Annual Report
of The Office of the Correctional Investigator
2010–2011

The Correctional Investigator Canada
L'Enquêteur correctionnel Canada

Canada

© Her Majesty the Queen in Right of Canada 2011

PS100-2011E-PDF
PRINTED IN CANADA

The Correctional Investigator
Canada

L'Enquêteur correctionnel
Canada

P.O. Box 3421
Station "D"
Ottawa, Ontario
K1P 6L4

C.P. 3421
Succursale "D"
Ottawa (Ontario)
K1P 6L4

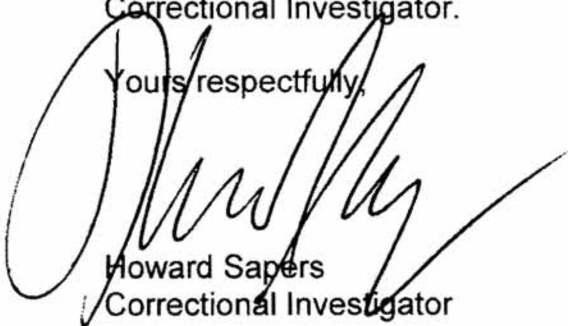
June 29, 2011

The Honourable Vic Toews
Minister of Public Safety
House of Commons
Ottawa, Ontario

Dear Minister,

In accordance with section 192 of the *Corrections and Conditional Release Act*, it is my privilege and duty to submit to you the 38th Annual Report of the Correctional Investigator.

Yours respectfully,



Howard Sapers
Correctional Investigator

Canada

Table of Contents

CORRECTIONAL INVESTIGATOR'S MESSAGE 4

EXECUTIVE DIRECTOR'S MESSAGE 9

1A Access to Mental Health Services 10

1B Physical Health Care – Special Focus on Elderly Offenders 20

2 Deaths in Custody 26

3 Conditions of Confinement 36

4 Access to Programs 43

5 Aboriginal Issues 46

6 Federally Sentenced Women 49

CORRECTIONAL INVESTIGATOR'S OUTLOOK FOR 2011-12 54

ANNEX A: ANNUAL STATISTICS 57

ANNEX B: OTHER STATISTICS 67

RESPONSE OF THE CORRECTIONAL SERVICE OF CANADA 69

Correctional Investigator's Message

Making a Difference

By their nature, prisons are largely closed to public scrutiny. Outside intervention, independent oversight and external review are not always embraced in such an environment, but the history of corrections in this country and elsewhere suggests that these are essential components of reform and progress. The Office of the Correctional Investigator (OCI) was, in fact, established in response to the violence and unrest that occurred within the Canadian Penitentiary Service in the early 1970s. Since that time, the Office has played an important role in ensuring that Canada's correctional system operates in a fair, transparent and accountable manner. It is through our work as an ombudsman for federal offenders and monitor of human rights that the Office is able to make a positive impact on federal corrections and a positive contribution to public safety in Canada. To its credit, the Correctional Service of Canada (CSC) embraces our role and works hard to be open and responsive to our efforts.

Canadians believe in the rule of law, and nowhere is the rule of law more important or necessary than in the administration of justice, particularly when it includes the loss of liberty. As Correctional Investigator, I serve Canadians by reporting to Parliament on the concerns that federally sentenced offenders bring to my Office and the ability of the CSC to implement solutions. As Ombudsman for offenders, I receive and investigate complaints from over 14,000 federal inmates incarcerated in 57 penitentiaries across the country. Employing over 17,000 staff, CSC is a large, complex and decentralized system that administers court-ordered sentences of two years or more. Operating independently of the Correctional Service, the OCI's mandate is to ensure federal sentences are managed lawfully and that offenders are treated in compliance with domestic and international human rights standards.

As an impartial and non-adversarial body, he Office conducts investigations into the problems of federal offenders related to decisions, recommendations, acts or omissions of the CSC that affect federal offenders, either individually or as a group. Offering complainants a redress system that operates outside of the courts, the OCI provides timely, accessible, independent review and resolution of individual and systemic complaints. In the course of its work, the Office attempts to resolve complaints at the lowest level possible.

My staff and I spend our workdays trying to make Canadian penitentiaries as good and as useful as they can be. In 2010-11, the Office's team of investigators spent 341 days in federal institutions, interviewed more than 2,100 offenders, received over 5,700 complaints and inquiries from federal offenders and conducted 844 formal investigations. During this period, we received more than 22,000 contacts on our toll-free number and nearly 1.75 million 'hits' on the OCI website. Our use of force team conducted over 1,000 reviews. We also reviewed over 100 *Corrections and Conditional Release Act (CCRA)* section 19 cases involving serious bodily injury and deaths in custody. These are significant achievements for an organization whose staff complement averaged less than 30 full-time employees throughout most of FY 2010-11.

To be effective and credible, the relationship between an Ombudsman's office and the agency it oversees must be grounded in values of professionalism, integrity and trust. Consistent with Ombudsman practice, the OCI relies on its independence to conduct investigations, resolve complaints and address issues that affect offenders. My staff and I do not take sides in complaint resolution – the OCI is not an advocacy body or a substitute for the internal complaints and grievance system administered by CSC. Under the law, my Office is given full discretion as to whether a complaint will be investigated. We may decide not to investigate a complaint for lack of supporting evidence showing that the Service had acted improperly or unreasonably or because there was no basis to the complaint in the first place.

At the same time, the nature of the work – to assess whether CSC has acted fairly, equitably and reasonably in matters that are brought to our attention – assures there will invariably be points of difference between my Office and the CSC. Although not always in agreement with one another, both CSC and the OCI share a common and mutual goal – the safe, secure and humane custody of federally sentenced offenders. In fact, both organizations serve a larger public safety interest – to assist offenders to lead a responsible and law-abiding life upon release. Indeed, the legislation which empowers the OCI to investigate offender complaints and gives CSC authority to administer federal sentences provides that the two bodies operate in parallel, not in conflict.

Responding to Parliamentary concern regarding issues that affect Canadians is one of the most satisfying aspects of my job. In the past year, the Office appeared several times before Parliamentary Committees to provide information, insight and testimony on a wide range of criminal justice issues. From our experience, the ability to engage Parliamentarians on correctional and sentencing reform issues from an independent and impartial perspective is increasingly important, and I regard this as part of my Office's public service mandate. It is a role which I value and respect.

I am proud to offer the Office's 38th Annual Report. In reporting on key achievements as well as ongoing areas of concern, this year's report contains several case illustrations where the Office's influence and interventions made a positive impact on federal corrections in FY 2010-11. Thematically, the report is organized into six key priorities around which the Office's investigative, reporting, resolution and policy resources are now largely structured:

- **Access to physical and mental health services**
- **Preventing deaths in custody**
- **Conditions of confinement**
- **Issues facing Aboriginal offenders**
- **Access to correctional programming**
- **Issues affecting federally sentenced women offenders**

These priorities orient staff visits to correctional facilities and are key reference points in meetings, debriefings and correspondence between members of my staff and the Service. We expect that as correctional populations increase, so will the importance of these priorities.

It bears reminding that offenders have identities and lives apart from their crimes. They are imprisoned as a consequence of their transgressions, not to be deprived of their humanity. The law follows offenders into prison – it does not stop at the prison gate. As the *Corrections and Conditional Release Act* recognizes, "offenders retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence." This legal principle is a fundamental expression of Canadian values. It reflects the fact that no one among us – including those deprived of liberty – forfeits

or forgoes the right to be treated equally, humanely and with dignity.

In the course of investigating a complaint, it is often my Office's experience that the nature of the complaint, while specific and particular to an individual offender, has a more general or systemic base. Indeed, as the layers of a complaint are peeled back, its origins often rest on narrow or restrictive policy interpretation or an unreasonable denial of a specific individual or group right or privilege. Over time, these restrictions can become part of the normal routine. Such was the case of the decision to refuse permission for a maximum security woman inmate to participate in group activities – a right that is extended to male inmates in similar circumstances. In this case, the Warden agreed with the Office's assessment that the security designation of an offender or the unit where that individual resides does not, in and of itself, preclude participation in group activities. In a multi-level institution where women offenders are individually assessed, classified and placed according to their own risk and needs, the distinction between security level and placement is an important one, as it determines the nature and limitations of rights and privileges that can only be enjoyed in association with others.

The Office continues to deal with fundamental human rights issues and legal compliance cases. For example, on the basis of equality and language rights, the Office successfully intervened in the case of an offender who had been denied access to correctional programming in his official language of choice. Similarly, the Office was instrumental in pursuing the case of a group of Aboriginal inmates whose outside yard had been significantly reduced in size over the years, rendering opportunity for group access to fresh air and outdoor exercise impossible. In still another example, my Office intervened in the case of an elderly and bed-ridden inmate housed at a treatment centre who, unable to even dress himself, was required to be strip-searched in order to receive visitors. In the Office's view, this practice was unnecessary, exceptionally invasive and humiliating.

These are but a few examples of how the Office makes a difference in ensuring correctional practice is fair and respectful of both the law and of human dignity. Every person – regardless of ethnicity, social status or conflict with the law – deserves fair treatment before and under the law. The vast majority of incarcerated individuals will one day be free and need to restart their lives amongst us, respectful of the law that once restricted their freedoms.

On some policy-related matters that seemed intractable not so long ago, there has been significant movement in the past year:

1. **On the basis of the OCI's investigation into the dangerous use of firearms at a maximum security institution, the display of a weapon by correctional staff will again be treated as a 'reportable' use of force, and therefore subject to a higher threshold of safeguards – including monitoring and reporting – similar to when a police officer displays his/her weapon in public.**
2. **After conceding that the Management Protocol for high-need women offenders was inconsistent with effective corrections and committing that it would be rescinded once a suitable alternative had been identified, the Service is set to finally end this problematic practice, effective May 2011.**
3. **Following a number of internal and external reports critical of the declining quality of dynamic security, the Service is in the course of rolling out a national refresher training program in this vital area of corrections.**

4. **A Complex Needs Program and unit in the Pacific Region for serious/chronic self-injurious offenders and an intermediate mental health care unit at a maximum security institution in the Ontario Region are being piloted.**
5. **In response to concerns raised by this Office, the Commissioner of Corrections committed that double-bunking in segregation is an action of absolute last (emergency) resort, that all other alternatives must be exhausted beforehand and that the Service's position is still that "single accommodation is the most appropriate means of meeting the housing needs of offenders." At a time when the national double-bunking rate is standing at 13% and increasing, these are important commitments.**

Of course, it is the nature of an oversight office to identify areas where performance could and needs to be improved. In this year's report, we continue to identify gaps in service delivery and capacity challenges, particularly for offenders with mental health issues. The growing number and needs of older offenders aged 50 and over is a special focus of this report, one which is deserving of more attention and action. Indeed, the concerns and issues affecting elderly offenders cut across other priority areas – mental and physical health, deaths in custody, conditions of confinement and access to programming. Several other issues of concern are also highlighted, including use of force, long-term segregation, involuntary treatment and informed consent in a correctional setting, and impacts of prison crowding.

Perhaps more so than in previous years, this Annual Report acknowledges and credits what the Office considers model or best practices in corrections. In doing so, we hope to encourage adoption of best practices Service-wide. CSC employs an incredibly rich, diverse and dedicated workforce. In many cases, local initiative, innovation and resolve allows operational staff to manage around national policy gaps. That there will be regional and even localized discrepancies in service levels, resources and capacity is to be expected in an organization as large, decentralized and complex as CSC. The important point is that there needs to be continuous focus on adaptation, learning and improvement.

In presenting the 38th Annual Report of the Office of the Correctional Investigator, I thank the extraordinarily committed and dedicated staff of my Office, who should never doubt that their efforts do indeed make a difference.

Howard Sapers
Correctional Investigator of Canada

“Canadians believe in the rule of law, and nowhere is the rule of law more important or necessary than in the administration of justice, particularly when it includes the loss of liberty.”

Executive Director's Message

Organizing for Success

This year's strategic planning and priority exercise has helped to identify and consolidate six areas of focus and concern that will orient and drive our work forward into FY 2011-12: access to mental and physical health services, prevention of deaths in custody, conditions of confinement, Aboriginal corrections, access to programs and issues affecting federally sentenced women.

Information Management is becoming more of a concern and priority across government, just as it is for the Office. In the OCI's case, investment in this area is required to ensure operational integrity. During the reporting period, the Office staffed an indeterminate Chief, Information Management, position and we are developing a three-year Information Management Strategic Plan that will facilitate the management, retrieval, storage and classification of information.

Of note, the Office underwent two significant external audit and compliance exercises in the course of the reporting period – one involving a core control audit of corporate services and the other involving staffing accountability. In both cases, we were able to demonstrate full compliance against all policies and guidelines, with only the most minor variances. For a small Office, these are notable achievements.

Looking forward, the Office has updated its integrated human resources plan. Corporately, the plan captures the organization's three-year strategic direction and priorities affecting the management of human resources. With a consolidated increase in the operating budget, the Office is in a substantially better financial position to do an excellent job of pursuing our investigative mandate while building on our reputation as a workplace of choice.

In the coming year, I also look forward to enhancing the rigour and quality of our investigations and the degree of our follow-up with the Correctional Service. We know there is some work ahead of us in terms of meeting higher and more aggressive service delivery standards, particularly with respect to timeliness and accessibility. With respect to accessibility, we intend to revise and update the Office's awareness and promotional materials that make our services available to federal inmates.

An important piece of the OCI's mandate is to maintain public awareness of federal correctional issues. The Office will launch a substantive and interactive update of its website platform in 2011-12 that will present issues in a more accessible, relevant and user-friendly format. In reaching out in this way, we hope to provide an authoritative and balanced perspective on what are complex and challenging, but always engaging, issues.

Ivan Zinger, LL.B., Ph.D.
Executive Director and General Counsel

1A Access to Mental Health Services

The increasing demands for mental health services continue to pose significant challenges for CSC. The latest internal CSC data suggest that 38% of the male federal offenders admitted to penitentiary require further assessment to determine if they have mental health needs. For admitted women offenders, more than 50% require further mental health assessment.[1] These are, in all likelihood, lower than actual figures, as mental illness is typically under-reported in the prison environment, due to stigma, fear and lack of detection or diagnosis. We know, for example, that this data does not include a significant range of mental disorders, as federal corrections has limited capacity to systematically assess cognitive ability, attention deficit disorder, Foetal Alcohol Spectrum Disorder(s) and other neurological dysfunctions upon admission to a federal penitentiary.

New resources and additional capacity in community and institutional mental health services have led to some important improvements, most notably:

1. **The implementation of a computerized mental health screening and assessment system at admission.**
2. **Enhancements in primary institutional mental health care.**
3. **Basic mental health awareness training for front-line staff.**
4. **Clinical discharge planning to support offenders with mental disorders released to the community.**

Despite these investments and program enhancements, there can be little doubt that CSC faces an extraordinary set of challenges and constraints:

- **Access to treatment and intervention services in most penitentiaries remains inadequate.**
- **Only one pilot project for an intermediate care unit has been launched and one pilot program for men who self-injure has been established. (No specialized services exist for women offenders who self injure.)**
- **Segregation remains all too often the only alternative to house offenders with acute mental health symptoms.**
- **The Service's strategy to enhance recruitment and retention of mental health professionals – especially clinical nurses, psychologists and psychiatrists – has not yet yielded expected dividends.**

1 G. Wilton, "Validating the Computerized Mental Health Intake Screening System (CoMHISS)," *Emerging Research Results*, No. 10-2, Ottawa: CSC Research Branch, October 2010. See also, "Regional Mental Health Findings Summaries (Needs Analysis)," manual file reviews, November/December 2009.

Issues in Focus

Portrait of Psychological Distress

Based on a sample of 1,300 incoming male offenders between February 2008 and April 2009:

- 38.4% reported or were assessed at intake as showing symptoms associated with possible mental health problems that require follow-up assessment by a mental health professional. These included:
  - Obsessive-Compulsive (29.9%)
  - Depression (36.9%)
  - Anxiety (31.1%)
  - Paranoid Ideation (30.6%)
  - Psychoticism (51%)
- 78% of those reporting a substantial to severe dependence on alcohol also reported mental health distress (concurrent disorder).
- Aboriginal offenders were five times more likely to be categorized as severely dependent on alcohol as non-Aboriginal offenders.
- 29% scored high on scales assessing depression and hopelessness; over 20% endorsed at least one item on the current or historical suicide indicator scale.

Source: CSC, *An Initial Report on the Results of the Pilot of the Computerized Mental Health Intake Screening System (CoMHISS)*, March 2010.

Built for a different generation and profile of inmates, Canada's federal penitentiaries are struggling with physical infrastructure and design limitations that compromise the delivery of programs and services needed to address the rising complexity and demands of offenders with mental health concerns. Prisons are not hospitals, and the conditions that prevail there are far from therapeutic or rehabilitative. Incarcerating persons with mental health problems in conditions and environments that are poorly suited to meet their needs promotes neither public safety nor rehabilitative objectives. Simply put, there is not enough capacity, resources or professionals to meet the increased demands being placed on a system that was never intended to cope with such a profoundly ill population.

Under Warrant

In September 2010, an expert report commissioned by the Office entitled *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's Mental Health Strategy* was publicly released. (This report was shared with the Service in March 2010.) The independent report was authored by Dr. John Service, the previous Executive Director of the Canadian Psychological Association and former Chief Operating Officer of the Mental Health Commission of Canada. Among its findings, the report noted that while the Correctional Service of Canada (CSC) received new funding and launched its mental health strategy in 2004, it was unable to provide a comprehensive and management-approved planning document and accountability framework for this initiative. The report found other gaps in the planning and delivery

of mental health services, noting that a significant portion of the inmate population that suffers from mental illness is "falling through the cracks," as they do not have access to intermediate care in their penitentiary nor meet the admission criteria of the five regional psychiatric treatment facilities.

In endorsing the report's key findings, the Office issued five summary recommendations:

1. **CSC publicly release its updated and approved Mental Health Strategy for transparency and accountability purposes.**
2. **CSC immediately commission an independent audit of its management framework and accountability structures for the delivery of mental health services and make the results public.**
3. **CSC reallocate resources to fully fund the implementation of its mental health strategy, with a particular focus on intermediate care.**
4. **CSC expand, explore and develop alternative mental health service delivery partnerships with the provinces and territories.**
5. **CSC enhance its support of the development of a National Strategy for corrections and mental health and work with partners and stakeholders to establish clear guidelines, timeframes and governance structures for implementation by the end of 2012.**

In response, the Service provided a copy of its updated Mental Health Strategy, as approved by its senior management committee in July 2010.

