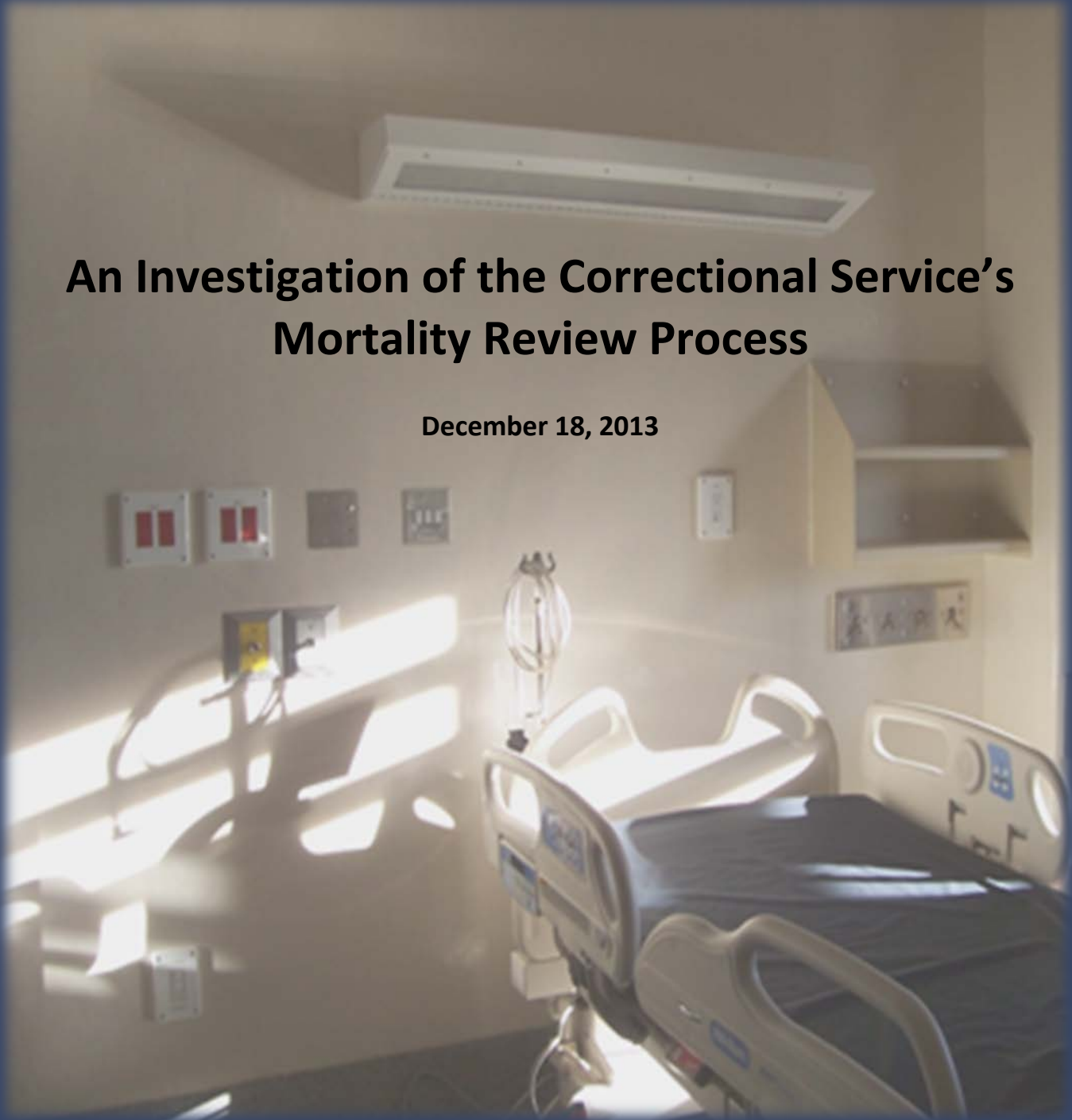


Office of the Correctional Investigator

An Investigation of the Correctional Service's Mortality Review Process

December 18, 2013



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FINAL REPORT

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CONTEXT AND PURPOSE

1. There is little that is natural about dying in a federal penitentiary. In the 10-year period (2003 to 2013), 536 offenders died in federal custody. Fully two-thirds of all deaths (355 of 536) were attributed to natural causes. On average, about 35 federally sentenced offenders die each year from naturally attributed causes. In 2012-13, 56 inmates died in federal custody, including 12 suicides and 31 deaths from natural causes. The number of in-custody deaths attributed to natural causes far exceeds all other causes reflecting the combined effects of a significant proportion of the incarcerated population serving a life or indeterminate sentence, an increasing percentage of offenders sentenced later in life and an accumulation of the inmate population aged 50 or more. More offenders are growing old in custody and succumbing to chronic disease in prison.¹

Deaths in Federal Custody by Cause: 2003 - 2013

	FY2003-2004	FY2004-2005	FY2005-2006	FY2006-2007	FY 007-2008	FY2008-2009	FY2009-2010	FY2010-2011	FY2011-2012	FY2012-2013
Accident	1	0	1	0	0	0	1	0	0	1
Natural Causes	41	33	34	43	30	46	32	30	35	31
Murder	8	3	3	3	1	2	1	5	3	1
Overdose	3	2	1	5	3	2	1	2	1	0
Suicide	10	9	10	10	5	10	10	4	8	12
Unknown Causes/ Other	2	1	0	0	1	5	4	8	6	11
Use of Lethal Force	0	0	0	0	0	0	0	1	0	0
TOTAL	65	48	49	61	40	65	49	50	53	56

Source: CSC Data Warehouse, accessed September 20, 2013.

¹Section 121(a) of the *Corrections and Conditional Release Act* (exceptional cases) allows for release of a terminally ill offender to die with some semblance of dignity in the community. Few offenders meet the exceptional requirements for compassionate release. In the last five years (2008-09 to 2012-13), only 11 cases have come forward for decision to the Parole Board of Canada; 7 were granted and 4 denied.

2. Pursuant to section 19 of the *Corrections and Conditional Release Act (CCRA)*, when an inmate dies or suffers serious bodily injury, the Correctional Service of Canada (CSC) shall “forthwith” investigate the matter and report to the Commissioner of Corrections. Section 19 also provides that CSC shall give a copy of its report to the Office of the Correctional Investigator. The *Act* does not further define the parameters, content or conduct of a section 19 investigation. As far as the *CCRA* is concerned, it is not the particular cause of the death or serious bodily injury that leads to the duty to investigate; rather, it is the occurrence of the death or serious bodily injury itself, regardless of the cause, which triggers the requirement to investigate “forthwith.” According to policy guidelines, national investigations are to be completed and prepared for review by CSC’s Executive Committee within six months from the date of the Convening Order which activates the incident investigations process.

3. As the statutory power and responsibility to investigate implies, the investigative process must be timely, thorough and credible. An additional requirement that goes to credibility is the need to ensure a degree of separation, independence and/or objectivity between those who are responsible to investigate and those who are being investigated. To meet such a requirement, investigations convened by the Commissioner must always include at least one community member² on the board of investigation.

4. As Commissioner’s Directive 041 (*Incident Investigations*) states, investigations are conducted to ensure that CSC takes appropriate, transparent and accountable action following an incident. The Service rightly expects the investigative process to yield findings, and not infrequently, recommendations that could result in improvements in organizational policy and practice. The purpose of investigating a life-ending incident, regardless of cause, is to possibly prevent or avert similar incidents from occurring in the future. The major findings, recommendations and lessons that are generated, learned and shared through the investigative exercise contribute to raising awareness within the organization, ultimately leading to the implementation of corrective measures at the local, regional or national levels.

² According to Commissioner’s Directive 041, a community member is defined as “an individual who is not employed nor has ever been employed by CSC or the National Parole Board, who participates as a member of a board of investigation.”

5. In that sense, CSC's incident investigations exercise is primarily intended to be corrective in scope and function; there is an entirely separate investigative stream that handles staff disciplinary matters.³ Finally, as CD-041 makes clear: "the fact that the police may be conducting a criminal investigation into a particular incident does not, in and of itself, preclude the need for CSC to conduct its own investigation into that incident." This directive would seem to apply equally to Coroner/Medical Examiner's offices that may concurrently be investigating a fatality, regardless of its cause, that occurred in a CSC facility.

