REPORT OF INQUIRY

MILLHAVEN INCIDENT

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3rd NOVEMBER, 1975

Commissioner:

Inger Hansen, Q.C.

Commission Counsel:

Brian A. Crane Esq.

15 June, 1976

TERMS OF REFERENCE

In accordance with Order in Council P.C. 1973-1431, the Solicitor General appointed a Commissioner to be known as the Correctional Investigator, under Part II of the Inquiries Act, with a mandate to investigate complaints from or on behalf of inmates as defined in the Penitentiary Act, and report upon problems of inmates that come within the responsibility of the Solicitor General, subject to certain limitations as set out in Appendix A.

By letter dated the 27 November, 1975, the Honourable Warren Allmand, Solicitor General of Canada, requested the Correctional Investigator:

> "... to inquire into the matter of the Millhaven incident in accordance with the following terms of reference:
>
> (1) the events leading up to the use of gas and force in the cell range G-1 and the ECA (environment control area) of Millhaven Institution, on November 3rd, 1975, as well as the events following the said use of gas and force, and whether the directives, instructions, and standing orders which pertain to the use of gas and force were followed:
>
> and to
>
> (2) make suggestions with a view to improving the directives, instructions, and standing orders which pertain to the use of gas and force, and/or the way in which such directives, instructions, and standing orders are used."

These specific tasks were accepted by the Correctional Investigator by letter dated 27 November, 1975. This letter suggested that the investigation should be conducted by way of formal hearings.

PROCEDURES

Hearings

The hearings began the 15th day of January, 1976, at a partly vacated administration building outside the fence, near the entrance to the grounds of the Millhaven Institution.

The last two days of hearings were in Ottawa; a total of 22 days were spent hearing evidence and submissions.

Counsel

Brian A. Crane Esq., was Commission Counsel.
Stuart Willoughby, Esq., Q.C. appeared on behalf of 20 Correctional Officers. He was assisted by Ms. Helen King. David Cole, Esq. represented most of the inmate witnesses. From time to time Paul Copeland, Esq. or Allan Manson, Esq. appeared in Mr. Cole's place. Counsel for the inmates were also assisted by Messrs. Ron Wilson and George Asquith, law students at Queen's University.

While Counsel for the Correctional Investigator had the conduct of the proceedings, Counsel for Correctional Officers and Counsel for inmates participated fully. They had the opportunity to adduce new evidence in chief after the witness had been examined by Commission Counsel, and opportunity to cross-examine any witness adverse in

interest and the opportunity to call further witnesses, to object and to make submissions.

The rules of evidence were followed during the hearing of evidence relating to the use of force, but were deliberately relaxed at other times.

Counsel for inmates were advised during the course of the inquiry that the Correctional Investigator had no mandate to make any charges of misconduct against inmates.

The terms of reference did not require any findings as to specific responsibilities of members of the Canadian Penitentiary Service. Nevertheless, in compliance with the Inquiries Act, Counsel were advised that prior to the submission of final argument, Counsel for the Correctional Investigator would give written notice to any witness about whom it was possible to consider a finding of misconduct. Anyone given such a notice would have the opportunity to make submissions or representations with respect to any possible specific charge of such misconduct. Bringing matters to attention during the course of the proceedings was considered but rejected as being too complicated.

Prior Administrative Inquiry

Some of the events which the Correctional Investigator was asked to consider have also been the subject of an administrative inquiry and certain disciplinary proceedings, internal to the Canadian Penitentiary Service. With the exception of the examination of certain gas containers and photographs, the evidence or findings of those administrative inquiries were not considered in the preparation of this report.

Witnesses

All witnesses who were called to appear at the hearings were served with a formal notice set out in Appendix "B".

After the evidence had been heard some witnesses were served with notices in the form set out in Appendix "C".

Relations with the Press

Before embarking on the inquiry, the Correctional Investigator had invited the media on condition that no names and no information leading to the identification of witnesses be published. Considerable thought was given to this arrangement, and while it may not necessarily be appropriate for other inquiries, it appeared useful in this particular case. It was

obvious that most witnesses wished to have the media represented at the hearings. It was also felt that the forthright manner of most of the witnesses was encouraged because their identity was not revealed.

At no time were the hearings closed to the media.

NOTES OF APPRECIATION

I should like to thank the officials and officers of the Canadian Penitentiary Service for their cooperation and assistance during the Inquiry.

To all witnesses, I should like to express my appreciation for their candour and for the calm manner in which they presented their evidence.

Lastly, may I express my sincerest appreciation to counsel and their assistants, technical advisers, reporters, and my own staff for their constant help and untiring efforts during the preparation and conduct of the hearings.

THE MILLHAVEN INSTITUTION

The Millhaven Institution lies just outside of the Village of Bath, about one-half hour drive from Kingston, Ontario. The institution is surrounded by a double chain-link fence and there are observation towers outside the fence. Visitors are required to report and identify themselves at a hut located outside the fence. Appendix "D" shows the general layout of the institution. Most gates and doorways from section to section in the institution are mechanically controlled. At the entrance (T control) are administrative offices, the keepers' hall, the mess hall for staff, the visiting area and interview rooms. There is also an armoury and a central room (T control) from which access to the institution is directed. N control is the centre of the institution. The area with which this investigation is primarily concerned may be reached by passing N control, going through the area indicated as H range past E control. E control is the centre of ranges F, G and H and contains the mechanical devices relevant to that area.

The events on 3rd November, 1975 took place in range G and in the so-called Environmental Control Area (ECA) which may be reached by passing through the small area numbered 2. That second

area is generally referred to as the hole. G range is a two-storey building and the inmate witnesses in this investigation were housed on the lower floor (G-1). Access from E control to range G is through a retractable, metal-grilled gate, approximately eight feet wide. The grille is also covered by almost sound-proof plexiglass The range has 30 identical cells numbered from 101 to 130. When standing at E control looking into the range one will see cells numbered with uneven numbers on the right and even numbers on the left.

The corridor between the cells is eight feet wide and about 165 feet long. Immediately next to the entrance, generally referred to as the top of the range, there is a stall on the right with one shower; there is an empty cell on the left. At the end of the range, usually referred to as the bottom of the range is a swing-type door locked by a key.

The cells are approximately six by eleven feet. The outside cell has a window with bars and heavy grille. The window can be opened from the inside. Each cell has a bed, a metal plate desk screwed to the wall, a toilet bowl and a small hand sink. The cell door is a sliding door made of solid metal plate with a small window and a food slot covered with a metal plate designed to be opened from the outside only. The cell doors can be opened one at a time by means of mechanical

controls activated at E control. They can be opened manually as well.

It is possible for inmates to look through the window in the cell door and to observe a portion of the corridor and some of the cells immediately across. Through the space between cell doors and wall, inmates have an opportunity to look either towards the top of the range or the bottom of the range, (i.e. towards the door to the Environmental Control Area) depending on which way their sliding door moves. It is also possible for inmates to communicate with the range above by shouting through open windows.

During the summer of 1974, the walls made of cement bricks were reinforced with metal plates.

The Environmental Control Area, commonly known as the hole contains 16 cells. They have no windows, no desks. Their bedding consists of foam mattresses and blankets, the inmates usually are wearing coveralls in that area. The cells are used as punishment cells for institutional offences. Two of the cells have no toilet bowls; there is a hole in the floor and water is flushed through automatically at regular intervals. These cells are referred to as the chinese cells.

EVENTS BEFORE NOVEMBER, 1975

The terms of reference ask for an inquiry "into the events leading up to the use of gas and force...". There is a temptation to write the whole five-year history of the Millhaven Institution. One could start with a description of its premature opening in an atmosphere of violence and the subsequent bitterness on the part of both staff and inmates. Then one could analyze the effects and reasons for each recurring wave of tension and relaxation; the abortive attempts at making an inmate committee work; the investigation by the Parliamentary Committee; the deaths of inmates, the escapes, the gassing incidents; the allegations of staff harassment; the styles of management of four different directors; the reaction of the surrounding community, the changing values of society and the changing attitudes to crime and criminals; and the extensive press coverage of events at Millhaven. A study of any of these items would throw light on the specific events which this inquiry examined. There is no doubt, each study would have relevance to the events of November, 1975; there can be no doubt either that greater understanding would be achieved with greater knowledge of all these events and conditions.

But that task is insurmountable and beyond the scope of this report. May it suffice to make the banal comment that the event cannot be viewed in isolation. It was part of a

process of which the present inquiry and this report is also a part.

A few specifics should, however, be mentioned: during the month of August, 1975, attempts had been made by inmates to organize themselves into an inmates' union. Various tactics had been used by the inmates to draw attention to their purpose, in particular, there was a "sit-down" or "strike" which took place during the first two-week inmate vacation from normal work. The majority of the inmates participated in the refusal to leave their cells, some because they felt they had to go along. Friction between inmates and inmates, and between inmates and the administration resulted. Some of those assumed to be the leaders of the sit-down were placed in segregation on range G-1 under Penitentiary Service Regulations, article 2.30 (1)(a), that is, for the "good order and discipline of the institution". This form of dissociation is entirely within the discretion of the administration, no reasons need be given in law and no time limits for the segregation are prescribed by law.

Three inmates had been dissociated under the same authority because they had been involved either as witnesses or as accused in a controversial trial arising out of the murder of another inmate in the Millhaven institution.

There were others placed on G-1 as well, for "the good order and discipline of the institution" and some were there of their own volition.

Some inmates in G-1 had missed their showers on several occasions, complaints had been made but the problem persisted. Some of the inmates described above reported that they felt they were being harassed deliberately by staff because of their particular background.

To appreciate the importance of the showers, several factors must be remembered. None of the inmates in G-1 are employed in any meaningful work. Most of them are young, active and intelligent. They spend their days in their cells, generally relieved only by meals and a short (about one-half hour in winter, one hour in summer) exercise period in an enclosed yard and, by the bi-weekly showers.

Some of them crave for action, any action, to relieve the boredom.

Some of them are very proficient in manufacturing, hiding and distributing "brew", others enjoy the fruits of their labour.

The design of the range provides minimum physical contact between inmates and staff. Conversation

is usually reduced to requests, orders, cat-calls and obscenities. Polarization of attitudes, distrust, and strong loyalty to one's own group are fostered in these surroundings. Older officers and older inmates spoke with nostalgia of the good old days when there was "some respect" and presumably more of an accommodation between keeper and kept, possibly established through greater personal contact.

The segregation range reduces the correctional officer solely to security work. It is boring, unrewarding and occasionally dangerous. There is no incentive for the officers to take an interest in the inmates and it came as no surprise that some of the officers were thoroughly depressed and cynical about their tasks.

