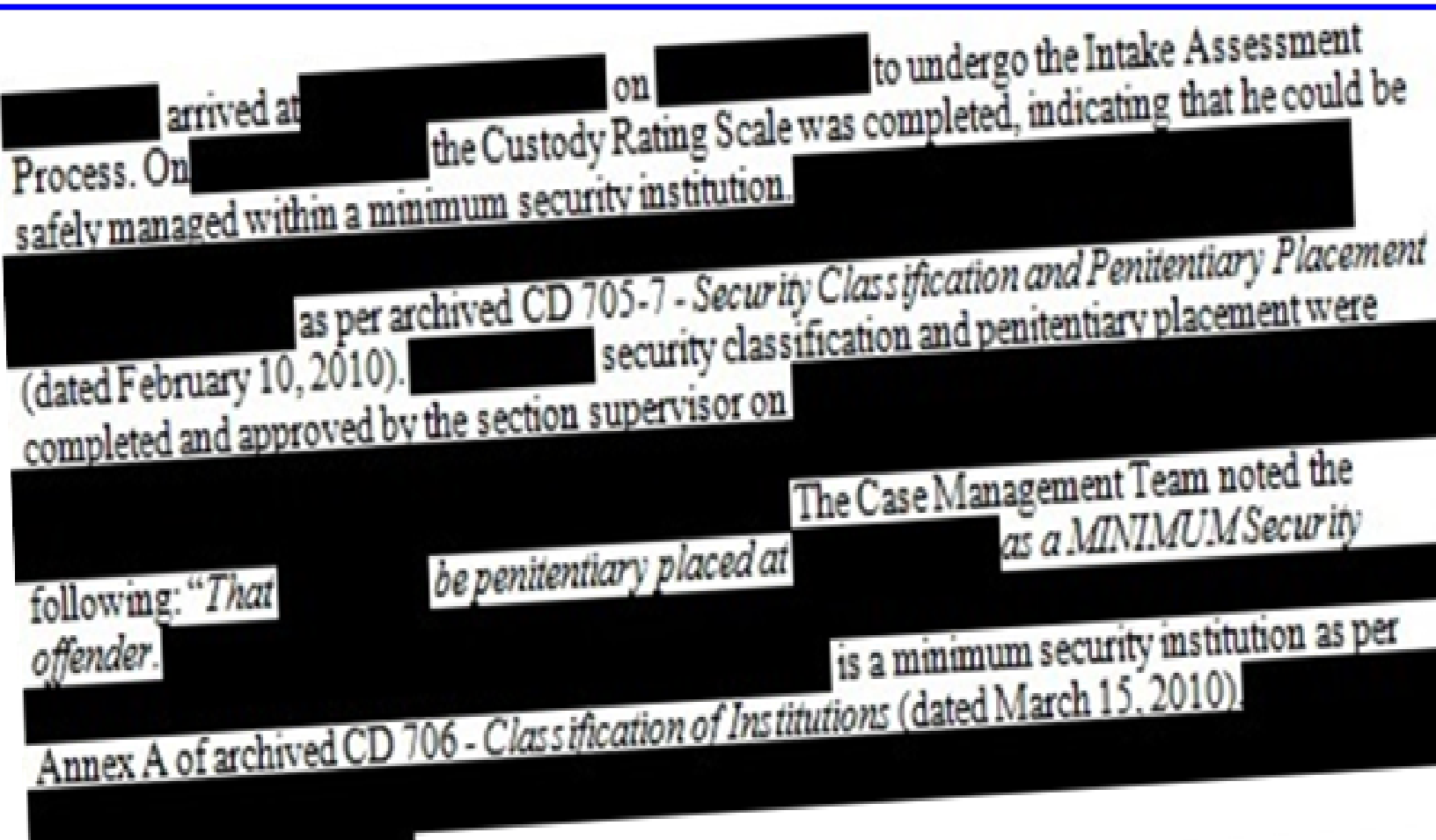
In the Dark:

An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections

Final Report

August 2, 2016



CAT. No.: PS104-13/2016E-PDF
ISSN: 978-0-660-05823-8

PRINTED IN CANADA

In the Dark:

An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections

Final Report

Office of the Correctional Investigator

Table of Contents

In the Dark: An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections

Context and Background

In 2015-16 there were 65 deaths in federal custody, the majority (65%) of which were attributed to 'natural' causes.[1] When an inmate dies in custody or sustains serious bodily injury, the Correctional Service of Canada (CSC) is obligated to "forthwith" investigate the matter (s. 19 of the *Corrections and Conditional Release Act (CCRA*)) and report to the Commissioner of Corrections. The report from these investigations is also shared with the Office of the Correctional Investigator (OCI). The purpose of investigating a death in custody is to possibly prevent similar incidents from occurring in the future. The findings and recommendations from these investigations can be used to make improvements in organizational and institutional policy and practice.

Despite the statutory requirement to investigate all fatalities, there is no legal obligation requiring CSC to openly or proactively share the findings of these investigations publicly or even with next of kin or designated family members of the deceased. Regardless of how an inmate dies in custody (natural cause, suicide, murder, overdose, accident), it is reasonable to expect that family members would want to know what happened, whether the care provided was adequate, or if anything more could have been done to prevent the death. This investigation examines CSC's information sharing and disclosure practices with family members following a death in custody. As the investigation finds, families often face a difficult and protracted process to access information following the death of a family member in federal custody.

Families (or next of kin)[2] continue to contact the Office of the Correctional Investigator requesting assistance and advice in accessing information from CSC about a family member who died while in federal custody. They have identified difficulties and barriers, including outright refusal, in attempting to access this information from CSC,

[1] 'Natural' cause deaths include: cancer, respiratory failure, cardiovascular issues, liver problems (cirrhosis or liver failure), infection and renal failure. 'Natural' cause in-custody deaths are not routinely or independently investigated by provincial Coroner/Medical Examiner Offices.

[2] Commissioner's Directive 530 (*Death of an Inmate: Notifications and Funeral Arrangements*) uses different terms to refer to the person who an offender designates as their contact in the case of an emergency (e.g. "next of kin", "emergency contact", "personal representative"). The term "next of kin" is most often used in CSC's forms, directives and manuals, and is generally understood to mean the closest family member to the offender. While offenders can designate non-family members as emergency contacts or another individual as a "personal representative" (generally to administer their estate), the Office uses the term "family" or "next of kin" interchangeably throughout this report primarily because all persons interviewed for this investigation were immediately related to the deceased offenders.

particularly with respect to the immediate circumstances and precipitating events leading up to the death of their family member. The Office raised concerns about the lack of information provided to families by CSC in its 2012/13 Annual Report. The Office again raised this issue in its investigation into CSC's Mortality Review Process (December 2013). In that report, the Office recommended that: "In the interest of transparency and openness, upon request mortality reports in their entirety should be shared, in a timely manner, with the designated family member(s)."[3]

In response, the Service largely disregarded the issues and concerns behind the recommendation and simply restated that: "CSC works with the designated family member to assist the family following a death in custody. Mortality Review Reports are shared with the family upon the family's request and in accordance with privacy and other legislation."[4] The refusal, denial or delays to proactively share information with next of kin often leads them to suspect the worse, feel suspicious or apprehensive about what may have transpired behind bars and impedes their ability to pursue legal remedies. In cases of in-custody death (or serious bodily injury), openness, transparency, accountability, compassion, timeliness and respect are important organizational and humanitarian principles that should weigh positively in the decision to release as much information as possible as it becomes available. Withholding information leads to unnecessary frustration and distrust and denies families closure as they grieve their loss.

