Damage/Control

Use of force and the cycle of violence and trauma in BC's federal and provincial prisons

Prisoners' Legal Services, a project of the West Coast Prison Justice Society

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The West Coast Prison Justice Society operates Prisoners' Legal Services, a legal aid clinic for federal and provincial prisoners in British Columbia. This report was written by staff at Prisoners' Legal Services and was developed with input from our clients.

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THE LAW FOUNDATION OF BRITISH COLUMBIA

WEST COAST PRISON JUSTICE SOCIETY

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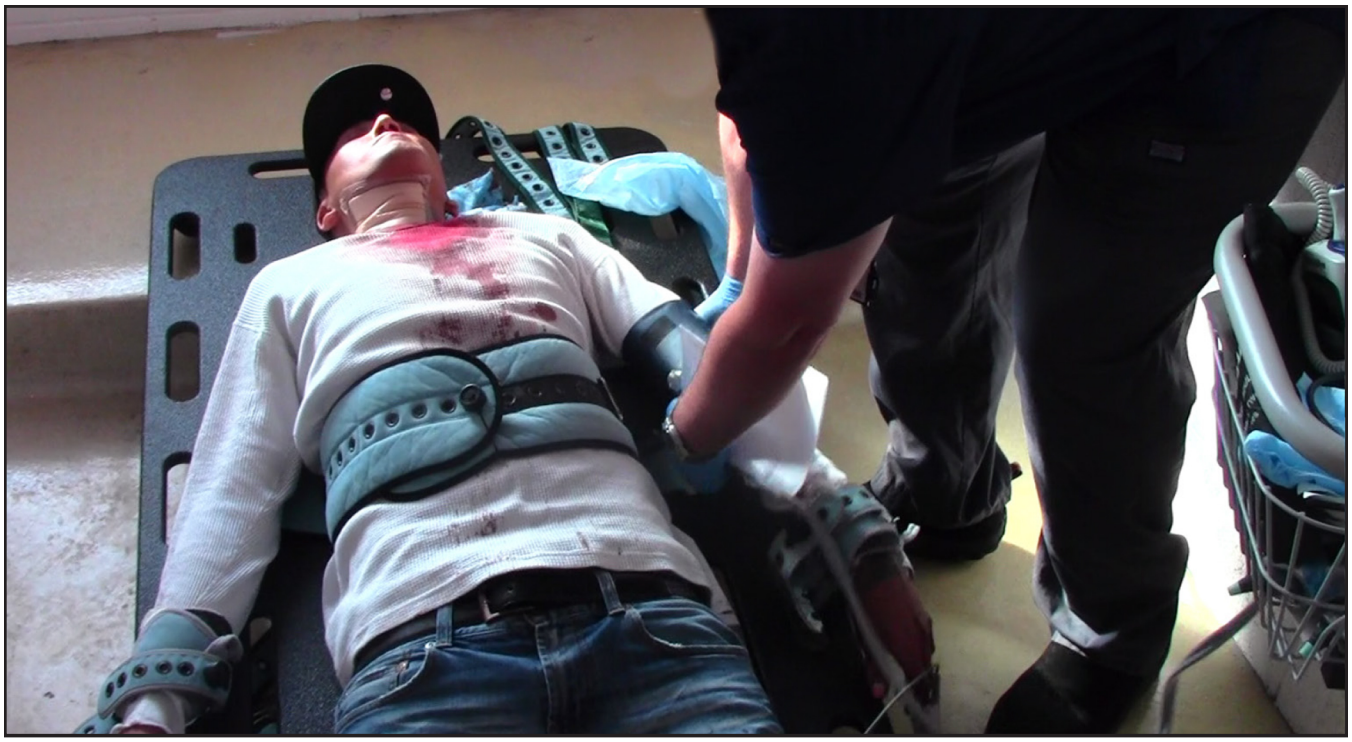


JOEY'S STORY

Joey grew up on the Black Lake First Nation in northern Saskatchewan. When he was a teenager, both of his primary caregivers — his mother and his grandfather, whom he was very close to — died in rapid succession. He describes these losses as devastating.

Joey ended up in youth custody, where he was abused by officers. "I remember the staff taking me down, twisting me up, banging my head against the floor, and putting me in straps. They hit my head so hard on the ground that my mouth would bleed. The straps were kind of like a Pinel bed or a straitjacket, but my legs were strapped together tight and pulled up to my chest. They would leave me like that and put me in an observation cell for a long time while they sat and watched me."

Since then, Joey has spent most of his life in prison. He has spent more than 2,100 days in segregation as a federal prisoner on top of his time in isolation in provincial custody. He describes being repeatedly assaulted by both correctional officers and other prisoners. He has suffered the losses of additional family members while incarcerated – losses he was never able to properly grieve. He has been diagnosed with conditions including Post-Traumatic Stress Disorder and Major Depressive Disorder.

Joey began regularly self-harming in prison as a coping mechanism. Because of his self-harm, Joey has been pepper-sprayed and forcibly removed from his cell by the Emergency Response Team ("ERT"), a group of officers in riot gear with weapons like pepper spray and shields. He has been strapped down in Pinel

restraints (a system of straps and buckles used to prevent self-harm) and placed in suicide smocks (short, sleeveless smocks made of thick fabric that cannot be torn). He has been placed without any belongings in bare "observation cells" – small cinderblock cells with windows in the doors so that officers can observe prisoners on suicide watch. These cells have the lights on 24 hours per day and Joey says they are sometimes contaminated with urine, feces, blood and OC spray. Sometimes they have concrete slabs for prisoners who are denied mattresses to sleep on. Joey says these things have happened to him more times than he can remember.

Joey says these experiences were so traumatic that now, when he worries the ERT is coming, he often waits with a razor blade to his throat. Recently, he waited with a noose wrapped around his neck. He says, "I've been through that so many times and I can't go through that again." He has written request forms saying that if the ERT comes, they should kill him.

Joey remembers an incident in September 2017 when he slashed his leg with a medical staple he had removed from a previous self-inflicted wound. Officers strapped him to a Pinel bed and he began hitting his head against the side rail and chewing through his lip and tongue. He said officers put a "spit mask" on him – a covering that officers sometimes put over a prisoner's face to keep them from spitting on them – and that it had to be replaced several times because of all the blood.

Joey says these kinds of experiences have made him afraid to be honest about when he's feeling suicidal or wants to self-harm because he worries what the consequences will be.

Joey also describes an incident in May 2018 when he was in distress and threatened to hurt himself. The prison brought a negotiator, who promised the ERT would not come. But Joey says he saw the ERT crouched on the ground and he slit his throat, partially severing his jugular vein. He remembers blacking out and waking up on a stretcher being rushed to the hospital, where he had emergency surgery.

When he returned to prison after more than a week of hospitalization, he ripped out one of the stitches in his neck and officers pepper-sprayed him until he felt like he could hardly breathe. He remembers his wrist, leg and ankle being twisted to the point where he had bruises and lost feeling in his hand. He was put in Pinel restraints and threatened with more pepper spray if he tried to remove his stitches again. He was placed in an observation cell on "bag feed" (i.e. finger foods) with nothing in his cell except one book. "I felt like a dog," he says.

In April 2019, Joey repeatedly cut himself with a razor blade until he blacked out. A nurse found him unresponsive on the floor of his cell and officers took him to the hospital by ambulance. He says while he was waiting for medical attention he began to remove the dressing on his arm and officers grabbed him, took him to the ground, punched him repeatedly in the back of the head and kicked him so hard in the ribs he thought he might have a broken bone. He remembers an officer saying something like, "I hope you bleed out and lose consciousness and die." He was returned to prison without receiving medical treatment, and he said the prison nurse dismissed his concerns about his aching ribs. He was placed on suicide watch in an observation cell with nothing but a suicide smock and blanket, and he immediately cut his arm open again. That evening staff found him unresponsive in his cell a second time.

A few weeks later, in May 2019, Joey was in distress because he believed officers were taunting and laughing at him and had been contaminating his cell and belongings with urine and feces. He harmed himself by cutting his arm, hitting himself in the head with a bar

from his chair, and punching himself in the face. A negotiator arrived and then the ERT came to move him to an observation cell, where he would be placed on suicide watch. Joey says the ERT pepper-sprayed him numerous times, including when he was on the floor complying with their instructions. He says the ERT came in, twisted his wrists and feet, hit him in the back of the head, and handcuffed him. He says the floor of his cell is still covered in pepper spray.

Joey told us that when a correctional manager came to interview him about the incident, Joey told her he felt the officers had used excessive force. He reports the correctional manager said, "that's not excessive use of force" and walked away, laughing. He also says the nurse who assessed him did not look at the back of his head, which was swollen.

Just a few days later, Joey self-harmed as a way to cope with the one-year anniversary of when he almost died after cutting his throat. He says the ERT came to his cell and, anticipating that he would be pepper-sprayed again, he tied a rope around his neck and began punching himself in the face. He also tied a rope around his arm so that, if the ERT used force, he could cut his arteries more effectively. He says he only relented and moved compliantly to an observation cell when it appeared to him the ERT would not assault him.

I. INTRODUCTION AND OVERVIEW

Prisoners' Legal Services ("PLS") is a legal aid clinic for all federal and provincial prisoners in BC. We assist prisoners with thousands of prison law issues each year, and we push for systemic and policy reforms based on their experiences. In 2018, our team of advocates and lawyers helped nearly 1,400 prisoners. Because we are in daily contact with a large number of prisoners across the province, we are uniquely positioned to report on how use of force affects prisoners, including its long-term impact on many of their lives.

Between January 2017 and June 2019, we spoke to more than 100 people who had force used against them by correctional officers when they were in the custody of BC Corrections and Correctional Service Canada ("CSC"). Joey's story encapsulates many of the experiences they shared. Our clients told us about officers in riot gear coming to their cells. They told us about being pepper-sprayed for harming themselves. They told us about being physically assaulted while having seizures. They told us about times when they refused to follow an officer's instructions and the officer's aggressive response caused the situation to escalate. Occasionally they told us about officers using force or weapons against them for no discernible reason.

When we could get access, we watched videos and read internal reports about these incidents. BC Corrections was particularly transparent

in this regard. Some videos confirmed our clients' reporting. Some video was missing or of poor quality. Sometimes internal reports acknowledged improper actions by officers, but other times they failed to do so or glossed over the misconduct.

It is common sense to anyone who has ever tried to resolve conflict that threats and physical force may temporarily achieve a result, but they do not resolve problems. As such, there is widespread agreement in a variety of contexts that conflict resolution and de-escalation are preferable to force, have a positive impact on public safety, and improve relationships and trust. In hospital settings, there is a movement away from the use of restraints and seclusion and toward care that is trauma-informed and based on least restrictive principles. Police departments increasingly emphasize de-escalation and understanding mental illness. Throughout Canada and the US, numerous health-police partnerships now seek to jointly intervene with people in crisis in ways that avoid violence and conflict.

CSC and BC Corrections have both recently developed policies that, at least in part, recognize this perspective. This report is about the need to expand those policies and to ensure that they are meaningful and properly implemented, as the stories of our clients indicate there is significant work still to be done.

This report is also about the need to listen to prisoners, whose stories make clear that force is not only an isolated incident of physical violence but also a psychological event with long-term implications for their wellbeing, their relationships to their environment, and their relationships to other people.

Stories like Joey's underscore the potential long-term traumatic effects when officers use force, particularly on people with mental health disabilities who repeatedly have force used against them. A group of researchers who examined use of force by police making arrests concluded:

> Trauma resulting from violent events is often experienced long after violent incidents occur, once shock or denial subside….It is important, therefore, to consider whether exposure to police use of force impacts suspects' long-term psychological wellbeing.
>
> …[I]nmates who experienced force may identify correctional officers with police officers as a source of threat and mistrust, which may lead to increased anxiety and depression throughout their daily interactions with correctional officers." [1]

The same ideas apply to force by corrections officers against prisoners in their custody.

United Nations Special Rapporteur on Torture Nils Melzer writes that force by state agents must be necessary, legal and proportionate – principles echoed in Canadian law and policy. He explains that proportionality requires officers to weigh the harm likely to be caused by the force against the benefit of achieving their goal – in other words, if officers are going to use force that is likely to cause harm, they'd better have a really good reason for it. Melzer further explains that officers ought to consider not only physical harm but also "mental suffering and emotions of humiliation and distress."[2]

The experiences of Joey and many others demonstrate that the impact of an act of force — even mundane force in accordance with policy — can be long-lasting, and can influence a person's future interactions with, and perceptions of, officers. Yet use of force incidents are reviewed by corrections as isolated events, with a focus on whether the force was appropriate in the moment. They do not generally even examine the circumstances leading up to the incident, much less look at historical uses of force against the prisoner

and how that might impact their behaviour or emotional state.

BC Corrections recently amended its use of force policy to incorporate a reference to trauma-informed practice, which is the idea that people who have experienced trauma need not only trauma-specific services but also an overall environment where they can experience physical and emotional safety, choice and control, and where they are not further traumatized.[3]

We applaud this move, and encourage CSC to do the same. However, it is critical to recognize that acts of force are *sources* of trauma and of re-traumatization for many prisoners. A report on trauma-informed practices by the US-based National Resource Center on Justice Involved Women points out that cell extractions, searches (including strip searches) and restraints are examples of the day-to-day features of prison life that may cause extreme distress in prisoners with histories of trauma. As a result, the report notes, "women in institutions often live day-to-day in an unnecessarily heightened state of stress."[4] The stories of our clients, both female and male, confirm this observation.

As such, making corrections trauma-informed should mean not only reforming but also aiming to *eliminate* these practices. For instance, it works at cross purposes for mental health units and treatment centres, which house some of the most vulnerable prisoners with disabilities, to create therapeutic environments when they employ Emergency Response Teams. Sometimes also called Cell Entry and Extraction teams in BC Corrections, ERTs are teams of officers wearing helmets, protective gear, shields and sometimes gas masks, who are often called in to forcibly extract prisoners from their cells or respond to other emergencies. Their mere presence is often intimidating — they sometimes march loudly down the hall, bang on the door and shout commands before they use physical force.

Reducing conflict and avoiding force will also support the wellbeing of officers, since using force puts them at risk of physical injury and psychological trauma. Indeed, a recent examination of institutional violence at the Toronto South Detention Centre found that in 11 percent of incidents, an act of violence by a prisoner against staff was reportedly preceded by a use of force.[5] A discussion about protecting the physical and mental safety of correctional officers, then, ought to include strategies for reducing conflict with prisoners and reducing reliance on force.

This report is designed to bring prisoners' stories to the forefront and highlight the way even "justified" uses of force can create environments of mistrust, trauma and fear. It argues that eliminating acts of force, as far as possible, is to the benefit of BC Corrections and CSC, as well as to the people in their custody, and is particularly urgent when it comes to the treatment of vulnerable prisoners. It builds on what recent policy changes by both BC Corrections and CSC implicitly seem to acknowledge — that force by officers is a problem rather than a solution, and that it is the source of other problems, including increased mental health concerns among and tensions between prisoners and corrections officers.

WHAT IS "USE OF FORCE"?

When we talk about "use of force," we generally mean circumstances in which correctional officers use physical force to make a prisoner do something or stop doing something – by grabbing and pinning their body parts, tackling them to the ground, pushing them against a wall, striking them with a hand or knee or manipulating their limbs to achieve "pain compliance." We also mean circumstances when officers use weapons – most often OC

spray (pepper spray), a substance made from hot peppers that causes a person's skin to burn, or CS (tear gas). Prisoners often refer to being OC- or CS-sprayed as being "gassed." Other weapons could include batons, shields and, rarely, Tasers and guns. Officers also sometimes put "spit masks" (or "spit hoods") over prisoners' faces to keep them from spitting — though some prisoners tell us they are accused of spitting at officers when they are in fact trying to get OC spray or blood out of their mouths.

Prisoners who are self-harming are sometimes placed in restraints to physically keep them from hurting themselves. CSC uses Pinel restraints, which are a series of belts and buckles that allow officers to strap a prisoner's arms, legs and chest down to a bed. Prisoners considered at risk of self-harm are placed in "observation cells"— empty cells with cameras and windows in the door so officers can keep eyes on them. Our clients tell us the walls of observation cells are sometimes covered with urine, feces and blood. BC Corrections policy references the BOARD (designed to immobilize a self-harming person and physically prevent them from hurting themselves) and WRAP (a matrix of straps that binds a person's limbs together and prevents them from moving), though we have not recently heard prisoners describe these being used, and the data provided by BC Corrections indicates they are used very infrequently. Both federally and provincially, these restraints are authorized and applied by correctional staff and are not restricted to use in psychiatric facilities. We consider restraint under these circumstances always to be a use of force, though CSC policy excludes incidents when the prisoner complies with the restraint.

The deployment of the ERT represents an especially high level of force, since they are called upon to bring their weapons and tactical gear, as well as their training, to situations likely to involve or — in the view of correctional staff — require violence. Because their presence is meant to indicate that force will occur, some prisoners — particularly those who have experienced force from the ERT before — tell us their deployment induces panic. For this reason, we consider all ERT deployments (regardless of whether the ERT directly intervenes with a prisoner) as well as threats to deploy the ERT to be uses of force.

We also consider strip searches to fall within the realm of use of force since they are "inherently humiliating and degrading" and can result in psychological harm,[6] especially for people with a history of sexual abuse. Even when the prisoner is compliant, strip searches cannot be described as consensual. The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls calls for the elimination of strip searches.[7]

Correctional officers also use intimidation, such as threatening to use pepper spray or to bring the ERT. These actions are not considered reportable acts of force by CSC or BC Corrections. Using this kind of intimidation represents a show of force by officers and has the potential for significant psychological effects, especially if used repeatedly. As such, it should be subject to justification and scrutiny.

In corrections, the tactics that constitute a "use of force" are often referred to with sanitized names like "physical handling" to refer to tackling a prisoner to the ground, "inflammatory agents" to refer to pepper spray, and "balance displacement" to mean kicking someone's feet out from under them so they fall to the floor. An officer using their hands or knees to hit a prisoner is referred to as a "distraction technique." Even the term "use of force" is somewhat sterile and is often used with the passive voice. For example, a report might say "inmate X was involved in a use of force" instead of "officers used force against X." On the other hand, prisoners who speak about their experiences talk about being "twisted up,"

"gassed," "punched," "kicked" and "assaulted." As Craig Haney and Joanna Weill write in an article on the forms of moral disengagement that allow prisoner abuse to happen, "the use of euphemistic language to describe the normatively painful, often life-altering, and frequently psychologically harmful experience of incarceration — including the trauma and humiliation it entails — renders it more palatable and less inhumane."[8]

Steve J. Martin, a long-time corrections consultant and use of force expert in the United States, describes what he sees as a pattern of officers using force "that is legitimately initiated, but needlessly escalates to a level disproportionate to the objective risks presented by the inmate." This type of force, he says, "used to achieve total submission of a subject after necessary control has been achieved is tantamount to the gratuitous infliction of pain and is…prohibited." He contends that these uses of force are "cloaked with, or protected by, an air of legitimacy or facial validity" but are nonetheless unlawful, and that they are often used against prisoners with mental health disabilities "whose behavior, viewed by inadequately trained officers, is to be punished rather than treated."[9]

In this report, we aim to use language that is neither sanitized nor hyperbolic. When we describe force and its harms in detail, we include not only abuses and assaults, but also many uses of force that may fall within legal limits but are nevertheless harmful.

WHY THIS PROJECT?

Both federally and provincially, use of force has been the subject of ongoing complaints from PLS clients. It has also been a long-standing area of concern for the Office of the Correctional Investigator, an ombuds office for federal corrections, which reviews every CSC use of force incident and, as such, plays a critical oversight function. Further, recent policy changes, public reports and PLS's own consultations with CSC and BC Corrections indicate that corrections agencies themselves recognize that force can lead to serious problems for prisoners and prisons.

In 2007, Ashley Smith, a 19-year-old federal prisoner, died of self-strangulation in her segregation cell at Grand Valley Institution while officers looked on. During her 11.5 months in federal custody, staff used force, including the ERT, against her more than 150 times to stop her from hurting herself. Sometimes this happened multiple times per day.[10] The Office of the Correctional Investigator notes, in its report *A Preventable Death*, that "almost all of Ms. Smith's assaultive behaviours (grabbing, spitting, kicking and biting) occurred in circumstances when physical force was being applied against her by correctional staff."[11]

A Coroner's Inquest ruled Ms. Smith's death a homicide and a jury issued more than 100 recommendations, including several related directly or indirectly to use of force practices.[12]

The suicide death nine years later of Terry Baker, a federal prisoner who also frequently self-harmed and had force used against her numerous times, demonstrated that many of the lessons from Ashley Smith had been unheeded by CSC. The CSC investigation conducted after her death found, according to the Correctional Investigator, that the often security-focused interventions to address self-injury could be counterproductive, "increas[ing] rather than decreas[ing] distress and dysregulation resulting in further self-injurious and suicidal behaviour."[13] The investigation recommended focusing on protective factors – such as meaningful human contact and activities outside of one's cell – rather than on restraints.

Reporting from our clients shows that, too often, these punitive practices persist. PLS has heard from many federal prisoners who have been OC-sprayed, cell-extracted, forcibly placed in Pinel restraints and subject to other traumatic practices in response to desperate acts of self-injury. These cases demonstrate the need for more intensive interventions by compassionate and well-trained mental health staff that support prisoners who struggle with self-harm, rather than punitive responses from officers that exacerbate their distress and cause further harm. This is backed up by research on self-harm, which finds that focusing on trying to prevent people from self-harming is likely to *increase* harm in the long run, since it intensifies feelings of powerlessness and makes it more likely people will self-harm more seriously and in secret and that they will attempt suicide.[14]

In 2015, Matthew Hines, a federal prisoner at Dorchester Penitentiary in New Brunswick, went into medical distress after being OC-sprayed in the face numerous times and beaten by officers.[15] Mr. Hines had physical and mental health issues and had recently been returned to prison on a parole suspension.[16] The incident started one evening on his unit when he was acting confused and refusing to return to his cell. Officers handcuffed him and escorted him off the range. Officers used force numerous times, and he ended up lying on the floor of the shower, a T-shirt over his face, choking and seizing. Though he was convulsing, spitting up blood and struggling to breathe, neither

correctional nor medical staff tried to save his life. When he arrived at the hospital, he was pronounced dead.[17]

CSC's press release stated that Mr. Hines was "found in need of medical attention" and that staff "immediately began performing CPR"[18] — neither of which were true. Two of the officers involved were charged with manslaughter and criminal negligence, though a judge later determined they would not stand trial.

The Correctional Investigator has cited Matthew Hines' death at the hands of correctional officers as a "watershed moment in the history of Canadian corrections," eliciting a rare but sincere admission of responsibility from CSC and helping to usher in significant policy change, including the introduction of the Engagement and Intervention Model.[19]

While the new model appears to include many promising elements, the Office of the Correctional Investigator has concerns that the change has not resulted in improvements to uses of force practices, and that the rate and severity of use of force incidents may have increased since its introduction. [20]

Within the BC provincial system, PLS has historically been aware of prisoners beaten to the point of serious injury by officers or restrained for hours on end. We are aware of prisoners who were held down so that their clothes could be cut off — including multiple prisoners with histories of sexual abuse, who described the experiences as extremely traumatic (this practice is now banned by BC Corrections).

In September 2017, a number of correctional officers at the Fraser Regional Correctional Centre used force against a prisoner with serious mental health issues, including schizophrenia and bipolar disorder. BC Corrections dismissed seven staff. In November 2018, four of the officers were criminally charged with assaulting the prisoner. The union representing the officers alleges that the prisoner initiated the attack, and that the officers who are standing trial came to help defend the responding officer.[21] However, criminal charges against correctional officers, as with police officers, are quite rare and suggest serious misconduct. BC Corrections' response to this assault speaks to its desire to take misconduct seriously and its willingness to address inappropriate and even criminal uses of force against prisoners.

During the course of this project, we have seen provincial and federal corrections leadership take promising steps to address problematic uses of force. We urge them to continue that trend.

Policy change is critical, but so is culture change. Prisons are environments ripe for abuse, and a review of use of force policies and practices must be considered in the context of the culture of corrections. The relationship between a culture of fear and intimidation and excessive uses of force are central to a 2013 report by the Ontario Ombudsman entitled *The Code*. This extensive examination of use of force practices in provincial jails in Ontario describes the "code of silence" among correctional officers that allowed inappropriate and excessive force incidents to go unreported, and sometimes to be intentionally covered up.[22] That report's first recommendation is for a direction to all staff from the Deputy Minister, Correctional Services that the code of silence would not be tolerated, and that officers who remain silent or enforce the code will be subject to discipline, including dismissal. The report also found that "problems [usually] stem not from a lack of policies, but from inadequate enforcement."[23]

PRISONERS WITH MENTAL HEALTH DISABILITIES

Prisoners have significantly higher rates of mental health problems than the general population, including significant histories of trauma.

According to the Medical Director of Correctional Health Services for the Provincial Health Services Authority, an estimated 60 percent of people in BC Corrections custody have mental health and addictions issues.[24]

Federally, CSC estimates that approximately 73 percent of male prisoners had a current mental disorder at intake. Alcohol and substance use disorders were the most prevalent, and more than one third of prisoners had a concurrent disorder. Approximately 12.4 percent were diagnosed with a major mental illness, including psychotic disorders, major depression and bipolar disorder. Approximately 11 percent were currently diagnosed with Post-Traumatic Stress Disorder.[25]

CSC also estimates that 79.2 percent of women in federal custody have a current mental disorder; that number rises to 95.6 percent of Indigenous women. As with men, alcohol and substance use disorders were very common. Nearly one-third of women met the criteria for Post-Traumatic Stress Disorder. Seventeen percent met the criteria for a major mental illness.[26]

An estimated 80 percent of federal prisoners have a serious substance abuse problem upon admission.[27]

Prisoners also have particularly high rates of trauma. New research on the prevalence of childhood abuse among prisoners shows the rates to be extraordinarily high among both men and women – 47.7 percent of prisoners had been physically abused as children, and more than 50 percent of prisoners suffered childhood emotional abuse. A very large number had also been sexually abused as children (50.4 percent of women and 21.9 percent of men).[28]

According to the Canadian Human Rights Commission, 80 percent of women in federal prisons report having been physically and/or sexually abused during their lifetimes. That number is 90 percent for Indigenous women.[29]

Suicide rates for federal prisoners are six times the Canadian average. In the ten-year period from 2001-2002 to 2010-2011, 92 federal prisoners died by suicide, making up 17.4 percent of all deaths in CSC custody.[30]

Our review found that officers frequently used force to deal with prisoners in emotional distress. Any discussion of use of force in prison must account for the magnitude of the suffering experienced by people in custody and the ways the prison environment exacerbates that suffering.

REDUCING FORCE INCREASES PUBLIC SAFETY

Studies indicate that using physical force does not enhance safety; rather it may negatively impact safety. By contrast, reducing punitive and violent approaches to misbehaviour and better understanding the mental health needs of prisoners contribute to reducing violence.

For instance, researchers analyzed an initiative at a prison in Indiana where the superintendent invited the local chapter of the National Alliance on Mental Illness to conduct a ten-hour training on mental health for officers on the "supermax" unit. The study found that, following the training, both use of force by officers *and* incidents of prisoners throwing bodily waste at officers declined significantly.[31]

Research from the United States on police department use of force guidelines found that where *more* restrictive use of force policies were in place, officers were *less* likely to be killed and assaulted in the line of duty. [32]

In the mental health field, including forensic psychiatry, there are numerous efforts to reduce the use of restrictive and coercive measures (such as restraint and seclusion) against patients. Research in that domain has shown that "coercive measures are suggested to have paradoxical effects in provoking further violent and aggressive behaviours, counter to the behaviours they purport to contain, manage and control."[33]

As the recent report on institutional violence in Ontario by Independent Advisor Howard Sapers and his team finds:

> Research on strategies for reducing institutional violence refute claims that it is dependent on the degree of dangerousness of inmate populations, rather, it is a "direct product of prison conditions and how [government authorities] operate [their] prisons." […] Empirical literature continuously demonstrates that humane conditions of confinement ease both inmate and staff experiences of correctional environments and institutional misconducts including violence.[34]

METHODOLOGY

Since January 2017, Prisoners' Legal Services has spoken with at least 112 prisoners about use of force incidents in federal and BC provincial institutions. Of these, 41 were federal prisoners and 71 were provincial prisoners. Some had been subject to repeated uses of force. We also met with senior BC Corrections and CSC officials to discuss the project and our findings. The Provincial Health Services Authority, which provides healthcare in BC provincial facilities, declined to meet with us.

Because of an agreement with BC Corrections, our office was also able to review the videos, use of force reports and internal reviews for about half of these provincial files. CSC did not make this information regularly available to PLS.

In each case, the prisoner felt that the use of force was excessive or inappropriate. Several reported that the use of force was traumatizing and some expressed anxiety that they would be subjected to force again. Some stated that if they behaved the way the officers behaved, they would be charged – institutionally or criminally. In several cases, often after reviewing video evidence, we had serious concerns that prisoners who were in medical or emotional distress, who were compliant or who were merely refusing an order had force used against them.

The importance of PLS being able to regularly review video footage and use of force reports cannot be overstated, and it is a testament to BC Corrections' commitment to transparency and accountability that we were allowed to do so. It has allowed PLS to play an important oversight role; among other things, our review found that some of the incidents we examined had not been reported to headquarters at the time they occurred. It has also allowed us to engage in a more informed way with BC Corrections about the concerns raised by our clients. And it allows us to understand when concerns have already been identified by BC Corrections management and when it is important for us to intervene on our clients' behalf. We are grateful to BC Corrections for their willingness to be transparent and to consider the concerns we have raised, both on an individual and on a systemic level.

The same cannot be said of CSC. With some exceptions, we were not permitted to view video footage or related documents for most of our federal clients who reported being the victims of unjustified force. We also, in many cases, received only pro forma responses to our submissions on their behalf, and sometimes received no responses at all. We or our clients were told to trust the internal review process or to request the information via a *Privacy Act* request.

However, the Office of the Correctional Investigator has repeatedly questioned CSC's ability to police itself, writing in its most recent annual report that CSC's process for conducting national investigations "has become seriously compromised" and the recommendations that result from those investigations "rarely match the seriousness of the incidents under review."[35]

In reference to the death of Matthew Hines, Catherine Latimer, the Executive Director of the John Howard Society of Canada, points to the misinformation initially shared by CSC about the circumstances of Mr. Hines' death, noting that the truth may never have been publicly revealed "had it not been for the probing of investigative journalists and the persistent questions from the family."[36]

Further, CSC's Access to Information and Privacy division is hopelessly backlogged. In some cases we have been waiting more than two years for our clients' personal documents. This is not viable and does not give prisoners the opportunity to challenge inappropriate uses of force by officers in a timely way.

This lack of transparency is compounded by inadequate opportunities for prisoners to raise their concerns about use of force incidents. Clients have told us they feel their concerns are not taken seriously—as in Joey's experience, when a correctional manager laughed at him after he alleged officers had used excessive force. We hope CSC will, in the interests of transparency and accountability, reconsider its level of openness.

Fortunately, all federal use of force incidents are reviewed by the Office of the Correctional Investigator. In addition to functioning as an external oversight body for each individual use of force, the Correctional Investigator looks at use of force incidents nationally and tracks trends – something CSC should also do on its own. Reporting from our clients mirrors many of the Correctional Investigator's findings over the years, and this report is not intended to duplicate – though it does rely on – their invaluable work.

SUMMARY OF KEY FINDINGS

Both CSC and BC Corrections have recently made important changes to their policies on use of force. These policy changes represent acknowledgement that force has been used inappropriately in the past, that it can contribute to rather than resolve conflict, and that best practices call for better use of de-escalation practices and recognition of the medical and mental health needs of prisoners.