6. In practice, CSC has developed two separate processes to investigate in-custody fatalities. In the case of the death of an inmate by natural causes, a mortality review is convened by the Commissioner. In the case of death by suicide, homicide, overdose or unknown cause, a National Board of Investigation (hereafter "Board") is convened within 15 working days of the incident by the Commissioner. Described in more detail later in this report, the critical points of difference between a mortality review and a National Board of Investigation (NBOI) involve:
 - a. timelines to collect preliminary incident data, convene, conduct and complete the investigative exercise;
 - b. composition, selection and number of board members, inclusive of the requirement to appoint an external community member and/or consideration of including an expert member (e.g. mental health professional, medical doctor, etc.)
 - c. method and scope of the inquiry (file review versus an investigative process that involves questioning of witnesses, staff interviews, site visits, consultations with experts, management debriefings, etc);
 - d. number, quality and applicability of findings and recommendations;
 - e. identification and implementation of corrective measures/action plans to respond to significant findings and recommendations;
 - f. assessment and consideration of the significance of the report's major findings and recommendations (e.g. national, regional, local), and; distribution of significant findings, lessons learned and lessons shared post-incident to prevent similar incidents from occurring in the future.

³ In fact, according to policy, no finding, statement or fact arising from the incident investigative exercise can be used in a staff disciplinary investigation.

7. Over the years, CSC has sought to reduce some of the administrative burden associated with conducting national (or Tier One) board of investigations. Reflecting a 2005 decision by CSC's Executive Committee that "an alternative investigative process would be appropriate for cases of deaths by natural cause," the very first mortality review was completed in February 2006. This report contained files for 30 inmate deaths which occurred between October 2004 and August 2005.⁴ It was conducted by a permanent National Investigator and a member of the community and contained five recommendations and five best practices.

8. The purpose of conducting so-called "bulk" or mass file reviews of natural cause deaths (which were initially grouped either by region(s), fiscal year or number of fatalities) was to look for efficiencies in terms of resources and to meet policy standards for timeliness. At the time, it was expressed that there was little perceived gain or benefit to the Service in convening a full NBOI process in cases of natural cause deaths, especially those that were expected or anticipated. As such, procedural changes to the section 19 investigative process based on cause of death were not meant to be a quality improvement exercise; the alternative mortality review process was driven by more expedient and administrative concerns.

9. To be sure, the mortality review exercise has evolved over time. For example: by the end of 2011 individual mortality reviews had replaced the earlier "bulk" reports; the overall responsibility for the exercise was formally transferred from the Incident Investigations Branch to the Health Services sector at National Headquarters (NHQ) in June 2009,⁵ and; reviews over the last three years or so show an increased focus on the quality of care provided.⁶ Nevertheless, the average time that elapses between a fatal incident and the point at which a mortality review is convened is about ten months; the actual timeline from point of death to completion of the exercise can often take two years or more. Such delays cannot possibly be seen to respect the statutory "forthwith" expectation written into the *CCRA*.

⁴ Between FY 2005/06 and FY 2009/10, CSC convened 11 separate "bulk" mortality reviews, comprising 144 deaths. Nine of these investigations included a community member on the board.

⁵ *Mortality Review Guidelines* were issued in June 2009 by CSC's Health Services Sector. In September 2009, the Commissioner convened the first Mortality Review Process conducted by Health Services. As of October 2013, Clinical Services had completed 79 mortality reports.

⁶ In 2012, after the Office informed the Service of its intention to investigate the mortality review process, the number of significant findings formulated in individual reviews began to noticeably rise, though even still, most of these are aimed at documentation and record-keeping issues.

10. Moreover, coinciding with Health Services assuming responsibility for the mortality review process, the board consists of only one person, a registered nurse working at NHQ for the Clinical Services Branch. Despite being convened by the Commissioner, there is no requirement for external or community member representation either on the board or the Mortality Review Committee itself. The terms of reference for the mortality review exercise remain essentially the same since their inception: examination of the cause of death; assessment of the care provided against CSC policy and existing community standards; and, whether alternative sentence management measures (“parole by exception”) for palliative or terminally ill offenders were appropriately considered and documented.

11. The Office is not opposed to CSC identifying efficiencies through which to meet its legal duty to investigate in-custody fatalities. However, having reviewed some of the earliest “bulk” mortality reports, a number of concerns about the quality, thoroughness and integrity of these reviews began to surface among the Office’s investigative staff, not least of which was the fact that they were typically devoid of any analytical content or critical commentary about the quality of health care provided at end of life. Between May 2005 and June 2009 (before the mortality review exercise was formally reassigned from Incident Investigations Branch to the Health Services Sector at National Headquarters), only a handful of best practices and almost no recommendations of national significance or substance had been issued in any of the mortality reports even though 144 natural cause deaths had been moved through this “alternative” process.⁷

12. Despite the fact that 30% of all deaths by natural causes reviewed between April 2009 and March 2012 were considered “unexpected” or “sudden,” not one single recommendation, lesson learned, significant finding or major point of interest has emerged from the mortality reports. Not surprisingly, a significant proportion of these “sudden” deaths were due to cardiac arrest. Even still, this is concerning, given that a prior cardiac condition of some kind was known to CSC in a significant number of these sudden death cases. As opposed to simply unexpected, the cause of death in some of these cases might be more appropriately considered “premature,” and even possibly, avertable or preventable. There is simply no way of knowing with any degree of certitude because the process does not allow for probing any other possible or alternative explanation for death beyond what the file and Convening Orders indicate – death by natural causes.

⁷ From June 2009 to October 2013, CSC’s Health Services has conducted another 79 mortality reviews.

13. In its 2009-10 Annual Report, the Office raised substantive accountability, quality and procedural gaps in the mortality review process:

- i. No requirement to include an external member in the composition of the Mortality Review Committee.
- ii. None of the mortality reviews had been independently or expertly reviewed.
- iii. No requirement to interview staff or independently corroborate the clinical care and treatment provided.
- iv. Mortality files often lacked critical documentation, including Closure Memos, Coroner Reports and Cause of Death Certificates.
- v. While compliance issues are sometimes identified, corrective measures are rarely noted and recommendations hardly ever issued.⁸

14. At that time, the Office recommended that the mortality review process be suspended until the guidelines could be independently and expertly validated to meet section 19 requirements. The Office additionally called on CSC to make the results of this expert review public. In response, the CSC maintained that the exercise “follows a rigorous and formal process to review deaths by natural causes,” and, in its view, “no further action” was required.

15. Nevertheless, concerns persist that the mortality review process is an inappropriate and inadequate model for investigating deaths in CSC facilities. In the Office’s view, the exercise fails to meet recognized investigative standards, such as independence, thoroughness and credibility. As an investigative tool, the process appears to lack substantive features that can reliably detect errors and mistakes (and learn from them) as well as take corrective action that would potentially avert future preventable or premature deaths by natural cause in federal custody.

16. Citing these concerns, in the Office’s 2010-11 Annual Report the Correctional Investigator asked the Minister of Public Safety to intervene to direct the Service to suspend the mortality review exercise until its guidelines could be independently and expertly validated. As an interim measure, the Office further recommended that

⁸ Annual Report of the Office of the Correctional Investigator 2009-2010.

an external medical doctor review all natural cause deaths in CSC facilities and independently report his/her findings to the Commissioner of Corrections.

17. For reasons that still remain largely unexplained (having never received a direct response from the Minister), the Office's recommendations that the mortality review exercise be suspended have been rejected by the Service. From CSC's perspective, the exercise continues to make process improvements and is still considered to be a fundamentally "systematic and comprehensive approach" for reviewing end of life care. As recently as October 2011, CSC's Health Care Advisory Committee assessed the mortality review guidelines as "very adequate ... and exceeding the current practice in our communities."⁹ The fact that there is no equivalence between "current practice in our communities" and the state's legal duty to care for an incarcerated individual appears to have been overlooked. When an inmate dies in custody the state has an obligation to examine the factors and circumstances that led to that fatality.

