REPORT ON THE CIRCUMSTANCES SURROUNDING THE DEATH OF A FEDERAL INMATE

A FAILURE TO RESPOND

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The name of the deceased has been removed from this Report out of respect for the family and in consideration of Privacy legislation.

1. INTRODUCTION

1. The subject was a 52-year-old First Nations offender who, at the time of his death, was housed on the Pathways Aboriginal Program Unit at a medium-security federal institution. In the early hours of Tuesday, October 3, 2006, the subject self-inflicted a wound to his left arm which resulted in the laceration of his brachial artery. At 0237 hours, he pressed his cell emergency button which prompted the Correctional Officer on duty on the Unit to attend his cell and to call for additional staff assistance. By the time paramedics arrived, at approximately 0310 hours – 33 minutes after he pressed his cell emergency button – they found the subject alone, unconscious on the floor of his cell, with evidence of blood soaked into the mattress and not breathing. The paramedics initiated Cardio Pulmonary Resuscitation (CPR). They attempted to revive him with the use of defibrillator equipment, and continued to attempt to revive the subject while he was being transported, in leg irons, to an outside hospital. He was declared dead at 0413 hours.

2. The internal investigations conducted by the Correctional Service of Canada (CSC) concluded that the CSC staff who attended to this medical emergency failed to respond adequately as per policy, and did little to attempt to save the subject's life during the 33-minute period, except to call for an ambulance 10 minutes after the cell emergency button was pressed.

3. As a result of the violations of CSC's *Standards of Professional Conduct* and *Code of Discipline* that were identified in a Fact Finding Investigation, four CSC employees directly involved in the incident received disciplinary sanctions. These sanctions were based on the conclusion that the CSC employees had negligently performed their duties. While circumstances differ from case to case, the key elements were that CSC employees failed to administer first-aid and failed to action any attempts to preserve human life. The sanctions ranged from ten- (10) to twenty- (20) day suspensions without pay.

4. In the immediate aftermath of the subject's death, the CSC issued an internal Situation Report (SITREP) on October 3, 2006, advising middle and senior managers across the country of the death. A public News Release was also issued by the Correctional Service on the day of the incident. The SITREP stated that staff immediately attended the cell after the cell call emergency button had been pushed and found the subject bleeding from both arms. It was further stated that an ambulance was called and the inmate became unconscious when being placed into the ambulance. The News Release stated that after he pushed his cell alarm, he was discovered with a "potentially life-threatening injury" and an ambulance was called "immediately". The information contained in both the initial SITREP and the News Release was inaccurate. Subsequent internal reports prepared following the incident provided a more detailed and accurate account.

5. On October 6, 2006, the Warden convened a Fact Finding Investigation into this death to examine "the adequacy of the staff response". A report was completed on October 27, 2006.

6. On December 6, 2006, the Commissioner of Corrections convened a National Board of Investigation (NBOI) as required by Section 19 of the *Corrections and Conditional Release Act* (*CCRA*). A report was completed on February 16, 2007.

7. On April 24, 2007, more than five months after the subject's death, the Office of the Correctional Investigator (OCI) received a copy of the NBOI Report. Subsequently, on August 29, 2007, the OCI received copies of the National Headquarters' (NHQ) summary documents that were prepared for review by the Correctional Service's Senior Management Committee (EXCOM) at its meeting in September 2007.

8. Based on a review of the above documentation related to the CSC's NBOI into the subject's death, the OCI identified the following three significant areas of concern:

1. Staff's response to a medical emergency.
2. Serious allegations of discrimination.
3. Delays in the investigative process.

9. On September 22, 2007, the OCI initiated an investigation pursuant to s.170 of the *Corrections and Conditional Release Act* (*CCRA*) to assess the Correctional Service's responsiveness to these areas of concern. The purpose of this investigation was not to re-do the CSC's investigations or disciplinary process, but rather to review issues of concern and seek clarification where needed. The Investigation Team reviewed the following documents:

- CSC Report by the National Board of Investigation (NBOI) convened December 6, 2006, and its Report dated February 16, 2007.
- NHQ summary documentation presented to EXCOM on September 5, 2007.
- EXCOM closure memo dated September 12, 2007, detailing actions outstanding.
- NBOI Investigators' interview notes and briefing material.
- Fact Finding Investigation convened October 6, 2006 and its Report dated October 27, 2006 (inclusive of subsequent corrective actions received at OCI November 13, 2007).

