2016

Investigations and Standards Office Inspection Report

ISO
INVESTIGATIONS
& STANDARDS OFFICE

INVESTIGATIONS AND STANDARDS OFFICE

INSPECTION 2016

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Message from the Director responsible for Correctional Investigations and Inspections in Yukon

This inspection report comes at an important time in the evolution of the Investigations and Standards Office (ISO) as an agency providing independent oversight of corrections in Yukon. The Office was created out of the *Corrections Act, 2009*, SY 2009, c 3 (the "Act") and the *Corrections Regulation*, OIC 2009/250 (the "Regulation") and was a key component of "Correctional Redevelopment".

Since 2010, ISO has been at the nexus of inmate complaints, appeals and other inquiries. From this unique position, ISO is able to speak from a perspective informed by over 100 complaints and inquiries per year, 20–30 inmate discipline appeals and numerous special investigations and inspections.

ISO has also sought to ensure that we remain open to best practices from Canadian and international jurisdictions in carrying out our investigations and inspections. The Office has, for example, drawn from the experience of the B.C. Inspections and Standards Office—the only other like-mandated agency in Canada—as a community of practice.

ISO has chosen two high risk areas of correctional centre operations for the focus of the 2016 inspection report: use of force incidents and the use of separate confinement. While ISO carries out inspections on a periodic basis, the special investigations and complaint investigations conducted also provide insight into current correctional practices.

Like this inspection report, it is a central objective of ISO recommendations that not only are individual complaints and situations properly investigated and addressed but that correctional practices are improved and strengthened over time.

Sincerely,

Jeff Ford
Director

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1. MANDATE OF THE INVESTIGATIONS AND STANDARDS OFFICE

Through the *Corrections Act* and *Regulation* the Investigations and Standards Office (ISO) is mandated to carry out inspections of the Whitehorse Correctional Centre (WCC) and report on its findings and recommendations to the Deputy Minister of Justice.

The Minister of Justice must provide for periodic inspections of WCC by the Director of Investigations and Standards. The Minister or the person conducting an inspection may enter and access any part of WCC, and examine anything or any record, except a medical record of an inmate. The person conducting an inspection must report their findings in writing to the Deputy Minister. The Deputy Minister must respond in writing within 90 days and indicate any proposed action to be taken as a result of the report.

Our Office also makes recommendations to the Minister on the scope and timing of inspections.

ISO uses a risk assessment process when determining what programs and services to select for inspection. Programs and services that have the highest potential for risk are prioritized, such as those where non-compliance with corrections policy could result in serious injury or death, or where the rights of inmates may be significantly affected. Lower risk programs may also be the subject to inspection. At the time of writing this inspection report, the inspection framework governing the timing and focus of future inspections was under review.

The inspection process undertaken by ISO is intended to:

a) provide assurance to the Department of Justice and public that the correctional facility operates within the parameters of applicable laws, regulations and policies;

b) identify weaknesses in operational or corrections practices, internal controls and management systems; and

c) identify opportunities, where applicable, to improve operational or correctional practices and make recommendations to this effect.

2. PAST INSPECTIONS AND FOCUS OF THE 2016 INSPECTION

Since receiving its mandate under the Act, ISO has carried out two comprehensive WCC inspections. The inspections focused on the following areas:

2011

- Use of long term separate confinement (segregation);
- Earned remission and release date of inmates.

2014

- Separate confinement including short and long term;
- Inmate complaint system.

In addition to the inspections above, ISO completed a number of spot inspections and special investigations, including:

- special investigation on long term confinement (2012);
- special Investigation on use of force related to escort of inmate to video court (2014);
- special investigation of separate confinement pending disciplinary hearing (2015); and
- spot inspections of the WCC physical plant examining cleanliness, health, and safety of inmate living units and Arrest Processing Unit (APU) (2015 and 2016).

ISO also investigates and responds to inmate complaints where the inmate is not satisfied with the response from WCC and requests a review by ISO. For example, ISO has carried out in depth investigations of food services, use of force incidents, access to health services, and correctional programming.

3. FOCUS 1 – USE OF FORCE

A. BACKGROUND

1. ISO has undertaken a number of investigations into use of force incidents at WCC. For example, ISO completed a special investigation into a use of force incident in 2014 involving one inmate. ISO made recommendations for changes in policy and practice which were submitted and accepted in full by the Deputy Minister of Justice. In follow-up to that investigation and others, ISO is aware that many of the recommendations have been implemented. Appendix 'A' provides an overview of past ISO recommendations as they relate to use of force. As part of this inspection, ISO reviewed all recommendations and has categorized the status of implementation of these recommendations based on whether they were implemented, partially implemented, and not implemented from ISO's perspective.

2. While ISO has conducted a number of investigations into individual use of force incidents, use of force as an operational area of correctional practice has not been subject to inspection by ISO.

3. The 2016 inspection, which is the subject of this report, examined how use of force was carried out within WCC, the circumstances that triggered the use of force, the number of planned versus unplanned (spontaneous) use of force incidents, and how well staff complied with policies related to use of force. Part of the review examined the reporting requirements established by WCC and the collection of information from each incident.

Additionally, ISO reviewed the training requirements and standards for use of force as well as the compliance for recertification for active duty corrections officers. In total, ISO reviewed 38 separate use of force incidents from data and reports that were compiled from October 2014 to October 2016.

4. The ISO investigators that conducted the use of force inspection have a combined experience of over 40 years of use of force training and experience in assessing, responding, and reviewing a wide variety of use of force incidents. Investigators also have experience in providing court testimony in relation to use of force and articulating the use of force under cross-examination.

5. WCC has the responsibility of housing inmates that are both sentenced and remanded, and those individuals recently arrested by the Royal Canadian Mounted Police (RCMP). Sentenced and remanded inmates are housed in main living units and prisoners are housed in the Arrest Processing Unit (APU). The majority of unplanned use of force incidents occur in the APU, often as a result of prisoners being under the influence of drugs or alcohol. RCMP officers and corrections officers may respond jointly or independently to situations requiring use of force in the APU.

6. Situations giving rise to use of force incidents are dynamic, evolve quickly, and can be unpredictable and violent in nature. The National Use of Force Framework is used nationally amongst peace officers and law enforcement agencies. The Framework is a "decision-making" tool that was implemented to assist peace officers in training to assess and evaluate a situation and how to use a variety of intervention options; one of the intervention options is verbal direction or communication. WCC corrections officers use the framework to learn about specific behaviours of inmates/prisoners, risk factors in an incident, and intervention options when interacting with inmates/prisoners. Ultimately, the Framework facilitates understanding and articulating an incident where a peace officer uses force. See Appendix 'B' for the National Use of Force Framework graphical representation.

7. After a use of force incident, corrections officers are required report in writing what they experienced, how they responded, and what type of force was applied in a situation that can be only seconds or minutes in duration, and where they have limited time to respond. Additionally, when more than one corrections officer is involved, perceptions and perspectives of the incident and what transpired may differ. These factors were taken into consideration during the inspection and review process.

8. While use of force incidents can be dynamic in nature, corrections officers must follow law and policy and apply their training to ensure an appropriate response.

B. LAW AND POLICY GOVERNING USE OF FORCE

9. The *Act* and section 2(b) of the *Criminal Code* designate corrections officers as peace officers. Section 25 of the *Criminal Code* authorizes peace officers to use as much force as necessary in the administration or enforcement of the law in relation to their duties.

10. *Applicable* policies from the WCC Adult Custody Policy Manual 2013 that are related to use of force and training include:

    - B 2 "Use of Force"
        - B 2.1 "Use of Force: Authorities and Considerations"
        - B 2.2 "Use of Restraints"
        - B 2.3.1 "Scale of Issue Nov 2016"
        - B 2.3 "Scale of Issue – Authority to Approve Nov 2016"
        - B 2.4 "Cell Entry Teams and Process Nov 2016"
        - B 2.5 "Use of Force: Reporting and Investigation Procedures Nov 2016"
    - G 2 "Forms"
        - G 2.4 "Use of Force Report Sept 2014"
    - E 1 "Staff: General"
        - E 1.3 "Staff Training"
    - E 3 "Staff Safety"
        - E 3.3 "Critical Incident Debrief"

C. METHODOLOGY

11. Two ISO investigators attended WCC in October of 2016 and requested WCC management provide all of their documentation for Use of Force Files from October 2014 to October 2016.

12. ISO also conducted an interview with the Acting Deputy Superintendent of Operations in December 2016. The interview was used to clarify operational procedures, documentation procedures and training standards.

13. WCC provided ISO investigators with 37 physical files and 25 electronic files.

14. The physical files were folders of each use of force incident; each folder was labelled with the inmate/prisoner name and the date of the incident. Each file was considered complete if it contained documents pertinent to the use of force incident identified in Policy B 2.5, "Use of Force: Reporting and Investigation Procedures", which include:
    - Use of Force Reports
    - Information Reports completed by corrections officers
    - Photographs

- USB drives with videos of the incident

15. The 25 electronic files provided were provided via a copy of the WCC electronic file.

16. ISO categorized the use of force incidents into planned and unplanned incidents. The definition of an unplanned use of force incident is that it is spontaneous in nature, and requires immediate response by corrections officers. The definition of a planned use of force incident is any use of force incident where a team was assembled and there was a coordinated response where each corrections officer had a well-defined role. The coordinated team is referred to as Cell Entry Team (CET). The CET is a team of correctional officers who are specifically selected and trained for the purposes of safely removing potentially violent inmates from cells or other close-quarter spaces. The team consists of officers with specially assigned duties. Corrections officers wear protective equipment and follow the National Use of Force Framework.

17. Trained corrections officers with prior authorization from the Manager of Correctional Services may also use batons and a 37 millimeter Oleoresin capsicum (OC) gas gun and pepper ball launcher when the circumstances require these intermediate weapons.

18. ISO also reviewed WCC Policy B 2.1 "Use of Force: Authorities and Considerations", provision 7 ("Duty to Report Use of Force"), a Use of Force Report is required only when there are uses of force involving physical techniques or intervention tools, including warnings given of potential use of force. Routine escorts and the use of restraints are not considered use of force incidents by WCC management. Additionally, as per Policy B 2.5 "Use of Force: Reporting and Investigation Procedures", corrections officers are required to submit a written report prior to the completion of their shift.

19. The review of each use of force incident was broken down into two parts:
    a) The incident. A review of the video, if possible, and a review of all available corrections officers' reports. The review required investigators to consider the incident in its totality, and therefore required a review of inmate/prisoner behaviour, the situational factors, each corrections officer's perception of the incident and their tactical considerations. The review examined the actual use of force or intervention used on the inmate/prisoner and whether it was appropriate and proportionate.
    b) The post incident. A review of whether proper documentation was completed, whether the inmate/prisoner offered medical care, and whether the corrections officers offered to debrief in particular traumatic events

D. REVIEW OF WCC USE OF FORCE FILE MANAGEMENT

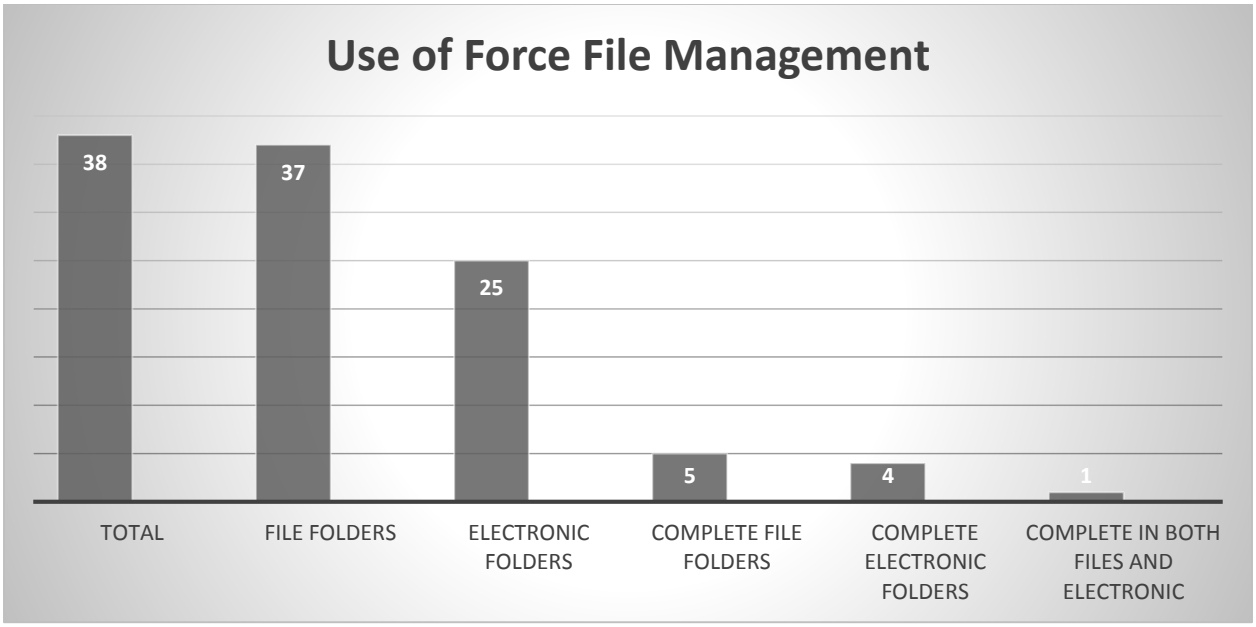
20. Physical File Findings:

- There were 13 physical files that did not have a corresponding electronic file on the data drive.
- Five files had USBs attached to them; four of these contained video from various angles of the use of force incident, and one contained nothing relating to the use of force incident.
- Two files contained black and white photographs.
- One use of force incident had two separate physical files.
- There were five physical files that were complete which contained Information Reports and the Use of Force Report, and if applicable, also had the USB attached with video of the incident.