18. Despite assurances to the contrary, the Office continues to hold serious reservations about the adequacy and appropriateness of the mortality review process to investigate natural cause deaths in CSC custody. The objective of this investigation is to more closely examine the exercise by focussing on an assessment of the quality and adequacy of end of life care provided to a sample of fifteen deceased offenders. In doing so, the Office retained the services of a medical consultant to independently and expertly assess the manner in which these deaths were reviewed and reported upon by CSC. The investigation draws conclusions about how the Service fulfills its legislative obligations through the mortality review exercise and concludes with recommendations in this regard.

I. METHODOLOGY

19. CSC's mortality review process is essentially based on a file review of the deceased inmate's health care and correctional records. As such, the medical consultant reviewed the same charts, files and records that were part of CSC's mortality review exercise. Our review was not intended to "reopen" or "reinvestigate" matters after the fact. The focus was exclusively on examining the files and procedures by which CSC conducts reviews of natural cause deaths in its facilities. This was a compliance

⁹ Yvette Thériault, Chair, Health Care Advisory Committee, in correspondence to Don Head, Commissioner, dated October 19, 2011.

review, focused on assessing the quality and thoroughness of CSC's mortality review reports and process.

20. The cases reviewed by the Office were not randomly selected. All of the cases raised some level of initial concern or questions based on the Office's non-medical preliminary review of the mortality reports provided by CSC. The sample covers the period of deaths occurring in 2009 or 2010. For the 15 files reviewed, the average delay between the time of death and the convening orders was more than six months (6.3 months), ranging from 3 to 13 months. All of the mortality reports were completed by CSC's Health Services Sector.
21. The Office contracted with a distinguished medical doctor and health care consultant with considerable experience in critical incident management to conduct the expert review of the fifteen mortality files. The doctor was asked to assess the thoroughness and quality of care provided in the fifteen cases and to identify potential issues, gaps or concerns with the mortality review process itself. In addition to the mortality reports, the contracted physician reviewed relevant CSC health care policy, audits, guidelines and accreditation reports. The full list of documents consulted by the contracted physician is listed at Annex A.
22. Through the review period, the medical consultant identified a number of recurring issues in the selected sample. The principal investigator met with or conducted phone interviews with CSC staff to gather additional information concerning their roles, responsibilities, and their understanding of the purpose of the mortality review process. The Office did not interview CSC staff members on the specific findings of any of the selected mortality reports. The consultant also visited one of CSC's Regional Treatment Centres in order to better understand the manner in which health care services are provided to federally sentenced offenders.
23. With respect to the sample itself, all the cases involved male inmates. In all but one case, the death was "anticipated" by CSC. More than two-thirds of the cases (11) involved inmates serving a life sentence. The others were serving terms of less than four years.

24. In addition to the sample, the Office also reviewed an additional 80 mortality reports prepared between 2009 and 2012. Only a handful of these contain some finding(s) of non-compliance related to the quality of care provided. Until very recently in fact, not a single mortality report had generated a recommendation of any significance.
25. The findings flowing from the assessment of the mortality reviews that were part of this investigation can be summarized in four thematic areas:
- a. Quality of Health Care Provided
 - b. Management of Medical Files
 - c. Information Sharing and Continuity of Care Concerns
 - d. Consideration of Alternatives to Incarceration
26. With respect to the mortality review process more generally, the areas of concern identified are:
- A. File Review
 - B. Applicable Standards
 - C. Corrective Measures
 - D. Lessons Learned
 - E. Section 19 Requirements

II. LEGISLATIVE AND POLICY FRAMEWORK

27. The *CCRA* requires the Correctional Service of Canada to investigate “forthwith” all cases where an inmate dies or suffers serious bodily injury. In practice, CSC has developed two separate investigative processes depending on the cause of death. If, from the preliminary reports coming into National Headquarters, the fatality is deemed to have been from “natural” causes, the Senior Deputy Commissioner recommends conducting a mortality review rather than convening a Board of Investigation. Ultimately, the Commissioner signs the Convening Order that decides whether the review of the fatality will be conducted by a Board of Investigation (under the auspices of the Incident Investigations Branch) or by the “alternative” mortality review process (under the purview of CSC’s Health Services Sector). The two types of investigative processes are described in more detail below.

Board of Investigation

28. In the case of death by suicide, homicide, overdose or unknown cause, a Board of Investigation (hereafter “Board”), usually consisting of three members, is convened by the Commissioner within 15 working days of the incident. Generally chaired by a National Investigator¹⁰ from CSC’s Incident Investigations Branch, the Board must also include a member of the community who is independent of CSC. In the case of a prison suicide, the Board may include a member with expertise in the field of mental health. Under the terms of the Convening Order, its members travel to the site of the incident and may consult any document and interview any person, as well as examine the application of policy directives and operational practices. After completing its work, the Board presents its findings and recommendations to the Warden and CSC’s Incident Investigations Branch.

29. Boards of Investigation are typically mandated to investigate the following areas:

- a) the possible existence of immediate, proximal and/or long-standing precipitating/risk factors to the incident under investigation and, if so, the attention provided and action taken concerning, but not limited to, medical and mental health issues;
- b) the security classification of the inmate involved in the incident and his or her placement at the institution;
- c) staff presence in the area where the incident occurred, including the frequency and quality of the monitoring of inmate activities;
- d) care, treatment and supervision of the inmate before the incident;
- e) the quality of the response, including medical care, provided to the inmate following the incident.

30. As part of its investigation, the Board must prepare a chronology of events, describe the context of the incident, provide a profile of the involved inmate(s) and produce a statement of findings. These findings may be purely factual or interpretive, and may be reported as opinions formulated by the Board about an element of the circumstances that is supported by evidence, but may not be established with

¹⁰ CSC’s Incident Investigations Branch retains a dozen or so permanent National Investigators. These individuals have significant experience and expertise and often chair National Tier One investigations into major incidents.

certainty. Findings may also take the form of a compliance review with policies, directives or established practices. These are referred to as “findings of non-compliance.” Boards may also issue (where relevant) recommendations, the primary objective of which is to prevent incident re-occurrences. Recommendations play a key preventive (or corrective) role by indicating what might have been done differently to avoid the incident.

31. Upon completion of its report, the Board presents its key findings and recommendations to the Warden as well as authorities at Regional and National Headquarters. These may be accepted or rejected. When a finding is not accepted, it is usual practice to explain why. When a recommendation or non-compliance finding is accepted, corrective measures, usually in the form of an Action Plan, are implemented. The report is vetted by, presented to and ultimately signed off by CSC’s Executive Committee (or EXCOM). This body is also responsible for verifying full implementation of the corrective measures and ensuring, when required, follow-up on outstanding action items until completion. Given the issues at stake and the profile of the incidents that attract or warrant a National Board of Investigation (NBOI), EXCOM’s interest, engagement and involvement throughout the investigative exercise is both substantial and expected.

32. There is an expectation that lessons learned and corrective measures will be generated by the NBOI exercise, ultimately leading to improvements in operational policy and practice. The investigative process in cases of non-natural deaths is primarily preventive and/or corrective in purpose and design. Indeed, there is an underlying assumption in the NBOI process that leads investigators to probe cause, confirm precipitating factors and draw conclusions as to how similar fatal incidents might be prevented or averted in the future. This contrasts significantly with the mortality review exercise that is much more perfunctory and superficial in form and content. In the mortality review exercise, the cause and precipitating factors leading to the fatality have largely already been determined elsewhere and by others even before the review process is convened. Indeed, there appears little to be gained by or learned from investigating a fatality that was, for all intents and purposes, expected. The lines of inquiry are largely determined before the formal review process is ever initiated.

Mortality Review Process

33. The mortality review process (hereafter mortality review) differs significantly from the NBOI process described above. To begin, the “board” of a mortality review consists of only one member, a registered nurse working at the Clinical Services Branch, National Headquarters. The nurse’s mandate is essentially to review the Health Care Record of the deceased inmate and, incidentally, the inmate’s correctional file. The review is not normally supplemented or corroborated by an on-site visit or formal interviews, though in some instances a staff member at the institution where the death occurred may be consulted, usually for clarification regarding file documentation.
34. The objective of the mortality review “is to review the clinical care provided and the circumstances leading up to the death.”¹¹ In practice, the review typically focuses primarily on the two years prior to death, although Health Services may review records as far back as is deemed necessary. In general, the mortality review reports:
- a. cause of death;
 - b. the possible existence of immediate precipitating/risk factors to the death;
 - c. the medical care provided related to the cause of death and whether it was in accordance with CSC policy and consistent with accepted professional standards of care.

