Louise Nadeau, Serge Brochu, Robert Cormier

Fourth Independent Review Committee on Non-natural Deaths in Custody that occurred between April 1st, 2014 to March 31st, 2017

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Introduction

The matter of non-natural deaths in penitentiaries has been a matter of concern for many years at CSC and in other countries concerned about fundamental rights. This matter was examined by the three previous independent review committees (2010, 2012, 2015). Following recommendations from those reviews, CSC has taken steps to improve investigation policies and practices as well as strategies to prevent non-natural deaths in custody. The mandate for this Committee was the following:

- the quality, breadth and generalizability of the findings and recommendations made by the Boards of Investigation, and of the corrective measures and action plans taken by the Service in order to address the identified gaps, including but not limited to, an analysis of the strength of the Service's managerial accountabilities with respect to investigations which are intended to influence organizational policies and practices and prevent future deaths in custody; and,

- successful and best practices in other international correctional jurisdictions with respect to their investigative processes in general, and specifically in relation to deaths in custody, and how these processes could inform a revitalized investigative process in CSC.

In particular, the Committee was asked to focus on more systemic approaches to the challenges in this area.

We should not be surprised at the magnitude of the issue of deaths in custody, given that detention conditions have historically not been intended to ensure the dignity and respect of inmates. Beginning with the earliest days of incarceration in Canada, conditions were harsh and punitive. Prior to the late 19th century, corporal punishment was part of the sanctions, and no formal training existed for staff.[1] Historically, in many cases, inmates

[1] http://www.csc-scc.gc.ca/about-us/006-2001-eng.shtml

were defenceless against authorities and against other inmates. Many deaths related to detention conditions were not reported as such. In short, historically, the health and safety of inmates have not always been ensured during incarceration. In fact, all of it was a reflection of the standards that prevailed throughout society at that time.[2]

The fact remains that the prevalence of non-natural deaths during incarceration is inseparable from the vulnerability of individuals in a penitentiary. As such, the Committee has identified two categories of people vulnerable inside the walls. Firstly, CSC staff who are in contact with inmates are vulnerable. Many inmates were incarcerated because of their violence, and many still are violent. The Committee cannot exclude the possibility of incarceration provoking that violence. CSC staff need to be protected. Secondly, inmates are vulnerable. They are vulnerable to suicide for multiple reasons, as the Committee sets out in detail later, but they can also be violent toward others and commit homicides. They may also want to escape psychologically from an environment they find intolerable, or flee their history—which incarceration constantly reminds them of. Drug use can seem like a good escape route for some. The risk of overdose cannot be ruled out. Thus, the penitentiary makes both staff and inmates vulnerable, but to varying degrees and for different reasons.

CSC has made many changes to ensure the safety of its employees and of the inmates, as this report will show. You should therefore read it with two things in mind: first, Canadian penitentiaries are places where physical and mental safety risks are high; second, given that context, Canadian penitentiaries nevertheless have a small number of non-natural deaths. Furthermore, CSC conducts an investigation into all deaths, and especially non-natural deaths that occur within its institutions.

This report takes the existing situation into account which examined a sample of the non-natural deaths that occurred in 2014–15, 2015–16 and 2016–17. In the course of examining Boards of Investigation (BOIs), as well as corrective measures and best practices, the Committee questioned the balance between staff and inmate safety imperatives and

[2] http://www.csc-scc.gc.ca/about-us/006-2001-eng.shtml

preventing non-natural deaths on one hand and maintaining a good-quality living environment on the other hand. In fact, CSC's Transformation agenda, which focuses on enhancing offender accountability, eliminating drugs, enhancing correctional programs and interventions, modernizing physical infrastructure and strengthening community corrections led to the Committee's positive validation of efforts made by CSC over the years. CSC performs well at the international level in terms of dignity and respect for individuals placed in its care. Perhaps the time has come to question the place of safety with respect to inmates' dignity and quality of life.

There are five parts to this report: the first covers suicides, the second deals with fatal overdoses related to psychoactive substances, the third covers homicides in custody, and the fourth is on the case of Matthew Hines. The final section addresses best practices in the investigation process that leads to a focus on engagement with families in cases of non-natural deaths in custody. The Committee has thus made recommendations in this report that encourage CSC to consider this context throughout their endeavours to change lives and protect Canadians.

Part 1: Suicides

This section is dedicated to the cases of suicide that were submitted to the Committee. Of the 22 cases of non-natural deaths presented to us, 12 involved individuals who took their own lives, and one was a case of strangulation resulting from self-stimulation of a sexual nature. Of note, suicide is the most common cause of non-natural death at CSC.

The Committee, in the process of carrying out its mandate for this review, noted that much attention has been paid to the issue of suicides at CSC, and as part of our review of recommendations and corrective measures taken by CSC, we note that these recommendations have led to policies on suicide and segregation. During our review, the Committee examined the suicide rate in Canada, reviewed risk factors for suicide as per recent scientific literature. As a result, the Committee highlights two areas for CSC to consider. The first is a focus on a particular sub group of offenders that may present as higher risk. The second is regarding the breadth and scope of CSC incident investigations and giving consideration to CSC's core values in the treatment and respect for inmates. This is illustrated through a case study. Finally, the Independent Review Committee (IRC) examined the right to suicide in the context of federal incarceration.

Suicide prevention at CSC

Reports by previous committees on non-natural deaths have placed considerable emphasis on suicides. A review of scientific literature on suicide, its risks and prevention was done—and done well. The previous reports also made a set of recommendations based on a review of both scientific documentation and suicide deaths that occurred during incarceration. CSC followed up on those recommendations, which led to policies on suicide and segregation or dissociation. In short, at CSC, there have been numerous reports dedicated to inmates' vulnerability to suicide and prevention programs that have been established in penitentiaries. This report does not set out to repeat what has already been well stated. In addition, CSC always conducts a post-incident analysis of the circumstances leading up to

and following an inmate's suicide and proposes improvements and amendments to policies, practices and procedures, where appropriate.

In the following pages, the Committee will examine the suicide rate in Canada and at CSC. Thereafter, we will first describe the risk factors that were recently highlighted in scientific literature since the last report's publication and that are relevant to the cases submitted to the committee. Next, we will examine a case study to illustrate areas the Committee feels should be a focus for invigorating CSC's incident investigation process. Finally, we will ask a difficult question concerning the inmates' right to suicide in the context of the 1982 *Canadian Charter of Rights and Freedoms.*

Suicide data

Suicide is a topic that has been well studied for a long time and by various disciplines. In January 2018, there were 76,000 entries in PubMed[3] on this subject. Suicide during incarceration has also been the subject of numerous studies. In March 2018, there were 703 titles under the descriptor "suicide and prison" in PubMed and 105,000 in Google Scholar.[4]

In Canada in 2009, the suicide rate was 11.5/100,000 among the Canadian population: 17.9/100,000 for men and 5.3/100,000 for women.[5] Naturally, these rates vary slightly from year to year; however, the five year average rate among the Canadian population is 11.4/100,00. It should be noted that in all locations where data are available, suicide is more common amongst men than women.

For this report, we examined the suicide rate in penitentiaries and compare it to the rate in the general population. The analysis serves as a benchmark for comparing the current

[3] https://www.ncbi.nlm.nih.gov/pubmed
[4] https://scholar.google.fr/scholar?hl=fr&as_sdt=0%2C5&q=suicide+and+prisons&btnG=.
[5] In 2009, approximately 238,000 deaths were recorded in Canada, of which 3,890 were attributable to suicide; this results in a suicide rate of 11.5 deaths per 100,000 people. During this year (2009), a total of 2,989 men took their own lives (17.9 deaths per 100,000 persons) compared to 901 women (5.3 deaths per 100,000 persons). As these figures show, men were three times more likely than women to commit suicide. http://www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm, 2018.02.08

situation in Canadian penitentiaries with the Canadian population as a whole. At CSC, like in the general population, suicide is committed mostly by men. It should also be noted that all of the cases of suicide submitted to the committee involved men.

According to CSC's *Annual Report on Deaths in Custody* (2015/2016), there were nine suicides in 2015/2016 in a population of approximately 14,712 inmates. The 2015/16 rate would therefore be nine suicides/14,712 inmates, or 61/100,000.

Based on the aforementioned 2009 among the general population of Canada (11.5/100,000), and noting that there is little variation in the five year average, the rate at CSC was over five times higher than in the general population.[6] These figures are relative, but they give us an indication for making national and international comparisons.

Comparisons with suicide rates in other countries help shed a light on the situation at CSC. In 2011, Fazel, Grann, Kling et al. stated that the CSC suicide rate was three times higher than that of the Canadian population—which is a smaller gap than in our own approximate calculations, bearing in mind; however, that the calculation of a rate when an event is relatively rare makes it particularly sensitive to changes in population from year to year. In any case, this is the number that is most often cited in the scientific literature. These data contrast with the rate reported by Kaster, Martin & Simpson (2017) in an article on Canadian penitentiaries that states that the suicide rate was eight times higher than in the general population. However, the authors do not provide any numbers to support their assertion in the theoretical context of their paper. It is impossible to know where that figure comes from. The most recent study, which is in the public domain, is that of Fazel, Ramesh and Hawton (2017), who are three researchers from Oxford University in England. That study examined suicide rates in prisons—in all detention facilities—in 24 countries that are considered developed countries. Those authors report that the suicide average in prisons is over 100/100,000 in Norway, France, Belgium, Portugal and Sweden while, in their study, the Canadian rate for all incarcerations including men and women in both federal and

[6] http://www.csc-scc.gc.ca/research/005008-rb-16-04-eng.shtml 14,637 inmates in 2016

provincial facilities was 23/100,000: the lowest rate after Croatia's (10/100,000) and the United States (21/100,000). We can therefore see that Canada has a low suicide rate in prisons compared to other countries similar to ours.[7]

Correlation of risk factors

As noted above, previous reports have documented suicide risks. For the purposes of this report, suffice it to establish that suicide is perceived as a public health problem that is the result of an interaction or cumulative effect of biological, psychological and contextual factors (Séguin & Chawky, 2017). While these three types of factors are at work in suicide risk, it is difficult to determine which one carries the most weight in this algorithm for a given individual. For example, in a case of suicide, it is difficult to measure what—impulsiveness (a biological aspect), mental disorders (a psychological aspect) or abuse (a contextual aspect)—contributed to a person's death by suicide. In the cases that were submitted to the committee, most individuals presented with a combination of risk factors.

Previous reports on suicide thoroughly documented the risks associated with alcohol and drug consumption as well as substance abuse disorders. The evidence is well known, considering the vast array of data on the subject. In January 2018, there were over 10,000 articles on the subject in PubMed.

Furthermore, of the cases submitted to the committee by CSC regarding inmates who took their own lives, many had this exact profile: a hostile family environment, interpersonal violence experienced and observed, and repeated placements in foster care. Recent data,

[7] "3,906 prison suicides occurred during 2011–14 in the 24 high-income countries we studied. Where [suicides were broken down] by sex (n=2,810), 2,607 (93%) were men and 203 (7%) were women. Nordic countries had the highest prison suicide rates of more than 100 suicides per 100,000 prisoners, apart from Denmark (where it was 91 per 100,000), followed by western Europe, where prison suicide rates in France and Belgium were more than 100 per 100,000 prisoners. Australasian and North American countries had rates ranging from 23 to 67 suicides per 100,000 prisoners. Rate ratios, or rates compared with those in the general population of the same sex and similar age, were typically higher than 3 in men and 9 in women." Article summary at: https://www.ncbi.nlm.nih.gov/pubmed/29179937

published since the last report, provide a better understanding of the key role of abuse and interpersonal violence in the occurrence of suicide.

Child Abuse

Events that happened during childhood and adolescence interact with those of adult life, which are more recent. Research shows that a large proportion of prisoners suffered abuse as children and as teenagers which includes parental indifference and/or antipathy, physical violence, excessive or insufficient control, role reversal (the child having to play the role of the parent) and sexual assault. Furthermore, according to the research, childhood abuse has a long-term effect on substance use and mental health in adulthood. Childhood abuse can cause further problems in adult life, particularly mental health problems. It can affect the way individuals respond, particularly with the onset of depression, cause cognitive developmental problems and difficulties regulating emotions, increase the risk of teenage criminality, and increase the risk of suicide. Those data were known before 2015. The ACE study (*Adverse Childhood Experience*), conducted in the 1990s of 17,421 participants, quantitatively confirmed (Fellici et al., 1998; De Venter et al., 2013) what had previously been observed in a number of other clinical studies, including the pioneering work of John Bowlby (1969, 1973, 1980). In short, we already knew that abuse had long-term effects, including delinquency and suicide.

More recent works, conducted with brain imaging and genetic techniques, have shown that childhood neglect and assault have an effect on neurobiology. Those works, known as epigenetics—including works from the laboratory led by Gustavo Turecki (2014, 2016; Turecki and Meany, 2016; Lutz, Mechawar and Turecki, 2017), at the Douglas Research Centre, McGill University—have shown that severe childhood abuse causes changes in gene expression.[8] Abuse produces long-term effects on cerebral organization and affects communication in the brain.

[8] http://ici.radio-canada.ca/premiere/emissions/les-annees-lumiere, report on abuse

These transformations are long-lasting, affect the entire adult life, and are one of the strongest risk factors for suicide. In other words, those data confirm that a threatening and violent environment during childhood has an effect on the brain's development. They also show that there is an interaction between certain trauma and the effects they have on neurobiological responses in individuals, including cognitive developmental problems, difficulty regulating emotions, repeated crime-related setbacks during teenage years, mental health problems including depression, and a higher risk of suicide. Thus, in their status reports on suicide risk factors, Sachs-Ericsson, Rushing, Stanley and Sheffler (2016), Séguin and Chawky (2017) and Turecki (2016; Turecki and Meany, 2016; Lutz, Mechawar and Turecki, 2017)—to name a few—reiterated the key role abuse plays in suicide risk. In short, when a person who has experienced abuse is placed under CSC's responsibility, we must acknowledge that person's suicide risk when he or she arrives at the penitentiary.

