CORRECTIONAL SERVICE CANADA

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Response to the Office of the Correctional Investigator's Report

Fatal Response: An Investigation into the Preventable Death of Matthew Ryan Hines

May 2017

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INTRODUCTION

On behalf of the Correctional Service of Canada (CSC) I want to start by expressing our deepest and sincerest condolences to Matthew Hines' family and friends regarding his death in custody. I also want to apologize on behalf of CSC to Mr. Hines' family for the inaccurate information that was shared with them at the time of his death.

I want to acknowledge up front that CSC recognizes that there were significant areas of concern with respect to the use of force against Mr. Hines and with the overall response to his medical distress situation that concluded with his death. Mr. Hines' death, as with any other death in custody, was an unfortunate tragedy and in this case possibly could have been prevented if there had been a series of different responses on May 26, 2015.

In the context of Canada's federal correctional system, the Office of the Correctional Investigator (OCI) plays an essential role in assisting the Correctional Service of Canada (CSC) to fulfill its mandate of supporting offender rehabilitation and maintaining public safety by identifying and reporting on areas of mutual concern and public interest.

The Correctional Investigator (CI) has exercised his right under section 193 of the Corrections and Conditional Release Act to table, in Parliament, a special report titled *Fatal Response: An Investigation into the Preventable Death of Matthew Ryan Hines.* The report examines the events that took place on May 26, 2015, leading up to, during and after the death in custody of Mr. Hines. In his report the CI concludes that Mr. Hines' death was preventable and he provides 10 recommendations on the CSC's policies and procedures, such as: the use of force (including the use of OC spray), as well as how the Service responds to medical emergencies and the sharing of medical information. Underpinning many of the CI's recommendations are notions of responsibility and accountability, at all levels of the Service, for preventing future use of force-related deaths in custody.

On behalf of CSC, I am accepting the recommendations put forward in the CI's final report and the following response reflects CSC's commitment to learn from Mr. Hines' death and continually work to improve our response to individuals in medical distress.

I want to assure Mr. Hines' family and friends, and all Canadians that the CSC takes every death in custody seriously and we are committed to making sure the important lessons learned from his death are engrained in the Service's response to similar situations in the future. While the following response highlights the change initiatives completed and/or underway within the Service in an effort to avoid use of force-related deaths in custody, we recognize that work remains to be done in order to fully address the issues and concerns identified by the CI. Our overall response will ensure, at the end of the day, that any medical distress situation results in a more timely and appropriate response with the primary focus of preserving life. The Service will continue to work diligently and deliberately to make the necessary improvements and to ensure that all existing and new staff understand fully their legislative and policy obligations.

Executive Summary

The following executive summary provides an overview of the CSC's response to the CI's recommendations, and outlines, in broad strokes, what the Service *is* or *will be* doing in response to each. A more detailed response follows this summary.

Recommendation 1: *Individual CSC managers at the institutional, regional and national levels should be held answerable and accountable for the deficiencies identified in the inappropriate, unnecessary and multiple uses of force that directly contributed to Matthew's medical emergency and ensuing death.*

The CSC agrees with this recommendation. Regardless of the federal public service's *Guidelines for Discipline*, CSC commits to implementing a higher level of scrutiny at the regional and national level for disciplinary decisions related to use of force incidents resulting in serious bodily harm or death.

Recommendation 2: *The case of Matthew Hines should be used as a national teaching and training tool for all existing and future CSC staff and management. The case study would include analysis and understanding of the gaps in the use of force and health care responses proximate to Matthew's death in CSC custody. (The Office notes that a Lessons Learned bulletin for staff "What does a Medical Emergency Look Like?" was published by CSC's Investigations Branch in November 2016. The learning scenario derives from the Matthew Hines case).*

The CSC agrees with this recommendation. The Service has reviewed its training materials to identify gaps and/or areas for improvement. The lessons learned from Mr. Hines' death have been incorporated into training scenarios for both new staff members and existing staff members in an effort to prevent similar tragedies.

