Submission re: ICCPR to the Human Rights Committee for seventh periodic report of Canada

February 2026

This document provides an overview of the *Tracking (In)Justice: a law enforcement and criminal legal data and transparency project*'s observations and questions to Canada in response to the Human Rights Committee's upcoming review of Canada's compliance and obligations under the *International Covenant on Civil and Political Rights (ICCPR)*. **Specifically, we focus on reporting on deaths in custody, deaths by police use of force, lack of civilian oversight, limited investigatory mechanisms, and racialized inequities.** We hope that this document will assist the Committee to seek further clarity in relation to Canada's ongoing and outstanding issues in Canada's adherence to the *ICCPR*. **This submission is public.**

About Tracking (In)Justice

1. This submission is prepared by *Tracking (In)Justice: a law enforcement and criminal legal data and transparency project*. We launched our initiative in 2021, which is housed at *Carleton University, and is led by the Data and Justice Criminology Lab*, at the *Institute of Criminology and Criminal Justice.*

2. As a civil society, collaborative and community-engaged scholarly initiative, we bring together criminologists, families and loved ones of people who have died in custody or due to police homicide, and people with lived experience of incarceration, social workers, legal experts and computer scientists to collectively document deaths in custody and due to police use of force. We aim to ensure our work is relevant, rigorous, and trauma and grief informed.

3. Our project houses and maintains two databases: **1) the largest and most comprehensive database on deaths due to police use of force across Canada**, and **2) the largest and most comprehensive database on deaths in custody across**

Canada. Both are publicly accessible via: https://trackinginjustice.ca/. Since our launch, we have had over 40,000 unique visitors engage with the databases. Our methodology for tracking and verifying deaths has been peer-reviewed, and our project is funded by multiple public grants.

4. In 2022, we launched the first of our two databases, which tracks deaths due to police use of force since the year 2000 with a web-portal making data on deaths searchable and accessible to the public. To date, we have documented 833 deaths, and **our analysis indicates that deaths by police homicide are on the rise**, and there was a bare minimum of 45 deaths occurred through police use of force in 2025.

5. In 2023, we launched an online memorial for those who have died in custody, and in 2024, we launched a web-portal making data on deaths in custody searchable and accessible to the public. Since the year 2000 the data includes over 2309 deaths that have occurred in police custody, jail institutions under provincial jurisdiction, youth detention, immigration detention, forensic psychiatric detention, and prison institutions under federal jurisdiction. **Our analysis indicates that deaths in custody are on the rise**, and a bare minimum of 83 deaths occurred across all such institutions in 2025.

Concerns regarding Canada's state party report

6. We are responding to the *List of issues prior to submission of the seventh periodic report of Canada submission to Non-discrimination* (arts. 2, 3, 6, 9, 25 and 26) ("the report" or "report"), specifically to, **Question 5, section a**, we also address in less depth sections b and c, which states:

> "Recalling the Committee's previous concluding observations (para. 18), please provide information about: **(a) reports of the lethal use of force and deaths in custody affecting individuals from racial minorities, and steps taken to investigate and prosecute all such incidents**; (b) efforts to prevent racial profiling by police officers; (c) measures to address the overrepresentation of individuals belonging to racial and ethnic minorities, particularly indigenous persons and those of African descent, including women, in the criminal justice system at all levels."[1]

7. To understand the scope of the problem of preventable deaths in custody, to identify patterns, and prevention interventions, and accountability mechanisms rests on effective monitoring. The effectiveness of *ICCPR* implementation rests on effective monitoring. As Article 40 outlines, states must report on: "the measures they have adopted which give effect to the rights recognised herein and on the progress made in the enjoyment of those rights."[2] Furthermore, as noted in the **Report of the Special**

[1] See Canada response documents here: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/SessionDetails1.aspx?SessionID=2837&Lang=en

[2] Article 40, paragraph 1: https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights

Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz, presented at the Human Rights Council Fifty-third session:

> "Comprehensive, reliable data on prisoner deaths are necessary to inform policy and practice and to enable accurate monitoring and evaluation of interventions aimed at preventing prisoner deaths. In 2019, the Human Rights Council recommended that States implement systems to collect and analyse data on prisoner deaths."[3]

A state cannot report on progress in the enjoyment of the right to life, and all other rights guaranteed under the *ICCPR* without effective monitoring and tracking outcomes over time. Canada has not heeded this call and due to the lack of quality monitoring of the issue of deaths in custody, answers to basic questions about realizing the human rights of prisoners' access to the right to life through preventing deaths in custody, can be avoided and unacknowledged, and unaccounted for, limiting possibilities for justice and accountability.

There is no systemic reporting and documentation of deaths in custody across Canada

8. **As evidenced by the report, there is no national, consistent, or consolidated monitoring of deaths in custody conducted by the government of Canada.** This gap in knowledge, and violation of human rights guidance is illustrated in the report, which is fragmented, lacking a Canada-wide analysis, provides no methodology, and addresses no contextual issues in data challenges. In its report, Canada discusses deaths in custody primarily through a patchwork of provincial correctional data, with limited federal data, and many gaps from provinces; notably absent are data from Ontario and Quebec, Canada's most populus provinces by population and by incarcerated population.[4] The exclusion of both provinces means that **Data on more than half of incarcerated people in the country are overlooked in the government's report. Additionally, data collection and reporting standards vary by province, where there is no uniform methodology to data collection and reporting. The outcome is that there is no government-reported overall national total for deaths in custody, no comparable indicators, and no synthesis explaining trends or systemic issues related to issues of equity, discrimination and access to justice.**

9. Of note is the province of Ontario, where data is missing in the report, and where, ongoing issues of data quality and access have been evidenced, such as during the Independent Review of Ontario Corrections in 2017, investigators attempted to obtain a concrete figure on deaths within Ontario provincial institutions but were unable to do

[3] Human Rights Council Fifty-third session. A/HRC/53/29: Deaths in prisons Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz. https://www.ohchr.org/en/documents/thematic-reports/ahrc5329-deaths-prisons-report-special-rapporteur-extrajudicial-summary

4 According to Statistics Canada, there were a total of 25,349 incarcerated persons under provincial jurisdiction in Canada in 2023-2024, 9,364 of which were incarcerated in Ontario, and 4,873 were incarcerated in Quebec. See Statistics Canada: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3510015401&pickMembers%5B0%5D=1.11&cubeTimeFrame.startYear=2019+%2F+2020&cubeTimeFrame.endYear=2023+%2F+2024&referencePeriods=20190101%2C20230101

so, as the figures provided by different branches of government did not align.[5] In 2023, the Chief Coroner of Ontario's report noted, that their team "struggled to access, interpret and apply data sources that ranged from archaic paper methods, to incomplete electronic records, and often illogical reporting patterns. They also encountered organizational units whose responses to their information requests ranged from eagerly cooperative to only tacitly willing".[6] The Coroner report called for the urgent need for greater transparency with consistent, open and reliable reporting on deaths in custody.