Since 2004, the OCI has repeatedly raised the issue of and reported on the care and treatment of prisoners with mental health concerns. Some of the Office's more significant recommendations include the following:

- **Reallocate resources to fully fund intermediate mental health care units.**
- **Enhance efforts to recruit, retain and train professional and dedicated mental health staff.**
- **Treat self-harming behaviour/incidents as mental health rather than security issues.**
- **Increase the capacity of the five Regional Treatment Centres.**
- **Prohibit forced medical injections of an uncertified offender who is physically restrained for health or security purposes.**
- **Prohibit prolonged segregation of offenders at risk of suicide or self-injury and offenders with acute mental health issues.**
- **Provide for independent and expert chairing of national investigations involving inmate suicides and incidents of serious self-injury.**
- **Expand alternative mental health service delivery partnerships with the provinces and territories.**
- **Provide health care coverage 24 hours per day / 7 days per week at all maximum, medium and multi-level institutions.**

Standing Committee's Report

Many of the Office's findings, observations and recommendations mentioned above were featured in the Report of the Standing Committee on Public Safety and National Security, *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System*, which was released in December 2010. As the Committee noted,

> *The concerns raised by the Correctional Investigator are similar to the issues the Committee has identified in its study. Mental health, self-harm, health services, correctional programs, types of segregation, Aboriginal offenders, federally sentenced women, deaths in custody and gaps in dynamic security are among the various concerns raised in his report. It is unfortunate that CSC has not yet implemented all the Correctional Investigator's recommendations, which in the Committee's opinion would increase CSC's ability to deal with the many issues relating to the makeup of its prison population.*

Issuing 71 recommendations in total – including a summation recommendation calling on CSC to implement all of the Office's recommendations from its 36th Annual Report – the Committee's report provides a substantive blueprint that could anchor much-needed reform of Canada's mental health and corrections framework. Responding to the Standing Committee's report will provide an important window of opportunity that CSC should not miss. I urge the Government to accept and implement key recommendations of the Standing Committee's Report, inclusive of those that address physical infrastructure deficiencies, strengthen mental health interventions and address gaps in recruiting and retaining professional mental health staff.

While the Government has not yet responded to the Committee's request to table a comprehensive response to its report, an area that holds considerable promise involves developing more partnerships and service delivery agreements between federal and provincial/territorial correctional and mental health authorities to ensure that federal inmates have the same access to health care as other Canadians. The Committee's report outlines the benefits of transferring responsibility for healthcare within the correctional system to provincial health authorities. It makes a specific recommendation in this regard, which is fully endorsed by this Office:

> *That Correctional Service Canada establish agreements with provincial psychiatric hospitals – that have suitable facilities to accommodate offenders without compromising public safety – to transfer some offenders who are posing a threat to themselves or others and who cannot be treated at regional treatment centres, along with financial compensation. These agreements should also allow correctional staff to be assigned to the facilities during a transfer in order to ensure public safety.*

In other words, on a case-by-case basis, an offender with mental health issues that cannot be effectively treated or safely managed within a CSC facility should be considered for transfer to provincial/territorial mental health facilities. In the reporting period, the Office intervened to press the Service to transfer two self-injuring women to alternative forensic custody arrangements in the province of Ontario. It was our view then, as it is now, that CSC had little to offer these chronically self-injuring women, either in terms of an effective clinical treatment program or an appropriate therapeutic environment. For the one woman who was transferred to provincial care, there was a dramatic and remarkable improvement in mental health functioning.

The case for alternative service delivery was, in fact, put forward in recommendation #16 of the Office's report into the death of Ashley Smith, which encouraged CSC to undertake "broad consultation with federal/provincial/territorial and non-governmental partners to review the provision of health care to federal offenders and to propose alternative models

for the provision of these services." In response, the Service commissioned an outside consultant to explore other models for delivering health care in the correctional setting.[2]

The consultant's report notes that Nova Scotia and Alberta have transferred to their health jurisdictions the responsibility for health service delivery to provincial inmates. It makes the case for a modest but evolutionary shift in CSC's mental health service delivery model, which would involve developing more partnership agreements with provincial hospitals, expanding the use of community providers and resources and allowing for contractual transfer of specialized health services to provincial health care authorities. This progression would be in line with the Standing Committee's report and would take CSC into an innovative and exploratory phase to find better ways of delivering correctional health services. The OCI endorses both the direction and the approach outlined in the *Assessment Framework* report.

1. **I recommend that the Service pursue alternative mental health service delivery arrangements and agreements with the provinces and territories consistent with the 'Assessment Framework for Alternative Service Delivery' as well as the Standing Committee's report on 'Mental Health and Drug and Alcohol Addiction in the Federal Correctional System.'**

Compliance Issues at the Regional Treatment Centres

Many of the treatment, governance and service delivery gaps identified in the *Under Warrant* report are further explored in a recent internal audit of Regional Treatment Centres (RTCs) and the Regional Psychiatric Centre.[3]

With a total capacity of 675 beds, 781 full-time equivalent positions and a consolidated budget approaching $75M, CSC operates five treatment centres (psychiatric facilities) which offer acute and chronic mental health care to inmates suffering from the most serious conditions requiring in-patient treatment. The RTCs are, in fact, 'hybrid' facilities: according to the *Corrections and Conditional Release Act (CCRA)*, they constitute a 'penitentiary' but operate as a 'hospital' under applicable provincial mental health legislation. With the exception of the Prairies Region, all Treatment Centres are co-located within the confines of other CSC institutions. Designated 'multi-level' security facilities, three of the five Treatment Centres are accredited psychiatric hospitals.

As the audit notes, "there have been several reports and reviews completed on the Regional Treatment Centres in recent years which raised the need for CSC to enhance the mental health services provided to inmates." The audit identifies several compliance issues:

- **Lack of clarity in terms of what constitutes an 'essential' versus ' non-essential' mental health service.**
- **Informed voluntary consent was not always obtained or documented prior to issuing treatment.**
- **Involuntary treatment and involuntary admissions did not consistently follow provincial legislation when treating inmates who lacked the capacity to understand the requirements of informed consent.**
- **Video-recording of use of force incidents, potentially involving application of physical restraints, were not in compliance with prescribed policy requirements.**

2 *Report on Assessment Framework for Alternative Service Delivery: CSC Response to Recommendation #16*, prepared by Jim Thomas, December 2010.

3 CSC, *Audit of Regional Treatment Centres and the Regional Psychiatric Centre*, January 2011.

- **Consideration of inmate mental health conditions in decisions to transfer, segregate and discipline was often not documented.**
- **Standards and criteria for admission and discharge to and from the treatment centres are not consistent across the country.**

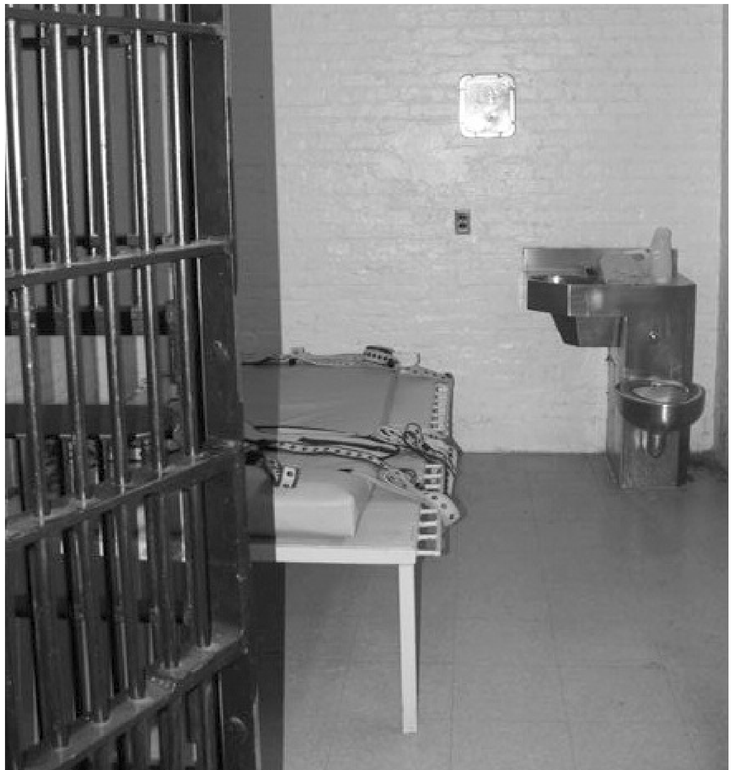
Many of these issues have been previously reported upon by this Office, most notably in context of the findings, recommendations and corrective measures emanating from the Ashley Smith case, which involved forced medical injections, use of chemical restraints and involuntary treatment. Indeed, CSC's National Board of Investigation into the death of Ashley Smith observed that there appeared to be a systemic lack of understanding of the policies concerning informed consent and involuntary treatment and the relevance of provincial legislation in this area of corrections. The internal investigation concluded that health care staff was left to their own devices to determine which provincial legislation applied to federal Treatment Centres.

In line with the audit's findings, OCI investigators have noted discrepancies between and among the Regional Treatment Centres in terms of their respective admission and discharge criteria. For instance, treatment centres may house inmates who do not have a mental health condition but may be physically impaired, in a palliative condition or otherwise vulnerable in their parent institution. Aside from the expense and inappropriateness of using psychiatric facilities for these purposes, this questionable practice creates operational challenges and dilemmas.

2. **I recommend that the Service implement the Management Action Plan to address compliance and performance deficiencies identified in the January 2011 internal audit of the Regional Treatment Centres and the Regional Psychiatric Centre in FY 2011-12, and provide an update prior to March 31, 2012.**

Use of Physical Restraints

The Office notes with concern that there is an inconsistent understanding of whether the use of physical restraints is a 'reportable' use of force or a clinical intervention. There is, in fact, confusion regarding when a use of force situation begins and ends when it involves the application of physical restraint equipment. This confusion highlights the lack of alignment between security practices and health care interventions in the management of self-injurious behaviour. This situation is troubling for front-line staff who manage



incidents and for those conducting use of force reviews that monitor legal and policy compliance. The Office is concerned that a self-injurious offender can be considered 'compliant' when acquiescing to be placed in physical restraints by several uniformed and heavily equipped correctional officers.

CSC policy should view the use of restraints as an intervention to preserve life and prevent serious bodily injury and not as a medical treatment. Therefore, all such applications should be treated as a 'reportable' use of force subject to applicable policy and procedural safeguards, including video and audio recording during the entire period that restraints are used. As this Office has stated before, placements in Pinel and other physical restraints are exceptional interventions of last resort and should be subject to the most rigorous accountability and monitoring framework possible. Further, instruction to the field should include explicit and unambiguous direction regarding:

1. **The least restrictive form(s) of intervention possible to be used to manage the situation.**
2. **The exceptional use of physical restraints (i.e., they should only be used if an offender presents an immediate and extreme risk of self-injury or injury to others).**
3. **Absolute prohibition against using restraints as a form of punishment or retaliation.**
4. **Restraints applied for the shortest possible period of time.**
5. **Clear and defined periods of assessment, observation and evaluation of an offender while in restraints.**
6. **Clear medical authority to use, maintain or discontinue the use of restraints.**
7. **Appropriate levels of documentation, reporting and monitoring.**

It is troubling to note that CSC auditors found that national and regional direction and oversight is lacking with respect to the frequency and appropriate use of physical restraint equipment in the Treatment Centres. On a number of occasions, the Office has provided its views on these matters only to be informed that revised policy directives are 'under review' or 'being consulted.' It bears reminding that the same compliance issues, governance and accountability problems noted in the January 2011 audit have prevailed since the death of Ashley Smith in October 2007. This situation is simply untenable.

3. **I recommend that all placements in physical restraints for health care purposes, effective immediately and without exception, should be considered a 'reportable' use of force. Staff who may be called upon to apply Pinel restraints should receive training with respect to the reporting, monitoring and safe use of this type of restraint device.**

Informed Consent and Involuntary Treatment

The Office has previously and extensively reported on the legal, policy and ethical aspects that define informed consent and involuntary treatment in a correctional setting. Our positions on these matters have been clear. We fundamentally disagree with the Service that the use of physical restraints on a 'compliant' inmate does not constitute a 'reportable' use of force. In the correctional setting, 'compliance' and 'consent' should not be considered synonymous. There are three fundamental and expressive elements of valid consent:

1. **Respecting a patient's freedom of choice (including the right to refuse or withdraw from treatment at any time).**

Issues in Focus

Informed Consent in Corrections

- Informed consent to medical treatment is a legally established concept.
- According to section 88 of the *CCRA*, an inmate's consent to treatment is informed consent only if the inmate has been advised of, and has the capacity to, understand
  (a) the likelihood and degree of improvement, remission, control or cure as a result of the treatment;
  (b) any significant risk, and the degree thereof, associated with the treatment;
  (c) any reasonable alternatives to the treatment;
  (d) the likely effects of refusing the treatment; and
  (e) the inmate's right to refuse the treatment or withdraw from the treatment at any time.
- Where an inmate does not have the capacity to understand all the matters described in (*a*) to (*e*), the giving of treatment to an inmate shall be governed by the applicable provincial law.

2. **Providing adequate disclosure of information (e.g., diagnosis, nature and purpose of treatment, risks of treatment and treatment alternatives).**
3. **Requiring a professional assessment of a patient's capacity and competence for decision-making.**

When these elements are missing or ignored, compliance is nothing more than coerced acceptance.

It is a concern that basic principles such as informed consent and involuntary treatment are not universally understood, documented or practised in accredited treatment centres, and it suggests the scope of the challenges that CSC faces in meeting professional and community accepted standards.

Lessons Learned

Many of the themes highlighted above capture and distil the lessons learned from individual cases and suggest necessary systemic improvements in the Service's capacity to better integrate security and clinical practices and policies in the management of serious mental health disorders, including chronic self-injurious behaviour. The OCI continues to document cases where the Service has relied on almost continuous use of seclusion and restraints in depriving environments to manage self-injurious behaviour. This approach is inconsistent with research and experience on protective factors for preventing self-injury in prison, which includes less time locked in cell, access to employment, individual counselling, participating in programs and regular contact with family. Engaging in self-injury is first and foremost a mental health, not a security, issue. While often a danger to themselves, in most cases chronic self-injurers are not a danger to others, so relying on security interventions to control or manage the behaviour may actually have the opposite effect.

In an important but still not well understood respect, there appears to be a relationship between conditions of confinement and the propensity for self-injury – the more depriving and restrictive the environment becomes, the more likely for self-injury to occur. Paradoxically, as was the case of one male offender who eventually succumbed to cumulative and catastrophic self-injury, more damage can be inflicted by a restrained inmate than when the behaviour is managed through a combination of de-escalation techniques, individual counselling and clinical treatment. Indeed, in the case of this particular offender, treatment gains were most often observed and consolidated when clinical practices were used to replace near-continuous reliance on physical restraints.

The literature suggests that effective clinical interventions are those that are informed by and address the underlying motivations for self-harming behaviour (often traumatic psychological, physical or sexual abuse) rather than interventions that simply try to momentarily stop it. In that respect, the Office endorses the suggestion of a draft policy revision that "the use of the Pinel Restraint System, in response to active self-injury or as a component of an inter-disciplinary management plan, does not replace efforts to understand the causes of the behaviour. Nor is it intended to be the principle intervention."

It is not clear that the Service acknowledges the relationship between deprivation and seclusion (i.e., conditions of confinement that restrict meaningful intervention, engagement and interaction), use of physical restraints and the propensity for self-injury, even though these appear to be findings emerging from its own research into this phenomenon.[4] It is not without significance that suicide watch, placement in segregation and the use of restraints are often viewed as punitive measures by individuals engaging in self-injurious behaviour.

There is also little doubt that chronic self-injury takes its toll on staff – the Office continues to see cases where chronic self-harmers are transferred to other facilities so that staff may have a respite. In other words, staff stress and fatigue can be factors behind the transfer of a self-injurious offender, and not consideration of the best treatment option or health care needs of offenders. It is recognized that the roles, responsibilities and working conditions of staff must be respected. However, these concerns do not displace CSC legal requirements regarding management of the health needs of offenders. While the primary mandate of correctional officers is safety and security in regard to ill offenders, their activities must occur within a clinically-driven model that recognizes security as an enabler for clinical interventions.

4. **I recommend that the Service's Health Care Advisory Committee be engaged to explore models for enhanced oversight and accountability of clinical treatment practices and guidelines for managing self-injury in prisons, inclusive of patient advocacy, use of physical restraints, involuntary treatment and informed consent in a correctional setting.**

4 See, for example, *A Comparative Review of Suicide and Self-Injury Investigative Reports in a Canadian Federal Correctional Population*, May 2010, and *Preliminary Results from the Women's Self-Injurious Behaviour Study*, July 2010.

Complex Needs Program and Unit

The Complex Needs Program pilot, a 10-bed unit that was established at the Regional Treatment Centre in the Pacific region in November 2010, is intended as a national resource offering treatment for chronic self-injurious male offenders. While a step in the right direction, in the absence of clear admission and discharge criteria (including provisions for both voluntary and involuntary transfer and consent to treatment), a proven treatment plan and a willingness on the part of all CSC regions to support the pilot by facilitating timely transfers of appropriate cases, it is not at all clear that it will survive intact beyond its 18-month trial status.

The Service's approach to self-injury has been defined as much by promise and pilots as by plans and priorities. It includes seemingly endless revisions to policy, action plans and strategies on a national basis. The activities and research associated with this overall effort, while necessary and important, remain a 'work in progress.'

It seems that a viable national framework that contains three elements for managing self-injurious behaviour – a permanent funding strategy; a proven treatment program/plan supported by clinical research; and a commitment to physical environments conducive to a therapeutic, patient-centred and continuum of care approach – remains as elusive as ever.

5. **I recommend – pending the development and evaluation of a proven treatment program at the Complex Needs Program/Unit pilot and permanent funding for its ongoing operation – that the most serious, chronic and complex cases of self-injury in CSC custody be reviewed for immediate transfer to provincial mental health care treatment facilities.**

1B Physical Health Care

Special Focus on Elderly Offenders

Life behind bars is not meant to be, nor is it, an easy life. The stress related to imprisonment, coupled with years of difficult and unhealthy living before arriving in prison, can add years to the chronological age of incarcerated individuals. Other stresses – separation from family and friends, the prospect of growing old in confinement, fear and the threat of victimization – account for the fact that an inmate's physiological age may exceed his or her chronological age.

