DEPARTMENT OF JUSTICE
INFORMATION ON INCIDENT REVIEW

Introduction:

This review focused on the circumstances surrounding the death of an offender while in custody at the Central Nova Scotia Correctional Facility (CNSCF) on July 25, 2011.

Consideration:

The review considered:

- The actions taken in response to the incident
- Whether all applicable policies, procedures and local operating procedures were followed
- If the appropriate policies, procedures, and local operating procedures are in place

Issue:

A 48-year-old offender died while in custody at CNSCF in the early morning hours of July 25, 2011.

Facts:

- The offender was remanded to the Central Nova Scotia Correctional Facility on November 11, 2009, on a charge of murder, contrary to section 235 of the Criminal Code.
- The offender was processed on admission and an offender security assessment was completed. The offender presented as: 1) not experiencing suicidal thoughts; and, 2) not having a plan to commit self harm.
- The offender was housed in a cell alone.
- On July 24, 2011, at 4:49 p.m. the offender was in the common area of unit day-room watching television and eating supper. At 6:10 p.m. all offenders in the day room were confined to their individual cells in compliance with a mandatory lock down protocol that takes place when there is a staff shift change. At 7:00 p.m. the unit cells were unlocked as per standard operating procedure and all offenders were permitted back into the day room. The offender in question remained in the cell and at 10:48 p.m., closed the cell door from the inside. At 11:00 p.m. all offenders in the day room were locked down in their cells for the night, as per standard operating procedure.
- After 11:00 p.m., correctional officers conducted rounds and checked each cell as per standard operating protocol. During this time, the offender was observed awake and standing next to the cell door window on two occasions, at 1:36 a.m. and at 3:37 a.m.
- While conducting a round at 4:06 a.m., a correctional officer observed the offender with a sheet around the neck, and the offender was suspended in a

semi-sitting position. The officer immediately called for medical assistance and for additional officers and the officer-in-charge to respond to the scene.

- Entry into the offender's cell was gained within one minute and fifty-eight seconds and officers then attempted to alleviate the pressure on the offender's neck.
- Thirteen seconds following cell entry, a paramedic employed by the Capital District Health Authority to provide after-hours, on-site emergency health services to the offenders at CNSCF, arrived on the scene and attempted to revive the offender by administering cardiopulmonary resuscitation (CPR) and providing oxygen.
- Approximately 15 minutes later Emergency Health Services (EHS) paramedics arrived at the scene, followed by an EHS supervisor and firefighters. EHS paramedics continued attempts to revive the offender.
- The offender was pronounced dead at 4:36 a.m.
- The scene was secured and Halifax Regional Police (HRP) was advised of the incident.
- HRP arrived on site at 4:47 a.m. to commence their investigation.
- The Nova Scotia Medical Examiner Service arrived at 6:30 a.m. to commence its investigation.

Findings:

- Staff rounds were conducted in compliance with policy and procedures.
- Correctional officers acted in compliance with existing standards when assisting an offender who is attempting self harm.
- The officer in charge acted in compliance with policy and procedures for dealing with a crisis incident and met response requirements relating to the death or serious Illness of an offender in custody.
- No deficiencies in policy and procedures were identified.

FOLLOW-UP ACTIONS AS A RESULT OF THE REVIEW

- The Halifax Regional Police advised Correctional Services this incident was not suspicious or a criminal matter.
- The Nova Scotia Medical Examiner Services completed its investigation and ruled the death a suicide.