The question of whether alternative sentence management (i.e. “parole by exception”) was considered before the death (sections 121(a), (b) and (c) of the *CCRA* and sections 748 and 748.1 of the *Criminal Code*, if applicable) is addressed in collaboration with CSC’s Institutional Reintegration Operations Division.

35. A supplementary document – *Health Related Elements to Review when Conducting a Mortality Review* – contains a more comprehensive list of items in the Health Care Record that should be evaluated as part of the mortality review.¹² These items include, but are not limited to:
- a. History of disease process and precipitating factors which caused death;

¹¹ CSC Health Services, “Mortality Review Process of Deaths by Natural Cause,” (June 2009), also known as the *Mortality Review Guidelines*.

¹² CSC, *Health Related Elements to Review when Conducting a Mortality Review*, undated.

- b. Review of all diagnoses (including assessments, monitoring and interventions) to determine compliance with professionally accepted standards and CSC policy;
- c. Review of all physicians' orders (e.g. medical prescriptions, orders for lab work, x-rays, follow-up, etc.);
- d. Proper documentation in the health care record;
- e. Continuity of care (e.g. transfer to another institution, community discharge plans, information sharing);
- f. Application of CSC's palliative care guidelines;
- g. Official documents – e.g. Health Care Record and notes, Death Certificate, Coroner's/Medical Examiner's Report, Autopsy Report, Toxicology Report (if applicable), etc.

36. From Convening Order to Closure Memo, key decision points in the mortality review process can be summarized as follows:

- i. Once a death in an institution is declared, preliminary reports are completed by institutional staff and sent to National Headquarters. If, from the preliminary findings it is deemed that the death was “expected” and attributable to “natural” causes, the Senior Deputy Commissioner makes a decision to refer the case to a mortality review rather than convening a formal section 19 Board of Investigation.
- ii. After a delay that can last several months, the Commissioner signs a Convening Order requesting that NHQ Clinical Services conduct a mortality review. By that time, Clinical Services has usually retrieved the medical charts from the institution. The Registered Nurse who is assigned the file may request the opinion of a contracted physician. The documentary review typically takes 6 to 8 weeks.
- iii. The draft report and findings are vetted through an internal quality assurance process, which is followed by a meeting of the Mortality Review Committee.¹³ At this stage, the review focuses mainly on the preliminary findings.

¹³ The Mortality Review Committee serves an oversight and quality assurance function. Chaired by the Director General Clinical Services, the Committee reviews the preliminary draft of the mortality report but does not have sign-off authority.

- iv. The findings and a summary of the report are then shared with the Manager of Clinical Services at the regional level – not institutional staff – during a conference call.
- v. If the report contains findings of non-compliance, the regional manager is responsible for ensuring that corrective measures are taken, typically involving the Chief of Health Services at the concerned institution.

37. The findings of the mortality reviews are, superficially at least, similar to those contained in a Board of Investigation report. However, the significantly smaller breadth and focus of the mortality review make the findings different in scope and nature. For example, mortality reviews typically only issue compliance findings pertaining to the documentation of health care records and record keeping and rarely touch on quality of care issues. Given that such reports rarely generate any major findings, corrective measures or action plans of any significant national interest, there is little expectation that they garner much in the way of engagement or involvement by CSC's Executive Committee, though its members are nominally required to review the report's summary and formally endorse the closure memo.

38. As mentioned, some mortality review reports take more than two years to complete after the death of an inmate. The longest part of the delay generally occurs between the date of death and the issuing of a Convening Order. Convening Orders typically request that the mortality report be completed within three months, but such Orders are sometimes signed more than 18 months after the death.¹⁴

39. There is an internal "failsafe" of sorts embedded within the process. If, during the course of a mortality review, the cause of death is determined to be anything other than natural causes, or the circumstances surrounding the death are suspect, or if issues identified require further investigation, it may be sent back to the Incident Investigations Branch, in which case a decision could be taken to determine the need to convene a NBOI. Curiously, Health Services may also send the mortality review back if it is deemed that interviews may be required to confirm or corroborate information that "operational issues" (e.g. failure to provide timely life-saving measures, for example) may have impacted the death. In other words, the failsafe makes it clear that the mortality review process is not intended to substitute for a standard investigative exercise, much less meet section 19 requirements. The

¹⁴ This compares to 15 days for the convening of a typical Board of Investigation after the incident in question.

potential to learn from failures or deficiencies in meeting CSC’s obligation to preserve life during a critical end-of-life incident is simply not something that the mortality review process is ever likely to encounter. The mortality review process is not about uncovering or shedding new light on how or why an inmate died in CSC custody. It merely assesses compliance with CSC health care policy and community standards based on a review of the medical charts.

40. Mortality review reports are shared with the Chief of Health Services, with a copy to the Regional Director of Health Services, the Warden and the Regional Deputy Commissioner. Despite these sharing arrangements, during our investigation a physician under contract with CSC told the Office that, to his knowledge, the Service did not conduct investigations into deaths by natural causes. The physician had not even heard about the internal mortality review exercise, even though he had been involved in the care of a number of deceased inmates who had been the subject of a mortality review.

III. FINDINGS – INDEPENDENT EXPERT ASSESSMENT OF MORTALITY REPORTS

This section reviews thematic areas of concern identified in the medical consultant’s review of the fifteen selected mortality reports.

A. Quality of Health Care Provided

41. In nearly half (seven cases), the review of the health care records raised issues regarding the quality of health care provided to the deceased inmates. One such issue concerns the diagnostic practices used by CSC health care providers. Some cases clearly showed that the established principles of differential diagnosis¹⁵ were not followed (or at the very least there was nothing in the file relating to how these principles were followed). The mortality review reports for these cases simply state that practices were in line with “applicable” professional standards.

42. In one case, an inmate complained of breathing pains, shortness of breath and general persistent discomfort. Five chest x-rays were completed at various times in the last two years of the inmate’s life. The treating physician diagnosed pneumonia and prescribed antibiotics on three occasions over this period. In addition, this

¹⁵ “Differential diagnosis” refers to a medical procedure by which the physician investigates the possible cause of a condition, normally by investigating the differential aspect of two or more possible hypotheses.

inmate presented with high blood test results¹⁶ that would normally raise serious questions, particularly given that a mass of some sort was already visible in the right middle lung, that the inmate had a long history of smoking and was showing signs consistent with chronic obstructive pulmonary disease. Follow-up x-rays were either not ordered or completed following several trials of antibiotic treatments. When the inmate was finally sent to an outside hospital for an emergency CT scan, the cancerous tumour that was discovered had become inoperable. The inmate died three months later.

43. In this case, the mortality review report produced by CSC does not raise any questions concerning the diagnostic process followed by health care providers and it does not consider the possibility that the initial diagnosis of pneumonia might have been incorrect. An order dating from two years prior to the death for a CT scan was not reported in the mortality review and appears to have not been completed. Further, a review of the medical chart showed:

- Lack of continuity of care
- Incomplete and poor documentation
- Lack of progress notes
- Lack of follow-up on treatment recommendations.

44. In another case, at the time of admission to the institution, the inmate had a serious case of hepatitis and also presented with symptoms of jaundice. A few months later, when he was transferred to another institution, the institutional physician decided to prescribe a TB prevention treatment protocol because the inmate had the virus, although it was dormant. However, this treatment is known to be hepatotoxic (chemically-driven liver damage) and is not recommended for patients with liver problems. CSC guidelines emphasize the risks associated with this treatment for inmates with hepatitis.¹⁷ The inmate became very sick after this treatment, and it was stopped shortly afterwards. It is concerning that there is no line of inquiry, analysis or questioning of the appropriateness of the original diagnosis and treatment course prescribed by the attending physician. In this particular case, the mortality report simply states that the care provided was “consistent with professional norms and standards.”

¹⁶ In this case, “high blood test results” refers to Ferritin, Hemoglobin and high white blood cell count.