Canadian prisons are increasingly home to greater numbers of the infirm, the impaired and the aging. Treatment of chronic diseases associated with aging – including cancer, emphysema, dementia, diabetes and cardiovascular disease – is becoming more of a concern as the proportion of the older offender population behind bars increases. Treatment for these types of diseases often requires access to outside medical facilities, and many offenders will require palliative care as a result of chronic illness.

The older offender is often a neglected, but significant and growing, segment of the offender population. Today, close to 20% of the federal incarcerated population is aged 50 and over, while 30% of offenders in the community are aged 50 and over.[5] Consistent with the overall 'greying' of the Canadian population, the number of older offenders in federal custody continues to grow annually. In the past decade, there has been more than a 50% increase in the number of older offenders under federal sentence.[6] Reflecting an aging Canadian society, the proportion of older offenders under federal jurisdiction will continue to accumulate in the coming years.[7]

Conditions of Confinement and the Older Offender

The physical design and infrastructure of a typical federal penitentiary do not take account of the needs of aging and elderly offenders. The average age of Canada's federal prison estate is 47 years. In fact, several penitentiaries are designated heritage buildings and five were built between 1835 and 1900. The penitentiaries in operation today were designed for young men and they are not typically very accessible to the mobility or sight-impaired. Physical ambulation and accessibility; independent care and living; palliative care; employment assistance; and vocational programming are some of the issues that older offenders face with respect to the physical conditions and limitations of prison confinement.

Retrofitting institutions with special assistive devices and equipment to meet everyday housing, ambulatory, toileting, bathing and feeding needs for a growing segment of the offender population is an expensive enterprise, especially considering that several federal facilities have already outlived their expected service life. Accommodating a growing proportion of older offenders into already crowded prisons that were designed and built for a younger generation of offenders poses considerable operational challenges, including consideration of age-segregated ranges, palliative care wings and other purpose-built facilities for the older offender.

Offenders with mobility concerns may feel threatened by the general inmate population.[8] Institutions which have designated ranges or units for older offenders are often set apart from the main parts of the prison. This impacts the offender's ability to participate in institutional routines. For some older offenders with mobility impairments, it can be an overwhelming challenge just to access fresh air exercise or participate in yard and other regular social and institutional routines and activities. Physically segregated older offenders may feel isolated, abandoned and marginalized.[9]

As a group, older inmates often have little social status within the prison order. Coupled with diminishing physical strength, they may be more victimized by intimidation, muscling and bullying by younger, stronger and more

5 Most jurisdictions, including CSC, use the 50-year old benchmark to refer to aging, elderly or older offenders. It is generally accepted that the aging process is accelerated by as much as 10 years or more in an institutional (custodial) setting.

6 Public Safety Canada, *Corrections and Conditional Release Statistical Overview: Annual Report 2010*. Ottawa: Public Safety Canada, 2010. See also CSC, *1999-2000 Departmental Performance Report*.

7 Close to 25% of the total offender population is serving a life or indeterminate sentence. The majority of these offenders (close to 3,200 individuals) are incarcerated. Most will eventually be considered 'elderly' before they are even considered eligible to apply for parole.

8 J.J. Krebs, "Inmate-on-Inmate Victimization among Older Male Prisoners," *Crime and Delinquency*, 53(2), 2007, pp.187-218.

9 J.J. Krebs, "A Commentary on Age Segregation for Older Prisoners: Philosophical and Pragmatic Considerations for Correctional Systems," *Criminal Justice Review 34*(1), 2009, pp. 119-139.

aggressive inmates. Younger inmates may act on and exploit ageist attitudes, beliefs and behaviours in the form of taunts, ridicule, humiliation, manipulation, harassment or assaults that ultimately deprive elderly offenders of their safety and security. In general, prison victimization research confirms four key findings:

1. **Older offenders are victimized by younger inmates.**
2. **They feel vulnerable to attack by younger offenders.**
3. **They prefer to live with inmates in their own age bracket.**
4. **They may live in age-segregated protective-custody units.**[10]

These are managerial as well as institutional security and personal safety issues.

Changes in normal prison routines and structure can be especially difficult for older offenders. For example, introduction of CSC's new drug formulary has involved new rules and changes to services, including restricted access to over-the-counter medications, remedies and preparations that previously were routinely provided. Issues related to daily living, pain management and who pays for a wide range of assistive devices required by elderly offenders are more than just cost efficiency or security management concerns. In the prison environment, elderly inmates have very little choice over who attends to their needs, how care is administered or what services are defined as 'essential.'

Programming and the Older Offender

Older offenders have different program needs. Increasing pressures on CSC to deliver correctional programs in a timely fashion (i.e., in advance of parole eligibility dates) results in many offenders with long-term sentences not accessing programs until very late in their sentence. Older offenders may not be considered as high a priority for programming and vocational training as younger inmates. They may not participate as fully or as enthusiastically in programming.

The Service's focus on vocational training, employment and employability – building skills to address a lack of job skills, low educational attainment or motivation – may or may not be relevant to older adults who may be approaching or past retirement age. The structure and content of existing correctional programming may have little relevance to their life status. What meaningful role, for example, does a focus on job market skills and vocational training play for an older offender approaching or beyond retirement age?

While equally deserving of rehabilitation and reintegration, there is often little appropriate activity provided in either regard for older inmates. Studies suggest that aging inmates rarely access existing counselling, educational or vocational prison programs. Many aging offenders simply elect to spend long periods of time locked in their cells during working or programming hours. This is not rehabilitative or productive for anyone.

10 Ibid.

Ensuring the relevance and appropriateness of correctional programming for older offenders is a task that is made more difficult by the fact that some older offenders, because of advancing age, are less competent or able to comprehend, interact and engage in programming that may be aimed at addressing their criminogenic needs. Older offenders often require specific accommodations in order to participate in correctional programming. They may require shorter sessions, enhanced accessibility, assistive aids and even more frequent bathroom breaks. Small changes to the way programming is delivered have the potential to greatly impact participation rates by older offenders. CSC's current program model, primarily focused on 'intensity levels,' may not adequately reflect or appropriately correspond to the needs of older offenders.

Correctional and vocational programming are an important component of an offender's successful reintegration into the community, and ultimately, public safety. But there needs to be an increased focus on the relevance and applicability of correctional and vocational programs for older offenders, as well as accommodations that may be necessary to deliver programs targeted at this increasingly growing segment of the offender population.

Physical and Mental Health Care

Elderly offenders use a disproportionate share of prison health-care services. The physical and mental impacts of aging are hard on the human body. Older inmates have higher rates of both mild and serious health conditions. United States data suggests that older prisoners are, on average, afflicted with three chronic health conditions at any given time. The most commonly reported health problems among older offenders include arthritis, back problems, cardiovascular diseases, endocrine disorders, respiratory diseases, sensory deficits (hearing and vision impairments) and substance abuse problems. Some older offenders find it difficult to maintain normal everyday routines (eating, dressing, hygiene) as a result of ongoing physical impairment.[11]

Mental health concerns impact an older offender's ability to live 'normally' in a prison setting, including their participation in daily institutional routines as well as their ability to live independently and with dignity – eating, dressing and maintaining a regular regimen of personal self-care and hygiene. The most common mental health disorders among elderly offenders are depression, Alzheimer's disease, anxiety and late life schizophrenia and dementia.[12] Offenders that may be suffering from age-related degenerative diseases characterized by memory loss or distorted thinking, such as dementia and/or Alzheimer's, often exhibit behaviours that are considered maladaptive in the correctional setting. Symptoms may include disruptive or difficult behaviour, anxiety, paranoia, major depression, self-injury and/or the refusal/inability to follow prison rules and routines.

11 Victoria Department of Justice, *Growing Old in Prison? A Review of National and International Research on Aging Offenders*, Corrections Research Paper Series, 2010.

12 J. Cox and J. Lawrence, "Planning Services for Elderly Inmates with Mental Illness," *Corrections Today*, June 2010.

Palliative Care

Managing terminally ill offenders consumes a great deal of time and resources and is an expensive and often exhausting endeavour. CSC's *Palliative Care Guidelines* recognize that an offender may have been very ill for an extended period of time and, in most cases, have few ties and supports outside of the prison walls. Release of a terminally ill offender from prison is often complicated by the fact that he/she may have little in the way of community or family supports, especially true in the case of longer serving inmates where primary relationships may be strained or severed altogether. The greatest fear of many longer-serving inmates growing old in prison is that they will die while incarcerated. And sometimes the only 'family' that a dying inmate may have is his own 'peer' group – other inmates.

The Correctional Service attempts to assist offenders in living their remaining time in relative comfort and personal security. It aims to deliver palliative care in a non-judgemental and compassionate manner. That being said, it is clear that relieving suffering and providing end-of-life care presents practical, ethical and moral challenges in a correctional setting. While there are positive, commendable and dignified practices in palliative care occurring in the most inhospitable of places, these are mostly thanks to the local initiative, compassion and effort of committed individual staff members and inmate peers.

Confronting the Past – Facing the Future

For the most part, as a group, the older offender population presents a low risk to reoffend. In general, older prisoners pose limited control problems for correctional authorities – indeed, most research suggests that longer serving older offenders are easier to manage because they are less likely to violate rules or require disciplinary measures. Research has also consistently concluded that age is one of the most significant predictors of future recidivism. Criminal activity peaks in late adolescence or early adulthood and decreases as a person ages. Many older offenders simply "age out" of crime and are much less likely to commit additional crimes after their release.

On the other hand, early release of the terminally ill, bedridden or severely incapacitated elderly offender runs up against other criminal justice goals and priorities, such as denunciation, deterrence and incapacitation. Although severe illness or deteriorating health may cause hardship for individual offenders of advancing age, it does not, in itself, constitute a sufficient reason to grant a conditional pardon or compassionate release.

Notwithstanding, there are ways that the denunciatory aspect of the sentence can be managed while still acting compassionately. There is little doubt that the combined effects of an inadequate prison infrastructure and increased impairment of older offenders will be an area of growing concern in federal corrections. The challenge is to make existing policies and practices more effective and to identify and assess new approaches to managing a population that is expected to grow in federal prisons.

In terms of the way forward, I recommend that:

6. **The Service develop a more appropriate range of programming and activities tailored to the older offender, including physical fitness and exercise regimes, as well as other interventions that are responsive to the unique mobility, learning, assistive and independent living needs of the elderly inmate.**

7. **Where necessary, CSC hire more staff with training and experience in palliative care and gerontology. Sensitivity and awareness training regarding issues affecting older offenders should be added to the training and refresher curriculums of both new and experienced staff.**

8. **Where new construction is planned, age-related physical and mental impairments should be part of the infrastructure design, and include plans and space for a sufficient number of accessible living arrangements.**

9. **The Service prepare a national older offender strategy for 2011-12 that includes a geriatric release component as well as enhanced post-release supports.**

2 Deaths in Custody

Preventing deaths in custody is challenging work. There are no shortcuts. Even the slightest of errors or omissions – failure to record or communicate a change in an offender's behaviour, for example – can lead to tragic, if unintended, consequences. Despite appropriate policy, a legal duty of care and the best efforts of staff, a prison is not a hospital. Security is always a factor. Managing health care emergencies is complex, precarious and demanding even in the most technologically sophisticated and advanced emergency departments. In a custodial setting, it is all the more complicated by the constant necessity to balance security concerns against a legal duty of care. (OCI – *Final Assessment*, September 2010)

On September 8, 2010, the Office released its fourth and final quarterly assessment of CSC's progress in responding to findings and recommendations from the Office's deaths in custody reports and investigations, including the preventable death of Ashley Smith.[13] The Final Assessment reviewed nine in-custody deaths (including three suicides, four natural deaths) that occurred between April 2008 and April 2010. It reported on a number of areas of continuing challenge and concern:

- **Response to medical emergencies**
- **Sharing of information between clinical and front-line staff**
- **Monitoring of suicide pre-indicators**
- **Quality and frequency of security patrols, rounds and counts**
- **Management of mentally ill offenders**
- **Quality of internal investigative reports and processes**

The issues identified in the *Final Assessment* are not new for CSC. Indeed, all of the factors contributing to the nine deaths had been identified in previous reports and investigations. In completing the quarterly review exercise, the Office stressed the importance of CSC translating findings, recommendations and lessons learned into demonstrable and sustainable progress. The report contained seven summary recommendations, which bear repeating:

1. **CSC must develop a comprehensive public accountability and performance framework that demonstrates measurable progress in addressing factors related to preventing deaths in custody.**
2. **CSC's internal investigative framework must be strengthened. External health care professionals should be appointed to chair reviews of suicide and serious self-injury, and these reports should be made public.**
3. **A senior management position should be created, responsible for promoting and monitoring safe custody practices.**

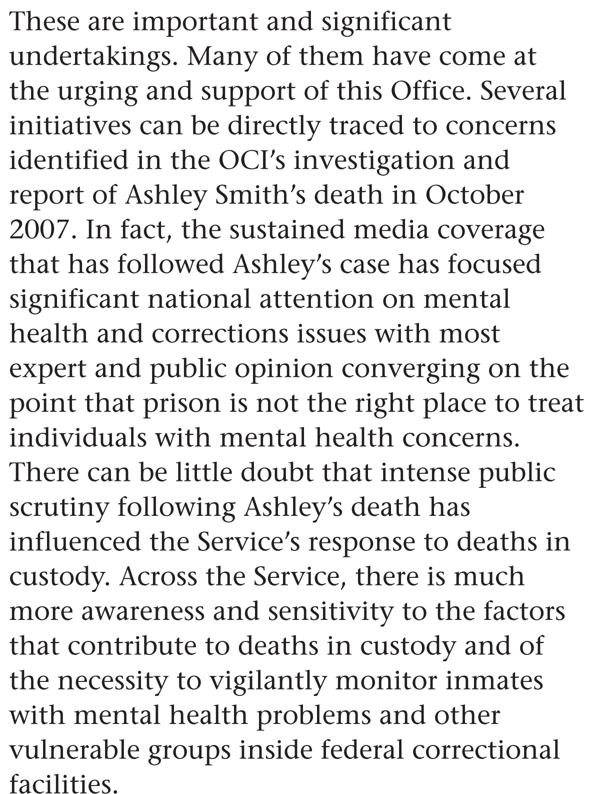
13 The OCI issued its *Initial Assessment* of CSC's *Response* in September 2009, followed by two other quarterly assessments in December 2009 and March 2010. The OCI's quarterly assessments and CSC's progress reports were publicly posted on each organization's respective websites.

4. The practice of placing mentally ill offenders or those at risk of suicide or serious self-injury in prolonged segregation must stop.
5. The quality of security patrols must be enhanced to ensure rounds and counts are conducted in a manner consistent with preservation of life principles.
6. Twenty-four hour health care at all maximum, medium and multi-level institutions must be provided to facilitate better response and management of medical emergencies.
7. Basic information and instructions for managing offenders at risk of self-injury or suicide should be shared with front-line staff to ensure that effective monitoring, crisis response strategies and prevention protocols are easily and readily accessible.

CSC's Response

The Office began to bring sustained attention to this issue with the public release of its *Deaths in Custody Study* in February 2007. Since that time, the Service has sought to reduce the number of 'non-natural' deaths in custody. The initiative and direction to address the known risks and factors related to preventable deaths in custody is to be commended. Several positive initiatives have been implemented in a concerted effort to preserve life, prevent deaths and reduce self-injury in federal custody:

- **Identification of physical infrastructure vulnerabilities linked to deaths in custody, such as cell call buttons, observation sight lines and potential ligature suspension points in cells.**
- **Installation of Automatic External Defibrillators (AEDs) in all federal correctional institutions.**
- **Promulgation of new policy direction in the areas of use of force, self-injury, use of restraint equipment and administrative segregation (i.e., need to take into consideration physical and mental health care status to initiate or maintain segregation placements).**
- **Front-line staff training in the fundamentals of mental health.**
- **Enhanced drug detection and interdiction.**
- **Public and internal progress and monitoring reports in preventing deaths in custody (e.g., Corrective Measures and Management Action Plan on Deaths in Custody Reports; *Highlights and Significant Findings in Deaths in Custody* – [summary reports, quarterly bulletins and activity reports]; *Report on Plans and Priorities* – rate of offender deaths by other than natural causes).**
- **Independent review of the internal inmate complaints and grievance system.**
- **Annual meetings between CSC and provincial/territorial Chief Coroner and Medical Examiners' Offices.**
- **Expert reports and recommendations addressing long-term segregation of mentally ill offenders.**
- **Creation of an Independent Review Group to assess corrective measures initiated in response to various deaths in custody reports and investigations.**
- **Convening of a field verification audit assessing CSC progress on key commitments relating to deaths in custody.**
- **Quarterly simulations of emergency response protocols (e.g., suicide attempts, overdoses, medical distress, self injury) at medium and maximum security institutions.**
- **Roll-out of dynamic security refresher training.**



These are important and significant undertakings. Many of them have come at the urging and support of this Office. Several initiatives can be directly traced to concerns identified in the OCI's investigation and report of Ashley Smith's death in October 2007. In fact, the sustained media coverage that has followed Ashley's case has focused significant national attention on mental health and corrections issues with most expert and public opinion converging on the point that prison is not the right place to treat individuals with mental health concerns. There can be little doubt that intense public scrutiny following Ashley's death has influenced the Service's response to deaths in custody. Across the Service, there is much more awareness and sensitivity to the factors that contribute to deaths in custody and of the necessity to vigilantly monitor inmates with mental health problems and other vulnerable groups inside federal correctional facilities.

It is encouraging to see a sustained focus on this issue. Although the number of in-custody deaths fluctuates annually, overdose deaths and suicides are showing year-on-year declines, as are the numbers of natural cause deaths. At the same time, it is concerning that there were five inmate murders in FY 2010-11, representing the highest number of homicides recorded in CSC facilities since 2003-04. One inmate also died of gunshot wounds from shots fired by Correctional Officers during an incident at a maximum security facility in October 2010. Significantly, the last time that an inmate died in federal custody as a result of a lethal response by CSC was 1984.

While it is important to recognize the many commendable initiatives at the local, regional and national levels, there is still much work yet to be done. For example, there are no national standards or policy guidelines to direct staff in designating enhanced monitoring status for potentially suicidal offenders. There is no standard method of documenting that mental and physical health status has been reviewed and considered in 24-hour segregation reviews, and physical infrastructure in many segregation units is simply inadequate to provide for effective mental health interventions.