It is from their perception of this environment that some of the most difficult and dangerous inmates draw their picture of the correctional system. The segregation range is <u>their reality</u>, and it is not surprising either that they view public statements about the benefits of the correctional system, and the help they are to derive from it, with the utmost of cynicism.

Before leaving the discussion of prior events, attention must be drawn to certain practices in the Millhaven institution.

Through evidence from correctional officers as well as inmates it was established beyond question that inmates have, from time to time, been restrained by being handcuffed behind their backs, shackled with their legs bent backwards and upwards in order that the chain between the legs could be pulled through the chain on the handcuffs. It was also established that inmates had been left in their cells for hours in this position and a number of officers agreed that they had witnessed inmates left lying in their own excrement. This treatment should not be tolerated by any society. If inmates are so violent or so self-destructive that they must be restrained within their cells, then they should be under constant medical observation and should be guarded by staff specifically trained to cope with such problems. It is dangerous and unfair to untrained staff and to inmates to do otherwise.

When questioned about these methods of restraint, the director of the Millhaven institution stated that he was not aware that this was taking place. He did not find the practice acceptable.

He was also questioned about the possibility that inmates might be left in the Environmental Control Area for days without it coming to his attention. He admitted that this

could happen in rare instances and that the remedy had been to impose a sentence for the disciplinary offence which took into account the time already spent in the area. He added that he personally makes daily inspections of the Environmental Control Area and that the inmates there have an opportunity to speak to him. In his view that is the best measure of control. Some inmates, he said, show a determination to spend all their time in this area.

There is little doubt that the director's approach which is preventive is the most practical and that it would be unrealistic to issue written documents ordering staff to be sensible and humane. That is a matter for selection and training of staff.

It would however seem proper to forbid the restraint practices described above. Such prohibition is useless unless it is accompanied by some guidance in how to deal with the situations which in the past have given rise to the misuse of restraint equipment. It is therefore recommended that:

(a) Precise written instructions be issued to penitentiary staff as to the way to use mechanical restraint equipment and

the types of equipment authorized by the Penitentiary Service, and

(b) Instructions make it compulsory that any inmate placed in mechanical restraint shall immediately be placed under the direct supervision of the medical services and if the equipment is used for longer than a specified period, the inmate shall be physically examined by a qualified physician who shall make a written report on the condition of the inmate to the director.

These instructions should probably appear both in the Divisional Instructions and in institutional Standing Orders.

3rd NOVEMBER, 1975

On the 3rd November, 1975 the inmates in G-1 had their evening meal at 1600 hours. These meals are served by food servers who place a tray on a slot in the centre of each cell door. After the meal, at approximately 1730 hours, the showering procedure started, commencing with the inmate in cell G-101 and continuing down that side of the range and up the other. At that time, shower time was to be from 1730 hours to 2000 hours. That evening there were 21 inmates on the range. One inmate at a time is let out to shower, his cell door is activated by an officer in E control and it takes from between 5 to 15 seconds to open and close a cell door. If all the inmates chose to shower, and if showers started and finished on time, and if everything operated without interruption, each inmate would have just about seven minutes to shower, possibly wash his hair, and mop out his cell.

Inmate witnesses complained that on several occasions in the past, showers had been cut off before all inmates had had an opportunity to shower. The lingering of one inmate on the range, or the distraction of the officer controlling the doors, could disrupt the schedule and result in some inmates missing their showers.

The usual procedure was to start the range either with cell G-101 or G-102 and go down one side and up the other. Perhaps it would be an improvement to start with a new cell every shower night and rotate.

One inmate witness who was not involved in the gassing incident said that he had missed ten showers since he came to the range in July. He stated that once he went for two weeks without getting a shower. He had grieved this problem through the internal grievance procedure and had been told that at the relevant time there was an allotment of 2 hours for up to 20 inmates and that this was considered sufficient provided the inmates each assumed responsibility for staying within their allotted time.

On the 3rd November, 1975 the inmates in cells G-102, G-104, and G-106 did not get an opportunity to shower. These same inmates had not been able to shower the week before as well.

When the showers were stopped, some of the inmates were listening to a radio program "As It Happens". They gave evidence that it finishes at 2000 hours and that it was still on when the showers were stopped. One inmate who had a watch said the showers were cut off about a quarter to eight.

At about 2000 hours the officer in charge of a unit is required to turn in a count of the inmates to the Keeper (the officer in charge of the institution). The officer in charge of E Living Unit, of which G-1 is a part, gave

evidence that as he went to take the count in G-2 upstairs an inmate was showering in G-1 and three had not yet showered. This, he said, was at 1955 hours. Another officer took the count in G-1. When the officer in charge of the unit returned from upstairs at about 2005 hours he said the inmates in G-1 were pounding on their cell doors. This he indicated was "pretty normal" and he did not investigate. Pounding on doors is the only way for inmates to attract the attention of officers as there have been no panic buttons in operation on range G-1 for about two years.

An officer not otherwise involved, was able to establish the time when the noise started. He had "no doubts" and was not challenged in cross-examination when he estimated that the "banging noises and shrieking" began about 30 minutes before 2000 hours.

For some reason the showers were cut off early on 3rd November, 1975.

Two undated documents signed by the Assistant Director, Security were introduced in evidence. One was entitled Rules and Regulations - Inmates under PSR 2:30 (A) and (B); the other had no heading. Both documents dealt with similar subjects and one read in part:

"Showering of Segregated Inmates

Segregated inmates on 1-G and 2-G ... are permitted two (2) showers per week and will shower beginning 1730 hours until 2000 hours or completion of range on shower evenings."

the other was worded, in part

"Shower Parade

Shower procedure will be as such: 1 inmate in the shower, one inmate waiting ... shower beginning at 1730 until 2000 on shower evenings."

There were no numbers on the documents to indicate which replaced the other. After some confusion, it was established that the second wording was the latest document. The removal of the words "or completion..." was interpreted by the officer in charge of G-1 on 3rd November, 1975 as leaving him no discretion to extend the showering period beyond 2000 hours. Before the change he had extended the showering time in similar circumstances.

The count for the unit was brought by the officer in charge of G-1 to the Keeper at about 2010 hours. The Keeper was told of the pounding and that in the officer's view there had not been time to shower all the inmates. The officer in charge returned to the unit and went to the top of the range to tell the inmates that the shower time had run out. The inmates demanded to see the Keeper.

There had been similar incidents in the past, and the inmates had normally quieted down after a while. He stated that inmates from an adjoining range were in a common room watching T.V. and had inquired of him why the noise could not be kept down. His major concern was that the disruption might spread.

The officer in charge of G-1 identified five or six inmates as being instrumental in keeping up the noise and finally called the Keeper, seeking authority to remove a few to the Environmental Control Area. In a second call about ten minutes later, the inmates assumed to be the leaders were named and authority was given to remove them. The Keeper telephoned the officer in charge of ECA to be ready to receive some inmates. He also directed the officer in charge of the unit to get the assistance of the second officer in command of the institution to have the extra officers required. The officer who eventually took charge of the use of gas stated that at about 2025 hours he was ordered by the "second in command" to go to G-1 "because there was trouble." He took a couple of other officers with him and about ten of them gathered in the office of E Living Unit. The officer in charge of the unit named five or six inmates as the instigators of the commotion and said it had been going on for one half hour. It was decided to move some of the inmates and another telephone call was made to the officer in charge of

the ECA to tell him inmates were coming.

The inmate who was moved first commented he knew it would be him. He had been warned by his friends not to take part in the noisemaking and said he took that advice. He went without incident and officers described his behaviour as "good". In the Environmental Control Area, the inmate was told to strip and was left naked and without a mattress in one of the chinese cells.
Nothing else untoward happened. The next one to be moved was described by one officer as "chewing the rag a little", but there were "no problems" while in G-1. He was not considered aggressive by the officer in charge of the move.

This inmate was a credible witness. He reported that after he came to the ECA he was told to get his clothes off and that when he was having trouble with a button not to take "all f... night". When he was finally naked he was going to walk toward his cell when, rightly or wrongly, he thought one of the officers was going to grab or hit him. The inmate then hit the officer in the face with his right hand. A fight involving four to six officers and the inmate ensued.

One officer's watch was broken and the inmate received injuries to his temple, elbow, back and big toe. Bruises of 1-2 inches in size were observable on the 6th November, 1975 as

was a split lip. His dentures were broken. He was left naked and without bedding in a chinese cell.

It was suggested on behalf of the officers that "you have to assume if an inmate deliberately waited to attack an officer, that possibly the rest were going to do the same thing".

The inmate told the inquiry that he left his glasses in his cell on G-1 range and

> "... I let a little pet mouse I had go,
> I had a little pet mouse in there".

It was suggested that this indicated deliberate planning on the inmate's part. I concluded that there was no planning and that the scuffle was spontaneous.

While this inmate was being taken down, the other officers in the E unit office were discussing the next inmate they intended to move. They were concerned about his impulsive nature and great physical strength. He was about 6'3" and "bulky".

When the officers returned from ECA it was reported that the inmate had "hit an officer" and it was suggested by the officer who later took charge of the gassing that gas be used. The Keeper was phoned by the officer in charge of the unit for permission. It was given. The keeper had,

as mentioned, been advised of the disturbance but had not been asked for the use of gas. Now the Keeper was told that it was "needed immediately". As soon as permission was granted an officer was detailed to pick up gas and equipment. No telephone calls or other contact was made with the hospital staff by anyone to determine whether some inmates should not receive gas on medical grounds.

The Keeper stated that at
first he had not considered that gas was necessary to resolve the problems in G-1, and that when it was finally requested, it was his opinion that there was no time to notify the hospital in advance. In reaching this conclusion he relied on the report of the officer in charge of the unit.

Five helmets, six gas masks and later two riot sticks and a gas unit called a duster were brought in. Two large canisters contained in a knapsack, known as crowd dispersers, were also brought in and the officer who eventually used the gas said in evidence "I'd never laid eyes on the thing before that time. I was quite impressed."

The officer in charge of gassing and the one in charge of the unit were of the same rank, but in accordance with established practice the officer not previously in the unit

took charge of the use of gas. He went to the head of the range where he stood silently displaying the gas equipment. In his opinion it was pointless to give any oral warning to the inmates because of the noise. He deployed his men, directing one of them to open the food slots in the door as and when "I point" the gas canisters. The group started down the range and as the officer described it "it was already established in my own mind that (the 6'3" inmate) was definitely going to get a dose of gas and any other inmate that was really crying out was going to get it...until I got the range quieted down".