Our review identified additional gaps in policy as well as practice that could better protect the rights of prisoners and ultimately reduce the level of violence in BC and federal prisons. Our findings and recommendations are aimed primarily at CSC and BC Corrections as well as the Provincial Health Services Authority. Broadly, they are as follows:

1. Force is used in response to medical and emotional distress.

Prisons are filled with vulnerable people, and many prisoners suffer with mental health disabilities and histories of trauma. Our review found that officers are using force to address behaviours, including self-harm, that should be understood and addressed as symptoms of mental health issues. We heard about CSC using the ERT in federal treatment centres, which are meant to be therapeutic environments. We heard prisoners describe the lasting psychological trauma they experienced as a result of an act of force by officers.

We also heard, especially from BC Corrections prisoners, about officers using force against them when they were in medical distress – including against clients while they were having seizures.

These kinds of punitive responses only serve to exacerbate prisoners' distress and, in several instances, caused situations to escalate. This approach is dangerous, placing people at risk of both physical and psychological harm. It also creates a climate of fear and distrust and increases trauma.

Officers must be able to recognize when a person is in emotional or medical distress and respond with an approach that helps de-escalate the situation, avoids force, and does not cause further trauma. This involves training and culture changes, as well as an investment in meaningful treatment for prisoners with mental health issues – including treatment at psychiatric facilities for people with serious disabilities and chronic self-harm.

Responses to situations involving prisoners in medical or mental health distress ought to more prominently involve health and mental health staff in decision-making and, when safe, allow them to take a leading role in responding to incidents. To this end, we recommend that both BC Corrections and CSC look to nurse-police partnership teams in the community, such as the Assertive Outreach Team (AOT) in Vancouver, and consider piloting similar teams in corrections.

2. Force is used to coerce compliance when there is no immediate safety risk.

Our review found many instances of prisoners disobeying an officer's instructions and having force used against them even when their behaviour was not posing an immediate risk to someone's safety. This included prisoners refusing to leave their cells, refusing to lock up, and other similar situations. We found this to be true even under CSC's new policy framework, which emphasizes that responses (including force) should be based on a thorough assessment of the risk presented in the moment.

Officers should use force only when necessary to prevent immediate harm to a person. Using force under other circumstances unnecessarily escalates conflict. Though it may achieve the desired result in the short-term, it creates an adversarial relationship between prisoners and officers in the long-term, which ultimately has a negative impact on safety.

3. Post-use of force medical assessments are inadequate and the role of healthcare is too narrow.

Our review found a need to bolster the role of medical staff in ensuring prisoners are not subject to ill-treatment. In provincial facilities, we found that medical assessments after uses of force are extremely lacking, and that the Provincial Health Services Authority has no policy to govern these assessments. Many of the assessments we saw were extremely brief – some lasting only 15-20 seconds – and involved only the most cursory set of questions and no physical examination. Sometimes these assessments took place through cell doors and other times in the middle of hallways, with ERT officers still holding onto the prisoner. Sometimes medical staff seemed to ignore prisoners' complaints.

While the handful of federal medical assessments we reviewed tended to be more substantive, they did not include any assessment of a prisoner's mental state – even when the prisoner was clearly stating that the force had affected them mentally. Some prisoners reported the assessments were not meaningful and nurses minimized their injuries.

Use of force situations present dual loyalty concerns for clinicians, and medical staff must ensure they are always acting in the best interests of their patients rather than in service of corrections in order to meet their ethical responsibilities. This involves thoroughly assessing patients for signs of harm (including psychological harm) or ill-treatment, documenting those signs, providing care, and reporting ill-treatment when they discover it.

4. Prisoners' voices are devalued, and prisoners are denied adequate access to information about the force used against them.

Stories from PLS clients demonstrate the significant disadvantage prisoners face in being heard after a use of force. Opportunities for them to share their accounts range from limited to nonexistent, and their testimonies appear to carry little

weight against the word of correctional officers.

BC Corrections does not solicit the prisoner's account following an act of force by officers.

Federal prisoners report CSC's practice of hearing their side is not meaningful. This becomes particularly significant when there is no video evidence, meaning the only version of events comes from officers. Federal prisoners also experience great difficulty and delay accessing documents related to uses of force against them. For these reasons, federal prisoners who allege misconduct are unable to substantiate their allegations.

Neither federal nor provincial medical staff are required to solicit the patient's version of events during medical assessments.

5. Greater public accountability is needed when officers use force.

Oversight, transparency and meaningful accountability should be hallmarks of any institution that authorizes people in power to lawfully use physical force against the people in their care. However, our review found that these mechanisms must be strengthened both federally and provincially.

We applaud the steps BC Corrections is taking internally, expanding and formalizing the role of headquarters and its use of force expert in reviewing use of force incidents. We also applaud their willingness to allow PLS to provide external oversight, and encourage them, along with the BC government, to create a formal system of external review through the Investigation and Standards Office.

Federally, the Office of the Correctional Investigator has been instrumental in bringing both individual unjustified uses of force and systemic concerns about force to light. However, there is a need for more meaningful opportunities for prisoners and their advocates to review acts of force and hold officers and institutions accountable. CSC national headquarters must also play a much larger role in scrutinizing officers' actions.

In addition, both BC Corrections and CSC would benefit from external evaluations of their use of force practices, particularly in light of CSC's switch to a new intervention model, to determine whether attempts to reform practices are actually leading to reductions in acts of force.

II. PRISONER ACCOUNTS

BC CORRECTIONS

PLS spoke to approximately 71 provincial prisoners who had force used against them by BC Corrections officers. We were able to watch video footage of many of the incidents they described. The following accounts are based on our clients' testimony and, where available, on our review of video and documents related to the incidents described.

Client A (2019)

Client A is a provincial prisoner. In January 2019, he was placed in segregation for 21 days, which he describes as very difficult to endure emotionally. He was released from segregation but returned approximately two days later.

That same day, Client A says he cut his wrists and then attempted to hang himself from the sprinkler in his cell. Video footage shows Client A climbing onto his sink holding what appears to be a twisted shirt. Approximately two minutes later he jumps down, quickly tucks the shirt

under his mattress, and lays down in bed. Moments later, officers rush into his cell, pile on top of him on the bed, and appear to grab his arms. One of the officers stands by with OC spray.

Client A is handcuffed and escorted, compliantly, out of his cell. Officers point OC spray at Client A as he is escorted down the hall. Client A says officers twisted his handcuffs to the point where he was concerned his wrist would break so he moved his hands. In response, Client A says officers slammed him face-first into the concrete floor and OC-sprayed him in the face, back and head. He says officers dropped him to the floor again later in the escort. After that, as they walked, two officers held his head down, with his body bent forward at the waist.

Video shows four or five officers placing Client A in the shower. His hands remained cuffed and he says officers washed his head but not his chest, arms or back (despite his bare skin being exposed to the OC spray, since he was not wearing a shirt). After three minutes the shower was turned off. When Client A asked for further decontamination, he recalls officers saying "we don't even have to do this."

Client A was moved to an observation cell. Video footage shows him kneeling with his face on the bed as officers uncuff him. He remembers officers saying something like, "if you move, you're going to hit the cement again." When officers leave, he continues to kneel with his face in the bunk. His shoulders shake and he may be crying.

Client A says he suffered extensive injuries, including a very large bruise on his arm and elbow as well as injuries to his eye, cheek, teeth, ribs, elbow, right wrist and hip, but that these injuries were not photographed. He told us it hurt to breathe, cough or sneeze.

The video does not show the post-use of force medical assessment, but Client A says the nurse only checked him through the window and that he could barely see her. He says he was screaming from the pepper spray.

Following a submission by PLS, the incident was reviewed by the warden, who concluded the officers' actions were appropriate. She justified officers' initial entry into Client A's cell by stating that he had covered his camera and window and would be moved to another observation cell, though the video clearly shows the camera was uncovered and he was out of immediate danger when officers came barging in. She also notes that it would not be appropriate to involve healthcare "until the situation was under control and there was no risk to their safety" – though Client A was locked in his cell and so would not have posed a danger if a nurse, mental health worker or other clinician had come to his door to speak to him.

Client B (2019)

Client B is a provincial prisoner who suffers from schizophrenia, bipolar disorder and a seizure disorder. One day officers told him he was unsafe on his unit and that he would be taken to segregation. He was placed in a holding cell. He reports that two officers repeatedly came to the window to taunt him, saying things like, "Oh, did I hear you want to kill yourself? Are you going to kill yourself? Shut the fuck up or you're going on Q15s" (meaning they would put him on suicide watch, which would require him to give up his belongings and wear a suicide smock). Client B says that when he asked for the officers' names, they refused, and one called him a "motherfucker" and a "loser."

The next day, Client B covered his window to draw the attention of staff. He explains that he fell asleep and woke up to the ERT at his door. He thinks he experienced a seizure. Video shows that when he sees them, Client B is clearly distressed by their presence and says "you guys

are going to come in here and attack me, right?" The ERT handcuffs him, makes him kneel facing the wall, and comes into the cell.

The ERT begins clearing debris out of Client B's cell, and Client B begins talking about how officers were telling him to kill himself. "You want me to kill myself, don't you?" he says. They do not respond. His distress escalates and when the ERT leaves, Client B begins banging his head against the cell door numerous times until he falls to the ground and appears to momentarily knock himself unconscious.

In response, the ERT simply says "are you done?" and asks if he wants his handcuffs taken off. They do not call for a nurse.

Client B curls up in the fetal position on the floor and appears to be crying. When he does not come to the door to have his handcuffs removed, the ERT leaves.

When the ERT returns approximately 15 minutes later, Client B sits up, looking dazed. He says something like, "Why are you here?" and his speech appears to be slurred. He moves to the door and his handcuffs are removed through the hatch.

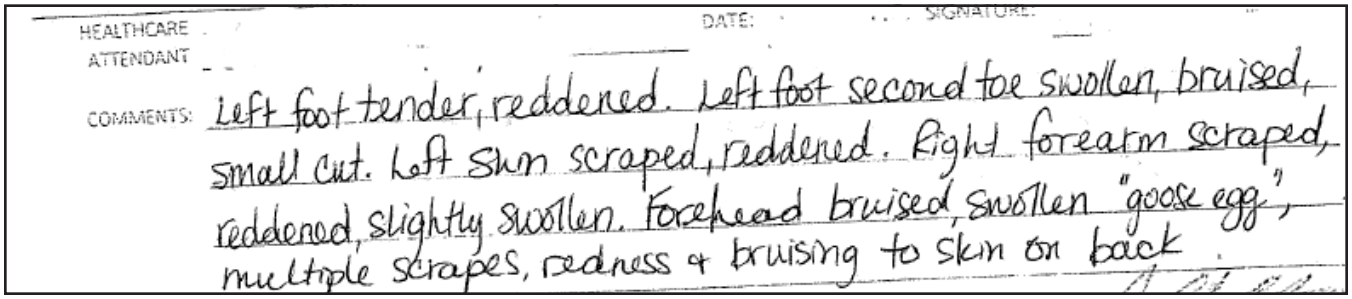
A nurse comes over and asks him, through the door with the entire ERT standing by, how his head is feeling. Client B appears confused. She asks him the date, which he gets wrong. She does not ask him any questions about his emotional state and does not appear to assess him for concussion. The assessment lasts less than two minutes and then the nurse and ERT leave.

The next day, Client B asked an officer to sign a complaint form. In response, he says the officer slammed the hatch closed, catching his hand, and told him, "Go fuck yourself."

Client C (2017)

Client C is a provincial prisoner with Asperger's Syndrome. In August of 2017, he was on his unit when he began experiencing chest pains and thought he was having a seizure. Video shows him clutching his chest and collapsing on the floor. Officers call a Code Blue (indicating a medical emergency) and nurses attend but leave after approximately seven minutes. Officers say he was noncompliant and had to be restrained but Client C disputes this and the video does not clearly show evidence of noncompliance. Officers restrain Client C on the ground, face down with his legs crossed and his hands behind his back.

Client C is lifted by officers into a wheelchair and taken to segregation, where he is placed on the floor of the ablutions area. He appears to be largely or entirely unconscious—as he lies there, his body twitches periodically but it is unclear if the motions are voluntary. Nurses return approximately 10-15 minutes later, but do not appear to do any further examination and then leave after about five minutes. Client C is alone for approximately 20 minutes, and then an officer comes and roughly removes


HEALTHCARE ATTENDANT
DATE:
SIGNATURE:
COMMENTS: Left foot tender, reddened. Left foot second toe swollen, bruised, small cut. Left shin scraped, reddened. Right forearm scraped, reddened, slightly swollen. Forehead bruised, swollen "goose egg", multiple scrapes, redness & bruising to skin on back

his shoes, socks, pants and underwear. (The officer later says he mistakenly believed Client C needed to be put in a suicide smock.) From the way Client C's legs drop to the ground when his pants are removed, it is clear at this point he is unconscious. He is then dragged by the armpits, naked from the waist down, to a segregation cell.

Client C says that when he regained consciousness, he found himself in the segregation cell with no pants or underwear on, and the whole left side of his body immobilized. An officer had to come help lift him from the floor and a nurse came in to dress him. He also remembers a nurse holding a cup to his genitals and asking him to provide a urine sample.

There is no video from the time Client C is dragged, unconscious and naked, into a segregation cell until approximately one hour later, when Client C is again fully clothed. When the video resumes, an officer can be seen wiping something off the camera. PLS watched this video with Client C, who expressed fear of not knowing what happened while he was unconscious and in such a vulnerable state.

BC Corrections' Provincial Director explained the gaps in footage by stating that the video footage saved was originally limited to the Code Blue incident and response, and that footage from the segregation area was saved because it involved a use of force. She further stated the final piece of footage – showing Client C fully clothed – was saved to show Client C "was in fair condition following the incident." And she stated the officer wiped the camera lens because prisoners sometimes cover the lenses with butter and other substances.

The institutional review of the incident does not acknowledge any problems, but the review by Headquarters finds that the actions of the officer who removed Client C's clothes and dragged him naked to a cell were "inappropriate" and not consistent with policy. The Provincial Director also stated that "senior management … fully investigated the incident and … t[ook] action as needed."

Client D (2017)

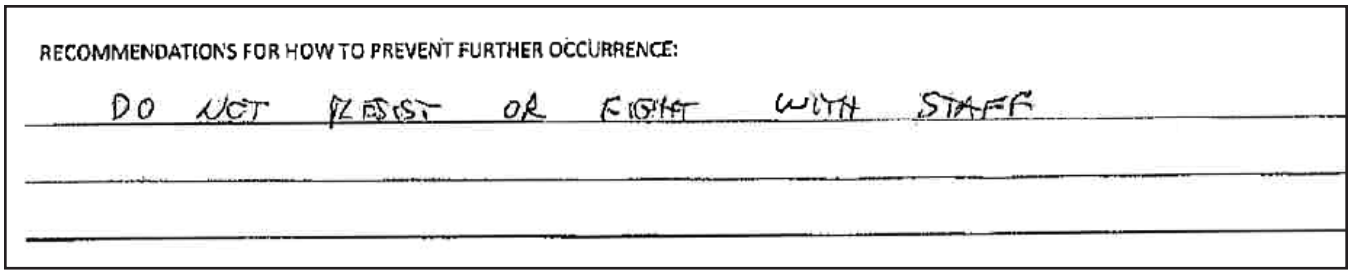
Client D is a provincial prisoner with epilepsy. In September 2017, he suffered a seizure while playing cards on his unit. He says other prisoners assisted him by bringing him back to his cell and rubbing his head and back. Officers came to his cell and told the prisoners to leave, calling a Code Yellow (for officer back-up). Video shows several officers attend and go inside Client D's cell, where there is no video coverage.

Client D says other prisoners told staff he was having a seizure, but some of the officers believed he was under the influence of drugs. The incident reports acknowledge Client D was "disoriented" and acting strangely, "[standing] next to his bunk swaying back and forth with his eyes closed and arms outwards." Officers say that when they tried to guide Client D out of the cell, he became combative. Client D says that other prisoners told him officers ordered him to get up and when he did not they assaulted him.

Video shows Client D being escorted off the unit backwards, bent at the waist at a 90-degree angle, with his hands cuffed behind his back and surrounded by several officers. His steps are slow and clumsy.

He is placed in the segregation holding cell; nurses attend and go in and out of the cell several times over the next half-hour.

Client D says he suffered several injuries, but despite his request, photographs were not taken until a week later, following a request by PLS. Photos show yellowish bruising to his forehead, wrists, arms and knees.


RECOMMENDATIONS FOR HOW TO PREVENT FURTHER OCCURRENCE:

DO NOT RESIST OR FIGHT WITH STAFF

Client E (2018)

Client E is a provincial prisoner who is deaf. She uses hearing aids that assist her in hearing some sounds, but her primary language is sign language.

Client E says she is the only deaf person in the jail, so her ability to speak freely with other people is limited and she keeps to herself a lot. She mainly communicates using a tablet.

She explains that sign language is expressive and often involves big gestures and facial expressions, which hearing people sometimes misinterpret as aggressive. She says deaf people using their voices can also sometimes be misinterpreted as aggressive.

Client E says that when she first came into custody, she was strip-searched without an interpreter present. She says no one explained to her what was going to happen, and she found it extremely scary and humiliating.

In September 2018, Client E goes to finish making oatmeal in the common area of her living unit after being told to lock up in her cell. Video shows her walking along the hall; an officer points in the other direction, but Client E pushes past her. The officer follows her and grabs her arm. Client E continues to walk towards the kitchenette area. A second officer arrives and points as if giving Client E direction to leave. Client E points and walks toward the microwave, and a third officer arrives. A few seconds later, one of the officers taps Client E on the shoulder and shows her OC spray. At this point there are four officers in the area and they appear to be exchanging words with Client E; the situation appears tense but Client E's body language does not appear to be aggressive or threatening.

Video shows that approximately 10 seconds later (and only about 30 seconds since the entire incident began), two officers grab Client E, and one appears to OC-spray her in her face. Client E is bent over and they scuffle. Officers appear to OC-spray Client E twice more. At this point, Client E, who now cannot hear or see, begins swinging her arms around and then goes over to the window, placing her back to officers. She is followed by approximately 10 officers and appears to be OC-sprayed again. Officers crowd around her and take Client E, who is now resisting, to the ground. Client E describes the entire experience as "extremely distressing and confusing."

Client E is handcuffed and escorted to segregation, where she is given a bucket of water to decontaminate herself. Client E describes feeling like her body was burning. A nurse comes and performs a medical assessment through the segregation cell door that lasts approximately 21 seconds.

Client E says that she repeatedly stated she did not understand what staff were saying to her, but that they yelled at her in response. No tablet is visible during any portion of this incident.

When officers document this incident, they acknowledge that "the situation escalated when officers attempted to guide the inmate to her

cell." However, the use of force review does not identify any concerns with the force used.

Client F (2018)

Client F is a provincial prisoner. In July of 2018, he was accused of making a threat and told he would be taken to segregation, which he refused because he denied the accusation against him. The ERT was deployed to force him to move to segregation. Video shows the ERT and Client F speak for approximately three minutes, and then the ERT commander gives the signal for the door to be opened and for a member of the ERT to spray OC spray into Client F's cell. This is done without any warning to Client F.

Client F begins yelling and cursing and inviting the officers to come at him. The ERT tries to speak to Client F after that, but the situation has deteriorated and Client F does not engage. Over the next 10 minutes, the ERT commander gives the command to open the door and OC-spray Client F without warning three more times. By this point Client F is angry and in pain.

The ERT then enters Client F's cell and escorts Client F, who is angry and groaning in pain but fully compliant with officers, out of his cell.

Client F is placed in the shower fully clothed with his hands cuffed behind his back. He is permitted to run his head under the water for just under three minutes. Client F says his body is burning and that he cannot even open his eyes. His clothes are not removed and his shower is ended. He is taken to segregation.

A nurse comes to Client F's cell and asks – through the door – if he is ok. He says his eyes are burning and he wants a shower, but the nurse does not follow up on this. The entire assessment lasts 15 seconds and the ERT team is standing at the door the entire time.

Approximately two hours later, Client F is permitted to return to the shower and proceeds to wash himself for close to 30 minutes.

Client F says he was charged with disobeying the order to go to segregation but not for the original accusation of making a threat.

Following the incident, much of Client F's body is covered in what a doctor describes as "widespread chemical burns," including on sensitive areas of his body such as his face, genitals and buttocks. Multiple medical staff confirm that the blistering, which persists for weeks, is a result of the OC spray. Despite this, the institution characterized his injuries as "rash-like symptoms" and claims there was no confirmation they had been caused by the OC spray.

Photos of Client F's injuries were not taken until six days after the incident, despite Client F's repeated requests for photos to be taken several days sooner.

Client G (2018)

Client G is a provincial prisoner. In August 2018, the ERT was assembled to move him from the segregation exercise area to his segregation cell. Officers alleged he was refusing to leave the yard and potentially had a weapon, but he is later searched and no weapon is found. The video footage shows the ERT arriving at the window to the segregation yard and commanding Client G to lie down on the ground. When Client G offers to stand with his hands behind his back, the ERT leader indicates that is not an option and says something to the effect of "if you do not comply, a high level of force will be used against you." Client G then asks why he cannot walk to his cell himself, to which the ERT leader replies that he will not be permitted to do that. The ERT leader gives Client G a "last chance" to kneel on the ground facing the wall with his hands behind his back.

During this exchange, Client G is on the other side of the window. The ERT leader says that he cannot fully see Client G and that, while he has dropped the pencil he was allegedly holding (no pencil is visible on camera), he has something else in his hand. This is also not visible on camera. Client G holds his hands up to show the officers – and indeed there is no indication of anything in either hand.

Just as Client G shows his hands – and approximately one minute and 20 seconds since the ERT arrived at the door – the ERT charges through the door into the yard. Banging and clattering sounds can be heard, and Client G is then seen face-down on the ground with several officers on top of him. He is pulled by the legs away from the door and can be heard groaning and cursing in pain. An officer holds his wrist at a 90-degree angle, and Client G states he is concerned his arm is broken. Nothing in the video suggests he resists at any point.

Client G is placed in hand and leg cuffs, stood up, and frisked. Client G is escorted out of the segregation yard and can be seen to be hopping and limping, with a bloody area on his forehead and red patches on his back.

Client G is scanned for metal devices (none are found) and then, as he is held in place by four ERT officers in what appears to be a hallway area, he is assessed by two nurses. This assessment takes approximately two and a half minutes and does not appear to include an examination of the injuries to his head or back. He is then escorted to a segregation cell. He is visibly hopping and limping and is compliant throughout.

When the ERT leader closes out the video, he notes something to the effect of "[Client G] fought with us and was not compliant," allegations that are not borne out by the video footage.

A few minutes later, the video resumes and the ERT goes back to take photos of Client G's injuries. The last two photos are taken through the cell window.

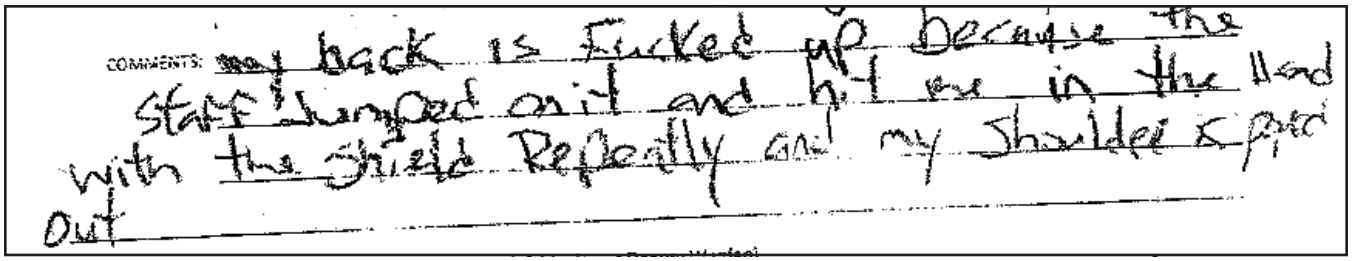
Later that evening, the ERT again prepares to move Client G, this time to an observation cell on suicide protocols. They indicate he has covered his window but give no indication that Client G is suicidal or has refused to move from his cell. Client G denies that he was suicidal or had a history of suicidality.

The ERT approaches Client G's cell and indicates their intention to move him. The ERT leader instructs him to remove the window covering, and states that if he does not, a "high level of force will be used against you." Client G removes the covering and says something to the effect of, "instead of coming here like this, why don't you just ask me to move?" The ERT instructs Client G to kneel on his bunk with his hands behind his back, and then the ERT opens the door and rushes in. Four officers get on top of Client G on his bunk. He is groaning and cursing and indicates he cannot breathe.

When Client G is raised to a standing position (in hand and leg cuffs), red bruises are visible on his face and back. Client G is escorted to the shower area, where he indicates he is not suicidal and so should not be placed in a suicide smock. However, he is compliant as his clothes are removed and he is placed in the smock. He is never given the option of changing into the smock himself.

Again, in what appears to be a hallway, a nurse comes to assess Client G while the entire ERT surrounds and holds onto him. This assessment lasts only 45 seconds, and though Client G indicates he has vision changes and feels dizzy, the nurse indicates the officers can proceed.

Client G is placed in an observation cell, after which he states something to the effect of,


COMMENTS: my back is Fucked up because the staff Jumped on it and H-4 me in the Head with the Shield Repeatly and my Shoulder is put Out

"That's all you guys had to do? All you had to do was ask me to move my fucking cell."

The ERT leader closes out the video by stating that Client G "was noncompliant and fought with us the whole time." This characterization is not borne out by the video footage.

On the client injury form, under "recommendations for how to prevent further occurrence," staff have simply written "comply with staff directions."

The incident was reviewed by BC Corrections' Force Options Coordinator (BC Corrections' use of force expert), who finds several problems with the force used against Client G. For instance, he finds "the dialogue focused on commands rather than crisis intervention and de-escalation" and that the ERT "had the time and opportunity to use language that may have de-escalated the situation." This review also found that during the second extraction "the dialogue focused on commands and consequences" and "there was time to engage in dialogue that focused on de-escalation and voluntary compliance."

The review further notes, "There is little evidence to support the ERT leader's statement that [Client G] "fought us the whole time." There does not appear to be any evidence to show [Client G] fighting with or assaulting the ERT members."

Finally, the review concludes that the use of a suicide smock "required a more fulsome explanation as there was no indication or assessment that [Client G] was suicidal."

Client H (2018)

Client H is a provincial prisoner. He was housed at the institution closest to his family, but because of a lack of staff, he and many other prisoners were being involuntarily transferred to other centres, sometimes with force. He refused to leave, and the ERT was deployed to force him to go.

Video shows the ERT arrive at his door and tell him if he does not comply by going with them, they will use force. When he does not agree, they rush in and pile on top of him. Client H says he pulled his arms away so as not to be cuffed, but he was not aggressive or combative. He says the ERT team kicked him in the back of the head, jumped on him, gouged his eye with their fingers, and grabbed his throat, choking him. The camera footage shows only the officers' backs and heads and Client H's bunk, so it is impossible to know exactly what is happening, but at one point Client H yells, "Ow! You fucking gouged my eye! Are you serious?!" Client H's roommate, who is there during the whole incident, can be heard saying one of the officers punched Client H. Officers can be heard telling Client H to stop resisting, and Client H can be heard groaning. Client H's roommate says he is not resisting.

The ERT asks Client H if he is going to cooperate, and he says something to the effect of, "you guys gouged my fucking eye out, kneed me in the head, jumped on my fucking legs, and you're going to ask me to cooperate now?" Client H then says, sarcastically, "Come on, put some more pressure points, hurt me some more!" The

ERT carries him out of the cell by his arms and legs.

In the hallway, while the ERT is holding onto him, a nurse comes to do a medical assessment. He states an officer gouged his eye and he has no circulation in his wrists. The nurse looks briefly at a bruise on the back of his shoulder. Client H says, "It's all good" and she leaves. The entire assessment lasts 15 seconds. Client H is moved into a holding cell and then out to the transport van.

A review of the incident by BC Corrections' Force Options Coordinator found that, instead of trying to talk with Client H and get him to comply, the ERT used "warnings and consequences." "More communication towards de-escalation should have been attempted," the review concluded.

The review further found that, while Client H was resisting the ERT's efforts, he was not being assaultive. As such, "the use of knee and hand strikes were not proportional to the risk that [Client H] was presenting. In my opinion, the strikes were not necessary." The review also noted that when the ERT pulled Client H by the chain of his leg shackles along the ground, this was unnecessary and "degrading."

Client I (2019)

One morning in January 2019, Client I was in line to receive his medication. He explains prisoners were being asked to stick their fingers in their mouths to prove they had taken their medication, which was, in his view, designed to antagonize people. Video footage shows Client I speaking with an officer in the medication area at the door to the living unit and being patted down. He can then be seen walking through the door and taking a complaint form from the desk. Client I reports he was frustrated and said something to the effect of "this is goofy" under his breath as he walked out.

The officer follows Client I through the door and puts a hand on Client I's shoulder, appearing to turn him around. Client I says the officer yelled something like, "What did you just call me?"

The video shows Client I walking backwards while the officer walks forwards, pointing his finger in Client I's chest. Client I has his hands up, the form in one hand, and continues walking backwards.

Client I then appears to turn to walk away, and the officer pushes him.

Client I walks away across the unit and back to his cell.

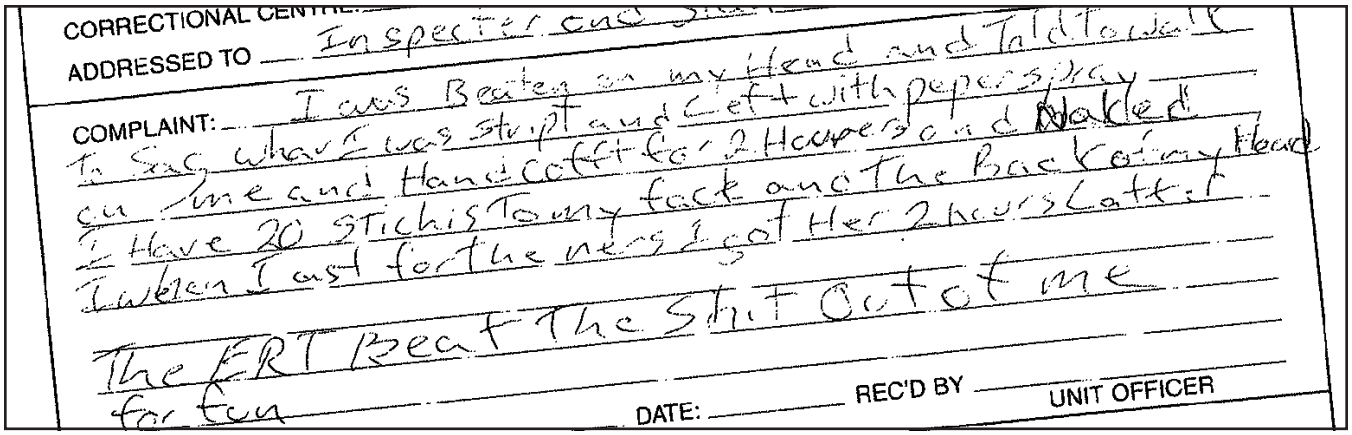
Client I reports a review by the deputy warden noted no concerns with the use of force.

Client J (2017 and 2019)

In 2017, Client J was in segregation when the ERT came to remove him from his cell and strip search him. Client J has a history of being sexually assaulted, and video shows that when the ERT comes to the door and states they have been authorized by the warden, he states, "Are you authorized to sexually assault me? I refuse to assist you." Client J complies with the ERT's instructions to lie on the ground and he is carried by his arms and legs to the shower area.

