A summary of the first Canadian 'national' death in custody study: Findings and Implications

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Deaths in Custody… CDN context

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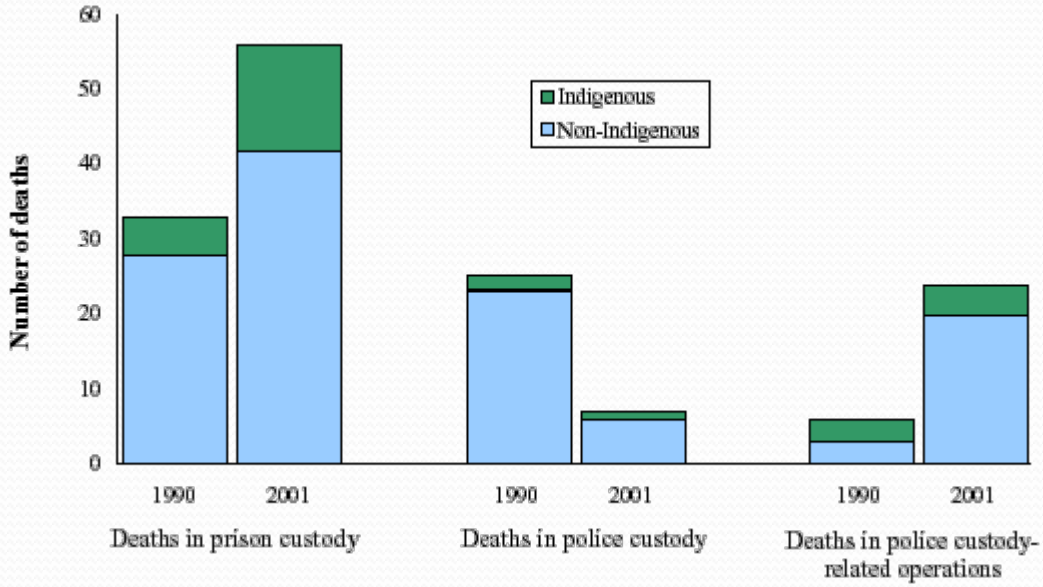
1910

Deaths in custody in Australia



Deaths in Custody: Background

- **1991 Royal Commission in Aboriginal deaths in custody**
  - **Peaked in 1997… but to many AB in custody and too often**
- **In Annual Report 2005/06, the OCI highlighted its concern about the high number of deaths and injuries in federal institutions.**
- **Each year, 50-60 inmates die in federal penitentiaries.**
- **Concerns led to the first commissioned study by a senior academic from the University of Ottawa to study deaths in custody.**

Deaths in Custody Study

- **The *Deaths in Custody Study* examined 82 reported suicides, homicides and accidental deaths in custody from 2001 to 2005, inclusive in Ontario.**
- **Study reviewed CSC board of investigation reports and action plans, Coroners/Medical Examiner's reports, correspondence between CSC and both OCI and Coroners/Medical Examiners' offices, and other documents pertaining to each fatality.**
- **Objective: identify areas in which improvements might enhance the CSC's ability to prevent or respond to medical emergencies, assaults and self-injury in the future.**

Deaths in Custody Study: Key Findings

- **The CSC *failed to consistently incorporate lessons* learned and implement corrective action over time and across regions.**
- ***Similar errors are repeated*, and similar findings and recommendations are being made time and again.**
- **The CSC resists or fails to reasonably act on a large proportion of Coroners/Medical Examiners' findings and recommendations, compared to the findings and recommendations of its own boards of investigation.**
- **The report concludes that *"…the Service fell short in implementing its own policies and practices, and in doing everything possible to avert a fatality."***

Deaths in Custody Study: Issues Raised

- Timeliness of CSC Investigative Process
- Delivery of Heath Care
- Delivery of Mental Health Care
- Training
- Record Keeping
- Information Sharing
- Quality of Security Videos
- Security Issues
- Monitoring At-Risk Factors

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National Roundtable for Preventing Deaths in Custody

