were between 18 and 44 years of age, while 83% were between 45 and 74 years of age. In comparison, 59% of offenders who died from non-natural causes were between 18 and 44 years of age and 40% were between 45 and 74 years of age. Offenders who died from natural causes were more likely to be serving indeterminate sentences in comparison to those who died by non-natural manner (i.e., 53% versus 40%).

Homicide-related index offences were the most common among both natural and non-natural deaths (i.e., 42% and 38%). Offenders who died by non-natural manner were more likely to have a robbery-related index offence (19%) compared to those who died of natural cause (12%). Sexual-related offences were more common among those who died from natural causes (25%) compared to those who died by non-natural manner (14%).

The security level of offenders who died by non-natural manner was more likely to be maximum (i.e., 28% compared to 9% for natural deaths), while the security level of those who died of natural causes was more likely to be minimum (i.e., 27% compared to 10% for non-natural deaths).

Compared to the previous six-year period, offenders who died of natural causes in 2015/2016 were more likely to live longer. More specifically, only 8% of natural deaths between 2009/2010 and 2014/2015 involved offenders over the age of 75, compared to 19% in 2015/2016.

Table 4

Characteristics of Offenders who died in Custody by Manner of Death for Fiscal Year 2015/2016.

Characteristics	Manner of Death							*Total*
	Natural	Non-natural						
		Suicide	Overdose	Homicide	Accident	Staff Intervention	In progress/ Undetermined	
Ethnicity								
White	33	6	6	2	2	-	2	*78% (51)*
Indigenous	8	3	-	1	-	-	-	*18% (12)*
Black	-	-	-	-	-	-	-	-
Other	1	-	1	-	-	-	-	*3% (2)*
Age								
18 – 24	-	1	-	-	-	-	-	*2% (1)*
25 – 34	1	3	5	2	-	-	1	*18% (12)*
35 – 44	5	2	1	-	-	-	-	*12% (8)*
45 – 54	6	1	-	-	1	-	-	*12% (8)*
55 – 64	14	1	1	1	1	-	1	*29% (19)*
65 – 74	8	1	-	-	-	-	-	*14% (9)*
75 – 79	4	-	-	-	-	-	-	*6% (4)*
80 +	4	-	-	-	-	-	-	*6% (4)*
Offender security level								
Maximum	5	3	2	1	-	-	-	*17% (11)*
Medium	24	5	5	2	2	-	2	*62% (40)*
Minimum	13	1	-	-	-	-	-	*22% (14)*
Not yet determined	-	-	-	-	-	-	-	-
Index offence								
Homicide related	22	2	-	2	1	-	1	*43% (28)*
Sexual	7	1	1	-	-	-	-	*14% (9)*
Assault	3	2	1	-	-	-	-	*9% (6)*
Robbery	6	2	3	1	1	-	1	*22% (14)*
Other violent	1	1	1	-	-	-	-	*5% (3)*
Property	-	1	-	-	-	-	-	*2% (1)*
Drug	1	-	-	-	-	-	-	*2% (1)*
Other non-violent	2	-	1	-	-	-	-	*5% (3)*
Sentence length								
Less than 4 years	7	3	1	-	-	-	-	*17% (11)*
4 to 6 years	2	1	1	2	1	-	1	*12% (8)*
6 to 10 years	2	1	3	-	-	-	-	*9% (6)*
More than 10 years	6	-	1	-	-	-	-	*11% (7)*
Indeterminate	25	4	1	1	1	-	1	*51% (33)*
Time served on sentence								
Less than three months	-	-		-	-	-	-	-
Three months to less than five years	12	4	4	1	1	-	1	*35% (23)*
Five years to less than 10 years	5	3	2	2	-	-	-	*18% (12)*
10 years to less than 20 years	4	2	-	-	-	-	-	*9% (6)*
20+ years	21	-	1	-	1	-	1	*37% (24)*
Total	42	9	7	3	2	-	2	65

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Table 5

Characteristics of Offenders who died in Custody by Natural and Non-natural deaths over a 6-year period (2009/2010 - 2014/2015).

Characteristics	Manner of Death		*Total*
	Natural	Non-natural	
Ethnicity			
White	174	74	*77% (248)*
Indigenous	28	26	*17% (54)*
Black	5	5	*3% (10)*
Other	5	5	*3% (10)*
Age			
18 – 24	1	8	*3% (9)*
25 – 34	2	35	*11% (37)*
35 – 44	15	22	*11% (37)*
45 – 54	48	26	*23% (74)*
55 – 64	74	14	*27% (88)*
65 – 74	55	4	*18% (59)*
75 – 79	12	-	*4% (12)*
80 +	5	1	*2% (6)*
Sentence length			
Less than 4 years	44	25	*21% (69)*
4 to 6 years	19	17	*11% (36)*
6 to 10 years	23	13	*11% (36)*
More than 10 years	14	11	*8% (25)*
Indeterminate	112	44	*48% (156)*
Index offence			
Homicide related	89	42	*41% (131)*
Sexual	53	15	*21% (68)*
Assault	13	9	*7% (22)*
Robbery	25	21	*14% (46)*
Other violent	5	5	*3% (10)*
Property	8	6	*4% (14)*
Drug	5	4	*3% (9)*
Other non-violent	14	8	*7% (22)*
Offender security level			
Maximum	20	31	*16% (51)*
Medium	125	59	*57% (184)*
Minimum	58	11	*21% (69)*
Not yet determined	9	9	*6% (18)*
Time served on sentence			
Less than three months	14	10	*7% (24)*
Three months to less than five years	78	61	*43% (139)*
Five years to less than 10 years	23	10	*10% (33)*
10 years to less than 20 years	36	18	*17% (54)*
20+ years	61	11	*22% (72)*
Total	*212*	*110*	*322*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Natural Deaths in Federal Custody

Manner of Death and Regional Differences

Between 2009/2010 and 2015/2016[5], there were a total of 254 natural deaths in federal custody (see Table 6). Averaging across those seven years, cancer was the leading sub-type of natural deaths (36%), followed by cardiovascular-related (29%), respiratory-related (11%), liver-related (9%) and infection-related (9%) deaths. In 2015/2016, cancer remained the leading sub-type and accounted for 40% of natural deaths, with cardiovascular-related conditions accounting for 33%. In 2015/2016, there were significantly less respiratory-related deaths (i.e., 2% versus 12%) in comparison to the previous six-year period.

Regional analyses showed some significant differences. In 2015/2016, cancer-related deaths were most likely to occur in the Prairie region (75%) and least likely to occur in the Pacific region (27%; see Table 7). Infection-related deaths and cardiovascular-related deaths were most likely to occur in the Atlantic region (i.e., 33% and 67%). Neurological-related deaths were most likely to occur in the Pacific region (18%). A more accurate picture of regional differences emerges when 2015/2016 is compared to the previous six-year period. Cancer-related deaths were most likely to occur in the Ontario and Pacific regions (i.e., 42 and 48%) and least likely to occur in the Prairie region (18%). Cardiovascular-related deaths were most likely to occur in the Quebec region (i.e., 43%). Infection-related deaths were most likely to occur in the Ontario region (i.e., 12%). Liver-

[5] Prior to 2009/2010, a different system was in place for mortality reports and boards of investigation. These older reports did not record information in the same way or contain the same information as current reports do. Thus, most analyses in this report start with data from 2009/2010.

related deaths were most likely to occur in the Ontario region (12%), while neurological-related deaths were most likely to occur in the Ontario and Atlantic regions (i.e., 7%, in each region). The regional distribution in 2015/2016 is similar to the previous six-year period for almost all sub-types with the exception of cancer-related deaths, which became more common in the Prairie region and less common in the Pacific region in 2015/2016.

Table 6

Offenders who died in Custody by Natural Death Sub-type from 2009/2010 - 2015/2016.

Natural Sub-types	Fiscal Year		*Total*
	2009/2010 – 2014/2015	2015/2016	
Cancer	74	17	*36% (91)*
Infection	16	6	*9% (22)*
Cardiovascular related	59	14	*29% (73)*
Respiratory related	26	1	*11% (27)*
Liver related	24	-	*9% (24)*
Neurological related	9	3	*5% (12)*
Other[a]	4	1	*2% (5)*
Total	*212*	*42*	*254*

Note: Results are accurate as of July 31,2017. Subsequent investigations or reviews may result in changes to this table.
[a]Also includes individuals where a specific natural sub-type was unavailable.

Table 7

Regional Distribution of Natural Deaths in Custody for Fiscal Year 2015/2016.

Natural Subtypes	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Cancer	-	4	7	3	3	*40% (17)*
Infection	1	2	1	-	2	*14% (6)*
Cardiovascular related	2	3	4	1	4	*33% (14)*
Respiratory related	-	1	-	-	-	*2% (1)*
Liver related	-	-	-	-	-	-
Neurological related	-	-	1	-	2	*7% (3)*
Other[a]	-	-	1	-	-	*2% (1)*
Total	*3*	*10*	*14*	*4*	*11*	*42*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a]Also includes individuals where a specific natural sub-type was unavailable.