Recommendation 3: *CSC should immediately develop a separate and distinct intervention and management model to assist front-line staff in recognizing, responding and addressing situations of medical emergency and/or acute mental health distress.*

The CSC agrees with this recommendation. The CSC is developing a distinct Situation Management Model 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.

Recommendation 4: *CSC should review and revise the channels, methods and flow of information between clinical and front-line staff to ensure first-response staff members are adequately prepared to safely manage medical and mental health needs.*

The CSC agrees with this recommendation. The CSC updated its *Guidelines for Sharing Personal Health Information* in order to provide clarification and direction regarding what offender personal mental and physical health information may (and should) be shared by CSC staff, when it can be shared and with whom. This material has been incorporated into training for frontline staff and management.

Recommendation 5: *A scope of practice review should be undertaken to ensure Registered - Nursing staff are adequately trained, supported and prepared to work in a correctional environment and include specific instruction in use of force, inflammatory agents and provision of emergency trauma care.*

The CSC agrees with this recommendation. Updated scenario-based training on use of force has been provided to nursing staff and managers. Also, effective immediately, the CSC commits to ensuring that nurses receive the *Emergency Trauma Care* training and an orientation to the correctional environment prior to being scheduled to work alone.

Recommendation 6: *CSC should ensure clarity in the leadership role of the officer in charge in situations where no Correctional Manager is present.*

The CSC agrees with this recommendation. In reviewing the events leading to Mr. Hines' death it is apparent that there was a lack of on-scene coordination in responding to his situation. The CSC will ensure that the roles and responsibilities of all staff within institutions during incidents are clearly understood, in particular those of a Sector Coordinator, a Correctional Manager, and the health care staff who arrive on scene.

Recommendation 7: *CSC should review institutional, regional and national controls on the use of inflammatory agents in federal penitentiaries. Policy direction should be issued to provide clear instruction that inflammatory agents can only be used after all other means of conflict resolution have been exhausted and only when there is a clear and present risk of imminent harm.*

The CSC agrees with this recommendation. The Service has undertaken a comprehensive analysis of Use of Force incidents, including the use of OC spray by frontline staff. The results of this review will be used to enhance policy, training and oversight. The CSC also implemented judgment-based scenario training for the use of OC spray, and will be stressing other de-escalation techniques that can be employed by staff.

Recommendation 8: *CSC front-line staff members should receive regular refresher and upgraded training in conflict de-escalation. Training should emphasize how to manage oppositional/defiant behaviours in situations where underlying mental health issues are present or previously identified.*

The CSC agrees with this recommendation. The Service has modernized its annual refresher training for Correctional Officers. The Correctional Officer Continuous Development training integrates decision-based training, placing a strong focus on the Situation Management Model; including a formal debrief process, conducted by Correctional Managers. The training scenarios employed are adapted from lessons learned and/or identified areas for improvement, and include a scenario containing a mental health component. As well, the re-designed Situation Management Model will be incorporated into the annual refresher training for all Correctional Officers and in the new recruit training course.

Recommendation 9: *CSC should immediately develop mechanisms to reconcile Board of Investigation findings with the staff disciplinary process.*

The CSC agrees with this recommendation. Although the staff disciplinary and incident investigation mechanism are separate processes with distinct objectives and operating under different legislative and policy authorities, the CSC will be taking steps to embed lessons learned from all investigatory processes used throughout the Service to ensure there are no discrepancies in facts for decision-making purposes.

Recommendation 10: *Boards of Investigation into deaths in custody should be required to examine and clearly state whether and how the death in question could have been prevented.*

The CSC agrees with this recommendation. The Service agrees with the need for a sound approach for investigating and reporting on deaths in custody in a manner that the Service can best learn from these events. The CSC will strengthen the content of its Board of Investigation reports, into use of force that results in serious bodily injury or death, by ensuring that a dedicated section of the report clearly identifies issues of non-compliance, as well as how these incidents could have been minimized, avoided or prevented where the facts clearly support such a finding.