The inmate in cell G-103 was standing at his door banging and shouting. In the words of the officer in charge of the gassing, "he just elected himself a candidate...so I pointed it at his slot and (another officer) opened it up and that mighty fine piece of equipment...just fell flat on its face...a very short minimal burst and it quit". He did not look to see where the inmate was, but aimed the nozzle in a general direction in and up and it "just went psh..." and he added "I could hold in my hand the amount of powder that went into the place...some went in but not very much". The inmate's evidence was that most of the powder went on the wall of his cell, but as he was immediately inside the door and had bent down expecting the officer to speak to him

at the slot, some of the gas hit his cheek from a very close distance. He went to the window to breathe and he yelled "gas".

The nozzle was switched to the other crowd disperser and the 6'3" inmate was given a one to two second burst of gas.

The next two inmates were chosen, the officer said, because of being particularly loud. Then the second canister of crowd disperser stopped functioning and the last of these two inmates was given "the finishing touch", a one to two second burst from a duster operated by another officer. One more inmate was chosen and when the food slot was slammed, the range was "dead silent" except for one inmate who was yelling to be taken to the hole.

Four of the five inmates who received gas directly were escorted, one at a time, to the hole.

They were stripped and placed naked in their cells. None of them were given an opportunity to shower in order to remove any gas powder which had come into contact with their skin.

The officer in charge of the gassing was certain these five inmates were given gas in succession before any one of them was taken to the hole. The officer in charge of the range insisted they were gassed and taken to the hole one at a time.

The inmate in G-103 who had received gas first was not taken to the ECA area. There was conflicting evidence as to the reasons for leaving him. The officer in charge of the gassing said he told the inmate, in response to his question whether he was going to the hole, that he would not "if he behaved". When an officer asked whether this inmate was to be moved, the officer in charge responded in the negative. Inmate witnesses described the remarks as an obscenity with the addition of a suggestion to "let him suffer". Regardless of which interpretation is correct, this inmate was not given an opportunity to shower or change clothes and he was left in a cell which had been sprayed directly.

The officer who had been in charge of the gassing went to the office of the Keeper and handed in a list of the names of the inmates who had received gas directly including the name of the one left on the range. The Keeper's official reports which were introduced in evidence indicated "inmates warned that gas would be used if they did not desist." From the evidence it is clear that the inmates were not so warned, in fact the officer in charge of the gassing agreed, individual inmates had not been warned as is required.

There was a certain amount of confusion over the number of

inmates who had been gassed as the Keeper was under the impression that the two who were moved first had also received gas. In fact, five had received gas, one of them had been left on the range, and a total of six had been placed in ECA by the time the incident was over at about 2130 hours.

No one at the hospital was officially notified after the incident either. When being questioned about this, the officer who was in charge of the gassing, and who incidently was very frank with the Commission throughout, said about the requirement to notify the hospital: "I didn't really understand it at that time, quite honestly, I had never heard of calling the hospital before gassing any one". He had read the Standing Orders, but not until after the 3rd November event had the requirement to notify the hospital become an integral part of his knowledge about his work. It should be mentioned in passing that this same officer had ranked highest in the CX-6 examination in the region, and in his words and attitude while giving evidence he showed a well-developed capacity to take responsibility for his own actions and no tendency to pass it to someone above or below him in rank.

This witness also stated, and his point of view was supported by the evidence from others, that:

> "a lot of Standing Orders are there but people really don't follow them. They are there for guidelines mostly. In the past the Standing Order (i.e. to notify the hospital) was not followed."

He also frankly admitted that he could, had he known the requirement, have telephoned the hospital while another officer went to get the gas and equipment.

When gas is sprayed into a cell on a range, it seeps through the spaces between cell doors and walls and through the ventilation system. Eventually it permeates the range. As discussed in the sections headed Gas and Medical Evidence, certain individuals should not be exposed to gas. This is the reason for notifying the hospital prior to the use of gas. There were three such individuals on range G-1 on 3rd November 1975: one had an ulcer, another had had two heart attacks and the third had an asthmatic condition.

The one who had the heart condition was fifty-nine years old. He told that, when the gassing started, he felt a pain in his heart; he took a nitro-glycerine tablet as he was having trouble breathing. He did not call out for the guards, and when the nurse was distributing medicine it was not like on a regular night"...she just came in and right out as fast as she could" and he had no chance to speak with her. He spent the night in his cell.

Two female nurses arrived shortly after the gassing was over. They passed out medicine which is part of their routine duties. Their stay was extremely brief because of the gas.

One or two fans were placed in the range, but no other decontamination procedures took place during the night.

The Night in ECA

The two female nurses also distributed medicine in ECA.

The inmate who had been in the fight was asked whether he had any complaints and told one of them that he was worried about his back. She spoke to him through the 4" x 8" window in the door and he was asked to move away from the door so that she could see. At his request she promised to put his name down for the doctor the following day. The other injuries were not discussed and the inmate gave evidence that he asked for nothing besides a glass of water for taking his medication. An officer who had been involved in the scuffle brought the water. The inmate was left naked in the empty chinese cell until he was called on sick parade the next day in the mid-morning.

The other inmates were likewise viewed through the cell windows.

One of them asked for a wet cloth; this was refused, and the nurse stated that it would not have done any good. The medical evidence supports that friction does indeed aggravate the effects of the gas; however, a thorough rinsing with water or a shower might have helped the situation.

The mattresses and blankets were removed from the cells before the ECA area knew whom to expect, or had any information as to their condition.

There was no evidence brought before the Commission which satisfactorily explained why inmates were left naked in the dissociation cells; two of them without proper toilets. All of them were left without mattresses and blankets for approximately thirteen hours.

To leave inmates in this condition for such an extended period without any medical advice that it was necessary, without any suggestion that they were attempting to escape or that they might destroy property or attempt to injure themselves, appearsto be intended to degrade them or to punish them. Only one of them had any history of prior mental instability and no attempt was made to have his condition assessed by a medically-trained person.

The Keeper stated in evidence that he had not ordered that inmates should be deprived of bedding and clothes and that

he expected standard procedure of issuing coveralls would be followed. The evidence of this and other incidents described by the witnesses leads to the conclusion that leaving inmates naked without bedding for one night was done either as a matter of routine, (with or without the implied consent of the Keeper) or for punitive reasons. Either way, the treatment contravenes the regulation that inmates shall be properly clothed and have adequate bedding. It also seems unreasonable.

In the case of the inmate who was involved in the fight, the nakedness could possibly have been accepted for a short period of time, to assess his attitude. Nevertheless, he caused no disturbance after he was in his cell and to leave him, without seeking medical concurrence, for about thirteen hours seems to have been unwarranted and punitive.

The naked inmates thought that the heat had been turned off. There was evidence that this was not likely to have happened by design or otherwise. There was medical evidence which better explains the situation: A person's body temperature goes down during the night and in order for a naked person not to be uncomfortable, the room temperature must be raised to about 80 degrees Fahrenheit; the general temperature in ECA was between 72 and 74 degrees Fahrenheit. The chinese cells were usually the coldest.

The Morning After

The Senior Health Care Officer learned about the gassing when he arrived at work at 0830 hours on 4th November. He contacted the director and complained that his staff had not been advised prior to the gassing. He dispatched one of his health care officers to the range and contacted the custody staff and advised them to implement the steps necessary for decontamination after he had received the report from his staff member that a fan was in operation and that the smell of gas was quite strong.

The Senior Health Care Officer did not visit the range until the afternoon, but as a result of reviewing the list of inmates on the range, he had the inmate with the heart condition removed from the range to the hospital for observation at about 1100 hours.

The health care officer attended in ECA early in the morning. He made arrangements for three inmates to go on sick parade shortly before 10:00 a.m.; one of them was the inmate who had asked to see the doctor; another who had been exposed to gas, complained about pain in his shoulder and his eyes were red. The health care officer examined these inmates but actually had them brought up with the intention that they should see the doctor. They did not. There was considerable confusion in the evidence as to why they did not see

the doctor. The most plausible explanation is that the doctor, who was filling in as relief for the regular doctor, did not attend at the institution on 4th November and no one contacted him to ensure his attendance.

The officer who is stationed in the hut at the entrance to the institution had no record of the doctor attending on 4th November.

The compartmentalized nature of responsibility of persons working in large institutions is curiously demonstrated by the delay in getting the inmates to a doctor.

The night nurse made a relatively cursory examination of the inmates involved in the gassing on 3rd November; she took the requisite steps required by her for them to see the doctor. As stated, the doctor was not there the following day.

The health care officer thought that the night nurse had made a thorough visual examination of all the inmates who had been directly exposed to gas. If he had known she had not done this, he himself would have made a more thorough examination.

On the 5th of November the relief doctor was in the institution. The Senior Health Care Officer complained to him that there were no escorts. Because of the suspension of

the Keeper, custodial staff had withdrawn their names from the overtime list and no one was available to take segregation and ECA inmates to the hospital to see the doctor. The Senior Health Care officer did not know if the doctor did anything about it. He was not too concerned because he had been assured by the night nurse and the health care officer that there were no serious injuries. Meanwhile it seems no one from the hospital knew that one inmate on G-1 had been exposed directly to gas and was still in his original cell in G-1. The inmates who had been directly exposed to gas did not get a thorough examination until the 6th of November.

The Standing Orders required that while the institution is closed the officer in charge of the institution shall, if the situation permits, notify the Director and the Assistant Director Security when gas is to be used or immediately after gas has been used.

The Millhaven institution also maintained a roster of senior duty officers who, for a week at a time inter alia, were to be available to assist an officer in charge of the institution during the evening and night.

None of these senior officers were contacted prior to the use of gas on 3rd November 1975.

GAS

Mr. Donald D. Peace, the Vice-President of Federal Laboratories Inc., Pennsylvania, U.S.A., was kind enough to give his time and expertise to the inquiry. Federal Laboratories manufactures tear gas and is a supplier of tear gas to the Canadian Penitentiary Service.

Mr. Peace has a graduate degree in chemistry. He did post-graduate work in bio-chemistry. He has been associated with the company for nine years, first as a chemist and later as vice-president, and is involved in both sales and the manufacture of tear gas.

He has travelled extensively throughout the world in connection with his work and conducts seminars and visits correctional facilities in the United States as a consultant. He gives training in the characteristics and the use of gas produced by his company. About a year ago, Federal Laboratories gave a three-day seminar in the Kingston area at which 85% of those attending were from Canadian correctional facilities.

Mr. Peace characterized tear gas as a weapon. For the last five years, cautions, warnings and training manuals have been supplied with the material sold by Federal Laboratories. The following is a summary of his evidence

of its nature and effect and how gas should be handled.

The Gas

Tear gas chemically is known as cloroacetophonon (CN). It is not a gas, but a crystalline solid. In its pure form, it is white in color and looks like table salt. It sublimates or vaporises quickly.