Last fiscal year (2015-16), in quick succession, three families contacted the Office requesting assistance in accessing information from CSC about a family member who had died in federal custody. These families experienced significant difficulties and delays trying to access information and details regarding the death of their family member. The Office shared these concerns with the Service in September 2015. In doing so, the correspondence reminded the Commissioner of Corrections of his obligation, as Deputy Head, to consider releasing information to these families under public interest disclosure provisions of the *Privacy Act*. The Office recommended that the Service take a more proactive approach to such disclosures and provide families

[3] Office of the Correctional Investigator, *An Investigation of the Correctional Service's Mortality Review Process* (December 13, 2013).
[4] Correctional Service of Canada, *Response of the Correctional Service of Canada to the Correctional Investigator's Final Report: An Investigation of the Correctional Service of Canada's Mortality Review Process* (March 2014) accessed at: http://www.csc-scc.gc.ca/publications/005007-2803-eng.shtml.

with a factual summary of the circumstances and events immediately preceding the death.

In response, the Service provided the Office with an update on the status of the formal access to information requests that had been filed by the families to that point, as well as the timeline for when CSC staff had met with them following the death of their family member. This response was disappointing as it did not address the concerns raised by the Office with respect to the lack of information that families had received to that point, the provisions in the *Privacy Act* that allow for the release of personal information or how these provisions might be applied in a more responsive manner to help grieving families understand and come to terms with their loss in a more timely and compassionate manner.

These three cases, and several others over the years, point to organizational and public policy gaps in how and when the Correctional Service discloses and communicates information to an offender's family following a death in custody. In light of this, the Office undertook an investigation to examine CSC operational policies and practices involving the extent and manner in which it shares and communicates information with next of kin following the death of a family member in federal custody. The objectives of this investigation were three-fold:

1. Review and assess CSC policy, law, procedures and operations governing the death of an inmate (e.g. notification of death, information sharing, funeral arrangements, return of personal belongings and the post-incident investigative process);

2. Review and assess the scope, nature, level and quality of information that is shared by CSC with designated family members/next of kin; and,

3. Benchmark CSC's organizational policy and practices in these areas with those of international correctional organizations.

Methodology

The investigation involved a research strategy which utilized the following:

- A review of relevant law (*Corrections and Conditional Release Act* and *Regulations*) and policy (Commissioner's Directives and Institutional Standing Orders from 45 institutions) as they relate to the notification of death, funeral arrangements, the return of personal effects, sharing of information and the investigative process.

- A review of the *Access to Information (ATI)* and *Privacy Acts* as well as interpretive materials on privacy and access to information produced by the Treasury Board of Canada and the Offices of the Information and Privacy Commissions of Canada .[5]

- Confidential interviews with the following groups:
    - Eight (8) families whose family member died in federal custody or sustained serious bodily injury over the last three years. Most of the families have been in contact with the Office to request assistance in accessing information from CSC. The deaths include four suicides, three deaths by 'natural' causes and one serious bodily injury. All of the families who participated in the interviews had some level of difficulty accessing information from CSC. Given the difficult subject matter involved in these interviews, the Office offered to conduct interviews at their place of residence, which many accepted.

    - CSC staff members with responsibilities associated with death of an inmate. These interviews included the Assistant Warden Management Services, a Social Worker and Chaplains contracted with CSC.[6] Interviews were also conducted with relevant staff and responsibility centres at National Headquarters (Access to Information and Privacy Branch and Investigations Branch); and,

[5] The Office retained the services of an external contractor with expertise in these areas to provide expert advice and guidance regarding these *Acts*.

[6] Chaplains are generally responsible for notifying next of kin following a death in custody.

    - The Canadian Families of Corrections Network (non-governmental organization). Interviews with this organization focused on their experience working with families and next of kin following a death in custody.

- A comparison and analysis of redacted National Board of Investigation (NBOI) reports released by CSC to families through the *Access to Information Act* versus the original (un-redacted) reports.

- A review of policies and practices associated with how other international correctional organizations interact with families and exchange information with them following a death in custody.

This report captures the experience of families who attempted to obtain information from CSC following the death of their family member in federal custody. To this end, a number of direct, but confidential quotes have been incorporated throughout the report to bring to life the detail, memory and emotion of their experiences. These interviews were very difficult for families (likewise for interviewers). A deep sense of frustration and disappointment pervaded these interviews.

With respect to timelines and due process, CSC was informed of the Office's intent to conduct this investigation in September 2015. A copy of the report was shared with the Service for factual review purposes on June 23, 2016. A copy of the report was also shared with families who were interviewed in advance of the public release. Interviews were conducted between December 2015 and April 2016.

Legislative and Policy Framework

Section 96 (y) of the *Corrections and Conditional Release Act* (*CCRA*) provides that "the Governor in Council may make regulations respecting the procedure to be followed on the death of an inmate, including the circumstances in which the Service may pay transportation, funeral, cremation or burial expenses for a deceased inmate." The *Corrections and Conditional Release Regulations* (*CCRR*) expand on and provide further detail to meet this statutory requirement. The *Regulations* governing the death of an inmate are copied in full in Annex A as they most directly relate to this investigation.

Commissioners' Directives (CDs) provide operational direction on areas prescribed by law or regulation. Several CDs are relevant to this investigation. CD 530 (*Death of an Inmate: Notifications and Funeral Arrangements*) lays out who is responsible for meeting the requirements identified in the *Regulations*. The stated purpose of CD 530 is: "To ensure that following the death of an inmate, notifications and funeral arrangements are completed pursuant to legislation." While formal and perfunctory, the CD does refer to "humanitarian reasons" when describing situations in which the Service will pay for funeral expenses, suggesting that a compassionate approach to managing a death in custody is important. CD 750 (*Chaplaincy Services*) establishes the responsibilities of the Chaplain when an inmate dies, presumably to ensure a compassionate and caring interaction with the next of kin. The media relations CD 022 sets out the parameters regarding when the name of an offender can be released publicly following a death in custody.[7]

The *CCRR* and relevant CDs provide the legal and operational requirements that must be followed in the event of an inmate death. These requirements are informed by fundamental principles such as openness, transparency, accountability, timeliness, respect and compassion. CSC's *Value Statements* provide another important source within which organizational responses, behaviours and decisions following an inmate death should be situated. Among others, the most relevant *Value Statements* include the following:

- **Respect**: "A good test of respectful behaviour is treating others as we would like to be treated." "Sharing accurate, relevant, understandable information in a timely manner."

- **Fairness**: "A good test for fairness is to treat others as you would like to be treated." "Treating others with dignity in even the most difficult circumstances."

- **Professionalism**: "A commitment to uphold our values in even the most difficult circumstances."

[7] CSC public News Releases following a death in custody refer not only to the offender by name, but they also contain his/her sentence, offence(s) and institution where he/she was held. While factual, it is not clear why these public releases reveal personal details of the offender's offence and sentence history. Chaplains who were interviewed reported that they often felt "rushed" to immediately locate and notify the next of kin of a death as the priority seemed to be ensuring that the news release was issued as soon after the death as possible.

- **Accountability**: "Displaying openness, transparency and a willingness to explain the rationale behind decisions affecting stakeholders, families and the public." "Exercising initiative."

Families consistently reported that these values were not reflected in their interactions with the Service.

Informal Access to Information

When an inmate dies, next of kin have a number of avenues to access information. The first is a direct informal request for information from CSC. This could involve, for example, a family member contacting the institution to informally ask for information regarding the death. Though CSC policy is not as clear or direct on this point as it could be, guidance regarding the informal release of information can be found in the Government of Canada *Policy on Communications and Federal Identity* (Effective date May 11, 2016).[8] It states that Deputy Heads are responsible for "enabling communications with the public about policies, programs, services and initiatives by ensuring that their department:

> 6.3.1: Provides timely, clear objective, factual and non-partisan information;
>
> 6.3.7: Responds to information requests or inquiries from the public promptly without undue recourse to the *Access to Information Act*."[9]

The Open Government Partnership

CSC must also take account of 'open government' and the actions and declarations of the Government of Canada with respect to open government. Open Government refers to increasing the transparency and accountability of public bodies by providing information to citizens proactively and regularly without the need for citizens to submit formal access to information requests.

