RELEASE DATE: *September 6, 2018*

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act* C.C.S.M. c. F52

AND IN THE MATTER OF: Devon Sampson, Deceased
(D.O.D: November 23, 2013)

Dwayne Mervin Flett, Deceased
(D.O.D: April 15, 2015)

Report on Inquest and Recommendations of
The Honourable Judge Brian Corrin
Issued this 31st day of August, 2018

VOLUME 2 of 2

APPEARANCES:

Ms. Stephanie Harland and Ms. Catherine Bator, Inquest Counsel
Mr. Alexander Menticoglou and Ms. M. Beth Tait, Counsel for Correctional Services of Canada (CSC)
Mr. Andrew W. Boumford, Counsel for Dr. Stanley Yaren and Dr. Daniel Globerman
Ms. Allison Fenske, Counsel for the John Howard Society of Canada (Manitoba Branch) and the Canadian Mental Health Association (assisted by Mr. K. Chadwick-Garrett)

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF:
DEVON SAMPSON AND DWAYNE MERVIN FLETT

APPENDICES

A. Convening Order and Terms of Reference re Devon Sampson

B. Convening Order and Terms of Reference re Dwayne Mervin Flett

C. Key Principles of Mental Health Services

D. 2013 Commissioner's Directive Guidelines

E. Supplementary Written Submissions - John Howard Society and the Canadian Mental Health Association, Manitoba and Winnipeg

F. Written Submission of the John Howard Society of Manitoba and the Canadian Mental Health Association Manitoba and Winnipeg

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: DEVON SAMPSON

WITNESS LIST

1 Kory Abrams
2 Lee Van Den Broeck
3 Kelly Campbell
4 Kimberly Fines
5 Peter Gibson
6 Dr. Daniel Globerman
7 James Gonzo
8 Dawn Hale
9 Matt Robinson
10 Orson Rowe
11 Deanna Slobodian
12 Dr. Kent Somers
13 Brent Yarechewski
14 Dr. Stanley Yaren
15 Warren Zimmerman

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: DWAYNE MERVIN FLETT

WITNESS LIST

1 Kory Abrams
2 Josh Beatty
3 Roderick Bilugan
4 Kelly Campbell
5 Jennifer Downie
6 Chard Ferens
7 Dr. Daniel Globerman
8 Craig Gunter
9 Dawn Hale
10 Dr. Raymond Rivera
11 Rutledge
12 Timothy Scott
13 Dr. Stuart Toews
14 Warren Zimmerman

APPENDIX A

PROTECTED B

CONVENING ORDER AND TERMS OF REFERENCE **ANNEX A**

CONVENING ORDER AND TERMS OF REFERENCE

BOARD OF INVESTIGATION INTO THE SUICIDE OF AN INMATE AT STONY MOUNTAIN INSTITUTION ON NOVEMBER 23, 2013

WHEREAS it is provided by Sections 19 and 20 of the *Corrections and Conditional Release Act* (CCRA), S.C. 1992, c. 20 that the Commissioner of the Correctional Service of Canada may appoint a person or persons to investigate and report upon any matter relating to the operations of the Service; and that the Service investigate and report when an inmate dies or suffers serious bodily injury;

And,

WHEREAS on the 23rd day of November 2013 at approximately 0805 hours, Correctional Officers in Unit 5 were notified that inmate Devon **SAMPSON** (FPS# 863786D) was hanging in his cell. The Correctional Officers attended cell E10 and found **SAMPSON** seated on his bed with a shoe lace tied around his neck and attached to the top bunk. The ligature was removed and first aid/cardiopulmonary resuscitation was administered. At approximately 0808 hours, an ambulance was contacted and Health Services Nurses were deployed to the scene. The paramedics arrived on the unit at approximately 0826 hours. **SAMPSON** was declared deceased at approximately 0847 hours.

NOW THEREFORE I, Don **HEAD**, Commissioner of Corrections, do hereby appoint, by virtue of Sections 19 and 20 of the CCRA, Hugo **FOSS**, National Investigator, Incident Investigations Branch, National Headquarters as Chairperson of the Board of Investigation, and Don **THOMPSON**, Senior Project Officer, Security Operations, Regional Headquarters, Ontario Region, and community member, as members of the Board of Investigation.

I DIRECT AND CHARGE the persons so appointed to faithfully execute the duties entrusted to them in the conduct of this investigation and to provide me with the complete circumstances surrounding the above-mentioned incident, including:

a) a background into the incident;

Any use for any person other than the recipient including distributing, copying or disclosure is strictly prohibited and may be unlawful. L'usage de cette information par tout individu autre que les personnes désignées, y compris sa distribution, reproduction ou divulgation est strictement interdit et peut être considéré illégal.

b) a succinct and relevant profile of the inmate involved in this incident;
c) a psychological review of the inmate (completed by the Psychologist); and,
d) a chronology of the events.

I FURTHER DIRECT that the Board of Investigation specifically analyze the following issues, as it relates to this case, including any issues of compliance to the law, policies and procedures having a direct impact on this incident:

a) the existence of pre-incident indicators, precipitating events or contributing risk factors to the incident under investigation and if so, were they known by staff and was any attention provided or action taken by them;

b) the security classification of the inmate involved in this incident and his placement at Stony Mountain Institution;

c) the care, treatment and monitoring of the inmate prior to the incident;

d) the staff presence in the area where the incident occurred, including the frequency and adequacy of the monitoring of inmate activities; and,

e) the staff response to the incident, including, but not limited to, the interventions and medical care that were provided to the inmate following the incident.

AND I FURTHER DIRECT the Board of Investigation to provide me with its findings on the above matters and any recommendations it considers appropriate and which may contribute to the effective resolution and/or prevention of similar situations or occurrences in the future

AND FURTHER, to ensure the success of this investigation, the Board of Investigation is authorized:

a) to adopt such procedures and methods as may be deemed necessary for the proper conduct of this investigation;

b) to be provided with adequate and secure working accommodation and administrative assistance as required;

c) to search any building, receptacle or thing on the property of and in the possession of the Correctional Service of Canada, and to seize and retain such books, documents or things as the Board may deem, on reasonable grounds, necessary for the successful execution of its mandate;

d) to have complete access to personnel employed by, or under contract with the Correctional Service of Canada;

e) to communicate, at the discretion of the Chairperson of the Board of Investigation, with any outside person, agency, office or organization which may assist in the successful completion of this investigation; and,

f) to disclose any personal information it deems necessary to enable the recipient of a Section 13 Notice to fully understand and respond to the statements made by the Board of Investigation in the report which indicate that the person breached the law or policy, and which may negatively affect the person's reputation.

The Annex to this Convening Order outlines further the powers and responsibilities bestowed on this Board of Investigation under Sections 7 to 13 of the *Inquiries Act* pursuant to Section 21 of the *Corrections and Conditional Release Act*. In applying the Section 13 process, the Board of Investigation shall apply the same considerations and follow the same procedures with Section 13 whether the person is a member of the public, a staff member, a Parole Board of Canada member, an offender or a contractor.

AND I FURTHER DIRECT the Board of Investigation to submit to me, through the Director General, Incident Investigations Branch, a written report marked "Protected B", no later than **the 21st day of May 2014.**

APPENDIX B

PROTECTED B

CONVENING ORDER AND TERMS OF REFERENCE **ANNEX A**

BOARD OF INVESTIGATION INTO THE DEATH OF AN INMATE AT STONY MOUNTAIN INSTITUTION ON APRIL 15, 2015

WHEREAS it is provided by Sections 19 and 20 of the *Corrections and Conditional Release Act* (CCRA), S.C. 1992, c. 20 that the Commissioner of the Correctional Service of Canada may appoint a person or persons to investigate and report upon any matter relating to the operations of the Service, and that the Service investigate and report when an inmate dies or suffers serious bodily injury;

And,

WHEREAS on the 15th day of April 2015,

NOW THEREFORE I, Don **HEAD**, Commissioner of Corrections, do hereby appoint, by virtue of Sections 19 and 20 of the CCRA, Hugo **FOSS**, National Investigator, Incident Investigations Branch, National Headquarters as Chairperson of the Board of Investigation, and Gina **MARCELLI**, Acting Correctional Manager, Beaver Creek Medium Institution, Ontario Region, and , community member, as members of the Board of Investigation.

I DIRECT AND CHARGE the persons so appointed to faithfully execute the duties entrusted to them in the conduct of this investigation and to provide me with the complete circumstances surrounding the above-mentioned incident, including:

a) a background into the incident;
b) a succinct and relevant profile of the inmate involved in this incident; and,
c) a psychological review of the inmate (completed by the Psychologist); and,
d) a chronology of the events.

I FURTHER DIRECT that the Board of Investigation specifically analyze the following issues, as it relates to this case, including any issues of compliance to the law, policies and procedures having a direct impact on this incident:

Any use for any person other than the recipient including distributing, copying or disclosure is strictly prohibited and may be unlawful.
L'usage de cette information par tout individu autre que les personnes désignées, y compris sa distribution, reproduction ou divulgation est strictement interdit et peut être considéré illégal.

a) the existence of pre-incident indicators, precipitating events or contributing risk factors to the incident under investigation and if so, were they known by staff and was any attention provided or action taken by them;

b) the security classification of the inmate involved in this incident and his placement at Stony Mountain Institution, and whether the social history of the inmate was considered in the decision-making process as per Commissioner's Directive (CD) 702, *Aboriginal Offenders*, CD 705-7, *Security Classification and Penitentiary Placement*, and CD 710-6, *Review of Inmate Security Classification*;

c) the inmate's overall mental health management plan, including the physical and mental health care and medications provided to the inmate during his placement at Stony Mountain Institution, and the extent to which the clinical management plan (if any) was followed;

d) the staff presence in the area where the incident occurred, including the frequency and adequacy of the monitoring of inmate activities; and,

e) the staff response to the incident, including, but not limited to, the interventions and medical care that were provided to the inmate following the incident.

AND I FURTHER DIRECT the Board of Investigation to provide me with its findings on the above matters and any recommendations it considers appropriate and which may contribute to the effective resolution and/or prevention of similar situations or occurrences in the future.

AND FURTHER, to ensure the success of this investigation, the Board of Investigation is authorized:

a) to adopt such procedures and methods as may be deemed necessary for the proper conduct of this investigation;

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c) to search any building, receptacle or thing on the property of and in the possession of the Correctional Service of Canada, and to seize and retain such books, documents or things as the Board may deem, on reasonable grounds, necessary for the successful execution of its mandate;

d) to have complete access to personnel employed by, or under contract with the Correctional Service of Canada;

e) to communicate, at the discretion of the Chairperson of the Board of Investigation, with any outside person, agency, office or organization which may assist in the successful completion of this investigation; and,

f) to disclose any personal information it deems necessary to enable the recipient of a Section 13 Notice to fully understand and respond to the statements made by the Board of Investigation in the report which indicate that the person breached the law or policy, and which may negatively affect the person's reputation.

The Annex to this Convening Order outlines further the powers and responsibilities bestowed on this Board of Investigation under Sections 7 to 13 of the *Inquiries Act* pursuant to Section 21 of the *Corrections and Conditional Release Act*. In applying the Section 13 process, the Board of Investigation shall apply the same considerations and follow the same procedures with Section 13 whether the person is a member of the public, a staff member, a Parole Board of Canada member, an offender or a contractor.

AND I FURTHER DIRECT the Board of Investigation to submit to me, through the A/Director General, Incident Investigations Branch, a written report marked "Protected B", no later than the **7th day of October 2015.**

Given under my hand in the City of Ottawa, in the Province of Ontario, this 8th day of June 2015.

Original signed by

Don Head
Commissioner
Correctional Service of Canada

1410-2-2015-13

Any use for any person other than the recipient including distributing, copying or disclosure is strictly prohibited and may be unlawful.
/L'usage de cette information par tout individu autre que les personnes désignées, y compris sa distribution, reproduction ou divulgation est strictement interdit et peut être considéré illégal.

APPENDIX C

Institutional mental health services are based on a collaborative care model, which:

- incorporates intake mental health screening information [Computerized Mental Health Intake Screening System (COMHISS)] to facilitate responsive and prompt access to mental health services (see COMHISS National Guidelines); and
- provides interventions as part of the wider Correctional Planning [Commissioner Directive (CD) 705-06] and Institutional Supervision (CD 710) frameworks.

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Key Principles

3. **Integration of Regional Mental Health Services.** No single service setting can meet all population mental health needs. Collaboration and information sharing across service settings (regular institutions, supportive living environments, Structured Living Environment Houses for women offenders, treatment centres and community) is essential to offender continuity of mental health care.

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4. **Mental Health Partnerships and Shared Responsibility.** The delivery of mental health services occurs within a strongly integrated and coordinated approach linking all CSC staff involved in managing offenders with mental health concerns, including CMHI staff and Regional Treatment Centres, as well as offender family and community supports. Accessing and participating in a broad range of institutional services, such as employment, education, cultural/spiritual activities and correctional programs, are important protective factors for offender mental health.
5. **Recovery focus:** Recovery from mental disorder is a process, sometimes lifelong, defined and led by the person with the disorder through which they achieve independence, self-esteem and quality of life.
6. **Merging of Intervention Models/Holistic Care:** To reflect current "best practices" there is a need to merge all intervention models, including medical, psychological, social, correctional and recovery.[8]
7. **Strengths Perspective:** Mental health services build on the offender's strengths and work with the offender to link them to required institutional resources.
8. **Level of Need and Triage:** Services are organised and coordinated based on a level of need structure to ensure that offenders have access to the services that best meet their needs and that those offenders with serious mental disorders are given priority for service.
9. **Individualised Care:** Each individual has different needs and these needs change over time. Mental health staff and offenders collaborate to develop and monitor their individual treatment plans. These plans focus on interventions that will facilitate recovery and the resources required to support the recovery process.
10. **Respect for Diversity:** Offenders come from diverse backgrounds and are not one homogeneous group. To respect diversity, mental health services are flexible to respond to the unique needs of each group with particular emphasis on women and Aboriginal offenders).
11. **Information Sharing.** Sharing of mental health information with the offender's case management team is essential to ensuring effective support and monitoring of progress. This sharing of mental health information is done in a way consistent with CSC policy and the need-to-know principle, and the information shared must be related to risk, need and responsivity factors. See CD 803, *Consent to Health Services Assessment, Treatment and Release of Information.*
12. **Evidence-based practice:** Mental health interventions are evidenced-based or clinically-informed, for which there is consistent evidence or at least some support in the literature showing that they improve client outcomes.

[8] Ohio Department of Mental Health Emerging Best Practices and Guiding Principles.

Government of Canada Gouvernement du Canada

APPENDIX D

Canada

Correctional Service Canada

Commissioner's Directive

Management of Inmate Self-Injurious and Suicidal Behaviour

Commissioner's Directive

- Number: 843
- In Effect: 2013-09-23

Related Links

- Policy Bulletin 333
- Policy Bulletin 372
- Policy Bulletin 406
- Policy Bulletin 411
- Policy Bulletin 422

AUTHORITIES

- *Corrections and Conditional Release Act* (CCRA), sections 85 to 88
- Provincial mental health legislation and regulations

PURPOSE

- To ensure the safety of inmates who are self-injurious or suicidal using the least restrictive measures for the purpose of preserving life and preventing serious bodily injury, while maintaining the dignity of the inmate in a safe and secure environment
- To encourage and support an interdisciplinary approach so that the inmate can resume regular activities as soon as possible

APPLICATION

Applies to staff members who contribute to efforts to ensure the safety of inmates in institutions (including Regional Treatment Centres) and excludes those working in Community Correctional Centres

CONTENTS

- Responsibilities
- Procedures for Assigning a Suicide Watch Observation Level
  - Screening for Suicide Risk
  - Suicide Watch Observation Levels (High Suicide Watch, Modified Suicide Watch and Mental Health Monitoring)
  - Modifications to Observation Levels
- Procedures for the Application of Restraint Equipment
  - Pregnant Inmates
  - Reporting the Use of the Pinel Restraint System
  - Assessment and Monitoring of the Use of the Pinel Restraint System
  - Activities of Daily Living While in the Pinel Restraint System
  - Pinel Restraint System: Follow-Up and Review Procedures

- Removal of the Pinel Restraint System
- Support for Inmates
- Transfer of Inmates
- Limitations
- Annex A: Cross-References and Definitions
- Annex B: Process for Self-Injury Intervention
- Annex C: Flow Chart of the Key Steps for Self-Injury Intervention in Institutions

RESPONSIBILITIES

1. The Institutional Head will ensure that:

   a. staff receive suicide prevention training and training on the use of the Pinel Restraint System, as per the National Training Standards

   b. a bed, or an appropriate chair or stretcher, to accommodate the Pinel Restraint System is available in their institution (except minimum security institutions and Healing Lodges)

   c. for cases in which the inmate is engaged in self-injury:

      i. he/she, or his/her delegate, as determined by a Standing Order, authorizes the application of the Pinel Restraint System and in accordance with the Situation Management Model

      ii. he/she, or his/her delegate as determined by a Standing Order, authorizes the reduction of use, or removal of the Pinel Restraint System

   d. an inmate is transferred, as soon as practicable, to a Regional Treatment Centre or an appropriate health care facility if any of the required assessments cannot be facilitated (i.e. mental health or health assessment) while in the Pinel Restraint System

   e. he/she decides whether to use the Interdisciplinary Mental Health Team (IMHT) or the Correctional Intervention Board (CIB) for overseeing the management of an inmate who is suicidal or self-injurious. Should the CIB be used, minimum membership will be the same as the IMHT, as outlined in CD 850 – Mental Health Services. The Team/Board will follow the Process for Self-Injury Intervention (Annex B)

   f. all behavioural indications, threats and actual situations of self-injury and attempted suicide are documented by those responsible for any aspect of the case

   g. a communication process is in place so that staff who have regular interaction with the inmate are informed, in a timely fashion, when an inmate has been placed in the Pinel Restraint System, on High Suicide Watch, Modified Suicide Watch, Mental Health Monitoring or when the observation level has been changed

   h. the Process for Self-Injury Intervention (Annex B) is communicated to staff and adhered to

   i. the Inmate Suicide Awareness and Prevention Workshop is available on a regular basis and inmates have access.

2. Staff will:

   a. intervene immediately when an inmate is discovered in the act of self-injury or suicide. Interventions must be in accordance with the Situation Management Model described in CD 567 – Management of Security Incidents

   b. ensure that interventions with a self-injurious or suicidal inmate are communicated to staff and contractors who have regular interactions with inmates.

3. A mental health professional may authorize the use of the Pinel Restraint System in cases where the inmate is not engaged in self-injury if it is part of the inmate's Treatment Plan. In this case, the mental health professional must seek input from the Duty Correctional Manager regarding the application, removal, or reduction of the Pinel Restraint System.

4. Any of the monitoring and/or assessments required in this policy may be overridden by a licensed mental health professional practicing within his/her scope of practice, with input from the Duty Correctional Manager. This directive must be written, dated and signed.

5. Unlicensed mental health professionals may provide any of the required monitoring or assessment under the supervision of a licensed mental health professional.

PROCEDURES FOR ASSIGNING A SUICIDE WATCH OBSERVATION LEVEL

Screening for Suicide Risk

6. All inmates will be screened using the Immediate Needs Checklist – Suicide Risk pursuant to CD 705-3 – Immediate Needs and Admission Interviews.

7. In addition to the requirements in CD 705-3 – Immediate Needs and Admission Interviews, the Immediate Needs Checklist – Suicide Risk will be used:

   a. within 24 hours of arrival to a new institution
   b. upon admission to administrative segregation
   c. by any non-health care staff interacting with the inmate when there is reason to believe that the inmate may present some risk for suicide and a mental health professional is not immediately available. This would include when returning from outside court or when the reason for placement in administrative segregation is changed.