The gas may be dissolved in a liquid and used with a pressurized device, for instance an aerosol container, and then squirted out.

The Duster

The unit referred to as the "Duster" by Canadian Penitentiary staff is known as a 271 complex. It consists of the 272 which is a CO_2 cylinder and the 273 which is the dust inserted in a black container; the container itself has no number. It holds fifty grams of CN.

The Crowd Disperser

The unit called the "Crowd Disperser", also introduced in evidence and used on 3rd November, is manufactured by another company, Penquin Industries.

The "Crowd Disperser" was not known to Mr. Peace and he could not indicate how much gas was contained in the

canister . The device had instructions but no warnings. On examining it he stated he would use it outdoors or in very large areas such as messhalls and shop areas. He described the device as holding "a healthy grab" of tear gas and reemphasized that:

> "The serious problems that can arise from the use of tear gas are dependent upon the amount of concentration a person is exposed to and the concentration is a variable which is associated with the volume that is emitted as well as the time the person is subjected to that concentration".

He continued that:

> "One who has had training and experience with the device should be quite capable of controlling the amount and duration of the expelled material ... but, I am not saying necessarily that I would recommend this for inside a prison where you have a one cell situation".

Federal Laboratories manufactures a similar product and it is "certainly not" suited for a cell situation and "it is so stated all over the label so that it is evident on the device ... it is for crowd dispersement only, out of doors".

Effect

If a person walks through a tear gas cloud, the gas causes a burning sensation of the nose, a stinging sensation to the eyes which immediately causes the

lacrimal glands to produce tears. It also causes the nose to run and the eyes to close.

If tear gas gets on the skin and remains there for one or more hours the individual would, in most instances, develop a rash or reddening of the skin, similar to a sunburn. If heavy concentrations of gas get on clothes it may penetrate to the skin and the effects of the gas would continue. Irritation would concentrate in moist body areas, and friction increases the irritation. Specifically, if gas is applied, for example from a duster, from a distance of three or four feet and it results in a fairly close application to the skin and the individual were not permitted to wash, or somehow get the dust off his skin, a reddening of the skin would probably occur. It is very dangerous at a distance of twelve inches. The probability of shooting particles from a duster device, or anything under pressure, might force the particles up and under the eyelid, and this would create "a probable cause for a long-range injury". It would also cause a reddening of the skin and if allowed to stay, it might cause blistering. To aim the duster at the head of an individual at less than five feet would be "pretty dangerous".

Cell Situation

The duster would be the proper applicator for a cell approximately 6 X 11 X 8 feet, provided it were used properly. The gas should normally be shot down at the ground and permitted to bounce up, or if the cell is dark and the position of the person in it is not known, it should be aimed at the ceiling. This permits a better and more efficient spread as well. A quick, one second burst or five grams of CN is sufficient for this cubic space. A two or three second burst would be within safe limits for up to ten or fifteen minutes.

A new and better device called "tear-dust" is now on the market. It contains approximately six grams in an aerosol can. Even if the entire shot were given it would not create a situation which could possibly require prolonged, close medical attention.

It would be dangerous to fire a duster through a food slot into a cell without knowing where the inmate is. To fire a crowd disperser in the same circumstances would be a dangerous move and permanent injury such as eye damage might occur.

Contra-Indications

Mr. Peace disclaimed medical expertise but reported that all guidelines in the institutions with which he had been associated had basic information that certain individuals who have medical problems, mostly cardiac problems, pulmonary problems of all kinds and respiratory problems should not be subjected to serious concentrations of the material. There is not much problem in ingesting gas as the body neutralizes it.

The medical people should be standing by to accept patients that are to be brought in under emergency conditions. If there is time, medical records of inmates should be checked prior to the use of gas.

There should be medical examinations to protect the health of the inmate. This also serves to protect staff against unwarranted complaints.

A person does not build up a tolerance to gas exposure but some individuals who know what to expect are better able to control themselves.

The medical aspect of the use of gas is also dealt with under the heading "Medical Evidence".

Decontamination

Decontamination procedures should be started as soon as possible. The temperature in the area where gas has been used should be raised as high as can be done and maintained at that level for approximately one hour. The reason is that vaporization is enhanced with increased temperature. When all of the CN vapour is in the atmosphere it should be flushed out by opening doors and windows to create a draft. Fans would be useful. This procedure is to be repeated since each time there is a predictable mathematical number of molecules that change to gas and disperse. If the temperature is not raised and windows and doors are opened during cold weather the CN particles still vaporize but will remain in place for a longer period of time.

Other methods would be to use a lot of soapy water, or a soda solution to wash the area. The alkaline solution acts chemically on the molecules so that they no longer irritate. A so-called wet vacuum sweeper can then be used to pull out the liquid.

If decontamination cannot be commenced, for instance, during the night shift, it would be preferable to protect staff and inmates by sealing off the area completely. If at all possible the inmates who have been indirectly exposed to gas should be evacuated from adjoining areas.

An individual who has been directly exposed to gas should be given the opportunity to wash up or he or she should be "forced to take a shower". The flushing water helps remove almost all traces of the CN material. If a person has been in an area of concentration for a good period of time the physician should be demanded to look at him. "They should not say; well, just do this; they should be made to actually physically see the inmate". This should be done as soon as possible after the emergency has been resolved.

A rational individual could decontaminate himself and his cell area, but if too much material got on his clothes and they are not cleaned, there would probably be chemical burns on his body and he would be exposed to re-gassing from the particles on his clothes. The same would apply to bedding in the cell where gas was sprayed. Since gas settles lightly there would probably not be a need to change bedding in areas that were not exposed to gas directly.

Decontamination is further discussed under the heading "Medical Evidence".

Training of Staff

The best training is to actually experience what the material is like.

> "Good training would consist of repeated practice sessions, using the equipment made available to personnel. There should be no substitute; they should actually use the equipment that they are going to be handed. After all, when you have a sidearm and you are challenged with using this as part of your tools and operations as a police officer and you do practice and you have to know how to use it effectively and correctly. The same thing applies with these tools, and these are weapons as well and there has to be training and practice with them."

Advantages of Gas

Tear gas is one of the most humane weapons for police and corrections work compared to billy-clubs, sticks, high-pressure fire hoses and fire-arms. There will be injuries with tear gas as well, and gas may be misused, but "we as a public have to equip (police and corrections people) with some device to use, and we cannot ask them to use inhumane methods".

Amount of Gas Used

No one was able to testify with a satisfactory degree of certainty how much gas was used from the crowd disperser and it is impossible to reach any conclusion whether the total amount of gas used on 3rd November was excessive.

The Armourer gave evidence that only half of one duster was used. That would amount to approximately twenty-five grams. It was used on two inmates. This would be in excess of what is sufficient but probably within safe limits for a person to remain in ten to fifteen minutes; provided it were properly used and evenly distributed. Three inmates received an unknown quantity of gas from the crowd disperser.

The officer in charge of the gas said both crowd disperser cylinders malfunctioned, and only a minimal burst was used in each case. The armourer said he had no way of determining how much was left in the crowd disperser canisters.

Fortunately, none of the inmates or staff suffered lengthy discomfort, but the smell and the discomfort of the gas persisted for several days.

The evidence made it abundantly clear that there is no proper inventory control for gas containers at the Millhaven Institution. The Armourer works day shifts only and he agreed that most gas is used during the shift from 1600 hours to midnight. When the armourer is not on duty he is able to determine what equipment has been in or out only by inspection. A complete log is not available. This is not satisfactory. While it should not take all the working hours of a shift, someone should be responsible at each shift for inventory control of the armoury, including completion of a log. It is possible to control the amount of all gas containers by weighing.

The Manner in which Gas was Used

It is abundantly clear that persons who handle the application of gas need to know the potential dangers of its use. In addition, it is most desirable not to expose those particularly vulnerable. Wrongful application is potentially dangerous. It is hazardous to spray gas directly at a person. It may cause permanent eye damage. It is safer to spray gas on the floor or possibly the ceiling through the cracks in cell doors.

These safety precautions were completely ignored by the officers on 3rd November 1975 and probably in previous gassing incidents as well. Gas was aimed at belt level through the food slots without any attention being paid to where the inmate was in the cell.

This happened because the officers were totally ignorant of the potential dangers. No one had ever taught them, even the staff training officer did not have a clear idea of the dangers described by the expert. They were not spelled out in the instruction notes.

This situation should not be permitted to continue.

The Standing Order concerning the use of gas at Millhaven requiresthat only trained and experienced officers be detailed to the use of gas. If that had been enforced,

there could have been no use of gas at the Millhaven Institution on 3rd November, 1975.

Gas was used in a potentially dangerous manner and it is through good fortune that no one was seriously injured.

This must be remedied by a continuing, practical training program.

The Armoury

The Millhaven institution has an armoury where most weapons and gas equipment are kept. There are no established criteria for the position of armourer and at present the position is filled by a low rank of officer with no formal training in weapons. Among other things his duties are to check equipment control, to do minor maintenance work on the equipment including decontamination of gas equipment, and to arrange for other work beyond his capacities to be done elsewhere. He works day-shifts exclusively. When the armourer is not available, the person who is in charge of the institution controls access to the armoury. When the armourer issues equipment he obtains a receipt and the withdrawal is entered in a log book. Equipment can, however, be taken in and placed back without his knowledge and it is obvious that control of this problem is not entirely his. The armourer agreed that there was room for improvement in the record keeping.

It was not possible to determine from the records of the armourer with any satisfactory degree of accuracy how much gas was used on 3rd November, 1975; he was reasonably certain that half the canister of 271 was spent but could not determine how much else was used out of the crowd disperser.

The crowd dispersers were purchased just previous to the November incident and no one appeared to know anything about them.

Attitudes of Correctional Officers to the Use of Gas

The Keeper who was charged with the responsibility of determining whether gas should be used on 3rd November, 1975 gave evidence that the Standing Orders regarding the use of gas were "taken down" in 1974 to be brought up to date and that he had not seen them since that time.

He was familiar with the requirement that the hospital had to be notified but as previously stated he did not think there was time to do so and after the gas had been used did not consider it necessary.

His blunt opinion was that the requirement was a "farce" and the inmates got away with "conning" the doctor. He pointed to the dilemma which arises when the inmates who cause the situation where gas needs to be used are the very inmates who cannot be exposed to gas. He stated he had consulted a medical officer and had concluded that gas would not cause a heart attack and that it might even improve the breathing of a person with an asthmatic condition.