10. For clarification, the Investigation Team found it necessary to conduct interviews with members of the NBOI and selected CSC employees, including:

- Warden of the medium-security institution.
- Regional Administrator – Aboriginal Initiatives, Regional Headquarters (RHQ).
- Regional Administrator – Security, RHQ.
- Assistant Deputy Commissioner – Institutional Operations, RHQ.
- Regional Analyst – Incident Investigations Branch, RHQ.
- Coordinator – Pathways Program, medium-security institution.
- Aboriginal Elder.
- Correctional Officer – medium-security institution.
- A/Aboriginal Liaison Officer – medium-security institution.
- Director General, Incident Investigations Branch, NHQ.

In accordance with the OCI's duty to act fairly, the CSC was provided an opportunity to comment on a draft copy of this Report and was notified of its pending public release.

2. BACKGROUND INFORMATION ON THE DECEASED

11. In 1974, at the age of twenty, the subject was sentenced to 28 months – his first federal sentence. While serving that sentence, he received an additional 10-year sentence which expired in 1987. In February 2000, he was convicted of manslaughter and sentenced to seventeen (17) years in federal custody. He was serving this sentence when he died on October 3, 2006.

12. In March 2000, the subject was admitted to a federal Assessment Unit, where the Correctional Service identified his criminogenic factors, which included severe alcohol abuse, and poor impulse control. At the Assessment Unit, he was referred to the Psychology Department because of his history of alcoholism, depression and three prior suicide attempts – one of which (the most recent) was in the community following his manslaughter offence in 1999. He was transferred to a medium-security institution on June 6, 2000, to serve his seventeen-year sentence. He had no contact with the Psychology Department at the institution but did meet, every three to four months, with the Institutional Psychiatrist. He was involved in the Native Brotherhood and Aboriginal cultural activities, and had ongoing contact with the institutional Elder. He was assessed by the institution as presenting no particular security concern.

13. The NBOI noted from their interview with the Elder that the subject recently began to disclose his experiences in Residential Schools. The Elder confirmed to the OCI Investigation Team that the subject was pro-active in searching out opportunities to discuss these experiences.

3. ANALYSIS

14. The OCI Investigation Team, as previously noted, identified three significant areas of concern: (1) Staff response to the medical emergency of October 3, 2006. (2) Serious allegations of discrimination. (3) Delays in the investigative process.

3.1 The Staff Response to the Medical Emergency of October 3, 2006

3.1.1 Applicable Policy

15. The relevant policy that governs staff responses to medical emergencies is detailed in the Service's *Security Manual* and *Commissioner's Directive 567* on Management of Security Incidents. The *Security Manual - Part II - Contingency Planning and Emergency Response Guidelines* defines a "crisis" in the following manner:

> *11. An emergency has the potential to:*
>
> *a) Endanger the public, inmates or staff.*
> *b) Damage or destroy public property.*

c) Affect the public image of the CSC, and thus the image of the Government of Canada.

12. Such events can result from natural or human causes. They may affect a single individual or cause complete and uncontrolled disruption of Service operations. Invariably, they have the potential for disastrous consequences.

13. The terms "crisis", "emergency" and "incident" are used interchangeably in these guidelines.

16. Paragraph 18 of *Commissioner's Directive 567*, on the Management of Security Incidents, states:

18. In responding to a medical emergency, the primary goal is the preservation of life, and each staff member has an important role to play:

a. Non-health services staff, arriving on the scene of a possible medical emergency, must immediately call for assistance, secure the area, and initiate CPR/first-aid without delay.

b. Responding non-health services staff must attempt CPR/first-aid where physically feasible; even in cases where signs of life are not apparent (the decision to discontinue CPR/first-aid can be taken only by authorized health personnel or the ambulance service in accordance with provincial laws).