Interpersonal violence

In addition to these works on abuse, a body of work points to the role of interpersonal violence as a risk factor for suicide (Haglund et al., 2016; Jordan and Samuelson, 2016; MacIsaac et al., 2017; Moberg et al., 2014; Stefansson et al., 2015). All of these works are relatively recent and converge to show that people who have committed interpersonal violence are at risk of suicide. Questionnaires developed by researchers at the Karolinska Institute in Stockholm (Stefansson et al., 2015) contribute to the validity of the observations, highlighting interpersonal violence as a significant risk factor for suicide.

A French study, conducted before the Karolinska work (Duthé, Hazard, Kensey and Shon, 2013), examined 301,611 periods of imprisonment and 353 suicides. These researchers found that suicide rates are highest among inmates who were incarcerated for homicide, although the nature of the suicide is not specified: "Suicide prevention programs must consider the major suicide risk associated with incarceration for a criminal offence against a person" p. 276. These authors therefore found that homicide is a risk factor for suicide.

This relatively recent dataset makes it clear that interpersonal violence and homicide constitute suicide risks, especially if the offender suffered abuse prior to committing the offence. These data hold important meaning for CSC because they indicate that inmates convicted of interpersonal violence combined with the homicide of someone close to them places them at higher risk of suicide than others.

In the cases of suicide that we examined, nine offenders out of 12, had been convicted for the homicide of a close relation—a spouse/common-law partner, a parent or step-parent, or a person they knew. It is hard to imagine that this over-representation of homicide cases of a close relation is purely coincidental. The convergence of research data and the over-representation of this type of homicide in our cases leads us to question the increased risk of suicide among inmates who have killed someone close to them.

Let us again consider the CSC offender profile for 2015–16.[9] CSC assumed responsibility for an average of 22,872 offenders every day. Of that number, 14,639 were incarcerated in federal institutions (including temporary detention) and 8,233 were released in the community and supervised by CSC. Of those offenders, approximately 20% were serving a sentence for homicide. These CSC figures remind us that 80% of incarcerations in a penitentiary are for crimes that did not result in death, though interpersonal violence may still have been present.

Let us look more closely at these figures. Of the total number of homicides, a certain proportion resulted from the settling of scores in drug trafficking or other types of criminal activity. Only some were homicides of close relations. According to the *Expert Committee Report on Family-Related Homicides* submitted in 2012[10] to the Quebec Minister of Health and Social Services and Minister Responsible for Seniors, 35% of homicides were family-

[9] http://www.csc-scc.gc.ca/publications/005007-3024-eng.shtml

[10] http://www.learningtoendabuse.ca/sites/default/files/Rapport_Comit%C3%A9.pdf. Other reports look at this issue. Ontario has produced a report similar to Quebec's, highlighting the same variables for family-related homicides
https://www.mcscs.jus.gov.on.ca/sites/default/files/content/mcscs/docs/ec069409.pdf
Spousal homicides were the subject of a specific report in Quebec:
https://www.criviff.qc.ca/sites/criviff.qc.ca/files/publications/pub_19062012_131333.pdf

related. Although the inmates in our nine cases had killed people close to them, not just their spouses or children, this number shows that homicides of close relations make up a fraction, which is not specified, of the total number of homicides. It would therefore be this subgroup of inmates among those serving homicide sentences who are at risk for suicide from the beginning of their sentence.

Several hypotheses may explain this increase in risk. Support from family members is often less present for an inmate when a member of the family has been killed. Visits may be extremely rare, if not non-existent. Social isolation and loneliness are a well-documented suicide risk. The prospects for reintegration are also more difficult after such a crime. Suicide often occurs after a certain number of years of incarceration, at a time when questions about returning to the community arise. It can also be said that an understanding of the seriousness of the crime develops throughout the years of incarceration, and can decrease self-esteem and increase despair. We can add that suicide requires unusual resistance to pain and a kind of unusual ability to inflict pain on oneself and others. It is a lot of work to take someone's life, whether it is a victim's or one's own life. Finally, we cannot leave out that having broken the age-old cultural and/or religious taboo of killing a close relation can make it easier to break the taboo related to suicide. As we mentioned previously, although there are several types of factors at play in the suicide risk associated with this type of homicide, it is difficult to establish which ones, for a given individual, carry the most weight in the act. The fact remains that the concentration of suicides relating to this type of homicide does not seem to be coincidental.

That being said, we should reiterate that suicide in this subgroup is still a rare phenomenon at CSC, even though there is an increased risk. Hypothetically, if in half of the homicides (a conservative proportion), offenders had killed a close relation, that would be 10% of 14,639 inmates, or 1,463 inmates. Still, there are approximately 10 suicides per year at CSC, and not all involve homicides. This low prevalence is a reminder of how difficult it is to predict who in this at-risk group of offenders will take their own life.

A subgroup of at-risk inmates

If our analysis is correct, then the subgroup of inmates serving a sentence for having taken the life of a close relation should be considered at risk for suicide, especially if there was abuse in their childhood. Thus, if CSC wants to reduce the number of suicides in its penitentiaries, that specific subset of inmates needs to be targeted.

This identification of a subgroup of inmates whose suicide risk is increased for both neurobiological and criminological reasons constitutes a double-edged sword, a dilemma for CSC.

- CSC could use this data to conduct interventions that limit inmates' quality of life but protect CSC from a suicide. These methods are known: increased if not constant surveillance, including by camera, cells stripped of various items, frequent security patrols. All of these measures affect the quality of life of all inmates involved, among whom 10 out of 1,500 (or 1 out of 150) are at risk of taking their own lives. Such a result is not acceptable or desirable. It is not what the Committee wishes. In fact, such measures would compromise the dignity and respect owed to inmates, which are core CSC values.

- CSC could use this data to conduct psychosocial interventions to reduce the risk of suicide. For that, we must accept that a zero risk of suicide rate is an impossible dream in a Canadian penitentiary.

It is currently difficult to propose effective, evidence-based, preventive psychosocial interventions. The Committee did not find any valid studies specifically devoted to suicide prevention for high-risk inmates. However, three studies suggest possible avenues for intervention. The first study (Jonson-Reid, Hold and Drake, 2012) suggests medical and psychotherapeutic interventions for adults in the community who have experienced abuse: "Child maltreatment chronicity as measured by official reports is a robust indicator of

future negative outcomes across a range of systems, but this relationship may desist for certain adult outcomes once childhood adverse events are controlled. Although primary and secondary prevention remain important approaches, this study suggests that enhanced tertiary prevention may pay high dividends across a range of medical and behavioral domains." Conditions for conducting psychotherapy are different in the community than in the context of incarceration. However, it cannot be ruled out that work on abuse could limit the transition to suicide for inmates who have taken the life of a close relation.

A second article (Martin, Dorken, Colman, McKenzie and Simpson, 2014) looked at the risk of self-harm in Canadian penitentiaries. This study makes a particular mention of offenders who are serving a sentence for homicide among those offenders who injure themselves. This article's conclusion is especially relevant in that self-injuries are often inflicted with the intention of suicide: "From a prevention perspective, the characteristics of these inmates also highlight the need for early interventions to reduce the impacts of early childhood events, poor social functioning, and symptoms of distress to prevent numerous long-term consequences, including self-injury." It would therefore be useful to intervene at the beginning of the sentence for this subgroup of inmates. The recommendation in this second article converges with the first one to suggest an intervention at the beginning of the sentence.

A final study (Pratt et al., 2015) produced positive results for suicidal inmates in England by using manualized cognitive-behavioural suicide prevention therapy. The authors' conclusion states: "The delivery and evaluation of CBSP (manualized cognitive-behavioural suicide prevention) therapy within a prison is feasible. CBSP therapy offers significant promise in the prevention of prison suicide and an adequately powered randomized controlled trial is warranted." It is helpful that the protocol for this intervention has been written, which could facilitate training at CSC.

In short, the few data available indicate that intervention at the beginning of the sentence is useful and that the cognitive-behavioural suicide prevention therapy model for inmates has

proved effective in England. These three articles are a matter of public record. It is difficult for us to make more specific recommendations for intervention. However, this is the type of intervention that the Committee has in mind—the type that does not affect inmates' quality of life. It may be useful for CSC to contact those authors to discuss the strengths and limitations of their interventions and their possible application at CSC.

We must nevertheless remember that psychosocial preventive intervention can have counterproductive effects and increase the risk of suicide. An increased awareness of one's personal distress could increase depression, which in turn, could increase the risk of suicide.

Conclusion

The fact remains that over three quarters of the cases of suicide submitted to the committee involved inmates serving sentences for the homicide of a person close to them. This over-representation does not seem to be coincidental and it is consistent with the scientific works. Those works have shed a light on the key role of abuse—in combination with interpersonal violence, including homicides—in suicide risk. Furthermore, given the very high number of higher-risk inmates and the very low suicide rate at CSC, experimental projects could possibly be implemented in a small number of institutions, preceded and followed by measures to assess their effectiveness.

Recommendations

The Committee recommends:

1. The homicide of a close relation be added to the list of suicide risk factors;
2. CSC contact the researchers who studied the correlation between abuse, homicide and suicide to determine whether it is appropriate to apply their model in some CSC penitentiaries;

3. CSC implement experimental psychosocial interventions, with long-term monitoring, to test whether such interventions can reduce the suicide rate among the subgroup of inmates at risk.

Case Study

As stated previously, the suicide rate at CSC is relatively low considering the plethora of risk factors that inmates tend to experience even before they are incarcerated. Then there is incarceration, which in itself is a risk factor. The Committee was impressed by this relatively low rate given the study population's high vulnerability to suicide.

According to the Committee, overall, the cases were handled in accordance with CSC's mission to ensure safety, dignity and respect for all. The Committee observes that, overall, the measures that have been put in place in recent years to prevent suicide seem to have been effective. With respect to the 2017 segregation policy, it clearly outlines that segregation is only used for the shortest period of time necessary, and specifies groups of inmates not admissible to administrative segregation, such as inmates with serious mental illness with significant impairment.

However, there was one exception amongst the cases reviewed, and this section is dedicated to that case. This suicide occurred prior to the publication of the recent suicide prevention policy at CSC and prior to the review of segregation policies and practices.

The Committee considers the poor decisions made regarding this case to be an exception, a rare scenario. To explain is not; however, to excuse or to legitimize the series of bad decisions that were made. The Committee feels it must point out the mistakes that were made and make recommendations that will reduce the likelihood that this scenario is repeated.

Overview of the Case

In 2015, an Indigenous inmate in a segregation cell at a medium-security institution took his life. Prior to his suicide, he had spent 74 days in segregation. The investigation report was completed in 2016.

A profile of the individual revealed that he exhibited many of the risk factors for suicide discussed in the previous section. Specifically, the individual was incarcerated for a violent crime that he committed at a young age. As a result of his crime, he was serving a life sentence with eligibility for parole after 14 years of incarceration. In 2015, he had reached his 13th year of incarceration. He also had a history of crimes prior to this homicide, but those other convictions did not involve physical violence.

His personal history resembled that of all too many inmates, from all different backgrounds, and contained many of the biographical elements which are considered risk factors for mental disorders and suicide. They are interrelated with the occurrence of homicide of a person close to the offender.

The individual in this case took his own life after 74 days of segregation. That is equal to two and a half months of segregation. Although the reasons for the placement in segregation were cited in the report, the Committee felt that none of these reasons justified two and a half months of segregation for an inmate who had no serious problems identified in his record in custody. Contrary to the reasons cited, segregation cannot be the response to a lack of space in a program for Indigenous offenders, nor can it be used for long-term protection against a conflicting inmate, and it cannot be the response to a wrongdoing where the inmate's intentions were judged non-aggressive.

It is understandable that, for a few days, segregation could be either punishment or protection. The inmate can also be informed that he will be given a new placement and that more time is needed to find an appropriate location which can be explained to an inmate.

Then, knowing that the end of segregation is near, the inmate can better cope with or even learn from the segregation.

That was not the case at all in this file. Here, segregation was prolonged for weeks and weeks—a total of 10.5 weeks—and had no known or foreseeable end. In his five-page suicide note, he explained his despair better than the Committee could: the feeling of failure, his guilt towards his family, his loneliness, and how he felt broken and without recourse for a possible relocation.

It is of particular concern to the Committee that the board of investigation did not produce any recommendations regarding the impact of two and a half months in segregation, despite acknowledging the many adverse effects. According to United Nations Standard Minimum Rules for the Treatment of Prisoners (the *Nelson Mandela Rules*), Rule 43 states that the confinement of prisoners for 22 hours or more a day without meaningful human contact, or solitary confinement for a time period in excess of 15 consecutive days shall be prohibited as it amounts to torture or other cruel, inhuman or degrading treatment or punishment. In the Committee's opinion, the board should have determined whether segregation in this case was paramount to prolonged/indefinite solitary confinement, referencing Rule 43, and then subsequently made recommendations to modify CSC's policy framework around segregation.[11]

Conclusions

The Committee was deeply saddened by the case study. It was our duty to make our views known as clearly as possible so that CSC, its management, front-line staff and the board charged with assessing this case, learns from what we considered to be inconsistencies with its own core values as well as international standards.

[11] https://www.penalreform.org/priorities/prison-conditions/standard-minimum-rules/

The decisions that preceded the inmate's suicide, as well as the reports that were made following his death, reflect serious deficiencies and serious errors in judgment made by CSC staff. The Committee appreciates that CSC is trying to address the needs of First Nations inmates. In this case, CSC's core values should have been considered along with First Nation membership in decisions made both before and after his suicide.

The inmate's farewell letter is consistent with the research this Committee highlighted earlier indicating an elevated risk of suicide for individuals with a particular profile. This individual was potentially facing a difficult return to society, the massive rejection by loved ones, shame and guilt. He was a human being with an increased risk of suicide who was isolated and kept in segregation for more than ten weeks without any information as to the length of his confinement or the possible or probable end to his confinement.