Table 8

Regional Distribution of Natural Deaths in Custody over a 6-year Period (2009/2010 - 2014/2015).

Natural Subtypes	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Cancer	5	18	28	7	16	*35% (74)*
Infection	1	3	8	2	2	*8% (16)*
Cardiovascular related	5	25	7	13	9	*28% (59)*
Respiratory related	1	6	10	6	3	*12% (26)*
Liver related	1	5	8	9	1	*11% (24)*
Neurological related	1	-	5	2	1	*4% (9)*
Other [a]	1	1	1	-	1	*2% (4)*
Total	*15*	*58*	*67*	*39*	*33*	*212*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a]Also includes individuals where a specific natural sub-type was unavailable.

Further Examination of Natural Deaths

In order to better understand the natural deaths that occurred between 2009/2010 to 2015/2016, detailed examinations of the factors related to and events surrounding these deaths were conducted. Again, the 2015/2016 fiscal year was compared to the previous six-year period (see Table 9). Certain characteristics were common among offenders who died from natural causes in 2015/2016. For example, 93% had at least one chronic health condition identified unrelated to the cause of death, 55% had at least one mental health disorder identified, 43% had cigarette smoking listed as a contributing factor, 36% were noted to be non-compliant with their medication, and 43% had medical personnel listed as their primary source of social support.

These characteristics were also common among offenders who died from natural causes in the previous six year-period. During this time, 96% had at least one chronic health condition identified unrelated to the cause of death, 48% had at least one mental health disorder identified, 53% had cigarette smoking listed as a contributing factor, 34%

were noted to be non-compliant with their medication and 30% had medical personnel listed as their primary source of social support.

Between 2009/2010 and 2014/2015, natural deaths were more likely to be related to either substance misuse (26%) or smoking (53%) when compared to 2015/2016 (i.e., 14% and 43%). However, for other factors that were examined, the proportions between the two time periods were relatively similar. For example, close to 50% of natural deaths had a Do Not Resuscitate (DNR) order on file and were receiving palliative care. Offenders were also likely to have next of kin involvement.

Overall, there was little regional variation with a few notable exceptions (see Table 10). In 2015/2016, natural deaths in the Pacific and Prairie regions were most likely to have been related to smoking. In the Prairie region, offenders whose manner of death was natural were more likely to have family/friends outside the institution as their primary source of social support. The Prairie region was the least likely to have at least one chronic health condition identified for natural deaths (50%). The Ontario region was most likely to have a history of drug use listed as a contributing factor in natural deaths (30%).

These characteristics were also common across the regions for the previous six-year period (see Table 11). Over half of natural deaths were related to smoking in each region (i.e., excluding the Ontario region). The Prairie (38%), Pacific (35%) and Atlantic (33%) regions were more likely to have natural deaths related to substance misuse. Those whose manner of death was natural were more likely to have medical personnel or family/friends outside the institution listed as their primary source of social support across the regions, more likely to have at least one chronic health condition identified and to have cigarette smoking listed as a contributing factor. There were also a few differences compared to

2015/2016. The Quebec region was the least likely to have natural deaths with non-compliance with medication listed, while the Prairie and Pacific regions were more likely to have a history of drug use listed as a contributing factor (i.e., 36% and 29%).

Table 9

Factors Related to and Events Surrounding Natural Deaths from 2009/2010 - 2015/2016.

Factors/Events	Fiscal Year		*Total*
	2009/ 2010 – 2014/2015	2015/ 2016	
DNR on file[b]	102	19	*48% (121)*
Received palliative care[b]	107	20	*50% (127)*
Parole by exception[ab]			
Did not apply	40	11	*20% (51)*
Applied but died prior to granting/hearing	26	8	*13% (34)*
Did not meet criteria of CCRA/Ineligible	36	-	*14% (36)*
Applied and denied	13	2	*6% (15)*
Applied and granted, no bed available	3	-	*1% (3)*
Unclear	7	-	*3% (7)*
Next of kin involvement[b]			
Yes[a]	65	16	*32% (81)*
Notified by CSC, not involved	28	2	*12% (30)*
Notified by non-CSC, not involved	6	1	*3% (7)*
No next of kin noted	16	2	*7% (18)*
Unclear	20	-	*8% (20)*
Final cause is related to			
Substance misuse	56	6	*24% (62)*
Smoking	112	18	*51% (130)*
Primary source of social support			
Family/friends outside the institution	63	10	*29% (73)*
Other offenders	3	1	*2% (4)*
CSC staff	9	1	*4% (10)*
Medical personnel	63	18	*32% (81)*
Not Indicated	74	12	*34% (86)*
Any chronic health condition identified	204	39	*96% (243)*
Any mental health disorder identified	101	23	*49% (124)*
Noncompliance with medication			
Yes	72	15	*34% (87)*
No	66	13	*31% (79)*
Not indicated	59	12	*28% (71)*
Total number of natural deaths			*254*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

[a] Includes contact, visits, decision-making and/or consent.

[b] These categories exclude unexpected deaths.

Table 10

Factors Related to and Events Surrounding Natural Deaths by Region for Fiscal Year 2015/2016.

Factors/Events	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
DNR on file[b]	-	5	8	3	3	*45% (19)*
Received palliative care[b]	-	5	9	3	3	*48% (20)*
Parole by exception[ab]						
Did not apply	-	1	5	1	4	*26% (11)*
Applied but died prior to granting/hearing	-	3	2	2	1	*19% (8)*
Did not meet criteria of CCRA/Ineligible	-	-	-	-	-	-
Applied and denied	-	-	2	-	-	*5% (2)*
Applied and granted, no bed available	-	-	-	-	-	-
Unclear	-	-	-	-	-	-
Next of kin involvement[b]						
Yes[a]	-	2	7	3	4	*38% (16)*
Notified by CSC, not involved	-	1	1	-	-	*5% (2)*
Notified by non-CSC, not involved	-	1	-	-	-	*2% (1)*
No next of kin noted	-	-	2	-	-	*5% (2)*
Unclear		-	-	-	-	-
Final cause is related to						
Substance misuse	1	-	5	-	-	*14% (6)*
Smoking	1	1	5	3	8	*43% (18)*
Primary source of social support						
Family/friends outside the institution	-	1	4	2	3	*24% (10)*
Other offenders	-	-	-	-	1	*2% (1)*
CSC staff	1	-	-	-	-	*2% (1)*
Medical personnel	-	8	6	1	3	*43% (18)*
Not indicated	2	1	4	1	4	*29% (12)*
Any chronic health condition identified	3	10	14	2	10	*93% (39)*
Any mental health disorder identified	3	1	8	3	8	*55% (23)*
Noncompliance with medication						
Yes	3	2	5	1	4	*36% (15)*
No	-	1	6	2	4	*31%*

						(13)
Not indicated	-	6	3	-	3	*29%* *(12)*
Total number of natural deaths						*42*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] Includes contact, visits, decision-making and/or consent.
[b] These categories exclude unexpected deaths.

Table 11

Factors Related to and Events Surrounding Natural Deaths by Region for 2009/2010 - 2014/2015.

Factors/Events	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
DNR on file[b]	7	22	36	23	14	*48% (102)*
Received palliative care[b]	7	25	39	21	15	*50% (107)*
Parole by exception[ab]						
Did not apply	2	9	19	6	4	*19% (40)*
Applied but died prior to granting/hearing	-	7	7	6	6	*12% (26)*
Did not meet criteria of CCRA/Ineligible	2	7	13	9	5	*17% (36)*
Applied and denied	3	5	5	-	-	*6% (13)*
Applied and granted, no bed available	-	-	1	1	1	*1% (3)*
Unclear	1	2	1	1	2	*3% (7)*
Next of kin involvement[b]						
Yes[a]	6	15	24	15	5	*31% (65)*
Notified by CSC, not involved	4	4	8	4	8	*13% (28)*
Notified by non-CSC, not involved	-	2	3	-	1	*3% (6)*
No next of kin noted	-	5	4	3	4	*8% (16)*
Unclear	1	4	10	4	1	*9% (20)*
Final cause is related to						
Substance misuse	5	9	15	15	12	*26% (56)*
Smoking	10	32	29	20	21	*53% (112)*
Primary source of social support						
Family/friends outside the institution	5	9	23	15	11	*30% (63)*
Other offenders	-	1	1	-	1	*1% (3)*
CSC staff	1	-	4	2	2	*4% (9)*
Medical personnel	4	19	21	9	10	*30% (63)*
Not indicated	5	29	18	13	9	*35% (74)*
Any chronic health condition identified	13	56	63	39	33	*96% (204)*
Any mental health disorder identified	7	16	35	21	22	*48% (101)*
Noncompliance with medication						
Yes	6	12	24	17	13	*34% (72)*
No	4	13	28	10	11	*31% (66)*
Not indicated	5	25	11	11	7	*28% (59)*
Total number of natural deaths						*212*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

[a] Includes contact, visits, decision-making and/or consent.

[b] These categories exclude unexpected deaths.