- **UK Forum created in October 2005 in response to an inquest into deaths in custody by the Joint Committee on Human Rights, made up of Peers and MPs.**
- **Forum established to learn lessons, share best practices and effect change to prevent deaths in custody across different institutions.**
- **Monitors and collect data on deaths in police custody, prisons, immigration custody, and those detained under the *Mental health Act*.**
- **Forum includes 15 members who have the responsibility for detaining and caring for those in custody.**
- **Multi-disciplinary approach, including Coroners, MH professionals, health care, Corrections, police, etc.**

Current situation

- **CSC is addressing some of the Deaths in Custody Study's findings, including the responsiveness of its investigative process and its capacity to provide timely mental health interventions.**
- **CSC is also addressing OCI recommendations of two separate reports:**
  - **the circumstances surrounding the death of Mr. Blackwind and Ashley Smith.**
- **Progress is slow**
- **…current study**

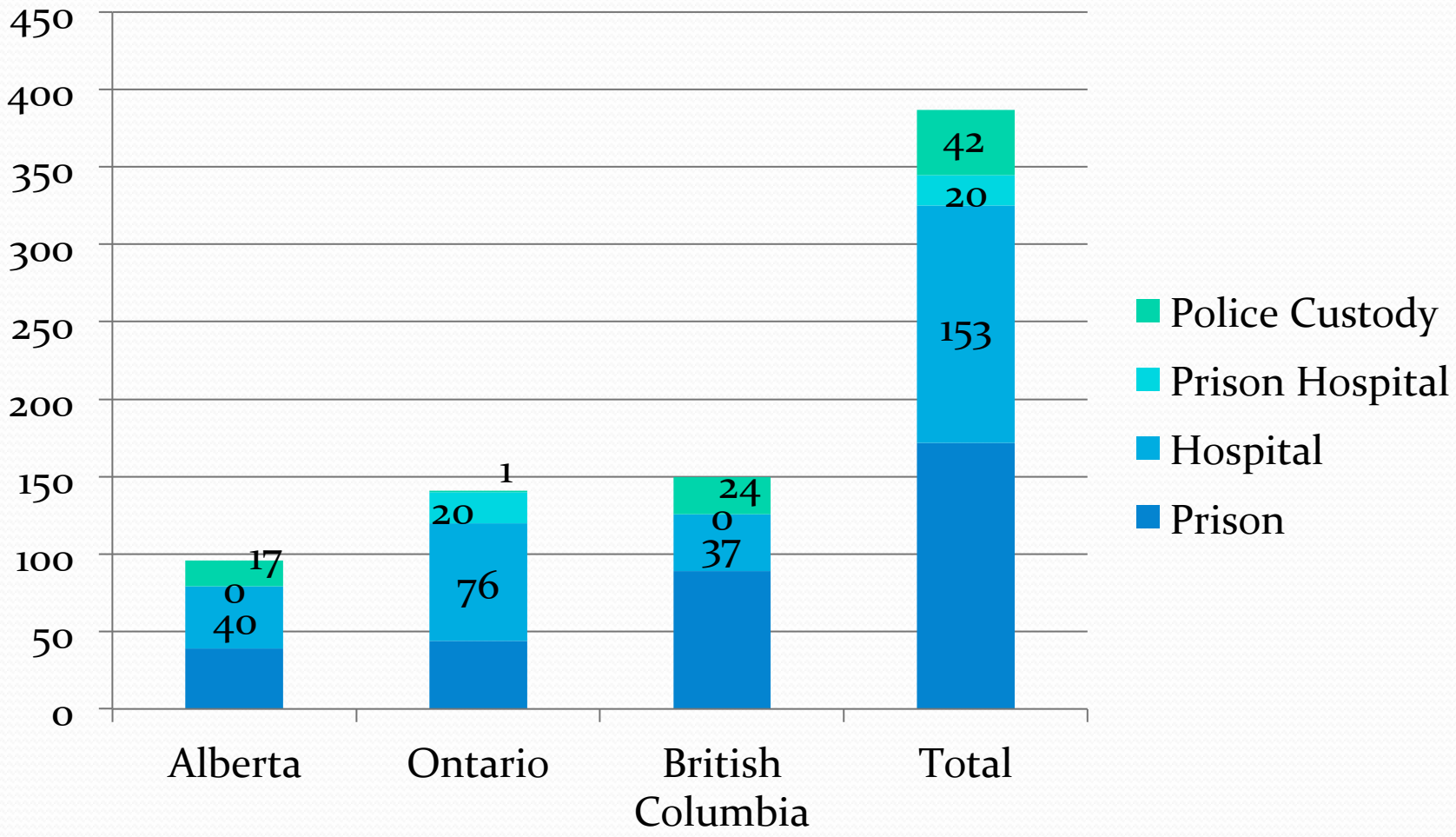
Current Study

- Three provinces
  - ON, BC, and AB
  - 300+ cases 2000-2009
    - Gabor 2005 and Woebeser et al. '06
  - Data – Medical Examiners' Office/Corners Office