Detailed Response

1. **Individual CSC managers at the institutional, regional and national levels should be held answerable and accountable for the deficiencies identified in the inappropriate, unnecessary and multiple uses of force that directly contributed to Matthew's medical emergency and ensuing death.**

   More can and will be done to ensure that those involved in an inappropriate use of force incident resulting in death or serious bodily injury are held answerable and accountable for their actions. Ensuring the safety and security of the public, our institutions, staff and offenders is our foremost priority. In support of this, my expectation is that all CSC employees abide by our policies and legislative mandate, and act according to the highest legal and ethical standards; this includes an obligation to take action in an effort to preserve life and support the rehabilitation of offenders.

   The CSC does not tolerate failure by staff to abide by the rules of professional conduct and code of discipline that are outlined in Commissioner's Directive (CD) 060, *Code of Discipline* (2011-08-02). All allegations of staff misconduct are thoroughly investigated by the CSC and disciplinary measures may be taken, where appropriate, in accordance with the Government of Canada (GOC)'s *Guidelines for Discipline* and the Service's *Instrument of Delegation of Authorities in the area of Human Resource Management*.

   While circumstances sometimes require that CSC staff use force to ensure safety and security, CD 567-1, *Use of Force* (2016-02-01), establishes the necessary procedures to follow. In any instance where an employee's use of force actions are reviewed and culpable misconduct is found, the Service may contemplate disciplinary measures (up to and including termination), in keeping with jurisprudence and Treasury Board of Canada Secretariat direction.

   In accordance with the GOC's guidelines, disciplinary measures are to be corrective in nature, rather than punitive. Given that immediate managers can more accurately assess the impact that a disciplinary measure will have on correcting an employee's behaviour, the responsibility for discipline is typically delegated to the most direct level possible.

Taking into account the information above and as highlighted in the CI's report, for use of force incidents resulting in death or serious bodily injury, more can be done to ensure the integrity of the Service's disciplinary process. Accordingly, I have directed that CSC establish a dedicated team that will be responsible for conducting disciplinary investigations into use of force incidents resulting in death or serious bodily injury. The establishment of this team will aim to enhance the functional independence and credibility of the CSC's disciplinary process through an internal review mechanism that is impartial, fair and transparent. The team will be comprised of external and former senior executives, with investigative skills, recognized for their expertise and experience.

The findings of this dedicated team's disciplinary investigation report will be used to support disciplinary decisions by the respective Institutional Head (IH). With respect to staff discipline for use of force incidents involving death or serious bodily injury, the Service commits to implementing a higher level of scrutiny for disciplinary decisions than is required by the GOC guidelines. Specifically, the CSC will amend the *Instrument of Delegation in the Area of Human Resource Management* to include mandatory consultation with the respective Regional Deputy Commissioner or Sector Head and the Director General, Labour Relations and Workplace Management, whenever disciplinary and other administrative measures are contemplated. Further, the decision makers will be required to provide written justification where the disciplinary measures taken diverge from the quantum advice provided by Labour Relations.

In addition, all cases where a use of force incident results in disciplinary measures, regardless of whether death or serious bodily injury has occurred, the decision maker will have to provide a written rationale for any sanction that is levied.

In cases where potential criminal behaviour is identified with respect to an employee's use of force actions, the CSC contacts the police force of jurisdiction to report the incident. As a result, the police may convene an investigation into possible criminal behaviour. A Coroner's inquest may also be held, which would include a review of the incident and response. Following Mr. Hines' death in custody, the Service requested that police authorities investigate this tragic situation and there is currently an ongoing RCMP investigation into the circumstance of Mr. Hines' death, with which we are cooperating fully. We will similarly provide our full support to a coroner's inquest, when convened. While both of these processes and their findings are independent of the CSC, they also provide opportunities for us to learn, and make the necessary changes and/or improvements moving forward.