Client J is placed face down on the floor of the shower and the ERT cuts off his clothes. He states, "I feel like I'm being sexually assaulted. I'm completely naked and they're touching me. I don't like this. I feel sexually degraded. They're touching my penis."

While the footage does not show the strip search for privacy reasons, Client J had no way of knowing this and was concerned his naked body was being filmed. Client J is returned to his cell naked.


CORRECTIONAL CENTRE:
ADDRESSED TO: Inspector and Staff
COMPLAINT: I was Beaten on my Head and Told to Suck what I was Stript and Left with pepperspray on me and Handcuffed for 2 Hours and Naked I Have 20 Stitchis To my face and The Back of my Head Taken Last for the ners I sat Her 2 hours Latter The ERT Beat The Shit Out of me for fun
DATE: REC'D BY UNIT OFFICER

Client J says no one asked him to submit to a search prior to the ERT arriving, and there is nothing in the video we viewed that explained the need for the ERT.

On a separate occasion in 2019, video shows Client J being handcuffed behind his back and moved to a segregation holding cell — an empty room with no sink, toilet or furniture. Officers place him in the cell and do not remove the cuffs. Client J remains in the cell with his handcuffs on from 9:50 p.m. until 4:55 a.m. the next morning. At 10:35 p.m., Client J vomits in the corner of the cell. Client J says he was refused access to a toilet, and at 1:20 a.m., he urinates in the same corner. Over the course of the seven hours, video shows Client J pacing around the cell, kicking the door, and banging his head against the wall. He repeatedly lays down and gets back up again, clearly having a very difficult time getting comfortable on the hard floor with his hands shackled together.

Officers allege that Client J refused to have his handcuffs removed, but Client J says he requested they be removed repeatedly, telling officers they were too tight and he was in pain. He says officers just smiled and walked away.

Client J says that his shoulder "hurt like hell" and his hands were so swollen he could not see his knuckles. He says he attempted to report his injuries, but a nurse only looked at him through the cell window and said she could not see him but would follow up. He says by the time a nurse followed up a day and a half later, the swelling had gone down.

A review of the incident found no wrongdoing.

Client K (2019)

Client K is a provincial prisoner. One evening he asked to be taken to healthcare because of a fever and terrible abdominal pain. Video shows him being escorted to healthcare, grimacing with his arms crossed across his stomach/chest. He says that as soon as he arrived he began vomiting profusely, and an officer ordered him to vomit into a garbage can. He reports he tried to comply but was unable to, and all of a sudden one of the officers OC-sprayed him at close range for his "noncompliance." He says officers then began kicking and kneeing him in the head and elsewhere. There is no video footage from inside the exam room.

Client K does not receive medical attention and is escorted to segregation. From the video footage, it appears officers are being rough with Client K, at one point bending or possibly pushing him forward, one officer pushing on his head. He is escorted around the segregation area and at one point they hold him over the sink. At another point Client K can be seen bent over, possibly throwing up, and officers place a spit mask on his face. He says the spit

mask made him choke on his own vomit. There is a scuffle and Client K lands on the floor with approximately six officers on top of him. The officers remove the spit mask. Client K is escorted, bent forward with his arms pulled up, to the second floor of segregation.

Client K says one of the officers put him in a choke hold while the other officers used his body as a "battering ram" around every corner. Client K also says he was not allowed to decontaminate or clean himself for multiple days. He reports injuries including two black eyes, bruises on his arm, a cut above his eye, a bruised wrist, and sore shoulders.

Client K says a nurse took his vitals through the meal slot in the door, but otherwise he received no medical attention.

We did not see video footage of any decontamination or post-use of force medical assessment.

CORRECTIONAL SERVICE CANADA

We began this report with Joey's story. His case represents one of the worst examples of CSC's abuses against Indigenous prisoners and prisoners with mental health disabilities, and exemplifies the psychological harm done to prisoners when officers repeatedly rely on force. His story demonstrates many of the issues covered in this report.

PLS spoke with approximately 40 other federal prisoners who had force used against them by CSC officers. Several of their stories are below. In many cases we did not have access to video footage or documents related to the acts of force, so we rely heavily on our clients' testimony.

Client L (2018)

Client L is a federal prisoner with mental health issues and a history of self-harm. In the past he had been housed at CSC's Regional Treatment Centre, but when his parole was suspended, he was sent to a mainstream institution.

In April 2018, Client L says he was in an observation cell and told staff he had found items in the cell that he could use to self-harm. He says the items were not removed, and that he began to slash himself with a piece of plastic he found under the bed.

Client L explains staff told him to drop the plastic, which he did, but that an officer began OC-spraying him nevertheless. He says the officer continued to spray him even when he had laid down and crossed his hands and feet, as he was instructed. He remembers being dragged out of his cell and that officers then jumped on his head and pushed it into the concrete floor to the point where he began to cry. He says he was not resisting, but that staff shouted "stop resisting," and an officer jerked his arm, hard.

Client L says he is allergic to OC spray and that he swelled up like a balloon. He also says he suffers from asthma and struggled to breathe but was denied an inhaler.

Client L lodged a complaint about his treatment, which confirmed that "the interventions used appeared inconsistent with policy and to what was necessary and proportionate to control and resolve the incident."

Client L remembers officers calling him a "retard" when he was in a suicide smock.

Client L also reports other occasions where he was extracted by the ERT with violent force in response to self-harm. He says, "they jump on you, use their shield, twist you up, and put their knee on the inside of your bicep to cause you massive pain for causing them to come in and

have to deal with blood. They get back at you for harming yourself." He says he used to cover the camera in his cell, but after being assaulted by officers he began taking the covering off to try to protect himself from excessive force.

Client M (2018)

Client M is a federal prisoner with mental health issues including PTSD and a history of self-harm. He explains that on this occasion he had self-harmed and, upon return from outside hospital, was placed in an observation cell on high suicide watch. He was given a suicide smock, which he says he refused to wear because he found it degrading, so he used a towel to cover his private parts. He says he began to remove the bandages from his legs, as per the doctor's instructions, and that an officer yelled something to the effect of, "Hey, what are you doing?" and began OC-spraying him. He remembers being sprayed on his legs where he had raw wounds, in the back of the head, and on his naked behind.

Client M says the decontamination shower he received was very brief and did not give him enough time to rinse the OC spray off.

Client N (2018)

Client N is a Black federal prisoner who suffers from schizoaffective disorder and Post-Traumatic Stress Disorder.

At the prison where he lives, breakfast lasts until 8 a.m. Because of his mental health issues, he is permitted to take his food out of the cafeteria and eat it in his cell.

One day in April 2018, Client N arrived at the cafeteria at 8:02 a.m. and was blocked from entering by officers. He says he attempted to explain to officers that he simply needed to pick up his meal and leave, but they responded by saying something like, "We're not your father and mother, we're not here to wake you up." They blocked him from entering with their bodies, and Client N tried to walk around them. He was not acting in an aggressive or threatening manner, and he explains that as a Black man he is very careful not to raise his voice or make any sudden moves. "I'm a Black guy. I know anything I do is interpreted as aggressive," he says.

Client N says, "I'm trying to be as meek as I possibly can be. I feel like crying at this point. It seems small and petty, but I feel so small and helpless. That's my meal right there." The video footage shows several other prisoners still inside the cafeteria at this point.

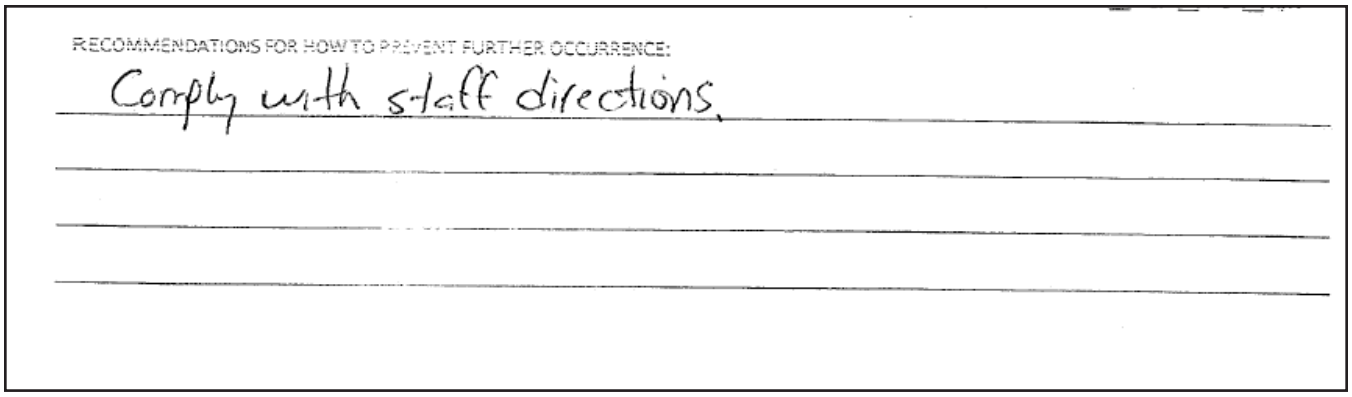
Client N reports that an officer grabbed his arm and then all of a sudden his legs were taken out from under him and officers were shouting "put your hands behind your back" and laughing. The video footage confirms Client N is taken to the ground approximately one minute after he arrived at the cafeteria entrance.

Client N says he could not immediately comply with the direction to put his hands behind his back because an officer was sitting on top of him, and that at some point an officer yanked his shoulder, hard. He was OC-sprayed in the eyes at very close range.

During the incident, other officers clear prisoners out of the area, but make no effort to obtain a handheld camera as required by policy. Client N is escorted out of the area at 8:06 a.m.

When Client N gets to segregation, the two officers who were involved in the incident remain in the area and continue to argue with Client N.

Client N repeatedly stated his need to see mental health. The post-use of force medical assessment covers his physical injuries but does not assess his mental state. Client N says that after the incident, he is afraid to use his sleep


RECOMMENDATIONS FOR HOW TO PREVENT FURTHER OCCURRENCE:
Comply with staff directions.

apnea machine because he is scared officers will come beat him up and he will not hear them coming. He says he would "rather starve" than have to go back to the dining hall for food.

One of the officers writes in his observation report that he assessed the situation as being "medium to high risk" because of Client N's "mental health issues" and "size." Client N is not a large person – he appeared on video to be shorter than the officers involved – but he is Black and the officers are not. Research has shown that people overestimate the size and strength of Black men, and that non-Blacks in particular perceive Black men to be more capable of physical harm than white men of the same size.[37]

Both the institutional and the national reviews find this force was necessary and proportionate, and neither note the discriminatory reliance on Client N's mental health issues as justification for their actions. An email from the Pacific Region's Assistant Deputy Commissioner of Correctional Operations, in response to a submission from PLS, reaffirms CSC's position that the force was appropriate, citing Client N's violation of institutional rules stating that prisoners cannot enter the dining area after meals end.

Client O (2019)

Client O is a federal prisoner with mental health issues who has attempted suicide in the past. In February 2019, Client O cut herself in the observation cell she had been placed in a week prior. She says staff came and provided bandages and were going to take her to the hospital, but required her to be strip searched first. Client O is gender-nonconforming, and says in that moment a correctional manager informed her that her strip-search protocol had been changed without her knowledge and she would be searched by male officers, against her wishes. This caused Client O significant distress, and she says when staff left she began spraying and wiping blood around the cell.

Client O says officers took her to the shower, where she continued to be in emotional distress, pacing around and shouting that she wanted medical treatment. She says she began to pick at her wound but stopped when instructed. Officers opened the door and OC-sprayed her. She says officers moved her to another shower and used a shield to hold her there until she agreed to be searched by male officers, at which point she was finally taken to hospital, approximately six hours after the incident of self-harm.

Client O says that though numerous officers participated in the response, not a single healthcare person ever arrived.

Client O says she was OC-sprayed again a few days later when officers believed she was self-harming in the observation cell.

Client O says that her "interview" about the incident, which is required by policy, simply involved a correctional manager saying, "Are you OK?" and her replying in the affirmative. She was not aware this was an opportunity to raise concerns about the force used against her.

Client P (2019)

Client P is a federal prisoner with mental health issues including borderline personality disorder, ADHD, anxiety, depression and PTSD. He explains he has been in prolonged segregation because he cannot safely integrate into the population at his institution, and he had requested a transfer to the Regional Treatment Centre.

Client P says that in January of 2019 several officers and two correctional managers came to his cell to try to convince him to leave segregation. He says one of the officers started berating him and criticizing him for not "being a man." He says they entered his cell and one of the officers grabbed him by the arm and tried to lift him off his bed. Client P still did not agree to leave, and he says when the officers left, one of them gave him the finger.

Client P reports that after this incident, staff turned off his power for a day, refused to give him a shower and denied him clean bedding.

Client Q (2017)

Client Q is a federal prisoner. One day, the institution was on lockdown and, as a result, he was only allowed out of his cell for 15 minutes per day. He explains he was waiting for his five minute warning to take his shower, but the warning never came and he missed his chance to shower. Officers told him to lock up but he refused, insisting he wanted the opportunity to shower. Video footage of the incident confirms that after less than one minute of conversation, the officer OC-sprayed Client Q, who was not making threats or being assaultive.

Client Q says an officer punched him and cuffed him behind his back. He says he was carried across the courtyard to segregation with some guards holding his legs and other guards holding the handcuffs, which wrenched his arms and caused significant pain.

He says that when he arrived in segregation he refused to strip and as a result, several guards held him down with a shield over his face and punched him several times. He says he was OC-sprayed in the face and mouth, and that officers forcibly cut his clothes off, cutting his skin in the process.

Client Q says he was left naked in his cell and was not given the opportunity to decontaminate. His skin burned for several days. He says he suffered a large laceration on his leg and multiple lumps on his head, and that for approximately two months he experienced breathing issues.

Client R (2018)

Client R is a federal prisoner. In March 2018, Client R says he exchanged words with officers on his range. He says he was walking back to his cell (and away from staff) when an officer came and twisted his arm and pushed him back into his cell. He says once they entered the cell he said something to the effect of, "Can you please stop? I'm in my cell," but a second officer OC-sprayed him without warning.

Client S (2018)

In December of 2018, Client S was instructed to go back to his cell and lock up. Video footage shows that he complied and began walking back toward his cell, accompanied by two officers, who trail a few feet behind. The footage shows that Client S does not turn around or exhibit any noncompliant behaviour, but all of a sudden one of the officers OC-sprays Client S twice without warning, first from behind and then, after running up alongside Client S, in the face, hitting him in the eye. Client S says when he asked the officer why he sprayed him, the officer replied, "get in your room or I'll spray you again." He says the officer then looked at another prisoner who had observed the incident and said, "if you don't go to your room, I will spray you too."

Client S explains he suffers from mental health issues that have been exacerbated by this experience.

Client T (2018-2019)

Client T is an Indigenous man with serious mental health issues, including ADHD and schizoaffective disorder. In late October 2018, Client T was placed in segregation, where he remained for approximately five weeks. His ADHD medication was discontinued, which he says made him extremely unstable. He remembers hallucinating and "fighting with demons" in his cell. He attempted suicide by cutting his wrists. CSC documents confirm multiple acts of self-harm as well as behaviours including "shadow boxing" naked, scratching at his body, attempting to eat EKG pads, and pulling at his eyes until they bled.

In November 2018, Client T began banging his head and punching himself. He was OC-sprayed and extracted by the ERT and transported to outside hospital, where he remained for two days.

Client T's memory of this incident involves being OC-sprayed for what felt like an hour and 45 minutes. He also remembers the ERT using "flash grenade bombs," hitting him in the face with a shield and knocking out his dentures, and stomping on his head. He reports officers putting something metal on his back and chest that made him feel like his skin was ripping off and that they were laughing. He remembers licking the OC spray that was getting in his mouth and laughing "like I was possessed." He states that since then he sees dots all over.

A nurse recommended Client T be transferred to the Regional Treatment Centre and placed in Pinel restraints, but this did not occur and he remained in segregation. In early December 2018, Client T was emergency transferred to a maximum security institution. When he arrived, CSC documents note he "presented as disheveled, and had an odd body odour. He stood in the A&D cell with arms outstretched in a 'Jesus Christ' pose, with a blank, unfocused stare."

Not long after, he was admitted to the Regional Treatment Centre as an involuntary patient. While there, Client T remembers being forcibly given antipsychotic medication via injection with approximately 20 officers involved.

In January 2019, while Client T was at the Regional Treatment Centre, the ERT arrived at his cell to move him to the "quiet room" (an observation/seclusion cell). Video footage of that incident shows the ERT arriving at Client T's door and speaking to him about moving to the quiet room and asking if he will comply. From his response and body language, it appears that Client T may be having difficulty fully comprehending what they are saying. He does not appear aggressive but does seem to ignore several of their requests and questions. He stands near the window with something in his mouth, putting his hands in his pockets and then on his hips. At one point he puts on deodorant.

He states he has a heart issue. He also states "they want to take me to the hospital, I know my rights" and then something like, "you guys are gonna pepper-spray me." At one point he asks if one of the ERT members is an officer from another institution. This behaviour indicates he may not have had a clear sense of reality during the interaction and so could not adequately respond to the officers' questions and directions, rather than being willfully defiant.

Approximately seven minutes after arriving at his cell, officers use OC spray against Client T, which does not appear to have any impact on him. They OC-spray him again approximately one minute later. Though his back is clearly covered in spray, he does not seem to react to it. He is ultimately cuffed through the hatch and moved compliantly out of his cell to the shower, where he is decontaminated and given a suicide smock. When a nurse attempts to perform a post-use of force medical assessment he states, shivering, "I'm good."

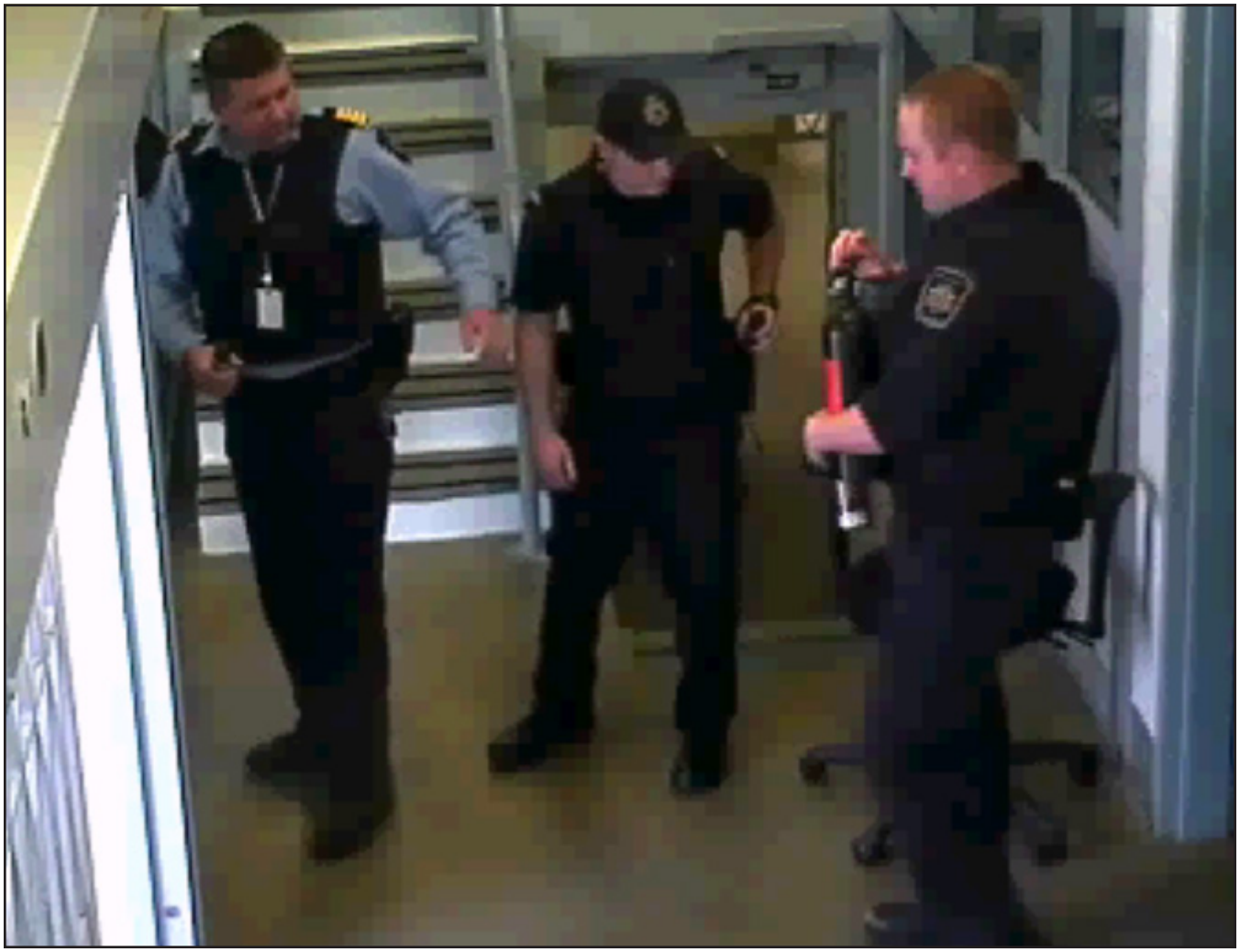
III. LEGAL FRAMEWORK

CANADIAN AND BC PROVINCIAL LAW

Federal and provincial correctional officers are peace officers[38] under the *Criminal Code of Canada*, which authorizes them, if they act "on reasonable grounds," to use "as much force as is necessary" to carry out their authorized duties.[39] The degree of force allowed is constrained by the principles of proportionality, necessity and reasonableness.[40]

For a peace officer's use of force to be considered reasonable under the *Criminal Code*, the officer's belief that the amount of force was necessary must be justified by the facts at the time. Officers cannot be expected to measure the level of force necessary "with exactitude."[41]

Factors considered by the courts in deciding whether the amount of force used was necessary include "the nature and quality of the threat, the force used in response and the characteristics of the parties involved in terms of



size, strength, gender, age and other immutable characteristics."[42]

Federal correctional officers are also bound by the *Corrections and Conditional Release Act* ("CCRA"), which requires measures used to be limited to what is necessary and proportionate to attain the purposes of the CCRA.[43] The purposes of the CCRA are to administer "safe and humane" sentences and assist in the rehabilitation and reintegration of prisoners.[44] The CCRA prohibits the use of "cruel, inhumane or degrading treatment or punishment" of prisoners[45] and requires CSC to take all reasonable steps to ensure that penitentiaries are "safe, healthful and free of practices that undermine a person's sense of personal dignity."[46]

Provincial corrections officers are also governed by the *Correction Act* s. 12(1), which states they may "use a reasonable degree and means of force":

(a) to prevent injury or death to a person;

(b) to prevent property damage;

(c) to prevent an inmate from escaping;

(d) to maintain custody and control of an inmate.

Labour arbitrations and civil cases brought by prisoners against correctional authorities tend to find fault against correctional officers if the prisoner was already subdued and force was used unnecessarily.

Labour arbitrators have found that correctional officers are to be held to a higher standard of conduct than other employees,[47] and that excessive use of force when restraining prisoners and failing to accurately report uses of force are serious disciplinary offences.[48] The employer is required to prove its case with clear and cogent evidence.[49]

In *Roberts v Treasury Board (Correctional Service of Canada)*,[50] a prisoner was being medically treated by a nurse after slashing his arm and swallowing a razor blade. He was wounded and restrained in a treatment chair by handcuffs behind his back. The Arbitrator found him to be in a "vulnerable condition."[51] The correctional officer grievor covered the prisoner's nose and mouth, and then pushed his head back and up with his hand. The prisoner asked "Is this how you treat people?" and called him a "goof." The officer then punched the prisoner in the face. The officer's termination was upheld at arbitration.

The Arbitrator in *Roberts* identified the factors relevant for consideration, which include whether the grievor accepted responsibility for their actions, the likelihood of a recurrence of the behaviour, and the duty of trust and importance of integrity and self-control in the correctional context.[52]

The Arbitrator noted the "imperative that the employer and fellow staff members have confidence in the judgment and comportment of a correctional officer," and the warden's testimony that "failure to respond forthrightly to an incident of excessive use of force sends a very negative signal to other officers and the inmate population, potentially undermining discipline, control and, ultimately, personal safety."[53]

In *Hicks v Deputy Head (Correctional Service of Canada),*[54] a correctional officer was suspended for 20 days for using excessive force and lying about it in his statement and observation report. The officer punched the prisoner six times, but reported that he struck the prisoner only once. The arbitrator found that the officer continued to punch the prisoner without stopping to assess the situation. The arbitrator found "these blows served no purpose other than to further agitate the inmate and to put the other CXs at risk."[55]

Legere v. Deputy Head (Correctional Service of Canada)[56] was a labour arbitration of two Kent Institution correctional officers' grievances of their dismissals. One was dismissed for using excessive force against prisoners and both were alleged to have colluded in their statements and failed to file observation reports. The arbitrator found that the failure to report the use of force warranted discipline. The officer who was found to have colluded with other officers to hide the incident from CSC was reinstated with a suspension.

The second officer's termination was upheld based on evidence that he kicked a prisoner who was handcuffed and lying face down on the ground, and because he "has not demonstrated a true understanding of the potential consequences of his actions and would no doubt resort to these tactics if faced with similar circumstances in the future, which would put the institution, the inmates and his fellow coworkers at risk."[57] The evidence demonstrated that the officer used excessive force against the prisoner, who was known to have mental health issues, when he posed no threat.

Bevan v. Ontario[58] was a civil action for damages for injuries suffered by an Ontario provincial prisoner. Mr. Bevan alleged that he was denied pain and anxiety medication, and he became agitated and swore at a nurse and correctional officers. When officers told him to calm down, he continued to shout and spit. He banged his head on the cell bars. Officers entered his cell to take him to segregation. Mr. Bevan testified that he was lying face down in his cell with his arms over his head and his legs spread. He testified that one of the officers pulled his arms behind his back with such force that his right arm broke. His evidence was preferred over the conflicting evidence of the officers.

The court found the degree of force used by correctional officers was unjustified and disproportionate in the circumstances. The prisoner was required to prove that the injuries were caused by the officers, and the officers were required to prove that (1) there were reasonable grounds to use force, and (2) the degree of force was justified. The officers failed to do so. Mr. Bevan was awarded $50,000 plus interest.

In *Peeters v. Canada,*[59] a prisoner who had taken an employee hostage was subjected to force by the ERT and was injured. On the way to the hospital, while bound to a stretcher, naked under blankets, officers beat him in the abdomen, groin and legs with a billy club. The next day he was taken to segregation and subsequently transferred to the Special Handling Unit where he was isolated for much of the almost four years he spent there. He suffered traumatic nightmares following the assault and testified that he did not feel safe because he could not trust the correctional officers whose job it was to protect him. Mr. Peeters filed a civil claim for damages.

Justice Muldoon's judgement states:

> It is beyond doubt that punitive or exemplary damages are called for. The defendant's servants' unprofessional lack of self-discipline, their brutality and thuggery, and their willful malice cry out for punitive or exemplary damages. Some officials of a civilized state they were! Barbarity always harms the State and especially if the State's officials be the perpetrators. It is a pity that the taxpayers have to pay for the thuggish misbehavior of Aitchison, Donahue and Hammond, when they themselves should be made to pay.

He agreed with the warden of the institution who found:

> Only that amount of force which is deemed necessary to ensure the safety or security of persons is acceptable in the performance of a Correctional Officer's duties.

> In my view, when Mr. Peeters was already restrained, there was no amount of force that was acceptable during the escort trip to the hospital.[60]

Mr. Justice Muldoon further comments on the role of CSC when correctional officers abuse their powers:

> Why do such persons – almost inevitably male persons – pervert their role by evincing such goon-squad machismo, which is always nothing more than cowardly brutality? That is not their duty. Why do they not just do it right? Because they are not well selected, trained and admonished by their employer, they engage in brutal criminal behavior and, by their example, make mockery of and push into disrepute the notion of a professional, proficient correctional service.

Justice Muldoon cites *LeBar v Canada* for the principle that it is fundamental to the rule of law that the government and its officials obey the law:

> It would be unthinkable, under the rule of law, to assume that a process of enforcement is required to ensure that the Government and its officials will faithfully discharge their obligations under the law. That the Government must and will obey the law is a first principle of our Constitution.

Justice Muldoon continues:

> Will they never learn just to carry out their duties in a lawful manner? Members of the same government agency as was involved in LeBar's case have once more attracted not merely general damages but punitive damages for their tort of malicious assault and battery against the plaintiff. Penitentiaries can be lawfully operated with sufficient strictness to teach the criminals lodged therein that they are being punished and denounced by society for their offences, without teaching the wrong lessons of brutality, sneakiness and "might is right" which so corrode the fabric of civilized society.

Justice Muldoon escalated the punitive or exemplary damages from *LeBar* in *Peeters v Canada*.

Where force was used excessively in the course of an arrest, courts have found that the accused's s. 7 and 12 *Charter* rights were violated, and this can be considered at trial or sentencing. Section 7 protects the right not to be deprived of "life, liberty and security of the person" except in accordance with the principles of fundamental justice. Section 12 protects the right "not to be subjected to any cruel and unusual treatment or punishment."

Where courts have found "abusive, gratuitously violent police misconduct against defenceless individuals" it has resulted in stays of criminal charges.[61] In one such case, a trial judge considered the fact that the accused was "avoidably hurt" during his arrest. This finding was upheld on appeal.[62]

HUMAN RIGHTS LAW

Human rights law in BC and Canada prohibits discrimination based on a number of protected characteristics, including race and disability.[63] To comply with human rights law, corrections must accommodate a prisoner's mental and physical disabilities to the point of "undue hardship."[64]

The federal court has found that the duty to accommodate prisoners' disabilities and to provide safe living arrangements under human rights law is "all the more important" because they are a "particularly vulnerable" group, having no control over their living environment.[65]

Many prisoners have mental health disabilities and, as a result, engage in behaviours that ought to be understood as manifestations of those disabilities rather than as intentionally disobedient or rebellious. For instance, prisoners with Fetal Alcohol Spectrum Disorder may act impulsively or without grasping the consequences of their actions. Prisoners with Post-Traumatic Stress Disorder may lash out because of hyper-arousal or refuse to do things because of past traumatic experiences. Prisoners with addictions may use illicit substances. Further, prisoners who have been subject to solitary confinement may exhibit symptoms such as paranoia, rage and self-harm that lead to conflict.

Similarly, prisoners experiencing medical issues, especially things like seizures or intoxication, may be perceived to be disobedient or dangerous when they are in fact in an altered state of consciousness.

Too often, prisoners are unable to get adequate treatment for their underlying disabilities. The prison environment, including and especially segregation, can exacerbate their symptoms. Using force to address these symptoms represents a failure to accommodate the prisoner's disability, particularly when therapeutic and evidence-based care is lacking, and when there is no strategy to reduce or avoid similar uses of force in the future.

Using a human rights lens to understand use of force requires us not only to examine individual cases, but also to scrutinize the frequency with which officers are using physical force against prisoners with mental health concerns and prisoners who are self-harming — which the Correctional Investigator has shown is alarmingly high.

A human rights lens also necessitates scrutiny of potential racial bias in use of force incidents – and again, the Correctional Investigator has shown that Black and Indigenous prisoners are disproportionately likely to have force used against them. We know from the policing context that racial bias plays a role in officers' assessment of risk and decisions about deadly force.[66] Reporting from PLS clients indicates that racial bias may also play a part in correctional officers' decisions about when and how to use force.

