One-Way Trip:
Prisoner Suicides in Ontario, 1992-2006

by
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B.A., Simon Fraser University, 2009

Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts

in the
School of Criminology
Faculty of Arts and Social Sciences

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SIMON FRASER UNIVERSITY
Summer 2014

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Abstract

This thesis explores the circumstances surrounding 110 prisoner suicides in Ontario’s provincial and federal correctional facilities between 1992 and 2006. Using data obtained from the Office of the Chief Coroner of Ontario, a detailed examination of all available files of Coroners’ inquests into suicides was conducted. Intersectionality served as a critical theoretical framework for the analysis of variables in this study. Several demographic, institutional, and clinical factors were associated with suicides in prisons. Consistent with findings from the Canadian and international literature, prisoner suicides are most common among young, single males. Suicides are more common in the early stages of incarceration, particularly among inmates housed in provincial remand facilities. A history of mental illness was documented in 39% of cases. The preferred method of suicide in prisons continues to be hanging, accounting for 94% of deaths in the sample. In light of the findings, prevention strategies and recommendations for change are discussed.

Keywords: prisoner suicides; suicide prevention; coroners’ data; intersectionality
Dedicated to all those who have taken their lives behind bars.
Acknowledgements

I would like to acknowledge a number of individuals who played an integral part in bringing this thesis to fruition. First and foremost, I would like to sincerely thank my supervisory committee. To my senior supervisor, Dr. Brian Burtch, I am incredibly grateful for your continued support, patience, and scholarly guidance throughout this entire process. This thesis greatly benefited from your remarkable attention to detail and amazing editing skills. To my supervisor, Dr. Ted Palys, thank you for your insightful comments and helpful suggestions with my thesis. Your knowledge and unique perspective were very much appreciated. A sincere thank you is extended to Dr. John Winterdyk for his role as my external examiner. Thanks also to Dr. Bryan Kinney for chairing my thesis defence.

The thesis would not have been possible without the co-operation of the Office of the Chief Coroner of Ontario who granted me access to utilize their data. A special thanks to Doris Hildebrandt for facilitating the approval process.

A heartfelt thanks to Dr. Margaret Jackson whose kindness, support, and encouragement have always been invaluable. A special thank you is extended to Dr. Simon Verdun-Jones for his sage advice. I am very grateful to my friend Dr. Gary Teeple for always being there for me. To Dr. Ezzat Fattah, thank you for your support. It was truly an honour to have you present at my thesis defence.

To my friends, Ehsan Jozaghi, Andrew Reid, Rebecca Carleton, Stephanie Dawson, Mohammad Shah Ferdosi, and Begum Yuksel, thank you for your constant support over the years.

To my family, thank you for your unconditional love and faith in me. To Riaz, my brother, my hero, thank you for encouraging me to “think big, be big”. Thanks for your love and loyalty. Mom, for all you do, for all you are, I will always be in awe of you. To my dad, my guardian angel, thank you for always watching over me.
Most importantly, to David, my love, my life. Thank you for taking this journey with me. I could not have done any of this without your love, unwavering support, and belief in me. You believed in me when I doubted myself. Thank you for being there for me every step of the way. I look forward to the next phase of our incredible journey together.
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List of Acronyms

CSC  Correctional Services of Canada
OCI  Office of the Correctional Investigator
RCIADIC  Royal Commission into Aboriginal Deaths in Custody
Chapter 1. Introduction

1.1. Deaths in Custody

Deaths in custody have attracted growing attention in recent years (Antonowicz & Winterdyk, 2014). This is a contentious yet important topic that warrants careful investigation, as prison authorities and others in a position of power are responsible for the safety and well-being of incarcerated populations. To date, there are two recent studies that provide a detailed examination of deaths in custody in the Canadian context: Wobeser et al. (2002) and more recently Antonowicz & Winterdyk (2014). Each of these studies broadly addressed the death in custody phenomenon, looking at all types of deaths arising in custodial contexts. Indeed, both of these studies looked at police custody and prison custody deaths together. Drawing on the work of these researchers, this thesis specifically focuses on suicides in the prison context.

1.2. The Prisoner Suicide Phenomenon

Suicide continues to be one of the leading causes of death in prisons, exceeded only by deaths due to natural causes (Dye, 2010; Hayes, 1999). This finding holds true for various countries including Canada, the United States, England and Wales, and Australia. Researchers confirm that the suicide rate in penal institutions is much higher than in the general population (Hayes, 1995; Office of the Correctional Investigator, 2011). Prisoner suicides have been of interest to researchers studying the lasting effects
of incarceration on inmate adjustment to life in “total institutions” (Goffman, 1961; Huey & McNulty, 2005). This term, coined by renowned sociologist Erving Goffman, refers to the closed worlds of institutions such as asylums and prisons, among others, where the daily activities of inmates are strictly regimented and imposed from above by a system of authority.

Goffman defined a total institution as a “place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable amount of time, together lead an enclosed, formally administered round of life” (1961, p. xii). Goffman’s (1961) analysis specifically focused on mental hospitals and the role of the institution, as opposed to the illness, in forming the self-identity of mental patients. However, his observations are applicable to inmates in other types of total institutions.

The term prisoner was used in lieu of inmate given how inmate is a generic term that can be applied to mental patients as well as those confined in other secure facilities. The term prisoner also better captured the essence of the thesis by explicitly stating who committed suicide while in custody. The use of the term prison was used interchangeably with correctional facility or institution throughout this thesis.

While deaths in custody have received increasing attention in recent years (Antonowicz & Winterdyk, 2014), many prisoner suicides rarely appear in Canadian news coverage. A recent exception involved the death of Ashley Smith, a 19-year old who committed suicide in 2007 at a Kitchener prison for women. This case received considerable media attention due to individual and systemic failures within the Correctional Service of Canada (CSC). An article in the Toronto Star detailed how her developing mental illness was left untreated and how correctional guards watched as
she strangled herself in a segregation cell (Zlomislic, 2009). They had been ordered by senior staff not to enter Smith’s cell as long as she was still breathing (CBC News, 2013). In December 2013, an Ontario Coroner’s jury ruled her self-inflicted choking death was a homicide (CBC News, 2013). According to Howard Sapers, the federal correctional investigator for Canada, this case raises questions about CSC’s willingness and ability to prevent suicides in light of Ashley Smith’s death (Zlomislic, 2009).

Several factors appear to contribute to inmate suicide. Suicidal prisoners often struggle with a lethal combination of alcohol and/or other substance abuse problems, mental illness including depression, mental and physical abuse, disadvantaged family backgrounds, parental neglect, and lengthy criminal histories (Office of the Correctional Investigator, 2012). Other factors that correlate with inmate suicide include the use of segregation, involuntary transfer or rejection of a transfer request to other facilities, stage of incarceration, and the security level of the facility. Researchers have found that suicides occur more frequently in maximum-security prisons, where the level of deprivation is greatest, compared to medium and minimum-security facilities, (Dye, 2010; John Howard Society, 1999). While inmates housed in maximum-security prisons generally receive the longest sentences, in order to determine whether variables such as sentence length are correlated with suicides or if suicides actually occur independently of sentence length, we would need to have access to more detailed information regarding the type of sentences received.

Researchers have also found demographic variables such as gender, age, marital status, and race to be correlated with prisoner suicides. The majority of inmates who commit suicide are male, young in age, unattached, and Caucasian. Younger offenders in the U.S. and the U.K. are at a greater risk of suicide in prison (Daniel, 2006;
Liebling, 1999). In addition, the U.S. literature has consistently reported the overrepresentation of White inmates and underrepresentation of racial minorities in prisoner suicides (Dye, 2010; Suto & Arnaut, 2010; Way et al., 2005). These racial disparities are more evident in certain jurisdictions such as New York where, according to one study, between the years 1993 and 2001 White inmates comprised 18% of the total inmate population but accounted for 37% of prisoner suicides (Dye, 2010). While ethnic and racial minorities are generally found to be underrepresented in inmate suicides, in Canada, Aboriginal inmates have a higher suicide rate than the non-Aboriginal inmate population (John Howard Society of Alberta, 1999).

Over the past two decades, a shift towards pursuing a “tough on crime” agenda in Canada has resulted in new challenges within prison systems, including prevention of inmate suicides. Part of this “tough on crime” approach has included legislative changes initiated in 1995 such as the rise of mandatory sentencing laws of four years’ imprisonment to be applied to any one of 10 offenses committed with a firearm (Department of Justice Canada, 2013). Another change involved Bill C-10, which expanded the circumstances under which a mandatory minimum sentence must be imposed, mainly in relation to sex offences and some drug offences, thereby increasing sentence lengths (Canadian Bar Association, 2011). The cumulative effect of these changes in legislation and an overly punitive criminal justice system has resulted in prison overcrowding, an increase in the inmate population, particularly women prisoners, and the aging or “graying” of the prison population (Office of the Correctional Investigator, 2012). Prison overcrowding has gained prominence as it has been tied to increased levels of suicide, violence in institutions, increasing psychological deprivation, and the spread of infectious diseases in prisons such as HIV/AIDS, Hepatitis B and C,
and tuberculosis (Fruehwald et al., 2010; Griffiths, 2010; Huey & McNulty, 2005; Office of the Correctional Investigator, 2012). Given the existing correctional challenges and prevailing social policy of increasing incarceration rates and length of stay in custody, the potential for even higher prisoner suicide rates in the future is a serious concern (Office of the Correctional Investigator, 2012). In part, elevated suicide rates in prison are a concern because correctional authorities owe a legal duty to minimize harm to those under their care and control.

1.3. Legal Duty of Care

There is considerable controversy surrounding deaths that occur in custody, particularly in an era of instant media coverage and communication (Grant et al., 2007). However, deaths in prison custody often go unnoticed compared to deaths that occur in police custody. In British Columbia, the infamous case of Polish immigrant, Robert Dziekanski, who was tasered to death by RCMP officers at the Vancouver airport in 2007, captured international headlines. Another case involved an Aboriginal man, Frank Paul, who died of hypothermia after members of the Vancouver Police Department (VPD) dumped him in an alley and left him to die in the winter of 1998. Police had picked up the New Brunswick Mi’kmaq native for being drunk in a public space, and police video footage captured Paul being dragged through the police lock-up the night he died (MacAlister, 2010). Nevertheless, some high-profile cases of deaths in prisons (e.g. Ashley Smith) have garnered attention in recent years. For some, every death in custody is a tragedy, especially those that occur suddenly and unexpectedly, and as such, they call into question efforts to carry out a legal duty of care.
Section 3 of the Corrections and Conditional Release Act states that: “The purpose of the federal correctional system is to contribute to the maintenance of a just, peaceful and safe society by

(a) carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders” (Corrections and Conditional Release Act, S.C. 1992, c. 20).

Correctional personnel are cumulatively responsible for the welfare of those incarcerated (Office of the Correctional Investigator, 2012). In Canada, the Correctional Service of Canada (CSC) has a legal duty of care to inmates under their supervision. Thus, prison staff are expected to take proactive measures to prevent an inmate from being abused while in custody or dying prematurely (Office of the Correctional Investigator, 2012). Rooted in English tort law, there is a legal obligation to ensure a person does not suffer from any foreseeable harm, loss or injury. In custodial settings, preventing deaths in custody becomes more complicated by the constant need to balance a legal duty of care against security concerns (Office of the Correctional Investigator, 2011).

1.4. Investigating Deaths in Custody

In Canada, deaths in prison custody are investigated by the provincial Coroner’s Office or the Medical Examiner’s Office, depending on the jurisdiction. Provincial jurisdictions operate slightly differently from one another. It is important to note that there are no standardized protocols in effect for Coroners or Medical Examiners; an issue that has been raised by previous studies and the correctional investigator for Canada (Antonowicz & Winterdyk, 2014). As such, the standards regarding expectations placed on federal and provincial institutions vary accordingly.
The Coroner’s Service is responsible for investigating all sudden, unexpected, unnatural, unexplained or unattended deaths (Ontario Ministry of Community Safety & Correctional Services, 2012). In all provinces and territories, the Coroner is responsible for gathering facts surrounding a death and their investigation must determine the following five questions: (1) who, (2) where, (3) when, (4) how (medical cause), and (5) by what means (manner of death) the deceased came to his or her death (Ontario Ministry of Community Safety & Correctional Services, 2012). While all deaths brought to the attention of the Coroner will be investigated, not all of these deaths will be the subject of a Coroner’s inquest.

1.4.1. Inquests

Inquests are public hearings intended to probe into the circumstances surrounding a death through a fact-finding process (Ontario Ministry of Community Safety & Correctional Services, 2012). Inquests are held in compliance with the Coroner’s legislation in force in the province or territory where the death occurred. In Ontario, by law, the Coroner is required to hold an inquest in cases where a death occurs while a person is in custody or being detained (Ontario Ministry of Community Safety & Correctional Services, 2012). However, if the death is a result of natural causes, while the death must be investigated by a Coroner, the decision to hold a formal inquest is discretionary (Ontario Ministry of Community Safety & Correctional Services, 2012). For example, section 10(4.3) of the Ontario Coroner’s Act states:

Where a person dies while committed to and on the premises of a correctional institution, the officer in charge of the institution shall immediately give notice of the death to a coroner and the coroner shall investigate the circumstances of the death and shall hold an inquest upon the body if as a result of the investigation he or she is of the opinion that the person may not have died of natural causes. (2009, c. 15, s. 10(4.3)).
Following every death in an Ontario prison, other than those arising from natural causes, a Coroner will preside over an inquest held before a jury who ultimately issues the inquest verdict. The jury may make recommendations to prevent future deaths in similar circumstances. It is customary for the presiding Coroner at an inquest to provide a synopsis of the events leading to the death and also provide background information. This makes reading the Jury’s verdict easier to understand by putting the findings and recommendations into context. This summary, however, is based on the presiding Coroner’s own understanding of the evidence and interpretation of the Jury’s reasons (Ontario Ministry of Community Safety & Correctional Services, 2012), a feature that will be critically assessed later in this thesis (see chapter 4).

1.4.2. Classifying Deaths in Custody

Deaths are classified by a presiding Coroner in one of five ways:

- suicide
- homicide
- natural
- accident
- undetermined

Deaths are designated as either self-inflicted or due to natural causes. The designation “self-inflicted” is applied to deaths that appear to be directly caused by the actions of the deceased, whether the action resulting in death was deliberate or accidental (Sandler & Coles, 2008).

It is important to note that prisoner suicide rates may be higher than statistics indicate due to a tendency to underreport such incidents (Suto & Arnaut, 2010). Many
suicides are actually categorized as accidental deaths (Suto & Arnaut, 2010). Correctional staff at some institutions may decide not to report some deaths as suicides for fear of legal action, or if an inmate dies in the hospital following a suicide attempt, official records may not indicate that he or she committed suicide in prison (Daniel, 2006).

1.5. Chapter Outlines

The focus of this thesis is a comprehensive examination of prisoner suicides in Ontario from 1992 to 2006, inclusive. The research involves three key objectives: (1) to provide a description of patterns and trends of suicide from Ontario’s federal and provincial correctional facilities from 1992 to 2006; (2) to offer a theoretical discussion of the critical concept of intersectionality as it applies to the research findings, and (3) to discuss suicide prevention strategies and related policy development in corrections.

This thesis is divided into six chapters. This first chapter provides a selective overview of the prisoner suicide phenomenon and related factors thought to contribute to inmate suicide. In addition, there is a discussion of the principle of “a legal duty of care” which prison officials must exercise for inmates under their supervision. Coroners’ investigations into deaths in custody and the role of inquests were outlined and classifications of deaths in custody are presented.

The second chapter presents a more detailed review of the existing literature from Canada, the United States, England & Wales, and Australia regarding prisoner suicides. This review identifies common factors and statistical trends and points out shortfalls in research studies and official documentation. Additionally, this chapter offers
a theoretical discussion of the concept of intersectionality, which is used as an initial framework to examine how gender, race, and other factors might intersect with specific forms of disadvantage to influence inmate suicide.

Chapter Three describes the nature of this archival study and the different analytic methods used for data analysis in this thesis. Variables of interest included standard demographic factors such as gender, race, ethnicity, and age as well as inmate characteristics including history of mental illness, alcohol and/or other substance abuse, and previous suicide attempts. These variables were coded using Microsoft Excel. Institutional variables were extracted from Coroners’ files such as type of institution (federal or provincial), security level of facility, type of sentence received, and stage of incarceration, where noted in the files. This chapter also outlines data sources and research decisions tied to this thesis.