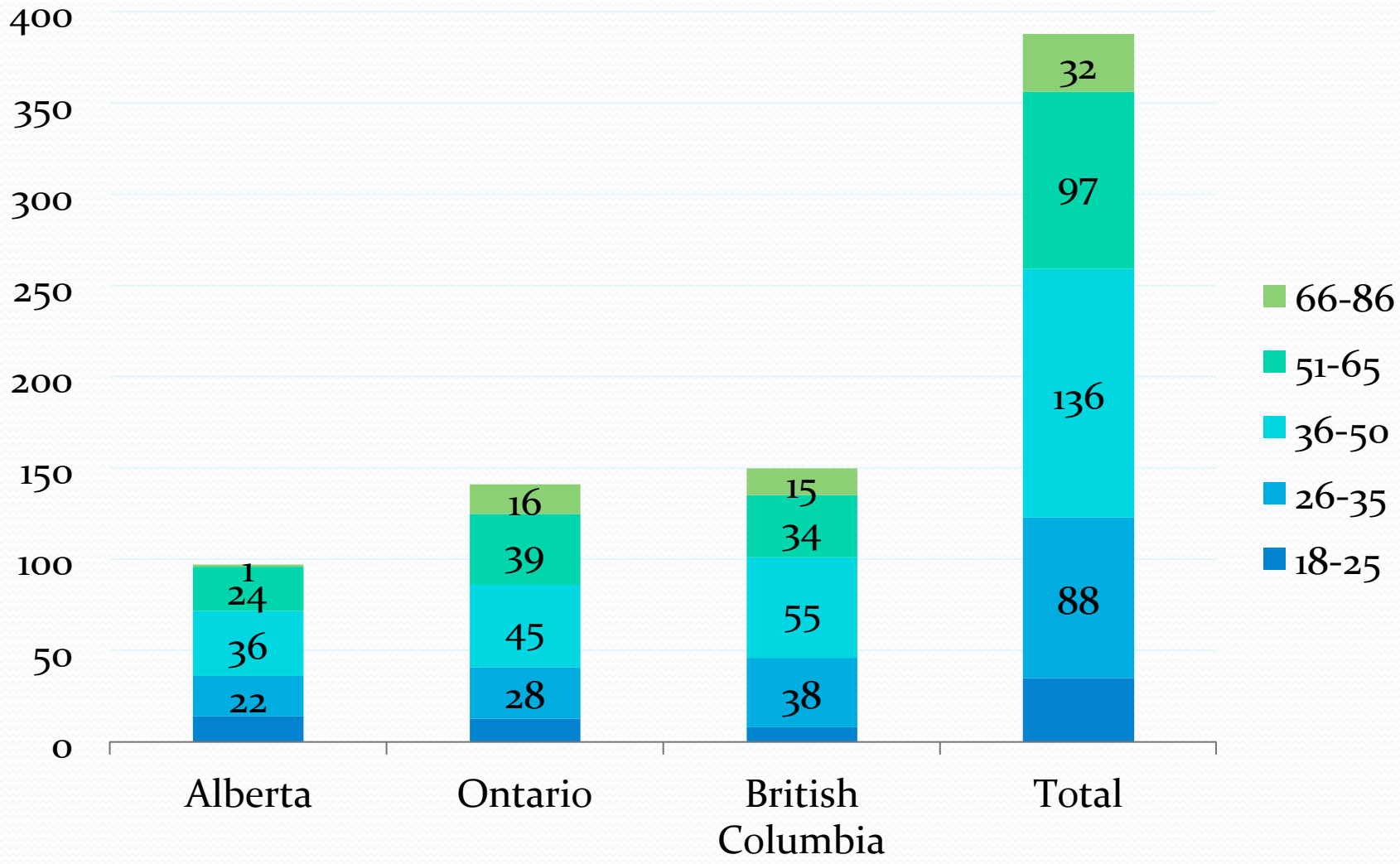
Overview of facts

- **Total deaths in custody for Ontario, British Columbia, and Alberta from 2000-2010: 388**
  - Alberta: 97 cases (25%)
  - British Columbia: 150 cases (38.7%)
  - Ontario: 141 Cases (36.3%)
- **Gender**
  - Males who died in custody: 356 (91.8%)
  - Females who died in custody: 32 (8.2%)
- **Aboriginal status**
  - Yes: 32 cases (8.2%)
  - No: 116 cases (29.9%)
  - Unknown: 240 cases (61.9%)