Limited analysis of ongoing structural inequalities impacted racialized people, Indigenous people, people with mental health issues, and people who use drugs

10. The report presents a limited analysis of racial and Indigenous disparities where the lack of data prevents a robust contextual analysis. While racialized and Indigenous deaths are noted, there is no explanation of overrepresentation, root causes, or links to systemic discrimination. Nor is there any reference to **Article 26 of the *ICCPR*, recognizing the right to non-discrimination, or Canada's obligation to address structural ongoing structural inequities.** Not stated in the report is that the Canadian criminal legal system is a product of ongoing colonization. In Canada, the normative order of society came to be maintained through the violent enforcement of colonial laws, customs, and ways of knowing. The history of enslavement and colonialism in Canada has a direct impact on the country's contemporary criminal legal system, which is characterized by racial profiling, the over-policing and incarceration of racialized and Indigenous populations, and disproportionate levels of state violence directed at these communities.[7]

11. The report presented a limited analysis of how incarceration impacts mental health and can exacerbate risk of suicide and substance use related deaths. Despite a wide base of scholarship on both issues, the report is absent of analysis. For example, in undertaking a meta-analysis of risk factors for suicide in prisons, **researchers have noted that a heavy reliance on remand affects deaths in custody as individuals on remand face heightened suicide and drug overdose risk compared to those serving sentences.[8] In some provinces, over 70% of provincial incarcerated people are on remand**.[9] Furthermore, others have noted that drug toxicity risk in pre-trial detention is heightened due to reduced drug tolerance and high turnover of people

[5] Sapers, H. (2017). Corrections in Ontario: Directions for Reform. Independent Review of Ontario Corrections, pg. 21 https://files.ontario.ca/solgen-corrections_in_ontario_directions_for_reform.pdf

[6] Expert Panel on Deaths in Custody. (2023). An Obligation to Prevent: A Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody. Chief Coroner of Ontario. https://www.ontario.ca/document/obligation-prevent-report-ontario-chief-coroners-expert-panel-deaths-custody

[7] Murdocca, C. (2010). "'There Is Something in That Water': Race, Nationalism, and Legal Violence," *Law & Social Inquiry,* 35, no. 2, 369–402.; and Murdocca, C. "The Racial Profile: Governing Race through Knowledge Production (Research Note)." Canadian Journal of Law and Society 19, no. 2 (2004): 153–67.

[8] Zhong, S., Senior, M., Yu, R., Perry, A., Hawton, K., Shaw, J., & Fazel, S. (2021). Risk factors for suicide in prisons: A systematic review and meta-analysis. *The Lancet Public Health*, *6*(3), e164–e174. https://doi.org/10.1016/S2468-2667(20)30233-4;

[9] See Statistics Canada: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3510015401&pickMembers%5B0%5D=1.11&cubeTimeFrame.startYear=2019+%2F+2020&cubeTimeFrame.endYear=2023+%2F+2024&referencePeriods=20190101%2C20230101

rotating through facilities, which facilitates the entry of drugs into institutions.[10] The report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody, titled *An Obligation to Prevent,* documents deaths in provincial custody from 2014, to 2021, where the cumulative number of deaths in that eight-year period had reached 192. **Of these, "deaths due to accidental drug toxicity and deaths by suicide featured heavily alongside accidental and natural causes", including 74 attributed to drug toxicity**, 52 to natural causes, and 45 to suicide.[11] Furthermore, scholars have found that approximately half of all deaths in custody across Canada occurred among those with a history of mental illness or substance use, and those deaths disproportionately occurred in local police or provincial custody, compared to those held in federal custody.[12] Multiple other reports indicate similar findings, which have been ignored in the government's report.[13]

12. In the face of widespread evidence that suicides and deaths due to drug toxicity are heightened in prisons in Canada, there is little discussion in the report of suicide prevention strategies, overdose prevention (e.g., medical care, harm reduction access), or mental health supports in custody. Additionally, prison staff themselves have acknowledged in a 2023 Ontario Chief Coroners' report that they are hesitant to administer naloxone owing to an (unfounded) fear they will be held liable if the person is not saved. [14] There have been ongoing reports indicating concerns regarding the of corrections guards deliberately refusing to administer naloxone, or the willful disregard of policies, leading to deaths. These gaps are in non-compliance with Articles 6 and providing the right to life and freedom from cruel or inhuman treatment.

Lack of effective oversight and accountability mechanisms

13. The report identifies that there are some processes in place, which are inconsistent across the country. The report does not address the effectiveness of those processes, nor the outcomes. The report emphasizes that reviews, inquiries, and investigations occur, but, it does not say how often recommendations are implemented nor does the report assess whether deaths are being prevented. Across provinces, authorities emphasize post-incident reviews and recommendations aimed at preventing future deaths. **The report lacks attention to prevention measures and there is no discussion of accountability standards – which is to be expected, as these do not**

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[10] Bucerius, S. M., & Haggerty, K. D. (2019). Fentanyl behind bars: The implications of synthetic opiates for prisoners and correctional officers. *International Journal of Drug Policy*, *71*, 133–138. https://doi.org/10.1016/j.drugpo.2019.05.018

[11] Expert Panel on Deaths in Custody. (2023). An Obligation to Prevent: A Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody.

[12] Vaughan, A. D., Zabkiewicz, D. M., & Verdun-Jones, S. N. (2017). In custody deaths of men related to mental illness and substance use: A cross-sectional analysis of administrative records in Ontario, Canada. *Journal of Forensic and Legal Medicine*, *48*, 1–8. https://doi.org/10.1016/j.jflm.2017.03.002

[13] See: Wobeser, W. L., Datema, J., Bechard, B., & Ford, P. (2002). Causes of death among people in custody in Ontario, 1990–1999. *CMAJ*, *167*(10), 1109–1113; Groot, E., Kouyoumdjian, F. G., Kiefer, L., Madadi, P., Gross, J., Prevost, B., Jhirad, R., Huyer, D., Snowdon, V., & Persaud, N. (2016). Drug Toxicity Deaths after Release from Incarceration in Ontario, 2006-2013: Review of Coroner's Cases. *PLOS ONE*, *11*(7), e0157512. https://doi.org/10.1371/journal.pone.0157512

[14] Expert Panel on Deaths in Custody. (2023). An Obligation to Prevent: A Report from the Ontario Chief Coroner's Expert Panel on Deaths in Custody.

exist in actual practice. The lack of effective mechanisms for accountability is in direct conflict with Canada's obligations to the *ICCPR* along with violating the *Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*,[15] the *Minnesota Protocol on the Investigation of Potentially Unlawful Death*,[16] and guidance issued by the *Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions.*[17]

14. **Ongoing issues related to lack of oversight, lack of implementing recommendations, lack of acknowledging the deaths of those due to incarceration period, underline a broken system that is unwilling to change.** Deliberate inaction to address recommendations is leading to exacerbating deaths in custody. Dr. Ivan Zinger's final report as Correctional Investigator highlights a persistent and systematic pattern in which Corrections Service Canada (CSC) fails to act on well-founded recommendations for reform.[18] His report details a years-long history in which CSC has routinely disregarded or deferred systemic recommendations, despite a $3.2 billion budget and a workforce of 19,000 employees. Federal corrections remain a low priority within the public safety agenda, contributing to long-standing inaction on preventing deaths in custody. In particular, Dr. Zinger emphasizes that CSC is fundamentally ill-equipped to care for individuals in acute psychiatric crisis and that inadequate mental health care constitutes a human rights violation, falling short of the Mandela Rules' requirement to prevent foreseeable harms. After years of experience, Dr. Zinger describes **a broken recommendation system in which expert findings and human rights obligations are acknowledged in principle but rarely implemented, allowing serious deficiencies to persist.**