17. There were two internal reviews relating to how CSC staff members responded to the medical emergency: 1) The Fact Finding Investigation convened by the Warden on October 6, 2006, and 2) The NBOI convened by the Commissioner on December 6, 2006.

3.1.2 The Institutional Fact Finding Investigation

18. The Fact Finding Investigation reached a number of conclusions on the adequacy of the staff response to the medical emergency, including:

- CSC employees responding to the cell alarm from the subject's cell failed to enter into any dialogue with him over the course of the intervention – other than the initial question as to how he was doing.

- There was no follow-up by staff after he showed them his arms.

- CSC employees failed to check for wounds until approximately 10 minutes after he had passed out on the floor.

- The evidence showed that the responding CSC employees failed to administer, or have any discussion, regarding first-aid in the 30 minutes prior to the arrival of the ambulance.

- The responding CSC employees left the subject alone, locked in his cell, and unattended, for large portions of this 30-minute period.

19. The Fact Finding Report also made concluding observations related to the staff's reporting of their interventions:

- There was inconsistency in the CSC employees' reports, both written and verbal, regarding the amount of blood observed and when it was observed.

- CSC employees were aware of the blood loss 10 minutes earlier than they initially reported.

- The initial written reports by two CSC employees varied significantly from their subsequent submissions to the Fact Finding Board with respect to their belief that the subject had been under the influence (alcohol).

- The Fact Finding Board concluded that there was no reason to believe that he was intoxicated.

- A toxicology report subsequently confirmed that the subject was not under the influence of drugs or alcohol on the night he died.

- That the second Correctional Supervisor on duty was never advised that the subject had been left locked in his cell and unattended.

- With respect to the application of the leg irons, the ambulance attendant was able to confirm that they were not applied until after their arrival, contrary to what some staff had initially reported.

20. The Fact Finding Report concluded that there were serious concerns respecting staff performance. Staff failed to respond in a manner that might have preserved life, and staff subsequently changed their recollection of the events surrounding the death. The Fact Finding Report was not part of the documentation presented to EXCOM in September 2007 for its review of the circumstances associated with the subject's death, although we are advised that the Regional Deputy Commissioner did provide an oral briefing. The CSC did not share the Fact Finding Report, or its conclusions, with the investigating Police Officer. The Police did not request the Report or its conclusions. It is the Service's practice to not share this information with Police unless a subpoena or production order is issued.

3.1.3 The National Board of Investigation (NBOI)

21. Consistent with current policy and practice, the National Board of Investigation (NBOI) looked at this death from a broader context than the Fact Finding Investigation. The NBOI examined the mental health at the time of, and just prior to, the subject's death, the institutional placement decisions in the days prior to his death, the staff response to the incident, Aboriginal programming issues, and the allegations from offenders and staff that discrimination may have played a role in his death.

22. With respect to the issue of the CSC employees' response to the medical emergency, the NBOI reported many of the same response failures as those identified in the institutional Fact Finding Report, including:

- Leaving the subject alone, unattended and locked in his cell.
- The failure of staff to have checked for the wound sooner.
- The failure to initiate first-aid.

23. The NBOI received a copy of the Fact Finding Report at the commencement of its investigation. However, the NBOI Report did not include any reference to the Fact Finding Report or its conclusions. The NBOI Report made no recommendations related to the staff's failure to respond appropriately to a medical emergency.

24. The Incident Investigations Branch at NHQ advised that it does not want Boards of Investigations to enter into any investigation being "unnecessarily tunnelled" on how they will look at a particular incident – hence the practice not to look at Fact Finding information until the "core investigations" are completed. Once the BOI's core investigations are completed, the Branch suggests that BOIs can then take into consideration other information that might be available, including Fact Finding conclusions. However, it also stresses that it does not believe that Fact Finding Report information and conclusions should normally be presented in an NBOI Report. While this is the known practice, the Branch also indicated that there is currently no policy or training on how BOIs are to manage the information from Fact Finding investigations.