8. If there is reason to believe that the inmate may be at imminent risk to attempt suicide, the staff member will immediately contact a mental health professional and the Duty Correctional Manager. The mental health professional will assign an observation level based on an in-person assessment. If no mental health professional is available, the Duty Correctional Manager will immediately place the inmate on High Watch and the inmate will be assessed by a mental health professional as soon as reasonably possible, but within 24 hours.

9. Referral to a mental health professional (use Referral Form Psychology/Institutional Mental Health Services, CSC/SCC 0450) must be documented in a Casework Record.

Suicide Watch Observation Levels (High Suicide Watch, Modified Suicide Watch and Mental Health Monitoring)

10. An inmate assessed as requiring High or Modified Suicide Watch will:

    a. be placed in a suicide watch cell

    b. have a mental health assessment, in person, by a mental health professional within 24 hours; the frequency of subsequent assessments will be determined by a mental health professional. The mental health professional will review and initial the Seclusion and Restraint Observation Report (CSC/SCC 1006) and incorporate any relevant information into the assessment

    c. be visited daily by a Nurse, pursuant to CD 800 – Health Services (section on Administrative Segregation).

11. Inmates on High Suicide Watch will be under constant, direct observation by a Correctional Officer/Primary Worker (or it may be a mental health professional in Regional Treatment Centres). Monitoring via camera only is not permitted.

12. Inmates on Modified Suicide Watch will be monitored as noted above, or under constant observation via Closed Circuit Television (CCTV). If constant observation takes place via CCTV, the CCTV monitor is not to be located in the Main Communications Control Post (MCCP). For women inmates, CCTV monitoring will be done in accordance with CD 577 – Operational Requirements for Cross-Gender Staffing in Women Offender Institutions.

13. The Correctional Officer/Primary Worker (or the mental health professional, if applicable) will document the inmate's activities on a Seclusion and Restraint Observation Report (CSC/SCC 1006), as required, but at least every 15 minutes.

14. When an inmate has been assigned to an observation level, the Nurse will consult with the Psychiatrist, or the institutional Physician, within 24 hours, to conduct a review of the inmate's medication profile. The review will include the method of medication administration, taking into account the inmate's level of risk for self-injurious or suicidal behaviour.

15. The mental health professional will complete the High Suicide Watch Observation Form (CSC/SCC 1434), the Modified Suicide Watch Observation Form (CSC/SCC 1435) or the Mental Health Monitoring Form (CSC/SCC 1436). A copy will be given to the Duty Correctional Manager, who will ensure that it is accessible to staff who have regular interaction with the inmate on all shifts. If the inmate has an active Interdisciplinary Management Plan (CSC/SCC 1432), the Suicide Watch Observation Forms are not required.

16. At shift briefings, the Duty Correctional Manager will advise Correctional Officers/Primary Workers of any inmates who are currently assigned an observation level and the conditions of the observation level.

High Suicide Watch

17. An inmate who is at imminent risk for suicidal or self-injurious behaviour is placed on High Suicide Watch.

18. An inmate placed on High Suicide Watch will be provided with, at minimum:

    a. a security gown, at all times

    b. a security blanket and mattress unless the inmate attempts to use these items in a manner that is self-injurious or affects staff's ability to monitor the inmate. In this case, the items can be removed from the cell, with the intention of returning the item as soon as safely possible

    c. food and fluids that can be easily consumed without cutlery or tableware (finger foods)

    d. hygiene items (the mental health professional, with input from the Duty Correctional Manager, will determine when to provide hygiene items if these items are associated with any risk for suicidal or self-injurious behaviour).

Modified Suicide Watch

19. An inmate who is at elevated risk for suicidal or self-injurious behaviour is placed on Modified Suicide Watch.

20. In addition to the items listed for an inmate placed on High Suicide Watch, an inmate placed on Modified Suicide Watch, at the discretion of the mental health professional and with input from the Duty Correctional Manager, will be provided with:

    a. personal items, including but not limited to clothing, books, writing materials, and hygiene products (see 22 d, above)

    b. cescutlery and/or tableware, and regular institutional meals.

21. This acs is given in order to move towards normalizing the inmate's environment to the extent that is possible. It also affords the mental health professional the opportunity to evaluate the inmate's response to a reduction of restrictions while the inmate is under continuous observation.

Mental Health Monitoring

22. An inmate who is at risk for suicide or self-injury, typically following removal of High or Modified Suicide Watch status, will be placed on Mental Health Monitoring.

23. An inmate placed on Mental Health Monitoring will remain under the care of a mental health professional, who will determine the frequency and intensity of Mental Health Monitoring. The inmate may remain in his/her regular cell or be placed in another appropriate cell following consultation between the mental health professional and the Duty Correctional Manager.

Modifications to Observation Levels

24. If there is an increase in perceived risk of self-injurious or suicidal behaviour, staff will immediately notify a mental health professional and the Duty Correctional Manager. If no mental health professional is available, the Duty Correctional Manager will increase the observation level to High Suicide Watch. Any change will be documented on the appropriate Observation Form (1434, 1435, or 1436).

25. The observation level will be reduced and/or discontinued only when a mental health professional completes an in-person assessment, consults with the Duty Correctional Manager, and determines that the inmate's risk can be managed on a lower observation level. The observation level will normally only be reduced one level at a time.

PROCEDURES FOR THE APPLICATION OF RESTRAINT EQUIPMENT

26. The Pinel Restraint System is the only restraint system to be used for self-injurious behaviour in maximum and medium security institutions, women's institutions, and Regional Treatment Centres. Minimum security institutions and Healing Lodges may use the Pinel Restraint System, if available.

27. The use of the Pinel Restraint System, in response to self-injury or as a component of an Interdisciplinary Management Plan, does not replace efforts to understand and address the causes of the behaviour, nor is it intended to be the principal intervention.

28. The Pinel Restraint System will only be applied by trained staff.

29. Inmates will be appropriately clothed or covered while restrained.

30. To avoid positional asphyxia, at no time will a restrained inmate be placed lying face down. An inmate restrained to a bed or an appropriate stretcher will be placed either in the recovery position (side lying) or on his/her back with his/her head elevated. See section below for pregnant inmates.

Pregnant Inmates

31. Restraints should only be used as a last resort with pregnant inmates. If the Pinel Restraint System is being considered for application on a pregnant inmate, approval by a Physician will be sought if time and circumstances permit (or the Physician will be contacted immediately thereafter).

32. If restraints are applied, extreme caution will be exercised to ensure that both the inmate and fetus are protected from injury (e.g. supported by staff on each side while walking).

33. Pregnant inmates who are restrained in bed will be tilted on their left side. They will not be positioned flat on their back at any time. Approval will be given by the attending Physician for any other position.

Reporting the Use of the Pinel Restraint System

34. The use of the Pinel Restraint System for a situation in which an inmate is engaged in self-injury is:

    a. a reportable use of force if the inmate is engaged in self-injury and is physically uncooperative. The Use of Force Report (CSC/SCC 0754) will be completed

    b. a non-reportable use of force if the inmate cooperates and/or requests the application of the Pinel Restraint System. If at any point before the removal of the Pinel Restraint System the inmate is uncooperative, it becomes a reportable use of force.

35. Where use of the Pinel Restraint System is part of a treatment plan and the inmate consents, it is neither a reportable incident nor a reportable use of force.

Assessment and Monitoring of the Use of the Pinel Restraint System

36. When the application of the Pinel Restraint System is a reportable use of force, the use of force will be considered complete once the inmate is secured in the Pinel Restraint System and the Nurse has completed the post-use of force physical assessment pursuant to CD 567-1 – Use of Force. At this time, video-recording will cease.

37. When a Nurse is present during the application of the Pinel Restraint System, he/she will conduct an initial assessment of the inmate's physical and mental health upon completion of the application of the restraints. This assessment will include at a minimum:

a. ability to breathe without restriction

b. heart rate, respiratory rate and oxygen saturation

c. circulation to the hands and feet

d. general mental health assessment

e. referral to another health care professional, as required.

38. When there is no Nurse present during the application of the Pinel Restraint System:

a. a Nurse will be called to attend the institution and complete the health assessment within two hours of its application. If this is not possible, arrangements have to be made to ensure this assessment is completed within the two-hour timeframe

b. while waiting for the Nurse to arrive, a first aid/CPR certified staff member will immediately complete a first aid assessment, take action as appropriate and notify the Duty Correctional Manager once the assessment is completed and if there are any concerns. For any concerns regarding the inmate's physical health, the Duty Correctional Manager will refer to the section on "Response to Medical Emergencies" in CD 800 - Health Services.

39. If the inmate refuses a post-use of force or health assessment, the Nurse may perform the assessment based only on observation and interview data. The Nurse will observe the inmate to ascertain whether or not there are any signs of physical distress which require immediate intervention. If no signs of physical distress are present, the Nurse will document the refusal and return at the next designated time to re-offer the appropriate assessment.

40. At a minimum, an inmate placed in the Pinel restraint equipment will be under constant observation by a Correctional Officer/Primary Worker (or it may be a mental health professional in Regional Treatment Centres), either by CCTV or in direct view. If constant observation takes place via CCTV, the CCTV monitor is not to be located in the Main Communications Control Post (MCCP).

41. In situations where the inmate is restrained in the supine position (i.e. laying face up), he/she will be constantly monitored, in person, by a Correctional Officer/Primary Worker (or it may be a mental health professional in Regional Treatment Centres).

42. The Correctional Officer/Primary Worker (or mental health professional, if applicable) will ensure the inmate's safety as well as record the inmate's general appearance and behaviour. Situations that are to be reported to the Nurse on duty (or to the Duty Correctional Manager when the Nurse has not yet arrived) include, but are not limited to the following:

a. excessive sweating

b. difficulty breathing

c. complaints of pain

d. increase in thirst

e. increase in restlessness, agitation, or change in level of consciousness; or

f. soiling of clothes.

43. The Correctional Officer/Primary Worker (or the mental health professional in Regional Treatment Centres) will record all observations on the Seclusion and Restraint Observation Report (CSC/SCC 1006), as required, but at least every 15 minutes.

44. After the initial health assessment, a Nurse will perform an additional health assessment:

a. every 15 minutes for the first hour (or more frequently, based on clinical need)

b. once every hour thereafter (or more frequently, based on clinical need)

c. following the removal of the Pinel Restraint System.

45. Following the first hour of the application of the Pinel Restraint System, range of motion exercises will normally be completed as part of each health assessment. If the inmate refuses or is too agitated for the restraints to be removed from individual extremities, this will be documented.

46. A mental health professional will complete a mental health assessment, in person, as soon as reasonably possible. This assessment will normally take place within six hours of the application of the restraints.

47. In situations of continuous or repeated application of the Pinel Restraint System in a 24-hour period, the mental health assessment by the mental health professional will be completed at least once every 24 hours, following the initial assessment.

48. The health assessment completed in response to the application of the Pinel Restraint System will replace any other health assessment that is required as per the levels of observation.

49. Where the requirements with respect to mental health and physical health assessments cannot be met, the inmate will be transported to an appropriate health care facility for assessment.

50. The mental health and physical health assessments must be done by professionals operating within their scope of practice and competence.

Activities of Daily Living While in the Pinel Restraint System

51. The inmate placed in the Pinel Restraint System will be offered:

    a. the opportunity to attend to activities of daily living to the extent possible

    b. food at regular meal delivery times (if this is not feasible, accommodations will be made to ensure that no meals are missed)

    c. fluids at least every two hours while the inmate is awake

    d. the opportunity to meet his/her elimination needs at least hourly while awake. Supervision will be provided by Correctional Officers/Primary Workers and Nurses of the same gender. Nursing assistance will be provided when required.

Pinel Restraint System: Follow-Up and Review Procedures

52. If the continuous use of restraint equipment exceeds an eight-hour period, the Interdisciplinary Mental Health Team (IMHT) or Correctional Intervention Board (CIB) will develop an intervention strategy to reduce and eliminate the use of restraints. The strategy must be in place no later than 36 hours from the application of the Pinel Restraint System.

53. If the continuous use of restraints exceeds 24 hours, a review of the use of the restraints will be completed as soon as possible, but no later than 48 hours from the IMHT/CIB discussion. The IMHT/CIB will task a mental health professional, who is not a member of the intervening team, to complete the review. The IMHT/CIB members will refer to the Regional Suicide/Self-Injury Management Committee if they need assistance in finding a mental health professional.

54. The review will, at a minimum, look at the following areas with respect to the use of the Pinel Restraint System:

    a. whether a treatment plan is in place

    b. consideration of all alternatives to the Pinel Restraint System

    c. a strategy to prevent future use of the Pinel Restraint System

    d. whether a plan to remove the restraints is in place

    e. the need for additional reviews.

55. The IMHT/CIB will continue to meet at least every two working days to evaluate the intervention strategy if the use of the Pinel Restraint System continues.

REMOVAL OF THE PINEL RESTRAINT SYSTEM

56. Following the removal of the Pinel Restraint System, the inmate will be assessed by:

    a. a Nurse who will complete a post-removal health assessment

    b. a mental health professional who will assign or modify an observation level.

SUPPORT FOR INMATES

57. Support for inmates following self-injurious or suicidal behaviour will be provided pursuant to CD 567 - Management of Security Incidents and CD 840 - Psychological Services.

TRANSFER OF INMATES

58. For any transfer of inmate at risk for suicide/self-injury, see CD 710-2 - Transfer of Offenders.

ENQUIRIES

59. Strategic Policy Division
National Headquarters
Email: Gen-NHQPolicy-Politique-SPC.ga.ca

Commissioner,

Original Signed by:
Don Head

ANNEX A

CROSS-REFERENCES AND DEFINITIONS

CROSS-REFERENCES

CD 567 - Management of Security Incidents
CD 567-1 - Use of Force
CD 567-8 - Use of Restraint Equipment for Security Purposes
CD 568-1 - Reporting and Recording of Security Incidents
CD 577 - Operational Requirements for Cross Gender Staffing in Women Offender Institutions
CD 705 - Intake Assessment Process
Immediate Needs Checklist - Suicide Risk as per CD 705-3 - Immediate Needs and Admission Interviews
CD 709 - Administrative Segregation
CD 710-2 - Transfer of Offenders
CD 800 - Health Services
CD 803 - Consent to Health Service Assessment, Treatment and Release of Information
CD 805 - Administration of Medication
CD 840 - Health Care Records
CD 840 - Psychological Services
CD 850 - Mental Health Services

Security Bulletin - Positional Asphyxia and Excited Delirium (2008-03-12)
Security Bulletin - Head Banging (2009-10-28)

DEFINITIONS

Activities of daily living : normal daily activities such as eating, bathing, dressing, and grooming.

Appropriate chair/stretcher: a chair/stretcher that can be immobilized in a secured area, and is suitable to the inmate's weight and height.

Cooperative: when there is no verbal or physical resistance and the inmate responds to staff presence, verbal communication and complies voluntarily with verbal commands or orders.

Health care facility: community hospital, Regional Treatment Centre, Regional Psychiatric Centre or CSC regional hospital.

High Suicide Watch: an observation status for inmates who are at imminent risk for suicidal or self-injurious behaviour, during which the inmate is under continuous direct observation.

Interdisciplinary Mental Health Team (IMHT): a team chaired by the Chief Psychologist/Psychiatrist, Clinical Manager or delegate, with team members that may include mental health staff, health care staff, Parole Officers, Correctional Managers, Elders, and ad hoc members as required. The IMHT discusses current clinical, operational and case management issues/concerns, short-term/long-term goals, and the roles and responsibilities of all staff intervening with the inmate, in order to respond effectively, and provide advice and support to the inmate.

Mental health assessment: an observation and description of an inmate's current state of mind, under the domains of appearance, attitude, behaviour, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgement.

Mental Health Monitoring: an observation status for inmates who are at risk for suicide or self-injury that typically follows removal of High or Modified Suicide Watch status.

Mental health professional: CSC staff and contractors who offer services for the purposes of improving an offender's mental health and are registered or licensed in Canada, preferably in the province/territory of practice. Individuals will operate within their scope of practice and competence. Examples include Psychologists, Psychiatrists, Physicians, Nurses, and Clinical Social Workers.

Modified Suicide Watch: an observation status for inmates who are at elevated risk for suicidal or self-injurious behaviour, during which the inmate is under continuous observation.

Physically uncooperative: when the inmate refuses to comply with staff directions or orders (e.g. refuses to move from an area or leave a cell). The inmate may offer active physical, but not assaultive resistance by pulling or running away or resisting staff attempts to move him/her to a standing position.

Positional asphyxia: asphyxia results when oxygen is reduced or elevated carbon dioxide levels are created in the body. Placing an inmate in restraints in certain positions or placing an officer's body weight on an inmate to subdue him/her can lead to positional asphyxia.

Restraint equipment: an approved device listed in the Security Equipment Manual intended to temporarily restrict or limit free movement.

Self-injury/self-injurious behaviour: the intentional, direct injuring of body tissue without suicidal intent.

Suicidal behaviour: a behaviour that intentionally puts life at risk and may result in death, done with the intention to end life.

Suicide: an intentional act to end one's life that results in death.

ANNEX B

PROCESS FOR SELF-INJURY INTERVENTION

1. OBJECTIVE

To outline a two-pronged method for intervening with inmates who self-injure:

i. short-term response - Critical Response and Incident Management Plan, which concentrates on the immediate intervention needs for an inmate following a self-injurious incident; and
ii. long-term response - Interdisciplinary Management Plan, which is a comprehensive approach to intervening with inmates who self-injure repetitively and whose ongoing behaviour is posing significant challenges to the institution.

2. CRITICAL RESPONSE AND INCIDENT MANAGEMENT PLAN

Purpose: A Critical Response and Incident Management Plan (CRIMP) is a review of an inmate's behaviour subsequent to an incident of self-injury.

- **Responsibility/Timeframes**

- The CRIMP is normally completed within 24 hours of the incident, by a mental health professional, at the institution where the incident occurred. The CRIMP must be completed after every incident of self-injury.

- An in-person interview of the inmate is required to complete the CRIMP.

Content/Details

- The review includes: reasons for self-injury, level of risk for further self-injury or suicide, level of intervention required, as well as recommendations for further mental health care.

- The Institutional Head will determine which group will review completed CRIMPs and manage the inmate's case, either the institution's Correctional Intervention Board (CIB) or the Interdisciplinary Mental Health Team (IMHT).

- As reasons for self-injuring may be different on each occasion, all incidents need to be considered and a CRIMP must be completed in response to each occurrence.

- In the event that multiple self-injurious situations occur in a 24-hour period, by the same inmate, or when an Interdisciplinary Management Plan is in place, an addendum to the CRIMP can be completed, substituting the need for a CRIMP for each self-injurious situation. In these exceptions, each incident of self-injury must be documented and the situation assessed, in keeping with professional standards.

- The CRIMP and the inmate's case are reviewed by the CIB/IMHT, at the next scheduled meeting. If the mental health professional believes the review should be completed sooner, a meeting will be convened.

- If the decision is made for an Interdisciplinary Management Plan, an interim management plan will be developed as soon as possible, normally within three to five working days.

- The objective is to encourage and support an interdisciplinary approach in order for the inmate to resume usual activities as soon as possible.

Documentation

- The CRIMP will not include any confidential health information.

- The individual completing the CRIMP will ensure activation of the OMS Alert "Current Suicide/Self-Injury Risk", if relevant, and notification of the appropriate personnel. Completion of the CRIMP will be documented as a "Memo to File" on OMS.

- Critical Response and Incident Management Plan (CSC/SCC 1430).

3. COMPREHENSIVE PSYCHOLOGICAL/PSYCHIATRIC ASSESSMENT

Purpose: A Comprehensive Psychological Assessment (CPA) is a mandatory assessment for all inmates who require an Interdisciplinary Management Plan. Treatment Centres have the option of completing a Comprehensive Psychiatric Assessment, in place of the Comprehensive Psychological Assessment. A comprehensive assessment is imperative for understanding the inmate and formulating appropriate clinical care.