2. **The case of Matthew Hines should be used as a national teaching and training tool for all existing and future CSC staff and management. The case study would include analysis and understanding of the gaps in the use of force and health care responses proximate to Matthew's death in CSC custody. (The Office notes that a Lessons Learned bulletin for staff "What does a Medical Emergency Look Like?" was published by CSC's Investigations Branch in November 2016. The learning scenario derives from the Matthew Hines case).**

   There is no question that Mr. Hines' death in custody is a tragedy and possibly could have been prevented had other courses of action been pursued on 26 May 2015. As is always the case, tragic incidents also provide crucial information on what the Service must focus on to address the findings from all external and internal investigations or other inquiries. In the shadow of Mr. Hines' death, the Service is committed to, and accountable for, identifying and responding to these gaps in order to prevent reoccurrence of similar incidents.

   The CSC's Executive Committee has taken an active role in addressing the findings and recommendations made in response to Mr. Hines' death. As part of this work, Regional Deputy Commissioners across Canada have discussed this case with regional and institutional management committees to share information and learn from this tragic incident. All Wardens have committed to ensuring that their staff members are briefed on this case, and that frontline staff and managers clearly understand and fulfill their roles, responsibilities and expectations in effectively responding to and managing all security incidents, including physical and mental health distress situations.

   As noted by the CI in his report, in November 2016, the CSC's Incident Investigations Branch published a lessons learned bulletin for staff. The bulletin, titled "*What Does a Medical Emergency Look Like?*" provides CSC staff with information on the signs and actions to consider when making decisions regarding the use of force in the face a potential medical emergency. The scenario presented in the bulletin is derived from Mr. Hines' tragic situation.

   In December 2016, the CSC's Security Branch published a Security Bulletin to remind frontline staff of the importance of proper arrest and control, and escorting techniques. The bulletin directly addresses many of the areas for improvement identified in the events leading up to Mr Hines' death. Specifically, the bulletin reminds staff of the expectation that: a lead officer will be designated to oversee the arrest, control and escort process; the use of restraint equipment and alternatives will be continuously reassessed against a variety of situational factors and inmate behaviour (e.g. offender health and wellbeing); and, staff will follow emergency medical protocols (e.g. first aid, CPR, obtain medical services) as necessary. In short, the bulletin reminds arresting/escorting staff that they assume responsibility and accountability for the safety and wellbeing of individuals under escort, particularly in cases where restraint equipment is applied.

The CSC has also reviewed its relevant training materials to identify gaps and/or areas for improvement, and to determine how the lessons learned from Mr. Hines' death could be incorporated into future training in an effort to prevent similar tragedies.

To date the Service has updated its Correctional Training Program (CTP) to include comprehensive material on Sudden In-Custody Death Syndrome (SICDS). The updates incorporate findings from the investigation into Mr. Hines' death, as well as current law enforcement trends and research. In addition to providing knowledge of the signs, symptoms and risk factors of SICDS, this training is intended to reinforce with staff their roles and responsibilities, as part of an interdisciplinary team, in recognizing and responding to medical emergencies.

In 2016, the CSC's Executive Committee provided direction to modify CSC's training approach for Correctional Officer's annual training from a technical skills focus to a decision-based model. The first training module adapted to this model was the chemical agents training, including OC spray. This new approach uses a variety of scenarios that Correctional Officers are expected to respond to in a manner consistent with the new model. In addition, Correctional Managers participated in this training to work with the officers to debrief on their actions and decisions. In order to do so, Correctional Managers received training to strengthen their supervisory and leadership skills on debriefing incidents in our federal penitentiaries across Canada. The above changes will strengthen the daily learning opportunities for the Service's frontline staff as officers will actively learn on the job from their direct supervisors through the debriefing process. The CSC is modifying all correctional officer annual training to follow this improved model. New scenarios will be added each year.

On April 1, 2017, a new decision-based training scenario, which includes a mental health component, was implemented into the Correctional Officer Continuous Development Training. This training provides increased opportunities for decision-based training with a formal debriefing process by the Correctional Managers. The addition of a mental health component to this training will allow correctional officers to practically apply their knowledge of the signs, symptoms and risks factors related to SICDS in a professional and safe learning environment. Moving forward, the Service will also develop videos and new scenarios in support of this decision-based training, as well as instructor materials (i.e. instructor notes) which clearly indicate the intended learning objectives.

