



Report on announced inspection in Canada by HM
Chief Inspector of Prisons for England and Wales

Grand Valley Institution for Women

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Introduction

The Canadian background

In 1989, the Correctional Service of Canada (CSC), in collaboration with the Canadian Association of Elizabeth Fry Societies, established a Task Force on Federally Sentenced Women. This resulted in the publication in 1990 of *Creating Choices*, setting out a different and more progressive model for the imprisonment of women. The report was accepted. Reform was further spurred on by the publication, in 1996, of Justice Arbour's report into events at the Kingston Prison for Women in 1994.

As a consequence, from 1995, CSC began to set up small institutions for federally-sentenced women, one in each of the five correctional regions; in addition to a Healing Lodge¹. Those institutions were an innovative attempt to put in place the five guiding principles of *Creating Choices*: empowerment, meaningful and responsible choices, respect and dignity, a supportive environment and shared responsibility. In 2000, the Kingston Prison for Women was closed.

The units in the new institutions have been designed as far as possible to normalize the experience of women in custody. Within a relatively low secure perimeter fence, women have free movement and small groups share houses in which they can take responsibility for themselves. They offer a radically different environment to that experienced in the majority of men's prisons, or in women's prisons elsewhere in Canada and in most other countries.

However, since then, following some security incidents, the model has been amended. External security has been enhanced by raising the perimeter fence. Maximum secure units were built within each facility (except the Healing Lodge) to house women who are deemed too difficult or unsafe to manage in the low secure units. Aboriginal women are over-represented in those units. And, as a positive move, structured living environments (SLEs) were set up to provide multi-disciplinary interventions for particularly needy and mentally disordered women.

Other issues have raised significant concerns within Canada: including the extent to which both security classification and the tools used to assess and provide for women's offending behaviour needs are sufficiently gender and culturally sensitive; and the support and control role-mix of primary workers (custodial staff).

In March 2001, the Canadian Human Rights Commission (CHRC) agreed to undertake a broad review of the treatment of federally sentenced women, following concerns expressed by a number of organisations, particularly about the treatment of incarcerated Aboriginal women and those with cognitive and mental disabilities. The CHRC's report, published in December 2003, made 19 recommendations for change, including one (Recommendation 19) which called for an independent external redress body for federally sentenced offenders.

The Inspectorate background

The CSC did not accept Recommendation 19 as such; but, as part of its action plan to implement the CHRC's report, in 2005 it asked the Chief Inspector of Prisons for England and Wales to carry out a full inspection of two federal women's institutions, Nova (in the Atlantic region) and Grand Valley (in Ontario).

¹ Offering a culturally appropriate setting for a small number of mainly Aboriginal women.

Her Majesty's Inspectorate of Prisons (HMIP) is an independent statutory body, set up in 1981 to inspect and report on conditions in prisons and the treatment of prisoners. The Chief Inspector is a Crown appointment, and therefore not part of any government department or service; nor can she or he have worked for the Prison Service. Successive Chief Inspectors have established a tradition of robust independence, and a methodology and inspection criteria that rest upon international human rights standards, rather than the current standards or targets of the domestic prison service. They are based upon four tests of a 'healthy prison' (a concept first introduced by the World Health Organisation): that prisoners are held in safety, that they are treated with respect for their human dignity, that they are able to engage in purposeful activity, and that they are prepared for resettlement (reintegration). Inspectors assess these areas against detailed criteria, *Expectations*, which cover all aspects of prison life. Those criteria have been used to inspect prison institutions in other parts of the British Isles and British territories; separate *Expectations* have been produced for immigration detention facilities and juveniles.

Inspections are carried out by teams of inspectors, appointed by the Chief Inspector, and including specialists in healthcare and substance abuse. Detailed reports are prepared and published, with a list of recommendations for action. While these are not mandatory, the Prison Service in England and Wales must respond with an action plan – and in practice accepts around 95% of recommendations. Inspectors return, without warning, to check whether those recommendations have been implemented; and find that around three-quarters have been implemented, wholly or in part.

The Canadian inspections were carried out by the inspection team that specializes in women's prisons, assisted by a specialist healthcare inspector. The Chief Inspector, Anne Owers, also took part in the inspections. The team spent a week in each establishment and had access to all documentation, as well as to all staff and inmates. They were also able to have discussions with representatives of the CSC, and with external stakeholders both nationally and locally.

In line with practice in England and Wales, a confidential survey was administered to the women in each institution, seeking their views on all aspects of imprisonment. The results of that survey provided a starting point for inspectors: they also allowed a comparison to be made between the two institutions, and also between them and the extensive survey data available for women imprisoned in England, who are largely held in cellular conditions in closed institutions. Those comparisons are attached and referred to in the reports. They provide lessons for those responsible for women's imprisonment in England and Wales, as well as Canada².

There are some important caveats about these inspections. They do not aim to look at the fundamental question of whether, and under what circumstances, women should be incarcerated: in what are inevitably structured and constrained environments, which affect both women and their families. They do not examine the whole area of corrections, including alternatives to custody, or the support that is available to women released from prison: though some aspects of reintegration practice are referred to. Nor do they specifically follow up the CHRC report, which deals in considerable detail with the issues of discrimination and human rights that fall under its remit; in particular these inspections are not a form of external redress, as recommended by the CHRC. They are, simply, independent reports on the treatment and conditions of the women who were in federal custody in those two institutions in September 2005. We are also acutely aware that these inspections do not represent most women offenders' experience of incarceration in Canada: the great majority are held in provincial institutions.

² Inspectorate researchers have since carried out confidential surveys in all other federal women's institutions.

Findings

These reports are a detailed examination of the conditions and treatment for women held in the Nova and Grand Valley Institutions for women in September 2005. We found areas where there was much to commend, and much that could be emulated elsewhere, under each of our four tests of a 'healthy' prison – safety, respect, purposeful activity and reintegration. Nevertheless, there were also areas under each test that need to be addressed, in order to support and protect the innovative model that had been developed; and where we make recommendations and put forward action points to secure improvements.

The open setting, and the opportunity for women to take responsibility for important areas of their lives, such as food and clothing, reflected many of the principles of *Creating Choices*. It is noticeable and laudable that this has, for example, resulted in much lower levels of self-harm and suicide than in the cellular environment of the Kingston Prison for Women, or in prisons in England and Wales. There were over 11,000 incidents of self-harm last year among the 4,500 women in prison in England, and there have been 32 self-inflicted deaths in English women's prisons over the last three years.

Other aspects of life in the two institutions equally deserve commendation. Women in both institutions were fully occupied, with program work, education or leisure activities. Correctional planning was highly developed and well resourced, and programs tailored to individual need. The structured living environments provided an impressive multi-disciplinary therapeutic environment for a small number of women with particular mental health needs. Women at both Nova and GVI had good individual links with the primary workers who were responsible for reviewing and implementing their plans; as well as with staff from other disciplines. Nearly all the responses in our surveys about activity, program work and sentence planning were significantly higher than those from women's prisons in England.

These are positive areas, and for many women the inspected institutions provided a relaxed and supportive environment. However, they are nevertheless controlled and closed institutions, holding women, some of whom are poorly socialized, marginalized or mentally disordered. One area which we did not believe had been adequately addressed was the issue of bullying ('muscling') or intimidation which could take place on the virtually unsupervised houses. In our surveys, women in both institutions reported significantly higher experience of victimization and assault than in English prisons, and nearly half the women surveyed said that they had felt unsafe at some time. At GVI, a serious assault had taken place just before the inspection, and inspectors were told of other women who had been victimized, for example on racial grounds.

We attributed this to a number of factors. First, there were no effective first night and induction systems for newly-arrived women, to provide initial orientation and support on arrival. Second, violence reduction strategies needed to be strengthened, given the greater opportunity for bullying in an open, as opposed to a cellular, environment. Third, while primary workers engaged with women individually in relation to their correctional plan, there was little or no proactive social engagement with, or support for, women while they were in the living units. There is, of course, a fine balance between supporting women and allowing them to take responsibility. However, *Creating Choices* envisaged a situation in which staff would

"create an environment where relationships based on role-modelling, support, trust and democratic decision-making can thrive between staff and federally sentenced women."

This needs to be reinforced, in residential as well as activity settings.

The difficulty of managing challenging, disruptive or high risk women, within an open and relatively unsupervised environment, had also led to the building of maximum secure units. Security classification in the federal Canadian system is a reflection of institutional behaviour, as well as a measure of the seriousness of the offence and the risk of escape. So, the maximum secure units held women who were bullies, who had exhibited problematic behaviour, and some of whom were mentally ill or suicidal. At the time of the inspections, like the federal system overall, they also held a disproportionate number of Aboriginal women³, indeed one in five Aboriginal women in federal custody were held in maximum secure units.

The contrast between these small units and the relaxed and virtually unsupervised houses was extreme. The culture and environment were based on control and constraint, not responsibility. Women were held in cellular accommodation. Though they had a considerable amount of time out of cell, there was limited access to activities and staff; those on the highest security level could only move off the units in leg irons. We were also concerned at the rise in the use of segregation and the extremely restrictive conditions for segregated women, including those in long-term segregation under the national Management Protocol.

We point to some areas for action in relation to some of the practices in the maximum secure units and in segregation. But this does not tackle the fundamental issue of the use of those units and the range of women held there. The CHRC report expresses significant concern as to whether the tools used to assess and reassess security are sufficiently culture and gender sensitive. We are aware that work is continuing to implement those recommendations, and urge that it proceeds swiftly. But we believe that the CSC also needs to develop a greater range of management tools, and culturally appropriate pathways, for dealing with difficult and damaged women in a more appropriate, and less coercive, way.

At the other end of the scale, those women who were classified as minimum security were held in conditions which were little different from those of medium security and, at the time of the inspections, with few opportunities to work outside the institutions or to live in genuinely open conditions.

There are a number of other national issues that arose during these inspections, and which we believe need further attention from CSC, to ensure that other needs, some specific to women, are sufficiently provided for.

First, there is very little formal family support and liaison for federally sentenced women. Though the arrangements for family visits are good, there is no federal financial support to allow those on low, or no, incomes to visit. This is of particular concern at Nova, given the distances and cost involved. Nor are there family support workers to help maintain links between women and their families during imprisonment.

Second, the focus of attention in the federal system has been on assessing and meeting women's individual criminogenic needs, and developing programs to meet those needs. Much of that work is ground-breaking, and has been copied elsewhere, not least in the UK. Again, however, the CHRC report expressed significant concerns about the diversity and cultural sensitivity of current assessment tools and programs. We are aware that new tools and programs are being evaluated, and we would urge that this is done quickly and in full consultation with experts and stakeholder groups, in the light of the CHRC recommendations. We also note that there had been concerns about the timeliness and quality of parole reports, which were being addressed at the time of the inspections, but which raised questions about the support and training needed for primary workers to carry out this task effectively.

³ Aboriginal women were 38% of the population of the maximum secure units in the two establishments, and 40% of the population in maximum secure units in the overall federal system.

By contrast to the program work, there had been relatively little attention to the employment and skills training needs of women. This has not been a focus of attention within the federal system, and we were told that the requirement that the services provided by Corcan (the main provider of prison work) should be self-financing has had a particularly damaging effect on provision for women, in establishments where the scale of provision is too small to be profitable. Both Nova and GVI had too little provision for women to acquire marketable skills and work experience.

Finally, we were surprised that neither of the individual institutions was able to provide local information about such important issues as parole, composition of the population and, in particular, ethnic monitoring. Detailed statistics were collected, to be passed to national headquarters, but there was no local analysis. Managers therefore lacked the information that they needed to assess and manage the communal environment, as opposed to the correctional plans and needs of individuals.

We also suggest that the CSC consider developing a feedback tool for regularly assessing the experience of women inmates. The Prison Service in England and Wales has developed a qualitative assessment tool, which provides institutions with data on prisoners' perceptions of various dimensions of prison life. A similar exercise in Canada would, we believe, provide valuable additional information.

This introduction focuses on some of the areas which need particular attention. But this should not obscure the general picture: which is that these institutions represent an innovative and responsive approach to the imprisonment of women, which seeks to minimize damage and maximize responsibility and positive change. It is an approach from which many other countries, notably the United Kingdom, could learn a great deal.

The recommendations and action points in these reports are designed to support and reinforce that model, and to prevent the slippage from responsibility to control which is the default setting for any custodial environment. The recent decision that custodial officers should revert to wearing uniform appears to exemplify this drift. It is also important continually to bear in mind that imprisonment is necessarily coercive and disruptive. The inherent danger of providing a better model for doing it is that it will become a more attractive option for sentencers. That is a paradox that we in the Prisons Inspectorate are continually aware of, and which needs to be guarded against.

As already stated, this inspection process is not, and should not be regarded as, meeting the requirements of the CHRC's Recommendation 19. Our model of inspection has been developed within England and Wales, though it is based on international standards and criteria. An independent monitoring mechanism for places of detention is mandated in the new UN Protocol on Inhuman and Degrading Treatment and Torture, which will come into effect in 2006, and which Canada is likely to sign. We suggest that because of this, and the CHRC recommendation, there should be a thorough examination, with existing bodies and stakeholders, of the monitoring mechanisms that now exist, and the extent to which they need to be supplemented or strengthened to provide regular independent monitoring and inspection.

It is a measure of its transparency, and its desire for continued improvement and best practice, that the CSC was brave enough to expose its institutions to external and independent inspection, with no limitations and with unhindered access to institutions, documents and inmates. We are very grateful to the Wardens and staff of the two institutions inspected, and to the Deputy Commissioner for Women and her staff, for their help and support for our task. We are equally grateful to all the stakeholder groups and organisations who met and talked to us. We are particularly grateful to the women at Nova and GVI, who shared their experiences with us, and whose conditions and treatment are at the heart of these reports.

Recommendations

1. There should be specific first night and orientation support, initially in separate accommodation, so that newly arrived women have access to objective and full information about the institutions and are prepared to move on to the houses.
2. The role of primary workers should be reviewed and reinforced, with a view to ensuring that properly trained staff have sufficient skills and time to carry out both the role of supportive role-models envisaged in *Creating Choices*, and the task of providing timely and high-quality parole reports.
3. Each institution should have a local anti-bullying policy and strategy to identify and prevent intimidation and assaults. It should include interventions for bullies and support for victims. Staff should receive training in this so that they are vigilant in identifying bullies and actively intervene to challenge them. The policy should be publicized and promoted to women inmates.
4. Implementation of the CHRC recommendations in relation to gender and culturally specific classification and assessment tools and programs should proceed swiftly, informed by expert advice. In particular, tools and interventions that recognize the specific needs of Aboriginal women should be developed as a matter of urgency, and pathways to the Healing Lodge and out of maximum secure accommodation developed.
5. Race and ethnic monitoring of all key areas of prison life within each institution should be established. This should include access to programs and facilities, and all disciplinary measures and classification decisions. Results should be published and any disproportionate patterns investigated.
6. There should be a comprehensive review of the management of difficult or disruptive women, with a view to ensuring that
 - the number of women in maximum security units is reduced, and the criteria for allocating women to those units reviewed to ensure that they are used only for women whose behaviour poses exceptional risks to others, and when other, less restrictive, interventions have failed;
 - a multi-disciplinary strategy, including mental health support, is devised to provide individual support and case management of women who require additional supervision and intervention outside maximum security conditions;
 - an expert Advisory Committee is set up to receive and comment on reports on the use of, and conditions for women in, maximum secure and segregation units, including those held under the Management Protocol.
7. Minimum security women should have the opportunity to have increased access to the community.
8. Leg irons should not be used on women inmates.

9. The Correctional Service of Canada, together with CORCAN, should draw up a strategy for education and skills training and employment for federally sentenced women, with a view to enhancing employability. Such training should form part of correctional plans.
10. More efforts should be made to encourage and support family ties. A social worker should be appointed in each institution to act as a family liaison/link worker to support and promote the maintenance of family ties and help with child custody matters. Financial support should be provided to help families on low incomes visit women in CSC institutions.
11. The CSC should consult with stakeholders to examine the monitoring mechanisms that currently exist, to determine whether and how they need to be strengthened to provide a national preventive mechanism, as set out in the Optional Protocol to the UN Convention against Torture.

Fact page

Task of the establishment

Grand Valley Institution for Women (GVIW) in Kitchener, Ontario, is one of six regional federal facilities for women offenders across Canada. GVIW is a multi-level institution responsible for the reception, assessment and placement of women receiving federal terms (i.e. sentences of two years or more) within the Ontario region. The warden at GVIW is also responsible for Isabel McNeill House, a separate minimum security institution for up to 10 women located in Kingston, Ontario.

Responsible organisation

Correctional Service of Canada

Number held

100

Maximum capacity

107

Brief history

GVIW opened in 1997 with nine living units and an enhanced (reception) unit. Two additional living units and the structured living environment (SLE) opened in 2001. The enhanced unit was replaced by the secure unit in October 2004.

Description of residential units

GVIW consists of 11 self-contained living units; an SLE; a secure unit, including a segregation unit; and a private family visiting unit.

Healthy prison summary

Introduction

HP1 All inspection reports carry a summary of the conditions and treatment of inmates, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is Everyone's Concern*, published in 1999.

The criteria are:

Safety inmates, even the most vulnerable, are held safely

Respect inmates are treated with respect for their human dignity

Purposeful activity inmates are able, and expected, to engage in activity that is likely to benefit them

Reintegration inmates are prepared for their release into the community and helped to reduce the likelihood of reoffending

HP2 Throughout the report, the results from the survey completed by the women at Grand Valley Institution for Women are compared with the aggregated responses from prisoner surveys carried out in 12 women's prisons in England since April 2003, which we call the comparator. References are also made to results from Nova Institution for Women in Truro, Nova Scotia, which we also inspected. The full survey results are at Appendix 3.

Safety

HP3 The open living arrangements at GVIW had created a positive environment that allowed women to exercise some choices in their lives. This appeared to have led to low levels of self-harm. A new inmate-led orientation program was operating well. However, many women in our survey reported feeling unsafe and we found some evidence of 'muscling'. There was no structured support for women before they moved to live in unstaffed houses. The very controlled environment in the secure unit was in stark contrast to the good, relaxed conditions in the rest of the institution.

HP4 Although not under the jurisdiction of the Correctional Service Canada (CSC), women arrived at the institution in leg irons irrespective of their security risk.

HP5 Although the admissions procedure was process-driven, an officer engaged with new women well and in our survey 79% (significantly better than the English comparator of 67%⁴) said that they had

¹ The benchmark figure is calculated by aggregating responses from all women prisoners surveyed since April 2003, in England and Wales, together and so is not an average across establishments.

been treated well or very well on admission. More sensitive assessments, such as for risk of self-harm, were carried out in appropriate privacy and strip-searching was carried out sensitively. All new arrivals received a free 15-minute telephone call. One problem for some new arrivals was insufficient funds to manage for the first few weeks in detention, which led to debt.

- HP6 There were no specific first night arrangements other than to place vulnerable women in the segregation unit and others on one designated but unstaffed house that did not provide sufficient support. A recently appointed orientation team of inmates met new arrivals on the day of their arrival but not during the admissions process. In our survey, only 73% of women said that they had something to eat on the day of their arrival.
- HP7 In our survey, 47%, significantly worse than the English comparator of 32%, said they had felt unsafe at GVIW. Many said they felt unsafe in their houses. There was almost an acceptance among women and staff of the inevitability of muscling as part of life in the institution. Forty-three per cent, against an English comparator of 24%, said they had been victimized (insulted or assaulted) by another inmate. There had been no internal survey or monitoring of women's experience of muscling but there was some monitoring of requests for house moves in case they were related to intimidation. Muscling as a specific subject was not routinely discussed at the inmate committee. Anti-harassment procedures and training were mainly related to staff employment issues. There was no clear reference in the inmates' handbook about muscling. Informal resolution, house moves or segregation were the chief responses when cases were identified.
- HP8 Levels of self-harm were very low and many women found support from others. However, a common response to those most at risk was to place them in segregation cells. There was no clear monitoring of the incidents or the use of strip-clothing and no alternative strategy. While there was some good ongoing support from specialists, particularly for residents of the structured living environment (SLE), there was little multidisciplinary involvement in the management of those at risk. Not all recommendations from an apparent self-inflicted death in 2003 had been implemented.
- HP9 Many security observations were recorded individually but monitoring of trends was limited and a computer system to analyse intelligence was not used because of lack of staff time. With no staff presence on houses there was relatively little interaction, and there was a reliance on good staff knowledge of individual women rather than knowledge of communal activity. It was known that some incidents of violence and intimidation in the houses were not reported.
- HP10 Most use of segregation was for short periods, with an average time of only three days. Segregation was properly authorised and supervised. Activities in the segregation unit were limited. There was little interaction and segregated women were routinely spoken to through the door hatch, through which they were also served meals and medication. The published objective of segregation was to provide a non-punitive, full regime for women out of association from the general population but this was not reflected in its operation.
- HP11 The restrictive conditions in the maximum secure unit contrasted greatly with the open environment and culture of the rest of the institution and appeared to sit uneasily with the principles of *Creating Choices*. In accordance with the CSC classification tool some women were reclassified as a response to poor institutional behaviour rather than risk of escape or risk to the public, and there

was an over-representation of Aboriginal women. At the time of the inspection, activities and programs for women on the secure unit were more limited than usual because of a recent serious incident. However, access to dialectical behaviour therapy, psychologists and behavioural counsellors was good. Education was limited and delivered individually, even though the women associated together. The women felt involved in the development of their targets and, although primary workers were supportive, the operation of the unit meant they had very limited interaction with the women.

- HP12 Disciplinary matters were well managed but there was a potential for inconsistency in approach between use of informal resolution by primary workers, which needed to be monitored. There had been an increase in the number of disciplinary hearings. A detailed review of compliance with disciplinary procedures had been undertaken and good support was provided to women after hearings.
- HP13 There was little use of force, either planned or spontaneous, and staff were well trained in the procedures. Planned use of force was video recorded, which was a good safeguard. The routine use of leg irons for some women was not an acceptable practice.
- HP14 The institution drug tested by urinalysis 5% of the population with 10% positive results in the year to date. The response was usually a serious institutional charge with typically a fine of \$15. Although the location of the site made it vulnerable to drug drops, this was not apparently a problem.

Respect

HP15 Relationships between primary workers and women were generally respectful with some good contribution to reports, but there were there was little interaction and positive role modelling outside formal programmed time. Living conditions were very good. Spiritual needs were generally met. There was no evidence of adverse outcomes by race or ethnic background but there was no regular monitoring to demonstrate this. Improvements were needed in the handling of complaints and in the delivery of healthcare services.

- HP16 Women gave us some mixed accounts about how they were treated by officers but 79% in our survey said they were treated with respect by most staff. However, 35% said they had been victimized (insulted or assaulted) by a member of staff and complaints about the conduct of staff were the biggest single category.
- HP17 There was limited interaction between primary workers and women on the houses and therefore little role modelling. The impact of staff recently changing to wearing uniforms was unclear. Only 23% said they met their primary workers in the first week, which was significantly lower than the 46% at Nova. However, most of the women said they found their primary worker helpful or very helpful and we saw good written contributions to casework reports.
- HP18 The open layout of the institution provided a relatively normal living environment. The houses were of a good standard, well looked after and personalized. There were no problems with access to

showers and baths or laundry and cleaning facilities. Efforts had been made to redecorate the houses but the house for new arrivals was in the worst condition and was a poor introduction to GVIW.

- HP19 The canteen worked well and the special needs of Aboriginal and black women were catered for through their support groups. In our survey, 90% of respondents, compared with only 17% in the English surveys, said they had access to canteen within 24 hours of their arrival.
- HP20 Apart from those on the secure and segregation units, all women catered for themselves. Each house was supposed to have a nominated cook but some did not. Some women reported difficulty in getting food on their first night. There was little training in cooking but 74% of respondents to our survey said they found the food good or very good. The communal arrangements meant that some women found it difficult to get culturally appropriate food. Supplies could be supplemented with food grown in the garden.
- HP21 In our survey, women said that they were not able to access complaint forms easily. They were available from the inmate committee office but this was not always open. About a third of women, similar to Nova, said that they had been made or encouraged to withdraw a complaint. Of the complaint forms we sampled, some had no answer and had been withdrawn without explanation. Responses to complaints were of variable quality and few apologies were given when complaints were upheld. Timescales for answering them were too long but there was an emphasis on resolving matters informally. There was no local analysis of data for management information and quality assurance.
- HP22 There were two Christian ministers, with active volunteer participation, and sufficient services. The secure unit had no agreed cover and was relying on the goodwill of one of the chaplains. Facilities appeared adequate for services. An elder led Aboriginal spiritual meetings, provided pastoral care and advocated for Aboriginal women. Some recent improvement has been made in meeting the spiritual needs of Aboriginal women but regular sweat lodge ceremonies were not provided.
- HP23 The population was made up of 63% Caucasian, 22% black, 11% Aboriginal and 3% Asiatic inmates. Although there was no evident discrimination, there was no regular monitoring to assure this. Support groups were run for black and Aboriginal women. Complaints with a racial element were not separately identified and there was only limited promotion of positive race relations or cultural diversity. There were eight foreign national women, all of whom spoke English. Liaison with the immigration authorities was good.
- HP24 At the time of the inspection, there was one mother and baby. Healthcare was provided in the prison and a qualified social worker acted as an advisor to the prison and supported the mother. Admissions procedures were based on the best interests of the child. However, there was no wider assessment of the appropriateness of the institution's facilities or the risks posed by other women. There was no formal child development plan, and the baby's room was not decorated in a child-friendly way.
- HP25 Women were dissatisfied with the healthcare service and 73% of survey respondents said it was bad or very bad. Staffing shortages were impeding effective delivery. We found some inadequate systems and waiting lists were poorly managed. Procedures for managing and administering

medication had insufficient safeguards. There was a high use of prescribed medication and most women were able to keep their medication in their possession. The mental health service was psychology led and dealt with women in crisis. There was no sharing of information between psychology and psychiatrists. Women were able to see a wide range of specialists, either in the community or in the institution.