The Committee acknowledges that cases similar to the case study are difficult and also acknowledges that inmates' past cannot be erased: shame, guilt, difficulties when returning to society, everything is more difficult in such cases and these factors are beyond CSC's control. However, recent data, released almost simultaneously with this suicide, highlighted the link between suicidal risk on the one hand, and the increased risk that follows abuse and interpersonal violence on the other. Now that this information has been documented, we hope that CSC staff will take this into account when dealing with similar cases.

Recommendations

The Committee recommends:

4. To ensure that the new CSC Directive on Administrative Segregation stipulating that segregation is only used for the shortest period of time necessary, and specifies groups of inmates not admissible to administrative segregation, such as inmates with serious mental illness with significant impairment, is implemented.
5. To explore, in its incident investigation terms of reference, the inclusion of i) CSC's core values of dignity and respect for inmates, and ii) international standards such

as the United Nations Standard Minimum Rules for the Treatment of Prisoners, as criteria relevant to CSC incident investigations for suicides that take place in segregation.

6. To take into account the increased risk of suicide, in segregation, of inmates who have been abused and/or who have killed a close relation.

The Right to suicide

This last section related to suicides in custody deals with inmates' right to suicide. Several books and articles have raised the issue of suicide and prison, including the risk caused by the degrading conditions of incarceration.[12] In this section, the Committee's perspective is different. The Committee wishes to examine the issue of the right to suicide of persons under CSC's jurisdiction under the *Canadian Charter of Rights and Freedoms*. We will attempt to examine whether Canadians' constitutional rights to suicide may extend to inmates and, if so, to what extent, given the very real constraints of CSC's responsibility for the health and safety of inmates placed in its custody.

After providing an update on suicide at CSC, we will underline the changes in Canada to the provisions of the *Criminal Code* with respect to suicide and the right to suicide of all Canadians, to subsequently ask if the right of any Canadian to refuse treatment and the issue of inmates' discernment can extend to the right to suicide. Finally, the Committee will ask what the balance might be between the health and safety requirements of inmates and their right to take their own lives.

[12] Several books, book chapters and articles in Google Scholar on the terms "suicide and prisons" describe incarceration, its conditions and their effects on inmates and the relationship of these conditions to suicidal ideation and successful suicides.

Suicide at CSC

Inmates accumulate risk factors, those already present when individuals are placed under CSC's responsibility, and those inherent in detention. When a person's childhood was mainly marked by rejection and abuse, when a person's life story includes early offending leading to repeated failures that impaired self-esteem, when serious crimes were committed that led to the State imposing a lengthy sentence, when, *a fortiori,* a loved one was killed, it can be argued that, for such a person, life has little meaning. We can therefore expect suicides in such cases.

It is the legal duty of CSC to take all reasonable measures to prevent suicides. CSC must protect inmates from suicidal impulsivity and ideation for multiple reasons. As the Canadian Association for Suicide Prevention and the World Health Organization[13] remind us, suicide is not a solution, and the authors of this report adopt this position, which is also the position of CSC. In addition to the human dimensions of valuing life and excluding suicide as a solution to a difficult and stressful situation, CSC must ensure that the vulnerability of inmates does not lead to various abuses that can even lead to death. CSC has made it its duty to ensure that persons entering a Canadian penitentiary come out alive. As stated before, CSC has a legal duty to take all reasonable measures to prevent suicides and preserve life. In fact, the prevalence of suicide at CSC is, on balance, relatively low and stable. As described above, rates are lower than in other comparable countries, including Western European countries.

CSC's response to suicide is twofold: (i) psychosocial prevention measures; (ii) repressive actions.

[13] http://www.who.int/mental_health/suicide-prevention/en/

Psychosocial prevention measures

Psychosocial prevention programs have been developed and implemented in institutions. Medical and psychotherapy services are available, and most of the cases of suicide that have been referred to the committee had used those services. CSC reports on suicides are almost all satisfactory and make recommendations. In short, the most recognised effective biopsychosocial prevention measures in prisons have been implemented to reduce the risk of suicide.

It should be noted however, that CSC's most robust components of psychosocial suicide prevention programs, those recommended by Canada, cannot be implemented.[14] The prison environment does not foster the development of constructive social support. It is also difficult to change the ecology in which inmates live, particularly when the level of security is high. Psychosocial intervention has to be done and is done, but psychosocial prevention programs in the prison setting are not as effective as in the community.

Repressive actions

CSC's anti-suicide strategy also uses physical controls and monitoring. Self-harm is also prohibited and therefore subject to monitoring. For example, points of suspension have been removed from cells, particularly to limit impulsive suicidal acts. The purpose of regular security patrols is to ensure the well-being of the inmates and that each cell includes "the presence of a living, breathing body." The use of surveillance cameras allows for monitoring of inmate behaviour. Periodic searches have a number of objectives, including searching for objects that could lead to death, injury or injury to others.

It should be noted however, that removing all suspension points further strips the cells, night security patrols can affect the quality of sleep, and camera surveillance can be considered an infringement of the right to privacy. These physical control and monitoring

[14] http://www.canadiensensante.gc.ca/publications/healthy-living-vie-saine/framework-suicide-cadre-suicide/alt/framework-suicide-cadre-suicide-eng.pdf

measures affect the quality of life of all inmates, including those who are not at risk of suicide. This means that nearly 15,000 people's quality of life is affected for about ten people who take their own lives every year. We cannot help but wonder about the high price all inmates pay for this suicide ban. There are also questions about the moral value of such a practice.

It is difficult to know whether the relatively low rate of suicide is due to psychosocial suicide prevention measures or the implementation of physical controls and surveillance.

1972 changes

The social context of suicide in Canada has changed significantly in the last half century. Prior to 1972, suicide was considered immoral and suicide attempts were considered premeditated homicides.

In 1972, a legislative amendment decriminalized suicide in Canada. This 1972 process was the result of the primacy of the right to autonomy of a person who wants to take his or her own life over the state's interest in protecting the lives of its citizens.[15] That is, there is a right to take your own life. Over the past five decades, we have seen a change of attitude toward suicide in Canada and in comparable countries.

Contemporary attitudes value helping people with suicidal ideation and bereavement, as noted in a visit to the Canadian Association for Suicide Prevention website.[16] Most countries have suicide prevention policies and adopt attitudes of prevention and support of distress. In Canada, on December 14, 2012, in the House of Commons, Bill C-300 was passed to establish a federal framework for suicide prevention. This was followed by a federal framework for suicide prevention.[17] Canada is committed to ensuring that Canadians at risk

[15] http://www.vosdroitsensante.com/1934/le-suicide
[16] https://suicideprevention.ca
[17] http://www.canadiensensante.gc.ca/publications/healthy-living-vie-saine/framework-suicide-cadre-suicide/alt/framework-suicide-cadre-suicide-eng.pdf

receive the support, if not the treatment they need to regain their desire to live. This framework also applies to Canadian penitentiaries.

It should be noted that this right to suicide must be distinguished from the end-of-life care[18] (medical assistance in dying) that has resulted in changes to the *Criminal Code* in 2016. This legislation is aimed for people who are very ill, or in the process of becoming very ill, who are asking for some form of medical assistance in order to take their own life in response to a free and informed request from them. Such is not the purpose of our argument.

Right to refuse treatment and discernment

The right to suicide in a Canadian penitentiary is a difficult issue that involves a tangled web of concepts and practices that are not easy to unravel in a prison setting. This section will try to put them side by side.

In Canada, every citizen has the right to accept or refuse health care. From that, we must respect the right of an adult who is able to make such a decision, who chooses to refuse care, provided, of course, that this consent is free and informed, that is, consent is given voluntarily. A Canadian cannot be forced to receive care, even if their refusal may result in death.[19] This right is also recognized for inmates at CSC. For example, one of the inmates who committed suicide had refused throughout his incarceration to discuss his private experiences and had refused to receive psychotherapeutic care, and his choice had been accepted. This decision was not questioned in the Incident Report following his death.

The question the Committee is asking is, if we recognize the ability to make a free and informed choice in health care, does that mean that we also recognize an inmate's ability to discern? In other words, should we conclude that the ability to make free and informed choices implies the ability of the individual to discern? We conclude that it does. Here is our reasoning.

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[18] https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html
[19] https://www.educaloi.qc.ca/en/capsules/consent-medical-care-and-right-refuse-care

If CSC recognizes the right of the inmate to refuse health care, then the inmate is recognized as having sufficient discernment to understand the consequences, even if the inmate's refusal causes his or her death. In other words, an inmate who is able to refuse health care, even if it may cause his or her death, means that CSC recognizes the ability to give free and informed consent, as does any Canadian. He or she is therefore implicitly recognized as capable of discernment. Moreover, if an inmate is not in a psychiatric institution specialized in forensic psychiatry, it means that the tribunal that convicted him or her recognized the inmate's ability to distinguish between good and evil, truth and error, right and wrong, according to a concept recognized in civil law as well as in criminal law.[20] The principle is that inmates in a penitentiary who are not in a mental health unit have that ability to discern. Does such a capacity also become generalized to the right to suicide? Logically, one could affirm it, but it's not that simple.

In several law-abiding states, a person whose mental health is a danger to himself or herself, specifically a risk of suicide, can be protected from himself or herself by means of a treatment order. It is therefore important to understand that an individual may be subject to treatment against his or her will, if there is an emergency and/or if he or she is found unable to give meaningful consent. In this case, according to the legal principle previously stated, the person lost his or her ability to discern. So you can take steps that can go as far as restraint to protect them from their desire to take their own life, or put them in isolation without means of taking their own life and under constant, direct observation by a Correctional Officer/Primary Worker. So there are situations in Canada where citizens lose their right to take their own lives. On the other hand, if the desire to end one's life does not stem from a mental state disturbed by a mental illness, in principle, that person cannot be prevented from ending his or her life.[21]

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[20] We can simplify this notion by defining it as a capacity to understand a situation in which a person is involved and evaluate the consequences of such.

[21] http://www.vosdroitsensante.com/1934/le-suicide
However, there is no consensus in the clinician community on the issue of compulsory treatment for people with mental disorders, and some see this as a human rights violation: "Four things can be said about compulsory admission to hospital as a measure for suicide prevention. First, it can save the lives of those who, without the care, treatment and management received in hospital, would have taken their own life. Second, owing to the poor suicide predictive capacity of the existing methods, false positives will occur and this results

In any penitentiary, here as in other law-abiding state, the issue of duress is difficult and ambiguous. Sentencing, which is deprivation of liberty, is in its very definition a constraint. It is justified because of the damage that the person has caused and the threat that this person creates to his or her community. So there is constraint by decision of the state, and it is justified, ethically as much as legally. It has also been mentioned that the behaviour of the person who has committed a crime and is incarcerated may also pose a threat to CSC staff and other inmates. Ensuring the safety of some requires the constraint of others.

Furthermore, as mentioned above, it is CSC's duty to protect inmates from their suicidal impulsivity and ideation. So how do we distinguish between a policy that essentially seeks to eliminate suicide at CSC and the right of Canadians to take their own lives if they are capable of discernment and if that is their choice?

Quality of life and prohibition of suicide

Suicides often occur at night because the security patrols are less frequent and concealment is easier in a bed. CSC policies require regular rounds, almost exact to the second, as reported. These inspections are random, meaning that inmates are not aware of the schedule, in order to prevent the suicidal act. Since the suspension points have been removed from cells and each new suicide leads to the further elimination of points of suspension, the cells are increasingly empty and the means used to commit suicide are often more inventive as they are horrific.

It must be understood that, for some inmates who present a personality disorder—and they are numerous in the cases we have reviewed—these preventative measures may constitute or become a sort of challenge, as if the only space of freedom they are left with, their only

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in unnecessary hospital admissions, which can be aggravated if legal accountability encourages defensive clinical practice. Third, there is the possibility that compulsory admission to hospital is partially responsible for the suicides of those who failed to seek help owing to the fear of involuntary detention or for whom the experience of being admitted to hospital contributed to the decision to take their own life. Fourth, it is still unclear how and if compulsory admission to hospital of people on the basis of their mental impairment and the risk of danger to themselves can be reconciled with the UN Convention on the Rights of Persons with Disabilities" (Wang and Colucci, 2017, summary).

power, their only way of being the strongest is to manage to kill themselves between two security patrols, using means that defy the imagination. Reading these strangulation stories makes you shudder. In the September 10, 2014 report of the Correctional Investigator of Canada, on pages 15 and 16, it states that "placement (...) in special suicide-resistant cells has both perceived and actual punitive aspects. (...) These factors can be expected to elevate rather than reduce suicidal tendency."

Therefore, it would be useful to examine closely whether physical controls and surveillance measures are effective. In fact, we have to question the potentially deleterious effects of the prohibition of suicide at CSC. For inmates who have a narcissistic or antisocial personality disorder as defined in the DSM-IV, this type of control can exacerbate their unreasonable need for control and oppositional conduct and thus increase their risk of suicide. To win against authority, they must be able to take their own lives between patrols at night, and it must be sordid.

What findings can be made? The Committee recognizes CSC's legal obligation to prevent suicide and reiterates the quality of work done by CSC. CSC must maintain its psychosocial suicide prevention programs and psychotherapy services for inmates. As the Canadian Association for Suicide Prevention points out, suicide is not a solution, and the authors of this report take that position. The Association also recognizes that not all suicides can be prevented.

It must be noted that, apart from one case, there was a will to take their own life in the cases that were submitted to the committee. So there is a willingness to die because the strategies have been planned for a long time, and the means that are used bear witness to a remarkable invention, in part because the points of suspension have been removed from the cells. Our reading is that these are not impulsive acts.

Suicide is prohibited at CSC. These detainees have to plan their death between the two security patrols, so they had been picking up equipment for a long time or thinking about

unusual equipment for a while to carry out their project. Is this fight against authority truly consistent with the *Criminal Code* as amended in 1972 and within the spirit of the 1982 *Canadian Charter of Rights and Freedoms*? How can we both protect prisoners from themselves and maintain a low suicide rate while avoiding a prohibitionist position that leads to a reduction in the quality of life of all inmates?