INTERNATIONAL LAW

Canada has agreed that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment"[67] and has committed to "tak[ing] effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction."[68]

United Nations Special Rapporteur on Torture Nils Melzer writes that force by state agents must be necessary, legal, and proportionate (to the necessary legal purpose being pursued). Uses of force that exceed this standard, he writes, are "an attack on human dignity amounting to cruel, inhuman or degrading treatment or punishment, irrespective of whether that excess occurred intentionally or inadvertently." [69]

Melzer defines the principle of necessity to mean that "any use of force must be "unavoidable" in the sense that non-violent or other less harmful means remain ineffective or without any promise of achieving the desired purpose," and thus involves "a factual assessment of the least harmful means that can be expected to achieve the desired purpose."[70]

He further writes that the principle of proportionality "involves an additional and separate value judgment as to whether the harm expected to result from the use of force can be

justified in the light of the benefit of the desired purpose."[71] This means, he notes, that there is an "absolute upper limit" for any use of force given its relationship to the purpose it seeks to achieve.

Importantly, Melzer explains that the "'harm' to be weighed in the proportionality assessment does not necessarily have to be of physical nature, but can also involve mental suffering and emotions of humiliation and distress" [emphasis added]. [72]

Finally, Melzer emphasizes the need to understand the broader circumstances surrounding a use of force, concluding that even if a use of force is "necessary and proportionate in the immediate circumstances," it may still be unlawful "if it results from a failure to plan, organize and control operations so as to minimize harm, respect and preserve human life and avoid any excessive use of force."[73]

In December 2015, the United Nations adopted *The United Nations Standard Minimum Rules for the Treatment of Prisoners* (the "*Mandela Rules*").[74] Among other things, these rules "encourage" corrections officials "to use, to the extent possible, conflict prevention, mediation or any other alternative dispute resolution mechanism to prevent disciplinary offences or to resolve conflicts."[75] Similarly, the rules specify that prison staff should receive training on "[s]ecurity and safety, including the concept of dynamic security, the use of force and instruments of restraint, and the management of violent offenders, with due consideration of preventive and defusing techniques, such as negotiation and mediation."[76] The rules also state that officers "must use no more [force] than is strictly necessary."[77]

The *Mandela Rules* mandate independent, impartial investigations into any serious injuries or deaths in custody, as well as any acts of torture or other cruel, inhuman or degrading treatment or punishment.[78]

The United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials speak to, among other things, the need for accountability within law enforcement agencies for the use of force, finding that superior officers must be held accountable "if they know, or should have known, that law enforcement officials under their command are resorting, or have resorted, to the unlawful use of force and firearms, and they did not take all measures in their power to prevent, suppress or report such use."[79]

The *Mandela Rules* speak extensively about the role of healthcare providers in prisons, which is relevant to use of force incidents.

Rule 30 requires prison healthcare providers to pay particular attention to "[i]dentifying any signs of psychological or other stress brought on by the fact of imprisonment," which would include being subject to or threatened with force.[80]

Rule 33 requires medical staff to report to the warden when "a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment."[81]

Rule 35 specifies that healthcare must inspect and advise wardens on "[t]he hygiene and cleanliness of the institution and the prisoners" as well as "[t]he suitability and cleanliness of the prisoners' clothing and bedding."[82] This means, for example, that healthcare staff must report to the warden if they witness prisoners whose cells, clothes or bedding are contaminated with OC spray.

Rule 32 prohibits medical professionals from "engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment."[83] This rule prohibits medical professionals from conducting fitness assessments for the continuation of acts that could be considered cruel. For example, PLS has viewed video of a BC prisoner who was restrained by correctional officers for a prolonged period of time in the WRAP. He was crying out in pain. A nurse periodically came and adjusted the straps when his feet turned blue. While it is essential for healthcare providers to ensure that officers' use of force or restraints is not causing physical harm, their role cannot be used to justify continued use of practices that could be considered cruel.

Rule 34 specifies that a healthcare professional who notices signs that a prisoner is being subjected to torture or cruel treatment must document the case and report it "to the competent medical, administrative or judicial authority."[84]

The Istanbul Protocol provides guidance to medical professionals working in prisons on how to document cruel treatment, noting that effective documentation is one of the most fundamental ways to protect individuals from torture or cruel treatment.[85]

The Istanbul Protocol states:

> Doctors have a duty to monitor and speak out when services in which they are involved are unethical, abusive, inadequate or pose a potential threat to patients' health. In such cases, they have an ethical duty to take prompt action as failure to take an immediate stand makes protest at a later stage more difficult.[86]

Proper documentation of signs of ill-treatment as a result of a use of force should include:

- A statement by the patient after interviewing them, including their description of their state of health and any allegations of ill-treatment;
- A full account of objective medical findings based on a thorough medical examination and psychological interview, including a record of traumatic injuries on a form for this purpose (with body charts for marking injuries);
- Photographs of any visible injuries (taken as soon as possible and within 24 hours);
- The healthcare professional's observations in light of the above, indicating the consistency between any allegations made and the objective medical or psychological findings;
- The results of additional examinations, detailed conclusions of specialists consulted; and
- A description of the treatment given and any procedures performed.[87]

Particularly given Melzer's explanation that a use of force that is not necessary, legal and proportionate amounts to cruel, inhuman or degrading treatment or punishment, the rules above mean that medical staff have a duty to

thoroughly document the impact of a use of force against a prisoner, including soliciting their version of events and fully examining them for injuries. As noted above, this applies to both physical and psychological suffering. They must also address any lingering harms – such as skin that has not been properly decontaminated or the need for trauma counselling. And, crucially, they must follow the *Mandela Rules'* imperative that they report to the warden when a prisoner is adversely affected by a condition of confinement, and to medical, administrative or judicial authorities whenever they see evidence a prisoner is cruelly treated.

Neither the post-use of force medical assessments conducted by CSC or by the Provincial Health Services Authority meet this standard.

DUAL LOYALTY OF MEDICAL PROVIDERS

The concept of dual loyalty refers to a prison healthcare provider's dual allegiance to both their patients and the prison system.

All healthcare providers have an ethical duty to always act in the best interests of their patients. The Canadian Medical Association's *Code of Ethics and Professionalism* requires physicians to "consider first the well-being of the patient" and to "always act to benefit the patient."[88] The United Nations *Mandela Rules* mandates "full clinical independence" for healthcare providers.[89]

Researchers Jörg Pont, Heino Stöver and Hans Wolff point to many international instruments establishing that "the sole task of health care professionals working in prisons is the care of physical and mental health of the prisoners," and that they must carry out their duties "with complete loyalty to the prisoners."[90]

In the prison environment, healthcare providers can feel pressure to bend their care to the expectations of the security side of prison administration, and those two allegiances may come into conflict. Pont, Stöver and Wolff note that "subtle … situations in daily prison life cause health care professionals to forsake loyalty to their patients, often unwittingly or by failing to scrutinize routine procedures, decrees, or laws against the standards of medical ethics and human rights."[91]

Similarly, the International Dual Loyalty Working Group warns of the danger that prison medical providers "try to accommodate their medical skills to the limitations imposed on them" and "often need to adjust standards of practice to institutional constraints."[92]

In the use of force context, healthcare providers may be asked or required to assess whether a prisoner suffered injuries during a use of force. Many federal and provincial prisoners describe post-use of force medical assessments as perfunctory and not designed to elicit or treat their concerns. Further, since they are generally conducted, both federally and provincially, in the presence of correctional officers (and provincially in the presence of the same officers who have just used force), providers may feel pressure to limit their assessments and findings. The Correctional Investigator has identified post-use of force healthcare assessments as a practical example of dual loyalty in CSC.[93]

Notably, in 2017 the BC government transitioned healthcare services for prisoners to the Ministry of Health (previously it was provided by BC Corrections through a private contractor). This transition represents a critical acknowledgement that prisoners must receive the same standard of healthcare as those in the community. It also helped to bring BC further in line with the *Mandela Rules*' mandate that prison medical staff enjoy full clinical independence.

The sole purpose of post-use of force medical assessment must be to identify any physical or psychological injuries and any signs of torture or cruel treatment, and must be done with complete loyalty to the patient. If the assessment happens before the incident has concluded, clinicians must not play any role in assessing a prisoner's fitness to sustain further use of pepper spray, restraints, or other types of force. Reforming use of force practices must include strategies for preventing dual loyalty pressures for medical staff.

IV. BC CORRECTIONS USE OF FORCE FRAMEWORK

BC Corrections keeps an average of 2,475 people in its custody each day.[94] This includes people who are on remand as well as people whose convictions involve sentences of less than two years.

BC Corrections does not comprehensively track how often its officers use force. However, data shared with PLS shows that from 2011-2018, there were 1,449 uses of OC spray, special restraint apparatuses (the WRAP and BOARD), Tasers or batons.[95]

The use of OC spray in BC Corrections facilities rose dramatically from 2011 to 2015, with only 100 uses in 2011, and 292 uses in 2015. In 2018, officers used OC spray 262 times. OC spray is the primary weapon used by BC Corrections staff. In 2018, officers used batons only twice and did not use Tasers at all that year (or any year dating back to 2011, the earliest year for which PLS has data). The WRAP and BOARD, which also represent a use of force, were used only three times in 2018.

BC Corrections does not maintain data on when officers physically intervene and use their hands or shields to control a prisoner. Nor does BC Corrections maintain data on deployments of the ERT or on the number of times spit hoods are used. As such, it is impossible to know how many times these types of force have been used. This also makes it impossible to know the total number of uses of force in provincial correctional facilities in a given year.

Data shared by BC Corrections with PLS shows that, from 2011-2018, 47 employees were subject to labour relations investigations of a use of force incident. As of June 13, 2019, seven of those investigations (all related to the September 2017 incident at the Fraser Regional Correctional Centre) resulted in dismissal. Thirteen investigations resulted in suspension, four resulted in letters of expectation, 11 resulted in letters of reprimand, two resulted in a coaching conversation, one employee resigned prior to discipline, six were determined to be unfounded allegations, and three are still in progress.

Recently, BC Corrections has taken steps to implement a trauma-informed approach to corrections and is making some significant changes to its use of force policy. However, much more needs to be done to ensure that force is used only when necessary and in a way that minimizes the long-term negative effects of this form of violence. More is also needed to ensure ongoing transparency and accountability in the form of external oversight and public reporting on uses of force.

LAW AND POLICY

As mentioned above, the *Correction Act* allows correctional officers to "use a reasonable degree and means of force" in a wide range of circumstances, including "to prevent property damage" and "to maintain custody and control of an inmate."[96] This broad discretion is not in line with prisoners' *Charter* rights.

Section 9 of the *Correction Act Regulation* allows for the use of physical restraints for the same reasons. Restraints may be used for more than four continuous hours only if authorized by the warden (or their designate) or if the person is being escorted in the community. Restraints can be authorized by the warden (or their designate) for up to 16 hours, and any further restraint requires approval from the provincial director and review every 12 hours. We would argue that this broad discretion to use restraints may violate prisoners' *Charter* rights, and we are pleased to hear from BC Corrections that the current Provincial Director has never given such approval since she was appointed in December 2014.

This broad discretion provided to correctional officers under legislation carries through to BC Corrections' Adult Custody Policy. The current use of force policy begins by stating that the objective is to maintain safety "by controlling aggressive and/or non-compliant inmate behaviour through the graduated use of force."[97]

PLS understands a new policy is imminent that replaces this objective with an emphasis on managing behaviour that may result in harm to self or others in a manner that is "consistent with the principles of trauma-informed practice and with the minimum amount of force reasonably necessary." This is a welcome change, as the new policy focuses on behaviours resulting in harm, instead of behaviours that are simply noncompliant. It emphasizes that force

should be the *minimum* amount needed, and it highlights the need to be trauma-informed. However, there is no definition of "trauma-informed" or clarity on how that framework is reflected in the remainder of the policy.

The new policy also replaces "oral commands" with "verbal communication," and makes reference to the need for "continued assessment of the situation." These are both welcome policy changes. However, the policy assumes force will be used, and significantly, there is no mention of nonviolent conflict resolution or de-escalation anywhere in the policy.

The new policy also continues to authorize force to "compel compliance," including the use of pressure points to physically control a person, "balance displacement" (knocking someone off their feet), and OC spray.

The policy on Cell Entry and Extractions is also broad.[98] Cell Entry and Extraction ("CEE") Teams (also known as Emergency Response Teams) are authorized to enter a prisoner's cell and forcefully remove them from it "when less forceful means of achieving compliance are unsuccessful or impractical" and "when the inmate might inflict self-harm, harm others, or significantly disrupt operations."[99] There is nothing in the policy about using CEE teams as a last resort. There is nothing in the policy about de-escalation or conflict resolution, and the use of the CEE team is not limited to circumstances when there is a risk to a person's physical safety. The policy also fails to consider the traumatic impact of a cell extraction on a vulnerable prisoner or the potential that a cell extraction could unnecessarily escalate an incident.

The Cell Entry and Extraction policy also describes a "secure escort" in which prisoners are walked backwards with officers on either side and a third officer walking behind, "facing the inmate, with the chemical irritant or stun device in the ready position."[100] PLS saw videos depicting prisoners walking backwards, bent forward at the waist, which the Ontario Ombudsman warns can cause breathing problems and elevate blood pressure.[101]

BC Corrections has noted this type of escort is discouraged and is not part of officer training materials on force options. They further note staff are reminded to take their time before escorting a prisoner to allow an incident to de-escalate, and that supervisors are encouraged to have staff who were not directly involved in the incident perform the escort. PLS agrees with this approach and we encourage BC Corrections to amend policy accordingly.

The internal oversight mechanisms outlined in the current use of force policy are limited, but are greatly expanded in the forthcoming policy – another welcome change. Under the new policy, all use of force incidents must be reported to the Provincial Director within two hours of the incident. Each staff person involved in a use of force must complete a report to the warden within 24 hours, and staff are prohibited from viewing video of the incident prior to completing their report.

An assistant deputy warden must then conduct a full analysis of the incident – the "primary review" – within 20 days, to identify whether officers:

- performed a duty authorized or required by law;
- acted upon reasonable and probable grounds;
- acted in good faith;
- complied with policy and approved training;
- exhausted all non-physical alternatives; and
- used the minimum amount of force necessary.

The emphasis on exhaustion of all non-physical alternatives is an important criterion. It ought to appear earlier in the policy as well. We suggest that this review should also identify whether force was necessary to protect the safety of a person.

The new policy also outlines guidelines for managers who review use of force incidents, specifying that reviews must be timely, supporting documents must be thorough and complete, and that all relevant evidence, including video and photographs, must be collected and retained. A reviewer's guide is forthcoming, which we understand will, among other things, require reviewers to assess whether the officer's actions led to the escalation of the conflict. It will also require allegations of excessive force to be immediately reported to police regardless of the outcome of the internal review.

The new policy specifies that if a prisoner is injured and requires medical treatment, their injuries must be photographed and an injury report completed. However, the policy does not clearly identify what constitutes an injury requiring medical treatment, nor does it clarify who is responsible for taking photographs. PLS has seen video footage of the ERT photographing the injuries of a prisoner whom they have just used substantial physical force against. Some of the photos are taken through the cell door.

Once the institutional review is complete, it is submitted to Headquarters, where an analyst conducts an assessment and notifies the Provincial Director of the outcome.

Some use of force incidents will be subject to a "secondary review," including incidents in which officers' actions may have been inappropriate or inconsistent with training or policy, or where a prisoner or staff member has been injured. A secondary review is also required for all incidents involving a special restraint device, a baton, a Taser, or an Emergency Response/Cell Entry and Extraction Team. The Provincial Director also initiates secondary reviews randomly. Secondary reviews must be completed by the institution and submitted to Headquarters within 30 days. They must identify areas of concern and recommendations to reduce the likelihood of a similar outcome.

Incidents subject to secondary review must also be assessed by the Force Options Coordinator (based at the Justice Institute of BC) in addition to an analyst.

Any recommendations resulting from secondary reviews will be tracked by the headquarters policy and program analyst responsible for use of force, a newly created position.

The forthcoming use of force policy also specifies that operational reviews may be ordered when a use of force "appears to be of a significant nature," such as incidents involving serious injuries or staff misconduct. It also specifies that critical incident reviews may be ordered when a use of force results in a death or an injury likely to result in permanent and significant disability.

The policy does not address decontamination or post-use of force medical assessments. The policy is also lacking in that it fails to require staff to interview prisoners for their side on use of force incidents or to provide them with copies of use of force reviews.

Also relevant is BC Corrections' policy on searches, which was revised in November 2018.[102] The policy states that the type of search must be the "minimum level required to achieve the lawful purpose." It also requires prisoners who are strip searched be provided clothing or other body covering as soon as possible, and prohibits prisoners being left naked before or after a strip search. In November 2017, BC Corrections issued a directive prohibiting officers from cutting or tearing off prisoners' clothing. This was a welcome change.

The November 2018 revision implemented a very important change: distinguishing between searches of compliant and noncompliant individuals and establishing a stricter standard for searches of prisoners who do not comply.

It states that for individuals who are compliant, the strip search is conducted in a private place and "in a manner that is sensitive to the privacy and dignity of the inmate," and that the prisoner remains unclothed for the shortest amount of time possible.[103] This is good policy, but should also apply to noncompliant prisoners as much as possible.

The policy specifies that, when a prisoner does not comply, correctional staff must obtain approval from the warden or their designate prior to conducting a strip search. Before authorizing such a search, the warden (or designate) must ensure that other less intrusive measures have been exhausted – including talking with the prisoner, confining them in their cell under observation, or using restraints. However, officers are allowed to conduct a strip search without approval from the warden where the delay is likely to "result in danger to human life or safety" or in the destruction of evidence.[104]

The policy also states that force can only be used in the context of a strip search "when a delay in the search would likely result in a significant risk to safety, and when all less intrusive measures have been exhausted or rejected as not appropriate."[105]

The strip search of a noncompliant prisoner is considered a use of force and is documented as such.

The policy further specifies that prisoners must never be escorted naked, and that "under no circumstances is an officer to forcibly remove contraband from an inmate's body cavity, including an inmate's mouth."[106]

The policy specifies that strip searches of compliant prisoners are not video-recorded, but that strip searches of non-compliant prisoners are recorded by handheld cameras with audio functions to document the officers' roles. In this circumstance, policy requires officers to make reasonable attempts to ensure the prisoner's dignity and requires institutions to handle the footage in a manner that maintains the person's privacy.

BC Corrections' Adult Custody Policy also addresses the use of special restraint devices, including the BOARD and the WRAP, discussed above.[107] According to policy, these restraints are authorized for prisoners who are "highly agitated," who are "engaged in violent, destructive behaviour," or who are involved in – or "might be involved in" – "self-harm that could result in injury or death." Prisoners placed in the WRAP are assessed by a nurse and correctional supervisor at least once per hour. However, policy notes a nurse only performs this assessment "when on duty."

Notably, the policy provides that prisoners "in reasonable health and with a normal physique" be placed face-down on the BOARD, a practice that is banned in the federal prison system because of the risk of positional asphyxia.[108] While BC Corrections notes the effects and warning signs of positional asphyxia are covered extensively in force options trainings, this policy is concerning, especially because there is no requirement that healthcare staff be consulted prior to placing a prisoner on the BOARD.

The special restraint policy also authorizes officers to use a helmet or spit hood "when required for the safety of the inmate or other persons."

BC Corrections officers should be prohibited from using devices such as the BOARD and the WRAP. BC Corrections notes that for all intents and purposes the BOARD is no longer used,

and the WRAP is only used as a last resort to manage self-harm in the absence of any other tool (and indeed data shows these are used very infrequently). However, a prisoner who represents such a high risk for self-harm or suicide that they must have their limbs bound does not belong in a prison environment and should be transferred to a psychiatric facility immediately. The fact that there is no mechanism for this except certification under the *Mental Health Act* is a major gap in law and practice for provincial prisoners with serious mental health needs.

If prisoners are *not* at risk of serious self-harm or suicide, there is no reason these special restraints should be used. A prisoner who is angry or agitated could simply be left alone in their cell or another area to calm down.

BC Corrections should also eliminate the use of spit hoods, which the UK-based human rights and justice organization Liberty has called "degrading" and "potentially lethal."[109] They cite multiple deaths in police and corrections custody of people who had been placed in spit hoods, including people who were bleeding and vomiting. The Correctional Investigator notes, in reviewing the death of Matthew Hines, that officers had pulled his T-shirt over his face "presumably to act as a makeshift spit mask." The shirt is still covering his face when officers place him in the shower and turn on the water, at which point he begins "making sounds consistent with spitting up or choking."[110] Client K told us being placed in a spit hood made him choke on his own vomit.

BC Corrections has recently taken additional steps to assist prisoners with complex needs and reduce the amount of violence in its correctional centres. For instance, it is piloting new "no violence units," which seek to create violence-free living environments by providing increased resources for programs and case management and by giving prisoners more control over their daily lives. The units have daily meetings to promote dialogue and there is increased opportunity for restitution and mediation when conflict occurs. The project is in its early stages, but we are pleased to see this recognition that things like meaningful activities, greater autonomy, and restorative approaches to conflict are being incorporated into BC Corrections' approach.

BC Corrections is also introducing complex needs units – smaller living units that provide prisoners with mental health needs or behavioural issues with more intensive and specialized supports. BC Corrections tells us the officers who work on these units are assigned based on skill and interest and receive enhanced training.

BC Corrections is replacing the term "inmate" with terms like "incarcerated men and women," "people" and "individuals." This is a very welcome change and will help emphasize the dignity of people in custody.

THE ROLE OF MEDICAL PROVIDERS

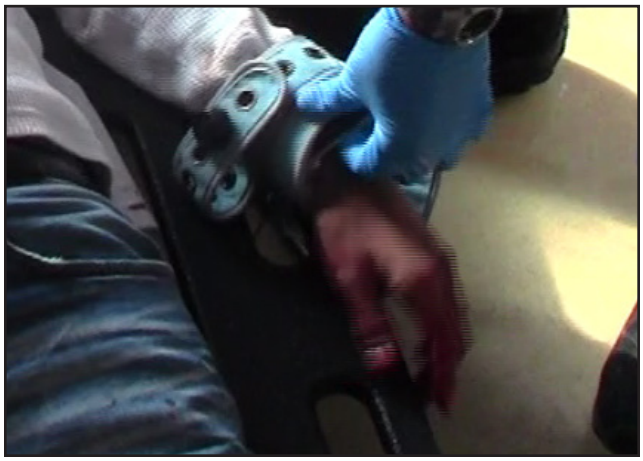
Healthcare in BC Corrections is provided by the Provincial Health Services Authority, which maintains a Correctional Health Services branch. As mentioned above, the Provincial Health Services Authority took over healthcare in October 2017; prior to that, healthcare was provided to prisoners by a private, for-profit contractor. This transition was a welcome change and helps BC meet international obligations around prison medical care.

The Provincial Health Services Authority does not have any policies related to conducting post-use of force medical assessments or any special forms for documenting their findings. This may explain why, in many of the videos we reviewed,

these assessments were cursory at best and often took place through the cell door or in the middle of a hallway. They often occurred in the full presence of the officers who had just used force (or were still in the process of using force) against the prisoner. We watched one assessment that took place while the prisoner was being restrained on the floor by the ERT.

The Provincial Health Services Authority's only relevant policy concerns the assessment of prisoners placed in physical restraints or subject to "control devices" including impact/stun devices, spray irritants and chemical agents. This policy is largely a restatement of the relevant sections of BC Corrections' Adult Custody Policy setting out consultation with healthcare staff when these devices are used, though neither the Provincial Health Services Authority policy nor the BC Corrections policy require consultation *before* restraints are applied or control devices are used. The policy further specifies that a "medical review" is done within two hours of placement in restraints and hourly after that within healthcare operational hours.[111] This means that, if a person is placed in restraints at night, they might remain restrained overnight with no medical assessment for several hours.[112] The policy also places the onus on BC Corrections to notify and consult healthcare.

Importantly, the policy is clear that only corrections staff have authority over the use of restraint and control devices, and instructs healthcare staff to recommend restraints be removed "where medically indicated."[113] This is important for compliance with the United Nations *Mandela Rules*, which prohibit healthcare professionals from participating, actively or passively, in acts that may constitute cruel, inhuman or degrading treatment.[114]



Regarding the use of OC spray, the policy simply states that a healthcare professional can flush the prisoner's eyes "upon request"[115] – though it is not clear whether this is based on the request of the prisoner or of corrections staff. There is nothing about ensuring the prisoner has the ability to decontaminate the rest of their body or to receive clean clothing.

Healthcare professionals must act in the best interests of their patients, and international standards, including the *Mandela Rules*, empower them to take action when they see signs of ill-treatment. We recommend the Provincial Health Services Authority immediately develop policy to ensure medical staff are carrying out this obligation with respect to use of force, where prisoners are vulnerable to harm and abuse.

BC Corrections' Adult Custody Policy also says very little about the role of healthcare providers with respect to force interventions. It rarely *requires* medical staff to take action, repeatedly using language such as "when practical."

The BC Corrections' Adult Custody Policy only provides for a medical assessment of a prisoner who has been subject to a use of force if spray irritants were used.[116] Though we understand post-use of force medical assessments are conducted following most or all use of force incidents, as noted above, they frequently appear to be cursory and superficial. Policy ought to require a thorough medical assessment of every prisoner who is subjected to force by officers.

TRAINING

According to information shared with PLS by BC Corrections, all BC corrections officers receive basic training that includes interpersonal communication skills, including conflict resolution. This occupies approximately one week of the six-week training for new recruits and is taught before the unit on force options, which also lasts approximately one week. The training includes role-plays and simulations, and trainers try to include a situation where mental health issues are at play.

Correctional officers also receive a nine-hour safety refresher every three years that includes an evaluation of officers on force application and techniques, with any concerns brought to the attention of the officers' managers.

The ERT receives an additional six days of training every year.

In general, BC Corrections officers receive only about half as much training as CSC officers – who receive 11-12 weeks of in-person training plus another 120 hours of online/take home work. They also receive significantly less than the 21 weeks of training for police officers in BC[117] and 26 weeks of training for RCMP officers.[118]

While the BC Corrections officer training materials include strategies for communicating with an angry person, they do not appear to include any significant information about communicating with someone whose ability to process information may be impaired by a mental health issue, a cognitive disability or a medical issue (such as intoxication).

According to BC Corrections' Force Options Coordinator, the training emphasizes de-escalation at every point and teaches officers not to use force if the person is compliant.

BC Corrections also offers a two-day training workshop for correctional officers designed to help them recognize and manage prisoners with mental health needs. It introduces officers to the major categories of mental disorders and their associated behaviours and symptoms. It covers trauma, suicide risk assessment and concurrent disorders, and emphasizes that behaviours such as self-harm and substance use are coping mechanism to deal with underlying issues. The workshop attempts to build officers' empathy, gives them skills for communicating with prisoners with mental health needs, and instructs them in how to document incidents and communicate with other staff.

The workshop is primarily for officers working regularly with prisoners with mental health needs, such as Mental Health Liaison Officers, officers working on mental health or complex needs units, and officers who work in segregation. However, there is no requirement that these officers take the training *before* they begin working in these areas, and for some officers (such as those who work in segregation) it is voluntary. There is no refresher requirement, though some officers voluntarily participate multiple times.

Mental Health Liaison Officers (correctional officers with a focus on mental health) also have the opportunity to participate in a monthly teleconference with BC Corrections' Director of Mental Health Services.

Force options instructors receive five days of face-to-face training. They must also take two online courses, Crisis Intervention and De-Escalation and Facilitation Skills, as prerequisites. Additionally, all managers and supervisors have access to an online course called Force Options Training for Correctional Supervisors and Managers, which highlights the important role that supervisors and managers play in establishing a positive culture of professional interactions with prisoners.

Force options instructors also recently attended a workshop on trauma-informed practice, with the goal of having them incorporate awareness of trauma into their trainings. Information about trauma-informed practice was also incorporated into a recent ERT Commanders workshop. BC Corrections informs us information on trauma-informed practice will be added to the Force Options Manual and the Officer Safety Refresher material by the end of this year.

BC Corrections also maintains a trauma-informed guide team which includes probation officers, deputy wardens, correctional officers, BC Corrections' Director of Mental Health Services, BC Corrections' Director of Programs and Interventions, and members of the First Nations Health Authority and Provincial Health Services Authority. Cultural awareness training is also provided to BC Corrections staff.

EXTERNAL OVERSIGHT

There is no formalized system for regular external oversight of uses of force in BC Corrections facilities.

Section 28 of the *Correction Act* establishes the Investigation and Standards Office, which is empowered to investigate issues relating to the administration of the Act and is entitled to access any correctional centre, prisoner, staff member, or file under the custody and control of the Ministry of Public Safety and Solicitor General.[119]

Provincial prisoners can also make complaints to the BC Ombudsperson about decisions, acts or omissions that were unfair, contrary to law, oppressive, discriminatory or otherwise wrong. The Ombudsperson has discretion to decide whether complaints will be investigated. The Ombudsperson can make recommendations to the investigated authority based on their findings.[120]

Prisoners' Legal Services recommends that the Investigation and Standards Office play an analogous role to the federal Office of the Correctional Investigator by reviewing every use of force incident in BC Corrections facilities. The Investigation and Standards Office is well-positioned to take on this role. It has the legislative authority to access necessary information and it has extensive knowledge of the correctional system in British Columbia. Additional resources and staff should be allocated so that the ISO can expand its capacity and perform this critical oversight function.

In the interim, the ISO should regularly review a random sampling of use of force incidents.

In addition, the inspections of BC Corrections institutions that were resumed in 2012 following an 11-year hiatus[121] should include more in-depth reviews of use of force incidents. At present, these inspections only include questions about protocols for reporting the use of control tactics, the functioning of the video equipment, whether staff who carry OC spray are up-to-date in their training, and whether staff know how to preserve video footage. These are important issues – indeed recent inspections have found that not all staff know how to preserve video footage.[122] However, the inspections should also include substantive reviews of use of force incidents themselves. For instance, inspections should assess not only whether staff *can* preserve video (a question that is part of the current inspection checklist), but whether they *have* preserved video for randomly selected use of force incidents. Inspections should also assess incidents to ensure force was used appropriately, decontamination was adequate, reviews were thorough and appropriate remedial action was taken.

There is also a great need for an audit of the Provincial Health Services Authority's post-use of force medical assessments and clinicians' compliance with their ethical obligations in this regard.

V. CORRECTIONAL SERVICE CANADA'S USE OF FORCE FRAMEWORK

People in Correctional Service Canada custody have received criminal sentences of two years or more. Some are also temporarily detained if their conditional release has been suspended.

Between October 2016 and February 2018, the Office of the Correctional Investigator was notified of 1,914 uses of force against federal prisoners.[123] The average daily count of adults in federal prisons during the 2016-2017 year was 14,425,[124] meaning that if each use of force were against a distinct individual, 13 percent of the prison population would have experienced a use of force during the 16-month period. However, it is likely that some prisoners were subjected to multiple uses of force in that time period.

Officers used pepper spray in nearly half of the 1,914 incidents. More than 40 percent of the time, force was used against at least one prisoner with a documented mental health concern. Almost half of the time, force was used against at least one Indigenous prisoner.[125] Black prisoners are also over-represented in use of force incidents.[126]

In more than 13 percent of cases, officers used force in a situation involving a prisoner who was self-injuring; officers used pepper spray in the "overwhelming majority" of these incidents. Most use of force incidents occurred in maximum security institutions, and approximately one third occurred in a prisoner's cell – meaning the prisoner was contained in an area with a door that either was or could be closed and locked. [127]

The Regional Psychiatric Centre in Saskatoon, which is supposed to be a therapeutic environment designed to treat prisoners with serious mental and physical health issues, was the institution with the highest number of use of force incidents. The Regional Treatment Centre in Ontario had the third highest number of use of force incidents.[128] This raises significant concerns about the environment of these treatment centres and CSC's strategy for responding to prisoners in emotional or medical distress.