15. In some provinces, **there is no independent civilian oversight body, and deaths are investigated under the same government ministry responsible for administration of provincial jails**. As per *Principle 17* of the *Minnesota Protocol*, deaths must be investigated by a "competent authority that is independent of the detaining authority and mandated to conduct prompt, impartial and effective investigations into the circumstances and causes of such a death".[19]

16. **Inquest jury recommendations are neither systemically analyzed nor legally binding, and there is no mechanism to ensure their implementation, despite prevention being the core statutory mandate of the process**. Unreasonable delays, of many years, in conducting inquests, further erode their evidentiary value, diminish public confidence, and impose profound emotional and financial burdens on families. A

[15] Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions Recommended by Economic and Social Council resolution 1989/65 of 24 May 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-effective-prevention-and-investigation-extra-legal

[16] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), Office of the United Nations High Commissioner for Human Rights, New York/Geneva, 2017. https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf

[17] Human Rights Council Fifty-third session. A/HRC/53/29: Deaths in prisons Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz. https://www.ohchr.org/en/documents/thematic-reports/ahrc5329-deaths-prisons-report-special-rapporteur-extrajudicial-summary

[18] Office of the Correctional Investigator. (2025). Annual Report 2024-2025. Correctional Investigator of Canada. https://oci-bec.gc.ca/en/content/office-correctional-investigator-annual-report-2024-25.

[19] Minnesota Protocol, para. 17, pg. 5

lack of procedural rigour and massive financial cost of hearings have limited the impact of accountability, leading to no justice being done. Rather than addressing these deficiencies through investment and structural reform, Ontario has responded to the growing backlog by proposing legislative amendments that would eliminate mandatory inquests altogether, replacing them with an annual administrative review of deaths in custody. **This approach risks further weakening an already deficient system over preventable deaths in custody, and violates obligations to ensure access to justice for deaths in custody are adequate, prompt and reparative, and, as outlined in *Principle 11* of the *Minnesota Protocol*, families have the right to access to evidence, and "to obtain information on the causes of a killing and to learn the truth about the circumstances, events and causes that led to it"**.[20]

17. Finally, the responsibilities remain unclear as to provincial government's obligations to adhere to the *ICCPR*. Canada does not explain how it ensures *ICCPR* compliance across provinces, despite being internationally responsible for all jurisdictions, nor is there a mechanism to ensure compliance. This weakens Canada's ability to demonstrate compliance with Article 2, the effective implementation of rights, and Article 6, the right to life.

Civil society reporting on deaths in custody in Canada

18. Counter to the limited data and analysis presented by the government of Canada, **civil society initiatives tracking deaths in custody present a disturbing trend of rising deaths in custody**. These trends are described in the following sections.

Tracking (In)Justice methodology

19. Unlike Canada's report data, our project uses a transparent peer-reviewed methodology.[21] We systematically track cases using web-scaping, targeted online searches, media scans, and access to information requests. New reports of a death are entered into the database using our project data dictionary, which provides a consistent definition of each variable. This data dictionary was developed through an ongoing community of practice involving the project's key stakeholders who are identified in paragraph 2 of this document. The new case is then subject to a verification process, where it is then reviewed by a minimum of 4 members of our team to ensure the database accurately reflects what is stated in the documents. A summary of the findings relevant to each variable is then subject to a verification process. Verification occurs by a second member of our team, who independently confirms that the information is an accurate summary of what is included from the sources.

20. We follow categorizations from Statistics Canada and the Ontario Human Rights Commission, in which racial categories reflect a general understanding of race as a

[20] Minnesota Protocol, para. 11, pg. 4.

[21] Crosby, A., McClelland, A. Sharpe, T. et al. 2025. Tracking (In)Justice: Documenting Fatal Encounters with Police in Canada. *Canadian Journal of Law and Society,* 1–25.

social descriptor that differs from ethnic origin, religion, and geographical region. Due to our data sources, information about a victim's race will often be drawn from media, coroner and/or oversight-body reports. We do not to independently assign race to an individual by looking at photographs or examining their name.

Deaths in custody appear to be on the rise

21. **Deaths in custody overall across Canada appear to be on the rise**, but lack of transparency and poor data quality make vital questions nearly impossible to answer. Over the 24-year period covered by the dataset there is an average of 87 deaths per year. However, over the ten-year period from 2013 to 2023 – where we believe we have more robust data in the database, due to increasingly working with either oversight bodies or coronial records – the average number of deaths in the database rises to 118 per year. **According to the data we currently have access to, there were 129 deaths in 2018, 134 deaths in 2019, 165 deaths in 2020, and 169 deaths in 2021, which is the highest number of deaths per year we have documented thus far.** This could indicate that overall deaths in custody are on the rise.

Deaths across provinces, territories and jurisdictions

22. There are more deaths in provinces which have higher populations of incarcerated people, inclusive of prisoners in federal, provincial and territorial jurisdiction. When examining deaths in custody by each province or territory, inclusive of all jurisdictions, from 2000-2024, Ontario has the highest number of deaths in custody within the database, with a total of 731. Quebec has 482 deaths, followed by British Columbia with 288, Alberta with 227, New Brunswick with 108, Saskatchewan with 106, Manitoba with 98, Nova Scotia with 35, Newfoundland with 23, Nunavut with 9, the Yukon with 6, the Northwest Territories with 4, Prince Edward Island with 2, and 12 unknown.

23. In the database, from 2000 to 2024, there are a total of 279 deaths in police custody (13.1%), 531 deaths in provincial/territorial custody (24.9%), of which 328 were incarcerated on remand, meaning they had not yet been to trial or bail. Furthermore, there are 749 deaths in federal custody (35.1%), and 494 deaths where our team did not have enough information to determine the jurisdiction (23.2%). In the database, there are also 77 deaths that occurred in jurisdictions that we deemed Other, which include hospitals (59 deaths), community corrections and/or youth facilities (13 deaths), and healing lodges (5 deaths).

Age of those deceased

24. **The average age of death for those in the database is 44.2 years old**. By comparison, according to Statistics Canada, life expectancy, as of 2022, was 81 years old.[22] This disparity indicates that conditions of confinement can lead to untimely death,

[22] See Statistics Canada: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310011401&pickMembers%5B0%5D=1.1&pickMembers%5B1%5D=3.1&pickMembers%5B2%5D=4.8&cubeTimeFrame.startYear=2016+%2F+2018&cubeTimeFrame.endYear=2020+%2F+2022&referencePeriods=20160101%2C20200101

in some cases cutting some incarcerated people's life expectancy by almost half. **The youngest person in the database was 14 years old at the time of death. The oldest person in the database was 90 years old at the time of death. Both people died in custody due to suicide**. There are 10 deceased people under the age of 18 years old in the database. Furthermore, there are 608 deceased people in the database with an unknown age. Often the age of the deceased is not released to the public because of privacy legislation.

Gender identity

25. Accurate information on the gender identity of those who have died in custody is also not reported institutionally, and as such it is difficult to confirm. There are 1479 deceased people who were identified as men in official documents we examined, which account for 69.4% of deaths in the database, and there was 1 two-spirited person. There are 129 people who identified as women in official documents, which account for 6% of deaths in the database. In 522, or 24.5% of cases, gender is unknown, as there is often not enough information to make a determination. There are 2 trans identified people in the database, one trans man and one trans woman, who have been included in the gender category with which they identified.