Purposeful activity

- HP26 Most women had good free movement throughout the site. Educational provision was reasonably good with many women involved. The majority of women were fully occupied, but there was room for developing work opportunities and skills training further, particularly for long-term women and lifers. There were plans for new opportunities in a computer workshop. Some new work release opportunities were being promoted to women. There were some good, organized leisure activities.
- HP27 There were good opportunities for recreational and purposeful activity. Women had regular periods of leisure time each day but opportunities for those in the secure unit were limited. We were told that this was partly as a consequence of a very serious incident there not long before the inspection. Some well-organized activity took place, including an excellent craft session that involved many women. There was also some educational recreation, although many of these were very recent initiatives.
- HP28 Educational needs were well integrated into the correctional plan. Approximately 49 women were participating in education, with 56 places available. The main emphasis was on adult basic education to complete high school and there had been progress in getting women through their grade 12 diploma. Many believed that the education skills they achieved would help them on their release. Some distance learning was also provided. Many knew who to contact to help them to arrange or continue further education on release but few did so. There were no links with the local community college, or any schooling provided using temporary absences.
- HP29 In our survey, 58% of respondents, higher than at Nova and against an English comparator of 44%, said they went to the library and resource centre at least once a week. However, the library was not open at weekends or in the evening. Only 25% said they could get access to a newspaper daily, which was only a local one. A good range of books covered diverse needs but there was only one computer.
- HP30 Each woman was allocated to activity and employment within two weeks of arriving and there were sufficient work opportunities to complement education and programs, which were the main activities. Most of the work was cleaning and maintenance with few more stretching or realistic jobs. This was unsatisfactory for women such as lifers who remained at GVIW for some time. There had been some previous short-term CORCAN (the CSC employment and training service for offenders) projects and plans were under way to provide a 'computer for schools' workshop. There were no formal vocational qualifications available. Forty-seven per cent of respondents to our survey said they felt their job would help them on release compared to 60% at Nova. We welcomed recent initiatives to encourage participation in work release opportunities.

HP31 Physical activity was not linked to health promotion and was too reliant on self-motivation. There was a gym and cardio-vascular equipment but no induction about how to use the equipment. The weights room was cramped and the equipment old and in a poor state of repair. There were few organized team games. The gym was closed between 8am and 4pm, when women were supposed to be involved in other activities. However, this meant that some such as house cooks could not use it at times convenient for their work.

Reintegration

HP32 An Ontario strategic reintegration committee aimed to meet the needs of women offenders but there was no strategic overview at institutional level to coordinate some of the good reintegration work which was taking place. Comprehensive correctional planning led to good involvement in high quality correctional programs but there was a need to ensure that these were appropriate for Aboriginal women. The SLE provided good therapeutic support. There had been recent improvements in meeting casework targets including for parole. A woman-centred drug program operated and met the needs of many women. There was insufficient support for survivors of abuse and trauma. More priority needed to be given to maintaining links with family and receiving help with jobs on release.

HP33 There was a relatively new strategic reintegration committee aimed at meeting the needs of CSC women offenders in the Ontario district. A number of local committees met to discuss aspects of reintegration but there was no clear strategic overview at institutional level to pull their work together. There had been some historical problems with casework but these had now been addressed, with considerable data collection and some analysis to help this. This information was well used operationally but did not inform the reintegration strategy.

HP34 Women's offending behaviour needs were fully assessed at intake and all assessments had been completed within the target period in the current fiscal year. In our survey, 61% of women, against an English comparator of 26%, said they were involved or very involved in the development of their correctional plan. Plans were comprehensive and identified women's prioritized needs, including women who had returned to the institution after a revocation of their license. The gender applicability of some of the assessment tools and their appropriateness for Aboriginal women were being reviewed. Past problems with delay and quality of plans and reports appeared to have been addressed with the appointment of an additional parole officer who provided training and mentoring to primary workers. Reports were quality assured.

HP35 The correctional programs offered generally met the prioritized needs of the population with few on waiting lists. Women were positive about programs and 64% of respondents to our survey, compared with 26% in English women's prisons felt that their correctional programs would help them on release. The SLE provided an impressive therapeutic milieu with a multidisciplinary approach not available elsewhere in the institution. It provided good specific treatment interventions and outreach support to previous residents as well as members of the general population. The survivors of abuse and trauma program was not meeting the full needs of the population. Only 15 women had been able to access individual therapy in the last contract year

and 26 women remained on the waiting list. We welcomed the intention to provide a new contract for group therapy but there was a need to ensure that the provision was sufficient to meet need.

- HP36 Security classification was as much about institutional behaviour as risk. There was little differentiation between medium and minimum security levels. There were too few minimum-security houses and few opportunities for women to experience open conditions. GVIW managed the minimum-security Isabel McNeill House in Kingston but there was little promotion of that facility for suitable women.
- HP37 Twelve women were serving a life sentence. The cases we sampled showed that the correctional planning had been done thoroughly. There was frequent contact between managers, caseworkers and lifers but arrangements for annual reviews did not fully involve the women lifers as part of the casework team. There was little opportunity for a full 'career' with meaningful employment for women who would spend many years in same institution. Until recently the policy was that all women lifers were held in maximum security for the first two years of their sentence unless it was agreed nationally that exceptional circumstances applied. We were told this had happened to some women within the two year period. This power had just been devolved to wardens.
- HP38 There were difficulties in obtaining appropriate identification documents as part of preparation for release. Identified family links and employment needs were not always addressed, but there was some use of escorted temporary absences to support contact with family. There was good community support work, including circles of support, which needed to be extended, particularly to cover the Toronto area, and to take account of the special reintegration needs of Aboriginal women.
- HP39 Visits facilities were good. These included the private visits facility, which was well used for visits and personal time out. Family days were popular. The visits area was pleasant and there were plenty of opportunities for visits at times accessible to families and friends. However, the system for checking visitors meant there were delays and many were not allowed because they had criminal records. Too many closed visits were used, including on a drug dog or ion scan indication alone.
- HP40 There was no formal provision for financial assistance for families who could not visit because of the cost, and no specific family support to encourage and facilitate family contact, although chaplaincy volunteers helped to bring some visitors. Women reported some difficulties with telephones, including delays in getting numbers authorized, the expense of the call-collect system and a lack of privacy.
- HP41 A good woman-focused drugs program involved many of the women and met their needs. It was run by a local therapeutic community and some women made good links that helped them after release. In our survey, 62% of respondents, compared with 31% in England, said they thought the substance misuse program would help them on release. Eleven women participated in the intensive support unit but, mainly due to staffing difficulties, there was little testing or ongoing support.

Section I: Arrival in custody

First days in custody

Expected outcomes:

Inmates feel safe on their reception into prison and for the first few days. Their individual needs, both during and after custody, are identified and plans developed to provide help. During an inmate's induction into the prison he/she is made aware of prison routines, how to access available services and how to cope with imprisonment.

- 1.1 Women were routinely escorted to the institution wearing handcuffs and leg irons, which was unnecessary and degrading. The majority of women said they had been treated well or very well on admission with survey results significantly better than the English comparator and than Nova Institution for Women. Reception procedures were efficient and respectful but the environment was not welcoming. New arrivals were not offered a meal and some did not receive one on their first night. The staged initial multidisciplinary assessment included a thorough assessment of the risk of self-harm. Those considered at risk were usually placed in segregation due to lack of staff cover on the houses. It was difficult to seek help in confidence on the first night. A peer orientation program was delivering well and women appreciated it.

Reception

- 1.2 Although not under the jurisdiction of the CSC, all women were transported to GVIW in handcuffs and leg irons irrespective of security risk. Such security measures were extreme and unnecessary for most women, for whom there was no individual risk assessment.
- 1.3 GVIW accepted new arrivals every other Friday, with the majority coming from Vanier provincial prison. Most of the information about new receptions was sent electronically from the provincial prison a few days in advance. We were unable to observe any new arrivals but spoke to a number of women about their experience. The reception area was small and unwelcoming. Although we were told that healthcare staff gave new arrivals snacks such as a granola bar, they were not given a meal or welcomed with a drink. Depending on the numbers, there were not always enough chairs for them.
- 1.4 The procedures were that the sentence management officer met all new arrivals and checked their warrants. The initial reception formalities were conducted by a dedicated admissions and discharge officer. We were told that the emphasis was on putting women at their ease, despite the fact that they were expected to absorb a great deal of information. They were given a lot of forms explaining areas such as personal property, visits and the personal identification number (PIN) telephone system. They were also given a copy of the inmate handbook and a key to their personal mailbox. In our survey, 79% of women, compared with 56% at Nova and 67% in the English comparator, said they had been treated well or very well on admission.

- 1.5 Women did not have to strip completely but were strip-searched in two stages: the upper body followed by the lower body. In our survey, 82% of women, against 66% at Nova, said they were searched in a sensitive way.
- 1.6 New arrivals could not shower in reception and the expectation was that they would be able to do so once they were on their house unit. However, only 70% of respondents to our survey said they had been given the opportunity to shower on the day of their arrival. This was significantly better than the English comparator of 38%, but meant that nearly a third of women had not been able to shower.
- 1.7 New arrivals were given a hygiene and a bedding pack, and a change of clothing from the prison stores to replace the purple suits of the provincial prison. Women new to GVIW were given new clothing, which was available in a range of sizes, but clothing for women returning because their conditional release had been suspended was often second-hand apart from underwear. While the second-hand stock was in good condition, we could see no reason for this differentiation and it was a source of complaint among the women.
- 1.8 Women could exchange any poorly fitting clothing the next day. Their personal property boxes were processed over the weekend and they could then access their own clothing on the Monday. Personal property was stored in boxes in a secure area in reception. No outstanding property was waiting to be processed at the time of the inspection and we were told that backlogs rarely occurred.
- 1.9 A very basic personal history, fingerprints and photographs were taken in reception. The emphasis was on moving the women through the basic routine procedures so that the more important procedures, such as interviews to take a full personal history and complete self-harm assessments, could be conducted separately and in private.
- 1.10 Following the basic procedures, new arrivals had an initial interview with the officer in charge (OIC). This interview began the first part of the initial assessment. At this stage, the OIC identified immediate needs and answered questions and concerns. The OIC's checklist included questions about incompatibles and history of self-harm. New arrivals were usually located on house 7 but could be located elsewhere if any concerns arose from the initial assessment. Those considered at risk of self-harm were usually placed in the segregation unit. Reasons for any different location were recorded. New arrivals were then given an initial health screening by the nurse before having a more in-depth interview with a psychologist to complete a thorough self-harm assessment.
- 1.11 The three-stage initial assessment process was designed to identify immediate needs and reassure new arrivals but too little attention was paid to anxieties about children. Neither the admissions checklist nor the psychologist's self-harm assessment contained any prompts about concerns about children although in our survey, 64% said they had children under the age of 18. Eighty-three per cent said they had problems when they first arrived and only 33% said they had received any help or support from staff in dealing with these within the first 24 hours.
- 1.12 New arrivals were told about the inmate orientation team and peer supporter, and arrangements were always made to meet with the two women who made up the orientation team the same day (see also section on orientation). The only trained peer supporter was not available to new arrivals in reception.

- 1.13 The reception checklist included the offer of a free 15-minute telephone call. In our survey, 78% of women, compared with 49% in English women's prisons, said they were given the opportunity to make a free telephone call on the day of their arrival. Thereafter, they needed to complete a form to access a PIN and submit for approval the telephone numbers they wished to use.
- 1.14 New arrivals were offered an immediate loan of \$30, repayable at 10% of their weekly earnings after the first week, and were usually able to visit the canteen on their first day. In our survey, 90% of women, against an English comparator of just 17%, said they had access to the shop/canteen within 24 hours of arrival. However, women without private cash or employment did not have enough money to meet their needs during the first few weeks, which meant some got into debt.

First days in custody

- 1.15 Anyone assessed as at risk of suicide or self-harm or who was vulnerable for any other reason was usually placed in the segregation unit, the only unit with staff supervision. Otherwise, most new arrivals spent at least their first few days on house 7, the designated reception house. House 7 was not a supportive environment for new arrivals and was also used for women who could not cope on other locations or had been moved because of their behaviour. In our survey, 31% of those who said they felt unsafe identified their house unit as a particular area where this was true.
- 1.16 New arrivals were escorted to their first night location but there were no routine procedures to ensure that new arrivals were checked by staff on their first night and they were generally left to organize themselves. Only 73% in our survey said they had been offered something to eat on their day of arrival. There was an assumption that house cooks would provide an evening meal for new women but this was not always the case. One house cook told us that it was not always possible to budget to ensure that there was enough food to cater for new arrivals on Fridays.
- 1.17 Two women worked as an inmate orientation team. They always met new arrivals on their first day to welcome them and answer any outstanding questions. One of the women was also a trained peer supporter but anyone in distress could not ask for help from staff or the peer supporter at night in confidence because the internal telephone was located in the lounge area in full view and hearing of other women (see paragraph 2.6). In our survey, only 19% of women, against a significantly higher English comparator of 31%, said they had access to a Listener/Samaritan/peer supporter within the first 24 hours.

Orientation

- 1.18 The inmate orientation team was a recent development and we heard some positive feedback about the service offered. The two team members had developed a very comprehensive program and were committed to their new role. They said staff and the warden gave them a great deal of help and held regular meetings with them.
- 1.19 The orientation program began immediately with a tour of the institution on the first night. Team members outlined what would happen in the first week and explained the application procedures. They made themselves available throughout the weekend if necessary and then continued with their program the following week. Various departments were scheduled to deliver sessions on finance, pay, complaints and

grievances, programs, case management, the chapel, the inmate committee and healthcare. All of these sessions were scheduled for Thursday, which meant that new arrivals spent almost a week in detention before receiving any formal orientation from staff on specialist areas. We were also told that staff did not always deliver their sessions at the allotted time for a variety of operational reasons. In our survey, only 53% of women said they had been orientated in the first week. This was significantly worse than the survey response from English prisons but much better than at Nova where the corresponding figure was 30%.

Action points

- 1.20 **New arrivals should be offered food and drink when they arrive.**
- 1.21 **The reception area should have enough seating for new arrivals.**
- 1.22 **New arrivals should be offered the opportunity to shower before they are taken to their house unit.**
- 1.23 **Interviews with new arrivals should include a discussion about possible concerns about children or other family members.**
- 1.24 **New arrivals should be given enough funds to ensure that they can manage during their first few weeks in custody and until their finances are organized.**
- 1.25 **New arrivals should be able to call for peer or Samaritan support in confidence.**
- 1.26 **Trained peer supporters should be available in reception.**
- 1.27 **Orientation sessions led by staff should begin the next working day after the arrival of new receptions and staff responsible for delivering these sessions should attend and do so on time.**

Section 2: Environment and relationships

Residential units

Expected outcomes:

Inmates live in a safe, clean and decent environment within which they are encouraged to take personal responsibility for themselves and their possessions.

2.1 The open environment, the good quality accommodation and the level of responsibility women were allowed provided a relatively normal living environment. Women had free access to baths, showers, laundry and cleaning facilities. They could wear their own clothes, buy new clothing through outside shopping and a set of clothing was provided for women due to be released.

Accommodation and facilities

- 2.2 GVIW promoted an open and independent environment, with women living in individual houses that could accommodate up to 10 women (eight in the SLE). Nine houses were designed in a horseshoe around a communal garden and gazebo, facing the administration centre. One of these was designated for new receptions, one was the mother and baby house, and another was the intensive support unit. All other houses were intended for medium- security women. At the time of our inspection, all nine houses accommodated both medium- and minimum-security women. The newer SLE and two further houses accommodating only minimum-security women were located beyond the horseshoe.
- 2.3 All houses were extremely well designed, light, well furnished and well ventilated. Most living accommodation had recently been redecorated and was in a good state of repair. A few houses, including the reception house, were awaiting redecoration. Apart from the SLE, all houses were based on a similar design: a communal living area, dining room and kitchen, four single bedrooms and a private bathroom downstairs, with four single and one double bedroom (originally intended to be used as a den) and a private bathroom upstairs. Washing facilities in the minimum-security houses had been designed to meet the needs of women with disabilities. All houses had a laundry and all medium-security houses contained an additional storage room downstairs. The SLE had similar well-designed facilities on a single level, with full facilities provided to a maximum of four women on each side of the unit.
- 2.4 In our survey, 76% of respondents, against an English comparator of 61%, said it was normally quiet enough to sleep at night.
- 2.5 All women had keys to their own house and room. Observation panels were not obstructed but shams were used to provide the women with some privacy.
- 2.6 There was one telephone on the ground floor of each house and one on each side of the SLE. The positioning of these provided some privacy for callers and telephones were accessible throughout the day and evening. An internal telephone (see paragraph 1.17) was also provided on each general house for use

in an emergency and emergency call bells were located in each bedroom in the SLE. Only 44% of respondents to our survey said emergency calls were responded to within five minutes.

- 2.7 Each house had a communal television, while the SLE had one on each side of the unit. Women could also have personal televisions in their rooms and could apply to the chair of the inmate committee to borrow one for six months if necessary. Televisions were allocated on a first-come, first-served basis.
- 2.8 The inmate committee met bi-monthly. Meetings were minuted, with action points followed up at the next meeting. However, its purpose was called into question by the fact that the committee had been instructed to obtain managers' agreement before adding issues to the agenda.

Hygiene, clothing and possessions

- 2.9 All women had 24-hour access to the kitchen and private bathroom facilities. They were responsible for maintaining the cleanliness of their own houses and cleaning materials were provided. All accommodation facilities were extremely clean and the women made efforts to personalize their communal living areas to create a more homely environment.
- 2.10 Although only 79% of respondents to our survey, compared with 91% in the English surveys, said they could get free sanitary products when required, these were provided to each new arrival and could be replenished free once a month. Each woman received a fortnightly allowance of \$4, which could be supplemented by other funds, to spend on hygiene items from the canteen.
- 2.11 New arrivals were also issued with a bedding kit or could request their own bedding. Women were responsible for laundering their bedding. Mattresses were generally in good condition. Blinds were installed in all living areas.
- 2.12 Women could wear their own clothing and buy additional items through outside shopping (see also section on reception). A set of clothing was provided for women due to be released. The women could use laundry facilities on their house units freely. Washing powder/liquid was provided and women could also buy laundry powder through the canteen.
- 2.13 Items not held in-possession were held in storage in admission and discharge (A&D). One storage box was allocated to each woman and two for those with a life sentence. Applications to access stored items were made to the A&D officer. This could be done at any time, although seasonal clothing could usually be changed only twice a year. Staffing pressures had led to delays in processing property and requests in late 2004/early 2005; only 25% of respondents to our survey said they could access their stored property when required. More recent allocation of staff support to A&D had allowed the A&D officer to reduce the backlog.

Action point

- 2.14 **Women should be able to exchange their clothes at least four times a year.**

Good practice

- 2.15 *The housing for minimum- and medium-security women and the relatively free movement within the boundaries of the institution provided a relatively normal living environment and allowed women to exercise some control over their day-to-day lives.*
- 2.16 *Women due to be discharged were provided with free release clothing, which was particularly beneficial to those with no private savings and/or who had been in the institution for some time. This allowed women to maintain some dignity and relieved them of one financial burden immediately following their release.*

Mothers and children

- 2.17 There had been 13 children with their mothers in the institution since it opened. All the children had left the prison when their mother finished her sentence so there had been no planned separations. Admissions procedures were thorough and based on the best interests of the child, but did not involve an appropriate child protection assessment of the environment. A qualified social worker supported women before and after their baby arrived, including those who did not bring the baby into the prison.
- 2.18 Pregnant women due to give birth during their sentence and those who had children before starting their sentence could apply to have their child with them. National guidelines allowed for children to live full-time in custody until they were four years old, and part-time until they were 13. All applications were decided giving primacy to the best interests of the child. No applications for older children to live in the institution had been made at GVIW and no women who had given birth prior to their sentence had applied to have their child in the prison with them.
- 2.19 Thirteen children had been allowed to stay with their mother in the seven years that GVIW had been open. The most children in the prison at any one time had been two and the maximum length of stay for a child had been 13 months. There was one mother with a six-month old baby in the prison during the inspection. We did not consider the facilities and arrangements suitable for post school-age children on a part-time or full-time basis.
- 2.20 Mothers and children in the prison were located in one of the normal residential houses, with slightly larger rooms. They used the same bathing and kitchen facilities as the other women living in the house. There was no child-appropriate wall decoration in the communal areas; this was limited to posters on one notice board in their shared bedroom and a mobile over the cot. Apart from their bedroom, there was no specific area dedicated to the baby or child.
- 2.21 Pregnant women lived in normal residential houses throughout the institution and were provided with ante-natal care by the healthcare services or the local hospital when necessary. They were seen by the manager responsible for the mother and child program and all aspects of the selection criteria and facilities were explained.

- 2.22 Babies were born at the local hospital and women remained there until medically discharged. New mothers returning to the institution could use the private family visits facility for a few days to allow her some privacy and quiet. Women who decided not to keep their baby in prison were provided with emotional and practical support to cope with the separation.
- 2.23 The application process required a full set of assessment reports from the mother's primary worker, parole officer, community parole officer, psychologist and a medical assessment. An assessment report was also commissioned from the local child and family services in Kitchener as to the best interests of the child. It was expected that this department would liaise with the mother's home child and family services before making this assessment. In assessment reports we saw, the Kitchener child and family services specifically stated that their assessment did not extend to confirming any child protection arrangements in the institution. We were assured that the institution carried out its own assessment of child safety provision.
- 2.24 There was no assessment of the facilities or the safeguards in place equivalent to that which would be undertaken for other state-maintained residential facilities for babies. There were no local child protection arrangements within the prison agreed with the local child and family services.
- 2.25 A qualified social worker acted as adviser to the prison and provided support and advice on parenting for pregnant women and mothers. The mother in the prison reported that she had weekly meetings with the social worker and found her advice and support very helpful.
- 2.26 In the course of arranging for a baby to come into the institution, an assessment was undertaken to assess the suitability of the other women who would live in the same house. However, babies could be taken to most areas of the institution without any formal child protection safeguards.
- 2.27 There had been three child protection referrals to the child and family services since the institution had opened. All of these had been investigated by the local department and none of the concerns had been founded.
- 2.28 A cot, mattress, bedding and age-appropriate chairs were provided. All other items required for the baby were expected to be provided by the mother, who was not entitled to state benefit for the baby. After the birth, mothers could have a 12-week period off work when they would receive their normal pay; an extension to this period could be agreed, allowing the mother to continue to care for her baby. Although there was a supply of baby clothing, the mother was expected to provide food, toiletries and clothing and consequently relied heavily on the support of her family.
- 2.29 The mother was required to nominate a woman to look after her baby when she was at an appointment or for up to two days should she have a medical emergency. She was encouraged to maintain complete control of her baby, including deciding who could hold the child. Arrangements were made for babies to spend 72 hours each month with suitable close family members to develop their family relationships and to accustom the baby to wider experiences outside the prison. For a baby who was over nine months old, arrangements had been made for the child to attend the local child care nursery in order to develop social and other developmental skills.
- 2.30 No additional training, such as child protection, baby resuscitation or child development, was provided to primary workers or healthcare staff.

Action points

- 2.31 The facilities and arrangements for the care of children in the institution should be subject to the same auditing and inspection arrangements as other residential child care facilities in the community.
- 2.32 Child protection protocols should be agreed with the local child and family services and an individual child care plan should be developed for each child in the prison.
- 2.33 Women caring for their babies in custody should have access to the same state financial benefits as mothers in the community.

Housekeeping point

- 2.34 Wall decorations should be appropriate to support the sensory development of babies and children.

Staff–inmate relationships

Expected outcomes:

Inmates are treated respectfully by staff, throughout the duration of their custodial sentence, and are encouraged to take responsibility for their own actions and decisions. Healthy prisons should demonstrate a well-ordered environment in which the requirements of 'security', 'control' and 'justice' are balanced and in which all members of the prison community are safe and treated with fairness.

