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3447-2-ULAYUK (NPB)

EXECUTIVE SUMMARY ONLY

NATIONAL JOINT BOARD OF INVESTIGATION
INTO THE RELEASE AND SUPERVISION
OF AN OFFENDER ON FULL PAROLE
CHARGED WITH FIRST-DEGREE MURDER
OF A PAROLE OFFICER
ON OCTOBER 7, 2004
IN YELLOWKNIFE, NORTHWEST TERRITORIES

Correctional Service of Canada
&
National Parole Board

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EXECUTIVE SUMMARY

Introduction

Louise **PARGETER** was a 34 year old Correctional Service of Canada Parole Officer who had worked in the Yellowknife Parole Office since 2001. At the beginning of October 2004, she was re-assigned the case of Eli **ULAYUK** and arranged to meet with the offender at his apartment on 2004-10-06 at 10:00hrs. She did not return to the office at 11:30hrs as scheduled and her colleagues made a number of attempts to locate her. Her body was found by the RCMP in **ULAYUK**'s apartment later that day and **ULAYUK** was arrested early the following morning.

ULAYUK has been charged with First-Degree Murder and at the time of the completion of this report, he is awaiting trial. He is presumed, by the law of Canada, to be innocent until found guilty by a court.

On 2004-11-04 the Acting Commissioner of the Correctional Service of Canada (CSC), Don **HEAD** and the Chairman of the National Parole Board (NPB), Ian **GLEN**, directed that an investigation be conducted and convened a Board of Investigation (BOI). The BOI was chaired by Andrejs **BERZINS**, Community Member, with Janice **RUSSELL**, Permanent Investigator, Incident Investigations Branch, National Headquarters, CSC, Simonne **FERGUSSON**, Regional Director, Ontario/Nunavut Region, NPB and Titus **ALLOOLOO** (Community Member) as members.

The Board of Investigation was given a very broad mandate by the Correctional Service of Canada and the National Parole Board. It was asked to examine how **ULAYUK** was dealt with by the CSC since he first entered the system in 1990 and to examine all of the NPB decisions including his grant of Full Parole in June 2004. The Board's mandate also included looking at **ULAYUK**'s supervision in Yellowknife and issues related to the personal safety of CSC community staff. The BOI was invited to make any recommendations that it considers appropriate.

had the sudden urge to have sex with the victim's dead body and killed her for that purpose. The police recovered the victim's body with her underwear removed and torn but **ULAYUK** maintained that he changed his mind after killing the victim and did not actually have sexual relations with her body.

Before his trial, **ULAYUK** was ordered by the court to undergo a psychiatric examination at the Clarke Institute of Psychiatry in Toronto (now known as the Centre for Addiction and Mental Health). There was a difference in opinion between doctors from the Clarke Institute and doctors retained by defense counsel as to whether **ULAYUK** had a mental disorder that would render him not criminally responsible for the offence. However, all agreed that he had the sexual deviance of necrophilia. At his trial in 1990, a jury rejected his defenses of "insanity" and intoxication and **ULAYUK** was found guilty of Second-Degree Murder. **ULAYUK** successfully appealed his conviction on technical grounds. In 1992, instead of proceeding with a new trial, the Crown accepted a plea of guilty to Manslaughter. In sentencing **ULAYUK** to life imprisonment, the judge made the following comments and recommended that he receive treatment within the CSC. *"Of the many cases of manslaughter to come before this court in the last 35 years, I can not help but class this as the worst in terms of its extraordinarily horrible facts."* *"Of the many offenders who have come before the courts of the Northwest Territories over the past 30 or more years, there are very few whom I remember to have been potentially as dangerous to the public as Mr. **ULAYUK**."*

The BOI found that important decisions were subsequently made, within the CSC and by NPB Members, without a complete understanding and careful analysis of **ULAYUK**'s index offence. The decision by the Crown to accept a plea of guilty to manslaughter, without explanation, partially contributed to this. The gravity and exceptional nature of the offence, particularly its deviant sexual motivation, necrophilia, tended to be minimized. The decisions affected by this lack of appreciation of the index offence and the offender included his diagnosis and treatment in programs, risk assessments, release decisions, and community supervision decisions. It appears to the BOI that this was at least

partially due to “naivete” and the inability to distinguish this case from the many other serious cases that CSC and NPB officials regularly had to deal with.

The Board found that warning signs were present which should have alerted authorities to the exceptional nature of the offence and the dangerousness of this offender. Considerable information was also available to the authorities that would have given them a clearer picture of this case but there was no vigorous attempt made to obtain that information. **ULAYUK**’s file from the Clarke Institute and the full reports of the doctors who testified at the trial were never obtained by the Correctional Service of Canada or National Parole Board.

ULAYUK in the CSC

ULAYUK entered [REDACTED] in 1992. His criminogenic factors were identified as substance abuse, education/employment and emotional stability. He participated in numerous programs but refused sex offender programming. He considered himself not to be a sex offender since he claimed he had not had sex with the victim’s body.

