Annual Report

2023-2024

Office of the Correctional Investigator

Bureau de l'enquêteur correctionnel

Canada

© His Majesty the King in Right of Canada, as represented by the Minister of Public Safety, 2024

Cat. No.: PS100-PDF
ISSN: 1493-5295

Cover Photo: Special Handling Unit, Quebec

OCI | BEC
Office of the Correctional Investigator | Bureau de l'enquêteur correctionnel

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

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

PROTECTED B
PROTÉGÉ B

June 26, 2024

The Honourable Dominic LeBlanc
Minister of Public Safety, Democratic Institutions and Intergovernmental Affairs
House of Commons
Ottawa, Ontario

Dear Minister,

In accordance with section 192 of the *Corrections and Conditional Release Act*, it is my privilege and duty to submit to you the 51st Annual Report of the Correctional Investigator.

Yours respectfully,

Ivan Zinger, J.D., Ph.D.
Correctional Investigator

Canada

Table of Contents

Correctional Investigator's Message 2

Executive Director's Message 6

National Updates 8

Risk Assessment and Classification with Indigenous Peoples since *Ewert* v. *Canada* (2018) 8

The Offender Complaint and Grievance Process 16

An Investigation of Quality of Care Reviews for Natural Cause Deaths in Federal Custody 32

Population Pressures in Women's Institutions: Overreliance and Impacts of Interregional Transfers 42

Six Years After the Engagement and Intervention Model: Mixed Results for Use of Force at Standalone Male Maximum-Security Institutions and with Vulnerable Prisoners 54

Promising Practices in Indigenous Corrections 67

CASE STUDY: Death at the Regional Treatment Centre – Millhaven 76

National Systemic Investigations 93

An Investigation of the Standalone Male Maximum-Security Penitentiaries in Federal Corrections 93

Hope Behind Bars: Managing Life Sentences in Federal Custody 124

Correctional Investigator's Outlook for 2024-25 151

Ed McIsaac Human Rights in Corrections Award 152

ANNEX A: Summary of Recommendations 153

ANNEX B: Annual Statistics 157

Response to the 51st Annual Report of the Correctional Investigator 166

Dr. Ivan Zinger, Correctional Investigator of Canada

Correctional Investigator's Message

Each year, the production of my Annual Report and the drafting of my introductory message provides an opportunity to reflect on the mandate and work of my Office, which serves as the ombuds for federally sentenced individuals and the external oversight body to Canada's federal correctional authority, the Correctional Service of Canada (CSC). Our daily work involves conducting regular visits to and inspections of federal penitentiaries, meeting with CSC staff and federally sentenced individuals, and investigating and resolving issues and complaints of prisoners, individually and collectively. We review use of force incidents in federal prisons, as well as deaths in custody and other serious incidents. Our interventions help to ensure federal sentences are managed in compliance with domestic and international human rights standards providing for safe, humane, and lawful custody.

As Correctional Investigator my focus and priority has been to identify, investigate and report on issues of national or systemic significance. This year's report includes findings and recommendations from two national-level investigations – the management of life sentences and a comparative review of the six standalone male maximum-security institutions. Both investigations break new ground for the Office: it is the first time that the Office has substantively reported on "Lifers" and the investigation of the standalone maximum-security institutions represents the first time that we have conducted a systemwide inspection and review of conditions of maximum-security confinement.

Our findings in these two areas cut to the very core of correctional intent and purpose by exploring what an indefinite sentence can mean in practice (a sentence that only expires upon death), or what purpose maximum-security confinement serves when the legislated goals of rehabilitation and reintegration are not being adequately met. On their own, each investigation raises tough public policy questions that go to the costs and consequences of sentences that are, by any measure, exceedingly long (as with Lifers), expensive and excessively harsh (as with maximum-security prisons).

With respect to our investigation of maximum-security institutions, we found that the Correctional Service of Canada lacks a clearly articulated statement of purpose for what maximum-security confinement is intended to achieve. We observed operational practices and conditions that were so punitive and restrictive that they seemed antithetical to any stated correctional intent, principle or outcome. Of significant concern, we found that use of force incidents in standalone maximum-security institutions now account for 46% of all uses of force nationwide, though these facilities house approximately 10% of the total in-custody population.

In our Lifers investigation, we encountered persons serving indeterminate sentences who meet all their program requirements but who often find themselves languishing in medium-security facilities long after their parole eligibility dates have expired. We found that lifers are kept at higher security levels for longer periods with no clear rehabilitative or reintegrative purpose. To different degrees, both the life-sentenced and maximum-security prisoner experience an unacceptable amount of wasted or idled time that serves little rehabilitative or reintegrative interest.

Policy-makers need to take heed of what happens to imprisoned people when prospects for release or cascading down security levels are arbitrarily delayed or indefinitely denied, or when excessive cellular confinement all too predictably leads to violence. As research has long confirmed, longer or harsher sentences are statistically co-related with an increase in more reoffending, not less. To serve a more constructive and redeeming purpose than punishment or retribution, which in any case are no longer part of the purpose or principles of the contemporary sentencing regime in Canada, correctional practice must offer up more than the nature and gravity of the offence and the degree of responsibility of the offender. The conclusion that I draw from these two very different investigations is that imprisonment without purpose or end is cruel, arbitrary, and unlawful.

My report also includes several important national policy updates. This year's collection includes, among others, a compliance review of CSC's internal complaints and grievances system, an update on population pressures in women's corrections, an investigation of CSC's quality of care reviews into natural causes of deaths in custody, and an assessment of CSC's (in)actions six years after the seminal Supreme Court of Canada decision in *Ewert* v. *Canada* found that a number of assessment tools used by CSC violate the law when applied to Indigenous peoples. Finally, the Office's investigation into a death at one of the five Regional Treatment Centres, which are accredited psychiatric or mental health hospitals staffed and run by CSC, raises significant concern about the operation and governance of these facilities, particularly the scope and degree of clinical practice in providing safe, effective, and unfettered patient care within co-located penitentiary settings.

Beyond systemic investigations, national policy updates, prison inspections and best practice reviews, there are other issues and concerns that occupied our attention in 2023-24. Unexpectedly, there was an unusual number of decisions impacting federal corrections that seemed to lack adequate consultation, engagement, or notice to

my Office. For example, buried deep in the federal budget tabled in April 2024 was a proposal to amend the *Corrections and Conditional Release Act* to allow for "high-risk" migrants to be detained in federal penitentiaries. This reference caught my Office and most other human rights advocates unaware. The proposed expansion of immigration detention into federal prisons on grounds of alleged public safety risk is a draconian measure, a dereliction of Canada's responsibility to provide safe haven to migrants and refugees fleeing persecution or war, or simply those seeking to live a better life. I acknowledge that there may be a few foreign nationals who may present to border enforcement or immigration authorities as a flight risk, but to detain them in a federal penitentiary seems unwise, excessive, and contrary to Canadian values. There must be more humane and compassionate alternatives.

Similarly, other decisions taken by the CSC during the reporting period also seemed to be lacking in responsiveness or consultation with my Office. One example includes technical amendments and repromulgation of *Medical Assistance in Dying* (MAiD) guidelines that occurred without notice or consultation. Significantly, the Government of Canada still allows for this procedure to be carried out in a federal penitentiary, under "exceptional" circumstances ("patient's" request). Equally, the decision to staff Patient Advocate positions with CSC employees rather than external and independent appointees sends a very mixed and distorted message, inside and outside the organization. I have long anticipated this unfortunate outcome, which prompted my decision to elevate my concerns to the attention of the Minister of Public Safety in my last Annual Report. At any rate, this decision moves in a direction that is contrary to other complementary provisions enacted at the same time as Patient Advocacy Services were adopted, and which serve to protect the clinical independence and professional autonomy of CSC's health care workers. Simply put, the government and CSC are missing an opportunity to support the provision of essential health care behind bars without undue influence or interference from security staff.

I want to finish this message on a positive and constructive note. In support of the office's maximum-security investigation, I made a point to visit all the standalone male maximum-security penitentiaries. I was professionally, warmly, and courteously received by the Wardens and members of the management teams at each of the max sites that I visited. I met with many dedicated and exceptional CSC staff members and engaged in several informative exchanges with program facilitators, teachers and frontline staff who related their challenges (and achievements), almost without exception, in a frank, honest and forthright manner. Their jobs are demanding, challenging and complicated and their duties are carried out in the most unusual, difficult, and extraordinary places of human deprivation and trauma. I truly respect what they do, even if I sometimes disagree with how they do it.

Our investigators relate the same experience of being engaged professionally, respectfully, and collegially by CSC staff, often relating to me that their access to staff and prisoners and to all parts of the penitentiary to which they are assigned proceeds efficiently, effectively, and usually without any interference or complication. The date and reason for prison visits are communicated well in advance and staff make appropriate arrangements to accommodate the smooth and efficient conduct of our business. Cooperation, engagement, and collaboration are part and parcel of prison oversight. Our investigators work hard to establish rapport, trust and confidence with the people who live and work behind prison walls. As a third party, it is how we get results in the complaints resolution business.

Unfortunately, the same degree of collaboration and cooperation is not always reciprocated when my staff approach National Headquarters to meet or discuss issues, or request information related to an ongoing investigation. We often experience protracted delays in receiving information and there seems to be a reluctance on the part of the Service to meet, share information or engage with the findings and recommendations of my Office. Rarely do we receive a call from the Office of Primary Interest that would inform, qualify, or clarify our request.

I acknowledge that relationship building and trust can take time with good-faith efforts from both sides. I do not expect warm, close, or friendly relations, as that is not only impractical but likely contrary to ombuds practices and principles of independence, neutrality, and impartiality. However, at the very least, I do expect cooperation at all levels and compliance with sections 172 (right to require information and documents) and 191 (consequences for hindering or obstructing) of the law. We work best when our respective staff members understand and respect our different but complementary roles and responsibilities. After all, our two agencies share the same legislation, we serve a common public safety purpose, we are housed under the same Public Safety Portfolio, we have the same Minister, and we are all employees of the federal public service. We serve government and Canadians, and we ultimately work to advance safe, effective, and humane care and custody.

Ivan Zinger, J.D., Ph.D.
Correctional Investigator
June 2024

Monette Maillet, Executive Director and General Counsel

Executive Director's Message

The Office's focus this year continued to be on creating an effective and efficient independent prison oversight body with the implementation of our multi-year Strategic Plan, supported by an increase in permanent funding. Creating a healthy workplace that is adequately staffed and ensuring the well-being of our employees has been, and continues to be, a priority, as is providing service excellence for the incarcerated individuals we serve. For the first time in recent memory, we have a sustainable number of Early Resolution Officers and Investigators taking live calls from people behind bars, resolving issues of concern, conducting institutional visits, and investigating issues of priority. We have also begun a process of 'leaning' our complaints process to find more efficiencies and enable us to focus on more systemic issues. We look forward to seeing and reporting on the results of this exercise next year.

In 2023-24, we created new positions that were desperately needed and finalized our organizational structure to better meet the needs of the people we serve in Canada's penitentiaries, as well as provide opportunities for career development for our employees. We also expanded our investigative approach by moving from institutional visits with investigators attending prisons alone to developing an inspection model that allows for more of a team approach. This facilitates more in-depth investigations as well as a sharing of the large workload that faces staff on these institutional visits. We have also been able to create more diverse teams with different areas of expertise to conduct our systemic investigations.

Although there remains work to be done to achieve a fully staffed and sustainable structure, we are well on our way. In the last year the Office addressed 4,299 complaints and spent 230 days in institutions where we conducted 1,258 interviews with federally incarcerated persons.

The hard work of our talented employees, our continued work and collaboration with the Correctional Service of Canada and several non-governmental agencies, including Indigenous organizations, reminds us that we are all working to achieve a common outcome – a safe, fair, and humane correctional system that is guided by domestic and international human rights laws and standards. In a country such as Canada, we must continue to strive for and expect better correctional outcomes. This is done not only with grit and determination, but by working together and sometimes thinking outside the box. Our Office is certainly up for the challenge.

Monette Maillet
Executive Director and General Counsel

National Updates

This section summarizes policy issues or significant individual cases raised at the institutional and national levels over the course of the reporting period. The issues and cases presented here were either the subject of discussions with institutional Wardens, an exchange of correspondence, a follow-up from previous Annual Reports, or an agenda item in bilateral meetings involving the Commissioner, myself, and our respective senior management teams. These areas of unresolved, unaddressed, or updated concerns remain under active investigation. Therefore, this section serves to document progress in resolving issues of national significance or concern.

Risk Assessment and Classification with Indigenous Peoples since *Ewert* v. *Canada* (2018)

> **"...it is the responsibility of service providers, correctional agencies, and professional bodies to ensure the responsible application of forensic risk, and any other assessment measures. Such applications should be conducted in a culturally responsive and anti-racist manner to promote decision-making that can maximize benefit and minimize harm for justice-involved persons, enhance community safety, and advocate for human rights and social justice."**
>
> **– *Olver et al. (2024)*[1]**

The Correctional Service of Canada (CSC) uses a variety of assessment and classification tools to inform decision-making regarding most aspects of an individual's sentence. These tools were largely designed to assist decision-makers in estimating the level of risk posed by an individual for problematic or criminal outcomes (e.g., institutional

[1] Olver, M. E., Stockdale, K. C., Helmus, L. M., Woods, P., Termeer, J., & Prince, J. (2024). *Too risky to use, or too risky not to? Lessons learned from over 30 years of research on forensic risk assessment with Indigenous persons.* Psychological Bulletin. Advance online publication.

misconduct, recidivism). Today, assessment and classification tools hold a significant amount of weight in guiding and determining the course of one's sentence, from admission to warrant expiry – including initial placement, security level, referrals to programming, access to services, time spent behind bars, timing and conditions of release, and intensity of community supervision. Given that these tools were developed by and for majority White individuals, in recent years, their validity and reliability when used with diverse populations have been the basis of considerable interest in public policy and academic discourse, as well as in the Canadian courts.

Most notable among these debates was the case of Ewert *v.* Canada (2018), which made its way through the Federal Courts and eventually to the Supreme Court of Canada (SCC).[2] In this case it was argued that a number of assessment tools used by CSC violate the law and sections of the *Charter* when applied to Indigenous peoples. Specifically, the complainant in the case, Mr. Ewert – a Métis man serving a federal sentence – argued that psychological and actuarial tools used by CSC have not been properly validated for use with Indigenous peoples and are therefore discriminatory, placing Indigenous peoples in a position of significant disadvantage. Mr. Ewert first raised concerns regarding the validity of assessment tools nearly 25 years ago, when he submitted his initial grievances to CSC on this matter. Fundamental to the arguments made in Mr. Ewert's case was that the Service's use of these tools not only violated legal requirements under section 4(g) of the *Corrections and Conditional Release Act* (CCRA) to "respect ethnic and cultural differences and be responsive to the special needs of Indigenous persons," but also the requirement set out in section 24(1), requiring that CSC "take all reasonable steps to ensure that any information about an offender that it uses is as accurate, up to date and complete as possible." Mr. Ewert further argued that the use of these tools infringed upon his *Charter* rights (under sections 7 and 15).

On June 13, 2018, the SCC rendered its decision on the case, and while the court rejected Mr. Ewert's arguments regarding violations of his Charter rights, it issued a discretionary remedy in the form of an official declaration, stating that CSC had breached its statutory obligation under s.24(1) of the CCRA. It was determined, contrary to CSC's position, that the results of actuarial assessments indeed constitute *information* and therefore, given what the court determined to be a lack of research conducted by the Service to demonstrate the validity of these tools, CSC had failed to take all reasonable steps to ensure information about Mr. Ewert was accurate, as required by law.

While this case focused on the validity of five specific psychological and actuarial tools[3], it serves to highlight broader and ongoing issues regarding not only the validity and accuracy of the impugned tools as applied with Indigenous peoples, but the validity, equity, impacts, and applicability of *all* tools CSC uses to make decisions about an individual's sentence. In the SCC decision, writing for the majority, Wagner J. raised these very concerns:

> **"the clear danger posed by the CSC's continued use of assessment tools that may overestimate the risk posed by Indigenous inmates is that it could unjustifiably contribute to disparities in correctional outcomes in areas in which Indigenous offenders are already disadvantaged."**

---

[2] Ewert *v.* Canada, 2018 SCC 30, [2018] 2 S.C.R. 165.

[3] Hare Psychopathy Checklist-Revised (PCL-R); Violence Risk Appraisal Guide (VRAG); Sex Offender Risk Appraisal Guide (SORAG); Static-99; and Violence Risk Scale – Sex Offender (VRS-SO).

To this point, six years after this decision was written, the disparities in outcomes for Indigenous peoples persist and, in some cases, have worsened. Indigenous peoples continue to be vastly over-represented in federal prisons overall (i.e., account for one third of the in-custody population) as well as in higher security levels, serve more of their sentence behind bars, and experience greater delays and barriers in accessing relevant programming. Given that assessment and classification decisions are often the starting point and serve as the basis upon which these decisions are made, it is even more crucial to understand the role these tools play in perpetuating these, among many other, obstacles Indigenous peoples face over the course of their sentence.

Previous Reporting and Recommendations

June 13, 2024, marked six years since the *Ewert* decision; however, concerns regarding the applicability of assessment and classification tools with Indigenous peoples go back decades. This Office has a long history of raising concerns regarding the quality, accuracy, and impacts of assessment tools. In the last twenty years, the OCI has issued eight public recommendations on assessment and classification practices with Indigenous peoples specifically, calling on the Service to take concrete steps to ensure the tools it uses are valid, reliable, culturally informed in their composition and application, and that the over-classification of Indigenous peoples – Indigenous women in particular – be properly investigated and corrected.

OCI PUBLIC RECOMMENDATIONS ON CLASSIFICATION AND ASSESSMENT WITH INDIGENOUS PEOPLES

2003/04: the Minister initiate an evaluation of CSCs policies, procedures, and evaluation tools to ensure that existing discriminatory barriers to the timely reintegration of Aboriginal offenders are identified and addressed. This review should be undertaken independent of CSC, with the full support and involvement of Aboriginal organizations, and report by March 31, 2005.

2005/06: in the next year the Correctional Service: implement a security classification process that ends the over-classification of Aboriginal offenders.

2009/10: the Service provide clear and documented demonstration that Gladue principles are considered in decision-making involving the retained of the rights and liberties of Aboriginal offenders in the following areas: segregation placements, access to programming, custody rating scales, penitentiary placements, access to the community, conditional release planning and involuntary transfers.

2012/13: the CSC audit the use of Gladue principles in correctional decision-making affecting significant life and liberty interests of Aboriginal offenders, to include penitentiary placements, security classification, segregation, use of force, health care and conditional release.

2015/16: develop new culturally appropriate and gender specific assessment tools, founded on Gladue principles, to be used with male and female Indigenous offenders.

2018/19: publicly respond to how it intends to address the gaps identified in the *Ewert* v. *Canada* decision and ensure that more culturally-responsive indicators (i.e., Indigenous social history factors) of risk/need are incorporated into assessments of risk and need; and, acquire external, independent expertise to conduct empirical research to assess the validity and reliability of all existing risk assessment tools used by CSC to inform decision-making with Indigenous offenders.

2022/23: the Minister direct CSC to work with the Section 81 Healing Lodges to identify the main causes of vacancy rates and identify actions that will be taken to increase and maintain higher occupancy rates, with attention to: Developing new and rigorously validated security classification tools for Indigenous peoples, from the ground up, that reduce their over-representation in medium and maximum security, consistent with the SCC decision in *Ewert* v. *Canada*, 2018.

In addition to recommendations made by this Office, over the last decade, at least a half-dozen other reports, inquiries, and commissions have similarly issued recommendations to CSC on this very issue.[4] Similarly, since 2018, three parliamentary committees have conducted studies focusing on the experiences of Indigenous peoples in the federal correctional system.[5] Seven recommendations specifically related to the issue of assessment and classification practices, including for CSC to:

- develop new risk tools that are more sensitive to Indigenous reality;
- review its security classification process, generally, but with specific attention to Indigenous women;
- ensure tools provide Indigenous offenders with greater access to culturally appropriate treatment and healing lodges;
- partner with Indigenous communities to redesign classification tools and processes;
- ensure staff have proper sociohistorical training and information to properly conduct assessments; and,
- work with independent experts to ensure classification and assessment tools include dynamic factors, contextual factors, and the unique experience of marginalized groups.

Classification and assessment of Indigenous peoples serving federal sentences has also been a significant point of concern raised in two recent Auditor General (AG) reports. In 2016, in *Preparing Indigenous Offenders for Release*, the AG made recommendations to CSC which, among others, were to explore additional tools and processes of security classification.[6] Positively, the Service agreed with *all* recommendations. Six years later, however, the AG released a subsequent report on *Systemic Barriers in Correctional Service of*

[4] In their final report, *Reclaiming Power and Place*, the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) issued 14 calls-to-justice on corrections, including that CSC improve classification scales and security levels for Indigenous women who account for half of all federally incarcerated women and nearly 70% of women in maximum security. Disappointingly, the government's National Action Plan (2021) in response to the MMIWG's calls-to-justice, offered only a vague goal to "implement Gladue principles that contribute to addressing systemic barriers"; however, no formal commitment was made to address the specific concerns regarding the assessment and classification of Indigenous women.

[5] House of Commons Standing Committees on Public Safety and National Security [SECU], 2018; Status of Women [FEWO], 2018; and, Standing Senate Committee on Human Rights [RIDR], 2021.

[6] Office of the Auditor General. (2016). *Report 3 – Preparing Indigenous Offenders for Release – Correctional Service of Canada.* Ottawa, ON.

Canada and found most of the issues raised in 2016 remained. The 2022 audit found that CSC had "failed to address and eliminate systemic barriers that persistently disadvantage certain groups of offenders."[7] Among their findings were that Indigenous individuals were placed at higher security levels at *twice* the average rate, were more likely to receive an override of their Custody Rating Scale (CRS)[8] to a higher security level, were given fewer overrides to minimum security, and that CSC did not monitor whether staff properly considered Indigenous Social History factors (ISH) for security classification decisions. All significant issues and barriers related to assessment and classification practices. Further to this second audit, the AG again recommended that CSC improve their security classification process by undertaking a review, with external experts, and taking any required action to improve the reliability of classification decisions. As was the case in 2016, the Service agreed with all of the AG's recommendations.

CSC Responses and Actions to Date

Most recommendations issued by my Office and others remain largely unaddressed or little has materialized from the Service's stated intentions. For over a decade, CSC has repeatedly indicated that they "recognize a need to ensure tools are culturally sensitive," that it continues to work to ensure its tools are "effective and culturally sensitive" and are considering changes to determine the "cultural appropriateness" of case management and assessment of Indigenous peoples. For example, in response to the AG's 2016 audit, CSC indicated that it would, "examine the need for and feasibility of developing new culturally appropriate assessment measures founded on the Gladue principles." Two years later, in response to the SECU 2018 report, the Service noted that, "ongoing work is examining the need and feasibility of developing new culturally appropriate assessment measures founded on the Gladue principles, with the goal of ensuring that Indigenous offenders have access to effective, culturally appropriate programs and interventions as early as possible." And as recently as 2021, in response to a recommendation made by this Office, CSC indicated that it was: "working with university partners on an Indigenous-led security classification process for Indigenous peoples in federal custody… to conceptualize, from the ground up, a risk assessment process for security classification, for both women and men inmates, that is culturally based." Again, while these responses signal good intention, the Service has been unreasonably slow in its progress towards developing any new tools, properly examining the accuracy of existing tools, and making the tools they use culturally relevant for Indigenous peoples.

This Office has sought updates from CSC on this issue on at least five separate occasions since the *Ewert* decision. Through a documentation request in 2022, this Office was made aware of an ongoing Memorandum of Understanding and Service Exchange Agreement between CSC and the University of Regina, set to expire in the 2024, for a number of projects. Among these include a systematic review of the validity of risk assessments with Indigenous peoples and an *Indigenous Community Engagement Strategy*, intended to engage Indigenous communities to develop a research design for a project entitled: *Validation of Risk Assessment Tools for Use with Indigenous Offenders*. While the systematic review (conducted by external experts) has since been completed and published, there has been little observable progress on the development of any new research or culturally informed tools.

---

[7] Office of the Auditor General (2022 May). *Report 4—Systemic Barriers—Correctional Service Canada*. Ottawa, ON.

[8] The Custody Rating Scale is an actuarial assessment and classification tool used for all individuals admitted to federal custody. It is used for determining an offender's initial security classification.

This Office met with, and was consulted by, the group of Indigenous-led researchers affiliated with the University of Regina. We are aware they provided the Service with a report and proposal, detailing what would be required to develop an Indigenous risk assessment tool; however, there do not appear to be any concrete plans in place for next steps on this work. In response to our recent and repeated attempts to obtain an update on all relevant work since the *Ewert* decision, it was shared by the Service that: "there have been challenges in the course of the undertaking of the research associated with the MOU, including changes in the University of Regina research team and in moving forward with Indigenous engagement strategies at the community level." The Service continues to signal that the work "remains ongoing," with more engagement and exploratory activities in the coming year; however, no further specific timelines or significant deliverables were identified, beyond consultation and strategy-building activities.

This Office recognizes that development of new tools from the ground up is a resource-intensive endeavour, and more so when led by external experts and with significant engagement by the community, as has been recommended; however, the development of new tools or practices is not new territory for the Service and should not be the cause for further delays. There is precedent for CSC developing tools, based in fieldwork and the consideration of group-level differences in their development.[9] At the writing of this report, CSC has still provided no public response to the *Ewert* decision. There are still no validated assessment or classification tools developed for or by Indigenous peoples and no anticipated timelines for one to be developed. There has also been no external primary research done by *independent* experts, of the CRS or other CSC-developed tools, or any concrete progress towards demonstrating proper consideration of ISH in decision-making, as evidenced by the AG's most recent audit. This situation is unacceptable and inconsistent with the urgency and severity of what is at stake.

Systematic Review of Risk Tools

Of the steps taken by CSC thus far, it is worth noting some key findings from the systematic review it commissioned by independent academic experts.[10] In their review of 91 studies of 22 risk assessment tools, Olver et al. found that while most assessment tools, including many in use by the Service, meet at least the minimum threshold for statistical validity, for the majority of the tools, validity was found to be *consistently poorer* when these tools are used with Indigenous peoples. In other words, their ability to accurately assess the risk for outcomes is consistently weaker for Indigenous peoples. On this point, the research is clear and consistent – these tools consistently don't work as well for Indigenous peoples. For some of the tools, including two developed and used by CSC, the accuracy for Indigenous peoples was among the worst of all 22 tools included in the review, just barely meeting statistically "acceptable" levels of validity.[11] They also found that there are currently *no* tools that incorporate culturally relevant factors in their estimations and measurements of risk. As these findings demonstrate, and as was argued in *Ewert*, there is a clear need (and responsibility) on the part of the Service, and other correctional agencies, to conduct research to better understand why these tools have consistently lower accuracy when used with Indigenous peoples and what needs to be done to address this gap. It should be noted that

[9] For example, Blanchette, K. & Taylor, K.N. (2007). *Development and Field Test of a Gender-Informed Security Reclassification Scale for Female Offenders.* Criminal Justice and Behavior, 34/3.

[10] *Ibid* Footnote 1.

[11] See results in Olver et al. (2024) on the Static Factors Assessment (SFA) and the Dynamic Factors Identification and Assessment – Revised (DFIA-R).

a number of tools CSC currently uses, including the Custody Rating Scale, were not included in this systematic review and therefore, more *independent* research is required.

Importantly, in addition to the meta-analytic findings, the experts offer some directions for correctional agencies, which warrant repeating here. Among them, they warn that correctional agencies should not place undue weight on assessments comprised of largely historical or unchangeable factors (i.e., "static" factors), as they have the *weakest* validity with Indigenous peoples and "the greatest potential for ethnoracial bias". As many others have pointed out and criticized, most of the tools CSC currently uses to make decisions rely heavily on static factors, making it not only impossible to assess changes in risk or demonstrate positive progress, but also make Indigenous individuals appear higher risk due to the colonial causes at the root of most of these factors (e.g., age at first federal admission, sentence length, number of prior convictions). Some of the tools the Service uses to make decisions are comprised almost *exclusively* of static factors (e.g., Custody Rating Scale, Static Factors Assessment, Criminal Risk Index). Assessing static factors through these assessments undoubtedly contributes to the over-representation of Indigenous peoples in maximum security, difficulties and delays in cascading to lower security levels, gaining access to Healing Lodges, barriers to accessing programming, and delays in being granted timely release, among other problematic barriers and outcomes.

The researchers recommend that static tools be meaningfully supplemented with valid, dynamic measures (i.e., factors that can change over time and through intervention). As they put it, "to not do this is committing an act of social injustice." They also call upon correctional agencies to conduct research on culturally specific risk factors, a recommendation that has been put to the Service many times. It remains to be seen how CSC intends to use the results of the work that it has commissioned and how evidence-based advice will inform any next steps.

Moving Forward

Last year, this Office released a report on *Ten Years since Spirit Matters*, an update on the state of various initiatives for federally sentenced Indigenous persons. It also marked 30 years since the implementation of the CCRA. As documented in this report, the troubling trajectory of the barriers and negative outcomes experienced by Indigenous peoples in the correctional system is counter to what was intended and expected when the CCRA was enacted. It is clear by most measurable outcomes that applying a one-size-fits-all approach to most practices and tools in corrections – including assessment and classification – is contributing to different correctional outcomes for Indigenous peoples. As Olver et al. so aptly reminded all correctional agencies, it is their responsibility in the application of *any* tool, that it be constructed and used in a "culturally responsive and anti-racist manner to promote decision-making that can maximize benefit and minimize harm." The various sections of the CCRA pertaining to the treatment of Indigenous peoples, among other groups, were written as explicit direction to the government to address the systemic discrimination and *harm* Indigenous peoples have experienced through the course of history and to this day. As described in the *Ewert* decision, "The requirement that the CSC respect differences and be responsive to the special needs of various groups reflects the long-standing principle of Canadian law that *substantive equality* requires more than simply equal treatment." CSC has fallen devastatingly short of this responsibility, which can in-part be attributed to a lack of *substantive equality* afforded to Indigenous peoples across most social institutions, including the prison system. Favouring an "equal treatment" approach in assessment and classification of Indigenous peoples, for example, is an illustration of this failure, the consequences of which are far reaching for those serving federal sentences.

With few exceptions, the common practice of developing generic tools based on the majority and applying them equally to groups with meaningfully different sociohistorical paths to the criminal justice system is a contradiction of this principle. And in the face of evidence demonstrating that these tools are inferior for Indigenous peoples, because they ignore such historical and social inequities, clearly suggests that better, different, tools and methods are needed. Tacitly accepting these disparities, while failing to advance meaningful improvements is tantamount to "an act of social injustice" and, per the *Ewert* decision, demonstrates contempt for, and constitutes a violation of, the rule of law.

In his May 27, 2022, Mandate Letter to the Commissioner of Corrections, the then Minister of Public Safety commended CSC on their work "to develop and incorporate Indigenous-informed risk assessment instruments and its efforts to fight systemic racism." Based on the lack of observable progress, this praise seems grossly premature. It should not be forgotten that CSC was found to be in violation of the law by the highest court in the country. It is unacceptable to have made so little progress on this issue. CSC continues to use these tools and continues to insist that they are sufficiently valid for use with Indigenous peoples, in spite of *Ewert* and external research that it has commissioned. Six years later, the spirit of many of the arguments put forward in *Ewert* remains a cause for concern.

1. **I recommend that the Service report publicly, in the next fiscal year, on concrete actions, deliverables, and timelines on how and when it will:**

   a. **acquire external, independent expertise to conduct empirical, primary research to assess the validity and reliability of *all* existing assessment and classification tools and methods used by CSC to inform decision-making with Indigenous offenders; and,**

   b. **develop new assessment and classification tools, Indigenous-led and from the ground up, for federally sentenced Indigenous peoples, that include culturally responsive and informed indicators of risk and need (i.e., Indigenous social history factors).**

The Offender Complaint and Grievance Process

The right of a prisoner to make a complaint about mistreatment or conditions of confinement without fear of reprisal is a foundational principle of international and domestic human rights law. An effective complaint and grievance process encourages prisoner involvement as a means of resolving problems and conflicts at the lowest level possible and in a pro-social manner. There is evidence to suggest that when complaints are taken seriously and complainants are treated fairly and respectfully, incarcerated persons are more likely to accept and abide by decisions and rules, even if the outcome is not in their favour.[12] An effective prisoner redress process has the following core features:

1. Prisoners have *confidential access* to a complaints process, and they have the capacity and means to use it.
2. Prisoners have *trust* in the system, and they use it in *good faith*.
3. Complaints are answered in a *fair, timely and expeditious* manner.
4. Responses are *meaningful*, complete, and easily understood.
5. Grievers do not suffer *negative consequences* for complaining.

On paper, the Correctional Service of Canada's offender complaint and grievance policy and process reflects and incorporates these basic principles. Section 90 of the *Corrections and Conditional Release Act* (CCRA) provides for

A grievance box at Millhaven Institution

a "procedure for fairly and expeditiously resolving offenders' grievances." Section 91 of the *Act* assures that every offender shall have *"complete access"* to a grievance procedure "without negative consequences." One of the foundational legal principles of the CCRA provides for the existence of an "effective grievance procedure." The *Regulations* further instruct that every effort will be made to resolve matters "informally through discussion." Other provisions require giving reasons when rendering a decision on complaints, provide a mechanism for referring matters to an Inmate Grievance Committee, define a process for dealing with Multiple Grievers and outline criteria for rejection of complaints that are considered "frivolous, vexatious or not made in good faith."

[12] See, for example, van der Valk, S., & Rogan, M. (2023). *Complaining in Prison: 'I suppose it's a good idea but is there any point in it?'* Prison Service Journal.

Commissioner's Directive (CD) 081 – *Offender Complaints and Grievances* – and associated Guidelines 081-1 provide policy and procedures on how these legal rules are to be interpreted and applied by staff, including criteria on how to administratively prepare a response to a grievance and provide decisions that are clear, complete, impartial, and fair. There is further guidance on how to process certain grievances, for example, allegations of harassment or discrimination, or other submissions, such as transfers to Structured Intervention Units, the Special Handling Unit, or dry cells. Policy requires that these matters be automatically elevated to the final (or national) grievance level.[13] As of November 2019, initial health-related grievances are submitted directly to Health Services at the Regional level. The Assistant Commissioner, Health Services, is the decision-maker for health-related grievances making their way to the final level.

Since the phasing out of the regional level of complaint review in 2014-15, today the formal complaint and grievance system consists of three levels:

1. **Complaint** – submitted at the institutional level, and responded to by the supervisor of the staff member whose actions or decisions are being grieved.
2. **Initial** – submitted to the Warden (institutional level).
3. **Final** – submitted to the Commissioner (national level).

When a griever is not satisfied with the decision at the complaint or initial level, they may escalate the matter to the next level, normally within 30 working days of receiving the response. According to policy requirements, routine priority issues submitted at the complaint and initial grievance levels are to be processed within 25 working days of receipt and within 15 working days for high priority matters. At the final level, processing requirements are extended to 60 working days for high priority grievances and 80 working days for routine priority grievances.[14] These requirements, including extended timelines to process final level grievances, have been in place since 2007.

Law and policy on these matters are clear and straightforward. Compliance, on the other hand is a matter of abiding concern, particularly as it relates to the capacity of the Service to address grievances within prescribed processing timeframes. The Office has frequently commented on the high number of *unresolved* complaints and grievances going forward to the next level and the excessive delays in processing them.[15] Up until very recently, it was not uncommon to wait up to a year to receive a response to a final level grievance (high priority or routine), and, in the case of an upheld grievance, even longer for a corrective action to be issued and implemented. The Office has often stated that internal dysfunction, delays and wait times of this magnitude are like having no remedy at all.

Purpose

This review updates Office findings in this important area and includes our latest assessment of the system's ability to provide timely and effective redress. It acknowledges recent CSC efforts to address unprecedented and crippling backlogs in final level grievance review and reduce overall wait times. Our review calls on CSC to prioritize efforts to address complaints informally, and at the lowest level possible, before they can be escalated to

[13] A separate administrative review process is in place for use of force incidents. Any grievance related to a reported use of force incident, or the use of force review process, is registered as a final level grievance.

[14] Commissioner's Directive 081 defines *"high priority"* complaints and grievances as those that concern matters that have a direct effect on life, liberty, or security of the person; others are designated as *"routine priority."*

[15] See, for example, Office of the Correctional Investigator (OCI). *Annual Reports: 2010-11, 2014-15, and 2016-17.*

become part of the formal grievance system. We encourage the Service to recognize the central importance of reallocating resources to better support the resolution of complaints and grievances at the institutional level. To that end, the Office calls on the Service to invest in training, skills, and capacity to successfully implement and sustain mediation and other alternative dispute resolution practices at all maximum-security and multi-level penitentiaries across Canada, including the Regional Treatment Centres and Women's institutions.

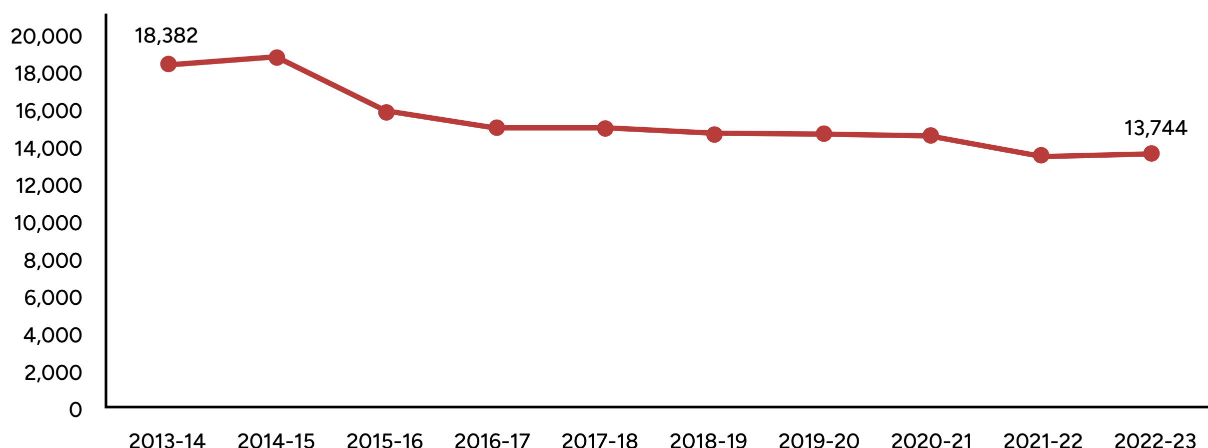
Analysis of Complaint and Grievance Trends

Ten-year trend data indicates that the overall number of complaints and grievances has decreased, and this trend seems to have picked up pace in the post-Covid period (see Graph 1). At the same time as the volume of complaints is decreasing, the number of grievances answered within prescribed timeframes has generally declined since at least 2016-17.

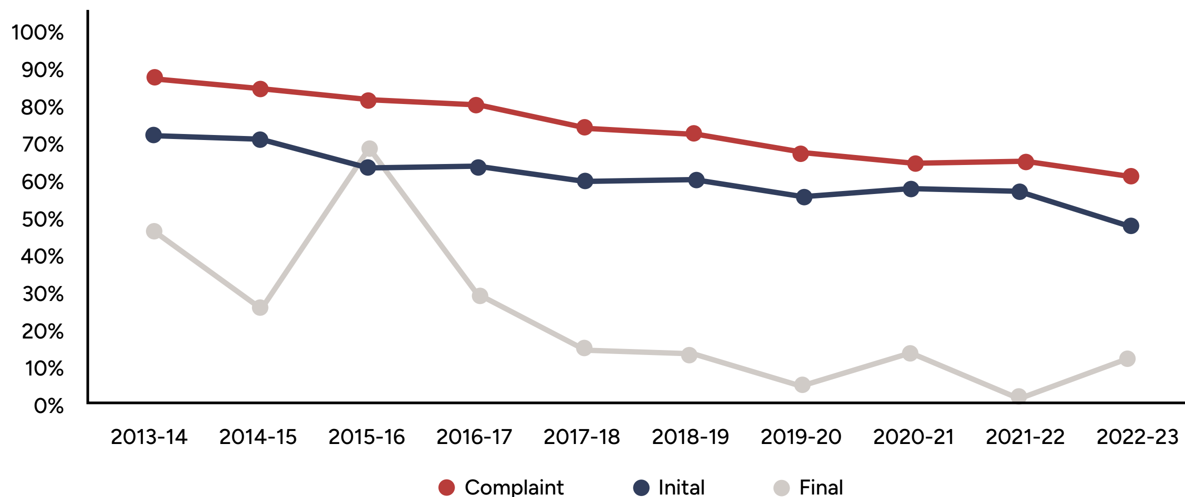
Over the same period, the complaints related to institutional conditions/routine (32.6%; e.g., food, diet, amenities), interaction (19.6%; e.g., staff performance), and health care (15.4%) accounted for more than two thirds of all complaints (see Table 1 in the Appendix for a complete breakdown). These subjects broadly mirror the top categories of complaints received annually by the OCI.

Disaggregating complaints by the ethnicity of the complainants, the numbers and proportions generally reflect changes in the overall demographic distribution and diversity of the federally incarcerated population (see Table 2 in the Appendix). For example, the proportion of complaints submitted by White prisoners declined from 62% in 2013-14 to 53% in 2022-23 and has increased for Black prisoners from 9% to 11% within the same period. For Indigenous prisoners, the proportion of complaints reflects their growing representation, i.e., from 24% of all complaints in 2013-14 to 31% in 2022-23.

GRAPH 1. TOTAL NUMBER OF COMPLAINTS SUBMITTED BY FISCAL YEAR



GRAPH 2. PROPORTION OF GRIEVANCES PROCESSED ON TIME BY LEVEL AND FISCAL YEAR



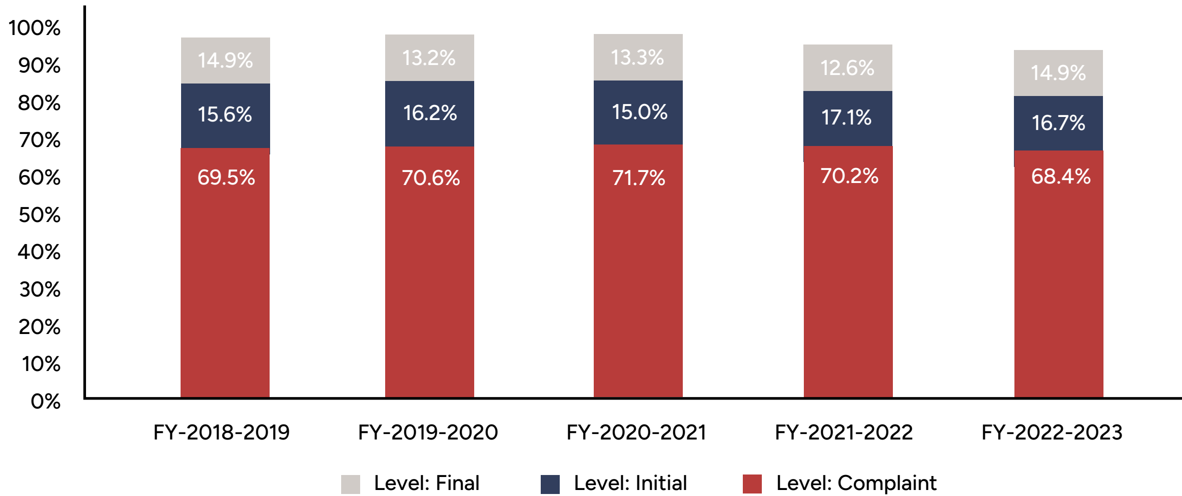
Trend data also shows that the proportion of grievances being processed on time has generally decreased (Graph 2). More recently, the number of grievances processed on time at the national level is showing substantive improvement.

Approximately 75% of all grievances reaching the final (or national) level are designated routine priority, meaning they should be resolved within 80 days. Since 2013-14, less than 30% of all routine grievances were completed within prescribed timelines (see Table 3 in the Appendix). The proportion of high priority grievances completed on time (within 60 days) was even less, averaging around 25% (see Table 4 in the Appendix). As the statistical tables indicate, 27.8% of all high priority grievances took more than 301 days to complete while 21.3% of routine grievances averaged more than 301 days to complete.

During this investigation, CSC advised that current processing times for final level grievances are now much closer to policy guidelines, gradually decreasing from 360 days in 2020, 310 days in 2021, 130 days in 2022 and now to less than 60 days. For the first time in CSC's history, the Office was also informed that there will be no backlog of final level grievances by fall 2024.

While recent trends in processing final level grievances are encouraging, the Service's ability to comply with prescribed processing timeframes is symptomatic of other problems. In the same way that "justice delayed is justice denied," the proportion of complaints that fail to be resolved informally through discussion, and those that are routinely escalated to initial, and then final decision levels raise serious concerns about the system's commitment to timely and effective redress. Few within or outside the Service would argue with the premise that routine issues at the institutional level should be properly and promptly dealt with at their source. However, once matters surpass the complaint stage, there is, in fact, not much variation between the proportion of grievances submitted at the initial (or institutional) level and those that are escalated to the final level. In other words, while

GRAPH 3. PERCENTAGE OF GRIEVANCES BY LEVEL (2018-19 TO 2022-23)



many complaints get resolved at the first complaint stage, a high proportion of initial grievances at the institutional level are unresolved and get pushed to the national level of grievance review.

There is no easy or single explanation for this degree of redundancy. In fact, there are few disincentives to escalating or bumping issues upward and onward; some grievers and even some staff wrongly assume that the national grievance level acts as a kind of final "appeal" stage. Some users seem to be of the belief that their complaint will only be taken seriously if it is elevated to the next level in the process. The commonly heard expression – *"let national decide"* – provides a convenient excuse for putting off dealing with sticky or potentially divisive issues at the institutional level. Though it may, at times, help a Warden to save face with staff, it does not save time. To put the same matter differently, there are few built-in incentives for institutional authorities to settle a complaint or answer a grievance on time.

Whatever the cause, the current operation of the complaint and grievance process does not seem designed in a way to support or deliver outcomes that are timely or responsive. In cases requiring more time for response preparation, it is standard practice to issue an extension letter, which is supposed to include a reason(s) for the delay and a revised date that the griever should expect to receive a response. A 2018 internal audit of the Offender Redress system found that these extension letters often took the form of a standard template, and often failed to provide a specific reason for why the response was delayed, or even when a response could be expected.[16] CSC claims that maladministration of this nature is now less common at the final grievance level; however, the issue of "overdue" responses at the initial (institutional) level remains, regardless of whether an extension letter (with revised due dates) was provided or not, leading to frustration and lack of confidence in the system.

[16] Correctional Service of Canada (2018). *Audit of Offender Redress.*

Though the quality of responses varies from one level to the next (generally improving as the complaint makes its way up), there is a tendency to answer grievances impersonally, in the third person, and usually in a manner that adheres to the strictest definition and letter of the governing regime. In the Office's experience in reviewing CSC responses to complaints, it often seems that the respondent is well versed in parsing, limiting, or rejecting the substance of complaints on procedural or technical grounds (e.g., out of jurisdiction, deadlines for escalation not respected, grievance raises a new issue, or an issue that has been addressed in a separate submission). Resolution or rejection often settles on the point of least resistance. There may be limited scope for acting on a grievance, but there is ample room to appeal to a higher level when grievers do not get the redress they wanted or expected.

Though the data and analysis amassed by the complaints and grievance system should provide management with important insight into emerging trends or issues of concern, it is not clear that these tools are being used optimally to monitor or improve performance. The latest audit of Offender Redress explains:

> **[Commissioner's Directive 081] … does not clearly assign responsibility or accountability for the Service-wide process to any single group. The result is a fragmented process, whereby Offender Redress Division is responsible for response activities at the national level and each site is responsible for managing their own respective process, resulting in potentially dozens of varying complaint and grievance processes across the Service, and no cohesive plan in place to resolve complaints and grievances at the lowest possible level. This increases the likelihood of diminished response capabilities, impacting offender confidence in the institutional process and resulting in reoccurring backlogs at the national level.[17]**

In other words, there is no governance mechanism in place to prevent future backlogs at the final level, little national capacity to support institutions to better manage complaints informally and at the lowest possible level, and no plan to better prevent escalation of complaints and grievances from one level to the next. Five years later, senior management has had more than enough time to address these identified deficiencies. Notwithstanding, there are few indications today that there is willingness to strengthen national oversight or overall accountability of the complaint and grievance system, bolster efforts to resolve matters informally, or improve the use and analysis of complaint and grievance-related data to drive performance. In the absence of national oversight and leadership, the redress systems which independently operate at each site cannot be expected to respond in a consistent or coordinated manner.

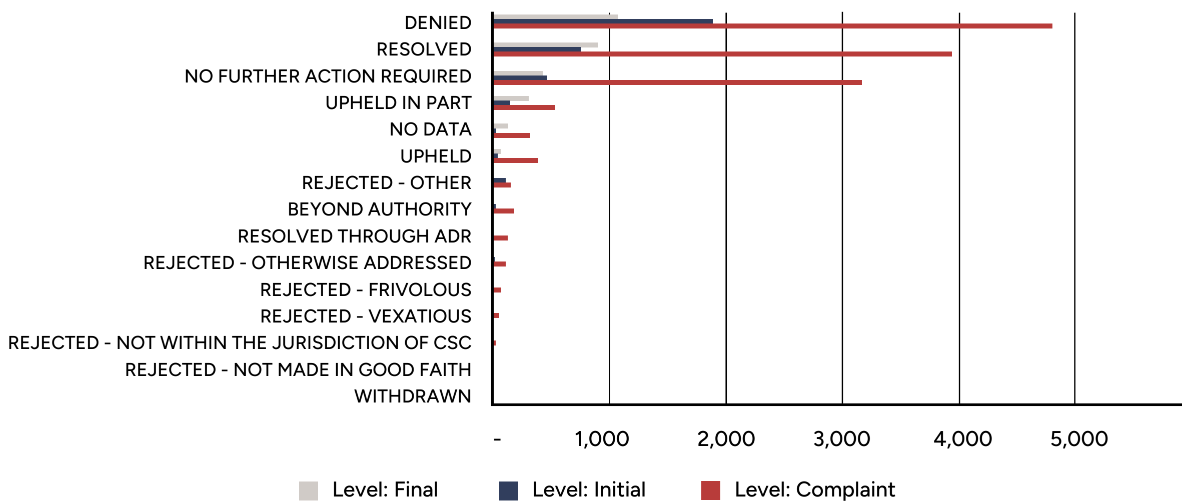
[17] *Ibid.*

Lack of Focus and Priority on Informal Resolution

Ideally, before a prisoner even files a written complaint, the *Act* instructs that every attempt be made to resolve issues informally. For many reasons, the statutory requirement to resolve matters at the lowest level possible through discussion is not a well established or ingrained practice, particularly at higher security level institutions. In fact, according to the 2018 audit, "evidence was often lacking to demonstrate that staff members at the institutional level had made an active effort in attempting to resolve matters informally."[18] Beyond a one-page Annex appended to the back of the *Guidelines*, there is little actual or active policy direction on how to facilitate or implement informal or alternative dispute resolution (ADR) mechanisms in federal prisons. Though the same Annex indicates that ADR must remain available throughout all stages of the redress process and that National Headquarters "is prepared to assist institutions in identifying and implementing alternative dispute resolution mechanisms," during this investigation the Office encountered only *one* active ADR project, which is running as a pilot at Kent Institution. Lacking ongoing and a permanent source of funding, this promising pilot is soon set to expire.