- 2.35 Women had mixed views about their treatment by staff but relationships observed were generally respectful. There was relatively little informal engagement between staff and women inmates and limited opportunity outside scheduled activity time for staff to model pro-social behaviour. We questioned the recent decision that primary workers should wear uniform.
- 2.36 We observed reasonably good and relaxed relationships between staff and women inmates. However, women in groups were not so positive about their treatment by front line staff. Stakeholders (a group of representatives from agencies that had some input in to the institution) told us that relationships had deteriorated in recent years and that staff concerns about labour relations problems had resulted in a loss of rapport between women and officers. Staff were divided between their security and their supportive roles and some did not have the necessary basic 'people skills'.
- 2.37 Women themselves said that officers did not interact with them when doing rounds of houses and it was clear from our observations and activity records that, with some exceptions, this was the case. Rounds of houses sometimes took less than one minute and patrols of all the houses could be completed in less than half an hour. This gave little scope for positive relationships to be established. Some women also expressed the view that staff were not welcome on the houses and that they would not want to be seen talking to them for fear of being regarded as informers. There had been some unsubstantiated complaints of primary

workers failing to announce themselves when entering the units. However, one case that had been formally investigated found that it was easy for women who were in their rooms at the time not to hear the officers' announcement and this should be done on entering both the lower and upper hallways.

- 2.38 The relatively few primary workers on duty each day meant that there was little opportunity for much informal interaction with women, although the interactions we observed were friendly and respectful. Often, involvement between primary workers and inmates was for a specific purpose only. There were some good relationships between women and other staff in the prison and also with managers, who made themselves available to the women and knew them well. The warden was particularly visible and approachable.
- 2.39 Most members of staff used women's first names when addressing them but sometimes used only surnames when referring to or writing about them. Lists and documents, including the official count sheet for primary workers on patrol, were often printed with only surnames, which did not encourage respectful address.
- 2.40 In our survey, 79% of women, similar to the English comparator, said that most staff treated them with respect, and 77% said they had a member of staff they could turn to for help if they had a problem. However, 35%, against an English comparator of 18%, said they had been victimized by a member of staff and 25%, compared with 10%, said staff had made insulting remarks to them. Staff conduct represented the single biggest category of complaint. Women often told us that they were treated inconsistently by staff.
- 2.41 The principles of *Creating Choices* (empowerment, choice, respect, dignity and responsibility) were in line with our expectation that women should be supported to take responsibility for their actions and decisions. *Creating Choices* also envisaged that staff should create an environment where relationships based on role-modelling, support, trust and democratic decision-making could thrive, but with little staff presence on houses, opportunities for staff to model pro-social behaviour were mainly limited to programmed activity time. We observed one staff-inmate committee meeting at which the interactions were positive and respectful. However, some of the women later told us that these meetings were orchestrated, with little willingness to engage in difficult issues.
- 2.42 Primary workers had recently begun to wear military-style uniform. Women told us that they had noticed a distinct difference in staff attitudes at first but that they had now got used to it. We considered that the impact on relationships was unlikely to be positive. *Creating Choices* noted that research indicated that women did not react well to the authoritarianism of uniforms, although we were told that current opinion was that the impact of wearing a uniform was neutral. It was difficult to see why a decision had been made that appeared contrary to the *Creating Choices* model.

Action points

- 2.43 **Primary workers should be encouraged to take longer on their house patrols and to spend time interacting with women inmates.**
- 2.44 **The impact of staff wearing uniforms on relationships between inmates and staff should be evaluated, taking full account of the specific perspective of women and the principles of *Creating Choices*.**

Primary workers

Expected outcome:

Inmates' relationships with their primary workers are based on mutual respect, high expectations and support.

- 2.45 Not all women were meeting their primary workers soon after arrival and others had some difficulties in access. Most women found their primary workers helpful and reports were completed to a satisfactory standard but there was little involvement of families.
- 2.46 Women were told the names of their case management team, including their primary worker, assistant team leader and team leader, soon after arrival. Primary workers were responsible for a wide range of tasks, including completing progress reports on the correctional plan, recommendations about pay and assessments on such matters as parole and temporary absences. The intention was that primary workers should meet the women for whom they were responsible at least monthly and complete a monthly structured casework record.
- 2.47 All primary workers received the standard 11-week correctional officers' program, two weeks of parole officer training, 10 days of women-centred training, and training in the offender management computer system. The women-centred training aimed to make staff aware of issues such as sexism, racism, disability, sexual orientation, physical and sexual abuse, self-injurious suicidal behaviour, addictions, mental health and Aboriginal traditions and spirituality. It also contained modules on wellness and maintaining boundaries. The parole officer training covered the skills required for completing assessments and reports. Despite this, some stakeholders said that primary workers were not sufficiently well trained and that reports were often late or completed without properly involving the woman. We saw no current evidence of late reports (although it was acknowledged that this had recently changed) but there were some examples of women not being fully consulted during the preparation of important reports.
- 2.48 In our survey, 62% of women, against an English comparator of 37%, said they found their primary workers helpful or very helpful. However, only 23%, compared to 46% at Nova, said they had met their primary worker in their first week. We met a number of women who had yet to meet their primary worker even though they had been in the institution for some weeks.
- 2.49 Shift work, leave and other commitments meant it was sometimes difficult for primary workers to have much face-to-face contact with the women for whom they were responsible. However, they were required to complete a monthly structured casework record reporting on progress on the correctional plan, use of time, attitude and other matters. Some of these reflected the difficulties women had in meeting their primary workers. One primary worker noted that an inmate had asked to meet the previous week to discuss current issues but 'to date this writer has not been able to meet with her due to work schedules'. It was nearly three weeks before she was able to do so. Some casework reviews indicated that the primary worker had met the woman on a 'couple of informal occasions' in the previous month and some showed that interviews were conducted over the telephone. Commendable efforts had been made to get casework up to date but women told us that one way of achieving this was by primary workers telephoning them in their houses late at night

or coming to see them as late as 1am. Some had agreed to this as the only way they could see their primary worker within a reasonable time but it was unsatisfactory.

- 2.50 The records we saw were all up to date and most were thoroughly completed with good quality contributions, which demonstrated that the primary workers had a good knowledge of the women for whom they were responsible. There were some references to family issues but little evidence that families were directly involved. Contributions to other reports were also satisfactorily completed.

Action points

- 2.51 **Primary workers should introduce themselves to the women for whom they are responsible within the first week.**
- 2.52 **Primary workers should have a personal talk with women at least once a month at a reasonable time in order to complete structured casework records.**
- 2.53 **Primary workers should make direct contact with inmates' families in appropriate cases to encourage the maintenance of family ties to support successful reintegration.**

Section 3: Duty of care

Bullying behaviour ('muscling')

Expected outcome:

Everyone feels safe from bullying (muscling) and victimisation (which includes verbal and racial abuse, theft, threats of violence and assault). Active and fair systems to prevent and respond to bullying behaviour are known to staff, inmates and visitors, and inform all aspects of the regime.

- 3.1 There was no formal anti-muscling policy. Many women said they had been victimized and that they felt unsafe, mainly on their houses where there was no supervision. A difficult balance between direct supervision and supporting the women's empowerment had to be maintained. Many women reported incidents to staff but the nature and extent of muscling was not monitored thoroughly enough.
- 3.2 In the CSC, bullying behaviour was usually referred to as muscling. We use this term in the report to refer to intimidation, victimization and harassment by other inmates, including verbal and racial abuse and threats and psychological intimidation. Such behaviour can also manifest itself in exclusion, isolation, being singled out and treated differently by other women inmates.
- 3.3 In our survey, 47% of women, significantly higher than the English comparator of 32%, said they had felt unsafe at GVIW. Of these, 31% had felt unsafe on their houses, 13% at the gym and 13% in leisure areas. We detected a sense of acceptance of the inevitability of muscling among women and staff. Forty-three per cent of women, against the English comparator of 24%, said they had been victimized (insulted or assaulted) by another inmate and 37%, much higher than the comparator of 14%, said they had reported victimisation.
- 3.4 There was no clear formal anti-muscling policy or strategy. Most CSC behaviour and conduct policies and training related to harassment by staff. This was supported by an anti-harassment coordinator and four anti-harassment officers. Inmate-on-inmate muscling had a lower profile and there was little publicity about the potential consequences of muscling on victims. The inmate handbook paid little attention to muscling, although it was a significant issue.
- 3.5 The anti-harassment officer completed a quick analysis of incidents between January 2004 and July 2005 and estimated that 17% of offences had been resolved informally and 49% of formal disciplinary cases were potentially related to muscling.
- 3.6 A number of women told us about their experience of muscling, including a serious physical assault. We reviewed a large sample of observation reports of incidents of assaults and fights between inmates, and looked at incident reports completed by the security information officer. Most incidents involved assaults that took place on the unsupervised houses. Other than to count women, officers were rarely on the houses long enough to detect problems. Each house was required to hold a monthly house meeting but staff did not routinely attend.

- 3.7 Women could contact the main control post from the house by telephone and officers were required to respond whenever the receiver was lifted, even if no one spoke. In some incidents, women had been afraid to be seen using this line. Concerns had been raised at one inmate committee about the length of time taken by officers to respond to calls from the houses. Other incidents had occurred during leisure and in the gym washroom.
- 3.8 The open environment was difficult to supervise. We heard anecdotal evidence that some women had deliberately behaved in a way that would lead to them being admitted to segregation as a way of finding sanctuary.
- 3.9 Many incidents were not single impulsive acts of aggression but related to problematic personal relationships. Some were associated with power struggles manifested through arguments over food and the catering arrangements. Problems associated with debt, race and the nature of offences were also evident. We were concerned that women new to the establishment could be particularly vulnerable to muscling as there was no structured support for them before they moved to live in unstaffed houses. There was insufficient peer support.
- 3.10 No internal survey of women's experience of muscling had been done to capture this information and devise a strategy. The information that was known was not being monitored and the exit survey organized by psychology did not specifically ask about views and experiences of muscling.
- 3.11 Staff demonstrated a good awareness of muscling. A risk assessment officer identified potential 'predators and non-compatibles' before they arrived at the institution. Observation reports, which included any unexplained injuries observed by staff, were highlighted at a morning staff meeting and investigated by the security information officer. Particular women were often identified as suspected bullies but the nature of the relationships and the environment made it difficult to gather evidence as some women were worried about reprisals. Requests for house moves were monitored by an assistant team leader. Staff and inmates did not routinely discuss muscling or feelings of safety at the inmate committee.
- 3.12 Women involved in muscling incidents, sometimes inappropriately the alleged victim, were moved to a different house. Many incidents were responded to informally, with staff working with the inmate chair in some cases. Some women were removed to segregation. There were no interventions to challenge bullies directly or to support victims. We were told that referrals could be made for participation in alternatives to violence or anger management.

Action points

- 3.13 **All incidents of muscling should be recorded and monitored to develop a profile of this behaviour across the institution.**
- 3.14 **Investigations into incidents of muscling should show evidence of action taken, and incidents should be followed up to support victims and challenge bullies about their behaviour.**
- 3.15 **There should be an annual confidential survey of women's experiences and perceptions of muscling, to inform the strategy.**

Self-harm and suicide

Expected outcome:

Inmates at risk of self-harm or suicide are identified at an early stage, and a care and support plan is drawn up, implemented and monitored. Inmates who have been identified as vulnerable should be encouraged to participate in all purposeful activity. All staff are aware of and alert to vulnerability issues, and appropriately trained and have access to proper equipment and support.

- 3.16 Levels of self-harm were low. Overall, there was a very caring approach for those at risk. Care was multidisciplinary, led by psychology and was particularly good on the SLE. But initial responses were too reliant on the use of segregation and protective clothing. There was no coordinated safer custody strategy to bring together all those involved.
- 3.17 Levels of self-harm were low. The relaxed and open environment was a significant contributory factor to this, and helped women to deal with stressful events.
- 3.18 There was no single register documenting incidents but some information about those at risk was available through a system of 'active alerts, flags and needs' on the computer-based offender management system (OMS). One report recorded that 30 women currently at GVIW had disclosed some history of self-harm, seven had self-injured at GVIW since January 2004 and four of these had harmed themselves on several occasions.
- 3.19 One woman had killed herself in 2003 and some, but not all, of the subsequent recommendations from the coroner's investigation had been implemented. These included suicide awareness workshops for women, several of which had taken place during 2004 with women co-facilitating alongside staff and suicide prevention trainers. Recommendations that had not been implemented included 24-hour healthcare and the provision of an on-site defibrillator.
- 3.20 There had been few very serious or near-fatal self-harm incidents. A report by the warden on the attempted suicide of one woman analysed the action taken and considered what, if anything, could be learned from how staff had responded to the incident.
- 3.21 The psychology team took the lead in the care of those at risk of self-harm, and the acting senior psychologist was the suicide prevention coordinator. Three psychologists were based in the healthcare department. Much of their time was taken up with their responsibilities on the SLE and secure unit and this was reflected in the minutes of their weekly departmental meeting. There were insufficient resources to respond adequately to other needs within the general population.
- 3.22 All new receptions were seen within 24 hours for an intake assessment that considered the risk of self-harm. In some cases, previous information about self-harm history from the community-based parole officer was available through the OMS. Any woman who had self-injured was referred to psychology who, in consultation with the team leader responsible for her unit, decided on a care plan. The warden or deputy warden approved the plan and informed the case management team.

- 3.23 The usual response to an incident of self-harm was to locate the woman in the segregation unit. A psychologist decided the frequency of the watch and whether she would be observed by a closed-circuit television camera. Six of the seven women who had self-harmed at GVIW had been placed in protective gowns in cells in the segregation unit where there were obvious ligature points. No specific record was kept of the use of security or protective clothing. One woman described how this had made her feel worse.
- 3.24 One woman was being held in these conditions during the inspection. No thorough assessment had been made of her previous history as the relevant reports were written in French and had not been translated. These had identified her as being at potential risk of self-harm.
- 3.25 A good range of resources was available to help the small number of women at risk of self-harm. Behavioural counsellors provided regular support to women in the SLE and secure unit, and to those moved to the general population. Staff on the SLE also provided 24-hour support and several primary workers had been trained in dialectical behaviour therapy. Multidisciplinary team meetings were held weekly to review all new admissions and other on-going cases where there were concerns. Additional weekly case meetings were held on the SLE and secure unit. A strong group of volunteers contributed to the support of women in the institution and some, such as the Elizabeth Fry Society, helped women after release. There was, however, insufficient sexual abuse counselling (see section on programs) and the limited direct contact with inmates' families or significant others was usually made by the chaplain following a crisis. Families were not included as part of the correctional plan.
- 3.26 Women provided a lot of mutual support but there was little formal peer support (see section on reception). In our survey, 51% of women, against an English comparator of 72%, said they were able to speak to a member of the peer support team at any time if they wanted to.
- 3.27 Standing Order 843 Prevention of Suicide and Self-Inflicted Injuries (issued 1/04/05 and reviewed annually) provided guidance for staff on procedures. Incidents of self-harm were recorded in observation reports, discussed at a morning meeting and referred to psychology for follow up. Although levels of self-harm were low, the different areas that contribute to safer custody, such as links with muscling, the pressures of the early days in custody, alternative strategies to segregation and the role of peer support, were not brought together under an overall strategy.
- 3.28 From the training records provided, it appeared that all staff who have direct contact with offenders had received some training as part of the correctional training program, the new employee orientation program or from modules on the women-centred training or dialectical behaviour therapy course. Training for some had been some years previously and there was no refresher training. It was planned that this would be delivered through computer-based training by November 2005.
- 3.29 Staff carried a protective mask, gloves and ligature cutters to respond to emergencies.

Action points

- 3.30 The records of incidents of self-harm should be improved to identify any emerging trends, and record use of segregation, protective clothing and other interventions.
- 3.31 The psychology-led behaviourist approach to women at risk of self-harm should be developed to involve primary workers in managing cases and a formal support scheme which should include overnight facilities where peer supporters can help women at risk.
- 3.32 All recommendations from the coroner's investigation into the self-inflicted death in custody should be implemented.
- 3.33 The resources available to the psychology department should be reviewed to ensure that it meets the needs of the entire population.
- 3.34 Systems should be put in place to ensure appropriate care for Francophone women at risk of self-harm and that all relevant reports are available in English before a transfer to GVIW.
- 3.35 Families and other significant people should be contacted and involved when a woman is at risk of self-harm, where this is appropriate and with the woman's agreement.
- 3.36 A safer custody forum should be developed to consider the relationship between the policy areas that contribute to feelings of safety. These include muscling, early days of custody, peer support and alternatives to segregation.

Race relations and diversity

Expected outcomes:

All inmates experience equality of opportunity in all aspects of prison life, are treated equally and are safe. Diversity is embraced, valued, promoted and respected.

- 3.37 Race relations were not an overt problem but there was no monitoring of outcomes for women from different racial and cultural groups. Aboriginal women were over-represented in the segregation and secure units. Aboriginal and black women's groups promoted their interests, but there was little wider promotion of cultural diversity issues. Black and Aboriginal women reported a cultural gap between themselves and the majority Caucasian staff.
- 3.38 Sixty-three per cent of women were Caucasian, 22% were black, 11% were Aboriginal and 3% were Asiatic. Black and Aboriginal women had support groups facilitated by a paid liaison officer. The native sisterhood group, assisted by a liaison officer and an elder, provided access to spiritual activities as well as cultural, linguistic and reintegration help and information. The black women were supported by a worker from the Black Inmates and Friends Assembly (BIFA). She was contracted for three visits a month but attended more

frequently. Both groups advocated well for women and had achieved better provision of toiletries and cosmetics for black women and of sweat ceremonies for Aboriginal women. Neither the elder or black inmates' liaison officer had keys to allow them independent access through the prison. There had been important celebrations of emancipation day and treaty day in recent weeks. Although these events had been designed to include the whole population, they had been perceived by most women as special days for minorities.

3.39 We met a group of Afro-Canadian women, who said that:

- they felt less important and had less consideration than Caucasian or Aboriginal women, not in access to resources or services but in less respectful treatment by other inmates and staff
- racist language used against them was treated as less serious than other discriminatory behaviour
- the majority of Caucasian staff did not understand cultural aspects of black inmates' communication and behaviour, which meant that they had to change to fit the cultural norms of staff
- the support of the BIFA group was important in allowing them to have a collective voice to negotiate services and to help organize special cultural events

3.40 Although there was some monitoring at national level there was no routine monitoring in the institution of access to facilities, services or outcomes by race or cultural identity to identify trends and reassure women of equity of provision.

3.41 A review undertaken during the inspection revealed that minority groups were represented in all residential houses apart from house 12, which was a minimum-security house for which there was a significant waiting list. The 11% of Aboriginal women were over-represented in the secure unit (33%) and accounted for 16% of minor and 22% of serious charges.

3.42 There was no separate system to report or manage cultural or racial complaints. There had been two significant racist incidents, one of which had been generated by an allegation that a Caucasian woman had said in the hearing of many others that 'all niggers should die'. This had been dealt with by discussions involving the inmate committee, BIFA and the elder. Representatives were sent to each residential house to warn about the consequences of such behaviour. Although the alleged perpetrator was individually advised about her conduct, many black women felt the issue had not been taken sufficiently seriously. In another incident, black women had protested by staging a sit-down protest. There was no single person responsible for promoting positive race relations or handling complaints about racist incidents.

3.43 A cultural awareness day had been held for all women in 2005 as well as events organized by the sisterhood and BIFA. There was no attention to race relations and cultural diversity as part of the reception or induction processes. The foundation training for staff covered race and diversity but there was no ongoing education and promotion of a commitment to positive race relations and cultural diversity.

Action points

- 3.44 **A system for staff and inmates to report perceived racist incidents should be introduced with complaints about racism identified and investigated separately.**
- 3.45 **There should be ongoing promotion of race equality and diversity for staff and inmates.**
- 3.46 **The support group liaison staff and elder should be issued with keys to allow them access through the prison.**

Foreign national inmates

Expected outcomes:

Foreign national inmates should have the same access to all prison facilities as other inmates. All prisons should be aware of the specific needs that foreign national inmates have and implement a distinct strategy, which aims to represent their views and offer peer support.

- 3.47 There was a small number of foreign national women whose immigration status was well managed. Access to information and support for women about their individual cases was good.
- 3.48 There were eight foreign national women: three from Jamaica, two from America and one each from Barbados, India and the United Kingdom. These women were identified during the reception process.
- 3.49 The administrative systems to address issues of immigration, deportation or repatriation were efficient and effective. The chief of sentence management had a good knowledge of the women's sentence and personal circumstances. There were good links with the local immigration office, which provided information about deportation status early enough for any appeals to be heard during their sentence. Immigration interviews were routinely held at the prison. One woman was appealing against deportation and was being well supported by administrative staff, including helping her contact external pressure groups and get legal advice. Foreign national women were confident that they understood their immigration status and knew whom to speak to about any related issues.
- 3.50 No woman had been detained in the prison on an immigration warrant beyond her sentence, although a woman could stay temporarily to make suitable travel arrangements.
- 3.51 All the foreign national women spoke English. We were told that where possible, those who did not or who had poor English were located with another woman able to speak their language and support them. External translators had been used for complex correctional plan and immigration interviews. The prison also maintained a list of staff and inmates with language skills that could be used.
- 3.52 Foreign national women received all the correctional planning, programs and privileges available to Canadian women, including access to healthcare.

- 3.53 None of the foreign national women believed a support group was necessary as they were satisfied with the help they got from primary workers and the chief of sentence management. Foreign national women could receive incoming telephone calls at times arranged at their convenience to help maintain contact with their families.

Family and friends

Expected outcomes:

Inmates are encouraged to maintain contact with family and friends through regular access to mail, telephones and visits.

- 3.54 Facilities for visits were reasonably good but restrictions placed on visitors indicated by the drug dog were disproportionate. Family days were popular and the excellent private family visiting facility was well used. No financial assistance was available to visitors who needed it. The security procedures for vetting visitors and telephone contact were restrictive and caused unnecessary delay.

Mail

- 3.55 There was no random censorship of mail, although all mail was opened to check for unauthorized items. Legally privileged mail was logged, signed for by women and opened in front of staff. There was no limit to the number of letters women could send or receive. Stamps, envelopes and paper could be bought through the canteen or brought in through visits.
- 3.56 Mail was collected and distributed to the women's individual private post-boxes daily by the visits and communications officer. In our survey, 34% of women said they had problems sending or receiving mail.

Telephones

- 3.57 Access to telephones was good with a telephone on each house. The system to check telephone numbers, similar to that for checking visitors, caused delays in women being able to contact family and friends. In our survey, 37% of women, significantly higher than the English comparator of 27%, said they had experienced problems in accessing the telephones. Women without telephone credit needing to make an urgent call could request to use an administrative telephone and have the cost of the call billed to their account. All such calls were recorded and there was evidence that this service was being offered.

Visits

- 3.58 In our survey, 43% of women, against an English comparator of 34% and 22% at Nova, said they had been given information about visits on the day of their arrival.
- 3.59 All visitors had to be security cleared before their names could be added to a list of approved visitors. Women were given the relevant forms to complete during reception and, if necessary, could ask the inmate

orientation team for advice about it the same day. The form was sent to the nominated visitor, who filled in their personal details before returning it for processing by the risk assessment officer. Delays frequently occurred if there were minor errors in the form or if the risk assessment officer was absent. Nominated visitors were checked with the Canadian Police Information Centre. Unlike at Nova, where staff focused on offences involving drug trafficking and family violence, applications for GVIW were likely to be refused if proposed visitors had a current, lengthy or recent criminal history. All completed applications were then brought to the fortnightly institutional review board for discussion and approval.

- 3.60 The whole process could rarely be completed in less than three weeks and on average took over a month. Women were understandably frustrated by the time it took to get security clearance for their visitors. There was some flexibility in special circumstances to allow visitors who had not been fully security cleared to visit but only closed visits were allowed. The institution did not regularly monitor the number of closed visits imposed but we found that there had been 33 in the previous 10 months.
- 3.61 Statistics of the number of visitor applications denied were unavailable but our examination of a sample of applications and the minutes of the institutional review board showed that this did sometimes happen. The most frequent reason for refusal was 'lengthy/recent criminal history' but the nature of the offence was not specified. In our survey, only 47% of women, fewer than Nova although distance was not such an issue, and significantly lower than the English comparator of 71%, said they were given the opportunity to have the number of visits to which they were entitled.
- 3.62 Approved visitors were sent a package of information detailing rules about visits, including searching procedures, and giving a drug tip line telephone number. Visitors could visit at any time without prior appointment unless they were visiting a woman in the secure unit or the segregation unit.
- 3.63 Women could have up to four visitors on a single visit. Visits were scheduled on two evenings during the week, and in morning and afternoon sessions at weekends. There was no limit to the visits that women could have within that schedule. Women in maximum security could have visits on one evening a week and on Sunday mornings. These had to be booked 48 hours in advance and the women were risk assessed to determine whether restraint equipment could be removed during the visit.
- 3.64 There was no family support work to actively encourage or facilitate family contact, and correctional plans did not cover the need to maintain family ties. No financial assistance was made available for visitors with significant travelling expenses. The chaplaincy offered occasional help for those travelling in the greater Toronto area.
- 3.65 Women were given a frisk-search out of sight of their visitors before entering the visits area. Visitors were screened for drugs using an ion scanner. Anyone with a positive reading could be turned away or offered a closed visit, or the police could be called. A drug dog was also used and we received many complaints about the dog's behaviour (see section on substance use). If the dog indicated, a threat risk assessment was carried out to determine what type of visit should be offered. If the risk was deemed low, designated seating was a theoretical option. In reality, there were too few staff to supervise and a closed visit was usually offered. All closed visits were regularly reviewed at the institutional review boards but aggregated data was not collected and there was no overall monitoring of them.
- 3.66 Facilities for visits were good. The area was comfortable, refreshments were available from a couple of vending machines, a few toys in reasonable condition were provided and the inmate committee occasionally

organized activities for the children. An attractive patio area with seats and tables could also be used except by maximum-security women.

