Nova Scotia's

Deaths in Custody Review Committee (DICRC)

Terms of Reference

June 22, 2023

Note: Nothing in this document supersedes legislation or regulation

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LEGISLATED AUTHORITY AND MANDATE

Section 11(1) of the *Fatality Investigations Act* requires deaths of persons in custody in a correctional facility and deaths of inmates while in hospital to be reported to a medical examiner or investigator.

The authority for the Minister of Justice to establish a Death Review Committee in consultation with the Chief Medical Examiner and the broad mandate for these Committees is provided under 39B of the *Fatalities Investigation Act (FIA)*.

Based on these legislative authorities, the mandate of the Deaths in Custody Review Committee (DICRC) is as follows:

1. Examine trends in all deaths of persons in the custody of Nova Scotia Correctional Services, including deaths that occur in hospitals, and explore how data may be used with a prevention focus to inform programs and policies.

2. Conduct multi-disciplinary in-depth case reviews of specific deaths of persons in the custody of Nova Scotia Correctional Services, including deaths that occur in hospital, where the person has died in circumstances referred to in sections 9 and 10 of the FIA. This includes persons serving a custodial sentence in a provincial correctional facility, being held in remand or in other temporary detention. The Committee may review one or more deaths during a specific case review.

3. Provide advice and recommendations to the Minister on how similar deaths may be prevented in future.

INFORMATION AND PROTECTION OF PRIVACY

CONFIDENTIALITY

The FIA provides that a member of a Death Review Committee shall not publish or disclose information acquired in their role as a Committee member to anyone, whether during or after their appointment, except as provided in the FIA.

Each Committee member is required to sign a confidentiality agreement, reiterating requirements contained in legislation with respect to the protection of privacy.

PRIVACY IMPACT ASSESSMENT

It is the responsibility of the Chair to consult with Privacy Specialists at Service Nova Scotia and Internal Services with respect to operational requirements for Privacy Impact Assessments (PIAs).

PIAs with respect to the Death Review Committee's work are required to be kept current and may be reviewed on an annual basis or as required.

INFORMATION USE, DISCLOSURE AND STORAGE POLICY

Information shall be used, disclosed, and stored in accordance with legislation, applicable privacy impact assessments, and the Province's Information Management Policies.

COMMITTEE STRUCTURE & OPERATIONS

Committee Membership

Position
(1) Chair, Chief Medical Examiner (CME)
(2) Crown Attorney
(3) RCMP Officer
(4) Mi'kmaw representative
(5) African Nova Scotian representative
(6) Primary care physician
(7) Retired Manager level or above in correctional services
Vice-Chair (note: selected from membership)

Other subject matter experts as required may be invited to attend meetings on an ad hoc basis.

The Committee is required to meet not less than twice annually, per section 9 of the *Death Review Committee Regulations*.

Committee Member Roles and Responsibilities

Chair, Chief Medical Examiner (CME)

- As per s.39E(6) of the FIA, consult with the Minister on the designation of a vice-chair
- Ensure Privacy Impact Assessments are conducted as necessary
- Report to the Minister as required, on behalf of the Committee
- Appoint any members to the committee that are not civil servants
- Act as spokesperson, including any communication required with next of kin

- Monitor Committee objectives and overall progress
- Advise the Minister upon commencement of a specific case review
- Upon completion of specific case reviews, ensure final reports are submitted to the Minister
- In consultation with the Public Prosecution Service, ensure a death review respecting a specific death does not interfere with a criminal investigation or prosecution

Vice-Chair

- Perform duties of the Chair in their absence and other duties assigned by the Chair, per section 8 of the *Death Review Committee Regulations*.

Staff Support

Epidemiologist

- Staffed in the CME Office, under the guidance of the CME provides epidemiological support to the committee.

Terms of Membership

As per Regulations:

- Membership terms expire every three years. There is no limit to the number of times that committee members can be reappointed.
- Membership may be revoked by the person who made the appointment, or their successor.

Manner of Appointment

- Civil servant members are appointed by the Deputy Ministers from their respective Department.
- Non-civil servant members are appointed by the Chair.
- The Chair will issue appointment letters to non-civil servant members, outlining the date of the appointment and expiry (three-year term).

Renumeration and Expenses

As per section six of regulations, committee members not employed in the public service or not otherwise receiving compensation from their employer for their participation on the Committee, must be paid $125 for each half day or $250 for each full day of participation in duly called Committee meetings.