Moreover, the data indicates that only a small number of complaints are resolved through ADR (see Table 5 in the Appendix). With respect to the disposition of complaints, they are answered, in ascending order, as Denied, Resolved, No Further Action Required, Upheld or Rejected. Only a small fraction of the thousands of complaints and grievances filed each year are found to be "upheld." Further, the proportion of Upheld grievances has declined over the past decade, from 1,030 or 3.6% of all grievances in 2012-13 to 532 or 2.7% in 2022-23 (Graph 4).

GRAPH 4. TOTAL NUMBER OF GRIEVANCES IN 2022-23, BY DECISION AND LEVEL



[18] *Ibid.*

As the Office found this year in investigating the standalone male maximum-security institutions, many of the components that support or feed into the formal complaints and redress process are either delinquent, defunct or deficient. This includes Inmate Welfare Committees (IWCs), Outside Review Boards, Inmate Grievance Committees, and Inmate Grievance Clerks. On the matter of incarcerated person involvement, an effective redress process relies on a functioning and recognized IWC where discussion and negotiation between elected Committee members and management can help to raise and resolve group matters before they become the subject of multiple individual grievances. At maximum-security sites, the tendency to appoint or acknowledge range representatives as a substitute for the IWC reinforces intra-group divisions and fuels the incessant conflict between sub-population groups in these institutions.

Lacking internal coherence, the system seems to respond to periodic pressures by extending prescribed processing time limits, delaying redress, and amassing backlogs. From users, these systemwide failures serve to increase distrust and lack of confidence in the system among federally sentenced individuals. In recent years, an enormous amount of effort and resources has been expended to clear a backlog in final level grievances that, by December 2020, had peaked at close to 4,000 submissions. This extraordinary effort included the formation, in November 2022, of a *National Complaint and Grievance Resolution Review Committee*. As part of its mandate, this Committee set out to review and address complaints filed by a select number of prolific grievers, a few of whom are responsible for hundreds of complaint submissions. There were a few important takeaways from the Committee's work, not least of which include never underestimating the importance that incarcerated persons place on the opportunity to air their grievances in person, to be taken seriously and to be heard by decision-makers. Though this level of engagement led to its own share of concerns and complaints, the learning points reflected below are instructive:

> **The in-person interviews gave the offenders the opportunity to express their concerns and allowed for the committee to engage them in the resolution of their complaints and grievances. The committee's presence at the operational sites meant the committee members could see firsthand what the complaints were about and work with operational staff to come up with solutions. The participation of offenders and the support of the regional and operational sites were key to resolving the majority of complaints, and to the success of the project.[19]**

Other measures to reduce grievance backlogs have been more contentious. In March 2017, temporary funding supporting alternative dispute resolution projects at ten penitentiaries was suspended and significant resources reallocated to National Headquarters to address the backlog of final level grievances. At that time, even though the suspended ADR projects were showing early but consistent signs of success, considering the growing backlog in final level grievances, this priority reallocation exercise appeared defensible. In retrospect, it is now conceded that a reciprocal

[19] CSC. (2024). *Taking action to resolve complaints and grievances.* Retrieved from *The Hub* on March 20, 2024.

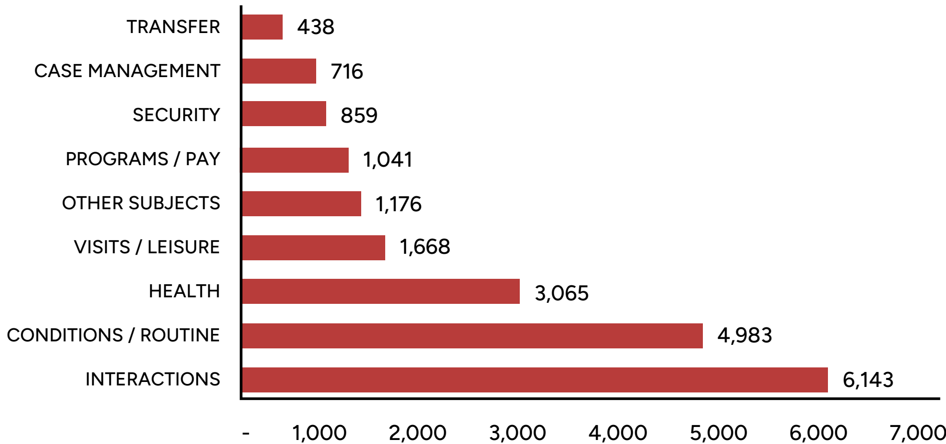
level of training, skills, resources, and priority is required to front-load the process to actively support and strengthen informal resolution of complaints at the lowest level possible, and thereby reduce pressures on other levels of the system. The learnings gleaned from these two "unclogging" exercises should quash any remaining doubt that mediation and fully supported and funded alternative dispute resolution programs should be made available in all federal penitentiaries.

The Issue of Reprisals

Incarcerated people continue to express widespread lack of trust and confidence in the system, often describing it as "flawed" or "useless". As the Senate Committee on Human Rights recently reported, most had given up trying to use the system because of delays, backlogs, and the fear of potential reprisal from staff.

The Committee heard that prisoners have little faith in the system because, in their eyes, it lacks credibility and independence.[20] For example, when complaints of mistreatment are made against a staff member, responsibility for responding to those allegations falls to that person's immediate supervisor. Perceptually and procedurally, there is little separation between the staff member who may be the subject of the complaint and the work colleague who assesses it. Complaints and grievances against staff, often falling under the larger category of "Interaction" (see Graph 5), are very difficult to prove and establish; these complaints are rarely deemed to be founded and even less likely to be upheld. Given that "staff performance" accounts for the largest single complaint filing under this category of complaints, it seems a natural fit to resolve these issues through mediation or ADR.

GRAPH 5. TOTAL NUMBER OF GRIEVANCES RECEIVED BY SUBJECT IN 2022-23



Note: The subject "Interactions" includes Cross-Gender Staffing (4), Discrimination (1,230), Harassment by staff (710), Sexual Harassment (64), and Staff Performance (4,135). The subject "Conditions/Routine" includes Food and Diet (758), Institutional Amenities (786), Personal Amenities (230), Appeals on claims against the Crown (218), Conditions and Routine in the Institution (881), Offender Accounts (376), Offender Canteen (251), Personal Effects (1,362), Deductions for Food, Accommodation and Telephone Administration (17), Shared Accommodation (104).

[20] Standing Senate Committee on Human Rights (2021 June). *Human Rights of Federally Sentenced Persons.*

On the point of reprisals, the Senate Committee's report states:

> **The Committee also heard that federally sentenced persons can face intimidation and retaliation for filing grievances or even for inquiring with correctional staff about filing grievances. According to witnesses, reprisals could take various forms including harassment, destruction of property, loss of privileges, interference with correspondence, visits and programming, neglect of responsibilities, excessive use of force, and delays in completion of paperwork as well as lack of support for access to programs and conditional release.**[21]

While conducting this investigation, my Office heard many of the same allegations, though the reality of reprisal or retaliation for using the complaint and grievance process manifests itself in less subtle ways. Interference, pressure, and intimidation can and does happen. These actions often take the form of pressuring complainants into withdrawing their complaint, or agreeing to sign off that a grieved matter was "resolved," even if it had not been addressed to the complainant's satisfaction or proposed remedy. When it comes down to it, there are few protections afforded to grievers who fear or experience negative consequences for exercising their right to complain.

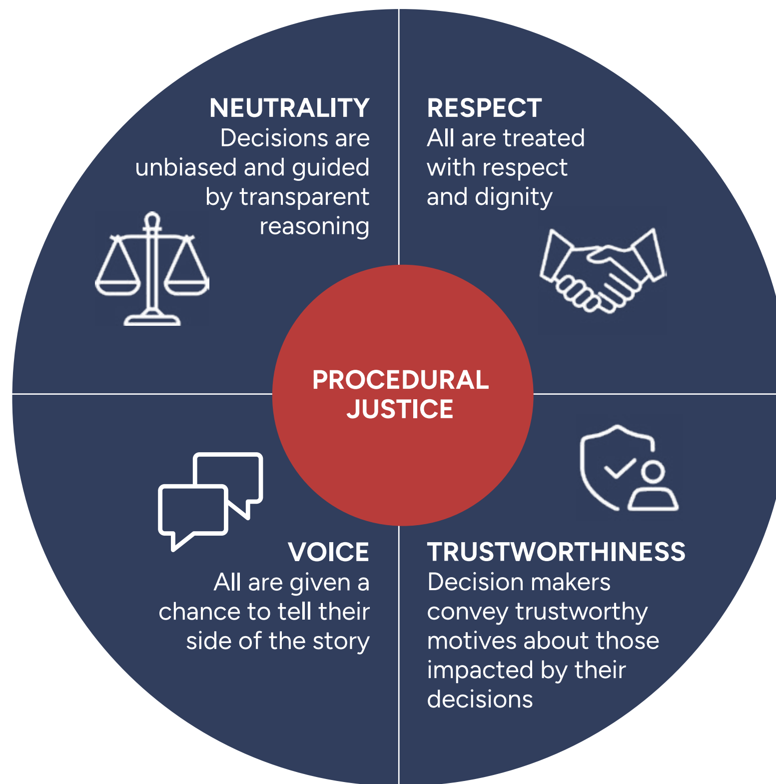
The redress system is consumed by paperwork and endless compliance reporting; from the outside, it appears more focused on meeting or extending established timeframes than providing substantive redress. Befitting a system that is primarily paper-based, responses to formal grievances are prepared and delivered in writing. The request or opportunity for grievers to speak with CSC staff regarding the status or substance of their complaint or grievance is not always accommodated. Responses are frequently delivered by the Grievance Clerk, and rarely by the person who is the subject or assessor of the complaint. Though it might be easier and administratively more convenient for staff to instruct an aggrieved person to *"put it in writing,"* such a requirement should not diminish or devalue the integrity of the complaint or the person making it, as so often seems to occur. Literacy and language barriers aside, a complaint process that relies exclusively on the submission, review, and signing of forms does not necessarily, in and of itself, encourage "good faith" engagement, by either party.

The general impression is that the system does not often yield satisfactory or quality outcomes, for either complainants or responders. Direct and personal accountability is often lacking. As one CSC respondent put it, what is missing from the complaint resolution process is genuine "person-to-person engagement." It is significant to note that one of the successful practices emerging from the latest effort to address the national backlog of grievances was the condition to meet with and interview grievers in person. Providing a trusted and confidential intermediary (mediation) between staff and grievers and giving complainants an opportunity to be genuinely heard are recognized best practices that open the possibility of improving timely and effective redress. The current process could benefit from applying more attention to and compliance with the pillars of procedural justice – fairness, voice, respect, trust, transparency, impartiality, and neutrality.

---

[21] *Ibid.*

THE FOUR PILLARS OF PROCEDURAL JUSTICE[22]



Conclusion

The broader policy and practical implications of this review should be in clear view. It is obvious that the upward movement of complaints and grievances without resolution from one level to the next is inefficient, resulting in periodic backlogs and unnecessary and lengthy delays in processing and redress times. There is a clear need to make investments and place far greater emphasis on the legal obligation to provide for informal resolution of complaints at the lowest level possible. Given that the law mandates such a focus, this finding should not come as a new insight.

Fourteen years ago, in 2010, an external review of the complaints and grievance process came to the same conclusion that CSC was not applying enough effort or resources to informal resolution of complaints. That review recommended that all maximum and medium security penitentiaries should have "a suitably qualified person designated as an Offender Complaints and Issues Mediator, appointed at management level."[23] Further, the review stressed that all staff having any interaction with incarcerated persons should be properly and adequately trained in the law and operation of the redress system, as well as the basic skills of informal dispute resolution. Now that the national grievance

[22] Yale Law School. (2024 April). *Procedural Justice*. The Justice Collaboratory website.

[23] Mullan D. (2010). *Report of External Review of Correctional Service of Canada Offender Complaints and Grievance Process.*

backlog has been mostly cleared and compliance with prescribed timelines is finally in view, it seems timely to implement mediation in all federal prisons.

It will not be easy to revive ADR practices or implement a viable mediated dispute resolution program into contemporary correctional practice. The training, skillset and personal attributes required for successful mediation in a prison context – empathy, neutrality, confidentiality, trust, ability to listen, problem-solving, patience, strong interpersonal and negotiation skills – are not easily transferrable. It is recognized that conflict resolution involving a mediator can be lengthy and demanding, and, in a prison context, doubly challenging for practitioners to be perceived as impartial or neutral parties. Both sides must have confidence and trust in the person and the process. Selection of suitably trained, qualified, and skilled candidates must be carefully considered.

As the Ombuds for federally sentenced persons, I acknowledge that my Office has a direct interest in the Service moving forward with ADR, and, in particular, mediation. It bears reminding that complaints filed against CSC are often the same issues that are brought to my Office for resolution. Not surprisingly, in some of the most important and highly contested complaint areas – conditions/routine, staff interaction, health care – there is considerable overlap. Moreover, prisoners are not required to exhaust CSC's internal system before accessing Office resources. Inefficiencies arise when unresolved issues, requests, and complaints that are minor or routine in nature simultaneously make their way over to my Office. It is safe to say that the same legislation that governs CSC and its oversight body did not anticipate this degree of duplication and redundancy. It is not in the continuing interest of CSC, my Office, or even grievers for that matter to be engaged on the same complaint at the same time.

The escalation of complaints from one level to the next or from one entity to another tends to harden positions, frustrate decision-makers, and perpetuate distrust. In too many cases, the formal grievance process is not delivering timely or reasonable redress. As with the de-clogging exercise, there is need for strong national leadership, mentorship, and oversight of the redress system. Mediated resolution needs to be taken seriously. It demands to be regarded as a fundamental component of the formal and informal redress system. Past experience dictates that ADR should not be an afterthought, add-on, or another pilot project that ends when temporary funding runs out. Ownership and accountability for the national redress system properly belong with the Offender Redress Division at CSC National Headquarters.

Given the power imbalances that are inherent between complainants and respondents in the context of imprisonment, there continues to be a need to retain the requirements of a formal complaint and grievance system. ADR is not a substitute or suitable remedy for settling certain and serious human rights violations, and it may not be appropriate for addressing allegations of discrimination or harassment. That said, it must be recognized that the current paper-based process can work to discourage, disempower, or otherwise delay dealing with the substance of legitimate complaints and grievances. Lack of access to other means of resolving disputes leads to their inevitable escalation, resulting in frustration and delay that encumbers timely and effective redress.

2. With respect to CSC's internal Complaints and Grievances process, I make three summary recommendations, to be phased and completed within the next fiscal year:

a. First, CSC should conduct a principle-based review of the complaints and grievance process informed by the pillars of procedural justice – voice, respect, neutrality, trustworthiness. The views and experiences of incarcerated people should be taken into consideration throughout this review.

b. Simultaneously, CSC should undertake a reallocation exercise to ensure proper and sustained focus, effort, and priority will be placed on resolving complaints and grievances informally, and at the lowest level possible. This could include reallocation of resources from national level redress to penitentiary-based resolution.

c. Finally, CSC should make significant investments in mediation and alternative dispute resolution training and skills building for all staff with the goal of implementing these practices at all maximum-security and multi-level penitentiaries across Canada, including the five Regional Women and Treatment Centre facilities. ADR and mediation would be central and permanent features of a significantly updated and revised Commissioner's Directive 081.

Appendix

CSC's Complaint and Grievance Process: By the Numbers

TABLE 1. TOTAL NUMBER OF COMPLAINTS SUBMITTED BY SUBJECT

	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
TOTAL	**18,382**	**18,684**	**15,861**	**15,099**	**15,042**	**14,723**	**14,777**	**14,693**	**13,661**	**13,744**
Case Management	1,021	917	824	670	720	686	621	590	600	507
Conditions / Routine	6,185	6,599	5,363	5,315	4,849	4,684	4,553	4,643	4,401	3,826
Health	2,113	2,347	2,112	2,148	2,229	2,550	2,290	2,814	2,585	2,632
Interaction	3,345	3,357	3,152	2,763	3,081	2,650	3,034	2,953	2,777	3,240
Other Subjects	636	613	423	434	471	403	369	652	541	668
Programs / Pay	1,795	1,765	1,377	1,172	1,107	1,063	991	983	825	887
Security	940	1,082	789	744	668	817	719	574	533	583
Transfer	23	9	7	10	18	9	14	3	5	9
Visits / Leisure	2,324	1,995	1,814	1,843	1,899	1,861	2,186	1,481	1,394	1,392

TABLE 2. TOTAL NUMBER AND PROPORTION OF COMPLAINTS BY ETHNICITY, BY FISCAL YEAR

	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
TOTAL COMPLAINTS	**18,382**	**18,684**	**15,861**	**15,099**	**15,042**	**14,723**	**14,477**	**14,693**	**13,661**	**13,744**
Indigenous	4,353	4,412	3,867	3,953	3,835	4,139	4,207	4,328	4,193	4,250
Non-Indigenous	14,054	14,276	11,995	11,148	11,209	10,584	10,570	10,367	9,467	9,490
Black	1,682	1,779	1,771	1,468	1,461	1,174	1,362	1,256	1,148	1,445
White	11,390	11,569	9,445	8,938	8,955	8,708	8,434	8,312	7,481	7,234

	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
Indigenous	23.7%	23.6%	24.4%	26.2%	25.5%	28.1%	28.5%	29.5%	30.7%	30.9%
Non-Indigenous	76.5%	76.4%	75.6%	73.8%	74.5%	71.9%	71.5%	70.6%	69.3%	69.0%
Black	9.2%	9.5%	11.2%	9.7%	9.7%	8.0%	9.2%	8.5%	8.4%	10.5%
White	62.0%	61.9%	59.5%	59.2%	59.5%	59.1%	57.1%	56.6%	54.8%	52.6%

TABLE 3. TOTAL NUMBER OF FINAL GRIEVANCES COMPLETED BY WORKING DAYS TO COMPLETION

DAYS TO COMPLETION	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	TOTAL
0-15 Days	104	618	77	30	5	4	2	0	2	**842**
16-25 Days	181	1,649	311	84	23	16	5	81	5	**2,355**
26-60 Days	532	2,544	420	497	196	125	59	35	17	**4,425**
61-80 Days	1,018	706	289	219	110	68	59	29	8	**2,506**
81-150 Days	1,374	606	505	464	515	276	158	87	33	**4,018**
151-300 Days	679	961	688	710	1,492	1,637	711	203	50	**7,131**
301+ Days	161	1,803	1,735	758	303	430	952	192	0	**6,334**
TOTAL	**4,049**	**8,887**	**4,025**	**2,762**	**2,644**	**2,556**	**1,946**	**627**	**115**	**27,611**

TABLE 4. TOTAL NUMBER OF HIGH PRIORITY FINAL GRIEVANCES COMPLETED BY WORKING DAYS TO COMPLETION

DAYS TO COMPLETION	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	TOTAL
0-15 Days	35	1	11	13	2	2	1	0	1	**66**
16-25 Days	4	16	70	48	9	9	1	0	3	**160**
26-60 Days	127	60	175	258	84	40	32	15	9	**800**
61-80 Days	219	45	161	79	59	29	21	10	6	**629**
81-150 Days	312	228	247	137	222	93	37	31	10	**1,317**
151-300 Days	121	352	179	173	410	509	202	67	17	**2,030**
301+ Days	46	412	559	259	86	134	377	51	0	**1,924**
TOTAL	**864**	**1,114**	**1,402**	**967**	**872**	**816**	**671**	**174**	**46**	**6,926**

TABLE 5. TOTAL NUMBER OF GRIEVANCES IN 2022-23, BY LEVEL AND DECISION

GRIEVANCE DECISION	COMPLAINT	INITIAL	FINAL	GRAND TOTAL
Withdrawn	4	0	0	**4**
Rejected - Not Made in Good Faith	6	3	0	**9**
Rejected - Not Within the Jurisdiction of CSC	13	5	3	**21**
Rejected - Vexatious	36	5	1	**42**
Rejected - Frivolous	71	4	0	**75**
Rejected - Otherwise Addressed	81	18	14	**113**
Resolved Through ADR	155	1	1	**157**
Beyond Authority	184	22	-	**206**
Rejected - Other	140	110	12	**262**
Upheld	353	63	116	**532**
No Data	299	30	239	**568**
Upheld in Part	491	157	224	**872**
No Further Action Required	3,277	435	425	**4,137**
Resolved	3,899	640	842	**5,381**
Denied	4,729	1,867	1,114	**7,710**
GRAND TOTAL	**13,738**	**3,360**	**2,991**	**20,089**

An Investigation of Quality of Care Reviews for Natural Cause Deaths in Federal Custody

In 2014, the Office published a public interest report, titled, *An Investigation of the Correctional Service of Canada's Mortality Review Process*. This report was triggered by successive decisions taken by the Correctional Service of Canada (CSC) between 2005 and 2009 to reduce the administrative burden of conducting national investigations under section 19 of the *Corrections and Conditional Release Act* (CCRA), where deaths in custody were attributable to natural causes. As of 2009, the responsibility for conducting investigations into deaths resulting from natural causes changed hands from CSC's Incident Investigations Branch to the Health Services Sector at National Headquarters.

My predecessor's findings concerning the old mortality review process (MRP) were unequivocal, calling it "flawed and inadequate" and not conducted in a timely and rigorous manner as required by law. Further, the MRP failed to "thoroughly establish, reconstruct or probe the factors that may have contributed to the fatality under review.":

> **For reasons that largely serve administrative convenience and expedient ends, the mortality review process was created as an 'alternative' to the formal Board of Investigation exercise. The process does not meet minimum standards for an investigative process or satisfy CSC's statutory duty to investigate fatalities *regardless of cause*. It certainly does not respect the immediacy and urgency that is written into the 'forthwith' clause of the statute that governs the Service. As such, the process exists somewhere on the margins of the law; even its *Guidelines* do not yet have the force or effect of a policy directive within CSC.[24]**

In light of this finding that the MRP fell short of investigative standards nor did it satisfy CSC's statutory duty to investigate regardless of cause, I was disappointed when in 2019 Parliament adopted Bill C-83 which eliminated CSC's obligations to investigate deaths in custody for individuals receiving medical assistance in dying (MAiD), thereby decreasing the statutory obligation to investigate deaths rather than increasing it. As per the new provisions under section 19 of the CCRA, CSC now has no obligation to investigate the circumstances and causes leading to an incarcerated individual receiving medical assistance in dying (MAiD). Moreover, when a CSC healthcare professional advises the Service that there are reasonable grounds to believe a death resulted from natural causes, the Service's obligations are limited to an internal review – also carried out by a CSC healthcare professional – of the "Quality of Care" provided to the incarcerated individual.[25]

[24] Office of the Correctional Investigator. (2014, February 17). *An investigation of the Correctional Service's mortality review process.*

[25] Section 19 (1.1) (b) and 19.1 of the CCRA.

There were some legitimate reasons behind this change. CSC's Health Services Sector wanted time to adopt a review mechanism aligned with community standards that focused on improvements to quality of care. However, the differences between community and custodial health care cannot be ignored – federal prisoners are not simply patients receiving hospice or inpatient care. Furthermore, the authoritative moral force of the UN's *Standard Minimum Rules for the Treatment of Prisoners* (or, the *Mandela Rules*) call for a "competent authority that is independent of the prison administration and mandated to conduct prompt, impartial and effective investigations into the circumstances and causes of [any custodial death]." These investigations are not limited to the quality of health care received. As I stated in last year's annual report and on other occasions, the fact that CSC investigates itself remains highly problematic.

The aim of this investigation was to examine reports produced under CSC's *Quality of Care Review* by the Health Services Sector against some of the findings raised in our 2014 investigation of the Mortality Review Process. Specifically, ten years after conducting our initial investigation into these matters, my Office was interested in exploring the following questions:

- How does the Quality of Care review compare to the Mortality Review process?
- How are alternatives to incarceration prior to death examined and documented?

Methodology

Between January 2023 and February 2024, my Office received copies of 96 reports on deaths from natural causes produced by CSC's Health Services Sector. Of these 96 reports, 19 had been produced under the previous *Mortality Review* model and 77 were produced under the new *Quality of Care Review*. Although the two approaches are not significantly different, my Office decided to concentrate on 74 of the 77 Quality of Care reviews that were considered " in scope."[26]

Within these reports, we identified cases where death was foreseeable or could have been expected and what efforts were made by CSC to examine the possibility of release on compassionate grounds. In addition, we closely reviewed cases to determine the level of involvement of correctional and case management staff with individuals approaching the end of life. Finally, we interviewed Health Services officials responsible for CSC's Quality of Care reviews to confirm our findings.[27]

Findings

Comparing the Mortality Review Model to the Quality of Care Review

Many of the conclusions and recommendations made in my Office's 2014 public interest report are still valid. Obviously, the legislative amendments of 2019 have rendered our conclusions related to the section 19 requirements moot, but other conclusions and findings related to the process itself are worth re-examining.

[26] In total, there were three excluded reports. One was, in our view, referred to the Quality of Care process by mistake as the death occurred before November 30, 2019, when Section 19.1 entered into force. CSC seems to have decided that the date of death should determine whether a case should be reviewed under the Mortality Review Process or under the Quality of Care process. The second was excluded because a coroner's report was received after the completion of the report, demonstrating that the cause of death was accidental and not natural. The third was related to a death which, although medically considered natural, raised so many concerns that CSC had also decided to convene a National Board of Investigations under section 20 of the CCRA.

[27] As it did not fall within the scope or objective of the current review, the Office did not seek an independent expert assessment of the Quality of Care Reviews by examining medical files against findings from CSC's Health Services Sector.

1. Delays Have Recently Improved

The 2014 report noted average delays of 6.3 months (ranging from 3 to 13 months) between death and the convening of a Mortality Review. The lengthy delays in completing Quality of Care Reviews have improved, but only very recently. In fact, there was no change immediately following the 2014 report and the situation worsened after the introduction of the Quality of Care Review in 2019-2020. For deaths that occurred between December 2019 and December 2020, the delay between death and the convening of a Quality of Care Review reached an average of 16 months, with three cases being convened more than two years after the deaths. These delays cannot be attributed to the implementation of the process itself, which occurred shortly before the pandemic.

This situation has now been resolved. Of the 21 reports reviewed for deaths that occurred between April 2022 and March 2023, the average delay for convening a Quality of Care Review is now approximately one month (28 days). In fact, the data from the 74 reports we examined showed that CSC's Health Services Sector deployed considerable efforts to addressing a backlog and adopting a more proactive approach. The timeliness for completing Quality of Care reviews has also improved. The 21 reports related to deaths that occurred between April 2022 and March 2023 were completed, on average, within 6 months after being convened.

2. Less of a Paper Exercise

The Office has been informed that the Quality of Care Review involves communications with institutional staff, although the reports themselves do not contain any information to this effect. An examination of medical records obviously forms the bulk of the review, but the process also involves a preliminary review by institutional staff, which is then shared with CSC's Health Services Sector at NHQ. Several reports indicate corrective measures taken shortly after the death and even before the Review was convened.

The extent and circumstances under which NHQ reviewers interview institutional staff is not described in guidelines or in the reports themselves. The Quality of Care reports do not list the sources of documentation, whether interviews took place or with whom, or whether consultations occurred with experts (other than the Chief Medical Officer).

Regardless, it is clear from the contents of these reports that they are informed by site-level interviews and information collection. Contrary to what was noted in our 2014 report, the Quality of Care reports now provide a medical history of the deceased that is more focused on what contributed to or precipitated death. The reports are comprehensive and sufficient to serve some of the purposes for which they are written. Still, these reports rarely provide information on the standards against which the quality of care is assessed. In our 2014 public interest report, we noted:

> **Mortality reports reviewed by the Office almost without exception claim that the care provided to inmates respected applicable professional standards. These standards, however, are often not specifically identified within the body of the report. (They are usually cited in the appendices in the form of a list). The references and notations used by Clinical Services to assess provision of health care are provided in a general form, as for example, the home page of a particular medical portal (i.e., www.lung.ca, www.ehow.com) or general title of some professional orders standards.**

The only appendices attached to the Quality of Care reports received since 2022 are the Convening orders. Therefore, while the quality of the reports seems to have improved, the model still lacks a clear record of how exactly the quality of care stands up to professional standards.

3. Better Corrective and Quality Improvement Measures

The number of reports where corrective measures were noted has significantly improved since the implementation of the Quality of Care Review model. That being said, most of the corrective measures are not directly attributed to the Quality of Care reports produced by CSC's Health Services Sector at NHQ, but rather through the site-level review that is required by the model. In most cases, the corrective measures reported in the Quality of Care reviews were implemented shortly following the death and before the convening order was even signed.

The new review model introduced the identification of "Quality Improvement Measures." These measures are adopted by the institution to improve the quality of care but are not considered corrective in that they are not related to findings of non-compliance with professional standards. These Quality Improvement Measures are implemented at the local level and only reported through the Quality of Care Review for documentation.

There appears to be a certain level of confusion among reviewers as to what constitutes a corrective measure, a Quality Improvement Measure, and which circumstances would or should lead to a recommendation to bring forward to the Quality Assurance Committee at NHQ for discussion. Some reports, although quite critical and raising multiple corrective measures, explicitly mention that the case does not need to be raised with the Quality Assurance Committee because no recommendations were made. Other reports mention that Quality Improvement *opportunities* were raised and sometimes even adopted by the Quality Assurance Committee, while other reports describe corrective measures taken, but label them as "quality improvement opportunities."

To improve the quality of healthcare, it is important to bring professional standards to the attention of institutional health care staff as soon as practicable following the death of a patient. The efforts to do so, documented through the Quality of Care Reviews, are noteworthy. Nevertheless, the current process has significant room for improvement.

3. **I recommend that the Quality of Care Review process be subject to an independent audit chaired by an outside medical examiner.**

4. Cause-of-Death Determinations Lacking Documentation from Independent Sources

In almost one third (22 out of 74) of the reports reviewed, the determination of the cause of death relied solely on CSC's medical records in consultation with CSC's Chief Medical Advisor. In the remaining 52 cases, the reports either indicate the presence of a coroner's or medical examiner's report/record or, alternatively, the presence of an autopsy report or records from an outside hospital. In other words, 30% of cases were reported as deaths from natural causes without documentation provided by sources outside of CSC's Health Services Sector. The reports in these circumstances typically read as follows:

> **The Coroner's Report was requested on [DATE OF REQUEST], however, was not available at the time this report was completed. In the absence of a Coroner's Report, the results of the Health Care Records review, in addition to a consultation with the Chief Medical Officer of Health,**

support a finding that [NAME OF INDIVIDUAL]'s death was presumed to be due to [CAUSE]. Once a Coroner's Report is available, an addendum will be made to this report if the cause of death is different from the presumed cause of death.

To be clear, we reviewed all 22 cases in question and have no reasonable grounds to doubt that the deaths resulted from natural causes. In most of the cases, the individuals were suffering from life-limiting conditions for which assessment and treatments had been sought in the community. The fact remains that CSC should take extra steps to ensure that, at least at the reporting phase, they obtain independently sourced documentation and evidence supporting the cause-of-death determination. The number of cases where no external assessment is available as to the cause of death should be exceptional. In all fairness, CSC's Health Services Sector must contend with the fact that there are different approaches to information sharing between provincial coroners or medical examiners' offices (my Office was informed that regular discussions are occurring with coroners' offices across Canada to facilitate and enhance communications), and CSC has no control over the availability of external assessments. However, the fact that out of 74 cases, 22 did not rely on independent sources is, in my view, far too high. At the very least, all efforts to seek independent views should be detailed in Quality of Care Reviews.

4. **I recommend that for determining the cause of death for the Quality of Care Review, CSC's Health Services Sector obtain independent and external verification or, when this is not possible, that all efforts to obtain independent and external verification be reported.**

5. No Record of Parole by Exception Applications and Decisions

In Canada, dying of old age or terminal illness behind penitentiary walls should only happen in exceptional circumstances. Imprisonment without a realistic possibility of parole constitutes punishment that is cruel and unusual by nature.[28] Cases in which the conditional release of an individual at the end-of-life stage would pose an undue risk to society would appear to be quite exceptional.

Section 121 of the CCRA (often referred to as "parole by exception" parole, or "compassionate release") provides that parole may be granted at any time – regardless of eligibility dates – to an incarcerated individual who is terminally ill.

In fact, courts are regularly referring to this disposition when faced with the sentencing of an older person or someone whose health is declining. In one recent decision, the provincial court of Nova Scotia had to examine the situation of an individual suffering from cancer but facing a minimum sentence of four years in prison. The court noted:

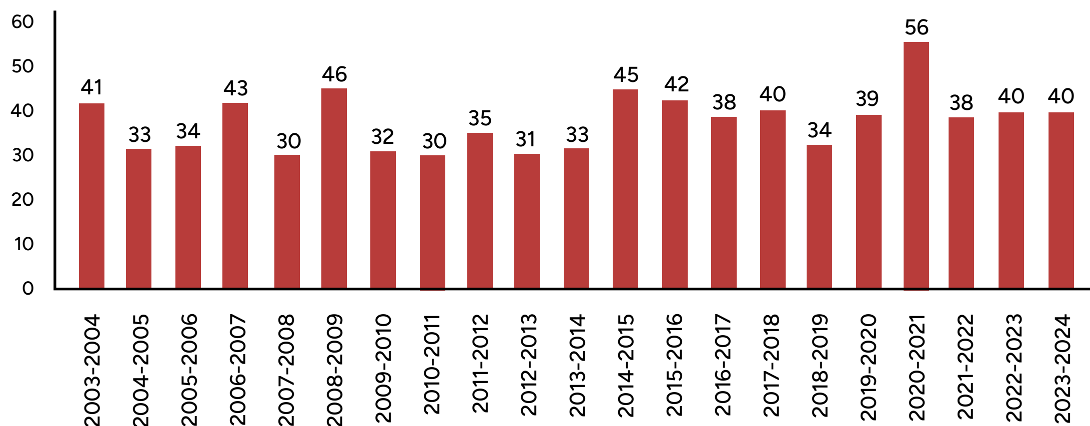
[28] See, *R.* v. *Bissonnette*, 2022 SCC 23.

[...] a sentencing judge should not speculate on the possible deterioration of the offender's health following sentencing. While this possibility increases with age, the sentence must be determined in accordance with the evidence when rendered. If health subsequently declines, 'it is incumbent on the relevant correctional authorities to take appropriate measures taking into account, notably, s.121 of the *Corrections and Conditional Release Act*.[29]

Despite the availability of this provision under federal law, the number of natural deaths of individuals incarcerated in federal penitentiaries remains generally consistent.

The Parole Board of Canada reports on the number of Parole by Exception decisions rendered under section 121. The last available reports at the time of writing (2019-2020) show that Parole by Exception was considered 20 times in the five previous reporting years and granted just 16 times.

GRAPH 1. NUMBER OF DEATHS BY NATURAL CAUSES, FROM 2003-2004 TO 2023-2024



Sources: For 2003-04 to 2012-13: *CSC Data Warehouse* (accessed September 2013). For 2013-14 to 2023-24, CSC's *Corporate Reporting System-Modernized* (CRS-M; Extraction date: April 29, 2024).

[29] *R.* v. *MacNeil*, 2021 NSPC 4. See also: *R.* v. *Kanthasamy*, 2021 ONCA 32; *R.* v. *Premji*, 2021 ONCA 721; *R.* v. *Shilling*, 2021 ONCA 916; *R.* v. *Hill*, 2007 BCCA 309; *R.* c. *Gaudreault*, 2024 QCCQ 590; *R.* v. *Swope*, 2015 BCCA 167; *R.* v. *Fast*, 2015 SKCA 56; *O'Reilly* c. *R.*, 2017 QCCA; and, *R.* v. *Milani*, 2021 ONCA 567. The Supreme Court of Canada alludes to this approach in *R.* v. *Morrisey*, 2000 SCC 39, par. 42.

TABLE 1. NUMBER OF PAROLE BY EXCEPTIONS CONSIDERED VS. GRANTED, FROM 2015-16 TO 2019-20

	DAY PAROLE BY EXCEPTION	FULL PAROLE BY EXCEPTION	TOTAL
Fiscal Year	Granted/Considered	Granted/Considered	Granted/Considered
2015-16	0	3/3	**3/3**
2016-17	0	1/2	**1/2**
2017-18	0	1/2	**1/2**
2018-19	1/1	6/6	**7/7**
2019-20	0/1	4/5	**4/6**
TOTAL	**1/2**	**15/18**	**16/20**

Source: Parole Board of Canada, *Performance Monitoring Report (2019-2020)*.

Though telling, this data does not present the full picture. Whenever an individual applies for parole, if they request a release based on compassionate grounds due to a terminal illness, their circumstances will obviously be taken into consideration, but such parole review will not be recorded as a "Parole by Exception" under section 121.[30] In other words, there are probably *more* parole decisions rendered on "compassionate" grounds than what is reported. There is currently no straightforward way to identify the number of such cases presented, considered, and granted on a yearly basis.

After reviewing the Quality of Care reports and the information available on CSC's Offender Management System, it became evident that certain cases exhibited confusion regarding the timing of parole application assessments once an individual becomes eligible for full or day parole.

When a person has reached parole eligibility and their parole application has been denied by the Parole Board, that person is normally barred from applying again for one year.[31] In the case of individuals becoming terminally ill or whose health rapidly declines shortly after a decision to deny parole, CSC staff have in some cases refused to consider the possibility of a parole application based on compassionate grounds.

The Parole Board's *Decision-Making Manual for Board Members* allows the Board to conduct a review earlier than these timeframes. In certain cases, the idea of an early review seems to have been lost on CSC's case management staff who may not have been aware of this possibility or simply believed that the individual failed to meet the criteria. Either way, there were no records indicating that this option was considered.

[30] An interpretation supported by the Federal Court in *Baldovi* v. *Canada (Attorney General)*, 2021 FC 779.

[31] Sections 122 (4) and 123 (6) for Day Parole Full Parole, respectively. Similarly, section 138 (5) provides that the PBC does not have to review before one year the situation of an individual whose parole has been revoked.

At any rate, it remains that there are currently no mechanisms to identify the number and circumstances under which Parole by Exception is requested, granted, or denied. My Office was informed that CSC and the PBC discussed and coordinated certain matters pertaining to Parole by Exception in 2018 and 2019, but there does not appear to be any record of these cases or any noticeable progress in the matter overall.

5. **I recommend that CSC consult with the Parole Board of Canada and establish a data sharing and reporting framework to publish information on section 121 *Parole by Exception* applications as well as applications of any kind of release based on compassionate grounds. This data should be disaggregated by the criteria listed under section 121 (1), regardless of whether the parole application is presented before or after an individual's eligibility dates.**

6. Considerations of Alternatives to Incarceration No Longer Present

Mortality Reviews were convened under section 19 of the CCRA and, as such, the reviews could not be limited to the quality of the health care provided. An assessment of whether alternatives to incarceration, or "Release Considerations," had been examined was legally required. As noted in my Office's 2014 public interest report, this part of the Mortality Review was completed in consultation with CSC's Institutional Reintegration Operations Division. While the 2014 report had focused on reviews conducted between 2009 and 2012, my Office noted the following:

In two recent mortality reports, a more critical tone has been sounded regarding CSC's responsibility to examine alternatives to incarceration. In these cases from 2012 and 2013, findings of non-compliance are noted: one in which the report states that no record of communication exists for the parole officer responsible for looking into community resources; in the other case, it concluded that a breakdown in communication between health care and correctional staff led to an absence of referral for a section 121 release. The critical findings in these two cases remain exceptional.

Critical findings into Release Considerations are now completely absent from Quality of Care reviews. While the orders governing these reviews mandate Nurse Analysts to analyze whether alternatives to incarceration were explored prior to the individual's death, the reports only offer brief summaries of the information provided by institutions. They did not delve into nor analyze the involvement of the case management team assigned to the deceased. On this matter, interviews with CSC's Health Services Sector suggest extremely limited involvement on the part of CSC's Institutional Reintegration Operations Division and no involvement from the Incident Investigations Branch.

There are, of course, cases for which an in-depth examination of Release Considerations would not be required. In roughly 40% (29 out of 74) of the cases reviewed by my Office, deaths were undoubtedly sudden, i.e., they could not have been foreseen by CSC staff. There are also individuals, highly institutionalized, who will simply refuse to apply for a release. For example, in one case reviewed, there was a man in his eighties who had not been released since his admission in 1980 and did not wish to apply for any form of release.

However, though most Quality of Care reports that we reviewed mentioned the involvement of case management teams, these reports also frequently stated that the examination of Release Considerations, "could not be completed prior to the inmate's death." It is not clear how or whether Registered Nurses conducting the analysis are expected to provide input in this regard. Some reports only mentioned that the parole application could not be completed before the death occurred, while other reports conclude – based on an informal standard – that the death occurred too suddenly, leaving the case management team with little time to process an application.

Herein lies two problems:

1) There are no specific guidelines or standards that could help determine whether a case management team reasonably assessed and explored options for section 121 parole on compassionate grounds; and,

2) CSC's Health Services Sector is evidently not suited to assessing this aspect of CSC's operations.

For example, a man in his late fifties who was fighting cancer received indications from the community cancer treatment centre that his condition was terminal. It took a few weeks to clarify the prognosis, but his case management team finally submitted an application for parole at the end of May. The Quality of Care report mentions that *"because his parole eligibility dates had passed, his application was treated as a standard parole application."* The report did not examine if this was due to a lack of documentation, a mistake by the case management team, or if this was business as usual. Soon after, near the end of summer that same year, the individual died.

Typically, this exercise probably should not rely solely on documentation. My Office reviewed cases where there had been no record of any meaningful interaction between the deceased and a Parole Officer for more than a year. In a few cases, the only interactions documented in the Offender Management System were so-called 45-day reviews entered by correctional officers, where copies of the same blurb were repeated month-after-month for years, without even changing the age of the incarcerated person! In other words, relying solely on a review of documentation creates a risk that pertinent information will be omitted.

More concerning are the various cases that have been rejected by the Parole Board of Canada due to the absence of viable release plans. Release planning largely involves members of case management teams and, as such, the assessment of whether suitable alternatives to incarceration have been considered requires expertise that should not be expected from healthcare professionals.

Two further cases raise the exact same issues in policy yet demonstrated very different outcomes. Both individuals were facing deportation orders under the *Immigration and Refugee Protection Act*. In one case, the Quality of Care Review noted that the situation limited the ability of the case management team to recommend a release. In the other case, the Quality of Care Review noted that the institution reached out to the Canada Border Service Agency who, in turn, accepted to *not* activate the removal order; rather, they would allow the individual's release on immigration bail through an unescorted temporary absence with conditions.

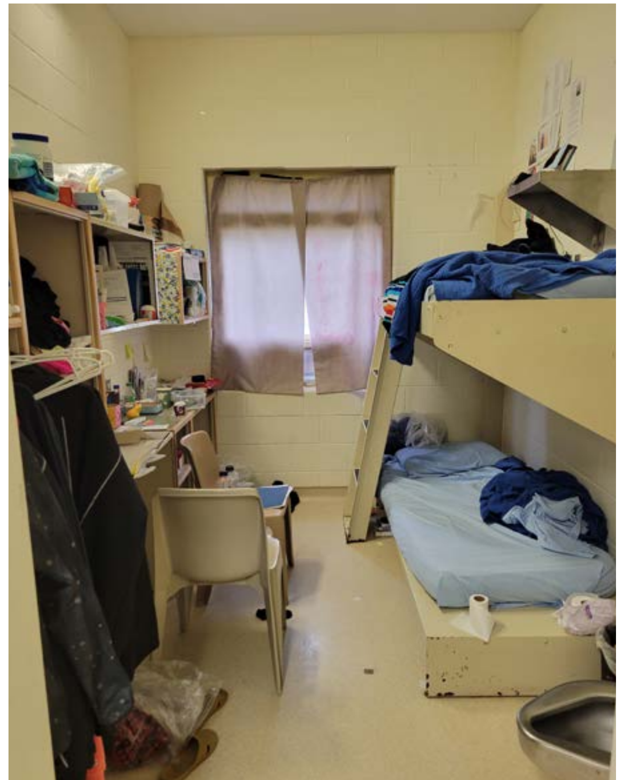
Conclusion

This investigation of the Quality of Care exercise used by CSC to review natural cause deaths, as compared to the old Mortality Review Process, has yielded concerning findings. I have on numerous occasions made my views known regarding the independence of investigative processes related to deaths in custody. I will not repeat them here. The fact that terminally ill people are still dying in federal prisons in highly undignified conditions should be a subject of serious concern for everyone. The fact that CSC dedicates extensive professional resources in reviewing the quality of the end-of-life care provided to terminally ill individuals yet does not examine with equal attention whether alternatives to incarceration were considered is unconscionable. The following recommendation is made with consideration of the current legislative framework:

6. **I recommend that assessments of release considerations in Quality of Care Reviews be conducted by CSC's Incident Investigations Branch, in collaboration with CSC's Health Service Sector. Such assessments should address the elements raised in the Office's 2014 public interest report and lead to the adoption of qualitative standards.**

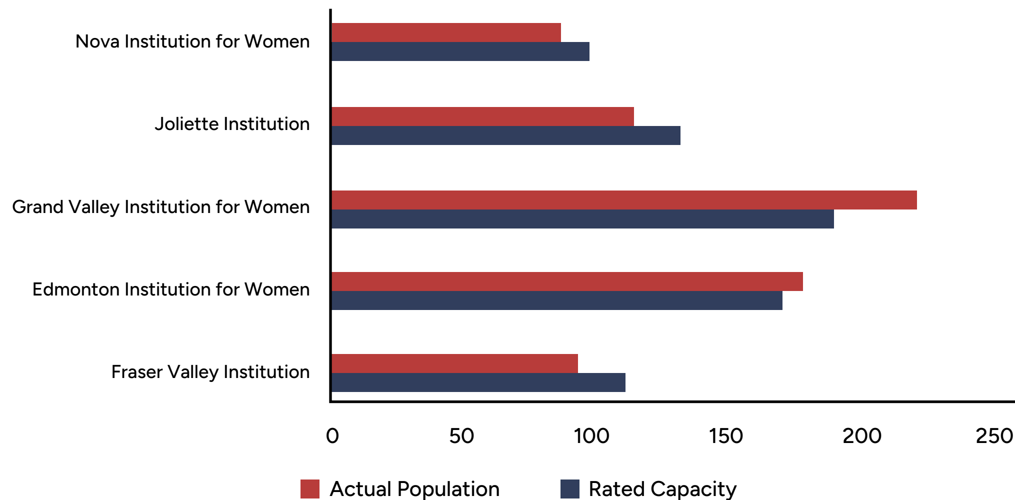
Population Pressures in Women's Institutions: Overreliance and Impacts of Interregional Transfers

Crowding and the resulting pressures have serious implications in a correctional setting. Population pressures contribute to an augmented level of stress and reduces the Correctional Service of Canada's (CSC) ability to effectively execute its mandate. The growing number of federally incarcerated women today presents significant challenges and has negative impacts on the operational realities at the five regional penitentiaries for women. In fact, the number of federally incarcerated women is at an all-time high, with two sites – Edmonton Institution for Women (EIFW) in the Prairie region and Grand Valley Institution (GVI) in the Ontario region – housing populations that exceeded their original rated capacities.



Double-bunked cell, maximum-security unit, Nova Institution

GRAPH 1. POPULATION OF WOMEN VS. RATED CAPACITY[32] AT REGIONAL SITES



Source: CRS-M (Extraction date: May 7, 2024)

To further exacerbate the issue, CSC research has found that women are presenting with more elevated and complex levels of risk and need, along with an increased requirement for correctional programming and substance use treatment, compared to previous cohorts.[33] As I have raised in previous reporting, steady increases to the population of incarcerated women have corresponded with an erosion of the key principles articulated in *Creating Choices*. In 2020-21, my Office completed a review of women's corrections 30 years after *Creating Choices* and found that the five principles integral to a woman-centred approach to corrections – empowerment; meaningful and responsible choices; respect and dignity; supportive environment; and shared responsibility – are intensely challenged by the realities (i.e., elevated number of incidents of self-injury, use of force, assaults, fights, attempted suicides and interrupted overdoses) in women's corrections today and the result is a system that cannot uphold the principles and intentions outlined in *Creating Choices*.[34]

[32] Rated capacities as published on CSC's, *The Hub*. This reflects the original and intended rated capacity for each regional facility.

[33] Wanamaker, K., & Chadwick, N. (2023). *Regional Profiles of the Canadian In-Custody Women Federal Offender Population* (Research Report R-467). Ottawa, Ontario: Correctional Service of Canada.

[34] Office of the Correctional Investigator. (2021). *Annual Report 2020-2021*.

