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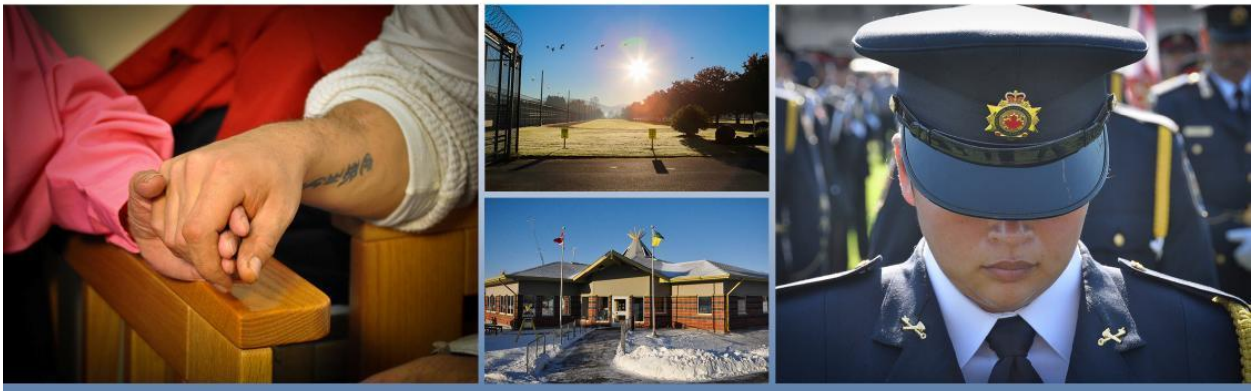

Annual Report on Deaths in Custody

2017/2018 to 2019/2020

2023

Nº SR-23-01

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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 under its custody and care. Examining and reporting on deaths in custody promotes organizational transparency and assists in identifying potential areas in need of improvement. As part of an ongoing reporting strategy, the current analysis examines all deaths in a federal institution between 2017/2018 to 2019/2020.

Between 2017/2018 and 2019/2020, there was a total of 168 deaths in federal custody, the majority of which were the result of natural causes (67%). More specifically, there were 40 natural cause deaths in 2017/2018, 34 in 2018/2019, and 39 in 2019/2020. Non-natural deaths across the three-year period included 23 suicide deaths, 19 overdose deaths, 11 homicide-related deaths, and two deaths that remain of undetermined cause. Approximately two-thirds of offenders who died in federal custody between 2017/2018 and 2019/2020 were White (64%); almost one-quarter (24%) were Indigenous, 4% were Black, and 7% were another race/ethnicity.

With respect to natural cause deaths, cancer (28%) and cardiovascular-related (21%) were the most common causes. In 95% of cases, individuals who died of natural causes had at least one chronic health issue identified. The most common types of chronic health issues identified were cardiovascular (67%) and gastrointestinal (67%). Those who died of natural causes were generally older (M = 63.87 years) and were often serving an indeterminate sentence (57%). In 81% of cases, individuals who died of natural causes had passed their parole eligibility dates. A number of offenders had previously been granted conditional release but were subsequently revoked. Reasons for a lack of recent parole application or the waiving of parole review included: the absence of suitable community residential facilities; limited or no community supports; and/or the preference for an institutional support system. Offenders who died of natural causes in custody were often receiving palliative care.

Suicide deaths were the most common type of non-natural death during the three-year period, with 23 cases. Over three-quarters of suicide deaths occurred by hanging (78%). Individuals who died by suicide tended to have histories marked by substance use (83%) and mental health concerns (83%). Most were between the ages of 25 and 44 (70%; M = 35.91). Indigenous representation was 44%.

Overdose deaths were the second most common type of non-natural death during the three-year period, with 19 cases. In cases for which investigations were complete, opioids were nearly always identified as a standalone or contributing substance (i.e., in 15 of 17 cases). All but one opioid-related incident involved Fentanyl. Narcan© was administered in most cases (94%). Offenders who died by overdose typically were classified as medium security (79%). They often had prior substance-related incidents in federal custody within the past year (i.e., 82%). Just under two-thirds were receiving interventions targeting substance use prior to the overdose incident. The average age of offenders who died by overdose was 36.76.

Homicide deaths during the three-year period were disproportionate to the Prairie region, where seven of the 11 incidents occurred. Various factors played a role in perpetrator motivation included Security Threat Group (STG) conflict, debt, and the perceived nature of the victim's offences. More than one instigator was involved in nearly three quarters of homicide cases (70%). A majority

of incidents involved offenders classified as maximum security (73%) and almost all involved offenders serving a sentence for a violent offence (82%).

CSC remains committed to understanding deaths in custody. The investigations and reviews conducted in relation to deaths in custody allow for the identification of need areas in the Service. Ensuring that appropriate medical treatment is provided to those with chronic and life-limiting illnesses and preventing non-natural deaths are ongoing organizational priorities. CSC continues to implement recommendations and consider policy and practice changes in light of findings from the Board of Investigations and Mortality Reviews/Quality of Care Reviews, with the underlying goal of promoting safe and humane custody and improving offender outcomes.

Acknowledgements

The Research Branch gratefully acknowledges the assistance of the Incident Investigation Branch and Health Services in gathering and assisting with the interpretation of the documents and reports used in analysis. The Annual Reports would not be possible without their continued assistance and co-operation.

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Introduction

The Correctional Service of Canada (CSC) contributes to public safety by encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure, and humane control. Deaths in federal custody, particularly non-natural deaths, are a complex and challenging issue. The Annual Report on Deaths in Custody is intended to contribute to organizational knowledge, inform operational practices, and promote transparency around these incidents.

CSC is required under the *Corrections and Conditional Release Act (CCRA)* to investigate or review all incidents involving the death of offender in federal custody[1]. As per *Commissioner's Directive (CD) 041 - Incident Investigations* (Correctional Service Canada, 2020a), CSC's Health Services Sector typically conducts a Mortality Review[2] (MR) for natural cause deaths, while the Incident Investigation Branch convenes a Board of Investigation (BOI) for all non-natural deaths and some unexpected natural deaths in custody[3]. The Research Branch (Policy Sector) utilizes information from these investigations and reviews, as well as case information from the Offender Management System (OMS), to produce Annual Reports.

This report first provides a broad overview of trends in deaths in custody over the last two decades, before presenting a detailed examination of deaths in custody that occurred across a three-year period (i.e., 2017/2018 to 2019/2020)[4]. Analysis includes attention to both natural deaths (i.e., cases in which the cause of death is the result of an illness) and non-natural deaths (i.e., all deaths that do not qualify as a natural death or where the cause is undetermined). Consideration is paid to the manner of death, the circumstances surrounding the death, and the profile of offenders involved. Where relevant, regional and yearly variations are examined. It is important to note that

[1] Cases involving Medical Assistance in Dying are not required to convene a BOI or MR/Quality of Care Review (Correctional Service Canada, 2022a). However, these cases are included in analyses in this report.
[2] Significant changes were made to the review process for natural cause deaths when *Bill C-83* came into effect on November 30, 2019. Quality of Care Reviews, convened by the Commissioner, are conducted by registered health care professionals to assess the quality of care prior to the death and to identify and address areas for improvement.
[3] Factors determining which investigative process is applicable include: the level of violence and injuries sustained; the profile of the offender(s) involved; public interest; the frequency with which similar incidents have occurred in the past; and the recurrence of similar incidents at a particular site. In certain instances, a BOI may be convened for a natural cause death.
[4] The Annual Report in Deaths in Custody is typically published on an annual basis. In addition to expected delays associated with the investigatory and review processes following deaths in custody, shifts in organizational priorities during the COVID-19 pandemic contributed to additional delays in producing Annual Reports. The present analyses therefore combines three fiscal years into one report, with numbers presented for each fiscal year.

due to low numbers, percentage differences over time and across region are prone to fluctuation, particularly in the case of non-natural deaths.

