DEPARTMENT OF JUSTICE
INCIDENT REVIEW SUMMARY
Introduction

This review focused on the circumstances surrounding the death of an inmate, Joshua Evans, following a medical emergency at the Central Nova Scotia Correctional Facility (CNSCF) on September 10, 2018.

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 9:30 PM an inmate was found in medical distress.

Facts

- Mr. Evans, 29, was admitted to the facility on August 1, 2018 on a Warrant of Remand.
- He was being held in the Transitional Day Room and was also being monitored by clinical staff of the Nova Scotia Health Authority.
- Mr. Evans had normal social interactions with other inmates and staff during the evening of September 10, 2018. He engaged in typical activities following dinner at 7:25 PM until the evening lock down at approximately 8:25 PM. He was the only occupant of the cell.
- The last recorded round was at approximately 9:00 PM. Nothing out of the ordinary was observed.
- Staff entered the Day Room at the next regularly scheduled round at approximately 9:30 PM. Mr. Evans was discovered in medical distress. Staff radioed for assistance and immediately administered first aid. Efforts to revive him continued until he was transported to the hospital at approximately 10:20 PM.
- Mr. Evans was removed from life support at the Victoria General Hospital. He passed away on September 11, 2018 at approximately 2:30 PM.
- The Medical Examiner's Office determined the cause of death was asphyxia due to suicide.

Findings

- Correctional Officers responded appropriately to the medical emergency; Health Care staff responded within 2 minutes; Halifax Regional Fire and Police Departments, and Emergency Health Services responded within 10 minutes, assisting health care staff in treating the inmate.
- Correctional staff did not complete daily progress reports on the inmate for six (6) days leading up to September 10, 2018. These reports are used to monitor and

record behaviour. Information from the reports is shared with clinical staff employed by NSHA.

- With exception to a round conducted at 7:04 PM, staff were absent from the Day Room between 5:58 PM and 7:26 PM, contrary to Policy and Procedures (P&P). Staff were responding to another incident in the building. Inmates were confined to their cells during this absence.
- Rounds of the Day Room were not completed at approximately 6:30 PM and 7:34 PM, contrary to P&P.

Next Steps:

- Measures taken to ensure all policies and procedures are followed, and roles and responsibilities of staff are clearly understood.
- An additional full-time social worker and an inspector position will be created to ensure compliance and mitigate risk in facilities.
- A program evaluation will be conducted to ensure policies and procedures are appropriate and effective for inmates with special needs.
- Correctional Services will meet with family to review the findings of the internal review.
- Correctional Services will make available a restorative conference that will include staff, family, senior managers and other individuals involved or impacted by the tragedy.
- Lessons learned from the restorative conference will be incorporated into an action plan to prevent a similar incident in the future.