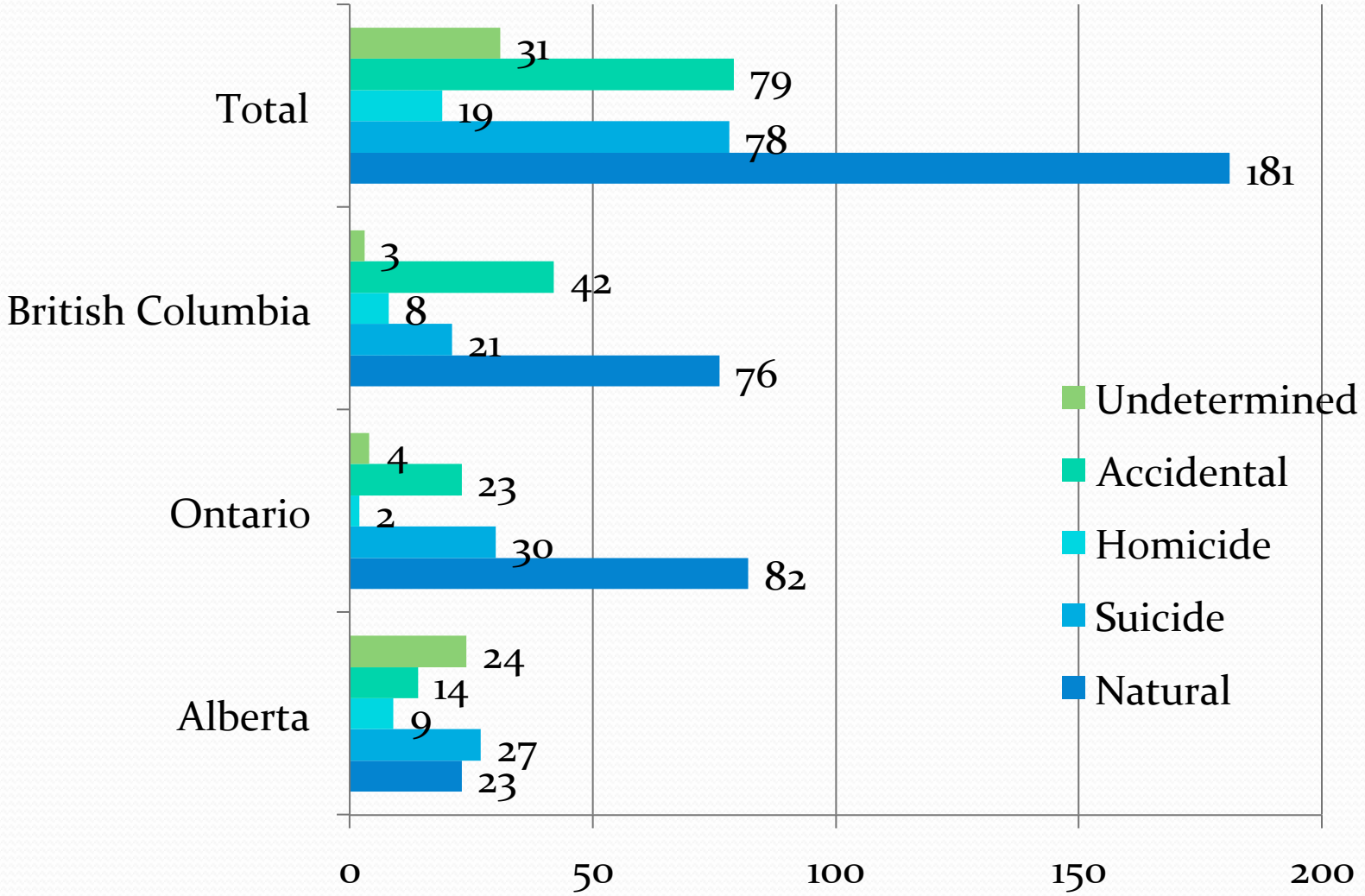
Place of Death by Province



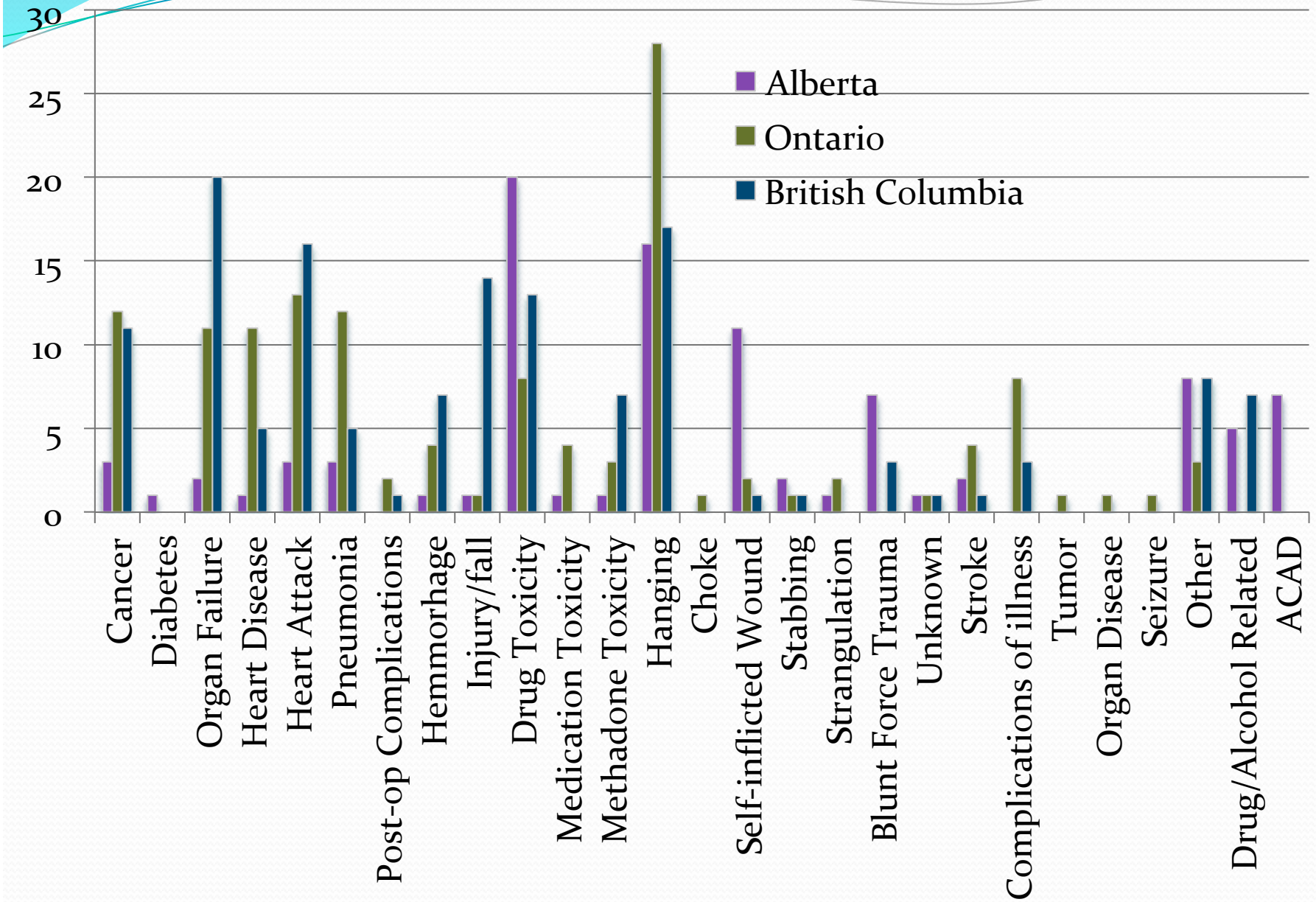
Age at time of Death by Province



Manner of Death



Cause of Death



Drug and Alcohol Abuse

- Cases involving drugs or alcohol abuse:
  - Yes – 36.7%
  - No – 0.3%
  - Unknown – 62.6%
- History of intravenous drug abuse:
  - Yes – 21.1%
  - No – 2.1%
  - Unknown – 76.5%

Known Medical Problems

- 62.1% died in custody had known medical problems
  - 19.3% had 'multiple medical problems'
  - 23.2% had drug related medical problems

- 22.9% had mental health problems
  - 5.7% had multiple diagnoses

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Institutions

- Deaths in custody occurred in **111** correctional centres and police detachments
- 50 cases (12.9%) occurred in RCMP custody
- Top 5 institutions that deaths occurred in:
  - Pacific Institution (BC) – n=26 (6.7%)
    - Capacity: 550
  - Kingston Penitentiary (ON)– n=23 (5.9%)
    - Capacity: 564
  - Matsqui Institution (BC) – n=18 (4.6%)
    - Capacity: 300
  - Maplehurst Correctional Complex (ON) – n=14 (3.6%)
    - Capacity: 1550
  - Edmonton Remand Centre (AB) – n=13 (3.4%)
    - Capacity: 750

Public Intoxication