¹⁷ Correctional Service of Canada & Health Canada. (2004) *Tuberculosis Prevention & Control Guidelines for Federal Correctional Institutions*. Ottawa, ON: Correctional Service Canada & Health Canada.

B. Management of Medical Records

45. In five of fifteen cases, recommendations for further testing or referrals to specialists were not followed and unexplained delays in treatment occurred. The mortality reports in question do not indicate the rationale upon which the treating physicians relied or why recommended tests or referrals were not followed. The files do not indicate whether the lack of follow-up was the result of an administrative error on the part of the institution or the community hospital, or perhaps even a refusal for treatment by the inmate. The mortality report merely concludes that further testing was recommended by physicians in the community but were either not carried out or carried out late. It does not probe any further to exclude fault or mistake by healthcare staff.
46. In another case, a chest x-ray dated 2006 revealed changes in comparison to previous x-rays. An analysis of the previous chest films, as well as a new test to check for any changes in the patient, was ordered. The health care records do not indicate whether this recommendation was acted upon and the mortality review does not mention or address this apparent lack of follow-up. According to the medical records, the inmate had repeatedly refused annual x-rays. It may very well be that he also refused the recommended follow-up. In any event, three years later the patient was taken to hospital with pulmonary fibrosis in the palliative stage. In the same file, a community physician who had assessed the condition of the inmate indicated that he would be a good candidate for Hepatitis C treatment. The inmate never received such treatment. The mortality report simply says that the medical files did not indicate whether the inmate received Hepatitis treatment, but this specific condition did not contribute to his death. There appears to have been reason for CSC to investigate further.
47. In a similar case, an x-ray taken three years prior to the inmate's death yielded inconclusive results. The mortality report suggested that another x-ray should be performed since some parts of the initial x-ray were not accurate enough to be sufficiently analyzed. However, the inmate was conditionally released to the community ten months later without the follow-up x-ray. The inmate was re-admitted to the institution a little over a year later and there was still no follow-up x-ray. One year after being re-admitted, the inmate complained of severe pain and an x-ray was requested; it was not completed until two months later. A CT scan at that time showed he had an inoperable and virtually untreatable tumour that had spread to his intestines. The inmate died a few days later. This case raises questions and

concerns regarding continuity of care, yet the mortality review concluded with no findings of non-compliance or any recommendations.

48. In a third case, the inmate was seen on a number of occasions for pulmonary exams. A mass appeared on an x-ray and a follow-up was requested to determine its nature. Unfortunately, this request was not carried out. One year later in a new test the mass proved to be a cancerous tumour. The inmate was immediately admitted to palliative care and died two months later.

49. As these cases indicate, the process as it currently exists does not allow for determining the cause of why a recommended follow-up medical test or procedure was not carried out. Under the current process, the absence of such critical information is not even considered an instance of non-compliance. More recent mortality reviews contain some more critical findings. Yet, even still, these tend to be limited to findings pertaining to lack of documentation. For example, a 2013 mortality report noted that there was no evidence that a palliative patient was seen by an institutional physician for almost two months. Whether the patient was medically assessed or not cannot be determined by the mortality review; it simply states that there is no evidence on file.

C. Information Sharing and Continuity of Care Concerns

50. Three cases raise important issues concerning the quality and content of information sharing between health care providers and correctional staff. In one case, the mortality review stated that the subject first went to health services because he reported coughing up blood for six weeks. It fails to mention whether correctional staff were aware of the situation or made efforts to assist. It appears that the inmate had a long-standing propensity to avoid contact with health services staff and that he regularly refused medical attention. He had identified mental health problems, and community releases had not been successful. Closer attention would normally have been expected from correctional staff, but the mortality review does not address this issue.

51. In three files reviewed, it is noted that the inmate did not show up for a medical appointment or for a scheduled treatment. In the majority of cases, the health care records do not make a distinction between whether an inmate refused to attend an

appointment or whether the inmate was not able to attend. In discussing inmate-patient communication issues with institutional nurses, the most frequent comment is that if the assessment or treatment is important, and if time allows, a nurse will normally (but not always) inquire with correctional staff or ask for a direct or indirect confirmation that the refusal of the inmate was made of his/her own volition. Offenders can refuse or withdraw from treatment at any time and consent would normally be documented in the health care records.

52. In two of the cases examined, the inmates in question had severe cognitive and/or mental health issues. In one case, an elderly inmate, who died in 2010 of dementia, was left partially paralyzed from a cerebral-vascular attack which occurred a few years earlier. During surgery for colon cancer, another tumour was found. The doctors deemed the patient inoperable because of the stage of the cancer, but the case was further complicated by the fact that the doctors were not able to communicate with the inmate because of his aphasia. In the analysis of the health care record, there is very little information on the follow-up after 2006 for the two cancers that this inmate had. Moreover, a review of the file raises questions concerning the patient rights and interests. For example, the report makes no mention of the presence of a legal representative or family member to discuss treatment options, although it appears that a “Do-Not-Resuscitate” (DNR) order was signed by the inmate. He died in his cell less than a month later. The impression given in reviewing the medical files and mortality report is that this inmate may have been incapable of making decisions at end of life. The mortality report does not probe this aspect and only reports that a DNR order was signed.
53. In the other case, an inmate’s lack of cooperation with health services staff is noted a number of times in the mortality review. However, the report does not examine the reasons or the methods used by staff to try to change this situation. The inmate was known to have mental health problems, but the review does not probe any further. It simply states that the subject refused to undergo TB tests and a chest x-ray, respectively in 2005 and 2007, but it does not discuss the potential consequences of this refusal or the efforts that might have been made by health services staff to try to persuade the inmate to change his mind. This inmate died of lung cancer.
54. In this case, the question is not whether better monitoring could have prevented the death, nor is it whether the patient had the capacity to make informed decisions

about his condition or care. The question rather concerns how CSC manages inmates suffering from serious cognitive or mental health issues and who refuse to cooperate with health services. The mortality report does not probe.

55. A similar situation is found in a mortality report a year later. The subject tested positive for tuberculosis but refused to have a chest x-ray. Once again, the mortality review report only noted the facts and did not address the potential consequences or the efforts, or lack thereof, by health care staff to educate and encourage the inmate to reconsider his decision.

56. Mortality review reports cannot provide, verify or assess information that goes beyond what is in the health care records. As well, in cases like those discussed above, the patient's ability to communicate with health services staff may be hard to evaluate unless the health care record itself contains an assessment or thorough notes to this effect. In one case noted earlier, the file contained a note stating that the attending physician was unable to communicate with the patient. The physician's note is open to interpretation since it could be read to mean that the inmate's inability to communicate played a role in the decision regarding available treatments. The mortality report does not refer to the physician's note, nor is the inmate's capacity to sign a DNR order questioned.

57. Communication between patients and health care providers or between health care staff and substitute decision-makers is often a source of conflict and misunderstanding in community settings. The same is true in penitentiaries. However, the mortality review appears unable to evaluate the attention given to an offender's health condition by correctional staff. At best, the reports identify a "gap" in communication or information sharing. In rare cases, a note will be made in the file to indicate that an officer contacted health services staff to report a health situation or condition.

D. Alternative Sentence Management

58. As but one part of the overall compliance exercise, the mortality review is to assess how and whether consideration of alternatives to incarceration, prior to death, were examined and documented as per section 121 of the *CCRA* ("parole by exception"), and sections 748 and 748.1 of the *Criminal Code* (Royal Prerogative of Mercy), if applicable. This part of the exercise, which is essentially an assessment of whether a

terminally ill or palliative inmate meets compassionate release requirements, is completed in consultation with CSC's Institutional Reintegration Operations Division. Very few inmates are ever released under either of these sections as the technical requirements, which include attestation of "clearly supported medical evidence," are exceedingly difficult to meet.¹⁸ For example, in a recent review of 35 "expected" deaths, CSC reported that 14 were considered for exceptional release, but none were in fact released – 6 died before the paper work and release planning could be finalized; 6 cases were brought before the Parole Board where 5 were denied; the other died during the adjournment of a hearing.¹⁹ Two others were considered under *Royal Prerogative of Mercy* requests but the risk was considered too high in both cases.²⁰

59. In two recent mortality reports, a more critical tone has been sounded regarding CSC's responsibility to examine alternatives to incarceration. In these cases from 2012 and 2013, findings of non-compliance are noted: one in which the report states that no record of communication exists for the parole officer responsible for looking into community resources; in the other case, it concluded that a breakdown in communication between health care and correctional staff led to an absence of referral for a section 121 release. The critical findings in these two cases remain exceptional.