When confronted with some of the evidence presented to the inquiry by the medical doctor and the gas expert, the Keeper agreed that he would obey the doctor if he were there, and would prevent using gas on specific inmates, if lists were left in the units. He indicated that he had never known

before that gas was a weapon and that if used improperly it could be dangerous, nor had he believed that certain individuals were exposed to particular risks if exposed to gas. He subsequently indicated that he would be interested in obtaining further information and was prepared to reconsider his views.

While the blunt manner of expression of the keeper was not shared by other correctional officers, some of them were equally concerned with the possible conflict between security concerns and concerns for the health of specific individuals. No doubt it is a difficult judgment call in each instance. From time to time there will be circumstances where considerations for the health of a few individuals may have to be postponed in order to prevent a greater tragedy.

In respect to attitude there is another area of concern. It was apparent from the evidence of the correctional officers that because tear gas is reputed to be more humane than any other control device, it may have been used with less care and not handled with the respect necessary to prevent improper or excessive application. It may also have been used when less drastic means might have worked. Those shortcomings could as well be remedied by proper and careful instruction.

The most striking fact was the ignorance, particularly of the officer who was responsible for the whole institution on 3rd November 1975.

Instructions and Standing Orders Concerning the Use of Gas

The main document instructing penitentiary staff in the Use of Force is a Divisional Instruction issued under the authority of the Commissioner of Penitentiaries. This document applies to all Canadian penitentiaries. In addition there are Standing Orders peculiar to each institution.

Divisional Instruction on the Use of Force

These Instructions deal with the general authority of correctional staff to use force and they indicate when the use of force is justified. The possible criminal and civil liabilities for the use of excessive force are also explained. It cautions that "the authority to use force is given on an individual basis and that it naturally follows that each individual must, in the final analysis use his own judgment, within the framework of the law, in carrying out this responsibility."

Specifically relative to the use of gas, the Instructions read:

> "... a Penitentiary Officer has therefore three levels of reaction to any given situation:
>
> (1) human physical responses - including the application of mechanical restraints;

(2) the use of gas;

(3) the use of firearms.

b. When the use of firearms is clearly not required, gas may be used to bring a situation under control. Gas is an effective instrument but should never be resorted to, unless all other lesser measures have proved ineffective and the situation must be arrested. The hazards inherent in the premature use of gas are paralleled only by those when it is used too late. Careful clear judgment must always be utilized. Gas is an application of force and, as such, the person directing its use is responsible for this action. The guiding principle remains "use only such force as is reasonable and necessary".

c. The following guidelines should be considered in the development of any institutional instruction related to the use of gas:

(1) Gas should be considered:

(a) to protect life or to prevent injury;

(b) to prevent or control rampages or riots;

(c) to break up passive resistant groups that are contributing to volatile or uncontrollable situations;

(d) to prevent excessive damage to property by violent groups of inmates (either contained in their cells or in open areas).

(2) Gas should not normally be used:

(a) when the inmate(s) causing the disturbance are in controlled environment and the officer(s) reacting are in no danger from assault by others;

(b) when the application of gas to control one situation will likely ignite another disturbance;

(c) when the persons against whom it is to be applied have not been warned that it will be used if their unlawful activities do not cease.

d. When gas has been used, every possible effort must be made to restore order as quickly as possible. Only enough gas to bring the situation under control should be used and immediate steps should be taken to remove those subject to it from lingering effects."

Millhaven Standing Order Concerning the Use of Gas

This document states inter alia that the procedures for the use of gas will be:

"...a) The Officer in Charge of the Institution on all shifts will be responsible for ordering gas to be used and only when he feels its use is justified.

b) The Officer in Charge of the Institution shall contact the Health Care Officer on duty prior to ordering the use of gas to ensure that the inmates who are to be affected are medically fit. He will likewise contact the Health Care Officer on duty, following the use of gas to have the inmates again medically examined.

c) He will arrange to remove inmates from the immediate area where gas has been used if the area is so contaminated by gas as to endanger the inmate's health.

d) A report form on all incidents requiring the use of gas shall be completed by the Officer in Charge of the Institution prior to being relieved from duty. This shall be completed in duplicate with one copy being mailed to the Director and the other to the A.D.(S)

e) A report form on all incidents requiring the Use of Gas shall also be completed by the Officer in Charge of the Institution in duplicate, prior to being relieved from duty. One copy to be forwarded to the A.D.(S) and the other to the CX 8. This report shall deal specifically with the amount of gas spent for inventory purposes to enable the CX 8 to replenish supplies.

f) He will make every effort to decontaminate the area where gas was used by opening windows, doors, where possible having removed all bedding and clothing to the open air and using a neutralizer as recommended by the Health Care Officer on duty.

g) He will only detail trained and experienced officers to dispense tear gas and instruct such staff only the required amount of gas is to be dispensed to effectively control the situation.

h) During the hours the institution is closed, the officer in charge will notify the Director and A.D.(S) when gas is to be used if the situation permits, or he will notify the Director and A.D.(S) immediately after gas has been used."

This order is quoted, as amemded 2nd May, 1974.

Mr. Peace from Federal Laboratories commented that the Standing Order was "a very excellent outline of what should be done" and he agreed that it would be dangerous to ignore the requirement to inform the medical people. He added that this was for the protection of both staff and inmates.

The Senior Health Care Officer at the Millhaven Institution has furthermore identified four specific steps which must be taken to decontaminate an area where gas had been used. They are:

1) Ventilate the area as soon as possible for up to 1 hour.

2) For CN dust a commercial water type vacuum cleaner or a regular vacuum cleaner with the bag wet should be used to pick up the dust.

3) Heat the area as hot as possible for 1 hour and place fans at openings in and off building to vaporize the dust.

4) Wash surfaces with a 5% Washing Soda or Baking Soda solution.

Mr. Peace described these steps as "perfectly legitimate" but suggested that it should be made clear that the elevation of the temperature should be before and contemporaneously with the ventilation.

The November, 1975 events indicated that the Instructions and Standing Orders might be improved by indicating the actual steps required to decontaminate areas and the precise measures necessary to assist those who have been exposed to gas.

They also suggested that general warnings by loudhailer of the proposed use of gas might be possible where an individual cannot be reached otherwise.

It is recommended that the Divisional Instructions and the Standing Orders be redrafted:

(a) to provide concise step-by-step procedures required to decontaminate areas where gas has been used;

(b) to provide concise step-by-step procedures to be used to assist inmates and staff who have been exposed to gas, including the requirement that anyone, staff or inmate, who has been exposed directly to gas be given a change of clothes and a shower as soon as possible and that he or she be physically examined by a duly qualified physician within a given minimum time after the emergency has been resolved;

(c) to require penitentiary staff to use a loudhailer to warn inmates that gas will be used if their unlawful activities do not cease; and

(d) to require the Medical Services to maintain and post in each unit a list of both staff and inmates who should not be exposed to gas for medical reasons.

Comment

The last suggestion is not intended to replace the requirement to notify the hospital. It is intended to be supplementary and to assist staff in a unit to identify those particularly vulnerable to gas and still remove them where it is impossible to contact the hospital to obtain the necessary information prior to the use of gas.

MEDICAL EVIDENCE

The Use of Gas

The doctor who serves as institutional physician has fifteen years experience as a medical practitioner. He has been attached to the Millhaven Institution since it opened in 1971. He holds daily sick parades, except during his annual vacation or if he is away for professional reasons. Another doctor relieves him on such occasions. He is responsible for public health of the institution and for direct medical services to inmates. He or the medical services of the institution attend to staff emergencies, but staff are referred to their family physicians for further treatment.

He directs the operation of the institutional medical services.

The doctor explained that it is necessary to notify the institutional hospital before the gas is used to make certain that the inmate in question is healthy enough to be subjected to gas. Inmates suffering from ulcers, heart and respiratory problems should not be exposed. A medical examination of inmates is also required if they have been exposed to gas.

He thought gas had been used at Millhaven Institution "six to ten times" during the four years prior to 1975 and twice in 1975 including the 3rd November. His reports disclosed instances of first and second degree burns on inmates caused by gas being applied at very close range.

The doctor had forwarded a number of memoranda between August, 1973 and early 1975 to senior administrators seriously urging that the hospital should have an opportunity to prevent the use of gas on certain inmates for medical reasons.

The memoranda and the evidence made it abundantly clear that the requirement to notify the hospital, though incorporated in the Standing Orders, was not adhered to by security staff. The doctor could not "think of any reason" why the hospital had not been notified, although he accepted that in a life-threatening situation where inmates were out of their cells and had access to staff, it would be impossible.

He had also "strongly" suggested that all possible avenues of exhausting the tear gas from the range as soon as possible after it has been used, be explored.

The doctor was certain the procedures for notice and decontamination were understood by the Senior Health Care Officer.

The Senior Health Care Officer assured the inquiry that his staff understood the steps to be taken, but he added that correctional staff did not understand the requirement to notify the hospital. He also indicated that a list of vulnerable inmates had been prepared once, but it had not been done regularly.

When asked whether the regular daily distribution of medication by nurses would be sufficient in itself to ensure that all inmates needing help were attended to, the doctor answered in the negative. While it is sufficient in normal society to inquire about physical complaints, he felt more would be needed in a penitentiary setting and that a visual examination would be required for a reliable diagnosis.

It is important that inmates be examined by the Health Care Officer or nurse as soon as possible after the gassing. The Standing Order requires that an inmate who has been directly exposed to gas should be given a change of clothing and measures taken to remove the gas from his person. If necessary he should be given a shower and the doctor should be notified and should see him. The examination should consist of viewing of the undressed inmate and looking for evidence of irritation of the skin, breathing difficulties and discomfort. The

doctor indicated that in the past he has come to the institution in situations where gas and physical force had been involved, and that he would do so after a situation involving gas alone.

The initial examination could be professionally performed by a Health Care Officer or nurse who would be qualified to determine the need for calling the doctor and the need for tests. In addition a change of clothes and a cell change is desirable as soon as possible, and if the gas has permeated, the other celled inmates should be removed and cells cleaned before they are returned. The latter inmates should be examined on request. Ideally these inmates should also be visually examined by the Health Care Officer depending on the circumstances.

The medical staff at the institution felt that to insist on visual examination might be seen as an intrusion of privacy by the inmates.

From both a medical and legal point of view, the insistence on a visual examination as soon as things have calmed down seems preferable.

On the question of whether nurses could be forbidden entry to a cell by security staff, the inquiry was informed that nurses are not subordinate to correctional officers in medical

matters, but they are in matters of security. The correctional officers' prime concern may be the safety of the nurses.

Whether the nurse and the patient should be alone together or whether the nurse should enter the cell alone is a judgment call in each case as the inmate may be upset and angry at everybody. At other times he may only be extremely angry with the people who have subdued him. If the inmate is violently aggressive in general, the nurse or Health Care Officer might have to do the examination from just outside the door and leave further examination until later.