Issues in Focus

Deaths in Custody

Based on a review of Coroner and Medical Examiner records of 388 deaths in custody that occurred between 2000-2009 in the provinces of Alberta, British Columbia and Ontario, findings from a research report (Winterdyk and Antonowicz, in press) commissioned by the OCI indicate:

Location of Death

- Offenders in federal institutions were found to be more at risk of dying in custody than those placed in provincial institutions.

Average Age and Cause of Death

- At time of death, the average offender was 44.55 years of age.
- Offenders that committed suicide were younger, averaging 36.71 years of age.
- The most common cause of death was natural causes, making up 46.65% of the cases.
- Accidental deaths and suicides accounted for 20.36% and 20.10% of deaths, respectively.
- Homicides accounted for 4.9 % of deaths in custody.

Substance Abuse and Prior Medical Conditions

- Drug or alcohol abuse was listed as the primary cause of death in 36.6% of deaths in custody.
- Of those deaths, 21.1% had a history of intravenous drug use.
- Of the 388 deaths that occurred over this period, 62.1% of individuals had known medical problems. Of these:
  - 23.2% had ‘drug-related medical problems’
  - 22.9% had ‘mental health problems’
  - 19.3% had ‘multiple medical problems’
  - 5.7% had ‘multiple diagnoses’ of mental health disorders.

Issues in Focus

In-Cell Emergency Call Alarms

In-cell emergency call alarms save lives. Seconds count when staff are responding to a life-threatening situation. In an emergency, an offender in medical distress or otherwise physically or mentally incapacitated cannot be reasonably expected to walk to a common area to press a call button in order to contact the patrol post.

For these reasons, following a visit to a medium security institution where an Investigator noted that cell alarms were not installed on a particular living unit, the Office called on the Service to provide for the installation of emergency call alarms in existing medium security facilities and as a required design standard in the future expansion of living units at this security level. While retrofitting existing facilities poses additional cost and infrastructure challenges, the Service agreed with the OCI's position, resulting in a commitment that cell call alarms will be installed in all future construction of medium security living units.

Further movement is still required in CSC's overall approach to preventing deaths in custody:

- **Inmates with mental health issues in long-term administrative segregation (beyond 60 days) are not independently and expertly monitored.**
- **There are not enough practical alternatives, such as intermediate mental health care units, to end the practice of housing offenders with mental health problems in long-term segregation.**
- **24 hour on-site health care support is not available in all medium, maximum and multi-level CSC institutions.**
- **Chronic self-harming offenders with serious mental health issues are still subject to a disproportionate number of involuntary placements in segregation and institutional charges.**
- **National Boards of Investigation involving incidents of suicide and serious self-injury are not required to be chaired by independent mental health professionals or be released to the public.**
- **The capacity to bring sustained effort, focus and performance monitoring together in one person (e.g., a senior management position responsible for promoting and ensuring Safe Custody practices) is lacking.**

On this final point, the CSC responded that it was not supportive of this specific recommendation on the basis that Safe Custody is the "responsibility of all operational management positions at the local, regional and national level." However, in a situation where everyone is said to be responsible no-one may ever be held accountable.

Public Reporting

In last year's Annual Report, the Office called upon the Service to publicly release its Performance Accountability Framework to Reduce Preventable Deaths in Custody in order that progress could be monitored and assessed on an annual basis. In its response to the *Final Assessment*, the Service indicated that it had developed a *Performance Management Strategy* designed to "implement a cogent and coherent approach to reducing the number of deaths in custody and to be able to measure the impact of that approach." The *Strategy* intends to track in-custody deaths by four major causes (suicide, homicide, accidental, natural), as well as monitor other relevant factors and sectors of activity, including mental health, security, safety and health initiatives.

While supportive of this effort, the strategy needs to go beyond simply recording the number, cause, type and other "tombstone" data (age, gender, and race) at time of death – it needs to do more than collect numbers. It should have the capacity to capture, monitor and analyze performance measures, trends and indicators that over time contribute to the intended result – a reduction in deaths. The number of deaths in custody are already publicly available – what is required is an *accountability framework* that commits the Service to regular public reporting on progress that is being made in reducing suicides, homicides, overdoses, natural cause deaths and self-injury cases in federal prisons. This is the difference between accounting and an accountability framework.

10. I recommend that CSC make its performance strategy for preventing deaths in custody public and annually report against clear performance indicators, as per the Office's recommendations contained in the Quarterly Reporting exercise.

Verification Review and Independent Review Committee

The extent to which there is room for improvement in CSC's effort to reduce deaths in custody is conveyed in two assessments that were made available to our Office during the reporting period. The first report – *Verification of Progress: Correctional Service of Canada Key Commitments Relating to Deaths in Custody* – examined 11 select medium and maximum security sites across the country. This internal verification exercise was conducted to determine the extent to which national commitments and policy direction consistent with preventing deaths in custody had been implemented at the operational level. The verification team examined six broad areas of activity – administrative segregation, security, mental health, policy, grievances and resources – and reported in May 2010.

The second initiative – *Final Report of the Independent Review Committee into Deaths in Custody: 2009-2010* – submitted its findings in mid-February 2011. As the assessors write: "The idea behind the Independent Review Committee is to benefit from the experience of independent experts and observers who might be able to identify ideas and options for improvement that may not be apparent to those within the organization." This

Committee was mandated to review all non-natural deaths (e.g., suicides, homicides, drug-related deaths) that occurred in CSC institutions during 2009-10, including the appropriateness and adequacy of the corrective measures initiated by CSC.

While the two initiatives differed in terms of their respective mandates, reporting structures, terms of reference and composition (e.g., internal vs. external members), there are a number of common findings, conclusions and recommendations. Both reports cite concerns regarding dynamic security, especially the quality of security patrols, rounds and counts in conducting verifiable live-body counts, ensuring a visible staff presence and maintaining ongoing interaction with inmates. For example, the verification team reported that the trend is towards front-line staff being primarily focused on security issues with increasingly less involvement in inmate interaction and intervention. Security is seen to take precedence over other interventions and activities. While staff was observed to perform its daily static security functions (e.g., pat downs and frisk searches, surveillance and indirect observation) in a professional manner, interaction with offenders was often limited to giving orders and receiving responses. Between rounds and counts and other functions, correctional officers were often observed to congregate in control posts, behind desks or counters. The verification team concluded its report in this way:

> *The Review Team was impressed by the quality of the work and the efforts the CSC is dedicating towards a complex correctional agenda and keeping all priorities, including deaths in custody at the forefront. The Review Team cannot be absolutely conclusive that the CSC can always prevent deaths in custody. We can conclude, however, that the CSC has conscientiously provided all institutions with the equipment, the systems and processes to respond to the physical distress of an inmate or for inmates to request help with their physical or mental health needs if they so choose. The larger challenge in regards to deaths in custody is that the number of inmates with mental health issues is increasing.*

For its part, the Independent Review Committee noted security rounds and patrols were often conducted so quickly that their quality was compromised, leading to failures to assure a live-body count. As the Office reported in its *Final Assessment*, there are often significant delays between the time a medical emergency is discovered and life-saving measures are initiated. Similarly, the Committee also noted the need for improvement in CSC's internal process of investigating deaths in custody (which has been the subject of previous comment by this Office). The report made the following observations:

- **The length of time elapsed between the incident that led to the death and the completion of the internal investigation process averaged 231 days.**
- **Of the 20 deaths that were reviewed by the Committee and internally investigated only 10 contained recommendations.**

- **All 10 suicide victims had a previous history of self-harm and of attempts to take their life.[14] All had difficulties in relation to mental health. Four of the suicide victims were serving sentences of either two or three years.**
- **While the internal investigative findings often indicated poor or non-compliant staff performance, there did not appear to be any significant disciplinary consequences.**

The Committee was sceptical whether investigating individual incidents after the fact and focusing on compliance versus performance was the best way to learn from and prevent death-in-custody events. While much attention is focused on process, less is paid to learning from outcomes.

11. I recommend that CSC make its response to the reports of the Verification Team and the Independent Review Committee public and provide annual updates on progress made against recommendations.

Mortality Review Exercise

While the focus of CSC's efforts have been on 'non-natural' deaths, the OCI continues to raise concerns about the appropriateness and adequacy of CSC's review of so-called "natural" deaths (e.g., those deaths that may be expected or anticipated). In last year's Annual Report, the Office raised substantive accountability and procedural gaps regarding the *Mortality Review Process (MRP)*, an alternative investigative process that the Service uses to review deaths resulting from natural causes. Our concerns reflect the fact that even a so-called 'alternative' process must meet section 19 requirements of the *CCRA*, and therefore satisfy basic principles of independence, credibility and oversight.

In response to the recommendation that the *Mortality Review* exercise be suspended until such time as its guidelines can be independently and expertly validated, the Service replied that it was satisfied that the process was sufficiently rigorous and formal enough to meet Section 19 provisions of the *CCRA* and that *no further action* is required. The Office continues to hold an opposite view, especially with respect to case preparation and support of terminally ill offenders who may be considered for 'release by exception' on compassionate grounds.

12. Pursuant to section 180 of the *CCRA*, I recommend that the Minister of Public Safety direct the Service to immediately suspend the *Mortality Review* exercise until such time as the *Guidelines* can be independently and expertly validated to meet requirements of the legislation. In the interests of transparency and accountability, the results of this review should be made public.

13. Until the *Mortality Review Process* is validated, I recommend that an external medical doctor review all natural in-custody deaths and independently report his/her findings and recommendations to the Commissioner of Corrections.

14 There were 9 suicide deaths in FY 2009-10. One other death was identified as an overdose at autopsy. The overdose death was included as a 'suicide' in the Review Committee's report.

Natural Deaths – 'Compassionate Release'

Paragraph 102 of Commissioner's Directive 712-1 *Pre-Release Decision Making* requires case management staff to "consider all release options for offenders who are terminally ill or otherwise meet any of the criteria identified in section 121 of the *CCRA* at the earliest possible time." In practice, 'compassionate release' of a terminally ill offender to the community to be cared for by his or her family, or to die with dignity, is rare. The criteria to satisfy 'release by exception' under the *CCRA* or conditional pardon under the *Royal Prerogative of Mercy* are basically the same, but they are exceptionally difficult. Even the most deserving of cases can be discouraged from applying – the referral and review process is complicated and lengthy, and the criteria have been further narrowed over the years to leave little room for discretion or compassion.

The Office recently investigated a case in which a terminally ill offender was approaching his Statutory Release date, but he was not supported for compassionate release on the basis that his release to the community was already imminent and that there was not sufficient expert evidence to attest to his palliative condition. The Office's experience is that it may be problematic for an institutional physician or medical expert to attest, in writing, how much time a terminally ill offender may have left to live. However, such is the burden and threshold of "clearly supported medical evidence" that this attestation must be given before the Parole Board can even consider granting a release by exception. In 2008, the Parole Board of Canada received 21 *Royal Prerogative of Mercy* requests and none were granted. In the last five years, there have been 22 'parole by exception' applications received by the Parole Board. Twelve were granted.

Notwithstanding these low referral and grant rates, the Office continues to see cases where the nature and circumstances of the offender's terminal illness would seemingly fit the 'parole by exception' criteria, but the applications were not considered, supported or prepared as diligently as they could be. The fact of the matter is that releases of inmates to die with dignity in the community are too often dismissed on technical and procedural grounds. The result is that a number of very ill offenders suffering from a life-threatening, non-curable illness are dying in federal penitentiaries, sometimes in very tragic and less than dignified conditions. Managing end of life in prison can be an emotionally trying and exhausting experience that also has impacts on staff.

14. I recommend that the Service's practices and procedures for preparing terminally ill offenders for 'release by exception' consideration be independently reviewed to ensure CSC standards are being met and that cases are being prepared with appropriate diligence, rigour and timeliness.

Issues in Focus

Release by Exception and Royal Prerogative of Mercy

Release by Exception

Under section 121 of the CCRA, parole may be granted, in exceptional cases, to an offender:

(a) Who is terminally ill.

(b) Whose physical or mental health is likely to suffer serious damage if he/she continues to be held in confinement.

(c) For whom continued confinement would constitute an excessive hardship that was not foreseeable at the time of sentencing.

This provision does not apply to offenders serving a life sentence or an indeterminate sentence.

Royal Prerogative of Mercy

Under the Criminal Code, the Royal Prerogative of Mercy is exercised by the Governor General or the Governor in Council (e.g., federal Cabinet) upon recommendation from the Minister of Public Safety or at least one other Minister. It is an exceptional provision that allows for a life-sentenced offender with a terminal illness to be considered for a conditional pardon and release to the community.

According to Parole Board criteria, there must exist “substantial evidence of excessive inequity, substantial injustice or undue hardship which would be out of proportion to the nature and seriousness of the offence and the resulting consequences.”

Release by Exception and the *Royal Prerogative of Mercy* are exceptional remedies, used under the most exceptional of circumstances and reserved only for the most deserving cases.

3 Conditions of Confinement

Kent Investigation and Report – A Dangerous Use of Firearms

In last year's Annual Report, the Office provided preliminary details on an exceptional search of a maximum security institution that generated 379 separate uses of force incidents over a ten-day period. It was noted that the events were the subject of an ongoing investigation by the Office. In March 2011, the Office completed its investigation and published its findings in a report entitled *Unauthorized Force: An Investigation into the Dangerous Use of Firearms at Kent Institution between January 8 and January 18, 2010.*

The *Kent Report* involved a substantive investment of the Office's investigative, research and policy resources. Its findings are troubling and indicate systemic weaknesses in a number of critical areas:

> *What happened at Kent Institution amounts to an abuse of correctional power and authority, systemic breakdowns in management accountability and oversight, gaps in use of force review and reporting procedures, deterioration in dynamic security practices and principles, and violations of human rights law and policy. These are significant deficiencies that increasingly call into question the effectiveness of CSC's internal use of force review process.*

The report noted failings within CSC's use of force review procedures, as well as the accountability mechanisms that allow for reasonable and legal uses of force in federal corrections. Only two recommendations were made:

i.) The Service should commission an expert and independent review of its legal, policy and administrative frameworks governing use of force interventions in federal penitentiaries. This review should identify gaps and deficiencies in the use of force review process and include recommended measures to strengthen accountability, monitoring, oversight and corrective functions at the regional and national levels.

ii.) In the interests of transparency, the Service should make its response to this investigative report public in the form of an action plan provided to the Minister of Public Safety and posted on its website within six months from March 21, 2011.

In light of the Service's public commitments that accompanied its response to the *Kent Report*, the Office is encouraged that long-required reforms to strengthen the overall rigour, quality and priority of use force review and reporting procedures at the institutional, regional and national levels will be initiated and implemented in the coming reporting year. The Office is particularly encouraged by the Commissioner's commitment that the display of a weapon will again be treated as a 'reportable' incident, although we remain

concerned by the fact that use of force incidents, particularly the use of chemical and inflammatory agents, are increasing even as the Service seeks to streamline its use of force review procedures.[15] The OCI looks forward to ensuring all commitments in response to the *Kent Report* are fully and transparently honoured.

Issues in Focus

CSC Commitments in Response to Kent Investigation

March 11, 2011

Commitment	Completion Date
1. Regional Deputy Commissioner Pacific to provide a full accounting of the management of the s. 53, lessons learned and action plans created at an upcoming ExCom meeting.	April 2011
2. RDC Pacific to review her previous decisions regarding the issuing of accountability letters and to minimally ensure there are performance expectation letters issued to appropriate staff/managers.	May 2011
3. Amend CD 567-5 Use of Firearms and CD 568-1 Recording and Reporting of Security Incidents to ensure that the displaying of a weapon is considered a reportable incident under Commissioner's Directive.	June 2011
4. A full "change of command" assessment/review will be conducted at Kent as part of the process of installing a new Warden at the institution. This will assist in identifying any residual issues or any other issues that the new Warden must focus on when he takes command of the facility.	June 2011
5. Review of the processes associated with section 53 searches to ensure more rigour around the post search reports.	June 2011
6. All institutions will review their current contingency plans to ensure they are consistent with existing national emergency management policy, with a further review/update to occur if required following the review identified in point 1 above.	June 2011
7. Review how CSC HQ levels can conduct in an expedited manner the review of situations of use of force to ensure compliance with policy, and to identify and mitigate organizational risk.	September 2011
8. Review CSC's use of force model and associated governance structure using a team of both internal and external experts.	September 2011
9. CSC will make available our reports and action plans for public access through the CSC or OCI website at the conclusion of the above actions.	October 2011

15 CSC reported 998 uses of force incidents in 2007-08 and 1,372 incidents in 2009-10, representing a 37% increase over this time period. Inflammatory and chemical agents were deployed in 522 uses of force incidents in 2009-10, accounting for 39% of all interventions. These agents are now standard issue in maximum, medium and multi-level institutions. As of May 2011, "removing a chemical or inflammatory agent from its holster and displaying it at an individual(s) is considered a use of force."

Impacts of Crowding – Federal Corrections by the Numbers

According to CSC, the federal offender population will increase by approximately 3,400 inmates by 2013. In the next three years, CSC is investing over $600M in new capital projects, which includes adding 2,500 new beds at over 30 existing facilities. Along with rising offender populations, CSC's budget will increase by 21% (or $521M) to $2.98B in FY 2011-12. The Correctional Officer group is expected to increase by over 1,300 employees in FY 2010-11.

Despite single cell occupancy being the stated policy, currently approximately 13% of the total inmate population is 'double-bunked' (i.e., more than one inmate accommodated in a cell designed for one person). CSC estimates that the number of double-bunked offenders will increase to 30% of the overall inmate population in the next three years before new construction can provide any substantive relief. The situation is particularly acute in the regional assessment/reception units, with double-bunking rates already exceeding 60% in some facilities. The Prairies region reports the highest use of double-bunking in the country – with a rate approaching 20%, followed by Ontario at around 14%.

Prison crowding is linked to increased levels of institutional violence and unrest and may be a contributing factor to higher incidences of disease transmission and infection rates in federal penitentiaries. There are growing concerns regarding incompatible inmates and other population management issues, including the influence of gangs, drugs and extortion. The Office is aware of at least one homicide during the reporting period that appears to be the result of an incompatible cell assignment. In FY 2010-11, CSC reported 19,769 security incidents, of which 1,258 required a use of force to manage.