21. Electronic File Findings
    - There were 25 individual files on the data drive, which all corresponded to the physical files WCC management provided, except for one that did not have a physical file.
    - These files corresponded to the physical files, however, there were 12 missing electronic files. The electronic files did not contain similar documents to the physical files.
    - The electronic files varied in their content from Information Reports and Use of Force Reports to video of the incident.
    - One electronic file had another prisoner's Use of Force Report and Information Reports in it.
    - There was also one empty electronic folder.
    - There were two physical files that contained two separate use of force files.
    - Only four of the 25 electronic files were complete and included Information Reports, the Use of Force Report and video of the incident; however, one of these files also contained data for one other prisoner.

22. In total:
    - One use of force incident contained no paperwork or electronic evidence. ISO investigators were unable to review any details of the incident and were unable to examine the use of force incident as a result. The physical file did have another inmate's use of force documents in it.
    - There were nine complete use of force files that contained all documentation and video on file, out of the 38 reviewed.
    - One use of force incident out of the nine complete files found was complete in both the electronic folder and in the physical file folder.

23. See bar graph below.



24. WCC was unable to provide a list of all use of force incidents for the period reviewed. It was clear that there was no consolidated list/files that contained all of the use of force documentation. ISO investigators cannot be sure whether all Use of Force Reports were received. There is no current policy governing what is required in a Use of Force file, or how the file should be compiled.

25. There is no common process that WCC staff is using to save and store data. Only the Deputy Superintendent of Operations had physical files, and was not sure where the previous Deputy Superintendent of Operations stored all of the files he reviewed. Furthermore, there was no tracking of the physical files, and access to the files was limited as they were located in the Deputy Superintendent of Operations' office.

E. USE OF FORCE INCIDENTS REVIEW

26. ISO reviewed 38 use of force incidents at WCC from October 2014 to October 2016. Between January 2015 and October 2016 WCC housed an average of 92 inmates per day. See table below for total number of use of force incidents per year.

Use of Force Incidents/Year	
Year	Number
2014	8
2015	25
2016	5

27. Use of force incidents at WCC are quite low when the number of yearly use of force incidents is compared to the daily number of inmates.

28. ISO made the following findings in regards to location of incidents based on the files provided by WCC:
    - There were a total of 30 unplanned use of force incidents at WCC with a majority (21) of these having occurred in the APU.
    - There were seven unplanned use of force incidents that occurred in living units and one unplanned use of force incident in the Seg/SLU.
    - Three female inmates with histories of mental health concerns accounted for all seven planned and unplanned use of force incidents in Bravo Unit.
    - Of the remaining 31 use of force incidents one male was involved in three separate use of force incidents.
    - Two incidents were fights between two males; except for these two incidents, all other incidents only involved one inmate/prisoner.
    - See table below

Location of Planned and Unplanned Use of Force Incidents			
Location	Planned	Unplanned	Total
Living Units	1	3	4
Bravo Unit (Women's Unit)	3	4	7
Seg/SLU	2	1	3
A&D	2	0	2
APU	0	21	21
WGH	0	1	1
Total	**8**	**30**	**38**

29. ISO made the following findings:
    - CET was deployed eight times out of the 38 incidents. Deployments occurred in the living units, segregation unit and the Secure Living Unit (SLU).
    - Five out of eight CET deployments required only verbal intervention and restraints to gain compliance.
    - OC spray was the only intermediate weapon used. OC spray was used two times in the incidents reviewed, and in review of both incidents, ISO found it was appropriate given the situations. Decontamination was completed in these cases, and on site health care was offered as per policy.
    - ISO did not find that the force used was excessive in any of the 38 incidents reviewed.
    - Overall, inmates/prisoners received minimal injuries (e.g., minor abrasions) as a result of the 38 use of force incidents.
    - Several corrections officers sustained serious injuries from inmates/prisoners as a result of intervening. Two corrections officers were bitten and another corrections officer was punched multiple times resulting in bruising and a split lip.

- Timely medical services were provided to inmates/prisoners in all incidents where there were obvious injuries. In certain circumstances, WCC staff escorted inmates/prisoners to Whitehorse General Hospital (WGH) for further medical treatment for mental health issues, or as a precaution.

30. In many cases corrections officers were able to gain control with only verbal intervention. In several other planned incidents of use of force, corrections officers intervened with soft physical control despite the assaultive behaviours displayed by the inmate/prisoner. ISO noted several circumstances of good verbal intervention and attempts at de-escalation. This was evidenced in cases where corrections officers used verbal commands when inmates/prisoners were resisting or non-compliant. Verbal intervention was regularly attempted when using force. Overall, given the level of resistance inmates/prisoners presented, corrections officers were able to contain the situations presented using minimal levels of force. See table below for the frequency of the type of forces used.

Types of Intervention	**Number of times used**	**Percentage (%) Used**
Verbal Direction	33	87
Restraints (Handcuffs and Leg Shackles)	26	68
Soft physical	30	79
Physical hard	1	2.6
Chemical Agents	2	5
Shield	8	21
Baton	0	0
Cell Extraction Team	8	21
Spit Mask/helmet/Suicide Prevention Gown	8	21

*One Incident can involve more than one intervention strategy.

31. A critical incident debrief[1] was not offered after every use of force incident; the debrief is offered at the discretion of the Manager of Correctional Services if the Manager of Correctional Services determines the incident was a critical incident and that there was a possibility of staff being traumatized (as per Policy E 3.3 “Critical Incident Debrief”). WCC offered a critical incident debrief after five separate use of force incidents out of the 38 reviewed. The offer of a critical incident debrief is tracked on the Use of Force Report.

32. ISO found that WCC adhered to the principle of using the least restrictive measures for restraints as per Policy B 2.2 “Use of Restraints”. For example, in two separate incidents

[1] A critical incident definition: an event that causes death or serious injury, or has the likelihood of resulting in death or serious injury to any person, or that exposes the correctional centre or the public to a substantial risk.
A critical incident debrief definition: designated staff and/or health care professionals respond to the needs of a staff member who has been involved in a traumatic critical incident.

where staff were dealing with youth prisoners in the APU, both of whom presented significant mental health concerns and possible self-harm, restraints were placed on the prisoner while in the cell. Staff appropriately monitored the youth and when they were reassessed by staff and considered safe from self-harm, the restraints were removed. Removal of the restraints occurred approximately one hour after they were placed on the prisoner. In another use of force incident, ISO noted that corrections officers implemented the proper practice of reassessing the situation, wherein staff removed restraints from a highly agitated inmate/prisoner once they felt the risk was diminished, despite the fact that he had recently been extracted from a cell by the CET.

33. In the review period of October 2014 to October 2016, according to WCC, there were no complaints of excessive use of force made by an inmate against corrections officers. Additionally, ISO received no complaints from inmates of this nature. Of the incidents reviewed where all appropriate documentation and video was available, ISO determined that corrections officers used an appropriate and proportionate amount of force during use of force incidents. In several circumstances, corrections officers used verbal intervention techniques when presented with aggressive and violent behaviour in attempts to de-escalate the situation.

F. REPORTING

34. Policy B 2.5 "Use of Force: Reporting and Investigation Procedures" requires all corrections officers who are involved in a use of force incident to complete a written report detailing all relevant facts regarding the incident. The policy also stipulates that the corrections officers involved must provide the person in charge with any evidence related to the incident, including any handheld video or closed-circuit television footage.

35. ISO made the following findings:
    - In every use of force incident, except one, there was a Use of Force Report completed.
    - All involved corrections officers completed Information Reports for 12 of the 38 incidents (31.5%).
    - All of the Information Reports completed by involved corrections officers were sufficient in detail in describing the inmate's/prisoner's behaviour. ISO noted five Information Reports that were very descriptive of inmate/prisoner behaviours and which used appropriate terminology that was in line with the training principles of the National Use of Force Framework.
    - Two of the use of force incidents reviewed did not contain sufficient details in the Information Reports to support the inmate/prisoner behaviour that was described on the Use of Force Report (e.g., such as combative/assaultive).
    - All eight of the planned use of force incidents were recorded with a handheld video camera as per Policy B 2.4 "Cell Entry Teams and Process".
    - ISO was only able to review 10 videos for 10 use of force incidents. On the Use of Force Report there is space where the Deputy Superintendent of Operations (DSO) indicates

whether he/she has reviewed the video, and if the video was retained. The table below documents the video review and retention findings.

Video Retention Record of 38 Files Reviewed		
DSO Indicated Reviewed Video	**DSO Indicated Saved Video**	**ISO Reviewed**
31	24	10

36. ISO was only able to find approximately 25% of the videos from all incidents. Two of the videos were limited in content, and three others were only found after searching inmates'/prisoners' electronic files on WCC's data drive. Policy B 2.5 "Use of Force: Reporting and Investigation Procedures" states that evidence including video must be provided with the corrections officer's report after a use of force incident. There is no policy dictating how long video should be retained after a use of force incident, or where it is to be kept. There was no evidence or documentation that the missing video footage on the use of force files was purged from the files.

37. Policy B 2.5 provision 7 provides that "each month the person in charge will submit a summary of uses of force to the Assistant Deputy Minister". There was no evidence found that a summary was provided to the Assistant Deputy Minister as per policy in any of the incidents. Based on the information provided by the Superintendent, the use of force reports are submitted to the Director of Corrections.

38. ISO found that the Manager of Correctional Services reviewed use of force reports within 1 to 3 days of the incident. In 13 files, ISO found that the Deputy Superintendent of Operations took 20 to 42 days to review the use of force report. The Deputy Superintendent of Operations took 1 to 10 days to review 13 other use of force reports.

39. ISO found that there were systemic issues with respect to documentation, electronic and hardcopy file organization, and retention of video footage. Requests for documentation in regards to the use of force inspection were delayed due to obvious gaps in the basic organization and administration of the files. ISO finds that this is a significant organizational gap and recommends building a robust file system with clearly articulated business rules. This may require additional capacity and resources within WCC to administer the system and, for example, to carry out data entry.

G. USE OF FORCE REPORT

40. ISO's inspection found that the majority of the Use of Force Reports contained all pertinent information that related to the incident. ISO found that in some incidents a description of the circumstances that led up to the use of force was lacking. The form provides a space for the Team Leader to provide details of the events leading up to the incident, however, the

Team Leader did not always provide the details. The form lacks a place to fully explain the behaviours of the inmate/prisoner and the situation that the corrections officer was confronted with. Consideration of a space for observed behaviours leading up to the incident is recommended.

41. In a planned use of force incident with the CET, the team leader is responsible for completing the form. It is then forwarded to the Manager of Correctional Services on duty for review. The Manager of Correctional Services reviews the Use of Force Report and incident, comments, and then forwards the Report to the Deputy Superintendent of Operations for review. The Deputy Superintendent of Operations reviews the video, reports and any other documentation provided, and if they see fit, they have the option to forward the completed Report to the Superintendent. There was no indication on any Use of Force Report that the Superintendent reviewed the Report. All Use of Force Reports were reviewed by the Deputy Superintendent of Operations.