Conclusions

In this section, the Committee wanted to remind CSC that the population under its responsibility brings with it a dark past, resulting in a constellation of suicidal risk factors. Research data from the past three years have added additional weight to empirical observations from previous years. As a result, CSC must accept that zero risk of suicide is an impossible dream in a Canadian penitentiary.

The issue of the right to suicide at CSC raises a series of uneasy questions. Here is the puzzle CSC faces:

- The detainee situation is contradictory. (i) Many of them experience understandable despair: long sentences, childhood abuse, crimes involving interpersonal violence, lack of social support, legitimate apprehension of a difficult return to society. In short, many people in similar circumstances would have suicidal ideation. (ii) CSC has a duty to protect inmates from suicidal intent.

- The rule of law requires two propositions, which are also contradictory: (i) the constitutional rights of detainees must be recognized, including the right to suicide; (ii) the incidence of unnatural deaths in a penitentiary have to be reduced to a minimum. These two propositions can lead to measures that are mutually incompatible.

- We must ensure that conditions of detention promote “dynamic security” and “constructive interactions,” to use CSC’s words, where possible. But, knowing this

population and the need to protect CSC staff and other inmates, this is not always possible.

- The number of suicides at CSC is low. The rarer a phenomenon, as is currently the case at CSC, the more difficult it is to prevent it. This report highlighted patterns, which can be identified as risk factors for abuse and interpersonal violence. But, even among inmates who have taken the lives of loved ones, the suicide rate remains low. If half of the homicides involved as victim someone close to them, that is 10% of 14,639 inmates, or 1,463 inmates. There are 10 suicides/year at CSC, and not all are homicide cases.

While there are many contradictions in the situation at CSC, the Committee believes that the potentially deleterious effects of prohibiting suicide at CSC should be questioned. For example, we have to ask ourselves whether suicide prevention measures, such as physical controls and surveillance measures, affect the quality of life of the inmates. Is the quality of the inmate's sleep affected by periodic monitoring or by the noise produced at night by that same monitoring or by any other cause? Do these controls affect the mental and physical health of inmates and the atmosphere of a range, a penitentiary that, in turn, increases the risk of suicide? Sleep quality improves depression control and improves physical and mental health. Is hyper surveillance to prevent suicide, with cell controls, still indicated? It is also important to consider whether the ongoing need to prevent suicide does not encourage some inmates to take action, as mentioned earlier.

We don't have the answers to these questions, and the answers may vary from one institution to another, from one team of stakeholders to another. What the Committee is proposing is that CSC—both its executives and front-line staff—look at the potentially deleterious effects of its suicide risk management strategies and the anti-suicide controls that are built into inmate supervision. It is also possible that committees of inmates, who live in cells on a daily basis, can contribute to the answers to this question, which may vary from institution to institution. In short, CSC is promoting that it wants to ensure that

conditions of detention promote “dynamic security” and “constructive interactions,” at CSC’s words, where possible.

We have to ask ourselves what the balance might be between the safety requirements of staff and inmates and the prevention of non-natural deaths and the maintenance of a quality living environment. Where is there a balance between the two? Management, other staff and inmates have answers to these questions that may differ from institution to institution, depending on the level of security, and may evolve over time. The time has come, according to the Committee, to raise the issue, and to also raise it with inmates.

Recommendations

Dialogue must be promoted at CSC on the issues surrounding measures taken to protect the health and safety of inmates to ensure that these measures do not contribute to the despair and depression that, in turn, have a consequence in increasing the risk of suicide attempts. These discussions should take place between management, institutional staff and all inmates known to be at risk of suicide.

The Committee recommends:

7. CSC examine the potentially deleterious effects of its suicide risk management strategies in reference to the quality of life of the approximately 15,000 people who are incarcerated under its responsibility;
8. CSC encourage dialogue between administrators, front-line staff and inmates to address the vicious cycle whereby measures taken to prevent suicide lead to a deterioration of the quality of life, thereby increasing the risk of suicide.

Part 2: Overdoses

After suicides, overdoses are the second most common cause of unnatural death in penitentiaries (Correctional Service of Canada, 2017). This section of the report will therefore focus specifically on these cases. After a review of the situation of overdoses in the free world, the Committee will look at overdoses in detention before specifically analyzing the overdose reports that were submitted to the Committee by CSC as part of this review.

Overdose is a current issue in Canada. These overdoses are mostly associated with opioid use. Opioids are narcotics derived from the opium poppy, or their synthetic analogues (World Health Organization, 2014). This category includes morphine, heroin and fentanyl. Opioids affect the central nervous system which, among other things, controls breathing. Using more opioids than the body can withstand can lead to overdose (Health Canada, 2017a).

According to the Canadian Institute for Health Information (2017), 16 people are reported to be hospitalized every day due to opioid overdose in Canada. For 2016, there were at least 2,861 deaths (7.9/100,000 population) related to opioid use in Canada (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2017); most of which were males aged 30 to 39 (Health Canada, 2017b).

Many of these overdoses were related to fentanyl (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2017). Fentanyl is a synthetic opioid, prescribed or manufactured in clandestine laboratories, which is thought to be at least 40 times more potent than heroin (Canadian Centre on Substance Use and Addiction, 2017; Santé Montréal, 2017). This substance can be prescribed or sold on the street as a powder or tablet, as heroin, cocaine or oxycodone, or found in their composition to increase the profits of resellers. The presence of fentanyl in street drugs significantly increases the risk of overdose in those who use them.

An opioid overdose can be identified by:

- difficulty walking, talking and staying awake
- blue lips or nails
- very small pupils
- cold and clammy skin
- drowsiness and confusion
- extreme sleepiness
- choking sounds, gurgling or snoring
- slow, weak or no breathing
- inability to wake up, even if the person is shaken or yelled at

Source: Health Canada (2017). Overdose of opioids. https://www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids/overdose.html Retrieved December 11, 2017.

Naloxone

Naloxone is a short-acting antagonist against opioids (Canadian Centre on Substance Abuse, 2016). It is often referred to as the antidote to opioid overdoses. It is used by medical professionals to counter the effects of opioid overdose. Naloxone may also be prescribed or distributed as a kit (naloxone vials, syringes and needles) to those at risk and those around them. Naloxone is very safe because, if it is given in error to someone who is not overdosing on opioids, it has no effect. Moreover, it cannot be used as a drug because it does not cause any euphoric effects. Finally, it is not addictive (CRAN Program, 2017). Naloxone (Narcan) is administered intramuscularly and may be re-administered after three to five minutes. Naloxone can also be administered using a nasal spray (naloxone hydrochloride).

In response to the increase in opioid overdose deaths, Health Canada changed the prescription status of naloxone, in March 2016, to increase its accessibility. So now, instead of requiring a prescription to sell naloxone to people who might need it, pharmacists can offer it without a prescription. As a result, first responders can administer this product

without requiring a prescription (Health Canada, 2017c). For example, several provinces distribute naloxone kits free of charge to first responders, opioid users and others.

In addition to situational prevention methods, the World Health Organization recommends a series of actions that would have the impact of reducing overdoses. These measures consist of the following:

- Increasing the availability of opioid addiction treatment, particularly for those addicted to prescription opioids
- Decreasing irrational or inappropriate prescribing of opioids
- Tracking the prescribing and dispensing of opioids
- Limiting the reckless over-the-counter sale of opioids

Source: World Health Organization (2014). Information on opioid overdose. http://www.who.int/substance_abuse/information-sheet/en/. Retrieved December-13, 2017.

Upstream from an overdose

A recent systematic literature review (Sordo et al., 2017) makes it clear that retention in alternative treatments (methadone or buprenorphine) is associated with a significant reduction in the risk of fatal overdoses. Furthermore, according to the research, the periods following the termination of such a program are particularly at risk for overdose.

Already, in 2002, Prendergrast, Podus, Chang and Uruda, following a meta-analysis, concluded that treatments for substance use disorders had a significant impact on drug use by participants. Furthermore, it must be recognized that the various types of treatment for substance use disorders that rely on conclusive data show rates of relapse comparable to the treatment of most chronic disorders such as diabetes, high blood pressure or asthma, that is between 40% and 60% (US Surgeon General, 2016). So it is not a panacea that has immediate and definite effects for all those who are exposed to it.

Drugs in penitentiaries

Penitentiaries are not drug-free environments. For example, for 2016–17, based on data made available to this Committee (Performance Online, 2016–17), there were 2,640 drug seizures and this number has been rising relatively steadily since 2011–12 (2,242 seizures). We can better understand the presence of drugs in penitentiaries when we know the large proportion of inmates who experience substance use problems upon their admission to penitentiaries and the number of inmates sentenced for trafficking or importing drugs.

CSC asks newly admitted inmates to complete a Computerized Assessment of Substance Abuse (CASA). Among other things, it collects information on the use of legal and illicit psychoactive substances and measures their degree of dependency using the validated *Alcohol Dependence Scale* (ADS) and the *Drug Abuse Screening Test* (DAST). According to the CASA data provided by CSC to the Committee, it appeared that at intake, one quarter of inmates (2015–16 1,363; 2016–17 1,389) presented with a moderate to high need of intervention related to substance abuse and this dynamic risk factor was directly related to their criminality. However, as per the data provided, it was impossible to know the proportion of inmates with opioid use disorders.

Moreover, if we now analyze the data provided by CSC about the resident population rather than the intake population, it becomes clear that, for the year 2015–16, there were 2,875 inmates sentenced for drug trafficking or importation, which represented 19.5% of the inmate population in penitentiaries. According to this data source, one third of inmates (36.5%) had moderate or severe substance use problems in that year. Penitentiaries are therefore a meeting place between people with a good illicit drug distribution network and a large number of potential users.

Actions taken by CSC

To discourage the use of drugs in penitentiaries, CSC has taken a number of measures to develop and implement drug interdiction strategies such as searches, drug detector dogs, ion scanners and urine tests. As an example of this, CSC doubled its urinalysis testing from 2011–12 to 2016–17 (2011–12: 7,711; 2016–17: 15,642) (Performance Direct, 2016–17).

Overdoses in penitentiaries

From 2011–12 to 2015–16, there were between 30 and 74 non-fatal overdoses and up to seven fatal overdoses per year (Office of the Correctional Investigator, 2016; Correctional Service Canada, 2017). The majority of people who overdosed in penitentiaries were between the ages of 30 and 49 (Office of the Correctional Investigator, 2016) and half of those who died were between the ages of 25 and 34 (Correctional Service Canada, 2017). The most common substance associated with overdoses in penitentiaries was fentanyl, accounting for 69% of overdoses in the last two fiscal years (Correctional Service Canada, 2017).

According to a study by Weekes and De Moor (2015), close to half of Canadian inmates who overdosed in a penitentiary were considered to have substantial or severe problems with one or more drugs, most often opioids. Generally speaking, these people had served half of their sentence. They therefore saw a decrease in physiological tolerance as a possible reason for some of the overdoses. The authors suggested using a drug use problem severity assessment as an indicator of increased risks of overdose.

Use of naloxone (Narcan) in penitentiaries

The National Commission on Correctional Health Care (2017) recommended increased accessibility to naloxone in detention. It also called for correctional and medical staff to be properly trained in the use of naloxone.

At CSC, use of naloxone (Narcan) is described in the Emergency Medical Directives – User's Guide (Correctional Service Canada, 2015a). These directives indicate that if medical history suggests that the situation is related to an overdose, nursing staff should administer naloxone at 0.4 mg intravenous (IV), intramuscular (IM) or subcutaneous (SC). A second dose of 0.4 mg of Narcan may be administered if no improvement has been noted after 60 to 90 seconds. If need be, staff must administer additional doses of 0.4 mg of Narcan every two minutes to a maximum of six doses or a total of 2.4 mg of Narcan.

Programs implemented by CSC to reduce illicit drug use

Preventing overdoses also means reducing illicit drug use during incarceration. Methadone and Suboxone are two drugs used in CSC's Opioid Substitution Therapy Program. Specifically, this treatment includes the administration of opioid substitution therapy (OST), symptom monitoring and, if necessary, supportive counselling. This is a voluntary program that can be used over a long period of time. Methadone is given to inmates during daily visits by health care centre staff. Furthermore, Suboxone, which is initially administered in daily doses, can then be administered in doses spaced further apart, depending on the advice of the doctor. OST may be stopped by CSC for reasons related to drug use, for example, if the inmate repeatedly refuses to provide a urine sample for drug testing despite repeated counselling or has provided positive urine samples multiple times. Other reasons related to the inmate's behaviours in connection with OST (e.g., violent or disruptive behaviours, threats, attempts to divert product) may explain the cessation of the therapy (Correctional Service Canada, 2015b).

According to data provided by CSC, as of April 2017, 920 inmates were on OST, or about 7% of the penitentiary population. The Pacific and Ontario regions had the highest number of inmates receiving OST. However, since there is no estimate of the number of inmates with opioid substance disorders, it is impossible to estimate the percentage of these inmates who received OST.

In addition, CSC offers the Integrated Correctional Program Model (ICPM) to offenders. This program is a holistic model where offenders can address all their risk factors and needs that led them to crime such as substance abuse, general violence, family violence, etc. The interventions are based on cognitive behavioural therapy techniques, which prominently feature the ABC (Antecedents – Beliefs – Consequences) model of human behaviour. The programs use a mix of group discussions, exercises, role-plays, opportunities to practice and homework assignments. This allows offenders with different learning styles to get the most out of the programs.

The program teaches skills to help offenders deal more positively with challenges in the community. Over time, this reduces their risk to reoffend.

The skills include:

1. Problem-solving;
2. Goal setting;
3. Social;
4. Communication and interpersonal;
5. Emotional arousal-reducing;
6. Identify, challenge and replace thinking which supports risky and criminal behaviour; and
7. Self-management, including self-monitoring.

Source: Correctional Service Canada (2018).

The ICPM program has three different streams, each with various levels of intensity (high intensity, moderate intensity, adapted moderate intensity and institutional/community maintenance). Each stream includes the readiness, main and maintenance components.

- Multi-Target ICPM
- Aboriginal ICPM
- Sex Offender ICPM

Source: Correctional Service Canada (2018).
Ottawa: Correctional Service of Canada, Reintegration Programs Division (2018).