- 3.67 A separate house in the main grounds was used as a private family visiting facility where women could spend up to 72 hours with partners, children, parents, siblings or grandparents. It had been used 73 times in the previous six months and was an excellent resource to support the promotion of family ties. Women could also apply to use the house on their own for some personal quiet time for up to 48 hours.
- 3.68 Family days were organized twice a year, in the summer and at Christmas. These were well received, with 113 visitors attending the last event.

Action points

- 3.69 **The process of security checks on telephone contacts and visitors should be revised and speeded up especially for those visiting minimum-security women.**
- 3.70 **Financial assistance should be provided to visitors who are not able to visit due to financial hardship.**
- 3.71 **The importance of maintaining family contact should be recognized in correctional plans.**
- 3.72 **Detailed data on the imposition of closed visits should be collected and routinely aggregated to ensure that the system is operating correctly.**
- 3.73 **Visitors should not be offered restricted visits solely on a drug dog indication.**
- 3.74 **Women should not be kept in restraints during a visit.**

Requests and complaints

Expected outcomes:

Effective application and complaint procedures are in place, are easy to access, easy to use and provide timely responses. Inmates feel safe from repercussions when using these procedures and are aware of an appeal procedure.

- 3.75 Request and complaint forms were not easily accessible. There was an over-reliance on formal requests and not all departments kept an audit trail. The timescales for investigating complaints and reporting back were too long. There was no quality assurance and no analysis of patterns or trends concerning complaints.
- 3.76 Details of how to make complaints and grievances were set out in the inmate handbook and on notices outside the office of the inmate committee. No comparable information about how to make a request was available, although this was covered by the inmate orientation team on a new arrival's first day.

- 3.77 The chief of administration services acted as the complaints/grievance coordinator and was scheduled to deliver a session about complaints to new arrivals on Thursdays, although this did not always happen (see section on orientation). In our survey, 42% of women, significantly higher than the English comparator of 30%, said they had been given information about how to make an appeal/file a grievance.
- 3.78 Women had to get request and complaint and grievance forms from the inmate committee office, which meant they were inaccessible when the office was unoccupied and locked. Women in the segregation and secure units had to ask staff for the forms. In our survey, only 66% of women, against an English comparator of 82%, said it was easy/very easy to get a complaint form, and 79%, compared with 87%, said it was easy to get a request form.
- 3.79 The wide range of different request forms suggested overuse of a formal system of requests. Requests went through the normal internal mail system and were distributed to the appropriate departments. The majority of departments logged the request for action on the central computer system so that it became part of a 'brought forward' file that could be tracked. Two departments, admissions and discharges and stores, did not log or track requests.
- 3.80 Women could write in confidence to the warden and place the complaint in a dedicated post-box. Women in the segregation and secure units used the usual post-box but only the warden and head of administrative service had keys to it.
- 3.81 Complaints were also dealt with through the normal mail system. Women used the general post-box and the admissions and discharge officer brought the complaints daily to the grievance coordinator. This included complaints about staff. The lack of confidentiality was inappropriate.
- 3.82 All complaints and grievances were processed through the chief of administration services, who collected complaints from a post-box to which he had the only key. Anyone wishing to speak to someone from outside the institution about their complaint was usually referred to the Correctional Investigator and the Elizabeth Fry Society. Both had freephone numbers that were given to all women.
- 3.83 The chief of administration services designated complaints and grievances as routine or high priority, with the timescale for investigation and reporting back set at 25 and 15 days respectively. These timescales were too long. If a complainant was not satisfied with the response, the complaint became a first level grievance stage and was referred to the warden. Appeals against first level grievances became second level grievances, which were referred to regional headquarters. Third level grievances were dealt with at national headquarters.
- 3.84 The chief of administration services tracked complaints through a status report that was brought to the morning briefings. There was no aggregated monitoring or routine analysis of complaints to identify trends. Regional headquarters and national headquarters carried out an annual audit and occasionally asked for information on specific areas such as timeliness or complaints about staff harassment. We had some doubts about the audit's validity and robustness since in some instances it relied on the institution selecting its own sample.
- 3.85 Twenty-three complaints had been submitted between 1 April and 17 August 2005. Complaints about lost or damaged personal effects were dealt with as claims against the Crown through a different process and submitted via the warden. We asked for some analysis of the complaints made during the previous 12

months, which showed that the largest proportions were about healthcare (21%) and staff conduct (33%). Such analysis was not undertaken routinely.

- 3.86 There was no quality assurance system to ensure consistency in responses, appropriateness and politeness of replies. We examined a sample of complaints and first level grievances and found the quality of responses varied considerably. Apart from in responses from psychology, apologies were rare and there had been no investigation into the five complaints that had been withdrawn. In our survey, 32% of women, significantly higher than the English comparator of 12%, said they had been made or encouraged to withdraw a complaint. We found no evidence of this and discovered from talking to some of the women involved that they had in fact chosen to withdraw their complaint because they had been unhappy with the outcome. It was important that when this happened it was clearly recorded.
- 3.87 Allegations of victimisation and/or harassment by staff were treated as a first level grievance, designated high priority (by-passing the complaints stage) and referred immediately to the warden. She took a robust line and we saw examples where some were referred to regional /national headquarters for investigation in case local preliminary investigation would be seen as compromising objective inquiry.

Action points

- 3.88 **The inmate handbook should outline the system for requests, and information should be displayed on notice boards.**
- 3.89 **In addition to the supply retained by the inmate committee, request and complaint forms should be made freely available.**
- 3.90 **Requests to all departments should be logged so that there is an audit trail.**
- 3.91 **Primary workers should take verbal requests daily to reduce the overuse of the formal system.**
- 3.92 **All complaints should be responded to within seven days, either with a resolution or interim reply explaining what was being done.**
- 3.93 **Complaints should be quality assured to ensure that responses are timely, respectful, legible, and address the issues raised.**
- 3.94 **There should be regular analysis of complaints to identify patterns and trends.**
- 3.95 **A supply of request and complaint forms should be freely available to women in the segregation unit.**

Section 4: Healthcare

Expected outcomes:

Inmates should be cared for by a health service that assesses and meets their needs for healthcare while in prison and which promotes continuity of health and social care on release. The standard of healthcare provided is equivalent to that which inmates could expect to receive in the community.

4.1 In our survey, 73% of women rated the overall quality of healthcare as bad or very bad. No health needs assessment had been carried out to determine whether the services met the needs of the population. Staff shortages were affecting delivery. Systems, particularly for managing the waiting lists, were lacking. There was a high use of prescribed medications and we had major concerns about how directly observed treatments were administered, in particular to women in the maximum security and segregation units. Many women could have their medications in-possession. The healthcare department had links with a wide range of specialists in the community. Mental health services were led by the psychology department, with sessions from a psychiatrist. There was no formal documented sharing of information between the psychology department and the psychiatrist, and we had concerns about the apparent difficulties in transferring a mentally ill woman to a bed in the community.

Environment

4.2 The healthcare department was within the main building adjacent to the maximum security and segregation units. There was a treatment room with a hatch to the corridor, a pharmacy store, a dental suite, a consulting room and two rooms where patients could be admitted for observation. One of the latter was a negative pressure room but was also used by visiting healthcare professionals such as the physiotherapist. There was a large fridge for storing Methadone in the pharmacy store; a lock was fitted to it during the inspection. A smaller fridge in the treatment room was used to store vaccines and other medications. There was a book to record minimum and maximum temperatures daily but the records were incomplete. There were staff and inmate washrooms. The psychology department occupied two offices. We were concerned to note that there was no defibrillator.

Staffing

4.3 The chief of healthcare was a registered nurse (RN). There were three other RNs in indeterminate (permanent) posts, one was on secondment from another federal institution. A fourth RN on a six-month contract had just joined, and a casual RN was employed to cover vacancies when required. These staff worked in the healthcare centre (the floor). Two further nurses, one dedicated to the SLE and the other to the maximum security and segregation units, were on long-term sick leave. All the nurses were required to have a licence to practise in the province of Ontario renewed annually. There was no formal system to ensure that these licences were valid, although all were in date. Nurses who worked the floor had annual appraisals by the chief of healthcare, but those for the nurses on the maximum security/segregation units and the SLE were undertaken by the relevant unit manager.

- 4.4 The nurses on the floor worked from 8am until 4pm. Three nurses excluding the chief should have been on duty each weekday but this was rarely achieved due to staff shortages. On one day of our inspection, only the chief and a new member of staff were on duty for the whole day. There were two nurses per day at the weekends. The nurses on the maximum security and segregation units and the SLE did not work at weekends.
- 4.5 None of the nursing staff had received first aid or resuscitation training within the previous two years. None had any formal clinical supervision and formal staff meetings had fallen into abeyance due to staff shortages.
- 4.6 An administrative clerk worked full time in the department but her duties were split between healthcare and the psychology department.
- 4.7 A woman general physician (GP) attended the prison every Thursday for the whole day. She had been working at GVIW since May 2005 but had not received any training on security or working with offenders. A psychiatrist undertook one half-day session a week on a Friday, and a liver specialist attended monthly. A physiotherapist, who also worked in the local community, undertook one session a week and a dentist attended one day a week. A dental hygienist also undertook sessions but had been off sick for some time and no cover had been provided.

Records

- 4.8 Clinical files were stored in locked filing cabinets in the consulting room. The filing system was obscure: files of women seen by the nurses in the preceding week were placed in one cabinet to be reviewed by the GP; back files of current inmates were filed separately from their current record; and the files of women on methadone were in a separate drawer. Records of women who left GVIW were kept for three months before being sent to Millhaven Institution, Kingston, Ontario, for archiving. If a woman returned to GVIW, a temporary clinical record was started and her previous records were requested; these usually arrived within three or four days. The files we reviewed were in a poor state: pages were not secured and the entries were not consecutive. Not all the notes had a major problems list, although we were told that each set should have one. No mention was made of when a woman left the institution. We also witnessed nurses writing in notes retrospectively. The psychologists kept separate case files about each of their clients.
- 4.9 Current medicine administration records (MARs) were kept alphabetically in ring binders in the pharmacy store. The prescriptions were clearly printed on the form at the dispensing pharmacy, following the receipt of a faxed copy of the doctor's orders from healthcare staff. However, no 'start date' was included on the prescription and in one case there were two doses of the same medication on the same prescription. The MARs comprised a two-page duplicate form, the back copy of which was detached and sent back to the pharmacy a week before a new supply of the relevant medication was required. Healthcare staff sent a medical profile (resident status form) of all new arrivals to the pharmacy regardless of whether they required any medication at that time. The pharmacy held a database of all women at GVIW and details such as allergies were highlighted when an individual was prescribed any medications and were automatically transcribed on to the MAR. Of the MARs we sampled, nursing staff had not annotated all correctly and it was unclear whether women had received the correct medication at the correct time. Nursing staff did not sign the MAR when they administered the medication.

- 4.10 Dental records were filed separately and kept in the dental suite.
- 4.11 Nursing staff worked to a variety of standing orders, some of which were local and some national. There were some discrepancies between the two sets and not all were dated.

Delivery of care

Primary care

- 4.12 In our survey, 73% of women said the overall quality of healthcare was bad or very bad. There had been no health needs assessment carried out so managers did not know whether the services provided matched the needs of the population and whether the staff had the appropriate skills.
- 4.13 New arrivals were seen by a nurse within their first few hours. In our survey, 83% of women, against compared with 72% in the English surveys, said they had had access to someone from healthcare within 24 hours of arrival. A healthcare assessment and the resident status form for the pharmacy were completed. If a woman was on medications, the doctor was contacted and a verbal order given to allow nurses to administer the medications for a week. This order was signed when the doctor next attended. Women also saw the psychologist, who completed separate paperwork relating to the woman's mental state at the time of admission. The inmate handbook detailed the services offered by the healthcare department and a specific healthcare booklet advised women about common health problems and how to manage them. Every new arrival had a two-stage Mantoux test to check for active tuberculosis. If the patient gave consent, healthcare staff contacted her previous doctor for her medical history.
- 4.14 Anyone wanting to see a member of the healthcare team usually had to submit a written request. Women we spoke to told of long delays in receiving responses to requests. We sampled a small selection of requests, which were all filed in each woman's clinical record (there was no central register of requests and the system was difficult to audit). Of the 14 requests from four patients looked at, the longest wait for a healthcare intervention was 16 days and the shortest was when a woman had been seen on the same day as her request. Nurses appeared to triage the requests based on the information provided by the patient rather than seeing the patient. Women could also contact the department via the master command control post (MCCP) and their request would be passed to healthcare staff who would then telephone the woman on her living unit.
- 4.15 Healthcare staff sent a response to each request and issued passes for healthcare if a woman had an appointment. Some women told us that they did not receive the passes, which were delivered by primary workers, until after their appointment.
- 4.16 Nurses saw women and undertook basic tests and blood work at a daily nurses' clinic. They were also able to treat a variety of complaints using previously agreed standing orders. Any treatments given were hand written on the MAR and the consultation was written in the clinical record. The GP then reviewed the records of all women seen by nursing staff.
- 4.17 Staff shortages meant that there was not always a nurses' clinic on a Thursday, which was when the GP worked at GVIW. The GP saw all new admissions and other patients referred to her by the nurses. She also saw all women prescribed methadone weekly.

- 4.18 Most women had their medications in-possession. Prescribed medications were heavily used. The pharmacist supplied the medications in blister packs and provided a patient information leaflet (PIL) for each newly prescribed medication. All psychotropic medications were given in seven-day blister packs, while most other medications were issued in 28-day packs. Women had to return used blister packs before being issued with a new one. The women had lockable drawers in their rooms in which to store medications but these were seldom used for their intended purpose. A stock of commonly prescribed medications was kept in the pharmacy store in blister packs. There was a dual-labelling system for re-ordering stock and patient-specific medications.
- 4.19 Some women had to be directly observed when taking their medications (DOT). Methadone was administered at 7.45am and there were further medication times at 8am, 11am and 2.15pm. Some women prescribed DOT night sedation had to attend the department just before it closed to take their medicine, which was poor practice. However, there was also a good system of using individual locked boxes which allowed the officer in charge of the institution to observe administration after normal working hours.
- 4.20 Women waiting for methadone lined up outside the healthcare department and there was no interaction with the nurse when they were let in. Each woman entered the treatment room individually to take her methadone. Bottles of methadone were on the counter, as were blister packs of medications. Not all women provided identification. The nurses did not sign the relevant MAR at the time of administration. The process was unsafe. Women waited 20 minutes observed by a primary worker to ensure that they had ingested the methadone.
- 4.21 Women needing other medication came to the hatch. They told us that, even though nurses were often late in starting the medication administration, they were told they had missed their opportunity if they were even a few seconds late. Most medications were crushed. Again, nurses did not sign MARs until afterwards.
- 4.22 Women were not able to see a pharmacist to discuss their medications, nor was there a local medicines and therapeutics committee.
- 4.23 Women in the maximum security and segregation units had their medications taken to them, including bottles of methadone, in an open plastic box. Some had been taken out of their original containers or blister packs and put into envelopes. The nurse did not take the relevant MARs with her. The nurse administered medications from the box at the door of the cell or pod on the unit with two primary workers attending. This was unsafe and did not provide confidentiality. The nurse usually annotated the relevant MARs on return to the healthcare centre, although we found examples where this had not been done. A nurse had to return to the institution in the evening to administer night sedation in the maximum secure unit, or it was given in the late afternoon, which was poor practice.
- 4.24 The physiotherapist aimed to see five patients per half-day session each week and saw most of her patients once every two weeks, giving them exercises to do between appointments. She had 15 patients. The one woman on the waiting list was located in the maximum security unit. She had been booked for two appointments but staff had not brought her to the healthcare department.
- 4.25 The dentist saw 10 patients on average at each visit. His appointments were organized by the administrative clerk. Women wrote a request for an appointment and their names were then added to the 'extras' list. They were called to be seen if another booked in patient failed to turn up for her appointment, a system that made it impossible to ascertain how long women waited for an appointment.

- 4.26 There was a waiting list for the dental hygienist, who had been off sick for some time. Women serving life were entitled to an annual free clean and polish; other women paid \$25 for the service (which we understood to be about a third of the cost in the community).
- 4.27 There were some health promotion activities. We were told that smoking cessation assistance was offered and nicotine patches were prescribed if the reason for giving up was medical; otherwise, women could buy patches from the department, repaying the cost in small instalments over a year. Condoms and lubricants, together with a variety of health promotion literature, were provided freely in the healthcare department and in the private family visits unit. Bleach kits (to ensure safe needle cleaning) were also available from the healthcare department. The house representative could return empty bottles each week and receive replacements. There was a protocol for post exposure.
- 4.28 No weight management or healthy eating programs were run, although a dietician attended the institution on an ad hoc basis to provide dietary advice. Women could weigh themselves using scales in the corridor outside the healthcare department.
- 4.29 Pap smears were undertaken every three years (assuming the previous two smears were negative) and mammography was offered to those over 50 or with symptoms that indicated the diagnostic test was necessary.
- 4.30 Inmate peer education counsellors had received 100 hours of training to deal confidentially with healthcare concerns of other inmates. They were able to provide infectious diseases information, ensure harm reduction supplies were available and provide peer support.
- 4.31 Community obstetricians and gynaecologists cared for pregnant women and healthcare staff provided post-partum care based on community standards. The department did not have an emergency childbirth kit and an incident investigation carried out in 2003 had commented that there was 'no evidence of medical treatment protocols for pregnancy'. We found a standing order for prenatal care and another for abortions. Any babies or young children without an Ontario health card had their care funded by the CSC until the mother had applied for the card.
- 4.32 The healthcare department closed at 4pm. Anyone becoming unwell after this time was expected to have purchased items such as cold remedies, cough syrup and painkillers from the canteen. Urgent cases were taken to the local hospital by paramedic services. A nurse was also on call for consultation after hours.
- 4.33 Anyone requiring observation could be taken to the healthcare department, although some unwell women remained in their living units being cared for by other women. The negative pressure room had apparently never been used to care for a patient with active tuberculosis (TB) but had once been used to isolate a patient pending confirmation. No records were kept of when the rooms were occupied, but if the rooms were used overnight, the primary worker in attendance was given a logbook to record events. A casual nurse was also employed. It was believed that the room had last been used in August 2005 for one night but no one could recall any previous occasions.
- 4.34 In our survey, women were particularly critical of the attitude of some healthcare staff. Examples included: "The only thing I can not tolerate is healthcare treating us as though all we want to do is drug seek."; "When it comes to emergencies dealing with illness it seems to take a long time to either go to hospital or

appointment check-ups. Very careless with our health issues here"; "When you put in a request and you are seriously sick they make you wait until the matter gets worse before answering you."

- 4.35 An action plan had been produced in response to a recent review of healthcare services in preparation for a forthcoming health services accreditation audit. The chief of healthcare was in the process of establishing a healthcare inmate advisory committee and the inaugural meeting took place during our inspection.
- 4.36 A medical discharge summary was prepared for every woman discharged from GVIW. If taking any medications, she would be given at least two weeks' worth of the prescription, or more if blister packs had already been made up for her. Anyone taking anti-viral medication or long-term treatment provided by the hospital was given a three-month supply. Staff also provided photocopies of recent blood results and consultation but did not assist women in finding a GP in the community.

Secondary care

- 4.37 Most medical appointments were in the community or hospital and were organized by the administration clerk. Women therefore waited as long for an appointment with a specific medical practitioner as they would in the local community. The department had arrangements with a wide variety of specialists, including general surgeons, an urologist, a cardiologist, an oncologist and an optometrist. There were also memoranda of understanding between GVIW and local general and psychiatric hospitals.
- 4.38 The number of escorts that could leave the institution on any one day was limited and determined by the security status of the woman and the distance to be travelled. The administrative clerk understood the system well. Over the previous three months, 22 appointments had been cancelled, of which eight were because the woman refused to attend and five were because the woman was no longer at GVIW. Only one had been due to staffing problems.

Mental health

- 4.39 Mental health services were managed by the psychology department. There were three staff in post: one was licensed as a forensic and clinical psychologist, one was a psychology assistant and the third was an offender counsellor. They saw all new arrivals within 24 hours and anyone needing to be seen was added to the waiting list. Women could self-refer or be referred by staff. Waiting times were potentially longer than six months, although the psychologist accepted that the waiting list was not a reliable indicator of the workload of the department. It reacted to 'crises'. The psychologists attended the daily management meeting to obtain details of any woman who might require their services immediately. They also met women within the institution informally and made them an appointment, so the waiting list was skewed and unreliable. Women described the system as a 'lottery'. Most women who saw a psychologist had six sessions of therapy.
- 4.40 When a woman was discharged, the psychologists either concluded the therapy with her or recommended future sessions in the community. The National Parole Board could impose ongoing psychology sessions as a condition of the woman's release but the psychologists did not know how often it did so.

- 4.41 Women could request to see the female psychiatrist or be referred by the GP or the psychologist. There was no formal, documented liaison between the psychologist and the psychiatrist and they did not have access to each other's records.
- 4.42 Women were seldom transferred to mental health beds in the community. We were told that transfers were difficult to arrange and the hospitals were reluctant to take offenders, particularly if they required an escort.
- 4.43 The SLE provided intensive intervention for women identified as having problems coping in the general population. A nurse with mental health knowledge and skills was assigned to the unit but had been off sick for several weeks before our inspection.

Action points

- 4.44 **A health needs assessment should be carried out to determine whether the services meet the needs of the population including mental health needs. This should include a workforce and skill mix review.**
- 4.45 **There should be a formal system to check the licences of all healthcare professionals.**
- 4.46 **All healthcare staff should have appropriate clinical supervision.**
- 4.47 **All healthcare professionals working at GVIW as indeterminate, determinate, casual or contract staff should have training on security issues and working with offenders.**
- 4.48 **Training in resuscitation, first aid and 'first on scene' for all staff should be annual.**
- 4.49 **An automated external defibrillator and an emergency childbirth kit should be provided.**
- 4.50 **Provision should be made for annual leave and sickness cover for all healthcare staff.**
- 4.51 **All medicine administration records should be annotated at the time of the administration of the medication.**
- 4.52 **Records of requests, waiting lists and other healthcare-related activities such as the use of the observation beds should be easily auditable.**
- 4.53 **Triage algorithms should be used and triage assessments should involve the patient, rather than being undertaken solely from a written request.**
- 4.54 **Provision should be made for all women (including those in the maximum security and segregation units) to receive night sedation at an appropriate time.**
- 4.55 **The administration of all medications, including to women in the maximum security and segregation units, should be undertaken in a safe manner to ensure that medicines are secure at all time and neither the patient nor staff are subject to unnecessary risks.**

- 4.56 **Women in the maximum security and segregation units should have confidential access to nursing staff.**
- 4.57 **Women should be able to speak to a pharmacist about their medication if they wish to do so.**
- 4.58 **Medical, nursing and security staff should develop a local drugs formulary and audit the use of prescribed medications.**
- 4.59 **Women's access to healthcare services should not be restricted by their security status.**
- 4.60 **Health promotion activities should include weight loss and healthy eating programs.**
- 4.61 **There should be a formal system of liaison between the psychologists and the psychiatrist to ensure continuity of care to women seen by them.**
- 4.62 **Clinical notes should provide a continuous, contemporaneous record of interventions.**
- 4.63 **All prescriptions should include a start date.**
- 4.64 **The system for delivering passes for healthcare appointments should be audited to ensure that women are receiving them with enough notice to be able to attend the department.**

Housekeeping points

- 4.65 **Minimum and maximum temperatures of all fridges used to store thermolabile medications should be recorded daily. These medications should be stored between 2 and 8 degrees Celsius.**
- 4.66 **The filing system for clinical records should be reviewed; previous sets of notes should be kept with the current set.**
- 4.67 **Standing orders should be signed, dated and based on evidence-based practice.**

Good practice

- 4.68 *The resident status form that was sent to the pharmacy for all new arrivals provided an audit trail and method of cross-checking for prescriptions.*
- 4.69 *The fact that most women were able to have their medications in-possession and that they received a patient information leaflet meant that they were able to manage their medications as they would in the community.*
- 4.70 *The system to allow night sedation to be administered when nurses were not available was a pragmatic solution to the problem and allowed women to make decisions about their medications.*
- 4.71 *The use of inmate peer education counsellors and the new healthcare inmate advisory committee provided useful conduits between healthcare staff and women.*

Section 5: Activities

Education, schooling and library provision

Expected outcomes:

Inmates are encouraged and enabled to learn both during and after sentence, as part of sentence planning; and have access to good library facilities.