Overall, these statistics reflect concerning trends repeatedly identified by the Correctional Investigator, including extensive reliance on OC spray, force in response to mental health crises or symptoms of mental illness, and the over-representation of prisoners of colour (particularly Black and Indigenous prisoners) as victims of use of force incidents.[129]

Use of force expert Steve J. Martin notes that "high-tech weaponry" including OC spray — which he says was developed in Canada to control bears — is subject to abuse, in part because it generally leaves no physical trace.[130] In 2016, the Office of the Correctional Investigator raised the alarm that since OC spray has become standard issue for most front-line correctional officers its use has tripled, replacing "less invasive methods of resolving tension and conflict behind bars." The Correctional Investigator found that 60 percent of all acts of force by CSC officers during the 2015/16 year involved OC spray, and that 54 percent of acts of force against a self-harming prisoner involved OC spray, which he considers inappropriate from a therapeutic, human rights and security perspective. The Correctional Investigator calls for policy requiring limits on the use of chemical agents to situations involving an imminent threat or danger.[131]

The Correctional Investigator has also consistently identified concerns about compliance with use of force policies, including problems with videotaping, decontamination after the use of OC spray, post-use of force healthcare assessments and more. For instance, uses of force in federal institutions must be videotaped — an important tool to ensure accountability — yet more than 60 percent of incidents involved problems with camera compliance.[132]

THE CULTURE OF CORRECTIONS

Edmonton Institution, a federal maximum-security facility in Alberta, has become notorious for a toxic culture of abuse of both prisoners and female staff. In 2013, a group of prisoners sued the institution, alleging guards put spit and feces in their food, beat them, OC-sprayed them, and forced prisoners to attack one another.[133] Another prisoner alleges that, in 2016, he was shot in the genitals at point blank range with rubber bullets by the ERT.[134] In 2018, several female officers filed their own lawsuit alleging they were bullied, sexually harassed and assaulted by male colleagues.[135]

In 2016, CSC commissioned an assessment of the working environment at Edmonton Institution, which concluded that the institution "can only be described as a culture of fear, mistrust, intimidation, disorganization, and inconsistency." It further concluded "Rarely is anyone held accountable for their actions" and

noted that the culture had gone on for years.[136] It also identified "several instances brought up in interviews of bullies physically or mentally abusing inmates," and that "both Correctional Officers and Intervention staff said that they had witnessed abuse but were too afraid to report it to Correctional Managers or any manager."[137]

It is no surprise that Edmonton Institution had the second highest number of use of force incidents in the country.[138] Data also shows it had the highest rates of self-harm by prisoners of any maximum security prison in Canada.[139]

In 2017, a female officer who worked for CSC filed a human rights complaint for the "humiliating" treatment she endured while training to be a member of an ERT, saying she found her underwear strewn about her dorm room, she was made to stand at attention in front of male colleagues in only a thin tank top and small shorts, and that during an exercise she had to lie on her back in a pitch dark room and fight off a male colleague who straddled her while the instructors yelled, "Do you wanna get fucking raped?"[140] The staff culture that would consider these actions appropriate in a training setting also allows for abuses of prisoners during use of force incidents.

An example of how the correctional culture within CSC results in violations of law, policy, and the dignity and human rights of prisoners is a 2010 lockdown at Kent Institution, which was reviewed by the Correctional Investigator. He found that the Pacific Region's ERT assumed a "lethal over-watch" function for 10 days, during which time "compliant and handcuffed inmates were removed from their cells at gunpoint." They were led down the ranges with loaded guns pointed at them and strip searched in a common area "often with little concern for dignity, modesty or privacy."[141] The Correctional Investigator found:

> As the lockdown continued and the search failed to turn up the alleged threat, the ERT and TAC [Tactical Team] response adopted an increasingly provocative and intimidating posture. Legal and policy provisions regarding use of force interventions were routinely violated as members of the Tactical Team operated in the absence of any management presence or effective oversight for the duration of the crisis. In daily reports of their activities, team leaders denied that weapons were drawn or pointed directly at inmates, despite videotape evidence to the contrary.
>
> …These events should concern Canadians as the issues and questions raised in this report are disturbing. They cannot simply be explained as a 'deviation from policy,' contrary to the perspective of the CSC. Rather, what happened at Kent Institution amounts to an abuse of correctional power and authority, systemic breakdowns in management accountability and oversight, gaps in use of force review and reporting procedures, deterioration in dynamic security practices and principles, and violations of human rights law and policy. These are significant deficiencies that increasingly call into question the effectiveness of CSC's internal use of force review process.[142]

It is not enough for CSC to adopt policies requiring that the lowest level of force be used in a situation. In order to change the staff culture described above, changes must be made that will ensure better review of uses of force with more transparency and public accountability.

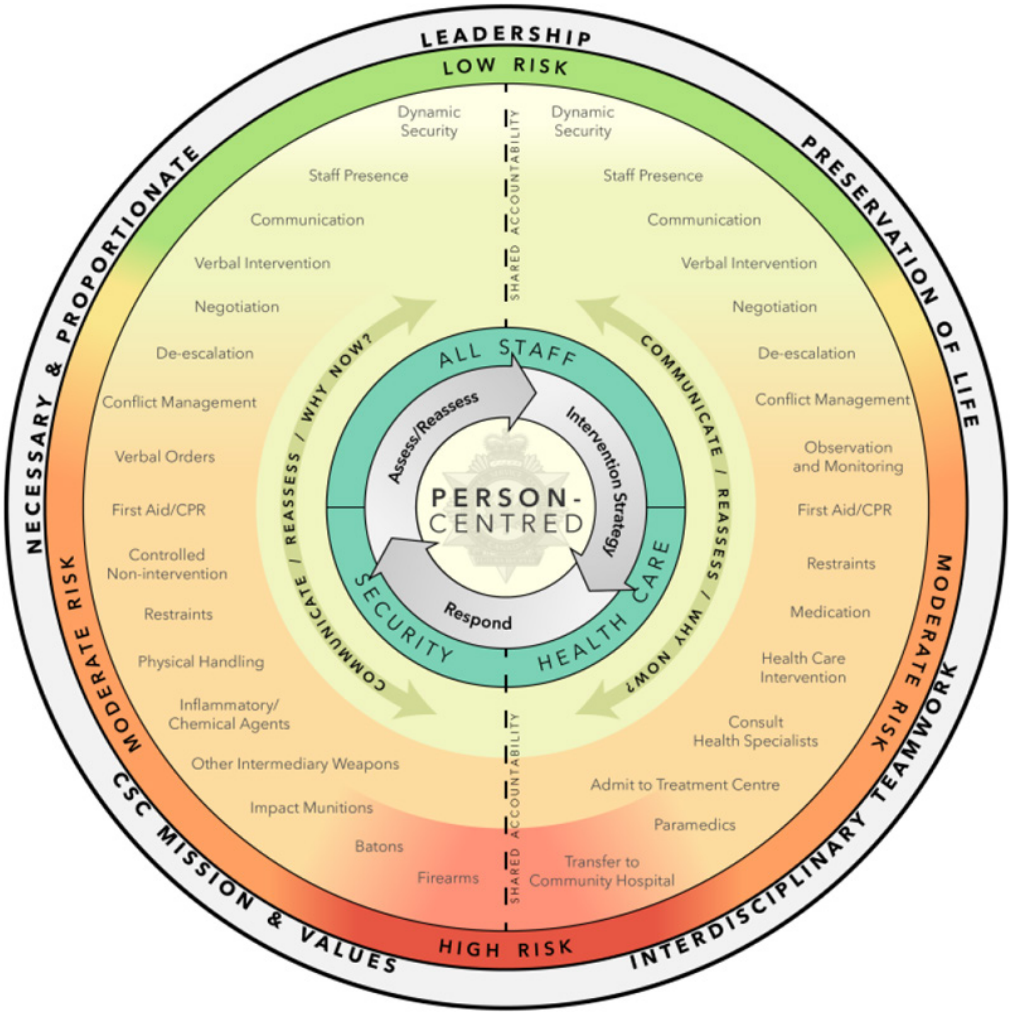
LAW AND POLICY

As discussed above, all corrections officers are governed by the *Criminal Code of Canada*, which authorizes them, if they act "on reasonable grounds," to use "as much force as is necessary" to carry out their authorized duties.

CSC officers are further bound by the CCRA, which limits actions "to only what is necessary and proportionate to attain the purposes"[143] of administering "safe and humane" sentences and assisting in the rehabilitation and reintegration of prisoners.[144]

Commissioner's Directive ("CD") 567 outlines CSC's Engagement and Intervention Model (EIM) for responding to incidents. This model was adopted in January of 2018, partly in response to the death of Matthew Hines due to several acts of force by officers at Dorchester Penitentiary in 2015. The Engagement and Intervention Model replaced the Situation Management Model and is, among other things, intended to better integrate security and healthcare responses, to emphasize the continual reassessment of risk, and to resolve incidents without force whenever possible.[145]

The Engagement and Intervention Model is meant to govern all interventions – not just by



CSC's Engagement and Intervention Model

correctional officers, but by anyone (including healthcare staff). It represents a switch to a risk-based model that considers behaviour and other factors, assigns a level of risk, and responds to that risk. Situations under this model are understood to be dynamic and the level of risk can change at any moment, requiring a different response. Any time a response is considered, the responder is to reassess the level of risk and ask: "Why now?" Responders are expected to continue to communicate with the prisoner throughout the incident.

The Engagement and Intervention Model involves healthcare providers as appropriate responders to healthcare crises. It is acknowledged that incidents can be security-related, health-related, or both, and CD 567 states that an interdisciplinary team approach should be used when possible. We understand from CSC that, under the previous policy, a prisoner who was refusing to lock up in their cell or who was exhibiting an altered level of consciousness would be considered physically noncompliant and could be subjected to OC spray. Under the new Engagement and Intervention Model, these scenarios are considered to involve a healthcare component requiring more information about the prisoner's medical needs.

Specifically, the Engagement and Intervention Model states that all interventions will:

- take into consideration the inmate's mental and/or physical health and well-being, as well as the safety of other persons and the security of the institution;
- when possible, promote the peaceful resolution of the incident using verbal intervention and/or negotiation;
- be limited to only what is necessary and proportionate; and
- take into consideration changes in the situation through the use of continuous assessment and reassessment.[146]

"Necessary and proportionate" is defined as follows:

> taking into account the reasonable need for maintaining certain operational routines, if the threat may be safely managed without a use of force, then force is unnecessary. The amount of force used must also be the minimally necessary force (proportionate) to safely manage the threat. The concept of necessary and proportionate also applies to health interventions.[147]

Policy also requires staff to use the AIM (Ability, Intent, Means) tool to evaluate the probability of harm occurring and the severity of that harm. The OCI notes that this risk assessment has historically been "lacking," finding that "inflammatory agents (pepper spray) have been over-used and over-relied upon to induce or compel compliant behaviour, even when the risk is considered minimal. Verbal intervention skills and de-escalation techniques have been eroded or minimized."[148]

According to policy, if "tactical intervention" is deemed necessary, possible interventions include:

- restraint equipment;
- physical handling;
- chemical and inflammatory agents;
- batons, impact munitions and other intermediary weapons; and
- firearms.[149]

Commissioner's Directive 567-1 – Use of Force outlines further procedures related to the use of force. We understand this policy was updated in December 2018, though as of June 2019, the new version has not been

made publicly available (an old version, dated February 1, 2016, is still on CSC's website, where all Commissioner's Directives are publicly posted).[150]

CSC's December 2018 use of force policy reiterates that force "will be limited to only what is necessary and proportionate to manage the incident." There is no discussion of de-escalation, conflict resolution, or peacefully resolving incidents without force. [151]

The policy distinguishes between planned and spontaneous uses of force. Importantly, the new policy clarifies that a spontaneous use of force is a situation where force is "required to prevent imminent harm to oneself or others."[152] This is a good standard that should be applied to all uses of force. Planned uses of force must be approved by a correctional manager or crisis manager.

The new policy clarifies that even if a use of force is initially spontaneous, "once the situation is contained, it should normally become a planned use of force."[153] This is important because officers must use a hand-held video camera — which, unlike closed-circuit television recordings, have audio — to record all planned uses of force from the outset and all spontaneous uses of force "as soon as possible"[154] once underway. The new policy also states that force is video-recorded for "safety, evidence and accountability."[155] It instructs camera operators to "safely position and reposition themselves in order to simultaneously capture the inmate's behaviour and the staff response"[156] whenever possible. These additions are welcome, though it remains to be seen whether they improve the quality and availability of handheld video footage.

According to the use of force policy, consultation with a medical professional only occurs prior to a use of force "if time and circumstances permit."[157] Similarly, officers can consult other sources of information related to the prisoner's health or mental health (such as CSC's electronic system) "if time and circumstances permit."[158] This is too broad an exception. PLS spoke to several clients who had force used against them during an emotional crisis, and the Correctional Investigator has highlighted the frequency of force against prisoners with mental health disabilities. This weak language continues to prioritize a punitive response and does not integrate the knowledge or skills of healthcare staff.

The new policy clarifies who is responsible during a use of force, highlighting the responsibilities of the sector coordinator and correctional manager/officer in charge. This is, presumably, designed to respond to the critique that, on the night Matthew Hines died, no single officer took charge of the situation despite numerous officers attending the scene.[159]

The new policy makes changes with respect to strip searches, clarifying that strip searches must be video-recorded when they are "required as a continuation of a use of force intervention."[160] If a prisoner does not comply with a strip search, officers must obtain authorization to conduct the search from the officer in charge. Further, force must be adjusted if the prisoner states they will cooperate at any point during the search – a good standard that should apply not just to strip searches but to all use of force interventions.

We are also pleased to see that the new policy removes the requirement that the officer in charge of the intervention repeatedly state:

> A strip search must be conducted. If you do not cooperate, physical handling, or chemical or inflammatory agents may be used. Will you cooperate and remove your clothes yourself? Do you understand? [161]

This language was overly aggressive and dehumanizing.

Notably, the removal, display or threatened use of OC spray is not considered a use of force – a policy change made by CSC in February 2016 that has repeatedly been criticized by the Correctional Investigator as reducing accountability.[162] The threatened use of the ERT is also not considered a use of force.

The new policy expands the language around decontamination, requiring that it take place "as soon as operationally possible"[163] (a rather vague requirement) and that handcuffs be removed unless officers determine through a risk assessment that "direct physical control"[164] is required. A decision not to remove handcuffs must be justified in writing. Decontamination must also be video-recorded.

In addition, the new policy requires staff "to monitor the overall well-being of the inmate throughout the decontamination process and … act on any cues of distress"[165] – another change that, presumably, responds to Matthew Hines' death. This is also a welcome change, though staff should be required to respond to a prisoner's distress at *all* times, not just during decontamination.

The use of force policy also requires that all prisoners be offered a post-use of force physical assessment by a healthcare professional, and outlines requirements related to video-taping, briefing, and follow-up treatment (discussed in greater detail in the section on medical providers below). If no healthcare professional is on site, a staff member certified in first aid and CPR will provide an initial first aid assessment. If the prisoner refuses a medical assessment, follow-up offers may be made depending on the level of force used.

Under the new policy, after the use of force, correctional managers must conduct a "post-incident debrief"[166] with as many of the staff who were involved as possible.

A correctional manager must also visit the prisoner to offer them an opportunity to make a verbal or written statement about the use of force, documenting any concerns.

A series of documents related to the use of force must be uploaded to CSC's Use of Force Review module, and within three working days, a correctional manager or more senior staff member must do a preliminary review to identify any major concerns — meaning that, if the correctional manager does not flag concerns, the use of force will not receive a higher level of scrutiny.

The reviews then proceed based on whether the force is designated as level 1, 2 or 3, which impacts whether they will be reviewed only by the institution or by regional or national headquarters.

Level 3 reviews involve situations where there may be serious violations of law or policy. The new policy defines "serious violations" as the "possibility that the law and/or policy was flagrantly or willingly disregarded and results in inappropriate practices, means, methods, operations or processes."[167] The new policy requires wardens to request that a use of force be designated as Level 3. If the Director General, Security approves the request, the incident is reviewed at the institutional, regional and national levels on an expedited timeline. The Correctional Investigator is also notified.

Every use of the ERT in response to self-injury is also reviewed at the national level.

The new policy clarifies that Level 2 reviews, a subset of which are also reviewed by regional and national headquarters, are conducted when:

- [the force involves] any actual physical use of inflammatory/chemical agents, intermediary weapons or firearms;
- the intervention management strategy is deemed to be inappropriate;

- the force used is deemed not to have been necessary;
- force was necessary but is deemed not to have been proportionate; or
- the use of force involves allegations of excessive force by the inmate.[168]

It is unclear from the policy whether any allegations of officer misconduct by the prisoner are sufficient to trigger a Level 2 review or whether the prisoner has to explicitly allege the force was "excessive."

Level 2 reviews must be completed by the deputy warden within 20 working days. Twenty-five percent of Level 2 reviews are also reviewed by regional headquarters, and five percent are reviewed by national headquarters. Regional headquarters also reviews all uses of force against prisoners designated as currently at risk of suicide or self-injury, prisoners in designated mental health beds (in treatment centres or mainstream institutions), and self-injurious prisoners, as well as force to administer medical treatment. National headquarters reviews 20 percent of these cases.[169]

This new articulation of Level 2 criteria appears to state that inappropriate interventions, unnecessary force, and disproportionate force by officers do not constitute "serious violations" of law or policy and do not need a high level of review. This is troubling, as these forms of misconduct are serious and ought to be scrutinized at the national level.

Level 1 reviews are done at the institutional level and are completed when the force involved anything not covered by levels 2 and 3. These reviews must be completed by the assistant warden, operations within 20 working days and are not reviewed at the regional or national levels.

The new use of force policy also specifies that, after a use of force review is completed, "all identified areas of improvement and corrective actions will be addressed as soon as practicable and documented as action plans in the Offender Management System Renewal."[170] However, the policy does not task anyone with responsibility for ensuring this happens.

Another new addition to the policy is the requirement that the Director General, Security "monitor and analyze intervention and use of force trends."[171] This is a positive addition, and we encourage CSC to make it meaningful by tracking uses of force against vulnerable prisoners, including prisoners with mental health disabilities, prisoners who self-harm, transgender prisoners and Indigenous and visible minority prisoners. This data should be made public.

Commissioner's Directive 567-4 outlines further policy regarding the use of chemical and inflammatory agents, including the procedures for decontamination following their use, which includes washing the contaminated skin, flushing the eyes for at least 15 minutes and providing a change of clothing.[172]

As mentioned above, the Correctional Investigator has repeatedly noted that the former policy model is inapproriate to respond to medical and mental health emergencies, and that reliance on it has ended in deaths, including that of Matthew Hines. In March of 2018, CSC released an internal audit of the former Situation Management Model, which included a number of critiques of how it was implemented in CSC, including a widespread failure to adequately address policy violations by officers.[173]

Among other things, the audit found that use of force reviews tended to be narrow, focusing on technical aspects of policy compliance rather than providing a broader critical analysis of the incident. As a result, serious issues were not

being adequately represented in these reviews. For instance, although management indicated they felt staff were failing to adequately assess and reassess the situation and adjust their interventions accordingly, only a tiny fraction (3 percent) of use of force reviews identified this as an area of noncompliance.[174]

The audit also found that, when noncompliance was identified, remedial actions taken by CSC staff were generally weak and were not calibrated to respond to the seriousness of the breach. The audit noted:

> Corrective action … was generally limited to management sending emails to the staff member(s) involved, or providing an in-person reminder of policy requirements. Further, we found that this same type of corrective action was utilized regardless of the significance of the policy non-compliance; for example, issues with first aid assessments not being completed were dealt with the same way as staff not stating their name and date prior to turning off the handheld video camera.[175]

The audit found these actions were ineffective, as the same problems repeatedly occurred. It also found that corrective action did not escalate to disciplinary action if the problem continued. Another highly troubling finding of the audit was that, in some of the situations where force was found to have been inappropriate – and even possibly criminal – there was either no corrective action identified or none taken.[176]

While the frankness of this audit is welcome and the transition to the Engagement and Intervention Model represents a positive change, reporting from clients and information from the Correctional Investigator raise concerns about whether it will in fact reduce reliance on force.

The Correctional Investigator notes it is not clear the switch has resulted in meaningful changes with respect to a number of key factors, including:

- De-escalation of incidents;
- Reduction in the number of use of force incidents;
- Over-reliance on OC spray;
- The involvement and role of other "partners" (such as healthcare) in managing or responding to incidents and behaviours that could lead to a use of force; and
- Compliance and disciplinary measures when CSC determines a use of force was inappropriate and/or excessive.

The Correctional Investigator has further noted that the general rate and severity of use of force incidents seems to have actually *increased* since the introduction of the Engagement and Intervention model last year.[177] These findings call for a rigorous external evaluation of the new model.

Further, the Situation Management Model audit identified major concerns with how the use of force is *evaluated* and how CSC managers respond to problematic behaviour by staff — meaning that, in addition to changing how officers are directed to act, CSC must also change how they are held accountable. This issue is exacerbated by prisoners' lack of access to information about the uses of force against them, including the video footage and use of force reviews (which in most cases prisoners are told to obtain through the Access to Information and Privacy process, which can take years).

CSC Guideline 081-1 specifies that all prisoner grievances related to use of force incidents or reviews are final-level grievances – meaning they are reviewed at the national level without having to go through lower-level reviews first. This is a good policy, but is not adequate to ensure acts of force against prisoners are reviewed in a

meaningful and thorough fashion, given that the Correctional Investigator has characterized the grievance system as "broken." [178]

THE ROLE OF MEDICAL PROVIDERS

Healthcare in CSC penitentiaries is not provided independently of corrections. Instead, healthcare providers are employees of CSC, though recently CSC has been making changes purportedly to encourage their independence. This is nevertheless a violation of the *Mandela Rules*, which requires that prison health services be "organized in close relationship to the general public health administration"[179] and that medical providers "act[] in full clinical independence."[180]

CSC provides guidance to healthcare staff with respect to use of force incidents.[181] The document's "guiding principles" state that healthcare staff must never act as members of the ERT "as there is an inherent conflict of interest between these two roles." While this is a good policy, it should be much broader, as there is an ethical conflict between the provision of healthcare in the best interests of the patient and playing a role in *any* use of force, whether or not the ERT is involved.

The guidelines specify that healthcare shall be consulted prior to a use of force "if the time and circumstances permit." Any information shared by healthcare staff must be general, and healthcare staff must not make any recommendations or provide advice about the types of force to be used.

The guidelines outline how to conduct a post-use of force physical assessment, which must be offered to every prisoner subject to a use of force. The assessment begins with a briefing from the correctional manager or ERT leader, who describes to the medical professional (generally a nurse) what occurred. This briefing is video-recorded, as is the assessment itself.

CSC has stated that the post-use of force medical assessment captures the prisoner's description of the force, but policy does not require this (the policy only mentions the prisoner's "pain or injury"). Since the clinician will already have been briefed by officers, this may bias them toward CSC's version of events. Nor are clinicians instructed to assess the prisoner's mental state; the policy refers only to a physical assessment.

The assessment must be offered "as soon as possible" after decontamination and after restraints have been removed, unless the restraints are to prevent self-harm. If OC spray or chemical agents were used, CD 567-4 requires the prisoner be provided with a shower and clean clothing. Healthcare policy requires clinicians, as part of their post-use of force medical assessment, to ensure decontamination has happened and check the person's respiration and eyes. However, nothing in policy requires clinicians to ensure prisoners have clean bedding or living environments (such as when prisoners are OC-sprayed in their cells). Indeed, Joey reports he has been living for weeks in a cell where the floor is covered in OC spray.

The healthcare professional is required to "directly observe" the prisoner during the assessment. If this cannot be done for safety reasons, a "cursory physical assessment" may be done through a food slot, window or other barrier, but must always be followed by a "comprehensive physical assessment" without a barrier once it is safe.

The guidelines also specify that the assessment should be in as private and confidential an area as possible.

If a prisoner refuses a medical assessment and the force is considered Level 2 or 3 (OC spray or other weapons were used, there is a concern

about excessive force or injury, etc.), healthcare staff must return within an hour to make a second offer.

The guidelines also specify the process for reviewing the healthcare professional's role in use of force incidents. If the review identifies areas of noncompliance with policy or professional practice standards, the Chief of Health Services must develop an action plan to address the deficiencies.

If the force was used to administer medical treatment, the review must involve the Regional Director Health Services – though to PLS's knowledge at least some of those regional directors do not have healthcare backgrounds. The Director General Clinical Services also reviews uses of force involving medical interventions or "serious clinical deficiencies," as well as any other uses of force the Director General Security deems appropriate. The role of the Director General Clinical Services – and/or other senior medical and mental health practitioners – ought to be expanded to provide oversight of all uses of force against prisoners with physical and mental health disabilities.

The lack of independence of healthcare professionals working with federal prisoners raises serious concerns about dual loyalty, as discussed above. Use of force is an area where medical professionals are particularly vulnerable to competing pressures. The use of force guidelines do not outline any obligations of medical providers to report signs of ill-treatment, and as such do not meet ethical standards.

TRAINING

Our review found that CSC's lack of transparency extended to access to information about the training that officers receive regarding use of force. PLS requested CSC's officer training materials in June of 2016. In January of 2018, we received a response saying that CSC was withholding all information in its entirety under the *Access to Information Act* s. 22 (information related to testing). We clarified we were not requesting testing material. Also in January of 2018, PLS submitted a complaint regarding this lack of disclosure to the Office of the Information Commissioner of Canada.

PLS also requested the training materials directly from CSC for use in this report. We were encouraged to put in a research application, which we did in September 2018. We were informed in November of 2018 that our "methodology requires access to documents that cannot be released by the Research Branch and need to be obtained through the Access to Information Privacy process."

Finally, in mid-March 2019 we received a response to our request that we understand contains over 10,000 pages. However, the compact disc that the records were provided on is damaged and we are unable to access the files. We requested a new disc from CSC's Access to Information and Privacy division and have yet to receive it.

CSC did provide us with the following outline of officer training:

Stage 1

This is an online learning program consisting of 50 modules. It requires 80 hours of online learning that is completed over 4-5 weeks.

Stage 2

This includes approximately 40 hours of workbook reading and assignments to be completed at home over a period of 2-4 weeks. Topics includes communication skills, responding to conflict and crisis situations.

Stage 3

This stage takes place in person through a 351-hour in-class program done over 11-12 weeks. It includes fundamentals of mental health training, knowledge of mental disorders and symptoms, and skills for effectively interacting with and supporting offenders with mental disorders, among other topics.

Without further information regarding officer training, we are not in a position to evaluate whether it adequately trains officers to treat prisoners with dignity and to use the least restrictive measures possible.

EXTERNAL OVERSIGHT

The CCRA establishes the Office of the Correctional Investigator, which serves as the ombudsperson for federal corrections. The Correctional Investigator takes and investigates complaints from thousands of individual prisoners each year. The office also reviews all CSC investigations into deaths of and serious bodily injuries to prisoners.

The Correctional Investigator plays a particularly critical external oversight role with respect to uses of force in the federal system, reviewing every reported use of force that occurs in a CSC facility. This responsibility arose in response to Justice Louise Arbour's investigation into a series of events at the now-closed Prison for Women in Kingston, including the strip-searching of female prisoners by a male Emergency Response Team.[182] The Correctional Investigator is notified every time a use of force review is created in CSC's electronic database (which may occur several weeks after the incident itself). The office conducts its own review of the incident in relation to law and policy, examining video footage and other documentation, and follows up with CSC when problems are identified.

The Correctional Investigator also identifies areas of systemic concern and makes recommendations to CSC for reform, publishing annual reports and, on occasion, special reports about topics of particular significance — such as the deaths of Matthew Hines and Ashley Smith. These reports provide invaluable information about and analysis of the federal correctional system to government and the public.

VI. LESSONS FROM HEALTH AND POLICING

THE FORENSIC PSYCHIATRIC HOSPITAL

The Forensic Psychiatric Hospital ("FPH") is BC's forensic facility that houses people who have come into conflict with the law but are deemed to be unfit to stand trial or not criminally responsible due to a mental illness. Many have committed acts of very serious violence, and the vast majority have been diagnosed with schizophrenia. Many have active psychosis. The facility can house up to 190 patients.[183]

FPH also provides psychiatric services on a short-term basis for BC Corrections prisoners who have been certified by two physicians under the *Mental Health Act*, meaning they can be admitted to hospital and treated without their consent.

PLS recently toured the facility, which the senior staff emphasized is a hospital and not a jail.

Indeed, we noticed many stark differences. The most notable difference is that the patients who live there are not locked in their rooms and can move about their units freely. (The only exception is when someone is placed in a seclusion room.) Every unit has access to outdoor space with grass and trees. Some patients have access to a wood shop, a music room, a school classroom and other educational spaces.

Security staff are not routinely stationed on the units. In fact, there are only six forensic security officers who serve the entire institution (that number drops to five during evening hours and four or five at night). The officers are supervised by a forensic security officer manager, who reports to the Senior Director of Patient Care Services — meaning the hospital's security staff are answerable to senior clinicians.

Instead of officers, nurses are the ones who interact regularly with patients. The unit we visited has approximately four nurses and three healthcare workers during the day. It is the clinical staff who intervene when patients are in distress and when conflicts occur, and security officers are called only when they are needed. All staff, including doctors, are trained to respond to emergencies.

FPH has recently transitioned to an approach called Therapeutic and Relational Security, which emphasizes the therapeutic rapport between staff and patients and relies on clinicians' knowledge of each individual patient's personality, triggers and needs to prevent aggression and de-escalate distress and conflict.[184] Forensic security officers are considered part of the team along with clinical staff, and all are trained in this model. In addition, trauma-informed practices are built into all aspects of care.

There is no ERT at FPH, and forensic security officers do not carry weapons. When staff use force against a patient, there is always one person who does not lay hands on the patient. That person explains to the patient what is happening, what they can do to end the use of force, and what will happen next. That person, senior staff told us, also acts as a check because they can more accurately describe what they saw than someone involved in the force. Staff debrief the incident after it occurs.

FPH's population has significant overlap with the correctional population, and the institution manages patients with very serious histories of violence and those who are highly volatile. Both BC Corrections and CSC should look to their approaches, including the Therapeutic and Relational Security model, trauma-informed practices and staffing models. Given the extremely high rates of mental health disabilities and addictions among prisoners, we recommend that both BC Corrections and CSC employ more nurses and social workers to work directly with prisoners on living units in all institutions, with higher ratios of therapeutic staff in treatment centres and mental health units.

In addition, the BC government should expand the role of FPH so that prisoners with serious mental health disabilities other than those who are certified, declared unfit to stand trial or not criminally responsible can nevertheless reside, for some or all of their remand stays or sentences, at the facility. This would help ensure prisoners with serious mental health needs can get the treatment they need instead of staying in jail, where their disabilities are likely to worsen and where they are vulnerable to landing in segregation or to having force used against them because of their untreated mental health needs.

COLLABORATIVE CRISIS RESPONSE

Around the country, health agencies and police departments are working together to respond collaboratively to crises involving people with mental health needs (including substance use issues) who come into contact with police. In BC, this includes a partnership between the Vancouver Police Department ("VPD") and Vancouver Coastal Health ("VCH").

The VPD-VCH partnership includes the Assertive Outreach Team ("AOT"), which pairs a police officer with a nurse (often a psychiatric nurse) to proactively reach out to people in the community and provide short-term support to individuals transitioning from jails or hospitals into the community. The partnership also includes Car 87/88 – a mental health crisis response car that pairs police officers and nurses to provide assessments and interventions for people with serious psychiatric problems.

The VPD has a mental health unit, staffed by officers who receive specialized training to respond to situations involving people with mental illness.