In 1995, **ULAYUK** was sent [REDACTED] [REDACTED] for a psychiatric assessment for parole purposes. While there, he agreed to go into the [REDACTED] Sex Offender Assessment and Treatment Program, [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

The BOI found that the quality of the assessment and treatment of **ULAYUK** in the [REDACTED] Program, as it existed in 1995, was less than what could be reasonably expected of a high intensity sex offender program of the CSC. However, it strongly influenced how **ULAYUK** was subsequently seen and dealt with by decision-makers within CSC and NPB. Essentially, most decision-makers understood that the professionals at the [REDACTED] had ruled

out sexual deviancy as a concern. Despite subsequent significant indications that sexual deviancy may still be an issue most decision-makers continued to rely on the 1995 conclusions. The BOI found that the authorities lost their focus on the pathology of the index offence from that point forward and **ULAYUK** would never undergo any further sex offender programming while incarcerated.

The BOI found an overall failure to recognize that sex offender treatment is a dynamic, long-term process requiring constant monitoring. **ULAYUK** having completed the [REDACTED] Program in 1995 was generally seen as an “inoculation” against future sexual offending. The BOI found a general over-reliance on professional assessments and completion of programs without considering the extent of treatment gains.

In 1997 **ULAYUK** was transferred from the minimum-security [REDACTED] Institution back to [REDACTED] as the result of an incident [REDACTED]. At about the same time a psychologist who had been counselling **ULAYUK** at [REDACTED] Institution filed a report describing serious disclosures **ULAYUK** had made to her during the sessions. [REDACTED]

The BOI found that these disclosures should have led to his immediate return to the [REDACTED] for further assessment and treatment. However, the BOI found that not only was this not done, the report was also inexplicably given little attention despite being placed in CSC and NPB files. It was referred to in only one of several subsequent risk assessments by psychologists and not mentioned in any NPB release decisions. The BOI could find no documentation indicating how the authorities considered that the risk revealed through those disclosures had been satisfactorily addressed.

A psychological risk assessment done for parole purposes in 1998 concluded that **ULAYUK** was a high risk to re-offend violently. Within a year however, another risk

assessment by a different psychologist concluded the opposite without substantiating any reason for this change.

[REDACTED]

[REDACTED]

In June 2000, **ULAYUK** was granted Day Parole to reside at the Salvation Army residence in Yellowknife. He refused to participate in the Sex Offender Maintenance Program and was referred to individual counselling with the contract psychologist to address anger management and impulse control. However, the sexual motivation for the index offence was not addressed in the counselling. During this period he was generally non-compliant with his parole officers. His release was suspended once by CSC and then he was re-released on their authority with a “behaviour contract”. **ULAYUK**’s Day Parole was eventually revoked in June 2001 by NPB on the recommendation of Parole Officer **PARGETER**, for violence and aggressive sexual activity towards his girlfriend.

Instead of being placed in a facility with specialized programs for sex offenders, **ULAYUK** was sent to [REDACTED] Institution which does not generally accommodate such offenders. The BOI found that the case management staff and counselling psychologists at [REDACTED] Institution were not trained or experienced in how to assess and treat sex offenders and were generally reluctant to acknowledge that **ULAYUK** had committed a

sexual offence. They felt that their role was to deal with the immediate issue that led to **ULAYUK**'s revocation and to prepare him for re-release. A psychological risk assessment concluded he was at a low to moderate risk to re-offend and this position did not change when he was expelled from an Aboriginal community-based program [REDACTED]
[REDACTED]

The BOI found that during **ULAYUK**'s periods of incarceration he completed a large variety of programs and incurred few institutional charges. His Escorted Temporary Absences and work placements were successful and he was considered suitable for minimum security. [REDACTED]

[REDACTED] he generally made a good impression on those directly dealing with him. [REDACTED]
[REDACTED]

[REDACTED] In some cases the behaviour was interpreted as being due to cultural differences.

During his last period of incarceration at [REDACTED] Institution he was considered a "model inmate". The BOI noted the research findings that good institutional behaviour is not indicative of low risk to re-offend.

ULAYUK under supervision in Yellowknife in 2003 and 2004

In 2003, **ULAYUK** was again released on Day Parole to Yellowknife. At this time Louise **PARGETER** was on leave and he was supervised by other parole officers. **ULAYUK** was closely monitored [REDACTED] and with a few exceptions, his overall behaviour was improved. He was employed, [REDACTED] [REDACTED] and participated in programs including a Sex Offender Maintenance Program, a newly stipulated requirement of his Correctional Plan, to which he agreed. In April 2004, Louise **PARGETER** returned to the Yellowknife Parole Office but did not immediately assume supervision of **ULAYUK**. In June 2004, **ULAYUK** was granted Full Parole and began living in an apartment in Yellowknife.

The parole officers, with the help of the contract psychologist, had to manage a series of events in August and September of 2004 concerning **ULAYUK**.