Decontamination

The procedure for decontamination should include the opening of all possible windows and doors to ventilate the area. A wet vacuum or a vacuum cleaner with a wetted bag should be used to pick up the CN dust, areas gassed should be washed with a weak solution of baking soda and if possible, the temperature should be raised to get the CN dust to vaporize more quickly and completely.

The doctor's main complaint is that although these procedures have been followed in the past, they have not been followed quickly enough.

Benefits of Gas

The doctor also gave evidence that if officers did not use gas to remove inmates from cells, they would have to use physical force, unless they could talk the inmate into coming out. Usually, in the past, he has observed back injuries and occasionally head injuries as the result of forcible removal of inmates.

Showers

The doctor said showers are a question of basic hygiene. Preferably, an individual should have a shower at least every second day. He has attempted to institute that but has been told that due to the custodial problems, this is impossible.

Two showers a week are adequate, but not ideal, and missing a shower for a week or two weeks at a time, could present a health problem.

Physical Examination of Inmates Involved

As discussed elsewhere in this report, the regular institutional physician did not examine the inmates involved in the 3rd November incident until he returned to work on 6th November.

He found no significant ailments as a result of the gas though one of the inmates had first degree burns to his left upper eyelid and both armpits, which seemed most consistent with exposure to tear gas.

The inmate who had been involved in the fight had one or two inch bruises from blows of some severity, he had a cut lip and his dentures were broken. The state of healing was consistent with the injuries having occurred on 3rd November.

General Conditions

The doctor thought that administrative segregation for the good order of the institution "is an admission of failure". Segregation does not make an inmate any better; if he is angry and aggressive he stays that way and he resents the officers who are working with him and they in turn are exposed to constant pressure. Ill feelings develop.

Some inmates take it amazingly well; they are not happy but, in their opinion, they are happier in segregation than elsewhere. Others become extremely aggressive and suicidal. Some become acutely psychotic, probably due to the lack of sensory stimulation. Sometimes they are removed to hospital to give them a little more stimulation, but they cannot be kept there forever. In one way or another the majority of inmates in segregation have been adversely affected emotionally.

For staff it is frustrating to deal with a concentration of people as angry as these people can be. Staff is reduced to security. The living unit is better for both officers and inmates.

The doctor explained that correctional officers previously operated on a disciplinary basis which was far more rigid but they often had quite close, good relationships with the inmates.

It is possible that younger, less-experienced officers are more threatened by situations such as exist in the Environmental Control Area. The doctor agreed that there is no alternative provided at Millhaven Institution and there are no other institutions available either.

The doctor thought it would be beneficial to have better trained correctional officers working with these inmates but the training should be related to developing psychological insight and maturity. He concluded that he does not like segregation at all, but has no clear alternative to offer.

STAFF

Attitudes

The specific problems illustrated by this hearing will not be solved by rewriting the Directives, the Instructions and the Standing Orders, nor will they be solved by dismissing X, Y, and Z.

A sincere effort directed towards improving the working conditions and staff morale in general is a better guarantee of proper treatment of inmates.

Correctional officers in general, and custody staff in particular, live with a great deal of tension from the criticism levelled at the system from time to time. They feel powerless and unappreciated. They are almost never pictured in the media as heroes. They do not catch the criminal after brilliant detective work or in one courageous moment; but they do have the frustrating and sometimes dangerous job of keeping these very same criminals in when they would rather be out.

The main complaints of penitentiary staff may be summarized this way:

> There is a feeling that the policymakers are too removed from reality and, as well,

There is dissatisfaction that headquarters or region does not give enough support.

There is a suggestion that upper echelon management hides behind the rules.

There is fear that the focus on inmates' rights will cause a reduction in staff rights.

There is resentment that staff does not have access to an independent arbiter while the inmates have the Correctional Investigator.

There is anxiety over civil and criminal liability and bewilderment over legal technicalities.

There is fear that do-gooders romanticize inmates.

There is seldom public and open commendation for a staff member who saves an inmate's life or the life of a fellow officer.

There is resentment that one reprimand on one's file has a greater effect than years of quiet effectiveness.

> There is a longing for the good old days.

Specifically, it is possible that as a result of the effort to bring professional staff into the Canadian Penitentiary Service custodial staff were forgotten as a group. They feel isolated and as a consequence display a well-developed sense of solidarity to their own group.

The correctional officers at Millhaven Institution are well organized and disciplined. Their union is highly effective and much of their loyalty is directed toward it and not to the institution or the Penitentiary Service as a whole. This seems an inevitable result of the feeling of isolation. It should perhaps be stressed that there is no suggestion that this loyalty is improper.

A sense of isolation is a common complaint in big organizations but in the Canadian Penitentiary Service, this barrier between policymakers and those who carry out decisions aggravates the already difficult task of the correctional officers.

It leads inmates to distrust the sincerity of the policymakers. They distinctly perceive a gap between policy and reality.

Segregation

In a segregation range, treatment is separate in time and place from life on the range. The inmate is "taken up" to have a precious hour with a professional and then placed back in storage until the next session comes along. There is little or no communication, understanding or community of purpose between those who guard him and those who treat him. This is bound to frustrate both inmates, custodial staff and professionals.

It is also possible that the quality of the treatment of inmates, particularly in segregation, has in fact deteriorated, because of the separation of treatment and custody staff.

Many witnesses gave evidence that in a maximum institution such as Millhaven there is a small core of inmates who cannot function together with the general population. They are constantly in and out of segregation. It was repeatedly argued that the maximum institutions would function better without this small group. Most staff recommended special institutions with specially-selected and trained staff for these inmates.

On this subject, the director agreed, in part, that once an inmate is sent to a special institution, it becomes difficult

to return him to an ordinary institution, gradually or otherwise. But, he rejected the idea that creating another type of special institution would involve the Penitentiary Service in a Pandora's Box situation where you would continue to need even more specialized environments. In his opinion, an institution such as Millhaven is not designed to deal with these particularly difficult inmates.

A major portion of the evidence given on the subject of segregation and inmates who end up in segregation generally supports the findings of the "Report of the Study Group on Dissociation".(1) There seems no need to repeat or rephrase the recommendations of that Commission except to state that they are supported by the evidence received by this inquiry.

Relations Among Staff Groups

There is not total harmony among the various groups working in the Canadian Penitentiary Service. A concerted effort seems necessary to defuse the adversary nature of the relations among the different groups in the system.

In-service training and meetings are time-consuming and costly, but they are imperative to foster mutual understanding and a feeling of community of purpose and they must be a permanent feature of the system.

(1) Vantour, James A. "Report of the Study Group on Dissociation." Published under the authority of Honourable Warren Allmand, Solicitor General of Canada.

The administration should permit input from all staff involved, before policy is set. Efforts are being made in this direction at the present time, but in addition to having the opportunity to be heard, those whose opinions have been sought must somehow be made aware that they have been consulted and that policy is frequently a compromise based on input from many sources.

It is by no means suggested that the union or any particular professional group should dictate policy, but it is no longer a realistic expectation that staff will simply do what they are told without question and without consultation.

Once policy has been set and communicated it should, of course, be clear that departure will not be tolerated.

Career Advancement

There is little opportunity and little incentive for correctional officers to advance.
It seems that very early in their career, they stop looking for career development within the Canadian Penitentiary Service.

This problem might be solved if there were any reasonable expectation by correctional officers that leaders might be identified and developed from within the Service.

This would be possible, if experience could be equated in a meaningful way to formal training and ranked equal in importance for purposes of promotion.

Schools and universities do not produce fully-qualified correctional officers, classification officers, or administrators for correctional facilities. The formal education provides professional competence and a framework, but the greater portion of the training must be specifically directed to correctional needs. This may be provided by the Canadian Penitentiary Service if it were to create an organized, uniform, in-service training program. By passing certain in-service examinations it should be possible, for instance, for a correctional officer to qualify to become a classification officer, an instructor or an administrator, provided he or she has the capacity and makes the effort. Many well-suited candidates are lost to the Service for want of academic qualifications.

The evidence at the hearing demonstrated a great need for proper and uniform job training for Canadian Penitentiary Service staff. It is beyond the scope of this report to make proposals for an in-service training program. It has, however, been suggested that a permanent staff training board could identify the

qualifications needed for each position in the Service and set internal examination standards for promotion. This seems a reasonable first step.

Overtime

Custody work is hard. It may be monotonous, and yet an officer must at all times be alert. The amount of overtime worked by custodial staff at Millhaven is alarming. Overtime has become a permanent feature of the Canadian Penitentiary Service; the expectations of the correctional officers are related to the amount of overtime they are earning. It appears that the life style of some officers is based on the money earned through overtime worked on an almost permanent basis. The amount earned would destroy any incentive to try for a promotion, which would mean only a small increase in pay, more problems and more criticism. There may have been some abuse of sick leave, of overstaffing of posts and accident leave, but the problem is more deep-rooted than that.

One officer stated that he worked two shifts of overtime regularly. He may be exceptional, but the effect both on the treatment of inmates and the welfare of correctional officers deserves to be thoroughly examined. It seems

incredible that proper standards can be maintained by officers who are working double shifts regularly.

There was no direct evidence that any of the specific incidents under investigation were related to overtime. This is probably not possible to prove.

But, almost forty percent of the correctional officers that were on duty the night of 3rd November were or had been working overtime.

Archambault Institution, another maximum institution similar to the Millhaven Institution, reported that during 1975 security staff worked almost 40,000 hours overtime. At Millhaven a little more than 70,000 hours were worked in overtime by custodial staff in 1975. The figures speak for themselves.

Training

The training of the officers who gave evidence appeared to be totally lacking in uniformity. Some have come directly to Millhaven from industrial or similar work and stayed there for a year or more without having any formal training apart from two weeks induction training at the institution itself.

The training at the Staff Training College has been given to some immediately when they entered the Service; for some it has been given in phases.

The Staff College has gradually improved and standardized its courses; but without any organized, uniform effort to see that refresher courses are given to those whose knowledge is outdated, it will take years before the improvements permeate the Service.

The attitude on the part of many correctional officers who gave evidence of the training that was given at the Staff Training College was, that it is irrelevant and they forgot about it in due course. Some considered it unrealistic.

Specifically, as stated elsewhere in this report, none of the officers had ever had any training in or supervised practice with the two types of gas equipment used on 3rd November.