Other police-health partnerships that pair nurses with officers include Vancouver Island's Integrated Mobile Crisis Response Team[185] and Toronto's Mobile Crisis Intervention Teams ("MCIT"), among others around the country.[186]

These models are based on shared decision-making between health providers and police. While the interventions themselves sometimes prioritize health responses over police intervention or vice versa, the team works in tandem to make decisions about how to treat each client's health needs and manage potential risks. Nurses and officers develop a partnership and a shared expertise that is strengthened over time in a way that would not be possible if they were not dedicated to this role.[187] In addition, because officers self-select into these roles, the teams attract officers who have a particular commitment to supporting the needs of people with mental health issues.

This collaborative model has been shown to help police understand behaviours associated with mental illness and to learn the de-escalation techniques of their mental health partners.[188]

Indeed, in his report *Police Encounters with People in Crisis*, the Honourable Frank Ioccubucci identifies several advantages of Toronto's MCIT, including the ability to share information between police and healthcare so that responses can be tailored to the individual in crisis, as well as the involvement of mental health nurses who "possess a depth of medical knowledge and skill in interacting with people in crisis that cannot be easily matched by a police officer."[189] He also noted that officers involved in MCITs played an important role in reducing bias against people with mental illness within the police force.

He further states that the officer-nurse pairs should more frequently function as primary rather than secondary responders, noting, "it is unfortunate that police officers without specialized training in mental health crises are required to make a crisis situation safe before the professionals most capable of managing and de-escalating that crisis…are allowed to intervene."[190]

PLS recommends both CSC and BC Corrections establish dedicated nurse-officer teams at each institution to act as first responders to medical and psychological crises. While each team member's role would vary depending on the situation, the teams would have shared decision-making responsibilities and would ensure the individual's health history and needs were incorporated into any response.

These staff could also perform their traditional roles, but would receive special training – including training to work in tandem – to respond to crisis situations.

Both CSC and BC Corrections have existing infrastructure that could support this model. In CSC, the Engagement and Intervention Model already encourages an interdisciplinary approach. A nurse-officer team model would help formalize such an approach by identifying and training particular staff to respond in an interdisciplinary manner.

The Mental Health Liaison Officers already employed by BC Corrections would be natural fits for these teams. In addition, there is already expertise within BC provincial health authorities about operating these models in the community, and those experts could assist with the development of a model for corrections.

INNOVATIONS IN POLICING

The Memphis Crisis Intervention Team ("CIT") model is one of the most widely recognized successful approaches for helping to resolve crises involving people with mental health disabilities. It has been implemented primarily in the United States, where 2,800 jurisdictions across 45 states have started CIT programs.[191]

The model, developed in partnership with the National Alliance on Mental Illness, includes 40 hours of training in mental health and crisis

Jacqueline Ronson/The Discourse
The Discourse is a community-funded journalism outlet committed to communities whose voices have been too seldom heard in mainstream media. (theDiscourse.ca)

de-escalation for a designated group of carefully selected police officers, as well as training for dispatchers. Training includes, among other things, medications and side effects, alcohol and drug assessment; co-occurring disorders, developmental disabilities, suicide, personality disorders and Post Traumatic Stress Disorders. The training also includes a five-part crisis de-escalation training that covers basic and advanced verbal skills, stages/cycle of a crisis escalation, and complex scenarios. [192]

While the model does not involve police-nurse teams, it emphasizes collaboration with mental health providers, people with lived experience, advocates and other community stakeholders, and the curriculum includes visits to mental health facilities and interaction with individuals with mental illness. An outline of CIT's core elements states:

> Experience has shown this is a minimum level of training hours. The material covered is complex. The desired learning outcomes go beyond simple cognitive retention of material. The outcome desired is the retention of behavioral changes learned as part of the training.[193]

Lt. Michael S. Woody, President of the Board of Directors of CIT International, writes that "wherever CIT is in place in the world officer injuries go down," and "the call for SWAT teams and hostage negotiators goes down an average of 60 percent. Needless to say the injuries to persons with a mental illness goes down drastically."[194]

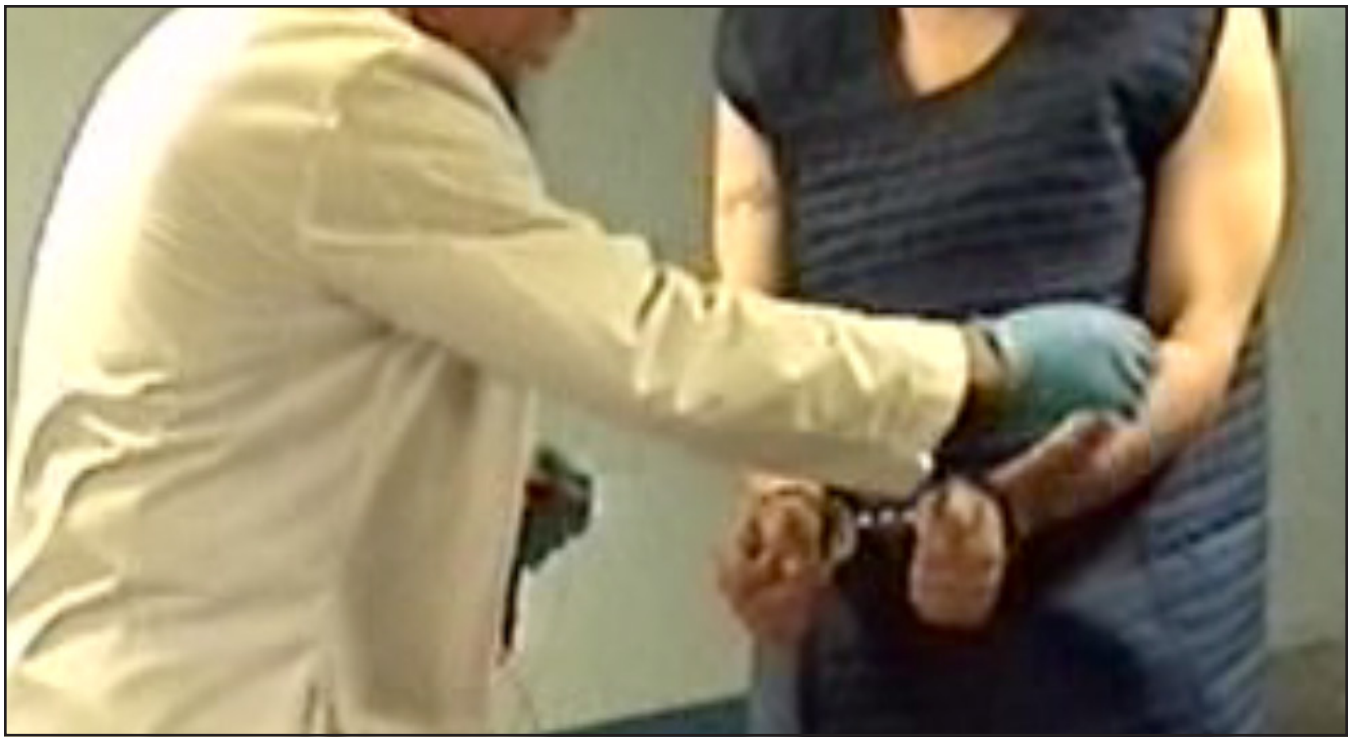
The Honourable Frank Iacobucci recommends in his review that the Toronto Police Service develop a pilot CIT program to complement the MCIT program.[195]

The Police Executive Research Forum ("PERF") has also focused on de-escalation and reducing force, particularly against people with mental health disabilities. In 2012, PERF convened police chiefs and experts for a summit in Washington, DC to discuss this issue.

The report that resulted identifies a number of promising practices from police departments around the United States, including the recommendation to establish the kinds of Crisis Intervention Teams described above. Other recommendations included dispatching a supervisor to potentially high-risk calls, noting that this can help slow down the response and potentially reduce uses of force, as well as training officers to understand that some situations do not require police action. "If an officer can walk away from a situation and no negative outcome results," the report notes, "in some cases that can be a more effective response than thinking an arrest or other intervention must always be made."[196]

Research on police-involved killings in the United States is also instructive. One study analyzed the relationship between police department use of force guideline and the prevalence of police-involved killings. The research identifies eight distinct policy elements, all of which were associated with lower rates of police-involved killings. The element resulting in the greatest reduction in killings — at a rate of 25 percent — was the requirement to comprehensively report both uses of force and threats of, or attempted, uses of force. The requirement to exhaust all other reasonable alternatives to deadly force also resulted in a 25 percent reduction in killings. Policies that required de-escalation resulted in a 15 percent reduction in killings, and policies requiring officers to intervene to stop another officer from using excessive force resulted in a nine percent reduction in killings.[197]

The same study found that police officers were less likely to be killed and assaulted in the police departments with the more restrictive use of force policies. [198]



VII. KEY FINDINGS

PLS has interviewed more than 100 federal and provincial prisoners about use of force incidents against them since January 2017. These are the primary issues that we have identified based on their experiences.

1. FORCE IS USED IN RESPONSE TO MEDICAL AND EMOTIONAL DISTRESS.

People with mental health issues, including histories of trauma, are significantly over-represented in the criminal justice system, too often having found themselves in custody because of a lack of community resources to address their needs. The prison environment, a stressful and volatile setting with very limited access to regular mental health supports, can exacerbate these issues. Further, there is broad consensus among researchers about the negative psychological effects of solitary confinement, and prisoners with preexisting mental health issues are particularly susceptible. Many of the symptoms associated with solitary confinement – such as irritability, aggression, rage, paranoia, hallucinations, anxiety, loss of emotional control, and self-harm[199] – could also lead to behaviours that might result in a use of force.

The policing community has begun to examine how to avoid force when dealing with people in crisis, in part because of tragic killings of people with mental health disabilities. The need to do the same in the prison environment is perhaps the most salient theme to come out of our interviews with prisoners.

Indeed, many clients we interviewed, including both federal and provincial prisoners, talked about officers using force against them when they were in emotional distress — including in response to self-harm. This is a very troubling strategy for addressing the needs of vulnerable prisoners.

Several prisoners, especially those in BC Corrections custody, pointed to instances when officers used force when they were in medical distress, such as when they were experiencing seizures or chest pains. In several cases, medical staff were either not called to the scene or were only notified after the force was underway.

These stories highlight a need to understand these incidents as medical issues – with a security element if needed – rather than the other way around.

Force against people in crisis

The International Association of Chiefs of Police ("IACP") defines "mental health crisis" as "an event or experience in which an individual's normal coping mechanisms have become overwhelmed, causing them to have an extreme emotional, physical, mental or behavioral response." The IACP goes on to say:

> A person may experience a mental health crisis during times of stress and in response to real or perceived threats and/or loss of control. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as an inability to focus, confusion, nightmares, and potentially even psychosis; physical reactions like vomiting or stomach issues, headaches, dizziness, excessive tiredness, or insomnia; and/or behavioral reactions, including the trigger of a "freeze, fight, or flight" response. Any individual can experience a crisis reaction regardless of previous history of mental illness.

This is a useful framework for understanding prisoners in crisis as well, and many of the IACP's recommendations for responding to these kinds of crises are applicable to the prison environment. For instance, the IACP notes that, though officers should be prepared for physical interventions, it is "critical that they do not come off as aggressive in their posture or stance" and that officers "should attempt to exhibit a caring attitude without becoming authoritarian, overbearing, condescending, or intimidating," since people in crisis "may be provoked by demeaning, condescending, arrogant, or contemptuous attitudes of others." The IACP emphasizes demonstrating empathy and "avoiding a tough or threatening manner."[200]

In many situations that we reviewed, the aggressive, threatening and intimidating tactics of officers caused crises to escalate. Use of force expert Steve J. Martin, in a discussion with Human Rights Watch, explains how the "strange, often violent, and irrational behaviour of agitated mentally ill prisoners, and their protracted struggle against being restrained, can scare correctional officers into acting more aggressively than they should." He further notes: "Once you're into the actual application of force, you have a "death escalation cycle." As the inmate is subject to a greater level of force, he develops a greater level of anxiety, his resistance escalates accordingly, which in turn requires a greater escalation of force."[201]

In 2013, the Ontario Ombudsman launched an investigation in response to police killings of people in crisis in Ontario. The investigation sought to examine alternatives to lethal force, including de-escalation. The resulting report looked at the way officer training often fails police who encounter people in crisis, who are not likely to respond to commands the way a person thinking rationally might. The report

quotes one trainer at the Ontario Police College who stated that "things that normally would work for a person who is not suffering and not in crisis, those same things will not work with those that are in crisis."[202] The report further notes:

> When facing a person armed with a knife, [police] are taught to pull their guns and loudly command the person to drop it. Although that tactic might prove effective with rational people, a person waiving a weapon at armed police is irrational by definition. Too often, the command only escalates the situation. It can exacerbate the mental state of a person who is already irrational and in a state of crisis. And once police have drawn their guns, using them is often the only tactic they have left.[203]

This finding is echoed by the Mental Health Commission of Canada, which noted in a report on police interactions with people with mental illness, "the standard police procedures and practices, which might typically disarm a non-mentally ill person, stabilize the situation or lead to cooperation, might have the opposite effect on a person experiencing a mental health crisis."[204]

This resonates with the conversations PLS has had with our clients with mental health disabilities. For instance, video footage of federal prisoner Client T shows him being OC-sprayed by the ERT while in his cell at a CSC treatment centre because he is not complying with their instructions to move to the back of his cell and put his hands on his head, despite his recent history of hallucinations and his demeanour indicating he may not fully comprehend what they are saying.

Joey has frequently described the panic he feels when he believes the ERT is coming for him. When he told us about cutting his throat, he explained that a negotiator had promised the ERT would not come, but that when he saw he had been deceived and the ERT was about to enter his cell, he slit his throat. Since then, he has described waiting with a razor blade or noose around his neck in case the ERT comes to assault him. It was not until an independent psychiatrist assessed him that he was diagnosed with Post-Traumatic Stress Disorder.

When the ERT arrived at provincial prisoner Client B's cell, he was in distress because he heard officers encouraging him to kill himself the day before. Video footage clearly shows that the ERT's presence causes him to become more distressed and to begin banging his head against the wall, to the point of momentarily losing consciousness.

It is notable that many of these uses of force occurred in prisoners' cells and that the prisoners were not in immediate danger — meaning that intervention by a mental health clinician or other medical provider would not have put the person at risk of harm, since they could simply talk to the person through the locked cell door if they felt that entering would be unsafe. Using force against a prisoner in their cell where, if officers were simply to leave, there would be no safety risk to a person, is not necessary or proportionate to attain the purpose of the CCRA to administer safe and humane sentences, or consistent with *Charter* rights.

Multiple other prisoners, particularly those in CSC custody, described officers using force against them in response to acts of self-harm. OC spray was a recurring weapon in these cases.

Self-harm and other emotional crises can be difficult for officers to address, especially with limited training on identifying health and mental health issues. But when force is used against prisoners who have histories of trauma or mental health disabilities, it only serves to further traumatize them, and can make the symptoms of their disabilities worse. It can also increase the likelihood that they will react

negatively the next time they are worried force will be used against them. This fails to accord with human rights protections for people with disabilities.

As the Canadian Patient Safety Institute notes in a training module on seclusion and restraint in mental healthcare, "behavioural emergencies" – which they define as violence or aggression – "are often a manifestation of unmet health, functional, or psychosocial needs that can often be reduced, eliminated, or managed by addressing the conditions that produced them."[205] They further outline the potential "serious negative physical, social, and psychological effects"[206] of restraining or isolating a patient with mental health needs, noting that "restraint and seclusion are not therapeutic care procedures" and have "no known long-term benefit in reducing behaviours."[207] They note the potential for psychological trauma, stating that "restraint use, particularly when employed on an ongoing basis, can be a major barrier to the person's recovery since the loss of control, social isolation, shame, and stigma can exacerbate feelings of despair and hopelessness." They also note that relying on restraints "paradoxically…increase[s] the risk of behavioural emergencies." And they point to the potential for medical complications, which include increased risk of asphyxia, thrombosis, blunt trauma, cardiac difficulties and death.[208]

As such, the Patient Safety Institute calls for a "culture of least restraint."[209] Corrections ought to adopt this framework as well – particularly for prisoners with mental health disabilities.

Force in response to self-harm

Self-harm occurs in prison at rates far higher than in the general population.[210] Prisoners are frequently accused of using self-harm to "manipulate" prison staff into giving them what they want. Our clients have described it as a means of being heard and communicating their distress when all else has failed. They also describe it as a way of coping with their surroundings. Self-harm is also a well-established effect of solitary confinement.[211] Research on suicide conducted for CSC argued that labelling self-harm as "manipulative" negatively impacted how staff dealt with such behaviours, and cited research showing that "acknowledging manipulation as a reason for self-injury validates hostile reactions from staff, and may serve to augment the seriousness of subsequent attempts."[212]

Using force to prevent self-harm may keep people from killing themselves, but does nothing to make people not *want* to hurt or kill themselves. In fact, it may exacerbate their distress and make them hide their self-harming in the future. The Correctional Investigator has repeatedly raised concern about the use of force – and the use of OC spray in particular – against people who are self-harming, concluding that "[o]utcomes such as these cannot be considered desirable or appropriate from a therapeutic, human rights or even security perspective."[213]

This is consistent with research on self-harm. For instance, in an article entitled "Should healthcare professionals sometimes allow harm? The case of self-injury," Patrick J. Sullivan explains that self-harm helps people cope with overwhelming distress, so preventing them from self-harming "reduce[s] their coping options and [is] likely to increase their distress or increase the risk of harm."[214] Sullivan further argues that the measures used to keep someone from hurting themselves "may increase their feelings of powerlessness and in extreme cases result in additional trauma and therapeutic alienation. This increases the risk that individuals will self-injure covertly, in more dangerous ways, or attempt suicide."[215] Ultimately, Sullivan concludes that "routine prevention is likely to lead to a net increase in harm,"[216] and argues that, for healthcare professionals, allowing

patients to self-harm "in fact…may be required if the benefits are significant and likely to outweigh such harm." [217]

Stories from PLS clients bear this out. Clients like Joey, Client M, Client L and Client O have talked about the trauma associated with being OC-sprayed, extracted by the ERT, and accosted by unsympathetic and sometimes explicitly antagonistic officers when they were self-harming or threatening to self-harm. Joey, Client B and others have told stories of officers encouraging them to kill themselves. Research on self-harm among prisoners has also found that negative and hostile reactions from staff negatively impacted prisoners' wellbeing.[218]

Echoing the recommendations of the Ashley Smith Inquest – which called for CSC to develop a distinct model to address medical emergencies and self-harm – the Correctional Investigator has repeatedly called for a fundamentally different response to self-injury. In its 2015-2016 Annual Report, the Correctional Investigator writes:

> …For a number of years, the Office has encouraged CSC to treat and respond to self-injurious behaviour as a mental health not security issue.
>
> …When confronted with a self-injurious offender, the SMM [Situation Management Model] requires staff to isolate and contain the threatening behaviour or situation as quickly and safely as possible. Non-clinical staff are trained and directed to respond as if all self-injurious incidents might result in accidental or intentional death. After verbal interventions fail, these situations can quickly escalate leading, in some cases, to some unhelpful or even punitive response options, up to and including the use of inflammatory agents, physical handling or restraints, disciplinary charges or placement in a segregation or observation cell.
>
> … An alternative response model would direct security staff to adopt a primary support role (i.e. ensuring everyone's safety) while the actual intervention, carried out by mental health professional(s), focuses on assisting the self-injurious offender.

While CSC's Situation Management Model has since been replaced by the Engagement and Intervention Model, PLS clients in federal facilities continue to experience security-oriented responses to self-harm, including force. Provincial prisoners sometimes experience this as well. This issue is poorly served by the lack of health and mental health staff at most federal institutions at night and on weekends.

Intervening with prisoners who self-harm is critical – we are not advocating for officers to look on idly while someone strangles themself to death, as in the case of Ashley Smith. We are arguing that the *type* of intervention must shift from a punitive and security-based approach that exacerbates a person's distress and makes them want to hide their self-harm to a therapeutic approach that prioritizes harm reduction, safety and intervention by mental health staff. This healthcare-oriented intervention must happen much earlier, when a prisoner is first known to engage in self-harm. Meaningful mental health services must be available to prisoners *before* they get to a state of crisis, and must be provided in a safe and therapeutic environment.

In addition, both BC Corrections and CSC ought to follow the Correctional Investigator's recommendation to place people who are chronically self-harming and suicidal at community psychiatric hospitals.[219] These prisoners do not belong in prisons and may have their mental health issues exacerbated by management strategies that involve repeated uses of force.

Force in response to medical distress

PLS spoke with several clients in the provincial system who had force used against them when they were in medical distress. This includes multiple prisoners who were experiencing seizures when the use of force occurred. Some of these prisoners told us officers thought they were under the influence of drugs. Even if they were intoxicated, that would still constitute a medical issue that could put the person's health at risk. This is not a justification for using force rather than involving healthcare staff.

One video we reviewed involved a prisoner who had a heart condition. In the video, he is complaining of chest pains, is clearly weak and at one point appears to lose consciousness. The ERT proceeds to place him in a suicide smock, extract him from his cell, and move him to the shower all before bringing him to healthcare. It takes 11 minutes for him to be given medical attention, though he is compliant – docile, even – from the outset.

Provincial prisoner Client C, who also suffers chest pains before collapsing and ultimately losing consciousness, is left lying alone and unconscious on the floor of segregation for a period of 10 to 15 minutes, and then for a second period of 20 minutes. Though medical staff had previously attended the scene, they cited his behaviour as a reason they could not treat him. However, video footage shows nurses stepping over his limp body before leaving him alone, lying unconscious on the floor.

These experiences recall the case of Matthew Hines, who died after officers' actions created a medical emergency, which they then failed to recognize and respond to. When a nurse finally arrived, she did not assess him or provide medical attention, though at this point he was convulsing, spitting up blood and struggling to breathe.

When officers suspect a prisoner may be experiencing medical distress, including symptoms of drug intoxication, they should immediately call for assistance from healthcare. Using force in this circumstance is dangerous and could exacerbate medical concerns. There is no reason a compliant prisoner, much less an unconscious prisoner, cannot receive medical attention without compromising safety. At the very least, if a prisoner in medical distress also poses a safety risk, healthcare ought to be involved in the decision-making about the approach to care.

2. FORCE IS USED TO COERCE COMPLIANCE WHEN THERE IS NO IMMEDIATE SAFETY RISK.

Being in prison means losing the ability to make basic choices about daily life. What and when to eat, who to associate with, how to spend time, and when to leave one's "house" (the term some prisoners use to refer to their cells) have been radically restricted. Prisoners have very little control over their environments, and must follow officers' orders or be subject to consequences.

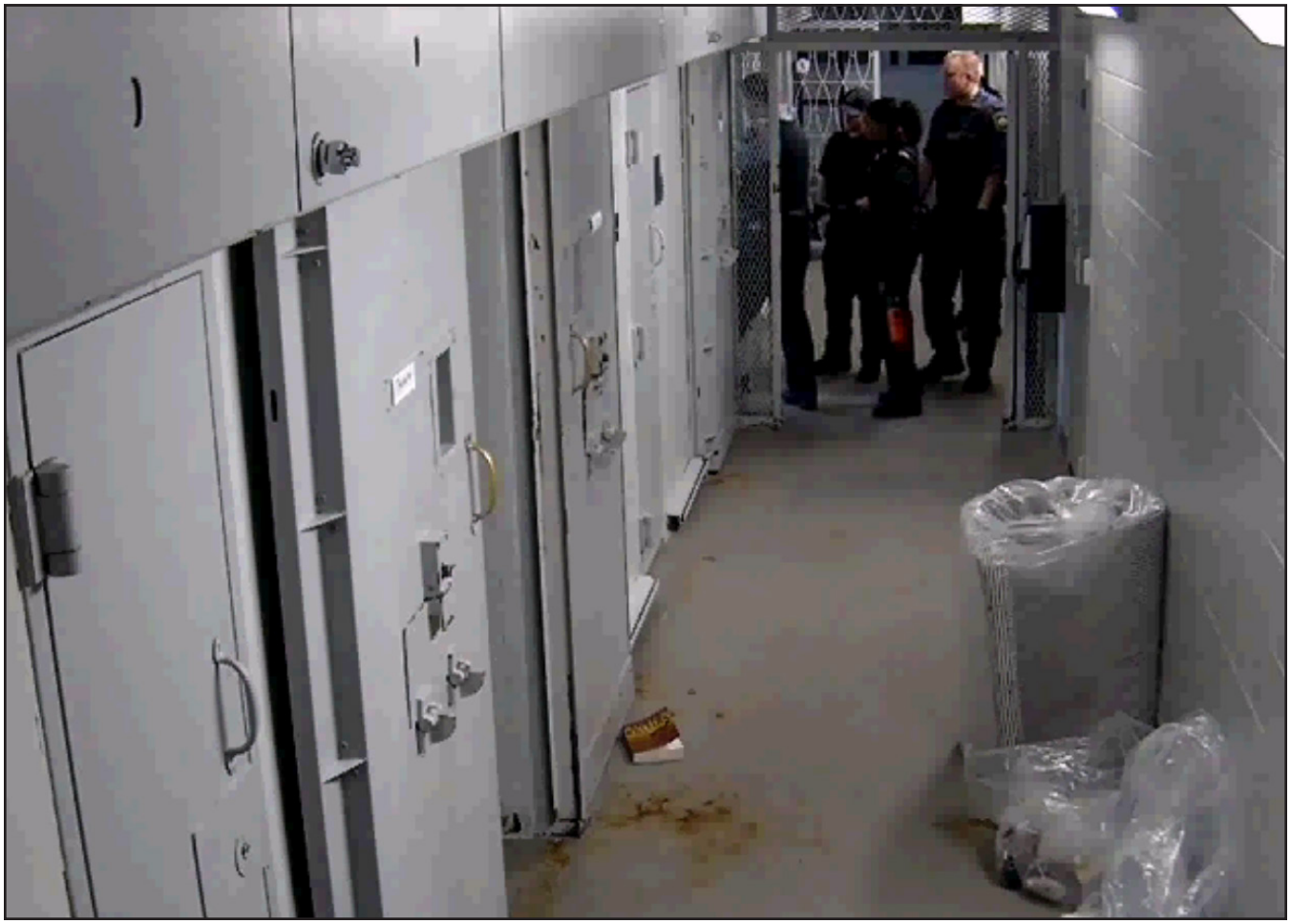
Sometimes, prisoners tell us, they do something intentionally disobedient, like cover their windows, when they feel they have no other way of expressing themselves. Misbehaving is almost always guaranteed to get officers' attention, and prisoners are rarely rewarded for being patient and using more "appropriate" channels.

PLS heard from many prisoners who were subject to force when they refused to comply with directions, but their actions were not threatening anyone's immediate safety. When a prisoner fails to follow an officer's orders in a way that does not create an immediate safety risk, officers have a series of options

for responding to that misconduct that do not involve violence. They can try to identify the underlying reason the prisoner is refusing to comply. They can try to negotiate with the prisoner. They can give the prisoner time to cool down or change their mind. They can give the prisoner a disciplinary charge. They can call in someone with whom the prisoner has a good rapport.

Using force in this circumstance often causes the incident to escalate, and while it may achieve the goal in the short-term, in the long-term it erodes relationships and creates an environment of fear and hostility.

Federally, this is what happened with Client P, who tells us officers berated him and grabbed him out of bed when he refused to leave segregation. This is also what happened with Client N, who because of mental health issues is permitted to take his meals from the cafeteria to his cell. Video shows that when he arrived approximately two minutes after breakfast ended, he was denied entry. Instead of leaving without his meal, he tried to go inside the cafeteria. Officers tackled him to the ground and OC-sprayed him. Client N is very clear about the psychological harm the incident caused him. He also makes clear that he believes officers perceived him as aggressive because he is Black. CSC has defended the officers' actions, which raises concerns about whether the new Engagement and Intervention Model will truly shift how officers respond to incidents representing no immediate safety risk.



Provincial prisoners have also experienced violence as a response to non-compliance without a risk to anyone's safety. For instance, Client F was repeatedly OC-sprayed after refusing to leave his cell and go to segregation for something he maintained he had not done. When officers responded to Client E with force when she refused to go to her cell before getting her oatmeal from the microwave, the situation quickly escalated and officers repeatedly OC-sprayed her and restrained her on the ground. Because Client E is deaf, she could neither hear nor see after being OC-sprayed. She struggled in response to the officers' actions, which *increased* rather than decreased the risk of harm.

Provincial prisoner Client K's account exemplifies a shocking example of force being used inappropriately for non-compliance. Client K reports he asked to be taken to healthcare because of a fever and abdominal pain, where he vomited. He says when he failed to vomit in a garbage can as instructed by an officer, the officer OC-sprayed him for non-compliance. Client K reports that the officer then kicked and kneed him in the head and other parts of his body. He was taken to segregation without medical attention.

Data from the Office of the Correctional Investigator shows that, consistently, at least one third of federal use of force incidents occur in a person's cell.[220] This means the person is contained. If needed, officers could simply leave and return later.

While there is no comparable data for BC Corrections, our review also shows that many of the use of force incidents reported by PLS clients in provincial facilities also took place in cells.

Since there is no video coverage inside most prisoners' cells and, in BC Corrections, no mandate to videotape spontaneous uses of force, these incidents are generally not caught on video. Even when officers bring handheld cameras, we have seen footage that does not capture relevant activity, as the officer holding the camera stands behind officers engaged in the use of force. We hear from clients that officers used unjustified or excessive physical force against them in their cells but they have no way to back up their claims. When the incident is reviewed by the institution, the officers' version of events generally prevails.

The Crisis Prevention Institute, which provides "nonviolent crisis intervention" trainings to corrections, medical, security and other staff, teaches that physical intervention should be used only in an emergency when someone poses "an immediate danger to self or others."[221]

This is a good standard. It is not appropriate for officers to use physical force when a prisoner is merely noncompliant without an immediate risk to safety, especially when doing so is likely to escalate rather than resolve conflict.

3. POST-USE OF FORCE MEDICAL ASSESSMENTS ARE INADEQUATE AND THE ROLE OF HEALTHCARE IS TOO NARROW

Both domestic and international obligations require prison healthcare staff to act solely to promote the wellbeing of their patients. However, PLS found that medical staff are only conducting the most cursory of assessments after a use of force and are not taking these opportunities to support prisoners' physical and mental health. This is particularly the case in BC correctional centres, where health care is provided by the Provincial Health Services Authority.

As mentioned above, PLS also found that corrections staff were intervening with force when prisoners were in emotional crisis. In these circumstances, a mental health approach would have been more appropriate and might have avoided physical violence. In some provincial cases, officers intervened with force during medical crises as well, such as in response to prisoners having seizures and to a prisoner complaining of chest pains who was clearly weak.

Addressing both of these problems requires an expanded role for health and mental health staff during and after emergencies.

Post-use of force medical assessments

Several of the prisoners we spoke to describe the medical assessments they received after officers used force against them as brief and superficial, and some said nurses either ignored or discounted their concerns. No one characterized the medical staff as allies. For instance, federal prisoner Joey described nurses repeatedly dismissing or minimizing his complaints of being injured during a use of force.

The Correctional Investigator has repeatedly expressed concerns about the inadequacy of federal healthcare assessments. In addition, because medical staff are not on-site after hours except at treatment centres, there is sometimes no nurse on duty during a use of force. Indeed, CSC's audit of the former Situation Management Model found that 24 percent of the incidents reviewed occurred during evening hours when no healthcare staff were on site, and that in half of these incidents, the first aid assessments required by policy were not completed.[222]

PLS's review of provincial uses of force found that the medical assessments by the Provincial Health Services Authority were particularly perfunctory. They generally lasted only a matter of seconds and often occurred through a barrier. For instance, after Client F was OC-sprayed four times, a nurse came to his segregation cell and asked if he was ok. When he said his eyes were burning and he wanted a shower, the nurse did nothing to acknowledge this symptom or to follow up. Her assessment lasted 15 seconds and was performed entirely through the cell door. A few days later, a doctor determined Client F was suffering from chemical burns all over his body. We have seen other provincial prisoners given a bucket of water or a cup to collect water from the sink for decontamination.