Responsibility/Timeframes

- The CPA is completed by either an institutional or contract Psychologist/Psychiatrist if one has not been completed within two years.

- If a CPA has been completed within two years, the decision to complete a second CPA would be determined by case specifics and at the discretion of the Chief of Psychology/Attending Psychiatrist.

- As the CPA is an integral part of the Interdisciplinary Management Plan, it will normally be completed four weeks from the date it is assigned to a Psychologist/Psychiatrist.

Content/Details

- The comprehensiveness of the psychological assessment and psychometric evaluation(s) is guided by case specifics such as complexity of inmate need (clinical profile), pattern of self-injurious behaviour and clinical judgement. The Chief of Psychology/Attending Psychiatrist will determine the content of the CPA.

- Every effort should be made to ensure the consent and participation of the inmate (via informed consent).

- In the event that an inmate is unwilling to provide consent, a comprehensive file review will be done to the fullest extent possible.

Documentation

- Due to the presence of confidential health information, the CPA will be placed on the Psychology File.
- If the inmate does not provide consent, this must be clearly documented in the introduction of the comprehensive file review.

4. COMPREHENSIVE SUICIDE/SELF-INJURIOUS ASSESSMENT

Purpose: The Comprehensive Suicide/Self-Injurious Assessment (CSSIA) is a detailed self-injury assessment, focused on triggers (past, present and changes), factors affecting risk, offender goals and treatment targets. It provides an overall analysis and synthesis of self-injury and suicidal behaviour over time (e.g. changes in mood, lethality, risk, areas of increased/decreased clinical concern, etc.).

Responsibility/Timeframe

- The CSSIA is completed by either an institutional or contract Psychologist/Psychiatrist.
- The request for a CSSIA is made at the discretion of the Chief of Psychology/Attending Psychiatrist. The CSSIA is not mandatory.

Content/Details

- The CSSIA is completed to obtain additional information related to the inmate's history of self-injury and to guide the identification of interventions. It may also be used as a part of the Comprehensive Psychological/Psychiatric Assessment.
- It may be completed as a step in the process to determine the need for an Interdisciplinary Management Plan.
- Completed CRIMPs contribute to the CSSIA and in turn the CSSIA contributes to the content of the Interdisciplinary Management Plan.

Documentation

- Due to the presence of confidential health information, the CSSIA will be placed on the Psychology File.
- In the event that an inmate is unwilling to provide consent, information will be obtained via a comprehensive file review, done to the fullest extent possible. This must be clearly documented in the introduction of the CSSIA.
- Comprehensive Suicide/Self-Injury Assessment (CSC/SCC 1438).

5. ALTERNATIVES/AVOIDING USE OF RESTRAINTS

Purpose: The Alternatives/Avoiding Use of Restraints is a tool to identify the causes of agitation. It also assists in the subsequent development of measures and/or interventions to avoid the use of restraints. The Alternatives/Avoiding Use of Restraints form is not mandatory.

Responsibility

The tool is completed by a mental health professional during an in-person interview with the inmate.

Content/Details

- Questions provide an opportunity for the inmate to contribute to the identification and development of interventions.
- It can be used in response to a single incident of self-injury or as part of the assessment process in the development of an Interdisciplinary Management Plan.

Documentation

- Alternatives/Avoiding Use of Restraints (CSC/SCC 1437).

6. CLINICAL OPINION AND BEHAVIOURAL SUMMARY

Purpose: The Clinical Opinion and Behavioural Summary (COBS) provides a synthesis of the information identified by the clinical team via the clinical file review and a synopsis of the information contained in the CPA. The COBS helps to complete the Interdisciplinary Management Plan.

Responsibility/Timeframes

- A Psychologist/Psychiatrist will normally complete the COBS within ten working days from the date of the completion of the CPA. The Psychologist/Psychiatrist responsible for drafting the COBS should seek input from other health care disciplines.

Content/Details

- The focus is to identify specific responsivity issues and behavioural concerns that impact the clinical and operational interventions for the inmate.
- The COBS also contains behavioural cues that are linked to an increase in risk of suicide/self-injury and integrated behavioural patterns, which will assist in the development of the Interdisciplinary Management Plan.
- Information obtained from Alternatives/Avoiding Use of Restraints (CSC/SCC 1437) may be included in the synthesis.
- The amount of personal health information in the COBS will be minimized.
- COBS will be shared with all members of the CIB/IMHT.

Documentation

- Clinical Opinion and Behavioural Summary (CSC/SCC 1431).

7. INTERDISCIPLINARY MANAGEMENT PLAN

Purpose: The Interdisciplinary Management Plan (IMP) is an integrated clinical, case management and security intervention plan to assist staff with the effective management of inmates with complex self-injury needs in order for the inmate to resume usual activities as soon as possible.

Responsibility/Timeframes

- The interim Interdisciplinary Management Plan will normally be completed within three to five working days following the decision to develop the plan.
- The CIB/IMHT will normally complete the Interdisciplinary Management Plan within ten working days from the date of completion of the COBS.
- All interim, current and updated Interdisciplinary Management Plans will be provided to the Institutional Head.
- All staff involved with the inmate must have access to the Interdisciplinary Management Plan.
- The CIB/IMHT is responsible for a weekly, formal review of the Interdisciplinary Management Plan.
- The Interdisciplinary Management Plan will be discontinued when the inmate has achieved a sustained level of stability, as determined by the CIB/IMHT. IMHT follow-up will continue as outlined in the Institutional Mental Health Service (Primary Care) Guidelines.

Content/Details

An Interdisciplinary Management Plan must be completed for those atypical inmates who repeatedly exhibit behaviour that endanger their life or physical integrity, who are often the subject of special incident reports, and for whom known standard intervention practices do not seem to produce the desired results.

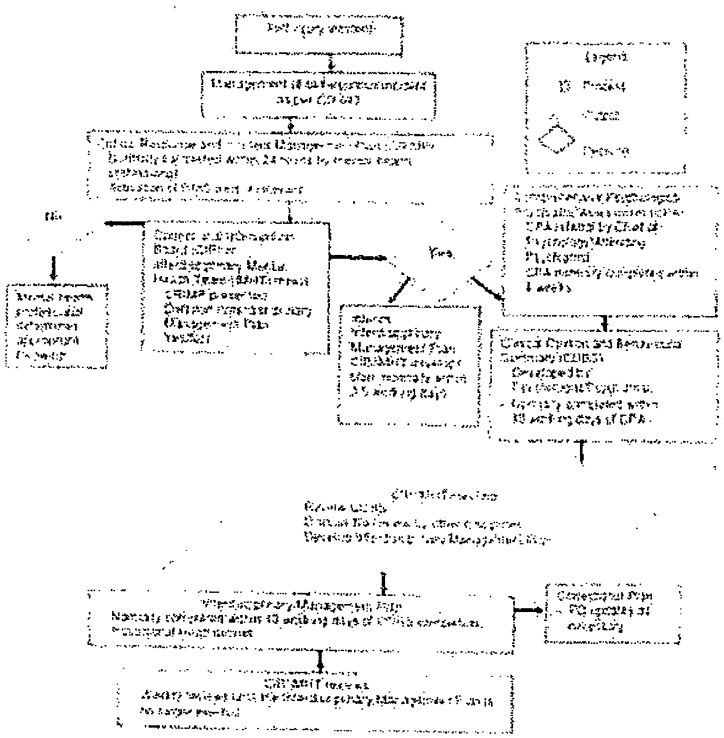
- The Interdisciplinary Management Plan outlines the current intervention guidelines and activities, based on the inmate's observation level (i.e. High Suicide Watch, Modified Suicide Watch and Mental Health Monitoring). The plan outlines the appropriate environment to ensure the safety of staff and inmates, during the crisis, as well as a return, as quickly as possible, while incorporating the less restrictive level of care. The Plan will identify behaviours and moods associated with vulnerability, methods to engage the inmate and identification of the process involved, as well as specific staff.
- The Interdisciplinary Management Plan will be enhanced through the participation of the inmate (via informed consent). In the event that an inmate is unwilling to provide consent, the Interdisciplinary Management Plan will be developed through secondary sources. Every effort should be made to encourage the inmate's participation. All efforts must be documented on OMS/Casework Record.
- The inmate's Parole Officer will update the Correctional Plan as required (please refer to CD 710-1 Progress Against the Correctional Plan).

Documentation

- Storage/filing of the Interdisciplinary Management Plan must be in a secure area (i.e. unit office, Correctional Manager's office).
- Interdisciplinary Management Plan (Daily Routine) (CSC/SCC 1432).

ANNEX C

FLOW CHART OF THE KEY STEPS FOR SELF-INJURY INTERVENTION IN INSTITUTIONS



▶ This flow chart depicts the key steps for self-injury intervention in institutions.

For more information

- Government-wide Forward Regulatory Plans
- The *Cabinet Directive on Regulatory Management*
- The Red Tape Reduction Action Plan
- The Canada–United States Regulatory Cooperation Council

To learn about upcoming or ongoing consultations on proposed federal regulations, visit the Canada Gazette and Consulting with Canadians websites.

Date modified : 2013-11-12

SUPPLEMENTARY WRITTEN SUBMISSIONS
John Howard Society of Manitoba and the
Canadian Mental Health Association, Manitoba and Winnipeg

Introduction

On request of Judge Corrin, the John Howard Society of Manitoba ("JHSM") and the Canadian Mental Health Association, Manitoba and Winnipeg ("CMHA") are providing the following information about their respective organizations.

John Howard Society of Manitoba

As outlined in its written submissions filed February 22, 2018, the JHSM, which celebrated its sixtieth anniversary in November 2017, is one of sixty-three John Howard Societies located across Canada.

Based in Winnipeg, JHSM provides a number of programs and services in support to men in conflict with the law before, during and after incarceration, in addition to advocating for the just and fair treatment of those involved in the justice system. JHSM advances evidence-based and humane approaches to incarceration, rehabilitation and crime reduction.

JHSM Governance

JHSM is a non-profit charity governed by a volunteer Board of Director to whom the Executive Director is accountable.

JHSM is funded by various government agencies, charitable organizations and foundations and also engages in direct fundraising to finance special project and programs.

JHSM also has both full and part-time staff members and is supported by numerous volunteers.

For more information about JHSM's Board, Staff and Funders, please see JHSM's most recent annual report (2016-17) attached as **Appendix A**. Previous annual reports can be found online at: http://www.johnhoward.mb.ca/wp/about-us/annual-reports/

Examples of Current Programming:

Reintegration

JHSM helps men released from custody reintegrate into the community. JHSM offers group training in parenting skills, dealing with aggression, coming to terms with substance abuse, and healthy intimate relationships.

As part of its reintegration services, JHSM also helps men in custody get birth certificates. The organization also operates 'We Fit You' Clothes Closet, where two afternoons a week JHSM distributes free free jackets, shirts, pants, boots, soap, deodorant and more to men released from custody and others who come in off the street.

Project Manitouwabi: Housing Program

JHSM is part of a multi-agency housing program for sentenced individuals being released from custody. JHSM Support Workers assist with a case plan for housing, income assistance, employment, addictions treatment, programming and access to cultural activities.

Referrals and self-refferals are accepted and priority is given to clients who self identify as Indigenous.

Literacy

JHSM offers a peer tutoring course at Headingley and Milner Ridge Correctional Centres where incarcerated men learn to teach literacy skills. JHSM also provides one-to-one tutoring for men at the Winnipeg Remand Centre.

In addition, JHSM publishes *The Inside Scoop* – a newsletter with poetry and art from individuals in custody. *Get the Story Out* is a JHSM service for incarcerated fathers to record their voice reading a story for their kids.

Canine Healing Services

Selected volunteers assist Mehgan Search and Rescue in training service dogs, with an opportunity for some participants to become certified dog trainers (Up to 2 year commitment). Clients must be referred, and priority is given to those who identify as Indigenous

Healing Program for Indigenous Men

This is a 14 session closed group program for Indigenous men who have experienced sexual trauma. It provides a safe place for participants to understand themselves, work on identifying triggers, share ideas about strategies and introduce new ways to cope in healthier ways. Participants learn about the effects of childhood trauma, including sexual abuse.

The program includes Elder services to cultivate and build on strength, courage and healing from a cultural perspectives.

Participants have the opportunity to attend group sessions and cultural activities, develop individualized case plans with a case-worker to help and receive follow up support.

Examples of Special Projects:

The JHSM routinely participates in special projects. Some example include (but are not limited to):

- producing and distributing:
  - Voters Guides for Incarcerated Voters (with respect to both federal and provincial elections)
  - Visitors Guides for men's correctional centres in Manitoba
  - Guide to obtaining a Pardon /Record Suspension
- participating in a CMHA-led committee looking to improve the *Mental Health Act*
- initiating a stakeholder working group on the effectiveness of the Law Enforcement Review Agency

- collaborating with the Public Interest Law Centre and the University of Manitoba on research related to the issue of prison overcrowding.
- participating in the Block by Block initiative through its Thunderwing Advisory Committee
- co-authoring a report with the Canadian Centre for Policy Alternatives on Bill C-10
- participating in the Gang Action Interagency Network (GAIN) as a member of its executive

The JHSM also used to run a Bail Assessment, Support and Supervision Program that assisted eligible clients with referrals, case planning and the support of a Caseworker to ensure that bail conditions were followed. JHSM is no longer able to operate this program as as result of provincial funding cuts to the organization.

Examples of Collaborations with Other Organizations

The JHSM frequently partners with other community organizations, examples of which include (but are not limited to):

- Ogijiita Pimatiswin Kinaamatwin (OPK) – an agency dedicated to helping former gang members reconnect to their traditional culture and find employment
- Oshki Giizhig – an Indigenous organization that provides supports to individuals with FASD, primarily those living in the Point Douglas area
- Willow Place – a place of safety for women fleeing domestic violence
- Eagle Urban Transition Centre – an Assembly of Manitoba Chiefs initiative that provides culturally relevant and non-discriminatory supports for Indigenous people transitioning to an urban centre. The EUTC provides a single window from which clients receive support, advocacy and access to needed programs in their efforts to achieve independent living
- Manitoba Association of Rights and Liberties – a non-profit, non-governmental, human rights and civil liberties organization
- Initiatives for Just Communities – a faith-based charitable organization operating four programs focused on individuals with intellectual disabilities and/or Fetal Alcohol Spectrum Disorder, as well as people who are currently or were formerly in prison around Manitoba.

The JHSM also regularly supports the activities of the John Howard Society of Canada. One significant recent example is JHSM's work to assist the John Howard Society of Canada create its evidentiary record in its lawsuit filed against the Attorney General of Canada (with co-plaintiff BC Civil Liberties Association) challenging the use of administrative segregation in federal penitentiaries. JHSM gathered research and case studies on behalf of the John Howard Society of Canada.

Additional programming, recent accomplishments and advocacy efforts are described in **Appendix A**, as well as in previous annual reports, online at: http://www.johnhoward.mb.ca/wp/about-us/annual-reports/.

Canadian Mental Health Association – Manitoba and Winnipeg

As outlined in written submissions filed February 22, 2018, the CMHA is part of a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. CMHA accomplishes its mission through advocacy, education, research and service.

CMHA regularly contributes to and participates in numerous coalitions and working groups in the area of mental health, housing, employment and disability issues with the goal to improve the quality of life for people living with serious mental health problems. CMHA works towards ensuring that people with mental illness become full participants in society and that all are mentally healthy.

CMHA Governance

CMHA in Winnipeg is governed by a Board of Directors that has a minimum of 8 members and a maximum of 14 members. The Board strives for representation that includes consumers, family members, and caregivers. Board members are elected at CMHA's annual general meeting in June of each year.

A major role of the Board is to define the CMHA's values and vision and the impact the organization will have in its community. Values are articulated in Board policy statements known as ENDS

statements. The current ENDS statements are:

"CMHA Manitoba and Winnipeg exists so that people are mentally healthy and people experiencing mental illness have support for their resilience and recovery.

People with mental illness are full participants in society.

- They participate meaningfully in their chosen roles in society; this includes employment, education, housing and social engagement.
- They benefit from public policy that supports community participation and integration of people with mental illness.
- They are accepted by society.

People of Manitoba and Winnipeg have an understanding of the factors involved in being mentally healthy.

- They are aware of and understand mental illness and mental health.
- They are aware of and can easily access appropriate services and supports.

Families and Caregivers have access to the appropriate supports required by themselves and those they care for.

- They have opportunity for caregiver self care.
- They have access to professional and/or peer supports.
- They have access to support and information regarding advocacy.

Decision Makers have adequate information to make informed decisions regarding mental health and mental illness.

- Decision-makers recognize the importance of mental health research.
- Researchers are recommending best practices using appropriate research methods with emphasis on relating to lived experiences from people with mental health issues.
- Media will have access to information on mental health issues."

CMHA also employs approximately 48 staff members and is supported by over 80 volunteers.

For more information about CMHA's Board, Staff and Funders, please see CMHA's most recent annual report (2016-17) attached as **Appendix B**. Previous annual reports can be found online at:

https://mbwpg.cmha.ca/about-cmha/annual-reports/

Examples of Current Programming:

Rehabilitation and Recovery Services

CMHA works with adults who have a mental illness, including those with a co-occurring disorder (mental illness and substance abuse or dependency). Services assist people in choosing, getting and keeping roles in housing, employment, education or socializing.

Participants work with a Rehabilitation Worker to learn skills and make changes necessary to be successful and satisfied. CMHA's practice is guided by psychological rehabilitation which promotes personal recovery, successful community integration, and satisfactory quality of life for persons who have mental illnesses or mental health concerns.

Examples of specific Rehabilitation and Recovery Services include:

- Community Housing with Supports – works with people who have experienced chronic homelessness or who have resided in transitional housing settings for an extended period. Participants are supported by a team consisting of Rehabilitation Workers, a Housing Coordinator, an Occupational Therapist, and a Peer Outreach Worker who all provide assistance to locate housing, establish their household, and maintain their housing with supportive services.
- Employment with Supports – includes employment counselling, skill development, school-to-work transition, vocational crisis intervention and crisis management, coordinating pre-employment work experience, active employment support, supportive employment marketing and career change support.
- Parent Wellness Initiative – works with single parents with children under the age of 6 who are

enrolled in the single parent category of the Manitoba Assistance program (Employment and Income Assistance or Welfare) and facing social stresses.

Mental Health Education – Community Education Service

CMHA assists services and individuals in understanding mental health and mental illness. CMHA offers approximately 35 different community-based courses about mental health, including Mental Health First Aid, Living Life to the Full, Mental Health Education for Families, Exploring the Journey of Recovery, and Mindfulness Based Stress Reduction (MBSR). CMHA also provides workplace and organizational workshops on topics such as workplace mental health and psychologically safe workplaces, general mental health awareness, and understanding the Mental Health Act.

Some youth-specific programming includes:

- School Based Mental Health Initiatives – MILE 5 (educating youth on mental health and mental illness to reduce stigma and encourage young people experiencing a problem to reach out early), and Youth Mental Health Summits (organizing regional summits to learn how to reduce stigma towards mental illness)
- Futures Forward (formerly the Building Futures Initiative) is a collaborative partnership between Youth Employment Services (YES), Community Financial Counselling Services (CFCS), and CMHA. This programming is designed to help youth reach their goals and fulfill their highest potential. CMHA works with those currently or formerly involved with the child welfare system, aged 15-29.

Information and Education services

CMHA provides individual, family, service providers, as well as community members with important information, consultation, guidance, and support. The services include responding to information requests and more detailed engagements with callers or walk-ins whose situations require active listening and problem-solving.

Services often assist people with information, access, and rights-related issues during times of extreme difficulty and stress, helping clients prioritize and navigate complex situations with a neutral, person-centered approach.