As 96% of all natural deaths between 2009/2010 and 2015/2016 had at least one chronic health condition identified unrelated to the cause of death, an examination of the common types of conditions was conducted (see Table 12). In 2015/2016, the most common type of chronic health condition was cardiovascular (64%) and the least common was reproductive (5%). Forty-three percent of natural deaths indicated a gastrointestinal condition. Both musculoskeletal and blood-borne virus/infections were indicated in 36% of cases. Endocrine conditions were indicated in 31% of cases, respiratory conditions were indicated in 26% of cases and central nervous system conditions were indicated in 21% of cases.

Between 2009/2010 to 2014/2015, cardiovascular conditions (72%) remained the most common type of chronic health condition and reproductive remained the least common (11%). Across this timeframe, respiratory conditions were indicated in 50% of cases (versus 26% in 2015/2016). Gastrointestinal (39%), musculoskeletal (38%), blood-borne virus/infection (36%) and endocrine (34%) conditions were all approximately as likely to be indicated in natural deaths. Finally, central nervous system conditions were indicated in 23% of natural deaths during this timeframe.

The most common type of chronic health conditions across all regions was cardiovascular (i.e., identified in 65% to 79% of natural deaths; see Table 13). The least common type across all regions was reproductive (i.e., identified in 6% to 11% of natural deaths). There were some regional differences. In the Atlantic and Ontario regions, the second most common type of chronic health condition was gastrointestinal (i.e., 56% and 46%). In the Quebec, Prairie and Pacific regions, the second most common type of chronic health condition was respiratory (i.e., 51%, 51% and 50%).

Table 12

Types of Chronic Health Conditions for Natural Deaths from 2009/2010 - 2015/2016.

Chronic Health Condition Types	Fiscal Year		*Total*[a]
	2009/ 2010 – 2014/2015	2015/ 2016	
Central nervous system	48	9	*22% (57)*
Musculoskeletal	81	15	*38% (96)*
Respiratory	105	11	*46% (116)*
Cardiovascular	153	27	*71% (180)*
Blood-borne virus/Infection	77	15	*36% (92)*
Endocrine	72	13	*33% (85)*
Gastrointestinal	82	18	*39% (100)*
Reproductive	23	2	*10% (25)*
Total number of natural deaths[a]	*212*	*42*	*254*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] These totals will not add to the total number of natural deaths as offenders may have multiple types of chronic health conditions.

In 2015/2016, only 10% of natural deaths had no chronic health conditions identified (see Table 14). Approximately 76% of natural deaths had between two and seven chronic health conditions identified. Twenty-one percent of natural deaths had four chronic health conditions identified. In the previous six-year period, only 5% of natural deaths had no chronic health conditions identified. Similarly to 2015/2016, approximately 75% of natural deaths had between two and seven chronic health conditions identified.

Table 13

Types of Chronic Health Conditions for Natural Deaths by Region Over a 7-year Period (2009/2010 - 2015/2016).

Chronic Health Condition Types	Region					*Total*[a]
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Central nervous system	3	7	22	11	14	*22% (57)*
Musculoskeletal	9	16	34	16	21	*38% (96)*
Respiratory	4	35	33	22	22	*46% (116)*
Cardiovascular	13	54	53	31	29	*71% (180)*
Blood-borne virus/Infection	6	17	31	20	18	*36% (92)*
Endocrine	5	25	24	18	13	*33% (85)*
Gastrointestinal	10	17	37	20	16	*39% (100)*
Reproductive	1	7	8	4	5	*10% (25)*
Total number of natural deaths[a]	*18*	*68*	*81*	*43*	*44*	*254*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] These totals will not add to the total number of natural deaths as offenders may have multiple types of chronic health conditions.

Table 14

Total Number of Chronic Health Conditions Identified for Natural Deaths from 2009/2010 - 2015/2016.

Number of Chronic Health Conditions Identified	Fiscal Year		*Total*
	2009/ 2010 – 2014/2015	2015/ 2016	
None	10	4	*6% (14)*
One	11	1	*5% (12)*
Two	26	7	*13% (33)*
Three	35	5	*16% (40)*
Four	32	9	*16% (41)*
Five	27	6	*13% (33)*
Six	23	4	*11% (27)*
Seven	17	1	*7% (18)*
Eight	8	2	*4% (10)*
Nine	11	2	*5% (13)*
Ten or more	12	1	*5% (13)*
Total number of natural deaths	*212*	*42*	*254*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

In 2015/2016, natural deaths were most likely to occur on a Sunday (21%) or on a Wednesday (21%; see Table 15). Between 2009/2010 and 2014/2015, natural deaths were most likely to occur on a Sunday (19%) and least likely to occur on a Tuesday (8%).

In 2015/2016, natural deaths were as likely to occur in the morning as in the evening (31% each; see Table 16). Between 2009/2010 and 2014/2015, natural deaths were most likely to occur in the morning (30%) or afternoon (29%).

Table 15

Natural Deaths by Day of the Week from 2009/2010 - 2015/2016.

Day of the Week	Fiscal Year		*Total*
	2009/2010 – 2014/2015	2015/2016	
Sunday	41	9	20% (50)
Monday	35	1	14% (36)
Tuesday	18	5	9% (23)
Wednesday	33	9	17% (42)
Thursday	25	8	13% (33)
Friday	25	7	13% (32)
Saturday	35	3	15% (38)
Total	*212*	*42*	*254*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Table 16

Natural Deaths by Time of Day from 2009/2010 – 2015/2016.

Time of Day[1]	Fiscal Year		*Total*
	2009/2010 – 2014/2015	2015/2016	
Morning[a]	64	13	30% (77)
Afternoon[b]	62	8	28% (70)
Evening[c]	48	13	24% (61)
Overnight[d]	38	8	18% (46)
Total	*212*	*42*	*254*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[1] Time of day refers to the time of day the death was confirmed and not necessarily the exact incident time.
[a] Deaths that occurred between 6:00am and 12:00pm.
[b] Deaths that occurred between 12:00pm and 6:00pm.
[c] Deaths that occurred between 6:00pm and 12:00am.
[d] Deaths that occurred between 12:00am and 6:00am.

Compliance Issues in Relation to Natural Deaths

In 2015/2016, the most common compliance issues in natural cause deaths identified in mortality reviews concerned search logs and reporting requirements, as well as the provision of support to both staff and offenders. Compliance issues in these areas, as well as in relation to exposure protocol, were also the most common issues over the previous six years.

Some compliance issues have seen notable improvements in the last seven years. For example, non-compliance with reporting requirements was noted in 21% of cases in 2010/2011 compared to 14% in 2015/2016 and non-compliance with exposure protocols was noted in 20% of cases in 2010/2011 compared to 5% in 2015/2016. As well, non-compliance with providing support to staff and offenders was noted in 77% of cases in 2009/2010, compared to 14% in 2015/2016.

The majority of the compliance issues noted were similar across the regions, with a few exceptions. The Atlantic region was the most likely to have compliance issues noted

regarding exposure protocols (25%) and compliance issues regarding reporting requirements noted (39%). The Quebec region was the least likely to have compliance issues regarding reporting requirements noted (19%). The Ontario region was the most likely to have non-compliance with providing support (critical incident stress management) to staff and offenders noted (i.e., 36% and 37%).

Non-Natural Deaths in Federal Custody

Non-Natural Deaths in Custody: Manner of Death and Regional Differences

In 2015/2016, there were 23 non-natural deaths in federal custody (see Table 17). Suicide was the most common type of non-natural death, accounting for 9 deaths, followed by overdose, which accounted for 7 deaths. Other types of deaths, including accidents, homicides, and deaths by other method, were relatively uncommon.

In the previous 6 years (2009/2010 - 2014/2015)[6], suicide was the number one method of non-natural death in federal custody in every fiscal year, accounting for 53% (58) of non-natural deaths overall. However, the number of suicides as a proportion of all non-natural deaths has decreased in the last four fiscal years. While suicide accounted for approximately 64% of non-natural deaths in 2012/2013, it accounted for 39% in 2015/2016. Overdose deaths have seen a proportional increase during this same period. While accounting for less than 10% of non-natural deaths in 2012/2013, overdose deaths accounted for 30% of non-natural deaths in 2015/2016.

Homicide was the third most common manner of non-natural death in the 6 previous years. The proportion of homicide deaths has fluctuated over this period, but has remained under 15% since 2012/2013.

[6] Prior to 2009/2010, a different system was in place for mortality reports and boards of investigation. These older reports did not record information in the same way or contain the same information as current reports do. Thus, most analyses in this report start with data from 2009/2010.

Non-natural deaths by other manners were relatively uncommon in the previous 6 years. During this period, deaths by accident and undetermined cause each accounted for around 7% of all non-natural deaths.

Table 17

Number of Non-Natural Deaths in Custody by Manner of Death over a 7-year Period (2009/2010 – 2015/2016).