- 5.1 Education provision was reasonably good, with many women involved and student success celebrated. Schooling was integrated in to the correctional plan but links with the local college were not well developed. Provision for women on the secure unit was insufficient. Library resources appeared stretched.
- 5.2 Three qualified teachers were managed by a team leader. The school was accredited by the Ontario Board of Education and the achievements of students were recognized in the community. The school was based in the programs department and included two classrooms and a computer suite. The computers were not networked.
- 5.3 Provision centred on adult basic education, levels 1 to 4. Within two weeks of entry, educational assessments (Canadian adult assessment tests) were completed by a guidance teacher. Previous transcripts were requested from any former institutions or schools attended. Education plans were developed for all those who tested below grade 12, and all those scoring below grade 10 were identified as a priority for schooling and required to attend part time as a component of their correctional plan. Of the current population, 67% of women had been tested at below grade 10. Teachers were assisted by some inmate tutors.
- 5.4 No teacher was contracted to work on the secure unit and it was increasingly difficult for teachers to devote adequate time to women there. At the time of the inspection, this amounted to one hour a day for 10 students. Cell study and independent learning courses were being offered on the secure unit, which meant that completed work was marked by staff from outside the institution.
- 5.5 Some women had progressed through the Ontario secondary school diploma (OSSD), with 26 graduating between June 2004 and April 2005. Appropriate award ceremonies were arranged to celebrate this success and the women involved could invite a guest.
- 5.6 Educational needs were integrated into the correctional plan through the initial assessments. These were considered by the program board and assignments were made within two weeks. There was a flexible approach to education to meet other aspects of the correctional plan. Any applications for education opportunities, including correspondence courses and cell or home study, needed to be approved by the programs board. Computers were not allowed in the houses, which did not help women in home study.
- 5.7 Students had no direct access to the internet and had to rely on staff to research subjects on their behalf. Some provision was available for students learning English as a second language. Post-secondary

education had to be paid for by students but they could qualify for a bursary. Some distance learning was also provided. Sixteen women were completing independent learning courses.

- 5.8 Approximately 49 women were participating in education (including the secure unit) and 21 of these were in full-time education. There were 56 places available.
- 5.9 Around 101 tests for vocational aptitude had also been completed during 2004/05, although none had been done since February 2005. Efforts were being made to recruit a teacher for this work. A computer-based career guidance program was also available.
- 5.10 In our survey, 67% of women, higher than the English comparator of 47%, said they felt education (including basic skills) would help them on release. Many knew whom to contact to help them to arrange or continue further education on release but few did so. This had been done for one woman wanting to continue an Autocad (assisted computer design) course. There were no established links with the local community college through students attending schooling there on unescorted temporary absences.

Library

- 5.11 The library was based on the second floor of the programs department next to education. It was open for two hours in the morning and again in the afternoon from Monday to Thursday. There was no evening or weekend provision and the library was closed on Friday for an inventory check and cleaning, although library assistants would accommodate some individual requests such as for videos for private family visits. Women who were not on programs or in school could visit the library during their coffee break but needed a movement pass to do so, which could inhibit access. Library staff visited the segregation unit every Tuesday. In our survey, 58% of women, more than the English surveys and Nova, said they went to the library and resource centre at least once a week.
- 5.12 The library was staffed by a part-time teacher with a part 1 librarian qualification. She worked three days each week and was supported by two inmate assistants. Some training needs in the use of the computer-based program for tracking book loans had been identified; a large part of the process still relied on book loans being tracked through an index card system.
- 5.13 Kitchener mobile public library visited monthly and book request forms were available. This provided access to a wide range of books and materials, including inter-library loans from local colleges and universities.
- 5.14 Only 25% of women, lower than the English comparator of 46%, said they could get access to a newspaper daily. The local paper was provided, as was access to a Toronto or French paper. A range of magazines was also available.
- 5.15 A reasonable selection of recreational audio compact discs and videos for loan was available for private family visits only. The library held a range of books reflecting diverse needs. This included sections on women's health, women's studies, Aboriginal culture, black history and world religions. Many books had been donated. There were some old legal textbooks. Commissioner's directives were available on compact disc but had to be accessed through the librarian or library assistant on the single computer for help in finding specific sections of directives. There were some out-dated hard copies.

- 5.16 It was difficult to ascertain whether the library was meeting the women's needs. We were told that requests from women were considered but no survey of the inmates' use of the library or how they felt this could be improved had been undertaken.

Action points

- 5.17 **Teaching provision for women held on the secure unit should be improved.**
- 5.18 **Computers for home study should be provided.**
- 5.19 **Supervised access to the internet should be provided.**
- 5.20 **Links with the local college should be developed and opportunities provided for students to study there on unescorted temporary absences.**
- 5.21 **Library staff and assistants should be trained in the computer-based program to monitor book loan and aid stock control.**
- 5.22 **The opening hours of the library should be extended to improve access to those women not attending activities in the programs department.**
- 5.23 **Computer resources in the library should be improved. Women should have access to a computer from which they can research current commissioner's directives and standing orders.**
- 5.24 **There should be an annual survey of women's use and views of the library.**

Housekeeping points

- 5.25 Computers in the computer suite should be networked to aid learning.
- 5.26 A wider range of daily newspapers should be provided and made accessible in the library.

Employment and vocational skills

Expected outcomes:

Inmates are engaged in safe work and are treated fairly. Work should prepare inmates for employment on release and help to reduce offending.

- 5.27 Work assignments were flexible and integrated into the correctional plan. Sufficient places were available but there were few realistic work opportunities and no recognized vocational qualifications. Some work releases were planned but not enough priority was given to the employment and employability program.

- 5.28 Operational Procedure No. 1 – Program Board (2004/07/09) outlined the processes and responsibilities of the program board and inmates involvement in these. The board assessed individual needs and priorities and ensured that appropriate program, work or education assignments were made as part of an inmate's correctional plan.
- 5.29 The board considered all applications, suspensions and terminations from work and reviewed those who were unemployed. A sample of the program board minutes indicated there were typically fewer than 12 women unemployed or working part time. This was usually because of suspension, sickness or through the woman's choice not to work. The program board highlighted the cases of unemployed women to their case management team. Women could attend the board in person and some did. The flexible approach to work ensured that women could attend other programs as part of their correctional plan.
- 5.30 There were sufficient work opportunities to complement education and programs, which were the main activities. Jobs with job descriptions were posted on the employment board in the programs department and advertised on teledon, an information channel available on television sets. Women could discuss positions with the pay clerk and were encouraged to apply for posts within the first two weeks of their arrival. They were assigned activities reasonably quickly, within two weeks. For some jobs in high demand, the application process attempted to simulate that in the community and involved interviews. There was no routine monitoring by race of successful applicants.
- 5.31 Instructors provided reports on performance, and inmates' pay levels were reviewed every 90 days. The level was dependent not only on work but on continued progress in the correctional plan.
- 5.32 The employment and employability program (EEP) had a low profile among staff and the EEP committee had recognized the need for staff training. A considerable amount of work needed to be done to meet the 2005/06 targets set for the institution. For example, only two certificates from a target of 40 had been achieved in the workplace hazardous materials information system (WHMIS) and none, against a target of 35, had been achieved in Safer Start, pre-employment certification. Ten Autocad (assisted computer design) certificates had been awarded, six at level one and four at level two, against a target of 15. (We were told later that targets for the year were eventually met.)
- 5.33 Few jobs were relevant to outside work. Most of the estimated 54 full-time and 67 part-time jobs involved cleaning and grounds maintenance and were not high quality. There was room for developing more realistic work opportunities, especially for those serving long-term and life sentences.
- 5.34 Minutes from the three EEP meetings held during 2005 evidenced some future plans for developing work opportunities, including making blankets for a world relief project. A computer workshop to recycle computers for schools was also planned in partnership with CORCAN (the CSC employment and training service for offenders). Six to eight women would be employed and some would also be involved in its construction. The work was scheduled to begin in October 2005, with the workshop operational by January 2006. There had been some previous short-term CORCAN projects that offered the opportunity for incentive pay but none since last year.
- 5.35 The program board evidenced that some efforts were being made to identify women who were eligible for work release. There were other planned work schemes such as graffiti cleaning, habitat for humanity and work with the Humane Society.

- 5.36 No formal vocational qualifications were available. The cosmetology course offered the opportunity for women to earn hours of credit towards an apprenticeship on release. Some basic computer-based training was available in food hygiene for house cooks. Around nine women had completed a course on entrepreneurship in 2004 and 10 had completed a self-development course, 'Steps to Success', in August 2005. The latter included a budgeting skills component. A new employment skills program for women offenders was scheduled to be delivered twice a year from January 2006. In our survey, 47% of women, compared with 34% in the English surveys, said they felt their job would help them on release.

Action points

- 5.37 **Greater emphasis should be given to the employment and employability program to generate more realistic employment opportunities, qualifications and vocational skills relevant to reintegration and to ensure women are 'job ready' on release.**
- 5.38 **The job application and appointment processes should be monitored, including ethnic monitoring.**

Physical education and health promotion

Expected outcomes:

Inmates are also encouraged and enabled to take part in recreational physical education, in safe and decent surroundings.

- 5.39 The gym was not used to its full potential and women with free time during the day were unable to make use of it. The weights room was too small and the equipment was old and in a poor state of repair. No one had induction training and some women sustained sports-related injuries. There were no links with health promotion through physical education activities and too much reliance on self-motivated women.
- 5.40 There was a large gymnasium and a small weights room within the main block. The gym had floor markings for a variety of games and a volleyball net in situ during the inspection. There was also one new treadmill, an old step machine, a television, a video player and some exercise videos, and two pool tables. The weights room, which was cramped and poorly ventilated, contained a range of fixed weights machines, all of which were old and in a poor state of repair.
- 5.41 In our survey, 17% of women said they did not want to go to the gym and 38%, against an English comparator of 25%, said they went twice a week. The gym was closed between 8am and 4pm to ensure that women who should have been attending programs did so, but this also meant that women with free time during the day could not use the facilities.
- 5.42 There was no induction to the gym or how to use the equipment, which resulted in some women sustaining injuries. An inmate recreations officer occasionally organized team games such as volleyball or basketball and assisted in arranging activities in the gym for family days.

- 5.43 The daily timetable indicated that aerobics was available every evening but this was 'self directed'. Women we spoke to could not recall there having been any aerobics within the last year and all said they did not feel inclined to use the exercise videos provided. The only activity we witnessed in the gym was a group of women playing dominoes.
- 5.44 No health promotion or personal fitness programs were arranged for women. We did meet some women who regularly walked around the grounds. They knew how far one circuit was and set themselves targets to achieve.

Action points

- 5.45 **Women should have a formal orientation on the use of the gymnasium, cardiovascular equipment and weights room.**
- 5.46 **The fixed weights machines should be replaced and housed in a room that is adequately ventilated and fit for purpose.**
- 5.47 **Health promotion activities should be encouraged and a physical education teacher should be employed to provide leadership and exercise classes.**

Spirituality

Expected outcomes:

All inmates are able to practise their religion fully and in safety. The chaplaincy plays a full part in prison life and contributes to inmates' overall care, support and resettlement.

- 5.48 Most spiritual needs were being met and women were positive about the work of the chaplaincy. Provision for the secure unit relied on goodwill. Many women were involved in chaplaincy-run programs and active volunteers provided links with the community. An elder led Aboriginal spiritual meetings and provided pastoral care. While there had been some recent improvement in meeting the spiritual needs of Aboriginal women, regular sweat lodge ceremonies were not provided.
- 5.49 The majority of women were Christian or declared no religion. There was only one Muslim woman, one Hindu, one Buddhist and one identified as solely native spirituality.
- 5.50 The spiritual needs of Christians were met by one full-time Protestant chaplain and one part-time Roman Catholic contracted to work six hours a week. The chaplains were occasionally assisted by religious students on field placements and by a large volunteer base from different traditions. The full-time chaplain oversaw the range of chaplaincy services apart from Aboriginal spirituality, and arranged for ministers of different faiths to see women or conduct services as necessary. Some women were escorted out of the institution by volunteers to attend particular services in their faith tradition, including Jehovah's Witness and Hindu. A recently appointed imam visited occasionally.

- 5.51 The chaplain promoted the spiritual services available through the orientation video and made an appointment to see all new arrivals. In our survey, 73% of women said their religious beliefs were respected and 80% said they were able to speak to a religious leader of their faith in private when required. Both results were significantly higher than survey results in England and higher than those at Nova.
- 5.52 The spirituality room was well located at the centre of the main building. It was light, attractive and well used, and an adequate size for the numbers attending regular formal services. There was also a quiet room for reflection and prayer.
- 5.53 Catholic Mass and a Protestant service were held each Sunday, with about five and between 20 and 30 attending each respectively. Services were well advertised and held at the same time each week. There were no constraints on women in the general population attending services.
- 5.54 There was, however, a problem with the provision of spiritual services for women in the maximum security unit. The chaplain visited the unit on request but believed that the additional facility had been built without any consideration of the need to increase chaplaincy resources. The Catholic chaplain had provided a contracted pastoral service on the unit between April and the end of August 2005 but the contract had ended and he was now providing the service voluntarily. Managers believed the chaplain should provide a service to the whole institution irrespective of the change in the facility. Whatever the correct position, women in the segregation and secure units were not getting an appropriate service.
- 5.55 The chaplaincy involved many external volunteers in running a wide range of classes and programs, although the scope to run some of these had been affected by budget cuts over the years. About 50 women were involved in spirituality programs.
- 5.56 Some good links to the community had been established and included regular visits by a group of women to a local Mennonite nursing home to serve dinner. Volunteer visitors were also arranged for women who did not have family or friends in the area. The practice of volunteers bringing in home-made food to religious celebrations to share with the women had been stopped due to liability issues and only commercially-produced food was now permitted. The chaplain believed this was an unnecessary restriction and not one imposed in male prisons.
- 5.57 While the chaplaincy was clearly a vibrant part of the institution's life, the chaplains were not routinely involved or consulted about the case management process. They provided contributions if requested by individual casework officers and always wrote reports on the outcome of programs such as the grief and loss programs but the chaplain was unsure whether these were used as part of the dossier for the parole board. They also occasionally acted as advocates for women in challenging such decisions as not to allow escorted temporary absences but were not routinely involved in cases of self-harm, which tended to be seen entirely as a psychological issue. They were not able to authorize telephone calls for pastoral reasons without the approval of a primary worker and parole officer, nor were they able to send a memo without the signature of a team leader.
- 5.58 One gap in provision was the lack of a community chaplain in Toronto, where a large number of the women came from and returned to at the end of their sentence. There had been one until two years previously who met women in the institution and arranged home gatherings and support in the community after release.

5.59 An elder who attended on Mondays and Tuesdays provided services and individual support to Aboriginal women, including to those in the segregation and secure units. Women who were not in the maximum secure unit had the use of the spirituality room, a sweat lodge and had just acquired a tepee. The elder was able to escort minimum-security women to ceremonies in the community such as Sun Dance ceremonies and Pow Wows. Aboriginal women considered the services provided insufficient and thought that there was a general lack of understanding among staff about their culture, including the importance of sweats to help release tensions and anxiety without the need for reliance on medication. The elder did not hold sweat lodge ceremonies. The last such ceremony had been held in August and the one before that in April. The women believed it would be possible to obtain the services of a community volunteer to run weekly sweat lodge ceremonies.

Action points

- 5.60 **Full chaplaincy services should be provided to women in the segregation and secure units.**
- 5.61 **The chaplain should be informed at the outset of all cases when a woman is regarded as a risk of suicide and self-harm in order to provide pastoral support and assist in case management in appropriate cases.**
- 5.62 **Chaplains should be able to authorize telephone calls when they judge this is necessary for the pastoral support of women.**
- 5.63 **Chaplaincy volunteers should be allowed to bring in home-produced food.**
- 5.64 **Efforts should be made to support a community chaplain scheme in the Toronto area.**
- 5.65 **Sweat lodge ceremonies should be provided weekly.**

Time out of room

Expected outcomes:

All inmates are actively encouraged to engage in out of cell activities, and the prison offers a timetable of regular and varied extra-mural activities.

5.66 Women living on the houses enjoyed free movement around the grounds. Other than for formal counts, they were given responsibility for managing their time. Most women were assigned programs, work or schooling and a good range of leisure activities was offered. A strong group of volunteers ran some popular activity sessions. There was little activity for those in the secure unit.

5.67 Women had keys to their own rooms and could move freely within their houses but needed to be present for formal counts. Minimum-security women were allowed on the porches of their houses from as early as 5.30am and most women had free movement around unrestricted areas from 7.45am until 10pm. We were told that appropriate clothing was made available in inclement weather.

- 5.68 Women in maximum security also had to be present for formal counts but otherwise were out of cell between 7.30am and 10pm. Those assessed as security level 1 to 3 had more restrictive movement but those at security level 4 could participate in structured activities with the general population under the supervision of staff. However, there were few activities on the secure unit itself.
- 5.69 Women in segregation were allowed one hour's exercise and time to shower and do personal laundry. They could also, by arrangement, have visits from members of the inmate committee and other inmate representative groups.
- 5.70 Trained primary workers and behavioural counsellors supervised activities on the SLE but residents were also encouraged to attend activities in the general population. Routines were explained in the inmate handbook.
- 5.71 The majority of women were fully occupied, including some good organized leisure activities. They were expected to be at their supervised assignments between 8am and 11.30am and again between 1pm and 4pm each day. Anyone not at her assigned activity required a movement pass to be elsewhere and anyone remaining on her unit had to explain why to patrol officers. Women were not paid for sessions they did not attend without authorisation.
- 5.72 Women had regular periods of leisure time between 6pm and 9pm each weekday. Many activities were supervised by contractors or volunteers while primary workers and social program officers patrolled. Overall interaction between inmates and volunteer staff was good. Gym and sports were the main activities at weekends along with a Stride nights run by volunteers as part of a community justice initiative. (Stride also ran circles of support in the community.) We saw some well-organized activity, including an excellent craft session supervised by Stride volunteers which involved 43 women and was a weekly event. One of the program goals was to create greater awareness among women of the circles programs in the community. Unfortunately, the community program was in jeopardy because of a lack of funds.
- 5.73 The institution relied heavily on volunteers, some of whom said that activities were sometimes cancelled at short notice without their being notified. There were no formal records of the number of cancellations or the reasons for these. Women were informed of cancellations on a notice board outside the gym or at the social program officer's office.
- 5.74 An inmate employed as recreation assistant generated ideas for, and organized, activities. The range of provision was good, including some educational recreation, a number of health promotion activities, religious and Aboriginal activities supervised by the chaplaincy and native spiritual leaders, and some self-help groups. Some timetabled pursuits, such as the parenting group and coping with separation, were not taking place. We compared the structured activities offered between June and September 2005 and found that many of those currently offered, such as the walking club, weight training, wellness workshops and an introduction to music therapy, were very recent initiatives, which should continue.
- 5.75 Women could be involved in several community service and charitable activities. An 'adopt a road' community service activity to improve the environment took place twice a year, and women had helped to make quilts for expectant teenage mothers. Minimum-security women trained by the Kitchener Humane Society could also take part in voluntary, unpaid work on the kitten program, which involved fostering pre-weaned kittens for three to five weeks.

Action points

- 5.76 **There should be improved leisure facilities for women held on the secure unit.**
- 5.77 **Volunteers should be given good notice when activities are cancelled and the reasons for cancellations should be recorded.**

Good practice

- 5.78 *The Stride volunteers provided good support and activity for women within the institution and promoted their services in the community to aid reintegration.*

Section 6: Good order

Security and rules

Expected outcomes:

Security and good order are maintained through positive staff–inmate relationships based on mutual respect as well as attention to physical and procedural matters. Rules and routines are well publicized, proportionate, fair and encourage responsible behaviour. Classification and allocation procedures are based on assessment of a inmate’s risks and needs; and are clearly explained, fairly applied and routinely reviewed.

- 6.1 Dynamic security was good with effective knowledge of individual women. Some trend analysis of security information was undertaken but the computer system was not used. Women were clearly informed of the institution’s rules. The classification protocols were followed, but there was considerable emphasis on institutional behaviour rather than risk, and maximum security was too severe a response for some women who needed more support to live in the general population. Aboriginal women were over-represented in the maximum classification. There was little difference between the arrangements for those classified as minimum and medium classification. Relationships in the maximum secure unit were good but the culture of control was in contrast with the rest of the institution and there was insufficient purposeful activity. The use of leg irons was not appropriate.
- 6.2 GVIW held women of minimum, medium and maximum security classification so security procedures had to cater for all levels. Inevitably this meant that minimum-security women were sometimes subject to more stringent procedures than strictly necessary for them individually – such as the need for a perimeter fence. This was offset to some extent by the relatively relaxed environment. Women outside the maximum classification were able to move unescorted through the grounds and there was little physical security such as camera observation on the houses. This meant that the houses were difficult to supervise effectively and it was recognized that some incidents of violence occurred in the houses which went unreported.
- 6.3 The location of a metal detecting body scanner inside the entrance between two areas of the prison meant it was difficult to operate effectively as staff had to walk through it frequently during the normal course of their working day. It was possible to enter the main residential areas without going through the detector which was sometimes not staffed.
- 6.4 There had been a very serious hostage incident in the maximum secure unit shortly before the inspection in August 2005. Such major incidents were reviewed at national level to learn from any security deficits and to take remedial action.
- 6.5 The general population lived in unsupervised houses, which primary workers patrolled on a predictable schedule. There was no orientation or assessment period before women were located in the house and there were reports of tensions and intimidation on some houses. Assaults, threats of assaults and trading prescription drugs were identified as the main security issues.

- 6.6 Security focused on dynamic security, and staff had a good individual knowledge of the women but with little staff presence on residential units it was difficult for them to be aware of communal dynamics. The security intelligence officer received approximately 60 general information reports each week. These were assessed and security information was recorded in individual records and included in trend analysis. The locally produced trend analysis included frequency of reports for each inmate, injuries, incidents, type of incidents, assault on inmate or staff, and fighting. More sophisticated analysis was possible through computer software for which the security intelligence officer had received training but this was not used because of lack of time. There was a pattern of reportable incidents increasing each year reflecting the increase in the population. Inmates, staff and released women could also use a 24-hour confidential telephone messaging system to give information to the intelligence officer. As well as helping deal with incidents in the institution this helped deal with licence breaches in the community.
- 6.7 The security intelligence officer had good links with local police services, counterparts in other women's prisons and community parole officers.
- 6.8 An institutional search plan outlined appropriate arrangements for searching inmates, staff, visitors, property and areas. Protocols required that women were never naked during a strip-search and strip-searching was conducted only by female staff. Staff carrying out strip-searches after incidents were routinely video recorded.
- 6.9 The passive drug dog was mainly deployed to search domestic visitors (see section on family and friends).
- 6.10 The rules of the GVIW were written clearly and set out in the inmate handbook, with instructions about roll checks, smoking, clothing and house rules. Different information packs with amended rules were given to women in the segregation and secure units. All information included information about local appeal or rebuttal arrangements and explained how to take grievances to the Office of the Correctional Investigator.

Classification

- 6.11 Women were classified as minimum, medium and maximum security. Nine women were classified as maximum security, 22 were medium and 51 were minimum; others were awaiting classification. Classification took into account assessments of institutional adjustment, as well as escape risk and security factors. Maximum-security women were those deemed to present a high probability of escape and a high risk to the public, or to require a high degree of supervision and control. We were told that a new classification tool, which was 'gender-informed' had been in operation since June and was expected to reduce the use of maximum security and increase minimum security categorisations. This had not happened by September; indeed numbers in maximum security were increasing. There was little evidence that it had any impact on the number of women in the high security classification or on the over-representation of Aboriginal women.
- 6.12 Previously, all women who had received a life sentence had been classified as maximum security for the first two years of their sentence unless it was agreed nationally that exceptional circumstances applied. Figures supplied by the CSC suggested that this had happened within the two year period. The power to decide whether to overrule this default position had been devolved to wardens shortly before the inspection. The classification of two life sentenced women in the secure unit had not yet been re-assessed but we were told that the process was underway. However, the new arrangement still meant that when a woman

sentenced to life was initially classified as maximum security a review might not take place for two years, which was too long.

- 6.13 Those presenting lower levels of risk of escape and to the public, and who required lower degrees of supervision and control were classified as either medium or minimum security accordingly. Thirty-seven minimum-security women were waiting for a place in a minimum-security house.
- 6.14 The information on which decisions were based was detailed but the classification process required considerable weight to be given to institutional behaviour in deciding security classification. This led to some women with adjustment or coping difficulties, learning deficits or mental health problems being placed in maximum security because of poor behaviour.
- 6.15 Security classification decisions were communicated to women in writing, with information about how to appeal. Minimum security classification was reviewed annually, that for medium and maximum security every six months and that for life-sentenced women at least every two years.
- 6.16 Women on the maximum secure unit understood what was required of them to help reduce their security classification. Medium-security women said they had little motivation to reduce their classification because their program and conditions would largely remain the same. The minimum-security women believed that they had more restrictions than their male counterparts in that they did not have accommodation outside the perimeter fence and had few opportunities to take part in activities in the community.