H. MANAGEMENT OVERSIGHT/REVIEW

42. Planned use of force incidents at WCC require the Manager of Correctional Services to determine when the CET is needed. Policy B 2.4 provision 7 dictates that the officer in charge (i.e. Manager of Correctional Services) may deploy the CET when an inmate is in a cell or other close quarters area and refuses to exit without potential violence. ISO found that the Manager of Correctional Services on duty authorized the CET and provided ongoing support in all the incidents reviewed. The authorization of use of force in these circumstances was documented on the Use of Force Report. The Manager of Correctional Services authorizing the use of force provided a firsthand review of the incidents and provided recommendations on some, as discussed below.

43. ISO noted three specific use of force incidents where management identified issues following their review of the incident. Recommendations were made to enhance policy, provide additional training, and on the use of proper handling techniques.

44. In one case, new procedures and policies were recommended in regards to highly agitated inmates/prisoners who presented with mental health issues. The Manager of Correctional Services made recommendations that Emergency Medical Services/health care staff should attend every time a use of force incident involves a youth. The Manager of Correctional Services also recommended that WCC place all mental health individuals in a cell without anything in it (e.g., no bench, sink, etc.). There were also recommendations on this review from the Deputy Superintendent of Operations. The Use of Force Training Officer also reviewed the incident to identify any training discrepancies.

45. In another case, the Manager of Correctional Services that was involved in the incident noted that specific handling protocols designed particularly for one inmate were not followed properly. In response to this finding the Manager of Correctional Services

reviewed the special handling protocols during a weekend training session with corrections officers.

46. In the last case, there was a thorough review done by the Deputy Superintendent of Operations and the Use of Force Training Officer. Three recommendations were made as a result of some errors made by the corrections officers during the use of force incident.

47. There were six use of force incidents reviewed by the Use of Force Training Officer, as indicated on the use of force reports reviewed.

I. TRAINING

National Use of Force Framework Background

48. The National Use of Force Framework is the national standard that all trained peace officers use when conducting their duties. The framework assists officers and the public in understanding and articulating why, and in what manner, an officer may respond with force. The framework has a graphical representation that assists officers in their training with articulating why they used force.

49. The Framework description states:

> "The National Use of Force Framework represents the process by which an officer assesses, plans and responds to situations that threaten public and officer safety… Authority to use force separates law enforcement officials from other members of society and the reasonable use of force is central to every officer's duties."

Corrections Officer Basic Training

50. Corrections officers are required to complete a six-week course known as Corrections Officer Basic Training (COBT). Training related to use of force is comprised of approximately five-and-a-half days in total. Use of Force Training includes a review of the authority for using force as set out in the *Criminal Code* and the *Act*. Training continues with classroom theory which includes a study of the National Use of Force Framework. Corrections officers spend the majority of their use of force training on practical training, whereby they practice control techniques including verbal commands, pressure points, joint manipulation, and restraints. Training progresses to close quarter hand-to-hand combat where corrections officers practice further use of force techniques.

51. COBT covers the process of removing uncooperative inmates/prisoners from their cells. This training covers the roles and responsibilities of the CET. Corrections officers then complete theory and practical training in the use of the defensive baton and OC.

52. Scenario based training and report writing for a use of force incident are also included during COBT. Corrections officers are required to participate and demonstrate physical competencies and also write an exam to test the knowledge of the theory.

53. It is important to note that ISO did not conduct a comparison of WCC's use of force training policy and curriculum with other correctional institutions. That focus was outside the scope of this inspection but may be beneficial to review in the future.

Other Training

De-escalation Training

54. This is a one-day training workshop focusing on de-escalating potentially violent situations. Training focuses on types of anger, warning signs and the defusing process. In November 2015 approximately 31 corrections officers received this training.

55. The following is a list of other training courses related to Use of Force that have been available to corrections officers based on the Use of Force spreadsheet provided by the Deputy Superintendent of Operations:
    - Cell Extraction
    - Cell Extraction Policy
    - Code of Conduct
    - Code Yellow Response
    - Corrections Officer II Training
    - Tactical Communication and Response Training
    - Handcuffing Techniques
    - Rapid Response Training
    - Use of Force Guidelines
    - Use of Force and OC Paintball[2] Training

56. ISO reviewed a table that detailed the training that corrections officers undertook in relation to the use of force. Some of this training was done on weekends while other courses were mini-modules of the use of force training. These are not formally recognized courses, but are still tracked for each corrections officer; they review use of force training techniques instructed by certified trainers ensuring that WCC staff are continuously improving their skills.

Training Policy

[2] [sic] Paintball is the term referenced in the spreadsheet provided but acknowledged by ISO that it references pepper ball

57. General Use of Force Policy covers the authorities, basic training requirements, use of restraints, requirements on reporting procedures after an incident, and the standards for CETs.

58. Current policy does not have any training standards or recertification timelines. According to WCC management current recertification standards (see table below) that are prescribed by WCC are based on those set by *MD Charlton*, the organization hired by WCC for training all new corrections officers. The policy does not set out which corrections employee is tasked with ensuring that staff training remains current. Recertification is required every two years for close quarters hand-to-hand combat and three years for both baton and OC spray recertification. These recertification timeline standards are in line with other peace officer agencies. In comparison, the RCMP use the same timelines, while the Yukon Sheriff's Office requires recertification for all three categories on an annual basis.

59. The staff list provided by Corrections management was comprised of 80 employees, including three administrative staff, with their names set out on an Excel spreadsheet. ISO removed from the review the three administrative staff, bringing the total number of employees included in the inspection to 77 corrections officers. This excel spreadsheet was extracted from the list of all training of WCC staff, and contained categories specific to corrections officers' use of force training, and when they completed the training.

60. Managers of Correctional Services, Deputy Superintendents and Case Managers (nine personnel in total) did not have documented use of force training. It is important that senior management are trained in use of force as they are responsible to authorize and review all use of force incidents; furthermore, senior management and Case Managers engage in one-to-one interactions with inmates within WCC. Use of force training for these employees is necessary to ensure the safety and security of all staff and inmates.

61. ISO found that over 50% of staff have expired certifications in baton and OC spray. Three-quarters of staff have current hand-to-hand combat training, meaning that 25% are also expired in hand-to-hand combat training. See table below.

Training Recertification Compliance (as set by MD Charlton)			
Training	Baton (3 years)	OC (3 years)	Hand-to-Hand (2 years)
Current	35 (45.5%)	37 (48.1%)	56 (72.7%)
Expired	42 (54.5%)	40 (51.9%)	21 (27.3)

J. SUMMARY OF FINDINGS

62. A central principle of the *Act* is that Corrections management and staff provide for the safety and security of staff, inmates/prisoners and the public using the least restrictive measures within WCC. The findings of this investigation support that Corrections is

following this principle for the incidents reviewed that had all documentation available. Unfortunately, ISO was unable to review all documentation for 28 of the 38 incidents; ISO did not have video to corroborate the CO's version of events in these 28 instances and there was no record that the video had been saved to the use of force file, or purged in accordance of a retention schedule.

63. ISO found that, for the incidents reviewed, the use of force intervention was carried out in an appropriate and professional manner. The incidents reviewed reflect strong compliance with policy, obvious attempts to de-escalate and defuse situations by corrections officers, and proportional uses of force consistent with the National Use of Force Framework.

64. However, ISO found that there are significant deficiencies with respect to the documentation and file management of use of force incidents in that there was no clear and concise system for tracking incidents, filing, and archiving reports with corresponding business rules. This area requires attention from WCC management.

65. WCC is able to access almost every angle of the facility with video, which provides the best evidence of the use of force and WCC should ensure it is available for review by all parties, management and any reviewing authority. The video record of an incident may supplement and enhance traditional documents used for training. Video records are also crucial to inmate/prisoner complaints. Video records facilitate responses to external reviews including the potential for judicial review of use of force incidents. While video appears to have been reviewed by WCC management, in most cases video retention was inconsistent and this remains a central concern to ISO investigators. ISO was unable to conduct a complete review of all of the incidents because of missing video. In our current legal and professional climate, there is an expectation that where force is used against an inmate and video exists, it will be available for review. Where it is not, it raises questions as to the reasons it is not available. WCC would be expected to provide an explanation. Video retention should no longer be seen as optional.

66. ISO's review of training recertification found that some corrections officers' use of force training certificates had expired. ISO also found that there was no officer designated as responsible for ensuring compliance with the recertification guidelines, and that there is no policy in place that defines timelines for maintaining currencies.

K. RECOMMENDATIONS

Inmate/Prisoner Behaviour and Perceived Threat Necessary on Use of Force Report

67. ISO recommends that the Use of Force Report include a section that sets out inmate/prisoner behaviour and that defines the perceived threat. This section is required to demonstrate the justification for using force and the corresponding appropriate level of force.

After Incident Follow-up

68. ISO recommends that following a use of force incident, Corrections management consider the option of interviewing the inmate/prisoner. This may add a different perspective and offer different use of force options in future circumstances and may lead to more effective de-escalation of inmates/prisoners.

After Incident Reviews

69. ISO recommends that notification of any critical use of force incident be forwarded directly to the Deputy Superintendent of Operations by the Manager of Correctional Services after their initial review. This will ensure timely reviews by the Deputy Superintendent of Operations for critical use of force incidents.

70. ISO recommends that Corrections management consider having all use of force incidents reviewed by the Use of Force Training Officer in conjunction with the Deputy Superintendent of Operations. The Use of Force Training Officer can properly assess the incident and advise Corrections management in relation to the National Use of Force Framework, the level of force applied, and potential areas requiring additional training.

File Management

71. ISO recommends the creation of a file management system and corresponding business rules to ensure that all reports/evidence/videos are compiled and stored in accessible electronic folders and accompanying paper folders as they occur. These rules should designate those responsible for compiling data and provide clear requirements of what is expected in each Use of Force file.

Video Retention

72. ISO recommends that policy be amended to include video retention specific to use of force incidents. Retention of video for use of force incidents should be listed as mandatory[3] and include where and how the video is saved and archived, and how long it is kept. The video evidence must be retained in the use of force file for each incident.

Training Standards

73. ISO recommends that WCC re-examine training standards for use of force and ensure these are fully covered in existing policy. WCC should update its policy to designate who is

[3] Current video retention policy states that video used for evidentiary purposes or other security reasons *may* be retained for a period of one year; the 'may' should be 'must' for use of force incidents.

responsible for monitoring and ensuring compliance with training requirements. WCC should also ensure that training currency timelines are complied with and properly documented for both corrections officers and Corrections management.

74. All correctional officer management should be trained in use of force.

Past Recommendations

75. ISO recommends that Corrections review ISO's past recommendations, particularly those that have been partially implemented, or not implemented (see Appendix 'A').

4. FOCUS 2 – SEPARATE CONFINEMENT

A. LAW AND POLICY GOVERNING SEPARATE CONFINEMENT

76. The *Act* and *Regulation* set forth all provisions governing custody of inmates at WCC. Separate confinement is an offender management tool which is only to be used in accordance with the *Act* and *Regulation*, and when less restrictive alternatives have been exhausted or proven ineffective. The relevant sections of the *Regulation* are set out in Appendix 'D' and are listed below.

77. Applicable policies from the Whitehorse Correctional Centre Adult Custody Policy Manual 2013 that are related to separate confinement:

- B 4 "Inmate Discipline and Control"
    - B 4.2 "Segregation Unit"
    - B 4.3 "Separate Confinement"
    - B 4.6 "Secure Living Unit"
- B 5 "Living Unit"
    - B 5.2 "Special-Purpose Living Units"
- G 1 Standing Orders
    - G 1.14 "Placement of Inmates under CAR Sections 20, 21, and 28"

78. Separate confinement is used to separate inmates from one another to provide higher levels of security and increase opportunities for observation by WCC. The reason(s) for separate confinement fall into two categories: a) disciplinary, or b) administrative.

79. Disciplinary separate confinement is punitive and is imposed upon inmates who have been charged or convicted of a disciplinary offence as outlined in the *Regulation*.

80. Administrative separate confinement is an offender management tool that is used to separate an inmate from the general population; it is not intended to be punitive in nature. Administrative separate confinement is divided into voluntary and involuntary separate confinement. Voluntary separate confinement involves the inmate choosing to be removed from general population and confined separately. However, the person in charge must still authorize any placement on voluntary separate confinement. Involuntary separate confinement (short or long term) involves an inmate being placed in separate confinement at the discretion of the person in charge. The authority and process for the person in charge to decide to hold an inmate in short term separate confinement and/or long term separate confinement is set out in Appendix 'D' at sections 20 and 21.