According to data provided to the Committee by CSC, each year, more than 1,000 inmates who were assessed as having needs related to psychoactive substance abuse were referred to a program to help them solve this crime-related problem (2010–11: 2,070; 2011–12: 1,803; 2012–13: 1,657; 2013–14: 1,698; 2014–15:1,395; 2015–16: 1,238; 2016–17: 1,247). A quick look indicates that these numbers are steadily declining. However, it is important to note that the number of admissions to penitentiaries has been declining for some years now. While admissions totalled 5,318 offenders in 2010–11, only 4,899 were recorded in 2016–17. It is therefore preferable to observe the proportion of newly admitted offenders who have been assessed as having drug abuse-related needs and referred to a drug treatment program. For 2015–16 and 2016–17, 91% (1,238/1,363) and 90% (1,247/1,389) of inmates, respectively, had a moderate or severe substance use disorder related to their crime. This was essentially nearly all inmates identified at admission. If we use resident inmates instead of newly admitted inmates for our analysis, we again see, for 2015–16, that the vast majority (79.4%) of people who were identified as having a substance abuse problem went through or were in a treatment program.

Analysis of overdose reports made available to the Committee

Only five overdose reports were provided to Committee members. However, two of these reports provided information on additional overdoses that occurred in the hours surrounding the one being investigated. For example, one report revealed information on a total of five overdoses in 24 hours, and one reported details on three overdoses. As the information surrounding all of these overdoses appeared to be fairly complete, the Committee used all of these data for its analysis, that is, a total of 11 overdose cases related to five investigations.

Of all the overdose cases analyzed, six occurred in a maximum-security penitentiary, while five occurred in a medium-security institution. The Committee does not see a pattern of when overdoses occur (four during the day, four in the evening and three at night).

All but one of the overdoses occurred in the inmate's cell. They were all reported by a correctional officer, except for one that was reported by a fellow inmate.

The vast majority of overdoses have been attributed to opioid use. Only one overdose was related to the use of Benadryl. However, naloxone (Narcan) was used in only two of those cases. In one case, Narcan was administered by medical personnel eight minutes after the distress was observed by a correctional officer. Three successive doses did not give the desired effect. In a second case, naloxone was successfully administered and the person survived (this was a case where three overdoses occurred in the space of a few hours). In none of the cases was it reported that paramedical staff (paramedics) used naloxone during their resuscitation attempts.

The analyzed reports showed that only four inmates who experienced an overdose episode were known to have substance use disorders, and half of them were enrolled in one of CSC's addiction assistance programs. One of these individuals had also taken a methadone maintenance program for a short time in the past. He had taken steps to again enrol in such a program before his death, but abandoned his efforts. These figures are somewhat different from those presented in CSC's report on non-natural deaths, as it was reported that 91% of inmates who died as a result of overdose had a history of substance abuse (Correctional Service Canada, 2017).

Conclusion

To begin with, since 2014–15, more than 1,300 inmates newly admitted to penitentiaries every year have been identified as having moderate or severe substance dependency issues related to their crime, whereas between two and seven inmates overdose each year. This is

estimated to be less than 0.005%, which is very low, given the characteristics of the persons incarcerated.

In any event, the first observation arising from the analysis of the reports that were provided to the Committee was the very low use of Narcan during overdose events. This is only hypothetical, but in many cases, the Committee believes that the use of Narcan could have saved lives. However, it is important to consider that during the period covered by the case analysis, fentanyl was a relatively unknown opioid and naloxone was rarely used. This is probably why only medical staff were authorized to use Narcan during opioid overdoses at the time, and it could be for this very reason that paramedics called in to respond to these cases had not used naloxone; at least, no naloxone used by paramedics was mentioned in the analyzed reports.

Some overdoses occurred on shifts during which no nurses were on site, making it impossible to use Narcan to prevent a fatal overdose.

The situation is now different. Since 2016, Narcan has been accessible to first responders who are not health professionals, <u>when such personnel are not accessible</u> (Correctional Service Canada, 2016).

> The purpose of this protocol is to enable Non-Health Services Staff to use Narcan nasal spray during a response to a suspected opioid overdose medical emergency of inmates or staff when no nursing staff is accessible (Protocol: Response by Non-Health Services Staff to known or suspected opioid overdose medical emergency, when no nursing staff is accessible, using NARCAN ® nasal spray (Naloxone hydrochloride), page 1, article 2.1, Correctional Service Canada, 2016).

According to the new naloxone protocol at CSC, Narcan is now located in the correctional manager's office (or in another easily accessible location), in a secure container.

CSC has also developed an information package (including a video) on its learning portal for its non-health care staff regarding the use of the Narcan nasal spray. This is something that is easy to do without the need for in-depth learning since it requires being able to correctly identify the signs of an opioid overdose and administering a dose of Narcan nasal spray by inserting the applicator tip into one of the victim's nostrils and pressing the plunger. The procedure can be repeated every two or three minutes if the person does not wake up.

Based on this protocol, it is likely that in all the cases analyzed, Narcan would have been used, either by medical staff or trained correctional officers. This is a significant improvement in procedure that certainly could have saved lives. However, one might wonder whether waiting for medical personnel to arrive is an optimal measure for saving lives, when in the free world, Canadian first responders are now equipped and trained to use naloxone during overdoses.

Discussions with CSC staff lead the Committee to believe that the reality of responding to medical emergencies is different. Sections 2 and 3 of Guidelines 800-4, *Response to Medical Emergencies,* state that:

> All staff and contractors (including non-health) will respond to medical emergencies. The primary goal is the preservation of life...
>
> Non-health services staff arriving on the scene of a possible medical emergency must immediately call for assistance, secure the area, and initiate CPR/first aid, according to their certification, without delay. The primary goal is the preservation of life...

Correctional officers are now trained to administer Narcan, but can they do so when nursing staff is in the institution? Here, the interpretation of the notion of accessibility to medical personnel is of paramount importance. According to reports from medical staff, when a correctional officer is the first to identify an overdose, technically nurses are not yet

accessible (they have been called, but are not yet on site). The correctional officer must therefore initiate assistance procedures and use Narcan according to the certification obtained since the primary purpose of his or her actions must be to "preserve life" (Guidelines 800-4, *Response to Medical Emergencies*). When the nurses arrive on site, they will then be responsible for managing the necessary emergency measures. This interpretation reassures the Committee and builds on best practices to prevent deadly overdoses.

But can we do something ahead of time to try and prevent an overdose? Based on Weekes and De Moor (2015), the Committee believes that inmates with substance use disorders must be properly identified and given special attention. Based on the content of the reports analyzed, only 4 in 11 overdoses were experienced by inmates identified as having drug use disorders. Was the initial assessment conducted by CSC when admitting these inmates lacking? Did the substance use disorder develop following the admission to the penitentiary? Were the people not identified by the initial assessment simply casual users? The data provided for the preparation of this report did not answer these questions.

However, effective actions taken with persons identified as having substance use disorders is difficult to apply since one quarter of inmates admitted to penitentiaries have such a disorder on admission. More focus must therefore be placed on the population that CSC should target to try to prevent an overdose event. Based on the case analysis and CSC's report on deaths in custody (Correctional Service Canada, 2017), the Committee believes that opioid-dependent individuals should be targeted. However, it appears that the CASA is currently unable to properly identify individuals with an opioid addiction. The instrument used, DAST, provides a measure of general dependency without specifying the illicit problematic substance. However, an analysis of the CASA items indicates that some of the questions already in it could be used as indicators of possible opioid use disorders. Specifically, inmates are asked to identify whether they were using any number of drugs 12 months prior to arrest. The list of drugs is extensive, ranging from THC and Opiates to inhalants, steroids and hallucinogens. Inmates are also asked whether they used these

drugs while serving time and if they have ever participated in a methadone maintenance program.

Optimal identification could provide inmates at risk of using opioids during their incarceration with appropriate supervision and possibly timely access to treatment (e.g., ICPM), particularly replacement programs without too many restrictions, thereby reducing the risk of overdoses (Sudo et al., 2017). The Committee could not determine the proportion of opioid addicts who were in methadone or Suboxone maintenance programs. The Committee believes these programs are effective harm reduction and overdose prevention measures that should be encouraged. One of the cases studied, a known addict, did not take this program because, according to the case report, too many constraints were associated with it. Unfortunately, these constraints were not reported specifically. This is just one inmate who may not reflect reality, but the Committee believes that all necessary measures should be put in place to promote access to methadone and Suboxone programs in penitentiaries.

However, this identification is not a universal remedy. In fact, some offenders will deliberately want to hide their opioid use or addiction, and others will develop it while incarcerated.

In the latter case, the prison context may have contributed to the overdose. A study (Plourde and Brochu, 2002) of 317 male inmates in one of the 10 Quebec penitentiaries indicated that the main motivation for using psychoactive substances in custody had to do with the need to reduce stress. This motivation appeared to be three times higher than for the same inmates prior to incarceration. Top predictors of illicit drug use in penitentiaries include short sentences, incarceration in a medium- or maximum-security penitentiary, and drug use prior to incarceration (Plourde, Brochu, Gendron and Brunelle, 2012).

One would think here, as in the case of suicides, that detention in a maximum-security institution could exacerbate the need to escape and that drug use could fill that need.

However, overdose cases are not specific to detention in maximum-security institutions since half of the overdose cases analyzed in this report occurred in a medium security. In addition, CSC's analysis on overdose deaths clearly stated that most of these events had occurred in medium-security penitentiaries (Correctional Service Canada, 2017).

In the longer term, the Committee believes that it would be wise to attempt to gain a better understanding of the causes of consumption inside penitentiaries. For instance, there are four pillars of addressing problematic substance use: prevention, treatment, harm reduction, and enforcement.[22] Currently, the investigation reports analyzed by the Committee focus heavily on enforcement as the focus is on compliance issues with policies (i.e, searching and other security measures). The investigation reports offer relatively little on the context surrounding the occurrence of overdoses. While it appears that policies and security measures have generally been well respected and followed, investigation reports do not offer much in the areas of prevention, treatment and harm reduction as we know too little about the context.

Recommendations

Naloxone

Although the Committee believes that the use of Narcan by first responders in some of the situations analyzed could have potentially saved lives, it does not make any specific recommendations regarding the use of naloxone, as the Narcan nasal spray can now be used by correctional officers. Correctional officers are now trained to use Narcan, and Guidelines 800-4, *Response to Medical Emergencies,* allow, if not requires them to act in the event of an overdose. Of course, the fentanyl/naloxone information kit for non-medical staff to be able to identify the signs of an overdose and use Narcan is essential. However, the Committee believes that it will be important for staff members to feel comfortable using the

[22] https://www.canada.ca/en/health-canada/services/publications/healthy-living/pillars-canadian-drugs-substances-strategy.html

Narcan nasal spray in an overdose situation by informing them periodically of the existence of the information kit, accessible on CSC's learning portal.

CASA

According to the information gathered, the CASA is currently not used to identify individuals who are at risk of using opioids during incarceration or who have an opioid-related substance use disorder. The instrument currently used to identify dependency within the CASA, the Drug Abuse Screening Test (DAST), does not link the rating provided to a specific substance. Yet, it is those at risk of using opioids illegally during incarceration and those addicted to opioids who are most at risk of overdosing due to the entry of substances such as fentanyl into institutions.

In the short term, the Committee recommends:

9. That CSC use questions from the CASA (i.e., PA6, PD4, ISU3 and PP18)[23] to identify individuals who are likely to use opioids during incarceration.

Methadone and Suboxone

The Committee believes that an effective harm reduction strategy to reduce drug smuggling and to prevent overdoses in penitentiaries is to encourage the involvement of inmates addicted to opioids in a methadone or Suboxone prescription program.

The Committee recommends:

10. CSC incident investigations examine all four pillars of addressing problematic substance use to inform on prevention, treatment, harm reduction and enforcement strategies.

[23] See ANNEX I

11. To encourage the involvement of opioid-dependant inmates in a Methadone or Suboxone prescription program, and analysing and minimizing existing access constraints to these programs.

Research

The Committee recommends:

12. establishing a study to develop predictive indicators on the use of opioids by inmates during incarceration.
13. developing a substance-related disorder assessment instrument that will link the level of dependency to specific substances.

Finally, the Committee was informed of a research project that CSC was conducting internally to provide an in-depth analysis of cases of lethal or non-lethal overdoses that occurred between 2012–13 and 2016–17. Specifically, this project will seek to better understand the nature and extent of these overdoses, specific details about the inmates involved (gender, age and other sociodemographic characteristics), the context surrounding these overdoses, and the specificities related to fatal overdoses.

The Committee recommends:

14. Continuing studies that will help provide a better understanding of the phenomenon of penitentiary overdoses and equip CSC to prevent them.

Part 3: Homicides

The Annual Report on Deaths in Custody 2015–16 showed that the proportion of deaths that were attributable to homicide was smaller than for suicide and overdoses. Over a seven-year period from 2009–10 to 2015–16, there were, on average, two or three homicides each year and, overall, they accounted for 13% of all non-natural deaths in custody. There have been small fluctuations in the number from year to year, but no discernable pattern in the time series.

In 2015–16, there were three homicides in federal custody (Annual Report on Deaths in Custody 2015–16). With an inmate population of 14,712 (Corrections and Conditional Release Statistical Overview, 2016), the rate of homicide in penitentiaries was roughly 20 per 100,000. The number of homicide victims in Canada in 2016 was 611, and as a rate, was 1.68 per 100,000 population (Homicide in Canada, 2016, Statistics Canada). Of course, one would expect a much higher rate of homicides in penitentiaries than in the general population. Offenders who are serving sentences in penitentiaries have generally committed serious and violent offences that resulted in long terms of incarceration. As we underlined in the earlier section on suicides, these individuals typically have histories of maltreatment during childhood and adolescence, interpersonal violence, deficits in emotional regulation and impulsivity. These are characteristics that they bring into the penitentiary milieu and lead to violent behaviour similar to the violent offences that brought them into the system to begin with. These characteristics are evident in the cases described below.