Data Source and Methodology

The information used to conduct the analyses presented in this report was gathered from a variety of sources. Information pertaining to the nature and circumstances of incidents was drawn from incident reports, Warden's Situation Reports, toxicology reports, Coroner's reports, Board of Investigation reports, and Mortality Reviews. Additional information pertaining to offender profile variables was gathered from the OMS. A two-pronged coding process was employed whereby a designated auditor reviewed all information coded by the research team for quality and consistency.

The categorization of incidents in this report is based on the cause identified in the most recent review/investigatory document. *Natural cause deaths* include incidents where the cause of death is the result of an illness. Deaths involving Medical Assistance in Dying (MAID) are included in the analysis of natural cause incidents, including the subtype of natural cause deaths (i.e., the associated life-limiting illness). All other types of deaths that do not meet the definition of a natural death are classified as non-natural deaths. Subtypes of non-natural deaths include the following:

- *Suicide deaths* include incidents in which the offender died as a result of intentional self-inflicted actions such as hanging, ligature, cutting, blunt force trauma, overdose, or other manner.
- *Overdose deaths* include incidents in which the offender died as a result of ingesting a drug or drugs (licit or illicit); overdoses are only classified as a suicide if there is clear evidence of intentionality (e.g., a suicide note).
- *Homicide deaths* include incidents in which the offender died as a result of injuries inflicted by another offender or other offenders.
- *Accidental deaths* include incidents in which the offender died as a result of non-natural causes due to an accident (e.g., slip/fall).
- *Staff Involved deaths* include incidents in which staff were directly involved in actions that lead to the death of an offender, regardless of intent (e.g., use of force during a security incident such as an attempted escape).[5]

[5] There has been a change in terminology from 'Staff Intervention' (used in certain prior reports) to 'Staff Involved.'

- *Undetermined deaths* include incidents in which the specific cause of death could not be determined, as well as deaths for which investigations remained ongoing at the time of analyses[6].

Note that data is presented in graphs throughout the body of the report, while the majority of tables are included in the appendix.

[6] At the time of the current analysis, investigatory processes remained underway for two non-natural incidents; however, there was notable evidence to indicate these incidents were fatal overdoses. Such incidents were classified in overview tables as overdose incidents, however, the two incidents were excluded from detailed analysis. It is possible that changes to classification may occur in future reports as a result of new findings from investigations and/or Coroner's reports.

Overview of Deaths in Federal Custody

Deaths in Custody over a 20-year period: Manner of Death and Regional Differences

Over the last two decades (i.e., 2000/2001 to 2019/2020), there were 1,072 deaths in federal custody (see Table 1). Notwithstanding fluctuation across fiscal years, natural cause deaths have accounted for two-thirds of deaths in federal custody. Suicide deaths accounted for 17% of deaths in custody, overdose deaths accounted for 8%, and homicide deaths accounted for 5%. Other types of deaths included accidental deaths (1%), staff-involved (<1%), and deaths of undetermined cause (2%). The ratio of natural and non-natural deaths varied by region. The percentage of natural deaths versus non-natural deaths was highest in the Quebec (75%), Pacific (70%), and Ontario (68%) regions (with counts of 209, 127, and 208, respectively; see Table 2).[7]As a percentage of all deaths within each region:

- Suicide deaths were most common in the Atlantic region (26%; 25) and the Prairie region (22%; 46);
- Overdose deaths were most common in the Ontario region (11%; 33), followed by the Prairie (9%; 20) and Pacific (8%; 15) regions; and
- Homicide deaths were most common in the Prairie region (12%; 26).

In the most recent three-year period under analysis (i.e., 2017/2018 to 2019/2020), there was a total of 168 deaths in federal custody. The total number of deaths was 54 in 2017/2018, 52 in 2018/2019, and 62 in 2019/2020. Consistent with prior overall trends, natural cause deaths accounted for roughly two-thirds of cases, with counts of 40, 34, and 39 across 2017/2018, 2018/2019, and 2019/2020, respectively. Also, generally consistent with prior years, suicide deaths were the most common type of non-natural death, with counts of six in both 2017/2018 and 2018/2019 and 11 in 2019/2020. Overdose deaths[8] accounted for five deaths in 2017/2018, six deaths in 2018/2019, and eight deaths in 2019/2020. Homicide deaths accounted for two deaths in 2017/2018, five deaths in 2018/2019, and four deaths in 2019/2020. Across the three-year period,

[7] These percentages are calculated within region given the variation in population size.
[8] The overdose count for 2017/2018 includes two cases that remain under investigation, but for which there is evidence to suggest the cause of death was overdose. Such incidents were classified in overview tables as overdose incidents, however, the two incidents were excluded from detailed analysis. Changes to classification may occur in future reports following the completion of investigations and/or Coroner's reports.

there were two deaths that remained of undetermined cause (i.e., one in 2017/2018 and one in 2018/2019). There were no deaths caused by accident or staff involvement in the three-year period.

The overall rate[9] of deaths in custody was 3.83 per 1,000 offenders in 2017/2018 (natural = 2.84, non-natural = 0.99), 3.68 per 1,000 offenders in 2018/2019 (natural = 2.40, non-natural =1.27), and 4.52 per 1,000 offenders in 2019/2020 (natural = 2.84, non-natural = 1.68). There continues to be regional variation in the frequency of deaths in custody and the relative percentage of natural versus non-natural deaths, with ongoing fluctuation by year. Across the three-year period, natural deaths were more common than non-natural deaths in all regions except for the Prairie region, where non-natural deaths accounted for 55% of cases. Quebec had the highest percentage of natural deaths (85%) relative to non-natural deaths across this period.

[9] Rates were calculated using the in custody population data for each fiscal year taken from CSC's Corporate Report System-Modernized (CRS-M).

Table 1

Deaths in Custody by Manner of Death Over a 20-year Period (2000/2001 to 2019/2020)

Fiscal Year	Manner of Death							*Total*
	Natural	Non-natural						
		Suicide	Overdose	Homicide	Accident	Staff involved	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	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	8	3	2	1	-	*65*
2016/2017	38	3	4	2	-	-	-	*47*
2017/2018	40	6	5[a]	2[a]	-	-	1	*54*
2018/2019	34[a]	6	6	5	-	-	1	*52*
2019/2020	39[a]	11	8	4	-	-	-	*62*
Total	*716*	*180*	*87*	*54*	*12*	*2*	*21*	*1,072*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] Some investigations are ongoing, which could result in categorization changes in future reports.

Table 2

Regional Distribution of Deaths in Custody by Manner of Death Over a 20-year Period (2000/2001 to 2019/2020)

Manner of Death	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Natural	57	209	208	115	127	*716*
Non-natural						
Suicide	25	39	41	46	29	*180*
Overdose	4	16	33	20	15	*87*
Homicide	6	6	10	26	6	*54*
Accident	1	2	5	1	3	*12*
Staff Involved	1	-	1	-	-	*2*
Undetermined	2	6	6	4	2	*21*
Total	96	278	304	212	182	*1,072*

Note: Results are accurate as of December 19, 2022. Investigations for four incidents in the most recent three years remain ongoing. Findings from subsequent investigations or reviews may result in changes to categorizations.

Table 3

Regional Distribution of Deaths in Custody Over a 3-year Period (2017/2018 to 2019/2020)

Manner of Death	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
2017/2018						
Natural	3	13	8	6	10	*40*
Non-natural	1	1	1	10	1	*14*
FY Total	*4*	*14*	*9*	*16*	*11*	*54*
2018/2019						
Natural	4	11	6	8	5	*34*
Non-natural	2	4	6	3	3	*18*
FY Total	*6*	*15*	*12*	*11*	*8*	*52*
2019/2020						
Natural	2	9	17	3	8	*39*
Non-natural	2	1	9	8	3	*23*
FY Total	*4*	*10*	*26*	*11*	*11*	*62*
Total	*14*	*39*	*47*	*38*	*30*	*168*

Note: Results are accurate as of December 19, 2022. There are two incidents in 2017/2018, one in 2018/2019, and one in 2019/2020 with investigations that remain ongoing. Findings from subsequent investigations or reviews may result in changes to categorizations.