Common room, maximum-security unit, Nova Institution

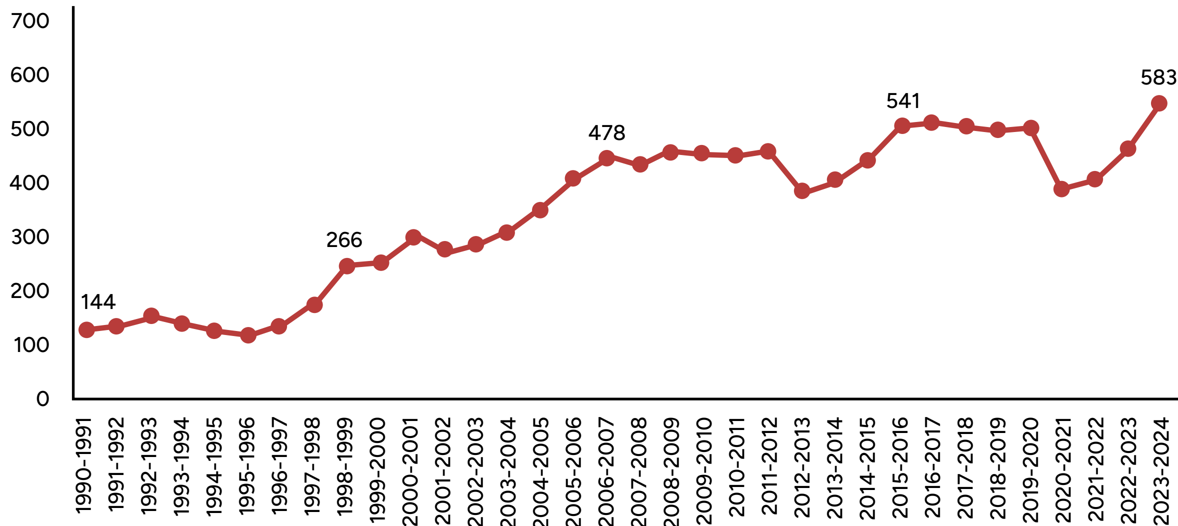
I have also reported grave concern regarding the over-representation of Indigenous women, particularly when the proportion of Indigenous women neared 50% of the prison population in 2021.[35] At the writing of this report, over-representation remains as troubling: 46% of women incarcerated at the five regional sites are Indigenous, and 75% of women in maximum-security are Indigenous.[36] My Office has made countless recommendations to increase the use of community-run Section 81 Healing Lodges and 84 agreements for the care, custody, and supervision of Indigenous women under federal sentences, as well as recommendations for the reallocation of resources to community programs, services, and activities. Inadequate advancement in these areas is undeniably contributing to unsustainable population pressures. Furthermore, my Office has been informed by CSC that population forecasting indicates that the pressures are projected to increase in the coming years.[37]

[35] Office of the Correctional Investigator. (2021). *Proportion of Indigenous Women in Federal Custody Nears 50%*. News Release.

[36] Data extracted from CRS-M on May 7, 2024.

[37] As provided by OCI Liaison on April 19, 2024: *Response: Data and Information Request - Overpopulation in Women's Institutions.*

GRAPH 2. ADMISSIONS OF FEDERALLY SENTENCED WOMEN (1990-91 TO 2023-24)



Source: CRS-M (Extraction date: April 16, 2024).

Overreliance on Interregional Transfers

CSC's most commonly used strategy to address overcrowding has been double bunking. Although an assessment must be completed pursuant to Commissioner's Directive 550 – *Inmate Accommodation*, prior to placing two persons in a cell, double bunking inherently carries an increased risk for agitation, tension, and violence. This can have serious consequences, particularly in a maximum-security setting, and contrasts with internationally accepted norms for prisoner cell accommodation. As my Office has asserted in the past, double bunking is not an appropriate or sustainable solution to crowding pressures.

At the writing of this report, 68 individuals were double bunked in women's institutions,[38] accounting for over 10% of the total population at the five regional sites. Even more troubling is that fact that 18 of these individuals were being double bunked in a maximum-security Secure Unit. With Indigenous women being disproportionately overrepresented in maximum-security units, they are inherently more likely to be double bunked, resulting in yet another gap between Indigenous and non-Indigenous offenders.

[38] Data extracted on April 29, 2024, from CRS-M: *Capacity Module – Double-Bunking Rates.*

Personal effects in the Admission and Discharge area of Fraser Valley Institution

With bed space becoming more and more scarce in some institutions, an additional tactic used by CSC to mitigate population pressures has been to transfer women to other regions. Over the past five years, CSC has operationalized 260 interregional transfers and out-of-region penitentiary placements of women. Of these, 176 (68%) stemmed from the Prairie region.[39] As I stressed in my 2020-21 Annual Report, transfers out of region should be minimized and used only as a last resort, not as a means of controlling population levels. In fact, by law, the *Corrections and Conditional Release Act* (CCRA) stipulates the following regarding placements and transfers:

> **28** If a person is or is to be confined in a penitentiary, the Service shall take all reasonable steps to ensure that the penitentiary in which they are confined is one that provides them with the least restrictive environment for that person, taking into account (...)
> **(b)** accessibility to
>
> > **(i)** the person's home community and family,
> >
> > **(ii)** a compatible cultural environment, and
> >
> > **(iii)** a compatible linguistic environment (...)

The intent of *Creating Choices* was that the size of each regional facility would reflect the regional population and that "effective implementation of community strategies should, over time, reduce the need and length of stay in these facilities."[40] Today, due in-part to these interregional transfers and placements, many women are being housed far away from their family, local community, and supports, further compounding the separation and fragmentation resulting from incarceration.

Over the reporting period, my Office noted an increase in the number of transfer-related complaints – primarily from women being transferred out of the Prairie region – and sought to better understand how these transfers were impacting both the women and the five regional sites. A total of 52 interviews were conducted – with 25 incarcerated women and 27 CSC staff. Hearing from women who have been directly impacted by interregional transfers that were largely prompted by population pressures, was essential to better understanding the scope, challenges, and impacts of this problem. While

[39] This figure represents transfers between the five regional sites and does not include transfers to psychiatric facilities, Healing Lodges, or Section 81 facilities.

[40] Correctional Service of Canada (1990). *Creating Choices: The Report of the Task Force on Federally Sentenced Women.*

a handful of women reported that a transfer away from their home region provided a fresh start, the majority expressed discontent, uncertainty, and even distress about the transfer. CSC staff also provided insight into how dynamics at the sites are shifting because of these transfers. It quickly became apparent that this issue has far-reaching consequences. In fact, many of the problems that prompted the Task Force leading to *Creating Choices* in 1990 persist and are being further aggravated by population pressures and interregional transfers. Today, the challenges associated with population management have resulted in a crisis situation.

Through our site visits and interviews, four thematic findings emerged:

1. Indigenous women are being disproportionately impacted by interregional transfers;
2. Women are being uprooted from their communities and families are experiencing undue fragmentation;
3. Tension levels and incidents are rising; and,
4. Language barriers are an issue in the Quebec region.

THE VOICES OF WOMEN

"I hate that, that's what they always use: "You're a long sentence, a lifer."

"I don't like it here. This place is just (pauses). I've never cried so much in jail. I never cry (...) I feel like I'm sitting here, withering away because I have a long sentence... I'm five provinces away from home. Why am I here?"

"[The interregional transfer] took everything from me."

"I was sent here because I was told it would be easier to get my medium, to get programs."

"It's making me very depressed... Being so far away, putting up with inmates, with guards, trying to keep myself together to go to the compound."

"They say I can't go back there. I pray every day and I wish I could. Then my kids could visit."

"I've just been a sitting duck here."

"I thought it was closer to Manitoba, so I came here."

"Big culture shock for sure"

Findings

1. Indigenous Women are Disproportionately Impacted by Interregional Transfers

Indigenous women are impacted by interregional transfers significantly more than their non-Indigenous counterparts. Over the past five years, a staggering 65% (169 of 260) of all interregional transfers and penitentiary placements of women involved an Indigenous woman.[41] Although the Prairie region has a CSC-run Healing Lodge and two Section 81 Healing Lodges in addition to the regional site, there is no CSC run facility for women in the province of Manitoba. This reality drastically increases the likelihood of Indigenous women being displaced out of their home region. Forced displacement and relocation by the Crown have deep roots in the broader history of the disenfranchisement of Indigenous peoples in this country, and as we heard during our interviews, many Indigenous women reported a strong reluctance to leave their home communities and social supports. The upheaval resulting from being moved away from home has negative consequences on community and family cohesion, mental health, and overall well-being. Among other traumas, many of these women are working to heal from the intergenerational consequences of displacement in particular[42]; therefore, involuntary interregional transfers can be particularly triggering and disruptive to this healing process. Clearly, there is an extraordinary need for more Section 81 Healing Lodges for women, particularly those that accept women with higher security levels and complex needs. Furthermore, increasing the use of other options available to the Service, such as Exchange of Service Agreements with provincial entities, would alleviate some of these population pressures, and importantly reduce the number of Indigenous women being separated from their families, communities, and supports.

2. Negative Impacts on Access to Visitation, Community, and Social Supports

Although the five regional sites were established to reduce the geographic separation of women from their families and community resources, many women remain housed far away from these important supports. This distance has a negative impact on the sustainability of these relationships and is detrimental to mental health, well-being, self-esteem, and motivation of the women. The unfortunate reality is that many families do not have the financial means to travel long distances to visit these sites. To further contribute to the financial burden, some sites require that the incarcerated woman and their intended visitors first participate in three regular in-person visits before a Private Family Visit[43] (PFV) is considered for approval. This means that family members who can financially afford to travel need to plan and budget for an extended stay to complete the additional step of demonstrating successful regular visits and "earn" a PFV. There is no requirement outlined in policy or in the Threat Risk Assessment for PFVs, however, that stipulates in-person visits are required before PFV eligibility.

CSC's own research has confirmed that incarcerated individuals who receive visits from friends and family and benefit from community

[41] This figure does not disaggregate by type of transfer. Although some transfers may be recorded as 'voluntary', interviews with federally sentenced women revealed that some women were pressured to submit a voluntary transfer to another region, with the promise that they could access programming faster, or cascade to a lower security level faster, due to population pressures.

[42] Government of Canada. (Retrieved: May 2024). *Highlights from the Report of the Royal Commission on Aboriginal Peoples*, (Date modified: September 15, 2010).

[43] As defined per Commissioner's Directive 710-8, Private Family Visits are, "visits that occur in separate structures inside the perimeter of the institution where the inmate may meet authorized visitors in private to enhance daily living skills, maintain positive community and familial relationships and responsibilities (e.g., parenting skills), and/or lessen the negative impact of incarceration on family relationships."

supports are more successful when released back into the community.[44] Despite acknowledging the importance of maintaining these connections when assessing the suitability of a transfer, population pressures and the absence of available bedspace become the overriding operational priority:

> **The CMT does support [the incarcerated woman] in remaining at EIFW as her mother is deemed to be a protective factor for her and a positive support while she is in the adaptation phase of her life sentence. Further, [the incarcerated woman] has the support of the FASD Network and a community worker that has sent a letter of recommendation for [her] to remain in Edmonton. EIFW is facing extreme population pressure on the Secure Unit and therefore a request has been made to the writer to Penitentiary place her out [sic] EIFW.**
>
> ***- Excerpt From an Assessment for Decision***

Additionally, to justify involuntary interregional transfers, CSC has encouraged the use of alternative virtual options for contact:

> **...Video visitation is available regardless of what institution you are in. Moreover, you can connect with family through other means such as video calls, phone calls and letters.**
>
> ***- Excerpt From a CSC Decision***

Some women have reported to my Office that video visits feel impersonal and can be confusing for children, so they opt not to participate in them at all. They are an inadequate alternative for in-person visits and women report feeling guilty, isolated, lonely, and depressed in the absence of physical connection with loved ones. Many women were emotional and tearful as they recounted their experiences to my staff. Furthermore, most incarcerated women are also mothers, and a transfer away from their home region or community renders participation in the Mother-Child Program nearly impossible.

3. Increases in Security Incidents

Crowding in an institutional setting leads to a number of significant population management challenges. With numbers on the rise, some women's institutions have been forced to implement strategies to integrate and manage the population. While efforts are made to avoid sub-populations and co-horting, a rise in generalized violence, incidents, and operational challenges have rendered this an inevitability. CSC management has reported to my Office that increased use of mediation between residents, as well as house meetings and Talking Circles, have been required to address tensions. Moreover, the management of Security Threat Groups (STGs) is reported to be increasingly difficult, with 82 incarcerated women being listed as having an affiliation with an STG.[45]

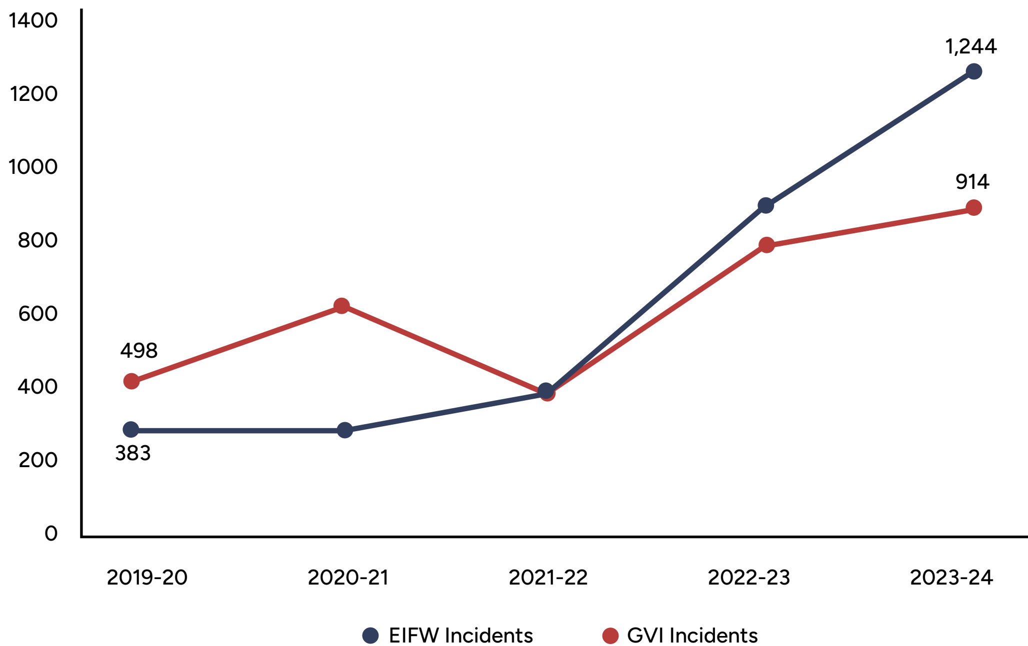
---

[44] Wardrop, K., Sheahan, C., and Stewart, L. (2019). *A Quantitative Examination of Factors Available in the Offender Management System Associated with Successful Release*. Ottawa: Correctional Service of Canada.

[45] Data extracted from CRS-M on April 29, 2024.

The *Creating Choices* principle that calls for the provision of a safe and supportive environment is rapidly eroding. In the two institutions for women that are currently exceeding their original rated capacities – EIFW and GVI – incidents appear out of control. Over the past five years, incidents at EIFW have more than tripled, from 383 incidents in 2019-20 to an overwhelming 1,244 incidents in 2023-24. Behaviour-related incidents (i.e., disciplinary problems, disturbances) have seen an almost 900% increase, contraband-related incidents have increased by over 300%, and assault-related incidents have doubled. Incidents at GVI have also risen significantly, with an almost 85% increase over the past five years, and notable increases in the same areas as EIFW. With the incarcerated population of women projected to continue growing, the situation is likely to become even more unmanageable and unsafe.

GRAPH 3. TOTAL NUMBER OF INCIDENTS PER FISCAL YEAR AT GVI AND EIFW, FROM 2019-20 TO 2023-24



Source: CSC Data Warehouse (Extraction date: April 10, 2024).

4. Language Barriers in the Quebec Region

For those federally sentenced women who have little or no opportunity to express themselves through their own language at the prison in which they are serving their sentence, communication barriers, frustration, loneliness, and alienation are common experiences.[46] Historically, Francophone women have faced barriers related to language, however the construction of Joliette Institution – the regional facility for women in the Quebec region – largely addressed this issue. Today, however, just over one quarter of incarcerated women at Joliette Institution have English listed as their preferred language. Over the past five fiscal years, 26 of the 28 women who were interregionally transferred to Joliette Institution have been English-speaking. The *Official Languages Act* requires federal institutions to provide services in the official language of an individual's choice. Yet, CSC's own case management documentation offers evidence that this requirement is not being upheld:

> **The lack of English resources as well as the French staff is quite irritating to [the incarcerated person], has [sic] [the incarcerated person] wants to reengage in [their Correctional Plan], but doesn't have the opportunities [sic] to do so (...) [The incarcerated person] is reactive to the language barrier (...)**

CSC is violating the *Act* by rendering decisions indicating that the needs of Anglophone women can be adequately met at Joliette Institution:

> **(...) CSC is satisfied that this penitentiary placement provides (...) access to a compatible linguistic and cultural environment and appropriate programs.**
>
> ***- Excerpt From a CSC Decision***

Anglophone women have reported to my Office that they feel unable to integrate into the population at Joliette in a meaningful way. Moreover, the ability of Joliette to accommodate the correctional programming and other needs of these women is lacking and impairs women's ability to cascade to lower security and affects their reintegration potential.

Once again, Indigenous women are disproportionately impacted by this issue, as the lack of English resources creates a barrier to providing necessary cultural services. Joliette Institution does not have a full-time Elder, nor an Elder that speaks English, yet at the time this report was written, it was housing 14 English-speaking Indigenous women, ten of which await programming. Despite this, transfers are being supported and operationalized under the guise that cultural supports exist:

> **In your rebuttal, you indicated that you wish to engage with an Elder and reconnect with your children. The warden has taken your comments into consideration and maintained his decision to transfer you [to Joliette Institution] due to operational pressures at EIFW... This**

---

[46] Correctional Service of Canada (1990). *Creating Choices: The Report of the Task Force on Federally Sentenced Women.*

placement provides you with accommodation and access to required interventions, including those related to your native culture.

- Excerpt From a CSC Decision

Although Elders are very open and flexible, trying as best as they can to support the needs of different populations by incorporating teachings from other regions and using non-verbal ways to communicate when there is a language barrier, these accommodations are often very difficult to make in real time, as teachings cannot easily be compared or translated. As emphasized in my *Ten Years since Spirit Matters* report, Elders are spiritual advisors at the centre of the healing process – through ceremony, teaching and counselling – and need to be adequately resourced to do this important work. It is inappropriate, unfair, and disrespectful to expect Elders to carry out their role with additional pressures and barriers in place.

Conclusion: A National Population Management Problem

Although CSC has asserted to my office several times that population pressures in women's institutions is a top priority, a formal Population Management Strategy has not yet been developed. At the site level, Wardens and their management teams review the population regularly to determine suitable candidates for a reduction in security level, transfers to a Healing Lodge or Section 81 facility, and they canvass the population for voluntary transfers. While these efforts can be helpful, they do not constitute a formal, national strategy. CSC has informed my Office that penitentiary placements and interregional transfers are currently being considered from a national perspective.

My Office has been assured that, "Concerted efforts are made to ensure timely case preparation and sound decision-making, taking into account, sentence length, family and community support during incarceration and in preparation for release, program availability, etc."[47] While CSC might be well-intentioned, the reality is that these lawful requirements are unattainable in many cases, particularly as population pressures rise and limited options currently exist. There is a disconnect between effort and intent, and what is plausible and happening in reality.

As demonstrated earlier, the increases in the number of federally sentenced women were not sudden or unexpected; rather, these population trends have been steadily occurring over decades. The Service has had ample warning, time, and opportunity to develop a population management plan in keeping with these demographic changes. The lack of observable progress towards a Women Offender National Population Management Strategy is therefore unacceptable. It has now caused a state of crisis in women's corrections that could have been avoided. Moreover, the fact that Indigenous women are excessively impacted by the symptoms and results of population pressures, constitutes systemic discrimination and is in flagrant violation of Canada's basic human rights obligations.

CSC informs my Office that they are actively exploring options to address the challenges associated with the growing number of federally sentenced women, including negotiations with provinces, community partners, and First Nations communities. As of the writing of this report, however, my Office has not been engaged or consulted on any planning or solutions towards the effective management of the women offender population across Canada. Furthermore, efforts by this Office to obtain information on any plans under consideration have been thwarted or rendered

[47] Provided by the OCI Liaison on April 8, 2024: *Response: Data and Information Request - Overpopulation in Women's Institutions.*

futile. To be clear, my Office is only supportive of efforts consistent with the principles of *Creating Choices* and those that contribute to the earliest release of women offenders into the community, particularly Indigenous women. Any "solutions" that lead to incarcerating more women – for example, new infrastructure projects that increase capacity in Secure Units or aim solely to increase general capacity – are unacceptable and not consistent with other government priorities, including reconciliation. A national population management strategy must seek to support the unique needs of women and expedite their reintegration into the community. My Office will be actively monitoring how this strategy evolves over the coming year and expects to be consulted on the short, medium, and long-term plans to address and alleviate population pressures.

7. **I recommend that CSC develop a National Population Management Strategy for Women, which includes:**

   a. **Expanded use of *Exchange of Service Agreements*, so women can serve their sentences closer to their home communities and social supports;**

   b. **Increased use of community-run Section 81 Healing Lodges and Section 84 agreements and releases;**

   c. **A comprehensive community release strategy for women and the reallocation of resources into the community; and,**

   d. **Increased allocation of resources dedicated to managing complex cases.**

Six Years After the Engagement and Intervention Model: Mixed Results for Use of Force at Standalone Male Maximum-Security Institutions and with Vulnerable Prisoners

On several occasions in recent years, my Office has raised the issue of the increasing use of force to respond to incidents that occur within penitentiary walls, expressing concern both about the increasing proportion of such incidents, and the extent to which certain types of force (particularly the use of inflammatory spray), are used against prisoners in vulnerable situations. This latter category includes individuals who are experiencing severe physical and/or psychological distress, which may manifest as behaviours such as self-mutilation and suicide attempts, among other mental health-related behaviours.

As recalled in various reports from my Office on the subject, force is considered *unnecessary* or *disproportionate* when the threat can be safely managed without the use of force, or with less force.

A sign at Grande Cache Institution

The Promise of the Engagement and Intervention Model (EIM)

In response to the findings and recommendations that I made in my May 2017 Special Report to Parliament concerning the tragic and preventable death of Matthew Hines at Dorchester Penitentiary,[48] and in light of subsequent investigative findings at three maximum-security institutions,[49] CSC responded by introducing a new Engagement and Intervention Model (EIM) that was intended to bring about change.

In abandoning the Situation Management Model (SMM) in favour of the Engagement and Intervention Model (EIM) in January 2018, the Service announced that the new model was designed to emphasize *"the importance of non-physical and de-escalation responses to incidents and to clearly distinguish response protocols for situations involving physical or mental health distress."*[50] In accordance with Commissioner's Directive (CD) 567, *Management of Incidents*, the new model's response protocols were to:

---

[48] Office of the Correctional Investigator. (2017, May 2). *Fatal Response: An Investigation into the Preventable Death of Matthew Ryan Hines.* Special Report to Parliament.

[49] The institutions were: Millhaven, Kent, and Atlantic.

[50] CSC. (2017 December). *Updates on Engagement and Intervention Model training – Monthly HR information sheet.* Taken from the CSC intranet.

- Take into consideration the inmate's mental and/or physical health and well-being, as well as the safety of other persons and the security of the institution.
- When possible, promote the peaceful resolution of the incident using verbal intervention and/or negotiation.
- Be limited to only what is necessary and proportionate.
- Take into consideration changes in the situation with continuous assessment and reassessment.
- When evaluating a response, staff will consider the many partners available [such as health care professionals] to create collaborative and appropriate interventions.
- Staff presence will be used generally and strategically to prevent and resolve incidents. The mere presence of a staff member demonstrating positive attitudes and behaviours can serve to de-escalate a situation.[51]

At the time, my Office welcomed this new approach because, that year, the number of use of force incidents in prisons was particularly high (1,536 in 2018-19). The Office's dedicated use of force team analyzed 1,914 incidents (a record high for the Office) that occurred between October 2016 and February 2018. Of the 1,914 incidents reviewed by my Office, we found that 46% used inflammatory sprays or chemical agents.[52]

Over the same period, my Office's review of the three selected maximum-security facilities revealed that, in most cases, the use of inflammatory agents had replaced verbal interventions and conflict resolution strategies – such as negotiation and de-escalation – to manage actual or potential incidents of self-injurious behaviour.

If the actions surrounding the implementation of the new model were to align with the Service's stated objectives, then my Office expected to see, over time, both a reduction in use of force incidents across the country (in favour of other interventions and alternative incident management strategies) and a reduced use of inflammatory spray and chemical agents in incidents involving vulnerable prisoners, among other groups.

Six years later, the facts tell a less hopeful story, even if some encouraging signs can be observed in other respects. I am once again compelled to draw the Service's attention to some concerning trends in the use of force.

A Concerning Trend

As a reminder, in my 2020–21 annual report, which had as its centrepiece an *"Investigation into uses of force involving federally incarcerated Black, Indigenous, Peoples of Colour (BIPOC) and other vulnerable populations,"* I noted an increase in use of force cases between 2015-16 and 2020-21, as well as the fact that inflammatory spray and chemical agents were the most common measures used (accounting for between 40% and 47% of the types of force used each year).

Since the EIM was only in its second year, I recommended that CSC should conduct a thorough evaluation of the EIM with a view to implementing changes that would reduce reliance on use of force options overall, and inflammatory spray in particular. I also asked the Service to provide concrete strategies for adopting evidence-based, non-force options for responding to institutional incidents.

---

[51] *Ibid.*

[52] Data received from CSC during the factual review exercise for the current report showed that inflammatory agents were, in fact, used in 49% of all use of force incidents in 2018-19.

In the same report, a review of use of force incidents involving people in vulnerable situations was carried out for all incidents between April 2015 and October 2020. It revealed that nearly half (46%) of those involved in a use of force incident had a history of self-harm or attempted suicide. To this end, I recommended that CSC review and revise its policy and practices regarding the use of inflammatory spray in incidents involving self-harm and suicide, with a view to reducing their use in interventions with inmates experiencing mental health crises.

Mid-term Evaluation of the EIM by CSC

In June 2021, CSC published an internal evaluation of the EIM, in which it acknowledged that while in some respects there were generally positive trends since the implementation of the EIM, the findings of the evaluation did not support the assertion that there had been an overall reduction in the use of force in institutional incidents. In addition, according to the Service, the findings suggested the need to address the higher frequency of use of force against inmates from various subpopulations,[53] including those most vulnerable due to mental health issues.

The assessment led to five major recommendations, two of which caught my attention. They touch on two important aspects of the EIM's aims; namely, the consideration of mental health distress (recommendation 2) and the effectiveness of corrective and disciplinary measures in the event of flagrant policy violations by staff (recommendation 4).[54]

EIM Six Years Later: Mixed Results in Standalone Maximum-Security Facilities

The following investigation examines the impact of the EIM (by implementing the lessons CSC learned from its own June 2021 evaluation) on the Service's management of incidents in the six years since the model was introduced.

In this year's Annual Report, my Office has turned its attention to standalone male maximum-security institutions, which are known to generate a large number of incidents in all categories. These institutions also house a significant number of incarcerated persons who are vulnerable due to mental health issues, particularly those kept in Therapeutic Units/Ranges which are designed to meet moderate intensity mental health needs.

[53] Correctional Service of Canada. (2021 June). *Evaluation report: evaluation of Correctional Service Canada's Engagement and Intervention Model.*

[54] *Idem.*

HIGHLIGHTS FROM KEY FINDINGS

- Although the introduction of the EIM was accompanied by the launch of "a national implementation plan for training"[55] aimed at staff working in different professional capacities, this has not resulted in a reduction in the use of force at standalone male maximum-security institutions. This trend also applies to the federal correctional system as a whole.
- The rate of unique[56] use of force incidents at standalone maximum-security institutions increased from 441 per 1,000 incarcerated individuals in 2018-19 to 651 per 1,000 in 2023-24.
- Since the introduction of EIM, use of force incidents in standalone male maximum-security institutions account for 46% of all use of force incidents nationwide, even though these prisons house approximately 10% of all prisoners in federal custody.
- In the six years following the introduction of the EIM, 58% of cases of inflammatory spray and chemical agent use in the federal correctional system took place in standalone male maximum-security institutions.
- As in the year prior to the introduction of the EIM, acts of self-harm remain the third most common incident type where force is used in standalone male maximum-security institutions (8% of incidents).
- The rate of use of force for incidents of self-harm, attempted suicide, and overdoses in standalone male maximum-security facilities remained stable between 2018-19 and 2023-24.

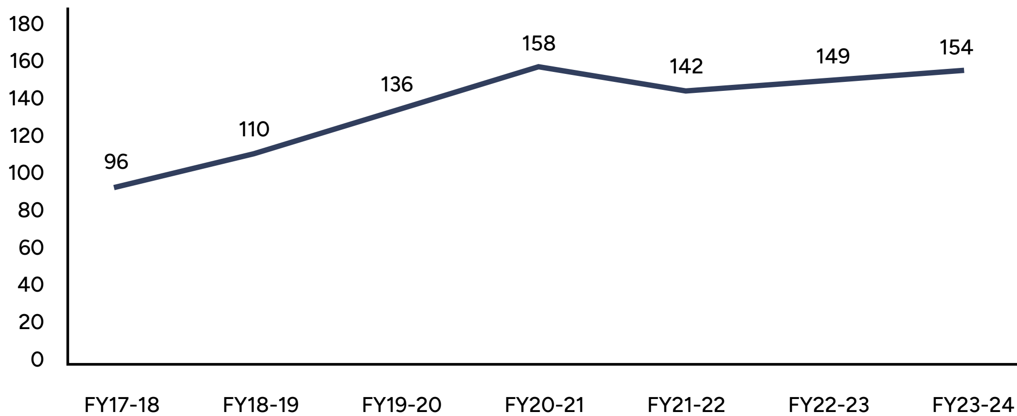
Use of Force Data for the Federal Corrections System (2018-19 to 2023-24)

The following analysis uses 2017-18 as the starting year, given that this is the fiscal year in which the EIM was introduced, while the change itself can be observed from 2018-19. As CSC data shows, the rate of use of force per 1,000 people in all federal institutions increased almost uninterrupted between 2017-18 and 2020-21, peaking at the height of the COVID-19 pandemic and remaining relatively stable ever since.

[55] Correctional Service of Canada (2017 October). *National Training Implementation Plan.*

[56] A use of force incident can involve multiple use of force measures.

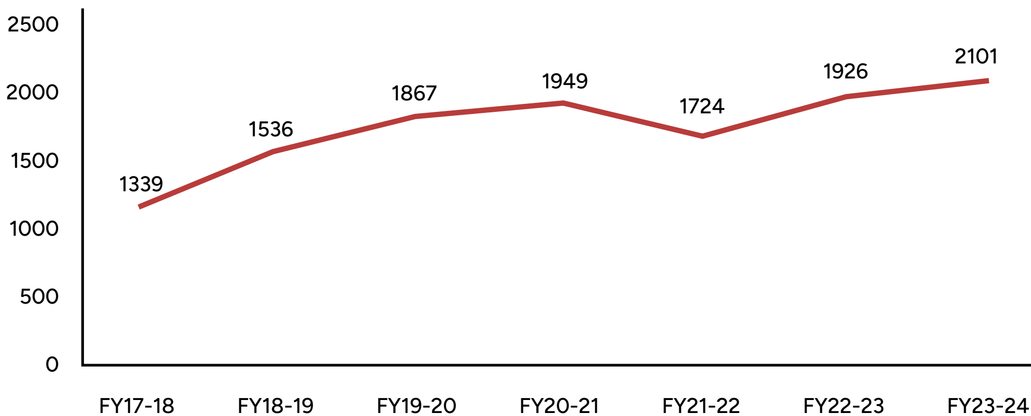
GRAPH 1. RATE OF USE OF FORCE PER 1,000 INCARCERATED INDIVIDUALS PER FISCAL YEAR (2017-18 TO 2023-24)

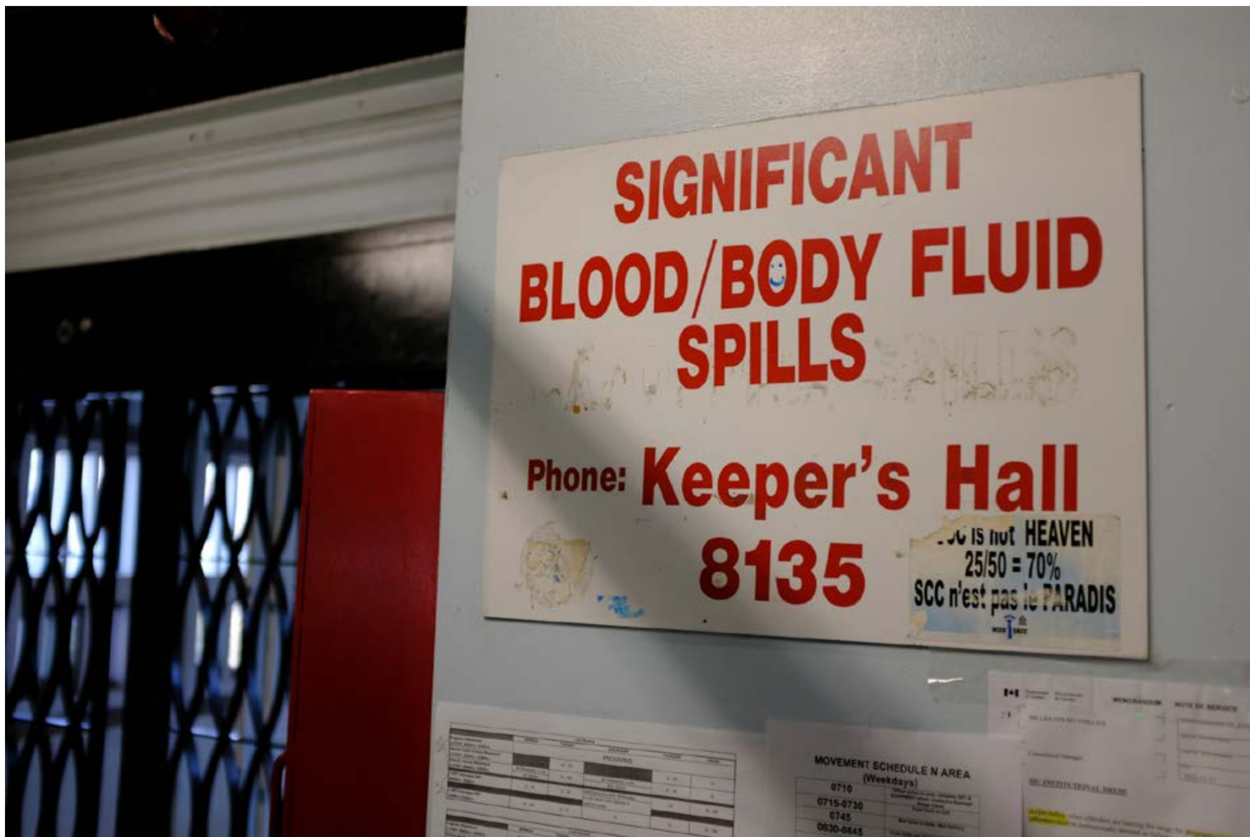


Source: CSC's Data Warehouse (data extracted in March 2024). In-custody counts obtained from CRS-M Offender Profile (Creation Date: June 16, 2024).

In real terms, the total number of unique federal use of force incidents increased by 36.8%, from 1,536 in 2018-19 to 2,101 in 2023-24, as illustrated below.

GRAPH 2. NUMBER OF UNIQUE USE OF FORCE INCIDENTS PER FISCAL YEAR (2017-18 TO 2023-24)





A sign at Millhaven Institution

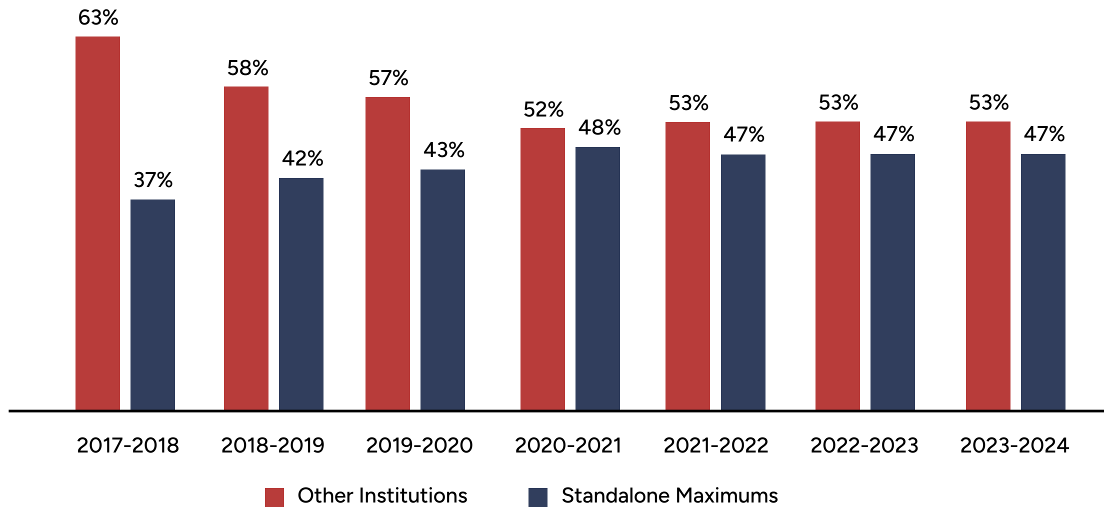
Use of Force at Standalone Male Maximum-Security Institutions

The overall increase in use of force across the federal correctional system, as shown in the previous chart, is largely attributable to a 52% increase in use of force incidents in standalone male maximum-security institutions[57] (from 642 cases in 2018-19 to 977 in 2023-24). This is a development that should get CSC's attention more than ever, both because of its scale and because of the continuation of a trend that cannot be interrupted without decisive and immediate action.

To put things into perspective and provide an overview of the situation at the federal level, the graph below illustrates the disparity between standalone male maximum-security institutions and other types of institutions. Specifically, unique use of force incidents at maximum-security standalone institutions accounted for 37% of all use of force incidents in 2018-19, and this increased to 47% in 2023-24. Between 2018-19 and 2023-24, the six standalone maximum-security prisons accounted for 46% of all unique use of force incidents, despite housing approximately 10% of all federal incarcerated individuals.

[57] CSC operates six standalone male maximum-security facilities across the country: Kent Institution in Agassiz, British Columbia; Edmonton Institution in Edmonton, Alberta; Atlantic Institution in Renous, New Brunswick; Millhaven Institution in Bath, Ontario; Port-Cartier Institution in Port-Cartier, Quebec; and Donnacona Institution in Donnacona, Quebec.

GRAPH 3. PERCENTAGE OF ALL UNIQUE USE OF FORCE INCIDENTS, STANDALONE MALE MAXIMUM-SECURITY FACILITIES COMPARED TO OTHER FACILITIES



Note: "Other facilities" include multi-level security facilities, women's facilities, medium-security facilities, minimum-security facilities, Regional Reception Centres, Regional Treatment Centres, and Indigenous healing centres.

Such a discrepancy cannot be attributed exclusively to the fact that these facilities house inmates with high security ratings, who have committed crimes of a violent nature or are identified as affiliated with a Security Threat Group (STG), as highlighted by the Service in a recent report.[58] De-escalation techniques such as negotiation or verbal interaction remain alternatives that should be considered at all times, regardless of the profile, previous offences, or disciplinary history of people involved in the incident.

Reasons for Use of Force in Standalone Male Maximum-Security Institutions

The reasons for the use of force in standalone male maximum-security institutions have not changed much since the introduction of the EIM. The top three incident types that resulted in a use of force between 2018-19 and 2023-24 are, and continue to be, "Behaviour" (46%), "Assaults" (39%), and "Self-injurious behaviour" (8%).

What immediately drew my attention in the course of this investigation was the fact that, six years after the introduction of the EIM, the number of self-injury incidents where use of force was deployed at maximum-security institutions has remained unchanged. There were 42 incidents

[58] Hanby, L., Smeth, A., & Cram, S. (2023) *Profile and Institutional Experience of Offenders Involved in Use of Force Incidents.* Correctional Service of Canada, pp. 18-21.

where self-injurious behaviour was "resolved" with use of force in the year prior to the introduction of the EIM (2017-18; 8% of all uses of force incidents), compared with 59 incidents in the first year after the EIM was introduced (or 9% of all uses of force incidents). This pattern remained the same in 2023-24 with 59 incidents (or 8% of all use of force incidents).

While perhaps encouraging that the situation has not worsened in six years, for vulnerable inmates in standalone maximum-security institutions, the EIM has had no measurable impact on the success of the Evaluation Division's recommendation that CSC devise *"options to increase capacity to respond to incidents involving mental health and physical distress."*

The Main Types of Force Used in Standalone Male Maximum-Security Institutions

Focus on Physical Control

Since 2018-19, the most frequent types of force in standalone male maximum-security institutions have remained constant, with physical handling accounting for 29% (2,403) of all uses of force over the past six years (N = 8,390). The following table shows the main types of force used in standalone male maximum-security institutions between 2018-19 and 2023-24, grouped into four categories: inflammatory spray, chemical agents and munitions; non-inflammatory and non-lethal measures; restraint equipment; firearms; and other types of force. Increased Use of Inflammatory Spray and Chemical Agents and munitions; non-inflammatory and non-lethal measures; restraint equipment; firearms; and other types of force.

TABLE 1. MAIN TYPES OF FORCE USED IN STANDALONE MALE MAXIMUM-SECURITY INSTITUTIONS (2018-19 TO 2023-24)

FISCAL YEAR	INFLAMMATORY SPRAY AND MUNITIONS[a]	NON-INFLAMMATORY AND NON-LETHAL MEASURES[b]	RESTRAINT EQUIPMENT[c]	FIREARMS[d]	OTHER TYPES OF FORCE	TOTAL
2018-19	469 (43.0%)	326 (29.9%)	205 (18.8%)	14 (1.3%)	77 (7.1%)	**1,091 (100%)**
2019-20	669 (49.0%)	378 (27.7%)	244 (17.9%)	18 (1.3%)	56 (4.1%)	**1,365 (100%)**
2020-21	760 (48.7%)	469 (30.1%)	282 (18.1%)	13 (0.8%)	36 (2.3%)	**1,560 (100%)**
2021-22	672 (50.0%)	428 (31.8%)	216 (16.1%)	16 (1.2%)	12 (0.9%)	**1,344 (100%)**
2022-23	709 (48.4%)	484 (33.0%)	228 (15.6%)	16 (1.1%)	28 (1.9%)	**1,465 (100%)**
2023-24	750 (47.9%)	520 (33.2%)	262 (16.7%)	15 (1.0%)	18 (1.2%)	**1,565 (100%)**
TOTAL	**4,029 (48.0%)**	**2,605 (31.0%)**	**1,437 (17.1%)**	**92 (1.1%)**	**227 (2.7%)**	**8,390 (100%)**

Note: Totals do not represent the number of use of force incidents, as a single incident can involve multiple measures.

a. Includes all measures using inflammatory spray and chemical agents.
b. Includes physical handling, use of shields, diversionary devices, and batons.
c. Includes handcuffs, flexible handcuffs, foot restraints and body belts.
d. Includes the use, aiming, deployment, display and/or discharge of a firearm.

Increased Use of Inflammatory Spray and Chemical Agents

OCI analysts found that since the introduction of the EIM, the use of inflammatory and chemical agents has not decreased between 2018-19 and 2023-24 in standalone male maximum-security institutions. More specifically, there was an increase in the use of inflammatory agents from 2018-19 to 2021-22 (from 43% to 50%), with a slight decrease of 2.1 percentage points since then.

This worrying finding reflects a general trend throughout the federal correctional system. In fact, the investigation revealed that in the six years following the introduction of the EIM, 58% of cases of inflammatory spray and chemical agent use in the federal correctional system took place in standalone male maximum-security institutions, i.e., in 4,029 incidents out of 6,962.

Further, a cursory review of the available data suggests that inflammatory sprays and chemical agents continue to be used with vulnerable people who are engaged in self-harm, attempting suicide, or overdosing – and the rates have remained virtually unchanged since before the EIM was introduced.

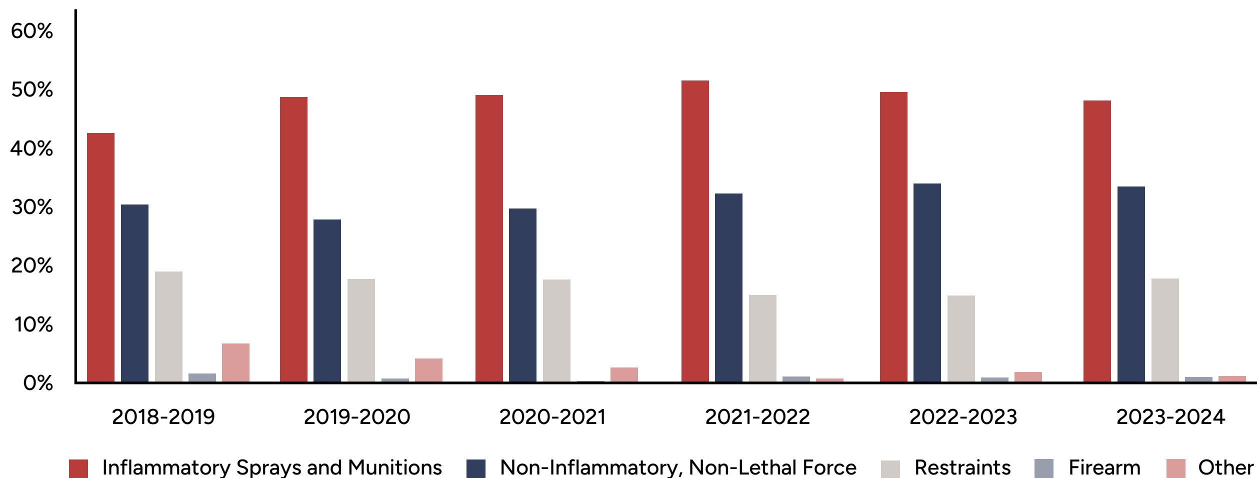
My office will be taking a closer look at the use of force with individuals suffering from mental health and addictions in its next Annual Report. For now, we can only sympathize with CSC's non-clinical staff who are forced to respond to individuals in acute mental distress or who present challenging behaviours that require specialized, therapeutic responses. Indeed, the Office often hears complaints from staff about the challenge of securing transfers from maximum-security facilities to Regional Treatment Centres.

As Graph 4 illustrates, the most frequent types of force used in standalone male maximum-security institutions have remained virtually unchanged since the introduction of EIM. The absence of any significant reductions for each of these types of force is unacceptable and suggests that the Service will have to redouble its efforts to achieve the original aims of the EIM.

"Yes, there's far too much use of force against X. What I can tell you … is that he doesn't belong here. X doesn't belong in a Max. We've asked several times for him to be transferred to an RTC, but the region isn't with us. We try to do the best we can, but as you can see, it's not easy."

– CSC manager, speaking to an OCI investigator about an inmate with a long history of mental health problems who experienced a high number of uses of force over the past year.

GRAPH 4. PERCENTAGE OF ALL USES OF FORCE AT MAXIMUM-SECURITY INSTITUTIONS BY TYPE AND FISCAL YEAR (2018-19 TO 2023-24)



Conclusions and Recommendations

My Office acknowledges that, when analyzing use of force interventions, each individual incident is subject to the dual criteria of "necessity" and "proportionality" mentioned above. Nevertheless, the fact that the changes hoped for when the SMM was abandoned in favour of a "human-centred" approach have not been reflected in the management of the use of force in maximum-security institutions over the past six years is a cause for concern. This only confirms the mixed impact that the EIM has had in managing the use of force within the federal prison system in general, and more specifically within standalone male maximum-security institutions.

The investigation shows that, when focusing on standalone male maximum-security facilities, the Service's stated objective of prioritizing *"non-physical and de-escalation responses to incidents,"* is not supported by a decrease in the number of use of force incidents, a change in the types of force used, or a reduction in the use of inflammatory agents, even in situations involving vulnerable inmates.

The three incidents presented at the end of this section demonstrate that contrary to two of CSC's key internal recommendations at the time of the 2021 EIM evaluation, consideration of mental health issues, as well as the importance of corrective action following serious violations of law and/or policy by some front-line officers, did not always guide the Service's actions throughout the period under review. However, without concrete action on these two aspects (among others), it would be illusory to expect real change.

8. **I recommend that CSC evaluate all the strategies put in place in response to its recommendations from the June 2021 EIM evaluation and publicize the measures it has taken in order to reduce the use of force; increase capacity to respond to incidents involving mental health and physical distress; and, ensure that violations of the law and/or policies do not go unchecked.**

EXAMPLES OF INAPPROPRIATE USE OF FORCE IN STANDALONE MALE MAXIMUM INSTITUTIONS INCIDENTS

Overt Failure to Consider Mental Health History when Responding to Incidents

Note: *Gender considerations were noted for this individual. They have an extensive, documented history of mental health concerns, suicidal, and self-injurious behaviour. A total of 60 uses of force have been used on this person in the last 6 years.*

On August 5, 2020, the prisoner returned to Kent Institution from the Regional Treatment Centre (RTC) via Emergency Response Team (ERT) escort. Approximately 30 minutes later, they became disruptive by breaking broom handles, barricading the upper slider and blocking the gun ports. Each time the gun port from the control post was opened, they tried to stab the officers with the broom handles.

An officer in the Control Post fired two impact rounds, initially missing. The second round ricocheted off the wall and hit them in the mouth. Staff rushed in to secure them before decontaminating and escorting them to an observation cell on High Watch.

A few hours later, they reopened two previous wounds on their arm, a significant amount of blood quickly pooled on the floor. They were escorted to a nearby hospital for medical assistance and were later re-admitted to the RTC.

The initial local and regional reviews conducted by CSC were in agreement, including the notation that the ricocheted impact round was an “accident,” and identified the use of force as appropriate given the circumstances. Regional Headquarters (RHQ) later changed their stance on the use of the impact rounds as not being proportionate to the situation.

The use of force review conducted by this Office noted several shortcomings, including the lack of de-escalation attempts and insufficient communication between staff members responding to this incident. It was also unclear why direct-impact rounds were fired even though an intervention was already underway. Without a direct line of sight, it was irresponsible to utilize the direct impact round launcher while having a “mostly obstructed” view.