25. With regard to the conclusions reached by the NBOI, some institutional staff indicated to the OCI Investigation Team that the issue of CSC employees' accountability did not receive the attention that they felt was warranted, given the circumstances surrounding the death. It was further indicated that the NBOI Report did not fully present the "severity" of the incident and that the Report's content was not strong enough to effectively deal with the issue of people not doing their jobs.

26. The Correctional Service's investigative process requires the NBOI to provide briefings to senior managers at three levels of the organization (institutional, regional and national) regarding their initial findings and concerns. In interviews with the NBOI members, the OCI Investigation Team asked whether there had been any concerns raised relating to the NBOI findings and recommendations. The OCI Investigative Team was advised that, at the debriefing at RHQ, the question had indeed been raised as to why the NBOI had not dealt more strongly with the identified staff failures.

27. Neither the NBOI nor the NHQ Investigation Branch prepared formal summaries of these debriefings. The OCI Investigation Team is concerned about the absence of any formal documentation relating to these debriefings – important steps in the investigative process.

28. The Correctional Service provided the Police with a copy of the NBOI Final Report in July, 2007 – nine months after the subject's death and five months after the completion of the NBOI Report.

3.1.4 Conclusion

29. While both investigative Reports identify failures respecting the employees' responses to the medical emergency, the tone and details of the two Reports are strikingly different. On one hand, the Fact Finding Report clearly described the seriousness of staff failure to respond to the medical emergency. On the other hand, the NBOI simply presented the issues as points of information, devoid of specific findings or recommendations. One might expect these differences given the different purposes for the Reports. While NBOI Reports must be impartial, the OCI Investigation Team concludes that the current national approach taken has resulted in the EXCOM not receiving, through the NBOI Report, the benefit of important information for its review and consideration of corrective action.

30. The OCI Investigation Team has serious concerns regarding the practice of the NBOI Reports not making reference to Fact Finding information and conclusions. The OCI Investigation Team appreciates the wisdom of not wanting the NBOIs to become "tunnelled" from the onset of their investigations. However, by not incorporating information from the other investigative processes in the NBOI Reports, the Correctional Service has, in effect, established self-imposed restrictions on the NBOIs' ability to present all relevant information in its final Reports. Such restrictions create the potential that important information fails to be shared with the most senior levels of the Correctional Service.

31. The Tassé Report[1] of July 2004, into a death in custody, recommended the implementation of a protocol to assist the Service in evaluating the management of medical emergencies. The Correctional Service's initial response in 2004 was that a protocol similar to its existing review process for use of force incidents would be established. A key element within that process, which has assisted the Correctional Service in the development of a more effective use of force review, is the policy requirement that incidents be videotaped. The Correctional Service, while implementing some policy changes, has yet to introduce a requirement to videotape responses to medical emergencies.

3.2 Allegations of Discrimination

32. Allegations were presented to the NBOI, by both offenders and staff, that the subject's race played a role in the failure of staff to reasonably respond to this medical emergency. Members of the NBOI also indicated to the OCI Investigation Team that the existence of allegations of discrimination made by offenders was raised by the Warden, without comment on their merits, at the onset of the NBOI's investigation. The information provided within the NBOI Report on this matter is limited.

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[1] Mr. Guimond died on October 18, 2002, in a segregation cell while under direct observation of staff with little or no attempt made to save his life. Following representation from the Correctional Investigator concerning the inadequacy of the Correctional Service's investigation and follow up related to this incident, the Correctional Service convened an Independent Investigation. The Chair was Mr. R. Tassé, former Deputy Minister of Justice.