Members are entitled to be reimbursed for actual and reasonable expenses they incur in the discharge of their duties, but reimbursement for those expenses must not exceed that normally payable to members of the public service.

Conflict of Interest

Committee members who may have had previous direct involvement with a person whose death is the subject of the Committee's review, or the persons' family, will not participate as committee members on a specific case review.

It is the responsibility of committee members to declare a conflict of interest and bring it to the attention of the Chair.

Reporting Structure

As per the FIA, the Committee reports directly through the Chair to the Minister of Justice.

DECISION MAKING PROCESS

- Decisions will be made based on consensus, whenever possible.
- Consensus means that all committee members agree.
- If consensus cannot be achieved, the Chair may choose to put matters to a majority vote. All committee members will be voting members. In the event of a tie, the Chair has the deciding vote.
- As per regulations, a Committee must not approve the Committee's final report in the absence of a quorum.

QUORUM

As per regulations:

- Two-thirds of the members of a Committee constitute a quorum.

DELIVERABLES and REPORTS

1. A detailed written report to the Minister, following each specific case review, as per section 39G of the FIA (refer to Appendix A for report format).

2. A de-identified summary and recommendations report, provided to the public by the Minister, following each individual case review, as per section 11 of the regulations. This will form the executive summary of each detailed report referenced above.

3. An annual public report to the Minister every year for publication, that includes a description of trends and a summary of the Committee's recommendations for system improvements.

REVIEW OF TERMS OF REFERENCE

This Terms of Reference will be reviewed after one year of the Committee's operation, at which time a review schedule will be established.

LIMITATIONS

- Subsection 39B(3) of the FIA provides that the Committee shall not conduct a death review until the Medical Examiner has completed their duties.
- Subsection 39G(2) of the FIA provides that the Committee's reports must not include any findings of legal responsibility or conclusions of law.
- Section 39F of the FIA provides that a death review may not interfere with a criminal investigation or prosecution.
- The Committee has no authority to make findings or to make recommendations regarding the conduct of individual employees which could relate to discipline of employees or their status as employees.

APPENDIX A – Information to be included in specific case reviews

Introduction

- Critical issue

Review Process

- Purpose
- Method
- Documents reviewed
- Personal interviews
  - Internal
  - External

Background

- Significant case history

Review Findings

- Sequence of events
- Critical issues
- Policy/case practice
- Other factors for consideration

Conclusion

Appendices

APPENDIX B- Death Case Review Process

STEP 1: Committee Notification

- Committee members will be informed of a death that requires a specific case review in one of two ways:
  1. By the Chair at a Committee meeting
  2. By individual Committee members, at a meeting

STEP 2: Notify the Minister of Justice

- CME notifies the Minster of Justice that a specific case review has begun.

STEP 3: Gather Case Relevant Information.

- All Committee members, and the epidemiologist, gather case relevant information. Provide to CME and epidemiologist for review before next meeting.

STEP 4: Case Discussion and Analysis.

- Cases may be brought back to review agendas multiple times, until the team is comfortable that all areas of concern have been properly addressed.
- Discuss the Delivery of Services

Questions that need to be asked regarding the delivery of services to those impacted by the death include:

Were services provided to family members as a result of the death?
Were services provided to other persons in custody?
Were services provided to responders, witnesses, or community members?
Are there additional services that should be provided to anyone?
Who will take the lead in following up on these service provisions?
Does the team have suggestions to improve service delivery systems?

These questions are not meant to place blame, but to ensure that those who may be touched by a death receive needed support services.

STEP 5: Identify Risk Factors

Identifying the risk factors involved in a person's death during the review can lead to recommendations that the team believes could reduce those same risk factors for other persons in custody, thereby preventing future deaths. Grouping risk factors into general categories can help guide this discussion:

- Health
- Social

- Economic
- Behavioral
- Environmental
- Systemic (e.g., Agency Policies and Procedures)

It is important to identify the risk factors involved in each death, as these become the basis upon which a team will formulate its findings. These findings are in turn used to generate recommendations for improved investigations, service delivery, changes in systems, legislation, or prevention initiatives. These systems improvements and prevention programming are the ultimate goal of a death review process that is based on a public health model.

STEP 6: Generate Recommendations and Report

STEP 7: Evaluation

Will the Committee track responses to recommendations made?
How will the Committee measure its success?