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 Southwest Nova Scotia Correctional Facility (SNSCF) on January 18, 2012.

The review considered:

- The actions taken in response to the incident
- Whether all applicable policies and procedures were followed

Issue:

The 44 year old offender died while in custody at SNSCF during the evening of January 18, 2012.

Facts:

The offender was remanded and admitted to the Southwest Nova Scotia Correctional Facility (SNSCF) on December 20, 2011 on charges of robbery, contrary to section 344 of the Criminal Code (CC); disguise with intent, contrary to section 351(2) CC; driving while disqualified, contrary to section 295(4) CC; and, possession of property obtained by crime, contrary to section 354(1)(a) CC.

All appropriate processes, including the completion of a security assessment, were completed when the offender was admitted to custody. There was no evidence at the time of admission that the offender was experiencing suicidal thoughts or had a plan to harm himself.

The offender was housed alone in a cell.

During the evening of January 18, 2012, the offender was in the common area of the unit day-room engaging in the normal unit activities, e.g., meals, playing cards. The offender went to his cell at 8:21 PM. No other person entered his cell after he entered his cell.

During the 9:40 PM security round the officer found the offender slumped against the wall of his cell. An emergency call was made for additional staff to respond; they arrived on the scene in 42 seconds. Cardiopulmonary resuscitation was commenced immediately.

Emergency Health Services (EHS) and the RCMP (Yarmouth Town Detachment) were contacted immediately. EHS paramedics arrived at the SNSCF in approximately 16 minutes and took over attempts to revive the offender. Despite their efforts, EHS

paramedics were not able to resuscitate the offender and he was pronounced dead at approximately 10:20 PM on January 18, 2012.

Yarmouth RCMP Major Crime Unit, acting in conjunction with the Medical Examiner Service, conducted an investigation into the death of the offender.

Findings:

The Yarmouth RCMP Major Crime Unit advised this incident was not suspicious or a criminal matter.

The Medical Examiner Service has ruled the death a suicide.

Correctional Officers conducted security rounds of the dayroom in compliance with their standard operating procedures.

Responding correctional staff acted in compliance with their training for responding to the incident and assisting an offender who has attempted suicide to harm themselves.

The officer in charge of facility followed all required policies and procedures when dealing with this crisis incident, including response requirements, notification of emergency services, e.g., police, EHS and Medical Examiner, and post incident requirements.

FOLLOW-UP ACTIONS AS A RESULT OF THE REVIEW

No follow-up action was required as a result of this review.