[8] Government of Canada, *Policy on Communications and Federal Identity* (May 11, 2016).

[9] Although the Policy only cites the *Access to Information Act (ATIA)*, the Supreme Court of Canada held that the *ATIA* and the *Privacy Act* must be read together since they create a "seamless code" which sets out the mechanism for determining where the competing interests of access and privacy should prevail one over the other. *Dagg v. Canada* (Minister of Finance), [1997] 2 S.C.R. 403.

Open Government, as a policy, has been led by developments in the United States, the United Kingdom and Australia and by the World Bank and the Organization for Economic Cooperation and Development. The Open Government Partnership (OGP) was created in 2011 and now includes 70 nations. In 2013 Canada accepted the Open Government Declaration and joined the OGP. The Declaration accepted by Canada includes a commitment to:

> **Increase the availability of information about government activities.** Governments collect and hold information on behalf of people, and citizens have a right to seek information about government activities. **We commit to promoting increased access to information and disclosure about governmental activities at every level of government.** We commit to increasing our efforts to systematically collect and publish data on government spending and performance for essential public services and activities. **We commit to pro-actively provide high-value information, including raw data, in a timely manner**, in formats that the public can easily locate, understand, use, and in formats that facilitate reuse.[10] [Emphasis added]

The Government of Canada first announced its plan for open government in the spring of 2011. This was comprised of three components: open dialogue, open data and open government. Canada's second Action Plan (2014-2016) consists of 12 commitments including, among others, the "open by default" principle which commits the government to "…shift to an environment where data and information are released openly to the public by default while respecting privacy, security and confidentiality restrictions"[11], improved access to scientific research data, increased information on federal government spending and expanded **proactive** (emphasis added) release of information on federal government activities, programs, policies and services. The commitment to the OGP was recently reaffirmed in the mandate letter sent to the Honourable Scott Brison, President of the Treasury Board in the following statement: "Accelerate and expand open data initiatives and make government data available

[10] Open Government Declaration accessed at: http://www.opengovpartnership.org/about/open-government-declaration.

[11] *Canada's Action Plan on Open Government 2014-16*. ISBN: 978-1-100-25318-3 Catalogue No. BT22-130/2014E-PDF.

digitally, so that Canadians can easily access and use it."[12] The Open Government Partnership and the commitments made within it highlight important principles that should be considered when making decisions with respect to the release of information held by government.

Release in the Public Interest

CSC has the discretionary power to release the personal information of inmates to next of kin under section 8(2)(m) of the *Privacy Act*. This does not require a formal application to trigger such a release.

Section 8(2)(m) permits, on a case by case basis, the release of personal information where, in the opinion of the Deputy Head, the public interest in disclosure clearly outweighs any invasion of privacy that could result from the disclosure or that disclosure would clearly benefit the individual to whom the information relates. The *Privacy Act* does not define what type of information can be released under this section, but it does not limit it either. This public interest assessment might address questions such as:

- What is the likelihood of harm from disclosure?
- Is the invasion of privacy minimal or serious in nature?
- Does the information concern an investigation into activity which is likely to generate public interest?
- Would disclosure of the information reassure the public about CSC activity?
- Would disclosure of the information subject the activities of CSC to public scrutiny?
- Is the information not being disclosed in order to avoid embarrassment or to avoid a scrutiny of government operations?

When next of kin request information about the circumstances of the death of a deceased inmate, the Deputy Head (Commissioner) could be expected to assess these factors when exercising his discretion.

[12] President of the Treasury Board of Canada Mandate Letter (November 2015).

Formal Access to Information

Family members can formally request information under the *Access to Information Act (ATI)*. Pursuant to section 19 (2) of the *ATI,* personal information can be released if: (a) the individual to who it relates consents to the disclosure; (b) the information is publicly available; or (c) the disclosure is in accordance with section 8 of the *Privacy Act*. The *Privacy Regulations* also provide for the disclosure of personal information pursuant to section 10 in order "…to administer the estate of that person, but only for the purpose of such administration."

Findings

The findings of this investigation have been divided into six areas, many of which correspond directly to statutory and regulatory requirements of the *CCRA* and *CCRR*. The areas include:

- Proactive information sharing
- Notification of death
- Burial arrangements and return of personal belongings
- The investigative process
- Accessing information following a death (via the *Access to Information and Privacy Acts*)
- An analysis of National Board of Investigation Reports processed by CSC's Access to Information and Privacy Branch.

To inform the analysis, the needs, experience and perspectives of grieving families were considered. Research has identified a number of needs of those who are grieving.[13] Among others, grieving families need:

- Information following the death. This is important in helping individuals process an event and progress through the stages of grieving. Talking about the death, discussing the details and events leading up to it are key to making sense out of the death and being able to find meaning in it.

[13] See: Janzen, Linda, Susan Cadell and Anne Westhues (2003/04). *From Death Notification through the Funeral: Bereaved Parents' Experiences and Their Advice to Professionals*. OMEGA, Vol. 48(2).

- To reconstruct the death scene. This is particularly important for those who may not have been present when the death occurred. Information is key to enabling those who are grieving to piece together the last moments of their family member's life.

- The opportunity to say goodbye. This includes viewing the body.

Though this research is not specific to the corrections field, it certainly enriches and provides important context for what grieving families could reasonably be expected to need/require following a death in custody.

I. Proactive Information Sharing

Proactive information sharing and disclosure assume an open exchange of facts and details that does not necessarily require filing a formal access to information request. On this point, the findings of this investigation were clear: CSC proactively shared as little information as possible with the eight families interviewed by the Office and, in fact, appears to have little to no interest to do so. Information that CSC may eventually disclose, share or exchange is typically done so retroactively, only after families have submitted a formal access to information request. Interviews with families confirm that CSC withholds as much information as possible at all points – from notification of death through to the investigative process. Families reported that CSC often cited the *Privacy Act* or the *Access to Information Act* when refusing to disclose or provide information. Though the *Privacy Act* operates on the presumptive principle in favour of non-disclosure and consent, it is also clear that federal privacy (and information) laws were never intended to act as a shield or blanket to automatically prevent or deny access to government information. Each *Act* contains provisions that can be used to balance privacy interests against the public's (in this case the family's) need to know.

CSC staff reported feeling "frustrated" when speaking with family members as they were not authorized to disclose anything other than the fact that a death had occurred. Though some staff indicated that a meeting is sometimes arranged with specific staff members (e.g. security intelligence officer, health care professional) and family members to discuss what occurred, this was certainly not a common practice. For the most part, CSC staff indicated that they felt legally obligated not to disclose information

and found it hard to be perceived as compassionate in such a context. One CSC staff member went so far as to state that families "…are left out in the cold for information."

The lack of information forthcoming from CSC compelled most families to do one or more of the following: conduct their own research, repeatedly call different CSC staff members, reach out to non-governmental organizations (e.g. John Howard Society, Elizabeth Fry Society, Canadian Families of Corrections Network), call the Coroner/Medical Examiner offices, contact this Office or hire a lawyer in an attempt to get access to information that might help them to understand what had happened to their family member. Many families reported leaving numerous messages for CSC staff that were never returned or having to speak to several CSC staff members before finally connecting with someone. "I called the prison and was put through to several different areas until finally I spoke with an acting Warden." "We'd send them emails using our personal emails and rarely would we ever get responses." One family member summed up his/her experience trying to access information from CSC as: "It was like talking to a brick wall, they weren't telling me anything."