The fourth chapter details the results of the current study. Findings from suicides in Ontario’s federal and provincial correctional facilities from 1992 to 2006 are provided. Demographic, institutional, and clinical factors of the sample are reported to identify common factors and highlight recent trends. This chapter ends with a detailed case study analysis on Aboriginal suicides (n=8) to further delve into case characteristics of this marginalized group.

Chapter Five offers a discussion of the research results. The current research findings are compared to similar research findings. Implications of the findings for academics researching this area and for policy makers in corrections are also addressed. A discussion of results on Aboriginal suicides centres on their socially disadvantaged position within society and their life circumstances which often result in
their disproportionate contact with the criminal justice system. This chapter will conclude with a discussion of the limitations of this thesis.

The final chapter advances a discussion of suicide prevention strategies and policy development in correctional practice. Additionally, conclusions and recommendations for future research on prisoner suicides are suggested.
Chapter 2. Literature Review

This chapter provides an overview of the existing literature on prisoner suicides, and outlines the theoretical framework to be applied. It begins with a review of various studies identifying the rate of prisoner suicides in various jurisdictions. It then goes on to highlight those studies that have addressed gender, race, and social disadvantage as it relates to prisoner suicides. The value of qualitative studies in understanding this subject area is also discussed. Finally, Intersectionality is presented as a theoretical framework that guided the present research.

2.1. Rates of Prisoner Suicide

Historically, very little was known about the risk of prisoner suicide or fluctuations in the rate of such suicides. It was a research area that had often been overlooked within criminological and correctional literature (Hayes, 1995). This oversight was due, in part, to prisoner suicide being considered neither worthy of investigation nor a serious problem. This lack of interest, including very limited media coverage of suicides in penal settings, has been tied to prisoners being seen as a discreditable, undeserving population (Greer, 2007). However, academic and public policy interest in this subject area has increased since the 1980s. Table 2-1 below presents major studies on prisoner suicides detailing an unfolding or evolution of the research literature.
<table>
<thead>
<tr>
<th>Research Studies</th>
<th>Time period</th>
<th>Jurisdiction</th>
<th>Suicide rate per 100,000 prisoners</th>
<th>Total # of deaths</th>
<th>% of deaths result of suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burtch &amp; Ericson, 1979</td>
<td>1959-1975</td>
<td>Canada</td>
<td>95.9 (federal penitentiaries) 272 (four largest maximum-security penitentiaries)</td>
<td>96</td>
<td>N/A</td>
</tr>
<tr>
<td>Hayes, 1995</td>
<td>1984-1993</td>
<td>United States (state and federal prisons)</td>
<td>20.6 (average rate)</td>
<td>1339</td>
<td>N/A</td>
</tr>
<tr>
<td>Dalton, 1999</td>
<td>1997-1998</td>
<td>Australia</td>
<td>N/A</td>
<td>76</td>
<td>44.7</td>
</tr>
<tr>
<td>Collins &amp; Mouzos, 2002</td>
<td>1980-2000</td>
<td>Australia</td>
<td>N/A</td>
<td>75 (women)</td>
<td>32</td>
</tr>
<tr>
<td>Wobeser, Datema, Bechard &amp; Ford, 2002</td>
<td>1990-1999</td>
<td>Ontario (federal and provincial institutions)</td>
<td>N/A</td>
<td>308</td>
<td>59 (men) 62.5 (women)</td>
</tr>
<tr>
<td>Gabor, 2007</td>
<td>2001-2005</td>
<td>Canada (federal custody)</td>
<td>N/A</td>
<td>82</td>
<td>61</td>
</tr>
<tr>
<td>Sandler &amp; Coles, 2008</td>
<td>1990-2007</td>
<td>England</td>
<td>N/A</td>
<td>115 (women)</td>
<td>76.5</td>
</tr>
<tr>
<td>MacAlister, 2010</td>
<td>1992-2007</td>
<td>Canada (police-involved deaths)</td>
<td>N/A</td>
<td>438</td>
<td>19.2</td>
</tr>
<tr>
<td>Sapers, 2010</td>
<td>1998-2008</td>
<td>Canada (federal custody)</td>
<td>84</td>
<td>532</td>
<td>20</td>
</tr>
<tr>
<td>Fazel, Grann, Kling &amp; Hawton, 2011</td>
<td>2003-2007</td>
<td>Cross-cultural comparison (12 countries)</td>
<td>70 (Canada) 58 –147 (all jurisdictions)</td>
<td>44 (Canada)</td>
<td>N/A</td>
</tr>
<tr>
<td>Antonowicz &amp; Winterdyk, 2014</td>
<td>2000-2009</td>
<td>BC, Alberta, Ontario (federal and provincial institutions)</td>
<td>N/A</td>
<td>388</td>
<td>20.1</td>
</tr>
</tbody>
</table>
In one of the earliest Canadian studies on inmate suicide, Burtch and Ericson (1979) found that between 1959 and 1975, the suicide rate among inmates in Canadian federal penitentiaries was 95.9 per 100,000 inmates and the suicide rate in the four largest maximum-security penitentiaries (St. Vincent de Paul, Kingston, Saskatchewan, and the British Columbia Penitentiary) was 272 suicides per 100,000 inmates. These rates are markedly higher than the corresponding rate of 14.2 suicides per 100,000 for non-prison males in Canada during this period. The magnitude of this difference between prison and non-prison populations has since been consistently reported in the literature. This study called for a recognition of the relatively low priority accorded to life-threatening situations vis-à-vis security concerns, development of suicide prevention programs, and further research on effective clinical services.

More recently, a Canadian study on the causes of death among people in custody in Ontario between 1990 and 1999 found a total of 308 inmates died over this period (Wobeser, Datema, Bechard & Ford, 2002), but data were available for only 291 inmate deaths (283 men, 8 women). Of the 283 men who died, 59% of deaths were the result of violent causes, with suicide by strangulation accounting for 90 deaths. Five of the eight deaths among women were also the result of suicide (Wobeser et al., 2002). A later Canadian study calculated that from 1998 to 2008 the suicide rate among inmates was 84 per 100,000 inmates (Office of the Correctional Investigator, 2010a). A total of 532 offenders died in federal custody in that period, with one-fifth (or 107 deaths) classified as suicide (Office of the Correctional Investigator, 2010a).

Similarly, Antonowicz & Winterdyk (2014) conducted a very recent analysis of deaths in custody (prison and police custody) from three Canadian provinces. Their study is the first in the Canadian context to examine deaths in custody across three
provinces - B.C., Alberta, and Ontario. All completed Coroners’ and Medical Examiner records of 388 deaths between 2000 and 2009 in the three provinces were reviewed to draw comparisons and identify mortality trends. Of the 388 deaths, 46.6% \( (n = 181) \) were the result of natural causes with suicides accounting for 20.1% \( (n = 78) \) of deaths in custody (Antonowicz & Winterdyk, 2014). Recommendations from this study largely pertained to improving intake screening practices for inmates.

Other countries have experienced similar trends in prisoner suicides. In Australian prisons, 76 deaths in custody (including suicides) were reported between 1997 and 1998, the highest number of deaths recorded over a 20 year period up to that point. Of these prison deaths, 34 inmates (44.7% of the inmates who died) took their own lives (Dalton, 1999). In the United States, a total of 1339 suicides occurred in state and federal prisons between 1984 and 1993, resulting in an average yearly suicide rate of 20.6 per 100,000 inmates (Hayes, 1995). However, this U.S. study revealed a gradual decrease in the national rate of prisoner suicide during the 10 years under study, with a high of 27.2 per 100,000 inmates in 1985, settling to a low of 16.1 per 100,000 in 1992. Despite this decline, the rate once again rose to 17.8 per 100,000 inmates in 1993, with 15 states experiencing increased rates of prisoner suicide. Hayes (1995) contends that several developing prison characteristics, such as overcrowding and mandatory sentencing laws, could result in higher suicide rates in the future. It is impossible to know whether these changing suicide rates are anomalous or part of a trend linked to identifiable factors.

A cross-cultural comparison of prisoner suicides from 12 jurisdictions (Australia, Belgium, Canada, Denmark, England and Wales, Finland, Ireland, Netherlands, New Zealand, Norway, Scotland, and Sweden) revealed that suicide rates among prisoners
are generally higher than the general public, but with some variation among these countries. Data collected on 861 suicides in prison between 2003 and 2007 revealed 810 male suicides and 51 female suicides (Fazel, Grann, Kling & Hawton, 2011). The rates of suicide among male prisoners varied between 58 and 150 per 100,000 prisoners and were at least three times higher than estimates of suicides in the male general population. Rates of suicide among female prisoners also varied widely ranging from 1 to 37 per 100,000 prisoners. An interesting finding from this cross-national study was that while there was little difference in suicide rates among the Western European countries, Australia, Canada, and New Zealand appeared to have lower rates in comparison to other nations.

2.2. Gender, Race, Disadvantage, and Prisoner Suicide

Women have been one of the fastest growing populations in prisons in recent years (Collins & Mouzos, 2002; Office of the Correctional Investigator, 2012; Sandler & Coles; 2008). In Canada, the in-custody population for federally sentenced women increased by 21% between March 2010 and March 2012 (Office of the Correctional Investigator, 2012). There have been serious concerns about the over-representation of Aboriginal women who currently represent 33.6% of all federally sentenced women in Canada (Office of the Correctional Investigator, 2013b). Many have questioned the purpose of imprisoning women and its subsequent consequences. While women dying in prison are not a homogenous group, they share a number of common characteristics and, oftentimes, similar life histories/backgrounds (Sandler & Coles, 2008). One Australian study investigating custodial deaths that occurred between 1980 and 2000 (Sandler & Coles, 2008) focused primarily on women. Given the paucity of research on
women dying in custody, Collins & Mouzos (2002) used a gender-specific analysis to understand the circumstances surrounding such deaths. This study included deaths that occurred in prison, police cells, and juvenile custody. They found that 75 women died in custody in Australia from 1980 to 2000. Consistent with the literature, hanging was the leading cause of death accounting for 32% of deaths. Many of the women who died in custody had experienced great adversity in their lives, such as alcohol and substance abuse, mental illness, domestic abuse, and a history of self-harm (Collins & Mouzos, 2002).

Collins and Mouzos (2002) also examined differences between Indigenous and non-Indigenous women to identify issues specific to Indigenous women. Indigenous women and visible minorities often face multiple, simultaneous systems of oppression in Australia. Their findings indicate that the majority of non-Indigenous women who died in custody, died in prison custody whereas Indigenous women were more likely to die in police custody. However, 54% of the Indigenous women and 28% of the non-Indigenous women were in custody at the time of death for “good order” offences. These include offences such as public drunkenness, administration of justice offences, prostitution, gambling, disorderly conduct, and vagrancy. This suggests a need for policy alternatives to divert individuals away from the criminal justice system for public drunkenness, prostitution, and other, less serious “good order” offences (Collins & Mouzos, 2002). The majority of Indigenous males died in prison custody as opposed to police custody, which contrasts with the situation for Indigenous women. The authors suggest that gender-specific prevention policies must be developed, given that women often do not die in the same circumstances as their male counterparts. While this finding has significant implications for policy formation and development, one major limitation of this study is
that the authors fail to proffer any concrete examples of gender-specific policies. This study reflects the gulf between identifying patterns of suicide and the lack of compelling theoretical explanations for suicidal behaviour.

Dalton (1999) examined deaths in custody in Australian prisons between 1980 and 1998. The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was established to investigate the deaths of Australia’s Indigenous people in custody during this period. The commission’s investigation confirmed two major features: (1) the high number of Indigenous deaths in custody; and (2) the disproportionately higher rates at which Indigenous people came into contact with the criminal justice system (Dalton, 1999). The most significant reason for this contact was attributed to the severely disadvantaged social, economic, and cultural position of many Indigenous people. The over-incarceration of Australia’s Indigenous people is well-documented and this is also true for many other countries including Canada, New Zealand, and the United States.

Findings reveal some interesting trends in custodial deaths over an 18-year period in Australia. Deaths in police custody have significantly declined since 1987, a development which has been attributed, in part, to Australia’s police services’ successful implementation of changes in their procedures for dealing with those detained in their custody such as cell design modifications (Dalton, 1999). Alternatively, deaths in prison custody rose steadily during this time, from 28 deaths in 1980-1981 to 76 deaths in 1997-1998. This increase occurred despite the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) recommendations which were aimed at addressing the over-representation of Australia’s Indigenous population in lock-ups. Dalton (1999) contends that an analysis of inmate demographics (age, gender, aboriginality, prior criminal and psychiatric histories, and other factors) could provide
important information pertaining to custodial deaths and help to identify significant
questions to be addressed in policy development. For example, she found that two-thirds
of deaths among younger prisoners occurred through suicide, while more than two-thirds
of prisoners over age 40 died from natural causes. Furthermore, Aboriginal inmates
were almost as likely to commit suicide as non-Aboriginal inmates. Additional information
collected through various stages upon entry to a correctional facility - from screening to
interviewing while in custody - can provide useful knowledge on preventing custodial
deaths.

Sandler and Coles (2008) provided an examination of women’s deaths in prisons
from 1990-2007 across England and other parts of the UK. Their study was primarily
descriptive and did not provide baseline data on the number of women in prison in
particular countries. The researchers found that a total of 115 women died in prisons in
England whereas Northern Ireland (n=2), Scotland (n=10), and Wales (n=0) had
considerably lower numbers. The majority of the deaths that occurred in England were
self-inflicted (n=88). The majority of women who died in prison were White; Black women
accounted for 12% of self-inflicted deaths. In fact, between 1998 and 2002, Black
women were under-represented in the numbers of self-inflicted deaths relative to their
proportion of the women prison population which ranged between 18 and 24% (Sandler
& Coles, 2008). Despite this under-representation, Sandler & Coles (2008) argue that in
general Black women were over-represented and marginalized within the prison
population.

The main focus of Sandler and Coles’ report was on self-inflicted deaths and
development of strategies to prevent women from dying in prison. Their in-depth
analysis raises issues about systemic inadequacies regarding the treatment of women in
prisons, the impact of imprisonment on women with mental illness, and imprisoning women who are mothers. They argue that imprisonment is an ineffective solution for certain crimes that have consequences and implications that extend far beyond the individual. Recommendations and best practices are also discussed such as the abolition of prison as the central response to women in the criminal justice system and the use of community-based alternatives (Sandler & Coles, 2008).

2.3. Qualitative Studies

The extant research on prisoner suicides has been criticized for being largely retrospective, correlational, and descriptive in nature. Way et al. (2005) noted that much of the research on prisoner suicides has focused on calculating and comparing suicide rates. Liebling (1999) argues that prisoner suicide researchers have largely ignored the potential for a richer, affective understanding of prisoners and instead relied on the use of official records. These largely descriptive studies often fail to describe the process by which inmates decide to end their lives.

In contrast, Suto & Arnaut (2012) employed a qualitative approach (phenomenological method) to provide a better understanding of inmates who attempted suicide. No preconceived hypotheses were formulated to allow researchers to identify factors not yet recognized in the literature (Suto & Arnaut, 2012). Inmates also were asked to make recommendations, based on their experiences, about ways to improve prevention programs. A total of 24 inmates (21 men, 3 women) were interviewed in six state prison facilities in Oregon between 2004 and 2005. A semi-structured interview format was used with questions developed to obtain a thorough description of factors
leading up to the inmates’ suicide attempts. Table 2-2 highlights factors associated with suicide based on the experiences of inmates in the sample.

Table 2-2: Categories, Themes, and Subthemes from Interviews

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health issues</td>
<td>Depressive symptoms</td>
<td>- Low mood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Depressive thoughts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Feelings of hopelessness</td>
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<tr>
<td></td>
<td></td>
<td>- Feelings of loneliness</td>
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<tr>
<td></td>
<td></td>
<td>- Feelings of guilt and/or shame related to their crime</td>
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<tr>
<td>Symptoms of anxiety</td>
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<tr>
<td>Hallucinations and/or paranoid ideation</td>
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<tr>
<td>Medication-related problems</td>
<td></td>
<td></td>
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<tr>
<td>Impulsivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious beliefs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship issues</td>
<td>Relationship problems with family of procreation/partner</td>
<td></td>
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<tr>
<td></td>
<td>Relationship problems with family of origin/adoptive family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relationship problems with inmates</td>
<td>- Not getting along</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Threats from inmates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Physical fights</td>
</tr>
<tr>
<td>Relationship problems with staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prison factors</td>
<td>Moves within the prison</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employment/activity-related difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Placement in DSU* (*Disciplinary Segregation Unit or the “hole”)</td>
<td></td>
</tr>
</tbody>
</table>

(Suto & Arnaut, 2012)

Overall, a combination of events, feelings and individual thoughts contributed to each inmate’s decision to attempt suicide. Further, decisions were preceded by a series of difficulties that drained the inmate’s ability to cope. As a result, inmate
recommendations included the desire to talk about their problems with almost all participants expressing a need to be heard and emotionally supported. Interestingly, no inmate recommended a higher dosage of medication as a tool to reduce his or her suicidal thoughts. The implications of these findings are that nonmedical solutions that boost inmates’ coping abilities need to be implemented in any effective suicide prevention program.