Finally, the CSC's Health Services Guidelines 800-4, *Response to Medical Emergencies* (2017-01-30), requires Institutional Heads to ensure that they hold quarterly on-site simulations of medical emergencies to allow staff members to practice and remain current in their skills. The Service has developed a new scenario based on the factors of Mr. Hines' case, which is being practised in institutions across the country.

3. **CSC should immediately develop a separate and distinct intervention and management model to assist front-line staff in recognizing, responding and addressing situations of medical emergency and/or acute mental health distress.**

   Where the management and/or control of security incidents are necessary to maintain a safe institutional environment, all interventions used to manage and/or control such incidents must be consistent with the Situation Management Model (SMM), which is a visual representation used to assist staff in determining appropriate intervention options.

   Unfortunately, as pointed out by the Board of Investigation (BOI) and in the CI's final report, there were significant breakdowns in the management and/or control of events leading up to Mr. Hines' death. This included the lack of ongoing reassessment of the situation by on-scene staff to ensure that the most appropriate measures were being used.

   CSC will be developing a distinct model that places more emphasis on the importance of non-physical intervention in cases of use of force incidents involving offenders who exhibit signs of physical and/or mental health distress.

   In addition, the Use of Force policy is currently being revised to strengthen the need to assess and continually re-assess the response during a situation, as well as reinforce the importance of verbal interventions, including the involvement of clinical staff and other non-security resources in the primary response to an incident when appropriate, based on situational factors.

4. **CSC should review and revise the channels, methods and flow of information between clinical and front-line staff to ensure first-response staff members are adequately prepared to safely manage medical and mental health needs.**

   CSC continues to be committed to meeting both the physical and mental health needs of all offenders incarcerated within Canada's federal correctional system. The Service understands and recognizes the importance of information sharing in order to meet this commitment. Accordingly, we will continue to work on ensuring that both health and operational staff have access to and receive the information they need to safely and appropriately manage offenders under the CSC's care and custody.

   In November 2015, the CSC updated its *Guidelines for Sharing Personal Health Information* in order to provide clarification and direction regarding what offender personal mental and physical health information may (and should) be shared by CSC staff, when it can be shared and with whom.

   In order to support staff in understanding and implementing the guidelines, we have incorporated this material into training for frontline staff and management. For example, in fiscal year 2016/17, CSC integrated material on information sharing into

training for the Assistant Wardens and Deputy Wardens and in the *Fundamentals of Mental Health* training targeted at frontline staff. Our efforts in this area are ongoing, and in fiscal year 2017/18 a module on information sharing will be added into the Parole Officer Induction Training. The aim of these various training packages is to ensure participants understand the importance of timely information sharing and the associated policy/legal framework.

5. **A scope of practice review should be undertaken to ensure Registered - Nursing staff are adequately trained, supported and prepared to work in a correctional environment and include specific instruction in use of force, inflammatory agents and provision of emergency trauma care.**

   The CSC is mandated by the CCRA to provide essential health care to every inmate and the delivery of care is provided by health care professionals who are registered and licensed in Canada. There is no question that nurses play an essential role in ensuring the provision of health care services to individuals incarcerated in Canada's federal correctional system, providing care within the scope of practice outlined by their professional governing body.

   As reaffirmed by the CI report, nursing is a difficult occupation in the best of circumstances and nursing in a correctional environment offers its own set of challenges. As identified in the CI report and the Service's Board of Investigation report, any gaps in the preparation of nurses to work in a correctional environment can lead to serious consequences. Accordingly, orientation, policy guidance, and training are provided by the CSC to build nursing competencies specific to a correctional environment. Competency enhancements include education and policy support on the role of the nurse in use of force circumstances (including when inflammatory agents are used). CSC nurses also receive mandatory emergency trauma care training by contracted community providers.