While federal healthcare providers must check whether decontamination has occurred, they do not have to ensure prisoners have clean clothing, bedding or cells — though the *Mandela Rules* specify this is within their purview.[223] Provincially, nurses do not inquire about any of these things.

Neither federal nor provincial nurses assess the prisoner's mental state after a use of force, even when the prisoner's emotional distress is readily apparent – as in the case of Client B, who began self-harming after the ERT entered his cell, or the case of Client N, who repeatedly stated he needed to see mental health because of the

incident. There is no requirement to follow up with the prisoner days or weeks later, when symptoms of Post-Traumatic Stress Disorder may begin to surface. Some prisoners, like Joey, report self-harming in the days following a use of force. Officers may use force again when this occurs. Healthcare staff should take an active role in documenting, reporting and preventing these repeat crises.

Experts including the Correctional Investigator have cautioned that use of force represents a potential area of dual loyalty for medical personnel.[224] Indeed, both federal and provincial medical providers may feel pressure to limit their examinations because their assessments are generally conducted in the presence of correctional officers. Provincially, they are often in the presence of the very officers who have just used force against the prisoner.

Neither federal nor provincial medical providers are required to interview the prisoners about what happened during the use of force. Federally, nurses receive a briefing from officers before conducting their assessment, which may bias them toward corrections' version of events. Without interviewing the prisoner in private to find out what happened, they cannot possibly fulfill their obligations under international law to identify and report signs of ill-treatment.

Further, neither federal nor provincial policies require medical staff to report signs of ill-treatment by officers to corrections or healthcare leadership, or to external oversight bodies.

A 2012 study on dual loyalty by the New York City Department of Health and Mental Hygiene, which provides health services to all New York City jails, found that 92.6 percent of correctional healthcare staff were aware of corrections officers pressuring prisoners to sign injury reports that contradicted the prisoners' version of events.[225] Given the number of post-use of force medical assessments our office viewed that were performed in the presence of correctional officers, we believe that this situation could also occur in a CSC or BC Corrections institution.

Both the Provincial Health Services Authority and CSC must empower medical staff to resist pressure to have their care influenced by corrections, ensure they can thoroughly and privately assess their patients, and document and report any signs of ill-treatment they identify.

Expanding the role of healthcare in responding to emergencies

As discussed above, too often officers respond with force to medical and mental health emergencies and to prisoners exhibiting symptoms of a mental health disability. This occurs not only at mainstream institutions but also at CSC treatment centres and on specialized units for prisoners with mental health needs.

Our review found a significant need to expand the role of healthcare staff in responding to these kinds of emergencies. If the situation poses little safety risk, healthcare staff should respond, with officers as back-up if needed. This approach can keep incidents from escalating into situations where there is a more serious risk of harm, and prioritizes early intervention to prevent emergencies from occurring. This is the model used in forensic psychiatric facilities, where trained nurses are the ones on the units interacting regularly with patients, and security staff are called only in emergencies.

This approach would also mean that, even if the prisoner is posing an immediate risk to someone's safety (including their own), healthcare can still have shared responsibility for decision-making. This is the approach used by community-based models such as the Assertive Outreach Team in Vancouver, where teams

of nurses and police officers work in tandem. Depending on the situation, a nurse may stay at a safe distance, but is still integrally involved in planning – and in some cases directing – the intervention. For instance, such a team could have jointly approached prisoners like Client T or Client B, both of whom were locked in their cells, and might have avoided the need for the ERT.

We encourage both BC Corrections and CSC to explore this model to help avoid the escalation and trauma that, in our clients' experience, comes with a security-oriented response to a mental health crisis. It would also allow staff to respond more quickly and effectively to medical emergencies so that prisoners like Client D, who was acting oddly and failing to follow officers' instructions because he was having a seizure, are not unnecessarily subjected to acts of force.

CSC's Engagement and Intervention Model already speaks to the idea of an interdisciplinary approach, but this model is distinct in that it would involve designated nurse-officer teams who regularly train and work in partnership, and would include officers with a particular interest in and aptitude for working with vulnerable prisoners. BC Corrections' Mental Health Liaison Officers would be natural fits for this role.

Such an approach would also require clinicians to develop stronger alliances with their patients. Many clients, particularly in CSC, describe adversarial relationships with health and mental health staff, whom they perceive as challenging their reporting and siding with officers. These staff can also issue disciplinary charges. Prioritizing healthcare interventions requires addressing these forms of dual loyalty so that medical staff can develop the kinds of alliances with their patients necessary to de-escalate conflict.

Finally, if Pinel restraints are to be used at all in prisons, they should be used only by healthcare staff as a healthcare intervention to prevent life-threatening self-harm. This decision must be made based on the patient's best interests, weighing the potential for causing psychological harm with the need to protect the patient's life. Pinel restraints should never be authorized by security staff or used for security purposes.

4. PRISONERS' VOICES ARE DEVALUED, AND PRISONERS ARE DENIED ADEQUATE ACCESS TO INFORMATION ABOUT THE FORCE USED AGAINST THEM.

Prisoner voices and internal use of force reviews

The experience of a use of force is significant and potentially traumatic for everyone involved. But for prisoners, there is the added experience of feeling that even if they raise concerns about unjustified force, they will not be treated fairly and objectively, and they will not be believed.

In BC Corrections, there is no requirement that a prisoner be interviewed after force is used against them. As such, the internal reviews are based solely on officers' versions and, when available, video footage. A prisoner may lodge a complaint about the use of force, but in our clients' experiences the responses to these complaints generally reaffirm the officers' version. This is especially problematic given that our review uncovered evidence of correctional officers misrepresenting the facts – such as the ERT leader who falsely claimed that Client G "fought with us the whole time."

CSC policy does require a correctional manager to interview the prisoner and give them a chance to raise concerns about the force officers used against them. However, prisoner reporting demonstrates this is inadequate. For instance,

Client O told us her "interview" by a correctional manager involved him saying something to the effect of "are you ok?" and her replying "yes." She was not aware this was a chance to raise concerns. Joey told us that, when he told the correctional manager he felt the force officers used was excessive, she simply stated "that's not excessive use of force" and walked away laughing.

There are no requirements that prisoners be interviewed during regional or national-level reviews.

Having their concerns dismissed or their complaints returned without a reasonable consideration of their evidence discourages prisoners from reporting concerns in the first place. Many prisoners tell us they feel it is useless to file a complaint. Complaining about a specific officer could also put them at risk of retaliation.

Giving prisoners more meaningful opportunities to describe the force used against them and giving weight to their accounts will help create a sense of fairness in the review process. It will also provide accountability for unjustified force. Prisoners should always be given a formal opportunity to make a written statement regarding the use of force against them. An interview should also be offered by a senior administrator and should be part of upper-level use of force reviews.

All use of force reviews should include a description of the prisoners' evidence. When a prisoner alleges misconduct and the review determines no wrongdoing, the decision-maker should include an assessment of the evidence and reasons for preferring one witness's evidence over another's.

Prisoners' access to their personal information

As discussed above, we applaud BC Corrections for providing PLS access to use of force videos and internal reviews on behalf of our clients during the course of this project. This has allowed us to raise concerns with the Provincial Director when we believed, based on evidence, that internal use of force reviews were not adequate.

We hope that this commitment to transparency will continue, and will include a change in policy to provide prisoners with internal reviews of the force used against them. These reviews should be considered prisoners' personal information. Providing reviews to prisoners will allow them to know when BC Corrections concluded officers acted inappropriately toward them. This will increase trust in the system, inform prisoners when meaningful reviews are happening, and allow them to contribute to the truth-finding process if important information has not been considered.

CSC has declined, in most cases, to share video footage of officers using force against our clients and to share the results of their internal reviews. As such, it is impossible for us — and for our clients — to know whether there is evidence of wrongdoing by officers and whether CSC acknowledges wrongdoing in the cases we have brought to their attention. However, the fact that CSC found the use of force against Client N, who attempted to enter the cafeteria when it was closed, to be appropriate raises serious concerns about the review process.

CSC has repeatedly told us to file *Privacy Act* requests for this information. However, when we followed this procedure to request use of force documents for Joey, the disclosure contained numerous gaping omissions. For instance, we are aware of at least 10 uses of force against Joey for which CSC produced no documents at all, and

of nine additional uses of force for which some classes of documents – such as video footage and internal reviews – were missing. PLS has also been waiting since January 2018 for a response to several other requests for disclosure of use of force reviews.

The Correctional Investigator has critiqued CSC's lack of transparency with respect to use of force videos, highlighting that "personal information belongs to the person, not the Service" and further noting:

> As other public safety agencies understand, video records are a means to protect front-line responders from unwanted or unwarranted allegations, demonstrable assurance that force was used as a last resort, and in a proportionate and judicious manner. Permitting access to and disclosure of video records to legitimate requestors is a means of demonstrating openness and transparency. Unfortunately, such principles appear not to be well ingrained in CSC organizational culture.[226]

The Correctional Investigator also notes that most requests for disclosure of use of force videos have historically been denied by CSC, concluding that:

> CSC has been able to create the perception, internally and externally, that use of force video recordings are out of bounds when in fact they should be routinely provided whenever inmates who are the subject of these interventions or their legal representatives request them.[227]

Further, CSC's access to information process is plagued with lengthy delays. The *Privacy Act* requires government bodies to respond to requests for personal information within 30 days, and permits them a 30-day extension under certain circumstances.[228] Despite this, PLS has more than 30 *Privacy Act* requests filed with CSC that are outstanding by more than *one year*. Many of these are close to two years old, and some are outstanding by more than two years. This is a clear violation of prisoners' right to government information about them, and their right to meaningfully raise concerns about state violence used against them.

By contrast, requests for personal information made to BC Corrections are generally received in a reasonable period of time.

Both federal and provincial prisoners should be routinely provided an opportunity to see video of use of forces against them. They should be provided the officer's observation reports, and a copy of all use of force reviews, without requiring an information request from the prisoner. If needed for security or privacy reasons, information can be redacted.

Finally, while the importance of the Correctional Investigator's role in reviewing federal use of force incidents cannot be overstated, the office does not routinely share their findings with prisoners who do not call them to complain. The Correctional Investigator's annual statistics for the 2017-2018 year indicate that the office received 58 complaints regarding use of force incidents,[229] which represents only four percent of the 1,487 uses of force the office reviewed during the same year.[230] Prisoners have reported to PLS that they find it difficult to reach the Office of the Correctional Investigator, particularly from the Pacific Region, where they may only have a short window of time out of their cells while the Correctional Investigator's office (in Ottawa) is open. While the Correctional Investigator has not released statistics on the number of uses of force about which they raised concerns with CSC, it is likely that many prisoners are not aware that the Correctional Investigator concluded officers used force inappropriately against them.

We recommend that every time the Office of the Correctional Investigator raises concerns about a use of force with CSC, the prisoner be notified. We also recommend the Correctional Investigator interview prisoners subject to force as part of their review, particularly in cases where there is a need for heightened scrutiny (such as force against prisoners with mental health disabilities, force at treatment centres, uses of the ERT, cases involving potential misconduct, and force against prisoners who have been repeatedly subject to acts of force). In PLS's experience, speaking to prisoners sometimes brings to light problems that would not have been obvious from the documentation provided by corrections.

5. GREATER PUBLIC ACCOUNTABILITY IS NEEDED WHEN OFFICERS USE FORCE.

Internal review

In 2012, CSC "streamlined" its use of force review process, radically reducing the number of incidents reviewed at the national level.[231] Now, only five percent of level 2 incidents are reviewed by national headquarters. Level 2 reviews include all uses of OC spray as well as uses of force that were unnecessary or disproportionate, but do not, according to CSC policy, constitute "serious violations."

The Correctional Investigator has repeatedly critiqued this "dilution" of oversight, writing in 2013:

> Surely the point of having a use of force review process is to hold the organization to account by identifying areas of non-compliance and correcting deficiencies. It is simply not wise to dilute oversight or download accountability for this high-risk activity.[232]

The Correctional Investigator also notes that "the dramatic increase in the use of inflammatory agents since 2010 tracks with a diluted use of force review and oversight framework and the ensuing decrease in accountability."[233]

One problem with CSC's three-tiered approach is that it requires the *institutions* to identify whether serious breaches have occurred. But as the 2018 audit of the Situation Management Model found, internal reviews of uses of force repeatedly failed to identify and address policy violations and even serious misconduct by officers.[234]

As the Correctional Investigator wrote in his 2017-2018 annual report:

> At the national level, there are not enough senior management eyes looking at decidedly high-risk activities and interventions: use of force, complex mental health cases, suicidal and self-injurious behaviour, to name but a few. The Service continues to assume the risk of running prisons without 24/7 health care coverage. There are only a handful of resources at national headquarters dedicated to conducting national-level reviews of use of force interventions. It is not clear how or if CSC leadership can be assured that the more than 1,200 recorded use of force incidents that occurred last year were all managed lawfully, in accordance with principles of proportionality, restraint and necessity.[235]

While it is positive that prisoners can grieve unjustified uses of force directly to national headquarters, for years the Correctional Investigator has critiqued CSC's internal complaint system,[236] describing it in his most recent annual report as "broken, ineffective, dysfunctional, and...likely beyond repair or

salvage."[237] The Correctional Investigator further notes that, on average, it takes more than 200 days to receive a decision at the national level; prisoners waited, on average, 217 working days for a response when their grievance was considered "high priority," and longer when it was considered "routine priority." And, in a whopping 97.7 percent of cases, the original institutional decision was affirmed.[238] This kind of internal grievance system does not act as an adequate check on abuse.

BC Corrections currently reviews all uses of force at headquarters, and its forthcoming use of force policy outlines an expanded process that formalizes a review by the institution, a review by headquarters, and an as-needed additional review by a use of force expert in certain cases. This is a good approach to internal review, and it shows BC Corrections is taking seriously its obligations to ensure officers are justified when they use force against prisoners.

A top-level review of all uses of force is important. During our investigation, we found uses of force in BC Corrections facilities that were not identified as problems by the institution, but which were flagged as problematic when reviewed by headquarters or by the Force Options Coordinator.

CSC ought to follow BC Corrections' example and significantly increase its number of national-level use of force reviews. At the very least, CSC national should review all uses of force involving prisoners with mental health disabilities, all uses of force at treatment centres, all uses of ERTs, and all cases involving allegations of misconduct (including but not limited to excessive force) or failure to follow policy. National should also be required to review a use of force upon the request of a prisoner, who should not be required to go through a lengthy grievance process.

Both BC Corrections and CSC should have senior clinicians review uses of force against prisoners with mental and physical health disabilities, particularly when they involve emotional crises, self-harm, or medical emergencies.

Both CSC and BC Corrections should examine use of force practices on an aggregate level, not just on an incident-by-incident basis. This should include identifying how often force is used against vulnerable prisoners, including prisoners with mental health disabilities, prisoners who self-harm, transgender prisoners and Indigenous and visible minority prisoners. It should also include setting goals around reducing force and eliminating it in certain contexts (such as in response to noncompliance). Ideally this review process should be completed with the help of outside partners.

In addition, both CSC and BC Corrections should examine the issue of prisoners who have force used against them repeatedly. Clients like Joey have made it quite clear that repeated uses of force against the same person, particularly someone with a history of trauma or mental illness, can cause that person to exist in a nearly continual state of panic and crisis. Joey reports that he now waits for the ERT with a noose around his neck or razor blade to his throat. This seems to be a version of the "death escalation cycle" Steve J. Martin refers to: a situation in which each use of force precipitates the crisis that leads to the next, further whittling away at productive alternatives while exacerbating the problems it is meant to address. Evaluating single acts of force against Joey in isolation to determine whether they are justified fails to address how an escalating and self-perpetuating pattern of force against him further destabilizes his health, placing him at risk of serious harm or death. Given the prevalence of officers using force against prisoners with mental health disabilities, and the trauma that entails for those prisoners, use of force reviews must account for historical uses of force against the same person.

External review

While internal review processes must be improved, external review is equally if not more essential. As the Correctional Investigator has written of CSC, "the impulse to contain bad news runs deep." He explains that "internal reviews, investigations and audits focus almost exclusively on policy compliance — even the preventable deaths of Ashley Smith and Matthew Hines failed to raise issues of managerial responsibility or corporate accountability."[239]

Recently, journalists discovered that a federal women's prison in Nova Scotia had waited three months to contact police while it internally investigated allegations that an officer had sexually assaulted a prisoner — and that CSC had provided misinformation to the media, initially claiming they had called police immediately.[240]

Having the Correctional Investigator's eyes on every use of force is critical.

In addition, CSC should commission an external evaluation of the Engagement and Intervention model by researchers who can evaluate whether it is reducing the amount of force used against prisoners, whether it is leading to positive outcomes, and whether there are any unintended negative consequences — particularly in light of the Correctional Investigator's concern that officers appear to be using force more often and more severely since the introduction of the new model.[241]

It is critical that the province also establish an external oversight mechanism for uses of force. We recommend this be done by expanding the mandate of the Investigation and Standards Office to include review of every use of force in BC Corrections facilities. The Investigation and Standards Office already has legislative authority to access necessary information and extensive knowledge of the correctional system in British Columbia.

Lack of video footage of use of force incidents

Our review found that, in many cases, there was no video footage, or inadequate video footage, of the use of force itself. This is due to both inadequate policy and practice.

CSC policy requires officers to video-record a planned use of force from the outset and to record a spontaneous use of force as soon as possible after it has begun. This is important because, when an incident is captured only by a prison stationary camera, there is no audio, often making it impossible to assess what took place. For instance, if officers justify using physical force by saying a prisoner was verbally threatening them, footage from a stationary camera is not going to help a reviewer evaluate whether the force was justified. And, of course, handheld or helmet cameras can be moved around — which is particularly important given the number of use of force incidents that take place inside a prisoner's cell, where (for good reason) there are no stationary cameras.

BC Corrections does not require handheld video recording except by the ERT, which means that most use of force incidents are captured only by stationary cameras (or are not captured at all). We recommend BC Corrections adopt CSC's policy of recording all uses of force manually.

Compliance with existing video documentation requirements is a concern for both CSC and BC Corrections. The Correctional Investigator has repeatedly flagged a failure to follow policy regarding handheld video recording and video preservation as a chronic problem in CSC.[242]

Our review identified video documentation as a chronic problem in BC Corrections. PLS has watched provincial use of force videos where footage that should exist is simply "missing," making it impossible to verify our clients' versions of events or to hold officers

accountable. Video footage is saved only for a short time before it is recorded over, so if it is not properly preserved at the outset, it will likely be too late to recover it once the problem is identified.

PLS has seen other BC Corrections use of force videos where handheld footage is only of the other officers' backs and where officers cover the camera when it does not appear they are doing so in order to protect the prisoner's privacy (such as during a strip search). These are not mundane bureaucratic issues – they are central to the ability to understand whether officers' force was justified. Without it, abuses can happen and accountability is compromised. Proper video documentation also serves to protect officers from unwarranted allegations of misconduct.

BC Corrections should expand its manual camera requirements, and both CSC and BC Corrections should ensure policies around documentation are followed. We also recommend both CSC and BC Corrections utilize helmet or body cameras, since these are more likely than handheld cameras to fully capture an incident and do not require an officer to put themselves in harm's way to capture the action. We have seen a handful of provincial ERT extractions where the officers wore helmet cameras and the quality of the footage is high.

VIII. RECOMMENDATIONS

TO BC CORRECTIONS

Regarding the Adult Custody Policy

1. Prioritize trauma-informed practice, de-escalation and peaceful resolution throughout the use of force policy and related policies.
2. Authorize force only when necessary to prevent imminent harm to a person. Prohibit use of force to address noncompliance or disobedience.
3. Require officers to weigh the risk of not intervening with force against the risk of harm (including psychological harm) resulting from a use of force and to ensure interventions are proportionate in light of this assessment.
4. Restrict the use of force in response to self-harm to circumstances where there is an imminent risk of grievous bodily harm.
5. Consider the removal, display, or threatened use of spray irritants, and threats to bring the ERT, reportable uses of force.

Regarding Emergency Response Teams

6. Limit the role of the ERT/CEE teams to emergencies involving imminent threats of serious physical harm, such as hostage takings or riots. Ensure decisions to deploy the ERT consider the potential traumatic impact of the team on the prisoner and weigh the potential for psychological harm against the potential benefit of using this high level of force. Amend the Adult Custody Policy to reflect this.
7. Equip all ERT/CEE teams with helmet cameras.

Regarding training

8. Expand training on conflict resolution, de-escalation skills, nonviolent crisis intervention and working with people with mental health disabilities. This should be designed in conjunction with mental health experts and people with lived experience.
9. Require advanced training in working with people with mental health disabilities for all Mental Health Liaison Officers as well as staff working on mental health and no-violence units, in segregation, and as members of ERTs as a prerequisite for performing these roles. Require regular refresher courses.

Regarding prisoners with physical and mental health disabilities

10. Create specialized officer-nurse teams to respond to situations involving emotional or medical distress using joint decision-making. This could follow models in the community that pair specially trained police with psychiatric nurses to respond to emergencies involving people with mental health issues.

11. Develop an alternative model for recognizing and responding to prisoners with mental health disabilities in crisis, in partnership with the Provincial Health Services Authority (including the Forensic Psychiatric Hospital) and people with lived experience. This includes prisoners in emotional distress (such as prisoners who are self-harming) as well as prisoners who are experiencing behavioural emergencies connected with their disabilities. These responses should be supportive and trauma-informed rather than punitive.

12. In partnership with the Provincial Health Services Authority, develop an alternative model for recognizing and responding to medical emergencies.

13. Identify an expert who can play a role similar to the Force Options Coordinator in reviewing uses of force against prisoners with mental health disabilities to identify problems and solutions.

14. Transfer authority for interventions to address self-harm and suicidality, including restraints, observation cells and suicide smocks, to the Provincial Health Services Authority. Eliminate the use of the BOARD and WRAP, except where authorized by the Provincial Health Services Authority for medical purposes.

15. Select officers who excel at conflict resolution and empathy to work as Mental Health Liaison Officers and on therapeutic units, and involve the Provincial Health Services Authority in their training.

Regarding prisoner voices and prisoners' access to their own personal information

16. Interview prisoners as part of primary and secondary use of force reviews. Provide them and their representatives the opportunity to make a written submission as part of the review process.

17. Give prisoners and their representatives the opportunity to view use of force videos upon request and provide observation reports as a matter of course.

18. Provide all use of force reviews to prisoners when they are complete.

Regarding video-recording

19. Amend the Adult Custody Policy to require that any planned or reasonably anticipated use of force be videotaped with a body camera from the outset, and that any spontaneous use of force be videotaped immediately after it begins.

20. Amend the Adult Custody Policy to require managers to ensure all relevant video footage of a use of force has been preserved within 14 days (so that footage is not deleted).

Regarding internal use of force reviews

21. Use of force reviews should identify the number of previous uses of force against the same prisoner. For prisoners who are repeatedly subject to force, develop a plan to reduce uses of force, in conjunction with the Provincial Health Services Authority for prisoners with disabilities. If force is not reduced, conduct an operational review.

22. Prisoners who are repeatedly subject to force should have all subsequent uses of force automatically reviewed by the Force Options Coordinator and, if appropriate, by the mental health expert mentioned in recommendation 13.

23. Use of force reviews should include a description of the prisoners' evidence. When a prisoner alleges misconduct and the review determines no wrongdoing, the decision-maker should include an assessment of the evidence and reasons for preferring one witness's evidence over another's.

24. In the absence of objective evidence, a use of force review should not conclude a use of force was appropriate. In other words, if the prisoner says force was abusive or unjustified and there is no video or other objective evidence, conclude that the appropriateness of the force is undetermined.

25. Use of force reviews by headquarters should include a narrative assessment of the circumstances leading to the use of force and a description of the force used. There should be a checklist to identify whether key policy requirements were followed (was the prisoner decontaminated, was video preserved, etc.). The review should also acknowledge and respond to any concerns raised by the prisoner or their representative. When the review identifies problems or noncompliance with policy, it should outline corrective measures taken.

Regarding oversight and accountability

26. Track and report publicly on all uses of force against prisoners, broken down by type (physical handling, OC spray, ERT, etc). Disaggregate data by race, gender, disability and centre.

27. Track repeated violations of policy by the same staff person or institution at the headquarters level.

28. In collaboration with the Investigation and Standards Office, approach the BC Government for funding to allow the Investigation and Standards Office to review every use of force in a BC Corrections facility. In the interim, have the Investigation and Standards Office periodically review a random sampling of use of force incidents.

29. Incorporate a more in-depth review of use of force incidents into the checklist for inspections of BC correctional centres.

30. Report all uses of force involving potentially inappropriate or unjustified force, or force resulting in injury to the prisoner, to police.

Regarding post-use of force practices

31. Amend the Adult Custody Policy to require decontamination showers (unshackled and with soap, for as long as necessary for proper decontamination) and fresh clothing to be provided immediately. The decontamination process should be videotaped (with provisions made to ensure privacy is protected).

32. Amend the Adult Custody Policy to require photographing of all visible injuries (whether or not they require medical attention). Clarify who is responsible for photographing a prisoner's injuries (it must not be staff who were involved in the use of force) and how soon the photographs must be taken.

Regarding strip searches and spit masks

33. Conduct an audit of strip searches with a view to reducing or eliminating their use and the resulting humiliation and re-traumatization of prisoners.

34. If a prisoner is strip-searched in a room with a camera, staff should cover it to allay prisoners' fears about being strip searched on camera. If a prisoner is strip searched in the presence of a handheld camera, allow the prisoner to see that the camera is turned away.

35. Eliminate the use of spit masks.

TO THE PROVINCIAL HEALTH SERVICES AUTHORITY

36. Develop policy and training on dual loyalty and the domestic and international ethical obligations of medical professionals working in prisons.

37. Immediately develop policy, guidelines and reporting forms to provide for post-use of force medical assessments of every prisoner subject to force. Ensure assessments involve thorough physical examinations in a private setting and that nurses document all reported and observed injuries. Train all staff in the new policy.

38. Ensure that post-use of force medical assessments are used solely to support the wellbeing of the patient and to document signs of ill-treatment. Any signs of ill-treatment must be reported to the Warden, BC Corrections Provincial Director, Provincial Health Services Authority Director of Correctional Health Services and the Investigation and Standards Office.

39. Require staff to make all reasonable efforts to ensure this assessment is not mediated by physical barriers such as bars, security glass, door hatches or screens. If officer presence is required for safety reasons, the officer(s) must not have been involved in the use of force.

40. Ensure post-use of force medical assessments include an assessment of the prisoner's mental state and any potential impact on the prisoner's mental health. When indicated, monitor and treat prisoners for Post-Traumatic Stress Disorder.

41. Ensure post-use of force medical assessments include a determination of whether the prisoner has been adequately decontaminated, has received clean clothing and bedding, and has a clean cell.

42. The healthcare professional should complete a written report that includes the prisoner's account of the incident and their assessment of any physical injuries and/or psychological impact. This report should be included in the use of force review if the prisoner consents, and a copy should be provided to the prisoner.

43. Conduct an audit of post-use of force medical assessments and clinicians' compliance with their ethical obligations.

TO THE BC GOVERNMENT

44. Amend s. 12(1) of the *Correction Act* to remove the authorization of force "to prevent property damage" and "to maintain custody and control of an inmate."

45. Provide the Investigation and Standards Office with the mandate and with increased funding to review and publicly report on all uses of force in BC Corrections facilities.

46. Expand the mandate of, and allocate funding to, the Forensic Psychiatric Hospital to house prisoners with serious mental health disabilities who are under the jurisdiction of BC Corrections on a long-term basis.

TO THE INVESTIGATION AND STANDARDS OFFICE

47. In collaboration with BC Corrections, approach the BC Government for funding to review every use of force in a BC Corrections facility. In the interim, periodically review a random sampling of use of force incidents. Reviews should include interviews with the prisoner involved.

TO CORRECTIONAL SERVICE CANADA

Regarding use of force policy and practice

48. Clarify in policy that force can only be used when necessary to prevent imminent harm to a person, not to address noncompliance or disobedience.

49. Adopt an explicitly trauma-informed approach to interventions.

50. Restrict the use of force in response to self-harm to circumstances where there is an imminent risk of grievous bodily harm.

51. Consider the removal, display, or threatened use of spray irritants, and threats to bring the ERT, reportable uses of force.

Regarding training

52. Expand training on conflict resolution, de-escalation skills, nonviolent crisis intervention and working with people with mental health disabilities. This should be designed in conjunction with mental health experts and people with lived experience.

53. Require advanced training in working with people with mental health disabilities for all staff working on mental health units, in treatment centres, in segregation/SIUs, and as members of Emergency Response Teams as a prerequisite for performing these roles. Require regular refresher courses.

Regarding prisoners with mental health needs

54. Create specialized officer-nurse teams at treatment centres and maximum and medium institutions to respond to situations involving emotional or medical distress using joint decision-making. This could follow models in the community that pair specially-trained police with psychiatric nurses to respond to emergencies involving people with mental health issues.

55. Develop an alternative model for identifying and responding to prisoners with mental health disabilities in crisis in partnership with mental health experts (including experts in forensic psychiatry) and people with lived experience. This includes prisoners in emotional distress (such as prisoners who are self-harming) as well as prisoners who are experiencing behavioural emergencies connected with their disabilities. These responses should be supportive and trauma-informed rather than punitive.

56. Eliminate the use of Emergency Response Teams in regional treatment centres and on mental health units. Ensure decisions to deploy the ERT consider the potential traumatic impact of the team on the prisoner and weigh the potential for psychological harm against the potential benefit of using this high level of force. Amend policy to reflect this.

57. Have senior mental health practitioners review all uses of force against prisoners with mental health disabilities.

58. Amend policy so that only healthcare staff can authorize and manage interventions to address self-harm and suicidality, including suicide smocks, observation cells and and Pinel restraints based on clinical need. Pinel restraints should only be used in psychiatric facilities.

59. As long as Pinel restraints are administered by correctional staff, consider their application a reportable use of force.

60. Involve healthcare leadership in selecting and training officers for all treatment centres and mental health units.

61. Transfer prisoners with acute mental health needs or histories of serious and chronic self-harm to community psychiatric facilities.

Regarding healthcare services

62. Develop policy and training on dual loyalty and the domestic and international ethical obligations of medical professionals working in prisons.

63. Provide 24-hour nursing care at all maximum and medium security and multi-level institutions. This will ensure medical staff are always available to respond to mental and physical health crises. It also ensures post-use of force medical assessments can happen at any time of day or night.

64. Provide healthcare independently of CSC through partnerships with provincial health ministries in order to ensure full clinical independence.

Regarding oversight and accountability

65. Ensure video-recording, particularly of spontaneous uses of force, happens in accordance with policy. Adopt the use of body cameras for spontaneous and planned uses of force, including by ERTs.

66. Commission an external evaluation of the effectiveness of the Engagement and Intervention Model. CSC should partner with independent researchers to evaluate the model's success in resolving incidents peacefully, reducing reliance on force and respecting prisoners' rights.

67. Report all uses of force involving potentially inappropriate or unjustified force, or force resulting in injury to the prisoner, to police.

Regarding internal use of force reviews

68. Significantly increase the number of national-level use of force reviews. At the very least, CSC national should review all uses of force involving prisoners with mental health disabilities, all uses of force at treatment centres, all uses of ERTs and all cases involving allegations of misconduct (including but not limited to excessive force) or failure to follow policy.