FINDINGS – MORTALITY REVIEW PROCESS

A. File Review

60. The mortality review process primarily involves a review of health care records. It is limited to assessing information that is contained or reported in the file. A simple compliance review of norms and standards can only provide a partial view of care

¹⁸ Until recently, offenders serving an indeterminate or life sentence were ineligible for Section 121 exceptional release. Few medical practitioners are willing to attest, in writing, how much time a terminally ill patient may have left to live.

¹⁹ CSC, "Mortality Review Report for Deaths by Natural Causes," January 2013.

²⁰ The *Royal Prerogative of Mercy* (or clemency, usually in the form of a conditional pardon) is exercised by the Governor General or Federal Cabinet. It is an exceptionally rare remedy in which considerations of justice, humanity and compassion must override the normal administration of justice.

and treatment provided at end of life. Incomplete records or insufficient file information can severely restrict the validity of the review process itself. Medical assessments and examinations, diagnosis and treatment, informed consent between a patient and health care provider(s) involve a level of detail that defy reduction to single statements. Most mortality reviews simply end with a Closure Memo indicating “no further action required.”

61. Even still, a medical file review – even a very thorough and quality one – does not constitute an investigation. At best, as CSC confirms, the mortality review is an “alternative” section 19 approach to reviewing natural cause deaths. Mortality reviews are derivative of the Convening Order. The reviewer is not asked to establish, reconstruct or inquire into the facts. There is little room to probe the context or even assess probable cause of the fatality beyond the initial determination that it was either “expected/anticipated” or “unexpected/sudden.”
62. A process that does not involve interviews with staff or managers at the institutional level to corroborate information contained in the file is not adequate. A review of medical charts and other health care records do not – cannot – tell the entire story. Interviewing staff and visiting the institution seem to be a requisite part of establishing the accuracy and thoroughness of the documentary record. A finding of non-compliance directed at a staff member is often not well-received at the best of times. If that person has not been given the opportunity to be interviewed, vet, corroborate or otherwise inform or correct the factual record, such findings may well lead to confusion and generate credibility issues.
63. Field interviews with institutional staff also have the indirect value of informing and raising awareness of issues that may be germane to the incident or its reoccurrence. It is understood that institutional visits can be costly and, depending on the context, may not always be necessary. Telephone interviews and videoconferencing are available and may be appropriate means of gathering, corroborating or supplementing file information. The fact that some institutional healthcare staff members are not even aware of the existence of a mortality review exercise or that the Service is required to review deaths by natural cause speaks volumes about the need to promote awareness within CSC as to the early detection, monitoring and prevention of risk factors that may lead to premature or excessive death in federal facilities.

B. Applicable Standards

64. Mortality reports reviewed by the Office almost without exception claim that the care provided to inmates respected applicable professional standards. These standards, however, are often not specifically identified within the body of the report. (They are usually cited in the appendices in the form of a list). The references and notations used by Clinical Services to assess provision of health care are provided in a general form, as for example, the home page of a particular medical portal (i.e., www.lung.ca, www.ehow.com) or general title of some professional orders standards.
65. The qualified and experienced nurses who prepare mortality review reports at NHQ certainly have extensive knowledge of the medical field. The fact that it is registered nurses who are primarily responsible for reviewing medical charts and decisions most often made by institutional physicians does not constitute a problem in and of itself. It is not necessarily the professional medical hierarchy that raises concern. Rather, it is the enormous amount of expertise that such an assessment requires given the variety of cases and conditions, norms and standards, scopes of practice, treatment protocols that must be considered and scrutinized. In some cases, since the health care records are analyzed for the entire period of incarceration, the reviewer must also have knowledge of the norms and standards that prevail for that professional group in that particular jurisdiction at that point in time.²¹
66. Registered nurses, given their expertise, have an important if not essential role to play in compliance reviews where health care delivery is a matter of concern. Nevertheless, having nurses reviewing the timeliness and appropriateness of diagnostic procedures and treatment conducted by physicians raises questions about the capacity and appropriateness of staff of one professional group commenting on the work and practice of members of another professional group. A similar situation where one registered nurse would be the sole reviewer of the diagnosis and treatment provided by physicians in a community hospital setting would not be considered acceptable. It is, in fact, standard practice of any proper investigative process for the reviewer to match or surpass the qualifications and authority of those being reviewed. To be clear, this is not to pass comment or judgement on the

²¹ Since Summer 2012, the Clinical Services Branch at National Headquarters has used the services of a medical consultant during the file analysis stage, not just during the report preparation stage. Nurses are now able to speak to a physician to get another perspective on a file, interpret a finding or a document, or to clear up any doubt. This appears to be a good practice.

qualifications or credentials of the registered nurse conducting the mortality review, but rather it is a concern that speaks to the legitimacy of the process itself.

C. Corrective Measures

67. Of the fifteen files selected for this investigation, there were only two findings of non-compliance with policy.²² It is understood that to make a formal finding of non-compliance there must be evidence. In this case, the evidentiary record consists of medical files and records. Questions that may arise about the quality of care or whether the follow-up was adequate are not sufficient to establish non-compliance. In large measure, the paucity of critical findings, recommendations or even lessons learned are largely the result of limitations inherent to the exercise itself. A file review of a death that was already determined to have been from “natural” causes cannot be expected to shed light on how any such deaths might have been prevented or averted. Only the most egregious or self-evident mistakes become the object of a formal finding of non-compliance in the mortality reports: errors of dosage, missed appointments and the like. Even when there is a finding of non-compliance, it is rare for a recommendation to be issued or a corrective measure identified.

68. In March 2010, the Office brought forward to CSC examples from individual mortality reviews that raised questions with respect to diagnostic and treatment paths that appeared out of synch with the often aggressive (and seemingly) “unexpected” or “sudden” progression of disease or chronic illness, leading to rapid deterioration and death. Other cases reviewed raised serious concerns about the access, quality and timeliness of diagnostic services provided, which did not seem to match the equivalent standard of care provided in community hospital settings. Still, in other cases, the Office reviewed files that raise concerns regarding the integrity of the diagnostic equipment used for procedures or to interpret results. The Service responded that the diagnostic equipment at the institution in question was in need of replacement and may not have met professional standards at the time. The medical consultant retained for this investigation confirms that there are ongoing and significant challenges with respect to detection, treatment and diagnosis of health problems that may be precipitating factors in what might be better considered as “unexplained” prison deaths.

²² Morality reviews that identify findings of non-compliance have become more frequent since 2012. However, most of these still pertain to record keeping rather than the quality of care concerns. Quality and thoroughness of the reports is more a factor of *who* conducts the review rather than *how*.

D. Lessons Learned

69. A learning organization must continually strive to improve. The focus of any internal review must be to learn and to bring about improvement, at both the individual and systems level. The objective cannot solely be limited to an assessment of compliance. Up to now, neither Clinical Services nor Investigation Branch has provided a structured management tool that would track and monitor commonalities in the compliance findings emanating from the mortality review exercise. Though mortality reviews have been convened since 2005, there is still no systematic method of sharing or tracking compliance findings that reach beyond the immediacy of the specific fatality in question.
70. To CSC's credit, in January 2013 Clinical Services produced a statistical report summarizing 50 individual mortality reviews.²³ According to the summary report, 35 of 50 deaths were "expected" (individuals had a documented terminal illness) and 15 were "unexpected" (individuals suffered sudden cardiac arrest or complications from medical procedures). Of the 35 expected deaths, 31 inmates were confirmed to have received palliative care. 30 inmates whose deaths were expected died in a CSC facility; the other 5 died in community hospital.
71. In the sample, cancer was the leading cause of death (42%), followed by cardiovascular disease (20%), infection (14%), respiratory disease (12%). 18 of 50 cases reviewed resulted in compliance findings related to adherence to professional practice standards by nurses and/or physicians, primarily in documentation, monitoring and treatment of chronic diseases. Significantly, the summary report assesses that inmates received end of life care "congruent" with CSC policy. Inexplicably, not a single recommendation was issued in any of the 50 cases reviewed. In a report of this nature, it is especially troubling that there were no preventive or corrective lessons of any kind to be drawn or shared beyond the immediate operational sites where the death occurred.
72. A series of learning questions (and accompanying best practices) could reasonably be anticipated from such a report:
- a. Are 'natural' cause death rates for federal inmates within 'expected' ranges?