Misgendering

26. Based on lack of institutional recognition of people's self-identified gender, there have been instances of misgendering of those who have died in custody. Coroner's and investigation documents related to someone's death may assume gender based on sex, and use of pronouns that are incorrect. In 2024, the government misgendered a trans person who died in custody, where the source notes the individual's self-identified gender.[23]

Identified race and/or ethnicity and Indigeneity

27. Most of the data on racialization is unknown and not institutionally reported.[24] **Of people who died in custody in the database, the identified race for 84% of deceased persons is unknown**. The many unknowns are due to a lack of demographic information being recorded or released to the public about people's racial identity and backgrounds. **For those deaths we have information on, 6.8% were identified as white, 7.8% were identified as Indigenous, and 1.3% were identified as Black. As a comparison, in federal prisons in Canada, self-reported statistics in fiscal year 2021 to 2022 show that white people make up 51.8%, Indigenous peoples make up 28.1%, and Black people make up 8.1% of the prisoner**

[23] See: https://www.chch.com/chch-news/family-of-inmate-who-died-while-in-custody-fight-for-answers/

[24] Coroner's documents do not explicitly identify race or ethnicity, and our team does not assign an assumed race based on photographs, and only assigns an identified race based on references in official and credible documents. If references to culturally relevant recommendations are made during an inquest we will identify that deceased person as from that racialized community. For example, if inquest recommendations refer to Indigenous specific support to prevent future deaths, or if the deceased is represented by an Indigenous organization during inquest we will identify the deceased as Indigenous.

population.[25] In comparison to the general population, both racialized and Indigenous peoples are disproportionately incarcerated.

Causes of death and Manner of death

28. Of all the deaths in custody in the database from 2000 to 2024, 615 of the deaths were deemed Natural (28.9%), 452 of the deaths were deemed to be Suicide (21.1%), 365 of the deaths were deemed Accidental (17.1%), 138 were Undetermined (6.5%), and 102 were Homicide (4.8%). We did not have a coroner's determination of the manner of death in 459 (21.5%) of the deaths.

29. Based on coroners' determinations of deaths where the Manner of Death is known, 37% (615 deaths) were deemed Natural and 8.3% (138 deaths) were deemed to be Undetermined. When Suicide, Accidental, and Homicide are combined as unnatural manners of death, they form a majority, or 54.7% (910 deaths). This means that for those **when Manner of Death is known, a majority of the deaths were potentially preventable.**

Natural deaths

30. The definition of a Natural death is one used by corners to classify deaths. Deaths that are deemed to have occurred from natural causes by a coroner do not require inquests in all provinces and territories except for British Columbia and Saskatchewan. **There are severe concerns about the classification of natural death, which is highly subjective and can be shaped by biases, misinformation, and stigma instead of evidence, science, and a desire to not claim accountability.**

31. There are many deaths that have been deemed "natural" in which seem far from natural. For example, **there are 15 deaths in the database from the years 2001 to 2017, which involved various tactical interventions, including either one of a combination of restraints, chemical/inflammatory agents, sedating agents, and/or physical handling from corrections officers or police.** Of deaths deemed "natural", after the year 2010, when inquests no longer became mandatory under the *Ontario Coroners Act*, we have documented 6 deaths in custody that occurred where force was involved, either with use of restraint equipment, physical handling, medical sedating agents, or a chemical/inflammatory agent.

32. Furthermore, **we have documented deaths classified as natural that involve use of force, the misuse of sedatives by healthcare staff, prolonged medical neglect, and denial of HIV medications leading to a death by AIDS**.[26] Another death deemed natural involved the death of a newborn after the labor pains of a woman in custody

[25] See: https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ccrso-2022/index-en.aspx

[26] Committee Transcripts: Standing Committee on Justice Policy - April 02, 2009 - Bill 115, Coroners Amendment Act, 2009

were ignored for hours and they were forced to give birth alone in a segregation unit. The baby later died.[27]

Medical Assistance in Dying (MAiD) counted as natural death

33. Furthermore, deaths by Medical Assistance in Dying (MAiD) are also deemed Natural by coroners. Based on access to information requests we received, there were 29 MAiD applications between 2017 to 2023 submitted by people in federal custody. Out of those, 11 people were granted approval and ended their lives through MAiD. A majority of granted MAiD applications were cancer related. Most of the MAiD deaths were completed in a hospital setting, and 1 was listed as being completed at a federal correctional institution. Furthermore, MAiD deaths were not reported to the Federal Correctional Investigator.

Use of force interventions leading to death

34. Tactical interventions are forms of force used by police and correctional officers before and/or during the death of the person in custody. For example, tactical interventions include, restraints (handcuffs, spit hoods, physical holds), pepper spray/foam, tasers, physical force, firearms, and medical sedating agents. These interventions are involved in a minority of cases of deaths in custody. In 62.9% of cases in the database (1340 deaths) our team does not have enough information on the death to determine the use of a tactical intervention. For the cases where there is information, such as details included in a coroner's report, or inquest document, 31% of the cases (663 deaths) had no use of tactical intervention, and **in 6% of cases (128 deaths), a tactical intervention was used in the context of a person dying in custody.**

35. **Of the 128 deaths that involved a known tactical intervention (most often a use of force), 68 involved a combination of multiple tactical interventions simultaneously**, such as deaths involving restraint equipment, and a chemical/inflammatory agent and physical handling. Overall, in the database, currently, there are 80 deaths involving physical handling, 92 involved restraint equipment, 15 involved intermediary weapons, 14 involved chemical/inflammatory agents, 8 involved medical sedating agents, 7 involved a firearm, and 2 involved a K9 (police dog).

Gaps and biases in government sources on institutional deaths

36. We recognize that what we identify as credible sources may not provide the entire context and may be biased and slanted towards state interpretations and interests. Sometimes, what the media, coroner or an oversight body presents as "facts" are contested or incorrect. We accept this as a limitation. Furthermore, issues can include the underreporting of incidents, incorrect information recorded and a lack of information on demographics—specifically gender, race, socioeconomic status and

[27] See: https://www.cbc.ca/news/canada/ottawa/julie-bilotta-jailhouse-lawsuit-settled-1.4556660

whether the victim was labelled with a mental health diagnosis. Thus, a reliance solely on institutional accounts of the incident may only tell one side of the story.

37. We rely on government accounts of a death, which are generally created by and for those who are responsible for the death and to justify the legality of it. Officials hold the power to frame people outside of how they knew themselves (e.g. via ID, self-identified gender vs. assigned sex, mental health diagnoses). Despite what is true about a person, in death, such documents stand as an official record.

38. Furthermore, in an absence of effective and rigorous documentation undertaken by government institutions, there are many gaps in what is available to the public, as a result, much is unknown, specifically key questions about identified race and/or ethnicity and Indigeneity. This is directly reflected in our database.

39. Until more analysis can be conducted, we urge caution in interpreting these results. But as this is the largest dataset on deaths in custody ever created in Canada, and our data sources are mostly directly from government sources, we believe the data can give us a strong indication of potential trends which warrant further investigation. We note the numbers as the bare minimum of what is known.