81. According to Policy B 4.3 "Separate Confinement" long term confinement is used to address chronic, high risk issues that are unlikely to change dramatically in a short period. Issues that may be addressed by long term confinement include inmate self-harm, and inmate-on-inmate violence. Long term confinement may also be used to prevent harm to other people living, working or visiting WCC.

82. Section 21 of the *Regulation* provides that the person in charge may extend the order to confine an inmate separately for one or more periods not longer than 15 days each. The order to extend can only be specified if the circumstances giving rise to the separate confinement are reviewed prior to the expiry of the existing confinement period and it is determined that the circumstances which justified the order still exist. The Regulation does not place a restriction on the number of times that a section 21 order can be renewed.

83. Under the *Regulation*, an inmate who is placed on long term confinement must be provided in writing: a) the reason for their confinement, b) the length of time that they will be separately confined; and c) the reason for the length that they will be confined. An inmate must be given reasonable opportunity to make submissions about why the separate confinement should not continue and/or why it should be for a shorter period of time. After considering the inmate's submission, the person in charge may confirm their decision, vary their decision or rescind their decision, and must notify the inmate of their decision with reasons in writing.

84. Individuals placed on long term confinement within WCC are removed from general population units and placed into a segregation unit. The female segregation unit is located on the third floor of the Women's Unit and not accessible by other inmates in the unit. The male segregation unit is located on the third floor of WCC adjacent to the SLU but separated by a central control pod for the two units.

85. Under the *Act* section 8 "Inmate Rights", administratively segregated inmates should receive the same rights, privileges, and conditions of confinement as the general population inmates, except for those that cannot reasonably be provided because of security and/or safety concerns.

86. The male segregation unit consists of seven cells. Six of the cells are single occupant cells and one is a negative pressure double occupant cell. The female segregation unit consists of five cells, two of which are negative pressure cells.[4] Unlike the male segregation unit, all cells in the female unit are single occupant. All segregation unit cells are the same size, have an exterior window, and are similarly configured to the cells in general population. The overhead lighting in the segregation unit cells is turned off during the night. However, unlike general population unit cells, segregation cells have a steel door with a window, and built-in security cameras. The fixtures in the segregation cells are stainless steel rather than porcelain and there is no desk or TV in the cell. The difference between regular living unit cells and segregation cells are for the safety of staff and inmates.

87. According to Policy B 4.2 "Separate Confinement" the segregation unit is an area of the correctional centre that is separate from other living units, with the highest levels of observation, security and resistance to damage, intended to house those individuals held on different types of separate confinement.

88. Both the female and male segregation units are self-contained units which include shower facilities, a telephone, and a fresh air yard. When inmates are unlocked from their segregation cells, they have unrestricted access to these amenities. The amount of time that inmates are allowed out of their cells was increased in 2016 from one hour to two hours. WCC may permit inmates additional time out of their cells. An exercise of this discretion is based on the inmate's individual circumstances, and the operational requirements of WCC and the segregation unit.

B. BACKGROUND

89. The use of separate confinement within provincial and federal correctional settings has come under increased scrutiny from the media, the courts, inmates, and inmate advocates. Calls for change have been prompted by a number of cases where inmates were housed in separate confinement for extended periods of time, and safeguards enshrined in law, correctional policies, and procedures, failed to ensure the rights of the inmates were upheld. The following is a sample of the more prominent cases to garner significant public attention:

    - Coroner's Inquest Touching the Death of Ashley Smith, Jury Recommendations of December 2013 from the Inquest and the response from Correctional Services of Canada;

[4] Negative pressure cells aid in the prevention of air-borne pathogens such as TB. Negative pressure is created by balancing the room's ventilation system so that more air is mechanically exhausted from a room than is mechanically supplied. This creates a ventilation imbalance, so that air flows from the corridors, or any adjacent area, into the negative pressure room, ensuring that contaminated air cannot escape from the negative pressure room to other parts of the facility.

- Report to the Minister of Justice and Attorney General of Alberta, "Public Fatality Inquiry into the death of Edward Christopher Snowshoe", (June 2014)
- The case of Adam Capay, who was allegedly held on separate confinement for four years in Thunder Bay Correctional Centre in Ontario. Capay's confinement resulted in a 2016 provincial review of separate confinement led by the former Correctional Investigator of Canada Howard Sapers.

90. The inquests and investigations into the abovementioned cases have opened a public policy discussion around the need for additional safeguards for ensuring appropriate and humane treatment of inmates in separate confinement, including specific limits on its duration, external oversight and other measures.

91. A number of international norms and standards are intended to inform correctional practices in Canada. These norms and standards provide guidance, and where Canada has signed on to treaties or conventions that include such standards, should also be applied by federal, provincial and territorial correctional authorities. Canada, for example, agreed to the Covenant on Civil and Political Rights on May 19, 1976, and must report to the United Nations on progress. Canada was also signatory to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture) in 1985 and ratified the Convention in 1987.

92. In 1975, Canada committed to ensuring full compliance and domestic implementation of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Mandela Rules"). The Mandela Rules were revised in 2015. Some of the excerpts from the Mandela Rules relevant to this inspection are set out below:

> "In order for the principle of non-discrimination to be put into practice, prison administrations shall take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings. Every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits.
>
> For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days.
>
> Solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority. It shall not be imposed by virtue of a prisoner's sentence.

> The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. The prohibition of the use of solitary confinement and similar measures in cases involving women and children, as referred to in other United Nations standards and norms in crime prevention and criminal justice, continues to apply.
>
> The following shall always be subject to authorization by law or by the regulation of the competent administrative authority: Any form of involuntary separation from the general prison population, such as solitary confinement, isolation, segregation, special care units or restricted housing, whether as a disciplinary sanction or for the maintenance of order and security, including promulgating policies and procedures governing the use and review of, admission to and release from any form of involuntary separation."

93. The UN Special Rapporteur on Human Rights has also provided comments and guidance on the issue of "solitary confinement". The Interim Report from the UN Special Rapporteur on Human Rights, 2011 is often quoted in the ongoing dialogue on separate confinement. In that report, the Special Rapporteur stresses that solitary confinement is a harsh measure which may cause serious psychological and physiological adverse effects on individuals regardless of their specific conditions. The Special Rapporteur found solitary confinement to be contrary to one of the essential aims of the penitentiary system, which is to rehabilitate offenders and facilitate their reintegration into society. The Special Rapporteur defined prolonged solitary confinement as any period of solitary confinement in excess of 15 days.

94. ISO would note that the Special Rapporteur uses the term "solitary confinement" and that depending on the country in question, the custodial settings encompassed by that term can vary significantly in their correctional practices, conditions of custody and in upholding standards in terms of the rights and duty of care of inmates.

95. The UN Special Rapporteur's recommendations were also referenced in the Coroner's Inquiry Touching the Death of Ashley Smith. The following is an excerpt of the recommendations from the Final Report of the Coroner's Jury[5]:

> "27. That, in accordance with the Recommendations of the United Nations Special Rapporteur's 2011 Interim Report on Solitary Confinement, indefinite solitary confinement should be abolished.

[5] Interim Report from the UN Special Rapporteur on Human Rights, 2011.

28. That there should be an absolute prohibition on the practice of placing female inmates in conditions of long-term segregation, clinical seclusion, isolation, or observation. Long-term should be defined as any period in excess of 15 days.

29. That until segregation and seclusion is abolished in all Correctional Services of Canada (CSC) operated penitentiaries and treatment facilities:

- CSC restricts the use of segregation and seclusion to fifteen (15) consecutive days, that is, no more than 360 hours, in an uninterrupted period;
- That a mandatory period outside of segregation or seclusion of five (5) consecutive days, that is, no less than 120 consecutive hours, be in effect after any period of segregation or seclusion;
- That an inmate may not be placed into segregation or seclusion for more than 60 days in a calendar year; and
- That in the event an inmate is transferred to an alternative institution or treatment facility, the calculation of consecutive days continues and does not constitute a "break" from segregation or seclusion.

96. In carrying out the analysis for this inspection, ISO also reviewed numerous research reports, investigative reports and documents pertaining to the use of separate confinement. A sample of the reports reviewed for the purpose of this inspection include:

- Solitary Confinement: A Case for Abolition. West Coast Prison Justice Society, November 2016.
- "Segregation: Not an Isolated Problem" Submission in response to the Ministry of Community Safety and Correctional Services consultation on its review of policies related to segregation of inmates," Paul Dubé, Ombudsman of Ontario, April 2016.
- Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives, VERA Institute of Justice, May 2015.
- "Solitary Confinement, Public Safety, and Recidivism", Shira E. Gordon, University of Michigan Law School, 2014.
- "The Effect of Solitary Confinement on Institutional Misconduct: A Longitudinal Evaluation", Division of Research and Advanced Studies, University of Cincinnati, Ryan M. Labrecque, 2010.
- Administrative Segregation in Federal Corrections - 10 Year Trends, Office of the Correctional Investigator of Canada, May 28, 2015.
- Interim Report from the UN Special Rapporteur on Human Rights, 2011.
- A Human Rights Approach to Prison Management, Andrew Coyle, International Centre for Prison Studies, King's College, London, 2009.

97. ISO has reviewed research on young persons and solitary confinement. The research strongly supports the conclusion that young people continue to develop cognitively between the ages of 18 and 24. Young inmates may be particularly susceptible to the negative effects of prolonged periods in separate confinement. There is evidence that prolonged periods of separate confinement of young persons can have detrimental effects on their cognitive development, health and well-being. Accordingly, the measures put in place for managing young persons in a correctional setting should be unique and appropriate to their particular developmental needs.

98. At the national level the Federal/Provincial/Territorial forum called the "Heads of Corrections" has considered best practices with the use of separate confinement. Yukon Corrections is an active participant and according to Corrections management, several of the practices initiated in Yukon in recent years are considered to be best practices which could be implemented in other provincial jurisdictions. Pertinent to this inspection report, Corrections management provided a draft document titled "Heads of Corrections – Adult Facilities – Segregation Working Group, Template" as a summary of best practices. The document sets out provisions to guide the use of separate confinement including alternatives which should be exhausted. The document is further referenced below.

99. As mentioned above, since its inception in 2010, ISO has completed three inspections of WCC programs and operations. These inspections generated a number of recommendations which are germane to the current inspection. For both the 2011 and 2014 inspections, Corrections management adopted the practice of providing confirmation of whether ISO's recommendations were accepted and what specific actions were to be taken in response. This was done after the Director of Corrections and Assistant Deputy Minister met with the Deputy Minister of Justice to review the findings and recommendations of ISO's inspection reports. This practice is consistent with article 36(4) of the Act, where the final report from an ISO inspection is provided to the Deputy Minister of Justice. Additionally, article 36(5) of the Act states that the Deputy Minister must respond in writing within ninety days to the report of findings and indicate any proposed action to be taken as a result of the report. ISO's past recommendations to Corrections are captured in Appendix 'C'. For this report, ISO has also tracked within the table at Appendix 'C' whether the recommendation was accepted and the status of implementation from the perspective of ISO.

100. In addition to recommendations arising out of ISO inspections, ISO has also carried out special investigations at the request of the Assistant Deputy Minister. For example, in 2015, ISO conducted an investigation into the use of separate confinement pending a disciplinary hearing and made several recommendations. Those recommendations were referenced as part of this inspection and are also outlined in Appendix 'C'.

C. METHODOLOGY FOR THE INSPECTION OF SEPARATE CONFINEMENT

101. Investigators selected a random sample of 20 WCC inmate files that contained short term confinement (section 20), long term confinement (section 21) and voluntary confinement (section 22) from the separate confinement spreadsheet WCC provided. Inmate files were selected from the 2015/16 period. ISO tried to ensure the inmate sample included males and females.

102. From the 20 inmate files, there were 59 cases of separate confinement, and 61 separate confinement forms. The discrepancy between the number of cases and the number of forms was caused by two separate cases of separate confinement that had two forms on file for the same time period. For the specific number of cases of inmates on separate confinement and the type of confinement, see table below.

Type of Confinement

Type of Confinement	**Number from Sample**
Short Term (s.20)	24
Long Term (s.21)	10
Voluntary (s.22)	25
TOTAL	**59**

103. When reviewing the separate confinement forms, investigators examined the following: the type of confinement; whether reasons for the confinement were provided; if a review was completed; if the review was documented; and if the the appropriate authority made the decision and conducted the review.

