Correctional Service Canada | Service correctionnel Canada

Commissioner | Commissaire
Ottawa, Canada
K1A 0P9

Your file | Votre référence
2015-0378-0097
Our file | Notre reference
1410-02-2015-17

Ms. Lisa Lapointe
Chief Coroner
Province of British Columbia
Metrotower II, Suite 800
4720 Kingsway
Burnaby, B.C. V5H 4N2

Re: Verdict at Coroner's Inquest into the Death of Christopher Robert ROY at Matsqui Institution on June 3, 2015

Dear Ms. Lapointe,

As a voluntary participant in the Inquest held on July 18-21, 2016 into the tragic death of Christopher Robert ROY at Matsqui Institution, the Correctional Service of Canada (CSC) thanks you for forwarding the Verdict at Coroner's Inquest dated July 21, 2016. While CSC recognizes that the recommendations are not binding on CSC as a federal organization, we have nevertheless taken them under consideration and provide you with the responses below. As you know, CSC also convened an internal investigation in July 2015 into the circumstances surrounding this incident and has responded to the recommendations arising out of that process.

Two recommendations from the Inquest were directed to the Government of Canada, and as such, CSC has shared these recommendations with Public Safety Canada.

There were 23 recommendations directed to CSC. You will recall that **Recommendations 5**, **6**, **8**, **9**, **10**, **13**, **15**, **16**, **17**, **18**, **21** and **23** relate to administrative segregation and the provision of mental health care. As you may be aware, decisions were recently rendered in the legal challenges initiated by the British Columbia Civil Liberties Association, the John Howard Society of Canada, and the Canadian Civil Liberties Association. While the courts found that changes are required to administrative segregation, the courts' decisions have not yet come into effect and are currently under appeal. Nonetheless, CSC continues to integrate evolving best practices into its policies, including those on administrative segregation and mental health care.

With respect to **Recommendations 3**, **4**, **7**, **11**, **12**, **14**, **19**, **20**, **22**, **24**, and **25**, CSC wishes to provide you with the following responses:

Recommendation no. 3:

CSC implement the recommendations (that are not already implemented) from the Board of Investigation into the Death of an Inmate at Matsqui Institution (sic) June 3, 2015, within 90 days.

In their investigation into Mr. Roy's death, the Board of Investigation made seven recommendations. All seven recommendations were supported by CSC, and corrective measures have been taken to address each one.

Recommendation no. 4:

CSC revise policy to increase the frequency of unit cell checks and increase staffing as necessary to achieve this. Cell checks should be staggered at unpredictable intervals to minimize inmate self-harm opportunities.

Revisions were made to Commissioner's Directive (CD) 566-4, *Counts and Security Patrols*, most recently in May 2017, which addressed the concerns raised in this recommendation to minimize inmate self-harm opportunities across CSC institutions. Of note, paragraph 30 of the CD states that "Patrols will be staggered to avoid predictability". Also, paragraph 37 indicates that "Where there is a heightened need to observe an inmate, special procedures will be detailed in the unit log book and will be followed by all staff".

Recommendation no. 7:

Take the steps to improve the availability of on-site psychiatric service at all institutions.

Revisions to the Statement of Work for the institutional physician, which includes the provision of primary psychiatric care, have allowed on-site psychiatrists additional time to focus on inmates with complex mental health needs. The changes have now been effected in all regions.

Recommendation no. 11:

Regular scenario training to prepare for possible future events, with the view to improving response times.

In 2015, CSC approved changes to the Correctional Officer Continuous Development Training in order to move from a technical skills training model to a decision-making model using scenario-based training. The new model was introduced in Fiscal Year (FY) 2016/2017 for Chemical Agents training and continued in FY 2017/2018 for Physical Skills training.

Further changes will be made to ensure that Correctional Officers are equipped to respond to the changing realities of their environment – moving from a technical focus to a focus on dynamic, judgement-based processes and procedures.

Each year CSC adds new training scenarios to ensure that officers' responses are reflective of current realities. This year, the following scenarios were added: Responding to a Non-Responsive Inmate, Inmate with Risk Factors Associated to Sudden in Custody Death Syndrome, Inmate Move to Segregation, Inmate Assault, and Inmate Overdose.

Recommendation no. 12:

Engineering solutions at national level to improve safety in all cells.

