**BACKGROUNDER
An Investigation of the Correctional Service of Canada’s**

**Mortality Review Process**

**Overview**

* Between 2003 and 2013, 536 inmates died in federal penitentiaries. Fully two-thirds of all inmate deaths were attributed to natural causes.
* Correctional Service Canada (CSC) has a legal obligation to promptly investigate every incident where an inmate dies or suffers serious bodily injury.
* CSC has traditionally convened a Board of Investigation to investigate all in custody deaths regardless of cause. Since 2005, cases involving death by natural cause(s) are investigated through a separate, more streamlined mortality review process.
* The objective of the mortality review is to review the health care provided and report on the circumstances and causes leading to death. The exercise primarily involves a review of the deceased’s medical records and is conducted by a registered nurse at CSC’s National Headquarters.
* The Office has repeatedly raised concerns about the quality, thoroughness and adequacy of the mortality review process, which the CSC has yet to address.

**What We Did**

* The Office contracted with a senior medical practitioner to conduct an independent and expert review of the quality and adequacy of medical care provided in a sample of fifteen deceased offenders.
* The fifteen cases were not randomly selected. All of the deaths had raised some level of concern upon initial review. All of the deceased were male inmates, and all but one death was “anticipated” by CSC.
* The physician consultant reviewed the same medical charts, files and records that were part of CSC’s mortality review exercise. This was a compliance review focused on assessing the quality and thoroughness of CSC’s mortality review reports and process; it was not intended to “reinvestigate” matters after the fact.

**What We Found**

* The medical consultant’s review raises serious compliance issues concerning the quality and adequacy of health care provided: questionable diagnostic practices; incomplete medical documentation; quality and content of information sharing between health care providers and correctional staff and; delays and/or lack of appropriate follow-up on treatment recommendations.
* Despite these critical findings, all fifteen individual mortality reviews conducted by CSC assess the care provided to the deceased inmates as “congruent” with “applicable” health care standards and policy.
* With respect to process, the time between a fatality and the convening and completion of the mortality review often exceeds two years. This timeframe does not respect the legislative obligation for CSC to investigate an inmate fatality “forthwith.”
* The investigation further notes that the reviewer is not asked to establish, reconstruct, corroborate or otherwise probe the facts or circumstances that contributed to the fatality beyond recording cause of death as either “expected/anticipated” or “unexpected/sudden.” Most mortality reviews simply conclude with a Closure Memo stating “no further action required.”
* To date, the mortality review process has failed to generate findings, recommendations, lessons learned or corrective measures of any national significance. Even when compliances issues are noted, there is no way of determining whether the death was potentially preventable or premature.
* The Office concludes that the mortality review process is an inadequate model for investigating deaths in federal penitentiaries. The exercise is not carried out in a timely or rigorous manner, and it fails to meet basic investigative standards such as independence, thoroughness and credibility.

**What We Recommend**

To enhance the quality, accountability and transparency of CSC’s investigation of an inmate death by natural cause(s), the report makes these key recommendations:

1. “Sudden” or “unexpected” fatalities, regardless of preliminary cause(s), should be subject to a National Board of Investigation.
2. The convening of a board of investigation should normally be within 15 working days of the fatality.
3. All mortality reviews, regardless of cause of death, should be led by a physician.
4. Mortality reports in their entirety should be shared, in a timely manner, with the designated family member(s) who request it.
5. The mortality review exercise should be subject to a quality control audit chaired by an outside medical examiner.