Among the 22 cases of non-natural deaths in custody reviewed by this Committee, there were three cases of homicide. The following is a brief description of each of theses cases and the Committee's observations on the investigation.

The first case involved the death of a 33-year-old Indigenous offender in a medium security institution serving a life sentence (25-year parole eligibility) for first degree murder. The

Board of Investigation report found that he was a full patch member of an inmate gang and had spoken with staff about disaffiliating from the gang. Staff were assisting him in the disaffiliation process. He had been moved from the sub-population range that housed the gang members to the general population, and had subsequently refrained from any negative activities within the institution. The alleged perpetrator was a 21-year-old Aboriginal offender who was serving a life sentence (25-year parole eligibility) for manslaughter, and was affiliated with the same gang. The victim sustained multiple stab wounds (estimated at 14), and despite determined efforts by correctional and nursing staff, he had died of blood loss soon after paramedics arrived on the scene. Although further information came to light after the incident indicated a heightened risk for the victim, there were no indications prior to the incident that would have alerted staff of the impending events.

The investigation report indicated that the room where the assault had taken place was the "Lifers' room," which consisted of one large room and three smaller rooms off to one side. The Lifers' room was located at the bottom of a flight of stairs and accessed through a closed door. Accordingly, the area was not visible to correctional officers, and there were no cameras monitoring activities there. Correctional officers were able to observe the comings and goings, and monitoring of inmate activity could occur through patrols. As described in the Board of Investigations (BOI) report, the Lifers' room had been a "no go zone," by which was meant that the inmates understood that violence and confrontations were not to occur given their respect for the privilege of using the area and not wanting to jeopardize this. By all accounts, this arrangement had been working, since no serious incident had occurred in the Lifers Room over a period of 26 years. The BOI found that the staff had responded quickly and effectively, and in compliance with all relevant policies. They made only one recommendation which was for the institution to evaluate the logistics of the Lifers room prior to reopening it. Our Committee considers the findings and the recommendation contained is this investigation report appropriate.

The second case of murder reviewed by the Committee was that of a 28 year-old Caucasian inmate housed in a maximum-security institution serving his second federal term for

convictions of manslaughter and assault with a weapon. He was found during a security patrol with knife wounds in the thorax and heart region. The nurse was quickly summoned. She assessed his status and applied the automated external defibrillator which indicated that shocks were not recommended. Cardio-pulmonary resuscitation was started and continued when the ambulance arrived. The ambulance team declared his death about 45 minutes after he was found in his cell, and the official declaration of death was made by the emergency doctor when the ambulance arrived at the hospital.

In their investigation of the background to this incident, the BOI found that he had been returned to the institution following a breach of a residency condition on his statutory release. Three days prior to the incident, at his request, he had moved from the general population to a separate unit where the incident occurred. The investigation also found that, during both of his federal terms, he was involved in drug trafficking, conflicts with other inmates, intimidation and aggression, and had incurred numerous disciplinary infractions.

Two other inmates were seen on video surveillance entering his cell shortly before his death. One was a 19-year-old Indigenous inmate serving a sentence for assault with a weapon and robbery. He had been transferred to maximum security following an incident in a medium security institution where he was the instigator in a fight with another inmate and had used a knife. The other inmate who entered the cell was a 51-year-old Caucasian inmate serving a life sentence for convictions of first-degree murder and conspiracy to commit murder. Following the incident, these inmates were placed in segregation cells pending further inquiry into their involvement in the death.

The BOI concluded that were no known indicators or precipitating factors prior to the incident, and no action could have been taken by staff to prevent the incident. In addition, the BOI concluded that all policies and procedures had been followed. No areas for improvement were identified, and there were no recommendations. Our observation is that this BOI was well done and reached appropriate conclusions.

The third case involved the death of a 55-year-old Caucasian inmate who was serving a sentence in a medium security institution for two convictions for robbery as well as convictions for causing a disturbance and being unlawfully at large. He had numerous physical health issues. He was found slumped over in the recreation yard. Emergency medical services were summoned. He was transported to a community hospital for treatment and died the following day.

In total, six inmates were identified as possible assailants and were placed in segregation. Following the police investigation, one of them was charged with second degree murder. He was a 21-year-old inmate with an extensive youth criminal record, including numerous violent offences, and was serving his first federal sentence for two convictions of aggravated assault, armed robbery and dangerous operation of a motor vehicle. The investigation found that an item stolen from an inmate's cell was the motive for the assault. The contributing risk factors to the incident were the vulnerable physical condition of the victim, and the impulsive and violent character of the inmate who had carried out the assault.

The BOI made no recommendations but identified security classification as an area for improvement. The issue was whether the inmate who was charged in connection with the homicide was properly classified as a medium security inmate. The BOI found that a few months earlier, following an incident of aggressive and threatening behaviour toward staff which had led to his being placed in segregation, the Security Reclassification Scale had been completed for this inmate. The score denoted maximum security but fell within a discretionary range where an under-ride to medium security could be considered if the Institutional Adjustment Rating could be justified as Moderate. The inmate's parole officer and the Manager, Assessment and Intervention had recommended a rating of high for Institutional Adjustment which would have resulted in a designation of maximum-security. However, the Warden had applied an underride that had resulted in the inmate being kept at the medium-security institution but had not provided a rationale for his decision.

The BOI presented the area for improvement as follow: "The Board of Investigation determined that as per Commissioner's Directive 710-6, *Review of Inmate Security Classification*, paragraph 4 (March 10, 2014), the Warden's rationale did not address the divergence from the recommendations by referencing factors outlined in the Commissioner's Directive 710-6, *Review of Inmate Security Classification*, Annex B (March 10,2014) which are to be considered when assessing an inmate's security classification." Our Committee's observation is that this was correctly identified as an area for improvement. However, we note that the BOI reported additional findings regarding the events surrounding the decision to maintain the medium security classification, and these findings raise concerns beyond the failure to comply with policy that was identified in the Area for Improvement. Specifically, the BOI report described these events as follows:

> "On March 11, 2015, following the operations meeting the Warden discussed (inmate's) segregation status with individuals who the BOI were unable to determine who they were. No records were made of the meeting, nor notes as to who was in attendance. However, neither the inmate's PO, nor the Manager, Assessment and Intervention (MAI) who supervised the case were at the meeting. The BOI was informed that this type of meeting was a regular means of discussing segregation at the institution."

The Committee questions whether the practice of holding an unofficial meeting and excluding staff who are best informed on the case meets the tests of transparency and optimal decision-making. Although the BOI concluded that the inmate was not appropriately placed at the medium security institution, it did not raise the nature of the operations meeting as an issue, nor did it make a recommendation regarding the practice that allowed him to continue to be housed there. In our view, the investigation report ought to have raised this as a key issue in a way that would ensure that this practice is discontinued, and decisions of this kind are made with the involvement of key staff and the rationale for decisions be properly documented according to policy.

As such, the Committee recommends:

15. CSC policy for incident investigations encourage incident investigators to go beyond assessing whether or not specific policies are adhered to and, in a dedicated section of their reports, highlight any findings and recommendations regarding improper practices, policy gaps and underlying issues.

Part 4: The Case of Matthew Hines

The death in custody of Matthew Hines is an extremely troubling case that warrants particular attention from our Committee. Following a Board of Investigation (BOI), this case was also the subject of a separate investigation by the Office of the Correctional Investigator (OCI), which produced a report titled, *Fatal Response: A Investigation into the Preventable Death of Matthew Ryan Hines*. In addition, police have laid criminal charges of manslaughter and criminal negligence causing death against two correctional officers in relation to the death. It is expected that a Coroner's Inquest will also be convened following the resolution of the criminal matters.

Our first observation is that this incident differs completely from all the other cases of a death in custody that the Committee reviewed. We also note that the BOI report provided a clear and very thorough description of what happened during the course of the incident as well as relevant background information on Matthew Hines.

The BOI report showed that the staff response, both from the perspective of the security interventions and medical care, was extremely problematic. There were numerous actions and omissions in the staff response that constituted serious violations of policy.
These included inappropriate application of distraction techniques (i.e., hand and knee strikes) and five inappropriate deployments of inflammatory agent; failure to protect him from injury when he was handcuffed from behind; failure to conduct ongoing reassessment of the security interventions despite indications of serious medical distress; absence of emergency health care; absence of anyone assuming a leadership role throughout the process; and failure to maintain the area where the incident occurred as a potential crime scene.

Following the analysis and presentation of significant findings, the BOI report listed 21 areas for improvement that essentially corresponded to the discrete instances of failure to adhere to policy and, in the case of the issue of the handcuffs, gaps in policy. The report

concluded with the following four recommendations: consider evaluating stretchers for safety features; conduct an audit of procedures related to inflammatory agents; consider reviewing the content of CSC Participant Manual *Sudden In Custody Death Syndrome*; and consider reviewing CSC Participant Manual *Arrest and Control* and CSC Trainer Manual *Personal Safety Refresher Training* to include information when more than one set of handcuffs is required.

In our Committee's view, the list of recommendations was <u>not</u> commensurate with the totality and gravity of the findings. This was also a major point in the OCI report, expressed by the Correctional Investigator as follows:

> "I fail to see how these measures would have any discernible impact on CSC's legal duty of care to take all reasonable steps to reduce, mitigate and prevent deaths in custody. While the quality of the report is above average, none of the recommendations substantively address the multiple and significant areas of non-compliance noted above. In fact, in this case, there is complete lack of congruence between the Board's findings of non-compliance (significant and systemic) and its corrective measures (weak and unfocused). "

The OCI concluded its report with 10 recommendations based on its investigation of the death of Matthew Hines. These recommendations were designed to prompt systemic changes that were indicated from the findings stemming from the BOI report on this death. In its response to the OCI report, CSC accepted all of the recommendations and has begun steps to action them. The Committee reviewed the OCI report and its recommendations as well as CSC response to them. We agree with the OCI recommendations and view CSC's response as a strong basis for improvements in policies, training and management in these areas. The OCI investigation report demonstrates how an investigation into a case of this nature can lead to significant recommendations regarding accountability for what occurred as well as strategic, organizational approaches to prevent a recurrence. In this regard, the two reports together may be useful as a training module for CSC investigators.

After reviewing all of the materials on this case, including both the CSC and OCI investigations, the Committee was still left with unanswered questions regarding the extreme events that led to the death of Matthew Hines. Given the constellation and magnitude of the breaches that led to this death in custody, it is difficult to imagine that there were no antecedent interactions between staff and inmates that would have foreshadowed the extreme, security-focused response with such little regard for the well-being of the individual. Were there warning signs in the months leading up to this incident?

CSC's Mission is the following: Correctional Service of Canada, as part of the criminal justice system and respecting the rule of law, contributes to public safety by encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control. Among the core Values of CSC is respect, which is elaborated as follows:

> Respect: Respectful behaviours honour the rationality and dignity of persons – their ability to choose their own path, within lawful order, to a meaningful life. A good test of respectful behaviour is treating others as we would like to be treated.

What happened in this case was a gross departure from the standards of practice expected of CSC, and strikes at the heart of the organization. In this circumstance, it behooves CSC to understand as fully as possible the genesis of these events. What was the staff supervision in the preceding six months? How was staff performance monitored and documented? How were the channels of communication operating among supervisors, staff and inmates? How were inmate complaints handled? Were there other incidents? Were there signs of deterioration in the functioning of the institution? Was there a culture in the institution that was permissive of disrespect towards inmates?

These are questions that may be addressed in the Coroner's Inquest. From the perspective of investigations policy, they indicate the need for wider terms of reference for

investigations in cases where multiple, serious compliance issues resulted in a death in custody. Accordingly, we make the following recommendation.

Recommendation:

The Committee recommends:

16. That the terms of reference for an investigation into a death in custody require, in those cases where the investigation finds multiple, serious failures to comply with policies, that the investigators examine factors related to the environment and operations at the site. These factors would include policies, plans and procedures that impact a healthy and respectful workplace, any workplace reviews or staff surveys, complaints and grievances by offenders, or any other warning signs that may have foreshadowed the incident.

Part 5: Best practices in the investigation process and engagement with families

The second part of the Committee's mandate was to conduct a review and analysis of:

- successful and best practices in other international correctional jurisdictions with respect to their investigative processes in general, and specifically in relation to deaths in custody, and how these processes could inform a revitalized investigative process at CSC.

We began by doing a Google Internet search on the topic of investigations of deaths in custody. Among the documents identified was one prepared by the International Committee of the Red Cross (ICRC), titled *Guidelines for Investigating Deaths in Custody*. This publication was the result of an extensive process engaging experts from all relevant fields, including medical, forensic, legal and prison administration, as well as experts in the field of investigating and preventing deaths in custody. The document sets out the international law pertaining to investigations of deaths in custody, which frames the obligations that states have in this area, and then provides guidance for each step of the investigation process as well as general recommendations regarding prevention of deaths in custody. The essential elements of the guidelines for investigations are summarized in Annex II, titled "Investigating Deaths in Custody: Eight Points of Note."

As a first step, the Committee examined CSC policies against the eight points of the *Guidelines* document. The results of this analysis are presented in a chart.[24] Essentially, the analysis shows that CSC has appropriate policies in place that correspond to each of these eight points.

These guidelines set out general parameters for conducting investigations of deaths in custody, based on accumulated international knowledge and expertise in this area. As such,

[24] See ANNEX II

they provide a platform for establishing suitable policies and practices. Our analysis indicates that CSC policies meet these basic international standards.