1. **I recommend that the Service proactively disclose factually relevant information to families of deceased inmates immediately following a death in custody. This disclosure should include a factual summary of the circumstances and events immediately preceding the death, life saving measures that were initiated upon discovery and preliminary details on the measures taken to manage pre-existing medical or mental health problems.**

II. The Notification Process

Commissioner's Directive 530: *Death of an Inmate: Notifications and Funeral Arrangements* indicates that the Institutional Head (i.e. Warden) or a designated staff member is responsible to promptly notify the inmate's emergency contact and/or next of kin following a death. In practice, interviews with CSC staff confirm that the Chaplain is typically designated to conduct the notification. Generally, the notification occurs over the phone after the Chaplain has been briefed on the incident. Most Chaplains reported that they provide very limited details to families when conducting the notification. However, they do provide family members with a CSC contact person who will follow-up with them (i.e. usually the Assistant Warden Management Services). Of note, one CSC staff member indicated that following the notification, a condolence

letter is immediately sent to the family, which also includes information regarding the funeral arrangements. Interviews with family members would suggest that this is certainly not standard practice. Indeed, none of the families interviewed by the Office reported or recalled receiving a formal condolence letter.

Families receive very little information

The Privacy Commissioner of Canada, in her 2012-13 Annual Report, stated that "CSC's responses to all the cases are troubling in that they appear to indicate an approach where denial of access is the starting point for handling requests for personal information under the Act rather than the openness and accountability that the Act was intended to promote."[14] While the findings of the Privacy Commissioner are now four years old, the Office found that CSC continues to largely operate in this manner. The investigation found that from the point of notification of a death, many families reported feeling kept in the dark. "You really don't know and from day one."[15] Some families were not informed of the cause of death in the initial notification. Instead they were simply told "I have some bad news; [name of offender] is dead." Another family member reported that CSC informed them that: "They found [name of offender] dead and they couldn't tell me anything because it was under investigation."[16] Families were not typically provided information regarding the circumstances leading up to the incident, what life saving measures may have been initiated or other relevant detail that might help them piece together the immediate events and circumstances leading up to the death. No other sector of Canadian society would accept such narrow limits to the sharing of information about a deceased family member.

Little consistency in what information is provided to families

Interviews with Chaplains and CSC staff (Assistant Warden Management Services) showed little consistency in what information they provided to families during the notification. Some Chaplains indicated that though they are usually responsible for the notification, they are often not well-informed regarding the details of the incident and therefore may not be in the best position to provide families with information. Some Chaplains indicated that they informed families of the cause of death if they knew, whereas others did not automatically provide or divulge this information. Some

[14] Office of the Privacy Commissioner of Canada, Annual Report, 2012-13.
[15] Quote from a family member describing the lack of information they received from CSC from the beginning.
[16] Quotes from a family member regarding what she/he was told when informed of the death of his/her family member by a CSC staff member.

informed families of a “suspected” suicide/overdose; whereas other CSC staff reported telling families that they could not provide them with a cause of death until it was officially confirmed by the Coroner or Medical Examiner.

The determination of an official cause of death can take a significant amount of time. If an inquest is held, it typically takes place a year or more after the death and often does not address the questions or concerns that are most pressing for families. In any event, the fact that the Coroner or Medical Examiner may decide to hold an inquest into the death does not negate CSC’s need to share information with families. Indeed, the Service (not the Coroner or Medical Examiner’s Offices) is best placed to share the kind of information that families seek in the immediate period following the death of a family member.

After an examination of CSC policy (Commissioner’s Directives and Institutional Standing Orders) there appears to be no national guidance regarding what information could or should be shared with families when notifying them of a death. This lack of structure has led to a situation in which some CSC staff reported saying as little as possible (other than a death had occurred) for fear of divulging too much or saying the wrong thing and possibly breaching privacy concerns. At the notification stage, it is understandable that CSC may not be in a position to immediately confirm the exact cause of death or that they may not want to inadvertently divulge information that may conflict with privacy interests or an ongoing investigation. That said, providing factually relevant and timely information, even if it is preliminary or subject to corroboration or investigation, would help alleviate initial concern and help answer basic questions as to what happened to their family member. Proactive disclosure is more in line with CSC’s *Value Statements* and Government of Canada policy.

Community hospital staff provide information

In a few instances families reported that offenders were transferred from the institution to a hospital (e.g. as a result of successful life saving measures taken by CSC staff or due to a medical emergency). In these cases, all families indicated that they received helpful information and regular updates regarding their family member from community healthcare staff working at the hospital (i.e. doctors, nurses). Families reported how helpful hospital staff was in explaining the situation and providing them with information about their family member. By comparison, these same families reported receiving a phone call from CSC where they were simply informed that their family member had been taken to the hospital. They were not provided with any information on the condition of the offender or given a contact at the hospital that could provide them with information. "He (referring to CSC staff member) didn't give us a lot of information…I think he gave me the number of the hospital and I called the hospital and talked with the male nurse. He was extremely helpful. He gave me all the particulars." One family reported being thankful that the nurse had forewarned them prior to seeing their family member in the hospital: "[the nurse] called me [aside] and said, when you come, you are going to be shocked because there are two jail guards standing in the

Consequences when little information is provided

One family member reported that CSC called to inform him/her that their family member had been taken to the hospital however no further information was provided and no indication was given as to how serious the offender's condition was. Without any indication that the situation was serious, the family decided not to come as it would have required them to fly from another country. The family member later found out that the situation was indeed serious and immediately flew to be with their family member. The family reported being very upset because had they been better informed of the seriousness of the situation or provided a contact at the hospital from CSC, they could have called the hospital to get more information and would have come immediately and been able to spend more time with the offender before death.

This situation was reported by at least one other family where CSC did not inform them about the seriousness of the situation or provide them with a contact at the hospital that could give them this information.

room, at the door of the room and thank god I was prepared for that. So I went and it was extremely shocking." The onus for ensuring that families are prepared before arriving at the hospital resides with CSC. Situations like these can be extremely distressing. It is important to ensure that families are prepared prior to seeing their family member who might be lying near death in a hospital bed, guarded by correctional officers and possibly cuffed to the bed. Leaving this kind of detail to the community medical staff is inappropriate.

CSC should also make sure that security staff posted to an offender in the hospital is adequately informed and well trained for this duty. One family reported showing up to the hospital after being told by a CSC official that their family member was in very serious condition. Initially, only the offender's father was allowed in the hospital room, not the offender's mother or sister. Though this situation was corrected, there was no credible explanation for this arbitrary restriction. When death is imminent it seems unreasonable that other next of kin would be denied access. Better, more upfront and direct communication and information sharing should be established in cases where next of kin have been called to a medical emergency at an outside hospital.

Lack of information leads to suspicion

When information is not forthcoming it often leads families to suspect the worse. In interviews, one family member stated, "We are always feeling like they are trying to cover something up. …You know, this is the feeling we get with all these delays, there's something they don't want us to see. And that's the issue. They are not communicating. I wouldn't know who to phone there." Another family member stated, "To me, like they were trying to hide things so there wouldn't be legal action. They were only concerned I would sue the government." Yet another stated, "I don't know what they (referring to CSC) are so afraid of, I don't know what they are trying to protect or who they are trying to protect."

These feelings of suspicion and distrust could be potentially alleviated by CSC providing more context and factual information. There are various points in the post-incident reviews of significant events (e.g. immediately after the death, upon completion of the Warden's Situation Report after five working days and during the investigative process) in which factually relevant information could be shared with the family without ever violating any substantive or residual expectation of privacy. For example, it would be

reasonable and appropriate to provide families with a factual summary of the circumstances and events immediately preceding the incident. It may also be appropriate to provide preliminary details of the adequacy of the CSC's response, including, for example, the measures taken to manage pre-existing medical or mental health problems.