Liebling (1995) summarized the main findings from two long-term comprehensive research studies carried out between 1987 and 1992 on suicide and suicide attempts in UK prisons. Both studies employed interviews with prisoners and staff as well as an epidemiological study intended to provide contextual material on the nature and frequency of suicide attempts and self-harm in prisons. The two studies highlighted important differences related to criminal justice histories and background demographics between suicide attempters and other prisoners. Suicide attempters tended to come from more disadvantaged backgrounds (characterized by family breakdown, poor educational and employment history) and were more likely to have violence and family problems in their histories (Liebling, 1995). Suicide attempters also had more frequent contacts with social services and criminal justice agencies. Additionally, suicide attempters’ reported accounts of prison life seemed to be more difficult for them compared to non-attempters.

Liebling's study provides a greater understanding of prisoners’ vulnerability and the significance of the prison environment in contributing to suicide risk. The findings outlined in her study only address one aspect of the prisoner suicide phenomenon. The results do not address issues pertaining to correctional staff, prisoners who did not physically attempt suicide but have expressed suicidal ideations, and problems affecting
specific groups such as lifers. Given the limitations inherent in statistical data on prisoner suicide and suicide attempts, the use of long semi-structured interviews coupled with observational methods, participation, and informal discussions with prisoners and correctional staff appears to be an ideal approach to this type of research (Liebling, 1995), where resources permit.

2.4. Theoretical Background

Various theoretical approaches can be taken to explain the suicide phenomenon. These include macro and micro levels of analysis. The most renowned macro-level explanation of suicide was provided by Emile Durkheim in his classic monograph, *Suicide* (1951, originally published in 1897), where he best illustrated the concept of *anomie*. While Durkheim was exploring varying suicide rates among Catholics and Protestants in the general population, his theoretical explanations are relevant to the high suicide rates found in prisons. He hypothesized that one reason for these varying suicide rates was that Catholicism more closely integrated the individual into collective life whereas Protestantism was correlated with a high level of individualism and materialism. The stronger social control exhibited among Catholics resulted in lower suicide rates compared to Protestants. Durkheim introduced the concept of *anomie*, which he defined as a state of “normlessness”,

Durkheim’s conclusions also can be applied to understanding the high rates of suicide found among the prison population. Prisons represent an environment where prisoners can experience the greatest degree of anomie after their removal from the outside society. In general, their removal from their family, friends, and community creates a high degree of social exclusion, increasing the risk of suicide. Conversely,
while high suicide rates can be found in societies where there is a lack of social integration, high suicide rates also can be seen in overly repressive, excessively regulated societies or environments such as prisons (Durkheim, 1951). In this context, the pains of imprisonment often become too much to bear and inmates would rather end their lives than continue living in prison (Sykes, 1958). Macro-structural theories, while useful in understanding society at large, are not ideally suited for studying phenomena arising in the institutional context nor are they particularly helpful for predicting risk of suicide for particular individuals.

Two dominant theoretical explanations surfaced over time. The importation and deprivation models each provide unique approaches by which researchers can seek to understand suicide in prisons. The deprivation perspective asserts that suicide is the result of a restrictive prison environment whereby inmates experience a profound loss of freedom, identity, and control over their lives (Clemmer, 1958; Huey & Mcnulty, 2005). At the same time, the importation perspective argues that demographic and psychological characteristics of inmates brought in from the outside can best explain suicide in prison. While there has been support for both the deprivation and importation models, both models have their weaknesses and limitations for explaining this phenomenon. The most obvious limitation is that each theoretical perspective solely examined either the prison conditions (environment) or inmate characteristics (individual composition) without considering the combined effects of these two models in explaining suicides in prison (Huey & Mcnaulty, 2005).

In recent years, a combination of the two models has gained prominence in explaining the prisoner suicide phenomenon. Researchers have advanced the idea of an integrated or combined approach (Liebling, 1995; Dye, 2010). By viewing the importation
and deprivation models collectively, inmate characteristics and the prison context surrounding suicides are both considered. The combined model recognizes that prisons are painful and that certain institutional conditions increase the likelihood of prison suicide for some inmates (Dye, 2010). This combined model also considers the role of the prison environment in either promoting or restricting prison suicide (Dye, 2010). Liebling (1995) has published extensively in this area and found that by combining the deprivation and importation perspectives on suicide in prison, she has been able to address the limitations and discrepancies found in previous works. As a way forward, my intention was to explore the benefits that the intersectionality perspective might offer, not to establish its superiority over the importation/deprivation approach.

### 2.4.1. Intersectionality: A Critical Framework

The term *intersectionality* is attributed to critical legal scholar and critical race theorist Kimberlé Crenshaw. This feminist sociological theory emerged in the late 1980s and early 1990s out of critical race studies (Nash, 2008). In her foundational work, Crenshaw (1989) was specifically interested in examining how race and gender interacted “to shape the multiple dimensions of Black women’s employment experiences” (as cited in Crenshaw, 1991, p. 1244). She argued that discriminatory social practices affected Black women differently than White women and Black men (Crenshaw, 1989). As a Black feminist, Crenshaw (1989) strongly disagreed with “the tendency to treat race and gender as mutually exclusive categories of experience and analysis” (p. 139). Similarly, other feminist researchers disagreed with the use of a “single-axis framework”, recognizing its inherent limitations (Crenshaw, 1989, p. 139). Such a myopic framework, for example, ignores how sexism and racism can occur simultaneously to specifically subordinate Black women. Consequently, Crenshaw
(1989) introduced the concept of intersectionality which was initially used to signify various ways in which race and gender interact to create multiple, simultaneous oppressions. Other feminist scholars also recognized the restrictions of using gender as a single analytical category and, as a result, both feminist and anti-racist scholars embraced the intersectionality perspective (McCall, 2005; Nash, 2008).

From its inception, intersectionality was applied largely to research and activism directed at the specific intersection of race and gender (Nash, 2008). While feminist researchers and social scientists deconstructed these discrete analytical categories over time, intersectionality scholars began to examine how various social divisions intersected such as race, class, gender, and others, to create structural arrangements of power and inequality (Parker & Hefner, 2013; Yuval-Davis, 2006). Further, these structural arrangements also operate on many levels in perpetuating systemic discrimination and social inequality (Parker & Hefner, 2013).

As with other complex social science approaches, intersectionality stresses the “multidimensionality of marginalized subjects’ lived experiences” (Crenshaw, 1989, p. 139). The intersectionality framework does not address one category in isolation; rather, intersectionality scholars view various characteristics as mutually reinforcing (Nash, 2008). Intersectionality theorists draw attention to patterns of systemic privilege and domination (Parker & Hefner, 2013). Within this framework, these various social characteristics or categories are viewed as multiplicative rather than additive (Crenshaw, 1991). That is, the cumulative effect of multiple disadvantages can produce an experience that is far greater than the sum of its parts. Further, intersectionality scholars view the impact of various social dimensions as an intersecting process deeply embedded within a structural and historical context (Parker & Hefner, 2013).
2.4.2. Inequality, Poverty, and Crime

Intersectionality may be particularly useful when investigating the relationship between inequality and crime (Chesney-Lind, 2006). Scholars have proposed intersectionality as an important framework to understand better the life experiences of disadvantaged, disenfranchised groups (Parker & Hefner, 2013). As intersectionality researchers assert, the social experiences of individuals differ based, in part, on their unique social position within society (Crenshaw, 1991). However, it is important to note that not all marginalized people are victims of social structure. Individuals possess a certain degree of human agency which allows them to exercise their individual will by making their own choices. Marginalized people also have the ability to work with others to buffer against hardships and oppression and changes in social norms, legislation, and social policy can provide some safety nets and opportunities for these people.

Intersectionality theorists may be critiqued for being overly critical, fixed only on social exclusion and social problems, thereby missing a more nuanced appreciation of struggle. Apart from the intersection of classic variables such as race, class, and gender, intersectionality theorists rarely factor in the variable of mental illness, something that seems to be fairly central to our understanding of suicide in prisons.

In their lasting contribution to critical approaches to the prison industry, *The Rich get Richer and the Poor Get Prison* (10th ed.), Reiman & Leighton (2013) examine the trajectory of the criminal justice process arguing that the system is biased against the poor. Given the marginalized position of the poor in society, they do not have the power to change laws that severely criminalize crimes of the poor, whereas crimes committed by those who are well-off are far too often ignored. Further, they argue, criminalizing the
poor is coupled with the refusal to remedy the causes of the problem as they see it: social and economic inequality, lack of education, and discrimination. Similarly, Cole’s (1999) analysis of race and class-based inequalities in America found inequalities reflected in every stage of the American criminal justice system. He contends that double standards allow for a two-tier system where the privileged are afforded constitutional protections without extending those same protections to racial minorities and the poor (Cole, 1999). The social costs of inequality are, in turn, reflected in crime statistics and the prison population. That is, the majority of the prison population consists of relatively poor and uneducated people who are often drawn from the margins of society. The disparities are greatest when race, class, gender and other forms of disadvantage intersect.

2.5. Current Research

2.5.1. Intersectionality and Prisoner Suicide

While the intersectionality framework initially emerged from a feminist approach, it can be applied to men, women and transgendered persons. The current research will situate prisoner suicides within a broader intersectionality framework to better understand the life experiences of disadvantaged groups. That is, by shifting the focus to understanding the life experiences/backgrounds of marginalized people, we can explore how the frequently used variables of race and gender intersect with other specific forms of disadvantage such as mental illness to influence prisoner suicides. Many disadvantaged, disenfranchised groups in society suffer multiple, simultaneous hardships in the community which may place them at an increased risk of suicide in prison. Many sub-groups of the prison population share similar characteristics that
specifically place them at an increased risk of suicide: adverse life circumstances, social and economic disadvantage, drug and alcohol abuse, repeated contact with the criminal justice system, lengthy criminal records, deprived family environments usually involving abuse or criminality, and poor educational and employment histories. In this high-risk environment, those who are most vulnerable are exposed to situations where survival and coping skills would serve them well but, without them, they become victims of physical and sexual assault, violence, psychological torment and other negative effects of imprisonment (Liebling, 1995). Consequently, self-injury may be the first overt symptom of a level of distress before the ultimate final act of despair in which they take their own lives in prison (Liebling, 1995).

The purpose of this thesis is to contribute to a better understanding of prisoner suicides by using the intersectionality framework. This thesis does not involve testing intersectionality theory nor does it employ the use of a grounded-theory approach. Rather, intersectionality is used as a framework to guide the present research. The data were examined from the intersectionality perspective, seeking to explore whether people dying in custody tend to come from the margins of society, are more likely to be males, disproportionately of Aboriginal background, and those who are troubled by other characteristics such as mental illness that could have rendered them social outcasts.

2.5.2. Research Questions

Given the theoretical limitations of much of the previous work in this area, a central objective of this study is to explore Crenshaw’s (1989) intersectionality theory as an explanation for prisoner suicide. In keeping with the intersectionality framework, the current research is situated within the premise of a broader, social context rooted in a
system of inequality, whereby disadvantaged groups in society are subjected to increased surveillance and discrimination based on the intersection of factors such as race, class, gender and various other social characteristics. This systemic inequality is perhaps most evident by the composition of the prison population despite the criminal justice system’s attempts to mask this reality. While it is arguable that incarceration invariably brings with it a level of stigmatization and ostracism, the pains of imprisonment may be disproportionately inflicted on minorities (Haney & Zimbardo, 1998). The impact of this incarceration may be greater for racial and ethnic minority groups than for white men (Haney & Zimbardo, 1998), with Aboriginal people being the most profoundly affected, at least in Canada. In the US however, African-Americans, and Hispanics to a lesser extent, are disproportionately adversely affected by imprisonment. At the same time, researchers should be leery of what the late prison abolitionist Claire Culhane called “groupism”, a tendency to use simplistic, broad-brush assertions applied to entire groups of people (B.E. Burtch, personal communication, November 2013). In fact, we should anticipate exceptions to these general formulations. Specifically, we should avoid simplistic cause-and-effect assumptions about which ethno-cultural groups are relatively oppressed or relatively privileged in prisoners.

The key research question is exploratory in nature and was formulated from a critical criminological perspective. The research question of interest is: What are the circumstances surrounding suicides that occur in prison? It is hoped that the data will begin to shed light on whether marginalized persons are at a high risk to commit suicide while in prison. Perhaps those who suffer multiple, simultaneous experiences of inequality, or the most marginalized of the prison population, are more likely to commit suicide in prison than those coming from mainstream backgrounds.
From a critical criminological perspective, incarcerated individuals who die in custody are already victims of a justice system marred by race and class inequalities, a system that reflects broader inequalities in society (Cole, 1999; DeKeseredy, 2012; Reiman & Leighton, 2012). Their journey to prison becomes a one-way trip in which the prison ends up being the place they die. While inmates are typically classified as offenders, when they die in prison, they are often rendered victims. In light of the limitations of the current research in this field, going forward, research must advance not only a theoretical understanding of prisoner suicide but must also employ a more robust methodology. The following chapter details the methodological approach used in this thesis.
Chapter 3. Research Methods

3.1. Coroners’ Data

Coroners’ data is particularly useful for exploring the key research question of interest in this thesis: it is independent of prisons, has the authority to categorize cause of death, and gives sufficient information about background characteristics of suicides that allows for the investigation of the current research question. Additionally, in many cases Coroners’ inquests and resulting reports have “often been the only avenue by which a deceased’s loved one[s] can learn the truth about what happened” (Ward, as quoted in Pablo, 2010, n.p) and possibly gain some closure.

Any death that is associated with unnatural causes or from natural causes that take place suddenly or unexpectedly is subject to a Coroner’s investigation. Across Canada, Coroners are responsible for investigating all in-custody deaths. These investigations are in addition to any internal investigations carried out by the relevant correctional authorities. While some jurisdictions such as British Columbia employ a lay Coroner system, in Ontario, all Coroners are medical doctors who have special training in death investigations (Office of the Correctional Investigator, 2012). The Office of the Chief Coroner is part of the provincial Ministry of Community Safety and Correctional Services.
Each province or territory in Canada is responsible for maintaining a record of all deaths that occur in police or prison custody. Even so, the criteria for reporting deaths vary somewhat by jurisdiction. While jurisdictions such as British Columbia and New Brunswick only publish aggregate data on persons who die in custody, Ontario provides fairly detailed records of each individual who dies in custody (this is true for both police custody and prison custody deaths). Information provided in Coroners’ files include basic, descriptive data including the name of the deceased, the date and time of death, the place of death, the cause of death, and by what means (category of death) the deceased died. The age and gender of the deceased are also included. Apart from descriptive data, Coroners’ files also offer verdict explanations for all inquests as well as jury recommendations. Each inquest involves the use of a jury to make determinations of fact and to come up with recommendations to reduce the likelihood of similar deaths in the future. The verdict explanation contains a brief synopsis of the evidence presented at the inquest, together with some explanatory remarks about the individual recommendations made by the jury.

3.2. Utility of Coroners’ Data

Coroners’ data are likely the most informative data we have in studying prisoner suicides, and as such, there is considerable utility in using this as a data source. Perhaps most importantly, Coroners are not generally involved in the circumstances giving rise to deaths that occur in custody, being brought into the matter only after a death has occurred. Moreover, Coroners are often placed in difficult situations when a death in custody happens at the hands of authorities (Pelfrey & Covington, 2007). Their inquest findings may reveal misconduct on the part of correctional administrators and
staff, which could result in criminal negligence charges against correctional guards or cause the deceased's family to pursue an unlawful death lawsuit against the correctional institution.