We know that there are a growing number of vulnerable individuals behind bars. The mentally and physically ill, the aged, religious and ethnic minorities, those with alternate sexuality, the poorly educated and the brain-injured all have unique and complex sets of needs in terms of providing appropriate, safe and secure accommodation and custody. Prison crowding impacts individuals and groups differently, but the general effects are felt with respect to accessibility to correctional programs, availability of mental and physical health services and less safe conditions of confinement in federal penitentiaries. This situation jeopardizes both staff and inmate safety and prevents effective correctional practice.

Double-Bunking in Segregation

In July 2010, the Office became aware that an institution in the Prairies region was double-bunking offenders in one of its segregation ranges. This is a troubling development in federal corrections, as this practice is particularly unsafe, contrary to human dignity, inconsistent with CSC's accommodation policy and, quite likely, a violation of international human rights detention standards.

According to the Commissioner of Corrections – who was required to approve the double-bunking exemption as an emergency procedure – "double-bunking in these circumstances is an action of absolute last resort and all alternatives must be exhausted beforehand. Should no other option exist in an emergency situation and double bunking in administrative segregation is deemed necessary, the goal is to return the offenders to single occupancy as expediently as possible." This correspondence closed with the statement that "the Service's position is that single accommodation is the most appropriate means of meeting the housing needs of offenders" and that the Service is "taking aggressive measures to ensure this temporary situation is resolved."

By all indications, the factors contributing to rising correctional populations appear far from temporary, and, to be fair, are largely outside the control of CSC. However, given high rates of mental illness, drug addiction, violence and criminal gang membership, it is difficult to see how double-bunking, in either general population or segregation, can be viewed as correctionally appropriate or a sustainable solution to population pressures in either the short or medium terms.

The OCI is aware that the Commissioner's Directive on Inmate Accommodation is being reviewed and updated. This is an opportune time to lay down some important policy markers that will guide the Service in managing the expected surge in population at current cell capacity levels over the next couple of years.

15. I recommend that the revised 'Commissioner's Directive on Inmate Accommodation' contain:

i. An explicit and express prohibition against double-bunking in all segregation settings, segregation-like settings and the Secure Units for women.

ii. Specific instruction that double-bunking assignments must be signed and approved by the Warden and reviewed by regional authorities on a quarterly basis.

iii. Exemptions to use non-purpose built space for inmate accommodation on a temporary or emergency basis must be approved by the Commissioner of Corrections and include a plan to return the space to its intended use within a defined time-frame.

Long-Term Segregation and Mental Health

The negative effects of long-term segregation (i.e., solitary confinement) on mental health functioning are well documented. *A Sourcebook on Solitary Confinement* (2008)[16] cites a number of research studies which suggests that between one-third and as many as 90% of prisoners experience some adverse symptoms in solitary confinement – insomnia, confusion, feelings of hopelessness and despair, hallucinations, distorted perceptions and psychosis. In any given year, there are approximately 7,500 individual segregation placements in federal prisons. In 2009-10, 16% of these placements involved durations exceeding 120 days.[17] The precise number of offenders with mental health

16 Sharon Shalev, *A Sourcebook on Solitary Confinement*, Mannheim Centre for Criminology, London, 2008.

17 *Corrections and Conditional Release Statistical Overview: Annual Report 2010*. Public Safety Canada, 2010.

concerns held in long-term segregation is not known, as the Service does not routinely collect this information. The Office has denounced this use of segregation as unsafe and has called on the Service to end it.

16. I recommend that the Service audit compliance with its legal obligation to ensure that mental health considerations are taken into account – and documented – in a decision to initiate or maintain segregation placements.

Segregation by any other Name

In last year's Annual Report, the Office made a recommendation for the Minister of Public Safety to direct the CSC to conduct an immediate review of all inmates in segregation-like units to ensure they are provided the same legislated protections and access to programs afforded to the general inmate population. The Office's concern in this matter arises as an increasing number of special 'temporary' units are being used to accommodate (effectively segregate) groups of offenders who, though not meeting the legal criteria for segregation, are nonetheless held in conditions of confinement that replicate or approach that of administrative segregation. The problem is that these units do not generally observe the same procedural, review and monitoring safeguards that legally govern administrative segregation placements.

In its response to our recommendation, the Office understands that the Service is developing a framework for "temporary" housing units and that a working group has been established with a mandate to draft a policy document for consultation purposes. While the OCI acknowledges this effort – and notwithstanding the challenges associated with safely managing a diverse range of sub-populations, all with varying needs and risk profiles – we would again remind the Service that the law recognizes only two populations: general population and administrative segregation. Technically speaking, all other 'temporary' units that have proliferated since the late 1990s amount to 'segregation by any other name,' and, in effect, run contrary to what the law directs. The Service is encouraged to make substantive head-way on this issue in the coming year.

Informal Resolution of Offender Complaints and Grievances

Timely and fair resolution of inmate grievances is a key component of an effective correctional system. CSC has reported a noticeable rise in the volume of offender complaints and grievances for the top five subject categories (see Table), rising from a total of 20,823 in FY 2007-08 to 28,263 in 2009-10. This represents a 36% increase in the most grieved areas over two years.

These areas of complaint broadly reflect OCI experience. Indeed, many of the top grieved subjects correspond to topics and priorities that the Office has reported upon in recent years:

- **General 'hardening' of the conditions of confinement.**
- **Declining quality of dynamic security and staff-offender interactions.**
- **Inconsistent quality of and accessibility to health care services.**
- **Access to programming.**
- **Restrictions on group privileges and individual rights.**

Issues in Focus

Offender Complaints and Grievances

FY 2009-10 Top 5 Subjects	Increase since 2007-08
1. Conditions and Routine	+23.1%
2. Interaction	+112.2%
3. Health	+37.5%
4. Programs and Pay	+18.4%
5. Visits and Leisure	+33.8%

Source: Correctional Service Canada, Corporate Reporting System.

The offender complaints and grievance system is an important barometer for gauging the experience of the inmate population. Just as important, the internal redress system provides management with tools, data and an opportunity for analysis of emerging trends and issues of concern and suggests both best practices and areas for improvement. One of the best practices that emerge from the analysis of trends in inmate grievance activity centres on the use of designated Mediators and/or Grievance Coordinators and Clerks within CSC facilities. CSC's own analysis suggests that it should commit more resources to the resolution of complaints and grievances at the institutional level:

1. Institutions with mediators appear to reflect an improved percentage of complaints and grievances resolved at the lowest level.
2. Institutions that retain a Grievance Coordinator for more than one year appear to process complaints and grievances more efficiently and at a higher rate.
3. Institutional Heads who place a high importance on the Offender Complaint and Grievance Process appear to reflect a higher percentage of resolved complaints/grievances and a lower percentage of overdue complaints.
4. Sufficient resources at the institutional and regional levels of the redress process can result in a substantial reduction in delays.

These best practices are independently verified in a recent external review of CSC's offender complaints and grievance process, which was submitted to the Service in July 2010.[18] Indeed, the expert reviewer reached many of the same conclusions: the importance of resolving complaints at the lowest levels; the need for offender involvement; and the use of dedicated staffing resources and models for effective and timely redress. Key recommendations put forward in the external review of CSC's internal redress system include:

18 *Report of External Review of Correctional Service of Canada Offender Complaints and Grievance Process*, July 13, 2010.

1. That there be a designated Mediator appointed at management level at every maximum and medium security institution.
2. That there be a Grievance Coordinator at every institution, appointed at an appropriate level of seniority, and, where numbers and complaint volume warrant it, a Grievance Clerk.
3. All institutions should appoint at least one Inmate Grievance Clerk to provide information about the redress process to assist offenders to resolve issues informally.
4. CSC should place greater emphasis on the internal redress system in new employee training and provide ongoing and refresher training for both employees and management.

Recognizing the increasing volume of legitimate offender complaints and grievances, the noted deficiencies in providing timely access to and resolution of inmate complaints and in light of the growing backlog in grievances that exists in some regions of CSC:[19]

17. I recommend CSC implement recommendations contained in the 'Report of External Review of Correctional Service of Canada Offender Complaints and Grievance Process' and move forward immediately with the introduction of Grievance Coordinators and Mediators at all medium, maximum and multi-level institutions.

19 CSC administers an inmate complaint and grievance system that includes institutional, regional and national levels of redress (and appeal). In April 2011, the Quebec region accounted for approximately 80% of the overall backlog in second level (regional) grievances across CSC, amounting to over 2,000 individual grievances.

Access to Programs

4

Timely access to correctional programming is a key and determining factor in establishing whether and at what point in the sentence an offender is eligible to be considered for conditional release. Safe and timely release relies on quality and active case management interventions. It includes a correctional plan that is accurate, complete and responsive to addressing needs associated with criminality. Behavioural and programmatic objectives, clearly specified in the correctional plan, are intended to inform correctional and parole authorities of an offender's progress and potential for safe reintegration. The overall performance indicators in this area of corrections – including the capacity of CSC to deliver required correctional programs in a timely and effective manner – are not very encouraging:

- **Federal day and full parole grant rates are decreasing annually, and are now at their lowest levels in a decade.**
- **Close to 53% of all offenders are now released on statutory release as the first release type on sentence, or when they reach the two-thirds point of their sentence.**
- **An increasing number of offenders never appear before Parole Board Canada. The proportion of federal full parole pre-release decisions delayed (postponed, and adjourned) or cancelled (waived or withdrawn) stands at over 60%.[20]**
- **The federal parole grant rate for Aboriginal offenders in 2009-10 was 23.7%, compared with 43.4% for non-Aboriginal offenders.**
- **The number of offenders granted temporary absences (escorted and unescorted temporary absences and work releases) are at their lowest levels in a decade. The number of offenders receiving work releases has decreased by almost 70% since 2000-01.**
- **In 2009-10, there were 9,207 offenders required to participate in nationally recognized programs as per their correctional plan. 5,539 actually participated.[21]**
- **In FY 2009-10, there were 22,508 enrolments/assessments in all CSC programs (includes correctional, educational, substance abuse) and 12,396 completions.**
- **In 2009-10, CSC allocated $42.6M to nationally recognized correctional programs. This represented 1.8% of total planned spending for FY 2009-10.**

From research and experience, we know that when correctional programs are properly targeted and sequenced, well-implemented and delivered to meet earliest parole eligibility dates they can reduce recidivism, save money in the long run and enhance public safety. According to CSC research, on average, every dollar spent on correctional programming returns four dollars in saved incarceration

20 T. Beauchamp, T. Cabana, K. Emono, and S. Bottos, *Waivers, Postponements and Withdrawals: Offenders, Parole Officers and National Parole Board Perspectives*, Ottawa: CSC, 2009.

21 CSC response to Parliamentary Order Q-472, October 19, 2010.

costs. Correctional programming interventions that work are:

- Based on empirically supported models of behavioural change;
- Founded on Risk-Need-Responsivity principles (R-N-R);[22]
- Focused on dynamic (changeable) factors related to criminal behaviour;
- Geared to the learning style and personality of the offender;
- Monitored, evaluated and accredited; and
- Implemented by well-trained, dedicated program staff.

Research suggests that there is upwards of 60% reduction in recidivism when all these features are present.

Integrated Correctional Program Model (ICPM)

With the introduction of its Integrated Correctional Programming Model (ICPM), CSC has embarked on an ambitious overhaul of its traditional approach to correctional programming. The Service began piloting the ICPM at all male institutions in the Pacific Region in January 2010. It has since expanded the pilot to the Atlantic Region. The ICPM consists of three distinct and comprehensive correctional programs – a Multi-Target program, a Sex Offender program and an Aboriginal-specific program – and includes an institutional and community maintenance component. The ICPM seeks to deliver a range of ascribed benefits by:

- **Initiating correctional interventions earlier in the sentence (timelier access to correctional programming);**

- **Streamlining program content and reducing the overall number of correctional programs offered (reducing costs and repetition);**
- **Better linking institutional and community interventions (providing a 'continuum of care' from admission to reintegration); and**
- **Making program content more relevant and accessible to offenders (introducing simpler language, concepts and content).**

The ICPM intends to respond to a number of challenges currently impacting the delivery, accessibility and management of correctional programming, some of which are alluded to at the start of this section. Currently, 50% of all new male admissions to federal corrections are serving a sentence of less than three years. According to an internal information paper, the overall goal of the ICPM is to enhance the Service's capacity to "engage more offenders in the right programming at the right time." In moving from the existing 'multi-program' model to what is called the 'next generation' of programming, the Service hopes to

22 See, for example, Jim Bonta and Don Andrews, *Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation*, Public Safety Canada, 2007. According to the authors: 1) the *risk principle* asserts that criminal behaviour can be reliably predicted and that treatment should focus on the higher risk offenders; 2) the *need principle* highlights the importance of criminogenic needs in the design and delivery of treatment; and 3) the *responsivity principle* describes how the treatment should be provided.

improve correctional outcomes by better targeting risk and needs and eliminating programming redundancies. In so doing, resources can be better diverted from lower to higher risk offenders.

In theory, the ICPM presents as a reasonable and pragmatic response to a set of internal and external circumstances – ongoing financial and human resource pressures, declining day and full parole grant rates, a more complex offender profile (including a trend toward short sentences) and limitations in the current 'multi'-program delivery model.[23] Although the ICPM is slated to be evaluated by CSC's Research Branch prior to full implementation, the pilot has already been expanded to the Atlantic Region and appears to be on a 'fast-track' implementation cycle, without benefit of a full evaluation or validated performance indicators.

There is considerable internal and external pressure on the Service to deliver correctional interventions that are timely, efficient, credible, relevant and accessible. Parole Board Canada, for example, demands assurances that offenders have been properly and appropriately prepared to lead a law-abiding life upon release. To grant parole, the Board must have confidence in the quality of the correctional programs that are offered to inmates. In that respect, there are concerns regarding the pilot's emphasis on reducing/collapsing a number of previously separate and discrete programs (e.g., substance abuse, violence prevention or anger management – into a 'one-size-fits-all' intervention).

Consistent with the push to identify and eliminate program redundancies, the Service's *Violence Prevention Program* and its Aboriginal-specific *In-Search of Your Warrior Program* have been replaced in regions where the ICPM is being piloted. These 'efficiencies' follow an earlier move that eliminated low intensity sex offender programming across the Service. Furthermore, under the ICPM model, time spent in programming is dramatically reduced – in some cases, by a factor of three. In short, there is therefore room to be both cautious and optimistic about the ICPM pilot and its expansion to other regions.

18. I recommended that the ICPM pilot be independently reviewed and expertly evaluated in the next fiscal year on the basis of clear performance and outcome indicators and that the results of this review should be shared with Parole Board Canada and made public. Aboriginal specific programming should be maintained until the evaluation is complete.

23 CSC currently has a roster of 64 types of nationally recognized correctional programs, including a number of distinct correctional programs for Aboriginal, women offender and ICPM programs. 'Core' correction programs include Sex Offender Programs; Substance Abuse Programs; Violence Prevention Programs; Family Violence Programs; Living Skills Programs; Aboriginal Programs; Women Offender Programs and Maintenance Programs.

5 Aboriginal Issues

Training in *Gladue* Principles

In last year's Annual Report, the Office recommended integration of 'Gladue principles' in federal correctional decisions affecting the retained rights and liberties of Aboriginal offenders, such as segregation placements, involuntary transfers, access to programming, custody rating, penitentiary placements, access to the community and conditional release planning. The Office noted that revised CSC policy offers a fairly expansive interpretation of Gladue factors, including: effects of the residential school system; impacts of community fragmentation, dislocation and dispossession; family histories of suicide, alcohol abuse and victimization; and loss of cultural/spiritual identity.[24]

The OCI is encouraged that during the reporting period the Service engaged external expertise to provide training on the application of *Gladue* principles at select operational sites and that an evaluation of this initiative will also be conducted. In the meantime, training on the Aboriginal components of case management consistent with *Gladue* (e.g., Aboriginal social history, healing plans and Elder reviews) has been initiated as CSC moves to further integrate the reality of Aboriginal offender experience into its policy directives. These efforts are to be encouraged and commended.

24 The *Gladue* case (1999) is a landmark Supreme Court of Canada decision requiring judges to take into account the unique circumstances of Aboriginal people when passing sentence on Aboriginal offenders.

Access to Spiritual and Cultural Services

As important as these initiatives are to improving correctional outcomes for Aboriginal offenders, the Office continues to see disconnects between what is officially reported by CSC and the situation that prevails for many Aboriginal inmates incarcerated in federal penitentiaries across the country. In providing some concrete illustration of the disconnect between theory and reality, the Office conducted a systemic investigation of Aboriginal inmates' access to spiritual and cultural services at a maximum security institution.

The investigation yielded a number of findings seemingly out of synch with CSC policy and the law:

- **Aboriginal inmates have been routinely denied access to sweat lodges and sweat ceremonies for the past two years on a variety of poorly substantiated security and operational grounds:**
  - Human resource constraints required to conduct individual security risk assessments precluded necessary approvals.
  - The sweat lodge facilities needed structural changes to allow for closer staff monitoring and security counts.
  - Perceived need to scan the firewood used for sweat ceremonies.
  - Restrictions on inmate movement, assembly and association required numerous cancellations of planned sweat ceremonies.
  - Unreasonable restrictions on the use, access and distribution of matches and spiritual bundles, including tobacco and sweet grass, required for smudging ceremonies.
- **Inappropriate questioning of claims to Aboriginal ancestry resulting in unsubstantiated allegations that offenders were trying to wrongfully gain access to perceived benefits associated with Aboriginal status.**
- **The absence of an Aboriginal Liaison Officer at the institution has had adverse effects on the time and tasks that the assigned Elder could devote to serving inmate needs.**

Although staff appeared generally aware and empathetic to the situation of Aboriginal offenders – including knowledge of *Gladue* principles and the negative effects of over-representation of Aboriginal people in the criminal justice system – they were unable to fully operationalize the practical intent of these principles. As a result, the initiatives that have been developed to respond to Aboriginal people in federal corrections (e.g., access to Elders, access to spiritual and culturally appropriate interventions, ceremonies, traditions and programs) have not been supported or developed to the extent national policy and the law requires.

Within CSC, as this investigation would suggest, there appears to be some confusion regarding the situation of those offenders who do not self-identify as Aboriginal but claim the right to participate in Aboriginal spiritual ceremonies in the name of religious freedom. The objective is to not unduly restrict access to Aboriginal programs to Aboriginal peoples. Legislation and policy is clear on these points: all refer to the ethno-cultural background of Aboriginal offenders and not their religious or spiritual beliefs or identification. It is important to note that the standard statements about Aboriginal spirituality services relate to program logic and not the exercise of religious freedom.