The armourer at the Millhaven Institution had received his training in the use of gas equipment from the Millhaven staff training officer. He now assists in the training sessions at the institution. When asked about the frequency of the training sessions he reported that there had been one during the summer of 1975 and the previous one "he imagined" was 1974. Between six or

eight officers would have attended. A notice is put up and attendance is voluntary. The training with gas equipment at the institution is only in the use of various forms of projectiles in the open air. There is no training in how gas is to be used in a cell situation and the crowd disperser was not demonstrated to nor used by anyone before at the Millhaven Institution.

The Staff College training in the use of gas consists of demonstrations of projectiles in the open air and exposure to vaporized gas in a hut. It is given by military personnel. No correctional officer, it seems, is given the opportunity to experience being in a cell situation and having gas sprayed into it; no correctional officer is given the opportunity to practice using spray type gas from time to time so that he is kept informed of the proper and safe manner in which to operate that equipment. It should be obligatory. Gas is used more for in-cell situations than in large areas.

Some officers expressed the desire for more training in simulated situations. This would be most effective, particularly in respect of the use of force of any kind.

The Canadian Penitentiary Service conducts numerous internal inquiries some of which concern the use of force. The transcripts of those inquiries and perhaps also of public inquiries should be a useful source for teachers at the staff colleges from which to create close-to-life scenarios.

Understanding of Policy

One half day is alloted at the Staff Training College to the reading of Directives, Instructions and Standing Orders. The general impression received from the evidence was that supervisors expected that when a person was directed to read something, he would do so. Great reliance was also placed on learning from actual situations. It is true that there is no substitute for experience but a thorough grounding in safety precautions is necessary where people may be exposed to potentially-dangerous situations.

The evidence at this inquiry demonstrated beyond doubt that it has been impossible for the administration to communicate the mass of instructions by asking senior people to read it and communicate it to those under their supervision. Senior officers who direct the work of the correctional officers must continually be involved in training and communication, which keep

their expertise and understanding of policy current. There must be opportunities for them in turn to ensure that the lower ranks understand and appreciate the nature of their work and the goals of the Service as a whole.

Directives, Instructions and Standing Orders

The rules governing the Canadian Penitentiary Service are voluminous. There are the Penitentiary Act, the Regulations, the Commissioner's Directives, Divisional Instructions, Standing Orders and uncategorized policy memoranda and letters. The binder which contains the Millhaven Standing Orders is about 2 1/2 inches thick.

The "Report of the Commission of Inquiry into Certain Disturbances at Kingston Penitentiary During April, 1971"(1) noted:

> "That the laws and rules by which both staff and inmates are governed, consist of a massive and almost incomprehensible collection of regulations, directives, standing orders, circulars and instructions and the like."

There have been some efforts to change this, but the problem persists.

The degree to which correctional officers were either ignorant of the existence of these rules or disregarded

(1) Swackhammer, J.W. "Report of the Commission of Inquiry into Certain Disturbances at Kingston Penitentiary During April, 1971." Published under the authority of Hon. Warren Allmand, Solicitor General of Canada. p.11.

them as unimportant and totally irrelevant was astonishing. The evidence was overwhelming that the important Standing Order with respect to the use of gas and decontamination was not understood and not known by most of the correctional officers.

It is axiomatic that unless the policies of the "head office" are accepted by the lower ranks, the policies will fail.

Any suggestions for improvement of specific Directives, Instructions and Standing Orders would be useless without attention to the reality of the situation.

The real problem is with training and attitude, not with the rules or the policies. The policies are somehow not communicated to the lower ranks and if communicated, their importance is not understood or accepted.

To further assist in the communication of policy as expressed in the Commissioner's Directives, Divisional Instructions and Standing Orders it is recommended that a permanent editorial board be established to supervise this, and in particular:

(a) that the board shall consist of persons with knowledge in law, editorial expertise and, without question, practical operational experience;

(b) that the board shall identify portions of the Commissioner's Directives, Divisional Instructions and Standing Orders in relation to job descriptions and in relation to each job category in the Canadian Penitentiary Service and designate the portions which it is obligatory for an employee to know, apply and understand for the purposes of his or her job category;

(c) that the board shall edit or cause to be edited, the Commissioner's Directives and Divisional Instructions and Standing Orders to remove superfluous matters, to simplify the language, and to standardize the format and content, bearing in mind that each institution may have particular need in respect of Standing Orders;

(d) that the board shall prepare or cause to be prepared, <u>one, unified cross-referenced indexing and numbering system</u> applicable to Commissioner's

Directives, Divisional Instructions and Standing Orders.

Comment

The Correctional Investigator's ordinary working experience has made apparent the urgent need for the immediate implementation of the above recommendation.

CONCLUDING NOTES

Much has been written about the dehumanizing effects of incarceration on inmates. Much less on the dehumanizing effects on custody staff. Few people today are prepared to endure humdrum jobs. Staff generally "serve time" longer than inmates. There are few comforts for them at their place of work. There are no showers for officers who have been exposed to gas, for instance. The lockers and common rooms are far from luxurious.

When correctional officers express a demand for greater involvement in decision making, this should be interpreted as a healthy sign. It is a demand for job satisfaction beyond the pay cheque.

Students of the history of labour-management conflicts generally agree that when "labour" is dissatisfied, workers find ways of retaliating.

In a prison setting that retaliation may take the form of harassment of inmates. This harassment may be at the subconscious level or so subtle that it is rarely discovered by conscientious administrators though they may suspect it. It is seldom capable of the high standard of proof required by a court and is often rejected by

other agencies including the Correctional Investigator because what might be a perfectly valid complaint is blown out of proportion by exaggeration.

Some inmates accept harassment with resignation, but others, often those with sharp, young minds and leadership potential, rebel. They may all use it as a rationalization for future anti-social behaviour. All of society pays the price.

SUMMARY

Correctional staff is entitled by law to use force and gas is an authorized form of force. The authority is granted to prevent escapes, injury to persons and damage to property. No more force than necessary in any given situation is permitted.

Gas and force have been used from time to time on inmates at the Millhaven Institution.

Handcuffs in combination with leg-irons have been used to subdue inmates in a manner which appears to be cruel and possibly dangerous. This practice should be stopped. Staff should have proper guidelines in the use of restraint equipment and medical services should be responsible for preventing misuse.

In respect of the events on 3rd November, 1975, bi-weekly showers for the inmates in the G-1 segregation range were stopped early. The inmates objected by shouting and banging on their cell doors. Some officers feared that the disturbance might spread. It was decided to move some of the inmates to the Environmental Control Area to stop the disturbance. The first one was taken without any incident, however, the second believed, rightly or wrongly, that he was going to be attacked by an officer. When he struck he was overwhelmed by the officers. At that point, it was

decided by the officers to use gas before removing anymore inmates from the range to the Environmental Control Area.

Gas was used on five inmates, four of them were taken to the hole, one was left on the range. More gas than was necessary was probably used, but in particular the gas was applied in a potentially-dangerous manner by officers who had had no practical training in the use of the specific equipment and no specific instruction in the inherent dangers in the use of gas. Although there was a requirement to notify the hospital services before a gassing when possible, this was not done. This requirement is to enable the removal of inmates who are particularly vulnerable to gas. There were three such inmates on range G-1.

The requirement to notify the Director or senior duty officer of the institution was not fulfilled either. Both omissions appear to have occurred because the reasons for having to notify were either not understood or accepted or, in some cases, not known.

The inmates who were taken to the Environmental Control Area were left in their cells naked and without mattresses or bedding. Two of them were in cells that, instead of a toiletbowl, only have a hole in the floor with water flushing automatically at intervals. The removal of bedding and clothing appeared to be done as a matter of routine, without any specific justification on either medical or

security grounds.

The expert evidence illustrated the necessity for permitting inmates who have been exposed to gas to flush off gas particles as soon as the emergency is over, preferably by taking a shower. This opportunity to shower was not granted. Medical examination of the inmates after the gassing, which is advisable, was cursory and none of them including the injured inmate had an opportunity for a proper medical examination until three days after the event.

The failure to protect inmates who were particularly vulnerable to the exposure of gas and the lack of attention for those who had been exposed to the gas appeared to have resulted from a compartmentalized attitude to responsibility. The use of gas in a manner which might result in serious and permanent physical injury appeared to have occurred from straight ignorance.

Standing alone, the acts or omissions of staff involved in the events which this inquiry examined, appeared to be due to human error, ignorance and failure to accept or understand policy. The gravity of the problem, however, is that the cumulative effect amounted to neglect of the welfare of individuals for whom the Canadian Penitentiary Service is responsible. It would be simple to suggest that the Canadian Penitentiary Service should remove X,Y and Z, however,

that will do little to solve the real problem. The blame must rest with a system in which a lack of concern for individuals may be tolerated. The proper remedy seems to be to enhance understanding, compassion and morale of those who work in the system and to encourage different groups of employees to work towards the common purpose of the service. A comprehensive in-service training for the Canadian Penitentiary Service seems an absolute necessity. That training must ensure that theory is made relevant and that the reasons for policy are understood and also that it be made clear that after consultation and formulation of policy, departure will not be tolerated. A sincere effort must be made to make all those who work in the system feel as members of the team and the gap between announced policy and reality must be diminished.

Having arrived directly from an industrial work situation with little or no training in dealing with human beings a new correctional officer may be engaged to work with extremely difficult, problem-ridden persons. After a minimum of induction training he may be handed a key, assigned to a post and possibly the next day he may have to disarm an inmate, use gas or force, or try to save the life of an inmate who has cut his wrist. His ability to react in a calm manner may be severely impaired

CANADA

PRIVY COUNCIL

Certified to be a true copy of a Minute of a Meeting of the Committee of the Privy Council, approved by His Excellency the Governor General on the 5 June, 1973

APPENDIX "A"
To Millhaven Inquiry Report
dated 15 June, 1976

The Committee of the Privy Council, on the recommendation of the Solicitor General, advise that, pursuant to Part II of the Inquiries Act, authority be granted to the Solicitor General to appoint Miss Inger Hansen, of the City of Ottawa, as a Commissioner, to be known as the Correctional Investigator, to investigate, on her own initiative or on complaint from or on behalf of inmates as defined in the Penitentiary Act, and report upon problems of inmates that come within the responsibility of the Solicitor General, other than problems raised on complaint

(a) concerning any subject matter or condition that ceased to exist or to be the subject of complaint more than one year before the lodging of the complaint with the Commissioner, or

(b) where the person complaining has not, in the opinion of the Commissioner, taken all reasonable steps to exhaust available legal or administrative remedies,

and the Commissioner need not investigate if

(c) the subject matter of a complaint has previously been investigated, or

(d) in the opinion of the Commissioner, a person complaining has no valid interest in the matter.