- 43 cases involved the victim being placed in custody for the charge of "public intoxication"
  - Several individuals in custody later died because they either failed to receive medical attention, or they fell while in the holding cells, which ultimately led to their deaths
- 5 cases involved the charge of "driving while under the influence", which also led to the victims being taken into custody, where they later died in police custody/ holding cells

Recommendations

- Each province proposes, utilizes, and classifies recommendations in a different manner
- General themes of recommendations:
  - Improper/inadequate training of staff with regards to CPR/ medical training
  - Inaccurate and inconsistent record keeping of rounds/ patrols
  - Poor or absent video surveillance
  - Hindrance by FOIP and confidentiality laws, leading to the inability to transfer/share information between agencies
  - Poorly maintained, or complete absence of, medical equipment
  - Failure to make structural changes in order to prevent suicides
  - Failure to effectively stop contraband from entering custody facilities

Conclusion…what we've learned to date

- The majority of deaths that occur in custody (excluding natural deaths) are preventable
- Poor resources, including staffing levels, prevent facilities from maintain sufficient care, custody, and control of offenders
- Varying record keeping methods between provinces prevents the accurate portrayal of deaths in custody on a national level
  - *For example, BC is the only province which requires that the victim's aboriginal status be known*
- Mental illness plays a significant role in the rate of deaths that occur in custody

- The responsibility of facilities, agencies, and departments to heed the recommendations needs to be encouraged and, if possible, enforced
  - *In several institutions, suicides occurred repeatedly in the same cells, despite recommendations to make structural changes to the cells in order to prevent deaths*
- Correctional and health care ministries need to work collaboratively in order to prevent deaths
  - *Information sharing is key; deaths often occurred because information from one agency could not be shared with another*
- Resources need to be made available to properly deal with those individuals being placed in custody as a result of drug or alcohol abuse/addiction
- Final report in March 2012 visit: : www.mtroyal.ca/cjrl