33. The NBOI's Report states:

> "At the time of the investigation, the Board noted that Aboriginal inmates and some Aboriginal staff at the institution continue to be seriously concerned about the implications of this incident. They feel that the inmate was not helped because he was First Nations and see it as an example of racism and discrimination."
>
> "The Board did not ask the responding staff if the inmate's race made a difference in their response, as it did not feel such a line of enquiry would be fruitful. It does feel that the lack of first-aid is serious in and unto itself, and that the observations and conclusions of the Aboriginal staff and inmates are equally serious and require attention at the institutional level. Assistance from regional and national headquarters should be offered to the institution in dealing with this issue." (p. 43)

34. There is no evidence that the Correctional Service's senior management, as a result of briefings or reviews of the Board's Report, have taken any action to address the specifics of the allegations raised.

35. The NBOI's Report provided forty (40) findings as a result of its investigation, of which only one touches on the issue of discrimination: "Aboriginal inmates and some Aboriginal staff at the institution continue to be seriously concerned about implications of this incident for the development and maintenance of respect and recognition of diversity."

36. The NBOI was advised by CSC officials at RHQ during the course of its investigation that an Aboriginal awareness staff training program was under development. The NBOI noted in its Report that, due to resource limitations, the training program "is not currently planned to be part of CSC's national training standards, although individual regions or institutions could deliver the program on a mandatory basis if resources could be found. As long as such training programs are not included in CSC's national training standards, there is little incentive to deliver or attend them. In order to begin to reach what is likely a small number of staff who are resistant to change in this area, this training needs to be mandatory."

37. The NBOI Report recommended:

> "The Service should implement an aboriginal awareness/sensitivity program currently in development at the national level as mandatory training for all staff in the [ ] Region working in direct contact with offenders." (p. 58)

38. This is the only recommendation related to the allegation that the subject's race played a role in the failure of staff to reasonably respond or the concerns identified, by the NBOI, in its above-noted Finding. The training program, eighteen months after the subject's death, has yet to be finalized and implemented.

39. While there was general support for the introduction of such a training program amongst those interviewed by the OCI Investigation Team, a number of individuals clearly

indicated, given the seriousness of the allegations, that the NBOI's recommendation fell well short of addressing the issue, even if it had been implemented.

40. The individual members of the NBOI, in interviews with the OCI Investigation Team, acknowledged that the allegations of discrimination were serious and required attention. In the end, the NBOI opted to report the allegations and recommend staff training with the expectation that the Correctional Service's senior managers would address the issue.

41. CSC's existing policy does not provide much guidance on how best to address allegations of discrimination against offenders raised by either CSC employees or by offenders (without filing a formal grievance). *Commissioner's Directive 081 – Offender Complaints and Grievances* provides detailed direction on the management of formal offender complaints regarding discrimination. There is, however, no similar policy directly relating to how CSC management is to address allegations of discrimination against offenders when those allegations originate with CSC staff members or when they are raised during the course of an investigation.

42. Sections 7 and 8 of *Commissioner's Directive 060 – Code of Conduct* – identify expectations regarding staff relations with both offenders and other staff. It does not, however, provide clear and detailed expectations on how allegations are to be managed.

> *7.* Relationships with other staff members must promote mutual respect within the Correctional Service of Canada and improve the quality of service. Staff is expected to contribute to a safe, healthy and secure work environment, free of harassment and discrimination.
>
> *8.* Staff must actively encourage and assist offenders to become law abiding citizens. This includes establishing constructive relationships with offenders to encourage their successful reintegration into the community. Relationships shall demonstrate honesty, fairness and integrity. Staff shall promote a safe and secure workplace and respect an offender's cultural, racial, religious and ethnic background, and his or her civil and legal rights. Staff shall avoid conflicts of interest with offenders and their families.

3.2.1 Conclusion

43. The NBOI confirmed that it was made aware of the allegations of discrimination from the beginning of its investigation. There is an acknowledgement by the NBOI that at the time of the investigation, Aboriginal inmates and some Aboriginal staff at the institution continued to be seriously concerned about the implications of this incident. Some staff and offenders believed that the subject was not helped because he was a member of a First Nation and they saw this as an example of discrimination.

44. The OCI Investigation Team does not believe that the NBOI review of the allegations and its recommendation to provide an Awareness/Sensitivity Program were sufficient to fully respond to the allegations of discrimination.