Ontario data on deaths in custody

40. **As this issue was not addressed in the government's report, we have provided a section presenting data on Ontario, Canadas's most populous province, both in the general population and within custodial settings.** This data comes from our database, and it is a preliminary analysis, with findings that are comparable to other studies in the area.[28]

41. Overall, inclusive of all jurisdictions, we have documented 763 deaths in custody in Ontario since the year 2000, inclusive of police (52 deaths), provincial jail and federal prison, along with immigration, mental health, and youth detention (711 deaths). Due to challenges in data quality, we are currently unable to disaggregate across most categories across the entire timeframe, however, we know that as of 2010 to 2024, 371 deaths have occurred in provincial custody. We further analyze these deaths below.

Increase in Ontario deaths in custody by 205% from 2010 to 2024

42. **Overall, data indicates that over time there is an increase in deaths in custody across Ontario**, inclusive of police, provincial jails, federal prisons, and mental health,

[28] Antonowicz, D., & Winterdyk, J. (2014). A Review of Deaths in Custody in Three Canadian Provinces. *Canadian Journal of Criminology and Criminal Justice*, *56*(1), 85–104. https://doi.org/10.3138/cjccj.2012.E04; Vaughan, A. D., Zabkiewicz, D. M., & Verdun-Jones, S. N. (2017). In custody deaths of men related to mental illness and substance use: A cross-sectional analysis of administrative records in Ontario, Canada. *Journal of Forensic and Legal Medicine*, *48*, 1–8. https://doi.org/10.1016/j.jflm.2017.03.002; Wobeser, W. L., Datema, J., Bechard, B., & Ford, P. (2002). Causes of death among people in custody in Ontario, 1990–1999. *CMAJ*, *167*(10), 1109–1113.

immigration, and youth detention. However, due to challenges with data consistency, accuracy and availability, there is much still missing from this analysis.

43. **From 2010 to 2024, deaths in provincial Ministry of the Solicitor General (SOLGEN) custody are on the rise and have increased 205%**, from 10 deaths in 2010 to an all-time high of 46 deaths in 2021, an unfortunate record also again reached in 2024.

44. Data derived from corner for our work was not tied to any other demographic data, although according to the government's own data portal, we have some insight in more recent years. For example, in 2023, of the 33 people who died in custody, two (6%) self-identified as female, while 31 (94%) self-identified as male. There were 20 people (61%) who had self-identified as white, 10 (30%) self-identified as Indigenous, and three (9%) identified as another race category or reported more than one race.[29]

45. Twenty-three (70%) of the people who died were between the ages of 25 and 49, and 10 (30%) were 50 or older. In terms of causes of death, 11 died from natural causes, and 6 died due to a "medical cause other than the categories above". While information on suicide is not provided, it is noted that, of the 33 individual deaths examined in this report, five individuals (15%) "had a mental health alert and one individual had a suicide risk alert on file". In 2024, we know that 11 of the 46 deaths were due to drug toxicity, but further details are still to be known.

Deaths have increased while incarceration rate has not

46. **While the average daily count of prisoners held in provincial custody has decreased over time, deaths have increased**. If we compare this rise to the average number of provincially people incarcerated, in 2010, there were a total count of 8,731 in SOLGEN institutions, meaning the rate of death per 1000, would be 1.71 (Statistics Canada, 2025). Between 2023, the average number of provincially incarcerated people was 7,943, with a rate of death of 4.15 per 1000. At the highest point, in 2021, with 6,409 incarcerated, there was a rate of death of 7.17 rate of death per 1000.[30]

Gaps in data and public reporting

47. Furthermore, SOLGEN policies are absent of sufficient direction regarding the notification of next of kin, the transfer of belongings and personal documentation such as medical records or hospital records, and access to official reports. SOLGEN is not required to inform the public of the death through news releases so there is no way for members of the public to keep track of decedents' names and demographic information. **In this context, families have found out their loved one has died inside provincial jail due to a Facebook post from the family of another prisoner.** Ontario provincial institutions receive little direction regarding information sharing following an individual death in custody. Again, this is in violation to the principles to the obligations to the *ICCPR* along with violating the *Principles on the Effective Prevention and*

[29] See: https://data.ontario.ca/dataset/data-on-inmates-in-ontario/resource/cc9dd090-25fe-45b1-b6b0-ae3409fa133b

[30] Statistics Canada, 2025

Investigation of Extra-legal, Arbitrary and Summary Executions,[31] the *Minnesota Protocol on the Investigation of Potentially Unlawful Death*,[32] and guidance issued by the *Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions.*[33]

Québec deaths in custody

48. **As this province was overlooked in the government's report, we have provided a section on data on Québec, Canadas's second most populous province in both general and incarcerated**.

49. Exclusion of data from this province is even more of a concern, in a context of the federal *Review Committee on Non-Natural Deaths in Custody*, who noted in their 2022 public report, when discussing provincially submitted information on death, "Of these 34 reports, 31 reports were reviewed as 3 BOI (Office of Investigation) reports were written in French and unfortunately the unilingual English committee members were unable to review these."[34] This federal committee is legally mandated to operate bilingually - to ensure access to justice, (and where Canada also has leading French language experts in this area who could assist). The consequences of such exclusion have potentially wide-ranging impacts on how the deaths of prisoners in Québec get documented and acknowledged, limiting access to the right to life, and to proper accounting and investigation of deaths.

50. **To supplement state knowledge gaps, we summarize data from another civil society led project, from Québec in a report titled: *Décès dans les prisons provinciales : État des lieu,*** prepared by researchers Catherine Chesnay, Professor at the l'École de travail social de l'Université du Québec à Montréal (UQAM), Mathilde Chabot-Martin, a graduate student at travail social à l'Université du Québec à Montréal, and Guillaume Ouellet of 'École de travail social de l'Université du Québec à Montréal.[35]

51. This report provides a quantitative overview of deaths in Quebec provincial prisons between 2009 and 2022, while emphasizing the significant limitations of such an exercise. Counting deaths is inherently dehumanizing, as it reduces the loss of human life to numerical data and fails to capture the uniqueness of each individual or the impact of their death on families and loved ones. The analysis relies on limited administrative data that does not allow for an examination of the criminalization or discrimination faced by overrepresented populations such as Indigenous people, Black people, and people experiencing homelessness. Despite these shortcomings, the research is intended as a first step toward understanding deaths in custody and contributing to the defense of incarcerated people's rights.

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[31] Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions Recommended by Economic and Social Council resolution 1989/65 of 24 May 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-effective-prevention-and-investigation-extra-legal

[32] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), Office of the United Nations High Commissioner for Human Rights, New York/Geneva, 2017. https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf

[33] Human Rights Council Fifty-third session. A/HRC/53/29: Deaths in prisons Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz. https://www.ohchr.org/en/documents/thematic-reports/ahrc5329-deaths-prisons-report-special-rapporteur-extrajudicial-summary

[34] https://www.canada.ca/en/correctional-service/corporate/library/deaths-custody/review-non-natural-2019-2021.html
[35] https://www.observatoiredesprofilages.ca/deces-dans-les-prisons-provinciales-etat-des-lieux/

52. The data used in this project were provided by Quebec's Ministry of Public Security (MSP) and cover the period from 2009–2010 and 2021–2022. More specifically, the figures come from the *Compilations of Events by Detention Facility*, produced by the MSP in response to access-to-information requests. Comparisons with data obtained through other access-to-information requests revealed irregularities in the reported number of deaths, indicating that the analyses presented offer only a partial picture of the true scope of deaths in provincial detention facilities.