²³ CSC, Health Services, *Mortality Review Report for Deaths by Natural Causes* (January 2013).

- b. What is the mortality rate for federal inmates by major chronic disease compared to the general population?
- c. Is a federally sentenced offender at higher risk of dying prematurely behind bars?
- d. What specific preventive or protective factors have been put in place to mitigate the incidence of cancer, cardiovascular disease, infection, respiratory failure in federal corrections?
- e. What specific risk factors (incidence and spread of infectious disease, diet, exercise, unhealthy lifestyles) does long-term institutionalization entail for incarcerated populations?
- f. What is CSC's duty of care to mitigate health care risks that contribute to mortality behind bars?

73. Further questions and concerns arise from an analysis of the response of CSC staff to medical emergencies. In February 2007, the Office released a comprehensive study of deaths in custody, a study which involved an analysis of 82 non-natural deaths (suicides, murders, accidents, overdoses) that occurred in CSC facilities from 2001 to 2005.²⁴ The report identified a series of deficiencies in the quality and appropriateness of CSC's post-incident emergency response:

- Failure of officers (or excessive delays) to perform life-saving measures;
- Delays in notifying health personnel or emergency responders;
- Concerns about the quality and access to emergency care, especially at night;
- Inaccessibility of emergency supplies in institutions;
- Adequacy of training of front-line officers in critical life-saving procedures;
- Quality of patrols, counts and live body verification; and,
- Information-sharing among staff.

The report concluded that "it is likely that some of the deaths in custody could have averted through improved risk assessments, more vigorous preventive measures and more competent and timely responses by institutional staff." In the absence of any analysis or information suggesting otherwise, there is little reason to believe that these concerns have considerably diminished over time.

²⁴ Thomas Gabor, *Deaths in Custody – Final Report*, February 28, 2007.

74. The *Deaths in Custody Study* also noted that CSC tends to act on the findings and recommendations of internal Boards of Investigation, but often resists or fails to act on recommendations that come forward from Coroner/Medical Examiner inquests. As but one example, the 2010 coroner's inquest into an offender who died at a medium security institution in Ontario in 2006 recommended that CSC provide for 24 hours per day, 7 days per week nursing coverage. In making this recommendation, the Coroner commented that: "medical emergencies can occur at any time and correctional officers were not trained health care professionals and able to assess and make emergency health care decisions ... the jury wanted to emphasize the extreme importance of having a trained health care professional on site to deal with night time medical emergencies." This finding was echoed in this Office's 2010 recommendation that the Service provide 24 hour per day 7 days per week health care coverage at all maximum, medium and multi-level institutions²⁵ and was repeated as recently as December 2012 in a public fatality inquiry into the 2009 death of a maximum security inmate in Alberta.²⁶

75. In response, the Service claims that CSC policy already provides for access to health services on a 24-hour basis. It is of the view that even when medical emergencies occur during periods of reduced primary coverage (e.g. night shifts and on weekends) these incidents can be dealt with: by front-line staff trained in emergency first aid; by calling in health care staff; or, if the situation requires, by external community providers (paramedic and/or ambulatory services). Such a response fails to acknowledge the multiple recommendations to the contrary and does not provide much in the way of assurance, given that correctional staff are not certified health care professionals and that a number of penitentiaries are located in remote under-serviced regions. More fundamentally, it fails to recognize CSC's legal duty of care to preserve life. In a potentially life-ending medical emergency, the quality and timeliness of the response is often the decisive factor between life and death.

76. Since 2005/06, more than 220 in-custody fatalities have now been subject to a mortality review, and yet there appears to be no way of knowing whether any of those deaths categorized as "sudden" or "unexpected" (approximately 30% of all deaths) could have possibly been averted or prevented. Further, there appears no

²⁵ Office of the Correctional Investigator, *Final Assessment of the Correctional Service of Canada's Response to Deaths in Custody*, September 2010.

²⁶ Report to the Minister of Justice and Attorney General Public Fatality Inquiry, Alberta, December 2012.

way of determining whether any of those deaths were premature. The elapsed time between a fatality and the convening and completion of the mortality review sometimes exceeds two years. This delay prompts significant concern about the adequacy of the process by which CSC reviews and adopts measures that could reasonably be expected to quicken or improve its response to sudden medical emergencies. At the very least, one would expect those responsible for the care of individuals at risk to strive to prevent as many of those incidents as possible, to thoroughly and rigorously analyze the factors behind them and to implement timely and constructive remedies as appropriate. The review and analysis of findings of non-compliance, the consideration of recommendations arising from such reviews, the sharing of lessons learned and best practices across CSC operational sites, and, most crucially, the implementation of corrective measures in response to identified deficiencies is seriously lacking in the mortality review process.²⁷

77. Mortality reports in their entirety should be shared with institutional staff most directly involved. It is not sufficient to only provide the institutional Chief of Health Services with a summary of compliance findings or a list of required corrective measures. Staff members should be given the opportunity to discuss the findings and learn from them as appropriate. Some findings may also be of interest/relevance to other operational sites. Respect for privacy rights is a given, but there are ways to share information without breaching confidentiality. A place to start would seem to begin with an attempt to answer some of the questions and outstanding concerns posed above.

²⁷A summary “lessons learned” perspective on natural cause deaths was produced in January 2009 by CSC’s Incident Investigations Branch. Entitled *Significant Findings from National Investigations into Deaths by Natural Cause*, the document reviews 58 natural cause deaths that occurred between October 2004 and April 2007. It includes a discussion of 11 recommendations and 10 best practices, though some of the fatalities summarized were subject to a National Board of Investigation not mortality review.

E. Section 19 Requirements

78. Determining whether the mortality review exercises meets section 19 obligations of the *CCRA* necessitates an understanding of what those requirements are. As we have seen, section 19 provides that CSC has a duty to investigate “forthwith” when a fatality occurs; it does not, however, further define the content or conduct of how that obligation is to be met. It is revealing that, when asked about the purpose of the mortality review process, CSC staff members interviewed provided a near unanimous answer: “to fulfil the Convening Order’s requirements.”
79. In any case, an exercise that does not visit incident sites or interview those most directly involved, that relies solely on information contained in the Health Care Record and that is conducted by a “board” of one far removed in time and space from when and where the fatality occurred fails to meet the most basic of investigative standards. A file review of medical charts is not an investigation. The appropriateness of the diagnosis and treatment regime, the extent of medical information shared with the patient, the capacity to provide informed consent at end of life, the quality of liaison with family members, the appropriateness and adequacy of palliative care plans, the statutory requirement to consider alternatives to incarceration for terminally ill/palliative offenders, the adequacy, timeliness or appropriateness of the emergency response measures in the event of a sudden or unexpected critical medical incident – these and so much more cannot be comprehensively assessed in a review of health care records.
80. The delay in convening a mortality review is often considerable. Timelines start when the Convening Order is issued. Waiting a year or more after a death has occurred before a review of the matter is even convened does not meet the intent or urgency of the language used in section 19 of the *CCRA*. Timeliness is an important issue, not least because the “alternative” mortality review process was initiated, in part if not wholly, to facilitate more timely and responsive reviews of natural cause fatalities in CSC facilities. As noted, the major reason provided by the Service to explain excessive delays in the exercise – waiting for the Coroner or Medical Examiner conclusions – is simply not valid.²⁸ The onus should be on the Service to share information about the nature and context of a fatal incident with the relevant

²⁸ Some Coroner or Medical Examiner’s Offices do not automatically review “expected” natural deaths in custody. A full Coroner’s inquest can take more than 2 years to complete. In cases where death results from a known pathology (cancer, hepatitis, etc.), their investigative role is actually quite limited.

authorities (police, Coroner's Offices) and family members, not the other way around.