Profile of Offenders Who Died in Federal Custody

Across the three-year period (2017/2018 to 2019/2020), offenders who died in federal custody were most often White (64%); nearly one quarter (24%) were Indigenous, 4% were Black, and 7% were another race/ethnicity (see Table 5 in appendix). The vast majority of incidents (i.e., 98%) involved men[10]. A majority of offenders had a history of substance use (75%) and a history of mental health concerns (72%; see Table 5 in appendix). Just under half (49%) of offenders were serving an indeterminate sentence, 43% were serving a sentence for a homicide offence, and just over half were classified as medium security (54%; see Table 6 in appendix). Two incidents occurred while the offender was on segregation status[11].

[10] The relatively small number of women and gender diverse persons who died in custody limits further analysis by gender due to privacy considerations.

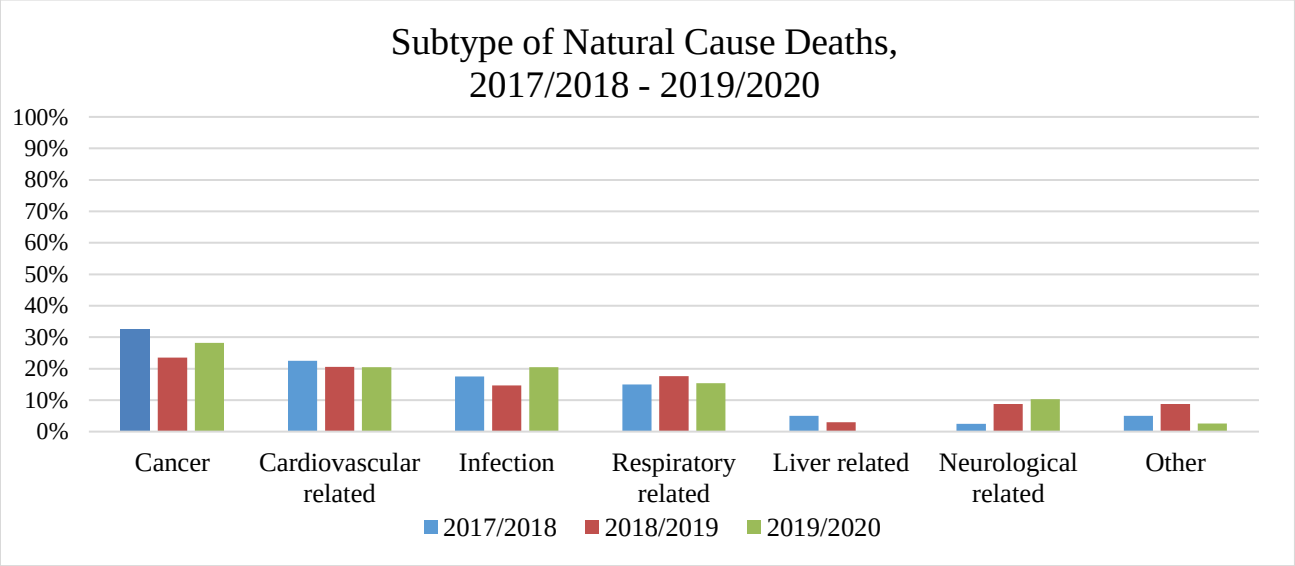
[11] The use of segregation within CSC ended on November 29, 2019 and Structured Intervention Units (SIUs) were implemented on November 30, 2019. No deaths in custody occurred in an SIU between November 30, 2019 and March 31, 2020.

Natural Deaths in Federal Custody

Details Surrounding Natural Deaths in Custody

Across the three-year period (2017/2018 to 2019/2020), there were 113 natural cause deaths in federal custody[12], accounting for 67% of deaths in federal custody. The percentage of natural cause deaths varied across the three years; 74% (40) in 2017/2018, 65% (34) in 2018/2019, and 63% (39) in 2019/2020. There were three offenders who received MAID[13]. The most common subtypes of natural cause deaths were cancer (28%) and cardiovascular-related (21%), followed by infection (18%) and respiratory-related (16%; see Figure 1 and Table 4 in appendix).

Figure 1. *Subtype of Natural Cause Deaths, 2017/2018 to 2019/2020*



Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table. Reviews remain in progress for two incidents and as a result, detailed information is not available.

[12] The reviews of two natural cause deaths are in progress and detailed information is not available. These cases have been excluded from analysis in this section.

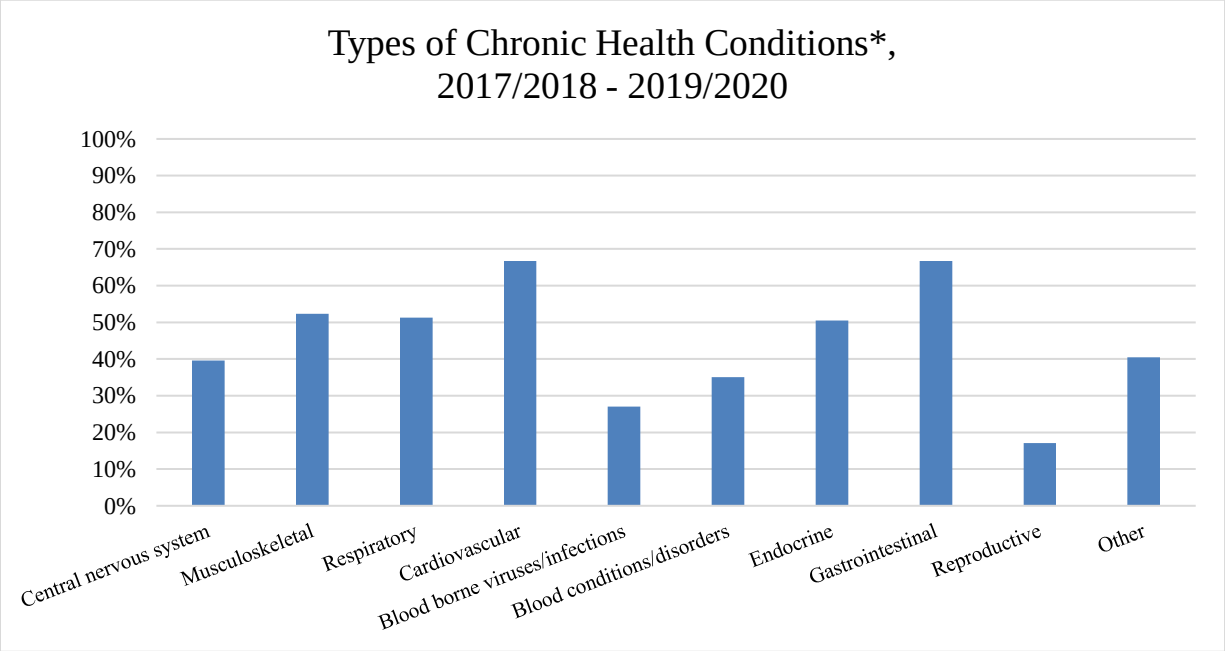
[13] In February of 2015, the Supreme Court of Canada ruled in *Carter v. Canada* that the provisions of the *Canadian Criminal Code* that prohibited MAID were in violation of the *Canadian Charter of Rights and Freedoms*. On June 17 of 2016, federal legislation was passed to allow eligible Canadian adults the ability to request MAID (more recent changes to this legislation will be discussed in future Annual Reports where such changes are applicable to the time period under analysis). CSC's MAID guidelines outline the procedures and criteria for providing access to MAID for eligible federally incarcerated individuals. The intention of the guidelines is to ensure that eligible individuals have access to MAID in alignment with the legislation. The guidelines include screening processes for security information and require review of all possible release options prior to the initial assessment (Correctional Service Canada, 2022a). Between June 17, 2016 and March 30, 2020, three federal offenders in CSC custody were provided MAID.