Deaths in the province have increased

53. **Over the study period, 256 people are believed to have died in Quebec provincial prisons, representing a net increase of 87% in the death rate over 13 years.** Deaths classified as natural causes accounted for 33% of cases, while 28% were attributed to undetermined causes—a proportion that raises serious concerns about oversight and monitoring. Suicides represented 38% of all recorded deaths, making them the leading cause. The data show an overall increase in suicide rates, with several sharp spikes, particularly during the COVID-19 pandemic, when especially restrictive detention conditions coincided with a marked rise in deaths classified as suicide.

54. The authors note in conclusion, whether it is deemed natural, undetermined, or a suicide, every death in prison is one death too many. Each is not only a tragedy in itself, but also a failure of the social body as a whole. In this sense, every death should be systematically recorded and taken into account by correctional institutions, ideally prompting action aimed at preventing similar deaths from occurring in the future.

Deaths due to police use of force or police homicide

55. While the Canadian report frames use of force solely in the context of custody, a missing implication is the loss of vital information on deaths due to police use of force overall. This has implications for the right to life as articulated in the *ICCPR*. Especially in a context where deaths in this context also appear to be rising.

56. **Our recent research outlines that from 2000 to 2024, there were a minimum of 807 recorded homicides involving police use of force across Canada**. These include police shootings, deaths after being subjected to other types of police weapons (e.g. tasers, batons) or physical interventions (e.g. punches, holds or restraints), or through environmental force (e.g. deaths resulting from no-knock raids, car chases, or falls).[36] We use the same methodology of developing and mobilizing a shared data dictionary and verify each case multiple times.

57. **Policing officials do not systematically collect or release data on the issue to the public**. A major study on Canadian police oversight bodies found an inconsistent and

[36] Crosby, A., McClelland, A. Sharpe, T. et al. 2025. Tracking (In)Justice: Documenting Fatal Encounters with Police in Canada. *Canadian Journal of Law and Society,* 1–25.

limited understanding of the issue, with some oversight representatives thinking that the use of force had decreased, while others felt that their numbers were going up.[37] The lack of available data has resulted in calls for a national standardized data-collection system requiring policing agencies to report on police homicides.[38]

Police homicides appear to be on the rise

58. Based on our tracking, **the number of police homicides has been on a steady increase over time. Between 2000 and 2011, there were an average of 23.3 deaths per year, and between 2012 and 2023 there were an average of 38.8 deaths per year. The most significant increases began in 2020, when annual deaths surpassed 50 and peaked in 2022 at 62 documented deaths in which police force was used**. In certain jurisdictions, the increase in deaths is intensified, such as British Columbia (BC) where police homicides have risen 700% in the last decade[39]

Firearms

59. Over time, there has also been an increase in police use of firearms resulting in death. Overall, **shooting deaths account 74.5% of all police homicides representing 555 out of 745 cases documented up-to 2023**.

60. **This increase in homicides at the hands of police has outpaced rates relative to population growth.** The average annual deadly use-of-force rate has risen by 46%, from 0.071 per 100,000 people between 2000 and 2011 to 0.104 per 100,000 people between 2012 and 2023. Furthermore, this increase takes place while rates of violent crime have remained relativity consistent, for example, the Violent Crime Severity Index notes the rate of 97.79 incidents per 100,000 people in 2000, which is almost identical to the 97.4 incidents per 100,000 people in 2022.

Intensified impact on Indigenous and Black people, and those experiencing mental health and substance use issues

61. Due to a rise in homicides at the hands of police, Canada is currently reckoning with unprecedented racial justice and decolonial movements, as well as intensified scrutiny of police conduct. In the fall of 2024, 9 Indigenous people died in less than a month from direct police interactions. Their deaths have further ignited calls for action, accountability, and justice.[40]

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[37] Wortley, S., Akwasi Owusu-Bempah, Erick Laming, and Carae Henry. 2021. "Police Use of Force in Canada: A Review of Data, Expert Opinion, and International Research Literature." Canadian Criminal Justice Association. https://www.ccja-acjp.ca/pub/en/wp-content/uploads/sites/8/2021/08/Full-Report-PUF.pdf

[38] Simpson, R., & Nix, J. 2024. Police Shootings in Canada: An Empirical Analysis and Call for Data. *Crime & Delinquency*, *0*(0). https://doi.org/10.1177/00111287231226182; Bennell, C., Alpert, G., Andersen, J. P., et al. 2021. *Advancing police use of force research and practice: Urgent issues and prospects*. *Legal and Criminological Psychology*, *26*(2), 121–144. https://doi.org/10.1111/lcrp.12191

[39] Hosgood, A. February 15 2023. BC, police-involved deaths have risen 700% in the last decade, The Tyee, https://thetyee.ca/News/2023/02/15/Rising-Police-Involved-Deaths/

[40] Spear Chief-Morris, J. December 16, 2024. Deaths of 9 Indigenous People at hands of Police in One Month Fuel Renewed Calls for Justice. Toronto Star. https://www.thestar.com/news/canada/deaths-of-9-indigenous-people-at-hands-of-police-in-one-month-fuel-renewed-calls/article_8df027aa-a12c-11ef-9197-cb6f211ca98e.html

62. Policing is central in the ongoing settler colonial project of Canada where police forces were founded to displace and contain Indigenous peoples in the West to open the land for settlement and Canadian expansion. Canada's colonial past and present have a direct impact on contemporary policing. Numerous public commissions and inquiries have recognized the systemic injustice experienced by Indigenous peoples from police, including the *Royal Commission on Aboriginal Peoples*[41] and *Truth and Reconciliation Commission*.[42] The Canadian Justice department has admitted that Indigenous peoples are both over-policed and under-policed, in that they are often targeted by police but also often neglected when assistance is needed.[43] The history of enslavement in Canada also has a direct impact on contemporary policing, which is characterized by extensive racial profiling, over-policing, unwarranted surveillance, and disproportionate levels of violence directed at Black and other racialized communities.[44]

63. **Data on police homicides underlines ongoing and systemic racial and colonial patterns of state violence. As of 2021, while Black people made up 4.3% and Indigenous people comprised 6.1% of the Canadian population, data show that people identified as Black represent 7.7% and people identified as Indigenous represent 16.1 of police homicides across the country. Systemic racial disparities are further reflected in the numbers specific to police killings involving firearms. Of the total number of the killings by police firearm, people identified as Black represent 8.3%, and people identified as Indigenous represent 18.2%.**

64. Other research indicates that racialized men in Canada experience intensified levels of deadly force when other less violent strategies are available, where shootings by police can occur at increased speed and include increased volume of firearm bullets than similar incidents facing white people.[45]

65. People experiencing mental health issues and/or people using substances, in public due to being under-housed are more likely to experience negative and violence

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[41] Royal Commission on Aboriginal Peoples (RCAP). 1996. Final Report of the Royal Commission on Aboriginal Peoples. Ottawa: Canada Communications Group. https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx

[42] Truth and Reconciliation Commission. 2015. Canada's residential schools: the final report of the Truth and Reconciliation Commission of Canada. Published for the Truth and Reconciliation Commission of Canada by McGill-Queen's University Press. https://publications.gc.ca/site/eng/9.807830/publication.html