The Committee further advise that a Commission do issue to the said Commissioner, and

1. that the Commissioner be appointed for a period of one year effective June 18, 1973;
2. that the Commissioner be paid a salary within the range from time to time authorized for a Senior Executive 2, at a rate to be fixed by the Governor in Council;
3. that the Commissioner be authorized to engage, with the concurrence of the Solicitor General, the services

...2

of such experts and other persons as are referred to in section 11 of the Inquiries Act, who shall receive such remuneration and reimbursement as may be approved by the Treasury Board; and

4. that the Commissioner shall submit an annual report to the Solicitor General regarding problems investigated and action taken.

The Committee further advise that authority be granted to the Solicitor General to reappoint the said Commissioner for the purposes and upon the terms and conditions set out herein for a further period of one year.

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by excessive overtime, once he has been in the Service for a while.

It is not fair to place the least trained staff with the primary responsibility for taking care of the most difficult inmates.

An in-service training program for the penitentiaries is costly and time-consuming, but there is no other way to ensure proper treatment of inmates and the continued co-operation of staff.

RECOMMENDATIONS

It is recommended that:

1. (a) Precise written instructions be issued to penitentiary staff as to the way to use mechanical restraint equipment and the types of equipment authorized by the Penitentiary Service.

   (b) Instructions make it compulsory that any inmate placed in mechanical restraint shall immediately be placed under the direct supervision of the Medical Services and if the equipment is used for longer than a specified period, the inmate shall be physically examined by a qualified physician who shall make a written report on the condition of the inmate to the director.

2. The Divisional Instructions and the Standing Orders be redrafted:

   (a) to provide concise step-by-step procedures required to decontaminate areas where gas had been used;

(b) to provide concise step-by-step procedures to be used to assist inmates and staff who have been exposed to gas, including the requirement that anyone, staff or inmate, who has been exposed directly to gas be given a change of clothes and a shower as soon as possible and that he or she be physically examined by a duly qualified physician within a given minimum time after the emergency has been resolved;

(c) to require penitentiary staff to use a loudhailer to warn inmates that gas will be used if their unlawful activities do not cease; and

(d) to require the Medical Services to maintain and post in each unit a list of both staff and inmates who should not be exposed to gas for medical reasons.

3. A permanent editorial board be established to supervise the communication of policy as

expressed in the Commissioner's Directives, Divisional Instructions and Standing Orders, and in particular:

(a) that the board shall consist of persons with knowledge in law, editorial expertise and, without question, practical operational experience;

(b) that the board shall identify portions of the Commissioner's Directives, Divisional Instructions and Standing Orders in relation to job description and in relation to each job category in the Canadian Penitentiary Service and designate the portions which it is obligatory for an employee to know, apply and understand for the purposes of his or her job category;

(c) that the board shall edit or cause to be edited, the Commissioner's Directives and Divisional Instructions and Standing Orders to remove superflouous matters, to simplify the language, and to

standardize the format and content, bearing in mind that each institution may have particular need in respect of Standing Orders;

(d) that the board shall prepare or cause to be prepared <u>one, unified cross-referenced indexing and numbering system</u> applicable to Commissioner's Directives, Divisional Instructions and Standing Orders.

4. A uniform comprehensive in-service training program be established by the Canadian Penitentiary Service.

APPENDIX "B"
To Millhaven Inquiry
Report
dated 15 June, 1976

IN THE MATTER OF AN INQUIRY
UNDER THE INQUIRIES ACT,
R.S.C. 1970, Chapter 1-13

SUBPOENA TO WITNESS

TO:

WHEREAS the Correctional Investigator is a Commissioner duly appointed pursuant to Part II of the Inquiries Act and Order in Council P.C. 1974-1696 dated the 25th day of July, 1974;

AND WHEREAS the said Commissioner has been requested by the Honourable the Solicitor General to inquire into

(1) "events leading up to the use of gas and force in the cell range G-1 and the ECA (environment control area) of Millhaven Institution on November 3rd, 1975, as well as the events following the said use of gas and force, and whether the directives, instructions, and standing orders which pertain to the use of gas and force were followed,

and to

(2) make suggestions with a view to improving the directives, instructions, and standing orders which pertain to the use of gas and force, and/or the way in which such directives, instructions, and standing orders are used."

AND WHEREAS it has been made to appear that you are likely to be a material witness to give evidence at the hearing of the said Inquiry;

THIS IS THEREFORE to command you to attend before the said Inquiry at what is commonly known as the old Administration Building situated on the grounds of Millhaven Institution, Village of Bath, Province of Ontario, on the 19th day of January A.D. 1976 at the hour of ten o'clock in the forenoon and thereafter as the said Commissioner may require,

to testify as to matters relevant to the said inquiry and to bring with you all relevant documents in your possession or under your control relating to the said Inquiry,

AND FURTHER TAKE NOTICE that pursuant to the Inquiries Act the said Commissioner will allow you to be represented by counsel if you wish.

Dated in Ottawa, in the Province of Ontario, this fifteenth day of December A.D. 1975.

"Inger Hansen"

Commissioner

APPENDIX "C"
To Millhaven Inquiry
Report
dated 15 June, 1976

NOTICE

IN THE MATTER OF an Inquiry into the events at Millhaven Institution on November 3rd and 4th, 1975.

WHEREAS this Inquiry has heard evidence relating to the events concerning the use of gas at Millhaven Institution on November 3rd and 4th, 1975 and into divers related matters.

AND WHEREAS Section 13 of the Inquiries Act pursuant to which this Inquiry has been conducted provides as follows:

> "No report shall be made against any person until reasonable notice has been given to him of the charge of misconduct alleged against him and he has been allowed full opportunity to be heard in person or by counsel."

AND WHEREAS allegations of misconduct have been made against you and consequently it is possible that a finding of such misconduct may be made in due course.

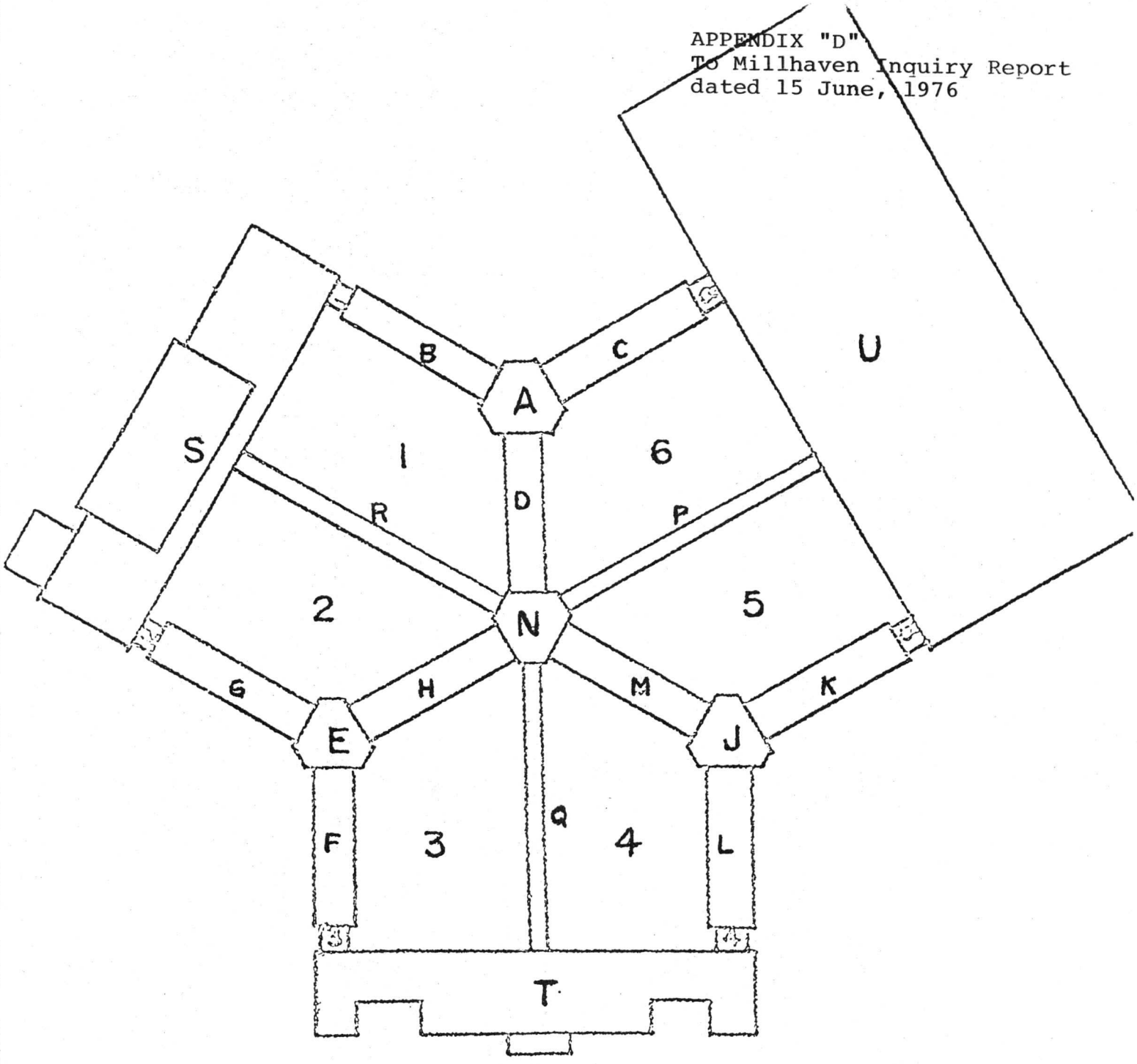
NOW THEREFORE, in compliance with the said Section 13, take notice that it has been alleged against you ... that you being ... on November 3rd and 4th, 1975, failed to take appropriate action ..., contrary to the conduct expected of you in the performance of your duties and in compliance with the orders of the Millhaven Institution and the Canadian Penitentiary Service.

AND TAKE NOTICE that you have the right to appear before the Commissioner forthwith, either in person or by counsel, to be heard further should you so desire.

AND FURTHER TAKE NOTICE that this Notice to you is in compliance with the said Section 13 and is not a finding of misconduct.

"Brian Crane"
Brian Crane, Esq.,
Commission Counsel.

APPENDIX "D"
To Millhaven Inquiry Report
dated 15 June, 1976



N - Central Control - co-ordination point

A - Control Point for B,C & D Living Units

E - Control Point for F,G & H Living Units

J - Control Point for K,L & M Living Units

T - IT offices, staff dining - T control, main entrance

S - Special Handling, hospital, chapel, hobbycraft, gym and dissociation

U - Training (vocational), industrial shops & school

P-Q-R corridors

1-6 Exercise courts

MILLHAVEN INSTITUTIONAL

COMPLEX - SATELLITE NO. 1