Profile of Offenders who Died of Natural Causes

Across the three-year period (2017/2018 to 2019/2020), offenders who died of natural causes were most often White (69%), while just under one-quarter (23%) were Indigenous (see Table 5 in appendix). Offenders were most often serving time for a homicide offence (48%; see Table 6 in appendix) and a majority of offenders were serving an indeterminate sentence (57%). The average age of offenders who died of natural causes was 63.87. While time served varied (M = 17.06 years), 42% had served over 20 years.

Health information for offenders who died of natural causes was further explored. Across the three-year period, 95% of individuals had at least one chronic condition[14] identified (see Table 7 in appendix). Notwithstanding some fluctuation across fiscal years, the most common types of chronic conditions included: Gastrointestinal (67%), Cardiovascular (67%), Musculoskeletal (52%), Respiratory (51%), and Endocrine (51%; Figure 2).

Figure 2. *Types of Chronic Health Conditions Among Offenders who died in Custody of Natural Causes, 2017/2018 to 2019/2020*



Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table. Reviews remain in progress for two incidents and as a result, detailed information is not available.
*At least one condition from the category was identified.

[14] Chronic health conditions refer to a diagnosed "long-lasting condition that can be controlled or treated but not cured" (Stewart et al., 2015).

In many cases, those who died of natural causes were receiving palliative care and/or had a do not resuscitate (DNR) order on file. Those who did not receive palliative care either died unexpectedly or their known illness progressed rapidly. The vast majority (i.e., 81%) of offenders who died of natural causes had passed their parole eligibility dates. Reasons for a lack of recent release application (i.e., either parole or parole by exception) and/or the waiving of a parole review included: limited or no community supports; a preference for an institutional support system; and lack of community residential facilities capable of accommodating medical needs. Of note, a number of offenders had previously been granted conditional release but were subsequently revoked, including at least one individual who had been granted parole by exception.[15]

[15] Section 121 of the CCRA is an exceptional provision that allows an offender who has not yet reached their day and/or full parole eligibility dates to be considered for parole. Pursuant to section 121 of the CCRA, parole by exception may be granted to an offender: (a) who is terminally ill; (b) whose physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement; (c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced; or (d) who is the subject of an order of surrender under the Extradition Act and who is to be detained until surrendered.
Pursuant to subsection 121(2) of the CCRA, offenders serving a life sentence imposed as a minimum punishment or commuted from a sentence of death, or an indeterminate sentence, are only eligible for parole by exception if they are terminally ill.
Please note that offender deaths that occur in the community during conditional release (including parole or parole by exception releases) are not included in the Annual Report on Deaths in Custody.

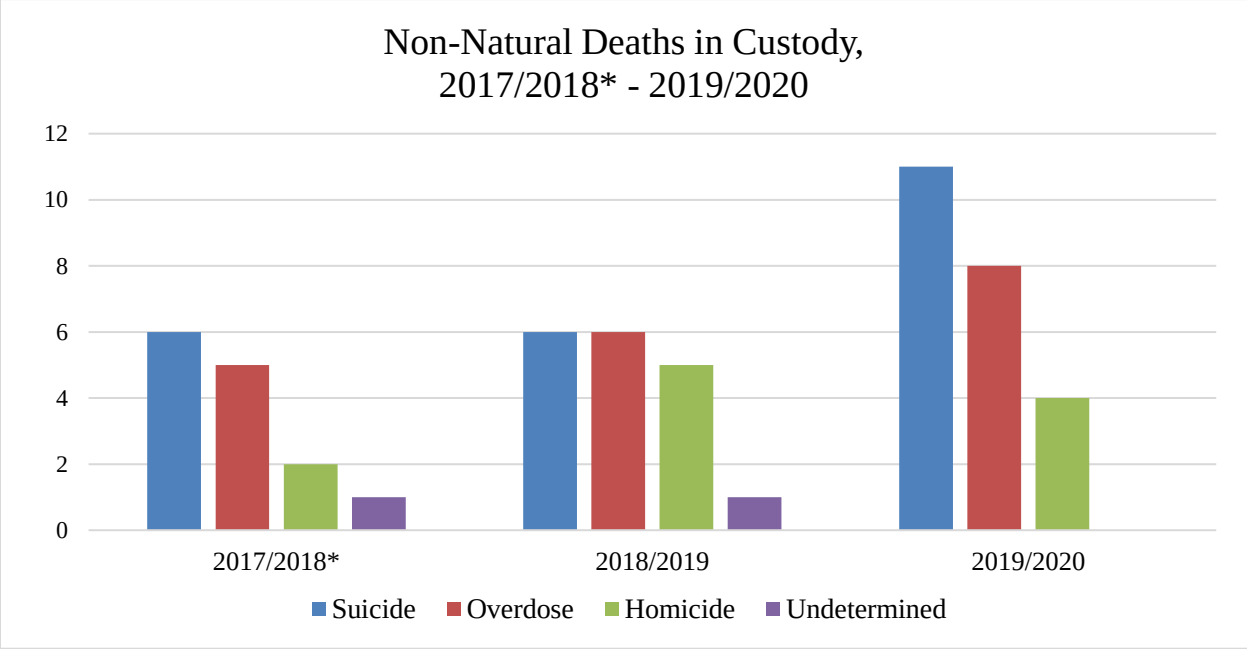
Non-Natural Deaths in Federal Custody

Manner of Death and Regional Differences

Between 2017/2018 and 2019/2020, there were 55 non-natural deaths in federal custody; this included 14 cases in 2017/2018, 18 cases in 2018/2019, and 23 cases in 2019/2020 (see Figure 3 and Table 8 in appendix). Notwithstanding variation across fiscal years, suicide deaths were the most common cause of non-natural death overall (42%; 23), followed by overdose deaths (35%; 19). Homicide deaths accounted for 20% (11) of non-natural deaths and two deaths remained of undetermined cause at the time of analysis.

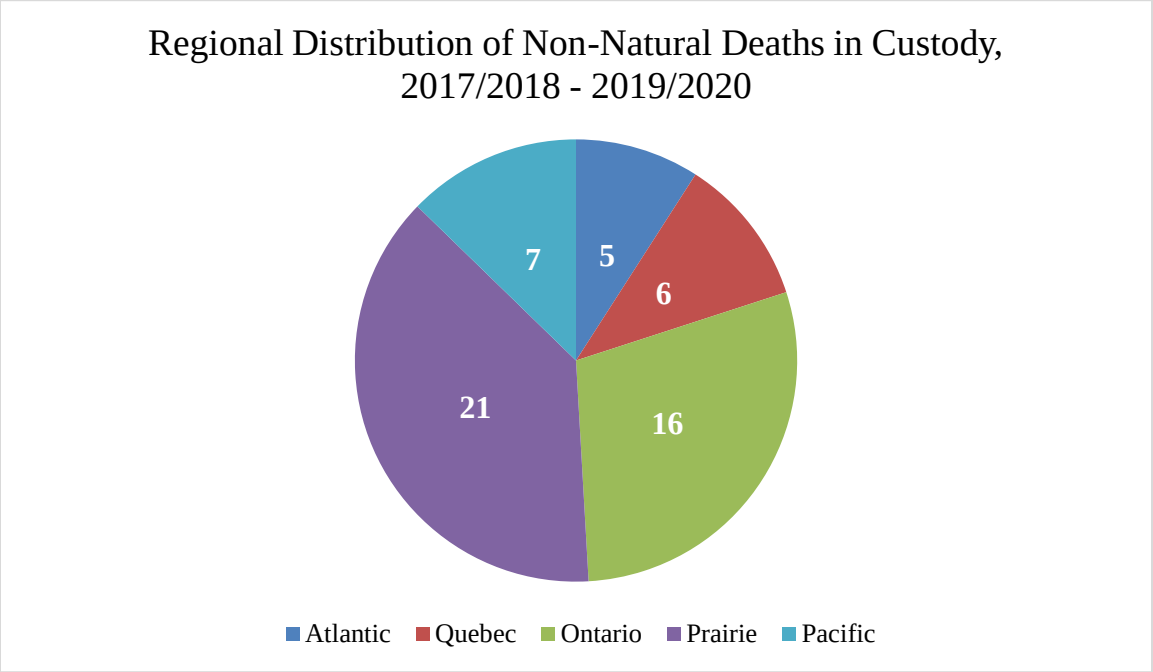
In terms of regional variation, non-natural deaths were most common in the Prairie region (38%; 21), followed by Ontario (29%; 16; see Table 9 in appendix). The Prairie region had the highest number of both suicide deaths (i.e., nine, compared to a range of two to six across all other regions) and homicide deaths (i.e., seven, compared to a range of zero to two). The Ontario region had the highest number of overdose deaths (i.e., eight, compared to a range of one to five across the other regions).