[43] Government of Canada. 2019. Overrepresentation of Indigenous People in the Canadian Criminal Justice System: Causes and Responses. Department of Justice, Research and Statistics Division. https://www.justice.gc.ca/eng/rp-pr/jr/oip-cjs/e.html

[44] Tulloch, Michael H. 2018. Report of the Independent Street Checks Review. Ontario Ministry of the Solicitor General. Toronto: Queen's Printer for Ontario, https://www.ontario.ca/page/report-independent-street-checks-review; Maynard, R. 2017. Policing Black Lives: State Violence in Canada from Slavery to the Present. Halifax and Winnipeg: Fernwood Publishing; Murdocca, C. 2010. "'There Is Something in That Water': Race, Nationalism, and Legal Violence," *Law & Social Inquiry,* 35, no. 2, 369–402; Ontario Human Rights Commission. 2017. Under Suspicion: Research and consultation report on racial profiling in Ontario. https://www3.ohrc.on.ca/sites/default/files/Under%20suspicion_research%20and%20consultation%20report%20on%20racial%20profiling%20in%20Ontario_2017.pdf

[45] Wortley, S., Akwasi Owusu-Bempah, Erick Laming, and Carae Henry. 2021. "Police Use of Force in Canada: A Review of Data, Expert Opinion, and International Research Literature." Canadian Criminal Justice Association. https://www.ccja-acjp.ca/pub/en/wp-content/uploads/sites/8/2021/08/Full-Report-PUF.pdf

encounters with police.[46] Across Canada there has been a crisis of police routinely killing people during mental health wellness checks.[47] This crisis has been exacerbated by mental health stigma held by police who are trained to eliminate threats and who use force to resolve social problems. One study notes, from 2000 to For example, in 2023, the Federal Housing Advocate noted in their observational report that a "disproportionate number of First Nations, Inuit and 2017, 70% of police killings and deaths in Canada involved people who struggled with mental health and/or substance use issues.[48] Métis people are unhoused and living in precarious housing" in BC.[49] Forced displacement has been linked to compounding health issues that lead to premature death.[50] These deaths are not generally attributed to police actions in formal tracking documents, nor through any legal means, and reflect racist colonial patterns in process and by who is targeted.

Vague use of force guidelines exacerbate deaths

66. Canadian police use of force guidelines are notoriously vague, under-researched, under-evaluated, and lack public reporting or transparency.[51] There is very limited data on use of force due to lack of police cooperation in reporting. In other jurisdictions, research indicates, that strict use of force guidelines results in fewer deaths at the hands of police, [52] whereas Canadian police use a fluid definition of use of force which enables and exacerbates violence and death. In many jurisdictions, current use of force regulations do not explicitly include de-escalation or crisis intervention, nor do they require that officers be trained on how to interact with individuals who are or may be labeled as experiencing a crisis.

67. To legally justify the lethal use of force, police often rely on claiming a weapon was present. However, due to the **pervasive culture and practice of deception and lawbreaking by police,[53] such justifications have been known to be inaccurate or**

[46] Parent, R. 2011. The police use of deadly force in British Columbia: Mental illness and crisis intervention. Journal of Police Crisis Negotiations, 11(1), 57-71.Government of Ontario. 2017. Office of the Chief Coroner, Verdict of Coroner's Jury: Andrew Loku. Toronto, ON: Office of the Chief Coroner.

[47] Toronto Police Service. 2014. Police Encounters with People in Crisis. An Independent Review Conducted by The Honourable Frank Iacobucci for Chief of Police William Blair, Toronto Police Service.

[48] CBC Deadly Force Database: https://newsinteractives.cbc.ca/longform-custom/deadly-force/

[49] Federal Housing Advocate. 2023. Observational Report British Columbia (August 23 to September 2, 2022) His Majesty the King in Right of Canada, as represented by the Canadian Human Rights Commission: https://www.chrc-ccdp.gc.ca/publications/federal-housing-advocates-observational-report

[50] Qi, D., Abri, K., Mukherjee, M. R., Rosenwohl-Mack, A., Khoeur, L., Barnard, L., & Knight, K. R. (2022). Health Impact of Street Sweeps from the Perspective of Healthcare Providers. Journal of General Internal Medicine, 37(14), 3707–3714. https://doi.org/10.1007/s11606-022-07471-y; Meehan, A. A., Milazzo, K. E., Bien, M., Nall, S. K., Vickery, K. D., Mosites, E., & Barocas, J. A. (2024). Involuntary displacement and self-reported health in a cross-sectional survey of people experiencing homelessness in Denver, Colorado, 2018–2019. BMC Public Health, 24(1), 1159. https://doi.org/10.1186/s12889-024-18681-w; Westbrook, M., & and Robinson, T. (2021). Unhealthy by design: Health & safety consequences of the criminalization of homelessness. Journal of Social Distress and Homelessness, 30(2), 107–115. https://doi.org/10.1080/10530789.2020.1763573

[51] Wortley, S, et al. 2021

[52] Sinyangwe, S. 2016. *Examining the Role of Use of Force Policies in Ending Police Violence*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2841872

[53] Puddister, K., and Danielle McNabb. 2021. "When the Police Break the Law: The Investigation, Prosecution and Sentencing of Ontario Police Officers." *Canadian Journal of Law and Society*, 36(3), 381–404.

lack credibility, and in some instances have been contested as false by other civilian eyewitnesses.[54]

68. However, when examining homicides where there was an alleged weapon present, police officers disproportionately use their firearms in comparison with the type of weapon that the victim was alleged to have. **For example, out of the 555 individuals killed by police firearms from 2000 to 2023, 391 (or 70.5%) were not alleged to be in possession of a firearm, and 27.5 percent (or 205 cases) were noted as being completely unarmed.**[55]

69. In some jurisdictions, such as the Ontario Provincial Police, inquests where autopsy information is presented have revealed that police are using hollow point bullets which are unsanctioned by the UN firearms standards, as they are known to increase deaths because of the flesh damage they create rather than solid bullets. In some instances, police unions have advocated for the use of such bullets as they are lighter for the officers to carry on their equipment belts.

Police custody deaths

70. From the year 2000 to 2024 there have been a minimum of 279 deaths in police custody across Canada.[56] In BC, the number of deaths in police custody has increased eightfold since 2013. In Saskatchewan, from 2018 to 2021, in the small town of Prince Albert, 6 young Indigenous men died in police custody - making it the city with the 5th highest rate of police custody deaths, despite only having a population of 37,756, placing it outside the top 100 most populous municipalities in Canada.

71. **Many deaths in police custody were preventable and occurred due to lack of appropriate medical and mental health attention, including medical neglect, drug toxicity, suicide, and a reliance on police custody over sending people to hospital**.[57] Furthermore, there are numerous police custody deaths due to use of force, and restraints, including controversial spit hoods –which are banned in other jurisdictions, such as in Australia, and have resulted in a minimum of 3 police custody deaths since 2014.[58]

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[54] Marin, A. 2008. Oversight Unseen: Ombudsman Report - Investigation into the Special Investigations Unit's operational effectiveness and credibility. Ombudsman Ontario. https://www.ombudsman.on.ca/Files/sitemedia/Documents/Investigations/SORT%20Investigations/siureporteng_1.pdf

[55] Crosby, A et al. 2025.