Information and Referral Services

CMHA assists people with accurate and timely information about services and supports across the city. The service often works with people or families experiencing mental health problems, providing guidance on issues as wide-ranging as residential tenancy matters, employer and relationship issues, and maintaining financial or other supports.

The service can include one-time calls that result in a direct referral or multiple contacts with clients whose situation may require multiple resources as well as assistance accessing support and problem-solving. Information and Referral is also a resource to other service providers, such as counsellors, teachers or social workers.

CMHA also publishes a mental health resource guide annually. This guide has a circulation of over 40,000.

Rights Consultation Service

This service helps people with a mental illness to know and exercise their rights when they have complaints about services they have received or feel their rights and entitlements have not been upheld. CMHA's Rights Consultant can explain the choices that are open to a person to have problems addressed.

The Rights Consultant can also provide information about rights under The Mental Health Act and other laws and can accompany people to hearings that are scheduled as a result of concerns raised.

Examples of Special Projects:

CMHA routinely participates in special projects. Some example include (but are not limited to):

- Bounce Back: Reclaim Your Health works with primary care to offer Cognitive Behavioural Therapy-based skills to people experiencing low mood or mild-to-moderate depression. CMHA is working towards making this program available to all Manitobans.
- Public Policy Initiatives through the CMHA Board's Political Linkage Committee ("PLC"). An example of a PLC project is a recent collaboration with the Public Interest Law Centre and community advisors to complete a review of the Manitoba Mental Health Act through the lens of the United Nations Convention of the Rights of Persons with Disabilities.
- Health Accord Working Group – CMHA national initiative in advancing the federal government's commitment to mental health and addictions in Canada
- Legal Aid Duty Counsel Pilot Project is a partnership with the Mental Health Review Board, Public Interest Law Centre, and Legal Aid Manitoba that established a new process to fast track and improve access to legal representation for persons appealing their involuntary status with the Mental Health Review Board. This work has been honoured through a Partnership Award for the 19th Annual Manitoba Service Excellence Awards.
- Youth Homelessness Research Project is exploring the potential for CMHA's Futures Forward program as a made-in-Manitoba model for youth homelessness prevention.

Examples of Collaborations with Government and Other Community Organizations

CMHA frequently partners with government and other community organizations, examples of which include (but are not limited to):

- CFS Board General Authority
- CMHA National Communication Committee
- CMHA National Public Policy Working Group
- CHIRP-CMHA research project
- Circle of Courage

- Doorways Steering Committee
- Education for ACTion – MB Association of School Superintendents
- Employment and Income Assistance Advocate Network
- Health Sub-Committee – MB Immigrant and Refugee Settlement Services Association (MIRSSA)
- Joint Mental Health Employment Initiative
- Kaleidoscope Committee
- Make Poverty History
- Manitoba Alliance for Mental Illness and Mental Health
- Manitoba Supported Employment Network (MSEN)
- Manitoba Trauma Collaborative
- Mental Health Promotion – 7 Oaks School Division
- Partners Seeking Solutions Advisory Board for Peer Support Project on Seniors with Mental Health and Addictions
- Perinatal Mental Health Advocacy Working Group
- PSR Manitoba Board
- PSR Canada Board
- PVR Winnipeg Steering Committee
- Social Planning Council of Winnipeg's Poverty Advisory Committee
- Street Census project partner
- Recovery Champions Advisory Committee
- Red River College Advisory Board for Community Disability and Support
- Right by You Campaign Committee (Partners for Mental Health)
- Right to Housing Coalition
- Winnipeg Organization of Recruitment Coordinators (WORC)
- Winnipeg Rental Network
- Winnipeg Suicide Prevention Network
- Youth Suicide Prevention Strategy Government of MB

APPENDIX A:

JHSM 2016-2017 Annual Report (September 19, 2017)

JOHN HOWARD SOCIETY OF MANITOBA

THE JOHN HOWARD SOCIETY

ANNUAL GENERAL MEETING

Annual Report
2016-2017

Highlights from the Board Chair

Welcome to all our guests. The John Howard Society of Manitoba has had another interesting year. Our biggest challenge at present is how to offer the same level of service to our clients when our provincial **funding has been decreased by 20 percent.** Fortunately, John and his management team are "on it." They are pursuing several possible new sources of funding.

We are very grateful that we can count on stable funding from our partners at the United Way. Corporate sponsors have also come through for us this past year. *Canadian Footwear* was generous enough to provide a newly-renovated room complete with state of the art shelving. The room is called the **We Fit You Closet** and is hosted by volunteer, Charlie Medd. With this facility we are able to provide free clothing to men getting out of prison and others in need.

Through a grant from Assiniboine Credit Union, we are able to assist incarcerated men in obtaining a birth certificate. We further support them with a letter they can use along with their new birth certificate to open a credit union account at ACU. This helps them avoid outrageous fees charged at pay day loan and pawn shops.

This past year we had a couple of **successful fundraising** events. In November, we hosted a **comedy show** featuring local talent that was well-attended and hilarious. In June, our Literacy department, in collaboration with the **Peter Gzowski Invitational** organization, put on a very successful Dining with the Pops event at the Canad Inns on Regent on June 8. The Winnipeg Pops Orchestra provided the entertainment and CBC's Shelagh Rogers was the featured speaker. Everyone left with a full tummy and a big smile. Mark your calendars, we'll host a similar event next year, **June 7, 2018.**

We have one other big event coming up this year: our **60th-anniversary** fundraising

Photo: JHSM Staff

John Howard Society of Manitoba annually joins organizers of the Ellice Street Festival. This past year again we served hot dogs (including veggie dogs) and juice boxes. Staff and clients work side by side throughout the day.

event here at the West End Cultural Centre in the evening of **Saturday, November 18.** I hope you will consider attending.

This past year, we finally provided John, our executive director, with a **new job description** that reflects all the work he does and a new performance evaluation which indicates what a great job he's doing. We are grateful for his leadership.

The John Howard Society of Manitoba seeks to be a good **community partner.** We've partnered this year with Willow Place, Eagle Urban Transition Centre, and continue to have a relationship with Ogijiita Pimatiswin Kinamatwin (OPK). We've also helped the Friends of Sherbrook Pool with a short-term loan which they needed until their funding came through.

There are still some outstanding issues from last year that we continue to advocate for. In particular, we are concerned with the **high rate of incarceration** of Indigenous men and use of solitary confinement as a population management strategy in correctional facilities in Manitoba. We will continue to speak for the men that are affected by the policies that enable these situations to exist.

Finally, I offer a heartfelt word of gratitude to my fellow board members and all the staff and volunteers at the John Howard Society of Manitoba. Your participation and contributions are much appreciated.

Ken Friesen, Chair of the Board of Directors

Report from the Executive Director

As mentioned in last year's report, we started 2016-2017 year with a newly elected provincial government, and we immediately began the process of developing a relationship with the new Minister and her staff.

A cordial and informative meeting was held with the Hon. Heather Stefanson about two months after she was appointed, and we have had ongoing communication on a number of issues.

This was also the second year of a new government in Ottawa. Together with John Howard Society Canada, we **raised several issues** with the Trudeau government, such as removing mandatory minimum sentences, changing the use of solitary confinement in Canadian prisons, and simplifying the process that allows someone with a conviction to have their record sealed, in both a timely and inexpensive way.

While the federal government appears receptive to the ideas we bring forward, they have yet to change or amend Harper's legislative crime agenda in any significant way. We continue to have lobbying work to do in this regard.

In regards to **solitary confinement**, a lawsuit brought by the B.C. Civil Liberties Association and the John Howard Society of Canada began last July. Our office helped gather research and case studies on behalf of John Howard Society Canada. The case is currently before the courts in British Columbia.

We **launched our Visitor's Guide** for Manitoba correctional facilities in November at a full-to-capacity public event at Urban Circle Training Centre on Selkirk Avenue. The guide is also up on our website where it can be accessed for free or downloaded as a PDF.

This spring we completed work on our **strategic plan**—something that was three years in the making—which was officially adopted by the board in April 2017. The plan includes a timetable for activities allowing us to regularly review the progress we are making in achieving the goals we have set.

This last year also saw us **expand our partnerships** with other agencies. John Howard Society of Manitoba continues to work closely with and provide administrative support to *Ogijiita Pimatiswin Kinamatwin* (OPK) – an agency dedicated to helping former gang members reconnect to their traditional culture and find employment.

We also continue to work with *Oshki-Giizhig*, an indigenous organization that provides support to individuals with FASD, primarily those living in the Point Douglas area. And in March, we entered into partnership with *Urban Eagle Transition Centre*.

All of these arrangements take the form of tri-partite funding agreements with ourselves, the partner agency, and United Way of Winnipeg.

I continue to be **thankful for our board of directors**. The directors were very busy last year finishing work on the strategic plan, creating new committees, and overseeing a dynamic funding environment.

In order for a relatively small staff to serve a large number of clients, we rely upon **volunteers** (especially in our Literacy department) **and students** on practicum placements from post-secondary schools (in both our Literacy and Reintegration programs).

These volunteers and students allow us to reach new clients and offer a more complete service to current clients. I offer a special word of appreciation for Mike Spence, who, in addition to his work as a practicum student, made a **soapstone carving** that we auctioned off at a funding raising event. Thanks Mike!

I would also like to offer **thanks to our**

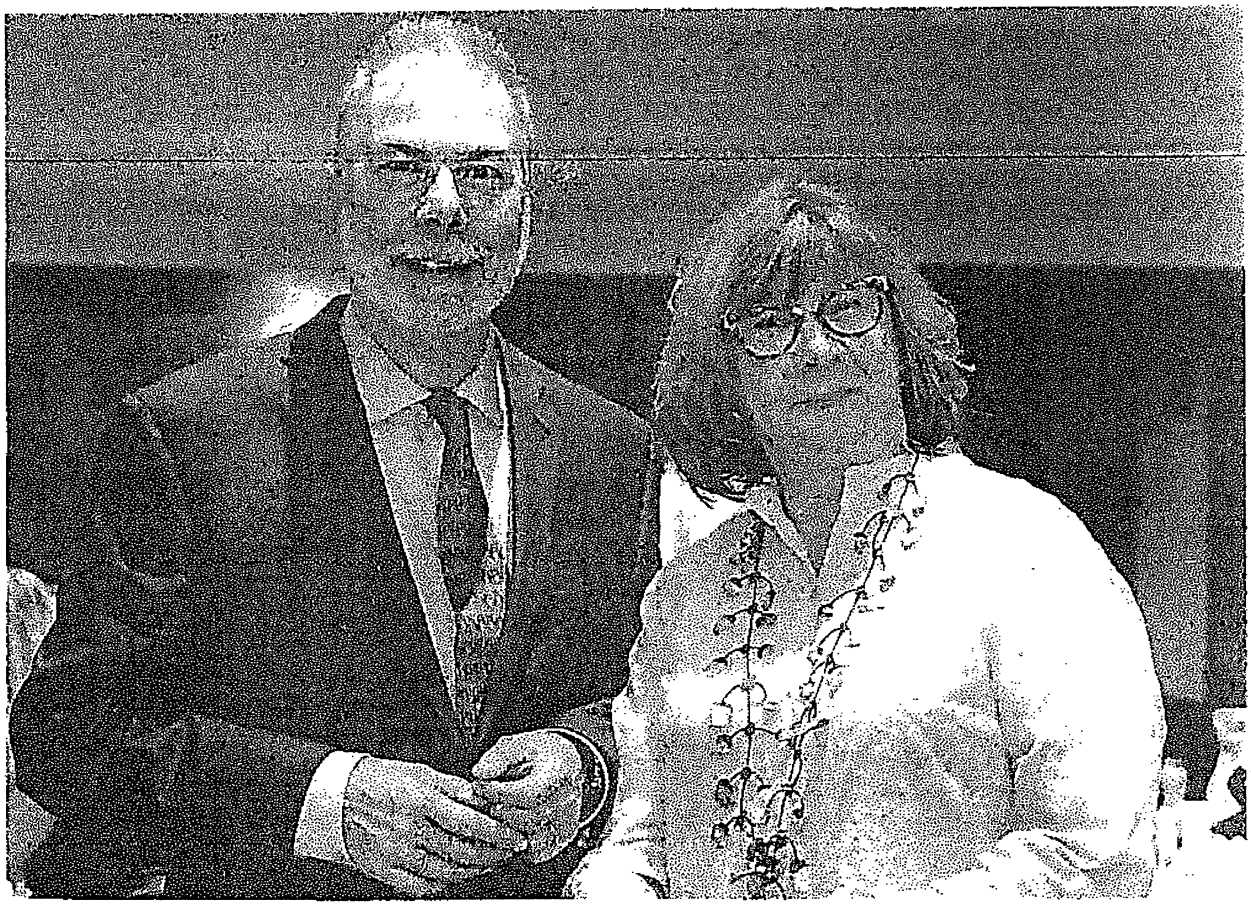


Photo: Dave Benson

John Hutton, executive director, and Shelagh Rogers, CBC Radio host, at the John Howard Society fundraising banquet for literacy, Dining with the Pops, Winnipeg, June 8.

funders. The *Winnipeg Foundation* recently granted us funding to begin work on a **service dog training program** that started in July. Clients will have volunteer opportunities and even be trained to work with service dogs. We hope to develop the capacity to train service dogs ourselves for those suffering from PTSD as a result of incarceration or work in a correctional centre.

United Way continues to be a strong supporter for which we are very grateful. Funding from an anonymous donor enhances the work of our Literacy program and allows us to begin new programming for families of those who are incarcerated. Meanwhile the *Province of Manitoba* continues to be our single largest funder as part of a decades-old partnership, going back to the 1960's.

Lastly, I would like to **acknowledge all of the staff** working here at John Howard Society of Manitoba. We have a great team who work very hard; they show dedication to our clients and to this organization every single day. Lastly, I want to wish a fond farewell to two long-term staff, Bernice Praymak and Janet Johnson, both leaving in September: you will be much missed!

John Hutton, Executive Director

Reintegration Program

The Reintegration program staff includes Tania Wiebe, Coordinator, and Carmen Vielfaure, Reintegration Worker. We are excited to be running three new programs through Manitoba Justice. We facilitated a total of four different courses, and we offer these on a rotating basis throughout the year. On average, three quarters of the registered participants are successful in completing their respective courses.

End to Aggression is a program designed to help participants avoid further assaultive and/or aggressive behaviour by understanding that how we think affects how we feel and ultimately affects our actions. This program runs twice a week for 5 weeks. We had 5 courses, with 66 registrants.

Coming to Terms provides information to participants that will help them evaluate their use of alcohol and other drugs and understand the consequences that this may pose on their lives and the lives of those around them. The course aims to develop self-awareness and aid in the progression through the Stages of Change. It runs twice a week for 5 weeks. We had 2 courses with 21 registrants.

Introduction to Healthy Relationships delivers information about healthy and unhealthy behaviour within relationships, and tools to promote behaviour change. This program is two half-day sessions. We had 3 courses with 26 registrants.

The Positive Parent Program aims to promote positive, caring relationships between parents and their children, and to help parents develop effective management strategies for dealing with a variety of childhood behavioural and emotional problems and common development issues. This program is for 5 consecutive days. We had 4 courses with 36 registrants.

Grand opening of the We Fit You Closet, with JHSM staff Tania Wiebe and major sponsor Brian Scharfstein from Canadian Footwear.

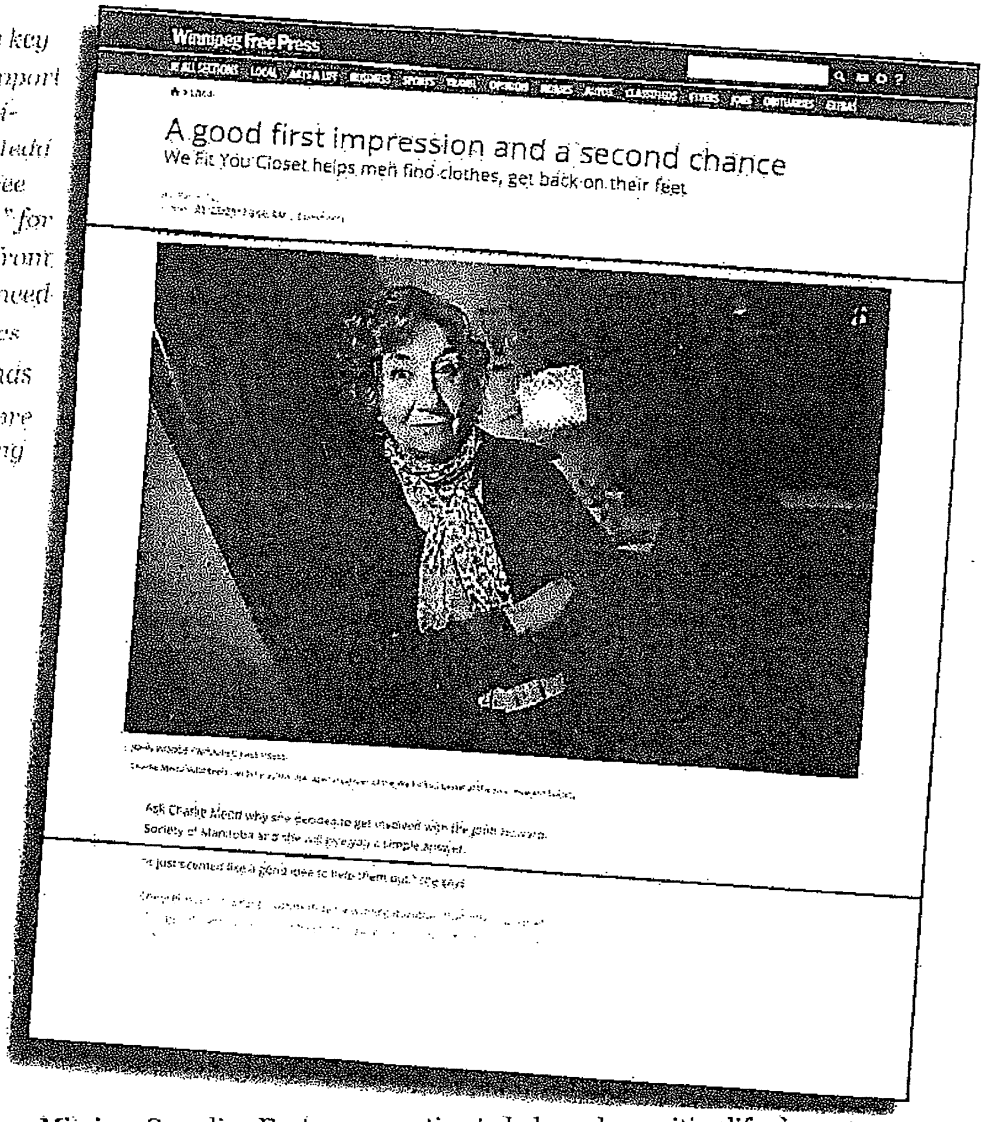
We are also excited to be funded by the *Assiniboine Credit Union* for our **new Birth Certificate Program**. This program provides incarcerated men the ability to obtain their birth certificates before their release. Having a birth certificate ready when they get out eliminates a six-week waiting period, making the reintegration process much easier.

The Reintegration department continues to support clients inside the institutions and in the community. Staff regularly visit Headingly Correctional Institution, Winding River Therapeutic Community, and Winnipeg Remand Centre.

We provide assistance in the release planning of clients, making the transition more successful and connected to community. Communications with clients from Milner Ridge Correctional Centre and Stony Mountain Institution are through telephone and fax and occasional visitations.

We are also very excited and blessed to have our *new clothing room*, called **"We Fit You Closet,"** funded by *Canadian Footwear* (thanks especially to company president Brian Scharfstein), with donations from Siloam Mis-

Volunteers are key to the extra support we can offer clients. Charlie Medd operates the free clothing "store" for men released from prison and in need of clothes. News of the service has spread and more people are using the service.