Figure 3. *Non-Natural Deaths in Custody, 2017/2018 to 2019/2020*



Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes.
*The overdose count for 2017/2018 includes two cases that remain under investigation, but for which there is evidence to suggest the cause of death was overdose. Changes to classification may occur in future reports following the completion of investigations.

Figure 4. *Regional Distribution of Non-Natural Deaths in Custody, 2017/2018 to 2019/2020*



Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes.

Suicide Deaths in Federal Custody

Details Surrounding Suicide Deaths in Custody

Across the three-year period (2017/2018 to 2019/2020), there were 23 suicide deaths. The most common method of suicide was hanging, evident in 78% (18) of incidents (see Table 12 in appendix). In nearly three-quarters of cases (74%; 17), offenders who died by suicide had historical incidents of self-injury and/or suicide attempts. A majority of offenders (83%; 19) had recently experienced a significant stressor (e.g., upcoming or recent transfer, recent suspension/revocation, loss of a significant relationship, death of a family member or loved one, upcoming case decision such as a parole hearing). Proximal indicators of suicide risk included self-injury incidents and/or suicide attempts in the past year (26%; 6), a recent psychotropic medication change[16] (22%; 5), and enhanced observation (i.e., high watch, modified watch, or mental health monitoring; Correctional Service Canada, 2017) within the week prior to the death (35%; 8).

Profile of Offenders who Died by Suicide

Most individuals who died by suicide were either Indigenous[17] (44%; 10) or White (39%; 9), were between the ages of 25 and 44 (70%; 16, M = 35.91), and were classified as medium security (48%; 11). Histories of substance use (83%; 19) and mental health concerns (83%; 19) were common. In terms of sentence information (see Table 11 in appendix), offenders who died by suicide tended to be serving either relatively short sentences of less than four years (39%; 9) or indeterminate sentences (35%; 8) and serving a sentence for a homicide offence (44%; 10) or robbery (22%; 5). Time served varied (M = 7.00 years), though many offenders had served between three months to less than five years of their sentence (48%; 11).

[16] Incidents in which a medication change was determined by the BOI to not have impacted the case were excluded.
[17] For reference, Indigenous offenders represented 28% to 30% of the in custody between 2017/2018 and 2019/2020 (taken from year-end data in CRS-M).

Overdose Deaths in Federal Custody

Details Surrounding Overdose Deaths in Custody

Across the three-year period (2017/2018 to 2019/2020), there were 19 overdose deaths[18]. This included three incidents in 2017/2018, six in 2018/2019, and eight in 2019/2020. Across the three-year period, investigations for 17 of the 19 cases were complete at the time of writing. Opioids were identified as a standalone or contributing substance in 15 of the 17 cases, with all but one opioid-related case involving Fentanyl (see Table 14 in appendix), while the two other cases involved non-opioid prescription medications. Narcan© was administered in 94% (16) of cases.

Most offenders (88%; 15) who died by overdose had prior substance use-related incidents in federal custody (e.g., drug-related charges, medication non-adherence, possession of drugs/drug paraphernalia, substance use), including incidents within the past year (82%; 14). Of those who died by overdose, 29% (5) were currently on or waitlisted for Opioid Agonist Treatment[19] (OAT) and 65% (11) were receiving other case management interventions/strategies targeting substance use.

Profile of Offenders who Died by Overdose

Profile information was explored for all 19 offenders who died by overdose. A majority (74%; 14) of individuals who died by overdose were White (see Table 10 in appendix), the average age was 36.76 and most offenders were classified as medium security (79%; 15). The vast majority had a documented history of substance use (90%; 17), while just under two-thirds (63%; 12) had a history of mental health concerns. With respect to sentence profiles, there was variation; however, most offenders who died by overdose were serving determinate sentences (84%; 16). Time served varied (M = 4.23 years), though many had served between three months to less than five years of their sentence (74%; 14).

[18] Two suspected overdose incidents were excluded from detailed incident analyses but included in profile analyses.
[19] Opioid Agonist Treatment was previously referred to as Opioid Substitution Therapy/Program or OST/OSP.

Homicide Deaths in Federal Custody

Details Surrounding Homicide Deaths

Across the three-year period (2017/2018 to 2019/2020), there were 11 homicide deaths. As noted, homicide deaths were disproportionate to the Prairie region, where seven of the 11 incidents occurred. At the time of writing, investigations for ten of the 11 cases were complete.[20] In regard to such cases, various methods were involved, including stabbing/knife injuries, blunt force trauma, asphyxiation/strangulation, or a combination. Contextual factors deemed to have played a role in perpetrator motivation included Security Threat Group (STG) conflict and debt. Perception of the victim as having committed sexual offences was also a factor in certain cases. In seven of the ten cases with completed investigations/proceedings (70%), more than one aggressor was involved.

Profile of Offenders who Died by Homicide

Profile information was explored for all 11 offenders who died by homicide. Offenders who died by homicide were most often White (55%; 6) and between the ages of 25 and 44 (91%; 10, M = 36.00). A majority had a history of substance use (91%; 10) and a history of mental health concerns (73%; 8). Most (82%; 9) offenders who died by homicide were serving a sentence for a violent offence (i.e., homicide, sexual, assault, robbery, or other violent). Most were classified as maximum security (73%; 8) and had served between three months and less than five years of their sentence (73%; 8, M = 2.44 years).

[20] Criminal proceedings remain underway in one case and as a result, the BOI remains unavailable. This case was excluded from detailed incident analyses but was included in the offender profile analyses.

Conclusion

CSC remains committed to learning from every death in custody in order to prevent future non-natural deaths and improve the treatment and care provided to offenders with life-limiting illnesses. This Annual Report aims to provide transparency around both natural and non-natural deaths.

Offenders aged 50 years and up account for 25% of the overall in custody population, while those aged 65 and up account for 5%, and many of these individuals have complex needs (McKendy et al., 2019; Public Safety Canada, 2022). CSC strives to provide compassionate, patient- and family-centered care to older offenders and those with chronic and life-limiting illnesses. In 2018, after consultations with a number of experts, CSC developed a national framework intended to build on current programs and services and to promote wellness and independence among the growing population of older persons in custody, with specific attention to Indigenous offenders, those residing in treatment centres, and those on a psychogeriatric/assisted living unit (Correctional Service Canada, 2018). More recently, updates were made to the palliative and end-of-life care guidelines (Correctional Service Canada, 2022c) to align with Health Canada's Framework for Palliative Care (2018).