[56] See: https://trackinginjustice.ca/what-does-the-database-tell-us-about-deaths-in-custody-across-canada-provinces-territories-jurisdictions-institutions/

[57] See: https://trackinginjustice.ca/what-does-the-database-tell-us-about-deaths-in-custody-across-canada-causes-manner-of-death-use-of-force/

[58]Boisvert, E. Nov. 25, 2024. *"Le masque anti-crachat, un outil controversé"* : https://ici.radio-canada.ca/nouvelle/2122233/police-force-masque-crachat; Tracking (In)Justice. 2024. Fact Sheets Spit Hoods Deaths in Custody in Canada, https://trackinginjustice.ca/wp-content/uploads/Fact-Sheet-Spit-Hoods-Deaths-in-Custody-in-Canada-4.pdf

Ineffective oversight

72. **Canada is plagued by a lack of transparency, and true accountability. In many cases agencies claim to be civilian led, but investigators are primarily former police or seconded from policing roles**. For example, as of 2023, at Ontario's Special Investigations Unit, of the 27 as-required investigators, 17 come to the Unit with a police background, and 9 of the forensic investigators have police backgrounds.[59] Again, this is in violation to the principles to the obligations to the ICCPR along with violating the *Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*,[60] the *Minnesota Protocol on the Investigation of Potentially Unlawful Death*,[61] and guidance issued by the *Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions.*[62]

73. Numerous reports have highlighted a lack of true accountability on the outcomes of police oversight in Canada, driven by a ubiquitous blue wall of silence—of cops protecting cops coupled with noncooperation of police officers in oversight investigations,[63] and a deliberate mishandling of cases.[64]

74. Counter to the transparent missions of oversight bodies, evidence can be restricted, leading to lack of due process, or the ability for independent review or interpretation. All components in the *Criminal Code* emphasize the importance of evidence. However, the families who have lost loved ones to police homicide find there is often a lack of evidence during periods leading to an inquest and at during the inquest proceedings themselves.

75. Unlike civilians, police are not charged until after long oversight investigations, and in some cases, police who are under investigation for deadly use of force can remain on duty and have even been promoted.

76. There is a very low rate of accountability, or findings of wrongdoing from investigations. For example, when police kill or injure someone, they seldom face charges or discipline and they rarely cooperate with independent oversight bodies.[65] **In Ontario, one study**

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[59] See: https://www.siu.on.ca/en/index.php

[60] Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions Recommended by Economic and Social Council resolution 1989/65 of 24 May 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-effective-prevention-and-investigation-extra-legal

[61] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), Office of the United Nations High Commissioner for Human Rights, New York/Geneva, 2017. https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf

[62] Human Rights Council Fifty-third session. A/HRC/53/29: Deaths in prisons Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz. https://www.ohchr.org/en/documents/thematic-reports/ahrc5329-deaths-prisons-report-special-rapporteur-extrajudicial-summary

[63] Puddister, K."Oversight and Accountability for Serious Incidents in Canada: Who Polices the Police?" Canadian Public Administration 66, no. 3 (2023): 390–408.

[64] Marin, A. 2008. Oversight Unseen: Ombudsman Report - Investigation into the Special Investigations Unit's operational effectiveness and credibility. Ombudsman Ontario. https://www.ombudsman.on.ca/Files/sitemedia/Documents/Investigations/SORT%20Investigations/siureporteng_1.pdf

[65] MacDonald, N. February 27, 2017. Police oversight bodies hindered by silence of accused officers, Globe analysis finds, Globe and Mail, https://www.theglobeandmail.com/canada/british-columbia/article-police-oversight-bodies-hindered-by-silence-of-officers-globe-

reported that 92% of oversight investigations into the deaths of racialized people resulted in no charges.[66] Furthermore, many families have reported that outcomes of investigations can seek to justify the death by blaming or pathologizing the person who was killed.

77. Like inquests into deaths in custody, inquest jury recommendations are never systemically analyzed nor are they mandatory by police forces to be implemented to prevent further deaths, despite being the purpose of the inquest. Unreasonable delays - of many years - in conducting inquests, along with a lack of procedural rigour and massive financial cost have limited the impact of accountability, leading to no justice being done.

Impact on families: trauma, intimidation & lack of support

78. **In the context of both deaths in custody and police homicides, in some instances, provincial governments have acknowledged that there is a widespread lack of support for families when their loved one is killed by law enforcement officials**.[67] Furthermore, trauma-informed, grief-informed, and culturally relevant supports are non-existent.

79. Many surviving families have observed and experienced a complete lack of political will to improve conditions for grieving families. Furthermore, lack of access to justice is a challenge for many families, as many are low income and under resourced. This is further intensified in rural communities, where there are less lawyers available.

80. Furthermore, Canada should be doing more than providing numbers on these issues, as numerical reporting alone is insufficient to convey the systemic, social, and human dimensions of these deaths. We have heard from family members about the lack of support in place when a death occurs. Numbers cannot help in understanding the depths of grief and system failure that families meet. For example, when someone is killed or dies during a police use-of-force incident, it is often not immediately understood by the state as wrongdoing or a crime. As a result, the family is often not eligible for Victim's Services programs and are thus left with little support. In many provinces, families must pay for legal representation at an inquest.

81. During death investigations by oversight bodies, family members have faced intimidation, coercion and surveillance from police and investigators. Additionally, vital information on the circumstances of the death, such as coroners' reports, or autopsy

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analysis/; MacDonald, N. and Hager M. February 3, 2023. Charges in Police-involved deaths a rarity in B.C, data show. Globe and Mail, https://globe2go.pressreader.com/article/281629604418483; Pinette, C. 2020. A call to modernize police accountability: An evaluation of the law's response to excess use of force by police in British Columbia [University of Victoria]. https://dspace.library.uvic.ca/bitstream/1828/11691/1/Pinette_Celia_LLM_2020.pdf

[66] Bhati, G. 2024. Accountability in Ontario Policing: Examining SIU Outcomes for Racialized Police Involved Deaths. Carleton University.

[67] Tulloch, Michael H. 2018.

records can be withheld, leaving families without vital information to which they are entitled.

82. Police oversight-body investigations can be lengthy, opaque and intimidating, and can lack a trauma and grief-informed approach. In B.C., it has been noted that the average timeline for the Independent Investigations Office to provide a report to crown counsel, or to provide a public report has been between 569 to 573 days.[68] Additionally, a loved one's clothing and belongings can also be withheld during an investigation, which can deny Indigenous families their traditional rights to hold culturally relevant ceremony to acknowledge their loss, which is a further violation of Canada's *UNDRIP* commitments, specifically, Article 11, the right of Indigenous people to practice and revitalize their culture, and Article 15 acknowledging Indigenous people's right to dignity in the practice of culture and tradition.

83. In summary, the experiences of families experiences indicate widespread violations to the principles to the obligations to the *ICCPR* along with violating the *Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*,[69] the *Minnesota Protocol on the Investigation of Potentially Unlawful Death*,[70] and guidance issued by the *Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions.*[71]

[68] Pinette, C. 2020

[69] Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions Recommended by Economic and Social Council resolution 1989/65 of 24 May 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-effective-prevention-and-investigation-extra-legal

[70] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), Office of the United Nations High Commissioner for Human Rights, New York/Geneva, 2017. https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf

[71] Human Rights Council Fifty-third session. A/HRC/53/29: Deaths in prisons Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz. https://www.ohchr.org/en/documents/thematic-reports/ahrc5329-deaths-prisons-report-special-rapporteur-extrajudicial-summary