   Ongoing identification of areas for improvement is a key driver in the Service's development of training priorities. For example, in September 2016, updated training materials on the use of force were provided to nursing staff and managers, highlighting the scenario where a use of force evolves into an emergency medical situation. Similarly, Health Services and Correctional Operations jointly developed a simulation of a medical emergency based on lessons learned from Mr. Hines' case. These simulation exercises will provide hands-on practical training experience on how to recognize and effectively deal with this kind of medical emergency.

   In addition, effective immediately, the CSC commits to ensuring that nurses receive the *Emergency Trauma Care* training and an orientation to the correctional environment prior to being scheduled to work alone. Compliance with this requirement will be confirmed by the Institutional Chief of Health Services.

6. **CSC should ensure clarity in the leadership role of the officer in charge in situations where no Correctional Manager is present.**

   Clear leadership is essential to the management and control of existing and/or emerging security incidents, including medical emergencies. However, following the review of the events involving Mr. Hines, it is apparent that there was a lack of coordination in the response and consequently no one to provide direction on actions to take or cease during the intervention with Mr. Hines.

   CSC post orders identify the Correctional Officer II as Sector Coordinator, who is responsible for taking the lead role during an incident to ensure the safe and secure operation of the institution pending the arrival of the Correctional Manager at the scene.

   Given the lack of coordination in the response in Mr. Hines' case, the role of the Sector Coordinators will be further defined in Institutional Post Orders. In addition, CSC is in the process of developing a training video that will include the roles and responsibilities of the Sector Coordinator in the coordination of non-routine situations, including medical emergencies. The video will be completed and implemented in June 2017, allowing Sector Coordinators to practically apply their knowledge in a professional and safe learning environment.

   Furthermore, new recruits are receiving First Officer on Scene training, which gives them fundamental knowledge on how to control and manage an incident if they arrive before a Sector Coordinator.

   Finally, as mentioned in the response to Recommendation 2, a new training module, targeting Correctional Managers has also been implemented. The debrief process is an essential component for constructively assessing and evaluating a response to a security incident. This training module provides support to the Correctional Manager group by providing them with the tools to systematically examine intervention components and ensure that the responses and interventions to an incident are appropriately developed and executed. This training will also assist Correctional Managers to work with staff to address any gaps, including on-scene leadership.

7. **CSC should review institutional, regional and national controls on the use of inflammatory agents in federal penitentiaries. Policy direction should be issued to provide clear instruction that inflammatory agents can only be used after all other means of conflict resolution have been exhausted and only when there is a clear and present risk of imminent harm.**

   CSC promulgated revisions to Commissioner's Directive (CD) 567 – Management of Security Incidents (2017-01-16) and it confirms that OC spray should only be used after verbal intervention has not worked or has been assessed as an inappropriate option for the situation given the level of risk or danger. The policy also requires that OC spray canisters are weighed when they are issued and when they are returned.

This ensures there is a mechanism in place to confirm when this tool and how much of it has been used.

In April 2016, CSC also implemented a new training approach that further emphasizes judgment-based scenarios for the use OC spray to balance the technical training elements in using the equipment.

The Service is also undertaking a comprehensive analysis of Use of Force incidents including the use of OC spray by frontline staff, to be completed in April 2017. This analytical review will be used to enhance policy, training and oversight, as required. In addition, the Service will be undertaking a review of the literature in relation to deaths or serious health injuries that occur proximate to the deployment of OC spray. This review will be completed by the Fall of 2017.

Finally the Service is committing to working with other correctional jurisdictions internationally to identify other non-lethal tools and techniques that could be employed when staff members are responding to stressful situations. This review will be completed by the end of the 2017/18 fiscal year.