Winnipeg Free Press

A good first impression and a second chance

We Fit You Closet helps men find clothes, get back on their feet

sions, Lighthouse Mission, Canadian Footwear, and others in the community.

Charlie Medd, is our **new volunteer** who manages the closet every Tuesday and Thursday from 2-4 p.m. She was featured in the *Winnipeg Free Press* for her dedication. We are happy to have her! This new service has freed up time for staff and has actually increased our client numbers. Last year we **served 332 clients** through the Closet.

Community connections remain a vital part of Reintegration, allowing us to have resources available to provide our clients with information to help make positive life changes. We work closely together with agencies that will aid in providing a solid plan in employment, housing, substance abuse, Employment Income Assistance, counselling, identification, and food.

We thank all our supporters and all those that make up this great team! We are excited for the next year and what it will hold in store for John Howard Society of Manitoba.

Tania Wiebe, Reintegration Coordinator

John Howard Society Offers a New Service Dog Program

The John Howard Society of Manitoba is pleased to announce a new opportunity available through our Reintegration program: the Beyond Bars Service Dog Program. Thanks to a partnership with *Mehgan Search and Rescue (MSAR)* and their founder *George Leonard*, and financial support from the *Winnipeg Foundation*, we can offer participants an opportunity to work with service dogs.

This is primarily an **employment preparation and reintegration** program. As participants volunteer with a PTSD service dog training program and receive direction from the project coordinator, clients receive assistance in overcoming obstacles to employment such as anger management, substance abuse, finding transportation, and developing basic interpersonal social skills. Additionally, in discussion with MSAR, three participants will be selected to pursue formal training and **certification as dog trainers** later this year.

The John Howard Society of Manitoba has partnered with master service dog trainer George Leonard and MSAR to provide employment skills and possible jobs for clients.

Photo from Mehgan Search and Rescue, used with permission

Volunteers and students in this program will be able to develop their public speaking and communication skills, gain further **employment skills** and diversify their avenues of support from the community via MSAR and John Howard Society of Manitoba.

This program encourages positive and prosocial behaviours among participants which is an important aspect of restorative justice and building safer, healthier and stronger communities for all.

Carmen Vielfaure, Reintegration Worker and Project Coordinator

John Howard Society of Manitoba again took part in Restorative Justice Week in Winnipeg. This year we launched our new visitor's guide called "Through the Bars," and we convened a panel discussion at the Urban Circle Training Centre, November 24, 2016.

Restorative Resolutions

Restorative Resolutions is a community-based sentencing program that is in its third decade of existence. As always, we continue to work with victims, clients, and the community to **address the contributing factors** and consequences of crime.

Our program creates an opportunity within the current criminal justice system to deal with court cases in a way that is more **closely aligned with the principles of Restorative Justice.** In this regard crime is viewed as an action that causes harm to the victim, the community, and the client. Our program seeks to include all these parties in the reparation of that harm.

By taking a more active role in working to resolve issues that impact them, participants take back some of the control that was lost when the offence occurred. Restorative Justice programs have demonstrated comparatively lower recidivism rates that speak the effectiveness of this approach.

Over the past year we continued to focus on Restorative Resolutions community-based plans, and we worked to increase awareness of our program within the legal profession and the community to the many benefits it offers to victims, clients, and the community at large.

We are looking forward to taking part once again in *Restorative Justice Week* this November and continuing valuable committee work that will lead to a successful integration of more Restorative Justice practices in our current system which will benefit us all.

Lisa Ginter, Area Director of Restorative Resolutions

Literacy Program Report

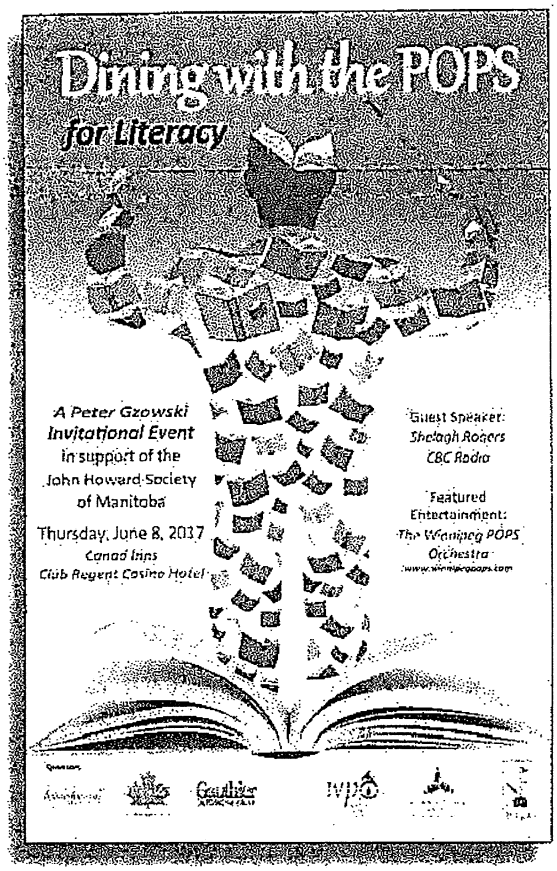
In terms of staffing, the John Howard Society Literacy program consists of two staff members, Dave Schmidt, Literacy Coordinator, and Katherine Johnston, Literacy Instructor.

Throughout the year there were **13 volunteers** that assisted with office-related work and tutoring students. Four university students, Carmen Linares, Danielle Carter, Michael Rose and Mike Spence completed their practicum field placement study with our department. In addition, two students from the Sociology department at the University of Manitoba, Alesta Heese and Cerah Dubé, conducted an in-depth research study on the peer tutor program.

Programs. This past year, literacy programming was offered at three institutions, namely the Winnipeg Remand Centre, Headingley, and Milner Ridge Correctional Centres. In addition, our services were provided to certain individuals from the community that met our criteria of working with offenders who are on bail or parole.

One To One Tutoring is for inmates that wish to improve their basic literacy and essential skills. This program was offered at the Winnipeg Remand Centre each Wednesday evening for three hours. Volunteers assisted as tutors with the inmates, covering a wide range of areas including basic literacy skills, working towards obtaining the General Education Diploma (GED) or Mature Grade Twelve Diploma. In addition, one-to-one instruction is offered in our office to men from our John Howard Society bail program and to certain individuals from the community who qualify for the program.

The **Peer Tutor Course**, held in a classroom setting inside various correctional centres, is a seven-week program designed to prepare participants for the role of teaching



their lower-literacy peers in essential areas such as reading, writing, math and problem solving. Upon release, the men can use the skills gained from the course to better themselves at work, at school, with their family or elsewhere in the community. Two classes were offered at Milner Ridge in the fall, four classes at Headingley Correctional Centre in November and December and another four classes at Headingly in the spring.

Get the Story Out is a program that invites incarcerated fathers to record themselves reading a story book to their children. The recordings are then transfered to a CD, gift-wrapped together with the book, and sent to the caregivers' home. The excitement in the children's eyes when receiving the package is heartwarming. The program is offered at the Remand Centre, Headingley, Milner

Photo: Dave Benson

Winnipeg Pops Orchestra conductor Dave Schmidt is also the John Howard Society of Manitoba literacy coordinator. This year his two roles merged in one lovely fundraising evening.

Ridge and Stony Mountain Institution. It has been successful in allowing men in jail stay connected to their children, grandchildren, nieces and nephews.

The Inside Scoop is a quarterly newsletter featuring poetry, stories, articles and artwork submitted from inmates across the country that are currently in jail or have been in jail. "The Scoop" is delivered to all correctional institutions across the province and to others across Canada. This has become a very popular venue for incarcerated individuals to exercise their creative writing skills. Unfortunately, due to staff workload and program demands this past year, fewer editions were published. It is anticipated to get back on track and the presses rolling for 2017 – 2018.

Some literacy program numbers

- Total students taught: 99
- Peer tutor students: 60 enrolled, 42 graduates
- One-to-one tutoring students: 39 (27 new students, 12 return students)
- Institutional phone inquiries and green request forms: 169
- Get the Story Out: 48 recordings and books sent out

National fundraising support. Our Literacy program was honoured to have been asked to partner with the Peter Gzowski Foundation for the purpose of promoting literacy awareness. Peter Gzowski was an award winning journalist, author and CBC Radio commentator, known for his daily show "Morningside." Before his passing in 2002, Mr. Gzowski established a celebrity golf

Darren Fisher (right) was the recipient of the PGI Learner Achievement award presented at the gala dinner, Dining with the Pops for Literacy in Winnipeg, June 8, 2017.

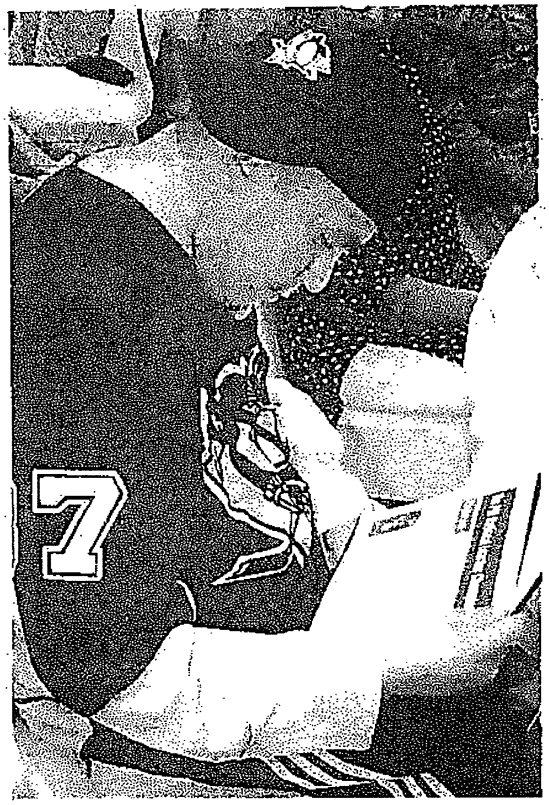


Photo: Dave Bergman

tournament to raise funds for literacy programs across Canada. This became known as a "PGI" event, taken from the golf acronym PGA, but referred to as the "Peter Gzowski Invitational". There is only one partner selected to represent each province and territory. Some PGI partners continued with golf tournaments, others host bonspiels, fishing derbies, fashion shows, wine tasting events and and gala dinners.

We held a successful gala dinner, "Dining with the Pops for Literacy" on June 8, 2017, at the Canad Inn Club Regent Casino Hotel. The evening featured celebrity guest speaker Shelagh Rogers from CBC Radio with entertainment by the 50-piece Winnipeg Pops Orchestra. Planning is already underway for next year's event to be held at the same location on June 7, 2018.

Research and presentations. An in-depth research project on the state of education in correctional centres across Canada was conducted by two sociology students from the University of Manitoba from September, 2016 to April, 2017. Alesta Heese and Cerah Dube presented their findings, which included a specific focus on our Peer Tutor program, at a Research Exposition at their university on April 27, 2017.

The Literacy department facilitated a workshop at the "Adult Secondary Education Council" (ASEC) conference, held at the Canad Inns (Polo Park) on Friday, October 21st, 2016. The presentation was entitled "On the Inside – The State of Educational Programming in Manitoba Correctional Centres."

The Literacy department also presented on a similar topic at the Manitoba School Superintendent's and Manitoba School Trustees Conference on April 20th, 2017.

Media coverage. CBC Radio produced a feature on our Get the Story Out program. Practicum student Danielle Carter was featured in an interview about her work with the program at the Winnipeg Remand Centre. Also interviewed was a child who had recently received three books and a CD recording of her dad's voice reading the stories. The feature by CBC producer Kim Kaschor aired on May 24, 2017 (to see the story online, search cbc.ca for "bedtime stories with dad").

Dave Schmidt, Literacy Coordinator

Bail Assessment, Support and Supervision Program

The staff in the program include Tal, Melissa, Sharon and Bernice (who upon retirement is being replaced by Jacquie).

The Bail program is a viable option for men who have been in conflict with the law. We are able to provide clients with an opportunity to remain in the community while they are awaiting trial and sentencing. The **structure and support** of the Bail program is what often makes the difference for the men who require assistance to address the static and dynamic factors that have led them to be in conflict with the law.

Common themes of substance abuse, anger management, parenting, family or community fragmentation, family violence, grief, employment and educational issues frequently emerge when the men share their stories with our Bail program staff. Through the use of assessments, the client and staff are able to determine their individual program needs and readiness for change. A case plan then emerges that the client can engage in.

Bail plays an integral role throughout the various junctures of the judicial system as it gives individuals an opportunity to demonstrate compliance with Court imposed conditions. Moreover, the **clients are able to encourage and motivate each other** as they move along their own healing path while simultaneously reconnecting with their families and community. The Bail program links these men to both internal and external resources to assist them with their individualized case plans.

The Bail program also has a **Residential component** consisting of 26 beds and operates 365 days a year along with the provision of meals. The Residential staff offers support and supervision on a 24 hour basis and work together with our Bail program caseworkers to ensure that we are offering well rounded services to the clients while they reside in our facility and to ensure open communication and dialogue between and amongst staff and client.

The Bail program operates on an integrated service model beginning with more intensive support and supervision and moving towards less supervision and readiness for independence within a community setting.

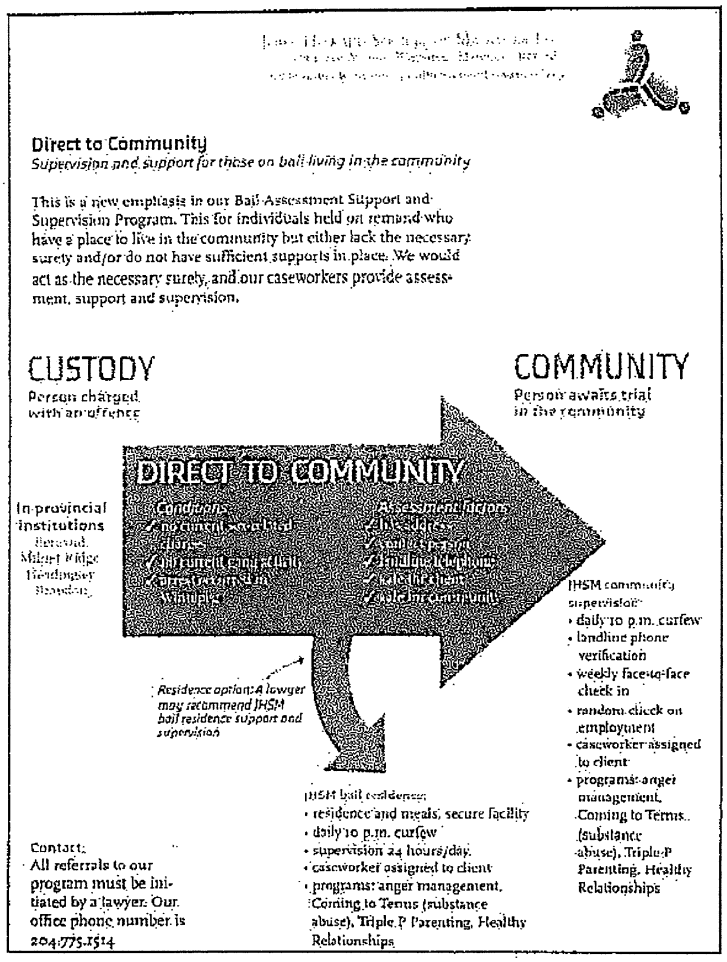
All referrals are done through the client's lawyer and our first referral was received in October, 2011 with the first client being released to our residence in January, 2012. The following are **some of the statistics** since the Bail program opened its doors to the public in 2011:

→ Total files open to date, 2,224.
→ Files that have been re-opened to date at the lawyer's request, 451.
→ Number of clients supervised both in the residence and in the community to date, 423.
→ Number of clients who successfully completed the Bail program since inception, 75.

These statistics demonstrate that despite some of the challenges their clients may face, the Bail Assessment, Support and Supervision Program continues to represent the best and most viable option for their client to pursue their potential release on bail. Those who have completed the Bail program means that they have dealt with their outstanding charges and have received dispositions. This number is steadily increasing, leaving one to conclude that the program is successful.

This spring the Bail program announced its **"Direct to Community" focus**, a new emphasis in our Bail Assessment Support and Supervision Program. In the past, most of

our clients started out under supervision in our residence facility before transitioning to the community. Now, **with our support and supervision, individuals on remand can go directly into the community as they await trial.** The direct to community focus is for individuals held on remand who have a place to live in the community but either lack the necessary surety and/or do not have sufficient supports in place. The bail caseworkers provide support and supervision.



Undoubtedly the Bail program is a much needed program in the community as we continue to be responsive to the lawyers who make referrals. The clients benefit as they address the factors that caused them to initially become in conflict with the law and as the resident and case management staff continue to build their collective experiences; the **clients and the community at large benefit** given that there are few alternatives for those individuals seeking bail to remain in the community.

The John Howard Society of Manitoba offers **an integrated and holistic approach** when working with clients in conflict with the law. It is not unusual for clients to be involved with all of our programs simultaneously or sequentially as the staff works with them in a correctional facility, in the community or while making a transition from an institutional setting to the community.

Many times the client's case plan involves programs and interventions that are offered by our Literacy program, Reintegration program and Bail Assessment, Support and Supervision Program. Although the needs of our clients are diverse there are **numerous opportunities for clients to become engaged in our services.** These services could include specific programming such as classes on parenting and anger management, accessing clothing, obtaining a birth certificate, improving their literacy skills, reaching out to their children through initiatives such as "Get the Story Out" or submitting their art, personal stories and poems for publishing in our *The Inside Scoop* newsletter.

Bernice Praymak (left), the Bail program's intake administrator, received assistance from Spark Winnipeg's Stephanie Sproule in developing a more robust data base to keep track of client records.

Depending on the client's identified need(s) our staff is able to connect them to both internal and external resources. In so doing, the client has the capacity to receive services that are tailored to meet their specific needs.

As an agency we continually strive to improve our services and opportunities; as such our **clients have an opportunity to give us feedback anonymously through both informal and formal evaluations** due to the fact that all programs have a self-report evaluation component to them.

We are grateful to our numerous partners who help and support us in our pursuit of acting as agents of change with the clients we serve allowing us to address the needs of individuals and the families of individuals who are incarcerated or living in the community.

Further, it should be noted that all of our programs are offered to men regardless of cultural identity, sexual orientation, family situation or living situation.

Sharon Perrault, Manager of Programs

Building Report

New tenant. This past year we acquired a new tenant. GAIN (Gang Action Interagency Network) is a network of agencies, government and law enforcement officials working on grass roots solutions to the gang problem in Winnipeg. GAIN is committed to taking action to address and solve the gang problem by building on research, current practices and developing the resources needed to prevent youth from joining gangs and help youth get out of gangs.

Building safety. We took measures to improve safety outside the building by installing more and brighter lighting. Extra video cameras were also installed in the front and side of the building. Software was installed on most computers so staff could monitor the exterior for safety concerns.

Fire code. Our fire panel and sensors were updated to the latest code. We had a building fire drill with a fire truck and firefighters in attendance to give us tips. They conducted a detailed fire inspection of the entire building. Everything is up to code.

Elevator. A major valve was replaced in the elevator. We received a grant from the Government of Canada, Employment and Social Development for an accessibility grant to provide easier access to the building for handicapped individuals. An intercom system linking the side entrance of the building to our bail office on the second floor was installed with a buzzer to buzz in clients. The door strike will be installed in the next fiscal year.

Flooring. Over the Christmas holidays the main floor offices got new carpets and vinyl in the kitchen and washrooms. This was a long overdue upgrade. The carpet it replaced was the original we installed when we purchased the building in 1992. This also gave us the opportunity to discard accumulated files and junk going back way too long.

Air quality. An air ventilation system was installed in the three rooms on the third floor – the GAIN office, the Tara Room and the Cultural Room. This will allow us to smudge in any of these rooms and most specifically in the cultural room. We also received a grant from the Manitoba Community Services Council for equipment and furnishing of the cultural room.