Bennewith et al. (2011) argue that Coroners’ inquest records provide an accessible source of information on suicides. In particular, they maintain the usefulness of Coroners’ data on suicides for providing information relevant to prevention. Coroners’ data provide well recorded information on some demographic characteristics or variables. For example, in the present study, gender and age were recorded for all suicide cases (n=110). Additionally, information pertaining to the source of the ligature used in suicides by strangulation was frequently noted. This information is particularly important in Coroners’ inquests into suicides that occur in custodial settings as these details are important in informing prevention strategies. Information regarding the presence of mental health issues was also recorded in the majority of cases, including the nature of the illness, their psychiatric treatment and contact, or lack thereof, with prison psychiatrists/psychologists. This information is especially important as it is a reasonable hypothesis that inmates with pre-existing mental health issues, coupled with adverse institutional conditions, may be at a heightened risk of suicide (Huey & McNulty, 2005).

3.3. Data Source

Data from the Office of the Chief Coroner of Ontario were obtained for this study. The data consisted of files pertaining to inquests into deaths in custody in Ontario’s provincial and federal correctional facilities. The original database comprised 405 Coroners’ files relating to inquest findings on the circumstances of death and also
recommendations for change to policies or practices that contributed to deaths in
custody in Ontario. The files cover the period from 1992 to 2006 inclusive. Deaths were
classified into one of five categories: suicide, homicide, accident, natural, or
undetermined. Only deaths that were deemed a result of suicide (n=110, or 27.2% of the
cases) were examined in this thesis.

Data for this thesis were solely obtained from the province of Ontario. The intent
was to gain a rich understanding of prisoner suicides from Canada’s most populous
province over a considerable period of time. The goal was not to carry out a comparative
analysis between different jurisdictions.

3.4. Methodology

The present research is a fairly straightforward archival study. There are a
number of advantages to using archival sources. In the current study, the use of archival
records proved to be a good set of data to use to investigate prisoner suicides for a
number of reasons. Among the numerous advantages of archival studies, it is
noteworthy that they tend to be inexpensive with relatively low costs associated with this
type of research method. For the present research, the Coroners’ data was freely
available. More importantly, the use of archival data involves unobtrusive measures
which are less influenced by the presence of the researcher-a phenomenon referred to
as “reactivity” (Palys & Atchison, 2014, p. 221). Like many archival data sources, the
Coroners’ data allowed for a longitudinal, comprehensive analysis covering a lengthy
time period.
Despite the advantages of archival studies, there are also limitations to archival sources. A well-known disadvantage of archival data is that it involves secondary data gathered and prepared for purposes other than research (Palys & Atchison, 2014). Although the data may be used for research purposes at some later point in time, its original purpose was likely unrelated to research and therefore may not contain information useful to researchers. The Coroners’ data used in this thesis suffer from this limitation. The information collected, recorded, and reported by Coroners’ does not consistently provide the depth of data sought by researchers.

Data were extracted from Coroners’ inquest files and coded into Microsoft Office Excel software. Information drawn from the relevant files was coded for age, gender, cause of death, time and place of death and, where available, race or ethnicity of the deceased. Additional categorical and ordinal variables were gathered including incarceration details such as the sentence the deceased received, the stage of incarceration when suicide occurred, the type of institution they were held in, and the security level of the facility. Additional data collected included whether the deceased was described as having had a history of mental illness, alcohol and/or substance abuse, the extent of their violence or criminal behaviour, and whether they had any previous suicide attempts.

A reliability check was not necessary to conduct on any of the standard categorizations. The nature of many of the variables being coded did not require the exercise of discretion. For example, age (a continuous variable which denotes biological age) was clearly identified in all 110 cases. Similarly, sex was coded as either male or female and was identified in all 110 cases. Other variables such as “history of mental illness” were coded as follows: Yes (presence of mental illness with specific details
about the nature of the illness where available); No (absence of mental illness) and; N/A
(not identified/stated). In coding the variable “stage of incarceration” at time of suicide
(see chapter 4), when information pertaining to “stage of incarceration” was not explicitly
stated in the Coroners’ files, this was coded as “missing data”. Similarly, in coding the
variable “sentence received”, when information on the type of sentence received was not
noted in the Coroners’ files, this too was coded as “missing data”. This took into account
that the period of incarceration will vary depending, to some extent, on what sort of
sentence they have received, which will be related to what sort of institution they were in
as well. In all other cases, classifications were made based on the Coroners’
categorizations noted in his/her comments. Given the detailed nature of the Ontario
Coroners’ files, additional notes were also made regarding each deceased individual to
offer a glimpse into their lives, either before coming to prison or while behind bars.

In addition to calculating and comparing suicide rates based on Coroner's
records, this thesis also employs a case study approach. The intersectionality framework
implies that the experiences of specific groups, such as Aboriginal people, would be a
plausible explanation for prisoner suicides. Therefore, the focus of this case study
analysis is on Aboriginal suicides (n=8), to weigh the merits of how specific case
characteristics of this marginalized group given their socially and economically
disadvantaged position in society.

3.5. “Research Decisions”: Time-span and methodological
approach

Developing a sound research study involves a series of complex decisions about
various methods and approaches (Palys & Atchison, 2014). The dataset used for this
research covers a 15-year period (1992-2006). As a result, a retrospective analysis on all available files of Coroners' inquests into suicides was conducted.

In addition to reporting descriptive data, as noted above, a decision was made to include a case study analysis of Aboriginal suicides to ensure the richness of the qualitative data would be captured. While some have debated the question of whether case studies can be "scientific", many scholars in various fields have employed this research methodology to produce valid research (Pelfrey & Covington, 2007). The use of a case-study design in the current research was not intended to produce generalizable findings, but rather to use the case studies of Aboriginal suicides to explore whether there was something qualitatively different about Aboriginal prisoners. The available literature suggests that this specific subgroup has a marginalized, disadvantaged background characterized by poverty, alcohol abuse, and family violence which could potentially make them more vulnerable to suicide. Therefore, a closer examination of Aboriginal suicides in greater detail using case studies was conducted.

3.6. Research Ethics

3.6.1. Ethics

This study was categorized as "Minimal Risk" by Simon Fraser University's Research Ethics Board since the foreseeable risks posed to the deceased subjects do not exceed that which would arise independently of the study. Nonetheless, potential risks to participants were identified and subsequently mitigated. For example, a key ethical issue centered on confidentiality of the subjects in this study. Ensuring confidentiality is crucial, especially when working with vulnerable groups of people
(Palys & Atchison, 2014, p. 81). The main concern pertained to the potential for invasion of the privacy interests of the deceased inmates or their families that might arise from discussing personal information contained in the files in such a way that the deceased individual could be identified. To maintain strict confidentiality, no first or last names were used in this study, and efforts were taken to ensure that individuals could not be readily identified from the discussion of case-specific facts. Finally, formal permission for this study was received from the Office of the Chief Coroner of Ontario on May 23, 2013. In addition, this study was approved by Simon Fraser University’s Research Ethics Board on May 24, 2013, in accordance with University Policy R20.01, *Ethics Review of Research Involving Human Participants.*
Chapter 4. Results

This chapter first highlights an overview of findings on all deaths that occurred in custody in Ontario from 1992-2006. Then, the next section specifically provides a statistical overview of suicides and gradually narrows it down to the 110 cases that constituted my sample, giving some summary characteristics for the sample as well. This is followed by reporting demographic, institutional, clinical, and “other” factors linked to inmate suicides. Finally, eight case studies of Aboriginal suicides are presented.

4.1. Overview of Findings

Between 1992 and 2006, a total of 405 people died in Ontario’s federal and provincial correctional facilities. Over this period, 202 deaths were the result of natural causes, 110 were the result of suicide, 71 were categorized as an accidental death, 13 were the result of homicide, and 9 were classified as undetermined (See Table 4-1).
Table 4-1: Total Number of Inmate Deaths in Ontario, 1992-2006

<table>
<thead>
<tr>
<th></th>
<th>'92</th>
<th>'93</th>
<th>'94</th>
<th>'95</th>
<th>'96</th>
<th>'97</th>
<th>'98</th>
<th>'99</th>
<th>'00</th>
<th>'01</th>
<th>'02</th>
<th>'03</th>
<th>'04</th>
<th>'05</th>
<th>'06</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>14</td>
<td>27</td>
<td>8</td>
<td>19</td>
<td>17</td>
<td>13</td>
<td>15</td>
<td>14</td>
<td>13</td>
<td>17</td>
<td>12</td>
<td></td>
<td>202</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(49.9%)</td>
</tr>
<tr>
<td>Suicide</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>11</td>
<td>8</td>
<td>11</td>
<td>7</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>8</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(27.2%)</td>
</tr>
<tr>
<td>Accident</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
<td>71</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(17.5%)</td>
</tr>
<tr>
<td>Homicide</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(3.2%)</td>
</tr>
<tr>
<td>Undetermined</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(2.2%)</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>22</td>
<td>18</td>
<td>24</td>
<td>46</td>
<td>24</td>
<td>37</td>
<td>32</td>
<td>25</td>
<td>27</td>
<td>28</td>
<td>32</td>
<td>21</td>
<td>26</td>
<td>19</td>
<td>405</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(100%)</td>
</tr>
</tbody>
</table>

Over the years, the number of deaths fluctuated for some death categories, with natural deaths and suicides having the most variation. The remaining categories - accidental deaths, homicides, and undetermined deaths - appear relatively stable over time (see Figure 4-1). Figure 4-1 shows the fluctuation of incidents entailing the different manner of deaths over the study period. As can be seen, there has been some noticeable fluctuation over the years such as the spike in natural deaths in 1996.

Figure 4-1: Deaths in Custody by Year and Manner of Death (n=405)
4.2. Statistical Overview of Suicides

The number of suicides in Ontario’s provincial and federal correctional facilities has remained fairly steady. From 1992 to 2006, the average number of suicides was 7.33 per year, with numbers ranging from a low of 4 in 1992 and 2004 to a high of 11 in 1996 and 1998 (See Figure 4-2). In the year 2000, suicide was the leading cause of death, surpassing death by natural causes and accounting for 40% of prison deaths.

**Figure 4-2: Total Number of Suicides by Year, 1992-2006**

Table 4-2 shows that the suicide rate in provincial correctional facilities has fluctuated slightly over the years, ranging from a low of 25.60 per 100,000 inmates in 2002-03, to a high of 119.54 per 100,000 inmates in 1996-97. Average daily prison counts have been published by the Canadian Centre for Justice Statistics since 1993. In Ontario, average daily provincial prison counts became readily available for the fiscal year 1995-96, and throughout 2006. There was a gap for 2007-08, when average daily
prison numbers were not released, only to become available again for the fiscal year 2008-09. The federal inmate population count by year was not available for individual provinces; instead, the counts published by the Canadian Centre for Justice Statistics included the average daily federal inmate population for all of Canada.

Table 4-2: Number of People in Ontario’s Provincial and Federal Prisons by Year, 1995-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Sentenced</th>
<th>Remand</th>
<th>Total</th>
<th>Number of Suicides</th>
<th>Rate per 100,000 Inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>95/96</td>
<td>4690</td>
<td>2465</td>
<td>7155</td>
<td>5</td>
<td>69.88</td>
</tr>
<tr>
<td>96/97</td>
<td>4819</td>
<td>2710</td>
<td>7529</td>
<td>9</td>
<td>119.54</td>
</tr>
<tr>
<td>97/98</td>
<td>4631</td>
<td>2915</td>
<td>7546</td>
<td>3</td>
<td>39.76</td>
</tr>
<tr>
<td>98/99</td>
<td>4441</td>
<td>3032</td>
<td>7473</td>
<td>7</td>
<td>93.67</td>
</tr>
<tr>
<td>99/00</td>
<td>4003</td>
<td>3146</td>
<td>7149</td>
<td>3</td>
<td>41.96</td>
</tr>
<tr>
<td>00/01</td>
<td>3737</td>
<td>3700</td>
<td>7437</td>
<td>7</td>
<td>94.12</td>
</tr>
<tr>
<td>01/02</td>
<td>3631</td>
<td>3999</td>
<td>7640</td>
<td>4</td>
<td>52.35</td>
</tr>
<tr>
<td>02/03</td>
<td>3438</td>
<td>4373</td>
<td>7811</td>
<td>2</td>
<td>25.60</td>
</tr>
<tr>
<td>03/04</td>
<td>2957</td>
<td>4490</td>
<td>7447</td>
<td>5</td>
<td>67.14</td>
</tr>
<tr>
<td>04/05</td>
<td>2896</td>
<td>4670</td>
<td>7566</td>
<td>3</td>
<td>39.65</td>
</tr>
</tbody>
</table>


4.3. Sample

The present study drew upon a census of all prisoner suicides identified by the Ontario Coroner’s office. The population comprised 110 inmates who had committed suicide in a federal or provincial correctional institution in Ontario between 1992 and 2006 inclusive. Within the sample, 95.5% were male and 4.5% were female. The mean age at the time of suicide was 33.8 years, with a standard deviation of 12.41. Ages ranged from 14 to 89 years old, with a median age of 32. The average age of men who committed suicide was 33.9. The average age of women who committed suicide was
29.8, with a median age of 33. Of the 110 suicides, 9.1% of all people committing suicide were clearly identified as Aboriginal or another racial minority. In 90.9% of cases, the race of the deceased was not stated.

Table 4-3: Sample by Gender, Race, and Age

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>95.5</td>
</tr>
<tr>
<td>Female</td>
<td>4.5</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>90.9</td>
</tr>
<tr>
<td>Non-Caucasian</td>
<td>9.1</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>33.8</td>
</tr>
<tr>
<td>Median</td>
<td>32.0</td>
</tr>
<tr>
<td>Age by Gender</td>
<td></td>
</tr>
<tr>
<td>Male (Mean)</td>
<td>33.9</td>
</tr>
<tr>
<td>Male (Median)</td>
<td>32.0</td>
</tr>
<tr>
<td>Female (Mean)</td>
<td>29.8</td>
</tr>
<tr>
<td>Female (Median)</td>
<td>33.0</td>
</tr>
</tbody>
</table>

4.4. Demographic Factors

4.4.1. Age

The available literature indicates that the majority of those who commit suicide in prisons or jails are between the ages of 25 and 34. Interestingly, the age category accounting for the largest number of suicides in this study was 34-38 years old, followed by 29-33 years old (see Figure 4-3). Prior research studies have confirmed that younger prisoners (below age 21) are at a heightened risk to commit suicide in prison (Daniel, 2006). This age group accounted for 10 of the 110 suicides (9.09%). The youngest
person in the sample who committed suicide in this age category was only 14 years old, making them the youngest person to commit suicide in Ontario between 1992 and 2006. On the other end of the continuum, the oldest person to commit suicide was 89 years old.

**Figure 4-3: Number of Suicides by Age, 1992-2006**

4.4.2. Gender

Of the 110 suicides that occurred, 105 involved men and 5 involved women (see Table 4-3). This finding is consistent with previous literature from other countries including the UK and Australia. The suicide numbers confirm that completed suicides by women in prison are relatively infrequent compared to their male counterparts. While the proportion of prison inmates who are women is typically around 10%, less than 5% of the prisoner suicides in this sample were women. However, women are more likely than men to engage in self-harming behaviour such as slashing and self-mutilation as an
emotional response to pain and isolation (Griffiths, 2010). According to Sapers (Office of the Correctional Investigator, 2013a), self-harming behaviour is on the rise in Canadian prisons.

### 4.4.3. Race

A few visible minority groups are disproportionately represented in the inmate population compared to their counterparts in society, including Aboriginals, Blacks and, in some jurisdictions, Hispanics. In Canada, Aboriginal people make up only four percent of the Canadian population, yet they represent 21.5% of federal prisoners (Brodbeck, 2013). In the same vein, Black people make up approximately two and a half percent of Canada’s population but now represent just over nine percent of the federal inmate population, with the majority (60%) of Black inmates incarcerated in Ontario (Brodbeck, 2013). According to Sapers, on a per capita basis, Blacks are not far behind Aboriginals when it comes to over-representation in Canadian federal prisons (Office of the Correctional Investigator, 2013a).