Fiscal Year	Non-Natural Manner of Death					*Total*
	Suicide	Overdose	Accident	Homicide	Undetermined	
2009/2010	10	4	1	2	2	*19*
2010/2011	4	4	-	5	1	*14*
2011/2012	8	5	1	3	1	*18*
2012/2013	14	2	2	1	3	*22*
2013/2014	9	2	1	2	-	*14*
2014/2015	13	6	2	1	-	*22*
2015/2016	9	7	2	3	2	*23*
Total	*51% (67)*	*23% (30)*	*7% (9)*	*13% (17)*	*7% (9)*	*132*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

In terms of regional variation, overdose was the most common type of non-natural death in the Prairie and Pacific regions in 2015/2016, accounting for half of all non-natural deaths (see Table 18). No overdose deaths occurred in the Atlantic and Quebec regions in 2015/2016. An equal number of overdose and suicide deaths occurred in the Ontario region. As a proportion of all non-natural deaths, suicide was most common in the Atlantic region in 2015/2016, accounting for 4 out of 6 non-natural deaths. Suicide was less common in all other regions, accounting for a quarter of non-natural deaths in the Prairie and Pacific regions, and no deaths in Quebec.

In the previous 6 years, suicide was the most common manner of non-natural death in all five regions (see Table 18). As a proportion of all non-natural deaths, suicide was most common in the Atlantic and Prairie regions, accounting for just under 60% of non-natural deaths, and the least common in Ontario, accounting for around 44% of non-natural

deaths.

Table 18

Regional Distribution of Non-Natural Deaths in Custody by Manner of Death from 2009/2010 – 2015/2016.

Manner of Death[a]	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Suicide	11	14	15	16	11	51% (67)
Overdose	2	8	11	5	5	23% (30)
Accident	1	2	3	1	2	7% (9)
Homicide	3	1	2	9	2	13% (17)
Undetermined	1	3	3	-	1	7% (9)
Total	18	28	34	31	21	132

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a]There are not enough cases to display the regional distribution in 2015/2016 in a table individually.

Profile of Offenders who died by Non-Natural Manner

Certain characteristics were common among offenders who died by non-natural method in federal custody in 2015/2016. For example, 81% had prior drug-related offences and/or incidents, 76% had histories of substance misuse, and 62% had an identified mental health disorder (see Table 19).

These characteristics were also noted among offenders who died by non-natural method in federal custody in the previous 6 years. During this time, 76% of offenders who died by non-natural manner had a history of substance misuse, 62% had prior drug-related offences and/or incidents, and 72% had an identified mental health disorder.

In terms of regional variation over the last 7 years, substance misuse issues were most common in the Atlantic region, where 88% of offenders who died by non-natural death had a history of substance misuse, and 82% had prior drug-related offences and/or incidents (see Table 20).

Table 19

Factors Related to and Events Surrounding Non-Natural Deaths Over a 7-year Period (2009/2010 – 2015/2016).

Factor/Event[a]	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
History of substance misuse	15	12	13	19	11	12	16	76% (98)
Prior drug-related offences/incidents	13	10	10	11	10	13	17	65% (84)
In segregation at time of death	4	2	3	8	5	2	4	22% (28)
Other offenders involved in incident	3	5	2	1	2	6	1	16% (20)
Any chronic health condition identified	8	6	10	15	3	9	11	48% (62)
Any mental health disorder identified	15	11	11	17	12	12	13	71% (91)
Total number of non-natural deaths	*19*	*14*	*18*	*22*	*14*	*21*	*21*	*129*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] Information for these variables is available for only 129 of 132 cases in the 2009/2019 - 2015/2016 period. Totals in these columns therefore may not match actual total number of deaths in all fiscal years.

Table 20

Factors Related to and Events Surrounding Non-Natural Deaths by Region Over a 7-year Period (2009/2010 – 2015/2016)

Factor/Event[ab]	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
History of substance Misuse	15	21	24	24	14	*76% (98)*
Prior drug-related offences/incidents	14	13	22	20	15	*65% (84)*
In segregation at time of death	5	6	3	9	5	*22% (28)*
Other offenders involved in incident	4	3	6	2	5	*16% (20)*
Any chronic health condition identified	11	13	17	10	11	*48% (62)*
Any mental health disorder identified	14	17	23	24	13	*71% (91)*
Total number of non-natural deaths	*17*	*28*	*32*	*31*	*21*	*129*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a]There are not enough cases to display the regional distribution in 2015/2016 in a table individually.
[b]Information for these variables is available for only 129 of 132 cases in the 2009/2019 - 2015/2016 period. Totals in these columns therefore may not match actual total number of deaths in all fiscal years.

Compliance Issues in Relation to Non-Natural Deaths

In 2015/2016, the most common compliance issues in relation to non-natural deaths in custody had to do with search logs and reporting requirements (see Table 21). Compliance issues in these areas, as well as in relation to exposure protocol, were the most common in the previous 6 years.

Some compliance issues have seen notable improvements in the last 7 years. For example: non-compliance with reporting requirements was noted in 68% of cases in 2009/2010, compared to 24% in 2015/2016; non-compliance with exposure protocol was noted in 42% of cases in 2009/2010, compared to 19% in 2015/2016; and non-compliance with search protocols was noted in 32% of cases in 2009/2010, compared to no cases in 2015/2016. In contrast, compliance issues in the area of search logs have become more common, noted in 16% of cases in 2009/2010, compared to 29% in 2015/2016.

Table 21

Compliance Issues in Relation to Non-Natural Deaths Over a 7-year Period (2009/2010 – 2015/2016).

Compliance Issue[a]	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Staff levels at time of incident not in accordance with policy	3	-	-	-	-	-	1	3% (4)
Offender security level at time of incident deemed not appropriate	1	1	-	2	1	-	1	5% (6)
Staff compliance issues with exposure protocol	8	3	5	6	4	3	4	26% (33)
All staff implicated in incident not up to date with certifications	2	1	-	2	5	2	2	11% (14)
Lack of appropriate and necessary equipment available to respond to medical emergency	2	3	-	2	-	1	4	9% (12)
Non-compliance with search protocols	6	2	5	2	3	6	-	19% (24)
Non-compliance with search logs and documentation of items found	3	4	5	3	1	5	6	21% (27)
Non-compliance with reporting requirements as per policy	13	10	11	12	4	5	5	47% (60)
Support not provided to staff following incident	2	-	2	-	-	-	1	4% (5)
Support not provided to offenders following incident	2	-	-	2	-	-	1	4% (5)
Aboriginal social history not taken into account in offender related decisions	1	-	2	5	2	-	1	9% (11)
Total number of non-natural deaths	*19*	*14*	*18*	*22*	*14*	*21*	*21*	*129*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] Information for these variables is available for only 129 of 132 cases in the 2009/2019 - 2015/2016 period. Totals in these columns therefore may not match actual total number of deaths in all regions.

Recommendations from Board of Investigation (BOI) Reports

A thematic analysis of BOI recommendations was conducted for the deaths that occurred between 2009/2010 and 2015/2016. The recommendations put forth in these reports were organized into eight general themes:

1. Review a current process or implement a new process,
2. Change or merge reports/forms,
3. Review or change the guidelines, roles, responsibilities, and/or

training of staff,

4. Change the type of equipment used in medical emergencies,
5. Changes to improve communication and sharing of information between services and departments,
6. Review current policy or implement policy change to prevent a similar situation,
7. Change institutional infrastructure, and
8. Best practices.

The most common recommendations in 2015/2016 involved reviewing or changing the guidelines, roles, responsibilities and/or training of staff, reviewing current policy or implementing policy changes to prevent a similar situation from occurring, and best practices. In comparison to the previous two fiscal years, there was an increase in each of these types of recommendations. The least common type of recommendation in both 2015/2016 and in the previous fiscal years involved a change to the institutional infrastructure.

Further expanding on the most common themes, there were some examples of recommendations that stood out. The types of processes that were recommended were varied (e.g., implementation of an audit function, implementation of various tracking systems, process to address bullying behaviour). The recommendations around reports/forms typically suggested updating a form in order to be more comprehensive, but concise, or more useful to staff (i.e., allowing them access to information quickly during emergency situations). Many of the recommendations regarding the guidelines, roles, responsibilities and/or training of staff and to review or implement policy changes were to clarify particular aspects of a staff member's position in order to eliminate confusion during medical emergencies or to improve the training of all staff members who come into

contact with offenders, especially contract employees. Finally, many of the recommendations across each category were to improve the services' overall care of individuals with mental health or substance misuse issues in order to prevent similar situations from occurring, whether through policy changes, more effective training for staff or improved communication between services and departments.

Suicide Deaths in Federal Custody

Profile of Offenders who Died by Suicide

In 2015/2016, there were 9 suicide deaths in federal custody (see Table 22). Offenders who died by suicide tended to be White and under the age of 45. Suicides were most common among medium security offenders and those either serving relatively short sentences or indeterminate sentences.

These characteristics also reflect those of offenders who died by suicide in federal custody in the previous 6 years. Of the 58 suicide deaths that occurred in this time period, most involved offenders who were White (64%) or Indigenous (26%), and most involved offenders under the age of 55 (84%). Suicide deaths have tended to occur among medium or maximum security offenders, among those serving either relatively short sentences or indeterminate sentences, and those serving time for homicide-related or robbery offences.