104. Investigators interviewed the only male inmate that was in the segregation unit during an ISO visit in January 2017[6], and reviewed his inmate file and progress log. There were no females in segregation at the time of ISO's visit. Investigators also interviewed the Superintendent, three Managers of Correctional Services, three segregation/SLU Unit staff, and one case management staff.

105. As an examination of alternatives to separate confinement, investigators interviewed three inmates that were placed in the SLU[7], and reviewed three inmate files and progress logs in addition to reviewing recent ISO complaint investigations. Investigators also interviewed the Superintendent, three Managers of Correctional Services, three segregation/SLU staff, and one case management staff.

[6] Date of collection of files for the inspection commenced at the end October 2016. All interviews were conducted in 2017.

[7] The SLU is defined in policy B 4.6 as follows: "Secure Living Unit (SLU): a secure living unit in a correctional centre that is separate from other living units, with higher levels of observation, security and resistance to damage, intended to house those male inmates who cannot cohabitate with other individuals or classes of inmates, or those requiring a level of monitoring not available elsewhere in the centre."

D. FINDINGS

106. The average age of the 20 inmates was 38 years old; the average age of the 15 males was 40 years old, and the average age of the five female inmates was 30 years old. Three of the inmates were between the ages of 19 and 25, two were male and one was female. One young adult male spent time in separate confinement for three separate lengthy periods; the first period was 32 days which included short term, long term and disciplinary separate confinement; the second period was 27 days which included short term, long term and voluntary separate confinement; the third period was 22 days all of which was spent on voluntary separate confinement.

107. Of the 20 files selected, five were female inmate files. One female inmate with mental health issues accounted for 18 of all separate confinement cases reviewed; nine of those 18 cases were voluntary confinement cases.

108. Additionally, one male accounted for nine voluntary confinement cases out of the 25 total voluntary separate confinement cases identified. In other words, two inmates accounted for 18 out of the 25 voluntary separate confinement cases.

109. 53 of the 61 separate confinement forms had reasons provided. Eight forms had no reasons included on the form, and only cited the relevant sections of the Regulation. Policy B 4.3 "Separate Confinement" provision 19 states that it is not sufficient to only quote the *Regulation* and that written reasons are required. The Superintendent has informed ISO that he has met with the Deputy Superintendent of Operations to reinforce WCC's position and direction that detailed reasons need to be included on separate confinement forms. According to the Superintendent, this direction is also going to be conveyed to all Managers of Correctional Services at an upcoming meeting.

110. *S*ection 20(2) of the *Regulation* states that the person in charge must release an inmate after 72 hours on short term confinement. The person in charge may extend the order for one or more periods of no longer than 15 days each, as per section 21, long term separate confinement. Policy G 1.14 provision 6 states that every weekday morning, the person in charge will discuss the status and circumstance of each inmate housed in segregation and that the status and decisions made for each inmate will be documented. Policy B 4.3 provision 27 states that the case manager will conduct a review of section 20 prior to the expiry of the 72 hours being expired. If the case manager believes that there is a need to extend to section 21, they will make recommendations to the Deputy Superintendent. The case manager's review should be documented in the progress log and the electronic file.

111. The majority of cases lacked proper documentation and investigators were unable to determine if reviews between short term and long term periods of separate confinements and extensions of long term separate confinements were completed. Only two separate confinement forms documented that a review of placement had been completed. These two forms documented specific details indicating that circumstances still warranted

separate confinement. The form lacks space to document whether a review has been conducted. The form only provides a place to note the upcoming review date and time. WCC management indicates that they conduct daily reviews of all inmates on separate confinements. Investigators reviewed "Morning Briefing Minutes", but found that only the inmate's name was documented; the details of the placement review discussion were not documented. There was no case managers' review of the placement recommendations found in the files reviewed.

112. Investigators could not determine by reviewing the separate confinement form whether an inmate had been released from segregation prior to the 15 day limitation. Investigators were only able to determine this by reviewing other documents. For example, one inmate's separate confinement forms indicated that she was separately confined for 18 days (three days short term and 15 days long term); however, her progress log indicated that she was placed on Secure Supervision Placement[8] Level (SSP) 3, three days into her long term confinement.

113. There were 10 instances of long term confinement of the 59 reviewed; of those, five inmates were released prior to the expiration of the 15 day time period. Deficiencies in documentation remains a serious concern as it points to the possibility that inmates are in separate confinement longer than they should be or without lawful authority.

114. Furthermore, in more than one instance, an inmate had both long term confinement and voluntary confinement forms for the same time period. There was no way to indicate the change of status on the original long term confinement form; in some instances, it appeared that an inmate spent the full duration on long term separate confinement, when in fact they had been transferred to voluntary separate confinement. There is no field on the separate confinement forms to document when the separate confinement has either ended or has been extended. Corrections management, when reviewing separate confinement documentation, should be able to review the form and find all requirements of the Act without having to cross reference other files. This is especially important for the mandatory review time periods.

115. There were also no documented reviews for long periods of voluntary separate confinement on the separate confinement forms. One male inmate was on short term confinement and voluntary separate confinement for 55 days consecutively; there were no documented reviews of his placement on his separate confinement forms.

[8] As per Policy D 4.5 "Secure Supervision Placement": Secure Supervision Placement is a case management strategy to address disruptive or dangerous conduct and may be used to enhance correctional centre security and increase the safety of everyone in the centre.

116. One female inmate was on all types of separate confinement (sections 20, 21, 22, 28 and 33) over an 83 day consecutive time period. In this instance, there were multiple documented attempts and plans to reintegrate this female back into the regular unit; however, the separate confinement forms did not document these attempts. Investigators had to search other documents in order to determine these efforts were made.

117. While examining the separate confinement forms, investigators found that there were five different versions being circulated during the timeframe in question, and that there were different versions of those versions also in circulation. ISO has received and confirmed that a new form was developed and that it should now be the only one in use. This new form addresses and resolves ISO's finding that there was no way to know if the inmate received their written notification within 24 hours as per the *Regulation* as the new form has a space for the date and time of service to the inmate.

118. Per the *Regulation*, the signature of the person in charge is required in order to lawfully place an inmate in separate confinement. All separate confinement sections in the *Regulation* delegate authority only to the person in charge. To be clear, a Deputy Superintendent and or Manager of Corrections Services may act as the person in charge, for example, during the night shift or on weekends. The separate confinement form needs to clearly indicate whether the officer signing off on a separate confinement placement is either the person in charge or is the acting person in charge. Some forms had only names typed and no signature. On some of the different versions of forms, the person in charge signature was in the review section, not in the person in charge section. Furthermore, Policy B 4.3 "Separate Confinement" provision 28 stipulates that the Deputy Superintendent will determine if an inmate's short term confinement will be discontinued or if the inmate will be placed on section 21. This is not in accordance with the Regulation, section 21(1). Determination of an inmate's placement is the exclusive responsibility of the person in charge.

119. Of the six officers interviewed (Managers of Correctional Services and corrections officers in charge of the segregation/SLU), ISO determined that, when serving the separate confinement form to inmates, Officers in Charge (OIC) or their designates were not always providing a verbal explanation of the reasons for placement on a consistent basis, as per Policy B 4.3 "Separate Confinement" provision 19 which states that the OIC or designate will deliver all written separate confinement forms to the inmate, and will also explain the forms to the inmate verbally.

120. Policy G 1.14 provision 7 states that on weekends, the Manager of Correctional Services is to speak with all inmates housed in segregation before noon and document this discussion in each inmate's progress log. Only one of the Managers of Correctional Services out of the three interviewed said that he usually attends all units on weekends before noon. The interview responses indicate that the practice is not being carried out consistently. Furthermore, there was no evidence that any discussions on weekends between inmates

housed in segregation and the Manager of Correctional Services were being documented in any inmate's progress log.

121. Policy B 4.3 provisions 30 and 31 dictate that case managers will meet with all inmates on section 21 and develop a transition plan; further, that they will also meet with all inmates on section 21 every three days and document a summary of these meetings in the inmate's progress log. The policy does not elaborate on the purpose and intent of the meetings. The interviews with the case managers confirmed that they were not conducting these steps as per policy requirements. In response to this finding, the Superintendent indicated that there is no plan to amend these provisions, as the Deputy Superintendent of Programs has informed him that they are reviewing placements on a daily basis to ensure inmates are transitioned from segregation as soon as possible. The Superintendent recognized that the intention of all provisions detailing contact with inmates on segregation was to ensure meaningful contact and to establish ongoing communication; therefore, provision 31 would not be amended and case managers would be directed to meet with inmates every three days.

122. The Regulation, section 21(3)(b) affords inmates the right to appeal a decision that extends their separate confinement to long term confinement, or to request a shorter extension. Investigators found that there was no consistency in practice with respect to corrections officers informing inmates of their right to appeal; one corrections officer that was interviewed said that he was aware of the clause and that he had offered it in the past.

123. From the case file review and interview with the inmate on segregation, ISO found that all policies except for one were being adhered to. Paperwork was being properly filled out, and the inmate was being served separate confinement forms, informed of his right to appeal, offered time out of his cell, and receiving visits from a nurse who attended and checked in on him. However, case management did not follow the policies and develop a transition plan or meet with the inmate every three days.

124. Corrections management provided statistics on the number of days inmates spent on each type of separate confinement for the years 2014, 2015, and 2016. The numbers indicate that the total number of days spent on all types of separate confinement dropped over 50 percent from 2014 to 2016. There appears to be a slight increase in the use of long term separate confinement between 2014 and 2015. See the table below.

Days Spent on Separate Confinement

Type of Confinement and Number of Days

YEAR	Section 20 (short term)	Section 21 (long term)	Section 22 (voluntary)	Section 28 (pending disciplinary hearing)	Section 33[9] (disciplinary)	Total
2014	184	119	265	98	468	1134
2015	140	164	348	169	109	930
2016	136	127	141	89	41	534

125. While there has been a decrease in the use of separate confinement, there has been an increase in the use of the SLU to house inmates who show challenging behavior and require enhanced supervision. This increase was brought to ISO's attention during the Superintendent of Corrections' interview, as well as through ISO complaint investigations and has been identified as a potential systemic issue.

126. The "Heads of Corrections – Adult Facilities – Segregation Working Group, Template", cited above, describes several alternatives to the use of separate confinement and states:

> "If an inmate is presenting behaviour problems WCC's case management team considers:
> Diversion through Secure Supervision Placement (SSP) is a three-level case management strategy to address inmates who have a pattern of disruptive or dangerous conduct. A case plan is developed and shared with the inmate; and the plan and the inmate's progress is reviewed weekly, and adjusted as appropriate.
>
> SSP is used to help manage offenders by identifying problem areas and regular review of successes in behaviour management, regularly reviewed by case management with a view to full integration into unit (sic).
>
> Diversion by movement to another unit or through rotational lock up – used to manage inmates with incompatibility issues within a common living area by avoiding direct contact; or to manage contact between incompatible groups (e.g., gang affiliates; incidents of aggression between multiple individuals within the protective custody unit).

[9] ISO is aware, through its appeal responsibilities that the number of inmate disciplinary hearings has significantly decreased. This correlates to a decrease in disciplinary separate confinement and the use of the segregation units. The decrease can be attributed to Corrections management placing greater emphasis on de-escalation tactics and informal resolution for addressing challenging inmates' behaviour.

Diversion through placement in the SLU – While SLU offers a more normalized unit environment than segregation/separate confinement; it also provides a higher level of supervision than a regular living unit through lower inmate/staff ratio and cell cameras.

Rather than a separate confinement placement due to an inmate acting out or a demonstrated incompatibility on a regular unit, a SLU placement is a much less restrictive alternative. SLU placements are also made for medical reasons (physical and mental) or due to perceived inmate vulnerability on living unit. SLU placements frequently result in psychologist referrals.

Diversion through placement in designated units:

1) A designated Protective Custody Unit. Placement may be due to nature of offence, personal incompatibilities, gang affiliations (or avoidance) or other inmates identified as vulnerable to victimization. (e.g., nature of offence, gang-affiliated units, no-contact orders/incompatibilities).

2) Regular Unit designations. Identified regular living units may house inmates of similar affiliation or to separate inmates with known or court-ordered 'No-Contact'."

127. The "Heads of Corrections" document further raises a number of challenges with respect to Yukon:

"Yukon has only one correctional facility; there is no option to transfer remanded offenders who present risk to the safe operation of WCC to another facility.