Banner. To freshen up our public face we had a beautiful retractable banner designed with info on our current programs and how to reach us.

Workbook orders. From April 2016 to March 2017 we had 12 workbook orders totalling $11,540.93. As in past years, a sizeable portion of these were from native communities and correctional institutions in Manitoba, Northern Saskatchewan and the Northwest Territories.

Janet Johnson, Office and Building Management

Thank You to Our Funders 2016/2017

The Government of Canada
Through a portion of a John Howard Society of Canada grant
Employment and Social Development Canada

Province of Manitoba
Department of Justice
Manitoba Department of Education and Training- Adult Literacy and Learning

Foundations and Friends:
United Way of Winnipeg
The Winnipeg Foundation
The Thomas Sill Foundation
PGI Canada
Assiniboine Credit Union
DeFehr Foundation
Canadian Footwear
Manitoba Community Services Council Inc.

Private Donors and Supporters
We thank all our supporters for their encouragment and generosity.

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2016-2017 Fiscal Year

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Wayne Lloyd, *Treasurer*
Wanda Houslow, *Secretary*
Kate Sjoberg, *Past Chair*
Zila Jones, *Member of Executive at large*
Katherine Johnston, *Staff Representative*
Paul Bourget
Allistair Clarke
Jonathan Coté
Chantal English
Charles Girard*
Phil Lancaster
Elvira Lausman
Glen Mazur
Leonard Monkman*
Nelson Sanderson*

**Resigned, or stepping down*

Staff 2016-2017

John Hutton, *Executive Director*
Sharon Perrault, *BASSP Manager/Manager of Programs*
Shuping Zhang, *Accountant*
Janet Johnson, *Administrative Assistant, Building Manager*
Gerry Pearson, *Special Initiatives Facilitator**
Aiden Enns, *Communications and Special Initiatives*
Melissa Burling, *BASSP Caseworker*
Tal Stimpson, *BASSP Caseworker*
Bernice Praymak, *BASSP Intake and Inquiries*
Rhonda Gosselin, *BASSP Residence Manager*
Colin Creally-Johnson, *BASSP Resident Assistant & term position as BASP Caseworker*
Tania Wiebe, *Reintegration Coordinator*
Carmen Vielfaure, *Reintegration Worker*
David Schmidt, *Literacy Program Coordinator*
Katherine Johnston, *Literacy Instructor*

Residential Care Workers

Ed Cooke, Shane David, Peter Imiefo, Patrick Larocque~, Sonja Lavallee~, Cecil McFarlane, Ahmad Moussa~*, Jason Penner*, Kim Russell, Zach Sundquist~
~casual staff
*resigned during the 2016-17 year

Social Work/Student Placements

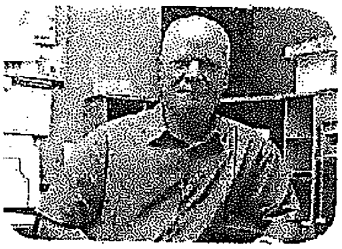
University of Manitoba, Social Work:
Danielle Carter, Paul Brar

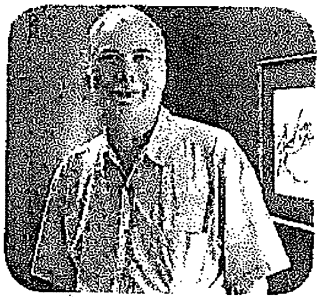
University of Manitoba, Sociology:
Alesta Heese, Cerah Dubé

CDI College:
Michael Rose

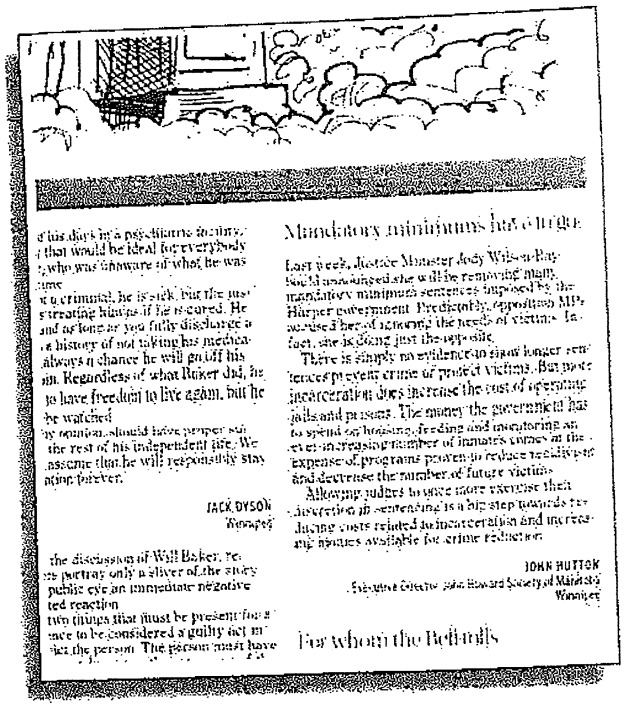
Booth University College:
Mike Spence

This year we say a sad farewell to two long-serving members of our staff team, Bernice (6 years) and Janet (14 years). We warmly welcome new staff, Jacquie and Ruth.





Staff, clockwise from top left: Tal, Carmen, Katherine, Dave, Colin, Aiden, John, Carlos, Toby, Tania, Shuping, Sharon; centre: Bernice (row 2), Janet (row 3); not shown: Melissa, Rhonda.



Mandatory minimums hurt crime

Last week, Justice Minister Judy Wilson-Raybould announced she will be removing many mandatory minimum sentences imposed by the Harper government. Predictably, opposition MPs accuse her of ignoring the needs of victims. In fact, she is doing just the opposite.

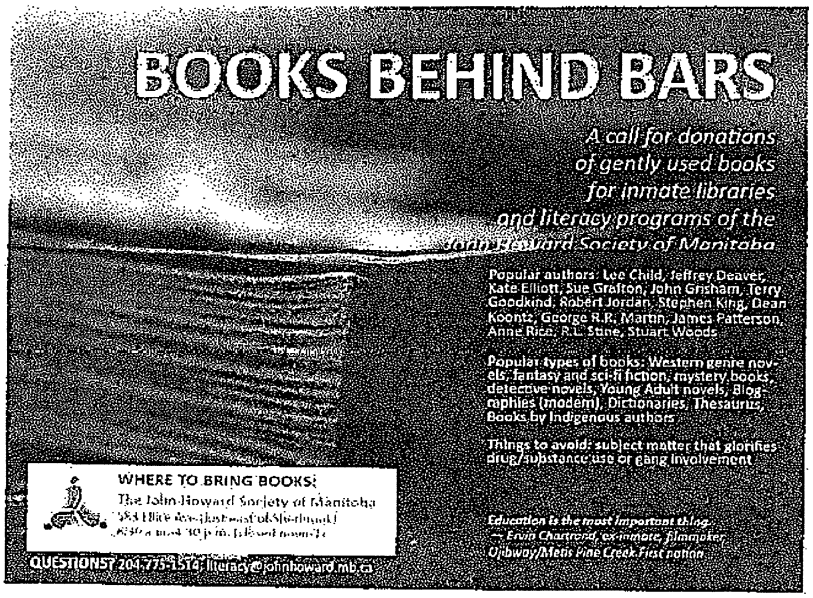
There is simply no evidence to show longer sentences prevent crime or protect victims. But more incarceration does increase the cost of operating jails and prisons. The money the government has to spend on housing, feeding and monitoring an ever-increasing number of inmates comes at the expense of programs proven to reduce recidivism and decrease the number of future victims.

Allowing judges to once more exercise their discretion in sentencing is a big step towards reducing costs related to incarceration and increasing options available for crime reduction.

JOHN HUTTON
Executive director, John Howard Society of Manitoba
Winnipeg

For whom the Bell tolls

John Howard Society of Manitoba contributes to the community discussion on fairness and justice for those incarcerated in Manitoba. Executive director John Hutton wrote opinion pieces and letters to the editor.



This past year we held a successful book drive to stock the library shelves and offer free books to clients in our literacy programs. Thanks to all who donated.

Scarrow & Donald LLP

CHARTERED PROFESSIONAL ACCOUNTANTS

September 19, 2017

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of The John Howard Society of Manitoba, Inc.:

We have audited the accompanying financial statements of The John Howard Society of Manitoba, Inc., which comprise the statement of financial position as at March 31, 2017, and the statements of operations and changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of The John Howard Society of Manitoba, Inc. as at March 31, 2017, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Other Matter
Our examination did not extend to the budget which has been provided as additional information and therefore we do not express an opinion concerning the budget.

Scarrow & Donald LLP

Chartered Professional Accountants
Winnipeg, Canada

For this communication, together with the work done to prepare this communication and for the opinions we have formed, if any, we accept and assume responsibility only to the addressee of this communication, as specified in our letter of engagement.

THE JOHN HOWARD SOCIETY OF MANITOBA, INC.

STATEMENT OF FINANCIAL POSITION

	March 31 2017	March 31 2016
ASSETS		
Current assets:		
Cash	$ 32,140	$ 13,483
Term deposit (Note 3)	5,753	5,716
Accounts receivable	43,392	74,165
GST recoverable	4,007	6,281
Prepaid expenses	14,344	11,905
	99,636	111,550
Capital assets (Note 4)	379,652	298,762
	$ 479,288	$ 410,312
LIABILITIES		
Current liabilities		
Line of credit (Note 5)	$ -	$ 35,435
Accounts payable	72,059	83,928
Deferred revenue	31,084	33,502
Commercial loan payable (Note 6)	266,721	95,070
	369,864	247,935
Deferred contributions related to capital assets (Note 7)	97,789	129,887
	467,653	377,822
NET ASSETS		
Net assets invested in capital assets	15,142	73,805
Unrestricted net assets	(3,507)	(41,315)
	11,635	32,490
	$ 479,288	$ 410,312

THE JOHN HOWARD SOCIETY OF MANITOBA, INC.

STATEMENT OF OPERATIONS

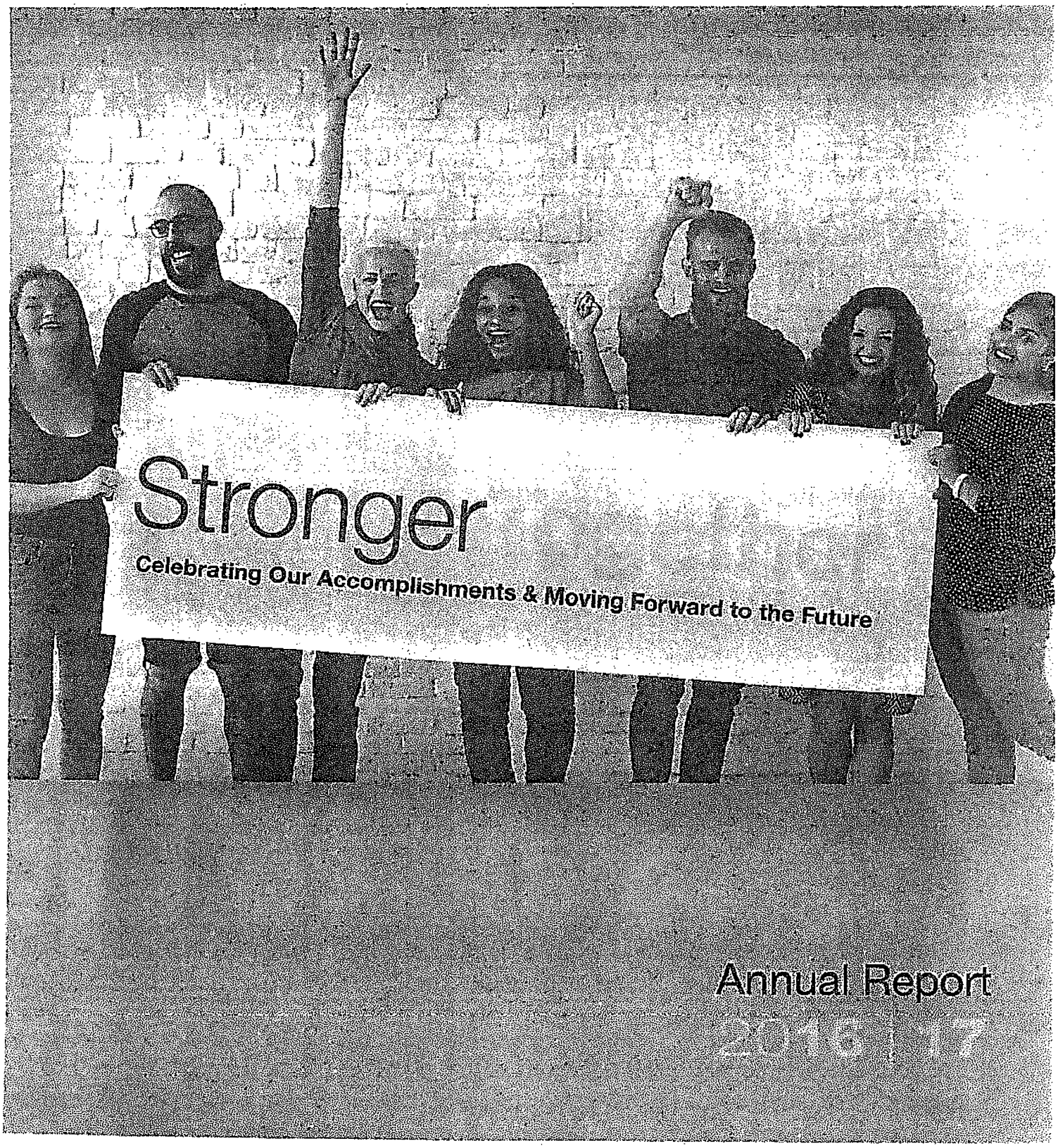
	Year ended March 31		
	Budget (unaudited)	2017	2016
Revenues:			
Administrative and other revenue	$ 91,959	$ 92,435	$ 93,852
Amortization of deferred contributions related to capital assets (Note 7)	38,397	32,098	38,397
Bail Assessment, Support and Supervision (Schedule A)	631,000	647,159	665,296
Donations and memberships	8,581	7,422	4,032
Government of Canada	4,314	7,875	-
Grants-			
Province of Manitoba-			
Department of Justice	86,000	86,000	86,000
Department of Advanced Education and Training	76,087	73,951	74,905
Ogijiita Pimatiswin Kinamatwin (Schedule B)	212,053	200,536	261,777
Oshki Giizhig	-	28,500	71,110
Rent	93,000	100,799	95,955
Special events	-	1,020	1,982
The John Howard Society of Canada	19,000	19,000	19,000
The Winnipeg Foundation	5,342	24,342	13,000
United Way	165,361	162,918	165,768
Willow Place	-	30,700	48,271
Total revenue	1,431,094	1,514,755	1,639,345
Expenses:			
Amortization of capital assets	62,959	56,743	62,959
Bail Assessment, Support and Supervision (Schedule A)	666,681	663,127	665,296
Building	194,198	105,962	159,387
General	24,417	16,635	22,969
Interest on commercial loan	6,000	8,047	3,872
Membership services	3,129	3,327	3,070
Office	19,197	16,842	17,047
Ogijiita Pimatiswin Kinamatwin (Schedule B)	212,053	186,091	268,400
Oshki Giizhig	-	28,500	71,110
Program materials	12,120	16,680	6,778
Salaries and benefits	392,516	402,956	381,775
Willow Place	-	30,700	48,271
Total expenses	1,593,270	1,535,610	1,710,934
Difference between revenues and expenses	$ (162,176)	$ (20,855)	$ (71,589)

APPENDIX B:

CMHA 2016-17 Annual Report

Canadian Mental Health Association

Mental health for all



Annual Report

Message from **Board Chairperson & Executive Director**

We have had another year of exciting partnerships, service delivery excellence and new opportunities. Our Board of Directors led a very successful strategic planning process for our organization and this work was further developed and affirmed by all staff at our retreat in November 2016. We now have a renewed mission that speaks to our provincial and regional role and clearly voices our commitment to a broad mandate of promoting mental health and well-being, and supporting mental illness and addictions recovery.

THE THEME FOR OUR 2017 CMHA Provincial Conference is Stronger Together: Bridging Mental Health and Addictions Supports in Manitoba. As we enhance our capacity to serve more Manitobans in recovery, we know that working in collaboration with the addictions sector is critical. With a new Mental Health and Addictions Strategy for Manitoba in development we look forward to working with our provincial partners to strengthen the bridge between these two systems of care to better meet the needs of Manitobans across the province.

We continue to develop our Divisional role within our CMHA federated structure and the theme Stronger Together carries into our regional relationships as well. Over the year we have been working with the CMHA Interlake Eastern board and staff to integrate the governance and operations under the umbrella of CMHA Manitoba and Winnipeg. It's also been a busy year with numerous branch visits to support board governance including education and coaching for CMHA Parkland and CMHA Central.

Our Mission: To honour and promote the mental health of all Manitobans and to support individuals who experience mental illness and addictions issues to achieve recovery and well-being within healthy and supportive communities.

We have been actively involved in several CMHA national initiatives including the Health Accord Working Group which played an important role in advancing the federal government's commitment to mental health and addictions in Canada. We were pleased to see dedicated funding ear-marked for mental health in the Federal Health Transfer Fund and we are optimistic that this will make a difference for Manitobans who need mental health and addictions care.

This year we also brought in several new community engagement and educational initiatives. We held our Inaugural Ride Don't Hide at Fort Whyte Alive and had over 160 participants and volunteers, raising over $33,250. We launched Talk Today, a nation-wide youth mental health promotion program reaching junior hockey players. In December 2016 we trained the entire team of the Brandon Wheat Kings in Safetalk, an evidence-based suicide alertness program aimed at promoting prevention and help-seeking. In partnership with CMHA Westman and the local mental health resources in the Brandon area we hosted the Talk Today Game Day which raised awareness about mental health resources in the community.

With the growth of our organization, we've taken on new challenges and embraced new experiences, while continuing to provide high-quality services in our communities. For example: assisting individuals who are homeless to access safe housing; helping individuals find jobs and keep them; reducing isolation and increasing connections and support pathways to full citizenship by providing rehabilitation and recovery services; reaching individuals with mild or moderate depression or anxiety with early intervention CBT thus improving quality of life and well-being; building psychologically healthy workplaces; and increasing mental health literacy through education and community engagement.

This coming year is gearing up to be a very exciting one as we approach our 100th year anniversary in 2018. We will use this milestone to continue to influence social justice, build mentally healthy communities and be the trusted resource and leader in mental health.

CMHA Manitoba and Winnipeg's success is a direct result of the dedication and tremendous efforts of our 48 staff and over 80 volunteers. Thank you for going above and beyond to advance the mission of CMHA.

Onward,

Debra Radi
Chair

Marion Cooper
Executive Director

Our Board of Directors

CMHA is a registered charity, governed by a volunteer Board of Directors

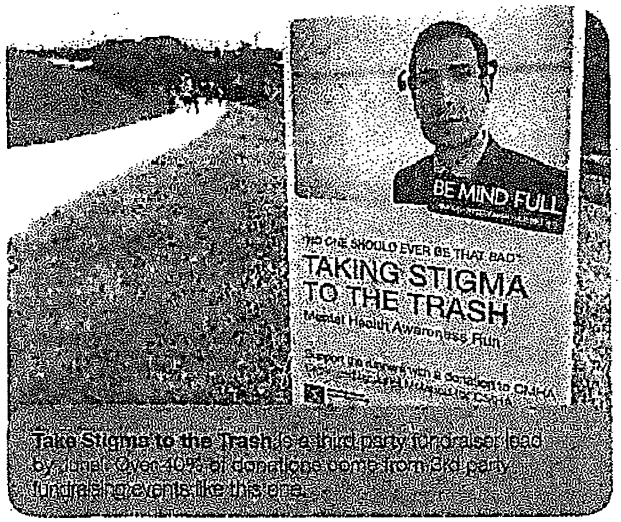
Our Board adheres to a policy-governance model, meeting regularly to provide organizational oversight and monitoring.