Further Examination of Suicide Deaths

In 2015/2016, hanging/asphyxiation was the method of all 9 suicide deaths in federal custody (see Table 23). Points of suspension in hanging deaths included windows, closets, smoke detectors, electrical conduits, and ventilation grates.

Hanging was also the most common method of suicide in the previous 6 years, accounting for 83% of suicide deaths. There is no single method of hanging that stands out as most common. Points of suspension included windows, ventilation registers, clothes rods, smoke detectors, electrical conduits and other types of hooks and bars.

Table 22

Characteristics of Offenders who Died in Federal Custody by Suicide for Fiscal Year 2015/2016 and Over a 6-Year Period (2009/2010– 2014/2015).

Characteristic	Fiscal Year(s)		*Total*
	2009/2010 – 20014/2015	2015/2016	
Ethnicity			
White	37	6	*64% (43)*
Indigenous	15	3	*27% (18)*
Black	4	-	*6% (4)*
Other	2	-	*3% (2)*
Age			
18 – 24	5	1	*9% (6)*
25 – 34	18	3	*31% (21)*
35 – 44	10	2	*18% (12)*
45 – 54	16	1	*25% (17)*
55 – 64	7	1	*12% (8)*
65 – 74	2	1	*4% (3)*
75 – 79	-	-	-
80 +	-	-	-
Offender security level			
Maximum	17	3	*30% (20)*
Medium	28	5	*49% (33)*
Minimum	8	1	*13% (9)*
Undetermined	5	-	*7% (5)*
Index offence			
Homicide related	24	2	*39% (26)*
Sexual	10	1	*16% (11)*
Assault	6	2	*12% (8)*
Robbery	12	2	*21% (14)*
Other violent	2	1	*4% (3)*
Property	1	1	*3% (2)*
Drug	1	-	*1% (1)*
Other non-violent	2	-	*3% (2)*
Sentence length			
2 to less than 4 years	13	3	*24% (16)*
4 to less than 6 years	8	1	*13% (9)*
6 to less than 10 years	8	1	*13% (9)*
More than 10 years	5	-	*7% (5)*
Indeterminate	24	4	*42% (28)*
Total	*58*	*9*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Table 23

Sub-types of Suicide Deaths in Custody Over a 7-year Period (2009/2010 – 2015/2016).

Subtype	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Hanging	9	3	8	11	8	9	8	*84% (56)*
Ligature	-	-	-	1	-	-	-	*1% (1)*
Asphyxiation	-	1	-	-	-	2	1	*6% (4)*
Cutting	-	-	-	1	-	2	-	*4% (3)*
Other	1	-	-	1	1	-	-	*4% (3)*
Total	*10*	*4*	*8*	*14*	*9*	*13*	*9*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

In 2015/2016, suicides were most common on Wednesday, when 3 out of 9 occurred, followed by Sunday, when 2 out of 9 occurred (see Table 24). Suicides were most common in the afternoon and overnight (see Table 25). In the 6 years prior, suicide deaths most often occurred in the middle of the week between Tuesday and Thursday, peaking on Wednesday, when 19% of suicides occurred. Suicides were most common in the afternoon, with 40% of suicides occurring between noon and 6:00 PM.

Table 24

Suicide Deaths by Day of the Week, Fiscal Years 2009/2010 - 2015/2016.

Day of Week	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Sunday	1	-	2	-	1	1	2	*10% (7)*
Monday	1	1	2	2	1	1	1	*13% (9)*
Tuesday	2	1	1	1	1	3	1	*15% (10)*
Wednesday	1	-	3	3	1	3	3	*21% (14)*
Thursday	3	-	-	4	2	1	1	*16% (11)*
Friday	-	2	-	3	1	1	-	*10% (7)*
Saturday	2	-	-	1	2	3	1	*13% (9)*
Total	*10*	*4*	*8*	*14*	*9*	*13*	*9*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Table 25

Suicide Deaths by Time of Day, Fiscal Years 2009/2010 - 2015/2016.

Time of Day[1]	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Morning[a]	-	1	1	4	3	1	-	*15% (10)*
Afternoon[b]	4	1	4	5	4	5	4	40% (27)
Evening[c]	1	1	3	3	1	3	2	*21% (14)*
Overnight[d]	5	1	-	2	1	4	3	24% (16)
Total	*10*	*4*	*8*	*14*	*9*	*13*	*9*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[1] Time of day refers to the time of day the death was confirmed and not necessarily the exact incident time.
[a] Deaths that occurred between 6:00am and 12:00pm.
[b] Deaths that occurred between 12:00pm and 6:00pm.
[c] Deaths that occurred between 6:00pm and 12:00am.
[d] Deaths that occurred between 12:00am and 6:00am.

In 2015/2016, all 9 offenders who died by suicide were identified as having histories of substance misuse and mental health disorders (see Table 26). The presence of a chronic health condition was also noted in all but one case.

These characteristics reflect a pattern of high rates of mental health and substance misuse issues among offenders who died by suicide in federal custody in the previous 6 years. During this time period, 88% of offenders who died by suicide had an identified mental health disorder, while 78% had a history of substance misuse. Half of offenders who died by suicide also had an identified chronic illness.

In terms of regional variation over the last 7 years, a history of substance misuse and prior drug-related offences and/or incidents were most common among offenders in the Atlantic region (see Table 27), with both items noted in 91% of cases. The presence of a chronic health condition was also the most common among offenders in the Atlantic region, noted in 73% of cases. Offenders in the Prairie region were most likely to be in segregation at the time of death.

Table 26

Factors Related to and Events Surrounding Suicide Deaths Over a 7-year Period (2009/2010 – 2015/2016).

Factor/Event	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
History of substance misuse	7	4	7	12	8	7	9	*81% (54)*
Prior drug-related offences/incidents	7	3	4	8	6	7	8	*64% (43)*
In segregation at time of death	2	2	3	8	5	2	4	*39% (26)*
Other offenders involved in the incident[a]	1	-	1	-	1	2	1	*9% (6)*
Any chronic health condition identified	4	1	6	9	3	6	8	*55% (37)*
Any mental health disorder identified	9	4	7	11	9	11	9	*90% (60)*
Total number of suicides	*10*	*4*	*8*	*14*	*9*	*13*	*9*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] Includes reporting or alerting staff.

Table 27

Factors Related to and Events Surrounding Suicide Deaths by Region Over a 7-year Period (2009/2010 – 2015/2016).

Characteristic[a]	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
History of substance misuse	10	10	12	14	8	81% (54)
Prior drug-related offences/incidents	10	5	9	11	8	*64% (43)*
In segregation at time of death	5	4	3	9	5	*39% (26)*
Other offenders involved in incident[b]	1	1	1	1	2	*9% (6)*
Any chronic health condition identified	8	5	9	8	7	*55% (37)*
Any mental health disorder identified	10	12	14	15	9	*90% (60)*
Total number of suicides	*11*	*14*	*15*	*16*	*11*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a]There are not enough cases to display the regional distribution in 2015/2016 in a table individually.
[b]Includes reporting or alerting staff.

Potential Predictive Elements in Suicide Deaths

In 2015/2016, certain predictive elements were common in cases of suicide death in federal custody (see Table 28). Most offenders who died by suicide had previously accessed mental health services while in custody. Most were also taking medication for mental

illness at the time of death. In 44% of cases, the offender had previously attempted suicide. These predictive elements were also common in suicide deaths in the previous 6 years. Out of 58 offenders who died by suicide during this period, 86% had previously accessed mental health services, 59% were on medication for mental illness at the time of death, and 60% had made prior suicide attempts.

In 2015/2016, 4 out of 9 offenders who died by suicide had experienced some type of change to their mental health medication prior to death. In these 4 cases, the medication change took place one to two weeks prior to death. Similar findings were noted in the previous 6 years; 38% of offenders who died by suicide during this time had experienced some type of medication change prior to death, and in nearly three-quarters (73%) of these cases, the medication change took place within four weeks prior to the death. The median number of weeks between the medication change and suicide was 3; in other words, in one half of cases, the number of weeks was less than 3, and in the other half, it was greater.

In terms of regional variation over the last 7 years, previous suicide attempts were most common among offenders who died by suicide in the Prairie region, noted in 69% of cases (see Table 29). Those in Atlantic and Pacific regions were most likely to be taking medication for mental illness at the time of death, noted in 73% of cases. Those in the Atlantic region were also most likely to be under observation prior to death.

Table 28

Potential Predictive Elements in Suicide Deaths, Fiscal Years 2009/2010 – 2015/2016.

Predictive Element	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Prior suicide attempts	6	4	6	10	5	4	4	*58% (39)*
Prior Regional Treatment Centre placement	2	1	3	3	2	5	4	*30% (20)*
Prior mental health services	9	4	7	12	8	10	8	*87% (58)*
Presence of a suicide note	4	1	3	8	2	5	4	*40% (27)*
On medication for mental illness at time of death	6	3	5	7	6	7	8	*63% (42)*
Was being monitored prior to death	3	1	-	3	2	1	4	*21% (14)*
Total number of suicides	*10*	*4*	*8*	*14*	*9*	*13*	*9*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Table 29

Potential Predictive Elements in Suicide Deaths, Fiscal Years 2009/2010 – 2015/2016, by Region.