Based on the Ministerial order for Yukon Review Board clients, WCC often gets inmates who might be better managed in a dedicated Mental Health Facility. Although plans are being made, Yukon does not currently have a Mental Health Unit or facility.

The SLU is also used to house people with cognitive or mental health problems which make them vulnerable in a regular living unit. Due to the varied cognitive, mental health and behavioural concerns as well as individual incompatibilities, individuals in SLU may be unlocked by group or individually. This is not ideal as it puts limits on access to the common area, fresh air yard and telephone but is necessary to ensure the safety of everyone held there. As much unlock time as can be safely managed is permitted in the SLU."

128. ISO recognizes that the use of the SLU may be justified for managing inmates as an alternative to separate confinement. However, there is an inherent risk in the SLU being overused for this purpose. While the SLU is not categorized as a unit for administrative segregation, ISO's experience with complaints emanating from that unit is that inmates are concerned that they are being housed in a segregation-like unit. In reports over the last five years, the Federal Correctional Investigator of Canada and Ontario Ombudsman have raised similar concerns related to units which could be deemed "seg-lite".

129. Over the last year, ISO has reviewed a number of complaints related to the SLU and as a result has undertaken a number of complex investigations which are relevant to this inspection. During the spot visit for this inspection, ISO staff reviewed the current population in the unit and their daily regime. At that time, owing to conflicts between inmates, the actual time out of cell for inmates was two to three hours. The current standard for inmates in the segregation unit is two hours of out of cell time. While inmates in the SLU have access to televisions, reading materials, and physical fitness equipment (recently introduced), their access to programming is significantly different from other inmates on the general units.

130. The SLU is also governed by separate policy as a result of an ISO recommendation that was implemented by Corrections in 2015. A SLU Placement Form was also developed and introduced as per ISO recommendations made in 2017. This form is completed when an inmate is initially placed on SLU and details the rationale of placing an inmate on SLU. This form is the only written communication an inmate received regarding their SLU placement.

131. Policy B 4.6 "Secure Living Unit" identifies when an inmate may be placed in SLU, and provides that a SLU Placement Form must be completed by a case manager and must include the following: details of the rationale for the placement, how the unit may be run, monthly reviews of the placement or as directed by the person in charge, and that review recommendations are to be forwarded to both the Deputy Superintendent of Operations and Deputy Superintendent of Programs.

132. Investigators interviewed three inmates that were placed on SLU, and reviewed three inmate files and progress logs. Investigators also interviewed the Superintendent, three Managers of Correctional Services, three segregation/SLU staff, and one case management staff.

133. ISO conducted the SLU review to determine if there was any paperwork provided to inmates detailing the reasons for their initial SLU placement and the reasons for their continued time on SLU. Investigators chose the three inmates interviewed because they had been placed on SLU for over 30 days. Policy B 4.6 "Secure Living Unit" states that after 30 days of placement on SLU the case manager and unit officers are to jointly review the SLU placement.

134. The Superintendent stated in his interview that case management may not be conducting the 30-day review, but that they are conducting a weekly review of all SLU placements. However, the policy does not indicate that any documentation is required to be given to the inmate, and WCC does not provide the inmate with any documentation regarding their placement on SLU besides the SLU Placement Form. Furthermore, he stated that the weekly review assists WCC management in ensuring that an inmate will be restaged to a unit when appropriate to do so.

135. ISO investigators have suggested to the Superintendent that inmates be provided with ongoing rationale for their continued placement on SLU because it may restrict their time out of their cell. The Superintendent has agreed that Policy B 4.6 "Secure Living Unit" may be amended to include the requirement that case management have a dialogue with all SLU inmates regarding their placement once a month. Furthermore, case management will document the communication in the inmate's progress log and include a summary in the weekly review after the meeting takes place. The Superintendent recognized that this practice would further promote meaningful contact. To date this amendment has not been implemented.

136. The length of stay on SLU for each inmate interviewed was approximately three months, six months and 13 months. Two of the three inmates did not want to be moved, as they were there voluntarily, although their initial placement on SLU was a decision by Corrections management. They stated that they were typically not in the common area with one another, and were out of cell on average three hours per day. One inmate did not recall any time out of his cell that was less than two hours. However, more inmates and more incompatibles on SLU results in less time out of cell time in the common area. At the time of ISO's inspection, the SLU was at its maximum occupancy.

137. ISO finds the fresh air yards to actually be more akin to fresh air rooms. The fresh air rooms in the segregation unit and SLU do not amount to "open air" and provide little more than an enclosed space with access to fresh air; the spaces are typically cold and provide limited space for movement.

138. Ensuring lawful authority and that all alternatives are exhausted prior to placing an inmate on long term confinement is a common focus of external reviews of corrections practice. The report from the 1996 "Arbour Commission of Inquiry into certain events at the Prison for Women in Kingston" and subsequent independent reports have recommended different forms of external and independent review. In a similar vein, ISO made a previous recommendation in its 2014 inspection report that any separate confinement (including voluntary) over 30 days triggers a process of external and independent review. In response, Corrections management raised privacy concerns with that recommendation but did not specify what they were. The reasons/justifications for the 2014 ISO recommendations still remain.

139. The Coroner's Inquest into the Death of Ashely Smith referenced above also recommends a much more stringent regime of timelines including a mandatory five day period outside of segregation following 15 consecutive days of separate confinement.

E. RECOMMENDATIONS

Separate Confinement Form Amendments

140. ISO recommends the creation of a PDF of the separate confinement form. This will prevent multiple versions of the form being circulated and allow for current requirements and recommended changes to be included.

141. ISO recommends the following changes to the separate confinement form, as the separate confinement form should contain all pertinent information regarding the separate confinement placement, and not require a search of various other documents and files:

- A field to capture the date and time of service of the form to the inmate;
- A space on the form to include date and time of review when completed, what was reviewed, the findings, and the outcome of the review (i.e., if separate confinement was ended or extended);
- A space for the signature of the person in charge;
- A field to document reviews for all voluntary confinement;
- Removal of check boxes; and
- A field to confirm that the inmate has been notified of the right to appeal their placement on separate confinement.

142. ISO recommends that Corrections quality assurance process ensures that the policy regarding the review process, written reasons and justification for separate confinement is complied with in every instance. Furthermore, ISO recommends that measures to ensure compliance with WCC policy are put in place and adhered to, to ensure greater accountability.

External Reviews

143. ISO believes that the *Act* also presents examples of best practices in Canada. The independent adjudicator hearing system for inmate discipline can be used as an example. While that system has faced challenges, it has evolved into a very effective mechanism of administering sanctions for disciplinary offences. A similar system of independent review could be put in place in Yukon in relation to separate confinement.

144. ISO recommends that, while ensuring that the review processes at the 15-day mark are robust and all appropriate measures are in place to provide for appropriate management of separate confinement as per the *Act* and *Regulation,* the Corrections branch and the Department of Justice explore an independent review model for long term confinement of 30-days duration or more.

Access to Open Air

145. The third-generation construction design of WCC was based on newly accepted standards of correctional practice. The Mandela Rules cited above and other international standards speak to the need to provide inmates with access to "open air" daily. ISO believes that the Correctional redevelopment process was premised on the careful consideration of the history and culture of Yukon including the desire to ensure connection with the land; ISO understands that the liberties of inmates are restricted to ensure the safety of inmates, staff and the wider public. ISO recommends that, to conform with international standards and as a best practice, periodic access to "open air" be considered where possible and where safe to do so in the segregation units and SLU as is already undertaken with other inmates within WCC (i.e. the gardening program).

Out of Cell Time

146. From ISO's research, there is no evidence that restricting out of cell time has any deterrent effect on future inmate behaviour including violence. As Corrections continues to ensure that programming and management of inmates is evidence based, ISO recommends the cessation of restricting out of cell time for inmates in segregation to two hours, and that the out of cell time in the segregation unit be based solely on inmate case plans and unit management.

Policy Compliance and Considerations

147. Policy B 4.3 should be amended to properly reflect the *Regulation* in relation to Deputy Superintendent of Operations signing authority; it should be changed to person in charge.

148. Policy G 1.14 provision 7 states that, on weekends, the Manager of Correctional Services will speak with all inmates housed in segregation before noon and document this discussion in each inmate's progress log. ISO found that this provision was not being complied with. Corrections management should review and clarify this provision and consider enhancing the policy to ensure meaningful contact and ongoing communication with inmates in segregation. ISO recommends that Corrections reinforce the need to verbally explain the reasons for being placed on separate confinement to the inmate when serving the separate confinement form as per Policy B 4.3 provision 19.

Review of Past ISO Recommendations

149. Appendix 'C' provides an overview of past ISO recommendations as they relate to separate confinement. As part of this inspection, ISO reviewed all recommendations and has categorized the status of implementation of these recommendations based on whether they were implemented, partially implemented, not implemented and unknown from ISO's perspective. ISO recommends that Corrections review ISO's past recommendations, particularly those that have been partially implemented, unknown or not implemented.

Managing Inmates with Mental Health Issues or Diagnosis

150. ISO recognizes that the current Corrections management understands the futility of charging inmates with acute mental health issues with disciplinary offences. Such a scenario, more often than not, leads to further escalation; ISO acknowledges the efforts of Corrections management to modify their approach to such inmates and find alternative ways to address their behaviour short of discipline. This may have resulted from the decrease in disciplinary charges and resulting decrease in days of disciplinary confinement from 2014–16. For those inmates acting aggressively or with violence whose behaviour relates to a mental health issue, Corrections should continue to explore health based alternatives consistent with emerging best practices in United States and Europe. ISO recommends that a new regime for inmates with acute mental health issues be developed in collaboration with Health and Social Services, Whitehorse General Hospital, and the Department of Justice.

Special Considerations and Policy for Young Persons in Separate Confinement

151. Research on incarcerated young persons aged 18–24 indicates that a different approach should be taken to their management in Corrections and that the approach should be consistent with the provisions of the *Youth Criminal Justice Act*.[10] For these reasons, ISO recommends that Corrections management adopt separate policy which sets appropriate restrictions on the use of separate confinement for young persons and which takes into account their unique developmental needs.

Management of the SLU

152. ISO supports the use of the SLU for managing inmate behaviour which cannot otherwise be addressed through other measures. However, ISO believes that to fulfill the *Act*'s central principle that Corrections use the least restrictive means, there needs to be robust policy for reviewing inmates' placement and possible alternatives to their placement in the SLU. ISO fully recognizes the challenges faced in managing aggressive inmate behaviour, de-conflicting inmates with gang affiliations or no contact orders, and managing inmates with

[10] Bulletin 5: Young Offenders and an Effective Response in the Juvenile and Adult Justice Systems: What Happens, What Should Happen, and What We Need to Know (Study Group on the Transitions between Juvenile Delinquency and Adult Crime): James C. Howell, Barry C. Feld, Daniel P. Mears, David P. Farrington, Rolf Loeber, David Petechuk: July 2013

acute mental health issues and that the SLU may present the safest means available for certain periods of time to manage these challenges. However, it is critical that the SLU does not become segregation by another name, especially with respect to time out of cell. Also, although it is less restrictive than segregation, it is still more restrictive and thus, every placement and every extension of that placement must be justified and carefully reviewed.

153. As discussed with the Superintendent, ISO recommends that Policy B 4.6 "Secure Living Unit" be amended to include a requirement for case management to have a dialogue with all inmates on SLU regarding their placement once a month and document the communication in the inmate's progress log to be included in the weekly review.

Alternatives to the Use of Separate Confinement

154. WCC should continue to explore an expanded program of alternatives to the use of separate confinement. Alternatives may include intermittent cell confinement, SSP, and restrictions on privileges. A cross-jurisdictional review of alternatives to separate confinement should ensure that segregation is truly a last resort.

F. CONCLUSION

155. ISO supports that the implementation of the recommendations set out above will serve to enhance correctional practices in the territory. ISO will continue to follow up on its recommendations with Corrections management and exercise its authorities under the Act to ensure independent oversight of Corrections.