Action point

- 6.17 **All life sentenced women should have their initial security classification decided on the basis of an individual risk assessment.**

Secure unit

- 6.18 Women classified as maximum security lived in the secure unit, a separate part of the prison, isolated from the general population and staffed by its own staff group. There were nine women there at the time of the inspection. The unit was accessed through electronically controlled doors and all communal areas were covered by cameras, although these did not have a continuous recording facility.
- 6.19 The unit had one central area with three pods, with five cells with integral sanitation and in-cell electricity. Each pod had a communal eating area, kitchen equipment, laundry facilities, an exercise machine and a social area with a television. The corridors were covered by live camera monitoring and women had their own cell key, so were able to secure their rooms during general unlock. There were two program rooms and office space for managers, specialist staff and the unit managers, as well as a good-sized exercise yard with a basketball net and small garden area. Primary workers visited each pod every 30 minutes primarily to complete security checks. When the unit had first opened we were told that staff routinely ate with women in the secure unit as part of pro-social modelling but that this practice had stopped as women did not welcome the practice. Women ate their meals together locked in the dining area on the pod.

- 6.20 The unit opened in October 2004 and was well designed and light and quiet. The general atmosphere was calm and well ordered. Relationships between primary workers, specialist staff and inmates were generally relaxed and familiar, and first names were used by all, but not always in documentation. Primary workers had a good knowledge of the individual women and worked in partnership with psychologists and behavioural counsellors to help them progress, but their opportunities to influence women were limited as they were locked on their units without staff for most of the time.
- 6.21 While there were superficially good relationships on the unit there was also a strong culture of control which was in marked contrast to the rest of the institution and unlikely to help prepare women for return to the general population or for release. Despite this, there had also been a number of assaults by inmates on others which staff seemed to accept as inevitable, particularly if a woman had given information about another.
- 6.22 Most of the women had between one and four hours of purposeful time programmed each weekday. Only those on level four, or occasionally three, of the security classification could participate in activities in the general population but these opportunities were very restricted because of the lack of staff for escorts. Some women were undertaking individual programs and self-directed learning or participated in a weekly horticulture project. Women were unlocked for 13 hours each weekday but some said that filling this time was difficult with so little focused activity and sharing the living space for a considerable time with only a maximum of four other women could become oppressive.
- 6.23 Within the maximum security classification, there were four levels of security applied to women being escorted off the unit. All the women started on level one without any individual assessment of risk and movement through the levels was usually slow. The levels were a measure of progress, improved behaviour, reduced risk and proximity to moving to medium security. Movement from level one to level four was recommended by an interdisciplinary team each week and agreed by the program board. Level one women were moved off the unit in handcuffs and leg irons. Yet all women, whatever their level, were unlocked on their pod without staff supervision. The contrast between this and the requirement for some to be moved in restraints was very marked. We did not consider the level of risk posed by any of the women justified the use of leg irons which was degrading (see use of force section).
- 6.24 It was not clear why women who could be safely unlocked together could not participate in schools or programs in small groups when they would be supervised by staff.
- 6.25 All nine women in the secure unit understood why they were there. Two were there because of the previous requirement that life-sentenced women had to spend the first two years of their sentence as maximum security. Their cases were under review. The other women were in the unit because of acts of violence or intimidation. Three of the nine women were Aboriginal which was disproportionate to the general prison population and reflected a national pattern.

Action points

- 6.26 Security procedures on entry to the institution should be reviewed to ensure that they are necessary and effective.
- 6.27 Security intelligence should be developed and analysed using the computer system to help target security resources effectively to ensure inmate safety.
- 6.28 The drug dog should not be used when it is overdue for its annual retraining and retesting.
- 6.29 Minimum-security women should have increased access to community programs and activities outside the perimeter fence.
- 6.30 Sufficient minimum-security places should be provided in the institution to match the number of women.
- 6.31 The overall number of women held in maximum security should be reduced by more focussed and frequent assessments concentrating on risk to the public rather than institutional adjustment and specific interventions to enable women to live in less secure conditions.
- 6.32 Risk assessments should result in individual management plans that provide a consistent and proportionate response to managing each woman's individual risk.
- 6.33 Each of the four levels of maximum security should represent a stage of identifiable progress to act as an incentive. Not all women should be started on level one unless this is merited by their risk assessment.
- 6.34 More programs and purposeful activity should be provided for women in the secure unit.

Discipline

Expected outcomes:

Disciplinary procedures are applied fairly and for good reason. Inmates understand why they are being disciplined and can appeal against any sanctions imposed on them.

- 6.35 The disciplinary process was designed to deal with misdemeanours quickly and at the lowest level. Punishments were generally low, but there were some inconsistencies in how particular offences were dealt such as when informal resolution was used. The number of serious charges was increasing. Use of force was low and well managed, but the use of leg irons for restraints was inappropriate. The average time spent in segregation was low but its overall use was increasing. Activities for segregated women were limited and contact with staff was very restricted.

Disciplinary procedures

- 6.36 A four-tier discipline system increased in seriousness through warnings, informal resolution, minor and serious disciplinary courts. Warnings attracted no specific punishment and were recorded on individual records. Staff of all grades could produce reports that could lead to any of the four levels of disciplinary action. Provided the woman agreed informal resolution was used when previous warnings had been given or if a misdemeanour was too serious for a warning. The informal resolution process was a commendable process designed to deal quickly with unacceptable behaviour with an open discussion with the primary worker. An internal review of the disciplinary process was completed in June 2005. This identified that many informal resolutions were unrecorded which made it difficult to ensure consistency of treatment. A small sample we examined suggested that similar behaviours were dealt with by different procedures.
- 6.37 Team leaders decided which cases went to disciplinary court and at what level, but there was no regular monitoring to ensure that charges were dealt with consistently and appropriately. A recent review of disciplinary boards including quality had provided some useful information and action points.
- 6.38 In the hearings we reviewed, most of the time was spent discussing the merits and practicality of potential punishments. Paragraph 44 of Commissioner's Directive 580 instructs that if an inmate renders a guilty plea: 'The person conducting the hearing ... need only review the summary of the evidence before rendering a verdict.' There was no onus on chairs to satisfy themselves that the charge was proved. This left some women vulnerable to being found guilty when a proper enquiry might have found they had a defence, such as being coerced to take the blame for the actions of others. The emphasis of the discipline process was to prevent repetition and punishments were not severe.
- 6.39 No women had used the rebuttal process to review the outcome of their hearing, although some had discussed the hearing with the team leader responsible to help clarify the implications.

Use of force

- 6.40 The incidence of planned and spontaneous use of force was low, with only nine incidents in the previous year, five of which had involved the same woman. All incidents were well recorded with detailed information from all staff involved, with extensive briefing for any planned use of force. Planned use of force briefings, the use of force itself, post-incident medical assessments and the conduct of strip-searches were all video recorded. Unplanned uses of force were videoed as soon as possible.
- 6.41 All uses of force were reviewed at local and regional level to identify any learning points. There was a well-trained cell extraction team and regional institutional emergency response team, all of whom were female. The regional institutional emergency response team had never been used.
- 6.42 There were no unfurnished or cells without integral sanitation. One cell in the segregation unit had a bed fixed in the centre of the room to allow access on both sides if soft restraints were used but this had never been done.
- 6.43 Maximum-security women on the highest security rating left the secure unit only with two primary workers escorting and in handcuffs and leg irons. Women on level two required one primary worker and handcuffs.

No individual assessment of the use of restraints was undertaken which were clearly unnecessary in many cases. Leg irons and handcuffs were also used routinely when moving any women outside the prison and were kept on throughout journeys. The use of leg irons appeared contrary to Rule 33 of the United Nations Standard Minimum Rules for the Treatment of Prisoners which says that chains or irons should not be used as restraints.

- 6.44 During the inspection, two women in leg irons were walked through the prison by two primary workers, even though the protocol indicated that there should be two primary workers for each woman. This was unsafe as without someone on either side of her, each woman was at risk of falling when negotiating stairs and ramps. Nor did the routine use of restraints contribute to security: we witnessed one woman who had cuffs applied so loosely when being taken to the secure unit that she slipped them off and handed them to staff when she got there.
- 6.45 Chemical agent spray was available but not routinely carried. Permission to draw or use chemical agent had to be given by a senior manager but we were told that it had never been used.

Segregation unit

- 6.46 The segregation unit was next to the secure unit and accessed through electronically controlled doors. It was small, with four cells and a shower, and a small outside area enclosed by high walls. The unit had its own laundry facilities and was clean and well ordered. Each cell had a fixed metal bed and table and a fixed sink; none contained a chair or stool. Two of the cells had camera cover and could be monitored live by a primary worker who managed all movement in the secure unit. One cell had a bed that had been fixed to the centre of the cell (see paragraph 6.42). All cells had many ligature points, including barred windows.
- 6.47 Mattresses and bedding were distributed to each woman as she arrived in the unit. Some women at risk of self-harm or prone to damaging property were issued with thin tear-proof rather than standard mattresses.
- 6.48 Records indicated that 30 women had accounted for the 33 segregations for the six months beginning April 2005. Of these women, 13% were black, 20% Aboriginal and 46% Caucasian (the remainder had been released from custody and records were not available). The average time spent in segregation was three days, with a range of one to 19 days. Records for the six months before the beginning of April showed that 13 women had accounted for a total of 15 segregations, with an average stay of 5.8 days and a range of one to 22 days. This again was a significant increase on the six months before that, when segregation had been used eight times for seven women for an average of 1.75 days. In the whole 18-month period, over half of the segregated women had left the unit on the same or following day.
- 6.49 Authorisation for segregation was recorded appropriately and reviews, which were held within the 72-hour, five-day and 30-day timescales, involved the women when appropriate but very few women were there long. The regime for segregated women was limited to one hour in the exercise yard and a daily shower. There were examples of a few women who stayed in the unit longer being allowed additional personal property and extra time out of their cell in the fresh air, cleaning or watching television in the corridor.
- 6.50 The assistant warden and secure unit assistant team leader visited segregated women daily and the warden visited weekly. There was no formal provision of spiritual support (see paragraph 5.54).

- 6.51 Segregated women were routinely spoken to through the hatch in the door, designed for serving meals to women who were too violent to unlock. During the inspection, one woman with a history of violence and a current risk of self-harm was spoken to through the hatch by a nurse on her daily rounds and by primary workers; she was also passed paperwork and meals through the hatch. Although positive interaction with staff was very limited, primary workers demonstrated sensitivity and patience. However, the woman had been subject to an emergency transfer and all her case records were in French. It had taken nearly a week before a French-speaking primary worker was assigned to her, reviewed the file and briefed others.
- 6.52 In the six months before the inspection, one woman had been segregated for 10 days as a punishment after a serious disciplinary court hearing and six women had been segregated because they were at risk of self-harm. Six of the segregated women in 18 months were recorded as voluntarily segregated.
- 6.53 The published objective of segregation was to provide a non-punitive, full regime for women out of association from the general population. This objective was not fulfilled.

Action points

- 6.54 **Disciplinary procedures, including informal resolution, should be monitored to ensure compliance with procedures and consistency and fairness of approach in charges and punishments.**
- 6.55 **Chairs of minor and serious disciplinary courts should satisfy themselves by reasonable enquiry that charges are proved before coming to a verdict, irrespective of whether an inmate pleads guilty.**
- 6.56 **In the light of better, alternative interventions to manage violent or self-harming women protocols to allow women to be restrained to beds or chairs should be abolished.**
- 6.57 **The programs and regime for a segregated woman should be individually tailored to address the reasons for her segregation.**
- 6.58 **Women in the segregation unit should not be spoken to or served meals through the door hatch.**
- 6.59 **Patterns in the use of segregation should be monitored to identify trends, including length of stay, reasons for segregation, ethnicity with the aim of reducing its use.**
- 6.60 **Full briefings in the appropriate language should be prepared before a woman at risk to others or herself is transferred between institutions.**

Good practice

- 6.61 *The video recording of the use of force and related administrative briefing and assessments safeguarded women and staff against unobserved assault or from false allegations arising from the incident.*

Section 7: Services

Catering

Expected outcomes:

Inmates are offered varied meals to meet their individual requirements and food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

- 7.1 Women were positive about the quality of food. Those in the security and segregation units had their meals prepared for them, but the majority in the houses cooked for themselves. Houses were supposed to have a designated cook but not all had, and there was no practical training. There was a heavy reliance on women having previous catering experience. Food met the 'Food for Canada' guidelines but some women could not easily obtain culturally appropriate food. Women could supplement their weekly food order with produce grown in their own house gardens.
- 7.2 In our survey, 74% of women, against an English comparator of 34%, said the food was good or very good.
- 7.3 The catering department was informed of each new arrival and added \$4 a day to the account of the house to which she was located. This amount had remained unchanged for some time. The house cook was also informed and was able get additional supplies from the catering department to meet the new woman's needs. However, our survey revealed that only 73% of women received something to eat on the day of their arrival (see section on first days in custody).
- 7.4 Within their first week, new arrivals met the catering manager. He gave them a pack of information about small meal preparation but did not have the facilities to provide practical training or demonstrations and relied on the women being able to cook.
- 7.5 We were told that each house had an allocated house cook, employed to cook both the midday and evening meals for the house residents from Monday to Friday. However, only half the living units had a nominated cook and those who were employed tended to provide meals on all seven days of the week. Women on living units without a cook either took turns to prepare meals or cooked for themselves. House cooks were selected by the programs board on the recommendation of the catering manager, but there was no input from the healthcare department. Some women were concerned that a woman with a communicable disease could be selected. Most house cooks had some previous experience of cooking for a group but none received any training in basic hygiene, catering or health promotion. The catering manager had an 'open door policy' and was happy to discuss issues with any of the women. This was confirmed by the women we spoke to.
- 7.6 Meals in the secure and segregation units were served just after roll count times. Women in the general population could eat whenever it suited them to do so.

- 7.7 The kitchens in the living units were equipped with a large refrigerator, a microwave, an electric cooker, a rack of coloured chopping boards (to ensure that various food items were not cut on the same boards), a deep fat fryer, an industrial coffee maker and a set of knives attached to the wall by metal cords. There was also a freezer in each house and the inmate committee had bought an electric barbecue.
- 7.8 The catering manager and his food services officers undertook monthly checks of the house kitchens. There were records of these visits but no audit trail of action taken to follow up issues raised with the house cook or others during the inspections.
- 7.9 All food supplied by the catering department met the 'Food for Canada' guidelines and was stored appropriately in the catering store. The Workplace Health and Public Safety Program of Ontario inspected the store annually.
- 7.10 Religious food requirements were provided within the allotted food budget, as were foods for vegetarians, diabetics and those requiring gluten-free products. However, we met one woman, who was not black, who said that she had had to join the black inmates and friends association simply to obtain her food requirements. The healthcare department informed catering staff of any woman requiring a therapeutic diet and her living unit order was checked to ensure the correct items were being ordered. Food ordered was for consumption by inmates only; the catering department did not provide any food for babies residing with their mothers. Pregnant women did not get any extra financial allowances but were advised to ensure that their living unit weekly food order included extra milk. Women supplemented the living unit food order with food grown in their gardens, including tomatoes, egg plant and fresh herbs.
- 7.11 Women in the secure and segregation units had their meals prepared by a food services officer who had qualifications in sanitation and hygiene. The menu was on a five-week cycle. Financial restrictions on the number of hours they could work in the kitchen meant that the food services officer did not start work until 9am and women were therefore given their breakfast on the previous evening. We were told this was not a problem and that no resident had ever complained. Lunch was served around noon and the evening meal at 4.45pm after the count for both units had been certified.

Action points

- 7.12 **The amount of money allocated for food for each woman should be independently reviewed to ensure that it is adequate to provide a healthy and nutritious diet.**
- 7.13 **All women should be given theoretical and practical training about food preparation and personal and food hygiene, and catering staff should ensure that every woman is able to prepare a variety of meals for herself.**
- 7.14 **A decision should be made in consultation with women whether house cooks are required. If so, there should be a healthcare screening process and managers should ensure that all houses have an appointed cook at all times.**
- 7.15 **Monthly checks of the living unit kitchens should record whether action has been taken to rectify previously identified problems.**

- 7.16 The food available should be sufficiently culturally diverse to meet the needs of the population.
- 7.17 Breakfast should be prepared and served on the maximum security and segregation units on the day it is to be eaten.

Good practice

- 7.18 *Women were able to supplement their food order with home-grown produce and were therefore able to take a pride in their own efforts.*
- 7.19 *The provision of barbecues provided an alternative method of cooking and opportunities for socialization.*

Canteen (Prison shop)

Expected outcomes:

Inmates can purchase a suitable range of goods at reasonable prices to meet their ethnic, cultural and gender needs, and can do so safely, from an effectively managed shop.

- 7.20 The canteen was well managed with good access. The collection and receipt system allowed women to rectify any mistakes and provided them with a record of their remaining finances. External shopping alternatives supplemented the canteen list and provided a source of ethno-cultural purchases.
- 7.21 On reception, women were advanced \$30 to spend in the canteen (see paragraph 1.14) and 90% of respondents to our survey, compared with 17% in the English surveys, said they had access to the canteen within their first 24 hours.
- 7.22 The canteen was owned and operated by the inmate committee. All funds for the canteen came from inmate funds and all profits (restricted to a maximum of 10%) went back to the inmate committee to fund events. Prices were reasonable, although the cost of tobacco products was high for those without private money.
- 7.23 The canteen was well managed. It employed three inmates as canteen operators and was open to women three times a week. Canteen items could be purchased direct from the shop. Representatives from the inmate committee monitored canteen with some additional oversight by the social program officer and patrol. Women in the secure and segregation units were issued with their canteen items on the unit. Individuals signed a receipt for their orders and were provided with a copy of the receipt stating their remaining available funds. Transfers from savings accounts to current accounts could be made up to four times a year, with one additional withdrawal for holiday canteen.
- 7.24 Women could suggest additions to the warden's optional canteen list via informal weekly meetings between the inmate committee chair and the head of management services. Ethno-cultural products could regularly be purchased through the inmate minority ethnic groups such as the black inmates and friends association and the native sisterhood. This allowed them to create funds to support cultural-specific events.

- 7.25 Only 41% of respondents to our survey said that the canteen sold a wide enough range of goods to meet their needs. However, the opportunity to purchase goods through outside shopping and specific inmate groups, as well as the separate arrangement for buying hobby materials, increased the purchase options for those with sufficient funds. Holiday canteen also gave women the opportunity to buy products outside the canteen list once a year, just before Christmas.
- 7.26 Women could fund their own subscriptions to newspapers and magazines.

Section 8: Reintegration

Reintegration strategy and planning

Expected outcomes:

Inmates are supported to return to the community in safety and dignity, using community and family links and appropriate licence and curfew arrangements to meet their practical needs and maximize the prospects for avoiding reoffending on release.

- 8.1 There was a good range of reintegration services. The institution was represented on a regional reintegration committee to coordinate services strategically. Good monitoring of individual cases was taking place but was not aggregated to build up a strategic picture. Problems with the quality of parole reports prepared by primary workers had been tackled and there was no evidence of current delay, but it was not always possible for women to complete all necessary program work before their first eligibility date. Local volunteers and community groups played a significant role in meeting the reintegration needs of the women. There were arrangements to secure accommodation on release but more could be done to help women to secure employment, further education or training and welfare benefits before discharge.
- 8.2 The delivery of reintegration services was based on the national community strategy for women offenders and the national program strategy for women offenders. A relatively new regional strategic reintegration committee had formed to consider the needs of Correctional Service of Canada women offenders in the Ontario region and the warden of GVIW had begun to attend. However, there was no GVIW-specific reintegration policy specifying how the reintegration needs of women would be met within the framework of the national strategies.
- 8.3 There were various operational committees at GVIW, involving outside parole officers, which met to discuss different aspects of reintegration such as housing, parole and programs. However, they did not have clear terms of reference, were not linked or coordinated and there was no clear strategic overview of the different strands of work. A considerable amount of data on individual cases was routinely collected and a report described as the 'reintegration report' was prepared monthly. This included information that managers could use to monitor timeliness of correctional plans and parole reports, outcomes of parole applications, escorted and unescorted temporary absences for work releases and family contact. The reports were discussed at quarterly reintegration meetings. We were told that the meetings were not minuted as they were purely a discussion of the report. The level of scrutiny of individual cases was commendable and effective but the potential to use the data to identify patterns and trends and to use it as a strategic management tool was being missed.
- 8.4 We heard complaints from women and members of some of the stakeholder groups that women were missing their first eligibility date for day parole because reports were not being prepared on time. Eligibility for day parole was after six months in the institution or serving one sixth of the sentence, whichever was the longer. Six months was a very tight timescale for some women with complex needs. The timescale for the completion of intake assessments was 70 days and it was therefore often difficult to ensure that women

completed all necessary program work in time to apply at the first eligibility date. We examined the reintegration reports in detail and were satisfied that robust systems were in place to ensure that reports were prepared on time and that there were no examples of delays. Many women were not applying for parole at their first eligibility date but there were usually reasons: some were completing programs; some were maximum security; and some had not applied because of their deportation status. The institution had recently appointed an additional parole officer to provide reports and at the time of the inspection, we found no evidence to suggest that women were being held back from applying for parole due to inefficiencies on the part of the institution.

- 8.5 We met with the parole board. Its members did not express concerns about delays in receiving reports but rather about the quality of parole reports. They felt quality had deteriorated since the responsibility for prepared reports and presenting cases to the board had moved from parole officers to primary workers. Difficulties particularly occurred when primary workers were not present at hearings due to their shift pattern and an uninformed substitute had presented the case. As a result, some cases had been adjourned causing delay.
- 8.6 Efforts had been made to resolve this problem by allocating all primary workers an intake parole officer as a mentor. These officers could attend parole hearings to assist with the presentation of the case and were always assigned to do so in the absence of the primary worker, having been fully apprised of the case. Further training had been offered to the primary workers, although they had completed the same national training for the preparation and presentation of parole reports as parole officers. The quality assurance system for reports had also been strengthened for primary workers to ensure that all reports were checked by intake parole officers in the first instance.
- 8.7 Women who left on day parole all went to half-way houses until they were eligible for full parole. Those released on full parole served the remainder of their sentences under supervision in the community. Women were not released on full parole unless the parole board was satisfied that they had suitable accommodation to go to and conditions of residence were often applied as part of the supervision conditions.
- 8.8 Between 1 April and 31 August 2005, there had been 16 unescorted temporary absences and 214 escorted temporary absences, almost all of which had been facilitated by volunteers. Many escorted temporary absences involved volunteers escorting women to half-way houses prior to their parole application and some involved visits home to rebuild contact with family and friends. Arrangements were in place to ensure that women had suitable accommodation to go to but not enough attention was paid to ensure that they had secured employment, further education or training or welfare benefits. There were also some problems ensuring that women had all the necessary ID before they were released.
- 8.9 Over 600 community volunteers offered a variety of services to the women, from recreational activities such as quilting to chaplaincy volunteers who provided services and concerts. The local Elizabeth Fry Society offered one-to-one work and group activities. Other community agencies such as Alcoholics/Narcotics Anonymous attended regularly. Stride Circles (introducing community circles of support) was part of a community justice initiative that offered reintegration counselling and an extremely popular weekly recreation program. However, there were funding difficulties with the community circles to support women on release.

- 8.10 Before discharge women were able to choose from a selection of new clothing held in the institution. A range of sizes was provided and women could try clothes on before deciding which outfit to have. Women were also given an appropriate bag for their clothes and other belongings on release.
- 8.11 In our survey, 55% of women, significantly higher than the English comparator of 43%, said they had done something or something had happened to them during their time at GVIW that would make them less likely to reoffend on release.

Action points

- 8.12 **All aspects of reintegration should be monitored and coordinated by the reintegration committee or policy group.**
- 8.13 **A range of reintegration data including information on parole should be collected and monitored to ensure managers can satisfy themselves about performance in this area and inform future policy**
- 8.14 **The parole board should be consulted as part of the process of quality assurance of parole reports.**
- 8.15 **There should be better provision for assisting women with welfare support, employment, further education or training before they are released.**

Correctional planning

Expected outcomes:

All inmates have a sentence or custody plan based upon an individual assessment of risks and needs, regularly reviewed and implemented throughout and after their time in custody. Inmates, together with all relevant staff, are involved with drawing up and reviewing plans.