69. Use of force reviews should identify the number of previous uses of force against the same prisoner. For prisoners who are repeatedly subject to force, develop a plan to reduce uses of force, in conjunction with a clinical team for prisoners with disabilities, and automatically review subsequent uses of force at the national level. If force is not reduced, conduct a national investigation.

70. Allow prisoners to have uses of force against them reviewed at the national level upon request and without having to go through the grievance process.

71. When an officer fails to follow policy on use of force, review subsequent uses of force by that officer at the regional or national level.

72. Use of force reviews should include a description of the prisoners' evidence. When a prisoner alleges misconduct and the review determines no wrongdoing, the decision maker should include an assessment of the evidence and reasons for preferring one witness's evidence over another's.

73. In the absence of objective evidence, do not conclude a use of force was appropriate. If the prisoner says force was abusive or unjustified and there is no video or other objective evidence, conclude that the appropriateness of the force is undetermined.

Regarding prisoner voices and prisoners' access to their own personal information

74. Inform the prisoner as to whether the incident will be subject to a Level 1, 2 or 3 review and advise them of the timeline for the review.

75. Interview prisoners as part of all regional- and national-level use of force reviews.

76. Provide prisoners and their counsel the opportunity to see video of uses of force against them upon request. Provide officers' observation reports and a copy of all use of force reviews without requiring a *Privacy Act* request from the prisoner.

Regarding post-use of force medical assessments

77. Ensure that medical assessments after acts of force are used solely to support the wellbeing of the patient and document signs of ill-treatment. Any signs of ill-treatment must be reported to senior CSC operational and medical staff and the Office of the Correctional Investigator.

78. Ensure post-use of force medical assessments include an assessment of the prisoner's mental state and any potential impact on the prisoner's mental health. When indicated, monitor and treat prisoners for Post-Traumatic Stress Disorder.

79. Amend policy to require that post-use of force medical assessments include a determination of whether the prisoner has received clean clothing and bedding and has a clean cell.

80. The healthcare professional should complete a written report that includes the prisoner's account of the incident and their assessment of any physical injuries and psychological impact. This report should be included in the use of force review if the prisoner consents, and a copy should be provided to the prisoner.

Regarding strip searches and spit masks

81. Conduct an audit of the use of strip searches with a view to reducing or eliminating their use and the resulting humiliation and re-traumatization of prisoners.

82. Eliminate the use of spit masks.

TO THE OFFICE OF THE CORRECTIONAL INVESTIGATOR

83. Interview prisoners as part of Correctional Investigator use of force reviews, particularly in cases where there is a need for heightened scrutiny (such as force against prisoners with mental health disabilities, force at treatment centres, uses of the ERT, cases involving potential misconduct, and force against prisoners who have been repeatedly subject to acts of force).

84. Inform the prisoner when the Correctional Investigator use of force review identifies inappropriate conduct by officers and advise them of any findings or recommendations shared with CSC.

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85. Increase funding to the Office of the Correctional Investigator for use of force reviews to include prisoner interviews.

86. Ensure that healthcare for federal prisoners is provided independently from CSC through partnerships with provincial ministries of health. Ensure funding is adequate to make this work.

87. Provide funding to allow federal prisoners to be accommodated at provincial psychiatric hospitals when they require this level of care.

ENDNOTES

1 Benjamin Meade, Benjamin Steiner & Charles F. Klahm IV, "The effect of police use of force on mental health problems of prisoners". *Policing and Society* Vol. 27, No. 2 (2017) ["Meade, Steiner & Klahm"] at 230-231.

2 Nils Melzer, *Extra-custodial use of force and the prohibition of torture and other cruel, inhuman or degrading treatment or punishment*, UNGAOR, 72nd Sess, UN Doc A/72/178 ["Melzer Report"], at 6-7. Online: https://undocs.org/pdf?symbol=en/a/72/178. Although this report is about use of force outside of the prison context, we see no reason why these principles should not also apply in a custodial setting.

3 See BC Provincial Mental Health and Substance Use Planning Council, *Trauma-Informed Practice Guide* (May 2013) at 12. Online: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf.

4 National Resource Center on Justice Involved Women, *Using Trauma-Informed Practices to Enhance Safety and Security in Women's Correctional Facilities* (2014) at 3. Online: https://www.bja.gov/Publications/NRCJIW-UsingTraumaInformedPractices.pdf.

5 Howard Sapers, et al. *Institutional Violence in Ontario Final Report Case Study: Toronto South Detention Centre,* Independent Review of Ontario Corrections (December 2018) ["*Institutional Violence in Ontario*"], at 45. Online: http://www.mcscs.jus.gov.on.ca/sites/default/files/content/mcscs/docs/Institutional%20Violence%20in%20Ontario%20Corrections%20Final%20Report.pdf.

6 *R v Golden*, [2001] 3 SCR 679, ¶ 90; cited in Gerry McNeilly, *Breaking the Golden Rule: A review of police strip searches in Ontario*, Office of the Independent Police Review Director (March 2019).

7 *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, Call for Justice 14.13 (2019).

8 Joanna Weill and Craig Haney, "Mechanisms of Moral Disengagement and Prisoner Abuse". *Analyses of Social Issues and Public Policy* Vol. 17, No. 1 (2017), at 297.

9 Steve J. Martin, "Staff Use of Force in U.S. Confinement Settings: Lawful Control Tactics Versus Corporal Punishment". *Social Justice* Vol. 33, No. 4 (2006) ["Martin 2006"], at 183.

10 Howard Sapers, Correctional Investigator of Canada, *A Preventable Death* (June 20, 2008) ["*A Preventable Death*"], pp. 5, 14. Online: http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20080620-eng.pdf.

11 *A Preventable Death* at 5.

12 Chief Coroner, Province of Ontario, "Inquest Touching the Death of Ashley Smith: Jury Verdict and Recommendations" (December 2013). Online: http://www.westcoastleaf.org/wp-content/uploads/2017/06/Ashley-Smith-Inquest-Jury-Verdict-and-Recommendations.pdf.

13 The Correctional Investigator of Canada, *Annual Report - 2017-2018* (June 29, 2018) ["OCI 2017-2018"] at 89. Online: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20172018-eng.pdf.

14 Patrick J Sullivan, "Should healthcare professionals sometimes allow harm? The case of self-injury," *Journal of Medical Ethics* (2017) 43 ["Sullivan 2017"] at 320.

15 The Correctional Investigator of Canada, *Fatal Response: An Investigation into the Preventable Death of Matthew Ryan Hines – Final Report* (February 15, 2017) ["*Fatal Response*"] at 4-7. Online: https://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20170215-eng.aspx.

16 Karissa Donkin, "What Correctional Service Canada didn't want the Hines family to know", *CBC News* (Apr 09, 2019). Online: https://www.cbc.ca/news/canada/new-brunswick/hines-investigation-redactions-1.5088924.

17 *Fatal Response* at 4-7.

18 Government of Canada, "Death of an inmate at Dorchester Penitentiary – Medium security unit" (May 26, 2015). Online: https://www.canada.ca/en/news/archive/2015/05/death-inmate-dorchester-penitentiary-medium-security-unit.html.

19 OCI 2017-2018, at 29.

20 Correspondence with the Office of the Correctional Investigator.

21 Kim Bolan, *Guards charged with assaulting inmate in Fraser Regional* Vancouver Sun, (January 21, 2019). Online: https://vancouversun.com/news/staff-blogs/real-scoop-guards-charged-with-assaulting-inmate-in-fraser-regional.

22 André Martin, Ontario Ombudsman, *The Code* (June 2013) ["*The Code*"]. Online: https://www.ombudsman.on.ca/Files/sitemedia/Documents/Investigations/SORT%20Investigations/The-Code-EN.pdf.

23 *The Code*, at 48.

24 Katie DeRosa, "Inmate health care improving, warden tells inquest," *Times Colonist* (May 24, 2019). Online: https://www.timescolonist.com/news/local/inmate-health-care-improving-warden-tells-inquest-1.23832293.

25 CSC, *National Prevalence of Mental Disorders among Incoming Federally-Sentenced Men* (February 2015).

26 CSC, *National Prevalence of Mental Disorders among Federally Sentenced Women Offenders: In Custody Sample* (April 2018). Online: https://www.csc-scc.gc.ca/research/r-406-en.shtml.

27 As cited in "House of Commons, Standing Committee on Public Safety and National Security, Drugs and Alcohol in Federal Penitentiaries: An Alarming Problem" (April 2012), p. 9. Online: http://www.ourcommons.ca/Content/Committee/411/SECU/Reports/RP5498869/securp02/securp02-e.pdf.

28 Claire Bodkin, et al., "History of Childhood Abuse in Populations incarcerated in Canada: A Systematic Review and Meta-Analysis," *American Journal of Public Health* (March 2019) 109(3): e1-e11.

29 Canadian Human Rights Commission, *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women* (December 2003) at 7. Online: https://www.chrc-ccdp.gc.ca/eng/content/protecting-their-rights-systemic-review-human-rights-correctional-services-federally.

30 Office of the Correctional Investigator, *Deaths in Custody* (Date modified: 2016-03-14). Online: http://www.oci-bec.gc.ca/cnt/priorities-priorites/deaths-deces-eng.aspx.

31 George F. Parker, MD, "Impact of a Mental Health Training Course for Correctional Officers on a Special Housing Unit," *Psychiatric Services* Vol. 60, No. 5 (May 2009).

32 Samuel Singyangwe, "Examining the Role of Use of Force Policies in Ending Police Violence" (September 20, 2016) at 4. Online: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2841872.

33 Ada Hui, Hugh Middleton, and Birgit Vollm, "The Uses of Coercive Measures in Forensic Psychiatry: A Literature Review", in B. Vollm, N. Nedopil (eds.), *The Use of Coercive Measures in Forensic Psychiatric Care* (2016) at 178.

34 *Institutional Violence in Ontario*, at 31.

35 OCI 2017-2018, at 9.

36 Catherine Latimer, "The Killing of Matthew Hines" (June 24, 2018). Online: http://johnhoward.ca/blog/killing-matthew-hines/.

37 John P. Wilson, Kurt Hugenberg and Nicholas O. Rule, "Racial bias in judgments of physical size and formidability: From size to threat." *Journal of personality and social psychology* Vol. 113, No. 1 (2017) at 59-80.

38 Federal Correctional officers are designated as peace officers under s. 10 of the CCRA. BC Corrections officers are peace officers under s. 2 of the *Correction Act*, SBC 2004, c. 46.

39 *Criminal Code of Canada*, RSC 1985, c. C-46, s. 25.

40 *R. v Nasogaluak*, 2010 SCC 6.

41 *R v Hannibal*, 2003 BCPC 504.

42 *R v Othen*, [2018] A.J. No. 172 at ¶ 168.

43 CCRA, s. 4(c).

44 CCRA, s. 3.

45 CCRA, s. 69.

46 CCRA, s. 70.

47 *Stead v Deputy Head (Correctional Service of Canada),* 2012 PSLRB 87 at ¶ 67, citing *McKenzie v Deputy Head (Correctional Service of Canada)*, 2010 PSLRB 26 at ¶ 80.

48 *Hicks v Deputy Head (Correctional Service of Canada),* 2016 PSLREB 99 ["*Hicks*"] at ¶ 71.

49 *Roberts v Treasury Board (Correctional Service of Canada),* 2007 PSLRB 28 ["*Roberts*"] at ¶ 223.

50 2007 PSLRB 28.

51 *Roberts*, ¶ 307.

52 *Roberts*, ¶ 295, 297 and 304-324.

53 *Roberts*, ¶ 321.

54 2016 PSLREB 99.

55 *Hicks*, ¶ 72.

56 [2014] CPSLRB No 65.

57 *Legere a*t ¶ 250.

58 2010 ONSC 3812.

59 [1992] FCJ No 500.

60 *Peeters v Canada*, [1992] FCJ No 500.

61 *R v De Silva*, 2018 BCSC 1068, citing *R v Tran*, 2010 ONCA 471, *R v Dickie*, 2014 ONSC 1576, *R v Wiscombe*, 2003 BCPC 418, *R v Walcott*, [2008] OJ No 1050 (Ont. SCJ) and *R v Spannier*, [1996] BCJ No 2525 (SC). See also *R v Bellusci*, 2012, SCC 44, *R v Nasogaluak*, [2010] 1 SCR 206 and *R v Jackson*, 2011 ONCJ 228.

62 *R v Dickie*, [2014] OJ No 1174.

63 *Canadian Human Rights Act,* RSC 1985, c. H-6, s. 3(1); *BC Human Rights Code*, RSBC 1996, c. 210, s. 8.

64 *Canadian Human Rights Act,* s. 15(2); *BC (Superintendent of Motor Vehicles) v BC (Council of Human Rights (Grismer)*, [1999] 3 SCR 868.

65 *Drennan v Canada*, 2008 FC 10 at ¶ 41.

66 Nix, Justin, Bradley A. Campbell, Edward H. Byers, and Geoffrey P. Alpert. "A bird's eye view of civilians killed by police in 2015: Further evidence of implicit bias." *Criminology & Public Policy* 16, no. 1 (2017) at 309-340.

67 *United Nations International Covenant on Civil and Political Rights*, 19 December 1966, 999 UNTS 171, Can TS 1976 No 47 (entered into force 23 March 1976) [*ICCPR*], art 7. Canada acceded to the United Nations International Covenant on Civil and Political Rights on May 19, 1976.

68 *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987) [*Convention Against Torture*], art 2.1. Canada ratified the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on June 24, 1987.

69 Melzer Report, at 17. Although this report is about use of force outside of the prison context, we see no reason why these principles should not also apply in a custodial setting.

70 Melzer Report, at 6-7.

71 Melzer Report, at 7.

72 Melzer Report, at 6-7.

73 Melzer Report, at 7.

74 *The United Nations Standard Minimum Rules for the Treatment of Prisoners* ["*Mandela Rules*"]. 1 General Assembly resolution 70/175, annex, adopted on 17 December 2015.

75 *Mandela Rules,* Rule 38.1.

76 *Mandela Rules*, Rule 76.1(c).

77 *Mandela Rules*, Rule 82.1.

78 *Mandela Rules*, Rule 71.1-2.

79 *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials* Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, 27 August to 7 September 1990 s. 24.

80 *Mandela Rules*, Rule 30(c).

81 *Mandela Rules*, Rule 33.

82 *Mandela Rules*, Rule 35(b) and (d).

83 *Mandela Rules*, Rule 32(d).

84 *Mandela Rules*, Rule 34.

85 Office of the United Nations High Commissioner for Human Rights. Geneva. Professional Training Series No. 8/Rev. 1. *Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (2004) [Istanbul Protocol], at 1.

86 Istanbul Protocol, at 15.

87 Penal Reform International and OSCE Office for Democratic Institutions and Human Rights (ODIHR), *Guidance Document on the Nelson Mandela Rules*, (Warsaw and London: 2018), at 160; citing 23rd General Report, CPT/Inf (2013) 29, op. cit., note 342. Online: https://cdn.penalreform.org/wp-content/uploads/2018/07/MR_Guidance_Doc.pdf.

88 Canadian Medical Association, *Code of Ethics and Professionalism* (2018). Online: https://policybase.cma.ca/documents/policypdf/PD19-03.pdf.

89 *Mandela Rules*, Rule 25(2).

90 Jörg Pont, Heino Stöver and Hans Wolff, "Dual Loyalty in Prison Healthcare," *American Journal of Public Health*, March 2012; 102(3) ["Dual Loyalty in Prison Healthcare"], at e1.

91 Dual Loyalty in Prison Healthcare, at e2.

92 Physicians for Human Rights and School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty, *Dual Loyalty and Human Rights in Health Professional Practice; Proposed Guidelines & Institutional Mechanisms* (2002) at 41. Online: https://phr.org/wp-content/uploads/2003/03/dualloyalties-2002-report.pdf.

93 OCI 2017-2018, at 18.

94 Average daily count for 2018 as provided by BC Corrections to PLS.

95 Data provided by BC Corrections to PLS.

96 *Correction Act,* s. 12(1).

97 Government of British Columbia, *Adult Custody Policy* ["*Adult Custody Policy*"] 1.2 – Use of Force (revised: April 2006).

98 *Adult Custody Policy* 2.4 – Cell Entry and Extractions (April 2005).

99 *Adult Custody Policy* 2.4.4.

100 *Adult Custody Policy* 2.4.12.

101 *The Code*, at 103.

102 See *Adult Custody Policy* 1.15 – Searches—Inmates (revised: November 2018).

103 *Adult Custody Policy* 1.15.8.

104 *Adult Custody Policy* 1.15.9.

105 *Adult Custody Policy* 1.15.9.

106 *Adult Custody Policy* 1.15.9.

107 *Adult Custody Policy* 1.3 – Restraint and Control Devices and Apparatus (revised: September 2016).

108 See CSC Commissioner's Directive 843, *Interventions to Preserve Life and Prevent Serious Bodily Harm* (2017-08-01), s. 34.

109 Rosalind Comyn, "The rise of spit hoods: dangerous, degrading and unjustified" (21 February 2019). Online: https://www.libertyhumanrights.org.uk/news/blog/rise-spit-hoods-dangerous-degrading-and-unjustified.

110 *Fatal Response*, at 6.

111 Provincial Health Services Authority policy number CCR-735X, "Health Services Staff Response to the Use of Restraints and Control Devices" ["PHSA policy CCR-735X"].

112 While health services hours begin as early as 4:30am and end as late as 11:30pm in some BC Corrections facilities, the only correctional centre with 24-hour health services is the Alouette Correctional Centre for Women.

113 PHSA policy CCR-735X, s. 4.

114 *Mandela Rules,* Rule 32(d).

115 PHSA policy CCR-735X, s. 8.

116 *Adult Custody Policy,* 1.3.19.

117 Justice Institute of British Columbia, *Recruit Training* (Last updated January 12, 2019). Online: https://www.jibc.ca/programs-courses/schools-departments/school-criminal-justice-security/police-academy/recruit-training.

118 Royal Canadian Mounted Police, *Cadet training* (Date modified: 2018-09-04). Online: http://www.rcmp-grc.gc.ca/en/cadet-training.

119 *Correction Act,* s. 28(2).

120 *Ombudsperson Act*, RSBC 1996, c. 340, s. 23.

121 The Office of the Ombudsperson, *Under Inspection: The Hiatus in BC Correctional Centre Inspections*, Special Report No. 38 (June 2016).

122 Operational inspection reports provided to PLS by BC Corrections covering February 2016 – May 2018.

123 OCI 2017-2018, at 34.

124 Jamil Malakieh, *Adult and youth correctional statistics in Canada, 2016/2017*. Statistics Canada. Online: https://www150.statcan.gc.ca/n1/pub/85-002-x/2018001/article/54972-eng.htm.

125 OCI 2017-2018, at 34.

126 The Correctional Investigator of Canada, *Annual Report of the Office of the Correctional Investigator - 2016-2017* (June 28, 2017) ["OCI 2016-2017"], at 42, 56. Online: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20162017-eng.pdf.

127 OCI 2017-2018, at 34-35.

128 OCI 2017-2018, at 34.

129 The Correctional Investigator of Canada, *Annual Report of the Office of the Correctional Investigator - 2015-2016* (June 30, 2016) ["OCI 2015-2016"], at 31-32. Online: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20152016-eng.pdf; OCI 2016-2017, at 42.

130 Martin 2006, at 183.

131 "Correctional Investigator Concerned by Rising Use of Force Incidents Involving Inflammatory Agents 'Current review and control framework for use of pepper spray behind bars inadequate,' says Correctional Investigator," (October 31, 2016). Online: http://www.oci-bec.gc.ca/cnt/comm/press/press20161031-eng.aspx.

132 OCI 2017-2018, at 34.

133 Dean Bennett, "Edmonton inmates were forced into prison fight club, lawsuit alleges," *The Globe and Mail* (May 11, 2018). Online: https://www.theglobeandmail.com/news/national/edmonton-inmates-were-forced-into-prison-fight-club-lawsuit-alleges/article14736533/.

134 Andrea Huncar, "Edmonton inmate allegedly shot in genitals sues federal government," *CBC News* (November 5, 2018). Online: https://www.cbc.ca/news/canada/edmonton/edmonton-institution-alberta-lawsuit-shawn-keepness-shooting-rubber-bullets-genitals-segregation-solitary-1.4890306.

135 Janice Johnston, "Explosive allegations against male prison guards contained in lawsuit," *CBC News* (March 12, 2018). Online: https://www.cbc.ca/news/canada/edmonton/prison-guards-correctional-service-of-canada-waterboarding-1.4571728.

136 TLS Enterprises, *Organizational Assessment – Edmonton Institution* (March 2017) ["*Edmonton Organizational Assessment*"], at 12-13.

137 *Edmonton Organizational Assessment*, at 22.

138 OCI 2017-2018.

139 Andrea Huncar, "'I'm already dead': Edmonton prison has highest self-harm rates in Canada," *CBC News* (October 29, 2018). Online: https://www.cbc.ca/news/canada/edmonton/self-harm-self-injury-segregation-isolation-edmonton-institution-federal-prison-isolation-1.4880950.

140 Erica Johnson, "'I'm not signing it': Correctional officer says superiors tried to buy her silence after week of 'hazing'," *CBC News* (November 6, 2017). Online: https://www.cbc.ca/news/canada/british-columbia/female-correctional-officer-subjected-to-hazing-at-ert-training-1.4384238

141 Correctional Investigator of Canada, *Unauthorized Force: An Investigation into the Dangerous Use of Firearms at Kent Institution Between January 8 and January 18, 2010* (March 21, 2011) [*"Unauthorized Force*"], at 3. Online: https://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/KentReport-eng.pdf.

142 *Unauthorized Force*, at 3-4.

143 CCRA, s. 4(c).

144 CCRA, s. 3.

145 CSC Commissioner's Directive 567, *Management of Incidents (*2018-01-15) ["CD 567"].

146 CD 567, s. 8.

147 CD 567, definitions.

148 OCI 2017-2018, at 35.

149 CD 567, s. 27.

150 CSC Commissioner's Directive 567-1, *Use of Force* (2016-02-01) ["CD 567-1 (2016)"]. Online: https://www.csc-scc.gc.ca/politiques-et-lois/567-1-cd-eng.shtml.

151 CSC Commissioner's Directive 567-1, *Use of Force* (2018-12-17) ["CD 567-1 (2018)"].

152 CD 567-1 (2018), definitions.

153 CD 567-1 (2018), s. 9.

154 CD 567-1 (2018), s. 22.

155 CD 567-1 (2018), s. 21.

156 CD 567-1 (2018), s. 25.

157 CD 567-1 (2018), s. 14.

158 CD 567-1 (2018), s. 15.

159 *Fatal Response*, at 5.

160 CD 567-1 (2018), s. 33.

161 CD 567-1 (2016), s. 27.

162 OCI 2015-2016, at 34.

163 CD 567-1 (2018), s. 35.

164 CD 567-1 (2018), s. 36.

165 CD 567-1 (2018), s. 38.

166 CD 567-1 (2018), s. 49.

167 CD 567-1 (2018), definitions.

168 CD 567-1 (2018), s. 61.

169 These reviews, with the exception of uses of force at treatment centres, count towards regional headquarters' 25 percent quota.

170 CD 567-1 (2018), s. 66.

171 CD 567-1 (2018), s. 2.

172 CSC Commissioner's Directive 567-4, *Use of Chemical and Inflammatory Agents* (2016-02-01).

173 Correctional Service Canada, "Audit of the Framework and Implementation of Situation Management at CSC" (March 6, 2018) ["Situation Management Audit"]. Online: https://www.csc-scc.gc.ca/publications/092/005007-2546-en.pdf.

174 Situation Management Audit, at 17.

175 Situation Management Audit, at 18.

176 Situation Management Audit, at 18.

177 Correspondence with the Office of the Correctional Investigator.

178 OCI 2017-2018, at 9.

179 *Mandela Rules*, Rule 24(2).

180 *Mandela Rules*, Rule 25(2).

181 Correctional Service Canada, "Health Services Responsibilities Related to CD 567-1 Use of Force" (March 2013).

182 The Honourable Louise Arbour, Commissioner, *Commission of Inquiry into Certain Events at the Prison for Women in Kingston* (Ottawa: Public Works and Government Services Canada, 1996).

183 Information shared with PLS by FPH.

184 BC Mental Health & Substance Use Services, *Therapeutic and Relational Security* (2019). Online: http://www.bcmhsus.ca/about/developments-in-care/therapeutic-and-relational-security.

185 Island Health, *Integrated Mobile Crisis Response Team (IMCRT)* (2019). Online: https://www.islandhealth.ca/our-services/mental-health-substance-use-services/integrated-mobile-crisis-response-team-imcrt.

186 Toronto Police Service, *Mental Health Mobile Crisis Intervention Teams (MCIT)* (2019). Online: http://www.torontopolice.on.ca/community/mcit.php.

187 Information shared with PLS by AOT.

188 Camia S. Weaver, "Destroying Myths, Building

Success: Evidence-Based Development of Police Crisis Response" (2018) at 24-25.

189 The Honourable Frank Iocobucci, *Police Encounters with People in Crisis: An Independent Review Conducted by The Honourable Frank Iacobucci for Chief of Police William Blair, Toronto Police Service* (July 2018), ["*Police Encounters with People in Crisis*"], at 223-224. Online: https://www.torontopolice.on.ca/publications/files/reports/police_encounters_with_people_in_crisis_2014.pdf.

190 *Police Encounters with People in Crisis*, at 225.

191 National Alliance of Mental Illness, *Saving Lives, Changing Communities* (October 20, 2015). Online: https://www.nami.org/Blogs/NAMI-Blog/October-2013/Saving-Lives,-Changing-Communities.

192 Randolph Dupont, Major Sam Cochran, Sarah Pillsbury, *Crisis Intervention Team Core Elements*, The University of Memphis (September 2007) ["*Crisis Intervention Team Core Elements*"], at 14. Online: http://www.citinternational.org/resources/Pictures/CoreElements.pdf.

193 *Crisis Intervention Team Core Elements*, at 14.

194 Lt. Michael S. Woody (Ret), "The Art of De-Escalation" *The Journal* (Summer 2005). Online: https://www.citwisconsin.org/s/Woody-2005-The-Art-of-De-Escalation-2393.pdf, at 58.

195 *Police Encounters with People in Crisis*, at 237.

196 Police Executive Research Forum, *An Integrated Approach to De-Escalation and Minimizing Use of Force* (August 2012) at 37. Online: https://www.policeforum.org/assets/docs/Critical_Issues_Series/an%20integrated%20approach%20to%20de-escalation%20and%20minimizing%20use%20of%20force%202012.pdf.

197 Samuel Singyangwe, "Examining the Role of Use of Force Policies in Ending Police Violence" (September 20, 2016) ["Singyangwe 2016"], at 9. Online: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2841872.

198 Singyangwe 2016, at 4.

199 Craig Haney, "The Psychological Effects of Solitary Confinement: A Systematic Critique," *Crime and Justice* (2018) 47:1 ["Haney 2018"], at 372.

200 International Association of Chiefs of Police, "Responding to Persons Experiencing a Mental Health Crisis" (August 2018) at 7. Online: https://www.theiacp.org/sites/default/files/2018-08/MentalIllnessPaper2018.pdf.

201 As quoted in Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* (2003) at 80. Online: https://www.hrw.org/sites/default/files/reports/usa1003.pdf.

202 Ontario Ombudsman, *A Matter of Life and Death* (June 2016) ["*A Matter of Life and Death*"], at 48.

203 *A Matter of Life and Death*, at 7.

204 Mental Health Commission of Canada, *A Comprehensive Review of the Preparation and Learning Necessary for Effective Police Interactions with Persons with a Mental Illness* (2014) at 3.

205 The Patient Safety Education Program – Canada, *Module 13d: Mental Health Care: Seclusion and Restraint: When All Else Fails* (2017) ["Patient Safety Education Program"], at T1. Online: https://www.patientsafetyinstitute.ca/en/education/PatientSafetyEducationProgram/PatientSafetyEducationCurriculum/Documents/Module%2013d%20Seclusion%20and%20Restraint.pdf.

206 Patient Safety Education Program, at 2.

207 Patient Safety Education Program, at T1.

208 Patient Safety Education Program, at 2.

209 Patient Safety Education Program, at T1.

210 Jenelle Power & Shelley L. Brown, "Self-Injurious Behaviour: A Review of the Literature and Implications for Correction," Correctional Service Canada (February 2010). Online: https://www.csc-scc.gc.ca/005/008/092/005008-0216-01-eng.pdf.

211 Haney 2018, at 372.

212 Cherami Wichmann, Ralph Serin & Larry Motiuk, "Predicting Suicide Attempts Among Male Offenders in Federal Penitentiaries" (June 2000), at 2.

213 OCI 2015-2016, at 36.

214 Sullivan 2017, at 320.

215 Sullivan 2017, at 320.

216 Sullivan 2017, at 320.

217 Sullivan 2017, at 322.

218 Graham Towl & Danielle Forbes, "Working with suicidal prisoners." In G. Towl, L. Snow, & M. McHugh (Eds.), *Suicide in prison*. Oxford: BPS Blackwell (2002). See also Lisa Marzano, Karen Ciclitira and Joanna Adler, "The impact of prison staff responses on self-harming behaviours: Prisoners' perspectives," *British Journal of Clinical Psychology* 51(1) (2012).

219 OCI 2017-2018, at 90.

220 OCI 2015-2016, at 31; OCI 2016-2017, at 42; OCI 2017-2018, at 34.

221 Crisis Prevention Institute, *Physical Restraint Training* (2019). Online: https://www.crisisprevention.com/en-CA/Blog/June-2011/Physical-Restraint-Training.

222 Situation Management Audit, at 16.

223 *Mandela Rules*, Rule 35.

224 OCI 2017-2018, at 18.

225 Sarah Glowa-Kollisch, Jasmine Graves, Nathaniel Dickey, Ross MacDonald, Zachary Rosner, Anthony Waters, & Homer Venters, "Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail," *Health and Human Rights Journal* Vol. 17, No. 1 (June 11, 2015). Online: https://www.hhrjournal.org/2015/03/data-driven-human-rights-using-dual-loyalty-trainings-to-promote-the-care-of-vulnerable-patients-in-jail/.

226 OCI 2016-2017, at 43.

227 OCI 2016-2017, at 44.

228 *Privacy Act,* RSC, 1985, c. P-21, ss. 14-15.

229 OCI 2017-2018, at 106.

230 OCI 2017-2018, at 115.

231 The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator - 2012-2013* (June 28, 2013) ["OCI 2012-2013], at 30. Online: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20122013-eng.pdf.

232 OCI 2012-2013, at 30.

233 OCI 2015-2016, at 34.

234 Situation Management Audit, at 17-19.

235 OCI 2017-2018, at 10.

236 The Correctional Investigator Canada, *Annual Report of the Correctional Investigator – 2004-2005* at 19-20. Online: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20042005-eng.pdf. See also OCI 2016-2017, at 39-40 and OCI 2017-2018, at 9.

237 OCI 2017-2018, at 9.

238 OCI 2017-2018, at 9.

239 OCI 2017-2018, at 10.

240 Kristy Kirkup, "Corrections service waited three months to report sex-assault claim to police," *The Canadian Press* (May 24, 2019). Online: https://www.ctvnews.ca/canada/corrections-service-waited-three-months-to-report-sex-assault-claim-to-police-1.4436575.

241 Correspondence with the Office of the Correctional Investigator.

242 OCI 2017-2018, at 34; OCI 2016-2017, at 42; OCI 2015-2016, at 31; OCI 2014-2015, at 34; OCI 2013-2014, at 37.