APPENDIX 'A': Previous ISO Recommendations on Use of Force

2014 ISO Special Investigation:

YEAR/ #	ISO Recommendation	WCC Response	ISO Assessment - Status of Implementation
2014	**Special Investigation on Use of Force**		
1	Policy B 2.6 "Use of Force: Reporting and Investigation Procedures" should be amended to include that pre and post incident CCTV evidence be retained immediately following a use of force incident and added to the Use of Force file.	Where there is: 1. Evidence that can be substantiated by DVR footage; or 2. DVR footage available that is relevant to the Use of Force; That evidence will be preserved in the Use of Force e-file.	Partially Implemented - footage not saved to folder consistently, policy not amended.
2	An additional provision should be added to Policy B 2.6 "Use of Force: Reporting and Investigation Procedures" stipulating that a Use of Force electronic folder for each incident be created including all relevant documentation and a checklist of the needed documentation and evidence retrieval. This would aid in continuity of the evidence by ensuring all reports and video evidence from other units/persons are copied to a central folder.	Done.	Partially Implemented - provision not added, folder exists but not used consistently.
3	As per WCC Policy B 2.5 "Use of Force: Cell Entry Teams and Process" a critical incident debriefing is recommended in particularly traumatic events. ISO recommends that WCC management update the current Use of Force form to include a checkbox option identifying whether or not this was a critical incident and that a debrief was offered to staff.	Use of Force teams are routinely debriefed by the team leader and the shift MCS. In cases of unusually difficult events, the Deputy Superintendents/Superintendent may organize a critical incident debriefing. Future training is planned for facilitators to attend formal training in Critical Incident Stress Debriefing, after which a more formalized process will be developed to ensure that traumatic events are appropriately reviewed and debriefed for all affected individuals.	Implemented
4	An Additional provision should be added to Policy B 2.6 "Use of Force: Reporting and Investigation Procedures" that the Use of Force Report should be signed off by the Person in Charge and a review of the Use of Force incident completed as soon as practicable.	This is the current practice.	Implemented

5	It is recommended that WCC consider a revised Use of Force Report for the purpose of clearly describing the factors that are observed or perceived in a Use of Force incident.	The latest version of the Use of Force Report Form captures all these recommendations.	Partially Implemented - form was changed, however additional recommendations from current inspection.
6	WCC should ensure that the existing report is filled out completely following any incident (i.e. signatures and dates are included).	The latest version of the Use of Force Report Form captures all these recommendations.	Partially Implemented - current inspection found not all forms had signatures.
7	WCC should be recording any behaviours of the inmate in the Use of Force Report that may hinder the provision of immediate medical attention including the inmate's refusal of care.	New Use of Force Form will be amended to include this (Completion by Oct 1, 2015).	Implemented
8	The current WCC Policy B 2.5 "Use of Force: Cell Entry Teams and Process" states that: "Once the inmate is restrained, the CET leader will ensure that the inmate is decontaminated where OC Spray has been used, and then taken to a health care professional for assessment, where safe to do so and deemed necessary". WCC should consider an amendment to policy to ensure that medical attention is offered in every CET incident "as soon as possible" as opposed to if "deemed necessary", once the inmate's behaviour has de-escalated and it is safe to do so.	This change reflects that in most cases the Health Care Professional is brought to the inmate. There may also be other existing schedule conflicts for Health Care, such as Medication Rounds, that would prevent an immediate attendance to the inmate. Of course any need for immediate attention, such as significant injury, would be dealt with on a more urgent basis.	Not Implemented - explained that any emergency situation would be dealt with on a more urgent basis.
9	Policy B 2.5 (Use of Force: Cell Entry Teams and Process) should be amended to include that prior to every cell entry, the time on hand-held camera is correctly set.	This is current practice and policy B2.5 is being updated to include this recommendation.	Implemented

APPENDIX 'B': National Use of Force Framework

The officer continuously assesses the situation and acts in a reasonable manner to ensure officer and public safety.

APPENDIX 'C': Previous ISO Recommendations on Separate Confinement

YEAR/ #	ISO Recommendation	WCC Response	ISO Assessment - Status of Implementation
2011	**Inspection on the Use of Long Term Separate Confinement (segregation)**		
1	That WCC Management ensures all separate confinement reviews are completed and appropriate notifications provided in a timely manner. The WCC may wish to consider developing an electronic method to track all segregation placements, reasons for such placement, and the dates of upcoming review/notification deadlines.	Deputy Minister of Justice accepted all recommendations.	Partially Implemented - current inspection found that unable to confirm reviews, electronic folders not being used consistently.
2	That WCC Managers ensure processes are developed which allow staff ready access to information related to the status of separately confined individuals, and scheduled release or review dates. This could be accomplished in several ways including: 1. Identify on the Daily Inmate Placement Sheet the status and date of the next due review for each individual. This info would then be automatically carried forward with each successive daily printing; 2. An updateable notice board at the nearest staff station to the Segregation Unit identifying the Regulation under which each inmate is held and the release or next review deadline.	Deputy Minister of Justice accepted all recommendations.	Implemented - after later inspection.
3	WCC Management needs to improve the content of the 'Separate Confinement Notification Form' which is intended to inform affected inmates of applicable protocols and rights while housed in the Segregation Unit.	Deputy Minister of Justice accepted all recommendations.	Partially Implemented - form was changed, however additional recommendations from current inspection.

4	That WCC Management take additional measures to ensure staff are completing inmate Progress Log entries, particularly as they relate to inmate movements and placement decisions. Where inmates are placed in segregation, appropriate entries should identify the lawful basis for such placement.	Deputy Minister of Justice accepted all recommendations.	Partially Implemented - ongoing issue, current inspection recommending movements and placements be recorded on Separate Confinement Form.
2014	Inspection on Separate Confinement including short and long term		
1	WCC consider developing a centralized database such as an integrated case management system for inmate files. The centralized database would enable access to all logged client information in one place, provide real time information access, allow for task coordination, search and reporting tools and enable greater transparency and accountability. A centralized database would also allow for a reduction in hard copy paper within WCC. At a minimum, WCC implement a central system for documenting all inmates placed on long term confinement, reasons for placement or continuance of long term confinement, and next review date.	WCC has developed and populated a Separate Confinement Database retroactive to August 15, 2013. The database will include documentation of the name of inmate, date in/date out, reason for placement and next review date.	Partially Implemented - WCC does not have centralized database, created Excel sheet tracking separate confinements, improvements are still required.

2	In terms of written documentation ISO recommends that WCC consider the following:		Partially Implemented
	1. WCC improve the written documentation which justifies long term confinement placement such as creating a "Record of Decision" document. ISO recommends that the improved documentation for placement or extension of long term confinement should at minimum: identify who participated in the decision; identify what information was used as part of the decision making process; identify any concerns raised by participants, and document what steps are going to be taken by WCC to help transition the inmate back to a regular living unit.	1. WCC will establish a Long-Term confinement review conference group comprised of: the Superintendent or designate, one or more Deputy Superintendent(s), one or more MCS(s), one or more case manager(s), and Health Services Manager.	1. This is referring to the Morning Minute Meetings.
	2. A full description of the incident or circumstances leading to the decision for placement or extension of long term confinement should be documented in writing, placed in the inmate's progress log and provided to the inmate in addition to their long term confinement paperwork.	2. Minutes of Meetings concerning the placement of inmates onto Long-Term confinement will be recorded and saved electronically on the inmate file and the minutes shall include: Date, time, location of meeting; participants; full description of circumstances; information being used; alternatives considered to long-term confinement, as well as reasons why alternatives are not viable; and steps being taken to modify inmate behaviour and transition into a living unit.	2. Meetings are occurring and review of who is on separate confinement is documented, but only name of inmate and section of confinement. No other details documented. Current inspection is recommending details and specifics on separate confinement form.
	3. Written documentation is created to identify what alternatives to long term confinement were considered and to identify reasons why alternative placements were not viable. ISO recommends that this written documentation be placed in the inmate's progress log.	3. WCC will also implement: a) An appeal letter that the inmate may send to DSO. This letter will be given to the inmate by case management. b) All inmates on long-term confinement will automatically be placed on recorded observation sheets. Observation sheet to be sent to the Manager of Case Management. c) An engagement sheet, to record all offers of interaction offered, accepted and declined by the inmate, such as family visits, elders, counsellors, doctor, psychologist, all staff, including case managers, MCS and DS. d) Referrals to a mental health professional, including the contract psychologist and psychiatrist, will be entered on the inmate's file on a separate document. e) A mental health check-up by the Manager of Health Services between day	3. a) No appeal letter exists. b) Implemented c) No engagement sheet, but record offers in progress log and may record on electronic daily unit log. d) Unknown e) Unknown, did see some examples of this

3.	ISO recommends that WCC consider using a different colour of paper (e.g., yellow) for progress log entries made in the Segregation Unit. This would allow for Segregation Unit progress log entries to be easily identifiable and allow for more timely review.	WCC is investigating changes to logging practices by moving to electronic progress files by March 2015.	Not Implemented
4.	ISO recommends that, in addition to the existing avenues of complaints to the person in charge and appeal to ISO which are available to inmates in separate confinement, Corrections should examine possible models of mandatory independent review of the reasons for continuation of separate confinement at specific intervals. ISO believes that this would enhance the existing system by providing greater transparency around decision making and an additional mechanism of independent review.	Once new processes for '15 days' reviews are implemented as per recommendation 2 above, WCC will be satisfied there are sufficient safeguards for those individuals detained in separate confinement for extended periods. However, WCC will commit to examining other models. WCC believes that the privacy considerations of individual inmates preclude further review by other independent parties.	Not Implemented - recommending again in current inspection.
5.	In order to ensure that inmate files are easily accessed, ISO recommends that WCC develop a file logging system which would enable files to be "checked out". The logging system should identify the date when the file was requested, the date it was received, the identity of the individual using the file, the purpose of the file request and the date it was returned.	WCC DSP will develop a group to: establish current practice and status of files; identify best practices, and incorporate; develop a method of identifying when progress files are removed, by whom, purpose and date of return.	Unknown, do not believe practice was in place during inspection.
6.	ISO recommends that WCC review their Separate Confinement Policy and Mental Health Policy regarding what is required of nursing staff for individuals placed on long term confinement and ensure that the policies and procedures and roles and responsibilities identified are consistent in both documents. As a quality assurance measure ISO recommends that it is clearly communicated that all WCC staff including medical staff are responsible for knowing all WCC operational policy and procedures.	The Manager of Health Services will conduct a cross-jurisdictional review of mental health services and practices for administratively confined inmates. The Manager of Health Services will also be tasked with developing a QA process to ensure nurses are aware of, and compliant with, policy in this regard.	Unknown

7.	Correctional Service Canada's Administrative Segregation Commissioner's Directive requires an "Inmate Needs Checklist" to be completed upon admission to administrative segregation or when the reasons for placement in administrative segregation are changed. In addition, a psychologist must provide a written opinion on the inmate's mental health status within the first 25 days of the initial placement on administrative segregation and then once every subsequent 60 days. The use of the initial needs check list and regular reviews helps to set a base line of the inmate's mental health and regularly monitor an inmate's mental health while administratively confined. ISO recommends that WCC undertake a review of other correctional institutions' processes for reviewing mental health for administratively confined inmates to ensure WCC policy and procedure are in line with best practice.	The Manager of Health Services will conduct a cross-jurisdictional review of mental health services and practice for administratively confined inmates. The Manager of Health Services will conduct a mental health assessment between day 10 and day 13 of long-term confinement, and every 15 days thereafter. This review will consider referral to mental health professionals. While medical information including mental health assessments is private unless released by the inmate, the Manager of Health Services will provide recommendations to the long-term confinement review conference group based on his knowledge of the inmate's health status.	Unknown
8.	In addition to verbal updates, in order to ensure that all WCC staff are implementing policy and procedures consistently and are aware of changes, ISO recommends the development and implementation of a formal written communication strategy for providing information about new or amended policy, procedures and/or protocols.	WCC will continue to update ongoing policy procedure development through e-memo, briefings and through the MCS reporting structure. In cases where there is a significant change to work duties or responsibilities, WCC will consider those through weekend training sessions.	Not Implemented- not consistent
9.	As the segregation and special handling units are one of the "high-risk" areas within the correctional centre, ISO recommends that individuals working within the unit receive regular and ongoing specialized training based on the needs of the unit which could include regular review of the unit's policies and procedure. ISO also recommends that only those individuals who are physically fit and who meet identified training requirements be allowed to work in the unit.	WCC will ensure that the new rotation of regular Segregation and Special Handling Unit COs are up-to-date or scheduled for: 1. Alcohol and Drug Services training, including withdrawal; mental health training; and FASD training. 2. In addition, WCC will meet with these staff members to discuss the importance of documentation, interpersonal communication, patience, problem-solving and behaviour strategies when working with inmates on separate confinement. 3. WCC MCSs are tasked with daily rotation through the Segregation and Secure Living Units to review documentation and adherence to policies for management of these inmates. These practices will continue.	1. Unknown if training was delivered. 2. Implemented 3. Implemented

2012	Special Investigation on Long Term Confinement		
1.	The 72 hours during which an inmate can be held on short term confinement should be used to assess the need for long term confinement. Documentation of the need for long term confinement should be completed prior to the expiry of an individual's short term confinement. The end of the 72 hours should not be the start of the process for assessing long term confinement requirements. ISO recommends Corrections verify that the quality assurance system currently in place for separate confinement provides for appropriate assessment and documentation of the need for long term confinement prior to the expiry of the 72 hour timeframe.	QA processes have been incorporated into standing orders and include the following: 1. Case managers meet with MCS daily and review all inmates on separate confinement. 2. Case managers make recommendation as to whether an inmate will be placed on long term confinement before expiration of the 72 hours. 3. All inmates placed on long term separate confinement are assigned to a case manager. Case managers develop and implement a transitional case plan for the inmate to reintegrate back into a regular living unit. Example required. Standing order amended to reflect changes.	1. Unknown 2. Not Implemented - current inspection found no evidence of this practice. 3. Not Implemented - current inspection found no evidence of this practice.