2. **I recommend that CSC develop and implement a facilitated disclosure process based on best practices in this area. Facilitated disclosures should occur shortly after the death and include those individuals who were directly involved with the inmate as well as the Warden. Follow-up discussions should be made available to correct information, provide additional detail or report on measures taken as a result of the investigation.**

3. **I recommend that CSC clearly define procedures and protocols when an inmate is taken to an outside hospital in a medical emergency situation. This should include providing next of kin with a contact at the hospital, information regarding what family members can expect when they arrive at the hospital, and approved access for next of kin to enter the hospital room of their family member.**

III. Burial Arrangements and Personal Effects

The lack of sharing of information did not seem to improve much after the notification. It appears that CSC's focus is specifically on the funeral arrangements and the return of offender's personal belongings. While some families spoke with the Warden, a parole officer or medical professionals (doctor, nurse, mental health professional) after the notification, they reported that very little information was shared regarding the death. Most simply repeated what families had already been told when they were first notified of the death.

Who is responsible?

One family member reported calling the institution asking about the location of his/her family member's body and was told by a CSC staff member that they did not know where the body was. While CSC called back later with information on the location of the body, this caused significant distress and worry. The body had been transported to the Coroner.

Another family member informed CSC of the date that he would be coming to view the body, however upon arrival he was informed that his family member had already been cremated. To make matters worse, sometime later, the ashes were couriered to him without prior notice. "They cremated him and they sent him by Purolator…sending someone in the mail…it's just not right."

CSC policy provides that the Institutional Head or designate is responsible for the funeral arrangements and ensuring the return of personal belongings. In practice, the Assistant Warden Management Services seems to be delegated these responsibilities. Most families agreed that while the funeral arrangements were conducted in a professional manner, they reported being generally frustrated that they still could not get information about how their family member had died. In fact, after the funeral arrangements were completed and the personal belongings returned, families reported that they rarely heard from CSC again (unless they initiated contacted). There was no further follow-up or updates regarding the cause or circumstances of the death or the subsequent investigative process (though some families did receive a letter that an

investigation would be conducted), [17] the status of the investigation or even who was responsible for completing it. Families who had questions about the investigation reported that they did not know who to contact. "You are not informed throughout the process; I called so many people trying to get information." After examining CSC policy and interviewing staff, it appears that there is no specific contact person responsible for communicating with the family and following up to provide additional detail or information after the incident to inform them of what happened, how the investigative process would unfold or what they can expect following the investigation. The focus for CSC appears to be limited to fulfilling the minimal legal (*CCRR*) requirements which include the notification, the funeral arrangements and returning personal belongings.

Updating next of kin contacts

During interviews with CSC staff, many reported how important it is that the next of kin be regularly updated while an offender is in custody. While Commissioner's Directive 710-1: *Progress against the Correctional Plan* requires that the next of kin information be updated every 45 days as part of the structured casework record process, an investigation conducted by the Office at two maximum security institutions found that this requirement is not routinely met. At one institution a random sample of inmates found that the next of kin had not been updated in 95% of cases while at the other institution, it had not been updated in over 60% of cases. This is concerning particularly given the importance of immediately identifying and notifying next of kin in the event of an emergency. CSC staff discussed examples during interviews where the next of kin listed was someone with whom the offender no longer had contact and as a result the Service spent a significant amount of time attempting to track down the next of kin in order to notify them of the death.

Moreover, there is very little in terms of a coordinated effort to connect families with other organizations that may be involved in the post-incident process such as the Coroner's/Medical Examiner's offices or the police. In following up with these Offices, families reported receiving far more information from these sources than they did from

[17] CSC has clarified that families would only receive this letter if there was a next of kin contact identified in its system and the information, including address, was current.

CSC. "The first time I spoke to him (referring to the Coroner), I spoke to him for 45 minutes and it was very open. He didn't hide anything." Another family reported learning information from the police about events leading up to the death at the prison which had not been reported by CSC to the family.

Little explanation of CSC policy

Interviews with CSC staff indicated that as part of the process of completing the burial arrangements, the Assistant Warden Management Services was also responsible for explaining CSC policy and responsibilities following a death in custody. Most families reported that they were not informed of CSC's legal and policy responsibilities following the death. For example, most families were not aware that CSC was responsible for paying for the transport of the body to a funeral home in the hometown of the offender's next of kin or that money in the offender's trust fund would be used to cover these costs.[18] One family member indicated that: "The funeral home also advised us that the prison would recover the costs if my [family member] had money in a bank account/Canada Pension Plan death benefit." Information such as this should come exclusively from CSC staff. One family stated that had CSC informed them of the policy to transport the body to the hometown of the next of kin it would have "…saved us a lot of time and additional stress" as the family did not live near the institution and had to have the funeral home near the institution manage the burial arrangements.

In other cases, families were not informed about CSC policy with respect to claiming the body and what happens when the body is not claimed. Most families were also unaware that CSC can, on humanitarian grounds, "…where the costs of the funeral would prevent the body of the inmate being claimed, pay all or part of the costs of the funeral in the hometown of the inmate or the person who claims the body."[19] Interestingly and contrary to CSC's own policy, one CSC staff member indicated that the institution pays for the funeral expenses of all inmates who die in custody so that families are never required to pay.

While interviews with CSC staff members indicated that there are processes, checklists and procedures in place and that they do provide families with the information they

[18] See Commissioner's Directive 530: *Death of an Inmate: Notifications and Funeral Arrangements* for more information.

[19] Commissioner's Directive 530: *Death of an Inmate: Notifications and Funeral Arrangements.*

require, this was not consistent with what was reported by families. Understandably the death of a family member is a very difficult time. Important information can be forgotten, mistaken, misplaced or not fully understood. However, there appears to be a large gap with respect to what information families are hearing or are able to process following the death and what CSC says it does. This gap points clearly to the need for a family liaison person/contact that would be responsible for communicating with families following a death in custody. This person could be responsible for providing/sharing information about the death (both verbally and in writing), explaining CSC policies and legal responsibilities including funeral arrangements, return of personal belongings, follow-up and point of contact throughout the investigative process. Such a position would provide families with a single point of contact that could respond to their questions and concerns and ensure they are well informed and understand all aspects of the post-incident process. During interviews with family members, all families agreed that family liaison is essential and would have helped them immensely throughout the process.

Behaviour of CSC staff questioned by family members

> "I guess I would, I didn't, on the one hand I was surprised by how callous and unprofessional and not just like, what's the word, gratuitously mean they (referring to CSC) were because that is their MO, that's how it's always been. But I would suggest that when someone is near death and their family obviously cares very much for them and is coming to see them and doing everything they can, there should be a whole different attitude toward the family and the prisoner. I think the idea of punishment shouldn't play into the whole scene anymore, we got the point, our loved one spent decades in prison and isn't getting out, that's punishment enough. They don't have to be such jerks anymore. I think it would do everyone good, I think it would do their souls good if they felt they had permission to be kind and compassionate and accommodating because otherwise it is the very worst of human behaviour."

Many families had a similar assessment with respect to the manner in which information was sometimes communicated to them. "I felt like a criminal even asking

(referring to asking for information), the way they were talking to me, like just, they had no concern, they didn't care, that's like, I've had many sleepless nights at the beginning of all this because of wanting answers and not getting them, your mind, I'd lay awake." Another family member stated that, "It's the sarcastic remarks, you know, all the time…. (CSC) can't even call them (referring to offenders) by their first name, it's always the last name." Yet another stated: "But also it was again that situation that the family encounters all the time of being hurt by proxy, being hurt because you loved that person, because you treasured them, because they meant something to you, you'll go visit them, but Corrections Canada behaves with such animosity and they get away with it because we are so desperate to see that person and we will jump through the hoops."

These sentiments were a common thread running through interviews with family members. While it is certainly not the case that all staff failed to show compassion or empathy (as families also reported that some were very helpful and respectful), all but one family reported often multiple examples of seemingly inappropriate behaviour or insensitive comments by CSC staff members. Compassion, respect and sensitivity are integral to dealing with grieving families. It goes without saying that there is no room for sarcasm or contempt.

