SPOTLIGHT

Deaths in Custody

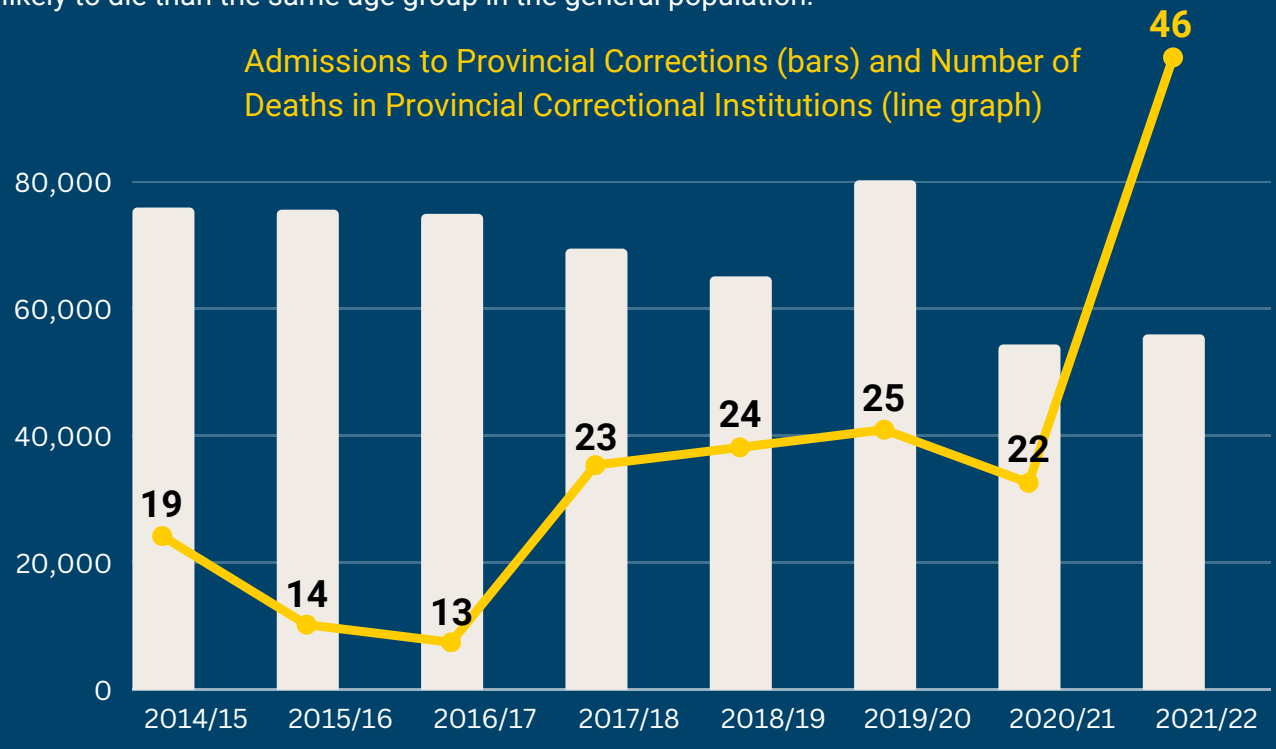
RECENT TRENDS AND RECOMMENDATIONS

Individuals inside Ontario's correctional institutions are there for a variety of reasons. Many are legally innocent, awaiting trial. Others are sentenced to less than two years. The role of the correctional system is punishment and to separate individuals who may pose a risk to the public. After time served or when an individual is no longer deemed to be a risk, they are meant to return to their communities, families and loved ones – except many do not.

Recent reports have highlighted a troubling trend of increasing numbers of deaths in Ontario's correctional institutions over the past decade. Admissions to provincial correctional institutions has largely declined over the years[1], yet number of deaths in custody has risen.

Between 2014 and 2021, there were 192 deaths in Ontario provincial correctional institutions, and the rates increased over time. Based on a review of in-scope deaths (i.e. not accounting for homicides), in 2014, 14 people died in Ontario correctional institutions, rising to 46 in 2021. [2]

The death rate among individuals in custody is significantly higher than the general population for individuals aged 18-44. Those aged 25-34 that are incarcerated are almost seven times more likely to die than the same age group in the general population.



Note: Deaths in custody data above only includes those categorized as in-scope by the CSDR and does not include deaths categorized as homicide. Data is also presented as calendar years in comparison to the fiscal year breakdown of admissions data.

MOST DEATHS ARE PEOPLE ON REMAND

Provincial institutions are comprised of sentenced individuals and people on remand. People on remand are legally innocent – these are individuals who have not yet been tried but were denied bail or are awaiting a bail decision, so they have to await their court dates in jail.