Non-Aboriginal offenders may wish to meet with an Elder, learn about Aboriginal spiritual practices and participate, to some extent, in spiritual activities. Notwithstanding, legislation and policies supporting Aboriginal programs are designed to assist Aboriginal offenders reclaim their ancestral traditions, rituals and values. The adoption of these provisions and programs is based on recognition of the historical injustice to Aboriginal communities and the connection between this history and the overrepresentation of Aboriginal offenders in the criminal justice system. The application of the principle of holistic healing is one of the ways to restore balance within Aboriginal communities. Following an Aboriginal healing plan in a CSC facility is not just a program, but a way of life.

It is especially troubling to note that security and operational concerns continue to trump access to spiritual and culturally appropriate Aboriginal services. The investigation noted that management did not normally consult with their counterparts at other maximum security institutions on protocols and best practices in order that safety and security requirements could be met while ensuring reasonable access to sweat lodge, smudging and other Aboriginal healing ceremonies.

The loss of an offender's access to matches, or for staff to unreasonably restrict their distribution (and therefore access), effectively translates into the loss of the right to practice traditional ceremonies associated with Aboriginal spirituality. Since access to and use of matches equates to the right to smudging ceremonies, only a negative 'individual' threat risk assessment could result in this type of sanction. Aboriginal ceremonies requiring burning, such as smudging, should not automatically be restricted or prohibited on the basis of local/institutional standing orders or operational routines. CSC policy provides that culturally and spiritually appropriate ceremonies are to be reasonably accommodated under the direction of an Elder/Spiritual Advisor. Legitimate and founded restrictions on an individual offender's access to matches should not unnecessarily impede the exercise of group rights. The seeming inability of staff to look beyond narrow safety and security concerns speaks to a general failure to reasonably accommodate and respect Aboriginal spiritual and healing ceremonies.

19. I recommend CSC undertake an operational review of Aboriginal offender's access to spirituality and ceremonies at all security designations to ensure practices at the institutional level are consistently supported and developed to the extent that policy and the law require.

Once again, I note with frustration that there is still no one CSC Executive Committee member who is specifically and exclusively responsible for Aboriginal issues.

Federally Sentenced Women 6

The average daily number of federally sentenced women in CSC custody last year was just over 500. According to CSC data, these women were involved in 1,524 security incidents in FY 2010-2011, of which 144 involved a use of force. In the reporting period, the Office received 436 complaints from federally sentenced women. Areas of concern most frequently identified by women in the five regional women's facilities include: conditions of confinement; physical health care concerns; cell effects; mental health services; administrative segregation and; issues regarding staffing, including allegations of discrimination and harassment.

In addition to addressing individual complaints, the Office continued to focus on systemic concerns and priorities related to women offenders. In the reporting period, these issues included access to programs, conditions of confinement and community reintegration, as well as concerns specific to the over-representation of Aboriginal women offenders. Recommendations issued in last year's Annual Report – the need for stand-alone accommodations for minimum security women offenders (both inside the regional facilities and for women residing in the community), and for ending restrictions on the Mother-Child Program – were further explored with the Deputy Commissioner for Women.

In September 2010, the Service celebrated the twentieth anniversary of *Creating Choices*, the report of the Task Force on Federally Sentenced Women upon which the five regional women's facilities were based. As the Commissioner of Corrections observed in his remarks to open the Forum marking the event, women's corrections in Canada is still "a work in progress in many ways; and we have not been 100% right 100% of the time, but we continue to learn, make adjustments and improve." In that light, during the reporting period an anti-bullying strategy in the regional women's facilities was one such improvement which the OCI identifies as a model practice. In addition, one regional facility has recently established an ethics committee. Both initiatives are welcomed. The Office is also encouraged by the Service's move to finally rescind the Management Protocol for high need/high risk women offenders effective May 1, 2011.[25]

25 Correspondence from the Deputy Commissioner for Women, dated April 13, 2011, informing the Office of the Service's intention to rescind the Management Protocol indicates that: "Women inmates who pose the highest-risk will be managed within the current policy framework, namely existing segregation authorities, enhanced Correctional Plans and robust Reintegration Plans. This will provide a comprehensive approach that is more individualized in terms of addressing risk and needs (and) will allow for greater flexibility and an increased focus on interventions."

Issues in Focus

Profile of Federally Sentenced Women

General

- As of August 2010, there were 512 federally sentenced women incarcerated in CSC facilities.
- 567 women offenders were under some form of community release supervision.
- In the last 10 years, the number of Aboriginal women in custody has increased by 86.4%, compared to 25.7% over the same period for Aboriginal men.
- 34% of the incarcerated women offender population is Aboriginal.
- More than 65% of new female admissions are serving a sentence of less than three years.

Personal Histories

- 77% of women offenders have children. Just over half indicated having experiences with Children's Aid.
- In 2010, 86% of women offenders reported histories of physical abuse, and 68% reported a history of sexual abuse at some point in their lives, representing an increase of 19% and 15% respectively since 1991.
- Approximately 45% of women offenders reported having less than a high school education at intake.
- 64% supported themselves financially.

Mental Health and Addictions

- In 2009, 29% of women offenders were identified at admission as presenting mental health problems, and this proportion has more than doubled over the past decade.
- 31% of women were identified, at intake, as having a past mental health diagnosis, representing a 63% increase over the past decade.
- 48% of women were identified, at intake, as having a current need for prescribed medication.
- Since 2003, at intake, approximately 77% of women report abusing both alcohol and drugs.
- Just under half of women self-report having engaged in self-harming behaviour.

Sources:

i.) M. Barrett, K. Allenby, and K. Taylor, *Twenty Years Later: Revisiting the Task Force on Federally Sentenced Women*. Research Report R-222, 2010.

ii.) *Corrections and Conditional Release Statistical Overview: Annual Report 2010.*

Impacts of Crowding at the Regional Women's Facilities

In the *Conditions of Confinement* section of this report we examined the general impacts of prison crowding. The situation at the five regional women's facilities is particularly acute, as there is little capacity or choice (as there is for male offenders) to transfer or cascade offenders to other less crowded or lower security facilities. CSC's women offender population forecasts suggest foreseeable annual population increases over the near and medium terms. Currently, three of the five regional women's facilities have requested approval to 'double-bunk' offenders in their secure units (i.e., maximum security). The Structured Living Environment unit at one of the women's facilities has been used to segregate women offenders, and this strategy may be under consideration as a population 'over-flow' option at other regional sites.

One facility has resorted to placing women in an interview room within the facility's secure unit. This room does not have any running water, toilet facilities or built-in cell call alarm system, nor does it offer the amount of living space, privacy and dignity that is available in a purpose-built cell. The women sleep on mattresses on the floor. Of further concern to this Office is that some of the women housed in this space have mental health needs. The Office has been further advised of plans to convert the facility's gymnasium into a dormitory and the private family visiting unit into temporary accommodation.

The use of non-purpose built space to manage increasing populations is highly disruptive and obviously inconsistent with their intended functions. Other population management strategies – such as inter-regional transfers to conduct intake assessment at less crowded facilities or resorting to involuntary transfers to provincial facilities due to a lack of space – are equally problematic.

20. I recommend that the Service aggressively implement a range of population management measures at the regional women's facilities that are consistent with *Creating Choices* and reflect the least restrictive principle enunciated in the *CCRA*.

Churchill Unit Review

It is estimated that 50% of federally sentenced women self-report a history of engaging in self-injurious behaviour. Unlike male offenders, there is no dedicated or piloted complex needs program or specialized unit to treat chronic self-injurious women offenders. Some of the most challenging and complex self-injurious cases in the federal system are managed on the female wing of the Regional Psychiatric Centre (RPC Prairies), on what is called the Churchill Unit.

Following a national board of investigation into the care and treatment of a woman offender residing on the Churchill Unit, a project team of experienced clinical and operational staff was assembled by the Regional Deputy Commissioner of the Prairies Region to conduct a review of the Unit's existing clinical management model. Its mandate was to "review community standards, current trends and community-based, similarly-profiled forensic psychiatric facilities to determine potential organizational models to strengthen clinical management on Churchill Unit to support modern, innovative and appropriate clinical treatment."[26]

26 CSC, *Review of the Regional Psychiatric Centre Churchill Women's Unit Existing Treatment Model*, dated November 26, 2010.

The 12-bed Churchill Unit first opened as a treatment unit for federally sentenced women in August 1996. Since its opening, the Unit has never been viewed as an optimal place to treat women patients needing predominantly psychiatric interventions. Despite some retrofits, the Unit was then – just as it continues to be – mostly an after-thought, originally utilized as an acute intensive psychiatric unit for men. The fact that the Churchill Unit is housed within a male facility severely compromises the ability of the women being treated there to access other off-unit venues, including much-needed programming, interviewing and counselling spaces. Indeed, the lack of appropriate space limits the number and type of interventions that can be offered on the Unit.

As the Unit has evolved over the years, correctional officers now outnumber clinical staff. As the review notes, "this imbalance between Correctional and Clinical operations is significantly impacting the ability to provide effective mental health treatment and interventions within a psychiatric hospital." Indeed, as this Office has observed, the tension within CSC between clinical and security interventions are often palpable and not altogether helpful in managing patients with serious mental health needs. Perceived security concerns, regardless of established risk, too often trump clinical interventions.

In the Mental Health section of this report, we previously noted that the Office intervened in the case of two chronically self-injurious women who were being treated at the Churchill Unit – one of whom was the subject of the use of force investigation which prompted the regional review of the Unit's existing clinical model. In the case of one offender, it was our view that treatment was not advancing as well as it might due to an escalation in the security response. The imbalance between health care and security interventions led us to recommend her for transfer to a provincial forensic facility. It is revealing to note that this offender is now residing and managing well in the community, seemingly without resort to the self-destructive tendencies for which her time within CSC facilities was marked.

That said, the Office endorses many of the 'modern, innovative and appropriate' practices outlined in the key findings section of the Churchill Review:

- **To be consistent with the least restrictive principle, restraint and seclusion should not automatically or immediately be applied to manage self-injurious offenders who are engaging in difficult or acting out behaviours.**
- **Isolation has the potential to exacerbate the symptoms of the patient, and that the use of seclusion as a method to prevent self-injurious behaviour can actually increase the motivation for and frequency of self-injury.**
- **De-escalation techniques are effective alternatives to the use of restraint and seclusion and provide for the safe and therapeutic treatment of patients.**
- **CSC should endorse the overriding management principle in its RTCs that treatment and operational requirements should take place "in the context of a penitentiary within a hospital setting rather than a hospital within a penitentiary setting."**
- **The environmental design of RTCs should incorporate elements that are known to promote wellness, such as natural light, fresh air, opportunity for exercise and space to engage in spiritual or cultural activities.**
- **Clinical staff, operational staff and the patient should be involved in the development of an individualized treatment or intervention strategy.**

- **All staff members should be involved and have a role to play in adhering to the clinical treatment plan.**

The Churchill Review is helpful in pointing the way forward for implementing changes in the Unit's existing clinical model and its approach to treating chronic self-injurious offenders. As this Office has noted, however, there is no stand-alone long-term accommodation and treatment facility within which CSC can treat women patients with significant mental health problems. This gap is becoming ever more problematic as the incidence and complexity of mental health issues increases in the women offender population – including histories of severe psychological trauma and physical and sexual abuse for which self-injury appears to be a coping/regulatory strategy.

21. I recommend that the Service explore additional partnerships and agreements with the provinces and territories to allow for the transfer of severely mentally ill women offenders to specialized treatment facilities.

Correctional Investigator's Outlook for 2011-12

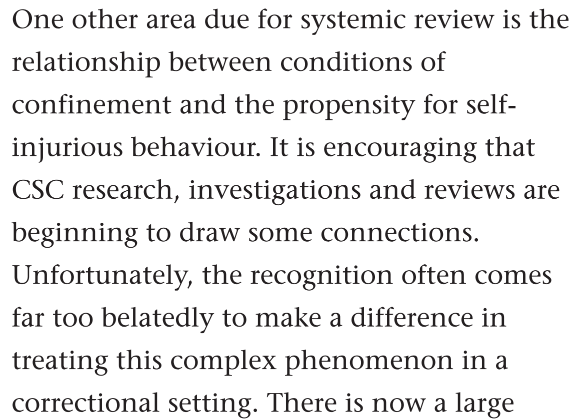
It is my experience that prison populations disproportionately include the more impoverished, poorly-educated, addicted and the mentally ill among us. A walk through a federal penitentiary in this country reveals that current criminal justice policy captures a high number of the most marginalized and distressed within our communities, including the socially disadvantaged, Aboriginal peoples, the aged and the infirmed. Who we incarcerate and how they are treated inside prisons speaks to the kind of society we are and the values we affirm as a nation.

The offender population is increasing and will continue to grow as recent policy and legislative initiatives fully take effect. Most CSC facilities are already operating at or above capacity. The pressure to provide appropriate, safe and secure accommodation and custody; meet growing mental health needs; and respond to the special needs of female, older and Aboriginal offenders will only intensify. These are issues of immediate concern.

Flowing from these population management pressures is the need to improve the quality of individual assessment and enhance the overall case-management process. To avoid simply warehousing offenders, CSC will need to find better ways to move offenders efficiently down security levels so as to better prepare them for timely release and safe reintegration. With as much as 50% of the total offender population during the last fiscal year serving less than a three-year sentence, it is a matter of increasing priority that CSC intervene as early in the sentence as possible. As population pressures mount, CSC will be under intense scrutiny to deliver quality, accessible and credible programs to facilitate offender re-entry into society.

In the coming year, my Office will continue to pursue and monitor areas of concern and priorities that have informed this Annual Report. With respect to preventing deaths in custody, my Office intends to conduct a systemic review of the *Mortality Review Process*, as we are simply not satisfied with CSC's response that "no further action is required." CSC's reluctance to address credibility concerns in this matter leaves little choice but to move forward with an independent review.

As our review of access to Aboriginal spirituality at one maximum security institution reveals, we will need to keep focused on reducing the gap in correctional outcomes for Aboriginal peoples. The relentless year-on-year increase in the percentage of Aboriginal peoples behind bars is discouraging. While attributable to a myriad of causes, there really are no excuses as to why Aboriginal offenders should be falling so far behind their non-Aboriginal counterparts on nearly every performance indicator while inside federal penitentiaries.



One other area due for systemic review is the relationship between conditions of confinement and the propensity for self-injurious behaviour. It is encouraging that CSC research, investigations and reviews are beginning to draw some connections. Unfortunately, the recognition often comes far too belatedly to make a difference in treating this complex phenomenon in a correctional setting. There is now a large collection of investigative reports, reviews, research, best practices and clinical experience which CSC can draw on to better equip itself to manage self-injury.

As Correctional Investigator, I am privileged to serve Canadians. In the coming year, I look forward to reporting on issues that concern corrections and affect public safety.

Ed McIsaac Human Rights in Corrections Award

On December 8th, 2010, Ms. Mary Campbell was presented with the *Ed McIsaac Human Rights in Corrections Award*. The award was established in December 2008, in honour of Mr. Ed McIsaac, long-time Executive Director of the Office of the Correctional Investigator and strong promoter and defender of human rights in federal corrections. It commemorates outstanding achievement and commitments to improving corrections in Canada and protecting the human rights of the incarcerated.

Throughout the past 25 years, Ms. Campbell has been at the forefront of policy and legislative reforms which have defined Canada's criminal justice and correctional systems. As Director General of, Corrections and Criminal Justice Directorate, Public Safety Canada, she provides expert policy, program, legislative and research advice to support the Minister of Public Safety and Parliament. As a lawyer and academic, Ms. Campbell's publications in the areas of prisoners' legal rights, sentencing reform and case law are standard reading in Criminology courses and law departments across Canada.

Ms. Mary Campbell and Ed McIsaac's careers serve as a reminder that the right to be treated with fairness, respect and dignity is retained by all members of society, including those deprived of their liberty.

Left to Right: Mr. Howard Sapers, Ms Mary Campbell (centre) and Mr. Ed McIsaac.

ANNEX A: ANNUAL STATISTICS

TABLE A: COMPLAINTS (1) BY CATEGORY

Complaints – see Glossary (1), Internal Response – see Glossary (2), Investigation – see Glossary (3)

Category	I/R(2)	Inv(3)	Total
Administrative Segregation			
Conditions	44	45	89
Placement/Review	87	170	257
Total	**131**	**215**	**346**
Case Preparation			
Conditional Release	26	30	56
Post Suspension	7	3	10
Temporary Absence	6	11	17
Transfer	8	20	28
Total	**47**	**64**	**111**
Cell Effects	**188**	**219**	**407**
Cell Placement	**10**	**25**	**35**
Claim			
Decisions	10	13	23
Processing	17	21	38
Total	**27**	**34**	**61**
Community Programs/Supervision	**5**	**16**	**21**
Conditional Release	**20**	**26**	**46**
Conditions of Confinement	**216**	**253**	**469**
Conviction/Sentence-Current Offence	**0**	**1**	**1**
Correspondence	**56**	**59**	**115**
Death or Serious Injury	**14**	**46**	**60**
Decisions (general) - Implementation	**67**	**62**	**129**
Diets			
Medical	2	7	9
Religious	6	11	17
Total	**8**	**18**	**26**
Discipline			
ICP Decisions	1	3	4
Minor Court Decisions	4	5	9
Procedures	15	15	30
Total	**20**	**23**	**43**
Discrimination	**3**	**6**	**9**

TABLE A: COMPLAINTS (1) BY CATEGORY (cont.)

Complaints – see Glossary (1), Internal Response – see Glossary (2), Investigation – see Glossary (3)

Category	I/R(2)	Inv(3)	Total
Double Bunking	**15**	**29**	**44**
Employment	**27**	**51**	**78**
Financial Matters			
Access	17	20	37
Pay	10	33	43
Total	**27**	**53**	**80**
Food Services	**21**	**39**	**60**
Grievance			
3RD LEVEL REVIEW	26	21	47
DECISION	19	16	35
PROCEDURE	113	89	202
Total	**158**	**126**	**284**
HARASSMENT	**38**	**50**	**88**
Health and Safety - Inmate Worksites/Programs	**3**	**6**	**9**
Health Care			
Access	110	277	387
Decisions	72	117	189
Medication	57	108	165
Total	**239**	**502**	**741**
Health Care - Dental	**7**	**49**	**56**
Hunger Strike	**1**	**16**	**17**
Information			
ACCESS/DISCLOSURE	54	50	104
Correction	48	50	98
Total	**102**	**100**	**202**
Inmate Requests	**8**	**7**	**15**
IONSCAN	**1**	**1**	**2**
Legal Counsel - Quality	**21**	**19**	**40**
Mental Health			
Access/PROGRAMMES	6	22	28
QUALITY	1	9	10
Self-Injury	12	62	74
Total	**19**	**93**	**112**
METHADONE	**9**	**21**	**30**
OCI	**1**	**2**	**3**

TABLE A: COMPLAINTS (1) BY CATEGORY (cont.)