[REDACTED]

At the end of September 2004, as the result of a re-organization of office responsibilities, **ULAYUK**'s case was re-assigned to Louise **PARGETER** with her agreement. The BOI found that it was not appropriate to transfer the supervision of **ULAYUK** [REDACTED], particularly not to Louise **PARGETER**, because of his unresolved resentment towards the Yellowknife Parole Office resulting from the revocation of his previous Day Parole and considering that she was instrumental in that action.

Louise **PARGETER** was aware of the circumstances surrounding **ULAYUK** in September and October 2004. She decided to visit **ULAYUK** at his home and could have scheduled her visit with him elsewhere. She did not request accompaniment, however, the BOI found that the practice and culture in CSC generally, including in the Yellowknife Parole Office, was such that it would have been unusual for any parole officer to make such a request.

The BOI found that a thorough analysis and an in-depth understanding of this case would have led to the conclusion that a parole officer, particularly a female, could be at undue risk doing an unaccompanied home visit with **ULAYUK** at this time. [REDACTED]

[REDACTED]



General findings and recommendations

In examining the overall quality of the information provided by the CSC to the NPB, the BOI found that in the Assessments for Decision, the parole officers essentially reviewed **ULAYUK**'s progress over the most recent periods of incarceration or community supervision and assessed his risk from that limited perspective. The BOI believes that it would have been more helpful to the NPB for the parole officers to also take into account and highlight the significant aspects of this case, that were relevant to risk, from the commencement of his sentence.

There was limited independent critical analysis by the NPB Members of the information on the file and at the hearings. The focus generally was on the most recent phase of the sentence. The BOI found that risk assessments by both Correctional Service of Canada and National Parole Board focused more on the positive aspects of **ULAYUK**'s case and did not accurately reflect the negatives. A contributing factor for both Correctional Service of Canada and National Parole Board was the multi-volume file and the conflicting reports. This complicated the analysis of the case in the limited time provided for review by National Parole Board Members and Correctional Service of Canada staff.

The BOI examined the issue of CSC community staff safety and made findings in specific areas. Overall, the BOI considers that CSC, as an organization, gave inadequate attention to this question. The BOI made a number of recommendations that include calling for the establishment of a comprehensive CSC policy on community staff safety. It is recommending that there be a presumption that all home visits by parole officers be accompanied. Reasonable criteria and procedures for exceptions to this general rule may be developed, but parole officer safety must at all times be the overriding consideration.

The BOI made recommendations relating to the CSC information gathering process at the intake stage, case preparation for NPB release decisions, and the supervision of offenders in the community. Given the history of this case, particular attention was focused on risk assessments by psychologists and psychiatrists. There is a need for CSC staff in the institutions and in the community to receive more specialized training on how to recognize signs of potential violent sexual behaviour.

The BOI addressed the issue of the changing profile of offenders in federal institutions. The proportion of offenders who are serving lengthy sentences for offences of violence has increased. This creates new challenges for the CSC and the NPB. The BOI made recommendations that stress the need for officials to remain focused on the index offence and to consider the offender's progress over the course of the entire sentence rather than during just the most recent part. In order to do that, officials, including NPB Members, must be provided adequate time to thoroughly review complex cases such as this and the files must be better organized in order that they can more readily identify critical information.

The BOI also recommended that the format for National Parole Board written decisions should be more structured and should direct decision-makers to address specific factors. In addition, National Parole Board members should be required to clearly justify the risk assessment and reasons for a re-release following revocation of an earlier parole.

The need for a strategy for supervision of Life-sentenced cases and long-term offenders and to respond to breaches of release in these cases was also noted. Additional recommendations were made related to management of future Boards of Investigation, follow-up to BOI recommendations and the need for development of protocols to improve information collection in cases resolved through plea bargaining.

The BOI made certain observations and recommendations relating to Inuit offenders. These included development of an Inuit-specific risk assessment tool and further

development of the Kajusiniq Inuit Action Plan. It also recommended additional training for National Parole Board Members and Correctional Service of Canada staff related to Inuit culture and history, as distinct from southern Aboriginal traditions.

The BOI found that Critical Incident Stress interventions were generally well managed for Correctional Service of Canada staff and for Louise **PARGETER**'s partner and parents, but that adequate support was not provided in this respect for the National Parole Board.

The BOI found that some positive steps have already been taken by the CSC and NPB to address some of the problems and issues identified in this report. In order to ensure that this constructive response to the tragic loss of a valuable employee continues without losing momentum, the BOI recommended that after 12 months from receiving this report, an independent body or person be appointed to review the extent to which all of its recommendations have been implemented.

In conclusion, the BOI would like to thank the staff of the Yellowknife Parole Office for their assistance and cooperation in this investigation. We found them to be dedicated, professional individuals who used their best judgment under crisis conditions on 2004-10-06. The BOI is satisfied that at all times during this crisis they acted with the best interests of their friend and colleague, Louise **PARGETER**, in mind.