79%

of people inside of Ontario's correctional institutions are those held on REMAND. [3]

Individuals on remand make up the largest proportion of deaths in custody.

80%

of deaths in provincial custody were individuals on remand, in 2021. [4]

Individuals on remand have limited access to supports and programming while incarcerated for a variety of reasons, including uncertainty about length of time in custody. The experience of pre-trial detention can cause or exacerbate mental health issues and individuals on remand face 4x a heightened suicide risk than those who are sentenced. [5]

CAUSES OF DEATH AND THE GROWING CONCERN OF MENTAL HEALTH ISSUE AND DRUG TOXICITY

Between 2014 and 2021,[6]

40%
of deaths were attributed to drug toxicity

28%
were deemed natural

24%
were death by suicide

8%
were accidental or undetermined

Drug toxicity was the most frequently identified cause of death for those who died in custody between 2014 and 2021, totaling 74 deaths (approximately 40% of all deaths).[8]

Individuals who are incarcerated are at a high risk for drug toxicity overdoses and deaths in comparison to the general population for reasons including reduced drug tolerance, high turnover of people in provincial facilities which can result in entry of drugs into institutions, and the potency of the drug supply which has risen substantially over recent years.

Mental health concerns are 2-3 times more prevalent in Canadian prisons than in the general population. [8]

Of those who died in 2020, 31% had a mental alert on file and 3% had a suicide risk on file. In 2021, 47% of those who died in custody had a mental alert on file, 29% had a suicide risk on file and 4% had a suicide watch alert. [9]

RECOMMENDATIONS

Experts have called for a number of recommendations to address systemic issues which contribute to increasing deaths in provincial corrections. The following are some key areas requiring attention.

ACCESS TO HEALTHCARE AND TREATMENT

There have been many calls to establish uniform standards of care between corrections and community. Healthcare in provincial corrections is delivered by the Ministry of Solicitor General, not the Ministry of Health. Currently, there are challenges with continuity of care for individuals moving between corrections and community and in ensuring proper access to health services and treatment while individuals are incarcerated. Ontario should implement new standards of care across provincial corrections that align with the rest of the healthcare system.

To address high rates of drug toxicity related deaths in custody, correctional facilities should remove barriers to accessing substance use health supports and treatment and increase access to harm reduction measures like naloxone. There should be consistent monitoring of the composition and toxicity of drugs inside corrections to inform preventative measures and interventions.

ACCESS TO PROGRAMMING

Frequent lockdowns, high staff turnover and concerns, compounded with a lack of available gathering spaces compromise the ability of correctional facilities to provide programming to incarcerated people. Individuals on remand are particularly impacted by the lack of programming and services. Lack of programming affects transitions back into the community and increases isolation and mental health issues inside corrections. Access to programming, including life skills, employment skills and training, literacy and education inside correctional facilities should be expanded.

OVERSIGHT AND TRANSPARENCY

Recent reports on deaths in custody echo other expert reviews in highlighting the lack of oversight of provincial corrections. Ontario should create an independent oversight body for provincial corrections that would be responsible for protecting the rights and safety of incarcerated people and staff through regular and detailed inspections of correctional facilities and the collection of data on correctional activities. Data should include race-based information to highlight any racial disparities and to inform appropriate recommendations and interventions. This data should be publicly available to increase public transparency. Information about ministerial reviews and tracking of inquest recommendations should also be made available to the public.

There should also be a mechanism for community engagement to enhance transparency and accountability in the provincial correctional system. In the context of deaths in custody, loved ones should be included in official committees and reviews to allow for information sharing and their participation in recommendations to prevent further deaths in custody.

REFERENCES

1. Statistics Canada. (2023). Adult admissions to correctional services.
2. Ontario Chief Coroner's Expert Panel on Deaths in Provincial Custody. (2023). An Obligation to Prevent: Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody.
3. Statistics Canada. (2023) Average counts of adults in provincial and territorial correctional programs.
4. Supra note 2.
5. Tracking (IN)justice. (2022). Ontario Deaths in Custody on the Rise.
6. Supra note 2.
7. Ibid.
8. John Howard Society of Ontario. (2021). Broken Record.
9. Ministry of the Solicitor General. (2022). Review of all inmate deaths within all facilities during 2021.
10. Independent Review of Ontario Corrections. (2017) Corrections in Ontario: Directions for Reform.

For further information, see these recent reports on deaths in provincial institutions in Ontario:

- An Obligation to Prevent: Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody
- Tracking (IN)justice. Ontario Deaths in Custody on the Rise