It was difficult to ascertain race in all 110 cases in my sample. Race was explicitly mentioned in the Coroners’ files in only ten cases. Eight of the ten cases were clearly identified as Aboriginal, while one was identified as Hispanic and one as Asian. There was no clear rationale for why race was determined in these ten cases and not mentioned in the vast majority of other cases. It is highly probable that other visible minority inmates were in the sample; however, these details were not available. While some argue that in some cases it may be possible to determine race and/or ethnicity based on surnames as revealed in the data source, this process of inferring race/ethnicity seemed fraught with difficulties and uncertainties, as many minorities have
names that are not ethnic-sounding. Indeed, only two of the Aboriginal cases involved an individual with a clearly Aboriginal-sounding name.

4.4.4. **Intersectionality: Demographic Factors**

Often, race intersects with various other characteristics such as gender and/or age to produce compounding effects such as the likelihood of arrest, prosecution, conviction and incarceration. The impact of intersectionality on prisoner suicide was explored. While women only account for a small percentage of suicides compared to their male counterparts, this study found two of the five women to be Aboriginal. Table 4-5 shows that two of the five women who committed suicide were known and identified to be of Aboriginal heritage. While these numbers are indeed very small, they are at least noteworthy.

**Table 4-4: Suicides by Race and Gender, 1992-2006**

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal</td>
<td>2 (1.8%)</td>
<td>6 (5.5%)</td>
<td>8 (7.3%)</td>
</tr>
<tr>
<td>Non-Aboriginal</td>
<td>3 (2.7%)</td>
<td>99 (90%)</td>
<td>102 (92.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>5 (4.5%)</td>
<td>105 (95.5%)</td>
<td>110 (100%)</td>
</tr>
</tbody>
</table>

Aboriginal inmates tend to be younger than their non-Aboriginal counterparts (Office of the Correctional Investigator, 2013b). Among young people who committed suicide, Aboriginal male youth represented 30% of suicides in the current study, all of whom were under the age of 21 years (see Table 4-6 below). This lends some support to the intersectionality framework’s hypothesis that multiple factors such as race and age could have a compounding effect. However, there was no compelling evidence of intersectionality as a major aspect of suicides in my sample.
Table 4-5: Suicides by Race and Age (under 21)

<table>
<thead>
<tr>
<th>Deceased</th>
<th>Race</th>
<th>Sex</th>
<th>Age (under 21 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>N/A</td>
<td>Male</td>
<td>20</td>
</tr>
<tr>
<td>#2</td>
<td>N/A</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>#3</td>
<td>Aboriginal</td>
<td>Male</td>
<td>19</td>
</tr>
<tr>
<td>#4</td>
<td>N/A</td>
<td>Male</td>
<td>19</td>
</tr>
<tr>
<td>#5</td>
<td>N/A</td>
<td>Male</td>
<td>20</td>
</tr>
<tr>
<td>#6</td>
<td>N/A</td>
<td>Female</td>
<td>14</td>
</tr>
<tr>
<td>#7</td>
<td>Aboriginal</td>
<td>Male</td>
<td>16</td>
</tr>
<tr>
<td>#8</td>
<td>N/A</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>#9</td>
<td>Aboriginal</td>
<td>Male</td>
<td>18</td>
</tr>
<tr>
<td>#10</td>
<td>N/A</td>
<td>Male</td>
<td>19</td>
</tr>
</tbody>
</table>

 Apart from age, gender, and race, characteristics suicidal inmates often have include a background of poverty, a history of family violence typified by abuse and dysfunction, a record of criminality, and a limited formal education. These characteristics are frequently found in the personal histories of prison inmates (noted in Coroners’ files) in general, not just those who commit suicide. The data from this study reveal that in 5 (of the 110) cases, clear mention was made of a presence of serious family abuse and torment. This number may under-represent the actual extent of family violence since many cases may not have identified its presence. In addition, in 23 of the 110 cases, or 20.9%, a history of violence in the offender’s background or a record of prior criminal behaviour was noted. The majority of people with a troubled family background also had a lengthy criminal history. In four out of five cases, there was overlap between these two factors of background and family history.
4.5. Institutional Factors

In addition to socio-demographic correlates, and building on the deprivation model of prisoner suicides, institutional factors can increase the risk of suicide in prison. Previous research in this area has largely focused on inmate characteristics while largely ignoring the prison context. To overcome this limitation, Dye (2010) examined how the importation (inmate composition) and deprivation (prison conditions) models can intersect to influence patterns of prisoner suicide. Institutional factors linked to suicide include stage of incarceration, type of institution, and security level of the facility.

The Coroners’ data reveals that the majority of offenders for whom data were available committed suicide when they were remanded into custody, followed by prisoners who were in the initial stage of sentenced incarceration. The next most frequent category involved inmates nearing the end of their term, followed by inmates who were mid-way into their prison term which was tied with inmates who were classified as “other” (see Table 4-6).

Table 4-6: Stage of Incarceration at Time of Suicide

<table>
<thead>
<tr>
<th>Incarceration Stage</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remanded into custody (awaiting trial or sentencing, held pending bail hearing)</td>
<td>40</td>
<td>74</td>
</tr>
<tr>
<td>Initial (first third of sentence or characterized in file as initial stage)</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Mid (middle third of sentence or characterized in file as mid or medium stage)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Late (final third of sentence or characterized in file as nearing the end of a prison term)</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Other (indeterminate sentence, NCRMD*)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>100</td>
</tr>
</tbody>
</table>

* NCRMD: Not Criminally Responsible on Account of Mental Disorder
Table 4-7 below shows that the majority of inmates were housed in a provincial jail at the time they decided to take their own life, followed by those being housed in a federal prison. Table 4-8 reveals that the majority of offenders died in the correctional facility in which they were incarcerated as opposed to making it to a hospital before passing away. While the majority of offenders died in a provincial jail, Table 4-9 reveals that, in almost half of the cases, the security level of the facility was classified as unknown. An online search was conducted to determine the security level of facilities not identified in the Coroners’ files but proved to be unsuccessful. In cases where the security level of the facility was known, the majority of inmates died in a maximum-security facility, followed by a medium-security institution. A small number of inmates died in a facility other than a prison such as a maximum-security hospital. This lends support to published studies where researchers found suicides to occur more frequently in maximum-security prisons where the level of deprivation is greatest (Dye, 2010; John Howard Society, 1999).

<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal prison</td>
<td>47</td>
<td>43</td>
</tr>
<tr>
<td>Provincial jail (including detention centers and remand facilities)</td>
<td>60</td>
<td>54</td>
</tr>
<tr>
<td>Juvenile remand facility</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Maximum-security hospital</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4-7: Custodial Authority
Table 4-8: Place of Death

<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal/Provincial Correction Institution</td>
<td>59</td>
<td>54</td>
</tr>
<tr>
<td>Hospital</td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td>Treatment Centre</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4-9: Security Level of Facility

<table>
<thead>
<tr>
<th>Security Level</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>Medium</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>Maximum</td>
<td>31</td>
<td>28</td>
</tr>
<tr>
<td>Multilevel (contains one or more of the above security levels in the same facility or on the same grounds) (Griffiths, 2010)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other (e.g. maximum-security hospital)</td>
<td>6</td>
<td>5.5</td>
</tr>
<tr>
<td>Unknown</td>
<td>46</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100</td>
</tr>
</tbody>
</table>

4.6. Clinical Factors

Several clinical factors are associated with inmates who are deemed to be at an increased risk for suicide. Specifically, a large proportion of the prison population suffers from alcohol and/or other drug dependency. In Canada, approximately 51% of prisoners incarcerated in the federal system have a documented history of alcohol problems and it is estimated that 48% suffer from problems with other drugs (www.ccsa.ca). Information in the Coroners’ files indicates that many prisoners had a history of alcohol and/or substance abuse. Furthermore, the high prevalence of mental illness among the prison population is well-documented. Griffiths (2010) notes that approximately 10% of inmates suffer from documented mental health problems at the time of admission to a
correctional facility. Table 4-10 illustrates the prevalence of mental illnesses among suicidal prisoners. The table clearly highlights that inmates with mental health issues are over-represented among suicides. As might be expected, most inmates who suffered from a mental disorder were diagnosed with depression. In addition, Table 4-11 shows that a large percentage of inmates had a history of prior suicidal threats, suicidal ideation, previous suicide attempt behavior, or were otherwise previously identified as a suicide risk. In 13 cases (11.8%), inmates who suffered from drug and/or substance abuse also suffered from a mental illness.

Table 4-10: Prevalence of Mental Illness among Sample

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>19</td>
<td>17.3</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>4</td>
<td>3.6</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Paranoia</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Other specified</td>
<td>7</td>
<td>6.4</td>
</tr>
<tr>
<td>Other unspecified)</td>
<td>8</td>
<td>7.3</td>
</tr>
<tr>
<td>No known mental illness</td>
<td>67</td>
<td>60.9</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100</td>
</tr>
</tbody>
</table>

* Twenty-four subjects had only one diagnosis, eight subjects had two diagnoses, and one subject had three diagnoses.
Table 4-11: Previous Suicidal Histories

<table>
<thead>
<tr>
<th>Suicidal History</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempts before or while incarcerated</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>Threats</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Ideation, tendencies, self-harming behaviour</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Risk identified while previously incarcerated</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>No known history or risk</td>
<td>76</td>
<td>69</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100</td>
</tr>
</tbody>
</table>

4.7. Other Factors

The Coroners’ files revealed additional variables that are not part of my intersectionality approach but which are standard measures used in the available literature and in developing suicide prevention strategies. This information provides a better understanding of the circumstances in which suicides occur. Table 4-12 details the variable of time of death. This information was noted in most of the Coroners’ inquest findings. Time of death was most frequent between the hours of 12:01 a.m. and 4:00 a.m. Risk for suicide was also relatively high between 4:01 p.m. and 12:00 midnight. Inmates were least likely to commit suicide between the hours of 4:01 a.m. and 8:00 a.m.

Table 4-12: Approximate Time of Death

<table>
<thead>
<tr>
<th>Time of Death</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:01 a.m. – 4:00 a.m.</td>
<td>30</td>
<td>30.3</td>
</tr>
<tr>
<td>4:01 a.m. – 8:00 a.m.</td>
<td>18</td>
<td>18.2</td>
</tr>
<tr>
<td>8:01 a.m. – 4:00 p.m.</td>
<td>25</td>
<td>25.3</td>
</tr>
<tr>
<td>4:01 p.m. – 12:00 p.m.</td>
<td>26</td>
<td>26.2</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
<td>100</td>
</tr>
</tbody>
</table>
A crucial factor extracted from the Coroners’ files was the method of suicide. Table 4-13 shows that the vast majority of inmates commit suicide by way of hanging, with the majority of people dying of asphyxia. Similarly, Burtch and Ericson (1979) also found that 88.5% of Canadian inmates hanged themselves. This seems to be the most common method of suicide decade after decade (Wobeser et al., 2002). Correspondingly, Table 4-14 indicates the methods and devices used to carry out the suicides by inmates. This information is provided for general interest, not an integral part of my theoretical approach.

### Table 4-13: Method of Suicide

<table>
<thead>
<tr>
<th>Suicide Method</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>103</td>
<td>94</td>
</tr>
<tr>
<td>Overdose</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>100</td>
</tr>
</tbody>
</table>

### Table 4-14: Device Used to Implement Hanging

<table>
<thead>
<tr>
<th>Apparatus</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Sheet</td>
<td>40</td>
<td>56.3</td>
</tr>
<tr>
<td>Clothing</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Rope</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>Boot/Shoe Laces</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>Cloth Material</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>Electric Cord</td>
<td>4</td>
<td>5.6</td>
</tr>
<tr>
<td>Wire Cable</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Towel</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Speaker Wires</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Window Curtains</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Shower Curtain Rod</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Homemade Noose (Unspecified)</td>
<td>3</td>
<td>4.2</td>
</tr>
<tr>
<td>Other (two or more implements used)</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>100</td>
</tr>
</tbody>
</table>
4.8. Coroners’ Jury Recommendations

A fundamental part of Coroners’ inquests is for juries and presiding Coroners to make recommendations to identify ways to reduce the likelihood of similar deaths in the future. However, it is not mandatory for Coroners’ juries to make recommendations, and in some inquest verdicts, no recommendations are offered, implying that a death in custody was not preventable.

In cases where suicide was deemed to be the cause of death, the nature of various recommendations was, at times, quite case-specific and there was some common ground in the recommendations made as part of these proceedings. The same factors were routinely identified across cases, highlighting systemic failures by correctional services to adequately address issues.

In the present study, over the 14 year period under investigation, the number of recommendations ranged from none to 54, with an average of 6.26 recommendations per jury. In 26 cases, no recommendations were made. Table 4-16 provides a summary of the most common jury recommendations for the cases researched in this study. The top three recommendations pertained to more efficient communication/information sharing among prison officials, better training and education for staff, and improvements in environmental/cell design.
Table 4-15: Top Fifteen Jury Recommendations Involving Suicides in Prison

<table>
<thead>
<tr>
<th>Recommendation:</th>
<th>Number of cases:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Enhance communication regarding an inmate’s medical/suicide history</td>
<td>39</td>
</tr>
<tr>
<td>2 Increase staff training and education, especially for identifying suicide risk</td>
<td>28</td>
</tr>
<tr>
<td>3 Improve cell design</td>
<td>25</td>
</tr>
<tr>
<td>4 Increased video monitoring</td>
<td>23</td>
</tr>
<tr>
<td>5 Mental health assessment of all inmates coming into the prison</td>
<td>21</td>
</tr>
<tr>
<td>6 Enhance cell checks and checking of other areas of the prison</td>
<td>19</td>
</tr>
<tr>
<td>7 Enhance staff awareness of emergency equipment or add equipment</td>
<td>11</td>
</tr>
<tr>
<td>8 Better control over medicines dispensed to inmates</td>
<td>8</td>
</tr>
<tr>
<td>9 Hanging-proof sheets and no laces</td>
<td>8</td>
</tr>
<tr>
<td>10 More staff on the range (guards, nurses, support staff)</td>
<td>8</td>
</tr>
<tr>
<td>11 CPR/first aid training for prison staff</td>
<td>7</td>
</tr>
<tr>
<td>12 Enhanced counselling availability for inmates</td>
<td>7</td>
</tr>
<tr>
<td>13 Hire additional mental health professionals</td>
<td>6</td>
</tr>
<tr>
<td>14 Staff should carry communication devices</td>
<td>6</td>
</tr>
<tr>
<td>15 Place inmates who previously attempted suicide on suicide watch</td>
<td>2</td>
</tr>
</tbody>
</table>

4.9. Aboriginal Suicides: Case Studies

Apart from the quantitative information presented above, a narrative of each Aboriginal suicide in the sample is offered to further explain the circumstances surrounding each death, the quality of care afforded to inmates, and to provide personal histories, where available, of this ostensibly disadvantaged group. Their backgrounds often include: deprived family upbringing, history of violence, mental health issues, and alcohol and other drug dependency. This following section provides a closer look at the eight cases of suicides by Aboriginal inmates. The information provided for each case was documented in the Coroner’s brief synopsis found in his/her report. The information provided below for each case was largely taken verbatim from the Coroners’ files and is illustrated with the use of quotation marks.
Case #1

A 19 year-old Aboriginal man committed suicide while incarcerated at the Sudbury District Jail (provincial facility) in March 1996. “Shortly after 1:00 am, a Correctional Officer doing appointed rounds at the Sudbury District Jail discovered an inmate hanging in his cell. He was pronounced dead on arrival at hospital. His death occurred at a time of reduced staffing due to a strike.” No additional information was provided regarding the deceased’s background or the events leading up to his suicide.