The systematic and consistent identification, inspection, repair, replacement or removal of cell vulnerabilities (i.e., protective covers that have been tampered with or removed) is an ongoing process within institutions as part of the National Cell Condition Checklist and regional maintenance programs in repairing tampered or broken cell fittings.

CSC has implemented cell design infrastructure changes over the years, including clothing hooks with load threshold, vent coverings with small perforations which will not permit items to be threaded between, and ongoing National Cell Condition Checklists. CSC will continue to review new design options for implementation to address concerns.

CSC's Technical Services and Facilities branch is working on a national plan to conduct field surveys of potential suspension point vulnerabilities at inmate cells. Vulnerabilities related but not limited to, doors, windows, hardware, furnishings, life safety equipment and ventilation duct openings will be collected and recorded in a trackable database system. This database will enable CSC to identify vulnerabilities, prioritize infrastructure changes and track safety improvements. The database will be completed by March 31, 2019.

In parallel, CSC's Engineering and Maintenance branch is working on completing a risk-informed guideline for the implementation of acceptable solutions that will limit the probability of the occurrence of suspension point incidents, while remaining in compliance with codes and standards. This guideline will inform the work identified in the database.

Recommendation no. 14:

Ensure all temporary detainment inmates have the means to access trauma-informed mental health and abuse treatment programs on an interim basis prior to their eventual institution placements.

To inform the provision of mental health care, all inmates who are referred to mental health services, including those inmates housed in the Temporary Detention (TD) units are triaged by a mental health professional. Mental health triage involves a preliminary assessment of an inmate's needs (including identifying a history that may include trauma) and the level of service required in order to inform the planning and prioritization of interventions. This mental health triage assessment, based on an interview and a review of files, is not a full, in-depth mental health assessment; rather, it is an assessment to identify mental health issues and the level of service required.

Inmates, including those who are temporarily detained in a CSC facility, identified based on the preliminary triage assessment as having a mental health need, are assigned for mental health treatment. The assigned mental health professional will further evaluate and identify treatment targets consistent with the inmate's individualized needs, based upon relevant assessments. As directed by an inmate's needs, this could include trauma-informed services which recognize the impact of violence and other traumatic experiences on the person's wellbeing.

Since Mr. Roy's death, the Pacific Region's TD Unit has been moved to Pacific Institution which is co-located in the same site as the Regional Treatment Centre which allows for a more efficient and timely response process.

Recommendation no. 19:

All control posts in every unit be equipped with an AED, a bag valve mask, and other items appropriate for an interim response to a potentially fatal self-harm incident. These items should be stored together in a bag or kit that can be brought to the scene.

The availability of Automated External Defibrillator (AED) units is not specific to locations. Response times are the primary consideration when determining the availability of the AED.

When initially introduced, institutions were required to measure response times to various sectors based on strategic placement of the AED units and they were supplied accordingly. Correctional Officers are trained in First Aid / Cardio Pulmonary Resuscitation (CPR) / AED Level C and carry a pocket mask on their duty belts, and are required to immediately deliver CPR to unresponsive individuals who are not breathing.

Nurses at our institutions receive Healthcare Provider level training which includes the bag valve mask as part of the response kit that is brought to the scene by this staffing group. There are other tools, such as 911 cutting knives and personal safety equipment, within each unit control post available that also facilitate appropriate response capacity.

Recommendation no. 20:

Request the Commissioner of Corrections Canada and/or the Regional Manager of Tech services and Facilities in Ottawa that more power be given to Wardens to allocate budgets to where they are needed, pertaining to their particular institution's needs.

Service Level Agreements (SLAs) exist between the Technical Services and Facilities Branch and each region. These SLAs, signed by the Assistant Deputy Commissioner, Institutional Services, the Assistant Deputy Commissioner, Correctional Operations, and the Director General, Technical Services and Facilities, outline a model put in place in December 2014 which clearly defines this new operational process for the provision of all facilities management activities, and includes a roles and responsibilities matrix for facilities maintenance, facilities planning and development, and fleet management. These SLAs were designed to ensure clarity regarding the operational priorities and expectations for delivery of the required facilities management services to the institutions, and specify

whether facilities management or the institutions have the responsibility for a number of different tasks, from defining the operational needs to the procurement of required goods.