45. The OCI Investigation Team concludes that, given the acknowledged seriousness of the allegations brought to the NBOI's attention, the issue of discrimination was not adequately addressed by the Service.

3.3 Delays in the Investigative Process

46. *Commissioner's Directive 041 – Incident Investigations* establishes timeline expectations relating to the stages of CSC's investigative process. The key elements of the timeline relate to convening of the investigation within 25 working days (5 weeks), 55 working days (11 weeks) to complete the actual investigation, 35 working days (7 weeks) to review and distribute the Final Report, and 15 working days (3 weeks) to have the Report reviewed and approval by the CSC senior executive at EXCOM. This represents roughly six months of elapsed time from the date of incident to the review and approval of the BOI Report. Full implementation of identified corrective measures often extends beyond this timeline.

47. Nine weeks elapsed between the day that the subject died and the convening of the NBOI – almost double the timeframe stipulated. The NBOI completed its mandate within the allotted eleven weeks, signing the Report on February 16, 2007. The Report and related submission were, however, only presented to the Correctional Service's EXCOM on September 5, 2007. This was almost a year after the death and five months longer than prescribed in *Commissioner Directive 041*.

48. The noted delays create a number of very real concerns, including the ability of witnesses to recall information about incidents, the undue delay in implementing recommendations calling for corrective action, and the viability of any additional review of the incident.

49. The OCI Investigation Team notes, with concern, that action taken by the Service in response to some recommendations has been excessively delayed. For example, the Awareness/Sensitivity Program recommended by the NBOI has yet to be delivered 18 months after the subject's death.

4. CONCLUSION

50. This death can only be described as tragic. The inmate was a First Nations federal offender in the care and custody of the Correctional Service of Canada (CSC). While in his cell, he self-inflicted a life-threatening wound to his left arm and, subsequently, called for help by pressing his cell emergency button. Help came but fell short of what must be expected from the CSC.

51. The Correctional Service has well defined policies, reinforced by training, that clearly identify responsibilities for responding to such medical emergencies and the duty to preserve life. The CSC employees who responded to this emergency alarm did not follow those policies.

52. The CSC conducted two internal investigations that looked at the response to the subject's call for help. In the final analysis, the first investigative report – the Fact Finding Report – portrayed the failure as a very serious breach of policy with deadly consequences and highlighted a number of contradictory statements from staff involved in this medical emergency. The second investigative report – the NBOI – did not specifically reference the conclusions of the first investigation and, as a result, the EXCOM was not fully informed. It is also our opinion that the disciplinary outcomes do not appear to reasonably coincide with the seriousness of the identified failures, regardless of which of the two Reports one chooses to reference.

53. There were allegations that discrimination may have had an impact on the circumstances of the subject's death. The recommendations of the NBOI do not adequately address this issue. Given their nature and seriousness, the allegations should have been referred to an independent body mandated and trained to investigate the sensitive issue of alleged discrimination.

54. Issues of staff responsiveness to emergency situations are not new for the Correctional Service. In February 2007, the OCI provided a copy of its *Deaths in Custody Study* to the Correctional Service. The *Deaths in Custody Study* examined 82 cases of reported suicides, homicides, and accidental deaths of prisoners while in the custody of the Correctional Service during the five-year period (2001 to 2005). Finding #5, one of the key findings in the *Deaths in Custody Study,* reads as follows:

> "It is likely that some of the deaths in custody could have been averted through improved risk assessments, more vigorous preventative measures, and more competent and timely responses by institutional staff."

55. The *Deaths in Custody Study* identified that in almost two-thirds of the cases reviewed, shortcomings were noted in staff response to medical emergencies.

56. The OCI is seriously concerned about the Correctional Service's rate of progress in addressing the many concerns raised in its *Deaths in Custody Study*. This tragic death is only one of the latest cases where the Correctional Service has not delivered on its mandate to provide safe and secure custody for all federal offenders.