- 8.16 Correctional plans and subsequent reports were detailed and focused. Prioritized needs were relevant and achievable and based on a thorough intake assessment. The intake assessment was being revised in response to concerns that it was not sufficiently culturally or gender sensitive. Correctional plans were resumed for revokees. Women said they felt part of the correctional plan process, but their contribution to the formulation of progress reports was unclear. The use of checklists was a good initiative to quality assure reports.
- 8.17 All new arrivals underwent a thorough intake assessment of their offending behaviour needs within 70 days (for women with sentences under four years) or 90 days (for women with sentences of four years or more). All assessment targets had been met this fiscal year. The intake assessment included detailed contributions from the woman, the community parole officer and the woman's friends and family. Correctional plans were then developed focusing on the prioritized dynamic risk factors identified during the assessment process. In response to concerns that the Dynamic Factor Identification and Analysis (DFIA) was not sufficiently culturally or gender sensitive, the instrument had been updated to include gender and culturally-responsive

interview prompts. A revised DFIA was being tested to ensure its validity for Aboriginal, racialized and disabled women.

- 8.18 We examined a random sample of 10 correctional plans. In all cases, the prioritized needs had been identified from the information collected during the assessment process. In our survey, 61% of respondents, against an English comparator of 26%, said they had been involved or very involved in the development of their correctional plan.
- 8.19 All revokees resumed their previous correctional plans. This applied to approximately 15% of the population at the time of our visit.
- 8.20 A case management team was assigned to each new arrival. This comprised the primary worker and the parole officer, in addition to the woman, with additional contributions from any other relevant parties such as psychology. The case management team contributed to monthly structured casework reviews as well as correctional plan progress reports that monitored the woman's progress against the correctional plan targets. Progress reports included information from relevant sources including the structured casework reviews, program feedback reports, the SLE and community contacts. Comprehensive reports to aid decisions were also completed for the warden or the national parole board. While all reports were signed by a member of staff to say that the content of the report had been shared with the woman, it was unclear from the description how involved she had been in the compiling of the report, despite being a member of the case management team.
- 8.21 All reports were subject to strict quality assurance before being finalized. The selection of quality assurance checklists developed in-house aided the quality assurance process. The appointment of an additional parole officer and the training and mentoring of primary workers by parole officers had been responses to previous problems with the delay and quality of reports.

Action point

- 8.22 **All women should be involved in the formulation of reports that relate to their correctional plan.**

Correctional and mental health programs

Expected outcomes:

Effective programs are available to address identified inmate risk and need, to allow timely progression through sentence.

- 8.23 The correctional programs offered appeared to meet the needs of most women. Women were allocated to programs on the basis of prioritized need. Programs had been developed or adapted specifically for women and a Circles of Change program for Aboriginal women was about to be introduced. The contracted intervention for survivors of abuse and trauma was not meeting demand. The SLE was an impressive example of support for women who were finding it difficult to cope in the open environment.

- 8.24 The program strategy for women offenders provided a choice of gender-specific programs for women based on a needs analysis of the population. Programmes had either been developed specifically for women offenders or adapted to meet their needs. Aside from the three WOSAP (women offender substance abuse program) modules, GVIW provided dialectical behaviour therapy (DBT), fraud prevention, anger and emotion management and relapse prevention programs for its general population. Sex offender therapy could be offered to those who required it. A random analysis of 10 correctional plans suggested that the correctional programs offered met the prioritized needs. We welcomed the proposed introduction of the Circles of Change program specifically designed to meet the needs of Aboriginal women.
- 8.25 National programs such as DBT and WOSAP had been validated and were subject to monitoring by headquarters. All facilitators for these programs had been trained according to national standards. On the SLE all the primary workers as well as the behavioural counsellors had been trained in DBT.
- 8.26 Following an in depth intake assessment, women were allocated to the next available program during weekly program board meetings. All programs apart from DBT were delivered a contracted number of times a year. Women were therefore prioritized for the next contracted program by their earliest date of release.
- 8.27 The small number of women in need of these specific programs meant that the majority were able to complete the necessary programs before their earliest release date. In addition, the six-month DBT program could be offered on an individual basis in order to meet prioritized need. However, there had been a couple of examples since April 2005 of women postponing their earliest opportunity for parole in order to finish a program. The lengthy intake assessment process and the restrictions of the contracts meant that the average length of time from admission to starting the first treatment program from April to September 2005 was 109 days. This had the potential to impact on women with short stays. Every attempt was made to prevent women missing their earliest date of release via the program board, cases brought forward and the quarterly oversight of waiting lists by the CSC. The correctional planning process also identified where a woman's needs might be met in the community.
- 8.28 Since April 2005, 24 women had completed one of the above programs: 12 had completed anger and emotions management, four fraud prevention and eight relapse prevention. Seven women were assigned to the anger and emotions management program due to start in October 2005, one woman was deferred to the January 2006 program and three women were attending the fraud prevention program. Four women in the secure unit were wait-listed to attend the anger and emotions program. Anger and emotions and DBT could be delivered on a one-to-one basis to women on the secure unit. Alternatively, women would be assigned to the next program once they returned to the general population.
- 8.29 The contract for individual sexual abuse therapy provided three cycles of 15-week interventions a year for a maximum of five women per cycle. Ongoing counselling and crisis support was offered. However, the contracted provision was not meeting the needs of the population. With existing contracted provision, it was estimated that some women on the waiting list would have to wait up to two years to receive therapy, if they were still in the institution by them.
- 8.30 As outlined in the program strategy for women offenders, the indirect link between a history of abuse and subsequent involvement in criminal activity supports the investment in this type of intervention, not least for a population with such a high prevalence of personal victimization experiences. We therefore welcomed the tender for a contract to provide group therapy for survivors of abuse and trauma. The challenge will be to ensure that the contracts for both individual and group therapy meet the needs of the total population.

- 8.31 The SLE was an impressive example of a therapeutic environment within which specific treatment interventions were delivered to women with mental health needs. Seven women were living on the SLE, all of whom were completing the DBT program. The psychosocial rehabilitation program was also available for SLE residents, although no-one had been assessed as in need at the time of our visit. Weekly community connections sessions provided contact with the community for all SLE residents in preparation for release.
- 8.32 Applications to the SLE were considered at weekly coordinated multidisciplinary care committee (CCC) meetings. Women were admitted to the SLE within a short period of approval. Women were able to attend a commitment week to acclimatize to the functioning of the unit before moving in. 'Catch-up' skills training groups were being run with four recent arrivals to prepare them for joining the main DBT group.
- 8.33 The progress of each resident was discussed by staff during the CCC meetings, and updated treatment plans outlining short-term goals and achievements were developed collaboratively between the residents and staff following each meeting. All the evidence suggested that the staff knew the women well through their constant interaction. Past and present residents of the SLE spoke highly of their treatment there both in terms of program intervention and relationships with staff.
- 8.34 All SLE residents were involved in activities within the general population as well as within the confines of the unit. Outreach support was provided by the SLE's behavioural counsellors to ex-residents and any member of the general population.
- 8.35 In our survey, 64% of respondents, against a n English comparator of 26%, felt that their correctional programs would help them on release.

Action points

- 8.36 **An annual needs assessment should be conducted to ensure that programs continued to meet the identified needs of women at GVIW.**
- 8.37 **The population's need for abuse and trauma intervention should be assessed and the institution should ensure that the individual and group program contracts meet this need.**

Good practice

- 8.38 *The SLE was an impressive holistic therapeutic environment that supported women with specific mental health needs, and offered additional support to encourage and maintain their successful return to the general population.*

Life-sentenced inmates

Expected outcomes:

Life-sentenced inmates should receive equal treatment in terms of their treatment and the conditions in which they are held. These expectations refer to specific issues, which relate to the management of life-sentenced inmates.

- 8.39 Twelve women were serving life sentences and there was some recognition of their specific needs as a group. Correctional planning was good but women lifers were not always fully involved in their case reviews. There was little opportunity for skills training and work was inadequate for women who would spend many years in the same institution with little opportunity of progression elsewhere. Reviews of security classification for those in maximum security were too infrequent.
- 8.40 Twelve women were serving life and were at various stages of their sentences. Immediately following sentence, when she was in a provincial facility, the woman would be seen by a community parole officer who completed a preliminary assessment. This process was the same for all women sentenced to two years or more. The assessment included relevant available material such as police reports, pre-sentence reports, information about victims and any judge's comments. Information about physical and mental health needs, history of self-harm and any security concerns was also collected and used to compile a preliminary plan on admission to federal custody. Most women sentenced to life transferred to GVIW within a month of sentencing.
- 8.41 We were told that the orientation program for newly admitted lifers was the same as for any other woman but with increased support from staff in the secure unit. Given the policy in place until recently that all life-sentenced women spent their first two years in maximum security conditions in the secure unit, the induction arrangements differed significantly in practice. There was no specific orientation program to explain fully the significance of a life sentence and no system to ensure that lifers received all the information they needed. There was some confusion about whether the relatively new inmate orientation team and the lifer representatives had access to lifers in the secure unit. The inmate representatives believed they had been refused access but the warden assured us this had been a misunderstanding and that the orientation team and lifer representatives would be allowed necessary access.
- 8.42 A new policy, issued on 1 September 2005, allowed wardens to make initial placement decisions for those serving life sentences based on the results of the custody rating scale. It was too early to assess the effect of this change. However, the policy still required a security classification review for lifers in maximum security only every two years. Given the contrast between living conditions and opportunities for women in GVIW's general population and those in the secure unit, this was too long. The two life-sentenced women in the secure unit had yet to have their classification re-assessed.
- 8.43 There was recognition of some of the specific needs of lifers, who were allowed to have additional allowances of clothes and access to catalogue purchases. An established lifer group met regularly with the warden and raised matters of concern. Some special lifer social and family days were held and were appreciated by the women involved. Support was also provided by a LifeLine worker.
- 8.44 Correctional planning for life-sentenced women was the same as for others and the cases we sampled indicated that correctional plans had been thoroughly completed. In accordance with CSC operating practice on security classification, an annual review to assess progress against the correctional plan was carried out. Lifers told us that they did not feel fully involved in these annual reviews and were not routinely invited to participate in them. Managers disputed this but there was evidence to indicate that reviews did take place without the lifer being present. In one case, the progress assessment completed on 13 March listed the case management team (CMT), which included the inmate, and then said 'consultation with CMT members occurred via email on March 13, 2005'. The response of CMT members was not apparent but the

woman had clearly not been involved as the review was being drafted. She had been given the completed report for comment later the same day.

- 8.45 Lifers had relatively good access to their casework team and senior managers individually throughout the year and could discuss their progress with them. However, this was not a substitute for an annual casework team meeting at which each member, including the life-sentenced woman, was present and which would allow for discussions about progress and any issues arising.
- 8.46 As with other CSC institutions for women, a lifer could spend many years at the same institution. Women could transfer but this rarely happened in practice and was unrealistic for many. There was reasonable provision of correctional programs and education, although most of the latter was focused at a basic level, and education above that level relied on the woman's self-motivation. There was little meaningful employment to allow women to acquire useful work-related skills. This had been identified by the women lifers as one of their main concerns. Some work release opportunities were beginning to be developed but too little use was made of the minimum secure provision at Isabel McNeill House in Kingston. This was managed by GVIW and could provide a good progression opportunity for lifers with the possibility of working in the community as a staged preparation for release.
- 8.47 Correctional planning aimed to ensure that lifers were prepared for release gradually with escorted and unescorted absences considered at appropriate stages of sentence, and release plans agreed with community parole officers before cases went to the parole board. Some lifers expressed the view that there was insufficient awareness of how momentous it was to return to the community after many years in prison, and more frequent and supported temporary absences would help.

Action points

- 8.48 **Orientation should ensure that needs of lifers are covered.**
- 8.49 **Women lifers in maximum secure conditions should have their classification reviewed at least every 90 days.**
- 8.50 **An annual review of progress against the correctional plan should be held with the full casework team, including the woman lifer.**
- 8.51 **Better employment opportunities should be offered to allow lifers to acquire appropriate vocational skills.**
- 8.52 **Isabel McNeill House should be better promoted as an opportunity for lifers to progress in their sentence and potential residents taken there to view the facility.**

Substance use

Expected outcomes:

Inmates with substance-related needs are identified at reception and receive effective support and treatment throughout their stay in custody, including pre-release planning. All inmates are safe from exposure to and the effects of substance use while in prison.

- 8.53 The women offender substance abuse program (WOSAP) met the needs of the women. It was run by staff from Stonehenge therapeutic community, an organisation with which GVIW had strong links. In our survey, 62% of women, against an English comparator of 31%, said the program would help them on release. The intensive support program was not properly resourced and provided little help for women who wished to be drug-free.
- 8.54 GVIW worked to the national drug strategy, which stated that each institution should develop and implement drug strategies to reflect the nature of the institution. There was no local drug strategy.
- 8.55 We were told that women requiring immediate detoxification from drugs or alcohol were unlikely to arrive directly at GVIW despite the fact that women could take unescorted temporary absences (UTAs) from the institution, and returned on revocation. While the healthcare department had standing order instructions for the management of a drugs overdose and specifically for a methadone overdose, there were no clear contingency protocols for dealing with women requiring symptomatic relief for drug or alcohol withdrawal. We were told that a woman needing detoxification would be sent to the local hospital.
- 8.56 Any woman wanting to receive methadone as an aid to relapse prevention had to submit a letter to the programs board stating her reasons and what benefits she thought would be gained. A member of the healthcare staff and her primary worker had to indicate their willingness to support her and she was then interviewed by one of the staff from Stonehenge therapeutic community. The final decision was made at the monthly multidisciplinary team (MDT) meeting based on harm reduction and risk assessment, and whether the woman met the criteria set out in the CSC methadone treatment guidelines. The general physician who attended GVIW once a week was licensed to prescribe methadone and saw each of the women weekly. They had a urinalysis test for methadone twice a week and attended the MDT once a month to discuss their progress. When they were to be released, healthcare staff referred them to a methadone prescriber in the community. We were told that this was an easy process and healthcare staff had never had any problems ensuring continuity of care.
- 8.57 Staff from Stonehenge therapeutic community conducted the WOSAP program. Each part of the program involved pre- and post-module testing. Every woman was recommended to complete WOSAP 1, which was about the effect drugs and other substances open to abuse had on society as a whole. This was a prerequisite for undertaking the other two WOSAP programs but was not compulsory. At the time of the inspection, six women were waiting to undertake WOSAP 1, which was due to start.
- 8.58 WOSAP 2 was for those with a personal substance use problem if it had contributed to their crime. The program was run over three months and consisted of 40 sessions. Thirteen women were undertaking WOSAP 2. The waiting list identified one woman waiting to start the course, with a provisional start date of

January 2006. WOSAP 3 was a generic relapse prevention and maintenance course, consisting of 20 sessions over as many weeks. Women could undertake it either at GVIW or in the community during ETAs or UTAs and could choose to do it more than once. Two groups were running at the time of our inspection, with a total of 13 participants.

- 8.59 There was no dedicated intensive support unit (ISU). Instead, women who wished to be part of the ISU program and have mandatory urinalysis merely applied to the ISU coordinator. Women were told about the program when they first arrived and there were occasional 'mail shots' to encourage participation. The scheme was under-resourced and relied on the efforts of one member of staff and only 11 were currently taking part. Women who were taking Methadone were not excluded from the program. Urinalysis testing was supposed to be carried out at least once a month. While there had been 24 on-site urinalysis tests undertaken in September 2005, none had been conducted in August, when there were four participants, and only three in July 2005, when there were also four participants (the reason for the latter being that one of the women was out of the institution on a UTA).
- 8.60 The ISU coordinator visited women in their house units to test them and told us that she involved the women in the testing process by encouraging them to use the test kit themselves. Anyone refusing to be tested or testing positive was removed from the program for 30 days. Women testing positive were not formally charged and the information was passed to their primary worker.
- 8.61 In order to encourage women to remain 'clean', they were offered incentives such as free 15-minute telephone calls to numbers on their telephone list, the ability to order items from the Sears catalogue, which they paid for, or the possibility of ordering food from local take out restaurants, which they also paid for.
- 8.62 Women we spoke to were dissatisfied with the scheme. They said they received no support and questioned whether the scheme was even active.
- 8.63 Random drug testing was carried out on 5% of the population, with the names of those to be tested supplied monthly by national headquarters. In 2004/05, there had been two positive finds (3%), and three positives (10%) in 2005/06 to date. Samples were sent away for testing and the results were provided three to four weeks later.
- 8.64 Many women complained about the drug dog. We were told of an instance when a woman indicated by the dog had been found clear of drugs following a body cavity search and x-rays. On another occasion, the dog had indicated positive on a woman returning to GVIW even though she had been escorted throughout her absence. Other women told us that the dog jumped up at them and on the kitchen counters when undertaking searches of the living units (see section on security). We observed the dog to be lively.

Action points

- 8.65 There should be a local drug strategy.
- 8.66 Protocols should be in place to allow drug or alcohol dependent women to be provided with symptomatic relief within the first 24 hours of arrival if clinically indicated, and a suitable detoxification or maintenance-prescribing program should then be provided.
- 8.67 More therapeutic and structured help should be provided to women in the intensive support program and more women should be encouraged to take part in the program.

Section 9: Recommendations, action points, housekeeping points and good practice

The following is a listing of recommendations, action points, housekeeping points and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

Recommendations

To Correctional Service Canada

- 9.1 There should be specific first night and orientation support, initially in separate accommodation, so that newly arrived women have access to objective and full information about the institutions and are prepared to move on to the houses. (1)
- 9.2 The role of primary workers should be reviewed and reinforced, with a view to ensuring that properly trained staff have sufficient skills and time to carry out both the role of supportive role-models envisaged in *Creating Choices*, and the task of providing timely and high-quality parole reports. (2)
- 9.3 Each institution should have a local anti-bullying policy and strategy to identify and prevent intimidation and assaults. It should include interventions for bullies and support for victims. Staff should receive training in this so that they are vigilant in identifying bullies and actively intervene to challenge them. The policy should be publicized and promoted to women inmates. (3)
- 9.4 Implementation of the CHRC recommendations in relation to gender and culturally specific classification and assessment tools and programs should proceed swiftly, informed by expert advice. In particular, tools and interventions that recognize the specific needs of Aboriginal women should be developed as a matter of urgency, and pathways to the Healing Lodge and out of maximum secure accommodation developed. (4)
- 9.5 Race and ethnic monitoring of all key areas of prison life within each institution should be established. This should include access to programs and facilities, and all disciplinary measures and classification decisions. Results should be published and any disproportionate patterns investigated. (5)
- 9.6 There should be a comprehensive review of the management of difficult or disruptive women, with a view to ensuring that
 - the number of women in maximum security units is reduced, and the criteria for allocating women to those units reviewed to ensure that they are used only for women whose behaviour poses exceptional risks to others, and when other, less restrictive, interventions have failed;
 - a multi-disciplinary strategy, including mental health support, is devised to provide individual support and case management of women who require additional supervision and intervention outside maximum security conditions;

- an expert Advisory Committee is set up to receive and comment on reports on the use of, and conditions for women in, maximum secure and segregation units, including those held under the Management Protocol. (6)

9.7 Minimum security women should have the opportunity to have increased access to the community. (7)

9.8 Leg irons should not be used on women inmates. (8)

9.9 The Correctional Service of Canada, together with CORCAN, should draw up a strategy for education and skills training and employment for federally sentenced women, with a view to enhancing employability. Such training should form part of correctional plans. (9)

9.10 More efforts should be made to encourage and support family ties. A social worker should be appointed in each institution to act as a family liaison/link worker to support and promote the maintenance of family ties and help with child custody matters. Financial support should be provided to help families on low incomes visit women in CSC institutions. (10)

9.11 The CSC should consult with stakeholders to examine the monitoring mechanisms that currently exist, to determine whether and how they need to be strengthened to provide a national preventive mechanism, as set out in the Optional Protocol to the UN Convention against Torture. (11)

Action points

To Correctional Service Canada

9.12 Women caring for their babies in custody should have access to the same state financial benefits as mothers in the community. (2.33)

9.13 Financial assistance should be provided to visitors who are not able to visit due to financial hardship. (3.70)

9.14 Chairs of minor and serious disciplinary courts should satisfy themselves by reasonable enquiry that charges are proved before coming to a verdict, irrespective of whether an inmate pleads guilty. (6.55)

9.15 In the light of better, alternative interventions to manage violent or self-harming women protocols to allow women to be restrained to beds or chairs should be abolished. (6.56)

9.16 Full briefings in the appropriate language should be prepared before a woman at risk to others or herself is transferred between institutions. (6.60)

Action points

To the warden

Arrival in custody

9.17 New arrivals should be offered food and drink when they arrive. (1.20)

9.18 The reception area should have enough seating for new arrivals. (1.21)

- 9.19 New arrivals should be offered the opportunity to shower before they are taken to their house unit. (1.22)
- 9.20 Interviews with new arrivals should include a discussion about possible concerns about children or other family members. (1.23)
- 9.21 New arrivals should be given enough funds to ensure that they can manage during their first few weeks in custody and until their finances are organized. (1.24)
- 9.22 New arrivals should be able to call for peer or Samaritan support in confidence. (1.25)
- 9.23 Trained peer supporters should be available in reception. (1.26)
- 9.24 Orientation sessions led by staff should begin the next working day after the arrival of new receptions and staff responsible for delivering these sessions should attend and do so on time. (1.27)

Residential units

- 9.25 Women should be able to exchange their clothes at least four times a year. (2.14)

Mothers and children

- 9.26 The facilities and arrangements for the care of children in the institution should be subject to the same auditing and inspection arrangements as other residential child care facilities in the community. (2.31)
- 9.27 Child protection protocols should be agreed with the local child and family services and an individual child care plan should be developed for each child in the prison. (2.32)

Staff–inmate relationships

- 9.28 Primary workers should be encouraged to take longer on their house patrols and to spend time interacting with women inmates. (2.43)
- 9.29 The impact of staff wearing uniforms on relationships between inmates and staff should be evaluated, taking full account of the specific perspective of women and the principles of *Creating Choices*. (2.44)

Primary workers

- 9.30 Primary workers should introduce themselves to the women for whom they are responsible within the first week. (2.51)
- 9.31 Primary workers should have a personal talk with women at least once a month at a reasonable time in order to complete structured casework records. (2.52)

- 9.32 Primary workers should make direct contact with inmates' families in appropriate cases to encourage the maintenance of family ties to support successful reintegration. (2.53)

Bullying behaviour ('muscling')

- 9.33 All incidents of muscling should be recorded and monitored to develop a profile of this behaviour across the institution. (3.13)
- 9.34 Investigations into incidents of muscling should show evidence of action taken, and incidents should be followed up to support victims and challenge bullies about their behaviour. (3.14)
- 9.35 There should be an annual confidential survey of women's experiences and perceptions of muscling, to inform the strategy. (3.15)

Self-harm and suicide

- 9.36 The records of incidents of self-harm should be improved to identify any emerging trends, and record use of segregation, protective clothing and other interventions. (3.30)
- 9.37 The psychology-led behaviourist approach to women at risk of self-harm should be developed to involve primary workers in managing cases and a formal support scheme which should include overnight facilities where peer supporters can help women at risk. (3.31)
- 9.38 All recommendations from the coroner's investigation into the self-inflicted death in custody should be implemented. (3.32)
- 9.39 The resources available to the psychology department should be reviewed to ensure that it meets the needs of the entire population. (3.33)
- 9.40 Systems should be put in place to ensure appropriate care for Francophone women at risk of self-harm and that all relevant reports are available in English before a transfer to GVIW. (3.34)
- 9.41 Families and other significant people should be contacted and involved when a woman is at risk of self-harm, where this is appropriate and with the woman's agreement. (3.35)
- 9.42 A safer custody forum should be developed to consider the relationship between the policy areas that contribute to feelings of safety. These include muscling, early days of custody, peer support and alternatives to segregation. (3.36)

Race relations and diversity

- 9.43 A system for staff and inmates to report perceived racist incidents should be introduced with complaints about racism identified and investigated separately. (3.44)
- 9.44 There should be ongoing promotion of race equality and diversity for staff and inmates. (3.45)

- 9.45 The support group liaison staff and elder should be issued with keys to allow them access through the prison. (3.46)

Family and friends

- 9.46 The process of security checks on telephone contacts and visitors should be revised and speeded up especially for those visiting minimum-security women. (3.69)
- 9.47 The importance of maintaining family contact should be recognized in correctional plans. (3.71)
- 9.48 Detailed data on the imposition of closed visits should be collected and routinely aggregated to ensure that the system is operating correctly. (3.72)
- 9.49 Visitors should not be offered restricted visits solely on a drug dog indication. (3.73)
- 9.50 Women should not be kept in restraints during a visit. (3.74)

Requests and complaints

- 9.51 The inmate handbook should outline the system for requests, and information should be displayed on notice boards. (3.88)
- 9.52 In addition to the supply retained by the inmate committee, request and complaint forms should be made freely available. (3.89)
- 9.53 Requests to all departments should be logged so that there is an audit trail. (3.90)
- 9.54 Primary workers should take verbal requests daily to reduce the overuse of the formal system. (3.91)
- 9.55 All complaints should be responded to within seven days, either with a resolution or interim reply explaining what was being done. (3.92)
- 9.56 Complaints should be quality assured to ensure that responses are timely, respectful, legible, and address the issues raised. (3.93)
- 9.57 There should be regular analysis of complaints to identify patterns and trends. (3.94)
- 9.58 A supply of request and complaint forms should be freely available to women in the segregation unit. (3.95)