Chair **Debra Radi**
Vice-Chair **Glen Mazur**
Treasure **Garett Surcon**
Secretary **Lisa Erickson**

Directors **Betty Edel, Damon Johnston**
Dessalegn Melesse (until May 2016), Michael Jordan
Reid Hartry, Stephanie Dudok, Yutta Fricke

930 Portage Avenue, Winnipeg, Manitoba R3G 0P8 (204) 982-6100

Impact in Programs & Services



Take Stigma to the Trash is a third party fundraiser lead by Janet Oven. 40% of donations come from 3rd party fundraising events like this one.

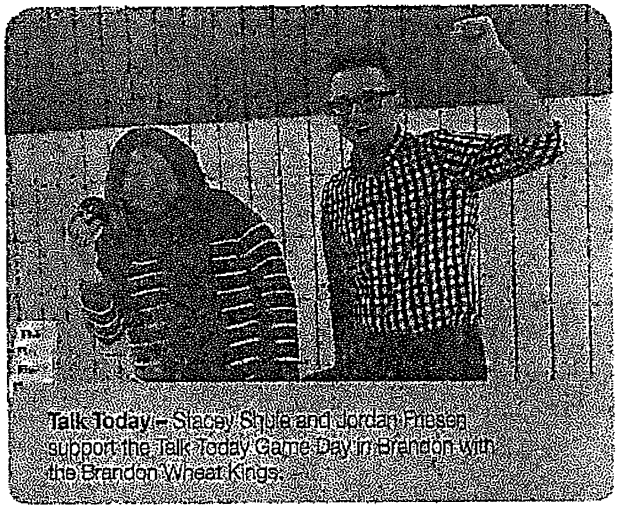
75% of participants in our Rehabilitation and Recovery Service met their goals in the area of housing, education, relationships, parenting or employment.

3,550 people were reached through our direct services, health navigation, brief intervention and school based programming.

Eric Glass of the Manitoba Paramedics Association, Hon Schuler, Minister of Crown Services and Marion Cooper at the launch of the Paramedic Licence plate campaign raising funds for PTSD and First Responders Initiative at CMHA

355 people were served through Bounce Back and over 115 primary care providers can refer to this program.

800 families and caregivers received service navigation assistance and 45 family members participated in our Mental Health Education for Families courses.



Talk Today – Stacey Style and Jordan Friesen support the Talk Today Game Day in Brandon with the Brandon Wheat Kings.

600 people improved their mental health literacy and well-being by taking one of our courses or workshops.

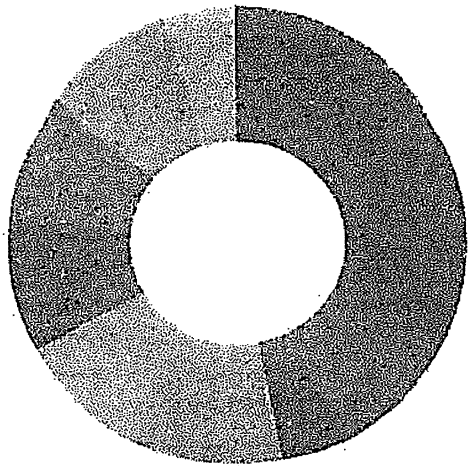
39 people received one-on-one assistance to understand their rights under the Mental Health Act.

40,000 copies of the Mental Health Resource Guide distributed.

Financial

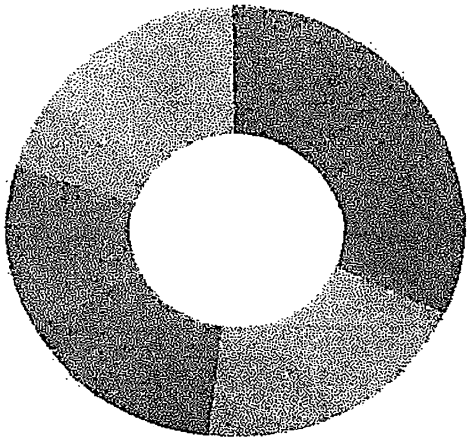
REVENUE

- **47%** WRHA
- **20%** Province of Manitoba
- **10%** United Way
- **9%** Grants
- **9%** Fee for service
- **3%** Donations
- **2%** Other



EXPENSES

- **32%** Rehabilitation & Recovery Services
- **20%** Housing & Community Supports
- **15%** Administration, Operations & Support Services
- **13%** Information Services and Education
- **5%** Divisional Supports, Policy & Communications
- **7%** Bounce Back
- **5%** Employment Supports
- **3%** Futures Forward



Highlights

Building Futures Collaboration received confirmation in November 2016 of the Government of Manitoba's Department of Education and Training commit to ongoing funding and enhancement to the program to include tuition waiver program and the addition of a second youth service navigator. In partnership with Youth Employment Services and Community Financial Counselling Services we have rebranded the program as Futures Forward.

Youth Mental Health Program Expansion education programming in schools continues to be a priority area for reaching youth. We continue to have more demand for the Mile 5 program than we can respond to and as a result we have developed a strategy for increasing our capacity through the development of a Mile 5 train the trainer that will equip schools to deliver the program in classrooms and have CMHA coordinate this work, ensuring up to date tools, resources, youth speakers and supports. The program is also growing outside of Winnipeg with schools in the Southern region delivered by CMHA Central with further expansion planned for the 2017-18 school year.

Legal Aid Duty Counsel Pilot Project is a partnership with the Mental Health Review Board, Public Interest Law Centre, and Legal Aid Manitoba that established a new process to fast track and improve access to legal representation for persons appealing their involuntary status with the Mental Health Review Board. This work has been honoured through a nomination for the Partnership Award for the 19th Annual Manitoba Service Excellence Awards.

Quality Improvement Accountability initiatives are essential to service delivery excellence. This year the Quality Improvement Committee identified priority areas including outcomes measurement and policy and practice review. Partnering with our CMHA colleagues in Toronto we are taking some of their lessons learned in a journey to excellence. An agency research and evaluation strategy has been finalized and outcome data is being collected including the measurement of recovery and personal goal attainment. The Recovery Assessment Scale: Domains and Stages (RAS-DS) is a psychometrically tested outcome measurement tool that has been implemented across our programs.

Youth Homelessness Research Project is currently underway to explore the potential of Futures Forward (formerly Building Futures) as a made-in-Manitoba model for youth homelessness prevention, funded by Employment & Social Development Canada, CMHA Manitoba and Winnipeg is leading this work but also working very closely with multiple partners including Youth Employment Services, Community Financial Counselling, Ma Mawi Wi Chi Itata Centre Inc., CMHA Thompson and CMHA Central.

Our Vision Mentally healthy people in a healthy society.

Priorities | Moving Forward in 2017 | 18

Partnership with Ma Mawi Wi Chi Itata Centre for Youth Mental Health Promotion recently received funding with donation from Bell MTS and Unifor for $200,000. Through the Strengthening Wellness Education to Love Life (SWELL) program, Ma Mawi and CMHA will deliver culturally relevant mental health programs to Indigenous youth and their families. Together with Ma Mawi we will partner to deliver promising practice programs including Listening to One Another, Mental Health First Aid for First Nations and Living Life to the Full programs, which will equip Indigenous families with healthy tools for mental health promotion.

Recovery Supports Program Innovation is a partnership with CMHA National that we have embarked on to establish a "Recovery Learning Centre" that includes both in-person and virtual opportunities for connection, community and access to evidence based supports. This work is operating from the principle of "nothing for us without us", therefore we are working closely with people with lived experience to co-create content and find innovative ways to build community to support recovery.

Service Navigation Hub is an exciting service enhancement that we have prioritized. Our re-organization of intake processes, and referral linkages will allow us to enhance our service navigation supports for individuals, families and others. By streamlining program intake we will ensure seamless transition to needed services.

Organizational Health is a priority at CMHA as we strive to be a healthy place to work. We are working to implement the Psychological Health and Safety Standard and have learned so much from the Guardian Minds@Work survey that staff completed this year. We recognize that we do many things well but have also heard from our staff how we might improve our workplace culture and strengthen the psychological health of our organization.

Getting ready in the Rain—Inaugural Hide Don't Hide at Fort White Alive with over 160 participants and volunteers.

Thank You to Our Major Funders

Winnipeg Regional Health Authority · Office régional de la santé de Winnipeg

Manitoba

United Way Winnipeg

The General Child and Family Services Authority

Canada

Thank You to Community Sponsors and Supporters

CN

Manitoba Liquor & Lotteries

Wawanesa Insurance

Bell Let's Talk

The Winnipeg Foundation

APPENDIX F

Court File No. 555-81963

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *THE FATALITY INQUIRIES ACT*, C.C.S.M. c. F52

AND IN THE MATTER OF: AN INQUEST INTO THE DEATH OF DEVON SAMPSON

WRITTEN SUBMISSION OF THE JOHN HOWARD SOCIETY OF MANITOBA and the CANADIAN MENTAL HEALTH ASSOCIATION MANITOBA AND WINNIPEG

PUBLIC INTEREST LAW CENTRE

200-393 Portage Avenue

Winnipeg, MB R3C 0B9

Allison Fenske

Telephone: (204) 985-8540

Fax: (204) 985 -8544

Email: afenske@pilc.mb.ca

RECEIVED

FEB 23 2018

PCJ CHAMBERS

RECEIVED

FEB 22 2018

JUDICIAL SERVICES

Table of Contents:

	Page
Table of Contents	i
Overview	1
The John Howard Society of Manitoba	1
The Canadian Mental Health Association, Manitoba and Winnipeg	1
Scope of Participation	1
Devon Sampson and the circumstances leading to his death	3
Only one formal psychological assessment for Devon was completed	4
The systemic neglect of how Devon's mental illness could be expected to impact his relative success in a prison setting	5
Inattention to mental illness in correctional planning	6
The revolving door of segregation	7
Gaps in information sharing	8
A lack of understanding of Devon's mental illness leads to his final placement in segregation	9
Devon's mental illness was not properly considered in the review of his segregation status, resulting in Devon's continued detention in segregation	10
The death of Devon Sampson	11
Segregation is no treatment for mental illness	12
There was no "rallying of the troops"	13

Recommended Findings of Fact in relation to the Death of Devon Sampson 14

There was inconsistent knowledge, application and implementation of the Institutional Mental Health Initiative (IMHI) guidelines 14

There is a significant reliance on inmate self-reporting in assessments of mental health which worked to the detriment of Devon Sampson 16

There was a lack of information sharing between mental health professionals, other health care professionals, and correctional staff and that lack of information was not solely related to privacy concerns; and
Devon's incarceration was characterized by repeated reference to significant mental health concerns that did not appear to inform correctional planning for him. 17

Knowledge of and response to Devon's issues with medication compliance was limited to his treating psychiatrist (external) and Stony Mountain Institution's mental health nurse. There was no knowledge of or involvement from correctional staff or Devon's own Case Management Team. 20

When segregation is available, it is too often used as a default. 22

There was a lack of robust mental health training for front-line staff 25

Outside of the Mental Health / Supportive Living Range, there is limited intermediate interventions available for someone who does not meet the certification requirements for involuntary placement at the Regional Psychiatric Centre, but who remains within general population with a serious mental illness. 26

Mental Health Services within the institution were under-resourced at the time of Devon's death. 28

Devon's circumstances at the time of the assault on the nurse and his final placement in segregation called out for a response that recognized his mental illness and all of the potential concerns with which he presented. 30

The core messages of these Inquests, and in particular the Sampson Inquest, are mirrored in the ruling in *British Columbia Civil Liberties Association v Canada (AG)*. 31

Opportunities in Preventing Future Deaths 34

1. Independent Review 34

2. Integration – Cooperation – Coordination 38

3. External Accreditation 40

4. Start with the presumption of mental health needs / active consideration of mental illness in correctional planning / augmented mental health services 41

5. Enhanced mental health training for staff 43

Appendix A: Jurisdiction 45

Overview

The John Howard Society of Manitoba

The John Howard Society of Manitoba ("JHSM"), which celebrated its sixtieth anniversary in November 2017, is one of sixty-three John Howard Societies located across Canada. Based in Winnipeg, JHSM provides a number of programs and services in support to men in conflict with the law before, during and after incarceration, in addition to advocating for the just and fair treatment of those involved in the justice system. JHSM advances evidence-based and humane approaches to incarceration, rehabilitation and crime reduction.

The Canadian Mental Health Association, Manitoba and Winnipeg

The Canadian Mental Health Association, Manitoba and Winnipeg ("CMHA") is part of a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. CMHA accomplishes its mission through advocacy, education, research and service.

CMHA regularly contributes to and participates in numerous coalitions and working groups in the area of mental health, housing, employment and disability issues with the goal to improve the quality of life for people living with serious mental health problems. CMHA works towards ensuring that people with mental illness become full participants in society and that all are mentally healthy.

Scope of Participation

Both the JHSM and CMHA have previously been granted standing in inquests under *The Fatality Inquiries Act*, CCSM c F52 (the "*Act*"). JHSM is also currently participating in the inquest into the death of Bradley Errol Greene which was called on May 1, 2016 and began hearings on January 29, 2018.

The inquest into the death of Devon Sampson (the "Sampson Inquest") was called on August 8, 2014 and JHSM and CMHA were granted standing on April 28, 2015.

In February 2016, JHSM and CMHA were informed that the inquest into the death of Dwayne Flett (the "Flett Inquest") would be joined with the Sampson Inquest. JHSM and CMHA were granted standing in the Flett Inquest on May 19, 2016 and did not receive disclosure of relevant materials from Inquest Counsel until nearly one year later, in April 2017.

In August 2017, JHSM and CMHA withdrew from the Flett Inquest and confirmed that their participation would be limited to matters pertaining to the death of Devon Sampson. In particular, JHSM and CMHA are concerned about the manner in which Correctional Service Canada ("CSC") (and in particular, Stony Mountain Institution) is able to deal with the mental health needs of offenders like Devon who are regularly housed within the general population of the prison. JHSM and CMHA are also concerned about the use of administrative segregation on inmates with mental illnesses.

JHSM and CMHA participated fully in the Inquests on matters relating to the death of Devon Sampson and also retained Dr. Somers, a clinical psychologist. Dr. Somers was qualified by the court on the agreement of all counsel to give expert opinion evidence in the areas of clinical psychology in a correctional setting. Dr. Somers also prepared a written report for the court's consideration.[1]

JHSM and CMHA are privileged to be able to participate as public interest intervenors in the Sampson Inquest given each organization's respective expertise in the areas of correctional services, mental health and mental illness and the needs of persons in custody – particularly those who may be suffering from mental illness.

[1] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11.

Devon Sampson and the circumstances leading to his death

Devon Sampson was born in Guyana on May 6, 1979 and emigrated from Guyana to Canada with his family in 1985. He struggled as a youth and first found himself involved in the criminal justice system at the age of 15. He was first placed in youth custody in 1997 at the age of 17.[2]

In 2001, Devon received his first adult sentence of probation for two counts of robbery and carrying a concealed weapon. In 2003 and 2004, Devon received provincial jail sentences (again primarily due to convictions involving theft or robbery and weapons offences). He entered the federal correctional system in June 2005, having been sentenced to 3 years for robbery (x5), escape lawful custody, and theft under.[3] At the time of his death, Devon was serving his third federal sentence.

Around the same time that Devon was becoming more frequently involved with the criminal justice system, he was also dealing with a diagnosis of, and institutional treatment for, schizophrenia.

Devon was first diagnosed with schizophrenia in 1999 at the approximate age of 19.[4] Between his diagnosis and his admission into the federal correctional system in June 2005, Devon was hospitalized at least 3 to 4 times, each time for a period of several months due to psychiatric concerns. On at least one occasion, he remained hospitalized for eight months.[5]

By 2003, it was clear that Devon had difficulties taking his prescribed medication regularly (often referred to by health care professionals in terms of compliance, or non-compliance with medication) and in following through with recommendations for treatment. It was observed that Devon "has a long history of severe, psychotic illness and intermittent non-compliance with

[2] Manitoba Justice Corrections Division, "Pre-Disposition Report", 10 March 1997, Exhibit 4A, Tab 51 at 2, 4, 6.
[3] Dr. Anastasia Barbopoulos, "Psychological Assessment", 25 October 2005, Exhibit 4D, Tab 15 at 2.
[4] Dr. Anastasia Barbopoulos, "Psychological Assessment", 25 October 2005, Exhibit 4D, Tab 15 at 3. See also Letter from Dr. J Waldman to Dawn Hale, Health Care Services, Stony Mountain Institution, 29 July 2010, Exhibit 4E, Tab 3 at 1.
[5] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 33.

treatment."[6] He had "fairly significant recurrent depressive episodes as well."[7] Devon also developed a fairly debilitating addiction to crack cocaine[8] and frequently traded compliance with his prescribed psychotropic medications for use of illegal substances, including crack cocaine.[9]

Devon's index offences on entry into the federal correctional system were characterized as impulsive and motivated by his drug addiction[10] and in effect, seriously linked to his mental illness. It is also worth noting that Devon had reportedly been non-compliant with his anti-psychotic medication for several weeks at the time of his offences.[11]

Only one formal psychological assessment for Devon was completed

Some months after Devon first arrived at Stony Mountain Institution, and after his first Correctional Plan was completed, Dr. A. Barbopoulos completed a psychological assessment, detailing Devon's mental status, cognitive abilities, mental health, and offending risk.[12] Dr. Somers noted that this was the only formally written and detailed psychological assessment for Devon in all of his time under federal warrant and as a result he reviewed this assessment in detail in his report.[13]

Notably, Dr. Barbopoulos observed that Devon:

- was unreliable in his self-reporting;[14]

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6 Michael K. Eleff, MD, Health Sciences Centre, "Case Summary: Sampson, Devon", 16 April 2003, Exhibit 4E, Tab 51 at 3. See also Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 5.

7 Dr. F. Vattheuer, "Psychiatric Consultation Report", 18 June 2012, Exhibit 4E, Tab 17.

8 Correctional Service Canada, "Correctional Plan", 26 August 2005, Exhibit 4A, Tab 55 at 4-5, 8.

9 Dr. Anastasia Barbopoulos, "Psychological Assessment", 25 October 2005, Exhibit 4D, Tab 15 at 3.

10 Correctional Service Canada, "Correction Plan", 26 August 2005, Exhibit 4A Tab 58 at 5.

11 Correctional Service Canada, "Criminal Profile Report", 19 March 2012, Exhibit 4A, Tab 07 at 15.

12 Dr. Anastasia Barbopoulos, "Psychological Assessment", 25 October 2005, Exhibit 4D, Tab 15.

13 Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 6-11. See also Testimony of Dr. Kent Somers, 6 November 2017.

14 This was also confirmed in Devon's responses to the Computerized Lifestyle Assessment Inventory administered as part of his intake into Stony Mountain Institution on June 30, 2005. See Correctional Service Canada, "Computerized Lifestyle Assessment Inventory", 30 June 2005, Exhibit 4B, Tab 111.

- was uncooperative and displayed a lack of insight and judgment;[15]
- had a "significant lack of insight into psychiatric issues and personal shortcomings";
- displayed a lack of acceptance of the reality that he suffered from a psychotic disorder for which he always needed to secure and to comply with treatment, including his reliance on psychotropic medication, bode poorly for effective rehabilitation and successful future integration; and
- required continuity of care and communication between the different professionals working with Devon.