In addition to a number of issues regarding the general quality and rigour of the reviews conducted by CSC, there were notable discrepancies between the Initial and Final RHQ Reviews. It is interesting to point out that the RHQ Review initially concurred with the Institutional Review before RHQ revised its position roughly two and a half months later without providing any substantive rationale for the changes apart from the fact that further “significant discussions” occurred at the regional level.

Same Prisoner (Above), Same Approach – Not Focused on the Well-Being of a Vulnerable Person

On September 22, 2021, after returning from the hospital, the prisoner began to self-harm by picking at their wounds that had just been stitched up. They were placed in an observation cell after the metal detector alerted around the abdomen, rectum, and groin areas. Their behaviour escalated to the point where they ripped out their sutures, reopening the wound on their arm which was previously treated at the hospital.

CCTV identified a blanket in front of the cell's food slot to prevent the guards from looking in. Officers instructed the offender to put their hands through the food slot so that handcuffs could be applied and if they did not comply, inflammatory spray would be used. They did not comply.

Given the lack of compliance and the severity of the offender's wound, officers opened the cell door. One officer deployed a burst of OC spray, while another officer removed the blanket out of the cell. A second burst of OC spray was deployed by the same officer after only one second. The offender raised both of their arms up in the air and officers used physical handling to apply handcuffs. The offender was taken to the RTC unit for medical care but became resistive when the nurse attempted to treat their wound. Officers reported physical handling was needed to bring the offender to the ground until they calmed down. They were later escorted to the hospital for treatment.

The OCI Analyst agreed with all three levels of review by CSC, that the use of OC spray was not necessary and was not proportionate to the situation. However, the use of physical handling and the application of handcuffs were appropriate and proportionate to the situation. The officer was not required to use OC spray as other types of interventions with a lower amount of force were available to use.

A Victim of Assault Harmed by Racial Prejudice?

On April 8, 2022, at Edmonton Institution, five inmates, including the victim, were in the gymnasium, while two others were in the yard. Suddenly, one of the inmates next to the victim punched him several times in the back of the neck, while calling for help from fellow prisoners lying in wait outside. A total of five held the victim down while administering blows, inflicting approximately ten stab wounds, before the officers came to the gate.

Inflammatory spray was deployed after the first orders were ignored. While the assailants eventually complied and headed for the courtyard, the victim struggled to keep a reasonable distance from the other instigators. The responding officers then pepper-sprayed him. The decision by staff was questionable, given that the inmate was isolated behind a barrier and officers were able to reasonably identify the five aggressors and observe the victim's passivity. Similarly concerning, rather than applying restraint equipment to the aggressors, the officers instead decided to handcuff the victim, who had just complied with the order to leave the gym.

Even more disturbing was the decision to use direct-impact ammunition on the victim. Although the victim had ignored the verbal orders, this could not justify the use of such force against him. In addition to presenting no real risk in this situation, his refusal to comply could have been due to the pain he was experiencing as a result of his injuries.

Concerningly, it seemed apparent that this individual was not considered by staff to be a victim. In addition to presenting no real risk in this situation, the OCI analysts found, on the contrary, that the officers attempted to justify the use of force against the individual by interpreting the perceived signs of distress as signs of aggression (the victim was said to be “threatening,” “agitated,” “in an aggressive posture”). Under the circumstances, considering that the victim was a Black inmate, OCI analysts couldn’t help but analyze the incident in terms of potential discriminatory treatment.

In the Office’s previous investigation into the experiences of Black inmates in federal custody (OCI Annual Report 2022), I drew the Service’s attention to the fact that several factors, including body language, were often misinterpreted by officers as threatening.

Whether or not racial prejudice played a role in this incident, the use of force was neither necessary nor proportional to the danger the victim might have posed, contrary to the conclusion reached by the Service. The response to a person in a state of distress, following a violent attack from which he suffered after-effects, including head injuries, was highly inappropriate.

Promising Practices in Indigenous Corrections

Prepared by Hazel Miron, Deputy Director, Indigenous Portfolio and OCI Indigenous Champion.

Correctional Investigator's Introduction

In last year's Annual Report, my Office released a ten-year update of *Spirit Matters*, an investigation that provided the Office's latest critical assessment of the state of Indigenous Corrections in Canada. As a follow-up, I asked our Office's Deputy Director, Indigenous Portfolio, who is a Cree woman and a member of the Sucker Creek First Nation in Alberta with extensive correctional and investigative experience and expertise, to identify and compile selected interventions that, in her view, are having a positive impact on Indigenous people incarcerated in federal prisons. Ms. Hazel Miron's review, backed up by site visits and interviews, identified core features that contribute to successful Indigenous-specific and focused interventions at the local level – use of traditional teachings; healing methods and principles; staff engagement and acceptance of Indigenous culture; facilitation of a safe and collaborative learning environment; and involvement of Elders and Indigenous organizations and communities. These core features for effective engagement of Indigenous People (applicable to both men and women) were best captured in *Creating Choices* in 1990 and are still relevant today.

Our intent in conducting a promising practices review is to recognize leadership and initiative at the local or site level and encourage CSC to properly fund and expand Indigenous-specific interventions and initiatives across the country. The key features of successful engagement of Indigenous People in federal custody identified through an Indigenous lens and world view should guide CSC in significantly expanding the number of initiatives and participants. Giving CSC Wardens and Executive Directors more latitude and resources to fund local grass-root Indigenous interventions should be a top priority for the CSC.

Introduction

I am a proud Indigenous Cree woman and a member of the Sucker Creek First Nation. It is a Treaty 8 First Nation. I am a direct descendant of Chief Moostoos, who was a signatory to Treaty 8, the largest Treaty in Canada. People in the area where he was Chief knew him as the "People's Chief," a very loved and respected man.

My family was deeply impacted by the abuses they suffered in residential schools. I too suffered from the intergenerational effects of these abuses. I was the seventh child and was given the name Te'pakoph – which means 'seven' – by an Elder. The Elder told me I had a special gift and would grow to see far. It has given me inner strength and a strong relationship with the Creator. These qualities guide the choices I made and make in my life.

My career in the federal correctional system began in 1995 as a Primary Worker with the Correctional Service of Canada. In 2000, I transferred to a Healing Lodge and worked as a Correctional Manager for ten years. During this time, I obtained a B.A. in Criminal Justice. In addition to the degree, I was gifted an eagle feather and a women's medicine protection bundle. These 'white' and Indigenous credentials set the stage for how I would approach federal incarcerated people: not favouring one world view over the other but having a holistic approach.

In 2011, I became a Program Officer with the Ottawa Parole Office, drawing from my academic knowledge, extensive work experience in the criminal justice system, and my lived experience as a First Nations woman to help me connect with my clients and make programming more effective.

Soon after, I joined the Office of the Correctional Investigator as a Senior Investigator. This was another opportunity to help Indigenous People. I have travelled to remote areas where Healing Lodges are located and I sat with Elders and residents on sacred grounds, where we could discuss their concerns. If they were older persons, I spoke my language – Cree – to make them feel comfortable, and I shared stories they can appreciate. I helped them to understand that I am an Indigenous person looking at the facts of their case with knowledge from the two worlds.

The Office of the Correctional Investigator provided significant support to help me complete my Master's degree in Legal Studies at Carleton University, Ottawa. This gave me additional insight about the impact of colonization on Indigenous People, and the reasons for their gross over-representations in federal Corrections. After years as the Office's Champion on Indigenous Issues, I was recently appointed as the first OCI Deputy Director, Indigenous Portfolio.

Coming with the knowledge of white policies and my Indigenous cultural credentials, I seek to help incarcerated individuals gain self-respect. And I share my story of resilience and perseverance, my commitment to making a mark on this world in a meaningful way, as long as the "sun shines and the rivers flow," as my great-grandfather envisioned.

In last year's Annual Report, I was honoured to apply my skills, knowledge, and Indigenous lens, and to contribute to a ground-breaking systemic investigation entitled *Ten Years Since Spirit Matters*. The OCI team produced a critical analysis of federal Indigenous Corrections and provided a much-needed roadmap for the reform of Indigenous Corrections in Canada. The findings were very critical of CSC's three signature initiatives, namely how Healing Lodges and Pathways only reach a small number of the overall Indigenous incarcerated population, and how Elders remain under-supported, undervalued, and underappreciated. I agree, though I am saddened by all the findings and criticisms raised in this systemic investigation. Nonetheless, the investigations did not discuss the benefits of local level initiatives and interventions that are positively impacting the limited number of select Indigenous participants. It also partly failed to fully recognize the dedication and determination of some CSC employees who, with few resources and support, are making a difference in the lives of those selected few participants.

Although the issues facing Indigenous Corrections will take a long time to address, I would like to bring attention to initiatives, interventions and practices that are having a positive impact on Indigenous people incarcerated in federal prisons. There is no lack of promising initiatives led by committed and passionate CSC staff, making a difference every day to contribute to better outcomes for the people under their care. My hope is that by highlighting the positive impact some of these initiatives and interventions have on Indigenous people's lives that the CSC will properly fund and expand them across the country.

Promising Practices

I was delighted when the Correctional Investigator offered me the opportunity to write about best promising practices in Indigenous Corrections from an Indigenous lens and world view. Over the winter months, I travelled to three institutions, and interviewed 11 correctional staff and 13 participants. Although there are many more examples of tremendous work being done at the local levels, I have chosen to highlight four initiatives in particular.

1. *The Four Season Missatim Ki-si-nah-ma-too-win* (Horse Teachings) – Okimaw Ohci Healing Lodge, Maple Creek, Saskatchewan

Okimaw Ohci Healing Lodge (OOHL) for Women was the first healing lodge to open in Canada and is now home to this unique Indigenous Horse Program. The Lodge sits on the traditional territory of the Nekaneet First Nation, and the Elders from this nation introduced the horse teachings in 1998 when they celebrated the opening of this lodge. It began as a pilot program and has now grown to provide four sessions representing the four seasons. The program is now known as the *Four-Season Horse Teachings* program.

The program is Elder-led and is holistic in its approach, targeting all areas of the participants' lives by focusing on the teachings of the Medicine Wheel where all things are a part of Creation. These teachings acknowledge and explore the Sacred Gifts of Life, the four Hills of Life, the Sacred Laws of Creation, the four Spiritual Principles, and the four Directions of the Universe. It is through these teachings that the participants learn to come together in harmony with the Creator, within the Circle of Life, and the Spiritual Path they walk.

The Elder begins their day with a morning smudge, prayer and talking circle, and then transitions into the daily program content, including basic horse care, anatomy, feeding, watering, grooming, hoof care, and maintaining the facilities. Participants are also given the opportunity to acquire safe riding skills, including equipment basics, saddling up, commands, mounting, riding in a round pen, obstacle practice in round pen, loading horses into trailers, and trail rides on and off site.

What I heard from participants is that the work they do with the Elder encompasses the traditional teachings from a Nekaneet perspective, while at the same time they are mastering the basics of equine care. Close contact with horses and the development of new skills have been shown

Horses from the Four-Season Horse Teachings program, Okimaw Ohci Healing Lodge

to contribute positively to women's healing and personal growth. To further this training, women can also attend Nekaneet ceremonies, such as the annual Sun Dance. This has proven to further develop and maintain a positive relationship with the community.

Upon completion of this visit and learning about the impact this program had on the participants, I learned that the staff and community involved in this program are committed and passionate about having the women connect with their culture. They shared that the women need to connect with their Indigenous roots, to give them a sense of who they are so they can move forward in living a healthy lifestyle grounded in Indigenous culture. We have always been told from our Elders that "we need to know where we came from in order to move forward and never forget who we are as Indigenous peoples."

Participants told me that this program can change the way they felt about their situation and attained a sense of self-worth from knowing more about their cultural and historical background. Many of the women participants have never had a connection to their Indigenous culture. It is

therefore important to ensure that any initiative designed to assist Indigenous women are culturally based and steeped in traditional teachings from the Elders. The Elders are the holders and teachers of the sacred knowledge and wisdom, passed down for centuries.

2. *Traditional Healing Program* – Okimaw Ohci Healing Lodge, Maple Creek, Saskatchewan

The Traditional Healing Program at Okimaw Ohci Healing Lodge (OOHL) began in the fall of 2020. Working in partnership with the Nekaneet First Nation, the program is designed to incorporate traditional Indigenous and western medicine into the health care service delivery model at OOHL. This program recognizes and acknowledges the practices and approaches of traditional Indigenous medicine and its contribution to health and well-being. Traditional Healers support and treat residents through medicines, cultural activities, and traditional healing practices, promoting better overall health and wellness of Indigenous individuals. Traditional Healers work with an integrated health team, which includes western trained medical practitioners, nurses, psychologists, social workers, and pharmacists.

The impact of the program could be felt by the women who participated. The combination of medicines, both traditional and western, proved to enhance their overall well-being. Holistic wellness led to better long-term results for the participants, families, and communities. Having access to sacred medicines is a crucial part of healing. Combining Indigenous traditional medicines and western medicines not only demonstrates reconciliation efforts but honours the well-known effects traditional medicines have on Indigenous peoples since time immemorial.

QUOTES FROM STAFF AND ELDERS:

"Talking about Identity and Emotions helps women identify where they are in life. It helps them to connect with the community and how to handle grief and loss – connection to the spirit world helps them learn to manage their emotions. They don't know what normal is – The horse program provides women with a maternal instinct, something to care for. They learn how to handle grief and loneliness in a good way."

– Elder at Okimaw Ohci Healing Lodge

"The men are very interested in learning about the bees, so they are highly engaged. The program appears to help men develop empathy and teamwork skills and it also appears to build self-esteem and a sense of satisfaction. It is working well as an unconventional way to earn high school credits. Men also see beekeeping as an attainable source of income after their release into the community because the overhead for startup is fairly low cost. Something new this year is that students from last year's group will be mentoring new

students during the hands-on learning time. This helps to build a sense of community and a sense of purpose for the mentors in the group."

– Staff at Stony Mountain Institution

"In the past we were fortunate to have one offender participating in a program at a time throughout various years. The COVID pandemic did impact participation as CSC was still experiencing the affects of the pandemic and continued precautions were required. As a result, a long pause did occur; however, offenders have been encouraged to inquire with Trade Winds To Success upon community release. On a positive note, TWTS staff have always been very accommodating when it comes to Indigenous offenders at EIFW and during all interactions that have been extremely supportive, welcoming, and accepting."

– Teacher at Edmonton Institution for Women

3. *Caring for Bees* – Stony Mountain Institution, Winnipeg, Manitoba

The Beekeeping initiative began in 2021 at the minimum-security facility at Stony Mountain Institution (SMI) – a multi-security level institution where more than 65% of its carceral population is of Indigenous descent. After a year of operation, some of the hives were moved to the medium facility to allow the men there to also participate in this program.

At the medium facility, the name of the initiative was changed to the Caring for Bees program. The new name came from the belief that participants are not in fact "keeping" the bees but working with them. A program educator explained that "this language is an important way to explore Indigenous perspectives and change the paradigm of hierarchy with humans at the top. Reframing understanding of humans as a part of nature rather than masters of nature can foster cultural connections as well as greater respect for the natural world." He further explained that "at the start of the new season, the group cleaned up the bodies of the bees who died through the winter and according to the advice of the Elder, the men took time to lay down an offering of cedar and say prayers of thanks for the bees who died so that they could continue harvesting honey."

This project is managed through the school program at SMI, with a retired volunteer beekeeper from the community and the help of the Elders working at SMI. They help the men in maintaining the hives, and participants can earn school credit at the same time.

Beekeeping initiative, Stony Mountain Institution

Since 2023, the institution has partnered with the University of Manitoba. The participants can watch video lectures and take a final exam to earn a Hobbyist Beekeeping Certificate from the Department of Agriculture at the University of Manitoba.

Between the two facilities, participants harvested more than 2,000 pounds of honey in 2023. The bulk of the honey is sold to a Manitoba honey co-op to help finance the program, while a smaller portion of the harvest is sold to SMI staff and incarcerated persons.

In addition to enhancing vocational skills, the cultural benefits of this program are that participants learned how to love, trust, and respect, which comes from the seven grandfather teachings and Indigenous law. All this speaks to the traditional Indigenous aspect of the interconnectedness whereby everything in the natural world is connected and dependent on each other, that all living things respect each other and have a purpose, sometimes to help others, which is a hallmark of Indigenous learning. The Elders spend time with the participants about respecting bees and discuss the lessons we can learn from bees. The Elder also teaches to “treat bees the way you would like to be treated.”

4. *Tradewinds to Success* – Indigenous Trade School, Edmonton Institution for Women

Trade Winds to Success Society was established in 2005 by the Joint Training Trust Fund. The program is a partnership with Indigenous community organizations and government funding agencies to provide First Nation, Metis, and Inuit an opportunity to receive pre-apprenticeship training and shop experience in construction trades.

The Trade Winds program provides an initial six-week training that incorporates essential skills, including digital workshops, financial literacy, problem solving and awareness of employment expectations, and apprenticeship requirements. The program also prepares students to write the Alberta Apprenticeship and Industry Training entrance exam. Students who successfully pass this entrance exam can go on and participate in the Pre-Apprenticeship Training, which ranges from two to 12 weeks depending on the selected trade. There are two options open to the participants if they pass the exam. The first option is to learn residential construction skills and apply them to build a small eco-smart home designed by Trade Winds at the Trade Winds shop in Edmonton. The second option is for the Industrial and Commercial stream, whereby training is provided by the various union training trusts in Edmonton, including Ironworker, Plumber, Steamfitter/Pipe trades, Industrial Mechanic, and Electrician.

The women I spoke to were especially grateful by the cultural aspects that are integrated throughout the learning experience, including smudging, talking circles, and resiliency workshops. Additionally, successful women are offered free personal protective equipment and are admitted to the pre-apprenticeship training.

QUOTES FROM PARTICIPANTS

"After interacting with horses, I feel happy after."

"Healing hurts, but it's worth it, this horse program has changed my life. I used to be disconnected from my spirit, now I'm connected."

"Being with horses helped me see."

"Horses know what you're feeling."

"So many of us learn to cry when dealing with horses."

"This program works if you believe in the culture and the medicines, and this belief has made a huge difference in my life."

"Emotions bring me to the traditional healers – such as loneliness, confusion. I cry every time I go to see (name of Staff). She broke through my shell."

"I believe in the medicines. Daily meditations and I think only of positives and the positives manifest itself."

"Healers provide wise words that are so helpful in relationships. Talking to Elders is so good."

"The program helped me re-identify myself and got me integrated in the workforce. They stood by me for 10 years as I continued my apprenticeship. The encouragement from the staff helped me believe in myself. I was discouraged at first, because I failed my entrance exam, but I went home and studied my books for math, called Tradewinds back, asked if I can rewrite, and they said yes, so I went back. It changed my life for the better, I worked hard to make trade winds look good and to better my life for me and my son. I started the program while on parole from EIFW and stayed with it and started 2009, July. I am still working as a plumber, and it is 2023."

Conclusion

Prior to first contact, Indigenous peoples taught their children through traditional means, through storytelling utilizing oral teachings. They described and demonstrated their knowledge and wisdom through Elders, and they promoted group socialization. They also encouraged participation in cultural and spiritual rituals and skill development, which was hands on. They were guided by the four principles that remain very much relevant today – Respect, Relevance, Reciprocity, and Responsibility – the 4 R's.

It is evident from my visits to the various sites that there are very dedicated staff who do what they can to integrate traditional teachings, and to provide more culturally informed and language-based support to Indigenous participants. This enhances and improves greatly outcomes and experiences for Indigenous peoples. I found that staff who support these initiatives are passionate, and they are accepting of Indigenous culture and understand we do not always learn and engage the same way.

The CSC must be guided by principles that increase the likelihood of successful intervention and engagement when developing and implementing its Indigenous programs and initiatives. These principles have been best captured by *Creating Choices*, the 1990 report of the Task Force on Federally Sentenced Women. The principles are applicable to both men and women, and should be regularly used to develop, implement, and evaluate any Indigenous intervention.

Finally, I urge CSC to immediately provide significant funding to empower its Wardens and Executive Directors to develop and implement new local Indigenous interventions in partnership with Indigenous organization or communities. These initiatives must be consistent with *Creating Choices* principles in order to ensure they will be responsive to the unique needs of Indigenous incarcerated People. Too few have access to these positive interventions, and most of the time these initiatives actually require little resources and funding to operate. Supporting this recommendation and making it a priority would contribute to reconciliation.

KEY FEATURES OF SUCCESSFUL INDIGENOUS INTERVENTIONS AND ENGAGEMENT

- Provide a safe space that supports culture.
- Indigenous taught.
- Historical teachings which teach where we came from, to get a sense of belonging and restore our self-esteem.
- The importance of interconnectedness with all living things and how we learn from them.
- Healing of psychological and emotional wounds caused by intergenerational trauma.
- Elder-led Indigenous teachings based on the wisdom of Elders, such as: a) the Medicine Wheel; b) learning forgiveness, love, grieving, accountability, responsibility, and balance in life which Indigenous wisdom holders strive to instill within their communities; and, c) teachings connected to the land, weather, environment, plants, and animals.
- Connection to the community.
- Skills and traditional knowledge that provides educational and vocational opportunities for employment after release.
- The 4 R's: Respect, Relevance, Reciprocity, Responsibility.
- Language, which is the heart of our culture and existence.
- Healing toward addressing displacement and historical colonial abuses.

CASE STUDY: Death at the Regional Treatment Centre – Millhaven

On December 17, 2021, Mr. Stéphane Bissonnette, a 39-year-old man serving his first federal sentence died in an observation cell while on modified suicide watch at the Regional Treatment Centre (RTC) Millhaven.[59] The deceased had previously spent significant parts of his sentence in administrative segregation in maximum-security facilities, as well as various placements in Regional Treatment Centres across the country.[60] To alleviate his long-term Structured Intervention Unit (SIU) status, in April 2021, Mr. Bissonnette was transferred from Kent Institution to Millhaven. He was initially placed in the SIU at Millhaven in May 2021 and then transferred to co-located RTC Millhaven in June 2021 where he remained until his death.

Stéphane Bissonnette

[59] The disclosure of Mr. Bissonnette's identity and personal information are made under section 183 (1)(a)(ii) of the *Corrections and Conditional Release Act*. In my opinion, as Correctional Investigator, the disclosure of sensitive personal information is considered necessary in establishing the findings and recommendations of my investigation. Although I have the legal authority to disclose information I deem to be in the public interest, I respectfully sought the consent and support of Mr. Bissonnette's family to release personal information about Stéphane in my report. The Office wishes to again express its condolences to the family of Mr. Bissonnette.

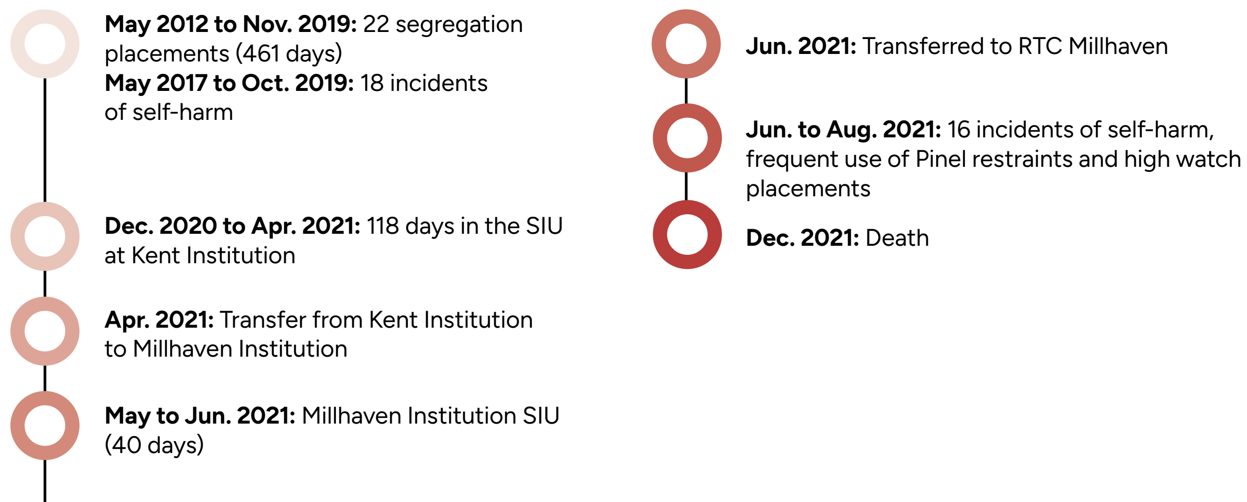
[60] Regional Treatment Centres (RTCs) are designated and accredited as psychiatric hospitals. These facilities are staffed and operated by the Correctional Service of Canada and provide inpatient psychiatric services. Mr. Bissonnette was a patient at RTC Millhaven when he unexpectedly died.

Mr. Bissonnette had served his sentence at numerous maximum-security penitentiaries across the country. Through the course of his federal incarceration, he was placed in administrative segregation on 22 separate occasions, cumulatively spending 461 days in solitary confinement. More recently, from 2019 onward, he spent a combined total of 158 days in Structured Intervention Units. Mr. Bissonnette had an extensive history of suicidal and chronic self-injurious behaviour.

Mr. Bissonnette had a lengthy history of involvement in institutional incidents, amassing 152 reported security incidents, many of which were related to self-injurious behaviour. He was often transferred and placed in Treatment Centres and often managed by way of Enhanced Observation (also known as "suicide watch"). He was frequently physically restrained to prevent self-injurious behaviour, often for prolonged periods at a time. He was known to intimidate, be verbally aggressive, manipulative, and even assault staff and other prisoners. These challenging behaviours may have been related to symptoms of his mental illness. His main mental health diagnoses on record were Post-Traumatic Stress Disorder, Attention Deficit and Hyperactivity Disorder, Antisocial Personality, and Borderline Personality Disorder.

From his initial placement at RTC Millhaven from June to December 2021, there were 15 documented episodes of Mr. Bissonnette causing harm to himself, mostly cutting, or banging his head on the wall or cell door. These and other erratic behaviours, including being unsteady on his feet, stumbling, falling to the ground, not alert, smearing blood on his in-cell observation camera and generally appearing to be in a "state other than normal," were all observed in the day preceding his death.

TIMELINE OF EVENTS



As recorded by CSC, during the entire period of his sentence, Mr. Bissonnette spent an estimated **9 days, 2 hours, and 40 minutes** in the Pinel Restraint System, and **67 days, 7 hours, and 25 minutes** under direct camera observation (high/modified watch).

I-Range, RTC Millhaven, where Mr. Bissonnette died in an observation cell

With respect to the immediate events and circumstances leading up to this death, all documentary and video evidence support the conclusion that multiple security patrols, counts and health care wellness checks conducted over a continuous six-hour period failed to notice that Mr. Bissonnette was in fact immobile and not living or breathing in his cell for the entire duration. On the day of his death, he had displayed some bizarre behaviours, expressed suicidal ideation, and engaged in self-harm. He was observed to have difficulty getting up from his bed, to be stumbling and falling to the ground in his cell for no apparent reasons.

CSC's internal investigation confirms that none of these troubling indicators were properly monitored, communicated, documented, or adequately assessed by staff members in the immediate lead up to Mr. Bissonnette's death. Disturbingly, no staff member on duty that evening, including nursing personnel responsible for the monitoring of Stéphane in his observation cell on the night of his death, were aware that he was on Modified Suicide Watch, or indeed what indications, behaviours, or conditions they should be vigilant to, or what needed to be observed, monitored, or reported to ensure his safety. None had read the email from Mr. Bissonnette's Clinical Care Coordinator indicating that Mr. Bissonnette had been placed on suicide watch via CCTV monitoring on the morning of December 16, 2021.

CCTV camera footage confirms that some security patrols conducted over that six-hour period in which Mr. Bissonnette was immobile and not breathing failed to even look into his cell. Most officers conducting security patrols that night simply glanced into his cell for one or two seconds or less as they walked by. For their part, nursing staff seemed unclear of what purpose a wellness check or health service walk served, or even, remarkably, how it was to be conducted. A few, also surprisingly, indicated that it was not their responsibility, but rather security staff's, to ensure signs of life. Regardless of how inadequately or improperly correctional officers or nurses performed their duties that night, some staff members could reasonably argue that they had little prior experience, lacked orientation training and knowledge of basic procedures such as how to work with or monitor complex mental health needs patients in a psychiatric hospital setting. In a telling post-incident visit to RTC Millhaven, OCI staff members struggled to confirm via in-cell camera monitors whether a patient, who was under a blanket at the time, was in fact breathing.

On the surface, Mr. Bissonnette's death could be attributed to staff negligence or gross incompetence in the performance of duties. In trying to explain his death, it bears reminding that even the Ontario Coroner could not, even after a post-mortem autopsy, ascertain a specific cause of death; the manner of death was officially categorized as *"Undetermined."* To put it differently, none of the individual failings of staff can definitively account for his death. In fact, as even the Board of Investigation concluded, Mr. Bissonnette was provided an "impressive amount of Mental Health interventions" while at RTC Millhaven. The Office has found no reason to doubt the NBOI's conclusion in this regard.

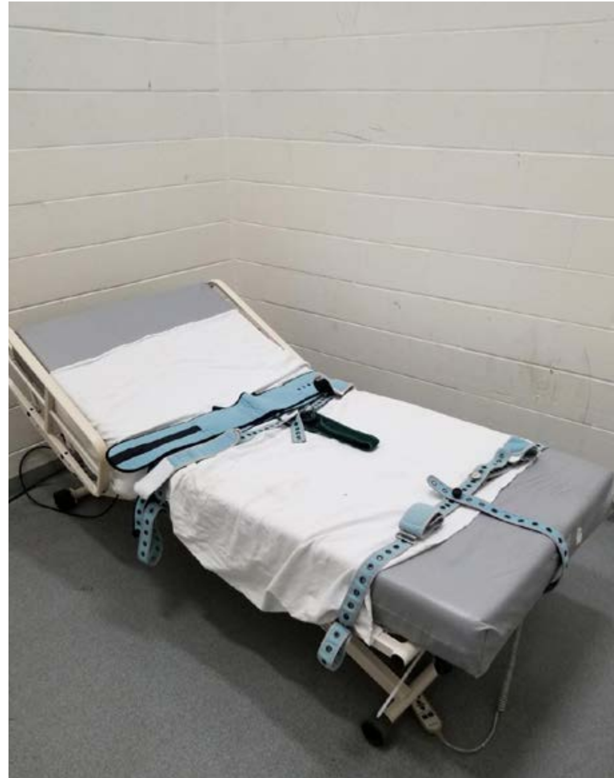
That said, the facts of the matter are that the contributing individual risk factors that Stéphane presented, serious compliance issues at RTC Millhaven and systemic failures in this case were multiple, cumulative, and, in their totality, fatal. At a systems level, these contributing and precipitating factors included:

1. Inadequate quality of security patrols and wellness checks (systemic failure to verify a living, breathing body or signs of medical distress).
2. Critical lapses in reporting, communication, assessment and monitoring of suicidal and self-injurious behaviour.
3. Mismanagement of seriously mentally ill, self-injurious and suicidal individuals in highly restrictive placements and inappropriate conditions of confinement.
4. Miscommunication and problematic interactions between and among health care and operations staff.
5. The tendency to regard and operate RTC Millhaven, an accredited multi-level psychiatric facility, as an extension of the maximum-security Millhaven complex.
6. Inappropriate suitability, selection and training of security staff working in an RTC setting.
7. The prevailing and deficient physical infrastructure at RTC Millhaven, based on a repurposed 96-bed maximum-security accommodation unit, which is known to hinder staff's ability to ensure quality, timely, safe, and effective inpatient care.
8. Problematic oversight and muddled governance and reporting structures leading to role confusion, conflicts and barriers between health care and operational/security staff at RTC Millhaven (dual loyalties).

Undoubtedly, as the staff disciplinary investigations suggest, some inexperienced correctional and health care staff found themselves in a troubling and impossible situation; they had inadequate training and were unprepared to manage a highly volatile, complex, and seriously mentally ill person like Stéphane. That said, the Office wants to make it clear that his death cannot be blamed or attributed to any one individual or any single omission. As previously stated, this incident needs to be understood in the context of significant, persistent, known, and recurring issues that continue to lead to tragic and preventable deaths in CSC care and custody. This investigation concerns the scope of Stéphane Bissonnette's death at RTC Millhaven, but the implications of our findings extend far wider and deeper.

Analysis and Assessment

Mr. Bissonnette was known to the Office, having been interviewed by two staff members just days before his death. During that interview, he openly discussed his history of self-harm and suicidal ideation, which he attributed to lengthy periods of time spent in solitary confinement. He made further allegations of reprisal for filing grievances, excessive use of force at the hands of correctional staff at both Millhaven Institution and the RTC, as well as neglect by health care personnel. He recounted lengthy periods of time spent in the Pinel Restraint System in response to his self-injurious behaviours. He had filed numerous grievances against staff, alleging that Correctional Officers had harassed him, threatened to hurt him physically or incited him to hurt or kill himself.



A PINEL restraint bed at RTC Millhaven

As per an Office recommendation, a number of these same allegations and grievances were also reviewed by CSC's National Board of Investigation (NBOI or Board) convened to examine this incident. To its credit, the Board's report devotes sufficient space and detail in describing the 17 grievances that Mr. Bissonnette submitted during his short stay at RTC Millhaven. However, in assessing the responses to his grievances, in the Office's view, the Board gives an inordinate amount of leeway to repeated staff assertions that no such alleged mistreatment was directly witnessed or substantiated.[61] Most of his formal complaints were, not surprisingly, rejected, denied, or

[61] In the Factual Review exercise, CSC takes issue with the Office's assessment of how the NBOI reviewed Mr. Bissonnette's grievances after his death. According to CSC, the NBOI's mandate is "to determine whether grievances were addressed according to policy, and not to evaluate the merit of the grievances submitted." I respectfully disagree. Irrespective of any differences in how the Board interpreted or applied itself, I had specifically recommended that the NBOI should investigate/corroborate allegations made by the deceased of his mistreatment at RTC Millhaven. The Convening Order to this investigation directs the Board to analyze "any complaints, grievances or allegations of mistreatment made by Mr. Bissonnette ... to other inmates, family members or to his intervention team or any other warning signs that may have foreshadowed the incident."

withdrawn. Four resulted in a finding of "no further action required" and four others were simply left unanswered, contrary to policy. In determining whether CSC responses to Stéphane's many grievances were addressed according to policy, it is significant to note that the Board interviewed 43 staff members but only *two* fellow patients from the RTC.

Preliminary Concerns

The Office was not notified by CSC of this tragic death; in fact, we learned of Mr. Bissonnette's death via a CSC media release and subsequent contact from his next of kin. In a follow-up, the Office requested a copy of the Incident Report and Warden's Situation Report, the latter being received on January 7, 2022. Upon review of preliminary documentation and discovering that this incident had occurred in an observation cell at a psychiatric facility while the prisoner was on suicide watch and under constant 24/7 observation, there was enough initial information and concern for further intervention. On January 26, 2022, I wrote to the Commissioner with my concerns, which included the following recommendations of how CSC should investigate this highly troubling death in custody:

1) The National Board of Investigation (NBOI or Board) should be chaired by an external mental health professional.
2) An Independent Observer (IO) should be appointed and empowered to issue a public report at the conclusion of the Board's work to enhance public confidence in the independence and integrity of CSC's investigation of this incident.
3) The Board's scope should be broadened to include a review of the functioning and governance of all five Regional Treatment Centres, not just RTC Millhaven.
4) The NBOI should examine the management of the entire sentence of the deceased, not just the last weeks of his life, to include an examination of his status, as a complex mental health needs offender.
5) The NBOI should involve the participation of incarcerated individuals who were associates or who knew the deceased.
6) The NBOI should investigate/corroborate allegations made by the deceased of his mistreatment at RTC Millhaven.

To its credit, CSC was generally responsive to the Office's preliminary set of concerns and recommendations in this case, inclusive of sharing the Correctional Investigator's correspondence with Board members for their review and consideration. Significantly, the Board included the appointment of an Independent Observer whose mandate was to oversee and evaluate the impartiality, thoroughness, and professionalism of CSC's internal investigation. In responding to the Correctional Investigator, the Commissioner had indicated that a public report would be provided at the conclusion of this investigation, though to date no such report has been published despite a series of Office reminders. Though a member of the community was included as a Board member, the Board's chairperson (a psychologist), was also a CSC employee.

INDEPENDENT OBSERVER – FINDINGS AND RECOMMENDATIONS

The Independent Observer (IO), the first ever to be appointed to a NBOI, was mandated to oversee and evaluate the impartiality, thoroughness, and professionalism of CSC's investigation of this incident. The IO determined that the process was rigorous and exhaustive, and that all investigative areas were sufficiently explored in a collaborative and professional manner. The IO further assessed that the internal investigation was carried out without prejudice.

The IO's report revealed that some of the Office's previous recommendations regarding the way Boards of Investigation should be completed were not acted upon. For instance, while the NBOI included members with experience in health services and psychology, these members (including the Chair) were all CSC employees.

The IO made four findings and recommendations touching on the following matters:

1. The timeliness in which NBOIs are convened, conduct their investigation and report on their findings. The IO recommended that the National Boards of Investigation be set up more quickly (less than six months after the incident) to speed up processes leading to the submission of a final report, without sacrificing the quality of the work.
2. The fact that some Board members did not understand French or were unable to communicate in French despite Mr. Bissonnette being a Francophone.
3. With regard to the recurrence of certain NBOI recommendations, the IO recommended CSC review 10 years of past reports to identify recurring observations (systemic problems) and to measure the extent to which these recommendations have been implemented.
4. Future IOs should be provided with an orientation guide detailing information and tools at their disposal that could help appointees retrieve relevant information and review relevant documentation and practices including fundamental principles and directives that are communicated to other members of the Board.

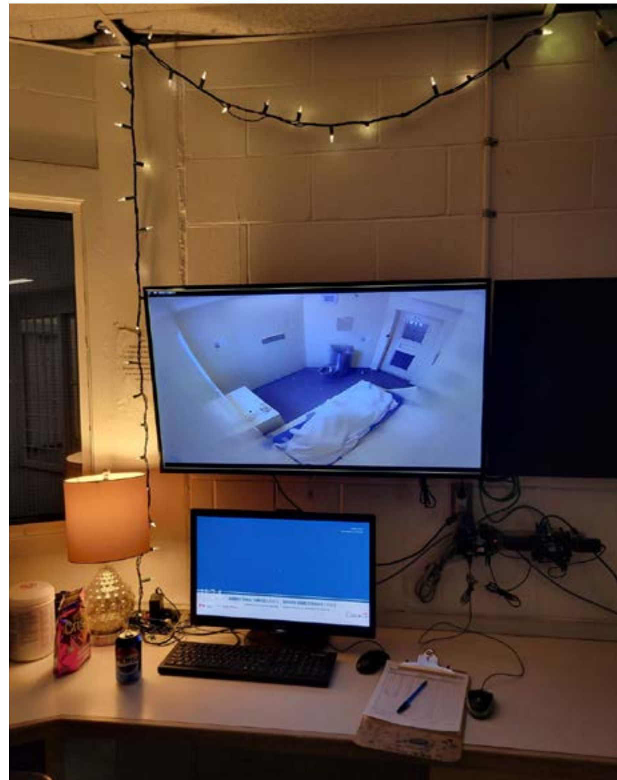
The Office generally concurs with the Independent Observer's findings and assessment of the quality and thoroughness of this investigation. The Office supports his recommendations and calls on CSC to release the IO's report and follow-up corrective measures.

An observation cell and camera, RTC Millhaven

The Office received the NBOI report in September 2023, 21 months after Stéphane's death. It provides extensive background information and includes an exhaustive chronology of the immediate events and circumstances that led to his death. Save for the few omissions mentioned above, the Office was generally impressed by the quality of the Board's report. In the Office's view, the appointment of an Independent Observer to the Board provided an additional and necessary level of assurance that the internal investigation would be conducted in a credible, comprehensive, and impartial manner. The next required step in public transparency and accountability demands that CSC release the IO's report, in full, to the public. The family of Mr. Bissonnette should also be provided a full and unredacted accounting of his death.

Stéphane's death occurred during the COVID-19 pandemic when medical isolation and other restrictions led to a general hardening of institutional routines, less out of cell time and more restrictive conditions of confinement. Though not related to COVID conditions, but still relevant, the Board made a specific recommendation (policy gap) for CSC to specify in policy the minimum amount of time outside of a cell that a patient under Enhanced Observation (suicide watch) should be offered daily for leisure, exercise, and to engage in significant social contact. The current policy provides for the following:

Recommendation 5. Given that Commissioner's Directive (CD) 843, *Interventions to Preserve Life and Prevent Serious Bodily Harm* (August 1, 2017) does not prescribe that a Health Care (HC) professional recommends the minimum amount of time outside of a cell for leisure, exercise and Significant Social Contact (for inmates/ patients under High Watch or Modified Watch) that should be offered per day (taking into consideration the risk-based assessment from a Health Care (HC) professional), given that the *High Watch Observation form* (CSC/ SCC 1434) and *Modified Suicide Watch Observation form* (CSC/SCC 1435) do not contain a section for a recommendation for this specific type of condition of the watch and given that time outside of their cells and social support could have a significant and positive impact on inmates/patients' mental health, the Board of Investigation recommends that the Assistant Commissioner, Health Services, address these requirements in policy.



CCTV monitor at RTC Millhaven

In this case, the Board noted that even though it was specified on the Modified Watch Observation form to allow Mr. Bissonnette out of his cell for exercise, phone and shower every day, time out of cell "almost never occurred." For security staff, getting patients out of observation cells for leisure or exercise did not seem to be considered a priority.

This is but one of several documented examples in which the Board finds security or operational staff to have limited the scope of clinical or therapeutic practice that may have significantly impaired the quality of care that Stéphane received. Staff members related to the Board that "some Correctional Officers had a personality not fit to work in a clinical environment." Others were thought to be disrespectful, belligerent, or dismissive towards other staff or patients. At the time, some Officers were said to have a maximum-security attitude, i.e., their interactions with inmates were mainly security-driven and they did not "possess the skills and interest to work with patients with Mental Health (MH) issues and as such should not be working at the Regional Treatment Centre." These are not new findings. As the Board also reports, at least one officer was removed from RTC Millhaven as some uses of force he participated in were found to be "excessive."

Compliance Issues

The Board made several significant findings that go to the quality of interactions between correctional and health care staff, and with Mr. Bissonnette in the hours preceding his death. The findings included lack of, or incomplete, physical assessments despite the patient exhibiting some genuinely concerning symptoms, including poor motor control, lack of balance, stumbling and even falling to the floor in plain view of staff in

the afternoon and evening of his death. Inadequate documentation, poor monitoring and insufficient communication also extended to correctional staff, who were tasked with constantly observing Mr. Bissonnette via camera surveillance or interacting with him at his cell door. Even Board members, in their post-incident review "observed the difficulty seeing Mr. Bissonnette breathing via the Closed Circuit Television (CCTV) for approximately two hours and 30 minutes on December 16, 2021." In any case, proper monitoring could not have occurred through the observation camera alone, especially after Mr. Bissonnette had turned off the light in his cell on the night of his death.

The Board seems to reserve its harshest criticism when it turns its attention to the quality and frequency of the counts, security patrols and observation while Mr. Bissonnette was on modified suicide watch on the day preceding his death. The key recommendation of the Board is worthy of quoting in full as it displays an unusual degree of frankness and even frustration:

> **Recommendation 2:** Considering that Correctional Officers (COs) at the Regional Treatment Centre believed that observing an inmate for one second or less was sufficient to ensure a live breathing body, given that the quality of counts and security patrols has been identified as a Compliance Issue across multiple federal institutions in Correctional Service Canada (CSC) for several years, and that Commissioner's Directive (CD) 566-4, *Counts and Security Patrols*, paragraph 3, 4(a, ii) and Annex B (May 29, 2017) is silent on quality assurance protocol procedures which demonstrate due diligence for ensuring live breathing bodies during inmates counts and security patrols, the Board of Investigation recommends that the Assistant Commissioner, Correctional Operations and Programs review policies to include specific quality assurance protocol procedures which demonstrate due diligence (including reviews of Closed Circuit Television footage and/or by another efficient means in ensuring that COs consistently look for a sufficient amount of time in cells to confirm that inmates are breathing and are not in medical distress) and documentation to ensure that the quality (CD 566-4, paragraph 7(a), ensuring a live breathing body) of counts and security patrols is assured.

As the Board notes, the inadequacy of security patrols is far from a unique or isolated issue. The report details numerous other National Boards of Investigation and expert reports where the quality of security patrols, rounds and counts were found to be non-compliant and/or implicated in the failure to confirm signs of life. The Office has consistently raised this issue as one of the top contributing factors to deaths in custody since its very first systemic review of this issue in 2007.[62] It is still unclear how or if the Service will implement the Board's key recommendation, considering that front-line unions oppose, in principle, the use of camera footage as an accountability measure to assess or monitor their performance. Not surprisingly, current policy is silent on such measures. However, the evidence is mounting that nothing short of a quality assurance protocol is necessary to save lives and prevent other deaths in custody simply because correctional officers so often fail to adequately perform what is one of the most vital aspects of their duties. The Office will be watching very closely whether and how CSC chooses to action the key corrective measure emerging from this incident and CSC's investigation of it.

[61] Gabor, T. (2007, Feb. 28). *Deaths in Custody – Final Report.* Ottawa: Office of the Correctional Investigator.

Similarly, the inferior quality and irregularities in the performance of "health services walks" (alternatively referred to as *Nursing Walks*) conducted by nursing staff on the night of Stéphane's death were also referenced in the report. Though the parameters or purpose of these *"walks"* (vs. patrols) are not described in any written procedure, it would seem to be part of any nursing role to regularly conduct vital checks to ensure patients are not in any medical distress. Again, the fact that the Board identified this as a policy gap, and therefore was compelled to issue a recommendation for CSC to provide written procedures on how nursing staff should conduct a wellness check in an inpatient hospital setting, seems somewhat incredulous. It is, perhaps, instructive that the only staff member to be terminated from their job for negligent or careless performance of duties was a Registered Nurse, who also happened to be on the probationary period of their employment with CSC.

In the case of Mr. Bissonnette's death, security patrols, counts and nursing walks rounds can only be described as wholly non-compliant in failing to sufficiently assess and verify signs of life. Unfortunately, such pervasive deficiencies are only addressed on an individual, incident-driven and retroactive basis, often following a serious incident or death. With respect to the Modified Suicide Watch process, RTC Millhaven installed larger monitors to try to better observe patients under constant watch via CCTV. However, the CCTV technology is still quite basic and lacks critical functionalities such as the ability to pan, tilt or zoom, all of which would enable staff to make better assessments of life or death. A step further might be to employ smart technologies designed for remote in-cell monitoring of vital signs – such technologies have been around for quite some time.

An Issue of Governance?

As recommended by the Office, CSC chose not to review the functioning and governance of the Treatment Centres as a whole, claiming that such a review would be overly broad and take too much time. On this point, RTC Millhaven is technically a multi-level mental health treatment facility; however, as a co-located facility, the Treatment Centre shares the same grounds, same perimeter controls, and even the same rules, procedures, and some of the same staff members as Millhaven Institution. At the time of Stéphane's death, RTC Millhaven maintained essentially the same security posture as any other maximum-security penitentiary (and still mostly does). As the Board's report notes, "despite the fact that the Regional Treatment Centre was a multi-level security institution, all patients were treated as if they were maximum-security inmates." Significantly, no explanation could be offered to the Board for why RTC follows maximum-security rules, including refusal to open cell doors on ranges (for a health care assessment or medication distribution) unless two officers were physically present. These procedures are known to limit, impede and delay health care access to patients.

Although the Board's report is noticeably silent on points concerning governance at RTC Millhaven, it is known that the Executive Director RTC Ontario, who oversees RTC Millhaven and RTC Bath, reports to the Warden of Millhaven on a functional basis. This reporting relationship makes for a confounding governance structure, one that holds important implications for the safe, timely and effective delivery of health care services at RTC Millhaven. For example, despite any medical knowledge, mental health expertise or experience, the Warden's approval is routinely sought for clinical decisions at the RTC, such as the placement in or removal of a patient from suicide watch and observation cells, or the use of Pinel restraints. For unknown reasons, which remains a mystery even to the Warden

himself, he was required to "approve" or authorize the application of these clinical procedures in Mr. Bissonnette's case. Obviously, this kind of governance structure does not seem to respect the principles of professional autonomy and clinical decision-making required to operate an accredited psychiatric facility. At any rate, it seems that the boundaries separating clinical and operational authority at RTC Millhaven are highly blurred, a situation that leads to confusion, role conflicts and an overreach of correctional authorities at the expense of health care. These facts are known, significant, and cannot be ignored.[63]

The governance issue at RTC Millhaven was, in fact, one of the central concerns of an earlier death at this facility that occurred in August 2020. A key finding of that NBOI concluded that the governance in place at RTC Millhaven presented challenges and had negative impacts on how the deceased was cared for. The Board specifically recommended "a review of the governance at Ontario RTC to ensure that physical and mental health interventions are decided and controlled by health care professionals."[64] Ultimately, the then-Assistant Commissioner of Health Services for CSC and the Warden at Millhaven at the time did not support the Board's findings. Consequently, and with important implications, this recommendation was never actioned.

More to the point, RTC Millhaven is not a purpose-built psychiatric hospital. Physically located at the rear of Millhaven Institution proper, RTC Millhaven was originally intended and designed to serve as a regular 96-bed maximum-security accommodation unit. Informally referred to as Y Unit, the repurposed facility is divided into four ranges, each with an upper and lower level. Opened in June 2016, RTC Millhaven provides care for persons with the most acute mental health conditions in the Ontario Region who require in-patient treatment. Prematurely forced into service, RTC Millhaven has been plagued by physical infrastructure and design limitations from the very beginning. Though nominally designated as a multi-level mental health facility, patients at RTC Millhaven are treated as if they are maximum-security inmates, a finding that even the NBOI acknowledges. It is decidedly not a therapeutic environment.

Access to patients in this facility can be challenging given that every range is either considered or designated as maximum security. There is nothing resembling a gym or comprehensive indoor physical fitness space for patients, monitoring and nursing stations are cramped, the exterior mini yards are paved and uninviting, there are not enough confidential interview rooms, and these rooms are not secure. There is a general lack of storage space for medical equipment. Offices for most mental health staff, including management, are located inside Millhaven proper, creating physical barriers to effective, safe, and accessible patient care.