4.1 Findings

57. The OCI Investigation Team made the following key findings:

A. The CSC employees responding to the medical emergency failed to administer first-aid, failed to determine the nature and extent of the wound, failed to remain with the subject for most of the 30 minutes prior to the arrival of the ambulance attendants, failed to respond in a manner that might have preserved life, and, subsequently, inconsistently reported critical information related to the death.

B. In the immediate aftermath of the subject's death, the CSC issued an internal Situation Report (SITREP) and a public News Release. Information contained in both the SITREP and the News Release was inaccurate.

C. As a result of current investigative practice, the NBOI Report did not include any recommendations concerning employee accountability.

D. The Fact Finding Report clearly described the seriousness of the employees' failure to respond to the medical emergency, whereas the NBOI simply presented the issues as points of information, devoid of specific findings or recommendations.

E. The CSC did not share the Fact Finding Report or its conclusions with the Police nor did the Police request the information.

F. The Fact Finding Report was not part of the documentation presented to EXCOM in September, 2007, for its review of the circumstances associated with the subject's death.

G. There is currently no policy or training on how BOIs are to manage the information from Fact Finding investigations.

H. Neither the NBOI nor the Investigation Branch prepared formal summaries of debriefings to senior managers at three levels of the organization (institutional, regional and national). There is an almost complete absence of any formal documentation relating to these important debriefings.

I. The Correctional Service committed in response to the 2004 Tassé Report to establish a protocol similar to the Use of Force process for the review of medical emergencies. The Use of Force process includes a requirement to videotape all incidents, and this should be further explored in relation to medical emergencies.

J. There is no specific CSC policy relating to how CSC management is to address allegations of discrimination against offenders when those allegations originate with CSC staff members or when they are raised during the course of an investigation.

K. The NBOI process did not adequately address the issue of discrimination. The NBOI's recommendation to provide an Awareness/Sensitivity Program was insufficient to fully respond to the allegations of discrimination.

L. CSC management, given the acknowledged seriousness of the allegations by the NBOI, did not adequately respond to the issue of discrimination.

M. Nine weeks elapsed between the subject's death and the convening of the NBOI – almost double the timeframe stipulated. The NBOI Report and related submission were presented to the Correctional Service's EXCOM on September 5, 2007. This was almost a year after the subject's death and five months longer than prescribed in CSC policy.

N. The outcome of the disciplinary process does not appear to reasonably coincide with the seriousness of the identified failures.

O. The concerns related to the failures by staff to respond to a medical emergency in this case are strikingly consistent with the concerns that have been raised in the past with the Correctional Service by its own NBOIs, Provincial Coroners and the OCI, including the OCI's *Deaths in Custody Study*.

4.2 Recommendations

1. The Correctional Investigator recommends that Boards of Investigations incorporate the findings and conclusions of Fact Finding Investigations in their final Reports.

2. The Correctional Investigator recommends that Boards of Investigations immediately refer allegations of discrimination to those mandated and trained to investigate such sensitive issues, inclusive of the Canadian Human Rights Commission.

3. The Correctional Investigator recommends that the Correctional Service amend its policy on Investigations to require the preparation of formal written debriefing summaries for each of the institutional, regional and national debriefing meetings.

4. The Correctional Investigator recommends that the Correctional Service develop new policy requiring that responses to medical emergencies be videotaped.

5. The Correctional Investigator recommends that the Correctional Service identify and dedicate the resources necessary to improve the timeliness and quality of the investigative process, from convening to the implementation of corrective measures and follow ups.

6. The Correctional Investigator recommends that the results of the Fact Finding Investigation into the subject's death be shared with the Coroner.

7. The Correctional Investigator recommends that the Correctional Service immediately deliver a Diversity Awareness/Sensitivity Program to all CSC employees across Canada.

8. The Correctional Investigator recommends that all information related to incidents of death and serious injury be shared with the Police in a timely fashion.

9. The Correctional Investigator recommends that the Correctional Service develop a policy on how CSC management is to address allegations of discrimination against offenders when those allegations originate with CSC staff members or when they are raised during the course of an investigation.