The jury made seven recommendations in hopes of reducing the likelihood of future deaths of this nature. The recommendations included improving “code blue” protocol in emergency situations. Code blue refers to “a medical emergency in which a team of medical personnel work to revive an individual in cardiac arrest” (WebMD, n.d.). The remaining recommendations involved informing inmates of the “counseling and cultural services available in the institution in a manner that encourages them to make use of the services”, staff re-training on suicidal ideation, developing a “support group program for first-time adult inmates to aid their transition into the system, [constant] assessment and possible redesigning of cells and correctional institutions to enhance the safety and protection of prisoners and institutional staff, control room locks and all punch clocks be checked and calibrated, if necessary, for accuracy on a weekly basis” and finally, to ensure “that each guard with punch clock responsibilities follow the outlined procedures” for checking on inmates on a regular basis.
Case #2

A 16 year-old Aboriginal youth committed suicide while incarcerated at Toronto Youth Assessment Centre (TYAC). This remand facility is designed to accommodate severely mentally ill youth. This young man was a "troubled youth from an early age with evidence of psychiatric and developmental problems in childhood. He had a history of substance abuse and encounters with the juvenile justice system. His family was very attentive and tried all ways to help him with his problems, seeing many psychiatrists in his late childhood and early teens." This youth "started stealing from his family money and other saleable objects to please his friends and eventually pay for his marijuana habit. His first contact with the juvenile justice system was in 2001 when he was charged with property offences and was given the maximum permissible time on probation with an agreement for him to go to a [boarding] school and he was enrolled in a Military-style academy in St. Catharines for the next year. (The actual wording in the file was “residential school”; however, the term residential school is widely used to describe the assimilative practices of confining First Nations children and youth in

Initially, he seemed to improve emotionally, but later became depressed and made a minor attempt at self-harm with a sharpened staple. He refused to go back to the academy and they refused to take him in as they felt they could not deal with a suicidal child. In the spring of 2002, after refusing to go back to the [boarding] school, he threatened his father and assaulted his mother. He was charged and taken into detention at the York Detention Centre. The judge at his remand hearing requested a psychiatric assessment and [he] was removed to the Syl Apps Centre for that
assessment. The Centre for Addiction and Mental Health in Toronto did the assessment and he returned to court when it was completed."

“[The young man] was sentenced to time served, parole and to reside at home with his parents in August 2002. The family soon noticed he had started stealing money again from them and eventually stole from a family friend. The family indicated to their friend that she should report the event to the police, which she did and [the youth] was persuaded to turn himself in to police rather than be arrested. He was kept overnight in the police station and attended court the next day and was remanded to Toronto Youth Assessment Centre (TYAC) until his bail hearing.

The family took a “tough love” stance with [the youth], indicating that they would not bail him out or provide a lawyer and he had to arrange things through Legal Aid. [The youth] attended court a number of times and neither his family or their lawyer attended, [he] eventually did get in contact with Legal Aid and a lawyer was selected. [The young man] indicated to his family that he was afraid of being in TYAC from what he had heard about it from his peers.” No mention in the Coroner’s file elaborating on these fears. “[He] was initially recognized as being suicidal on admission and was in secure isolation for a short period for observation but for some reason he was released to the range the next day even though the clinical staff had not indicated he was ready for release. On the range, he was noted to be depressed and was reassessed by the nursing staff some 28 hours after he got on the range and put back into secure isolation where he spent the next three days before returning to the range. The clinical staff, mainly the clinical psychologist, followed the [young man] as he had seen the psychiatrist the day after his admission and the latter only visits the institution once a week. He was in contact with his family, expressing remorse for his actions and promising to reform if they would get
him out of TYAC. Evidence was heard that [he] was subject to peer-on-peer violence in
TYAC.

On October 1st, [the youth] was at court and his legal aid lawyer was not there so
he was remanded yet again for a date in the future. This caused him a great deal of
concern as he had banked on leaving TYAC that day. He arrived back from court about
[4:30 p.m.]. Later on that evening, he had become very upset after a phone conversation
with his mother. [He] had received a sharpened staple from one of the other youths after
saying he wanted to harm himself but the youth did not inform the correctional officers
about event."

At 7:48 pm, the deceased was seen watching television by a correctional officer
at the door of his cell. “Another officer handing out clean clothing found [the youth] at
[7:52 p.m.] hanging from a noose made from a bed sheet tied to a metal bar on the side
of the top bunk. There was a delay in cutting [him] down as he was too heavy for the
single correctional officer who found him. The alarm was raised by this officer walking to
the ‘Sally Port officer’ and verbally telling him to call a medical emergency.” (“Sally port”
refers to a secured, protected entrance of a prison that is staffed by a guard in a
protected location who controls the door operation, applying strict protocols regarding
opening and closing specific doors to ensure security within the institution). “The inside
officer then quickly went to the other end of the range and locked up three youths still in
the day room area. The alarm was raised verbally as the ‘Sally Port Officer’s’ radio did
not function and he knew the nurse was in the adjacent range 7B handing out
medication. On his return to [the young man’s] cell, a second officer arrived, and the
nurse and the two officers were unable to get the pressure on the [deceased’s] neck, as
he weighed 240 lbs. “The nurse went for her emergency bag kept in the Nurse’s Office.
The Operational Manager on duty cut him down with a 911 knife as soon as he arrived on scene.” (These knives are first responder folding knives designed to facilitate cutting ligatures and seatbelts). “Only the Operational Managers have a 911 knife on their person during the daytime shift.

Resuscitation was started by the correctional officers and continued by the Toronto EMS (Emergency Medical Services) paramedics upon their arrival. [He] was resuscitated and transferred to St. Michael’s Hospital but had hypoxic encephalopathy” (a condition in which the brain does not receive enough oxygen)(NYU Langone Medical Center, n.d.). On October 9th 2002, the young man died.

Case #3

A 36 year-old Aboriginal woman committed suicide while incarcerated at Thunder Bay District Jail, “a maximum-security jail for detention and remand offenders. [She] was arrested for theft (under $5000), breach of a probation order and breach of conditional sentence order on Friday, August 16, 2002. She was escorted to the Thunder bay District Police station where she spent the night, assessed in the morning by a Justice of the Peace and transferred to Thunder Bay District Jail. [She] was placed in the dorm, originally designed as a kitchen. On one end, there is a single door entering a combination washroom and laundry room (accessible only from inside the dormitory). Over the weekend of her incarceration, [the deceased] became increasingly agitated and made numerous calls to attempting to get a hold of her lawyer. This proved unsuccessful. On the morning of August 19th, she attended a video bail court hearing in a room so designed elsewhere in the institution. She was remanded over to the next day to set a date for a bail hearing. There was evidence [she] was clearly further upset over
this unexpected turn of events. She returned to the dorm and subsequently was
discovered in the shower area, secluded from her fellow inmates, hanging from the
shower curtain rod. There was a quick response from the Correctional Officers and
Nursing Staff, but attempts at resuscitation unfortunately failed. She had left a suicide
note in the dorm. She was pronounced dead at the Thunder Bay Regional hospital.”

Case #4

A 25 year-old Aboriginal man committed suicide while incarcerated at Brantford
Jail. “On March 25, 2003, [the deceased] was arrested and charged with mischief,
endangering life, and dangerous driving. This followed an incident where [he] apparently
grabbed and turned the steering wheel dangerously toward a moving truck while he was
a front seat passenger in a moving vehicle. [He] was arrested, held in custody overnight
at Six Nations Police Station and taken the following day to a bail hearing at the
Brantford courthouse. On March 26th, [the young man] appeared in bail court and was
then transferred to the Brantford Jail. He made two more appearances at the provincial
court over the next two days and each time was remanded in custody and returned to
the Brantford Jail. In the early hours of March 31st, six days after his original arrest, [the
inmate] was discovered hanging by a bed sheet tied around his neck and the top of his
cell door. He was taken down and CPR was started. Paramedics arrived but he could
not be revived and he was pronounced dead at the scene.

There was no previous documentation obtained at the time of his arrest or in
subsequent evaluations to suggest that [the deceased] would be at increased risk of
suicide. He was therefore housed in the usual cell blocks and underwent the usual
routine observation schedules. The central issues explored at his inquest had to do with
obtaining and communicating information about a detainee’s mental health state and suicide risk at the time of arrest and during [his] incarceration.”

Case #5

A 45 year-old Aboriginal woman committed suicide while incarcerated at Grand Valley Institute for Women in Kitchener, a multilevel security federal facility. “[She] was sentenced to two years in prison on June 10, 2003 for armed robbery. [The deceased] was in a drug-induced state at the time of the robbery and at her sentencing, she requested a sentence that would place her in a Federal Institution where a substance abuse program would be available to her. [She] had a long history of drug and alcohol abuse and previous suicide attempts. The last attempt was more than a decade prior to her death.

Upon arrival at the Grand Valley Institute in Kitchener, she was given a psychological risk assessment and interviewed with regards to integration and ongoing placement inside the prison. [She] was initially placed in the general population, but she had difficulty getting along with other inmates. In August of 2003, she was moved into a residence in the Intensive Support Unit to address her longstanding substance abuse. She had a physical altercation with another inmate six weeks after her arrival and was then placed in a Structured Living Environment (SLE) unit on September 25, 2003.

The SLE unit houses eight minimum and medium-security inmates with cognitive and mental health concerns that would require intensive staff intervention programming and treatment. The unit has an east and a west wing with four women housed in each
wing. The inmates are supervised 24 hours a day – guards and behavioural counselors during the day and two guards at night.

[She] was initially placed in the east wing of the unit, but she had an aggressive verbal confrontation with other residents and was moved to the west wing on October 7, 2003. While on SLE, [she] participated in many programs, including spiritual courses offered by the Chaplain, Native sisterhood functions as well as self help recovery programs offered by Alcoholics Anonymous (AA), and Women Offenders Substance Abuse Program (WOSAP). She attended an AA Christmas party on December 19th, 2003 in the main building of the institution.

At this party, [she] made a point of approaching her best friend at that event and thanking her for being such a good friend. She also requested that a ribbon be given to another inmate with whom she’d had a previous conflict. [She] also asked that her friend apologize for her to other inmates. She returned to SLE and was seen to be occupied during the evening with usual activities - resting on her bed and making popcorn. Shortly after [10 o’clock], she advised another inmate that she was going to have a bath. A prisoner check at [11:35 pm] showed she was checked although not seen. It was reported that she was in the bath. At approximately [midnight] on the 20th of December, her whereabouts were again checked. This time a verbal response was not received. The locked bathroom door was opened with a passkey and she was found sitting upright in the bathtub with the shower head extension cord wrapped twice around her neck. Another guard promptly ripped the shower extension from the wall and loosened the cord. Emergency Services were summoned and CPR (Cardio-Pulmonary Resuscitation) [was administered] by the guards. Emergency personnel also attempted CPR and she was transferred to St. Mary’s Hospital in Kitchener where she was pronounced dead.”
Case #6

An 18 year-old Aboriginal man committed suicide while incarcerated at Sudbury Jail (provincial facility). “[The young man] was born in the remote Northwestern Ontario First Nations Community at Sachigo Lake, where he lived with his mother. In August of 2001, they moved to Thunder Bay where he attended high school. On May 8, 2004, [the young man] was placed in custody in the Thunder Bay Youth Centre. During a court-ordered assessment, he was diagnosed with schizophrenia. Two alerts were placed on the Youth Offender Tracking Information System (YOTIS) including ‘Special Needs’ and ‘Suicide Risk’. On July 28, 2004, [the deceased] was convicted on a number of charges resulting in a sentence of [1.5 years incarceration]. He remained at Thunder Bay Youth Centre until September 30, 2004 when he was transferred to the Cecil Fraser Youth Centre in Sudbury. On November 5, 2004, [the deceased] assaulted a staff member at Cecil Fraser which resulted in him being charged following a police investigation. On November 26, 2004, he appeared before the Court and was remanded in custody to the Sudbury Jail where he remained for 5 days. On December 1, 2004, [he] was returned to Cecil Fraser Youth Centre. On December 22, 2004, [the young man pled] guilty to the assault charge which resulted in 15 days being added to his remaining youth sentence, which was converted to an adult sentence. The young man was found hanging from the upper bunk with a cord around his neck.”

Case #7

A 33 year-old Aboriginal man committed suicide while serving a federal sentence at Millhaven Penitentiary, a maximum-security prison. “He was last seen on October the 26th, 2005, between 01:00 and 01:10 in the morning. During a routine range
walk and cell check at [2:15 a.m.], Officers discovered that he was hanging by his neck in his cell. He was cut down, CPR was commenced by Correctional Officers and subsequently carried on by paramedics who were called at the scene. Resuscitation attempts were unsuccessful and [the inmate] was pronounced dead at the Institution by the local Coroner.

Case #8

A 23 year-old Aboriginal man committed suicide at Thunder Bay District Jail (provincial facility). “[He] was arrested on August 16, 2006 and charged with the offence of aggravated sexual assault regarding an incident on August, 15, 2006. He was remanded by the courts for a seven-day Psychiatric assessment being ordered on August 21st and a further [30] day Psychiatric assessment ordered by the courts on September 21, 2006. [He] had an extensive past forensic Psychiatric history as well as a past criminal record. In the Thunder Bay Jail, [he] was placed on ‘constant’ and ‘suicide’ watch on a number of occasions, due to intermittent episodes of self-harming behaviour with fluctuating levels of self-harm risk, based on repeated assessments by various members of the Jail staff.

Several days prior to his death, when [he] was moved from one cell to another, a noose-type ligature was found in his cell. The communication of this finding appears to have been lost in the system. In the two days prior to his death, [the deceased], who was an articulate and communicative individual, had actively engaged and had been assessed by several members of the Jail staff (Nursing, Social Workers and Correctional Officers). During this time, the staff noted that he was depressed and angry at having to wait for his transfer out for his 30 day Psychiatric assessment; however, it was uniformly
felt by the staff that he displayed forward looking thoughts and that he was felt to be of relatively low risk for self-harm. At the time of his death, [the deceased] was not on any type of suicide watch but was in an area that required every 15 minute visual checks of inmates by the correctional officers. [The deceased] was found suspended from the end of his bunk by a noose made from torn bed sheet material. His roommate was asleep and the entrance to the cell was impeded by what appeared to be pencil fragments jammed into the cell door lock mechanism. Attempts at revival with CPR and timely 911-response were unsuccessful and [the deceased] was pronounced dead in the local Emergency Department."

4.10. **Summary**

This chapter provided the major findings of this study. In addition to findings pertaining to deaths in custody in Ontario and a statistical overview of suicides, demographic, institutional, clinical, and "other" factors linked to inmate suicides were presented. Case studies on eight Aboriginal suicides were also offered. To highlight some specific findings, suicide by hanging continues to be the most common way through which inmates take their own lives. While this finding has been established in various studies, it raises questions about why and how inmates have access to devices such as laces, particularly those known to be at risk of suicide. It also raises questions about institutional culpability, and their willingness to take active steps to reduce the number of suicides.

The Aboriginal case studies reveal the adverse impact of uncertainty and delay in the criminal justice system. Several of the Aboriginal prisoner suicides appear to have been distraught as a result of their treatment in the system. Interestingly, these factors
have not been explored in the inquest recommendations. The case studies also highlight the extremely disadvantaged backgrounds of these suicide victims, lending partial support to the intersectionality framework. The other cases in the study did not reveal the same extent of social disadvantage and hardships. It is still unclear which factors are in play in the complex processes of suicidal behaviour in prisons. The next chapter will discuss the results and expand on the implication of the findings.
Chapter 5. Discussion and Implications

This chapter provides a more detailed discussion of the main findings and compares this study’s results with prior research. This section is divided into specific sub-headings that emerged from the findings. This chapter also discusses the limitations of the current research. Implications of the findings for future research and public policy will also be addressed in this chapter. An important finding arising from this study relates to a key demographic variable revealed in the data. This finding pertains to the “graying” of Canada’s inmate population.

5.1. Aging Prison Populations

The aging of the prison population is clearly reflected in the present study with approximately 50% of deaths being the result of natural causes, now the leading cause of death in prisons. This finding is not particularly surprising given that, in recent years, there has been a growing number of elderly inmates behind bars. The rise in the number of older inmates in Canada mirrors a similar trend of aging prison populations in other western countries (Aday & Krabill, 2013).

In Canada, one-fifth of federal inmates are 50 years and older, constituting the fastest growing age group (Office of the Correctional Investigator, 2011). This growth in middle-aged and senior prisoners presents many challenges for correctional services. While an increasing proportion of Canada’s prison population is elderly, relatively few
inmates within this age group commit suicide. The majority of inmates who commit suicide tend to be fairly young, with the largest age group of inmates who committed suicide in the present study being 34-38 years old. This finding corroborates the findings of Winterdyk and Antonowicz (as cited in Office of the Correctional Investigator, 2011) who found that the average age of inmates who committed suicide to be 36.7 years of age. This changing demographic shift in prison populations could have potential implications for correctional services. On one hand, if the prison population is graying, we may expect to see suicide rates decrease over time as this cohort is not at a high risk of suicide. On the other hand, if prevailing social policy of increasing incarceration rates and length of stay in custody continues with fewer opportunities for release, this could have implications for the numbers of suicides.