These SLAs reflect CSC's national approach to facilities management, ensuring a consistent level of service across the regions and a more efficient use of resources dedicated to the maintenance and recapitalisation of our physical infrastructure. As a result, all maintenance activities and capital projects under $1M are managed at the regional level; capital projects in excess of $1M, as well as oversight of the Technical Criteria document, are managed at the national level. The Technical Services and Facilities Branch consults with Wardens as part of operational plan discussions and adjusts national maintenance and capital plans accordingly.

A thorough process to review and update the SLAs has been completed, during which regional maintenance staff and the Union of Safety and Justice Employees executive were consulted and comments/concerns were integrated into revised documents. Each regional SLA has been approved by the Assistant Deputy Commissioner, Correctional Operations and the Assistant Deputy Commissioner, Institutional Services from each region, and the Director General, Technical Services and Facilities as the functional authority. These SLAs are now in effect until November 30, 2021.

Recommendation no. 22:

The Offender Management System should be easily accessible by all authorized staff and should contain all inmates' files and paperwork.

OMS is an information system rated "Protected B" which contains offender-related data required electronically by CSC to effectively manage offenders. In compliance with Government policy on information security and classification and due to CSC-specific operational requirements, Protected C, Health information and some sensitive information (i.e., intelligence, preventive security, victim, etc.) is not currently stored in OMS; rather it is retained either on hard copy files and/or in other restricted access systems. Police and court information is located in the Police and Court Information Management Module which is accessible via OMS. It should be noted that once an offender meets their Warrant Expiry Date the authoritative source of information at CSC is still considered the hard copy case file.

All authorized staff are provided access to the Offender Management System (OMS). Most recently, an initiative was undertaken from February 2016 to April 2017 to provide read-only access to staff at the Correctional Officer I level (CO), who were not previously provided OMS accounts unless they worked in specific areas of an institution. During this period, 2,080 (78%) of these COs were trained and provided with read only OMS access in order to better equip them to interact and engage safely with inmates. Training is ongoing and all new COs will be trained.

Recommendation no. 24:

That CSC create a role akin to a family liaison to assist with timely and meaningful communication at such time an inmate has been hospitalized with a serious injury or medical condition.

Chaplains are often the first persons involved in communicating with family members of inmates. Family notifications following the death of an inmate are governed by CD 530, *Death of an Inmate: Notifications and Funeral Arrangements*. CD 530 was recently revised and promulgated on August 28, 2017 following the recommendation put forth by the Office of the Correctional Investigator in the report "In the Dark: An Investigation of Death in Custody, Information Sharing and Disclosure Practices in Federal Corrections". It is also noted that with respect to Aboriginal inmates, Aboriginal Elders and/or Aboriginal Liaisons are involved in communicating with family members where appropriate.

For medical emergencies, Correctional Managers are required to keep in contact with the Correctional Officers as to the inmate's medical situation, and will coordinate contact with the inmate's emergency contact or next-of-kin by designated staff.

Recommendation no. 25:

That all recommendations arising from this inquest and other processes which examine conditions and events at correctional institutions be taken seriously.

CSC takes all deaths in custody seriously and strives to review and analyze the information gathered during its own investigation process, as well as any external investigations, reviews or inquests. Best practices and lessons learned are shared across the organization in order to continue to work towards improving our responses. CSC's Incident Investigations Branch also works with external partners such as Independent Review Committees into non-natural deaths in custody to obtain an independent analysis with the goal of improving the safety and security of inmates in our care. CSC is continuously evolving in an effort to ensure that inmates are provided with the services and support they require while in custody and during their reintegration into the community.

I trust the foregoing information effectively responds to the Inquest recommendations. Thank you for the contribution of your office as CSC improves its efforts to protect the safety of those serving a sentence in federal corrections.

Yours sincerely,

Anne Kelly
Interim Commissioner

c.c.: Acting Senior Deputy Commissioner, NHQ
Regional Deputy Commissioner, Pacific Region
Director General, Executive Secretariat, NHQ
Executive Director and General Counsel, Legal Services, NHQ
Assistant Commissioner, Correctional Operations and Programs, NHQ
Assistant Commissioner, Health Services, NHQ
Assistant Commissioner, Human Resource Management, NHQ
Assistant Commissioner, Corporate Services, NHQ
Chief Information Officer, Information Management Services
Director General, Incident Investigations Branch, NHQ
Office of the Correctional Investigator