DEPARTMENT OF JUSTICE
INCIDENT REVIEW SUMMARY
Introduction

This review focused on the circumstances surrounding the death of an inmate following a medical emergency at the Central Nova Scotia Correctional Facility (CNSCF) on April 7, 2014 at approximately 0810 hours.

Considerations
The review considered the following:

- The events leading up to the incident.
- The actions taken in response to the incident.
- Whether policies and procedures were followed.

Issue
During a routine round at approximately 0820 hours an inmate was found unresponsive in a cell.

Facts

- The inmate was admitted to the facility on February 7, 2014 on a Warrant of Remand.
- The inmate engaged in normal activities after release from lock down on April 6, 2014 at 0756 hours until return to lock down at 2153 hours. He was assigned to a cell with another inmate.
- Staff rounds were conducted at regular intervals, every 27 to 32 minutes between the hours of midnight and 0859 April 7, 2014.
- No unusual activities or behaviours were observed by staff during the evening of April 6, 2014 and into the early morning hours of April 7, 2014.
- Breakfast was delivered to the cell at 0754 hours on April 7, 2014.
- The inmate sharing the cell was not able to awaken his roommate and called for staff assistance by waving his arms outside the cell at 0809 hours. Other inmates in the Day Room also waved their arms and called for staff.
- Staff entered the Day Room at 0822 hours and immediately went to the inmate's cell.
- First Aid was administered shortly after discovering the inmate unresponsive.
- The inmate was pronounced dead at 0859 hours on April 7, 2014.

Findings

- An intercom located in the cell, where inmates called out to staff for assistance was covered over contrary to policy, and there was no documentation to support the decision.
- Medication distribution procedures were not followed in relation to holding the inmates in a waiting area for 30 minutes after receiving medication from nurses employed by the Nova Scotia Health Authority. This mitigates the risk of medications being shared with other inmates. Frisk search procedures did not

meet performance standards.

- Performance standards respecting area searches did not meet minimum requirements.
- Correctional Officers responded appropriately to the medical emergency; Health Care staff responded in less than 30 seconds; and Emergency Health Services responded within 10 minutes and assisted health care staff in treating the inmate.
- The inmate consumed an unknown quantity of unauthorized medications between April 6 and April 7, 2014.
- The inmate died from an accidental methadone drug overdose. He did not have a prescription for methadone and it is unknown how he obtained the drug.

Follow-up Action

- Correctional Services conducted an exercise with staff to review what happened and the lessons learned.
- The audit process respecting intercoms was strengthened and the importance of documenting decisions over use of intercoms have been reviewed with staff.
- Proper use of Frisk procedures and performance standards respecting area searches have been reviewed with staff