In the current study, only two of the inmates in the sample who committed suicide would be classified as “older” or even “geriatric” offenders. Both men were over 70 years old. One inmate was a 71 year-old federal inmate serving time at Collins Bay Institution in Kingston, Ontario at the time of his death. His death, classified as a suicide by the Coroner, was the result of “a self-admitted overdose of approximately 50 Dioxin tablets and 20 Rivotril tablets. Additionally, there was a small superficial ice pick self-inflicted wound to the anterior chest.” Coroners’ files indicated that this inmate had a “significant past medical history of congestive cardiomyopathy of an unknown cause, as well as chronic obstructive lung disease, in the form of chronic bronchitis and emphysema.” The inmate was admitted to Kingston General Hospital where he was successfully treated for the overdose; however, the hospital stay was “complicated by the [inmate’s worsening heart failure and pneumonia]”, ultimately resulting in his death.
The other elderly inmate, a man who was 89 years old at the time of his death, was the oldest inmate to commit suicide identified in the current study. “It was alleged that [the deceased] killed [a fellow resident] with a knife in her apartment washroom at a retirement home in Kitchener, Ontario on March 30, 2002. Shortly after attacking [the victim], [the deceased] was interrupted while attempting to cut his own throat. He was disarmed and arrested by Waterloo Regional Police and transferred to St. Mary’s Hospital where he remained for several days under guard while he was being treated for his neck wounds. He was discharged from hospital on the 5th of April, 2002 and remanded in custody at the Maplehurst Detention Centre in Milton on the charge of second degree murder. Three days later, he was transferred to the Guelph Treatment Centre Special Needs Unit because of his advanced age, frail health, and special medical needs. On April 14, 2002, [the deceased] was found dead in his cell at the Guelph Treatment Centre. He had stuffed toilet paper up his nostrils and in his mouth and used a plastic bag pulled over his head and secured with pajama bottoms to suffocate himself. He had done this quietly and pulled his covers up and over his shoulders to escape detection. The jury had no recommendations because preventative measures were implemented prior to the inquest. [They concluded that the deceased] received the best possible care given his specific set of circumstances.”

5.2. Suicides: Recent Numbers

After death by natural causes, suicide is a leading cause of death in prisons, although these deaths are rarely publicly disclosed or discussed unless, as mentioned earlier, they involve high-profile cases such as the suicide of young Ashley Smith at the Grand Valley Institution for Women in Kitchener, Ontario, which captured national media
and public attention. However, the majority of incarcerated people who die in custody are rarely given much coverage in print or electronic media and, arguably, few people give their passing in custody much thought.

The present author’s study found a total of 405 inmate deaths in Ontario over a fifteen-year period between 1992 and 2006. Of these, roughly 27% (n=110) were determined to be the result of suicide. While the number of prisoner suicides in Ontario is not higher than other jurisdictions, it remains an ongoing concern given that correctional authorities owe a duty of care to inmates. A breakdown of suicides by year indicates that the number of suicides has remained fairly stable over time. In each year covered by this study, between four and 11 inmates committed suicide in Ontario prisons. Similarly, the total number of people in Ontario’s provincial prisons has not seen any dramatic increases.

One might expect a decline in the number of suicides over time as correctional services staff learn from past mistakes. A key part of Coroner’s inquests is the series of recommendations that are normally directed to detaining authorities, providing ideas about how to reduce the likelihood of future deaths occurring in similar situations. With these recommendations in mind, it should be possible to identify problematic policies and practices, thereby improving current practices by taking measures to prevent deaths in custody, particularly suicides. It is important to note that suicides are still relatively rare, often difficult to anticipate, and that there are literally thousands of shifts every year in Canadian correctional settings where suicide attempts are not encountered.
5.3. Prevalence of Mental Health Issues in Prisons

Various factors have been correlated with prisoner suicides. Of these, mental illness is one of the most crucial indicators of suicide. A recurring theme within the prisoner suicide literature is the prevalence of mental illness among suicidal inmates (Daniel, 2006; Dye, 2010; Hayes, 1995; John Howard Society, 1999; Way et al., 2005; Wobeser et al., 2002). Prior research has focused on underlying mental health indicators reflecting a suicidal history or pre-existing mental health conditions (Office of the Correctional Investigator, 2011). Depression was the most frequently identified mental health problem identified in the Coroners’ data. This is to be expected, as the connection between depression and suicide is well documented in the literature (Suto & Arnaut, 2010). Daniel (2006) also found depression to be closely linked to suicide. Other mental health problems were also identified for many of the inmates who committed suicide in the present study. Psychotic disorders and symptoms consistent with a psychotic disorder were also found. Research has shown that individuals with schizophrenia have a 50% lifetime risk of attempting suicide, and about 10% of those diagnosed with schizophrenia actually commit suicide (Cohen, Test & Brown, 1990). Various intersecting factors, apart from standard variables such as race, class, and gender, may put an inmate at a high risk of suicide. Wobeser et al. (2002) found those who committed suicide were more likely than other sub-samples of prisoners to have a history of psychiatric illness or substance abuse.

The increasing prevalence of mental illness in the prison population, including those at risk of suicide, can be closely linked to the broader, macro process of deinstitutionalization. Deinstitutionalization refers to the replacement of institutionalized care in psychiatric hospitals with community-based care in treating the mentally ill (Lamb
A large part of the twentieth century was spent treating people with serious mental illness through institutionalization in hospitals and asylums (Cook & Wright, 1995). Long-term confinement in strictly controlled environments, much like prisons, was much too common. However, beginning in the 1930s, psychologists began to argue against institutionalization of the mentally ill, and instead called for community-based mental health services (Gillon, 2000). By the 1950s, the deinstitutionalization movement was in full swing in Canada. Advocates of community-based intervention argued that the practice of “warehousing” mental patients in asylums was inhumane and not conducive to treatment (Gillon, 2000). Furthermore, by the mid 1950s, the rising costs of mental institutions created increasing financial burdens on governments who were looking for cost-saving alternatives. The availability of new psychopharmacological therapies and psychosocial rehabilitation practices also helped to promote the movement of the mentally ill from institutions to the community (Lesage, 2000). These social, economic and political conditions during the mid-to-late 1900s cumulatively created an environment that called for the deinstitutionalization of the mentally ill.

Deinstitutionalization was, in theory, a promising development for keeping the mentally ill out of institutions where they were treated with little to no human dignity. In practice, however, the process was a failure in many respects. As psychiatric institutions were closed or downsized, hundreds of vulnerable people were displaced to socially disorganized neighbourhoods, since post-deinstitutionalization policies were not properly implemented. In some cases, deinstitutionalization resulted in patients being shifted from large psychiatric facilities to the back wards of local hospitals (Morrow, Dagg & Pederson, 2008). Consequently, a lack of community residential facilities and
inadequate mechanisms to ensure the mentally ill adhered to consistent treatment plans contributed to the failure of deinstitutionalization.

The unintended consequences of deinstitutionalization have proved most troubling. Many in this marginalized group have been forgotten and left to fend for themselves as an outcome of what is termed “benign neglect”. New generations of non-institutionalized people living with mental illness are increasingly poor, homeless, and subjected to heightened criminalization (Lamb & Bachrach, 2001). Consequently, many critics argue that deinstitutionalization has led to large numbers of people, who would once have been inpatients, being incarcerated in jails and prisons or becoming homeless when outpatient services are not available, a trend referred to as “transincarceration” (Lowman, Menzies & Palys, 1987) or “trans-institutionalization” (Fazel & Danesh, 2002).

5.4. Aboriginal Inmates

The over-representation of Aboriginal people in corrections has been well documented (LaPrairie, 1992; Stenning & Roberts, 2001). In the Supreme Court of Canada ruling in R. v. Gladue (1999), the court ruled that sentencing judges must take their unique or systemic background factors that may have played a part in bringing the Aboriginal offender to court into account at the time of sentencing. It was hoped that this would help to alleviate their over-representation in Canadian prisons.

The trend of over-incarceration continues to grow with the high - and increasing - incarceration rates of Aboriginal people. As of February 2013, while Aboriginal people make up only approximately four percent of the Canadian population, they account for
23.2\% of the federal inmate population (Office of the Correctional Investigator, 2013). Further, Aboriginal men, women, and youth offenders are all over-represented in official statistics compared to their non-Aboriginal counterparts.

Regrettably, Aboriginal status is not routinely identified in Coroners’ inquest findings. The present study found that of the 405 deaths that occurred in custody, 11 of these deaths involved Aboriginal inmates, with 8 of the 11 being the result of suicide. This problem echoes the finding of Tatz (2005) where he noted, in the Australian context, that “inquest reports are not a ready avenue of identity” (Tatz, 2005, p. 48). Similarly, Maori status was not routinely identified in New Zealand Coroners’ records (Tatz, 2005). Accordingly, the extent to which this population is committing suicide in prison remains unknown. The lack of specificity in the inquest findings hinders researchers’ ability to identify the race or ethnic background of Canadian inmates who commit suicide.

5.5. Intersectionality: Aboriginal Women

The effect of intersecting characteristics may result in extreme social disadvantage. Women are particularly vulnerable as race and gender - as well as other social divisions - often intersect to create simultaneous barriers. Aboriginal women are arguably the most marginalized sub-group in society. Their histories often consist of poverty, alcoholism, violent victimization, as well as physical and sexual abuse. Aboriginal women in conflict with the law often do so based on their social and economic struggles related to their disadvantaged backgrounds. They are often convicted of crimes committed while under the influence of alcohol and drugs (Griffiths, 2010).
In the present study, two of the five women who committed suicide were clearly identified as Aboriginal. Both women had similar life circumstances. One woman had a history of psychiatric illness and the other had a documented history of past suicide attempts. The latter also suffered from a history of drug and alcohol abuse and was in a drug-induced state at the time of the offence that brought her to prison. Both women were arrested for crimes relating to theft/robbery.

5.6. Location of Death: Provincial versus Federal Institutions

An interesting finding in the present study was that inmates were more likely to commit suicide in provincial, rather than federal prisons (60 deaths versus 47 deaths respectively). While Ontario routinely provides data on the typical prison population in provincial facilities, CSC does not disaggregate their prison population statistics by province making it difficult to ascertain whether this number of suicides in provincial prisons is disproportionate. MacAlister (2010) found a relatively small number of detainees (n=33) committed suicide in police lock-ups over the same time frame as that covered in this study. By comparison, Wobeser and her colleagues’ (2002) study of in custody deaths in Ontario found that people were more likely to die of violent causes (suicides, poisoning or homicide) in police cells rather than in federal or provincial institutions. Similarly, the John Howard Society of Alberta (1999) noted that remand facilities showed the highest rates of suicides compared to other institutions. Even so, Winterdyk and Antonowicz found federal offenders to be more at risk of dying in custody than inmates placed in provincial institutions, but these deaths are likely due to natural causes, not suicides (as cited in Office of the Correctional Investigator, 2011).
Several researchers have suggested that suicides occur more frequently in maximum-security prisons compared to medium and minimum-security facilities (Dye, 2010; John Howard Society, 1999). Both the John Howard Society report (1999) and the current study found the majority of suicides occurred in provincial correctional facilities.

5.7. Stage of Incarceration

Researchers also have found that inmates are more likely to commit suicide in the early stages of imprisonment (John Howard Society, 1999; Hayes, 1999). The initial period of incarceration (remand or beginning a prison sentence) can entail a crisis situation where inmates become despondent and hopeless at the prospect of facing long-term incarceration. This hopelessness, coupled with the fear of an unknown environment and isolation from family, can lead some inmates to an emotional breaking point (Hayes, 1999). This finding is corroborated by the present research. In those cases where stage of incarceration was indicated, 74% of inmates committed suicide while on remand and another 13% of inmates committed suicide in the initial phase of imprisonment. At the other end of the continuum, research has identified inmates serving lengthy prison terms to be at a high risk of suicide (Sandler & Coles, 2008). The present examination of the Coroners’ data revealed that only five percent of all cases involving inmates nearing the end of their prison term committed suicide.

Prison authorities need to be particularly attentive to the higher likelihood of suicide for inmates on remand and in the early stages of confinement. Porter and Calverley (2011) reported that an increasing proportion of Canada’s incarcerated population is being held on remand rather than under sentenced custody. They note that 67% of Ontario’s incarcerated population was being held on remand in 2009/2010. Since
three quarters of the suicides in the present study committed suicide while on remand, and given that the remand population is growing, this should be a concern for those seeking to address suicide in custody. As the size of this subgroup of inmates increases, correctional authorities will need to devote greater resources to preventing suicides among this at-risk population.

5.8. Suicide by Hanging: Method of Choice

In the majority of literature available on prisoner suicides, the most common method of suicide in prisons is by hanging (Burtch & Ericson, 1979; Collins & Mouzos, 2002; Daniel, 2006; John Howard Society, 1999; Sandler & Coles, 2008), a finding that holds true decades later. Hanging has been consistently reported as the most common method employed. This finding supported by this study, which found 94% of suicides were carried out via hanging. Given that hanging is the most common method of suicide, removal of potential ligature points from cells should be a priority for correctional institutions.

In a significant majority of cases of inmate suicide, approximately 65% had readily available devices used to implement hanging. The use of implements was noted in the majority of cases. Not surprisingly, the use of bed sheets was employed in over 35% of suicides. Consequently, Correctional Services should explore some method of minimizing the use of bed sheets with material capable of forming a ligature, particularly for inmates who are known to be at risk of committing suicide. Other implements used by inmates raise the question of why inmates have access to shoelaces or ropes, given the risk of suicide. It is important to note that in some cases, inmates succeeded in killing themselves with homemade nooses or other objects that worked as ligatures.
5.9. A Critical Stance: Drawbacks of Coroners’ Data

McMullan (2006) examined the role of the official inquiry into the Westray disaster involving the controversy that arose over the deaths that occurred at a mine explosion. The public inquiry into the disaster disguised the truth using official accounts of the deaths. The official medical version of the public truth revealed an unwillingness to confront disturbing information (McMullan, 2006). That is, even after evidence exposed wrongdoing such as dangerous working conditions and illegal mining practices, company culpability was covered-up using official discourse. However, the use any records limits what one can find because no records can contain information about everything. The need for more comprehensive data is necessary to conduct a thorough analysis of prisoner suicides and deaths in custody more generally.

In many Canadian jurisdictions, Coroners do not need to be medically trained. In actuality, Coroners are often former police officers (MacAlister, 2010). As such, they are often closely aligned with the law enforcement agencies they may be called upon to investigate when there is a death in custody. Their ability to remain objective when investigating a death that has occurred in such circumstances is questionable. In particular, it is conceivable that a law enforcement agency might seek to protect its reputation by not revealing the precise nature of a police-involved death (MacAlister, 2010).

While Coroners ostensibly act as an unbiased component of the criminal justice system, their supposed neutrality may be disputed. In reality, Coroners are official agents of social control and part and parcel of the criminal justice system. However, the question of the relative autonomy of the state and its agents has been debated from a
variety of perspectives. According to Ratner, McMullan and Burtch (1987), different components of the criminal justice system have varying degrees of autonomy. Some components of the system act fairly autonomous of official state interests, revealing a willingness to be critical. In this vein, Coroners also have the potential to be quite critical of state exercises of power but tend not to do so.

At Coroners’ inquests, an agent of the Attorney General typically operates as the lead counsel who marshals witnesses and other evidence to be presented to the jury. Only rarely will the family of the deceased be able to have their own legal counsel present to ensure witnesses and physical evidence are scrutinized from a perspective that may be antagonistic towards protecting the system’s status quo. Ideally, provincial legal aid plans would provide adequate funding for families of the deceased.

5.10. Methodological Limitations

This study suffers from a few methodological limitations that must be acknowledged and addressed by future research. First, while the dataset covers deaths that occurred in federal or provincial custody in Ontario between 1992 and 2006, data covering the past seven years (2007-2013) were not sought and are not included in this analysis. Consequently, the latest patterns and trends could not be identified. A second limitation is that the dataset is exclusively from Ontario. While Ontario is Canada’s most populous province, the Coroner’s data is exclusively regional. A comparative analysis between various provinces/territories in Canada that focuses on suicides in prison would have been ideal.
A third major limitation of the current research is the paucity of information (the extent of missing data) in the files on key variables of interest. For instance, the majority of case files did not indicate the deceased’s race. As a result, most of the cases had race coded as N/A. In a minority of cases in this study, there was sufficient information in the files to infer the race/ethnicity of the deceased without overreaching. Race, however, appeared to be frequently noted when the deceased was of Aboriginal descent; however, it is unclear how consistent Coroners are in reporting this information. Coroners are likely to vary in the extent and completeness of their record-keeping. There may also be weaknesses with the use of such records as this information is not collected by Coroners for research purposes and it does not necessarily provide the details that are often sought by researchers (Bennewith et al., 2011). The use of a more sophisticated methodology, such as interviewing the families of those who committed suicide, could have made determining race more feasible.