---

[63] In the Factual Review exercise, CSC claims that many of the observations in this paragraph are "inaccurate." CSC claims, for example, that it is inaccurate to characterize the Warden's authorization to place patients at RTC Millhaven on Suicide Watch or in Pinel restraints as "clinical" decisions. Further, it is said that the use of these procedures should not be regarded as treatment or clinical decisions but rather as "crisis management / safety tools." Finally, CSC notes that the Warden's approval for such procedures at co-located Treatment Centres is required for "legal reasons as the head of the institution, as RTC is comprised within the institution." These "clarifications" are both confusing and confounding and do not respect the unique nature of these facilities, which functionally operate as accredited psychiatric hospitals within a federal penitentiary setting. It is the Office's view that Wardens at co-located Treatment Centres have no business being involved in or authorizing what should properly be regarded as clinical or medical decisions. CSC's clarifications in these matters fails to acknowledge or accept that current governance and reporting structures at its co-located Treatment Centres negatively impact on patient safety and impede on the effective and unfettered delivery of health services.

[64] Correctional Service Canada. *Board of Investigation into the death of an inmate at the Regional Treatment Centre – Millhaven Institution (Multilevel)*, File Number: 1411-1-20-08-22-421.

As a co-located facility, the selection and rostering of security staff deployed to the RTC has tended to mirror the standards that prevail at Millhaven Institution. However, the culture, attitude, training, and disposition of officers selected for duty at the RTC may not necessarily be suited to working with patients in a multi-level mental health treatment facility. RTC management confirmed that Health Services still does not have any direct say on correctional officers from Millhaven Institution who are rostered for duty at the RTC.

In past reports, the Office has raised serious concerns about the suitability, training, and selection of staff hired to work in its psychiatric hospital. In response, CSC has categorically stated that "all correctional staff, including those who are working in Regional Treatment Centres, are carefully recruited, selected and trained."[65] The incident featured in this Case Study proves otherwise. In fact, this NBOI is equally categorical in stating that Correctional Officers working in the RTCs lack training for working in a psychiatric facility with patients with mental health needs. Indeed, this lack of dedicated training in mental health poses a "national challenge" that, in the view of the NBOI, should be addressed "nationally." The Office emphatically agrees.

The lone Correctional Manager (CM) assigned to RTC, who is only on-site during daytime hours, is the fifth such manager assigned to the RTC over the past two years, with his own tenure ending during one of the Office's recent visits. The frequent CM turnover at the RTC appears indicative of an impractical balancing act of managing conflictual roles of health services and security, which comes with several additional reporting obligations and supervisory responsibilities.

WORKPLACE ASSESSMENT AT RTC MILLHAVEN

A Workplace Assessment of the unique work environment and challenges at RTC Millhaven was initiated in January 2022, with the report completed in July 2022. It was the second such assessment to address workplace issues at the RTC since 2020. The assessment consisted of voluntary and confidential interviews with staff members from various departments, including health services and operations. As the Assessment overlapped with some of the Board's mandate, it was included as documentary evidence.

The Assessment yielded numerous findings and included nearly 70 recommendations aimed at improving the culture, environment, and conditions of work by supporting a professional, healthy, and respectful workplace. The report described a "somewhat dysfunctional" relationship between mental health staff and correctional officers, which seemed to boil down to a lack of civility, trust and mutual understanding of each other's roles and responsibilities within a mental health hospital environment.

The Assessment included many practical suggestions to improve the physical space and working conditions at the facility, several of which are relevant to this investigation:

[65] CSC's response to 2017-18 Annual Report recommendation calling on the Service to "ensure security staff working in a Regional Treatment Centre be carefully recruited, suitably selected, properly trained and fully competent to carry out their duties in a secure psychiatric hospital environment."

- resolving the issue of camera placement and potential for deliberate obstruction in observation cells.
- reducing barriers to effective nursing care.
- increasing the number of proper hospital beds.
- creating dedicated rooms and office space for staff, and,
- increasing program space and ensuring interview rooms are secure.

Finally, the Workplace Assessment noted several concerns with chronic supply problems and inadequate equipment issues including shortages of basic supplies such as thermometers, adult diapers, wipes, bedding, gloves, etc. It is not clear whether or who – Health Services or Operations, the Executive Director of the RTC or the Warden of Millhaven – manages the resourcing and supply of health care items at the Treatment Centre.

Staff Disciplinary Measures

The Office requested and received details of staff disciplinary investigations arising from Mr. Bissonnette's death, including all sanctions and formal reprimands. In total, there were fourteen staff disciplinary investigations convened, which included eight on the operations side and six for Health Services. The disciplinary investigations seem all to have been completed by June 2022, which accords with the convening of the NBOI.

In total, six staff members – two Nurses and four Correctional Officers – received a disciplinary sanction of one kind or another for negligent performance of duties, mostly related to deficiencies in quality of security patrols/counts or quality of health care walks for nurses. As mentioned earlier in this report, the most serious disciplinary measure taken was the termination of a Registered Nurse. The other health care staff member who was formally disciplined received a written reprimand. With respect to security staff, two Correctional Officers received 30-day suspensions without pay, one received a 15-day suspension without pay and a fourth was sanctioned two days without pay. The documentation seems to indicate that the disciplinary investigations were conducted professionally and appropriately, with Regional Health Services authorities chairing the health disciplinary investigations and the Warden chairing the security boards.

From the tone and content of the disciplinary letters, it can be inferred that there was indeed a "culture" problem at RTC Millhaven, indicative of the way some staff members, who, in defending or justifying their (in)actions, referred simply to how "things were done here." Significantly, two members who received the harshest discipline were also the most inexperienced. It is also the case that the quality of security patrols and health care walks are the same areas which receive the most attention in the NBOI's analysis and commentary.

More Recent Findings

Since the Workplace Assessment exercise, some positive improvements and changes seem to have taken hold at RTC Millhaven. These have been witnessed and confirmed by follow-up on-site visits and interviews. For example, an expanded, more permanent staff complement of Correctional Officers now works at the multi-level psychiatric facility, offering more continuity to patients and

contributing to better rapport between operational and health care staff. Numerous staff agreed that problems arise when correctional officers from Millhaven Institution work shifts at the RTC, some of whom come in with a lack of understanding and empathy toward the mental health needs of patients, a more abrasive or abrupt communication style, and a general maximum-security disposition and approach to inmate/patient needs incongruous with that of a multi-level psychiatric hospital.

In follow-up visits, Office staff members have had positive interactions with RTC correctional staff, many of whom expressed a strong willingness to work exclusively at the facility, embracing the unique challenges of working in a mental health setting. While there appeared to be a genuine interest in working with complex needs individuals, officers expressed that they felt there is insufficient training to work in such a specialized facility. This raises concerns about the level of training provided to incoming recruits who are destined to work with mentally ill people in specialized mental health facilities and whether additional credentials or a distinct stream should be built into the Correctional Training Program. These and other findings that emerged over the course of our visit have provided sufficient evidence that a more in-depth review of the Treatment Centre governance model, including staffing, is warranted. This particular concern is likely to form the basis of a future systemic investigation.

On a final note, before issuing my recommendations in this case, I want to comment on what I believe to be a recurring issue in how CSC deals with and responds to families who have lost a loved one behind bars. In a 2016 report entitled *In the Dark: An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections*, the Office reported on the many challenges that families encounter when trying to access information following the death of a loved one in federal custody. The report notes that CSC does not routinely or proactively share information with families, does not apprise or follow-up with them during the investigative process and they are required to officially request reports through formal Access to Information and Privacy channels. When they finally receive these reports, the information contained in them is often heavily redacted. At that time, the Office called on the Service to presumptively share, in their entirety and in a timely manner, investigative reports with next of kin family members.

Many of these same issues were at play in the case under review here. In sharing my preliminary report with CSC, the Service noted several *Privacy Act* considerations related to the protection of Mr. Bissonnette's personal information, that of employees as well as potential security risks. CSC maintains that sensitive personal or security information, up to and including the main finding of its investigation (inadequate quality of security patrols), should not be released on the grounds that it does not believe the public interest outweighs the invasion of privacy.

I respectfully disagree. Now that my report is released and part of the public record, as it should be, I will defend my decision to release information that I believe to be relevant to my investigation and in the public interest. In this case, it is worth recalling that Stéphane died at RTC Millhaven in December 2021. A member of his family first contacted CSC to request information about Stéphane's death in April 2023. A redacted copy of the NBOI report was finally provided to family members in June 2024. The fact that they had to wait more than two and a half years to get answers about the circumstances of how their loved one died in CSC custody is frankly both unconscionable and unreasonable. Continuing to leave grieving families in the dark is not in anyone's interest and is not a practice we should expect of a transparent and accountable prison service.

Conclusion and Recommendations

In a number of disturbing respects, Mr. Bissonnette's death in the care and custody of CSC fits within a pattern of incidents sharing similar case histories that the Office has previously documented in public reports. Stéphane was a mentally ill person with complex behaviours and needs. He had a high propensity to direct violence inward, and, on occasion, toward others. His history of federal incarceration – prolonged placements in administrative segregation, numerous placements in Enhanced Observation (suicide watch), frequent transfers in and out of psychiatric facilities, multiple placements in restrictive confinement and the frequent use of Pinel restraints to manage self-injury or suicidal ideation – indicate that CSC struggled to safely and humanely manage this troubled individual. Though his case is unique in some respects, Stéphane's death follows a familiar pattern and illustrates the continuing (mis)management of serious mental illness in Canada's prison system.

During this investigation and review, which included site visits and comprehensive interviews with RTC and Millhaven staff, the Office sought to identify, confirm and contextualize the systemic factors, gaps and compliance issues that contributed to this incident:

1. Quality of security patrols (failure to ensure a live breathing body).
2. Security-driven and punitive responses to behaviours associated with mental illness.
3. Selection, recruitment, and training of security staff chosen to work in CSC Treatment Centres.
4. Deficient physical infrastructure for managing complex mental health needs.
5. Blurring of lines of between Health Services and Operations (dual loyalties).
6. Lapses in the continuity of care, including gaps in communication, reporting, monitoring and assessment.

None of these issues in isolation could be said to have directly led to Stéphane's death. However, in their totality and in their interplay, these factors all contributed to this tragic and preventable outcome.

I issue four new recommendations and repeat two others that have not been adequately answered or properly implemented to date:

9. I recommend that CSC should immediately release the Independent Observer's evaluation of the impartiality, thoroughness, and professionalism of this National Board of Investigation.

10. I recommend that CSC prepare and release a Case Summary of the facts and findings of this NBOI including recommendations, learnings and corrective measures that have been implemented at RTC Millhaven to date.

11. I recommend that an independent and external mental health expert conduct a full compliance review of patient safety at RTC Millhaven.

12. I recommend that CSC evaluate the suitability and feasibility of installing in-cell vital sign remote monitoring technologies in all high(er)-risk placement areas of federal prisons, including Structured Intervention Units, Enhanced Observation (suicide watch) cells, Regional Treatment Centres and health care cells in mainstream penitentiaries.

Re-issuing of previous recommendations

13. **I recommend that CSC ensure security staff working in a Regional Treatment Centre be carefully recruited, suitably selected, properly trained and fully competent to carry out their duties in a secure psychiatric hospital environment.**

14. **I recommend expansion of alternatives to incarceration options and increased bed space to facilitate the transfer and placement of federally sentenced individuals who are suicidal, chronically self-injurious or severely mentally ill in external community psychiatric facilities.**

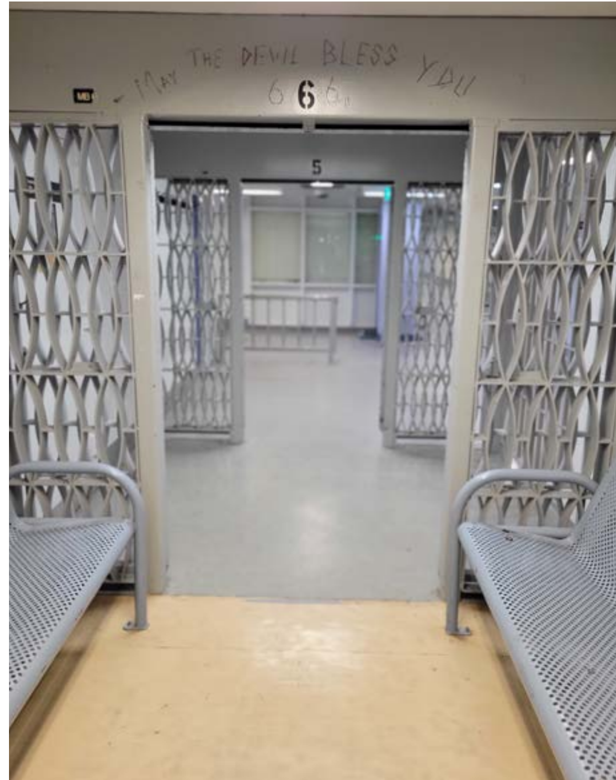
NATIONAL SYSTEMIC INVESTIGATION

An Investigation of the Standalone Male Maximum-Security Penitentiaries in Federal Corrections

SIU Yard, Port Cartier Institution

"... the classification of institutions into maximum, medium, and minimum security has merely compounded the problem: in order to illustrate differences between the three classifications, and as humanizing measures have been applied in medium and minimum security, the tendency has been to make life in maximum security institutions more repressive, security-oriented, and dehumanizing than ever."

- Justice J.W. Swackhamer **(April 24, 1972)**



Hallway at Edmonton Institution

Through the better part of the 20th century, various Task Forces, Working Groups and multiple Federal Commissions and Committees have struggled to define the purpose and improve the functioning of maximum-security penitentiaries in Canada. As early as 1938, the Archambault Commission found that there was a need for Canada's correctional system to emphasize prevention and rehabilitation, and to move away from the arbitrary classification of prisoners to achieve these two complementary purposes.[66] Much of this Commission's deliberations on the idea and purpose of corrections remains influential to this day.

A few decades later, both the Fauteux (1956)[67] and Ouimet (1969)[68] Committee reports favoured increasing the number of lower-security institutions with specialized treatment and rehabilitation programs. It was their belief that such programs were lacking in institutions that focused on controlling the small proportion of the incarcerated population who require maximum-security safeguards. For their part, the Fauteux and Ouimet Committee reports also found that there was insufficient training in the trades and meaningful work behind bars, a suboptimal educational program, and inadequate recreation opportunities to stave off the depressing effects of cellular isolation. Notably, they also advocated for smaller, not larger penitentiaries.

[66] Archambault Commission. (1938). *Report of the Royal Committee to Investigate the Penal System of Canada.*

[67] Fauteux, G. (1956). *Report of a Committee Appointed to Inquire into the Principles and Procedures Followed in the Remission Service of the Department of Justice of Canada.*

[68] Ouimet, R., et al. (1969). *Report of the Canadian Committee of Corrections.*

Later, the Mohr Committee (1971), was tasked to "determine the needs of inmates that the working group define as maximum security, determine the programs and staffing requirements necessary to satisfy these needs, and finally to determine the ideal institutional design and locations to facilitate implementation of these programs."[69] Like others before it, the Mohr report came down on the side that rehabilitation had to be the primary emphasis behind the walls of any federal penitentiary, including maximum-security institutions. Though this Committee grappled at length with defining who and what constituted maximum-security, ultimately it abandoned the exercise. The Committee urged the courts to set out concisely the aim of imprisonment – retribution, incapacitation, deterrence, or rehabilitation – so that the facility's security level could match the purpose of the sentence. More practically, the Committee proposed that maximum-security facilities should operate in such a way that prisoners have the greatest possible motivation to work towards an eventual transfer to lower security.

The *Report of the Commission of Inquiry into Certain Disturbances at Kingston Penitentiary during April 1971*, chaired by Justice J.W. Swackhamer and which led to the creation of this Office, was tasked to examine the immediate cause(s) of the deadly riot at Canada's most infamous prison, Kingston Penitentiary (KP). This Commission identified several familiar factors that had contributed to the frequency and severity of violence that had erupted not only at KP but nearly brought the entire Canadian Penitentiary System to its knees in the early 1970s. Most notably, the Commission found a lack of pro-social opportunities to occupy prisoners' time, which led to a culture of idleness, hostility, hopelessness, and violence:

We have observed that the inmate at Kingston Penitentiary was obliged to spend at least sixteen hours a day locked in virtual isolation in his cell. Within that restricted and narrow environment he was free only to sleep, read, write "authorized" letters and engage in a single hobbycraft if that was permitted to him and he could financially afford to pursue it. Can it be surprising that in these circumstances many inmates spent a great deal of their time in brooding and introspection? Boredom and a sense of helplessness and hopelessness was inevitable. The result was a furious sense of discontent and the breeding of violent and anti-social inclinations. Rehabilitation cannot even be contemplated let alone conducted in such an environment. Indeed, at Kingston it was not seriously attempted.

[69] Department of the Solicitor General of Canada. (1971). *Design of Federal Maximum Security Institutions.*

As this investigation suggests, fifty years after these troubling observations were first made, they remain as relevant today as they did then.

The debates and ideas that animated these seemingly distant and settled questions are, in fact, still relevant and occurring today. Indeed, the defining social purpose that maximum-security penitentiaries serve in 2024 remains as perplexing and elusive as ever before. During this investigation, the purpose of these institutions and who belongs in them became the focus of renewed public and political debate, a social discourse that often finds expression in demands for longer and harsher criminal penalties. The level of outrage that greeted recent decisions to transfer certain high-profile individuals to medium-security facilities this past year captures a segment of this popular sentiment.

In November 2023, in testimony before the Standing Committee on Public Safety and National Security (SECU) on the topic of *Rights of Victims of Crime, Reclassification and Transfer of Federal Offenders*, the Commissioner of the Correctional Service of Canada provided some revelatory glimpses into the contemporary maximum-security experience.[70] In her remarks to Committee and in response to questions from Parliamentarians, the Commissioner described difficulties in providing core interventions such as delivery of correctional/criminogenic programs in the maximum-security setting. She emphasized the violent nature of the persons sentenced to these facilities and acknowledged that most prisoners serving determinate sentences, including those in maximum-security, will eventually be released to the community.

To this last point, though the Commissioner's testimony upheld the goal and importance of reintegration, her remarks at Committee provided a candid if uneasy assessment of the difficulties

Cell at Atlantic Institution

and challenges that CSC faces to enforce pro-social attitudes and behaviours in conditions of maximum-security confinement. Ensuring individuals who have spent time in these facilities are better off when they are returned to society must be the aspiration goal of any correctional system. This investigation provides findings that leave even this aim very much in doubt. It is up to CSC to explain why basic correctional goals and outcomes, such as rehabilitation or reductions in reoffending, are not being met in today's maximum-security settings. The Office's investigation finds that maximum-security institutions are violent, dysfunctional, unpredictable and unsafe places; in some instances, we found operational practices

70 Standing Committee on National Security and Public Safety. (2023, November 27). *Evidence – Number 085, 1ST Session, 44TH Parliament.*

and conditions of confinement that were degrading and even dehumanizing, antithetical to any stated correctional intent, principle or outcome.

According to CSC policy, maximum-security facilities are designed to accommodate federally sentenced individuals who:

1. Present a greater threat to the safety of the public.
2. Require a higher degree of supervision; and/or
3. Have a higher chance of attempting to escape.

Section 28 of the *Corrections and Conditional Release Act* (CCRA) provides that:

28. If a person is or is to be confined in a penitentiary, the Service shall take all reasonable steps to ensure that the penitentiary in which they are confined is one that provides them with the least restrictive environment for that person, taking into account
(a) the degree and kind of custody and control necessary for

(i) the safety of the public,

(ii) the safety of that person and other persons in the penitentiary, and

(iii) the security of the penitentiary.

Of course, there are other, unstated or unofficial objectives that maximum-security penitentiaries serve. Beyond a doubt, terms such as "public safety" or "threat to safety" are elastic enough to incorporate incapacitation and deterrence, and even punishment and retribution. Afterall, placement in a maximum-security institution is not meant to be easy. And, as this investigation makes clear, it certainly isn't.

Beyond a few references noted above, there is, somewhat surprisingly, little legal or even policy guidance on what differentiates maximum-security institutions from other security levels. The stated correctional purpose of these facilities is to prepare incarcerated persons to cascade to medium-security through participation in programs, compliance with behavioural expectations, as well as enrollment in employment and educational activities.[71] *Commissioner's Directive 706 – Classification of Institutions* further sets out a range of subjective "behavioural norms" expected of maximum-security prisoners, including expectations to "interact effectively and responsibly, while subject to frequent direct/indirect monitoring, and demonstrate at least a minimum interest in participating in their Correctional Plan."

Although CSC's policy and operational framework for maximum-security institutions seem to lack a clear and defining purpose or goal statement, our Office has repeatedly found male maximum-security institutions to be highly restrictive and depriving to the point of undermining most other correctional objectives. Past reporting by this Office has shown that individuals incarcerated in men's maximum-security institutions are less likely to receive adequate time out of their cells, time off their ranges, and access to appropriate common areas, recreation spaces, and adequate yards. My Office has reported that maximum-security prisoners lack access to meaningful off-range activities, employment, education, and core programming.[72]

[71] Government of Canada. (2019 August). *Correctional Service of Canada – Security classifications,* (Date modified: August 2, 2019).

[72] OCI. (June 2022). *Restrictive forms of Confinement in Federal Corrections (Male Maximum-Security Penitentiaries).*

This investigation updates and reconfirms many of these findings. In particular, my Office has continued to find that Black[73] and Indigenous[74] individuals are overrepresented in maximum-security institutions, suggesting there is racial bias at play. Furthermore, the OCI's 2021-22 and 2022-23 Annual Reports demonstrated that Structured Intervention Units (SIUs) continue to play a paradoxical role within maximum-security institutions, in that conditions of confinement in SIUs could often be seen as *more* desirable than other units, leading some prisoners to deliberately seek admission for this reason. In other public reports and correspondence with CSC, my Office has made numerous related recommendations for the Service to:

- Develop a national policy for the use of Voluntary Limited Association Ranges (VLARs) and any other sub-population living unit or range.
- Publish forthwith a quarterly record of SIU placement authorizations under section 34 (2) of the *Corrections and Conditional Release Act* (CCRA), including the reasons cited for granting authorization. This record should also include the number of instances where the Service imposes restrictions on inmates' movements under section 37.91 (1) of the CCRA.
- Finalize and publish a timeline indicating how it plans to meet its legislated reporting requirements under section 37 (2) (Obligations of Service) and section 32 (3) (Physical barriers), as well as under section 37.2 (Recommendations to Institutional Head).
- Commission an independent, third-party expert, specializing in matters related to organizational culture (with specific knowledge of correctional dynamics), to assess and diagnose the potential causes of a culture of impunity that appears to be present at some maximum-security facilities, and prescribe potential short, medium and long-term strategies that will lead to sustained transformational change.
- Establish a working group, with external representation, to complete a review of all use of force incidents over a two-year period at maximum-security facilities.

Context

Due to these ongoing and unique challenges at maximum-security institutions, and the volume of complaints received by my Office annually from maximum-security prisoners, a dedicated team of investigators was assigned to all of the six standalone maximum-security institutions:

- Atlantic Institution
- Donnacona Institution
- Edmonton Institution
- Kent Institution
- Millhaven Institution
- Port-Cartier Institution

Their assignment coincided with my visit to Atlantic Institution in April 2023 during which I observed some very troubling conditions of confinement. I subsequently felt it necessary to instruct my staff to complete a systemic level review of the six standalone maximum-security facilities, conducted by way of a thorough series of institutional visits and inspections of all parts of these facilities over the course of the current reporting period. This would be a whole-of-Office effort involving teams comprised of Senior Investigators, Policy & Research staff, and Senior Managers. Every one of these site visits and inspections resulted in thematic findings, which were shared via correspondence with the Commissioner in real time. Based on these findings,

---

[73] OCI. (June 2022). *Update on the Experiences of Black Persons in Canadian federal Penitentiaries.*

[74] OCI. (October 2023). *Ten Years since Spirit Matters: Indigenous Issues in Federal Corrections* (Part I).

I repeatedly raised the need for intervention at a national level. At the time of writing, only three responses had been received.

In total, including six visits of my own, 23 days were spent visiting these institutions in 2023-24 fiscal year. The purpose of the investigation was to assess and compare the functioning of the six institutions to identify deficiencies, highlight best practices, and ultimately determine if the maximum-security environment effectively balances public safety requirements with rehabilitative and reintegrative objectives. This investigation was further prompted by the volume, type, and severity of complaints this Office has received from individuals incarcerated at these particular institutions. Several other findings and indicators (e.g., rising number of assaults on staff, high rates of inmate-on-inmate violence, elevated uses of force) paint a sobering and disturbing picture of the lived maximum-security experience in Canada.

Methodology

The following methods were employed for the purpose of this investigation:

1. Review of CSC policies, procedures, data and research on men's maximum-security institutions.
2. Physical inspections of each institution's premises.[75]
3. Interviews with more than 225 CSC staff, incarcerated persons, and external stakeholders.
    a. the CSC staff interviewed included representatives from all major institutional departments, management, and front-line correctional staff. Interviews were also conducted with community area directors from multiple regions.
    b. Interviews were conducted with representatives of the incarcerated population, including Inmate Welfare Committees (IWCs), and range, block, and unit representatives. As these visits were "closed" in nature, interviews were specifically sought with representatives and therefore not open to the wider institutional population. That said, concurrent routine "open" visits continued during the investigation and helped inform our findings.
    c. External stakeholders included but were not limited to legal advocates, "lifers" liaison groups, and Citizen's Advisory Committees.
4. Analysis of data from CSC and complaints made to the OCI.

Profile of Maximum-Security Institutions

At the time of writing of this report, there were 1,409 individuals incarcerated at these six institutions. The standalone maximum-security population is diverse, and institutions see significant over-representation among certain groups, namely Black and Indigenous peoples. At 66.1% of the total institutional population, Edmonton Institution counts the highest proportion of Indigenous prisoners. Donnacona Institution, in the Quebec Region, has the highest proportion of Black prisoners at 22.8%.

[75] Due to the aforementioned institutional assignment structure, multi-level institutions, which also include maximum-security units, were excluded from this thematic investigation.

TABLE 1. INSTITUTIONAL POPULATIONS BY ETHNICITY

INSITUTION	INDIGENOUS	BLACK	NON-INDIGENOUS/NON-BLACK	UNKNOWN
Atlantic	25.9%	19.5%	54.6%	0.5%
Donnacona	15.2 %	22.8%	62.1%	2.1%
Port-Cartier	28.7%	7.2%	64.1%	0.0%
Millhaven	31.9%	17.3%	50.8%	3.5%
Edmonton	66.1%	4.2%	29.7%	2.1%
Kent	44.4%	11.9%	43.7%	1.5%
TOTAL	**35.3%**	**14.0%**	**50.7%**	**1.7%**

Source: Data retrieved from CSC's *Corporate Reporting System-Modernized* (CRS-M; based on individuals at the institutions as of March 27, 2024).

According to data provided to my Office by CSC, the annual cost of maintaining an individual in a maximum-security institution is $231,339. This is approximately 60% more than maintaining an individual in a medium-security institution and nearly twice the cost associated with maintaining someone at a minimum-security facility.[76] Given this significant cost, one would expect maximum-security institutions to offer extensive reintegrative and rehabilitative resources.

Approximately 60% of those incarcerated at these institutions are serving their first federal sentence. It is also worth noting that 15% of the population has been the subject of at least one revocation,[77] or the termination of parole or statutory release.

These institutions include a segment of those incarcerated nationally that has been deemed, to a large extent, to be both "high-risk" and "high-needs" based on CSC's own actuarial tools.[78] Across the institutions, more than 95% of individuals have been assessed as having a "high need" level, and nearly 90% of prisoners are noted to have a "high risk" level.

Most of the standalone maximum-security institutions regularly find themselves considerably under capacity, which makes the lack of movement caused by subpopulations (more on this later) even more perplexing. At the time of writing this report, these institutions had an average occupancy percentage of about 70%. Atlantic Institution had the lowest occupancy at 56.70% and Port-Cartier Institution the highest with 86.50%.

[76] Global Summary – Cost of Maintaining an Offender provided by CSC lists costs, excluding Regional Treatment Centres, Healing Lodges and Reception Centres as: $231,339 (max), $136,987 (med), and $111,667 (min).

[77] CSC Data Warehouse (Based on individuals incarcerated at these institutions as of March 9, 2024).

[78] When determining an individual's security level, CSC assesses risk, or a measure of how likely it is that an individual will re-offend, and needs, or factors that may have led to one's criminal behaviour which may have an impact on reintegration.

TABLE 2. SNAPSHOT OF OCCUPANCY AT STANDALONE MAXIMUM-SECURITY INSTITUTIONS

INSITUTION	INSTITUTIONAL RATED CAPACITY	INSTITUTIONAL – GRAND TOTAL	% OCCUPANCY
Atlantic	331	188	56.7%
Donnacona	451	295	65.4%
Port-Cartier	237	205	86.5%
Millhaven	340	259	76.2%
Edmonton	324	252	77.8%
Kent	378	269	71.2%

Source: CRS-M (based on individuals at the institutions as of March 27, 2024).

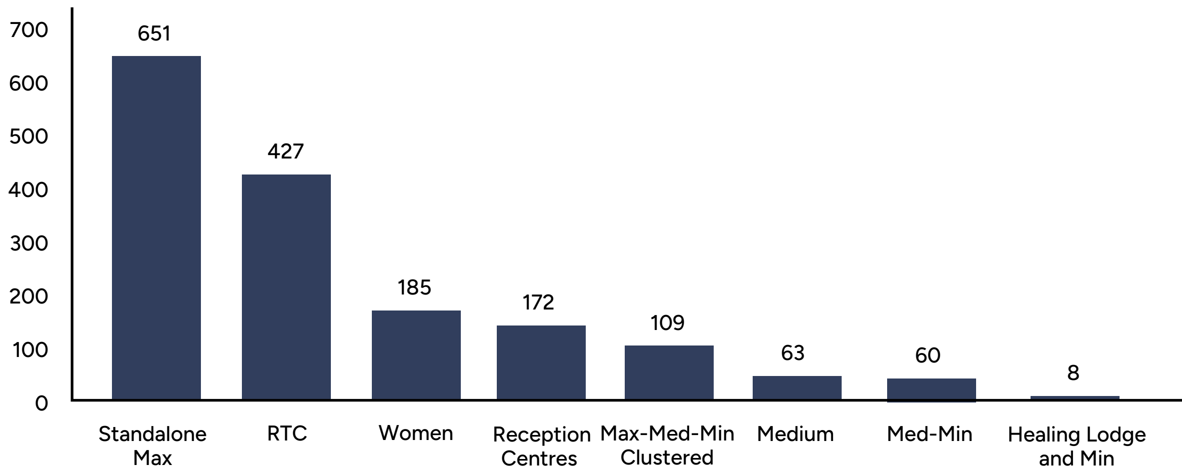
There is no question that conditions inside maximum-security institutions are disproportionately violent and pose a significant risk to both staff and prisoners. Individuals serving their sentence in a maximum-security environment are much more likely to encounter and engage in forms of violence: among the population, against staff, and at the hands of correctional staff during use of force incidents. Notably, the population at these six institutions represents only 10.3% of inmates serving a federal sentence. However, in 2022-23, there were 176 assaults on staff at the six standalone maximums alone, which accounts for 40% of all assaults on staff across all institutions that year. During the same year, there were 430 incidents of inmate-on-inmate assaults at the six institutions alone, accounting for 33% of all inmate-on-inmate assaults across all federal penitentiaries.[79]

As indicated earlier in this report, incidents at the standalone maximum institutions resulting in a use of force by staff have seen steady increases since Fiscal Year 2017-18. Force is also used at these institutions at a disproportionately higher rate than other security levels, as indicated in the following charts.

Makeshift weapons recovered at Edmonton Institution

[79] CSC Data Warehouse (period represents FY 2019-20 to March 9, 2024)

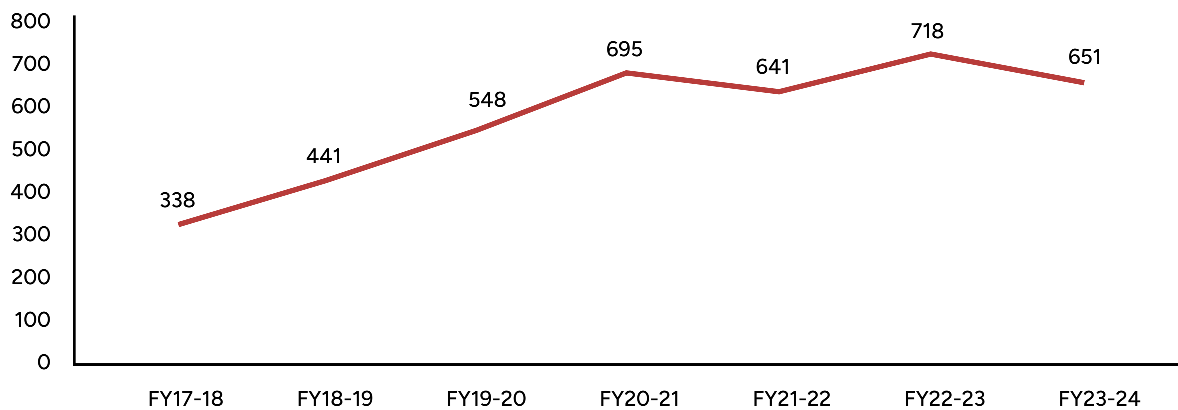
GRAPH 1. RATE OF USE OF FORCE PER 1,000 INCARCERATED INDIVIDUALS BY INSTITUTION TYPE (FISCAL YEAR 2023-24)



Note: A federal penitentiary may include more than one type of facility and security-type (e.g., Max-Med-Min). RTC stands for Regional Treatment Centre. Standalone Max includes the Special Handling Unit in Quebec.

Source: CSC's Data Warehouse (data extracted in March 2024). In-custody counts obtained from CRS-M Offender Profile (Creation Date: June 16, 2024).

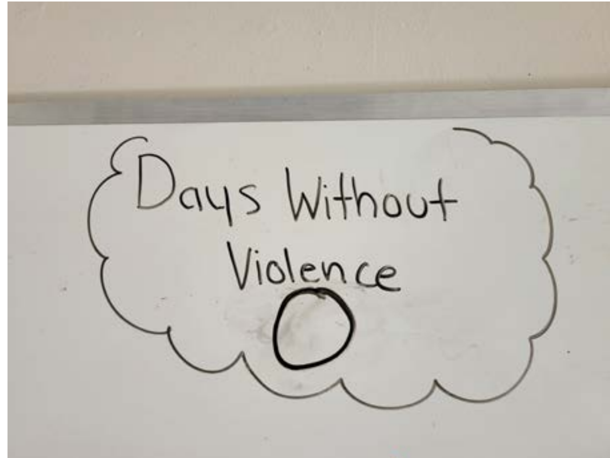
GRAPH 2. RATE OF USE OF FORCE PER 1,000 INCARCERATED INDIVIDUALS AT STANDALONE MAXIMUM-SECURITY INSTITUTIONS (FISCAL YEARS 2017-18 TO 2023-24)



Source: CSC's Data Warehouse (data extracted in March 2024). In-custody counts obtained from CRS-M Offender Profile (Creation Date: June 16, 2024).

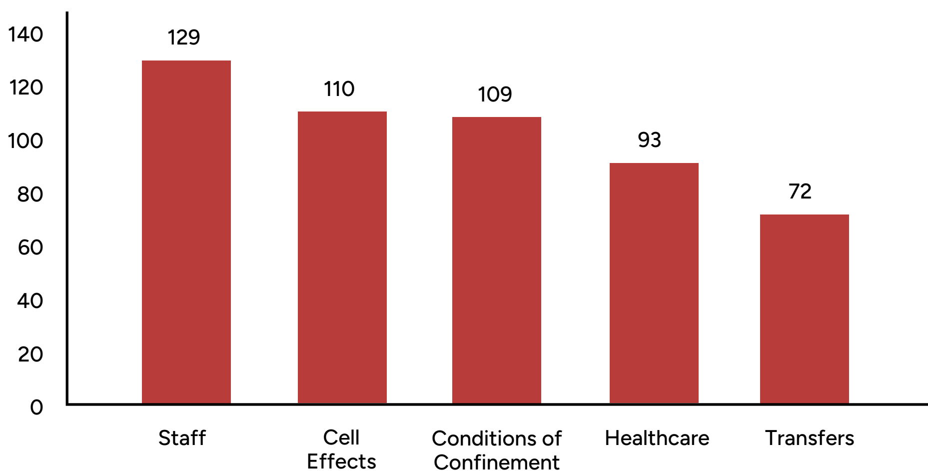
These institutions also see a significant number of self-inflicted injurious behaviour and attempted suicides. In 2023-24, for example, there were 360 incidents of self-inflicted injury at the six standalone maximums alone, representing nearly one third of all incidents of self-injury at all CSC institutions during that year. Over the past five years, there have been over 100 cases of attempted suicide at these institutions.[80] For institutional settings, these should be interpreted and acted upon as indicators of hopelessness and despair.

Prisoners at these institutions regularly seek assistance from this Office to resolve various issues. During the 2023-24 reporting period, the Office received over 1,000 complaints from persons incarcerated at maximum-security institutions, primarily for issues related to correctional staff, personal effects, conditions of confinement, healthcare, and transfers.



A note scribbled on a whiteboard in the Security Intelligence Office, Kent Institution

GRAPH 3. TOP 5 CATEGORIES OF COMPLAINTS TO THE OCI FROM STANDALONE MAXIMUM-SECURITY INSTITUTIONS BY NUMBER OF COMPLAINTS (FY 2023-2024)



[80] *Ibid.*

Thematic Findings

The findings that emerged from this investigation can be summarized under four thematic areas:

1. The overreliance on creating and managing subpopulations to address perceived security risks has an adverse effect on the aims of maximum-security institutions identified by CSC.
2. The emphasis on security, control, and confinement hinders staff engagement with the population, limits dynamic security practices, and restricts opportunities for group movement, assembly, and recreation.
3. The creation and implementation of the Structured Intervention Unit (SIU) have led to an inordinate consumption of institutional resources and attention, often having an inverse relationship on higher-needs units and leading to population management issues on a national scale.
4. Persons incarcerated in maximum-security facilities are poorly prepared to cascade to medium-security institutions and/or be released directly into the community.

1. The Overreliance on Creating and Managing Subpopulations

There is no clear definition of what CSC identifies a subpopulation. In the absence of such a definition, we have surmised that subpopulations are segments of the institutional population which operate independently from one another and are not permitted to mix and can be formed for a variety of reasons. These can include Security Threat Group (STG) affiliation, incompatibility issues, offence-type, mental health concerns, or profiles such as "Integrated" or "Non-Integrated" (colloquially referred to, respectively, as Protective Custody and General Population). It is challenging to define what constitutes a subpopulation, as certain groups (or even a few individuals) are kept separate for all but a few activities, which causes the reported subpopulation numbers to fluctuate depending on the context. The proliferation of subpopulations to *risk-manage* the incarcerated population is not a new phenomenon. CSC's *2006-07 Departmental Performance Report* provides an early glimpse of the problems generated by this segmentation: "The risks and needs posed by these offenders often require separation from the rest of the inmate population, which is a significant challenge for older institutions as the original structures were built to accommodate a homogeneous inmate population."[81]

Since my Office's reporting on *Restrictive Forms of Confinement in Federal Corrections* in the 2021-2022 Annual Report, in which I raised the fact that the number of subpopulations had continued to increase throughout the COVID-19 pandemic, the problem appears to have persisted, and in many cases, worsened. During this investigation, we found that three of the standalone institutions visited were managing up to a dozen subpopulations, making efficient movement and proper access to services a very challenging task. Although the remaining institutions had comparatively low numbers of subpopulations (i.e., under five per site) they still experienced similar access and movement challenges. The concern about subpopulations drives institutional routines, determines program participation and consumes an inordinate amount of staff time and resources. There should be a determined effort to reduce not create more subpopulations.

The prevalence of subpopulations has also interfered with the formation of appropriate representative bodies for the prisoner population. Inmate Welfare Committees (IWCs) ideally consist

[81] CSC. (2007 March). *Departmental Performance Report.*

of elected representatives from various units who are responsible for advocating and negotiating on behalf of the entire institutional population. Importantly, *Commissioner's Directive 083 - Inmate Committees* stipulates that IWCs are responsible for making recommendations to the Institutional Head regarding the use of the Inmate Welfare Fund and consulting on policy matters. Furthermore, IWCs are ordinarily tasked with submitting an Annual Report, and are expected to meet monthly with the Assistant Warden, Interventions, as well as quarterly with Institutional Management, including the Warden. During this investigation, I saw little evidence that these policies and practices were being respected. During my visit to Atlantic Institution, for example, the IWC in place at the time reported that they had never met institutional management and had no interlocutor to communicate their concerns. Unfortunately, some IWCs are unable to meet due to incompatibility of subpopulations, leading institutions to rely solely on range and unit representatives. In a few cases, institutions lacked an IWC altogether, as was the case when I visited Edmonton Institution, which counted 12 separate subpopulations at the time.

"Anything off range, it's iffy if we go or not."

- Individual incarcerated at Millhaven Institution

We found that the division of the institutional population into these subgroups increased range and unit confinement, often leading institutions to structure routines almost entirely within the units themselves. Restrictions on movement due to subpopulations tend to preclude prisoners from accessing significant areas of the institutions such as recreation spaces (centralized yards and gymnasiums), libraries, and program spaces. Some of these institutions benefit from a "relief valve" in the region, that is, an institution with a similar profile that can accept intraregional transfers to alleviate population pressures, but not all regions have such an option.

To reduce the growing number of subpopulations, institutions have actively sought to combine compatible groups. Some of these had been created during the COVID-19 pandemic as part of CSC's approach to limit infection was to separate the population into small cohorts. Through efforts such

BEST PRACTICE – MILLHAVEN INSTITUTION (MI)

At the time of my Office's investigation, Millhaven Institution had managed to keep the number of subpopulations to five main subgroups. Senior management appeared to give priority to reducing the number of subpopulations, while acknowledging that it was neither a simple process nor one without risk. They indicated that this is an ongoing, significant undertaking that requires collaboration among various departments to explore options, take part in mediation, and make efforts to conduct interviews with incarcerated persons. Security Intelligence and Interventions staff reported that this has proven to be effective due to institutional management's support for making calculated attempts to reduce the number of subpopulations within the institution.

as mediation and liaison with potentially compatible groups, some institutions have managed to keep the number of subpopulations to a minimum. While this is unlikely to ever be a reality for certain groups, such as rival STGs, these efforts have shown some promise. In certain instances, subpopulations were deemed to be incompatible due to the presence of a single individual. Other institutions appeared less eager to go through such an exercise, maintaining that the risk outweighs the reward. Unfortunately, this risk aversion restricts prisoners from having equitable access to constructive activities, ultimately hindering their ability to take part in their correctional plans and demonstrate preparedness for medium-security environments. This is but one of the numerous examples of risk aversion and the need to maintain the security of the institution outweighing the need for prisoners to engage in pro-social opportunities which could contribute to their rehabilitation and reintegration.

15. I recommend that CSC devise and implement a national subpopulation management strategy by the end of the fiscal year, with the goal of safely and considerably reducing the number of subpopulations within maximum-security institutions.

2. Impacts of the Emphasis on Security, Control, and Containment

Security and control, to varying degrees, are essential components of correctional institutions that serve to ensure the safety of incarcerated persons and institutional personnel. However, a sole or primary emphasis on these elements hinders staff engagement with the population, impedes dynamic security, and restricts opportunities for movement and recreation. Limited time out of cells and restrictive routines, compounded by outdated and deficient infrastructure, limit prisoners' access to even the most basic rights, such as access to fresh air exercise.

Time out of Cell and Routines

Those serving federal sentences at standalone maximum-security institutions are likely to find themselves spending an inordinate amount of time confined to their cells or ranges. During our investigation, routines were found to be highly restrictive and seemingly designed to isolate and contain prisoners whenever possible. Particularly egregious examples of this include Atlantic Institution, where common-room access is only accorded to half a range, or no more than five prisoners at a time, under the pretext of potential incident management. At Edmonton Institution, during the daytime, all units run on a variation of a schedule that privileges "shower time," whereby those confined to a particular range jockey for the opportunity to leave their cells to shower. This process inevitably causes conflicts between prisoners and staff and tends to favour more influential "heavies," to the detriment of others.

> **"It's a max. There are incidents all the time. We get locked down completely every few weeks. It's cyclical, sometimes it's more often than that."**
>
> ***- Individual incarcerated at Edmonton Institution***

What little time is offered to access common spaces is further diminished by the fact that these areas are generally barren, spartan, and devoid of even the most basic amenities to occupy one's time constructively. The corridor-style ranges at Millhaven Institution, for example, do not provide opportunities for interaction that are essential features of proper common areas; nor do they even have seating. Individuals who wish to leave the confines of their cells for any sort of social interaction are given no option but to repurpose mop buckets and trash cans to sit down, should they wish to call loved ones or get respite from pacing the ranges.

Range at Millhaven Institution

Range at Edmonton Institution

Furthermore, at some of the institutions visited, incarcerated persons are required to eat their meals while locked in their cells. This limits yet another opportunity for the most basic of social interaction and widens the divides within the population. In contrast, institutions that permit individuals to eat communally, such as Port-Cartier Institution, can considerably increase time spent out of cell.

Restrictive Infrastructure

The inadequate infrastructure identified in previous Office reporting still largely exists at maximum-security institutions today, reflecting a different era and correctional philosophy. Central to this issue is the age of these institutions: the six standalone maximum-security institutions were constructed and opened throughout the 1970s and 1980s. The infrastructure in place was designed to accommodate more consolidated, compatible populations, which has proven to severely impede proper movement and functioning given today's dynamics. For example, institutional layouts hinder movement to constructive and purposeful activities such as employment, programs, and education. In many cases, institutional traffic must filter through central choke points due to the institutions' radial designs, causing delays in moving subpopulations, or in some cases a single prisoner, to different areas of the institution.

"They want to know why there are so many stabbings, it's because it's unbearable. All you're doing is breathing down each other's necks. You're stuck on the range, and you just start nitpicking. Then things blow-up."

- Person incarcerated at Edmonton Institution

The institutions in question were designed in a correctional context that relied primarily on static security measures. There is a clear need for forms of physical barriers and security arrangements to ensure the safety of staff and prisoners, prevent escape, and maintain the overall functioning of a maximum-security institution. However, investigators found that much of the institutions' infrastructure and procedures made it almost impossible to complement static measures by developing constructive, staff-prisoner relationships and increasing awareness through regular staff interaction. Dynamic security, as a practice of corrections, is largely absent at maximum-security institutions.

A cell at Port Cartier Institution

A shower at Port Cartier Institution

Note: Investigators found that many areas within these institutions were falling into disrepair

In fact, much of the interaction between staff and prisoners occurs through range barriers and cell doors, which, as numerous senior managers and prisoners both agreed, inevitably heightens tension between parties, leading to confrontational exchanges. Furthermore, such environments lend themselves to being *reactive* to incidents and disturbances, rather than fostering early intervention or prevention. At some institutions, such as Millhaven and Donnacona, informal policies dictate that correctional staff do not patrol the ranges unless all incarcerated persons have been locked up in their cells. In many cases, prisoners looking to get staff's attention must resort to shouting at control modules from their range barriers, causing further conflict and tension. By design, modules, office space and other staff areas are mostly located away from living units. Reliance on static security at the expense of dynamic security heightens tensions and, likely, leads to more not less incidents.

The visible reminders that these facilities are violent places are omnipresent. For instance, over a dozen bullet holes had been left visible on walls inside Kent and Edmonton Institutions, despite requests by our Office to repair the damage. Some staff surmised that these were left intentionally, as a warning to prisoners.

To update existing infrastructure so that it is more responsive to the needs of today's population, some institutions have repurposed certain areas. Former meal serveries have been converted to Indigenous program spaces while passageways have been narrowed to include professional interview rooms. Additionally, former administrative segregation units are being renovated to expand interview space, program rooms, or to create new SIU cells.

"The chapel is supposed to be a spiritual place, but we have to use the space for a variety of other purposes because they don't have other places to do things."

- Chaplain

"We don't have a space for psychotherapy. I have a psychotherapist, but I can't get them in."

- Chief of Health Services

The problem here is that any new construction has largely involved the copy/paste application of the 96-bed accommodation model, first introduced about 10 years ago to accommodate an expected influx of prisoners related to legislative initiatives such as truth in sentencing and expansion of mandatory minimum penalties. This "tough-on-crime" period followed an increase in CSC's infrastructure budget which saw such units being built at all but one of these institutions. This model, the design for which was selected due to its ability to rapidly go for tender and be constructed, was inserted into pre-existing enclosed property. Many of these accommodation units now have been repurposed to include various segments of the institutional population, including SIUs, Intermediate Mental Health Care ranges (Therapeutic Ranges), Integrated/Non-Integrated ranges, and Transition ranges, for none of which they were specifically designed. While it has since been re-purposed as a multi-level Regional Treatment Centre, the 96-bed unit at Millhaven Institution has also been found to be poorly designed for its population and current purpose.[82]

[82] Information obtained from a Workplace Assessment Report compiled for RTC-MI (July 2022), in addition to findings included in a recently obtained Board of Investigation report.

Their horseshoe-shaped direct observation design offers what little semblance of dynamic security was observed at standalone maximum-security institutions. However, the units lack adequate program and office space, leading various disciplines to compete for these areas. Moreover, recreation spaces consist of mainly barren, paved yards, wedged between the spokes of the buildings. Touted as being “self-contained” in their ability to meet prisoners’ daily requirements on the units, this design aspect has conversely limited access to other significant areas of the institution. At Donnacona Institution, for instance, a 96-bed unit has sat idle for over *four years* due to structural and electronic issues.

Access to Recreation and Fresh Air

At standalone maximum-security institutions across the country, it is evident that providing sufficient outdoor recreation space for those incarcerated at these facilities is not a matter of sustained priority. In Kent’s case, for example, two 96-bed units now stand where the institution’s primary recreation space once was. Institutions whose large outdoor yards are still operational have regularly undergone lengthy closures due to the perceived risk of contraband drops from unmanned aerial vehicles, or “drones,” or because of labour disputes over the integrity of physical barriers. As an alternative to closure, one institution provides yard access on a randomized, rotational basis, often forcing individuals to choose between attending programs or getting fresh air.