Lack of training for CSC staff

Some of the issues and inconsistencies identified to this point highlight the need for staff training. There is currently no training for CSC personnel who are entrusted with communicating with families following the death of an inmate.[20] Most CSC staff indicated that they "learned on the job" or received guidance from others who previously held the job. Most CSC staff did in fact express the view that training would be helpful, particularly when speaking with grieving family members. Some CSC staff indicated a need for a discussion forum for staff across the country responsible for carrying out this type of work to discuss issues, share experiences and best practices as well as ask questions of their peers. Although all of the Chaplains indicated that they had training through their respective faith communities (no CSC specific training), most agreed that it would be helpful to discuss experiences and issues with others regarding the notification process and providing follow-up support. While there may not be a

[20] CSC reports that training is provided to all parole officers in the application of case management processes with respect to a death in custody, however, this is not training specific to communicating with grieving family members.

large number of deaths every year at a particular institution, this is difficult work that requires training, understanding and compassion. Training should address issues regarding how to support a grieving family as well as the type of information that can and should be made available to family members.

4. **I recommend that CSC establish a family liaison in each of the five regions to coordinate with National Headquarters and the institution in providing /sharing information with next of kin from the point of notification through to the completion of the investigative process.**

5. **I recommend that CSC develop and provide training to staff involved in communicating with families following a death. This should include a national forum for staff to discuss challenges, exchange best practices and lessons learned.**

IV. CSC's investigative process

Pursuant to section 19 of the *Corrections and Conditional Release Act*, when an inmate dies or suffers serious bodily injury, CSC is required to "forthwith" investigate the matter. In the case of natural cause death, the Service conducts what is referred to as a Mortality Review, which is based primarily on a file review of the deceased inmate's health care and correctional records. In the case of death by suicide, homicide, overdose or unknown cause, a National Board of Investigation (NBOI) is convened usually consisting of three members and a member of the community who is independent of CSC. The Board members travel to the site of the incident and may consult any document and interview any person, as well as examine the application of policy directives and operational practices. Following the investigation a final report is completed.

Families have very little understanding or information regarding CSC's Investigation

While a few family members recalled receiving a letter from CSC (Investigations Branch) informing them that an investigation would be launched following the death, overall they reported having very little understanding of CSC's post-incident investigative process. Most only realized much later that an internal CSC investigation would take place and few understood how to access information under *Access to Information* and *Privacy*. One family only learned that a mortality review would be completed following

the death of their family member during the interview for this investigation; they were also informed, for the first time, that they could access this report through an access to information request. "What is the mortality review? Is that where they say how the person died? I didn't even know it existed. I wouldn't know to ask for it." While CSC's Investigations Branch sends a letter to families informing them of the investigation that will take place following the death and their right to access the final report, it is not at all clear if a similar notification is sent to families whose family member died of natural causes and their right to access the mortality report. Of the three families interviewed where the offender had died of 'natural' causes, not one reported that they had been informed of the mortality review process from CSC or of their right to access the report.

Families should be clearly informed of the investigation in writing, as some families were (via a letter), but more importantly, this information should also be reinforced verbally and frequently with family members. It seems to be presuming too much to expect families to understand or even appreciate the importance of this notification. The letter itself, while extending condolences belatedly to the family, is perfunctory and provides very little detail other than identifying CSC's legal responsibility to conduct an investigation "…to establish the facts and circumstances surrounding the death". The letter provides families with an "expected" date that the final report will be completed as well as informing them of their right to access the report through Access to Information and Privacy. There is no contact information provided, no telephone number provided in case of questions and no further detail regarding the investigative process. Formulaic, it ends with "Your request (referring to an access to information request) will be reviewed in accordance with the *Access to Information Act*" indicating to families that, once again, they must "jump through the hoops to even get any information."[21]

For some of the families interviewed, they stated that it wasn't until they contacted a lawyer or the OCI that someone took the time to explain to them how the investigative process works, what they can expect and their right to access this information. Families need to clearly understand how the CSC investigation will unfold and what will be considered or examined during the investigation including interviews with CSC staff, interviews with inmates who may have witnessed something or a review of medical files and range videos. This type of information and explanation would go a long way to

[21] Statement from a family member referring to the barriers of accessing information from CSC.

alleviating the concerns and answering the questions of many grieving families. Indeed, during a few interviews with families, OCI investigators were able to provide some of this contextual information which helped allay the concerns of families. "Ok, so that has been examined obviously. So that…we can rule that out. Ok, you know, that's pretty much what I thought but it's nice to know that there's video footage so that can be ruled out."[22]

6. **I recommend that CSC send a letter of condolence to the next of kin forthwith following a death in custody.**

7. **I recommend that CSC develop a guide for families explaining CSC policy, responsibilities and investigative process following a death in custody. Contact information for the Coroner/Medical Examiner Officers and the police should also be included as well as any community contacts that may be helpful to grieving families.**

V. Accessing Information following a death in custody

> *"Yeah, you get a word and a whole paragraph blacked out and then one word at the end, why even bother."*

Trying to get an investigation report can be challenging

Given that CSC proactively shares as little information as possible with families following a death, often their only means of recourse is to formally submit an access to information request. However, families face a number of challenges when trying to access this report including:

- The time between convening of the investigation and issuing of the final report often takes a year or more to complete. Frequent delays often push back these protracted expected completion dates. One family reported waiting three years before finally receiving the mortality review report.

[22] Statement from a family member after finding out that range video would have been examined during the investigation.

- Before release, the report is reviewed by CSC's Access to Information and Privacy Branch and, in some cases CSC's Legal Services Branch. Large portions of the investigation report are often redacted (blacked out) making it extremely difficult for families to piece together what actually happened.

- CSC does not follow-up with families during the investigative process to provide updates or share new information nor do they proactively inform families of delays. Families are often left to languish for long periods of time without contact or news. One family reported following up with the Service on several occasions only to be given later due dates for the final report each time.

During interviews, most CSC staff agreed, families should not have to formally request a copy of the Mortality Review or the National Board of Investigation report; it should be proactively offered/shared with families upon completion. Moreover, for those families who want to be kept apprised of how the investigation is proceeding, that opportunity should be made available to them.

Challenges in accessing information

In one instance a family formally requested documents from CSC through access to information and privacy following the death of their family member and were told by CSC that "We have carefully searched our records and were unsuccessful in identifying any records regarding your request. We regret that we are unable to respond more favourably to your request."

Frustrated by CSC's response, the family wrote the following to the OCI: "I can only use the word 'outrageous' to describe their (referring to CSC) response. Either the documents were never done, or they were conveniently lost, or they don't want us to see them. All of which causes us to be suspicious and cynical in our attempts to further understand the circumstances surrounding [offenders name] death."… "This has been an extremely painful time for us and this has not only contributed to our pain and we are insulted by their (CSC) total lack of compassion and continued stalling attempts." After the Office intervened, CSC officials realized the mistake and phoned the family to apologize. The family stated that "They (referring to CSC) called it a 'bureaucratic' error. My thought is maybe they thought we will go away."

The required fee that is not really required

In general, when an access to information request is submitted, there is a $5 application fee that must be paid by those submitting a request. During the investigation, a number of families reported that they paid the $5 application fee to access information about the death of their family member. One family reported having to pay the fee twice to access information. "We received the letter from access to information….regarding the death of [name of offender] and it said the prescribed application fee of $5 is required." This information was brought to the attention of CSC staff over the course of the investigation and the situation has since been rectified. While CSC never required next of kin or family members to pay the application fee, some families sent the money with the form as the $5 requirement was indicated on the form. As of April 2016 the letter that CSC sends to families states the following: "Please note that the regular fee associated with this type of request is waived when the requestor is a family member or the next of kin."[23]

When information is released to families, much of it is redacted

A number of families indicated that the documents that they finally received from CSC after submitting an access to information request contained a number of paragraphs and indeed entire pages that were entirely redacted (i.e. blacked out). "There's so much lacking that you couldn't even understand it. It says like, the…black, black, black (referring to sections being blacked out). You wouldn't even know what the sentence was." Another family member stated, "Of the 88 pages, exactly 44 were blacked out." The vetting and excessive redacting adds to the frustration of families and the lack of transparency in CSC's disclosure process.