Risk Factor[a]	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Prior suicide attempts	6	9	9	11	4	*58% (39)*
Prior Regional Treatment Centre placement	3	4	4	5	4	*30% (20)*
Prior mental health services	9	12	14	15	8	*87% (58)*
Presence of suicide note	2	7	6	7	5	*40% (27)*
On medication for mental illness at time of death	8	7	9	10	8	*63% (42)*
Was being monitored prior to death	5	3	1	3	2	*21% (14)*
Total number of suicides	*11*	*14*	*15*	*16*	*11*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a]There are not enough cases to display the regional distribution in 2015/2016 in a table individually.

Compliance Issues in Relation to Suicide Deaths

In 2015/2016, the most common compliance issue in relation to suicide deaths had to do with search logs (see Table 30). Problems in this area were noted in 5 out of 9 cases. This proportion is somewhat higher than in previous years.

However, 2015/2016 saw improvements in the areas of exposure protocol and search protocols, where no issues were reported in 2015/2016. Improvements were also

made in the area of reporting requirements, where the proportion of problems was at a 7 year low.

Table 30

Compliance Issues in Relation to Suicide Deaths, Fiscal Year 2009/2010 – 2014/2015.

Compliance Issue	Fiscal year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Staff levels at time of incident not in accordance with policy	1	-	-	-	-	-	-	*1% (1)*
Offender security level at time of incident deemed not appropriate	1	1	-	1	1	-	1	*7% (5)*
Staff compliance issues with exposure protocol	4	-	2	5	2	2	-	*22% (15)*
All staff implicated in incident not up to date with certifications	1	-	-	2	4	1	1	*13% (9)*
Lack of appropriate and necessary equipment available to respond to medical emergency	1	2	-	2	-	-	1	*9% (6)*
Non-compliance with search protocols	3	1	-	2	3	2	-	*16% (11)*
Non-compliance with search logs and documentation of items found	2	2	-	2	-	2	5	*19% (13)*
Non-compliance with reporting requirements as per policy	7	4	4	7	3	4	2	*46% (31)*
Physical layout of institution impeded ability of staff to observe incident while happening	-	-	1	3	-	-	-	*6% (4)*
Support not provided to staff following incident	1	-	2	-	-	-	1	*6% (4)*
Support not provided to offenders following incident	-	-	-	2	-	-	-	*3% (2)*
Aboriginal social history not taken into account in offender related decisions	-	-	-	3	2	-	1	*9% (6)*
Total number of suicide deaths	*10*	*4*	*8*	*14*	*9*	*13*	*9*	*67*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Immediate Needs Checklist for Suicide Deaths

Offenders are screened for suicide risk upon arrival to any CSC institution, upon placement into segregation, and in other instances where deemed appropriate. The Immediate Needs Checklist (INC) is the tool used to assess the risk of suicide. Examples of questions on the checklist include: "Have you been feeling worried?" "Have you done anything or prepared to do anything with the intent to die such as giving away possessions within the last three months?"

For the purposes of this report, the INC checklist was retroactively re-administered for suicide deaths using all available information provided in the Board of Investigation (BOI) reports. The purpose of this re-administration was to consider whether the suicide risk rating of offenders was appropriate and included all relevant information. It should be noted that not all offenders had an INC listed in the Offender Management System that was completed close to the event. As the information captured by the INC is temporal in nature, the INC is only relevant when completed close to the event. In some cases, the BOI reports did provide information that would have informed the INC and which had the potential to result in an increased suicide risk rating. However, in the majority of cases, relevant information was only identified following the suicide and the lengthy investigation process. In other words, this information was unavailable to staff prior to the suicide and thus, would not have informed the INC had it been conducted prior to the event. In these instances, an increased suicide risk rating would likely not have been produced had staff administered the INC to these individuals.

There were a variety of reasons as to why this information was not available to staff. In some cases, another offender had the information and did not share it with a staff member until after the suicide. In other cases, the information was known prior to the suicide but it was not interpreted as a potential indicator for suicide. For example, some offenders had given away possessions prior to their suicide. While this is an indicator for suicide, it is also common behaviour when an offender is being transferred to another institution. In these cases, the offenders had an upcoming transfer which appears to have resulted in the staff regarding the behaviour as normal, rather than an indicator for suicide.

Overdose Deaths in Federal Custody

Profile of Offenders who died by Overdose

In 2015/2016, there were 7 overdose deaths in custody (see Table 31). Offenders who died from overdose tended to be White, under the age of 45, and classified as medium or maximum security.

These characteristics are similar to those of offenders who died by overdose in the previous 6 years. Out of 23 overdose deaths during this time, most involved offenders who were White (83%), and who were under the age of 45 (78%). Overdose deaths were most common among medium security offenders, and those serving time for homicide-related and robbery offences.

Further Examination of Overdose Deaths

In 2015/2016, there was a proportional increase in the number of overdose deaths as well as the number of overdose deaths involving Fentanyl (see Table 32 and Table 33). Fentanyl was identified as a standalone or contributing substance in 6 out of 7 overdose deaths.

In the previous 6 years, overdose deaths mostly involved illegal substances. In many cases, overdose deaths were caused by a mixture of substances. Fentanyl has become more common in overdose deaths, both in combination with other substances and as a standalone substance. In the last two fiscal years, Fentanyl was identified as a standalone or contributing substance in nearly 69% (9) of overdoses.

Table 31

Characteristics of Offenders who Died by Overdose, Fiscal Year 2015/2016 and Over a 6 Year Period (2009/2010 – 2014/2015).

Characteristic	Fiscal Year(s)		Total
	2009/2010 – 2014/2015	2015/2016	
Ethnicity			
White	19	6	83%(25)
Indigenous	4	-	13% (4)
Black	-	-	-
Other	-	1	3% (1)
Age			
18 – 24	1	-	3% (1)
25 – 34	10	5	50% (15)
35 – 44	7	1	27% (8)
45 – 54	3	-	10% (3)
55 – 64	2	1	10% (3)
65 – 74	-	-	-
75 – 79	-	-	-
80 +	-	-	-
Offender security level			
Maximum	5	2	23% (7)
Medium	16	5	70% (21)
Minimum	1	-	3% (1)
Undetermined	1	-	3% (1)
Index offence			
Homicide related	7	-	23% (7)
Sexual	-	1	3% (1)
Assault	1	1	6% (2)
Robbery	5	3	27% (8)
Other violent	2	1	10% (3)
Property	4	-	13% (4)
Drug	2	-	7% (2)
Other non-violent	2	1	10% (3)
Sentence length			
2 to less than 4 years	6	1	23% (7)
4 to less than 6 years	5	1	20% (6)
6 to less than 10 years	3	3	20% (6)
More than 10 years	3	1	13% (4)
Indeterminate	6	1	23% (7)
Total number of overdose deaths	*23*	*7*	*30*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

In 2015/2016, overdose deaths in custody most often occurred towards the end of the week, with 6 out of 7 deaths occurring on Thursday or Friday (see Table 34). In terms of the time of day, overdose deaths were most common in the morning, between 6:00 AM and noon, with 3 out of 7 overdose deaths occurring during this time (see Table 35). In the previous 6 years, there was no identifiable pattern in terms of the day(s) on which overdose deaths were most likely to occur. In terms of the time of day, overdose deaths were somewhat more common in the morning period, with 30% (7) of overdoses occurring between 6:00 AM and noon.

Table 32

Sub-type of Substance in Overdose Deaths, Fiscal Years 2009/2010 - 2015/2016.

Sub-type[a]	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Offender's prescription	-	-	1	-	-	-	-	*3% (1)*
Other prescription drugs	2	1	-	-	-	1	-	*13% (4)*
Illegal substance	2	2	4	2	2	5	7	*80% (24)*
Undetermined	-	1	-	-	-	-	-	*3% (1)*
Total	*4*	*4*	*5*	*2*	*2*	*6*	*7*	*30*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] Information is available for 30 of 31 overdose deaths in the 2009/2019 - 2015/2016 period. Totals in columns therefore may not match the actual total number of overdose deaths.

Table 33

Specific Type of Substance in Overdose Deaths, Fiscal Years 2009/2010 - 2015/2016.

Specific Substance[a]	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Mix	3	2	1	2	1	-	2	37% (11)
Fentanyl	-	-	1	-	1	3	4	30% (9)
Heroin	-	-	1	-	-	1	1	10% (3)
Morphine	-	1	1	-	-	-	-	7% (2)
Other	1	1	1	-	-	2	-	*17% (5)*
Total	*4*	*4*	*5*	*2*	*2*	*6*	*7*	*30*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] Information is available for 30 of 31 overdose deaths in the 2009/2019 - 2015/2016 period. Totals in columns therefore may not match the actual total number of overdose deaths.

Table 34

Overdose Deaths by Day of the Week, Fiscal Years 2009/2010 - 2015/2016.