8. **CSC front-line staff members should receive regular refresher and upgraded training in conflict de-escalation. Training should emphasize how to manage oppositional/defiant behaviours in situations where underlying mental health issues are present or previously identified.**

Ensuring that CSC staff members are properly selected and trained is one of the principles that guide the Service, and a responsibility that I and all senior executives take seriously. In 2016, the Service began modifying its training approach for Correctional Officer's annual training from a technical skills focus to a decision-based model. As mentioned, the first scenario developed for this training model focused on the deployment of chemical agents. In March 2017, the Service committed to further enhancing its Correctional Officer Continuous Development training, and is moving towards incorporating decision-based training in all subject areas.

The modernization of Correctional Officer annual refresher training is intended to ensure that Correctional Officers are fully engaged in the training process and that they have the ability to apply their acquired knowledge and skills in a professional and safe learning environment. Correctional Officers will practice their skills in a variety of situations in a manner that promotes respect for law and policy, including the principles of the Situation Management Model.

Notably, this new training model integrates increased opportunities for decision-based training, placing a strong focus on the SMM, which includes a formal debriefing, conducted by Correctional Managers with the support of the CSC's professional instructors. The training scenarios employed may be adapted from lessons learned and/or identified areas for improvement. As previously noted, on

April 1, 2017, a new decision-based training scenario which includes a mental health component was implemented into the Correctional Officer Continuous Development training. A new module on dynamic security will be developed in fiscal year 2017/18, with an implementation date of April 2018. Although current orientation training includes the use of communication skills to manage situations, this new module in the Correctional Officer's annual training will reinforce and further develop critical thinking and communication skills, specifically emphasizing the use of verbal intervention to de-escalate the situation.

In addition, the Service's new Sudden In-Custody Death Syndrome training content addresses the need to consider an offender's state of mental health and how this can impact their understanding of the situation during a crisis. It also emphasizes the importance of using communication and de-escalation techniques when faced with these situations.

9. CSC should immediately develop mechanisms to reconcile Board of Investigation findings with the staff disciplinary process.

I acknowledge and agree with the CI's concern with regard to the appropriateness of the disciplinary decisions in Mr. Hines' case, given findings that the actions of frontline staff did not comply with CSC policy at various points leading up to his death. As noted in our response to Recommendation #1, CSC commits to implementing a higher level of scrutiny at the regional and national level for disciplinary decisions related to use of force incidents resulting in serious bodily harm or death and a higher level of transparency in all decisions related to disciplinary sanctions.

I would note that there exist challenges in the timely reconciliation of Board of Investigation (BOI) findings with the staff disciplinary process given that these mechanisms have distinct objectives under different legislation and policies, and that they are undertaken at different times. Generally, the completion of the disciplinary process occurs several months prior to a BOI being completed. Challenges notwithstanding, I am committed to ensuring integrity in these processes by taking further steps to embed lessons learned from all fact finding processes throughout the Service.

10. Boards of Investigation into deaths in custody should be required to examine and clearly state whether and how the death in question could have been prevented.

I recognize the significance of the concern highlighted by the CI in his report, which speaks to the need for a sound approach for investigating and reporting on deaths in custody in a manner that the Service can best learn from these events.

The incident investigation process plays a key role in this regard by ensuring that the CSC adheres to the principles of responsibility, accountability and transparency.

This includes undertaking the important exercise of self-scrutiny and providing the opportunity to respond to an incident with appropriate and effective corrective measures, in order to promote a “lessons learned” approach across the Service. There is a heightened need to do so in cases of non-natural deaths in custody given the Service’s obligation to preserve life. These are tragic events that have profound impacts on an inmate’s family and circle of friends, as well as throughout the CSC community.

The Service is committed to strengthening its capacity to learn from incidents in order to foster an environment where good corrections is entrenched in our organizational culture and exemplified in each staff member’s daily work. As part of our efforts in this regard, the CSC will strengthen the content of its investigation reports into use of force incidents that result in death or serious bodily injury. Moving forward in cases with these types of incidents, BOIs will be directed to dedicate a section of their report to clearly identify issues of non-compliance, as well as how these could have been minimized, avoided, or prevented where the facts clearly support such a finding. This will include the ability for BOI investigators to identify issues related to accountability at all levels in the organization.