SIU yard, Port Cartier Institution

Mini yard at Edmonton Institution

Given these issues, coupled with the challenges of providing adequate yard access to a large number of subpopulations, institutions have taken to relegating many prisoners to small, restrictive unit-based yards for their daily access to fresh air. CSC refers to these oftentimes cage-like areas as "mini" or miniature yards.

By their very definition, these spaces are very small and offer only enough space to pace a short distance. In fact, the size of the enclosed outdoor exercise yards provided to dogs housed at Fraser Valley Institution far exceeds the square footage of the mini yards found on most of the units afforded to prisoners at Edmonton Institution.[83]

Mini yard at Edmonton Institution

Population pressures and movement issues have also rendered sizeable areas unusable, such as the inner courtyards at Edmonton and Kent Institutions where they now primarily serve as thruways for institutional traffic. The Office finds these spaces, in design and purpose, to be inherently depriving and dehumanizing.

16. I recommend that CSC ensure:

- **a. Institutional routines are established to allow all incarcerated persons, excluding those in SIU's, to have access to primary "large" yard spaces daily.**
- **b. All living units at standalone maximum-security institutions are equipped with basic amenities and seating.**
- **c. Policies related to institutional movement, including Standing Orders, be reviewed to ensure that they no longer limit individuals from engaging in their Correctional Plan.**

[83] Specifications obtained from CSC Real Property Services diagrams.

3. Consequences of the Implementation of Structured Intervention Units (SIU)

Following the abolishment of solitary confinement (Administrative Segregation) in 2019, SIU's were created as a replacement model. The new units were heralded as a new correctional model by CSC. SIU's and their guiding legislation mandate minimum amounts of out of cell time (including engaging in "meaningful human contact"), ensure that prisoners are offered daily access to fresh air, and provide several ongoing interventions by case management, health services and mental health staff. Their objective, in principle, is to reintegrate prisoners into the mainstream population as soon as possible.

SIU's were introduced at 15 institutions across Canada, including all six standalone maximum-security institutions. My Office has reported on their implementation on multiple occasions, including in our 2020-2021 and 2022-2023 Annual Reports. Among other findings, it was observed that many individuals find SIU conditions more favourable than the mainstream maximum-security prison population because of their greater access to services and interventions, daily visits by nurses and wardens, more opportunities to engage with non-security staff, and the possibility of greater out-of-cell time. Given this situation, some individuals refuse to leave the SIUs, as Independent External Decision Makers have also attested.

The current investigation revealed that these issues persist and pose a significant challenge at the standalone maximums. The SIUs require a significant concentration of resources and safeguards, as the aim is to offer prisoners a minimum of four hours outside of their cells each day, including two hours of "meaningful human contact." This includes interaction with various program staff, spiritual and ethnocultural supports, case management personnel and volunteers.

Individuals in an SIU have daily face-to-face access to the Warden or their delegates, and regular visits by nursing staff and mental health workers. Such access is not afforded on regular ranges. Moreover, SIUs are largely shielded from measures such as institutional lockdowns.

The sheer difference in the number of staff allocated to the SIU was visible at the institutions visited. Even so, when SIUs near capacity, which is not uncommon, meeting legal obligations for out of cell time becomes increasingly challenging, if not impossible. Senior managers are not exempt from these operational challenges, as the steady flow of SIU admissions and transfers account for much of their priorities and attention.

There is a notable contrast between conditions in SIUs and those outside of these units, due to the emphasis on meeting legislated entitlements in the SIUs and public scrutiny. The rules governing the SIUs do not extend to other areas of the institutions and thus fail to prevent segregation-like conditions from existing elsewhere. Investigators found that SIUs tend to monopolize resources and specialized staff at the expense of other units. For example, mental health staff at some institutions reported that while complex and high-needs individuals may reside elsewhere, such as in their Moderate Intensity Intermediate Mental Health Care (MIIC) Units or Therapeutic Ranges, priority is routinely given to those residing in the SIU, who's assessed mental health needs tend to be moderate to low.

These seemingly advantageous elements are not lost on the institutional population, many of whom let it be known to our investigators that they purposely get admitted to the SIU to increase access to recreation, time out of cell, meetings with their Case Management Team, and access to programs, spiritual services and education. For some, voluntarily sheltering in the SIU is also seen as an effective way to reduce the likelihood of being involved in incidents. Senior staff mentioned that in some cases, prisoners will make efforts to

get admitted to the SIU to abide by a common unwritten rule at a number of the sites, which is to remain incident free for six months before a transfer to medium security will be considered. This expectation was reiterated at multiple institutions, despite not being rooted in any official policy or legislation.

These conditions, and the relative ease with which prisoners can get admitted to the SIU, often trigger a series of transfers across the country to meet mandated guidelines for maximum time spent in SIU custody. Interregional transfers are not immune from the prioritization of SIUs either, as numerous staff members shared concerns about SIU-related transfers taking precedence over all other transfers. In turn, these operational priorities delay other offenders from transferring to more suitable institutions or regions, cascading to lower security, and progressing through their own correctional plans. These procedures can also prevent some institutions from transferring problematic prisoners from general population to other institutions, leading to prolonged periods of disruptive behaviour.

Those wishing to remain in the SIU often refuse to integrate at their existing institution or upon arrival elsewhere to intentionally prolong their stay. Many individuals, including more "complex" SIU cases, routinely cycle through the various institutions, using up substantial resources and requiring significant negotiation among institutions.

> **"We know they won't integrate when they get sent here. They tell us as soon as they get out of the van. I had an offender tell me 'Sir, I am threatening you.' Just like that. He was almost laughing when he said it. He told me he would never integrate at the institution and would do whatever it took to stay in the SIU or be transferred."**
>
> ***- SIU Correctional Manager***

These cases are discussed during a call between institutions that occurs with every interregional transfer "flight cycle," and includes Security Intelligence and Interventions staff. Concurrent or subsequent calls may also take place among senior managers to further negotiate which institution can accept which prisoner. Disconcertingly, staff at one institution referred to this process as "the hockey draft," while staff at another institution described it as "horse-trading." In speaking with these institutions, this process has inefficiencies, as it has led to infighting between sites due to a reluctance to accept cases. While institutions in some regions have been amenable to accepting more complex cases and routine transfers to alleviate population pressures elsewhere, others have resisted under the pretext of language barriers, regional "culture" or the absence of sufficient services in the other official language. Therefore, in the event of an impasse, institutions may have to refer cases to the Complex Transfer Case team at National Headquarters for further assessment and, if accepted, eventual recommendations regarding viable placement options. Examples of these exchanges and the discord among certain sites were noted in recent records of these calls provided by the Service. For instance, one institution was noted to have offered to take *six* SIU cases from another in exchange for sending a particularly challenging prisoner in return.

> **"It's like the hockey draft. We trade tokens with other institutions, I'll take this guy from you if you agree to take that guy from me. Or you'll owe me one on the next flight."**
>
> ***- Security Intelligence Officer***

> **"Essentially what we're doing is exchanging difficult cases for difficult cases. Guys doing indeterminate sentences just keep going from site to site. For the rest of your life, that's a long time to be bouncing around."**
>
> ***- Warden***

From a more general standpoint, collaboration and learning among maximum-security institutions is sporadic, often case-specific, and largely driven by population management pressures. Monthly calls among wardens, which seem to have only begun in the fall of 2023, offer opportunities to take part in training, hear from guest speakers, and share best practices from their respective institutions. Given the complexity and unique aspects of operating such facilities, why such a collaborative exercise was only recently instituted is somewhat confounding. Nevertheless, knowledge transfer between these institutions would serve to highlight some of the significant differences in their management and operational approaches, which investigators regularly note during visits.

17. I recommend that CSC develop a national policy surrounding complex SIU cases, which should include oversight and direction from the national level, to make SIU transfer processes more efficient and equitable.

4. Poor Preparation for Cascading and Community Release

> **"We don't rehabilitate them, we hold them, then we put them back on the street. We are setting them up to fail."**
>
> ***- Correctional Manager***

> **"The real rehabilitation happens in the mediums. We are not rehabilitating them here."**
>
> ***- Warden***

Lack of Meaningful Employment

Securing and holding meaningful employment is an essential way for prisoners to occupy their time in a constructive manner and has the potential to better equip individuals being released into the community to enter the workforce. While the current remuneration structure leaves much to be desired, income derived from institutional jobs is the only way for prisoners to avoid relying on their loved ones or turning to the institutional subculture to earn money. Furthermore, prisoners' employment and job performance reflect positively in the eyes of decision-makers such as the Parole Board of Canada.

Across all the institutions examined, there was a notable lack of meaningful employment for incarcerated persons. By and large, jobs available to the population consisted primarily of various forms of cleaning (e.g., range cleaners, shower cleaners, hall cleaners, Institutional Services cleaners). Many jobs were menial or rudimentary in nature and seemed to arise from a need to invent unit-based employment opportunities, such as "pop can sorters," "razor distributors" and "unit dishwashers." Furthermore, while individuals at these institutions may appear to be employed, oftentimes on a "full-time" basis, investigators found that many of the positions require little to no work throughout the day and there is virtually no staff oversight to ensure that jobs are being performed to a satisfactory degree.

Many of these positions are sought for the sole purpose of securing time out of one's cell during working hours. For example, at one institution, there were more than a dozen Inmate Grievance Coordinators whose primary duties include assisting fellow prisoners to prepare and process grievances. Interviews revealed that they had rarely, if ever, assisted with a grievance. Moreover, they had not received any training to carry out their duties, aside from being provided with a written job description. The same institution employs more than ten Peer Mentors, positions for which the Office has previously advocated, yet they have not received any training. In addition to the potential to provide valuable skills and employment, such positions could prove beneficial to these institutions as they offer support for individuals experiencing acute emotional distress, who may otherwise go without help due to the absence of sufficient mental health resources.

CORCAN Industries, which offers employment-related training and opportunities for incarcerated persons across various manufacturing sectors and trades, has virtually no presence at any of the standalone maximum-security institutions. Half of the institutions I visited employ between six and eight individuals, some of whom only work on a part-time basis. The remaining institutions: Millhaven, Kent, and Edmonton, have no CORCAN opportunities whatsoever. Apprenticeship opportunities and vocational training are scarce as a consequence, and there is a lack of partnerships with external organizations or educational institutions that could provide job training. As reported in last year's Annual Report, an outdated and inadequate pay system, worsened by the inability for maximum-security prisoners to attain higher levels of pay, fails to offer much in the way of motivation or incentive to work. Employment in Food Services, a once attractive opportunity to gain practical culinary skills under the guidance of professional cooks, nowadays primarily consists of washing dishes. This is due to the consolidation of the food services modernization initiative ("cook-chill"), whereby, at all but one of the max sites, a significant proportion of the food is mass-produced off-site and shipped to the institutions to be reheated.[84] A Food Services manager at one of the sites informed me he had difficulty attracting employees, as they could earn the same pay completing an hour or two of cleaning on their unit instead of working five days a week completing current kitchen duties.

Resulting boredom aside, the absence of meaningful work opportunities prevents prisoners from gaining marketable skills which could serve them well upon release. The lack of responsibility and ownership over legitimate jobs leads to idle hands, contributing to some of the pent-up angst and agitation that is generally observed among the population.

[84] Port-Cartier Institution has retained much of its food preparation due to supply-chain issues caused by its remoteness.

"Not once have they asked, 'What do you want to do when you get out?' No questions about training, nothing about trades, nobody asks if you want to be a truck driver, work in construction. Nothing."

- Incarcerated person at Edmonton Institution

"We have been forced to get creative with it. 'Pop can sorter'. Is it really a full-time job? We look for something, anything, for them to do."

- Assistant Warden, Operations

"Guys are taking jobs just to get out of their cells."

- Incarcerated Person at Kent Institution

Barriers to Programs

Successfully completing correctional programs is a key consideration when determining whether an individual will be cascaded to a lower security level or be supported for release. Standalone maximum-security institutions face several challenges with respect to program delivery. Program staff reported that the prevalence of subpopulations within institutions limits the ability to assemble suitable group sizes to deliver correctional programs. It also reduces the number of days that programming can occur. Incidents, lockdowns, and searches also hinder program delivery, as prisoner movement frequently comes to a halt. Similarly, slow movement within these institutions leads to delays that prevent participants from arriving on time for programs. Program staff indicated that cumulatively, delays often extend the projected timelines for program completion. At some of the institutions, a lack of dedicated program space has forced staff to deliver programs in inadequate locations, such as common rooms, further reducing the number of participants.

Collectively, these challenges have impacts on an inmate's progress through their correctional plan, lead to the deferral of parole hearings, impede opportunities for cascading, and limit access to pro-social outlets through which prisoners can constructively occupy their time.

"Guys – lifers in particular – need to know the steps. They need to know what they have to lose. Guys don't know about their opportunities to get out. They don't know that they can get out."

- Individual incarcerated at Kent Institution

With respect to the programs themselves, the institutions we reviewed have curtailed the amount and frequency of core programs, with more emphasis on primer programs, or initial "readiness programs" that are comparatively short, requiring between 10 and 12 sessions to complete. The Commissioner commented on this during a recent appearance before the Standing Committee on Public Safety and National Security (SECU), confirming that it is not as easy to take part in programming at maximum-security institutions, as compared to medium-security institutions,

which offer more opportunities for interventions and programming.[85] In other words, those most in need of programs may be less likely to have access to them. Waitlists to begin correctional programs at these institutions are extensive. As of April 7, 2024, the waitlist to commence correctional programs across these six institutions totalled 820 individuals, representing 1,170 individual programs.[86]

In addition to the challenges regarding delivery of "mainstream" programs, the barriers for the delivery of specialized programs are even greater. For example, Pathways, considered to be a signature intervention in CSC's Indigenous corrections approach, is not available to persons incarcerated at maximum-security institutions in the same manner in which it is at medium and minimum-security sites. Instead, some institutions have previously offered "Pre-Pathways" to a small number of individuals to prepare them for medium-security Pathways. The Pre-Pathways program, or a variation thereof, was only offered at two of the institutions with a total of only 14 individuals enrolled.[87] This is particularly concerning as there are nearly 500 Indigenous prisoners, accounting for 35% of the total population at these sites. This echoes what the Office found in *Ten Years since Spirit Matters: A Roadmap for the Reform of Indigenous Corrections in Canada (2023)*, in that significant barriers to accessing cultural programming and services exist for Indigenous individuals in maximum-security institutions, as Pathways Initiatives are primarily concentrated in minimum and medium-security environments. As the report also highlighted, Indigenous individuals encounter impediments to cascading to lower security levels.

PRE-PATHWAYS PROGRAM AT EDMONTON INSTITUTION (EI)

During a visit to Edmonton Institution, I met with an Elder on the Pre-Pathways unit, which counted a total of eight participants, limited to attending three sessions per week. With a significant waitlist, the Elder informed me that he believed EI could operate a full Pathways unit and he would gladly accept more participants, but funding is currently limited to eight individuals. Why the Pre-Pathways Program at EI, whose population is 66.1% Indigenous, is limited to such a meager number of funded participants, is incomprehensible. This raises further questions about CSC's reluctance to implement a mainstream Pathways Program on a larger scale at maximum-security institutions. At Edmonton Institution, I found the spiritual grounds used for ceremonies to be symbolic of the Service's attitude towards such a program. I found it to be barren, lacking any semblance of spirituality, with materials used for ceremonies locked away in a nearby sea container.

[85] Standing Committee on Public Safety and National Security. (2023 November). *44th Parliament, 1st Session.*

[86] Data Warehouse (Current up to 2024-05-05). Note: of the total number of individuals waitlisted, 229 were identified as *scheduled to attend*, 13 were *scheduled to attend next FY* and a further 189 were noted to be *pending*.

[87] At the time of writing, while other institutions had funding for Pre-Pathways beds, only Edmonton Institution and Port-Cartier Institution counted a total of eight and six participants registered in Pre-Pathways, respectively.

Indigenous grounds at Edmonton Institution

Challenges with Education

Much like correctional programming, educational opportunities can play a significant role in the level of support one will receive for cascading or eventual release. Aside from these outcomes, a strong educational program helps individuals gain knowledge and insight, secure and retain employment once released, and lowers their risk of recidivism. Our investigators found that individuals wishing to take part in education programs are likely to find themselves completing cell studies, exchanging assignments with teaching staff on a periodic basis. Barriers to movement, numerous subpopulations, and operational constraints negatively impact the ability to deliver educational programs in a classroom setting. Opportunities for students to gather in a group setting are limited to short time slots and offered on an occasional basis. For example, teaching staff at multiple institutions informed me that students only attended in-person once or twice a week for half days, or approximately two and a half hours. While enrollment numbers can be encouraging at a glance, the mode of delivery – compounded by outdated and inadequate technology – and time allotted for classroom or group instruction are problematic.

BEST PRACTICE – KENT INSTITUTION

I met with teaching staff at Kent Institution, where since April 2021, university-level courses have been offered to incarcerated persons looking to obtain post-secondary credits. With assistance from CSC teaching staff, prospective students can apply for individual courses offered by two accredited universities, but only if these universities agree to offer coursework in a paper-based format. Given the expenses associated with these courses, most students apply for the JD Hobden Scholarship Fund, offered through the John Howard Society (JHS), to cover these costs. Again, these courses are primarily completed via cell studies, as teaching staff have limited opportunities to meet with prisoners outside the units for individual support. This arrangement is not without challenges due to CSC's outdated technology, as teaching staff must negotiate with the universities to offer alternate assignments if classwork requires the use of computers, the internet, or audio/visual equipment. Online quizzes, for example, must be converted to hard copies and proctored by a staff member, who must find time and meeting space to do so. Due to these barriers, extensions are sought for nearly all courses, as they can rarely be completed on time. Sources of funding and the logistics associated with delivering such programs present obvious gaps. Nevertheless, this initiative has been successful, with approximately 20 students taking part in the program, thanks in large part to some enterprising and creative staff members.

Case Management and Release Planning

> **"They have less access to vocational training programs than what you would have in [minimums] and mediums, so they don't have the opportunity to work on vocational skills. They don't have the opportunity for ETAs and UTAs. There is no transition, no gradual process, nothing to prepare them to return to the world."**
>
> ***- Community Area Director on offenders released directly from maximums.***

> **"Maximum security offenders being released are less likely to succeed."**
>
> ***- Deputy Warden***

> **"In an ideal world nobody would come from a max, but that's not the reality. Failing that, having somebody with the sole responsibility to work with institutions and community to better prepare for release, being the go-between."**
>
> ***- Community Area Director on releases directly from maximums.***

> **“Having them released from a max on [statutory release] is not fair and does nothing to benefit public safety.”**
>
> ***- Assistant Warden, Interventions.***

The number of releases directly from these institutions is substantial. In fact, data provided by the Service from two recent fiscal years revealed that each year, there were more than 500 individuals released directly from the six maximum security institutions into the community via statutory release, which represents a significant portion of the total population.[88]

Considering the higher perceived risks and needs of the individuals housed in maximum-security institutions and the significant number of prisoners these institutions release directly to the community, intensive case management is essential to support CSC’s stated goals for cascading inmates to lower security facilities and release planning.

Investigators found that there is a minimal frequency and depth of interaction between case management staff and incarcerated persons. For many, interactions with parole officers (POs) occur through cell doors and range barriers, seldom taking place in private meeting spaces more conducive to building rapport and engaging in case management work. When prisoners are afforded time to speak with their PO in a private setting, it is not uncommon for some institutions to position correctional staff directly outside the interview space or within earshot of these interactions.[89]

Concerningly, most of the prisoners interviewed had difficulty even identifying their primary worker (CX-02), could not recall the last time that they had met, and could not provide any details of their interactions. *Commissioner’s Directive 710-1 - Progress Against the Correctional Plan*, stipulates that incarcerated persons are to meet with their CX-02 every 45 days at a minimum, to complete a Structured Casework Record. Both current and former CX-02s confirmed that very little is done in the way of case management. For example, one CX-02 had difficulty recalling the number of incarcerated persons they were responsible for, noting that the variation in posts at their institution does not lend itself to regular interaction in this respect, nor do they have the time or space to speak privately.

In theory, CX-02s make up an integral part of the case management team, when consistent, constructive interaction takes place with individuals assigned to their caseload. Moreover, there appears to be a willingness among the CX-02s to increase such engagement. At a recent appearance before SECU, the President of the Union of Canadian Correctional Officers (UCCO) confirmed that correctional staff currently play a small role in the case management team, adding, *“we sometimes question why we’re not more involved in the assessments for decisions, as our members are with the inmates 24-7 and have a better understanding of their particular caseload of inmates than most members of the case management team.”*[90] While this may not presently be the case at standalone maximum-security institutions, there appears to be room to strengthen the case management approach through greater involvement of these staff members.

---

[88] Data for releases directly from the six standalone maximums was provided by CSC with information extracted from Data Warehouse for fiscal years 2021-22 and 2022-23.

[89] The Office acknowledges that there is a reluctance to engage with case management personnel among some segments of the population, as the institutional culture is such that communication with staff can be perceived as suspicious. However, the current form of this interaction is not conducive to productive or honest dialogue.

[90] Standing Committee on Public Safety and National Security (2023 November). *44th Parliament, 1st Session.*

I heard similar concerns from correctional staff with responsibilities for community corrections. For example, some area Directors raised concerns about the lack of discharge planning for individuals released directly from maximum-security institutions, as they generally arrive in the community with entrenched institutional mentalities, a tendency to react aggressively, and typically lack communication and interpersonal skills. While the Directors believe that some of these behaviours results from offenders' reluctance to work on correctional plans while incarcerated, they noted as well that these individuals are released with no vocational training, few employment skills, and are therefore more reliant on social services. These institutions lack dedicated release planners and, consequently, most of these responsibilities fall on Parole Officers, who are already managing significant workloads.

The potential consequences of these case management and release planning practices are not insignificant. A review of data obtained from CSC's National Recidivism Study (2019) indicated that recidivism rates are notably higher for those released from standalone maximum-security institutions (approximately 61%), as compared to medium-security (40%), and minimum-security (22%) facilities.[91] Research also suggests that for maximum-security prisoners serving shorter sentences (e.g., three years or less), their inability to undergo security reclassification prior to their statutory release date prevents a significant number of individuals from cascading to lower security before their release.[92]

While precipitating factors for recidivism are difficult to pinpoint, the investigation pointed to gaps in the way case management occurs at these institutions. It is therefore essential to bolster the level of involvement between prisoners and *all members* of their case management teams, including clarifying and assigning release planning responsibilities.

18. I recommend that CSC increase availability of meaningful employment and apprenticeship opportunities at standalone maximum-security institutions, while mandating basic oversight of these jobs, to ensure that prisoners can occupy their time constructively.

19. I recommend that CSC provide consistent access to Indigenous services, programs and supports, including establishing and maintaining Pathways programs, at each of these institutions without delay.

20. I recommend that CSC assign dedicated Release Coordinators at each standalone maximum-security institution and bolster related policy to establishing clear responsibilities surrounding discharge planning.

21. I recommend that CSC develop policy establishing a minimum frequency of in-person contacts between Institutional Parole Officers and incarcerated persons on their caseloads. This policy should clearly outline expectations regarding what is to be addressed during these interactions and include additional language clarifying CX-02 involvement in a maximum-security setting.

[91] Percentage of Any New Offence (i.e., revocation, new WOC, or CPIC) after Releases.

[92] Gobeil, R., et al. (2015). *Releases of Men Offenders Classified as Medium and Maximum Security.* Ottawa: Correctional Service of Canada.

Conclusion

A clear articulation of the goals or purpose of maximum-security facilities is required to assess whether their stated aims are being achieved. In conducting this investigation, my Office found that the federal correctional system lacks a clearly articulated and common statement of purpose for maximum-security institutions. This same confusion extends to the way clear behavioural expectations, programming requirements and engagement in one's Correctional Plan, or lack thereof, are shared with incarcerated persons by case management and correctional staff. Beyond remaining incident free for arbitrary or even indefinite periods of time, maximum-security prisoners often seem confused, frustrated or unclear as to what is specifically required of them to be moved down or "cascade" security levels in a timely manner. As it plays out in the unpredictable and often chaotic environments of a maximum-security institution, this state of anxiety, idleness and constant uncertainty among the population creates conflict and tension, and leads to individual and institutional violence.

Goal-setting surrounding such a bare minimum expectation of pro-social behaviour, a generally inadequate level of support to achieve this aim, and an absence of sufficient opportunities to acquire meaningful life skills or demonstrate law-abiding behaviour, are hardly in line with the overarching reintegrative and rehabilitative purposes of incarceration in Canada. Lacking clear policy direction, Canada's highest security institutions have drifted toward a correctional model that is extremely rigid and restrictive, and highly intolerant of non-compliant behaviour. The correctional goal, particularly in a maximum-security setting, should not be to create model inmates but rather better people.

During this investigation, OCI staff members came across numerous examples of prisoner entitlements or rights being curtailed or removed, and rarely ever restored to their previous level. It bears reminding that the sentence and the deprivation of liberty that it implies is the punishment for criminal offending in Canada. The Office finds that unstated goals of containment and incapacitation are just as likely to serve as the aims of contemporary maximum-security incarceration as rehabilitation or reintegration. To be certain, punishment and retribution are still meted out inside the walls of our maximum-security penitentiaries, even if they are no longer part of the legislated purpose of federal custody. Though the principle of least restrictive confinement still applies as does the maxim that imprisonment should be used sparingly and with maximum restraint, so equally the administration of a sentence is to be carried out proportionate to the nature and gravity of the offence. There is enough guidance in these concepts to ensure even maximum-security incarceration is carried out with restraint, proportionality, purpose and meaning.

Furthermore, there is a need for CSC's leadership to set expectations for how staff deliver on organizational goals and stated aims of imprisonment. This extends to its recruitment strategy, how new staff are trained, and what emphasis gets placed on which aspects of their role, as they have a collective impact on the messaging to the institutional population.

As we have seen, specialized units like SIUs consume an enormous number of institutional resources, attention, and are in many cases targeted by individuals seeking to escape the monotony and risk associated with general population. The constant cycling of individuals through these units has caused division between sites in various regions, highlighting the absence of a clear collaborative strategy.

The physical facilities which house these prisoners are outdated and not conducive to meeting modern correctional goals and principles. Even newly constructed units have been duplicated or repurposed across these various sites with little attention to the needs of the populations they house, instead serving to contain and control movements and restrict mixing of various subpopulations. Those serving federal sentences at these facilities too often sit idle, in close quarters, with few options for meaningful or purposeful activity. The level of violence in maximum-security institutions is a predictable and cumulative result of ever more restrictive and repressive conditions of confinement. The rates and level of violence in these settings render even the most basic requirement for the state to provide safe and humane custody as a goal, not a guarantee of contemporary imprisonment. This overall lack of reintegrative and rehabilitative purpose has turned maximum-security facilities into places of *incapacitation* and *containment*. In their present form, their primary function appears to be simply holding prisoners until they can idle long enough to secure a transfer to medium-security, or worse yet, reach their release date without any sort of meaningful preparation.

In reflecting on the findings and recommendations of earlier Commissions of Inquiry and related reports and reviews, there have been both evolution and regression in our understanding of the purpose of maximum-security incarceration. The Office encountered many extremely dedicated staff members serving in these facilities. The problem, as the Office sees it, is not one of commitment or dedication, but rather one of intention and purpose. The Office finds that these institutions are unnecessarily punitive and restrictive to the point of calling the Service's interest in positive correctional outcomes into question. Cumulatively, the situation is troubling and worthy of a comprehensive review, to clarify the correctional, and just as importantly, the social purpose of these facilities.

22. I recommend that CSC establish a clear purpose statement for maximum-security institutions, against which its aims can be assessed to ensure that optimal outcomes are achieved and that prisoners' essential human rights and dignity are upheld.

NATIONAL SYSTEMIC INVESTIGATION

Hope Behind Bars: Managing Life Sentences in Federal Custody

Springhill Institution

Voices of Lifers

“Why bother now? I am going to die in here anyway.”

“If you behave for ten years it doesn’t count for anything, but if you do a bad thing it counts for 25 years.”

“All it takes is for someone to listen to what I have to say, to take the time with me. The lack of encouragement is challenging, and one is left to feel hopeless.”

“A lot of guys give-up. There should be something in place to identify if they need support.”

“Doesn’t take 25 years to find out you f----d up!”

“The purposes of a sentence of imprisonment or similar measures deprivative of a person’s liberty are primarily to protect society against crime and to reduce recidivism. Those purposes can be achieved only if the period of imprisonment is used to ensure, so far as possible, the reintegration of such persons into society upon release so that they can lead a law-abiding and self-supporting life.”

Rule 4 (1), The United Nations Standard Minimum Rules for the Treatment of Prisoners *(the Nelson Mandela Rules)*

In the course of day-to-day operations, OCI investigators routinely encounter individuals sentenced to a mandatory minimum of life in prison under section 745 of the *Criminal Code* (i.e., Life-Min), who are also near or well past their parole eligibility dates; have completed most if not all their core programs; and are employed and engaged in their Correctional Plan. Yet, these same individuals face multiple barriers when requesting transfers from medium- to minimum-security institutions. Therefore, my Office decided to launch the current investigation with the aim of highlighting some of the key issues in case management, security reclassification, and sentence planning for those with Life-Min sentences at medium-security institutions[93] by exploring the following questions:

- Is the security level review and reclassification process fair?
- What are the barriers to cascading to minimum security?
- What are the *"Four Phases of a Long-Term Sentence"* and is CSC applying these to sentence planning?

In addition to reviewing CSC's policies and documentation and an analysis of population-level data, the current investigation involved an analysis of 35 individual cases from 11 institutions[94] across all five regions using a standardized coding framework. These individuals were selected after having been identified as concerning cases by OCI Senior Investigators during routine visits and investigations. Concerns typically related to problems with case management procedures or security reclassification decisions that interfered with transfers to lower security institutions. In addition to case reviews, in-person interviews were conducted with 24 incarcerated persons and 20 staff members at seven institutions.[95]

Tragically, two of the individuals in our case review died by suicide in the first few weeks of 2024. A third individual who was approved for minimum transfer died in March 2023 shortly before the transfer was completed. He was an elderly individual with several health and mobility issues. Indeed, these deaths serve as an ever-present reminder that "life means life."

[93] For increased clarity, this investigation did not include those with a Dangerous Offender designation under section 753(4) of the Criminal Code or individuals sentenced to the maximum penalty of life in prison where there is no mandatory minimum sentence prescribed in law (i.e., Life-Max).

[94] At the time of the review, these individuals resided at the following institutions: Dorchester, Springhill, Bath, Beaver Creek, Collins Bay, Mission, Mountain, Archambault, Cowansville, Bowden, and Grande Cache. One individual had just been released from medium-security and was, at the time, residing at a Community Correctional Centre in the Atlantic region.

[95] In-person interviews were conducted between February and March 2024, at Mountain, Bath, La Macaza, Beaver Creek, Pacific, Matsqui, and Mission institutions.

LIFE SENTENCES AND THE *CRIMINAL CODE*

As of February 18, 2024, there were approximately 3,600 federal prisoners with indeterminate sentences (i.e., when the term of imprisonment does not have an end date), also known as "Lifers," representing 26% of the total in-custody population. The term *Lifer* applies to individuals sentenced as follows:

- Those serving a mandatory-minimum life sentence under section 745 of the *Criminal Code* and who are not eligible for parole until they have served between 10 and 25 years (as determined by the court). Currently, 80% of federal prisoners with indeterminate sentences are serving a mandatory-minimum life sentence (Life-Min).
- Those declared a Dangerous Offender (DO) under section 752 of the *Criminal Code*. Of individuals serving indeterminate sentences, 17% have the DO designation.
- Those who are serving a life sentence where there is no mandatory-minimum sentence prescribed in law. Such cases are referred to as Life-Max and a judge can impose a maximum discretionary period prior to parole eligibility. Currently, 3% of those with indeterminate sentences are serving Life-Max.
- The remainder (less than 0.5%) of those imprisoned for indeterminate periods are mostly individuals found "not criminally responsible on account of a mental disorder" (NCRMD) and committed to custody under section 672.54 of the *Criminal Code*.

Policy and Legislative Context

In 1976, with the passage of Bill C-84, Canada was among the first countries to abolish the practice of capital punishment. Following abolition, Canada adopted mandatory-minimum sentences of *life* in prison. This meant that individuals would remain incarcerated for a prescribed period before being eligible to apply for conditional release.[96] Since the late 1970s, we have seen the courts impose increasing periods of parole ineligibility at sentencing leading to more time behind bars – even beyond parole eligibility dates.[97]

On December 2, 2011, the *Protecting Canadians by Ending Sentence Discounts for Multiple Murders Act* came into force, allowing judges to impose consecutive 25-year parole ineligibility periods for multiple 1st degree homicides. At the same time, through Bill S-6 (the *Serious Time for the Most Serious Crime Act*), the "Faint Hope" clause was abolished. Before December 2011, this provision under section 745.6 of the *Criminal Code* allowed individuals serving life sentences to apply to have their parole eligibility reviewed after serving at least 15 years. These legislative changes were made despite findings from a parliamentary study

[96] See, Manson, A. (1990). *The easy acceptance of long term confinement in Canada.* Criminal Reports, p. 265 – 275. In this article, Manson looks at the compromises made during this period to secure the abolition vote in Parliament. Specifically, he argues, "The 25-year parole ineligibility period was created as a political expedient in the face of compelling data pointing to a lower minimum term."

[97] Parkes, D., Sprott, J., & Grant, I. (2022). *The evolution of life sentences for second degree murder: Parole ineligibility and time spent in prison.* Canadian Bar Review.

showing that "Canada exceeds the average time served [in custody by an offender with a life sentence] in all countries surveyed."[98] As a result of these amendments, Canada's mandatory-minimum parole ineligibility period for first-degree murder now ranks among the harshest out of similar common law jurisdictions.[99]

In a 2019 report published jointly with Canada's Human Rights Commission, the Office commented on the impact of indeterminate sentences:

"... long periods of incarceration may no longer meet the purpose or original intent of the sentence and may not be necessary from a public safety perspective. In addition, long periods of incarceration may, in some cases, be inconsistent with respect to human dignity."[100]

This concern was also highlighted by Penal Reform International in its April 2012 briefing, "Life after death: What replaces the death penalty?"

"The conditions of detention for lifers, compounded by the indeterminate nature of the sentences, typically have a profound sociological and psychological impact on prisoners, which negate the rehabilitative purpose of punishment."

Understandably, community reintegration is not on the immediate horizon for those Lifers who are still at the early stages of their sentence. Most Lifers will serve a significant period of their sentence in prison and will remain under supervision for their lifetime; that is, if they are supported for parole at all. Over the last two decades, Lifers (excluding Dangerous Offenders) have accounted for 2.7% of all releases, despite representing 20% of the entire federal custodial population within the same period.[101]

While limiting a person's chances of release, an indeterminate sentence alone should have little bearing on eligibility for lower security classification, so long as they meet the threshold set by section 18 of the *Corrections and Conditional Release Regulations*. Namely, the classification of minimum, medium, or maximum security is applied based on the degree to which the person being assessed:

[98] MacKay, R. (2010 March 5). *Legislative summary of Bill C-54: An Act to amend the Criminal Code and to make consequential amendments to the National Defence Act (Protecting Canadians by Ending Sentence Discounts for Multiple Murders Act).* Library of Parliament: Legal and Legislative Affairs Division.

[99] See, van Zyl Smit, D., & Appleton, C. (2019). *Life Imprisonment: A Global Human Rights Analysis.* Harvard University Press. In Canada, those sentenced under section 745 of the *Criminal Code* for first-degree murder must serve a 25-year sentence before eligibility for parole. In comparison, though the minimum period of parole ineligibility varies by state/territory, the average in Australia falls around 22 years; England & Wales = 15 years; New Zealand = 10 years; Ireland = 12 years.

[100] Office of the Correctional Investigator (OCI). (2019). *Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody.*

[101] Data obtained by the OCI from CSC's Data Warehouse.

a) presents a **probability of escape** and **risk to the safety of the public** in the event of escape; or,

b) **requires supervision and control** within the penitentiary (i.e., "institutional adjustment").

Of course, there are additional constraints as determined by law to accessing parole and temporary absences[102] and most lifers will begin their sentence serving a minimum of two years in maximum security (see text box on the "Two-Year Rule", below). Section 28 of the *Corrections and Conditional Release Act* (CCRA) is also triggered in security classification and placement decisions and requires that CSC take "all reasonable steps to ensure that the penitentiary in which they are confined is one that provides them with the least restrictive environment." This is accomplished by balancing safety and security concerns (section 28[a]) with access to supports, culture, and language, as well as the availability of programs and services.

POLICY BULLETIN 107 AND THE TWO-YEAR RULE

In the late 1990s, following media coverage of certain high-profile cases, political direction was given that any offender convicted of first- or second-degree murder in Canada should serve the first two years of their sentence in a maximum-security institution. CSC responded by adjusting the Custody Rating Scale so that classification at intake would essentially align with government direction. On February 23, 2001, CSC published *Policy Bulletin 107*, which stated the following:

> Since first and second degree murder are the most serious crimes that can be committed in Canada, and are subject to the most severe penalty in the Criminal Code, CSC's policies and procedures must more clearly reinforce this aspect of our criminal justice system. Consequently, **offenders serving a minimum life sentence for first or second degree murder will be classified as maximum security for at least the first two years of federal incarceration**, which is congruent with the reasons for sentencing. During the first two years, CSC will have the opportunity to observe the behaviour and adaptation of these offenders at the beginning of the sentence and ensure that these offenders demonstrate the behaviour and motivation required to justify a reduction in security classification. [*Bolding our own*].

This policy came to be known as the "Two-Year Rule." The Office has often expressed concern with this policy, which we regard as a one-size-fits-all approach that does not adhere to the principles of individualized risk assessment and classification outlined in the *Corrections and Conditional Release Regulations*.

Policy Bulletin 107 has since been revoked. However, though no longer a formal policy, it appears that the "two-year rule" is maintained in practice through the lingering effects of this policy and CSC's security classification and placement framework. The classification score one receives by

[102] See section 746.1 of *Criminal Code*.

virtue of committing a murder, for example, is enough to ensure placement in maximum security. Irrespective of risk, section 7 of CD 710-6: *Review of inmate security classification*, requires a security classification review to be "completed at least once every two years for inmates classified at maximum or medium security." In addition, section 1 of CD 705-7: *Security Classification and Penitentiary Placement* states, "initial classification to other than maximum security, for an inmate serving a life sentence" requires a final decision by the Assistant Commissioner for Correctional Operations and Programs. Policy and practice imply that placing a *Lifer* in "max" upon admission is the rule, not the exception.

Of course, there are other forces at play that affect security classification and placement decisions beyond CSC's legislative and regulatory obligations or policy guidelines. There is a belief among some, or perhaps a general assumption, that prisons should *deliver* punishment. This view fails to recognize that imprisonment *itself* is the punishment prescribed for certain offences. Courts mete out punishment by depriving liberty through imprisonment. The severity of the punishment is tailored "by selecting the amount of time in which liberty will be deprived."[103] When sentencing people to prison, courts rarely if ever consider the conditions or quality of custody[104]; the criminogenic impacts[105] of incarceration; or the inherent economic[106] and social costs.

The challenge also lies in both the perceived and actual public safety risks posed by individuals with indeterminate sentences. Security reclassification and the reintegration of life-sentenced individuals carry political risk, resulting in little pushback against these views and therefore contribute to Lifers languishing at higher security levels, seemingly to serve punitive or retributive ends.

Human rights standards, however, require fairness and proportionality in decision-making. In practice this means that, *all else being equal*, Lifers should experience the same correctional outcomes as other federal prisoners for progress made along their Correctional Plan.

[103] Kerr, L. (2019). *How the prison is a black box in punishment theory.* University of Toronto Law Journal, 69:1, 85-116.

[104] *Ibid*, though in paragraphs 135 to 136 of *R.* v. *Hills* (2023 SCC 2), Justice Martin argues: "Courts should consider the effect of a sentence on the *particular* offender. [...] where the impact of imprisonment is greater on a particular offender, a reduction in sentence may be appropriate."

[105] Decades of criminological literature, much of it grounded in Canadian research, has found imprisonment itself to increase the likelihood of reoffending: See, for example, Cullen, F. T., Jonson, C. L., & Nagin, D. S. (2011). *Prisons do not reduce recidivism: The high cost of ignoring science.*; Gaes, G. G., & Camp, S. D. (2009). *Unintended consequences: Experimental evidence for the criminogenic effect of prison security level placement on post-release recidivism.* Journal of Experimental Criminology, 5(2), 139-162; and, Gendreau, P., Cullen, F. T., & Goggin, C. (1999). *The effects of prison sentences on recidivism* (pp. 4-5). Ottawa, Ontario: Solicitor General Canada.

[106] See, Office of the Parliamentary Budget Officer. (2018 March 22). *Update on Costs of Incarceration*, which shows that the estimated cost per offender increases with security level.

"At its heart is the idea that recognition of the human dignity of all offenders requires that, no matter what they have done, they should be given the opportunity to rehabilitate themselves. Rehabilitation is not possible without the prospect of release. Prisoners need to be able to retain some hope for a better future."

- Dirk van Zyl Smit, *Life imprisonment and the right to hope* (July 24, 2013)

Thematic Findings

The current investigation revealed several serious issues with case management and sentence planning. Though some of these do not apply exclusively to Lifers, their effects are compounded by lengthier sentences and a higher threshold of public scrutiny.

A Biased Security Reclassification Scale (SRS) and Inadequate Assessments of Risk

"Feels like the SRS is the driving force for too many decisions on security classification."

- *Lifer*

Security reclassification decisions for men are informed by an actuarial tool, the Security Reclassification Scale (SRS), in conjunction with the structured professional judgment of an individual's public safety risk, escape risk, and institutional adjustment. For the great majority of cases in our review (83%), we found reclassification decisions to align with the recommendations produced by the SRS. However, we also found that security reclassification assessments lacked a thoughtful accounting of risk and overlooked obvious biases built into the SRS that disadvantage Lifers.

THE SECURITY RECLASSIFICATION SCALE

The SRS for men is scored[107] on fifteen items: Serious and minor disciplinary offences, recorded incidents, pay grade, detention referral, Correctional Plan motivation and progress, drug and alcohol rating, successful Escorted or Unescorted Temporary Absences and work releases, age at review, psychological concerns, escape and incident history (based on Custody Rating Scale scores), and transfers to Structured Intervention Units. A nine-item tool, the SRS-W, is used for federally incarcerated women. The items on the SRS-W differ somewhat from the SRS and include factors validated specifically for women such as “Maintains regular positive family contact.”

An overall SRS score is calculated, providing a recommended security level rating or classification: Minimum (9.5 to 15.5), Medium (16 to 24), and Maximum (24.5 to 33). The security rating recommended by the SRS is considered along with other factors, such as Indigenous Social History, to prepare an overall Assessment. Currently, neither policy nor law require CSC to base their classifications on SRS scores alone. The SRS scores are subject to professional judgment, i.e., the SRS recommended score can be “overridden” and a different recommendation can be presented based on a comprehensive assessment of three ratings: Institutional Adjustment, Escape Risk, and Public Safety Risk.

Temporary Absences. An example of how the SRS systematically disadvantages Lifers is in its inclusion of temporary absences. In theory, temporary absences serve as an important correctional tool in the rehabilitative process, facilitating the safe and timely movement of sentenced individuals to lower security levels and, eventually, their release and reintegration. However, Lifers in medium-security facilities struggle to access temporary absences, undermining their ability to demonstrate readiness for lower security, directly impacting their SRS score. In our case review, we found that 66% (23 out of 35) had applied for ETAs, 15 of these were approved, but only four individuals completed an ETA.[108]

> **“I cannot recall the last time I wrote a report for an ETA.”**
>
> ***- CSC Staff Member***

At the same time, many staff reported an increased demand from decision-makers for successful Escorted Temporary Absences (ETAs) before supporting Lifers for minimum security. More precisely, decision-makers are citing the *lack* of successful ETAs to justify maintaining Lifers at higher security. However, staff often questioned this requirement, unconvinced that ETAs *actually* mitigate risk or help prepare individuals for lower security placements, despite insistence from decision makers as in the example below.

---

[107] See Annex C of Commissioner’s Directive 710-6: *Review of Inmate Security Classification* (in effect: 2018-01-15).

[108] On February 9, 2024, pursuant to section 172 of the CCRA, a request was sent to CSC for data on all absences (ETAs, UTAs, and Work Releases) from 2012-13 to 2023-24, disaggregated by sentence type and other variables. This data would have allowed the Office to assess the availability of and access to temporary absences for Lifers at medium-security institutions. Though multiple follow-ups occurred, no data was received at the time of writing.

█████ applied for a transfer to ██ MIN and was supported at the institutional level by ██ Institution ████ and ██ MIN. However, this case also requires support from Regional Headquarters (RHQ). In his final receommendation, Assistant Deputy Comissioner of Correctional Operations (ADCCO) █████ was not supportive of reclassification to minimum security for █████. As direction, the following was provided by the ADCCO, "While Mr. █████'s institutional conduct is deemed conformis and he has passed eligibility dates, his ability to manage his risk factors in a minimum security environment remains concerning. Pursuit of Escorted Temporary Absences (ETAs) or other means of demonstrating his ability to manage risk factors within new situations would assist in addressing concerns and demonstrate further progress in building credibility to support capacity for effective management in a less secure setting."

Screenshot from a case record where a regional Assistant Deputy Commissioner of Correctional Operations (ADCCO) refused to reclassify a Lifer to minimum-security, citing ETAs as a means of obtaining support.

Instead, ETAs have become "checklist items" that impede support for lower security reclassifications with little, if any, clear indication on how they address risk factors. In practice, ETAs can range from a drive around town to participation in community activities, though the latter is far less common.

> **"We did an escorted temporary absence where we drove a Lifer around the city for a tour and got lunch at a drive-thru to check off the personal development box."**
>
> ***- CSC Staff Member***

Staff also reported a dearth of ETA programs developed specifically for Lifers. They highlighted significant challenges with operational staff refusing to participate in or support Lifers for ETAs. At some sites, Correctional Officer II staff have outright delayed or refused to conduct temporary absence application reviews, which they are required to complete as per CD 710-3: *Temporary Absences*. The same staff are demanding that Lifers be escorted for ETAs rather than recommending non-security escorts, irrespective of whether they have conducted a comprehensive threat risk assessment. As a result, some Lifers are offered ETAs, but only if they agree to be escorted by armed officers while wearing shackles. This practice not only undermines the rehabilitative effects of temporary absences, but also triggers resistance from community partners who are uneasy with the sight of shackled prisoners flanked by officers carrying weapons.

Interviews also revealed a general lack of support for family contact ETAs from medium-security institutions. Staff were often unfamiliar with family contact ETAs or claimed that they "don't do those here." This, despite the well-established rehabilitative value of family contact, especially for Lifers who have been incarcerated for long periods.

> **"This jail doesn't support ETAs. I had one lined up for an appointment with children's aid with my daughter, which they requested, but my parole officer told me it could be done by phone."**
>
> ***- Lifer***

Correctional Plan Updates. The Correctional Plan (CP) Update plays a major role in the security reclassification review. However, it is common knowledge that CP updates for Lifers are rarely completed on a timely basis and do not always reflect the actual progress a person has made. Yet, security reclassification reviews, including the SRS scale, refer to progress made against the Correctional Plan to inform decision-making. As of February 18, 2024, individuals with determinate sentences had their CP updated two to three times more recently than those with indeterminate sentences.[109]

As Table 1 illustrates, individuals with Life-Min sentences are waiting longer than all others for CP updates, with one quarter waiting between 2 and 5 years and 7% (*n* = 198) waiting between 5 to 13 years.

TABLE 1: FEDERAL PRISONERS BY PERIOD SINCE LAST CP UPDATE WAS COMPLETED AND SENTENCE TYPE

	DETERMINATE		INDET. OTHER		LIFE-MIN	
Period since last CP update	**#**	**%**	**#**	**%**	**#**	**%**
Less than or equal to 2 years	8,379	95%	560	81%	1,859	68%
More than 2 and less than 5 years	439	5%	125	18%	697	25%
More than 5 and less than 8 years	20	0%	5	1%	143	5%
More than 8 and less than 10 years	1	0%	1	0%	30	1%
More than 10 years	0	0%	1	0%	25	1%
TOTAL	**8,839**	**100%**	**692**	**100%**	**2,754**	**100%**

Source: CSC's Data Warehouse.
Note: Does not include 335 Correctional Plan Updates triggered by transfers to Structured Intervention Units.

[109] CSC's Data Warehouse.

Given these timeframes, security reclassification reviews are therefore often based on outdated events and assessments that overshadow recent progress made by Lifers. While CSC acknowledged this issue in a Case Management Bulletin[110] dated, February 26, 2024, reminding staff that "...the Correctional Plan will identify the objectives and significant events for the offender to gain support for reduced security classification," its implementation remains challenging.

Delayed Correctional Plan Updates have been attributed to human resource issues and caseloads. During interviews, staff expressed feeling overwhelmed at having to deal with high caseloads and staff turnover, interfering with their ability to meet with incarcerated persons, especially Lifers.

> **"We do not have time to review extensive Lifer files and then we struggle to have time to set and manage objectives. No one can get a good grasp on their cases."**
>
> ***- CSC Staff Member***

Fence at Mountain Institution

Escape Risk. The assessment of escape risk is another important component of security reclassification reviews. Our case review showed a high degree of subjectivity in escape risk assessments. For example, those deemed "moderate" in their escape risk (almost half of the cases) often had the line, "would escape if provided the opportunity" included as justification. Although this wording is found in policy, it is essentially being copied and pasted into security reclassification reviews, and then used as a reason to forgo any further assessment. We also found the use of day parole eligibility dates to justify the conclusion of a higher escape risk, the logic being that the further a person is from day parole eligibility the more likely they are to consider and/or attempt an escape. Neither of these justifications drew from actual indicators of risk. Indeed, the more we examined the relationship between escape history and the assessment of escape risk, the more arbitrary the assessments appeared.

The security reclassification review must also consider whether the incarcerated person is at *low* to *no* risk to the public. In many cases, Lifers were maintained at "higher risk to the public" primarily due to their indeterminate sentence and a dated Correctional Plan.