Another key variable of interest that was not clearly identified was the deceased’s social class. It was not noted whether the deceased was employed or homeless at the time of arrest, and subsequent death. This meant that socio-economic classification was not possible, and this absence again places considerable limitations on an application of a critical analysis based on intersectionality. Such information is vital to understanding the disadvantaged backgrounds many people come from who make up the prison population. While the data did not allow me to pursue an intersectionality analysis in any detail, it would be very useful if there were more comprehensive data that would allow for that sort of analysis. The fifth drawback stems from Coroners’ recommendations, which are normally geared towards preventing deaths in similar circumstances, do not focus or address the broader, systemic issues at play. Instead, many of the
recommendations focus on micro, individual factors such as environmental or cell design changes as opposed to macro-structural factors such as oppression or social exclusion. Given the mandate of Coroners to identify the manner and cause of death and provide recommendations for death prevention in similar circumstances, it is understandable that the files contained the limited range of data that they did. However, it is unfortunate that this precluded the performance of an intersectionality assessment due to the limited nature of this data. In their study, Parai et al. (2006) examined the validity of the manner of death certification of unnatural deaths by Ontario Coroners. While they found that Coroners occasionally misclassified deaths (e.g. mixing up whether a death was by suicide or by accident), such discrepancies appear to be relatively rare, particularly when looking at suicides arising in custody which rarely appear to be mistaken for accidental deaths.

A further limitation of inquest findings is that they rarely contain information garnered from family members or other inmates familiar with the deceased. This limits the diversity of views that are represented in the Coroners’ reports. Finally, it is also noteworthy that Coroners are agents of the state and may be expected to approach cases from a perspective that is less critical of government officials. However, the quasi-judicial nature of the position of Coroners offers a reason to favour the use of Coroners’ inquest findings as a data source over other alternatives, such as correctional facility files or police reports of the deaths, which are so closely connected to the facilities being investigated that possible bias would be a greater problem. The involvement of peer juries in Coroners’ inquests also adds a layer of objectivity to the files that is not found in alternative data sources such as correctional files and police reports.
5.11. Summary

This chapter provided a discussion of the main findings from this thesis and compared it to results from the available literature on prisoner suicides. Implications of findings were situated and discussed within the realm of broader, systemic issues. Contrary to the researcher’s expectations, however, suicides among elderly inmates are still relatively rare. Suicide in prison has been a constant challenge over the years, with numbers remaining fairly constant over time. In the context of the wide range of prison mental health issues, one of the most pressing challenges is the need to first identify and then prevent suicide among inmates suffering from mental disorders. Aboriginals have suffered in Canadian society over its history, and this suffering is particularly tragic when it results in Aboriginal men, women, and youth taking their own lives while in custody. At times, mental health issues and racism intersect to some extent further marginalizing Aboriginals. This chapter ended with a critical discussion of Coroners’ data and the methodological limitations of the present research. The next and final chapter will present a discussion on suicide prevention in corrections. Recommendations for change and future research will also be suggested.
Chapter 6. Conclusion and Recommendations

The focus of this concluding chapter is on prevention efforts. While not all deaths in custody can be prevented, as some inmates may be intent on taking their own life, there can be little doubt that developing and maintaining suicide prevention strategies should be a matter of concern to policy makers. This chapter will discuss suicide prevention strategies along with recommendations for change and directions for future research on suicide in prisons.

6.1. Whose Responsibility Is It?

In an environment such as the prison context, where inmates are often closely monitored and supervised, many deaths, particularly suicides, are seen as preventable and even as a failure of the state’s duty of care (Carmilleri & McArthur, 2008). The concept of “duty of care” was discussed earlier; it flows from the premise that correctional services staff have a legal duty to protect inmates from any foreseeable harm and to prevent inmates from dying prematurely (Office of the Correctional Investigator, 2012).

The responsibility for the welfare of individuals in custody is shared among different sectors of the criminal justice system that come in contact with detainees. In correctional institutions, correctional guards often bear the brunt of this responsibility as front-line workers. However, as Daniel (2006) notes, preventing suicides is a
collaborative responsibility between administrative, custodial, and clinical staff. Too often, there are miscommunication failures between clinical workers and correctional guards (Daniel, 2006; Hayes, 1995, 1999; Sandler & Coles, 2008). This failure has been repeatedly identified by Coroners’ recommendations for enhancing communication, and by the Federal Correctional Investigator, Howard Sapers, who has routinely noted the information-sharing inadequacies between clinical and custodial workers in various reports. Indeed, the most common Coroners’ recommendation found in the present research was to enhance communication regarding an inmate’s medical/suicide history. Communication inconsistencies and difficulties in sharing critical information were noted in many of the suicides in the present study. Enhancing communication among various staff may be difficult in the prison environment, but it is essential to suicide prevention.

In the prison community, everyone should share the responsibility to look out for inmates at risk of committing suicide. Custodial staff, treatment staff, educational and training staff, prison administrators, and even other inmates should play a role in suicide prevention.

6.2. Failure to Comply with Recommendations for Change

In his final assessment of the *Correctional Service of Canada’s Response to Deaths in Custody* (2010b), the Office of the Correctional Investigator specifically identified a summary of the Office’s concerns. The following were among the concerns found to be in need of attention: “quality of care received, lack of appropriate or timely medical follow-up or intervention, critical information-sharing failures between clinical and front-line staff, improper or inadequate observation, surveillance and evaluation of suicide risk, and quality of the national board of investigation reports” (Office of the
According to an internal Activity Report carried out by CSC, they also identified issues similar to those noted by the Office of the Correctional Investigator. Subsequently, CSC reported that “corrective measures had been taken to address all the issues identified above” (Office of the Correctional Investigator, 2010b, p. 5). However, despite any preventive efforts taken by CSC, the total number of suicides for the fiscal year 2008/09 and 2009/10 did not show a reduction in the number of deaths by means other than natural causes. The total number of suicides for both years revealed a high figure of nine deaths, the highest reported number since 2001.

Post-death investigations carried out by the Office of the Correctional Investigator and Coroners’ inquests provide learning opportunities for past shortcomings. They also potentially act as preventive tools to reduce future deaths. However, subsequent deaths in similar, if not identical, circumstances suggest these opportunities for suicide reduction are not being maximized (Sandler & Coles, 2008). Despite recurring recommendations arising from juries at Coroners’ inquests, not all recommendations have been rigorously and systematically implemented. The reasons behind this non-compliance primarily have to do with budgetary constraints and limitations, difficulty hiring fully trained mental health professionals and correctional staff, and the nature of correctional work (Daniel, 2006). Without any mechanisms in place to ensure recommendations are being enforced, there is little incentive to implement change (Sandler & Coles, 2008). This was recently echoed by the Correctional Investigator of Canada, Howard Sapers, who stated that “coroners’ reviews and inquests have had little sustained impact in part because there is no official body to share, let alone enforce their findings or recommendations” (Quan, 2014). Further, Hayes (1999) argues that
meaningful suicide prevention efforts are often impeded by negative attitudes and a systemic view that inmate suicides are simply not preventable.

6.3. Recommendations and Best Practices

The key components of a well-designed suicide prevention program have been outlined in several studies (Daniel, 2006; Hayes, 1995, 1999). These components involve all aspects of prevention, screening, assessment, evaluation, intervention, as well as training and education for all correctional, mental health and medical staff working in institutions (Daniel, 2006). All of these components are important and work in conjunction with one another. Training and education of all medical, mental health and correctional staff is crucial to producing effective change. Investing in providing prison staff with the necessary training to recognize and identify signs and symptoms of mental illness, not only enhances awareness but could likely prevent any suicidal behaviour, whether self-harm or death. Educating prison staff on mental illness will also help them understand prisoners’ needs better. This training and education must be provided early in the training program, and it must be on-going and provided regularly to all correctional staff. Providing better mental health services in prisons needs to be a priority given that, in Canada, correctional institutions have a higher proportion of the offender population who suffer from mental health concerns than in the past (Office of the Correctional Investigator, 2013a). In addition to training and prevention, responses to suicidal inmates should be more therapeutic than punitive. For instance, the Correctional Investigator has maintained that reliance on use of force and control measures, such as physical restraints, in the management of suicidal offenders should be minimized wherever possible. He has also noted that when restraints are applied, it should be done so only
as a last resort and for the shortest period necessary in order to protect an offender from self-harm. Similarly, placement on “suicide watch” should always be properly monitored.

Correctional organizations need to ensure information regarding an inmate’s risk for suicide is effectively communicated to all staff coming into regular contact with that inmate. Inmates who are transferred should have the information pertaining to their risk for suicide transferred with them in order to ensure correctional and treatment staff who are unfamiliar with the inmate are made aware of their mental status.

The present study highlights how particular attention needs to be paid to inmates with special needs. Aboriginal youth, inmates suffering from mental illnesses, inmates experiencing family disruption, and especially those who are on remand and are experiencing delays or uncertainty in their judicial proceedings should be given special consideration, ensuring proper diagnostic and suicide prevention measures are in place.

The incompleteness of Coroners’ data in recording ethnic or racial variables precluded this study from ascertaining whether Aboriginal people in custody are more likely to commit suicide than their non-Aboriginal counterparts. One key recommendation would be to improve data gathering methods by encouraging CSC to keep data on minority status.

6.4. Developing a National Forum on Deaths in Custody

Recently, the Correctional Investigator of Canada, Howard Sapers, called for the resumption of annual meetings with Canada’s Chief Coroners and Medical Examiners to discuss preventing deaths in custody (Quan, 2014). It is unclear why these annual
meetings suddenly ended. In addition, Sapers has been calling for the formation of a National Advisory Board on deaths in custody. This advisory panel would, theoretically, help identify trends and suggest future research into deaths in custody. This initiative has great potential in making positive contributions to preventing deaths in custody if only it was supported by government resources, in which case, the panel could have a significant impact on policy development (MacAlister, 2010). Canada lags behind other countries in this regard particularly the United Kingdom where they implemented an Independent Advisory Panel (IAP) on Deaths in Custody in 2008, and Australia where the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was established in 1991.

6.5. Future Research

As an exploratory study, the current research was probing into selected circumstances surrounding suicides that occur in prisons. While the current study was designed to shed light on the life experiences/backgrounds of disadvantaged groups by using an intersectionality framework, data limitations produced unanswered questions. Many studies have relied on the use of official records in studying prisoner suicides (Antonowicz & Winterdyk, 2014; Wobeser et al., 2002); however, missing information, even in more recent databases and records prevented a thorough analysis. Coroners’ should be encouraged to better record key variables of interest to social researchers such as race in order to identify whether an offender is of Aboriginal heritage or another racial minority.

These limitations can be addressed in future research by supplementing Coroners’ data with correctional files and/or interviews with surviving family members,
other inmates, and correctional staff in the institution. This could likely fill in some of the gaps in the Coroners’ files. In addition, interviewing the correctional investigator for Canada, Howard Sapers, would complement official records and provide a unique insight. To date, there is little information from the standpoint of correctional officers whose role in suicide prevention is imperative. Conducting interviews with prisoners who have attempted suicide can also provide a more affective understanding of the motivations behind suicide. As it stands, there is a lack of qualitative understanding of prisoner suicides as a process rather than an event. Further, more theoretically framed examinations of prisoner suicide and a more robust methodology are needed. Future research could also focus on a gender-specific analysis of prisoner suicide, drawing out any patterns or factors uniquely characteristic of women, or use masculinities theory given the proclivity of men to commit suicide.

6.6. Conclusion

This thesis makes an original contribution that complements the available Canadian and international literature on prisoner suicides. It brings forward hitherto unavailable analyses of records from Canada’s most populous province (Ontario) in this time period. This thesis has contributed to a better understanding of prisoner suicide in the Canadian context, as well as some insight into the life histories or backgrounds of this marginalized population, paying specific attention to the plight of Aboriginal inmates. This thesis has drawn on an intersectionality framework to provide a deeper theoretical analysis of prisoner suicides than has been possible through existing atheoretical, descriptive research. While the data were not sufficiently detailed to allow a thorough understanding of the prisoner suicide phenomenon, the framework may eventually help
to provide an awareness of why and how these individuals initially come into contact with the criminal justice system. In future, an intersectionality framework could be more nuanced and more refined to allow for mental health factors that increase the risk of suicide on the one hand, while accounting for other factors that increase resiliency and act as a buffer against suicide (e.g. Services and programming available to Aboriginal people in prisons such as the Native Brotherhood/Sisterhood which has been well established in many institutions or family support/protective factors).

Coroners’ inquests provide a unique insight into the various circumstances surrounding prisoner suicides, and contain many recommendations designed to ensure these unfortunate occurrences are minimized. Tragically, most of the recommendations made by Coroners’ inquests are routinely ignored. In fact, an analysis carried out by the Toronto Star in 2014 revealed that approximately two thirds of almost 5,000 Coroners’ inquest recommendations made between 2001 and 2011 had not been implemented (Kane, 2014). Regrettably, there is no statutory enforcement mechanism in place to ensure that inquest recommendations are followed.

It is a tragedy when any individual takes their life in prison, away from their family and their home, left to die alone. This thesis underscores how inmates who commit suicide are a vulnerable, marginalized group, often with adverse life histories who deserve to be treated in accordance with the duty of care the law imposes on those who have a responsibility to detain individuals. It is sincerely hoped that recommendations for change identified in the various Coroners’ inquest reports will be implemented in order to help prevent future deaths.
References


Coroners Act, R.S.O. 1990, c. C.37.


Royal Commission on Aboriginal Peoples. (1996). *People to people, nation to nation*. Ottawa: Minister of Supply and Services Canada.


Appendix A.

A Sample Verdict of a Coroner's Jury without Recommendations

Pseudonyms were used to protect the identity of the deceased.

VERDICT OF CORONER'S JURY

the jury serving on the inquest into the death of:
Surname       Given names
DOE        JOHN

aged 31 years held at ONTARIO COURT (GENERAL DIVISION) KINGSTON,  ON
on the 11th day(s) of MAY, 1994 by Dr. (Name of Coroner) Coroner for Ontario,

having been duly sworn, have inquired into and determined the following:

Name of deceased   JOHN DOE
Date & time of death  TUESDAY, SEPTEMBER 21/1993
                      APPROXIMATELY 14:11 HRS
Place of death   KINGSTON PENITENTIARY- E BLOCK, CELL 17- 2-E
Cause of death  ASPHYXIA DUE TO HANGING
By what means  SUICIDE

WE FEEL MR. DOE HAD INTENTIONALLY TAKEN HIS OWN LIFE ON  SEPTEMBER
21, 1993 BY HANGING USING A ROPE THAT WAS AVAILABLE IN HIS CELL.

________________________________________________________________
THIS VERDICT WAS RECEIVED BY ME THIS 11TH day of MAY, 1994
__________________________________________________________
Signature of Coroner

We wish to make the following recommendations:

NO RECOMMENDATIONS.
Appendix B.

A Sample Verdict of a Coroner's Jury with Recommendations

Pseudonyms were used to protect the identity of the deceased.

VERDICT OF CORONER'S JURY

the jury serving on the inquest into the death of:

Surname       Given names

DOE       JOHN
aged 22 years held at Superior Court of Justice, 5 Court Street, Kingston, Ontario
on the 28th day of November, 2005

by Dr. (Name of Coroner), Coroner for Ontario,

having been duly sworn have inquired into and determined the following:

Name of deceased:   John Doe
Date and time of death:   July 16, 2003  2:07am
Place of death       Collins Bay Institution, Segregation
                      Unit Range Two, Cell 166
Cause of death: HANGING
By what means: Suicide

This verdict was received by me this 1st day of December, 2005

Dr. (Name of Coroner)
WE WISH TO MAKE THE FOLLOWING RECOMMENDATIONS:

1. Video cameras pointed down all three segregation ranges. Images to be retained for thirty days. Any incidents out of the ordinary on a given day retain as a reference of back up to the unit log.

2. Inmates should be able to receive their personal effects within forty-eight hours of being relocated within the same institution.

3. Weekly maintenance check performed to ensure Dystar timing is accurate.

4. Equip each cell with its own dustpan and brush as opposed to a corn broom which could be used as a tool/weapon or a method of concealing contraband.