Beyond these guidelines, our mandate required the committee to review and analyse "successful and best practices in other international correctional jurisdictions with respect to their investigative processes." This required the committee to address the question: what constitutes a "best practice?" There are, of course, many definitions in the literature of best practice. The Committee adopted the following general definition: "a procedure that has been shown by research and experience to produce optimal results and that is established or proposed as a standard suitable for widespread adoption." (https://merriamwebster.com/dictionary/best%20practice)

In order to gather information about best practices from other jurisdictions, the Committee prepared a brief survey questionnaire[25]. The questionnaire asked respondents whether they had what they considered to be best practices in relation to investigations of deaths in custody; whether they had benchmarked their practices with other jurisdictions in order to determine best practices; and whether they were aware of any studies designed to identify best practices for the investigation process in prisons. With the assistance of the Intergovernmental Relations Division of CSC, the questionnaire was sent to an established CSC network of 13 countries.[26]

Responses to the questionnaire were received from five jurisdictions. Overall, the jurisdictions described various practices in conducting investigations and for preventing deaths in custody, but none of the responses indicated that they had benchmarked their practices against other jurisdictions to determine best practices. Similarly, none of the responses identified any studies designed to identify best practices for the investigation process in prisons. One respondent, after providing a brief overview of their policies and procedures with respect to investigations of deaths and serious incidents in custody,

[25] See ANNEX III
[26] The countries were Argentina, Australia (all jurisdictions), Belgium, Denmark, Estonia, Finland, France, Hong Kong, Iceland, Norway, Poland, Sweden and the United States of America.

concluded: "I am unable to say whether we would consider them best practice, in the sense of evaluating against other countries' techniques." This statement provides an apt summary of the overall results of the survey.

Our conclusion regarding best practices in the investigation process is that rather than adopting best practice from other jurisdictions there is a need to develop best practice. A report prepared by the Office of the Correctional Investigator (OCI), titled, *In the Dark: An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections*, brings into focus one area where there is an opportunity to develop best practice. The ICRC guidelines concerning the engagement of the next of kin in the investigation process, state: "The investigation may also contribute to reducing trauma and providing an effective remedy for the next of kin ".[27] How can this policy objective best be achieved?

The impetus for the OCI study was that some families of offenders were contacting the OCI seeking assistance and advice regarding accessing information from CSC following the death of a family member. These families reported that they had encountered difficulties in getting information, particularly about the events leading up to the death and the circumstances surrounding it. The OCI study comprised the following components: a review of relevant law and policy related to engagement with the next of kin and the investigation process; a review of the *Access to Information* and *Privacy Acts* and related interpretive documents; confidential interviews with eight families (most of whom had been in contact previously with the OCI to request assistance) whose family member died in federal custody, interviews with CSC staff members with responsibilities related to deaths in custody and Access to Information and Privacy, and interviews with staff of a non-governmental organization (Canadian Families and Corrections Network) regarding their experience with families in this context; a comparison of National Board of Investigation reports that had been redacted for release through the Access to Information Act with the

[27] The terms "family" and "next of kin" are used interchangeably in the discussion that follows.

original (un-redacted) reports; and a review of policies and procedures in other jurisdictions concerning engagement with families following a death in custody.

The study found that the families that were interviewed were very dissatisfied with the lack of information that they received from CSC initially and throughout the investigative process, leading to feelings of suspicion and distrust; there were inconsistencies in the kind of information that CSC staff would share with families; there was a lack of information from CSC on the condition of the family member in circumstances where they are taken to hospital; that families lacked information about the policies, procedures, responsibilities of CSC, and the investigation process; staff who were involved with families had not received training to assist them in carrying out the sensitive work of communicating with families in these situations; families expressed frustration in cases where significant amounts of an investigation report had been redacted; and there were inconsistencies in the application of exemptions under the *Access to Information* and *Privacy Acts* and a practice of exempting errors, shortfalls and policy non-compliance.

Based on these findings, the OCI report made nine recommendations. These recommendations included proactive disclosure of information early in the process and on an ongoing basis; defined procedures and protocols in relation to the family when an inmate is taken to an outside hospital in a medical emergency; establishing a family liaison within CSC for families to receive information throughout the investigative process; develop and provide training to staff who communicate with families following a death; CSC send a letter of condolence to the next of kin immediately following a death in custody; develop a guide for families explaining the policies, responsibilities and the investigative process as well contact information for the Coroner/Medical Examiner officers, the police and community agencies that may provide support for grieving families; investigative reports be shared, presumptively and routinely, in their entirety with next of kin; and that the Commissioner of Corrections routinely consider releasing information to families of inmates who have died in custody under the public interest disclosure provisions of the *Privacy Act*.

In response to the recommendations of the OCI report, CSC has undertaken a number of important initiatives intended to improve their engagement with families in cases of a death in custody:

- Develop and implement a facilitated disclosure process.
- Establish a guideline outlining procedures regarding notifications to the family in circumstances of serious medical emergencies.
- Establish CSC points of contact with families (i.e., Family Liaison Officers) from notification through to the completion of the investigative process.
- Provide suitable training for Family Liaison Officers to assist them in communicating with families in these circumstances.
- Send a letter of condolence to the family.
- Prepare a guide for families to explain the policies and processes following a death in custody and key contacts and community services that may be helpful to them.
- Modify the approach to vetting and releasing information by establishing a dedicated team of Access to Information and Privacy experts to work closely with the family members and other partners and stakeholders to ensure that information is shared appropriately and consistently.

Our understanding is that most of these initiatives have been implemented, and work is ongoing to develop the new facilitated disclosure process. We would add a caution however, that not all families have the same concerns following a death in custody and the disinterest of certain families should also be respected. Indeed, some families may not want information regarding the death, and this wish should be accommodated.

This set of initiatives, once they have been fully developed and implemented, could be viewed collectively as a model for engagement with families in these circumstances. This model could be evaluated to determine whether it is more effective than the policies and procedures in place prior to these developments.

Recommendation

The Committee recommends:

17. That CSC conduct a research study on a model that incorporates recent enhancements to CSC's policies and practices regarding engagement with families of offenders who die in custody, with a view to establishing best practice in this area.

On the matter of trauma, which is a central aspect of the policy objective to engage with families, we make the following observations. Engagement with families in these circumstances is a very complicated matter. In cases where there has been a history of abandonment, abuse or violence towards family members there may be layers of trauma that are evoked by the death. One cannot prescribe how families will react to the news that their family member has died in prison, and CSC's response should be guided by the wishes and needs of the family. The family liaison officers must show great sensitivity in their interactions with the family and listen carefully to chart a path with them that responds to their wishes and needs. At the outset, the family liaison officer should review the offender's file to gather information regarding the social/family history, the criminal history as well as the institutional records concerning communication (i.e., telephone, visits, letters) between the family and the deceased offender. In short, the officer should be informed of the history of the relationship with the family and the nature of the engagement with the offender, if any, prior to his death. At one end of the spectrum, the work of the family liaison officer may be no more than notifying the family member of the death and perhaps providing a copy of the guide. At the other end, it may involve frequent contact to answer questions that the family has, keep them apprised of developments, address other requests that they may have, build a relationship of trust, and sit with them to review the BOI report when it is completed. The key is that the policies and practices of CSC need to encompass the full range of responses such that the needs of the families, whatever they may be, are reasonably met.

CONCLUSION

Based on this review of non-natural deaths at CSC, the Committee identified three key factors over the course of its work. Firstly, given the constellation of risk factors among the individuals placed under CSC's responsibility, there are a small number of incidents involving a non-natural death. This finding serves as a barometer of the overall quality of the services implemented and maintained by CSC.

Secondly, in our report, we reviewed recent research data on suicide and found that the interaction between childhood negligence and abuse and interpersonal violence increased the risk of suicide. Independently, an over-representation of homicides in inmates who took their own lives was found in one study with a large sample. As a result, the Committee thought it would be appropriate for CSC to concentrate its prevention and treatment efforts on the subgroup of inmates who took the life of a close relation. These efforts should be gradual and scientifically assessed. Further, given the low suicide rate, the Committee wondered whether suicide prevention initiatives affected the quality of life of inmates under CSC's responsibility, and suggests CSC encourage dialogue among administrators, front-line staff and inmates on these issues.

Thirdly, the Committee examined the rare cases of deaths where the practices of CSC staff could be called into question. The Committee found that it would be useful in such instances for the investigation to include the prevailing culture in the institution in the months preceding the incident. Meaning, the approach and conduct of management, staff and inmates, staff relations with inmates or anything else that would provide investigators with information on the workplace on the one hand, and relations with inmates on the other, which could be associated with the death. The Committee concluded that this type of examination of the culture of an institution in the months preceding the incident could lead to the implementation of better preventative measures.

Whether it be suicides, overdoses or homicides, it seems that the circumstances surrounding non-natural deaths in penitentiaries play a crucial explanatory role. In our opinion, this context should be reviewed more closely in all non-natural deaths. This could eventually lead to a better understanding and the implementation of an innovative action plan to prevent these deaths.

Finally, the Committee would like to thank CSC for its contribution to this work and to reiterate that, despite its mission-related constraints, CSC's efforts are true to the spirit of the Canadian Charter of Rights and Freedoms.

List of Recommendations

With respect to suicide, the Committee recommends:

1. The homicide of a close relation be added to the list of suicide risk factors;
2. CSC contact the researchers who studied the correlation between abuse, homicide and suicide to determine whether it is appropriate to apply their model in some CSC penitentiaries;
3. CSC implement experimental psychosocial interventions, with long-term monitoring, to test whether such interventions can reduce the suicide rate among the subgroup of inmates at risk.

With respect to the Case Study, the Committee recommends:

4. To ensure that the new CSC Directive on Administrative Segregation stipulating that segregation is only used for the shortest period of time necessary, and specifies groups of inmates not admissible to administrative segregation, such as inmates with serious mental illness with significant impairment, is implemented.
5. To explore, in its incident investigation terms of reference, the inclusion of i) CSC's core values of dignity and respect for inmates, and ii) international standards such as the United Nations Standard Minimum Rules for the Treatment of Prisoners, as criteria relevant to CSC incident investigations for suicides that take place in segregation.
6. To take into account the increased risk of suicide, in segregation, of inmates who have been abused and/or who have killed a close relation.

On the issue of the right to suicide, the Committee recommends:

7. CSC examine the potentially deleterious effects of its suicide risk management strategies in reference to the quality of life of the approximately 15,000 people who are incarcerated under its responsibility;

8. CSC encourage dialogue between administrators, front-line staff and inmates to address the vicious cycle whereby measures taken to prevent suicide lead to a deterioration of the quality of life, thereby increasing the risk of suicide.

Regarding overdoses, the Committee recommends:

CASA

9. That CSC use questions from the CASA (i.e., PA6, PD4, ISU3 and PP18)[28] to identify individuals who are likely to use opioids during incarceration.

Methadone and Suboxone

10. CSC incident investigations examine all four pillars of addressing problematic substance use to inform prevention, treatment, harm reduction and enforcement strategies.
11. To encourage the involvement of opioid-dependent inmates in a methadone or Suboxone prescription program, and analyzing and minimizing existing access constraints to these programs;

Research

12. Establishing a study to develop predictive indicators on the use of opioids by inmates during incarceration;
13. Developing a substance-related disorder assessment instrument that will link the level of dependency to specific substances;
14. Continuing studies that will help provide a better understanding of the phenomenon of penitentiary overdoses and equip CSC to prevent them.

Following its review of the cases of homicides, the committee recommends that:

15. CSC policy for incident investigations encourage incident investigators to go beyond assessing whether or not specific policies are adhered to and, in a

[28] See ANNEX I

dedicated section of their reports, highlight any findings and recommendations regarding improper practice, policy gaps and underlying issues.

In the case of Matthew Hines, the Committee recommends:

16. That the terms of reference for an investigation into a death in custody require, in those cases where the investigation finds multiple, serious failures to comply with policies, that the investigators examine factors related to the environment and operations at the site. These factors would include policies, plans and procedures that impact a healthy and respectful workplace, any workplace reviews or staff surveys, complaints and grievances by offenders, or any other warning signs that may have foreshadowed the incident.

Regarding best practices for engaging next of kin, the Committee recommends:

17. That CSC conduct a research study on a model that incorporates recent enhancements to CSC's policies and practices regarding engagement with families of offenders who die in custody, with a view to establishing best practice in this area.

References

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., … SolbergL. I. (2014). Health Care Contacts in the Year Before Suicide Death. *Journal of General Internal Medicine*, 29(6), 870–7. http://doi.org/10.1007/s11606-014-2767-3

Bowlby, J. (1969). Attachment and Loss, vol. I: Attachment. Harmondswarth, England: Penguin, 1978.

Bowlby, J. (1973). Attachment and Loss, vol. 2: Separation: Anxiety and Anger. New York: Basic Books.

Bowlby, J. (1980). Attachment and Loss, vol. 3: Loss: Sadness and Depression. New York: Basic Books.

Canadian Centre on Substance Use and Addiction (2016). First Do No Harm: Responding to Canada's Prescription Drug Crisis. Ottawa: CCSA

Canadian Centre on Substance Use and Addiction (2017). Prescription Drugs and Opioids. http://www.ccsa.ca/eng/topics/prescription-drugs/pages/default.aspx. Accessed on December 13, 2017.

Canadian Institute for Health Information (2017). Opioids in Canada. https://www.cihi.ca/en/opioids-in-canada. Accessed on December 11, 2017.

CBC News. 2 guards charged with manslaughter in New Brunswick prisoner's death, January 3, 2018

CBC News. Case of Dorchester prison guards charged in inmate's death adjourned until March, February 26, 2018

Correctional Service of Canada (2013). National Program Descriptions. Ottawa: Correctional Service of Canada, Reintegration Programs Division.

Correctional Service of Canada (2015a). Emergency Medical Directives – User's Guide. Clinical Services Branch. Health Services Sector. Ottawa: Correctional Service of Canada.

Correctional Service of Canada (2015b). Specific Guidelines for the Treatment of Opiate Dependence (Methadone/Suboxone®). Ottawa: Correctional Service of Canada.

Correctional Service of Canada (2016). Protocol: Response by Non-Health Services Staff to known or suspected opioid overdose medical emergency, when non nursing staff is accessible, using Narcan nasal spray (Naloxone hydrochloride). Ottawa: Correctional Service of Canada.

Correctional Service of Canada (2017). Annual Report on Deaths in Custody 2015–2016. Report SR 17-02. Ottawa: Correctional Service of Canada.