Complaints – see Glossary (1), Internal Response – see Glossary (2), Investigation – see Glossary (3)

Category	I/R(2)	Inv(3)	Total
Official Languages	**5**	**2**	**7**
Operation/Decisions of the OCI	**15**	**10**	**25**
Outside Court	**2**	**5**	**7**
Parole Decisions			
Conditions	16	14	30
Day Parole	15	14	29
Detention	10	6	16
Full Parole	13	4	17
Revocation	27	15	42
Total	**81**	**53**	**134**
Police Decisions or Misconduct	**2**	**1**	**3**
Private Family Visits	**33**	**76**	**109**
Programme/Services			
Women	0	3	3
Aboriginals	12	23	35
Access	24	71	95
Decisions	15	23	38
Language Access	0	3	3
Other	8	6	14
Total	**59**	**129**	**188**
Provincial Matter	**0**	**2**	**2**
Release Procedures	**32**	**33**	**65**
Religious/spiritual	**10**	**23**	**33**
Safety / Security			
Incompatibles	14	29	43
Worksite	0	1	1
Total	**14**	**30**	**44**
Safety/Security of Offender(s)	**32**	**58**	**90**
Search and Seizure	**9**	**18**	**27**
Security Classification	**54**	**81**	**135**
Sentence Administration	**11**	**6**	**17**
Staff	**173**	**174**	**347**
Telephone	**67**	**101**	**168**

TABLE A: COMPLAINTS (1) BY CATEGORY (cont.)

Complaints – see Glossary (1), Internal Response – see Glossary (2), Investigation – see Glossary (3)

Category	I/R(2)	Inv(3)	Total
Temporary Absence			
Escorted	6	15	21
Unescorted	4	3	7
Total	**10**	**18**	**28**
Temporary Absence Decision	**5**	**21**	**26**
Transfer			
Implementation	43	46	89
Involuntary	69	81	150
Pen Placement	15	10	25
Section 81 / 84	0	2	2
VOLUNTARY	35	68	103
Total	**162**	**207**	**369**
Urinalysis	**5**	**9**	**14**
Use of Force	**11**	**53**	**64**
Visits	**34**	**62**	**96**
Uncategorized(*)			**176**
Grand Total			**5914**

(*) Includes: complaint topics which are not represented by the complaint categories outlined above, or complaints that address multiple categories at the same time.

GLOSSARY

Complaint: Complaints may be made by an offender or a third party on behalf of an offender by telephone, facsimile, letter or during interviews held by the OCI's investigative staff at federal correctional facilities.

The legislation also allows the OCI to commence an investigation at the request of the Minister or on the OCI's own initiative.

Internal Response: A response provided to a complainant that does not require consultation with any sources of information outside the OCI.

Investigation: A complaint where an inquiry is made with the Correctional Service and/or documentation is reviewed/analyzed by the OCI's investigative staff before the information or assistance sought by the offender is provided.

Investigations vary considerably in terms of their scope, complexity, duration and resources required. While some issues may be addressed relatively quickly, others require a comprehensive review of documentation, numerous interviews and extensive correspondence with the various levels of management at the Correctional Service of Canada prior to being finalized.

Systemic investigations examine areas of common concern of offenders and can be aimed at the institutional, regional or national level.

TABLE B: COMPLAINTS BY INSTITUTION/ REGION (*)

REGION / INSTITUTION	Number of Complaints	Number of Interviews	Number of Days Spent in Institution
FSW			
Edmonton Women Facility	63	29	6
FRASER VALLEY	41	15	7
FSW-RPC	0	0	0
Grand Valley	124	48	9
Joliette	99	39	7
Nova	42	23	5.5
Okimaw Ohci Healing Lodge	31	16	3
Total	**400**	**170**	**37.5**
Atlantic			
Atlantic	240	85	16
Dorchester	151	85	13
Shepody Healing Centre	22	2	3
Springhill	70	7	10
Westmorland	5	1	2
Total	**488**	**180**	**44**
Ontario			
Bath	99	25	6.25
Beaver Creek	31	10	1
Collins Bay	194	106	10.5
Fenbrook	146	18	9
Frontenac	15	9	1.5
Joyceville	170	97	8.5
Kingston Penitentiary	377	125	12
Millhaven	127	46	4.5
Millhaven-Assessment Unit	35	13	4.5
Pittsburgh	36	19	3
RTC Ontario	99	41	4
Warkworth	506	321	13
Total	**1835**	**830**	**77.75**
Pacific			
Ferndale	28	7	1
Kent	282	71	12
Kwikwèxwelhp	0	0	1
Matsqui	100	31	9.5
Mission	52	21	9
Mountain	171	9	6
RTC Pacific	48	15	12.5
William Head	21	16	4
Total	**702**	**170**	**55**

TABLE B: COMPLAINTS BY INSTITUTION/ REGION (cont.) (*)

REGION / INSTITUTION	Number of Complaints	Number of Interviews	Number of Days Spent in Institution
Prairies			
Bowden	117	41	8
Bowden Minimum	2	0	1
Drumheller	86	33	11
Drumheller Minimum	1	0	1
Edmonton	240	75	15
Grande Cache	80	26	8
Grierson Centre	13	2	1
PE SAKASTEW	11	6	1
Riverbend	19	5	1
Rockwood	11	9	1
RPC-Prairies	250	125	11.5
Saskatchewan Maximum	126	11	3
Saskatchewan Penitentiary	104	19	3
Stan Daniels Centre	1	0	1
Stony Mountain	87	9	6
Willow Cree	2	0	0
Total	**1150**	**361**	**72.5**
Québec			
Archambault	109	43	9.5
Archambault-CRSM	55	15	4
Cowansville	80	32	7
Donnacona	107	15	14
Drummond	73	28	5
FTC	45	12	2
La Macaza	123	33	6.5
Leclerc	75	25	4.5
Montée St-François	31	18	3
Port Cartier	285	126	12
RRC Québec	69	28	9
SHU-USD	69	5	9
Ste-Anne-Des-Plaines	26	15	3
Waseskun	7	2	1
Total	**1154**	**397**	**89.5**
CCC/CRC/ Parolees in Community	162	0	0
Federal Inmates in Provincial Institutions	12	0	0
Uncategorized	11	0	0
Grand Total	**5914**	**2108**	**376.25**

TABLE C: COMPLAINTS AND INMATE POPULATION – BY REGION

REGION	Total Number of Complaints	Inmate Population (*)
Atlantic	514	1,256
Quebec	1208	3,206
Ontario	1883	3,955
Prairie	1183	3,579
Pacific	721	1,825
Women's Facilities	395	581
Provincial Facilities	8	N/A
Uncategorized	2	N/A
Total	**5914**	**14402**

(*) Inmate Population broken down by Region: As of June 2011, according to the Correctional Service of Canada's Corporate Reporting System.

TABLE D: DISPOSITION OF COMPLAINTS BY ACTION

ACTION	Disposition	Number of Complaints
Internal Response		
	Uncategorized	0
	Advise/Information Given	1275
	Assisted by Institution	117
	Pending	6
	Recommendation	395
	Refer to Grievance Process	242
	Rejected as unfounded	173
	Systemic/Multiple	47
	Withdrawn	152
	Subtotal:	**2407**
Inquiry		
	Uncategorized	2
	Advise/Information Given	861
	Assisted by Institution	772
	Pending	24
	Recommendation	586
	Refer to Grievance Process	102
	Rejected as unfounded	199
	Systemic/Multiple	27
	Withdrawn	67
	Subtotal:	**2640**

TABLE D: DISPOSITION OF COMPLAINTS BY ACTION (cont.)

ACTION	Disposition	Number of Complaints
Investigation		
	Uncategorized	7
	Advise/Information Given	200
	Assisted by Institution	221
	Pending	36
	Recommendation	243
	Refer to Grievance Process	35
	Rejected as unfounded	64
	Systemic/Multiple	38
	Withdrawn	23
	Subtotal:	**867**
	Grand Total:	**5914**

TABLE E: AREAS OF CONCERN MOST FREQUENTLY IDENTIFIED BY OFFENDERS

Total Offender Population

CATEGORY	#	%
Health Care	741	12.53%
Conditions of Confinement	469	7.93%
Cell Effects	407	6.88%
Transfer	369	6.24%
Staff	347	5.87%
Administrative Segregation	346	5.85%
Grievance	284	4.80%
Information	202	3.42%
Programme / Services	188	3.18%
Telephone	168	2.84%

TABLE E: AREAS OF CONCERN MOST FREQUENTLY IDENTIFIED BY OFFENDERS (cont.)

Aboriginal Offenders

CATEGORY	#	%
Health Care	75	10.59%
Staff	64	9.04%
Conditions of confinement	63	8.90%
Transfer	45	6.36%
Administrative Segregation	42	5.93%
Cell Effects	30	4.24%
Mental Health	28	3.95%
Grievance	27	3.81%
Visits	26	3.67%
Security Classification	22	3.11%

Women Offenders

CATEGORY	#	%
Conditions of confinement	58	13.30%
Health Care	45	10.32%
Cell Effects	27	6.19%
Mental Health	27	6.19%
Administrative Segregation	23	5.28%
Staff	22	5.05%
Visits	18	4.13%
Transfer	17	3.90%
Telephone	15	3.44%
Case Preparation	14	3.21%

ANNEX B: OTHER STATISTICS

A. Section 19 Reviews Conducted in 2010-11

As per section 19 of the *Corrections* and *Conditional Release Act (CCRA)*, the Correctional Service of Canada is required to conduct investigations into incidents involving inmate serious bodily injury or death. By law, these investigations are shared with and reviewed by the OCI.

- **Number of Section 19 investigations reviewed by the Office: 112**
- **Number of Section 19 investigations of natural deaths in custody convened under the Mortality Review Process reviewed by the Office: 6**

Notes:

1. *The Correctional Service of Canada has adopted different policy processes to investigate "natural" versus non-natural deaths in custody. For natural deaths, CSC uses a Mortality Review exercise — a file review conducted by a Nurse at National Headquarters.*
2. *For deaths involving non-natural causes (e.g., homicides, suicide and overdose), the CSC convenes a National Board of Investigation (NBOI). The Board is required to investigate and issue a formal report to the Executive Committee (EXCOM) of the CSC. EXCOM reviews the report and recommendations of the NBOI and approves corrective measures to be taken.*

B. Use of Force Reviews Conducted in 2010-11

Total number of use of force files reviewed by OCI: 1,265

- **Initial review: 573**
- **Full review: 382**
- **Reviews pending or requiring follow-up with CSC: 310**

Notes:

1. *The Correctional Service is required by policy to provide all pertinent and relevant use of force documentation to the Office.*
2. *A "full review" involves reviewing all use of force documentation specified in Commissioner's Directive 567 — Use of Force. The use of force package includes, but may not be limited to: the Use of Force Report, a copy of incident-related video, Checklist for Health Services Review of Use of Force, Post-Incident Checklist, Officer's Statement/Observation Report, and action plan to address deficiencies.*
3. *An "initial review" involves a review of select documentation in the Use of Force package. This review includes: the use of Force Report, the Post Incident Checklist, Inmate Statements (if applicable), Institutional, Regional and (if applicable) National assessments, as well as the Offender Management System (OMS) incident report.*
4. *A specific follow-up may be initiated by the Office at the institutional, regional and/or national level.*

C. Toll-Free Contacts in 2010-11

Offenders and members of the public can contact the Office by calling our toll-free number (1-877-885-8848) anywhere in Canada. All communications between offenders and the Office are confidential.

Number of toll-free contacts received in the reporting period: 20,011

Number of minutes recorded on toll-free line: 82,182

D. Systemic Investigations Conducted in 2010-11

31 systemic (in-depth) investigations were conducted in 2010-11.

TYPE OF COMPLAINT	#	%
Conditions of confinement	7	22.58%
Death or Serious Injury	4	12.90%
Programmes/Services	4	12.90%
Administrative Segregation	3	9.68%
Security Classification	2	6.45%
Use of Force	2	6.45%
Other	9	29.03%
Total Count of Disposition	**31**	

Response of the
CORRECTIONAL SERVICE OF CANADA
to the
38th ANNUAL REPORT
of the
CORRECTIONAL INVESTIGATOR
2010 - 2011

INTRODUCTION

The Correctional Service of Canada (CSC) is responsible for administering court-imposed sentences for offenders sentenced to two years or more, including supervising those under conditional release in the community. CSC also administers post-sentence supervision of offenders with Long Term Supervision Orders for up to 10 years. On an average day in fiscal year 2010-2011, CSC was responsible for 14,200 incarcerated offenders and 8,600 offenders in the community. CSC manages 57 institutions, 16 community correctional centres, 84 parole offices and sub-offices and employs approximately 17,400 people.

While CSC's original five priorities remain its pillars, a sixth priority was added to reflect the reality that CSC does not, and cannot, work alone to fulfil its mandate:

1. Safe transition to and management of eligible offenders in the community;
2. Safety and security of staff and offenders in our institutions and in the community;
3. Enhanced capacities to provide effective interventions for First Nations, Métis and Inuit offenders;
4. Improved capacities to address mental health needs of offenders;
5. Strengthening management practices; and
6. Productive relationships with increasingly diverse partners, stakeholders, and others involved in public safety.

The sixth priority recognizes the role of CSC partners and stakeholders in the federal correctional process and reiterates CSC's commitment to enhancing public safety through building, sustaining and improving these productive and collaborative relationships.

The recommendations of the 2007 Report of the CSC Review Panel *"A Roadmap to Strengthening Public Safety,* formed the basis of CSC's Transformation Agenda that focused on five areas:

1. Enhancing offender accountability
2. Eliminating drugs
3. Enhancing correctional programs and interventions
4. Modernizing physical infrastructure
5. Strengthening community corrections

With Phase One – Transformation - and Phase Two - Integration - both now completed, CSC is now in Phase Three which focuses on ensuring continued integration of these initiatives. CSC has made significant progress in integrating into its daily operations the recommendations of the Review Panel. The ongoing integration and strengthening of these initiatives continues to be of utmost importance to ensure CSC effectively manages today's challenging offender population.

The introduction of new legislation such as the abolition of Accelerated Parole Review, as well as legislation such as the *Truth in Sentencing Act* and the *Tackling Violent Crime Act* is expected to result in increased numbers of federal offenders with a wider range of needs, underscoring the requirement for both short and long-term capital planning and for adjustments to correctional programming and population management strategies. CSC has developed a multi-faceted accommodation strategy to address the increase in the offender population that includes extending and increasing temporary accommodation measures as well as constructing new units within existing institutions. This will result in more than 2,700 additional spaces in federal correctional institutions across Canada.

Over the last decade, CSC has been facing numerous challenges stemming from a more complex and diverse offender population profile, resulting in new pressures on CSC and its operations. Aboriginal offenders continue to be disproportionately represented and generally assessed as higher risk and higher need. Overall, offenders now have more extensive histories of violence and CSC is managing more offenders associated with gangs and organized crime and offenders with Long Term Supervision Orders. CSC has witnessed an increase in the proportion of male offenders and female offenders identified with mental health problems at admission. CSC is striving to improve both the level of care and the correctional results for offenders with mental disorders by implementing its comprehensive Mental Health Strategy. The Strategy works to address offenders' mental health care needs at all stages of incarceration, from intake to transitional care for offenders being released into the community.

Offenders also continue to exhibit a high prevalence of substance abuse problems and infectious diseases. In addition, as the offender population ages, the prevalence of health problems increases resulting in increased pressure on CSC health care systems.

CSC's priorities and objectives are focused on the protection of the public and the safety of staff and offenders. In response to the challenging offender profile, and to contribute to public safety, CSC will continue to focus on its priorities, further enhance Transformation initiatives and foster productive relationships with stakeholders, partners and the Office of the Correctional Investigator.

ACCESS TO MENTAL HEALTH SERVICES

Recommendation #1:

I recommend that the Service pursue alternative mental health service delivery arrangements and agreements with the provinces and territories consistent with the 'Assessment Framework for Alternative Service Delivery' as well as the Standing Committee's report on 'Mental Health and Drug and Alcohol Addiction in the Federal Correctional System.'

CSC continues to pursue alternative mental health service delivery arrangements and agreements with the provinces and territories where appropriate and cost effective. CSC has existing arrangements that have led to enhanced partnerships with other jurisdictions. For instance, CSC recently engaged with a community psychiatric facility that is currently providing services for a federal offender. In addition, the introduction of Grand Rounds at a CSC regional treatment centre is another way in which CSC currently engages community partners. Grand Rounds is a forum usually held every 4-6 months, for health care professionals in which a speaker, typically a subject matter expert, will do a case study presentation or topic presentation to aid with the development and learning for the health care professionals attending. This is followed by a Question and Answer session. Also, CSC has had a lengthy working relationship with Institut Philippe-Pinel in Montreal.

When crises arise in institutions, CSC uses local hospitals and/or local psychiatric facilities for short term interventions. These transfers are carried out in accordance with the applicable legislation, e.g. pursuant to consent to treatment legislation or the applicable mental health act however, CSC recognizes the need for more established links to external specialized mental health services and continues to pursue these partnerships.

CSC is currently reviewing existing partnerships for mental health service delivery with a view of determining feasibility of replicating similar partnerships in other regions. It is anticipated this review will be completed in December 2011.

Recommendation #2:

I recommend that the Service implement the Management Action Plan to address compliance and performance deficiencies identified in the January 2011 internal audit of the Regional Treatment Centres and the Regional Psychiatric Centre in FY 2011-12, and provide an update prior to March 31, 2012.

Through its internal audit processes, CSC continually looks for opportunities to enhance efficiencies and effectiveness with respect to the services it provides to offenders.

CSC is currently implementing actions identified in the Management Action Plan from the internal audit of the Regional Treatment Centres and the Regional Psychiatric Centre (2011).