Offender preferences to receive end-of-life care in the community or in an institution can vary (e.g., Aday, 2006; Crawley & Sparks, 2006; Morton & Anderson, 1991). While the Service continues to ensure that offenders with life-limiting illnesses are able to be considered for release, such decisions take into consideration risk to public safety. Case reviews continue to indicate that some offenders wish to remain in custody for reasons such as limited community supports, the presence of an institutional support system, and/or lack of community residential facilities available to accommodate medical needs. In certain cases, offenders with life-limiting illnesses may consider the MAID process and the Service must consider all release options (e.g., parole) for all MAID applicants (Correctional Service Canada, 2022a). CSC's person-centred approach to care allows offenders to communicate their treatment and end-of-life-care preferences, which may have a positive impact on their experiences of care, even in an institutional setting (e.g., Sanders & Stensland, 2018).

With respect to non-natural deaths in custody, CSC continues to improve upon prevention strategies. Interdisciplinary mental health teams work together to provide comprehensive health

services that include, but are not limited to: initial and ongoing screening/assessment (e.g., screening instruments to identify mental illness and suicide risk; Archambault et al., 2010; Correctional Service Canada, 2020b; Mills & Kroner, 2010; Stewart et al., 2009), triage of services, comprehensive assessments, treatment planning/delivery (e.g., individual and/or group treatment), and detailed progress reports (Correctional Service Canada, 2017; 2020b). Additional strategies are also in place to identify and manage acute changes in mental wellbeing (e.g., transfer to a Treatment Centre). A growing comprehensive and multi-faceted approach (i.e., combining both health care and case management perspectives) to overdose prevention also aims to improve offender health outcomes and prevent fatal overdoses (Government of Canada, 2016). This approach includes: detection and prevention strategies such as the use of ion scanners, urinalysis testing, intelligence gathering to lead searches, and drug detection dogs (Correctional Service Canada, 2017; Johnson, Cheverie, & Moser, 2010); interventions and programming targeting substance use needs, including opioid agonist treatment (Cheverie et al., 2014; Farrell MacDonald & Beauchamp, 2022); psychosocial support such as Self-Management and Recovery Training (SMART; Correctional Service Canada, 2021), and peer support; and a host of harm reduction measures such as prison needle exchange programs, an overdose prevention service, and the availability of Narcan© to both medical and non-medical staff working in CSC institutions.

For all deaths in custody, findings from investigations and reviews allow for the identification of need areas in the service. Ensuring that comprehensive medical care is provided to those with chronic and life-limiting illnesses and preventing non-natural deaths are ongoing organizational priorities. CSC continues to implement recommendations and examine changes to policy and practice so as to promote the mission of providing safe and humane custody while contributing to public safety for all Canadians.

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Appendix – Tables

Table 4

Offenders who died in Custody by Natural Death Subtype, 2017/2018 to 2019/2020

Subtype	*Count/ Percentage*
Cancer	*32* *28.3%*
Cardiovascular related	*24* *21.2%*
Infection	*20* *17.7%*
Respiratory related	*18* *15.9%*
Liver related	*3* *2.7%*
Neurological related	*8* *7.1%*
Other	*6* *5.3%*
Review in progress[a]	*2* *1.8%*
Total	*113*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] The reviews are in progress for 2% (2) of incidents and as a result, detailed information is not available.

Table 5

Characteristics of Offenders who died in Custody by Manner of Death, 2017/2018 to 2019/2020

Characteristics	Manner of Death		*Total*
	Natural	Non-natural	
Race/Ethnicity			
White	78	30	108
	69.0%	54.5%	64.3%
Indigenous	26	15	41
	23.0%	27.3%	24.4%
Black	3	4	7
	2.7%	7.3%	4.2%
All Others	6	6	12
	5.3%	10.9%	7.1%
Age			
18 – 24	-	5	5
	-	9.1%	3.0%
25 – 34	4	24	28
	3.5%	43.6%	16.7%
35 – 44	4	17	21
	3.5%	30.9%	12.5%
45 – 54	12	6	18
	10.6%	10.9%	10.7%
55 – 64	32	3	35
	28.3%	5.5%	20.8%
65 – 74	43	-	43
	38.1%	-	25.6%
75 – 79	9	-	9
	8.0%	-	5.4%
80 +	9	-	9
	8.0%	-	5.4%
History of substance use	79	47	126
	69.9%	85.5%	*75.0%*
History of mental health concerns	81	40	*121*
	71.7%	72.7%	*72.0%*
Total	*113*	*55*	*168*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.

Table 6

Sentence Information of Offenders who died in Custody by Manner of Death, 2017/2018 to 2019/2020

Sentence Information	Manner of Death		*Total*
	Natural	Non-natural	
Sentence length			
Less than 4 years	20	18	38
	17.7%	32.7%	22.6%
4 to 6 years	4	10	14
	3.5%	18.2%	8.3%
6 to 10 years	14	3	17
	12.4%	5.5%	10.1%
More than 10 years	11	6	17
	9.7%	10.9%	10.1%
Indeterminate	64	18	82
	56.6%	32.7%	48.8%
Index offence			
Homicide	54	18	72
	47.8%	32.7%	42.9%
Sexual	29	2	31
	25.7%	3.6%	18.5%
Assault	3	10	13
	2.7%	18.2%	7.7%
Robbery	11	11	22
	9.7%	20.0%	13.1%
Other violent	2	2	4
	1.8%	3.6%	2.4%
Property	2	3	5
	1.8%	5.5%	3.0%
Drug	7	7	14
	6.2%	12.7%	8.3%
Other non-violent	5	2	7
	4.4%	3.6%	4.2%
Offender security level			
Maximum	8	17	25
	7.1%	30.9%	14.9%
Medium	60	30	90
	53.1%	54.5%	53.6%
Minimum	40	4	44
	35.4%	7.3%	26.2%
Not yet determined	5	4	9
	4.4%	7.3%	5.4%
Time served on sentence			

Sentence Information	Manner of Death		*Total*
	Natural	Non-natural	
Less than three months	5	4	9
	4.4%	7.3%	5.4%
Three months to less than five years	40	35	75
	35.4%	63.6%	44.6%
Five years to less than 10 years	8	8	16
	7.1%	14.5%	9.5%
10 years to less than 20 years	13	6	19
	11.5%	10.9%	11.3%
20+ years	47	2	49
	41.6%	3.6%	29.2%
Total	*113*	*55*	*168*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.

Table 7

Other Factors Relating to Natural Cause Deaths in Custody, 2017/2018 to 2019/2020

	Fiscal Year			*Total*[a]
	2017/2018	2018/2019	2019/2020	
At least one chronic health condition identified	36 90.0%	33 100%	36 94.7%	*105* *94.6%*
Type of chronic health conditions				
Central nervous system	14 35.0%	12 36.4%	18 47.4%	*44* *39.6%*
Musculoskeletal	17 42.5%	17 51.5%	24 63.2%	*58* *52.3%*
Respiratory	19 47.5%	20 60.6%	18 47.4%	*57* *51.4%*
Cardiovascular	26 65.0%	19 57.6%	29 76.3%	*74* *66.7%*
Blood borne viruses/infections	12 30.0%	6 18.2%	12 31.6%	*30* *27.0%*
Blood conditions/disorders	13 32.5%	9 27.3%	17 44.7%	*39* *35.1%*
Endocrine	20 50.0%	16 48.5%	20 52.6%	*56* *50.5%*
Gastrointestinal	23 57.5%	22 66.7%	29 76.3%	*74* *66.7%*
Reproductive	8 20.0%	3 9.1%	8 21.1%	*19* *17.1%*
Other	8 20.0%	16 48.5%	21 55.3%	*45* *40.5%*
History of cancer	4 10.0%	3 9.1%	6 15.8%	*13* *11.7%*
Parole eligibility dates had passed	33 82.5%	28 84.8%	29 76.3%	*90* *81.1%*
Total[a]	*40*	*33*	*38*	*111*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] Totals will not add to the total number of natural deaths as offenders may have multiple types of chronic health conditions identified and the reviews are in progress for 2% (2) of incidents and as a result, some detailed information is not available.