Consultations with CSC's ATIP Branch indicated that prior to reviewing a NBOI report for release to a family, the ATIP analyst will examine community assessments for the deceased offender as well as recorded visits and/or telephone call log information in order to make an assessment regarding the nature of the familial relationship between the requestor and the offender. The intent of this assessment, according to CSC's ATIP

[23] Following a Treasury Board of Canada directive, CSC recently (June 21, 2016) distributed an *Interim Directive on the Administration of the Access to Information Act* where, consistent with the Government of Canada's open by default principle, institutions were instructed to waive all fees prescribed by the Act and Regulations, other than the $5 application fee. The interim directive is an important step in CSC aligning its practices with those of the Government; however the $5 application fee should also be waived for grieving families as per section 11(6) of the *ATI Act*.

Branch, is to be as open and transparent as possible with next of kin. While it is important to determine the relationship of the requestor to the deceased (i.e. is the requestor in fact next of kin) to ensure privacy is not breached, such a process can lead to questions and possibly inconsistencies in how a request from two different family members would be processed.[24] It is possible that one family member would receive information, possibly based on their perceived 'closer' relationship with the offender, and another would not. It is important that this process not make judgements about the relationship and that once the next of kin has been established, the focus should be on meeting the needs the family. The decision to disclose information and to whom under section 8(2)(m) of the *Privacy Act* ultimately rests with the Commissioner. When considering the needs of families, this decision should come down on the side of disclosing as much information and with as little formality as possible.

8. **In the interest of transparency and openness, investigative reports (Mortality reports and NBOIs) <u>in their entirety</u> should be presumptively and routinely shared, in a timely manner, with next of kin.**

VI. Analysis of National Board of Investigation Reports processed by CSC's ATIP Branch

The Office reviewed seven NBOI reports that were processed through CSC's Access to Information (ATIP) Branch for offenders who died in custody between 2013 and 2015 and whose families had submitted a formal access to information request to obtain the report. These reports, provided to families pursuant to an access to information request, were compared to un-redacted versions of the same report. The intent of this comparative analysis was to examine whether CSC consistently, appropriately and respectfully exercised appropriate discretion in providing family members with information (through the release of information in the NBOI report) following a death in custody.

In terms of method, the Office's Access to Information analyst reviewed the files through both an Access to Information and Privacy lens to examine the exemptions that were applied and the consistency of the information that was released. The Office's

[24] There are situations where an offender has explicitly requested that their information not be shared with a particular next of kin.

analysis of the NBOI reports found that CSC released some personal information that, according to the *Access to Information* and *Privacy Acts*, could have been considered mandatory exemptions. Notwithstanding, the analysis found that the processing of the reports was inconsistent and not transparent.

There were numerous instances where exemptions were inconsistently applied within and between reports. For example, specific times (e.g. the time an inmate was found unresponsive) are vetted in one part of the report but the minute-by-minute account of the incident later in the report is not redacted. In another case, the time that an inmate was found unresponsive by correctional officers is vetted in numerous reports as per section 16(1)(c)(iii) of the *Access to Information Act,*[25] however, the same information is not exempted in other reports for similar types of incidents. Finally, there was at least one NBOI where information was exempted that had been released publicly in CSC's media release. The frequency in which these inconsistencies were identified brings into question the validity of the exemptions applied by CSC to justify releasing information in some cases and not in others.

More concerning was the consistent redaction of information in which possible errors, shortfalls or policy non-compliance were noted in the original report. This finding lends credence to the perception of families that "in a situation like a prison, there are things that go on in those places that are not on the surface, nobody will know about it". The current practice of exempting errors, shortfalls and policy non-compliance leaves little room for public scrutiny, accountability or in fact legal recourse.[26]

Finally, there are numerous instances where redactions within a section of the report completely change the context of the information that is provided. For example, in one NBOI, CSC exempted all information about how the inmate had threatened to kill himself and that these threats had not been shared amongst CSC staff or documented as is required by policy. However, CSC released information that the Psychologist stated that the inmate had denied any suicidal ideation. The redactions in this case lead the reader to believe that the offender was not suicidal and that CSC staff were compliant

[25]The information is considered to be injurious to the enforcement of any law of Canada or province or the conduct of a lawful investigations or that was obtained or prepared in the course of an investigation.

[26] Interestingly, section 17(5)(a) of the Province of Alberta's *Freedom of Information and Protections of Privacy Act*, provides that one factor that weighs in favour of disclosing personal information is when "…disclosure is desirable for the purpose of subjecting the activities of a public body to public scrutiny."

with law and policy, when in fact this was not the case. It seems especially disingenuous to apply exemptions that change the context or meaning of the information being released.

The Office acknowledges that not all information can be released to families. There are some valid, reasonable and mandatory reasons to exempt information. Although decisions must be made on a case by case basis, the rationale for exempting information from release should be consistent and should not serve to shield the organization from criticism or prevent a public organization from being held accountable. The Office also recognizes that some of the personal information contained in the NBOI files and records could be injurious to individual family members and possibly further add to their grief and suffering. Notwithstanding, every attempt should be made to provide families with factual, accurate and timely information.

Increased use of public interest disclosure provisions in the *Privacy Act* (section 8(2)(m)) would allow the Service to provide families with the information they are seeking in a more transparent and responsive manner. Although CSC ATIP officials stated that the Service uses section 8(2)(m) of the *Privacy Act*[27] "very frequently", statistics reported in CSC's *Annual Report to Parliament on the Privacy Act* suggest otherwise. CSC reported using section 8(2)(m) of the *Privacy Act* "regularly" in 2009-10 (28 times) and 2010-11 (25 times); however, its use has decreased substantially since that point. CSC used it just five times in the last two years (3 in 2012-13 and 2 in 2013-14). No reason is provided for this precipitous decline.

9. I recommend that the Commissioner of Corrections routinely consider releasing information to families of deceased inmates under public interest disclosure provisions of the *Privacy Act*.

Best Practices

As part of this investigation, the Office requested information from a number of international correctional authorities regarding their policies and practices following a

[27] 8(2) Subject to any other Act of Parliament, personal information under the control of a government institution may be disclosed (m) for any purpose where, in the opinion of the head of the institution, (i) the public interest in disclosure clearly outweighs any invasion of privacy that could result from the disclosure, or (ii) disclosure would clearly benefit the individual to whom the information relates.

death in custody. Information was received from nine countries.[28] The following best practices were identified:

1. Police are responsible to notify the next of kin at their place of residence following a death in custody. Information of the designated contact person within corrections is provided to the family as part of the notification.

2. Within 1-2 days following notification, a facilitated meeting between the family and correctional officials is held to explain circumstances and provide preliminary factual information such as the institutional history of the inmate, where the incident happened, etc.

3. A designated family liaison[29] or someone who can support the family throughout the process from the point of notification to the completion of the investigation. This person offers families the opportunity to ask questions and raise concerns that can be considered as part of the investigative process, helps families prepare for any aspect which is likely to be surprising or distressing and provides regular updates throughout the process. According to the United Kingdom's Prison and Probation Ombudsman, the purpose of the family liaison is to "…help families obtain answers to their questions regarding the circumstances of the death, and to have a clear point of contact."[30]

4. Proactive disclosure of all relevant information to the family of the deceased. When documents need to be withheld from family members, families can be provided with a verbal summary or outline of the information contained in the document.