[110] See, CD 705-6: *Correctional Planning and Criminal Profile.*

Though engaged with programming and making progress on their Correctional Plans, many Lifers remain in medium security for longer periods because of poorly prepared risk assessments that exaggerate the risk of escape and reoffending. During interviews, OCI investigators heard that this is partially a consequence of national guidelines on security reclassification. The emphasis is placed on demonstrating an *absence* of risk rather than on developing strategies to effectively mitigate risk for Lifers.

"The risk doesn't change... rather, it's about the mitigation strategies you develop that will determine if risk is 'manageable'."

- CSC Staff Member

"We need to look at how we do risk management and how to move away from a culture of being so risk-averse."

- CSC Staff Member

Psychological Risk Assessments. In addition to the issues presented in this section, our Investigators were also made aware of significant delays related to transfer decisions to minimum security for those requiring psychological risk assessments (PRAs). Over the course of the last year, the Office has heard about the impact of PRA delays on transfer and release-related decisions. During interviews with staff and Lifers, virtually all expressed major concerns with PRA timeliness; namely, that delays impact the incarcerated person's right to timely decisions. OCI staff were told that these delays stemmed from staff shortages; however, many noted that policy changes, such as the requirement for PRAs before approving minimum-security transfers in certain cases,[111] have exacerbated the issue.

"I have been running in circles with COVID delays and PRA delays so much so that it has been four years since my original application."

- Lifer

[111] See Interim Policy Bulletin 642 (December 19, 2019), which states: "A psychological risk assessment, completed within the past two years, is required in the case of any inmate supported by their case management team for a minimum security classification in the following instances: 1. The inmate has a dangerous offender designation; or 2. The inmate has been convicted of a sex-related offence (current sentence); or 3. The inmate meets the following three criteria: had an initial rating of maximum on the Custody Rating Scale; and is serving a sentence for an offence causing death or serious harm; and has three years or more before their day parole eligibility date.

Subject to Unreasonable Behavioural Expectations

It is not uncommon to encounter situations in federal corrections where non-compliant, assertive, and outspoken individuals are penalized simply for "being difficult" or confrontational with staff. This was captured on record in a recent PBC decision, where the Board shared the following in their assessment of the Lifer under review for day parole:

> "Another area of diverging opinions on file, and discussed at your hearing, relates to your level of collaboration and cooperation with your CMT. In the latter's opinion, there are issues in these areas that require improvements to move your case forward. At your hearing, you and other participants spoke to the issue of character interpretation. Your assertiveness, passion and tendency to question certain decisions may have been interpreted as a lack of willingness to work closely with your CMT."

This speaks to an unreasonable threshold of expected behaviours required by CSC staff. Having an abrasive or assertive personality does not equate to risk or criminality and should not be used against incarcerated persons in the administration of sentences. CSC's purpose is to prepare "law-abiding" citizens, not outstanding ones. However, compliance with unreasonable behavioural standards is precisely what is expected of federal Lifers.

"They're looking for perfection in Lifers."

- CSC Staff Member

Our case review revealed many instances of Lifers described as opinionated or outspoken. Some of these individuals were actively involved in the grievance process, litigation against CSC, or were vocal with their CMT about how their case should be managed. These same CMTs tended to provide commentary on personality traits, such as describing them as arrogant, hostile, or selfish, and relating these characteristics back to their risk. Two examples are provided below.

Furthermore, some CMTs interpreted any involvement in litigation or grievances against CSC as indicative of higher risk. This is, in fact, a common deterrent for many incarcerated people seeking recourse through these mechanisms. In contrast, there was one exception in our case review where a staff member noted a particular Lifer's unpleasant personality traits, acknowledged them, and then explained that these were not subject to intervention.

EXAMPLE 1.

Present CMT have been witness to Mr. [redacted]'s arrogance, as he is not transparent with his CMT and makes decisions surrounding his case without their input. He does not heed the advice of his CMT and continues to do things in a fashion that is contrary to the direction provided to him. Working collaboratively with Mr. [redacted] is trying, which does not inspire confidence for a successful reintegration at this point in his sentence.

Mr. [redacted] needs to be right on all occassions and makes comments such as, "I remember every conversation verbatim," to this writer in an attempt to influence and control.

EXAMPLE 2.

que son côté revendicateur ainsi que l'importance qu'il accorde à son entourage, soit deux facteurs contributifs, ont fait l'object d'une certaine réflexion.

Two screenshots of case records (one in English and one in French) showing CMT commentary on difficult personality traits and behaviours, and how these are related back to risk.

Inadequate Integration of "Four Phases of a Life Sentences" into Correctional Plans

According to CD 705-6: *Correctional Planning and Criminal Profile* (in effect: April 15, 2019), sentence planning for individuals serving sentences of 10 years to life "will include the four phases [of a long-term sentence]." This model is an attenuated version of the LifeLine Program (see text box, below), implemented in 1991 to support "offenders who are serving life or indeterminate sentences."[112] The four phases have not changed since being first introduced by the Task Force Report on Long-Term Sentences in 1991.[113] They are as follows:

1. **Adaptation:** Coming to terms with the reality of confinement.
2. **Integration to the prison environment:** Living within the context of that reality.
3. **Preparation for release:** Preparing for release in a progressive manner. This can include consideration for placement or transfer to an institution without a secure and directly controlled perimeter.
4. **Reintegration into the community:** Assuring a coherent and continuous process leading to safe reintegration. This can include consideration for placement or transfer to an institution without a secure and directly controlled perimeter, assuring a coherent and continuous process leading to safe reintegration.

As per section 44 of CD 705-6, "offenders classified as medium security must be in the 'preparation for release' or 'reintegration to the community' phase to be eligible for placement in, or transfer to, an environment without a secure and directly controlled perimeter …" (i.e., minimum security). There is little else written into policy to guide the integration of the *four phases* into case management and sentence planning. This absence of policy direction was apparent in our case review.

[112] CSC. (2009, December). *Evaluation Report: LifeLine Program.* Evaluation Branch, Policy Sector.

[113] In its 2016-17 response to a recommendation from our Office, CSC stated that it was "committed to addressing the unique needs of offenders serving a life sentence and offering targeted programs that provide appropriate support for all offenders as they work towards their rehabilitation." It would do this through its Lifer Resource Strategy (LRS), which CSC reported was "available in all institutions." As of April 16, 2024, the webpage on CSC's internal Hub dedicated to the LRS includes the following note: "the LifeLine Program is no longer delivered to offenders in CSC. The information provided here is for resource purposes only. It was written for staff working with offenders with indeterminate sentences." On February 9, 2024, pursuant to section 172 of the CCRA, a request was sent to CSC for "Any materials … pertaining to [CSC's] 'National Lifer Strategy' being led by the Offender Programs and Reintegration Branch." At the time of writing, no response had been received.

EVOLUTION OF THE LIFELINE PROGRAM

- LifeLine was implemented in 1991. LifeLine was a national program providing in-reach peer support to individuals sentenced to life or indeterminate periods of incarceration (i.e., Lifers).
- The Lifer Resource Strategy (LRS) was developed in 2010 in collaboration with experts (St. Leonard's House Windsor, Canadian Training Institution, and Maison Cross Roads) and people serving life sentences, as a tool to assist In-Reach Workers with providing support at each stage of a life sentence.
- The LRS was redesigned in 2019 and includes 11 modules that are tailored to each of the four stages of a life sentence. St. Leonard's Society of Canada owns the rights to the Lifer Resource Strategy.
- In 2012, LifeLine was officially cancelled. In response, several community stakeholders formed a partnership and established the PeerLife Collaborative (PLC).
- PeerLife now seeks to provide specialized, supportive services – including the delivery of the LRS – to life-sentenced individuals in Ontario institutions. It does this through experienced peer In-Reach Workers.
- PeerLife currently has a four-year contract with CSC to deliver the LRS to Lifers in the Ontario region. The contract includes a specialized focus on women, Indigenous, and Ethnocultural Lifers.

> **"I believe there is very strong importance to have programming being delivered by experts in the community who are separate and objective from CSC. It's not that CSC's programs are ineffective *per se* — they serve a purpose — but I feel they are more meaningfully delivered and received by individuals inside when there is not a report that is going to be written afterwards or it's not going to be held against them."**
>
> ***- Catherine Brooke, Executive Director (St. Leonard's House Windsor)***
> From appearance before the Standing Senate Committee on Human Rights, March 18, 2024.

Of the Lifer cases included in our review, 51% included no mention of the *four phases* in their documentation. For the remaining, little more than a third included the *four phases*, but our analysis found them wholly inadequate. For the most part, the only mention of the four phases was a copy and paste of policy. Moreover, these cases displayed a lack of individualized assessment and analysis to identify the person's current stage and what actions were being taken to help them progress to the next.

There is currently no CSC training or guidelines to assist parole officers with sentence planning for Lifers. Most were unfamiliar with the above-mentioned policy and others admitted to simply cutting and pasting the information from previous Correctional Plans. Instead of offering a comprehensive assessment with an informed sentence plan, the Correctional Plan often presents a series of statements and opinions with limited supporting evidence, concluding with a list of

behaviours to avoid and other extraneous tasks: incident free for x number of months, no substance use, must adjust well, complete programs, comply with CMT directives, show remorse, and so forth.

Compounding this issue, Lifers find themselves adrift in their reintegration plans, lacking clarity on their trajectory. While they are asked to revisit their offences and dwell on the past, they are not provided with clear guidance on their future path and the steps they are expected to take to progress towards a timely and successful release.

> **"[There are no] reintegration plans; rather, [there is a] list of things for Lifers to do to get support for minimum from decision makers."**
>
> ***- CSC Staff Member***

Overprogramming and Inappropriate Use of Correctional Interventions

Virtually all the lifers in our review were assessed as "engaged" with their Correctional Plans. At the time of writing, we found that the lifers in our review had completed an average of four correctional programs each, virtually all were consistently employed, over 80% completed or were in school, and more than a quarter were enrolled in post-secondary studies.

> **"I have applied to minimum. They keep telling me it's too early. I was told I would not be supported for anything until 15 years into my sentence. Yet, I have completed my core program, I am working, and engaged in my Correctional Plan."**
>
> ***- Lifer***

Maintenance Programs. While core programs teach skills that aim to address problem behaviours, "maintenance programs" reinforce these through scenario-based learning. The intent is to observe skills learned in programming applied to real-life situations.[114] When speaking with program staff, many emphasized that the maintenance program does not focus on skill development; rather, it provides an opportunity to put self-management skills into practice.

> **"People don't have a good understanding of the purpose of maintenance, there is some over-programming for sure."**
>
> ***- CSC Staff Member***

[114] According to CSC's internal Hub webpage, titled, *Correctional programs for men* (retrieved on March 26, 2024): "The maintenance programs are offered in the institution and the community … They are for moderate or high-risk offenders who have completed an (ICPM) program. The main goal of these programs is to manage the risk of reoffending by providing follow-up to main programs. Offenders review core self-management skills and apply them to real-life situations."

Nonetheless, while the maintenance program is not mandatory for transitioning to lower security facilities, it has become a "checklist item" for decision-makers in determining support for minimum-security transfers, posing an additional hurdle for Lifers. Our review revealed that Case Management Teams (CMTs) made several requests for maintenance programming as a condition for supporting transfers to minimum-security facilities, even though the individuals in question had previously completed the program successfully. This was often the case where the individual took the program earlier in their sentence, so the CMT requested additional maintenance closer to day parole eligibility to show progress against the Correctional Plan.

A lack of recent participation in the maintenance program should not, in and of itself, be used as a reason to deny support for minimum security. In fact, some argued that maintenance programs were best delivered *in* the minimum-security environment:

> **"Lifers are better served participating in the maintenance program at minimum … as it provides extra support in a less restrictive environment."**
>
> ***- CSC Staff Member***

The challenge for many Lifers is to demonstrate to their CMT that, after 10 to 20 years of incarceration, they have maintained engagement and progress against their Correctional Plan. To elicit support from decision-makers and to demonstrate progress and engagement, Lifers are referred to maintenance programming. However, even after participating in maintenance programming (sometimes for a second or third time), some still fail to obtain support for minimum security since programming is not the only factor being assessed by decision-makers. For example, there are limited interventions available to incarcerated persons, let alone Lifers, at medium-security institutions to address risk factors related to substance abuse, mental health, and trauma. Consequently, case management teams are reluctant to assess risk as "zero" or "low" if substance abuse is an identified risk factor.

> **"How can we assist someone to rehabilitate when the individual is surrounded by drugs and does not have supportive interventions to address these issues?"**
>
> ***- CSC Staff Member***

Indigenous Lifers in Pathways. The Pathways Initiative[115] is sometimes recommended to Indigenous Lifers as a means of garnering support for minimum security. More than a third of the Lifers in our case review were Indigenous and almost *all* were assigned to Pathways, yet very few were supported for minimum. Pathways is rarely of benefit to Lifers wishing to cascade to minimum security. Unless they are nearing parole eligibility, Lifers are spending lengthy periods in Pathways and are rarely considered for reclassification to minimum security. This, even though Indigenous Lifers are often more intrinsically motivated to better themselves through a traditional healing path.[116] As one Pathways staff put it during our investigation for the 2022-23 Annual Report:

[115] The Pathways Initiative is one of CSC's signature Indigenous interventions. It is an Elder-driven initiative that facilitates the provision of intensive programs, interventions, and other activities for individuals following a "Healing Plan." As reported in last year's Annual Report, it is the Office's position that, "Indigenous individuals who meet the criteria for admittance into Pathways do not really need to be kept in penitentiaries at all, and could likely do just as well pursuing their healing path in a community-based Healing Lodge."

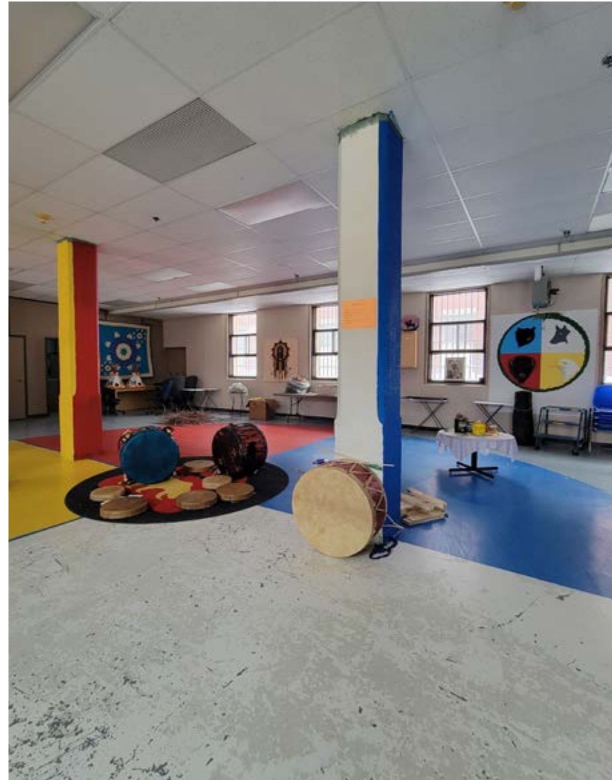
[116] See the OCI's 2022-23 investigation into CSC's Pathway's Initiative in the 2022-23 Annual Report.

"A Lifer who just came to medium should not be on Pathways for six years – not appropriate to do this program for years at a time. The six-month review is redundant for Lifers. When I do reviews for these guys [Lifers] I hardly change anything, unless they've completed programs. They are not getting reclassified."

During interviews, our investigators learned that Pathways is offered to certain Lifers as a means of keeping them engaged and motivated. Therefore, many individuals with distant day parole eligibility dates are placed in Pathways with no prospect of being supported for minimum-security in the short term. Like programming, Pathways has become another "checklist item." However, without an upcoming day parole eligibility date or recent participation in a maintenance program, they are unlikely to be supported.

"Unfortunately, it seems that there are a lot of barriers and opinions on each case and that prevent Lifers from moving forward. In my view, many Lifers seem ready to move to minimum."

- Elder



Pathways cultural space at Saskatchewan Penitentiary

Moreover, for those included in our case review, we found the documentation of progress in Correctional Plan updates specific to their Pathways participation to be wanting. Further, participation in Pathways was usually highlighted if the CMT had already supported a reclassification to minimum. In many cases, however, the progress made in Pathways was hardly considered in the overall assessment of risk.

Similarly, less than half of the Indigenous Lifers in our case review had their Indigenous Social History (ISH) adequately documented. For the remainder, the consideration of ISH factors was superficial and not individualized to lived experiences. Only in one example did we find a documented consideration of ISH, applied thoughtfully to every risk factor in their assessment.

Languishing in Medium-Security Well Past Parole Eligibility Dates

> **"Medium is the place where lifers get caught in the strainer."**
>
> ***- CSC Staff Member***

As of May 2024, those Lifers in our case review had resided in medium security for an average of 11 years, and 66% were past their Day Parole eligibility dates by an average of 13 years.

These statistics triggered a more comprehensive examination of the Lifer population. What we found was troubling. In total, 8,591 (63%) of federal prisoners are past their Day Parole eligibility date (DPED). Of those, 6,632 (or 49% of all federal prisoners) are also past their Full Parole eligibility date (FPED). For those with indeterminate sentences, 59% are past their DPED (49% for Life-Min) and 49% are past their FPED (39% for Life-Min). These percentages should be considered against the length of life sentences in Canada. An analysis of the available data suggests that Lifers can expect to serve anywhere between 11 (for those serving a minimum of 10 years), and 31 (for those serving 25) years before reaching minimum-security.[117]

A Living Unit, La Macaza Institution

[117] This is based on data acquired from CSC's Data Warehouse (as of February 18, 2024). Individuals with Life-Min sentences at minimum-security institutions who are also past their DPEDs are, on average, between 4 and 9 years past their DPEDs. For an explanation of sentence calculation, see: Public Safety Canada (2021). *Sentence calculation: Fast Facts – Offender serving a life sentence for 1st degree murder*. National Office for Victims of Crime; and Public Safety Canada (2021). *Sentence calculation: Fast Facts – Offender serving an indeterminate sentence*. National Office for Victims of Crime.

Further, Lifers and staff reported to OCI Investigators that it is easier to meet the threshold for day parole than to transfer to minimum security. There is an opportunity here for CSC to learn from the Parole Board in how to assess risk manageability, and then to incorporate these learnings into security reclassification reviews.

Inversely, we heard that it's easier to "send a Lifer back to medium" than to find support for minimum. Despite the insurmountable obstacles that a Lifer must overcome to be supported and transferred to minimum, the threshold to reclassify a Lifer to medium security is low. Often one event will trigger an involuntary transfer back to medium without consideration of mitigation strategies that could maintain them in minimum security. This might explain why so many Lifers refuse to even consider minimum security and aim for Day Parole instead. There is a popular belief among the life-sentenced population that the Parole Board's expectations are more realistic and attainable.

> **"I see people being sent back to medium for smoking a cigarette after working so hard to get to minimum".**
>
> ***- CSC Staff Member***

Conclusion

As has been shown through this investigation, the inherent bias in the Security Reclassification Scale (SRS) and poorly prepared risk assessments pose systemic barriers for Lifers during their security reclassification review. This is further exacerbated by inadequate sentence management and planning. The cumulative effect of these shortcomings in policy and practice is that Lifers are kept at higher security levels for longer periods with no clear rehabilitative or reintegrative purpose. Rather than requiring staff to satisfy long and arbitrary "checklists", the Correctional Service of Canada should be developing risk mitigation strategies to support Lifers in their eventual reintegration. Too often, in order to appease public outcry and scrutiny, national direction and operational decisions are made in light of a small number of high-profile cases that thwart the reintegration process for a great many others. We acknowledge that supporting the reintegration of Lifers can carry political risk; however, arbitrarily maintaining individuals at higher security levels is unlawful and contributes little, if anything, to the public safety of Canadians.

Recommendations

23. I recommend that CSC review and revise security reclassification processes to:

   a. provide additional support to staff in preparing risk assessments and recommendations; and,

   b. ensure a thorough and mandated review of decisions that would reclassify Lifers from minimum to medium security. These decisions should require an exhaustive consideration and actioning of risk mitigation strategies.

24. I recommend that CSC review its policies around Correctional Plan Updates with the aim to:

   a. reduce delays in completing updates for Lifers; and,

   b. discontinue the imposition of unreasonable behavioural expectations.

25. I recommend that CSC review its Sentence Planning process and provide support to staff in developing individualized sentence plans for Lifers.

26. I recommend that CSC draw on the experience and expertise of national voluntary organizations, such as the St. Leonard's Society of Canada and the PeerLife Collaborative, to provide support to federal Lifers from intake to community release. Further, these organizations should be supported by:

a. providing a significant increase in funding and access commensurate with their identified needs;

b. involving them in ongoing discussions, planning, projects, and strategies pertaining to the life-sentenced population; and,

c. supporting their efforts to provide peer support and opportunities for gang disaffiliation within federal prisons.

27. I recommend that CSC review the requirement for Psychological Risk Assessments for individuals seeking transfers to minimum security, with the aim to reduce delays that impede timely decision-making.

28. I recommend that CSC's *National Lifer Strategy:*

a. explicitly acknowledge and integrate the findings of this investigation;

b. be national in scope and responsive to the experiences of Lifers at all security levels;

c. draw from consultations with incarcerated Lifers, the staff directly involved in Lifer case management, and external stakeholders; and,

d. be made public with specific timelines for how CSC plans to address the concerns raised in this investigation, along with other concerns identified through consultations.

Appendix

Life-Min Population: Profile and Location Statistics

The representation of Indigenous individuals with Life-Min sentences is lower than for the total prisoner population (29.4% compared to 33.1%); however, Black prisoners have a greater representation among those sentenced to Life-Min (12.2% compared to 9.7% of all federal prisoners). Women make up a slightly smaller proportion of those with Life-Min sentences (4.6%) compared to their representation within the total prisoner population (5.6%). In age, those with Life-Min sentences tend to be older (47.9 years compared to 41.8 years for all federal prisoners), owing perhaps to their longer sentences and lengthier periods of parole ineligibility.

TABLE A: FEDERAL PRISONER PROFILE BY SENTENCE TYPE (SNAPSHOT, FEBRUARY 19, 2024)

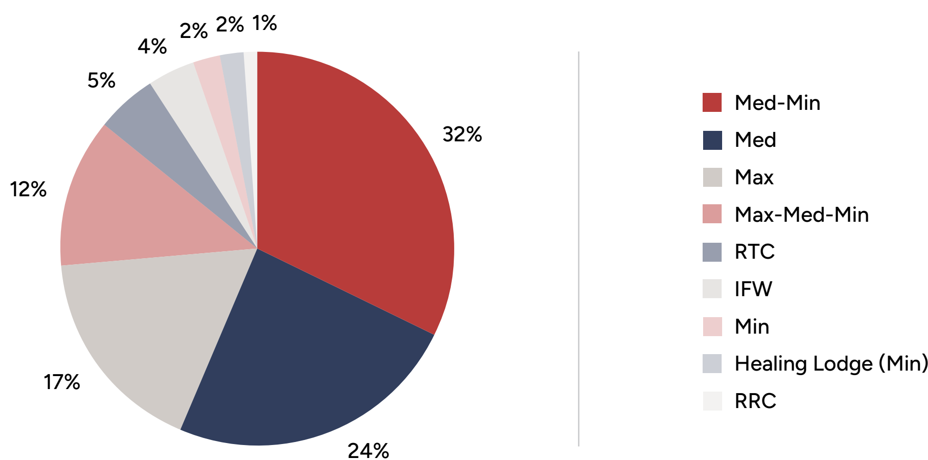
	DETERMINATE		INDETERMINATE		LIFE-MIN		TOTAL IN-CUSTODY	
	#	(%)	#	(%)	#	(%)	#	(%)
TOTAL	**10,022**	**(100.0)**	**3,599**	**(100.0)**	**2,874**	**(100.0)**	**13,621**	**(100.0)**
Gender								
Female	622	(6.2)	139	(3.9)	131	(4.6)	761	(5.6)
Male	9,398	(93.8)	3,460	(96.1)	2,743	(95.4)	12,858	(94.4)
Intersex	2	(0.0)	-	-	-	-	2	(0.0)
Ethnicity								
White	4,514	(45.0)	1,737	(48.3)	1,367	(47.6)	6,251	(45.9)
Indigenous	3,413	(34.1)	1,096	(30.5)	844	(29.4)	4,509	(33.1)
Black	907	(9.1)	418	(11.6)	350	(12.2)	1,325	(9.7)
Other	1,188	(11.9)	348	(9.7)	313	(10.9)	1,536	(11.3)
Average Age	39.0 years		49.4 years		47.9 years		41.8 years	
Security Level								
Max	1,131	(11.3)	751	(20.9)	654	(22.8)	1,882	(13.8)
Med	5,831	(58.2)	2,117	(58.8)	1,584	(55.0)	7,948	(58.4)
Min	1,826	(18.2)	687	(19.1)	601	(20.9)	2,513	(18.4)
Missing	1,234	(12.3)	44	(1.2)	37	(1.3)	1,278	(9.4)

	DETERMINATE		INDETERMINATE		LIFE-MIN		TOTAL IN-CUSTODY	
Region								
ATL	1,035	(10.3)	258	(7.2)	219	(7.6)	1,293	(9.5)
QUE	2,149	(21.4)	772	(21.5)	636	(22.1)	2,921	(21.4)
ONT	2,729	(27.2)	1,099	(30.5)	849	(29.5)	3,828	(28.1)
PRA	3,241	(32.3)	682	(18.9)	549	(19.1)	3,923	(28.8)
PAC	868	(8.7)	788	(21.9)	621	(21.6)	1,656	(12.2)
Past DPED	6,342	(63.3)	2,111	(58.7)	1,418	(49.3)	8,453	(62.1)
Past FPED	4,753	(47.4)	1,759	(48.9)	1,112	(38.7)	6,512	(47.8)
Pay Level								
None	94	(0.9)	7	(0.2)	6	(0.2)	101	(0.7)
Allowance	2,422	(24.2)	436	(12.1)	342	(11.9)	2,858	(21.0)
Level D	649	(6.5)	307	(8.5)	233	(8.1)	956	(7.0)
Level C	5,645	(56.3)	1,375	(38.2)	1,105	(38.4)	7,020	(51.5)
Level B	1,079	(10.8)	1,026	(28.5)	821	(28.6)	2,105	(15.5)
Level A	133	(1.3)	448	(12.4)	367	(12.8)	581	(4.3)
Risk Level								
None	758	(7.6)	26	(0.7)	24	(0.8)	784	(5.8)
Low	375	(3.7)	42	(1.2)	41	(1.4)	417	(3.1)
Med	3,227	(32.2)	391	(10.9)	362	(12.6)	3,618	(26.6)
High	5,662	(56.5)	3,140	(87.2)	2,447	(85.1)	8,802	(64.6)
Need Level								
None	772	(7.7)	26	(0.7)	24	(0.8)	798	(5.9)
Low	187	(1.9)	86	(2.4)	77	(2.7)	273	(2.0)
Med	2,154	(21.5)	971	(27.0)	798	(27.8)	3,125	(22.9)
High	6,909	(68.9)	2,516	(69.9)	1,975	(68.7)	9,425	(69.2)
Accountability								
None	1,029	(10.3)	35	(1.0)	31	(1.1)	1,064	(7.8)
Low	1,859	(18.5)	1,017	(28.3)	780	(27.1)	2,876	(21.1)
Med	6,169	(61.6)	1,890	(52.5)	1,532	(53.3)	8,059	(59.2)
High	965	(9.6)	657	(18.3)	531	(18.5)	1,622	(11.9)

	DETERMINATE		INDETERMINATE		LIFE-MIN		TOTAL IN-CUSTODY	
Motivation								
None	805	(8.0)	29	(0.8)	27	(0.9)	834	(6.1)
Low	1,360	(15.0)	686	(19.1)	511	(17.9)	2,046	(16.1)
Med	6,033	(63.8)	1,972	(55.3)	1,600	(56.2)	8,005	(61.5)
High	1,225	(13.1)	873	(24.8)	701	(24.9)	2,098	(16.2)
Registration Level								
None	796	(7.9)	29	(0.8)	27	(0.9)	825	(6.1)
Low	3,949	(39.4)	2,379	(66.1)	1,799	(62.6)	6,328	(46.5)
Med	3,962	(39.5)	1,115	(31.0)	978	(34.0)	5,077	(37.3)
High	1,315	(13.1)	76	(2.1)	70	(2.4)	1,391	(10.2)

Individuals with Life-Min sentences are generally located at higher security institutions. As of February 18, 2024, 41% were kept at standalone maximum and medium-security institutions (see Graph A). Further, individuals with Life-Min sentences account for 20% of all prisoners at standalone medium-security and 34% of standalone maximum-security institutions.

GRAPH A. PERCENTAGE OF LIFE-MIN SENTENCED INDIVIDUALS BY FACILITY TYPE

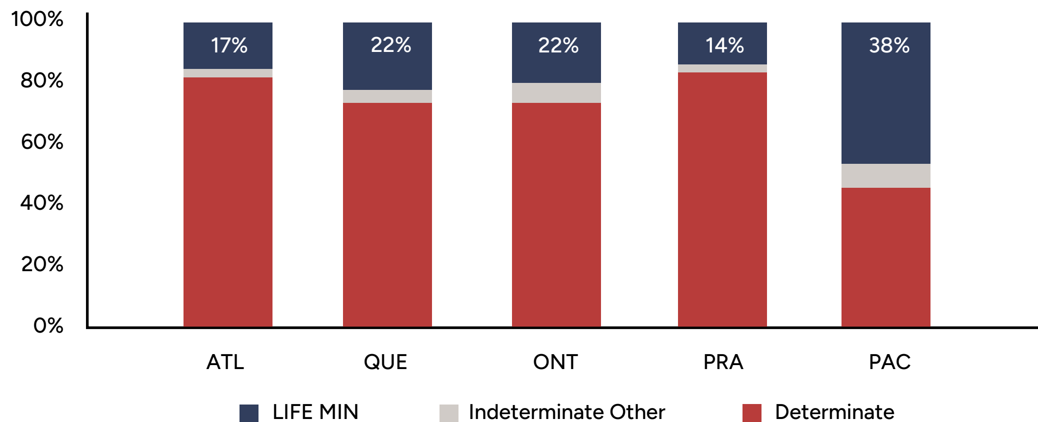


Note: A federal penitentiary may include more than one type of facility and security-type (e.g., Max-Med-Min). Facility types include: RTC = Regional Treatment Centre; RRC = Regional Reception Centre; and IFW = Institution for Women (all three security levels). Though a small number of individuals with indeterminate sentences reside at RTCs overall, they represent 51% of RTC prisoner-patients.

Thirty percent of individuals sentenced to Life-Min reside in the Ontario region, followed by Quebec (22%) and the Pacific region (22%), Prairies (19%), and Atlantic region (8%). Interestingly, despite the Pacific region accounting for 12% of the total custodial population, almost half of prisoners in that region are serving indeterminate sentences with 38% sentenced to Life-Min (see Graph 2).

A third of all individuals sentenced to Life-Min are held at just six federal prisons: Beaver Creek Institution (ONT; 7.5%), Mission Institution (PAC; 6.5%), Bath Institution (ONT; 5.0%); Collins Bay Institution (ONT; 4.9%); the Federal Training Centre (QUE; 4.8%); and Cowansville Institution (QUE; 4.8%).

GRAPH B. PERCENTAGE IN CUSTODY BY REGION AND SENTENCE TYPE



Correctional Investigator's Outlook for 2024-25

After celebrating and recognizing the Office's 50th anniversary, the past year was a time of change and renewal for my office. Looking forward, with the implementation of new funding underway, we have made improvements to how we approach all aspects of our work. As evidenced by the investigation into standalone maximum-security institutions, my office has and will continue to pursue and prioritize more comprehensive, teams-based, preventative inspections to inform and complement our thematic and systemic investigative work going forward.

In the coming year, my office will be focusing on issues related to mental health in federal corrections. Access to services, management of complex cases, balancing security concerns with effective and humane clinical practice, prevalence of mental health issues in corrections, alternatives to incarceration for seriously mentally ill individuals, among many other issues have been long-standing concerns for my office. As described earlier in this report, the investigation and findings of the Case Study into the death at the Ontario Regional Treatment Centre (RTC), revealed numerous structural, policy and practice-based deficiencies that provide significant impetus for a systemic-level review of these facilities. With involvement from external experts, we intend to conduct an in-depth investigation of the five RTCs, which serve as inpatient psychiatric hospitals.

My office will also report on other areas of concern, including the population pressures at federally sentenced women's sites. Furthermore, I will continue to monitor progress on prior government commitments to advance a prevalence study on sexual coercion and violence in federal prisons; conduct a five-year review of Structured Intervention Units; and, to implement new regulations on the use of dry cells and body scanners. I also look forward to being consulted on the results and actions stemming from CSC's first ever audit of its organizational culture.

On a personal and professional note, I also look forward to continuing my work as the Chair of the *Expert Network on External Prison Oversight and Human Rights* of the International Corrections and Prison Association (ICPA). This past year, I was honoured to have been selected as the recipient for the Head of Agency Award by the ICPA. This international recognition is testament to the rigour and reach of the Office's work. I look forward to continuing to bring this international network of ombuds together to exchange knowledge and best practices in the field of prison oversight, as we collectively strive to ever-improving how we uphold the principles of humane and lawful corrections.

Ed McIsaac Human Rights in Corrections Award

The Ed McIsaac Human Rights in Corrections Award was established in December 2008, in honour of Mr. Ed McIsaac, long-time Executive Director of the Office of the Correctional Investigator and strong promoter and defender of human rights in federal corrections. It commemorates outstanding achievement and commitments to improving corrections in Canada and protecting the human rights of incarcerated persons.

The 2023 recipient of the Ed McIsaac Human Rights in Corrections award was Susan Haines. Susan currently serves as the Executive Director for the National Associations Active in Criminal Justice, having a breadth of professional and volunteer experience in the correctional context, including community-based corrections. A strong advocate for human rights and social justice, Susan continues to play a long-standing role in supporting incarcerated persons and their families through initiatives such as the Millhaven Lifers Liaison Group and previously, the Infinity Lifers Liaison Group at Collins Bay Institution.

From left to right: Ed McIsaac, Susan Haines, and Dr. Ivan Zinger

ANNEX A: Summary of Recommendations

1. I recommend that the Service report publicly, in the next fiscal year, on concrete actions, deliverables, and timelines on how and when it will:

    a. acquire external, independent expertise to conduct empirical, primary research to assess the validity and reliability of *all* existing assessment and classification tools and methods used by CSC to inform decision-making with Indigenous offenders; and,

    b. develop new assessment and classification tools, Indigenous-led and from the ground up, for federally sentenced Indigenous peoples, that include culturally responsive and informed indicators of risk and need (i.e., Indigenous social history factors).

2. With respect to CSC's internal Complaints and Grievances process, I make three summary recommendations, to be phased and completed within the next fiscal year:

    a. First, CSC should conduct a principle-based review of the complaints and grievance process informed by the pillars of procedural justice – voice, respect, neutrality, trustworthiness. The views and experiences of incarcerated people should be taken into consideration throughout this review.

    b. Simultaneously, CSC should undertake a reallocation exercise to ensure proper and sustained focus, effort, and priority will be placed on resolving complaints and grievances informally, and at the lowest level possible. This could include reallocation of resources from national level redress to penitentiary-based resolution.

    c. Finally, CSC should make significant investments in mediation and alternative dispute resolution training and skills building for all staff with the goal of implementing these practices at all maximum-security and multi-level penitentiaries across Canada, including the five Regional Women and Treatment Centre facilities. ADR and mediation would be central and permanent features of a significantly updated and revised Commissioner's Directive 081.

3. I recommend that the Quality of Care Review process be subject to an independent audit chaired by an outside medical examiner.

4. I recommend that for determining the cause of death for the Quality of Care Review, CSC's Health Services Sector obtain independent and external verification or, when this is not possible, that all efforts to obtain independent and external verification be reported.

5. I recommend that CSC consult with the Parole Board of Canada and establish a data sharing and reporting framework to publish information on section 121 *Parole by Exception* applications as well as applications of any kind of release based on compassionate grounds. This data should be disaggregated by

the criteria listed under section 121 (1), regardless of whether the parole application is presented before or after an individual's eligibility dates.

6. **I recommend that assessments of release considerations in Quality of Care Reviews be conducted by CSC's Incident Investigations Branch, in collaboration with CSC's Health Service Sector. Such assessments should address the elements raised in the Office's 2014 public interest report and lead to the adoption of qualitative standards.**

7. **I recommend that CSC develop a National Population Management Strategy for Women, which includes:**

    a. **Expanded use of *Exchange of Service Agreements*, so women can serve their sentences closer to their home communities and social supports;**

    b. **Increased use of community-run Section 81 Healing Lodges and Section 84 agreements and releases;**

    c. **A comprehensive community release strategy for women and the reallocation of resources into the community; and,**

    d. **Increased allocation of resources dedicated to managing complex cases.**

8. **I recommend that CSC evaluate all the strategies put in place in response to its recommendations from the June 2021 EIM evaluation and publicize the measures it has taken in order to reduce the use of force; increase capacity to respond to incidents involving mental health and physical distress; and, ensure that violations of the law and/or policies do not go unchecked.**

9. **I recommend that CSC should immediately release the Independent Observer's evaluation of the impartiality, thoroughness, and professionalism of this National Board of Investigation.**

10. **I recommend that CSC prepare and release a Case Summary of the facts and findings of this NBOI including recommendations, learnings and corrective measures that have been implemented at RTC Millhaven to date.**

11. **I recommend that an independent and external mental health expert conduct a full compliance review of patient safety at RTC Millhaven.**

12. **I recommend that CSC evaluate the suitability and feasibility of installing in-cell vital sign remote monitoring technologies in all high(er)-risk placement areas of federal prisons, including Structured Intervention Units, Enhanced Observation (suicide watch) cells, Regional Treatment Centres and health care cells in mainstream penitentiaries.**

13. I recommend that CSC ensure security staff working in a Regional Treatment Centre be carefully recruited, suitably selected, properly trained and fully competent to carry out their duties in a secure psychiatric hospital environment.

14. I recommend expansion of alternatives to incarceration options and increased bed space to facilitate the transfer and placement of federally sentenced individuals who are suicidal, chronically self-injurious or severely mentally ill in external community psychiatric facilities.

15. I recommend that CSC devise and implement a national subpopulation management strategy by the end of the fiscal year, with the goal of safely and considerably reducing the number of subpopulations within maximum-security institutions.

16. I recommend that CSC ensure:

a. Institutional routines are established to allow all incarcerated persons, excluding those in SIU's, to have access to primary "large" yard spaces daily.

b. All living units at standalone maximum-security institutions are equipped with basic amenities and seating.

c. Policies related to institutional movement, including Standing Orders, be reviewed to ensure that they no longer limit individuals from engaging in their Correctional Plan.

17. I recommend that CSC develop a national policy surrounding complex SIU cases, which should include oversight and direction from the national level, to make SIU transfer processes more efficient and equitable.

18. I recommend that CSC increase availability of meaningful employment and apprenticeship opportunities at standalone maximum-security institutions, while mandating basic oversight of these jobs, to ensure that prisoners can occupy their time constructively.

19. I recommend that CSC provide consistent access to Indigenous services, programs and supports, including establishing and maintaining Pathways programs, at each of these institutions without delay.

20. I recommend that CSC assign dedicated Release Coordinators at each standalone maximum-security institution and bolster related policy to establishing clear responsibilities surrounding discharge planning.

21. I recommend that CSC develop policy establishing a minimum frequency of in-person contacts between Institutional Parole Officers and incarcerated persons on their caseloads. This policy should clearly outline expectations regarding what is to be addressed during these interactions and include additional language clarifying CX-02 involvement in a maximum-security setting.

22. I recommend that CSC establish a clear purpose statement for maximum-security institutions, against which its aims can be assessed to ensure that optimal outcomes are achieved and that prisoners' essential human rights and dignity are upheld.

23. I recommend that CSC review and revise security reclassification processes to:

- **a. provide additional support to staff in preparing risk assessments and recommendations; and,**
- **b. ensure a thorough and mandated review of decisions that would reclassify Lifers from minimum to medium security. These decisions should require an exhaustive consideration and actioning of risk mitigation strategies.**

24. I recommend that CSC review its policies around Correctional Plan Updates with the aim to:

- **a. reduce delays in completing updates for Lifers; and,**
- **b. discontinue the imposition of unreasonable behavioural expectations.**

25. I recommend that CSC review its Sentence Planning process and provide support to staff in developing individualized sentence plans for Lifers.

26. I recommend that CSC draw on the experience and expertise of national voluntary organizations, such as the St. Leonard's Society of Canada and the PeerLife Collaborative, to provide support to federal Lifers from intake to community release. Further, these organizations should be supported by:

- **a. providing a significant increase in funding and access commensurate with their identified needs;**
- **b. involving them in ongoing discussions, planning, projects, and strategies pertaining to the life-sentenced population; and,**
- **c. supporting their efforts to provide peer support and opportunities for gang disaffiliation within federal prisons.**

27. I recommend that CSC review the requirement for Psychological Risk Assessments for individuals seeking transfers to minimum security, with the aim to reduce delays that impede timely decision-making.

28. I recommend that CSC's *National Lifer Strategy*:

- **a. explicitly acknowledge and integrate the findings of this investigation;**
- **b. be national in scope and responsive to the experiences of Lifers at all security levels;**
- **c. draw from consultations with incarcerated Lifers, the staff directly involved in Lifer case management, and external stakeholders; and,**
- **d. be made public with specific timelines for how CSC plans to address the concerns raised in this investigation, along with other concerns identified through consultations.**

ANNEX B: Annual Statistics

TABLE A. TOTAL COMPLAINTS

	ACTIVE	ADDRESSED	GRAND TOTAL
Total Complaints[118]	387	3,912	4,299

TOP FIVE MOST-FREQUENTLY IDENTIFIED COMPLAINT CATEGORIES BY PRIORITY POPULATIONS

TOTAL IN-CUSTODY

CATEGORY	#	%
Staff	489	11.4%
Health Care	484	11.3%
Conditions of Confinement	397	9.2%
Cell Effects	308	7.2%
Transfer	254	5.9%

INDIGENOUS

CATEGORY	#	%
Health Care	155	12.3%
Staff	154	12.2%
Conditions of Confinement	111	8.8%
Cell Effects	92	7.3%
Transfer	78	6.2%

[118] The data reported in these annexes are a snapshot of the OCI's internal data from the week of April 8, 2024. Future reporting may be different as cases are updated.

WOMEN

CATEGORY	#	%
Health Care	50	11.9%
Conditions of Confinement	46	11.0%
Staff	42	10.0%
Security Classification/Cell Effects/Condtional Release[119]	18	4.3%

TABLE B. CASES, INDIVIDUAL COMPLAINANTS, AND IN-CUSTODY POPULATION BY REGION

REGION	CASES	INDIVDUALS[120]	IN-CUSTODY POPULATION[121]
Atlantic	386	180	1,324
Quebec	1,053	481	3,000
Ontario	815	408	3,834
Prairies	877	456	3,981
Pacific	845	321	1,716
TOTAL[122]	**3,976**	**1,846**	**13,855**

[119] There were 18 complaints for each of these three categories: Security Classification, Cell Effects, and Conditional Release.

[120] The number of individuals who contacted our office to make a complaint (i.e., complainants).

[121] Year-end count of in-custody population broken down by Region for fiscal year 2023-24, according to the Correctional Service Canada's *Corporate Reporting System – Modernized* (CRS-M).

[122] Totals do not include Community Correctional Centres and Community Residential Centres (CCC-CRCs), or Parolees in the community. There were 191 unique contacts from the community. Also, 132 cases were removed because the complainant(s) wished to remain anonymous.

TABLE C. INDIVIDUAL COMPLAINANTS AND CASES BY INSTITUTION TYPE

INSTITUTION TYPE	CASES	INDIVIDUALS
Institutions for Men	**3,362**	**1,548**
Multi-Level	1,451	766
Maximum[123]	1,071	373
Medium	829	401
Minimum	11	8
Institutions for Women	**372**	**185**
Treatment Centres	**221**	**97**
CCC-CRC	**115**	**79**
Community	**76**	**41**
Healing Lodges	**21**	**16**
GRAND TOTAL[124]	**4,167**	**1,966**

TABLE D. COMPLAINANTS AND CASES BY SELF-REPORTED ETHNICITY

ETHNICITY	WOMEN		MEN	
	CASES	INDIVIDUALS	CASES	INDIVIDUALS
White	217	102	1,661	823
Indigenous	169	85	1,094	562
Black	15	11	610	208
Other Visable Minority	10	8	246	95
Multi-Ethnic or Unspecified	9	5	136	67
TOTAL[125]	**420**	**211**	**3,747**	**1,755**

123 Includes the Special Handling Unit (SHU).

124 Totals do not include 132 cases from anonymous complainants.

125 *Ibid.*

TABLE E. DISPOSITION OF CASES

ACTION	#
Internal Resolution	2,175
Investigation	2,443
TOTAL	**4,618**[126]

Toll-Free Contacts in 2023-24

Federally sentenced individuals and members of the public can contact the OCI by calling our toll-free number (1-877-885-8848) anywhere in Canada. All communications between federally sentenced individuals and the OCI are confidential.

Number of toll-free contacts received in the reporting period: 19,005

Number of minutes recorded on toll-free line: 58,126

TABLE F. MANDATED REVIEWS[127] BY TYPE OF INCIDENT (2023-24)

INCIDENT TYPE	REVIEWS
Death (Natural Cause)[128]	74
Assault	8
Overdoses	7
Suicide	6
Murder	5
Attempted Suicide	2
Self-Injury	1
Overdose Interrupted	1
TOTAL	**104**

[126] A case may be reopened and re-resolved more than once, each with its own reasons for why it is closed. This is the reason that the total in this table is larger than the actual number of complaints reported in Table A.

[127] As per the *Corrections and Conditional Release Act* (CCRA), the Office of the Correctional Investigator reviews all CSC investigations into incidents of serious bodily injury or death involving an incarcerated person. However, the numbers in this table represent reviews conducted during fiscal year 2023-24, not the total number of incidents.

[128] Deaths due to "natural causes" are investigated under a separate Mortality Review process involving a file review conducted at National Headquarters.

TABLE G. USE OF FORCE REVIEWS CONDUCTED BY THE OCI IN 2023-24[129]

	ATL	QUE	ONT	PRA	PAC	NATIONAL
Reported Incidents Reviewed by the OCI	19	108	108	158	71	464[130]
Most Common Measures Used[131]						
Inflammatory Spray (IS) or Chemical Agent (CA)[132]	4	27	19	62	58	170
Physical Handling	0	9	35	21	2	67
Impact Rounds	0	0	0	1	2	3

TABLE H. OCI COMPLAINTS BY CATEGORY AND RESOLUTION STATUS[133]

COMPLAINT CATEGORY	ACTIVE	ADDRESSED	GRAND TOTAL
Administrative Segregation	0	4	4
Case Preparation	2	25	27
Cell Effects	12	296	308
Cell Placement	8	33	41
Claims Against the Crown	0	26	26
Community Supervision	1	9	10
Conditional Release	8	124	132
Conditions of Confinement	50	351	401
Death of Inmate	2	3	5
Diets	3	46	49
Discipline	3	53	56

[129] The data in this table represents only incidents reviewed by the OCI in 2023-24, which is a subset of all use of force cases received during the same period. The Correctional Service of Canada provides all use of force documentation to the Office, which typically includes: a use of force report; copy of the incident-related video recording; the checklist for Health Services' review of the use of force; a post-incident checklist; the officer's Statement or Observation Report; and an action plan to address deficiencies.

[130] Of these, 23 incidents were from women's institutions. Readers will notice a drop in the number of Use of Force cases reviewed by the OCI in 2023-24 compared to 2022-23. This is due to a reorganization of OCI's resources over the last quarter of 2022-23 and the two first quarters of 2023-24. This reorganization has led to a significant portion of resources being dedicated to the review of allegations related to use of force incidents, rather than in-depth analyses of said incidents.

[131] A use of force incident often involves more than one measure. The numbers provided here reflect the main measure used in those incidents requiring an in-depth review.

[132] Inflammatory Sprays commonly referred to as OC (oleoresin capsicum) or "pepper spray," contain a natural active ingredient capsaicin derived from pepper plants. Chemical Agents contain an active chemical ingredient and result in extreme irritation of the eye tissues, producing the involuntary closure of the eyes.

[133] The OCI may commence an investigation on receipt of a complaint by or on behalf of a federally sentenced person, or on its own initiative. Complaints are received by telephone, letters, and during interviews with the OCI's investigative staff at federal correctional facilities.

COMPLAINT CATEGORY	ACTIVE	ADDRESSED	GRAND TOTAL
Discrimination	21	80	101
Employment	6	31	37
File Information	13	105	118
Financial Matters	5	126	131
Food Services	6	49	55
Grievance	10	90	100
Harrassment by Inmate	1	17	18
Harm Reduction	1	16	17
Health and Safety	5	22	27
Health Care	42	442	484
IEDM	0	3	3
Inmate Request Process	4	26	30
Legal Access	10	91	101
Mail	4	52	56
Mental Health	6	64	70
Mother-Child Program	1	6	7
Office of the Correctional Investigator[134]	10	98	108
Official Languages	0	11	11
Outside Jurisdiction	3	91	94
Programs	10	90	100
Release Procedures	1	17	18
Safety and Security	12	155	167
Search	2	34	36
Security Classification	8	83	91
Sentence Administration	1	25	26
Spiritual or Religious Observance	5	4	9
Staff	40	449	489
Structured Intervention Unit (SIU)	8	57	65
Telephone	7	117	124
Temporary Absence	5	40	45

[134] The vast majority of these are general inquiries and administrative calls that are not, in fact, complaints.