Table 8

Non-Natural Deaths in Custody by Manner of Death, 2017/2018 to 2019/2020

Manner of Death[a]	Fiscal Year			*Total*
	2017/2018	2018/2019	2019/2020	
Suicide	6	6	11	*23*
	42.9%	33.3%	47.8%	*41.8%*
Overdose[b]	5	6	8	*19*
	35.7%	33.3%	34.8%	*34.5%*
Homicide	2	5	4	*11*
	14.3%	27.8%	17.4%	*20.0%*
Undetermined[b]	1	1	-	*2*
	7.1%	5.6%	-	*3.6%*
Total	*14*	*18*	*23*	*55*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] There were no accidents or staff involved incidents during these three fiscal years.
[b] The investigation for at least one incident is still ongoing and this may result in changes to numbers in future reports.

Table 9

Regional Distribution of Non-Natural Deaths in Custody by Manner of Death, 2017/2018 to 2019/2020

Manner of Death[a]	Region					*Total*
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Suicide	3	3	6	9	2	*23*
	60.0%	50.0%	37.5%	42.9%	28.6%	*41.8%*
Overdose[b]	1	2	8	4	4	*19*
	20.0%	33.3%	50.0%	19.0%	57.1%	*34.5%*
Homicide	1	1	2	7	-	*11*
	20.0%	16.7%	12.5%	33.3%	-	*20.0%*
Undetermined[b]	-	-	-	1	1	*2*
	-	-	-	4.8%	14.3%	*3.6%*
Total	*5*	*6*	*16*	*21*	*7*	*55*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] There were no accidents or staff involved incidents during these three fiscal years.
[b] The investigation for at least one incident is still ongoing and this may result in changes to numbers in future reports.

Table 10

Characteristics of Offenders who died in Custody of Non-Natural Causes, by Manner of Death, 2017/2018 to 2019/2020

Characteristics	Manner of Death[a]				*Total*
	Suicide	Overdose	Homicide	Undetermined[b]	
Race/Ethnicity					
White	9	14	6	1	*30*
	39.1%	73.7%	54.5%	50.0%	*54.5%*
Indigenous	10	2	3	-	*15*
	43.5%	10.5%	27.3%	-	*27.3%*
Black	1	1	1	1	*4*
	4.3%	5.3%	9.1%	50.0%	*7.3%*
All Others	3	2	1	-	*6*
	13.0%	10.5%	9.1%	-	*10.9%*
Age					
18 – 24	4	1	-	-	5
	17.4%	5.3%	-	-	9.1%
25 – 34	9	10	4	1	24
	39.1%	52.6%	36.4%	50.0%	43.6%
35 – 44	7	3	6	1	17
	30.4%	15.8%	54.5%	50.0%	30.9%
45 – 54	-	5	1	-	6
	-	26.3%	9.1%	-	10.9%
55 – 64	3	-	-	-	3
	13.0%	-	-	-	5.5%
65 – 74	-	-	-	-	-
	-	-	-	-	-
75 – 79	-	-	-	-	-
	-	-	-	-	-
80 +	-	-	-	-	-
	-	-	-	-	-
History of substance use	19	17	10	1	*47*
	82.6%	89.5%	90.9%	50.0%	*85.5%*
History of mental health concerns	19	12	8	1	*40*
	82.6%	63.2%	72.7%	50.0%	*72.7%*
Total	*23*	*19*	*11*	*2*	*55*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.

[a] There were no accidents or staff involved incidents during these three fiscal years.

[b] The investigation for at least one incident is still ongoing and this may result in changes to numbers in future reports.

Table 11

Sentence Information of Offenders who died in Custody of Non-Natural Causes, by Manner of Death, 2017/2018 to 2019/2020

Sentence Information	Manner of Death[a]				*Total*
	Suicide	Overdose[b]	Homicide	Undetermined[b]	
Sentence Length					
Less than 4 years	9	8	-	1	*18*
	39.1%	42.1%	-	50.0%	*32.7%*
4 to 6 years	2	4	4	-	*10*
	8.7%	21.1%	36.4%	-	*18.2%*
6 to 10 years	1	1	1	-	*3*
	4.3%	5.3%	9.1%	-	*5.5%*
More than 10 years	3	3	-	-	*6*
	13.0%	15.8%	-	-	*10.9%*
Indeterminate	8	3	6	1	*18*
	34.8%	15.8%	54.5%	50.0%	*32.7%*
Index offence					
Homicide	10	3	4	1	*18*
	43.5%	15.8%	36.4%	50.0%	*32.7%*
Sexual	1	-	1	-	*2*
	4.3%	-	9.1%	-	*3.6%*
Assault	4	4	2	-	*10*
	17.4%	21.1%	18.2%	-	*18.2%*
Robbery	5	3	2	-	*11*
	21.7%	15.8%	18.2%	-	*20.0%*
Other violent	-	2	-	-	*2*
	-	10.5%	-	-	*3.6%*
Property	1	2	-	-	*3*
	4.3%	10.5%	-	-	*5.5%*
Drug	1	5	1	-	*7*
	4.3%	26.3%	9.1%	-	*12.7%*
Other non-violent	1	-	1	-	*2*
	4.3%	-	9.1%	-	*3.6%*
Offender Security Level					
Maximum	6	2	8	1	*17*
	26.1%	10.5%	72.7%	50.0%	*30.9%*
Medium	11	15	3	1	*30*
	47.8%	78.9%	27.3%	50.0%	*54.5%*
Minimum	3	1	-	-	*4*
	13.0%	5.3%	-	-	*7.3%*
Not yet determined	3	1	-	-	*4*
	13.0%	5.3%	-	-	*7.3%*
Time served on sentence					

Sentence Information	Manner of Death[a]				*Total*
	Suicide	Overdose[b]	Homicide	Undetermined[b]	
Less than three months	4	-	-	-	*4*
	17.4%	-	-	-	*7.3%*
Three months to less than five years	11	14	8	2	*35*
	47.8%	73.7%	72.7%	100.0%	*63.6%*
Five years to less than 10 years	2	3	3	-	*8*
	8.7%	15.8%	27.3%	-	*14.5%*
10 years to less than 20 years	4	2	-	-	*6*
	17.4%	10.5%	-	-	*10.9%*
20+ years	2	-	-	-	*2*
	8.7%	-	-	-	*3.6%*
Total	*23*	*19*	*11*	*2*	*55*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] There were no accidents or staff involved incidents during these three fiscal years.
[b] The investigation for at least one incident is still ongoing and this may result in changes to numbers in future reports.

Table 12

Events Surrounding Suicide Deaths in Custody, 2017/2018 to 2019/2020

	Fiscal Year			*Total*
	2017/2018	2018/2019	2019/2020	
Method				
Hanging	4	4	10	*18*
	66.7%	66.7%	90.9%	*78.3%*
Ligature	-	1	-	*1*
	-	16.7%	-	*4.3%*
Asphyxiation	-	-	1	*1*
	-	-	9.1%	*4.3%*
Cutting	1	1	-	*2*
	16.7%	16.7%	-	*8.7%*
Other	1	-	-	*1*
	16.7%	-	-	*4.3%*
History of self-injury or suicide attempts	5	3	9	*17*
	83.3%	50.0%	81.8%	*73.9%*
Self-injury or suicide attempts in the last year	-	1	5	*6*
	-	16.7%	45.5%	*26.1%*
Recent psychotropic medication change[a]	2	1	2	*5*
	33.3%	16.7%	18.2%	*21.7%*
On observation within the last week[b]	-	2	6	*8*
	-	33.3%	54.5%	*34.8%*
Experienced recent significant stressor	5	3	11	*19*
	83.3%	50.0%	100.0%	*82.6%*
Total	*6*	*6*	*11*	*23*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] Any incidents where the medication change was found by the BOI to not have impacted the incident were excluded.
[b] This includes mental health monitoring, suicide watch, or enhanced observation.