CRAN (2017). Naloxone. http://www.cran.qc.ca/en/node/463. Accessed on December 13, 2017.

De Venter M, Demyttenaere K, Bruffaerts R. [The relationship between adverse childhood experiences and mental health in adulthood. A systematic literature review]. *Tijdschr Psychiatr*. 2013;55(4):259–68. Review.

Duthé G, Hazard A, Kensey A, Shon JL Suicide among male prisoners in France: a prospective population-based study. *Forensic Sci Int*. 2013 Dec 10;233(1-3):273–7.

Fazel, S., Grann, M., Kling, B. et al. Prison suicide in 12 countries: an ecological study of 861 suicides during 2003-2007. *Soc Psychiatry Psychiatr Epidemiol* (2011) 46: 191. https://doi.org/10.1007/s00127-010-0184-4.

Fazel S, Ramesh T, Hawton K. Suicide in prisons: an international study of prevalence and contributory factors. *Lancet Psychiatry*. 2017 Dec;4(12):946–52.

Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P., Marks J.S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14, 4, 245–58

Haglund A, Lindh ÅU, Lysell H, Renberg ES, Jokinen J, Waern M, Runeson B. Interpersonal violence and the prediction of short-term risk of repeat suicide attempt. *Sci Rep*. 2016 Nov 14;6:36892.

Health Canada (2017a). Opioid overdose. https://www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids/overdose.html. Accessed on December 11, 2017.

Health Canada (2017b). National report: Apparent opioid-related deaths in Canada (December 2017). https://www.canada.ca/en/public-health/services/publications/healthy-living/apparent-opioid-related-deaths-report-2016-2017-december.html. Accessed on February 23, 2018.

Health Canada (2017c). Questions and Answers – Naloxone. https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/prescription-drug-list/questions-answers-naloxone.html. Accessed on December 14, 2017.

International Committee of the Red Cross. Guidelines for Investigating Deaths in Custody, 2013.

Jonson-Reid, M., Kohl, P. L., & Drake, B. (2012). Child and Adult Outcomes of Chronic Child Maltreatment. *Pediatrics*, 129(5), 839–45. http://doi.org/10.1542/peds.2011-2529.

Jordan JT, Samuelson KW. Predicting Suicide Intent: The Roles of Experiencing or Committing Violent Acts. *Suicide Life Threat Behav*. 2016 Jun;46(3):293–300.

Lutz PE, Mechawar N & Turecki G. Neuropathology of suicide: recent findings and future directions. *Mol Psychiatry*. 2017 Oct;22(10):1395–1412. doi: 10.1038/mp.2017.141. Epub 2017 Jul 11. Review.

MacIsaac MB, Bugeja L, Weiland T, Dwyer J, Selvakumar K & Jelinek GA. Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia. *Asia Pac J Public Health*. 2017 Nov 1:1010539517743615.

Martin, M. S., Dorken, S. K., Colman, I., McKenzie, K., & Simpson, A. I. F. (2014). The Incidence and Prediction of Self-Injury Among Sentenced Prisoners. *Canadian Journal of Psychiatry*, 59(5), 259–267.

Moberg T, Stenbacka M, Jönsson EG, Nordström P, Asberg M, Jokinen J. Risk factors for adult interpersonal violence in suicide attempters. *BMC Psychiatry*. 2014 Jul 7;14:195.

National Commission on Correctional Health Care (2017). Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths. https://www.ncchc.org/naloxone-for-the-prevention-of-opioid-overdose-deaths. Accessed on December 15, 2017.

Office of the Correctional Investigator (2016). Annual Report 2015-2016. Ottawa: Correctional Investigator.

Office of the Correctional Investigator. An Investigation into the Preventable Death of Matthew Ryan Hines, Ottawa, 2017.

Office of the Correctional Investigator. In the Dark: An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections, 2016.

Plourde, C., & Brochu, S. (2002). Drugs in prison: A break in the pathway. Substance Use and Misuse, 37(1), 47–63.

Plourde, C., Brochu, S., Gendron, A., & Brunelle, N. (2012). Pathways of substance use among female and male inmates in Canadian federal settings. *The Prison Journal*, 92(4), 50–524.

Pratt, D., Tarrier, N., Dunn, G., Awenat, Y., Shaw, J., Ulph, F., & Gooding, P. (2015). Cognitive Behavioural Suicide Prevention for Male Prisoners: A pilot randomised controlled trial. *Psychological Medicine*, 45(16), 3441–51. http://doi.org/10.1017/S0033291715001348

Prendergast, M. L., Podus, D., Chang, E., & Uruda, D. (2002). The effectiveness of drug abuse treatment: A meta-analysis of comparison group studies. *Drug and Alcohol Dependence*, 67(1), 53–72.

Public Safety Canada. 2016 Corrections and Conditional Release Statistical Overview.

Sachs-Ericsson NJ, Rushing NC, Stanley IH, Sheffler J. (2016). In my end is my beginning: developmental trajectories of adverse childhood experiences to late-life suicide. *Aging Ment Health*. 2016;20(2):139–65.

Santé Montréal (2017). Opioid Overdose. Public health, Quebec. https://www.santemontreal.qc.ca/en/public/advice-and-prevention/opioid-overdose/.

Séguin, M., Chawky, N. (2017). Comment le cumul de facteurs de risque influence-t-il les différentes trajectoires de vie des personnes suicidaires ? *Psychologie*, 34,7, 28–30.

Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment:

systematic review and meta-analysis of cohort studies. *British Medical Journal*, 357; j1550.

Special Advisory Committee on the Epidemic of Opioid Overdoses (2017). National report: Apparent opioid-related deaths in Canada (January 2016 to June 2017). Published online. Ottawa: Public Health Agency of Canada: https://www.canada.ca/en/public-health/services/publications/healthy-living/apparent-opioid-related-deaths-report-2016-2017-december.html. Accessed on January 11, 2018.

Statistics Canada. Homicide in Canada 2016.

Stefansson, J., Nordström, P., Runeson, B., Åsberg, M., & Jokinen, J. (2015). Combining the Suicide Intent Scale and the Karolinska Interpersonal Violence Scale in suicide risk assessments. *BMC Psychiatry*, 15, 226. http://doi.org/10.1186/s12888-015-0607-6

Tännler, C (2014). Les mesures de contrainte : approche juridique et philosophique. Collège Rousseau
https://www.unige.ch/collegetheologie/files/6914/4066/6872/Prixtheologie_2015_TANNLER_Charles.pdf

Turecki G. Preventing suicide: where are we? *Lancet Psychiatry*. 2016 Jul;3(7):597–8. doi: 10.1016/S2215-0366(16)30068-2. Epub 2016 Jun 8.

Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behaviour. *Lancet* (London, England), 387(10024), 1227–39. http://doi.org/10.1016/S0140-6736(15)00234-2

Turecki G, Meaney MJ. Effects of the Social Environment and Stress on Glucocorticoid Receptor Gene Methylation: A Systematic Review. *Biol Psychiatry*. 2016 Jan 15;79(2):87–96. doi: 10.1016/j.biopsych.2014.11.022. Epub 2014 Dec 13. Review. PubMed PMID: 25687413; PubMed Central PMCID: PMC4466091.

Tyler S. Kaster, Michael S. Martin and Alexander I. F. Simpson (2017). Preventing Prison Suicide With Life-Trajectory-Based Screening. *Journal of the American Academy of Psychiatry and the Law*, Online March, 45 (1) 92–98.

US Surgeon General (2016). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Substance Abuse and Mental Health Services Administration; Office of the Surgeon General (US). Washington (DC): US Department of Health and Human Services.

https://addiction.surgeongeneral.gov/

Wang, D. W. L., & Colucci, E. (2017). Should compulsory admission to hospital be part of suicide prevention strategies? *BJPsych Bulletin*, 41(3), 169–71. http://doi.org/10.1192/pb.bp.116.055699

Weekes, J., De Moor, C. (2015). Drug overdose among federally incarcerated men offenders Research in Brief. 15-03. Ottawa: CSC

World Health Organizations (2014). Information sheet on opioid overdose. http://www.who.int/substance_abuse/information-sheet/en/. Accessed on December 13, 2017.

ANNEX I

Questions from the CASA

PA6. Look back to the 12 months before your arrest for this current offence(s). What drug were you using the most (choose one)?

1. THC, marijuana or hashish
2. Opiates (codeine, Tylenol® with codeine: Tylenol 1, 2, 3, 4, Oxycontin®, Percodan®, Percocet®, Dilaudid®, Demerol®, morphine, fentanyl, oxycodone, hydromorphone)
3. Heroin
4. Cocaine
5. Crack
6. Ecstasy (MDMA)
7. Methamphetamine or crystal methamphetamine
8. Stimulants (Ritalin®, Concerta®, Adderall®, Dexedrine®)
9. Benzodiazepines (Rohypnol®, Valium®, Ativan®)
10. Other tranquilizers and sedatives (GHB, barbiturates, Librium®, Xanax®)
11. Street methadone
12. Hallucinogens (PCP, LSD, mescaline, salvia)
13. Inhalants (glue, gas, aerosols)
14. Steroids/performance enhancing drugs
15. Mephedrone
16. Ketamine
17. Other:

PD4. Look back to the 12 months before your arrest for this current offence(s). Which of the following prescribed drugs did you abuse or misuse most often (choose one)?

1. THC, marijuana or hashish

2. Opiates (codeine, Tylenol® with codeine: Tylenol 1, 2, 3, 4, Oxycontin®, Percodan®, Percocet®, Dilaudid®, Demerol®, morphine, fentanyl, oxycodone, hydromorphone)
3. Stimulants (Ritalin®, Concerta®, Adderall®, Dexedrine®)
4. Benzodiazepines (Rohypnol®, Valium®, Ativan®)
5. Other tranquilizers and sedatives (GHB, barbiturates, Librium®, Xanax®)
6. Methadone
7. Other:

ISU3. What kinds of substances have you used while serving time?
1. Alcohol
2. THC, marijuana or hashish
3. Opiates (codeine, Tylenol® with codeine: Tylenol 1, 2, 3, 4, Oxycontin®, Percodan®, Percocet®, Dilaudid®, Demerol®, morphine, fentanyl, oxycodone, hydromorphone)
4. Heroin
5. Cocaine
6. Crack
7. Ecstasy (MDMA)
8. Methamphetamine or crystal methamphetamine
9. Stimulants (Ritalin®, Concerta®, Adderall®, Dexedrine®)
10. Benzodiazepines (Rohypnol®, Valium®, Ativan®)
11. Other tranquilizers and sedatives (GHB, barbiturates, Librium®, Xanax®)
12. Street methadone
13. Hallucinogens (PCP, LSD, mescaline, salvia)
14. Inhalants (glue, gas, aerosols)
15. Steroids/performance enhancing drugs
16. Mephedrone
17. Ketamine
18. Other:

PP18. Have you participated in a methadone maintenance program?

1. No

2. Yes

ANNEX II

Summary of Investigations Guidelines

ICRC Guidelines for Investigating Deaths in Custody: Eight Points of Note	CSC Policy
1. All deaths must be investigated promptly by an independent and impartial body regardless of whether the relatives of the deceased request it.	CD -041 Incident Investigations, must be investigated – para 22 (CCRA 19 (1)); independent and impartial – paras 28 and 29
2. The main purpose is to: clarify the circumstances surrounding the death. The investigation may also contribute to: reducing trauma and providing an effective remedy for next of kin; prosecuting and punishing those responsible; and preventing the occurrence of deaths in custody	Clarify the circumstances – Convening Order of the Commissioner CD 530 Death of an Inmate: Notifications and Funeral Arrangements CD – 041 Incident Investigations, para 1 states that investigations "are intended to ensure responsibility, accountability and transparency, and to enhance the ability of the Correctional Service of Canada to contribute to the safety of the public by ensuring that: a) CSC takes appropriate action following an incident; b) the review and analysis of reports influence organizational policy and practices where appropriate; and c) significant findings from investigation reports are shared in order to prevent similar incidents in the future."
3. The Investigation must be thorough. This implies that it must seek to: obtain and preserve physical and documentary evidence in connection with the death; identify possible witnesses and record their statements; identify the deceased; determine the extent of involvement of all those implicated in the death; establish the cause, manner, place and time of death, as well as any pattern or practice that may have caused it; differentiate between natural death, accidental death, suicide and homicide.	CD 568 – 4 Preservation of Crime Scenes and Evidence Convening Order from the Commissioner
4. The scene of death should be regarded as potentially a crime scene, especially if the death was unexpected.	CD 568 – 4 Preservation of Crime Scenes and Evidence
5. A thorough autopsy by a trained medical officer, is a must – especially where the	CD 530 Death of an Inmate: Notifications and Funeral Arrangements, para 4 iii. notification of

death was unexpected.	coroner
6. The next of kin should be immediately informed of their relative's death and kept abreast of the progress and findings of the investigation.	CD 530 Death of an Inmate: Notifications and Funeral Arrangements, paras. 4 and 8
7. A complete death certificate should be issued to the next of kin as soon as possible after the death.	CD 530 Death of an Inmate: Notifications and Funeral Arrangements and the Corrections and Conditional Release Act Regulations 116 to 119
8. On completion of all post-mortem examinations essential to the investigation, the body should be returned to the next of kin in a manner that is fully respectful of the dignity of the deceased.	CD 530 Death of an Inmate: Notifications and Funeral Arrangements and the Corrections and Conditional Release Act Regulations 116 to 119

ANNEX III

Brief Survey Questionnaire

PURPOSE

Best practices for investigating incidents in the institutions

Questions

1. a) Do you have any policies or practices related to investigations into serious incidents in prisons, particularly non-natural deaths in custody (suicides, overdoses and homicides), that you consider to be best practices?

   b) If so, what are they?

2. a) Have you established benchmarks with other jurisdictions to determine best practices?

   b) If so, what did you find?

3. a) Do you know of any studies that identify best practices for the prison investigation process?

   b) If so, could you please provide us with the references?

Note

Please be sure to attach any relevant documents, and provide us with the names and email addresses of those with whom we could follow up.

Thank you for your cooperation.