The Audit and Management Action Plan (http://www.csc-scc.gc.ca/text/pa/adt-rtc-rpc-378-1-252/adt-rtc-rpc-378-1-252-eng.shtml) documents were made publicly available in April 2011. An updated response will be available prior to March 31, 2012

Recommendation 3:

I recommend that all placements in physical restraints for health care purposes, effective immediately and without exception, should be considered a 'reportable' use of force. Staff who may be called upon to apply Pinel restraints should receive training with respect to the reporting, monitoring and safe use of this type of restraint.

CSC's National Training Standards already includes the training of staff on the application of the Pinel restraints. This training is compulsory to meet organizational priorities including the requirements of Commissioner Directives 567 (*Management of Security Incidents*); 567-1 (*Use of Force*); 844 (*Use of Restraint Equipment for Health Purposes*) and to meet our legislated mandate pursuant to *Corrections and Conditional Release Act* (CCRA) and *Corrections and Conditional Release Regulations* (CCRR). At the completion of the training the individual will successfully demonstrate proficiency in the practical application and the theoretical knowledge of law and policy that are required to be qualified in the physical application of the Pinel soft restraint system.

While we do not support the recommendation for all placements in Pinel restraints to be considered a reportable use of force the newly revised CD 843 (*Prevention, Management and Response to Suicide and Self-Injuries*) clearly defines the conditions, circumstances and processes for those cases in which it is to be considered a reportable use of force. This policy will be promulgated in the near future and CSC will review a sample of occurrences of the use of physical restraints for health care purposes with the external Health Care Advisory Committee in the coming year.

Recommendation 4:

I recommend that the Service's Health Care Advisory Committee be engaged to explore models for enhanced oversight and accountability of clinical treatment practices and guidelines for managing self-injury in prisons, inclusive of patient advocacy, use of physical restraints, involuntary treatment and informed consent in a correctional setting.

CSC will consult with the Health Care Advisory Committee in the coming year to assess and identify models for enhanced oversight and accountability of clinical treatment practices and guidelines for managing self-injurious behaviour in federal penitentiaries.

Recommendation 5:

I recommend, pending the development and evaluation of a proven treatment program at the Complex Needs/ Unit pilot and permanent funding for its ongoing operation that the most serious, chronic and complex cases of self-injury in CSC custody be reviewed for immediate transfer to provincial mental health care treatment facilities.

CSC is committed to providing appropriate essential mental health services within professionally accepted standards and applicable legislation. Individual assessments will be conducted on those offenders who have been identified as the most chronic and complex cases of self-injury to provide assurances that appropriate treatment options are in place and if required, cases will be assessed as to whether a placement in a provincial mental health facility is possible.

In addition, the Health Care Advisory Committee is scheduled to visit various Pacific sites in September 2011, including the Complex Needs Unit/Program. CSC will seek feedback from this advisory committee, as appropriate.

PHYSICAL HEALTH CARE – SPECIAL FOCUS ON ELDERLY OFFENDERS

Recommendation 6:

I recommend that the Service develop a more appropriate range of programming and activities tailored to the older offender, including physical fitness and exercise regimes, as well as other interventions that are responsive to the unique mobility, learning, assistive and independent living needs of the elderly inmate.

Upon admission, all older offenders and those with self care needs undergo a functional assessment, which measures their ability to perform daily living activities. Results of this assessment influence further health related consultations as well as special needs for accommodation and services. Throughout the inmate's sentence he/she is assessed in terms of their ability to function in their environment.

In addition to the above, CSC is currently conducting research on male and female older offenders that will help inform future strategies and initiatives.

Recommendation 7:

I recommend where necessary, CSC hire more staff with training and experience in palliative care and gerontology. Sensitivity and awareness training regarding issues affecting older offenders should be added to the training and refresher curriculums of both new and experienced staff.

In 2009, CSC updated the national Hospice Palliative Care (HPC) Guidelines to provide direction and tools necessary for a consistent approach to the provision of care to terminally ill inmates within CSC. Consistent with professional practice standards, CSC uses a patient- and family-centred HPC approach that seeks to address the physical, psychological, social, and spiritual needs and expectations of the offender in collaboration with their close relations. The updated guidelines were followed by the development of a pilot Palliative Care Training Module in November 2010 and the launch of the training sessions in March 2011.

Similarly, in November 2010, CSC launched the "Older Offender Training Module" for CSC nurses with the opportunity for other members of the interdisciplinary team to participate. The two day training provides education in a number of areas such as normal aging, diseases associated with aging, performing a comprehensive geriatric assessment, and behaviour issues (bullying, depression, suicide, and delirium).

Recommendation 8:

I recommend where new construction is planned, age-related physical and mental impairments should be part of the infrastructure design, and include plans and space for sufficient number of accessible living arrangements.

The new units that are being constructed include cells and rooms that are accessible. In conjunction with the new units being built, we are also continuously modifying some of our facilities as the needs of the inmate population change.

As part of the development of its Long Term Accommodation Strategy, CSC will continue to take every opportunity to ensure the needs of the inmate population are considered.

Recommendation 9:

I recommend that the Service prepare a national older offender strategy for 2011-12 that includes a geriatric release component as well as enhanced post-release supports.

CSC recognizes that a comprehensive discharge plan that addresses the physical, mental, emotional, social and spiritual needs of individuals, best ensures post-release access to health care and other community services to facilitate continuity of care after a period of incarceration.

CSC will continue to implement the framework that is already in place to ensure appropriate release planning of offenders, including geriatric offenders. As part of the planning process, when indicated, a functional assessment is completed by health care services and identified areas of concern are taken into consideration in the development of an individualized release plan. For example, a functional assessment might suggest the need for a certain type of accommodation.

As well as part of the pre-release decision process, a community strategy is developed that outlines the way in which the various dynamic factors will continue to be addressed in the community, the way in which the offender will be monitored and determines the level of intervention to be applied upon the offender's release to the community. The identification of the offenders' functional needs and required resources are included in the plan.

Continuity of care is directed by health services and institutional/community reintegration policies, discharge planning guidelines for both physical and mental health needs, and affiliated official forms to be completed for all types of transfers and a release to the community. CSC Regional Discharge Planners continue to develop a network of community resources through education, networking, and partnerships.

DEATHS IN CUSTODY

Recommendation 10:

I recommend that CSC make its performance strategy for preventing deaths in custody public and annually report against clear performance indicators, as per the Office's recommendations contained in the Quarterly Reporting exercise.

CSC is moving in this direction, the first report for the period of April-September, 2010 of the Offender Deaths in Custody Performance Measurement Strategy – April, 2010 to April, 2015 is being finalised and will be shared with the Office of the Correctional Investigator and made publicly available by October, 2011.

Recommendation 11:

I recommend that CSC make its response to the reports of the Verification Team and the Independent Review Committee public, and provide annual updates on progress made against recommendations.

The Corrective Measures and Management Action Plan (CMMAP) for the Verification Team Report and the Independent Review Committee (IRC) are being finalized and will be submitted to the Executive Committee in September 2011 for approval. Once approved by the Executive Committee, appropriate steps will be taken to publish the IRC final report and the CMMAP on CSC internal and external websites and updated twice a year in order to reflect progress made against recommendations in the reports.

Recommendation 12:

Pursuant to section 180 of the CCRA, I recommend that the Minister of Public Safety direct the Service to immediately suspend the Mortality Review exercise until such time as the Guidelines can be independently and expertly validated to meet requirements of the legislation. In the interests of transparency and accountability, the results of this review should be made public.

The Mortality Review Process offers a systematic and comprehensive approach to reviewing natural in-custody deaths. As part of the Mortality Review Process we regularly consult with Coroners. In August 2010, CSC presented an overview of the Mortality Review Process at the Annual Meeting of Coroners/Medical Examiners. In general, our process for reviewing death by natural causes was well received and they offered some helpful suggestions for improvements.

CSC will continue to actively liaise with coroners and seek their input as we review natural in-custody deaths.

Consistent with our built in accountability measures, the Mortality Review Summaries and file closures will continue to be presented for CSC Executive Committee decision; and periodically a roll-up of key findings will also be prepared for CSC Executive Committee and widely distributed throughout the organization as a way of sharing the results of the process, demonstrating transparency and providing information that CSC can use to improve or modify practices. In addition, we plan to seek the input of Health Care Advisory Committee on the process.

Recommendation 13:

Until the Mortality Review Process is validated, I recommend that an external medical doctor review all natural in-custody deaths and independently report his/her findings and recommendations to the Commissioner of Corrections.

The Mortality Review Process offers a systematic and comprehensive approach to reviewing natural in-custody deaths. For example, in August 2010 CSC we presented an overview of the Mortality Review Process at the annual meeting of Coroners/Medical Examiners. In general, our process for reviewing death by natural causes was well received and they offered some helpful suggestions for improvements.

In addition, we plan to seek the input of the external Health Care Advisory Committee on our process. As part of the built in accountability measures, the mortality review summaries and file closures will continue to be presented to CSC Executive Committee; and periodically a roll-up of key findings will also be prepared for CSC Executive Committee and widely distributed throughout the organization as a way of sharing the results of the process, demonstrating transparency and providing information that CSC can use to improve or modify practices.

Recommendation 14:

I recommend that the Service's practices and procedures for preparing terminally ill offenders for 'release by exception' consideration be independently reviewed to ensure CSC standards are being met and that cases are being prepared with appropriate diligence, rigour and timeliness.

The Mortality Review Process reports on the inmate's eligibility for Parole by Exception and records the reason why he or she may not have been considered or released under this authority. Management within CSC worked closely to ensure that there was sound case management in the review of each case. In any instances where it would be determined that from a case management perspective could have been accomplished, this continues to be the appropriate venue for it to be raised.

In terms of care provided, in 2009, as noted earlier, CSC updated the national Hospice Palliative Care (HPC) Guidelines to provide direction and tools necessary for a consistent approach for the provision of care of terminally ill inmates within CSC. Consistent with professional practice standards, CSC uses a patient- and family-centred HPC approach that seeks to address the physical, psychological, social, and spiritual needs and expectations of the offender in collaboration with their close relations.

In cases where inmates are not eligible, are not supported or are denied Parole by Exception by the Parole Board of Canada, CSC ensures that there are measures taken, although taking into consideration any operational requirements, to help the offender and their close relations in the final stages of the inmate's life. For example, CSC may accommodate special visits, more possibilities for telephone calls, etc.).

CONDITIONS OF CONFINEMENT

Recommendation 15:

I recommend that the revised Commissioner's Directive on Inmate Accommodation contain:

i. **An explicit and express prohibition against double-bunking in all segregation, segregation-like settings and the Secure Units for women.**

   Double-bunking in the secure unit or administrative segregation will only be used as an option of last resort when all other alternatives have been exhausted. CSC reviews its policies to ensure institutional heads clearly understand that double-bunking in those areas are a last resort.

ii. **Specific instruction that double-bunking assignments must be signed and approved by the Warden and reviewed by regional authorities on a quarterly basis.**

   CSC will review its processes for approving and monitoring double-bunking assignments and issue a new protocol by October 2011.

iii. **Exemptions to use non-purpose built space for inmate accommodation on a temporary or emergency basis must be approved by the Commissioner of Corrections and include a plan to return the space to its intended use within a defined time-frame.**

   Exemptions to use non-purpose built space for inmate accommodation on a temporary or emergency basis will continue to be the responsibility of the Regional Deputy Commissioner and they will report all occurrences to the Commissioner of Corrections on a weekly basis. The Regional Deputy Commissioners will be required to identify a plan to return such space to its intended purposes as soon as practical.

Recommendation 16:

I recommend that the Service audit compliance with its legal obligation to ensure that mental health considerations are taken into account – and documented – in a decision to initiate or maintain segregation placements.

At present, CSC is already monitoring this process through the National Audit Tool conducted yearly on segregation issues by National Headquarters. In addition to this ongoing practice, for the next 12 months, CSC (National Headquarters) will conduct a random review of segregation placements and maintenance of placements and report these results to the Commissioner of Corrections on a quarterly basis. At the end of the 12 months, the practice of quarterly reviews will be re-considered by CSC's Executive Committee.

Recommendation 17:

I recommend CSC implement recommendations contained in the 'Report of External Review of Correctional Service of Canada Offender Complaints and Grievance Process' and move forward immediately with the introduction of Grievance Coordinators and Mediators at all medium, maximum and multi-level institutions.

Alternative Dispute Resolution (ADR) has been identified in the Offender Redress External Review as an important means to reduce the number of complaints and grievances at the institutional level who deal with 79% of complaints and grievances yearly. CSC's has initiated a pilot project that will occur in one maximum and one medium security institution in each of the five regions. The project will be launched in September 2011 for an 18 month period.

ACCESS TO PROGRAMS

Recommendation 18:

I recommended that the ICPM pilot be independently reviewed and expertly evaluated in the next fiscal year on the basis of clear performance and outcome indicators and that the results of this review should be shared with Parole Board Canada and made public. Aboriginal specific programming should be maintained until the evaluation is complete.

A study on ICPM's efficiency has been drafted by CSC and the study on ICPM's effectiveness will be conducted with results expected in fiscal year 2012-2013. CSC will also proceed with an independent external research study on ICPM. In addition, correctional programs are scheduled to be evaluated in accordance with CSC's Five-Year Evaluation Plan. The evaluation will be shared with the public, Parole Board of Canada, the Office of the Correctional Investigator and other key stakeholders.

The ICPM includes a specific culturally relevant stream for Aboriginal Offenders to ensure the Continuum of Care Strategy for Aboriginal Offenders is fully incorporated. The Aboriginal ICPM is anchored in Aboriginal culture and has a repertoire of skills within its content. As with the other streams of the ICPM, the Aboriginal program is designed around the Risk-Needs-Responsivity principles, and conforms to the same standards as the other ICPM streams. As with the other streams, there is an intake Primer, High, Moderate, Institutional Program Maintenance and Community Program Maintenance, all of which are Aboriginal specific.

In addition, the Aboriginal ICPM is facilitated by an Aboriginal Correctional Program Officer (ACPO) and assisted by an Elder with reference to specific session deliveries as well as lead by an Elder for ceremonies and spiritual components. The Program Elder is also called upon to assist within the Motivational Module intervention strategy when an Aboriginal offender drops out of a program, refuses to participate in the program or requires assistance with program content to gain a further understanding of correct interpretation and implementation of program content and skills.

Therefore, programming for Aboriginal offenders will be maintained as part of the Aboriginal ICPM and is part of the pilot and therefore, will be part of the evaluation.

ABORIGINAL ISSUES

Recommendation 19:

I recommend CSC undertake an operational review of Aboriginal offender's access to spirituality and ceremonies at all security designations to ensure practices at the institutional level are consistently supported and developed to the extent that policy and the law require.

CSC will carry out a review to ensure institutional Aboriginal offenders have access to spirituality and ceremony in a manner that is consistent with national policy.

The Strategic Plan for Aboriginal Corrections (SPAC) is undergoing a comprehensive evaluation. Given the SPAC is based on the continuum of care, which is centered on spirituality and culture, CSC should receive recommendations related to any gap in offender accessibility.

CSC is currently conducting a comprehensive review of all the standing orders related to Commissioner's Directive (CD) *259–Exposure to Second-Hand Smoke* to ensure the appropriate accommodation of Aboriginal spiritual practices at each institution. This review should be completed by September 2011. Where standing orders exist relating to CD-702, *Aboriginal Offenders* the review will begin in September 2011.

Regions will be asked to provide a site by site review of the availability of Elders, spiritual services, and other relevant information related to spirituality.

CSC is in the process of expanding its Pathways Initiative, from seven sites to up to 25 sites. These sites are currently undergoing a review and approval process to be completed in March 2012. All information with the exception of the SPAC evaluation will be available by April 2012.

FEDERALLY SENTENCED WOMEN

Recommendation 20:

I recommend that the Service aggressively implement a range of population management measures at the regional women's facilities that are consistent with Creating Choices and reflect the least restrictive principle enunciated in the CCRA.

CSC has developed a population management strategy for women offender institutions that considers the unique needs of federally sentenced women and is consistent with the principles of Creating Choices and the CCRA.

The long-term measure to address additional forecasted population pressures is an increase of 144 beds at women offender facilities over the next two fiscal years.

In the interim, short- and mid-term options include:

- Maximizing current capacity through double bunking in the Secure Unit;
- Facilitating voluntary transfers to other regions;
- Amending the Section 81 agreement with Native Counselling Services of Alberta to include up to 16 beds for women;
- Exploring innovative Exchange of Services Agreements with provinces to identify the possibility of additional beds for women offenders.
- Examining the possibility of using temporary accommodations such as portable units/trailers at some sites;

- Exploring opportunities for additional mental health beds for women;
- Emphasising timely and effective case management planning and preparation for security reclassification and parole board reviews at the earliest opportunity for eligible offenders;
- Augmenting staffing levels in key areas (i.e. Social Workers, Correctional Program Officers, Employment Counsellors) to promote timely and effective interventions; and
- The use of non-purpose built space to accommodate women offenders occurs on a case by case basis and only when no other reasonable options are immediately available. In these instances, the privacy and dignity of the women is a primary consideration.

Recommendation 21:

I recommend that the Service explore additional partnerships and agreements with the provinces and territories to allow for the transfer of severely mentally ill women offenders to specialized treatment facilities.

CSC continues to pursue additional partnerships and agreements with the provinces and territories where appropriate and cost effective. CSC has existing arrangements that have led to enhanced partnerships with other jurisdictions. For instance, CSC recently engaged with a community psychiatric facility that is currently providing services for a federal woman offender. In addition, the introduction of Grand Rounds at a regional treatment centre is another way in which CSC engages with community partners. Grand Rounds is a forum usually held every 4-6 months, for health care professionals in which a speaker, typically a subject matter expert, will do a case study presentation or topic presentation to aid with the development and learning for the health care professionals attending. This is followed by a Question and Answer session. Also, CSC has had a lengthy working relationship with Institut Philippe-Pinel in Montreal.

When crises arise in institutions, CSC uses local hospitals and/or local psychiatric facilities for short term interventions. These transfers are carried out in accordance with the applicable legislation, e.g. pursuant to consent to treatment legislation or the applicable mental health act; however, CSC recognizes the need for more established links to external specialized mental health services and continues to pursue these partnerships.

CSC is currently reviewing existing partnerships for mental health service delivery with a view of determining feasibility of replicating similar partnerships in other regions. It is anticipated this review will be completed in December 2011.