Day of the Week	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Sunday	-	2	1	-	-	1	-	13% (4)
Monday	1	-	-	-	1	-	-	7% (2)
Tuesday	-	-	-	-	-	2	1	10% (3)
Wednesday	1	1	1	-	-	1	-	13% (4)
Thursday	-	-	1	2	1	-	3	23% (7)
Friday	1	-	-	-	-	1	3	17% (5)
Saturday	1	1	2	-	-	1	-	17% (5)
Total	*4*	*4*	*5*	*2*	*2*	*6*	*7*	*30*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Table 35

Overdose Deaths by Time of Day, Fiscal Years 2009/2010 - 2015/2016.

Time of Day[1]	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Morning[a]	1	-	1	1	1	3	3	33% (10)
Afternoon[b]	1	2	1	-	1	1	1	23% (7)
Evening[c]	1	1	-	-	-	2	1	17% (5)
Overnight[d]	1	1	3	1	-	-	2	27% (8)
Total	*4*	*4*	*5*	*2*	*2*	*6*	*7*	*30*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[1] Time of day refers to the time of day the death was confirmed and not necessarily the exact incident time.
[a] Deaths that occurred between 6:00am and 12:00pm.
[b] Deaths that occurred between 12:00pm and 6:00pm.
[c] Deaths that occurred between 6:00pm and 12:00am.
[d] Deaths that occurred between 12:00am and 6:00am.

Certain characteristics were common among offenders who died by overdose in federal custody in 2015/2016. For example, 5 out of 7 offenders who died by overdose were identified as having histories of substance misuse, 5 were also identified as having prior drug-related offences or incidents, and 4 had positive urinalysis test(s) results within the year prior (see Table 36). These characteristics reflect those of offenders who died by overdose deaths in the previous 6 years. During this period, 91% of offenders who died by

overdose had histories of substance misuse, and 96% had prior drug-related offences and/or incidents.

In terms of regional variation over the last 7 years, offenders in the Pacific region were less likely than those in other regions to have a history of substance misuse (see Table 37). Offenders in the Prairie region were most likely to have had positive urinalysis test(s) results in the year prior and have an identified mental health disorder. Those in Quebec were most likely to have a chronic health issue.

Among those who died by overdose in 2015/2016, 2 out of 7 were identified as having an active drug management strategy. This is somewhat lower than the rate in the previous 6 years, during which time, 44% of offenders who died by overdose were identified as having an active drug management strategy. At the institutional level, in 2015/2016, an institutional drug interdiction strategy was noted in all 7 overdose deaths. In the previous 6 years, a drug interdiction strategy was identified in 78% of overdose deaths.

Compliance Issues in Relation to Overdose Deaths

In 2015/2016, the most common compliance issues in overdose deaths related to the handling of the automated external defibrillator (AED), exposure protocol, necessary equipment, and reporting requirements (see Table 38). In each of these areas, 2 compliance issues were noted.

Table 36

Information Related to Overdose Deaths, Fiscal Years 2009/2010 – 2015/2016.

Characteristic/Event[a]	Fiscal Year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	
History of substance misuse	4	4	4	2	2	5	5	*87% (26)*
Prior drug-related offences/incidents	4	4	4	2	2	6	5	*90% (27)*
In segregation at time of death	1	-	-	-	-	-	-	*3% (1)*
Positive urinalysis test(s) within one year prior	n/a*	2	2	n/a	n/a	n/a	4	*n/a*
Other offenders involved in the incident[a]	1	2	1	-	1	3	1	*30% (9)*
Any chronic health condition identified	1	2	2	1	-	2	1	*30% (9)*
Any mental health disorder identified	2	4	2	1	2	1	3	*50% (15)*
Total number of overdose deaths	*4*	*4*	*5*	*2*	*2*	*6*	*7*	*30*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] Information is available for 30 of 31 overdose deaths in the 2009/2019 - 2015/2016 period. Totals in columns therefore may not match the actual total number of overdose deaths.
*Not enough information available to determine.

Table 37

Information Related to Overdose Deaths, Fiscal Years 2009/2010 – 2015/2016 by Region.

Characteristic/Event[ab]	Fiscal Year					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
History of substance misuse	2	8	9	5	2	*87% (26)*
Prior drug-related offences/incidents	2	7	10	4	4	*90% (27)*
In segregation at time of death	-	1	-	-	-	*3% (1)*
Positive urinalysis test(s) within one year prior	1	n/a*	4	4	2	*n/a*
Other offenders involved in the incident[a]	1	2	4	-	2	*30% (9)*
Any chronic health condition identified	-	4	3	-	2	*30% (9)*
Any mental health disorder identified	1	2	6	5	1	*50% (15)*
Total number of overdose deaths	*2*	*8*	*10*	*5*	*5*	*30*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a]There are not enough cases to display the regional distribution in 2015/2016 in a table individually.
[b]Information is available for 30 of 31 overdose deaths in the 2009/2019 - 2015/2016 period. Totals in columns therefore may not match the actual total number of overdose deaths.
*Not enough information available to determine.

In the previous 6 years, the most common compliance issue in relation to overdose deaths had do to with reporting requirements. Problems in this area were noted in 52% of

cases. Other common compliance issues related to search logs, search protocols and exposure protocol. However, there were improvements in all of these areas in the 2015/2016 year.

Some compliance issues were more common in certain regions over the last 7 years (see Table 39). In relation to exposure protocol, the Quebec region had the highest percentage of compliance issues, noted in 63% of cases. Ontario had the greatest number of compliance issues when it came to search logs, noted in 60% of cases. Finally, in relation to reporting requirements, the Prairie region had the greatest number of issues, noted in all cases.

Table 38

Compliance Issues in Relation to Overdose Deaths, Fiscal Years 2009/2010 – 2015/2016

Compliance Issue[a]	Fiscal year							*Total*
	2009/ 2010	2010/ 2011	2011/ 2012	2012 2013	2013/ 2014	2014/ 2015	2015/ 2016	
Compliance issues related to post-use handling of AED	-	-	-	-	1	1	2	*13% (4)*
Staff levels at time of incident not in accordance with policy	2	-	-	-	-	-	1	*10% (3)*
Offender security level at time of incident deemed not appropriate	-	-	-	-	-	-	-	-
Staff compliance issues with exposure protocol	2	2	1	1	1	1	2	*33% (10)*
All staff implicated in incident not up to date with certifications	1	-	-	-	-	-	-	*3% (1)*
Lack of appropriate and necessary equipment available to respond to medical emergency	1	-	-	-	-	1	2	*13% (4)*
Non-compliance with search protocols	2	-	3	-	-	3	-	*27% (8)*
Non-compliance with search logs and documentation of items found	1	-	4	-	1	3	1	*33% (10)*
Non-compliance with reporting requirements as per policy	3	2	4	1	1	1	2	*47% (14)*
Support not provided to staff following incident	-	-	-	-	-	-	-	-
Support not provided to offenders following incident	1	-	-	-	-	-	-	*3% (1)*
Total number of suicide deaths	*4*	*4*	*5*	*2*	*2*	*6*	*7*	*30*

Note: Results are accurate as of July 31,2017. Subsequent investigations or reviews may result in changes to this table.
[a] Information is available for 30 of 31 overdose deaths in the 2009/2019 - 2015/2016 period. Totals in columns therefore may not match the actual total number of overdose deaths.

Table 39

Compliance Issues in Relation to Overdose Deaths, Fiscal Years 2009/2010 – 2015/2016, by Region.

Compliance issue[ab]	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Compliance issues related to post-use handling of AED	0	0	3	1	0	*13% (4)*
Staff levels at time of incident not in accordance with policy	0	1	1	1	0	*10% (3)*
Offender security level at time of incident deemed not appropriate	-	-	-	-	-	-
Staff compliance issues with exposure protocol	0	5	4	0	1	*33% (10)*
All staff implicated in incident not up to date with certifications	0	0	1	0	0	*3% (1)*
Lack of appropriate and necessary equipment available to respond to medical emergency	0	0	3	1	0	*13% (4)*
Non-compliance with search protocols	1	0	4	2	1	*27% (8)*
Non-compliance with search logs and documentation of items found	0	0	6	2	2	*33% (10)*
Non-compliance with reporting requirements as per policy	0	3	3	5	3	*47% (14)*
Support not provided to staff following incident	-	-	-	-	-	-
Support not provided to offenders following incident	0	0	1	0	0	*3% (1)*
Total number of overdose deaths	*2*	*8*	*10*	*5*	*5*	*30*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a]There are not enough cases to display the regional distribution in 2015/2016 in a table individually.
[b]Information is available for 30 of 31 overdose deaths in the 2009/2019 - 2015/2016 period. Totals in columns therefore may not match the actual total number of overdose deaths.

Non-Natural Deaths in Federal Custody by Homicide, Accident, and Undetermined Cause

Profile of Offenders who Died by Other Manner (Homicide, Accident and Undetermined Cause)

In 2015/2016, deaths in federal custody of other manner included 3 homicides and 2 accidents (see Table 40). Offenders who died by other method tended to be White, medium security offenders serving time for homicide-related or robbery offences.

In the previous 6 years, homicide was the third most common manner of non-natural death in federal custody, accounting for 14 deaths. Offenders who died by homicide tended to be White (64%) or Indigenous (21%) and under the age of 45 (71%). Homicide deaths were most common among medium security offenders, those serving indeterminate or medium length sentences, and those serving time for homicide-related or robbery offences.