COMPLAINT CATEGORY	ACTIVE	ADDRESSED	GRAND TOTAL
Transfer	26	228	254
Urinalysis	1	16	17
Use of Force	13	49	62
Visits	9	127	136
VLAR	0	2	2
Not Enough Information to Categorize at Resolution	2	33	35
GRAND TOTAL	**387**	**3,912**	**4,299**

TABLE I. INTERACTIONS AND INTERVIEWS BY REGION AND INSTITUTION

REGION / INSTITUTION	INTERACTION	INTERVIEWS[135]	DAYS IN INSTITUTIONS[136]
Atlantic	**400**	**126**	**29**
Atlantic	132	39	5
Dorchester	104	25	7
Nova Institution for Women	83	41	7
Shepody Healing Centre	16	0	0
Springhill	54	20	7
CCC-CRC[137]	7	1	3
Community	4	0	0
Quebec	**1,180**	**339**	**56**
Archambault	123	49[138]	9
Centre régional de santé mentale	28	-	-
Cowansville	181	12	1
Regional Reception Centre	60	16	2
Donnacona	130	28	7
Drummond	66	46	8

135 Between fiscal years 2020-21 and 2021-22, the Office pivoted to a virtual visit model, which guided how investigators conducted business during the pandemic. These visits involved a combination of videoconferencing and telephone interviews. Readers should keep this in mind when comparing the data in this table to that of previous Annual Reports. For the purposes of this table, "Interviews" only include those conducted *in-person*.

136 "Days in Institutions" represents the number of days that the OCI spent visiting CSC facilities during the reporting year. Most visits are conducted by individuals; however, OCI staff sometimes visit facilities in teams of two or more. In these situations, each day of their visit is counted once.

137 Community Correctional Centres and Community Residential Centres.

138 Includes Centre régional de santé mentale.

REGION / INSTITUTION	INTERACTION	INTERVIEWS[135]	DAYS IN INSTITUTIONS[136]
Federal Training Centre	145	53	6
Joliette	87	47	7
La Macaza	81	44	5
Port-Cartier	177	36	6
Special Handling Unit	40	5	2
Waseskun	1	1	1
CCC-CRC	46	2	1
Community	15	0	1
Ontario	**911**	**264**	**44**
Bath	125	59[139]	9
Beaver Creek	88	23	3
Collins Bay	38	0	0
Grand Valley Institution for Women	66	37	6
Joyceville	55	50[140]	6
Joyceville Assessment Unit	101	-	-
Millhaven	236	68[141]	17
Regional Treatment Centre - Bath	-	-	-
Regional Treatment Centre - Millhaven	40	-	-
Warkworth	93	27	3
Community	34	0	0
CCC-CRC	35	0	0
Prairies	**928**	**259**	**53**
Bowden	130	14	2
Buffalo Sage Wellness House	1	0	0
Drumheller	100	15	3
Eagle Women’s Lodge	0	5	4
Edmonton	140	65	14
Edmonton Institution for Women	62	43	3

139 Includes Regional Treatment Centre at Bath.

140 Includes Joyceville’s Assessment Unit and TD Unit.

141 Includes the Regional Treatment Centre, Assessment Unit, and the TD Unit.

REGION / INSTITUTION	INTERACTION	INTERVIEWS[135]	DAYS IN INSTITUTIONS[136]
Grand Cache	85	12	3
Grierson	3	0	0
Okimaw Ohci Healing Lodge	0	9	4
Pê Sâkâstêw Centre	9	5	1
Prince Albert Grand Council Healing	2	0	0
Regional Psychiatric Centre	91	16	3
Saskatchewan	208	46	8
Stan Daniels Healing Centre	4	0	0
Stony Mountain	58	29	8
Willow Cree Healing Lodge	2	0	0
Community	15	0	0
CCC-CRC	18	0	0
Pacific	**888**	**270**	**48**
Fraser Valley Institution for Women	81	27	7
Kent	228	60	9
Kwìkwèxwelhp Healing Village	2	0	0
Matsqui	94	24	4
Mission	259	67	8
Mountain	120	48	11
Pacific	21	43[142]	8
Regional Reception Centre	18	-	-
Regional Treatment Centre	28	-	-
William Head	8	1	1
Community	15	0	0
CCC-CRC	11	0	0
Unspecified Institution[143]	3	0	0
GRAND TOTAL	**4,307**	**1,258**	**230**

[142] Includes the Regional Treatment Centre and Regional Reception Centre.

[143] In all 3 cases, the complainant(s) requested to remain anonymous. One of these cases concerned matters outside of the OCI's jurisdiction.

Response to the 51st Annual Report of the Correctional Investigator

Introduction

I would like to thank the Correctional Investigator and his team for their 51st Annual Report. Operating 43 correctional institutions across Correctional Service of Canada (CSC) and working to rehabilitate other human beings is tireless work requiring the input and perspectives of many stakeholders and interest groups. We are always open to further improving our world-class correctional system, and I appreciate the thought and effort placed into these reports.

Our work in delivering effective corrections is something we take to heart and our response to the Correctional Investigator's report details the ways we are addressing the recommendations put forward while working to tackle some larger issues. For context, over the past fiscal year, we have undertaken several key initiatives to support correctional and government-wide priorities.

An organization is nothing without its people. This statement is even more true when it comes to working in correctional environments. CSC recognizes that relationships are at the heart of our work. Improving the organizational climate at CSC has been the focus of considerable and sustained efforts. National scale initiatives that contribute to the mental health and well-being of our staff have taken many forms, which continue to evolve. One important initiative is the Audit of Organizational Culture, which is helping us better understand the challenges and opportunities of our various workplaces from coast to coast to coast.

CSC recently released the Audit report, which provides important information on how our diverse CSC employees experience the workplace. This initiative is near and dear to me and, as such, we have stood up a team to focus on developing a detailed action plan and overseeing our culture evolution moving forward.

Another major initiative is the development of a new Offender Management System (OMS) that is more user-friendly, efficient, effective, and will introduce many new ways of working. This is a significant step forward in CSC's goal of fulfilling its mandate by using modernized technology and practices. The new OMS represents an important change to how we will work on a daily basis and, as such, we are incorporating input from employees at each stage of its development.

With respect to contraband detection, to build on the already tried and true dynamic security measures CSC uses, we continue to work with Innovation, Science and Economic Development Canada (ISED) and its Innovative Solutions Canada program on relevant solutions to contraband challenges. Institutions are now equipped with various drone detection systems, which are paying off. From January 1 to June 30, 2024, out of 90 drone incidents, 98% of drones were detected. In addition, CSC has deployed, in all five Regions, detector dogs capable of detecting electronic storage devices, including cell phones.

This year, CSC demonstrated that it can respond swiftly to any emergency. For example, this past June, we transferred more than 220 maximum security inmates from Port-Cartier Institution in the Quebec Region during a 24-hour period to escape the raging wildfires that were threatening the institution. In a letter to me dated August 8, 2024, the Correctional Investigator described the unprecedented transfers as "a feat" and agreed that "this large-scale operation in an emergency and high-security context was carried out masterfully." CSC's ability to manage through

these extraordinary challenges is due to the hard work, dedication, and resiliency of our staff, partners, volunteers, and community stakeholders.

CSC's mandate is to contribute to public safety by assisting and supporting offenders in their rehabilitation and eventual return to our communities as law-abiding citizens. A key part of this is providing them with education, programming, interventions, and services that contribute to this end goal. Since 2021-2022, the percentage of offenders who:

- upgraded their education prior to first release has increased by more than 15% to 77.4%;
- completed a required correctional program prior to first release has increased by almost 10% to 77.8%; and,
- received a vocational certificate has increased by 38%.

In addition, CSC has made significant efforts to increase the access to culturally-relevant interventions and programs for Indigenous offenders. In 2022-2023, there was a 144% increase from the previous year and, in 2023-2024, CSC saw a further 45% increase in the total number of Indigenous offenders transferred to Section 81 and CSC Healing Lodge facilities over the previous fiscal year.

Overall, during the past decade, there has been a steady and substantial improvement in the percentage of federal offenders not returning to federal custody within 5 years of sentence expiration:

- from 83.3% in 2014-2015 to 89.9% in 2023-2024 for all offenders
  - 89.4% for men in 2023-2024
  - 96.2% for women in 2023-2024
- from 74.8% in 2014-15 to 83.8% in 2023-24 for Indigenous offenders
- from 88.7% in 2014-15 to 90.4% in 2023-24 for Black offenders

CSC and the OCI work in partnership to fulfill the crucial and important partnership of upholding public safety and supporting offender rehabilitation. It has been six years since I was appointed as the Commissioner of Corrections to lead this outstanding organization and contribute to the safety of Canadians. I am proud of CSC's exemplary team, including the contribution of many volunteers and stakeholders, who continue to propel us forward towards the achievement of our shared goal.

Anne Kelly
Commissioner
Correctional Service of Canada

Responses to Recommendations

1. **I recommend that the Service report publicly, in the next fiscal year, on concrete actions, deliverables, and timelines on how and when it will:**

    a. **acquire external, independent expertise to conduct empirical, primary research to assess the validity and reliability of *all* existing assessment and classification tools and methods used by CSC to inform decision-making with Indigenous offenders; and,**

    b. **develop new assessment and classification tools, Indigenous-led and from the ground up, for federally sentenced Indigenous peoples, that include culturally responsive and informed indicators of risk and need (i.e., Indigenous social history factors).**

Response: In 2023-2024, the Research Branch, under the guidance and advice of an expert external advisory panel comprised of academics of diverse background external to CSC, undertook a validation exercise of the Custody Rating Scale (CRS) in relation to men offenders, Black men offenders, Indigenous men offenders, Indigenous women offenders, and non-Indigenous offenders. This research affirmed the predictive validity of the CRS at intake for diverse offender groups.

The meta-analysis conducted by Olver et al. (2023) offers important contributions to the knowledge base examining risk assessments and federally incarcerated Indigenous peoples. The review involved 91 studies featuring 22 risk tools and 15 risk/need/cultural domains drawn from the broader risk assessment literature. It resulted in a sample size of N = 59,693, Indigenous and N = 237,729, non-Indigenous/White individuals. The authors note that, although there may be opportunities to enhance existing risk measures, "there are very few potentially cultural-specific predictors and the research to date is scant" (p.538).

Findings from the meta-analysis highlight important areas of consideration for CSC and others in the field. These include strengthening staff professional competencies such as cultural safety, cultural humility, and general responsivity as well as the following:

- ***Incorporating dynamic measures into service delivery with Indigenous persons*** (i.e., measures that contain items that are amenable to change such as education/employment, substance abuse etc.) along with static risk measures.
- ***Considering strengths and protective factors that can mitigate risk.*** Protective factors may attenuate elevated risk scores with Indigenous persons by focusing on those factors that promote positive outcomes (e.g., prosocial coping, cultural and family supports, spirituality, positive leisure). Further research on strengths and protective factors for Indigenous peoples is worthwhile and may serve to strengthen correctional and reintegration planning.
- ***Incorporating Indigenous perspectives***, by seeking input/assistance through consultation with experts in Indigenous culture (e.g., Elders, staff specially trained in working within Indigenous cultures). These consultations can assist in interpreting the cultural context of behavior, which may be important in assessing/understanding risk factors as well as the effective use of risk assessment tools.

Taking these findings into account, CSC will be:

- examining means of incorporating dynamic measures alongside static risk measures into service delivery with Indigenous peoples; and
- exploring potential strengths and protective factors that may mitigate risk.

Under a four-year Memorandum of Understanding (MOU) with the University of Regina, CSC completed research that explored the feasibility of developing a culturally-informed risk assessment tool/process. This research partnership provided valuable insight relating to strategies of Indigenous community engagement, the legal landscape surrounding Indigenous risk assessment, and the use, and efficacy of actuarial tools with Indigenous peoples in federal custody.

The Research Branch continues to engage with external, independent experts to develop evidence-informed and culturally responsive approaches to strengthen and enhance the assessment and classification process for federally sentenced Indigenous peoples.

In addition, to support these activities, the Research Branch will establish an Indigenous Research Advisory Circle. The role of the Advisory Circle will be to guide and advise culturally respectful and informed research involving federally sentenced Indigenous peoples. Establishing an Advisory Circle represents an important commitment in CSC's reconciliation journey to build respectful and reciprocal relationships with Indigenous partners. The Advisory Circle will engage Indigenous Elders, Indigenous researchers/scholars/academics, and Indigenous community practitioners and leaders in meaningful dialogue in support of culturally responsive research and will provide guidance on the integration of Indigenous perspectives, knowledge, teachings, values, oral traditions, and worldviews into research approaches and practice.

Next Steps and Timeline: To ensure effective communication, the Research Branch will publicly release annual updates on the research and development activities in respect of assessment and classification tools, and methods used by CSC to inform decision-making with Indigenous offenders beginning at the end of Fiscal Year 2024-2025.

2. With respect to CSC's internal Complaints and Grievances process, I make three summary recommendations, to be phased and completed within the next fiscal year:

a. First, CSC should conduct a principle-based review of the complaints and grievance process informed by the pillars of procedural justice – voice, respect, neutrality, trustworthiness. The views and experiences of incarcerated people should be taken into consideration throughout this review.

b. Simultaneously, CSC should undertake a reallocation exercise to ensure proper and sustained focus, effort, and priority will be placed on resolving complaints and grievances informally, and at the lowest level possible. This could include reallocation of resources from national level redress to penitentiary-based resolution.

c. Finally, CSC should make significant investments in mediation and alternative dispute resolution training and skills building for all staff with the goal of implementing these practices at all maximum-security and multi-level penitentiaries across Canada, including the five Regional Women and Treatment Centre facilities. ADR and mediation would be central and permanent features of a significantly updated and revised Commissioner's Directive 081.

Response: 2 (a): CSC has made several transformative changes to its Offender Complaint and Grievance process over the past three years. These include:

- increase in training and orientation of grievance analysts, team leaders and managers, which has led to a rise in productivity;
- the use of technology (e-signature) for decision-making, thereby minimizing administrative delays;
- direct engagement with operational sites to provide policy and strategic support to their respective local complaint and grievance administrative processes;
- increase participation of, and voice of offenders in grievance resolution process;
- increase monitoring of the implementation of corrective measures;
- reorganization of the Offender Redress Division to foster agility in the exercise of its duties and functions; and
- the implementation of the Complaint and Grievance Resolution Review Committee (CGRRC).

These changes have enhanced CSC's capacity to provide impartial and complete responses to offenders, addressed historic delays in responding to grievances as required by the *Corrections and Conditional Release Act* (CCRA) and improved the confidence of offenders and other stakeholders in CSC's complaint and grievance process.

For example, in November 2022, CSC put in place the CGRRC to respond to offenders with high frequency and volume of complaints and grievances across the country. The initiative made it possible for the offenders (with their consent) and a representative of their choosing to participate in the direct review of their complaints and grievances. A member of the site's Citizen Advisory Committee also participated in the review process as an observer. By participating in the review of their respective grievances, offenders were able to succinctly provide context to their grievances and collectively identify corrective measures to adequately address those complaints and grievances.

While transformative, this approach is in keeping with the four pillars of procedural fairness and is expected to be incorporated into the next version of the Commissioner's Directive (CD) 081.

Next Steps 2 (a): To identify additional areas of opportunity for improvement and engrain its successes and best practices of the CGRRC into the complaint and grievance process, CSC's Audit and Evaluation Sector is currently conducting a review of the CGRRC. The findings of the review will inform the upcoming review of CD 081 and GL 081-1.

Timeline: The review of the CGRRC is underway and the updates of CD 081 and GL 081-1 are scheduled to be completed by Summer 2025.

2 (b): CSC recognizes the importance of addressing offenders' complaints and grievances informally and at the lowest possible level and, to that end, is engaged in providing support to operational sites to ensure that this legislative requirement is met.

For example, the Offender Redress Division has been involved in providing information sessions to regional and institutional staff to enhance their ability to respond to offender complaints and grievances in a timely manner, and in accordance with the four pillars of procedural fairness. Training for frontline officers and managers have also been improved following ongoing discussions with the CSC's Learning and Development Branch to ensure that the importance of addressing offenders' concerns informally and at the lowest level is emphasized as frontline staff exercise their duties and functions.

The Rights, Redress and Resolution (RRR) Branch is committed to continue to offer the necessary support to CSC's frontline staff to ensure that they are adequately prepared to respond to offenders' concerns proactively and in a fair and timely manner, at the lowest level. To that end, the Human Rights Division is working closely with the Offender Redress Division to support operational sites and policy holders in raising awareness of the importance of fostering empowering dynamic interactions with offenders, including in the context of resolving their concerns.

Next Steps 2 (b): CSC will continue to support operational sites in providing information sessions aimed at facilitating the expeditious and fair response to complaints and grievances. The Offender Redress Division will also ensure that information and tools to support this objective are available via the CSC internal website Hub.

Timeline: The RRR Branch will administer information sessions on a regular basis during the fiscal year.

2 (c): CSC is committed to providing support to frontline staff to be adequately equipped to respond to offender complaints and grievances at the lowest possible level, including by using mediation and alternative conflict resolution measures.

CSC sought and received funds through Federal Budget 2022 to enhance redress resolution, including human rights complaints. One of the core activities of the Federal Budget 2022 initiative is the implementation of Alternate Dispute Resolution (ADR) at 5 institutions across the country. CSC has commenced ADR pilot at Kent Institution in the Pacific Region. The pilot will assist in establishing operational and administrative processes for expansion to other four operational sites by the end of the fiscal year.

Next Steps 2 (c): CSC will glean lessons learned from the ongoing implementation of ADR at Kent Institution and identify four other operational sites by the end of the fiscal year for the implementation of ADR during 2025-2026 fiscal year. Key successful activities of the initiative will be considered as part of CD081 and GL 081-1 review.

Timeline: Spring 2026

3. **I recommend that the Quality of Care Review process be subject to an independent audit chaired by an outside medical examiner.**

Response: CSC takes the death of every individual in its custody very seriously. Each death in custody is externally reviewed by the provincial coroner/medical examiner. CSC continues to support these external investigations and facilitates ongoing communication and information sharing to assist in this review, including sharing CSC's final Quality of Care Review (QCR) report with the provincial coroner.

CSC currently has a National Health Professional Advisory Committee (NHPAC), which is comprised of Health Care Professionals (Primary Care Physicians, Psychiatrists, Dentists, Nurse Practitioners, etc.). This Committee provides advice and recommendations to CSC on matters relating to professional practice, as well as policies respecting or impacting Medical Practitioners, and the quality and organization of health services to federal inmates. The NHPAC is chaired by CSC's Chief Medical Officer of Health, who is responsible for the review of health issues related to the provision of care, as well as medical advice for CSC Health Services Senior Management. As part of this role, the Chief Medical Officer of Health reviews and signs all QCR reports.

Although there have been improvements in the timelines for completion of QCR reports, as mentioned in this 2023-2024 Correctional Investigator's (CI) Annual Report, CSC recognizes that there is room for enhancements. As such, CSC is currently reviewing the QCR process and associated guidelines from a quality improvement lens, including the engagement of an external expert. The objective of this review is to improve the alignment of CSC's QCR process with community standards for investigating inmate safety incidents. During this review, CSC will assess the definitions and implementation of recommendations, opportunities for quality improvement, and corrective actions. Additionally, CSC will consider other solutions, including identifying influencing factors that prioritize holistic and preventative care in accordance with strategies from Health Standards Organization, which is affiliated with Accreditation Canada. It is anticipated that the renewed process will explore additional opportunities to identify systemic issues, drive data-informed innovation and identify opportunities for continuous quality improvement.

Next Steps: With the engagement of an external expert, CSC will conduct a review of the QCR process and associated guidelines from a quality improvement lens.

Timeline: Summer 2025

4. **I recommend that for determining the cause of death for the Quality of Care Review, CSC's Health Services Sector obtain independent and external verification or, when this is not possible, that all efforts to obtain independent and external verification be reported.**

Response: As part of CSC's current QCR process, CSC submits a formal request to the provincial coroner for a copy of the autopsy report or Coroner's Report to confirm the cause of death. This request is submitted as soon as feasible, following the convening of the QCR. It is important to note, as mentioned in this CI's Annual Report, CSC must contend with the different approaches to information sharing between provincial coroners or medical examiners offices, and the fact that CSC does not have control over any timeframes related to the final Coroner's Report.

As highlighted in this CI's Annual Report, CSC is currently making efforts to engage in discussions with coroners' offices throughout Canada, with the support of our contracted Chief Medical Officer of Health to enhance communication and information exchange. Most provincial coroners have recently committed to strengthen our collaboration and emphasize the significance of sharing information. CSC is hopeful that with enhanced partnerships in place we may be able to reduce the number of reports finalized without a confirmed cause of death.

Similarly, CSC also recognizes the importance of documenting efforts made to obtain external verification. With this in mind, all communications with the provincial coroners and medical examiners will be saved in the inmate patient's Electronic Medical Record going forward. As part of the review of the QCR process, outlined in the response to Recommendation 3, CSC will also explore opportunities to incorporate standardized timelines for initial contact with coroners and medical examiners, as well as the need to include follow-ups that are documented in the final QCR report.

Next Steps: CSC will engage in discussions with all coroners' offices throughout Canada to enhance communication and information exchange. Additionally, CSC will ensure appropriate documentation of communication with provincial coroners and examiners.

Timeline: Winter 2024

5. **I recommend that CSC consult with the Parole Board of Canada and establish a data sharing and reporting framework to publish information on section 121 *Parole by Exception* applications as well as applications of any kind of release based on compassionate grounds. This data should be disaggregated by the criteria listed under section 121 (1), regardless of whether the parole application is presented before or after an individual's eligibility dates.**

Response: CSC will work with the Parole Board of Canada to establish a mechanism that will enable data sharing and reporting so that cases presented for a parole hearing for health reasons, whether the inmate has met their parole eligibility date or under section 121 of the CCRA, can be properly identified and monitored.

Next Steps: Based on previous consultation processes, the relevant screens in the Offender Management System will be reviewed to enhance our current data sharing and reporting process. CSC is currently engaged in the technical modification discussions for the changes to be completed by Winter 2025. CSC will continue engagement with PBC to establish a collective mechanism that enables information sharing between both organizations.

Timeline: Winter 2025

6. **I recommend that assessments of release considerations in Quality of Care Reviews be conducted by CSC's Incident Investigations Branch, in collaboration with CSC's Health Service Sector. Such assessments should address the elements raised in the Office's 2014 public interest report and lead to the adoption of qualitative standards.**

Response: Although the Quality-of-Care Reviews include a brief analysis of early release considerations, as they have been carried out to date, they do not allow for CSC to conduct a detailed retroactive analysis of release considerations as proposed by this recommendation. CSC recognizes the need to examine whether appropriate considerations for a possible exceptional release on compassionate grounds have been afforded to terminally ill offenders who ultimately die of natural causes while in CSC custody. Accordingly, starting in the Fall of 2024, CSC will collect data from relevant natural cause death cases and will conduct regular systemic reviews to assess whether CSC needs to develop the OCI's recommended qualitative standards.

Next Steps: CSC will conduct an assessment of natural cause deaths where exceptional releases should have been considered and determination made whether qualitative standards are needed.

Timeline: Spring 2026

7. **I recommend that CSC develop a National Population Management Strategy for Women, which includes:**

    a. **Expanded use of *Exchange of Service Agreements*, so women can serve their sentences closer to their home communities and social supports;**

    b. **Increased use of community-run Section 81 Healing Lodges and Section 84 agreements and releases;**

    c. **A comprehensive community release strategy for women and the reallocation of resources into the community; and,**

    d. **Increased allocation of resources dedicated to managing complex cases.**

Response: Although women represent a small proportion of the federally incarcerated population in Canada, over the past 20 years, the rate of women in federal correctional institutions has increased by 50% (Balfour, 2020), with Indigenous women continuing to be the fastest growing population. This growth is troubling, and all efforts are being made to ensure that women offenders have adequate support to achieve successful and lasting reintegration outcomes. Recent research has demonstrated that the national profile of in-custody women has changed over time, with more complex risk and need profiles than those observed in previous cohorts. More specifically, recent profiles are marked by a greater proportion of women with poor or very poor criminal risk ratings, low reintegration potential, more likely to be serving a sentence for a violent offence, and more likely to be rated as having a high overall level of criminogenic need. In addition, the proportion of offenders in women's institutions with a Security Threat Group (STG) affiliation has increased (Motiuk & Keown, 2022, Wanamaker, K., & Chadwick, N., 2023).

CSC is undertaking the development of a coordinated cross-sectoral national strategy to address population management challenges and pressures from the beginning of the sentence until warrant expiry, which will include internal and external stakeholders (e.g., the OCI and Canadian Association of Elizabeth Fry Societies). This strategy will focus on key women offender population management pressures, including women with complex risk and need profiles, to ensure the placement of women offenders in the appropriate facility commensurate with their risk and needs level. This will include the use of Exchange of Service Agreements (ESAs) and community-operated Section 81 Healing Lodges and Section 84 agreements and releases. The strategy will also focus on ensuring measures and processes are in place to assist women offenders to be prepared for their parole reviews by their parole eligibility date, to support their successful reintegration into the community. This will be achieved through the development of a community release component, which will guide management decisions, business planning, and policy changes, as may be required.

Next Steps: CSC will:

- review existing ESAs and explore the potential for new agreements to provide additional options for women to serve their sentences closer to their home communities and social supports with consideration to their risk and needs;
- continue to monitor and review Section 81 healing lodges bed usage with the goal of increasing their bed utilization (ongoing);
- continue to support the Wardens to increase use of Section 84 or engagement of the Indigenous communities in the release case preparation of Indigenous women (ongoing);
- develop a community release strategy for women (Summer 2025);
- assess the current allocation of resources dedicated to managing complex cases (Fall 2024); and
- develop a coordinated cross-sectoral national strategy to address population management challenges and pressures from the beginning of the sentence until warrant expiry to inform management decisions, business planning and policy changes, as required (Summer 2025).

8. **I recommend that CSC evaluate all the strategies put in place in response to its recommendations from the June 2021 EIM evaluation and publicize the measures it has taken in order to reduce the use of force; increase capacity to respond to incidents involving mental health and physical distress; and, ensure that violations of the law and/or policies do not go unchecked.**

Response: CSC is committed to ensuring that interventions are managed in accordance with the Engagement and Intervention Model (EIM), using the safest and most reasonable response. Since its introduction, several measures have been implemented to promote and reinforce the principles of the EIM.

Specifically, in response to the recommendations from the June 2021 EIM evaluation, CSC undertook a review of its curriculum related to the EIM and developed a training course specific to the role of the Sector Coordinator as well as an Interdisciplinary Teamwork Guide to enhance staff understanding of the roles and responsibilities of various interdisciplinary team members during incident management. CSC has also developed and implemented effective scenario-based training that incorporates responding to the mental and physical health needs of its diverse population of inmates. New training topics are proposed each year to ensure the security-related trainings are relevant and meet operational needs and organizational priorities.

All use of force interventions are subject to a review process where a thorough examination of the actions taken during an incident occurs, identifying any serious violations of law or policy that may exist and ensuring accountability and appropriate corrective action and/or discipline is taken, where required. In November 2022, guidance was issued through a Security Bulletin requiring local sites to implement measures to monitor and track areas of non-compliance, including corrective action. It was reinforced that corrective action must be completed in a timely and effective manner, while ensuring that progressive corrective action is taken where continued areas of non-compliance are noted during use of force reviews.

CSC will continue to promote and reinforce the principles of the EIM through appropriate measures to ensure every intervention is managed using the safest most reasonable response and be limited to only what it is necessary and proportionate to resolve the situation. Use of force is only one component of the much larger EIM and while a reduction in use of force incidents would be considered ideal, several situational factors are considered in the decision-making process when determining if force is required to safely manage an incident.

The Management Action Plan resulting from the 2021 Evaluation of the EIM Model will be published to clearly indicate the actions and deliverables that were implemented to address the five recommendations that were made. It should be noted that all deliverables have been implemented.

Next Steps: As part of the development of its upcoming Risk-Based Audit and Evaluation Plan, CSC will further analyze and assess the risks of the strategies implemented in response to the recommendations to determine which targeted engagements could be undertaken.

Timeline: Winter 2025

9. **I recommend that CSC should immediately release the Independent Observer's evaluation of the impartiality, thoroughness, and professionalism of this National Board of Investigation.**

Response: CSC will publish the vetted copy of the Independent Observer's (IO) Report in relation to the investigation, on its internal and external websites.

Next Steps: CSC's Access to Information and Privacy team will review the IO report to ensure compliance with the *Access to Information Act* and *Privacy Act* prior to publication of the report. Following the review of the report, CSC will publish the report on its internal and external websites in accordance with the Government of Canada publication requirements.

Timeline: Fall 2024

10. **I recommend that CSC prepare and release a Case Summary of the facts and findings of this NBOI including recommendations, learnings and corrective measures that have been implemented at RTC Millhaven to date.**

Response: CSC will publish a vetted case summary of the investigation including facts, findings, learnings and corrective measures in relation to the 10 recommendations in the investigation report in both official languages, on its internal and external websites.

Next Steps: CSC's Access to Information and Privacy team will review the case summary to ensure compliance with the *Access to Information Act* and *Privacy Act* prior to publication of the report. Following the review of the report, CSC will publish the report on its internal and external websites in accordance with the Government of Canada publication requirements.

Timeline: Fall 2024

11. **I recommend that an independent and external mental health expert conduct a full compliance review of patient safety at RTC Millhaven.**

Response: CSC has an integrated mental health service delivery model and provides services along a continuum of care from admission to the expiration of an offender's sentence or long-term supervision order and is responsive to the specific level of care required.

As part of this model, CSC has five Regional Treatment Centres (RTC) which are designated psychiatric hospitals (except for the Regional Mental Health Centre in Quebec), and which are accredited by Accreditation Canada. RTCs provide clinical assessment and inpatient treatment for individuals with serious mental health conditions. The CCRA and CSC health policy outline requirements for the clinical admission and discharge process for RTCs.

CSC continues to look for opportunities to enhance health services delivery. To this end, CSC is conducting a national review of RTCs, including the RTC in the Ontario Region. The review will inform the development and implementation of standardized policies and programs to support nationally consistent health service delivery at the RTCs. Processes and requirements related to inmate patient safety will be included in this review. Further, as part of the review, CSC and the National Senior Psychiatrist, will engage with both internal and external stakeholders, including the OCI and external experts. The review will also support alignment with the ongoing work related to the implementation of the Person Health Care Home model of primary care, the provision of intermediate mental health care and the work on CSC's Health Centre of Excellence.

Next Steps: CSC will complete quality improvement initiative on the RTC admission and discharge process by Spring 2025.

Additionally, CSC will develop and implement processes for standardization of treatment centre policies and programs to support nationally consistent service delivery, the future vision of hospital-based care in CSC and alignment with the Person Health Care Home Model and Intermediate Mental Health Care.

Timeline: Spring 2025 and 2026

12. **I recommend that CSC evaluate the suitability and feasibility of installing in-cell vital sign remote monitoring technologies in all high(er)-risk placement areas of federal prisons, including Structured Intervention Units, Enhanced Observation (suicide watch) cells, Regional Treatment Centres and health care cells in mainstream penitentiaries.**

Response: CSC is committed to maintaining safe living and working environments in all its facilities, while delivering on its public safety mandate. CSC will be implementing purposeful hourly rounding at Regional Treatment Centres to support ongoing monitoring of health needs. Rounding is a systematic, proactive nurse-driven evidence-based practice that can promote inmate patient safety, foster team communication, and improve inmate patient satisfaction. This will be implemented in all Regional Treatment Centres in Fall 2024.

In addition, CSC will evaluate the suitability and feasibility of installing in-cell vital sign remote monitoring technologies in select high(er)-risk placement areas of federal prisons by implementing a pilot project in one institution by Fall 2027.

Next Steps: CSC will pilot in-cell vital sign technology in one institution to test its feasibility and suitability by 2027. The pilot will include the completion of a Privacy Impact Assessment, communication strategy, and data collection plan by Spring 2025; the development of a statement of work and completion of the contracting process by Spring 2026; the physical installation of the tool by summer 2026; and, the post implementation testing and evaluation by Fall 2027.

Timeline: Fall 2027

13. **I recommend that CSC ensure security staff working in a Regional Treatment Centre be carefully recruited, suitably selected, properly trained and fully competent to carry out their duties in a secure psychiatric hospital environment.**

Response: CSC continues to recruit, assess, and select talent who meet position requirements, as outlined in approved statement of merit criteria. All employees receive training, throughout their employment, to support them in performing their duties.

CSC's Human Resources Management continues to engage with management, including on its national review of Regional Treatment Centres, which will include a review of optimal team composition. CSC will consider the Treatment Centre review's findings in the context of departmental recruitment and training plans/activities.

Next Steps: CSC will conduct an annual planning discussion to identify recruitment needs for the Regional treatment Centres.

Timeline: Ongoing and recurring action

14. **I recommend expansion of alternatives to incarceration options and increased bed space to facilitate the transfer and placement of federally sentenced individuals who are suicidal, chronically self-injurious or severely mentally ill in external community psychiatric facilities.**

Response: Liaising with external mental health resources is considered a key factor in achieving CSC's priority to address the mental health needs of federal inmates and, as such, CSC continually engages with partners to support service delivery. For example, CSC has a long-standing MOU with the Philippe Pinel National Institute of Forensic Psychiatry for the provision of specialized psychiatric and forensic services in both official languages.

It is important to recognize that CSC cannot compel external hospitals to enter into ESAs. With the assistance of our contracted National Senior Psychiatrist, CSC is developing a Health Services Partnership plan to explore opportunities to establish and strengthen partnerships for mental health assessment, treatment and inpatient care for CSC's inmate patients. Moreover, CSC continues to collaborate effectively with diverse partners and stakeholders, including external hospitals. Mental health consultants are also contracted on an as-needed basis for extensive case reviews of complex cases and to provide clinical guidance.

CSC is committed to exploring opportunities to work in collaboration with external mental health experts on an ongoing basis, to ensure that CSC continues to provide the highest standard of care in line with community standards.

Next Steps: In Fall 2024, the Health Services Sector will develop a partnership plan to enhance engagement with community health services.

By Spring 2025, the Health Services will engage forensic psychiatric hospitals to explore opportunities to establish MOUs for mental health assessment, treatment and inpatient care for CSC's inmate patients.

Timeline: Spring 2025

15. **I recommend that CSC devise and implement a national subpopulation management strategy by the end of the fiscal year, with the goal of safely and considerably reducing the number of subpopulations within maximum-security institutions.**

Response: As one can appreciate, institutions are microcosm of the broader society. There are inmates who do not "get along" or are deemed "incompatible" due to their gang affiliations, personalities, behaviours, profile, status (e.g., debt), etc. For these reasons, sub-populations are a necessary tool to maintain safe living and working conditions within each institution, especially at maximum security institutions. CSC recognizes the challenges that these sub-populations present in terms of inmate movement. For this reason, there is a consistent and concerted effort at the site and regional levels to mitigate and reduce the number of sub-populations.

In 2023-2024, CSC revitalized the National Population Management Committee (NPMC), which is the senior strategic and decision-making body for population management. The Committee monitors national trends, maintains strategic oversight over population management pressures and provides a forum for cross-sectoral review and analysis regarding decisions with impacts population management, including the number of sub-populations and institutional routines. The NPMC also facilitates cross-sectoral awareness of region or sector-specific initiatives (proposed or ongoing), current challenges/considerations as well

as proposed and upcoming policy changes. To date, seven of nine maximum security institutions have reduced their number of distinct routines over the last number of years.

As part of CSC's 2023-2024 Risk Based Audit and Evaluation Plan, CSC has committed to completing an evaluation of maximum-security institutions. This evaluation is being conducted in two parts. The first part is a comprehensive examination of the objectives, activities and intended outcomes of maximum-security institutions. This part of the evaluation is scheduled to be completed by December 2024. The second part, expected to be completed by December 2025, will assess whether maximum security institutions are achieving expected results. The NPMC will consider the findings of the evaluation to address issues unique to maximum-security institutions, with a view to find new ways to respond to incompatibility challenges and reduce the number of sub-populations.

Next Steps: Completion of the first part of the evaluation.

Timeline: December 2024

16. I recommend that CSC ensure:

- **a. Institutional routines are established to allow all incarcerated persons, excluding those in SIU's, to have access to primary "large" yard spaces daily.**
- **b. All living units at standalone maximum-security institutions are equipped with basic amenities and seating.**
- **c. Policies related to institutional movement, including Standing Orders, be reviewed to ensure that they no longer limit individuals from engaging in their Correctional Plan.**

Response: The safety and security of staff, inmates and visitors are of paramount priority to CSC. CSC is faced with constraints, whereby some facilities do not have large yard spaces due to the legacy nature of their infrastructure. Despite this, the Wardens have Standing Orders in place to maximize institutional movement and daily routines that ensure the safety, health, and wellness of inmates. This includes rotation for equitable distribution of access to the main gym/yard area among sub-populations, access to gym equipment, as well as seating areas in common and multi-purpose rooms. All inmates are regularly encouraged to participate in the range of interventions and recreation/social activities that are available including when there are changes to movement resulting from infrastructure changes and temporary construction projects.

Next Steps: The Wardens have established Standing Orders related to institutional movement to ensure increased access to programs and interventions to improve results, and better facilitate reintegration efforts.

In Fall 2024, CSC will be launching its consultation process for the development of its Risk-Based Audit and Evaluation Plan and will ensure it includes a review of the policies related to institutional movement.

Timeline: Winter 2025

17. I recommend that CSC develop a national policy surrounding complex SIU cases, which should include oversight and direction from the national level, to make SIU transfer processes more efficient and equitable.

Response: CSC has established an inter-disciplinary process, consisting of an integrated team of staff members from various disciplines, including mental health, reintegration programs, population management, intelligence, and SIU

operations, to identify options for the integration of complex SIU cases, and to support the associated decision-making process. Lead nationally, this process serves as a complementary framework to the current transfer process and provides additional tools and intelligence information to support decision-making about inmates who do not have identified transfer options out of the SIU.

The Complex Case Transfer (CTC) process is a component of CSC's approach to complex cases and is a reoccurring engagement with national and regional senior management to discuss complex SIU cases and find them a viable alternative.

In addition to the Complex Transfer unit, CSC also has a National Person-Centred Health Committee (NPCHC) and Inter-Sectoral National Complex Case Health Committee (ISNCCHC), which support care teams and national information sharing on complex cases to support an effective continuum of care to inmates. Criteria for inclusion for review by these committees include a small sub-population of inmates with significant mental health needs or any serious self-injury or suicide attempt while in the SIU. In FY 23/24, approximately 25% of cases (or 1-2 cases per month) discussed at the intersectoral committee involved inmates who were in the SIU.

The concerted efforts are having a positive impact on length of stays in the SIU. More specifically, in 2023-24, the median number of days spent in Structured Intervention Units (SIUs) was 13 days.

Next Steps: In its review of the SIU policy, CSC will consider whether to include direction regarding the management of complex cases.

Timeline: June 2025

18. I recommend that CSC increase availability of meaningful employment and apprenticeship opportunities at standalone maximum-security institutions, while mandating basic oversight of these jobs, to ensure that prisoners can occupy their time constructively.

Response: CSC recognizes the importance of providing meaningful employment to inmates to occupy their time constructively and help them develop marketable skills to find and hold meaningful employment upon release. This includes on-the-job and vocational training opportunities, including at standalone maximum-security institutions. CSC has developed various partnerships with organizations and educational institutions to provide training using a third-party certifier, through various formats such as classroom training and\or self-paced learning.

CSC is currently conducting an Employment Review across the country to maximize and make efficient our offender employment assignment practices with the goal of establishing an integrated employment model based on standardized operational protocols. As a result, this integrated model is expected to increase availability of meaningful on-the-job training and allow oversight of those assignments. CSC is also leveraging existing on-the-job training opportunities by introducing, at a national level, third-party certified vocational training in cleaning. The training, which will be available at standalone maximum-security institutions, will be conducted in a self-paced format, thus allowing offenders to acquire vocational training without interfering with other correctional interventions.

In terms of apprenticeship, CSC provides inmates the opportunity to register as apprentices in various trades. Inmates can accumulate hours through employment assignments and write their block exams. This program is available in medium and minimum institutions for inmates closer to release to be able to complete the program in the community. The current focus in maximum security institutions

is to provide on-the-job training and vocational training as well as other correctional interventions. Building on this work, CSC will assess the feasibility of introducing apprenticeship opportunities at maximum-security institutions, while ensuring that any additional training would not interfere with other correctional interventions that directly assist inmates in transferring to medium security institutions.

Next Steps: CSC will conduct an Employment Review with the goal to develop an integrated employment model. Additionally, CSC will assess and develop employment strategy for maximum security institutions where required.

Timeline: Winter 2024

19. **I recommend that CSC provide consistent access to Indigenous services, programs and supports, including establishing and maintaining Pathways programs, at each of these institutions without delay.**

Response: All five Regional Management Committees have prioritized the access, support, and monitoring of Indigenous interventions. At the national Executive Committee table, the presence of the Deputy Commissioner for Indigenous Corrections enhances consideration of the needs of Indigenous offenders in all discussions. The Deputy Commissioner of Indigenous Corrections and the Regional Deputy Commissioners have undertaken several initiatives to ensure Indigenous services, interventions, and supports continue to be readily available and are well supported to meet the complex needs of Indigenous offenders. These initiatives consider the needs of Indigenous offenders in maximum-security institutions, with the goal of reducing their security level and preparing them for their successful reintegration into the community.

Next steps: CSC will revitalize Pathways Initiatives at maximum security institutions and ensure Indigenous cultural services are available and documented.

Timeline: Pathways Indicator Report are completed every quarter. Site reviews are ongoing.

20. **I recommend that CSC assign dedicated Release Coordinators at each standalone maximum-security institution and bolster related policy to establishing clear responsibilities surrounding discharge planning.**

Response: Discharge planning responsibilities fall under the existing duties and functions of the assigned Parole Officers. Policy and legislation already provide a clear framework for the process of pre-release decision-making and includes several staff members to ensure a holistic and individualised approach (such as Institutional and Community Parole Officers, Health Services staff, Indigenous Community Development Officers, and Indigenous Liaison Officers, etc.). Additionally, it is important to recognize that the offender's collaboration and engagement are crucial in the discharge planning, as it cannot be completed by the Parole Officer alone. The offender is required to actively participate in developing a release plan with their Parole Officer and to meet their identified goals in their Correctional Plan.

In addition, health-related discharge planning is also provided to all offenders being released from the institution to the community. The health care team works collaboratively within an interdisciplinary team, including the offender, to assess their health needs and develop a discharge plan. Referrals to community health services, such as physicians, harm reduction services and pharmacies, are made

prior to discharge. With the individual's consent, the health care team will share relevant healt information with their Case Management Team and community providers to help ensure continuity of care.

Notwithstanding the above, current data shows that the number of offenders being released from maximum security institutions has been consistently around 550 offenders per year since 2018-2019, which is less than 2% of the overall releases from all federal institutions and healing lodges in each region. CSC is currently conducting a data analysis to review the cases that have been released directly from maximum- security institutions. Some of the data extracted will include information such as offender demographic, sentence/offence, criminogenic risk/need information, institutional behaviour (incidents, charges, SIU), security classification decisions, etc. This data analysis will provide information that will be reviewed to determine if any changes to our policies and procedures linked to pre-release decision-making and discharge planning are needed.

Next Steps: Data analysis on the cases that have been released directly from maximum security institutions will be completed to determine if changes to policies are required.

Timeline: Spring 2025

21. I recommend that CSC develop policy establishing a minimum frequency of in-person contacts between Institutional Parole Officers and incarcerated persons on their caseloads. This policy should clearly outline expectations regarding what is to be addressed during these interactions and include additional language clarifying CX-02 involvement in a maximum-security setting.

Response: The case management process described in our current policy framework includes a requirement for several in-person contacts between the Institutional Parole Officer and inmates on their caseloads. This includes, but is not limited to, the initial interview case conference, the admission interview, meetings to update the Correctional Plan, meetings to review the inmate's security classification, etc. In-person meetings can also occur upon the inmate's request.

In addition, the Correctional Officer II/Primary Worker (CO-II/PW), who is also part of the case management team has a minimum frequency of contact set at each 45 days. Policy clearly states that the CO-II/PW must meet with the inmate and complete a Structured Casework Record (CWR).

Notwithstanding the above, as part of CSC's 2023-2024 Risk Based Audit and Evaluation Plan, CSC has committed to completing an evaluation of maximum-security institutions. This evaluation is being conducted in two parts. The first part is a comprehensive examination of the objectives, activities and intended outcomes of maximum-security institutions. This part of the evaluation is scheduled to be completed by December 2024. The second part, expected to be completed by December 2025, will assess whether maximum-security institutions are achieving expected results. Using the findings of these evaluations, CSC will consider potential changes to the intervention model, including for the case management team.

Next Steps: Completion of the first part of the evaluation.

Timeline: December 2024

22. **I recommend that CSC establish a clear purpose statement for maximum-security institutions, against which its aims can be assessed to ensure that optimal outcomes are achieved and that prisoners' essential human rights and dignity are upheld.**

Response: As part of CSC's 2023-2024 Risk Based Audit and Evaluation Plan, CSC has committed to completing an evaluation of maximum-security institutions. This evaluation is being conducted in two parts. The first part is a comprehensive examination of the objectives, activities and intended outcomes of maximum security, which is expected to be completed in December 2024.

Using the findings of the evaluation, CSC will consider establishing a clear purpose statement for maximum-security institutions.

Next steps: Completion of the first part of the evaluation.

Timeline: December 2024

This section of the document will address recommendations 23 to 28 given the recommendations focus on Lifers, except for recommendation 27, which will be addressed separately.

23. **I recommend that CSC review and revise security reclassification processes to:**
    a. **provide additional support to staff in preparing risk assessments and recommendations; and,**
    b. **ensure a thorough and mandated review of decisions that would reclassify Lifers from minimum to medium security. These decisions should require an exhaustive consideration and actioning of risk mitigation strategies.**

24. **I recommend that CSC review its policies around Correctional Plan Updates with the aim to:**
    a. **reduce delays in completing updates for Lifers; and,**
    b. **discontinue the imposition of unreasonable behavioural expectations.**

25. **I recommend that CSC review its Sentence Planning process and provide support to staff in developing individualized sentence plans for Lifers.**

26. **I recommend that CSC draw on the experience and expertise of national voluntary organizations, such as the St. Leonard's Society of Canada and the PeerLife Collaborative, to provide support to federal Lifers from intake to community release. Further, these organizations should be supported by:**
    a. **providing a significant increase in funding and access commensurate with their identified needs;**
    b. **involving them in ongoing discussions, planning, projects, and strategies pertaining to the life-sentenced population; and,**
    c. **supporting their efforts to provide peer support and opportunities for gang disaffiliation within federal prisons.**

28. **I recommend that CSC's *National Lifer Strategy*:**
    a. **explicitly acknowledge and integrate the findings of this investigation;**

b. **be national in scope and responsive to the experiences of Lifers at all security levels;**

c. **draw from consultations with incarcerated Lifers, the staff directly involved in Lifer case management, and external stakeholders; and,**

d. **be made public with specific timelines for how CSC plans to address the concerns raised in this investigation, along with other concerns identified through consultations.**

Response to Recommendations 23, 24, 25, 26 and 28: CSC is aware of the unique realities and the concerns expressed towards offenders serving a life sentence and work was already underway on the development of a Lifer Strategy.

The guiding principle in the development of this strategy is to ensure that a holistic perspective is incorporated throughout the correctional continuum, including integrating insights from the voices, and lived experiences of lifers, as well as insights from stakeholders and various CSC staff members implicated in their case management. Other guiding principles include fostering meaningful engagement (i.e., encouraging life-sentenced offenders to develop and maintain future-oriented goals) and mobilizing resources (i.e., situating the strategy in-line with existing research and strategies).

One of the main objectives is to review the sentence planning guidance in the policy framework related to the four phases of a long-term sentence to ensure that Correctional Plans are meaningful and regularly updated in a way that contributes to lifers being continuously engaged in the work required to meet specific, attainable and meaningful objectives. This development of the strategy will also include a review of the risk assessment and security classification processes to individualize the sentence planning for offenders serving a life sentence and ensure that they are placed in the appropriate security classification and institution to have access to the programs, services and interventions required.

To conduct the work that will lead to the development of the Lifer Strategy, a working group has been established and includes National Headquarters Representatives from various areas as well as regional representation. In addition, as mentioned above, the work will also include engagement with internal and external stakeholders, people with lived experience, experts, and national voluntary organizations.

In parallel, CSC is also working on a National Security Threat Group (STG) Strategy, aimed at addressing barriers for offenders affiliated to an STG and safely managing these offenders throughout their sentence. The Strategy will inform ways that CSC can provide additional support to assist offenders affiliated with an STG, including initiatives designed to assist offenders in disengaging from the STG lifestyle. To date, the STG strategy consultations have identified a need to supplement existing interventions by increasing partnerships with community organizations who specialize in gang prevention and/or disengagement measures and explore peer mentorship initiatives. In all regions, CSC is currently engaged with various community organizations, some of which do address gang disengagement as part of their work with offenders.

These valuable partnerships will be further explored by the National STG Strategy Working Group as part of the efforts to better support STG disengagement and reintegration. Additionally, the development of an internal stakeholder registry is currently underway to facilitate access to information about organizations or individuals that are currently working with or seeking to work with CSC. Information on specializations—such as gang disengagement—is part of the information that regions and sites will be able to search when using the registry.

CSC will maintain a working alliance with community stakeholders and organizations to benefit from lifer-support services. It will connect and collaborate with a network of stakeholders to comprehensively support lifers as they navigate through their life sentence, including adaptation, integration, preparation, and release into the community. Organizations, such as the St. Leonard's Society of Canada and the Peer Life Collaborative, will be consulted as part of the processes. A review to assess the possibility and feasibility of allocating more funds to these organizations will be considered.

Next Steps: The issues raised by the OCI will be taken into consideration by the working group responsible for developing the new Lifer Strategy. As part of this work, CSC will engage its partners to get the benefit of their knowledge and experiences.

Timeline: Spring 2026

27. **I recommend that CSC review the requirement for Psychological Risk Assessments for individuals seeking transfers to minimum security, with the aim to reduce delays that impede timely decision-making.**

Response: CSC and the Parole Board of Canada are currently reviewing the policy requirements for Psychological Risk Assessments (PRA). The aim of the review is to ensure these assessments are reflective of the most current research and knowledge in the field of risk assessment and are completed only when necessary and assist the case in making recommendations to decision-makers. This review should be completed by the end of Spring 2026.

Next Steps: CSC will review the requirement for Psychological Risk Assessments and consider changes to relevant policies and practices, as required.

Timeline: Spring 2026