81. In any event, a mortality review is not solely about determining the exact medical cause of death (which is properly left to the relevant provincial Coroner/Medical Examiner authority). Determination of cause of death is important, but it is not the compelling reason to conduct a fatality inquiry. The context of the death, the quality of health care provided, information sharing issues (inclusive of notification and liaison with next of kin and family), and whether release by exception alternatives were adequately and timely explored in palliative cases are equally important objectives. In most instances, these issues do not need a Coroner's certificate on official cause of death before they can be efficiently reviewed.
82. Even though draft mortality reports are seen and assessed by a "committee," the core of the report is prepared by only one "board" member. If the nurse at National Headquarters misses a critical piece of information, there is no safety measure to correct the situation. A review board minimally composed of at least two qualified members, ideally one of whom is independent of the CSC, is necessary for quality assurance, credibility and accountability reasons. A transparent and accountable review process must be open to some kind of public or independent scrutiny. The mandatory inclusion of a community member is a best practice in any internal review process, particularly where a fatality in a state institution is involved.
83. CSC's Health Services Sector has a vested interest in improving the overall quality of health care provided to federal inmates. The Clinical Services Branch also has a vested interest in ensuring that quality measurement tools, including transparent reviews of deaths by natural causes, are in place. Nevertheless, it is incongruent that the same sector that is accountable for managing health care service delivery is also the delegated body for reviewing fatalities by natural causes. In such a framework, an actual and perceived conflict of interest arises on both practical and principled grounds. There must be a degree of functional and investigative independence.

VI. CONCLUSION

84. The Office has concluded that the mortality review process does not meet the requirements of section 19 of the *CCRA*. This does not mean that we do not find any

value in the exercise. Undoubtedly, the practice of medical charts review is a valuable asset for continuous quality assurance schemes and health care accreditation exercises within CSC. Clinical Services has developed an expertise in the review of medical charts and section 19 investigations into other types of incidents (suicides, self-harming behaviours, some cases of inmate assaults, for example) could most probably benefit from the experience acquired to date.

85. We have seen that the process does not easily lend itself to assess a range of precipitating criteria that might speak to a more complete assessment of the overall quality and timeliness of care provided. By comparison, the United Kingdom's Prisons and Probation Ombudsman independently investigates the following criteria even in cases of "anticipated" (terminal or palliated) death:

- i. The appropriateness and timeliness of the diagnosis process of the terminal illness.
- ii. The appropriateness of the information provided to the inmate about his or her illness and treatment options.
- iii. Assessment of the appointments, treatments and follow-up evaluations in the case of the inmate in comparison with the standards in the community.
- iv. Appropriateness of the palliative care plans and administration of pain relief medication.
- v. Appropriateness and timeliness of the decisions regarding the most suitable location for the inmate and the conditions of detention.
- vi. Whether alternatives to incarceration have been considered in a timely manner from diagnosis of a possibly terminal illness to the determination of palliative status.
- vii. The appropriateness of the liaison with the family with consent of the inmate.
- viii. The measures taken to ensure that the inmate was able to make decisions or that substitute consent was secured where needed.

86. For reasons that largely serve administrative convenience and expedient ends, the mortality review process was created as an "alternative" to the formal Board of Investigation exercise. The process does not meet minimum standards for an

investigative process or satisfy CSC's statutory duty to investigate fatalities regardless of cause. It certainly does not respect the immediacy and urgency that is written into the "forthwith" clause of the statute that governs the Service. As such, the process exists somewhere on the margins of the law; even its *Guidelines* do not yet have the force or effect of a policy directive within CSC.

87. The mortality review process (inclusive of outcomes) is largely determined at the point in which the fatality is moved into the "alternative" investigative stream. In reality, one of the principal "findings" of the mortality review (i.e. cause of death) is established long before the review is even convened. With cause of death taken to be either "expected" or "unexpected," the mortality report becomes essentially derivative of the Convening Order; it is descriptive in nature and largely devoid of substance and analysis. Even when compliance issues are raised, the assessment of care provided at end of life is almost uniformly found to be "congruent" with CSC health care policy and standards. Given the limitations of the process, there is little opportunity or expectation that it could conclude otherwise.

88. In any event, a strictly medical health record review conducted at national headquarters by a board of one cannot possibly reconstruct the events, decisions, actions (or inactions) that contributed to the fatality, whether it was expected or not. Beyond noting the occasional compliance issue (nearly always related to record-keeping, documentation errors or information-sharing 'gaps'), in its current form the process has little redeeming corrective or preventive function within CSC's overall strategy to reduce deaths in custody. It is largely a perfunctory exercise that too often concludes with Closure Memos that contain little or no insight into the factors that may have contributed/precipitated the fatality.

89. Meantime, the number of offenders serving life or indeterminate sentences and growing old in prison continues to mount. One in five federal inmates is now over the age of 50. Chronic disease management and provision of acute care in a prison setting is an increasingly expensive and challenging endeavour as the inmate population grows progressively older and sicker. There is little evidence to date by way of lessons generated, shared or learned to suggest that the mortality review exercise is up to these challenges. It does not appear to have led to any material improvements in how end of life care is provided for inside federal facilities.

90. Finally, one of the more disturbing aspects of this investigation concerns the possibility that potentially avertable or premature deaths may go undetected simply because the initial reporting back to National Headquarters indicated that the fatality, even those that were “unexpected,” was nonetheless attributed to “natural” cause – heart attack, stroke, diabetic shock, aneurysm, among the more notable causes of “sudden” death. It remains the case that the quality, appropriateness and timeliness of care provided during a medical emergency continue to be challenges that CSC regularly faces, even in its accredited hospitals. In regular penitentiaries, where there is no round-the-clock 24/7 primary health care coverage, there remains a higher than acceptable risk that things can go wrong in the course of managing a critical medical incident. In the outside community, medical misdiagnosis and lack of proper follow-ups are increasingly pursued through the courts. Operating a federal penitentiary means managing risk at the best of times – fill it with individuals disproportionately afflicted with addictions, mental disorders, chronic or infectious disease and the risk is multiplied exponentially.

VII. RECOMMENDATIONS

1. As per Section 19 of the *Corrections and Conditional Release Act*, the Correctional Service of Canada (CSC) should “forthwith” convene an investigation as soon as practical after the death of an inmate, regardless of the cause of that fatality or whether or not other outside agencies (e.g. police or Coroner’s Offices) are concurrently involved. The convening of a board of investigation should normally be within 15 working days of the fatality.
2. Section 19 reports into fatalities in CSC facilities should be shared with Coroner/Medical Examiner’s Offices as soon as practical.
3. “Sudden” or “unexpected” fatalities, regardless of preliminary cause(s), should be subject to a National Board of Investigation.
4. The Senior Deputy Commissioner’s recommendation to convene a mortality review should be informed by the opinion of an independent medical practitioner.
5. All mortality reviews, regardless of cause of death, should be chaired by a physician.
6. At a minimum, the mortality review board should consist of at least three individuals – a registered nurse, the National Medical Advisor and the relevant Regional Manager of Clinical Services.
7. Medical record reviews should become a standard component of section 19 investigations to assess quality of health care provided.
8. CSC should modify the general template for mortality reviews into expected deaths to include criteria followed by the Prisons and Probation Ombudsman for the United Kingdom.
9. When relevant, the Convening Order for mortality reviews should include a specific mandate to: interview any involved staff members; visit institutions and; verify the accuracy and thoroughness of information contained in the documentary file.
10. CSC should conduct a comprehensive lessons learned exercise with a view to identifying best practices for reducing natural cause deaths and implementing measures to prevent or reduce fatalities.
11. To promote best practices, individual mortality reports containing significant findings should be shared widely and completely as possible within CSC.

12. In the interests of transparency and openness, upon request mortality reports in their entirety should be shared, in a timely manner, with the designated family member(s).
13. The investigative responsibility and function for reviewing natural cause fatalities should be separate and distinct from CSC's Health Services Sector.
14. On a priority basis, the mortality review exercise should be subject to a quality control audit chaired by an outside medical examiner.

ANNEX – DOCUMENTS CONSULTED BY CONTRACTED PHYSICIAN

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