5. Families are offered a copy of the investigation report without the need to formally request it.

[28] Information was received from the following countries: Australia, Finland, France, New Zealand, Norway, Sweden, Switzerland, United Kingdom, and the United States.
[29] The Department of National Defence has a similar position called the Designated Assistant who is responsible when a member of the service dies.
[30] United Kingdom Prison and Probation Ombudsman.

6. Protocols specific to the needs/spiritual beliefs of minority faiths and Indigenous offenders as well as how these needs/beliefs will be respected.

7. A guide that is provided to families containing the necessary information they require regarding the processes and investigation following a death, as well as contacts for counselling services and therapeutic support available in their area.

It is clear from examining the practices of a number of international correctional authorities that there are many best practices that could improve CSC's current process. The good work being done in a number of other countries should be reviewed and incorporated wherever possible.

Discussion

The Office has concluded that the Service does not presumptively, proactively or fully disclose or share information with families of a deceased inmate. While there is no specific legal requirement for CSC to share any information, there are principles embedded in the legislation (*CCRA*, *CCRR*, the *ATI* and *Privacy Acts*) and reinforced in CSC's own *Mission* and *Value Statem*ents that could inform a more compassionate, open and transparent approach. Rather than leaving families in the dark, sharing factual and relevant information regarding the circumstances and events immediately preceding the incident as well as treatment, diagnostic and intervention plans would go a long way to providing families with some important context to situate the incident and help them better cope with their family member's unexpected (or unexplained) death.

Likewise, investigation reports should be routinely shared with families and next of kin without the need to file a formal access to information request. Given the length of time these investigations and reports take to complete, families should be updated on a regular basis as to the status of the investigation, expected completion dates and the reason for any delays. The current process where families are provided very little information and then receive a heavily redacted investigation report is not in keeping with a modern, responsive, and accountable correctional system nor is it aligned to the Government of Canada's open by default policy.

Facilitated disclosures that include the involvement of an appropriate professional (medical doctor, psychiatrist, social worker, etc.) to explain the findings of an investigation or provide additional medical or professional detail would also help ensure families have the proper context to understand the information that is being provided to them. Having the opportunity to meet with staff members directly in a facilitated disclosure process helps families to reconstruct the events/circumstances that preceded the death and make some sense out of it. Of course, such facilitated disclosures would need to take place on the understanding that information being shared with families is preliminary and subject to final review, corroboration or assessment of the NBOI, Mortality Review or Coroner/Medical Examiner processes.

There are processes and guidelines in place elsewhere that are instructive. The Canadian Patient Safety Institute (CPSI), for example, has developed *Canadian Disclosure Guidelines* for organizations to be transparent with patients and families following a patient safety incident.[31] The CPSI states that the initial disclosure of information should include the following:

- Agreed upon facts known at the time;
- A brief overview of the investigative process that will follow which includes timelines and an explanation of what is expected from the investigation;
- An offer to have further discussion;
- Contact information;
- Time for questions and responses provided; and,
- Provision of community resources who can offer support.

The CPSI also suggests that follow-up discussions should be offered to continue to provide support, reinforce or correct information given in the initial facilitated disclosure, provide additional details and update on actions taken as a result of the investigative findings. The *Guidelines* also suggest that those most involved in the patient's care should be part of the disclosure team and that someone should be identified to act as a contact for the patient/family with the disclosure team. It is not difficult to see how these practices could inform a similar process for corrections.

[31] Canadian Patient Safety Institute. Canadian Disclosure Guidelines: Being Open with Patients and Families (2011).

Many of the findings of this investigation point to issues of fairness, openness, transparency, compassion and respect. These principles not only ensure that law and policy are respected, but represent an approach that is considerate of families who have just lost a family member. For a grieving family, privacy concerns should not routinely be used to trump their right to know how their family member died in state custody. There is a broader, and much more compelling, public interest to be considered and balanced in such disclosures.

Summary of Recommendations

1. I recommend that the Service proactively disclose factually relevant information to families of deceased inmates immediately following a death in custody. This disclosure should include a factual summary of the circumstances and events immediately preceding the death, life saving measures that were initiated upon discovery and preliminary details on the measures taken to manage pre-existing medical or mental health problems.

2. I recommend that CSC develop and implement a facilitated disclosure process based on best practices in this area. Facilitated disclosures should occur shortly after the death and include those individuals who were directly involved with the inmate as well as the Warden. Follow-up discussions should be made available to correct information, provide additional detail or report on measures taken as a result of the investigation.

3. I recommend that CSC clearly define procedures and protocols when an inmate is taken to an outside hospital in a medical emergency situation. This should include providing next of kin with a contact at the hospital, information regarding what family members can expect when they arrive at the hospital, and approved access for next of kin to enter the hospital room of their family member.

4. I recommend that CSC establish a family liaison in each of the five regions to coordinate with National Headquarters and the institution in providing /sharing information with next of kin from the point of notification through to the completion of the investigative process.

5. I recommend that CSC develop and provide training to staff involved in communicating with families following a death. This should include a national forum for staff to discuss challenges, exchange best practices and lessons learned.

6. I recommend that CSC send a letter of condolence to the next of kin forthwith following a death in custody.

7. I recommend that CSC develop a guide for families explaining CSC policy, responsibilities and investigative process following a death in custody. Contact information for the Coroner/Medical Examiner Officers and the police should also be included as well as any community contacts that may be helpful to grieving families.

8. In the interest of transparency and openness, investigative reports (Mortality Reviews and National Board of Investigations) in their entirety should be presumptively and routinely shared, in a timely manner, with next of kin.

9. I recommend that the Commissioner of Corrections routinely consider releasing information to families of deceased inmates under public interest disclosure provisions of the *Privacy Act*.

Annex A

Corrections and Conditional Release Regulations (*CCRR*)

116 (1) Where an inmate dies, the institutional head or a staff member designated by the institutional head shall promptly notify

(a) subject to subsection (2), the person who the inmate indicated to the Service in writing was to be notified;

(b) the coroner or medical examiner who has jurisdiction over the area in which the penitentiary is located; and

(c) the Commissioner or a staff member designated by the Commissioner.

(2) Where an inmate has not indicated the name of a person pursuant to subsection (1), the institutional head or staff member designated by the institutional head shall, as soon as practicable, notify the inmate's next of kin.

117 (1) Where the body of a deceased inmate is claimed by the person referred to in paragraph 116(1)(a) or by the inmate's next of kin, the institutional head or a staff member designated by the institutional head shall arrange, at public expense to the extent that the moneys standing to the inmate's credit in the Inmate Trust Fund are insufficient to cover the cost, for the body to be transported to a funeral home in the person's or next of kin's hometown.

(2) The Service may, on humanitarian grounds or where the costs of the funeral of an inmate would prevent the body of the inmate being claimed, pay all or part of the costs of the funeral in the hometown of the inmate or of the person who claims the body.

118 Where the body of a deceased inmate is not claimed by the person referred to in paragraph 116(1)(a) or by the inmate's next of kin, the institutional head or a staff member designated by the institutional head shall arrange, at public expense to the extent that the inmate's estate is insufficient to cover the costs, for the body to be

(a) where practicable, buried, cremated or otherwise dealt with, in accordance with the instructions left by the inmate; or

(b) buried or cremated, where the inmate did not leave instructions, or where it is not practicable to carry out the inmate's instructions.

119 (1) The Service shall deliver the portion of the estate of a deceased inmate that is under the control of the Service to the inmate's personal representative, if any, in accordance with applicable provincial laws.

(2) For the purposes of subsection (1), the portion of the estate of a deceased inmate that is under the control of the Service includes

(a) any pay that was owed to the inmate by the Service at the time of death;

(b) any moneys standing to the inmate's credit in the Inmate Trust Fund; and

(c) the inmate's personal belongings, including cash, that are in the care or custody of the Service.