Healthcare

- 9.59 A health needs assessment should be carried out to determine whether the services meet the needs of the population including mental health needs. This should include a workforce and skill mix review. (4.44)
- 9.60 There should be a formal system to check the licences of all healthcare professionals. (4.45)

- 9.61 All healthcare staff should have appropriate clinical supervision. (4.46)
- 9.62 All healthcare professionals working at GVIW as indeterminate, determinate, casual or contract staff should have training on security issues and working with offenders. (4.47)
- 9.63 Training in resuscitation, first aid and 'first on scene' for all staff should be annual. (4.48)
- 9.64 An automated external defibrillator and an emergency childbirth kit should be provided. (4.49)
- 9.65 Provision should be made for annual leave and sickness cover for all healthcare staff. (4.50)
- 9.66 All medicine administration records should be annotated at the time of the administration of the medication. (4.51)
- 9.67 Records of requests, waiting lists and other healthcare-related activities such as the use of the observation beds should be easily auditable. (4.52)
- 9.68 Triage algorithms should be used and triage assessments should involve the patient, rather than being undertaken solely from a written request. (4.53)
- 9.69 Provision should be made for all women (including those in the maximum security and segregation units) to receive night sedation at an appropriate time. (4.54)
- 9.70 The administration of all medications, including to women in the maximum security and segregation units, should be undertaken in a safe manner to ensure that medicines are secure at all time and neither the patient nor staff are subject to unnecessary risks. (4.55)
- 9.71 Women in the maximum security and segregation units should have confidential access to nursing staff. (4.56)
- 9.72 Women should be able to speak to a pharmacist about their medication if they wish to do so. (4.57)
- 9.73 Medical, nursing and security staff should develop a local drugs formulary and audit the use of prescribed medications. (4.58)
- 9.74 Women's access to healthcare services should not be restricted by their security status. (4.59)
- 9.75 Health promotion activities should include weight loss and healthy eating programs. (4.60)
- 9.76 There should be a formal system of liaison between the psychologists and the psychiatrist to ensure continuity of care to women seen by them. (4.61)
- 9.77 Clinical notes should provide a continuous, contemporaneous record of interventions. (4.62)
- 9.78 All prescriptions should include a start date. (4.63)

- 9.79 The system for delivering passes for healthcare appointments should be audited to ensure that women are receiving them with enough notice to be able to attend the department. (4.64)

Education, schooling and library provision

- 9.80 Teaching provision for women held on the secure unit should be improved. (5.17)
- 9.81 Computers for home study should be provided. (5.18)
- 9.82 Supervised access to the internet should be provided. (5.19)
- 9.83 Links with the local college should be developed and opportunities provided for students to study there on unescorted temporary absences. (5.20)
- 9.84 Library staff and assistants should be trained in the computer-based program to monitor book loan and aid stock control. (5.21)
- 9.85 The opening hours of the library should be extended to improve access to those women not attending activities in the programs department. (5.22)
- 9.86 Computer resources in the library should be improved. Women should have access to a computer from which they can research current commissioner's directives and standing orders. (5.23)
- 9.87 There should be an annual survey of women's use and views of the library. (5.24)

Employment and vocational skills

- 9.88 Greater emphasis should be given to the employment and employability program to generate more realistic employment opportunities, qualifications and vocational skills relevant to reintegration and to ensure women are 'job ready' on release. (5.37)
- 9.89 The job application and appointment processes should be monitored, including ethnic monitoring. (5.38)

Physical education and health promotion

- 9.90 Women should have a formal orientation on the use of the gymnasium, cardiovascular equipment and weights room. (5.45)
- 9.91 The fixed weights machines should be replaced and housed in a room that is adequately ventilated and fit for purpose. (5.46)
- 9.92 Health promotion activities should be encouraged and a physical education teacher should be employed to provide leadership and exercise classes. (5.47)

Spirituality

- 9.93 Full chaplaincy services should be provided to women in the segregation and secure units. (5.60)
- 9.94 The chaplain should be informed at the outset of all cases when a woman is regarded as a risk of suicide and self-harm in order to provide pastoral support and assist in case management in appropriate cases. (5.61)
- 9.95 Chaplains should be able to authorize telephone calls when they judge this is necessary for the pastoral support of women. (5.62)
- 9.96 Chaplaincy volunteers should be allowed to bring in home-produced food. (5.63)
- 9.97 Efforts should be made to support a community chaplain scheme in the Toronto area. (5.64)
- 9.98 Sweat lodge ceremonies should be provided weekly. (5.65)

Time out of room

- 9.99 There should be improved leisure facilities for women held on the secure unit. (5.76)
- 9.100 Volunteers should be given good notice when activities are cancelled and the reasons for cancellations should be recorded. (5.77)

Security and rules

- 9.101 All life sentenced women should have their initial security classification decided on the basis of an individual risk assessment. (6.17)
- 9.102 Security procedures on entry to the institution should be reviewed to ensure that they are necessary and effective. (6.26)
- 9.103 Security intelligence should be developed and analysed using the computer system to help target security resources effectively to ensure inmate safety. (6.27)
- 9.104 The drug dog should not be used when it is overdue for its annual retraining and retesting. (6.28)
- 9.105 Minimum-security women should have increased access to community programs and activities outside the perimeter fence. (6.29)
- 9.106 Sufficient minimum-security places should be provided in the institution to match the number of women. (6.30)
- 9.107 The overall number of women held in maximum security should be reduced by more focussed and frequent assessments concentrating on risk to the public rather than institutional adjustment and specific interventions to enable women to live in less secure conditions. (6.31)

- 9.108 Risk assessments should result in individual management plans that provide a consistent and proportionate response to managing each woman's individual risk. (6.32)
- 9.109 Each of the four levels of maximum security should represent a stage of identifiable progress to act as an incentive. Not all women should be started on level one unless this is merited by their risk assessment. (6.33)
- 9.110 More programs and purposeful activity should be provided for women in the secure unit. (6.34)

Discipline

- 9.111 Disciplinary procedures, including informal resolution, should be monitored to ensure compliance with procedures and consistency and fairness of approach in charges and punishments. (6.54)
- 9.112 The programs and regime for a segregated woman should be individually tailored to address the reasons for her segregation. (6.57)
- 9.113 Women in the segregation unit should not be spoken to or served meals through the door hatch. (6.58)
- 9.114 Patterns in the use of segregation should be monitored to identify trends, including length of stay, reasons for segregation, ethnicity with the aim of reducing its use. (6.59)

Catering

- 9.115 The amount of money allocated for food for each woman should be independently reviewed to ensure that it is adequate to provide a healthy and nutritious diet. (7.12)
- 9.116 All women should be given theoretical and practical training about food preparation and personal and food hygiene, and catering staff should ensure that every woman is able to prepare a variety of meals for herself. (7.13)
- 9.117 A decision should be made in consultation with women whether house cooks are required. If so, there should be a healthcare screening process and managers should ensure that all houses have an appointed cook at all times. (7.14)
- 9.118 Monthly checks of the living unit kitchens should record whether action has been taken to rectify previously identified problems. (7.15)
- 9.119 The food available should be sufficiently culturally diverse to meet the needs of the population. (7.16)
- 9.120 Breakfast should be prepared and served on the maximum security and segregation units on the day it is to be eaten. (7.17)

Reintegration strategy and planning

- 9.121 All aspects of reintegration should be monitored and coordinated by the reintegration committee or policy group. (8.12)
- 9.122 A range of reintegration data including information on parole should be collected and monitored to ensure managers can satisfy themselves about performance in this area and inform future policy. (8.13)
- 9.123 The parole board should be consulted as part of the process of quality assurance of parole reports. (8.14)
- 9.124 There should be better provision for assisting women with welfare support, employment, further education or training before they are released. (8.15)

Correctional planning

- 9.125 All women should be involved in the formulation of reports that relate to their correctional plan. (8.22)

Correctional and mental health programs

- 9.126 An annual needs assessment should be conducted to ensure that programs continued to meet the identified needs of women at GVIW. (8.36)
- 9.127 The population's need for abuse and trauma intervention should be assessed and the institution should ensure that the individual and group program contracts meet this need. (8.37)

Life-sentenced inmates

- 9.128 Orientation should ensure that needs of lifers are covered. (8.48)
- 9.129 Women lifers in maximum secure conditions should have their classification reviewed at least every 90 days. (8.49)
- 9.130 An annual review of progress against the correctional plan should be held with the full casework team, including the woman lifer. (8.50)
- 9.131 Better employment opportunities should be offered to allow lifers to acquire appropriate vocational skills. (8.51)
- 9.132 Isabel McNeill House should be better promoted as an opportunity for lifers to progress in their sentence and potential residents taken there to view the facility. (8.52)

Substance use

- 9.133 There should be a local drug strategy. (8.65)

- 9.134 Protocols should be in place to allow drug or alcohol dependent women to be provided with symptomatic relief within the first 24 hours of arrival if clinically indicated, and a suitable detoxification or maintenance-prescribing program should then be provided. (8.66)
- 9.135 More therapeutic and structured help should be provided to women in the intensive support program and more women should be encouraged to take part in the program. (8.67)

Housekeeping points

Mothers and children

- 9.136 Wall decorations should be appropriate to support the sensory development of babies and children. (2.34)

Healthcare

- 9.137 Minimum and maximum temperatures of all fridges used to store thermolabile medications should be recorded daily. These medications should be stored between 2 and 8 degrees Celsius. (4.65)
- 9.138 The filing system for clinical records should be reviewed; previous sets of notes should be kept with the current set. (4.66)
- 9.139 Standing orders should be signed, dated and based on evidence-based practice. (4.67)

Education, schooling and library provision

- 9.140 Computers in the computer suite should be networked to aid learning. (5.25)
- 9.141 A wider range of daily newspapers should be provided and made accessible in the library. (5.26)

Good practice

Residential units

- 9.142 The housing for minimum- and medium-security women and the relatively free movement within the boundaries of the institution provided a relatively normal living environment and allowed women to exercise some control over their day-to-day lives. (2.15)
- 9.143 Women due to be discharged were provided with free release clothing, which was particularly beneficial to those with no private savings and/or who had been in the institution for some time. This allowed women to maintain some dignity and relieved them of one financial burden immediately following their release. (2.16)

Healthcare

- 9.144 The resident status form that was sent to the pharmacy for all new arrivals provided an audit trail and method of cross-checking for prescriptions. (4.68)
- 9.145 The fact that most women were able to have their medications in-possession and that they received a patient information leaflet meant that they were able to manage their medications as they would in the community. (4.69)
- 9.146 The system to allow night sedation to be administered when nurses were not available was a pragmatic solution to the problem and allowed women to make decisions about their medications. (4.70)
- 9.147 The use of inmate peer education counsellors and the new healthcare inmate advisory committee provided useful conduits between healthcare staff and women. (4.71)

Time out of room

- 9.148 The Stride volunteers provided good support and activity for women within the institution and promoted their services in the community to aid reintegration. (5.78)

Discipline

- 9.149 The video recording of the use of force and related administrative briefing and assessments safeguarded women and staff against unobserved assault or from false allegations arising from the incident. (6.61)

Catering

- 9.150 Women were able to supplement their food order with home-grown produce and were therefore able to take a pride in their own efforts. (7.18)
- 9.151 The provision of barbecues provided an alternative method of cooking and opportunities for socialization. (7.19)

Correctional and mental health programs

- 9.152 The SLE was an impressive holistic therapeutic environment that supported women with specific mental health needs, and offered additional support to encourage and maintain their successful return to the general population. (8.38)

Appendix I: Inspection team

Anne Owers	HM Chief Inspector of Prisons
Michael Loughlin	Team Leader
Fay Deadman	Inspector
Paul Fenning	Inspector
Louise Falshaw	Inspector
Gabrielle Lee	Inspector
Elizabeth Tysoe	Inspector
Julia Fossi	Researcher

Appendix II: Prison population profile

Incarcerated	%	Community	%	Total
412	46.9%	467	53.1%	879

Source: OMS, as of August 21, 2005

Incarcerated includes: Women offenders, in federal institutions, and those on temporary absence.

Population Profile	Incarcerated	% of the total women offender population
Nova	57	14.1%
Joliette	73	18.1%
GVI	98	24.3%
OOHL	23	5.7%
RPC (Prai)	10	2.5%
EIFW	97	24.0%
FVI	46	11.4%
National total	404	100.0%

Source: OMS, as of August 21, 2005

- There are also 8 women offenders located in other correctional facilities who are not included in this profile: 6 at Isabel McNeill House, one woman at the Territorial Women Correctional Centre and one woman at the Surrey Pre-Trial Service Centre.
- Legend:
 - Nova: Nova Institution for Women (Atlantic Region)
 - Joliette: Joliette Institution (Quebec Region)
 - GVIW: Grand Valley Institution for Women (Ontario Region)
 - OOHL: Okimaw Ohci Healing Lodge (Prairie Region)
 - RPC (Prai.) Regional Psychiatric Centre (Prairie Region) *
 - EIFW: Edmonton Institution for Women (Prairie Region)
 - FVI: Fraser Valley Institution for Women (Pacific Region)

* RPC is an 11 bed mental health unit located in a male mental health facility.

WOMEN OFFENDER PROFILE FOR NOVA AND GVIW

Population Profile	Incarcerated	% of the total women offender population
Nova	57	14.1%
GVI	98	24.3%

Source: OMS, as of August 21, 2005

ETHNIC ORIGIN

Ethnic Origin	Aboriginal	%	Black	%	Asiatic	%	Caucasian	%	Other	%	Total
Nova	10	17.5%	6	10.5%	0	0.0%	38	66.7%	3	5.3%	57
Joliette	2	2.7%	5	6.8%	0	0.0%	66	90.4%	0	0.0%	73
GVI	11	11.2%	22	22.4%	3	3.1%	62	63.3%	0	0.0%	98
OOHL	22	95.7%	0	0.0%	0	0.0%	1	4.3%	0	0.0%	23
RPC (Prairie)	7	70.0%	0	0.0%	0	0.0%	1	10.0%	2	20.0%	10
EIFW	53	54.6%	0	0.0%	3	3.1%	36	37.1%	5	5.2%	97
FVI	16	34.8%	0	0.0%	2	4.3%	28	60.9%	0	0.0%	46
National Total	121	30.0%	33	8.2%	8	2.0%	232	57.4%	10	2.5%	404

Source: OMS, as of August 21, 2005

ETHNIC ORIGIN (NOVA AND GVIW)

Ethnic Origin	Aboriginal	%	Black	%	Asiatic	%	Caucasian	%	Other	%	Total
Nova	10	17.5%	6	10.5%	0	0.0%	38	66.7%	3	5.3%	57
GVI	11	11.2%	22	22.4%	3	3.1%	62	63.3%	0	0.0%	98

Source: OMS, as of August 21, 2005

SECURITY LEVEL

Institutions	Maximum	%	Medium	%	Minimum	%	Not available	%	Total	% Total
Nova	10	17.5%	17	29.8%	17	29.8%	13	22.8%	57	14.1%
Joliette	10	13.7%	33	45.2%	30	41.1%	0	0.0%	73	18.1%
GVI	8	8.2%	15	15.3%	63	64.3%	12	12.2%	98	24.3%
OOHL	0	0.0%	13	56.5%	6	26.1%	4	17.4%	23	5.7%
RPC (Prai.)	1	10.0%	7	70.0%	0	0.0%	2	20.0%	10	2.5%
EIFW	10	10.3%	49	50.5%	27	27.8%	11	11.3%	97	24.0%
FVI	0	0.0%	27	58.7%	14	30.4%	5	10.9%	46	11.4%
National Total	39	9.7%	161	39.9%	157	38.9%	47	11.6%	404	100.0%

Source: OMS, as of August 21, 2005

- Not available: Correctional planning process, including the intake assessment to be completed within 70 or 90 days calendar days of an offender's admission into federal custody following sentencing (depending upon the length of sentence), therefore the security classification is determine within 90 days of their admissions.

SECURITY LEVEL (NOVA AND GVIW)

Institutions	Maximum	%	Medium	%	Minimum	%	available	%	Total	% Total
Nova	10	17.5%	17	29.8%	17	29.8%	13	22.8%	57	14.1%
GVI	8	8.2%	15	15.3%	63	64.3%	12	12.2%	98	24.3%

Source: OMS, as of August 21, 2005

AGE PROFILE

Institutions	<=20	%	21-30	%	31-40	%	41-50	%	51 +	%	Total
Nova	5	9%	27	47%	14	25%	9	16%	2	4%	57
Joliette	2	3%	13	18%	26	36%	22	30%	10	14%	73
GVI	0	0%	22	22%	39	40%	27	28%	10	10%	98
OOHL	1	4%	9	39%	12	52%	1	4%	0	0%	23
RPC (Prai.)	1	10%	6	60%	1	10%	2	20%	0	0%	10
EIFW	5	5%	36	37%	36	37%	18	19%	2	2%	97
FVI	2	4%	16	35%	15	33%	11	24%	2	4%	46
Total	16	4%	129	32%	143	35%	90	22%	26	6%	404

Source: OMS, as of August 21, 2005

AGE PROFILE (NOVA AND GVIW)

Institutions	<=20	%	21-30	%	31-40	%	41-50	%	51 +	%	Total
Nova	5	9%	27	47%	14	25%	9	16%	2	4%	57
GVI	0	0%	22	22%	39	40%	27	28%	10	10%	98

Source: OMS, as of August 21, 2005

OFFENCES PROFILE

Institution	Violent Offences						Non-Violent Offences				Total
	Murder 1	%	Murder 2	%	Sched I	%	Sched II	%	Non Scheduled	%	
Nova	0	0%	7	12%	28	49%	4	7%	18	32%	57
Joliette	9	12%	7	10%	37	51%	13	18%	7	10%	73
GVI	1	1%	12	12%	43	44%	33	34%	9	9%	98
OOHL	0	0%	0	0%	16	70%	4	17%	3	13%	23
RPC (Prai.)	0	0%	4	40%	5	50%	0	0%	1	10%	10
EIFW	5	5%	9	9%	51	53%	17	18%	15	15%	97
FVI	1	2%	8	17%	29	63%	3	7%	5	11%	46
Total	16	4%	47	12%	209	52%	74	18%	58	14%	404

Source: OMS, as of August 21, 2005

OFFENCE PROFILE (NOVA AND GVIW)

Institution	Violent Offences						Non-Violent Offences				Total
	Murder 1	%	Murder 2	%	Sched I	%	Sched II	%	Non Scheduled	%	
Nova	0	0%	7	12%	28	49%	4	7%	18	32%	57
GVI	1	1%	12	12%	43	44%	33	34%	9	9%	98

Source: OMS, as of August 21, 2005

LENGTH OF SENTENCE

Institution	Life	%	Under 4	%	4 to 5	%	6 to 10	%	11 and more	%	Total
Nova	7	12%	40	70%	7	12%	2	4%	1	2%	57
Joliette	17	23%	34	47%	13	18%	9	12%	0	0%	73
GVI	13	13%	50	51%	18	18%	15	15%	2	2%	98
OOHL	0	0%	14	61%	5	22%	4	17%	0	0%	23
RPC (Prai.)	4	40%	3	30%	2	20%	0	0%	1	10%	10
EIFW	14	14%	57	59%	12	12%	11	11%	3	3%	97
FVI	9	20%	21	46%	7	15%	6	13%	3	7%	46
Total	64	16%	219	54%	64	16%	47	12%	10	2%	404

Source: OMS, as of August 21, 2005

LENGTH OF SENTENCE (NOVA AND GVIW)

Institution	Life	%	Under 4	%	4 to 5	%	6 to 10	%	11 and more	%	Total
Nova	7	12%	40	70%	7	12%	2	4%	1	2%	57
GVI	13	13%	50	51%	18	18%	15	15%	2	2%	98

Source: OMS, as of August 21, 2005

- Nova Institution for Women has 82% of its population serving a sentence for less than 6 years.
- Grand Valley Institution for Women has 69%.

WOMEN OFFENDER ADMISSIONS

Institutions	Fiscal year	Warrants of Committal	%	Revocations	%	Other Admissions	%	Total
Nova	02/03	21	52.5%	19	47.5%	0	0%	40
	03/04	30	57.7%	21	40.4%	1	2%	52
	04/05	15	50.0%	15	50.0%	0	0%	30
	05/06 to date	19	70.4%	8	29.6%	0	0%	27
Nova Total		85	57.0%	63	42.3%	1	1%	149
Joliette	02/03	27	60.0%	13	28.9%	5	11%	45
	03/04	36	75.0%	9	18.8%	3	6%	48
	04/05	36	59.0%	20	32.8%	5	8%	61
	05/06 to date	14	50.0%	13	46.4%	1	4%	28
Joliette Total		113	62.1%	55	30.2%	14	8%	182
GVI	02/03	70	69.3%	29	28.7%	2	2%	101
	03/04	74	77.1%	16	16.7%	6	6%	96
	04/05	75	64.7%	34	29.3%	7	6%	116
	05/06 to date	24	54.5%	17	38.6%	3	7%	44
GVI Total		243	68.1%	96	26.9%	18	5%	357
OOHL	02/03	0	0.0%	7	100.0%	0	0%	7
	03/04	0	0.0%	5	83.3%	1	17%	6
	04/05	0	0.0%	6	100.0%	0	0%	6
	05/06 to date	0	0.0%	3	75.0%	1	25%	4
OOHL Total		0	0.0%	21	91.3%	2	9%	23
RPC (Prai.)	02/03	0	0.0%	0	0.0%	1	100%	1
	03/04	0	0.0%	0	0.0%	1	100%	1
	04/05	0	0.0%	0	0.0%	1	100%	1
	05/06 to date	0	0.0%	1	100.0%	0	0%	1
RPC (Prai.) Total		0	0.0%	1	25.0%	3	75%	4
EIFW	02/03	53	55.8%	42	44.2%	0	0%	95
	03/04	70	53.8%	59	45.4%	1	1%	130
	04/05	81	58.3%	58	41.7%	0	0%	139
	05/06 to date	32	69.6%	14	30.4%	0	0%	46
EIFW Total		236	57.6%	173	42.2%	1	0%	410
FVI	02/03	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	03/04	n/a	n/a	1	100%	n/a	n/a	n/a
	04/05	23	69.7%	9	27.3%	1	3%	33
	05/06 to date	9	75.0%	3	25.0%	0	n/a	12
FV Total		32	69.6%	13	28.3%	1	2%	46
National Total		709	60.5%	422	36.0%	40	3%	1171

Source: OMS, as of August 21, 2005 (Data from April 1, 2002 to August 21, 2005)

WOMEN OFFENDER ADMISSIONS NOVA AND GVIW

Institutions	Fiscal year	Warrants of Committal	%	Revocations	%	Other Admissions	%	Total
Nova	02/03	21	52.5%	19	47.5%	0	0%	40
	03/04	30	57.7%	21	40.4%	1	2%	52
	04/05	15	50.0%	15	50.0%	0	0%	30
	05/06 to date	19	70.4%	8	29.6%	0	0%	27
Nova Total		85	57.0%	63	42.3%	1	1%	149
GVI	02/03	70	69.3%	29	28.7%	2	2%	101
	03/04	74	77.1%	16	16.7%	6	6%	96
	04/05	75	64.7%	34	29.3%	7	6%	116
	05/06 to date	24	54.5%	17	38.6%	3	7%	44
GVI Total		243	68.1%	96	26.9%	18	5%	357

Source: OMS, as of August 21, 2005 (Data from April 1, 2002 to August 21, 2005)

Appendix III: Summary of inmate interviews and questionnaires

Inmate survey methodology

A voluntary, confidential and anonymous survey of the total inmate population was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

At the time of the survey on the 17th August 2005, the inmate population at GVIW was 103. The baseline sample size was 103. Overall, this represented 100% of the inmate population.

Completion of the questionnaire was voluntary. Refusals were noted and no attempts were made to replace them. Two respondents refused to complete a questionnaire.

Interviews were carried out with any respondents with literacy difficulties. In total, no respondents were interviewed.

Methodology

Every attempt was made to distribute the questionnaires to each respondent on an individual basis. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- to have their questionnaire ready to hand back to a member of the research team at a specified time;
- to seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire.

Response rates

In total, 93 respondents completed and returned their questionnaires. This represented 90% of the prison population. The response rate was therefore also 90%. In total, two respondents refused to complete a questionnaire, three were returned blank and five questionnaires were not returned.

Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted, in order to mimic a consistent percentage sampled in each establishment.

The results from this survey are compared to the results of the Nova survey as well as the benchmark figures for all prisoners surveyed in women's prisons in the UK. This benchmark is based on all responses from prisoner surveys carried out in 12 women's prisons since April 2003.

In all the above documents, statistically significant differences are highlighted. Statistical significance merely indicates whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by a black background and where there is no significant difference, there is no shading.