Deaths in Custody Review Committee

On April 17, 2026, the Deaths in Custody Review Committee provided the Minister of Justice with a review report. The report includes the following advice and recommendations.

RECOMMENDATIONS RELATED TO PREVENTING A SIMILAR DEATH IN THE FUTURE

Recommendation 1: The admissions and intake processes are critically important. We recommend that these processes be redesigned to be person-centered, with an explicit focus on suicide prevention and health care assessment.

The admission and intake process at the time of this individual's death was inadequate and failed to meet their needs. Suicide and mental health risks were not identified in a timely manner, limiting the ability of the staff to respond adequately. Preventing future suicide deaths starts with robust intake procedures that support early identification of suicide and mental health risks and enables intervention. Correctional staff should have the information necessary to make informed operational decisions and initiate appropriate responses.

Recommendation 2: We recommend that Correctional Services work with the Nova Scotia Health Authority (NSHA) to implement a consistent, province-wide correctional health care standard that guarantees 24/7 access to medical and mental health services across all facilities, grounded in culturally safe and trauma-informed practice.

The Committee is aware that the facilities operated by Correctional Services have different service standards with respect to health care, which is not justifiable and poses an ongoing risk to government. For example, Central Nova Scotia Correctional Facility (CNSCF) currently operates with healthcare on a 24/7 basis, while other facilities do not, including the facility where this death occurred. Preventing suicide deaths requires a uniform approach.

We also note that the current departmental policies and procedures of the NSHA do not include a policy or standard operating procedure specifically addressing trauma-informed or culturally informed approaches in correctional facilities. A review of existing health policies found no provisions explicitly focused on trauma-informed care in relation to mental health and overall well-being.

Recommendation 3: We recommend a province wide suicide prevention strategy and implementation plan. This plan must be accompanied by defined mechanisms for ongoing review and evaluation.

This case provides powerful proof that the risk factors for suicide are established early in life. Deaths of this type are tragic, and there are many points when intervention can change the outcome. Most people's lives are spent outside custody, therefore efforts to prevent deaths in custody must be embedded in a broader strategy that prioritizes upstream efforts at prevention. We note that such a strategy was imagined by the proposed *Suicide Prevention Strategy Act*.

Recommendation 4: We recommend that Correctional Services adopt a formal suicide prevention strategy and implementation plan. This plan must be accompanied by defined mechanisms for ongoing review and evaluation.

Although Correctional Services has a number of policies and procedures that pertain to suicide prevention, we note that it does not have an overarching, evidence-based, suicide prevention strategy. Preventing deaths of this type requires a broad all-encompassing strategy that is not limited to improved procedures at intake or supplying persons in custody with suicide kits. Suicide prevention strategies have been shown to be effective in reducing suicides in correctional settings[1].

The suicide prevention strategy should have some or all of the elements outlined in the United Nations Standard Minimum Rules for the Treatment of Prisoners[2], sometimes referred to as the Nelson Mandela Rules. The future strategy should also include measures to reduce the time between wellness checks to better align with evidence-based practices.

Recommendation 5: We recommend that provincial government should fund the Mi'kmaw Legal Support Network (MLSN) in a sustainable manner.

Since Mi'kmaw Legal Support Network (MLSN) was established, it has not received sustainable, sufficient, operational funding. As a result, the organization relies on short-term or project-based funding to sustain basic operations, limiting service delivery. In addition, program funding that currently does not exist, such as for Bail Verification & Supervision Program and justice navigation, could have had a significant impact on the outcome for this individual.

Recommendation 6: We recommend that government implement "data standards for the Government for the collection and use of information to identify, monitor and address systemic hate, inequity and racism" as referenced in section 11(1) of the *Dismantling Racism and Hate Act*.

The collection and use of timely and high-quality data is at the heart of any effort at the prevention of deaths of any type, including this death. To ensure our committee and others can effectively analyze circumstances surrounding deaths, identify patterns, systemic issues, and recommend evidence-based reforms, it is essential that a robust, culturally responsive, and trauma-informed data collection framework be established.

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[1] Stijelja S, Mishara BL. Preventing suicidal and self-Injurious behavior in correctional facilities: A systematic literature review and meta-analysis. EClinicalMedicine. 2022 Jul 22;51:101560. doi: 10.1016/j.eclinm.2022.101560. PMID: 35898320; PMCID: PMC9309412.

[2] Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977