DEPARTMENT OF JUSTICE
INCIDENT REVIEW SUMMARY
Introduction

This review focused on the circumstances surrounding the death of an offender following a medical emergency at the Central Nova Scotia Correctional Facility (CNSCF) on November 2, 2016 at approximately 0705 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 0705 hours an offender was found unresponsive in a cell.

Facts

- The offender was admitted to the facility on June 21, 2016 on a Warrant of Remand.
- The offender was last recorded, on camera, looking out of the cell door window on November 1, 2016, at 10:31 PM. There was only one occupant in the cell at the time.
- No unusual activities or behaviours were observed by staff during the evening of November 1, 2016 and into the early morning hours of November 2, 2016.
- The offender was found unresponsive at approximately 0705 hours.
- First Aid was administered shortly after discovering the offender unresponsive.
- Staff rounds were conducted on average every 30 minutes in compliance with Policy and Procedures.
- The minimum requirement established by provincial policy for conducting area searches of cells and dayrooms was met. However, the facility did not follow the schedule prescribed by CNSCF Standard Operating Procedures.
- Nova Scotia Health Authority (NSHA) did not contribute to the Incident Review. The *Personal Health Information Act* prevents health care staff participation in investigations and does not allow access to health records by Correctional Services personnel.
- The offender passed away on November 7, 2016.

Findings

- Correctional Officers responded to the medical emergency within 18 seconds, providing first aid until relieved by health care staff approximately 2 minutes later. Emergency Health Services Paramedics took over approximately 13 minutes later and transported the offender to the hospital at approximately 0744 hours.
- The offender consumed prescribed medication and an unknown quantity of non-prescribed medication between November 1 and November 2, 2016.

- The offender died from complications resulting from an accidental drug overdose, according to the Office of the Medical Examiner.
    - Source information reported that the offender:
        - was known to divert prescribed medication for use at a later time.
        - ingested another offender's medication during the evening of November 1, 2016.

- **Follow-up Action**
- Correctional Services will meet with NSHA to review medication distribution protocols.
- Correctional Services will continue consultations with health care professionals and other agencies to consider intervention options to reduce the risk associated with drug overdose.
- A new audit process respecting person and area searches was developed with local and provincial oversight.
- Continue follow-up critical incident and stress management work with staff as required.