2.	The use of long term separate confinement must be consistent with the principles set out in the Act, specifically section 2(g) which states: "[T]he Correction Branch uses the least restrictive measures with offenders consistent with the protection of the public, staff members and offenders." While long term confinement is an offender management tool it should be used as a last resort due to the potential negative impacts that it may have on an inmate. Separate confinement places an inmate in a cell for 23 hours a day, depriving them of meaningful social contact and interaction with others and with little sensory or mental stimulation. While separate confinement is often used to address underlying behaviour by an inmate, it can also cause additional behavioural or health issues which the centre needs to manage such as depression, anxiety, rage, hallucinations, distorted perceptions, claustrophobia, or acting out. Daily visits by medical professionals (in addition to daily medication rounds) to inmates on long term confinement need to occur in order to ensure that the medical and mental health needs of the inmate are assessed regularly, and that any existing or emerging medical needs of the inmate are not exacerbated by their ongoing separate confinement. All visits by medical staff should be documented in the inmate's progress logs. ISO recommends that WCC management ensures doctors and medical staff have care plans in place for inmates placed on long term confinement as well as systems and processes in place for medical staff to raise concerns with WCC management about the mental wellbeing of an inmate on long term confinement.	Standing orders have been amended to include the following: 1. Nursing staff will attend the segregation/observation area twice daily at a minimum to assess the medical needs of all inmates confined in that area. The standing order has been amended to reflect this change. 2. Nursing staff will develop a standardized assessment procedure to ensure a care plan for each inmate based on their individual needs. The standing order has been amended to reflect this change. 3. Nursing staff will provide the DSs, Superintendent, case managers and MCSs a daily summary after each shift. The summary will include an update and any concerns on each inmate on separate confinement. 4. All visits by medical staff are documented in the progress log, unit log and in the daily unit report by the segregation officer. The unit report will be amended to reflect this change in procedure. 5. The officers in charge are required to provide daily shift reports to the nursing staff. The standing order will be amended to address this requirement. 6. All inmates placed on long term confinement are referred to OSS and/or a contracted psychologist. 7. The DSP meets daily with nursing staff to discuss inmate concerns.	1. Implemented 2. Unknown 3. Unknown 4. Unknown 5. Unknown 6. Not Implemented 7. Unknown

3.	Inmates should be informed of the reasons for their separate confinement in writing within 24 hours of being placed on long term confinement in sufficient detail and in a format and language they can understand. The decision to place an inmate on long term confinement should be fully explained to an inmate in a one-to-one setting, allowing for the inmate to ask questions about the justifications for confinement. ISO recommends that Corrections verify that the new quality assurance system includes timely, complete notification and explanation of the reasons for long term confinement.	Standing orders and operational practice now include the following: 1. Written reasons for confinement are documented on the separate confinement form and are explained verbally to the inmate in a one on one setting if safe to do so. 2. Prior to the expiration of short term confinement case managers review the inmates' status and allow them to ask questions about their confinement. 3. All long term confinement paperwork is served by the MCS on duty. The MCS also explains the reasons for confinement to the inmate. 4. All inmates placed on long term confinement are provided an opportunity to ask questions about the justifications for their status upon being served the confinement papers by the MCS.	1. Not Implemented - current inspection found not consistent. 2. Not Implemented N-I 3. Not Implemented 4. Not Implemented
4.	Care plans to prevent psychological deterioration should be developed immediately after placing an inmate on long term confinement. ISO recommends that WCC consider developing policy regarding medical checks and care plans for individuals who are on long term confinement.	Standing orders have been altered to require the following: 1. Medical staff develop a standardized assessment procedure and ensure a care plan for each inmate is developed based on their individual needs. 2. The recently completed medical review may also inform practice in this area.	1. Unknown 2. Unknown
5.	As part of their transition plan, inmates on long term separate confinement should be granted access to mainstream activities where a risk assessment allows and phased returns are practised to encourage return to general population. ISO recommends that transition planning starts as soon as possible after an individual has been placed on long term confinement, in order to ensure that inmates are held on long term confinement for the shortest possible time and helped to return to general population at the earliest opportunity.	Integrated offender management team now has responsibility for transition plans including: 1. Transition plans include the inmates' access to programs based on behaviour and risk. 2. Inmates on long term confinement have transitional case plans developed by a case manager that explains their access to programs, and what they need to do to earn more privileges including transition to regular unit.	1. Unknown 2. Not Implemented

6.	WCC management should be more proactive in providing information and documentation to inmates. WCC management should ensure that consistent information regarding an inmate's reason for long term confinement is provided to corrections officers working in separate confinement to ensure that anyone interacting with the inmate is able to provide consistent information. ISO recommends that WCC review internal communication processes for providing information to staff and for staff providing information to WCC management.	Communications have been reviewed and enhanced in the following ways: 1. A standing order on QA and separate confinement was developed in May 2012. Further revised on November 14, 2012 to further address recommendations within ISO report. 2. At the start of every shift, the MCS briefs all security staff on segregation placements. The MCS also completes a shift briefing report at the end of every shift. 3. In the segregation area and the MCS office white boards have been installed to provide immediate and up to date details regarding inmates on separate confinement. 4. Each officer assigned to segregation fills out a unit report before the end of every shift. The report is accessible on the computer by all staff and denotes incidents, behaviour, and morale, areas of concern, and daily routine information. 5. Segregation officers have been directed to log each inmate in the progress logs on each shift. 6. Progress logs for each inmate on confinement are maintained in the segregation unit while the inmate is housed there.	1. Implemented 2. Implemented 3. Implemented 4. Implemented 5. Implemented 6. Implemented
2015	**Special Investigation on Separate Confinement Pending Disciplinary Hearing**		
1	ISO recommends that every time an inmate is ordered to be confined under section 28 the following should be noted on the separate confinement form: 1. the subsection that applies and an elaboration on the reasons to justify this type of confinement; 2. the charges being forwarded; and 3. the specific details that are causing the inmate to be confined in segregation (e.g., the behaviour and date of incident). If an incident gives rise to more than one reason under section 28, list all reasons that apply.	1. MCSs will be trained to be specific on separate confinement forms relating to all types of separate confinement (did briefing at MCS meeting on July 14, 2015). 2. A memo will be developed and sent to all MCS and A/MCS with a sample of a correctly completed s. 28 form (sample posted in MCS office July 22, 2015).	1. Implemented 2. Implemented

2	Creation of new separate confinement forms that are used for each type of separate confinement.	WCC will create 3 separate confinement forms; 1 for s. 22 (voluntary), 1 for s.28 and 33 (pending disciplinary and disciplinary), and 1 for s. 20 and 21 (short term and long term) (completed).	Partially Implemented, - current inspection recommending new format.
3	ISO recommends the development of an electronic database to track inmates, their placements and all relevant documentation in relation to separate confinement.	1. A contractor is being sought to provide a useful database that captures appropriate information and who is able to generate reports. 2. Contract will be sole-sourced. Contractor has been identified and contractor is with WCC finance. (RFP posted May 26, 2015).	1. Not Implemented 2. Not Implemented
4	ISO recommends that when the person in charge reviews the confinement every 24 hours, any change of circumstances should be noted on the separate confinement form (state that there is no change in circumstances if there are none).	1. Currently the management group reviews all people separately confined every morning. This review is documented in meeting minutes. 2. On weekends the MCS will contact the on-call manager to discuss continued s.28 confinements. (Done, practice to be discussed at July 14, 2015 MCS meeting, and follow up practice memo sent to MCSs July 22, 2015).	1. Partially Implemented - meeting minutes not properly documented. 2. Implemented

APPENDIX 'D': Excerpts from the Corrections Regulation – Separate Confinement

Separate confinement – short term

20.(1) The person in charge may order that an inmate be confined separately from other inmates if

(a) the person in charge believes on reasonable grounds that the inmate

(i) is endangering themselves or is likely to endanger themselves,

(ii) is endangering another person or is likely to endanger another person,

(iii) is jeopardizing the management, operation or security of the correctional centre or is likely to jeopardize the management, operation or security of the correctional centre,

(iv) would be at risk of serious harm or is likely to be at risk of serious harm if not confined separately,

(v) must be confined separately for a medical reason, or

(vi) suffers from a mental illness;

(b) the person in charge has requested an examination of the mental condition of the inmate for the purposes of the Mental Health Act; or

(c) the person in charge has reasonable grounds to believe that the inmate has contraband hidden in the inmate's body.

(2) Subject to subsection (3) and subsection 21(1) [separate confinement – longer term], the person in charge must release an inmate who is confined separately under subsection (1) from separate confinement within 72 hours of the commencement of the confinement.

(3) The person in charge must release an inmate from separate confinement if

(a) the person in charge has requested an examination of the mental condition of an inmate for the purposes of the Mental Health Act; and

(b) within 5 days of the commencement of the separate confinement, the person in charge has not authorized the transfer of the inmate or caused the inmate to be transported out of the correctional centre to a mental health facility in another province.

(4) The person in charge must, within 24 hours of making an order under subsection (1) to confine an inmate separately from other inmates, give the inmate the reason for the confinement under subsection (1) in writing.

Separate confinement – longer term

21.(1) If an inmate is ordered to be confined separately under paragraph 20(1)(a) [separate confinement – short term], the person in charge may decide to extend the order for one or more periods of not longer than 15 days each, provided that the person in charge

(a) reviews the circumstances of the separate confinement before

(i) the inmate must be released under subsections 20(2) or (3) [separate confinement – short term], or

(ii) the expiry of an extension made under this subsection;

(b) determines that the circumstances that justified the order under paragraph 20(1)(a) [separate confinement – short term] still exist; and

(c) determines that the separate confinement should continue.

(2) An extension under subsection (1) begins on the day after the person in charge makes the decision to extend.

(3) The person in charge must, within 24 hours of making a decision to extend an order to confine an inmate separately from other inmates,

(a) give the inmate, in writing,

(i) the reason for the confinement under subsection (1),
(ii) the period of time during which the inmate will be in separate confinement, and
(iii) the reason for the length of time of separate confinement; and

(b) give the inmate a reasonable opportunity to make submissions about why the separate confinement should not continue or why the separate confinement should be for a shorter period of time.

(4) After considering the submissions made by the inmate under paragraph (3)(b), the person in charge may, within a reasonable period of time,

(a) confirm their decision;

(b) vary their decision; or

(c) rescind their decision.

(5) The person in charge must notify the inmate of their decision under subsection (4), and give written reasons.

Voluntary separate confinement

22.(1) If the person in charge and an inmate agree that the inmate would be at risk of serious harm or is likely to be at risk of serious harm if not confined separately, the person in charge and the inmate may agree that the inmate be confined separately from other inmates.

(2) The person in charge must confirm the agreement under subsection (1) to the inmate in writing.

(3) If the person in charge and an inmate are in agreement in accordance with subsection (1), the inmate may be confined separately from other inmates and may at
any time request in writing that the person in charge review the separate confinement.

Termination of separate confinement by person in charge

23. Despite anything in sections 20 [separate confinement - short term], 21 [separate confinement - longer term] or 22 [voluntary separate confinement], the person in charge may at any time terminate the separate confinement of an inmate.