Table 13

Events Surrounding Suicide Deaths in Custody by Region, 2017/2018 to 2019/2020

	Region					*Total*[a]
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Method						
Hanging	2	2	4	9	1	*18*
	66.7%	66.7%	66.7%	100.0%	50.0%	*78.3%*
Ligature	1	-	-	-	-	*1*
	33.3%	-	-	-	-	*4.3%*
Asphyxiation	-	-	1	-	-	*1*
	-	-	16.7%	-	-	*4.3%*
Cutting	-	1	1	-	-	*2*
	-	33.3%	16.7%	-	-	*8.7%*
Other	-	-	-	-	1	*1*
	-	-	-	-	50.0%	*4.3%*
History of self-injury or suicide attempts	2	1	6	7	1	*17*
	66.7%	33.3%	100.0%	77.8%	50.0%	*73.9%*
Self-injury or suicide attempts in the last year	1	-	4	1	-	*6*
	33.3%	-	66.7%	11.1%	-	*26.1%*
Recent psychotropic medication change[a]	1	-	1	3	-	*5*
	33.3%	-	16.7%	33.3%	-	*21.7%*
On observation within the last week[b]	2	-	3	3	-	*8*
	66.7%	-	50.0%	33.3%	-	*34.8%*
Experienced recent significant stressor	3	3	4	8	1	*19*
	100.0%	100.0%	66.7%	88.9%	50.0%	*82.6%*
Total	*3*	*3*	*6*	*9*	*2*	*23*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] Any incidents where the medication change was found by the BOI to not have impacted the incident were excluded.
[b] This includes mental health monitoring, suicide watch, or enhanced observation.

Table 14

Events Surrounding Overdose Deaths in Custody, 2017/2018 to 2019/2020

	Fiscal Year			*Total*[a]
	2017/2018	2018/2019	2019/2020	
Opioid was involved[b]	3	5	7	*15*
	100.0%	83.3%	87.5%	*88.2%*
Fentanyl was involved[ab]	3	5	6	*14*
	100.0%	83.3%	75.0%	*82.4%*
Non-opioid prescription medication was involved	-	1	1	*2*
	-	16.7%	12.5%	*11.8%*
Documented substance use-related incidents in federal custody, excluding overdose incidents, **ever**[c]	2	5	8	*15*
	66.7%	83.3%	100.0%	*88.2%*
Documented substance use-related incidents in federal custody, excluding overdose incidents, **in the last year**[c]	2	5	7	*14*
	66.7%	83.3%	87.5%	*82.4%*
Prior overdose incident in federal custody	-	2	2	*4*
	-	33.3%	25.0%	*23.5%*
Narcan© was administered	3	6	7	*16*
	100.0%	100.0%	87.5%	*94.1%*
Currently on OAT[d]	1	-	3	*4*
	33.3%	-	37.5%	*23.5%*
Currently Waitlisted for OAT[d]	-	-	1	*1*
	-	-	12.5%	*5.9%*
Receiving other case management interventions/strategies targeting substance use	3	4	4	*11*
	100.0%	66.7%	50.0%	*64.7%*
Total	*3*	*6*	*8*	*17*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] As the investigation for two suspected overdose deaths are in progress, information is only available for 17 of 19 overdose incidents. Totals in columns may therefore not match the actual total number of deaths.
[b] In two incidents, the substance was suspected but not yet confirmed.
[c] Prior drug incidents (excluding overdose incidents), charges, medication incompliance, under the influence incidents, being found with drugs while in federal custody.
[d] Opioid Agonist Treatment, previously referred to as Opioid Substitution Therapy/Program or OST/OSP.

Table 15

Events Surrounding Overdose Deaths in Custody by Region, 2017/2018 to 2019/2020

	Region					*Total*[a]
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Opioid was involved[b]	1	1	8	2	3	*15*
	100.0%	50.0%	100.0%	100.0%	75.0%	*88.2%*
Fentanyl was involved[b]	1	1	8	2	2	*14*
	100.0%	50.0%	100.0%	100.0%	50.0%	*82.4%*
Non-opioid prescription medication was involved	-	1	-	-	1	*2*
	-	50.0%	-	-	25.0%	*11.8%*
Documented substance use-related incidents in federal custody, excluding overdose incidents, **ever**[c]	1	2	6	2	4	*15*
	100.0%	100.0%	75.0%	100.0%	100.0%	*88.2%*
Documented substance use-related incidents in federal custody, excluding overdose incidents, **in the last year**[c]	1	2	5	2	4	*14*
	100.0%	100.0%	62.5%	100.0%	100.0%	*82.4%*
Prior overdose incident in federal custody	-	1	3	-	-	*4*
	-	50.0%	37.5%	-	-	*23.5%*
Narcan© was administered	1	2	8	2	3	*16*
	100.0%	100.0%	100.0%	100.0%	75.0%	*94.1%*
Currently on OAT[d]	-	-	1	1	2	*4*
	-	-	12.5%	50.0%	50.0%	*23.5%*
Currently Waitlisted for OAT[d]	-	-	1	-	-	*1*
	-	-	12.5%	-	-	*5.9%*
Receiving other case management interventions/strategies targeting substance use	-	2	5	2	2	*11*
	-	100.0%	62.5%	100.0%	50.0%	*64.7%*
Total	*1*	*2*	*8*	*2*	*4*	*17*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.

[a] As the investigation for two suspected overdose deaths are in progress, information is only available for 17 of the 19 overdose incidents. Totals in columns may therefore not match the actual total number of deaths.

[b] In two incidents, the substance was suspected but not yet confirmed.

[c] Prior drug incidents (excluding overdose incidents), charges, medication incompliance, under the influence incidents, being found with drugs while in federal custody.

[d] Opioid Agonist Treatment, previously referred to as Opioid Substitution Therapy/Program or OST/OSP.

Table 16

Events Surrounding Homicide Deaths in Custody, 2017/2018 to 2019/2020

	Fiscal Year			*Total*[a]
	2017/2018	2018/2019	2019/2020	
Method				
Asphyxiation or strangulation	-	1	-	*1*
	-	20.0%	-	*10.0%*
Blunt force trauma	-	1	1	*2*
	-	20.0%	25.0%	*20.0%*
Cutting instrument	-	1	3	*4*
	-	20.0%	75.0%	*40.0%*
Combination	1	2	-	*3*
	100.0%	40.0%	-	*30.0%*
Motive				
STG related	1	1	1	*3*
	100.0%	20.0%	25.0%	*30.0%*
Debt related	1	1	-	*2*
	100.0%	20.0%	-	*20.0%*
More than one aggressor	1	2	4	*7*
	100.0%	40.0%	100.0%	*70.0%*
Total	*1*	*5*	*4*	*10*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] One incident has been excluded from this table as the criminal proceedings are still underway and as a result, the BOI remains unavailable.

Table 17

Events Surrounding Homicide Deaths in Custody by Region, 2017/2018 to 2019/2020

	Region					*Total*[a]
	Atlantic	Quebec	Ontario	Prairie	Pacific	
Method						
Asphyxiation or strangulation	-	1	-	-	-	*1*
	-	100.0%	-	-	-	*10.0%*
Blunt force trauma	-	-	1	1	-	*2*
	-	-	50.0%	16.7%	-	*20.0%*
Cutting instrument	1	-	-	3	-	*4*
	100.0%	-	-	50.0%	-	*40.0%*
Combination	-	-	1	2	-	*3*
	-	-	50.0%	33.3%	-	*30.0%*
Motive						
STG related	-	-	-	3	-	*3*
	-	-	-	50.0%	-	*30.0%*
Debt related	-	-	-	2	-	*2*
	-	-	-	33.3%	-	*20.0%*
More than one aggressor	-	-	1	6	-	*7*
	-	-	50.0%	100.0%	-	*70.0%*
Total	*1*	*1*	*2*	*6*	-	*10*

Note: Results are accurate as of December 19, 2022. Subsequent investigations or reviews may result in changes to this table.
[a] One incident has been excluded from this table as the criminal proceedings are still underway and as a result, the BOI remains unavailable.