In 2015/2016, 2 out of 3 homicide deaths occurred on a Monday (see Table 41), and all occurred in the evening (between 6:00 PM to 12:00 AM; see Table 42). Similarly, in the previous 6 years, 4 out of 14 homicide deaths took place on Monday, making it the most common day for homicide deaths, and 64% of homicide deaths took place in the evening.

Deaths by accident and undetermined cause both accounted for 7 non-natural deaths in the previous 6 years. Offenders who died by accident and undetermined cause tended to be White. There are not enough cases to determine when these types of deaths are most likely to occur.

Table 40

Characteristics of Offenders who Died in Custody by Accident, Homicide, and Undetermined Manner, Fiscal Years 2009/2010 – 2015/2016.

Characteristics	Accident		Homicide		Undetermined		*Total*
	2009/2010 - 2014/2015	2015/2016	2009/2010 - 2014/2015	2015/2016	2009/2010 - 2014/2015	2015/2016	
Ethnicity							
White	5	2	9	2	4	-	*67% (22)*
Indigenous	2	-	3	1	1	-	*21% (7)*
Black	-	-	1	-	-	-	*3% (1)*
Other	-	-	1	-	2	-	*9% (3)*
Age							
18 – 24	-	-	2	-	-	-	*6% (2)*
25 – 34	1	-	4	2	1	-	*24% (8)*
35 – 44	1	-	4	-	-	-	*15% (5)*
45 – 54	1	1	2	1	4	-	*27% (9)*
55 – 64	2	1	1	-	2	-	*18% (6)*
65 – 74	1	-	1	-	-	-	*6% (2)*
75 – 79	-	-	-	-	-	-	-
80 +	1	-	-	-	-	-	*3% (1)*
Offender security level							
Maximum	2	-	3	1	3	-	*27% (9)*
Medium	5	2	8	2	2	-	*58% (19)*
Minimum	-	-	1	-	1	-	*6% (2)*
Undetermined	-	-	2	-	1	-	*9% (3)*
Index offence							
Homicide related	3	1	6	2	2	-	*42% (14)*
Sexual	2	-	1	-	2	-	*15% (5)*
Assault	-	-	1	-	1	-	*6% (2)*
Robbery	-	1	3	1	1	-	*18% (6)*
Other violent	-	-	-	-	-	-	-
Property	-	-	-	-	1	-	*3% (1)*
Drug	-	-	1	-	-	-	*3% (1)*
Other non-violent	2	-	2	-	-	-	*12% (4)*
Sentence length							
2 to less than 4 years	1	-	1	-	4	-	*18% (6)*
4 to less than 6 years	-	1	4	2	-	-	*21% (7)*
6 to less than 10 years	-	-	1	-	-	-	*3% (1)*
More than 10 years	1	-	2	-	-	-	*9% (3)*
Indeterminate	5	1	6	1	3	-	*48% (16)*
Total number of other deaths	*7*	*2*	*14*	*3*	*7*	-	*33*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Table 41

Day of the Week for Non-Natural Deaths in Custody by Accident, Homicide, and Undetermined Manner, Fiscal Years 2009/2010 – 2015/2016.

Day of Week	Accident		Homicide		Undetermined		*Total*
	2009/2010 -2014/2015	2015/2016	2009/2010 -2014/2015	2015/2016	2009/2010 -2014/2015	2015/2016	
Sunday	-	-	1	-	3	-	*12% (4)*
Monday	2	-	4	2	-	-	*24% (8)*
Tuesday	1	2	1	-	1	-	*15% (5)*
Wednesday	1	-	1	-	-	-	*6% (2)*
Thursday	1	-	1	-	-	-	*6% (2)*
Friday	2	-	3	-	2	-	*21% (7)*
Saturday	-	-	3	1	1	-	*15% (5)*
Total	*7*	*2*	*14*	*3*	*7*	-	*33*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

Table 42

Time of Day for Non-Natural Deaths in Custody by Accident, Homicide, and Undetermined Manner, Fiscal Years 2009/2010 – 2015/2016.

Time of Day[1]	Accident		Homicide		Undetermined		*Total*
	2009/2010 - 2014/2015	2015/2016	2009/2010 - 2014/2015	2015/2016	2009/2010 - 2014/2015	2015/2016	
Morning[a]	1	-	1	-	1	-	*9% (3)*
Afternoon[b]	3	-	4	-	3	-	*30% (10)*
Evening[c]	2	-	9	3	2	-	*48% (16)*
Overnight[d]	1	2	-	-	1	-	*12% (4)*
Total	*7*	*2*	*14*	*3*	*7*	-	*33*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[1] Time of day refers to the time of day the death was confirmed and not necessarily the exact incident time.
[a] Deaths that occurred between 6:00am and 12:00pm.
[b] Deaths that occurred between 12:00pm and 6:00pm.
[c] Deaths that occurred between 6:00pm and 12:00am.
[d] Deaths that occurred between 12:00am and 6:00am.

Further Examination of Offenders who Died by Other Manner

Among the 14 offenders who died in federal custody by homicide between 2009/2010 and 2014/2015, issues related to substance misuse and/or mental health were relatively common; 7 had histories of substance misuse, 7 had prior drug-related offences and/or incidents, and 6 had an identified mental health disorder (see Table 43).

Substance misuse issues and mental and physical health problems were also relatively common among offenders who died by accident and undetermined cause during this period.

Table 43

Characteristics of Offenders who Died in Custody by Accident, Homicide, and Undetermined Manner, Fiscal Years 2009/2010 – 2015/2016.

Characteristic[a]	Accident		Homicide		Undetermined		*Total*
	2009/2010 - 2014/2015	2015/2016	2009/2010 - 2014/2015	2015/2016	2009/2010 - 2014/2015	2015/2016	
History of substance misuse	4	1	7	-	5	-	*55% (17)*
Prior drug-related offences/incidents	1	1	7	2	2	-	*42% (13)*
In segregation at time of death	-	-	-	-	1	-	*3% (1)*
Other offenders involved in incident	-	-	4	-	2	-	*19% (6)*
Any chronic health condition identified	5	-	3	1	6	-	*48% (15)*
Any mental health disorder identified	4	-	6	-	5	-	*48% (15)*
Total number of deaths	*6*	*1*	*14*	*3*	*7*	-	*31*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.
[a] Information is only available for 7 out of 9 accidents in the 2009/2010 – 2015-2016 period. Totals in columns may therefore not match the actual total number of deaths.

Compliance Issues in Relation to Deaths by Other Manner

In 2015/2016, compliance issues noted in relation to deaths by other manner concerned exposure protocols, search logs, and support for offenders (see Table 44). In the previous 6 years, common compliance issues in relation to non-natural deaths by other manner included problems related to reporting requirements, noted in 14 cases, and exposure protocol, noted in 12 cases.

Table 44

Compliance Issues in Relation to Deaths by Accident, Homicide, and Undetermined Manner, Fiscal Year 2015/2016 and a 6-year Period (2009/2010 – 2014/2015).

Characteristic[a]	Accident		Homicide		Undetermined		*Total*
	2009/2010 – 2014/2015	2015/ 2016	2009/2010 -2014/2015	2015/ 2016	2009/2010 -2014/2015	2015/ 2016	
Staff levels at time of incident not in accordance with policy	1	-	-	-	-	-	*3% (1)*
Offender security level at time of incident deemed not appropriate	1	-	-	-	-	-	*3% (1)*
Staff compliance issues with exposure protocol	1	1	3	1	6	-	*39% (12)*
All staff implicated in incident not up to date with certifications	-	-	3	-	-	-	*10% (3)*
Non-compliance with search protocols	-	-	4	-	1	-	*16% (5)*
Non-compliance with search logs and documentation of items found	n/a	-	-	3	n/a	-	*10% (3)*
Non-compliance with reporting requirements as per policy	3	-	7	-	4	-	*45% (14)*
Support not provided to staff following incident	-	-	1	-	-	-	*3% (1)*
Support not provided to offenders following incident	-	1	1	-	-	-	*6% (2)*
Total number of deaths	*6*	1	*14*	*3*	*7*	-	*31*

Note: Results are accurate as of July 31, 2017. Subsequent investigations or reviews may result in changes to this table.

[a] Information is only available for 7 out of 9 accidents in the 2009/2010 – 2015-2016 period. Totals in columns may therefore not match the actual total number of deaths.

Conclusion

CSC takes seriously its obligation to ensure the safety and security of all offenders in its custody. Therefore reducing the number of deaths in custody, particularly non-natural deaths, is a fundamental priority of the organization. CSC strives to prevent deaths in custody and prioritizes learning from any deaths that occur. This report, produced annually, contributes to the organization's ability to quickly identify trends, areas for opportunity, and initiatives leading to reducing deaths in custody. This report also aims to provide clear, transparent, and open communication regarding both natural and non-natural deaths, thereby facilitating collaboration with stakeholders and experts who may contribute to the important goal of preventing these deaths.