Rather curiously, the discussion of mental health supports in this assessment focused on the support as a matter of "his future release to the community."[16] Dr. Somers suggests that the "inference allowed by this is that Mr. Sampson's time in the institution is exempt from expectation that there is need to respond to, accommodate, or even treat his serious mental disorder, schizophrenia."[17]

The systemic neglect of how Devon's mental illness could be expected to impact his relative success in a prison setting

On review of Dr. Barbopoulos' assessment, Dr. Somers suggested that despite Dr. Barbopoulos' findings, certain key observations were "systemically neglected" within correctional services provided to Mr. Sampson during his three tenures at Stony Mountain Institution:

- that he had been diagnosed with schizophrenia and likely qualified for a dual diagnosis (a mental disorder with a co-occurring substance abuse problem);
- his self-reporting was unreliable, in part because he lacked insight into his own cognitive functioning and generally appeared to be in denial as to his having schizophrenia;

[15] Dr. Somers suggested that an implication of being uncooperative is that of Devon "having difficulty in effectively communicating and problem-solving with others, and it suggests a general lack of wherewithal so as to cope effectively within the environment in which he found himself." See Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 7.

[16] Dr. Anastasia Barbopoulos, "Psychological Assessment", 25 October 2005, Exhibit 4D, Tab 15 at 9.

[17] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 10.

- he was likely quite limited in the quality of his language skills (which would limit the effectiveness of programming if not adequately addressed); and
- he was prone to being impulsive and having poor interpersonal problem-solving or conflict resolution skills.[18]

Inattention to mental illness in correctional planning

Overall, Devon's time within the federal correctional system was marred by inattention to his mental illness in the course of correctional planning. While Dr. Somers was fair in acknowledging the references to Devon's mental health issues in many of the documents associated with correctional planning, Dr. Somers' primary concerns centre around the notion that "the potential impact of his stay in custody of his schizophrenia is not anticipated and, as such, appropriate planning and preparation for those needs does not occur."[19]

As a general observation, Dr. Somers determined that during Devon's time in federal custody:

> ...case management documentation appears to largely orient to his behaviour – including his impulsivity, lack of insight, his anger and resentment – as being defaults of his conduct if not his character, portraying him as being incorrigibly antisocial, without factoring into an understanding of his behaviour the role of his previously diagnosed schizophrenia. This appears to be the underlying understanding of Mr. Sampson, guiding correctional strategy applied to him, despite the advent of the IMHI [Institutional Mental Health Initiative] and the Guidelines intended to steer that initiative.[20]

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18 Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 10.

19 For example, observations that Devon's "behaviour tends to go up and down depending on the day... some days there are no problems and then other days his attitude deteriorates tremendously" seem entirely divorced from the key features of both the positive and negative symptoms of schizophrenia. See: "Correctional Plan Progress Report", 16 January 2006, Exhibit 4B, Tab 111 in contrast with the testimony re schizophrenia from Drs Yaren, Globerman and Somers, and Mr. Zimmerman.

20 Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 17-18.

The revolving door of segregation

Devon's time in federal corrections was also characterized by a kind of revolving door between regular range assignments and placement in administrative segregation. He was routinely placed in administrative segregation and on more than one occasion remained there for hundreds of consecutive days.

For example, starting in 2006 and through 2007, Devon spent approximately 294 consecutive days in segregation. He was only released from segregation because his federal sentence expired. He went straight from segregation to community release and was only in the community for 3 days before he was sent back to Stony Mountain Institution for failing to return to a community residential facility. He returned to Stony Mountain Institution and was immediately placed in segregation for 10 days before being released back into the community. He spent 2 days in the community before he breached the conditions of his release and was again readmitted to Stony Mountain Institution and again admitted directly into segregation where he remained for another 62 days. By December 2007, Devon had been admitted to segregation for another 27 days. In 2006 and 2007, he spent more time in segregation than not.[21]

Another notable stay in segregation occurred starting in December 2011 through to June 2012 when Devon was incarcerated first in Stony Mountain Institution and then in Saskatchewan Penitentiary. On admission to Stony Mountain Institution from Headingley Correctional Centre (on remand) Devon spent approximately 167 days in segregation, at which point he was transferred to Saskatchewan Penitentiary. While Stony Mountain Institution would have considered him released from segregation, it should be noted that on transfer to Saskatchewan, Devon was immediately admitted to segregation in that institution, awaiting placement. He spent an additional 20 or 21 days before being placed on a general population range. This amounted to a total stay of approximately 187 consecutive days in segregation, between two CSC institutions.[22]

[21] Correctional Service Canada, "Assessment for Decision", Exhibit 4A, Tab 6 at 3.
[22] See: Correctional Service Canada, "Assessment for Decision", Exhibit 4A, Tab 6 at 3); Correctional Service Canada, "Segregation Log", Exhibit 4F, Tab 2; Correctional Service Canada, "Review of Offender's Segregated

Gaps in information sharing

By May 2013, Devon was serving his third federal sentence and had just been transferred from Saskatchewan Penitentiary back to Stony Mountain Institution.[23] He was noted as "reluctant to resume [his] psychiatric medications"[24] and was seen as being "in danger of relapsing (diagnosis of schizophrenia) without psychiatric medications."[25] As of June 20, 2013 Devon was refusing his anti-psychotic medications.

By the following month, Devon's behaviour was described by a correctional officer as "odd" however, this same correctional officer was neither aware of Devon's schizophrenia, nor of his need for and refusal to take anti-psychotic medication.[26] Devon's own Institutional Parole Officer was not aware that he was not complying with his medication regime.[27]

Psychiatrist Dr. Stanley Yaren testified that schizophrenia is a condition where relapses in psychosis are typical. Often, medication is used to prevent relapses, and in a patient with a history of non-compliance with medication it is predictable that they would have a relapse. What is less predictable is a person's length of recovery.[28]

By October 23, 2013 the Health Services Department was made aware by Stony Mountain Institution's Psychiatric Liaison Nurse that Devon had not taken any of his required psychotropic medications in the past six months and was currently experiencing psychotic symptoms. That day, he accepted a small dose of his medication and was waiting to be seen by a psychiatrist. On October 29, 2013 he was seen by Dr. Yaren who observed continuing symptoms and increased

Status Institutional Review", Exhibit 4F, Tab 20 at 1; Correctional Service Canada, "Notice of Offender's Release From Segregation", Exhibit 4F, Tab 21; Correctional Service Canada, "Segregation Log", Exhibit 4F, Tab 22; Correctional Service Canada, "Voluntary Segregation Placement", Exhibit 4F, Tab 23; and Correctional Service Canada, "Notice of Offender's Release from Segregation", Exhibit 4F, Tab 28. All told, Devon was in segregation from 16 December 2011 until 20 June 2012 inclusive.

23 Correctional Service Canada, "Transfer Warrant Regional", 15 May 2013, Exhibit 4C, Tab 02; Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 25.

24 Correctional Service Canada, "Referral for Consultation and Report", 29 May 2013, Exhibit 4E, Tab 35.

25 Correctional Service Canada, "Referral for Consultation and Report", 29 May 2013, Exhibit 4E, Tab 35.

26 Correctional Service Canada, "Officer's Statement/Observation Report", 2 July 2013, Exhibit 4B, Tab 111.

27 Testimony of Brent Yarechewski, 12 September 2017.

28 Testimony of Dr. Stanley Yaren, 14 September 2017.

his medication. At this same time, none of the correctional staff were aware that Devon was experiencing psychotic symptoms. Dr. Yaren also testified that it was possible that Devon was relapsing earlier than staff could detect and was not disclosing his symptoms.[29]

A lack of understanding of Devon's mental illness leads to his final placement in segregation

On November 10, 2013, while still experiencing psychotic symptoms, Devon assaulted a nurse. He was subdued by force and immediately placed in administrative segregation. Despite Devon's long-standing struggles with mental illness, the individual completing the "Immediate Needs Checklist: Suicide Risk" for Devon on admission to segregation indicated "no" in answer to the question "Have you [the inmate] ever been treated for emotional or mental health problems."[30]

This was not the only time an Immediate Needs check on Devon did not accurately or appropriately identify Devon's struggles with mental illness. When a similar error was made during admission to segregation in July 2013, Dr. Somers described it as "unfathomable that this false statement should have been repeated."[31] And yet, less than 4 months later the same error was made again.

Devon saw one of the contract psychiatrists on November 12, 2013 and the Psychiatric Liaison Nurse made Devon's Institutional Parole Officer aware that Devon was currently "paranoid, psychotic, and misinterpreting the actions of others. He does recognize that he is ill currently, and is agreeable to treatment (medications). He remains unpredictable in terms of aggressive behaviour due to his ongoing psychotic symptoms, and history of impulsivity."[32]

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29 Testimony of Dr. Stanley Yaren, 14 September 2017.
30 Correctional Service Canada, "Immediate Needs Identification and Referral" 29 July 2013, Exhibit 4A, Tab 15 at 1; Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 26.
31 Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 25.
32 Email from Dawn Hale to Brent Yarechewski, 13 November 2013, Exhibit 4H, Tab I08 at 2; Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 27.

Devon's mental illness was not properly considered in the review of his segregation status, resulting in Devon's continued detention in segregation

On November 18, 2013 as part of Devon's Review of Offenders' Segregated Status: Fifth Working Day Review, correctional staff stated that they had "not been advised of any concerns that would preclude continued segregation, and no concerns are noted by the Psychology Department"[33] – a statement which is difficult to reconcile with the substance of communication between the Psychiatric Liaison Nurse and the Institutional Parole Officer. Dr. Somers surmised that "this statement was evidently based on the November 15, 2013 contact by the Social Worker, but without any reference to Health Services' and psychiatry's findings, despite the inquiry by the IPO."[34]

The interactions between a Psychology Department social worker and Devon could be described as lacking. The social worker testified that she had never had any other interactions with Devon and did not know prior to meeting with him in segregation that he had been diagnosed with schizophrenia, had not been taking his medication and was experiencing active psychosis.[35] While Devon volunteered information about his mental health, diagnosis and the medication that he was taking, the social worker focused on what she characterized as anger management issues. She provided him with an anger management booklet and did not have any further interactions.[36]

In contrast, Dr. Yaren testified that he had concerns about the placement of Devon in segregation, as it would not have been conducive to recovering from psychosis. Dr. Yaren's particular concerns did not appear to have been communicated more widely[37] and a far less adequate assessment from a social worker who had never met Devon before was relied on in the course of the Fifth Working Day Review to continue Devon's segregation.

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[33] Correctional Service Canada, "Review of Offender's Segregated Status Fifth Working Day Review" 18 November 2013, Exhibit 4F, Tab 41 at 5; Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 27.
[34] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 27.
[35] Testimony of Deanna Slobodian, 11 September 2017.
[36] Testimony of Deanna Slobodian, 11 September 2017.
[37] Testimony of Dr. Stanley Yaren, 14 September 2017.

Devon did not have any other interactions with any other members of the psychology department or other mental health professionals before his death.

The death of Devon Sampson

On November 23, 2013, Devon was found in his segregation cell at Stony Mountain Institution, partially suspended by a shoelace around his neck. Correctional, health services and emergency medical personnel responded and attempted resuscitation but were unsuccessful. An autopsy concluded the cause of death was hanging.[38]

At the time of his death, there should be no question that Devon was suffering from a deteriorated mental state that included psychosis. His psychotic symptoms had been known to health care professionals within the institution for an entire month.[39] While he had resumed taking his anti-psychotic medication, he had not yet reached therapeutic levels.[40]

It should also be noted that Dr. Yaren testified that psychosis is a risk factor for suicide and individuals without medication are at a greater risk of suicide. In terms of someone like Devon who had not been taking his anti-psychotic medication, while there would be some immediate effects of restarting psychosis medication, most of the therapeutic effects (in terms of symptom management) are delayed. Psychotic symptoms could take weeks, sometimes months to abate. Dr. Yaren also observed that generally, with each relapse into psychosis, "the level of recovery tends to take longer and be less complete – people with multiple relapses get sicker and sicker, and take longer to go into remission."[41]

Dr. Yaren agreed that given Devon's history of multiple and lengthy hospitalizations (for active psychosis), Dr. Yaren would expect that Devon's mental health would deteriorate with each relapse. As Dr. Yaren opined in response to questioning around Devon's history of

[38] Office of the Chief Medical Examiner, File 1340/13, Exhibit 4.
[39] Testimony of Dawn Hale, 13 September 2017.
[40] Testimony of Dr. Stanley Yaren, 14 September 2017.
[41] Testimony of Dr. Stanley Yaren, 14 September 2017.

hospitalizations, including a stay of eight months:

> If someone has spent many months in hospital... they don't have beds growing on trees. If an individual is kept for that period of time, it would suggest to me that person is severely ill.[42]

Segregation is no treatment for mental illness

Compounding his active struggles with mental illness, Devon had been placed in administrative segregation, where he had previously been left to languish on numerous other occasions during his time in federal custody. He was also facing potential criminal charges as a result of the November 10 assault on the nurse and correctional staff were considering an increase in Devon's security rating, from medium to maximum security.[43]

While Devon was interacting with correctional staff and had some engagement with health care professionals in the days leading up to his death, his deteriorated mental state and the ongoing effects of his psychosis were not well understood by all of the correctional or health care staff involved in his care.

For example, neither of the correctional officers who were supervising the segregation range knew Devon struggled with schizophrenia, nor did they know he had not been compliant with his medication and had been dealing with the onset of psychosis.[44] They were operating under the belief that Devon had assaulted the nurse on purpose, in order to avoid certain debts.[45]

[42] Testimony of Dr. Stanley Yaren, 14 September 2017.

[43] Testimony of Brent Yarechewski, 12 September 2017; Email from Brent Yarechewski to Dawn Hale, 13 November 2013, Exhibit 4H, Tab 108 at 1.

[44] Testimony of Matthew Robinson, 18 September 2017; Testimony of Orson Rowe, 18 September 2017.

[45] The Inquests heard testimony from a number of different sources about security risks associated with debts between inmates and heard about what was referred to as a "solid check-in". Correctional Officer Robinson explained a "solid check-in" as an inmate deliberately acting in a manner that would have them removed from the range where they were experiencing difficulties. Devoid of any understanding of Devon's mental health needs, it is understandable that a correctional officer might believe that Devon's assault on the nurse was motivated by a deliberate attempt to circumvent the informal economy with the prison and avoid dealing with debts. However, it could just as easily be that Devon's symptoms of psychosis – including what Dr. Yaren and Dawn Hale described as paranoid ideation and misinterpreting the actions of others, and aggressive behaviour,

The physical health care nurse who assessed Devon on admission to segregation did not know of his diagnosis, his medication non-compliance or his psychosis.[46] Another physical health nurse who was handling segregation rounds in the days preceding Devon's death knew of his schizophrenia but was not aware of his medication non-compliance or his psychosis.[47]

The only mental health professionals who were aware of Devon's current mental state were Dr. Yaren and Dawn Hale. They saw Devon together on November 12, and Ms. Hale returned on November 13 to administer medication for Devon.[48] The information relayed by Ms. Hale to Devon's Institutional Parole Officer Brent Yarechewski and Manager of Assessment and Interventions Lee Vandenbroeck did not result in any further actions taken by correctional staff.

There was no "rallying of the troops"

As a result, the individuals tasked with regularly monitoring Devon in the days leading up to his death were operating with an incomplete understanding of Devon's mental health needs. Some professionals acknowledged had they had more information, they would have altered their approach to dealing with Devon at the time.[49] This stands in contrast to the Manager of Assessment and Interventions who suggested shortly after Devon's death that Dawn Hale's November 13 update should have resulted in a "rallying of the troops"[50] but who testified at the Inquests that a "rallying of the troops" was not really necessary and she would not have done anything differently.

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coupled with his impulsivity, poor problem-solving skills led directly to his assault on the nurse. Any temptation to debate whether inmate indebtedness or psychosis were the driving forces behind Devon's actions simply emphasize the disconnect in information available to correctional officers versus the mental health professionals, and the ongoing inability of correctional staff to appreciate the impact of Devon's mental illness on his behaviour.

46 Testimony of Kim Fines, 14 September 2017.

47 Testimony of Kelly Campbell, 18 September 2017.

48 Correctional Service Canada, "Progress Notes", 12-13 November 2013, Exhibit 4E, Tab 50 at 7.

49 See e.g. Testimony of Kim Fines, 14 September 2017.

50 Testimony of Lee Vandenbroeck, 19 September 2017. In her testimony, Ms Vandenbroeck explained that by "rallying the troops" she meant a meeting with Devon that included IPO Brent Yarechewski and someone from the psychology department.

Recommended Findings of Fact in relation to the Death of Devon Sampson

There was inconsistent knowledge, application and implementation of the Institutional Mental Health Initiative (IMHI) guidelines.

The Institutional Mental Health Initiative ("IMHI") was a mental health strategy introduced by CSC in 2009. It was created in response to an increasing proportion of offenders entering federal corrections with a mental disorder and in recognition that "the rates of suicide in CSC's prisons exceed those of the general population in Canada."[51] The IMHI was meant to represent "the implementation of 'a comprehensive mental health strategy' in response to those concerns."[52]

The IMHI recognized that Commissioner's Directive 850 (Mental Health Services) had "long required that Mental Health Teams (MHT) be established in all federal institutions to contribute to the improvement and maintenance of offender's mental health."[53]

CSC policy indicated that MHTs would have as team leader a psychologist or psychiatrist, and would otherwise be comprised of "a psychologist, nurse, institutional parole officer (IPO), a psychiatrist when necessary, and ad hoc members as appropriate".[54]

Notwithstanding the clear policy direction that individuals like Devon would have the benefit of a mental health team, there was no evidence that Devon received such care. As Dr. Somers observed, "the IMHI clearly called for communicating and meeting regularly... including [regarding] correctional planning... not only was there no mental health team, they weren't even being included on information. A mental health representative was not part of the board that

[51] Correctional Service Canada, *Institutional Mental Health Service (Primary Care) Guidelines*, 5 November 2009, Exhibit 2, Tab 6(a) at 4.
[52] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 15.
[53] Correctional Service Canada, *Institutional Mental Health Service (Primary Care) Guidelines*, 5 November 2009, Exhibit 2, Tab 6(a) at 5. See also, Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 15.
[54] Correctional Service Canada, *Institutional Mental Health Service (Primary Care) Guidelines*, 5 November 2009, Exhibit 2, Tab 6(a) at 5.

made the correctional plans for [Devon]".[55]

The IMHI did not function as intended

In answer to why there appeared to be such a significant disconnect between the IMHI guidelines and the delivery of mental health services in Stony Mountain Institution, one need only look to the lack of knowledge, application and implementation of the IMHI by those most responsible for providing mental health services to Devon.

Within Stony Mountain Institution, psychiatry services are delivered by external contract. Dr. Stanley Yaren, who has held the primary contract for psychiatry services within Stony Mountain Institution for the last 35 years, testified that he was aware of the existence of CSC guidelines but would not typically review them in great detail. He would rely on other professionals in the institution to alert him to any policy changes that he would need to take action on.[56]

Dr. Daniel Globerman was sub-contracted by Dr. Yaren to attend to 2 of the 4 half days of clinic hours in the years leading up to Devon's death. He was also Devon's treating psychiatrist at Stony Mountain Institution until approximately one month before Devon's death. Dr. Globerman testified that he had no knowledge of the IMHI; he did not know what it was and was never provided a copy of the IMHI Guidelines. He also testified that he did not know if he would consider himself part of any mental health team. If there were any team meetings, he never participated him. He did not believe there was any formal team operating within the Institution.[57]

Of the staff in the institution, it was the psychiatric liaison nurse / mental health nurse that had arguably the most treatment contact with Devon. In this case, Dawn Hale was the liaison between the internal CSC Health and Psychology departments and the psychiatrists on external contracts. Ms Hale testified that she did not believe that the IMHI was ever implemented.[58]

[55] Testimony of Dr. Kent Somers, 6 November 2017.
[56] Testimony of Dr. Stanley Yaren, 14 September 2017.
[57] Testimony of Dr. Daniel Globerman, 11 September 2017.
[58] Testimony of Dawn Hale, 13 September 2017.

It was clear from the testimony of Drs. Yaren and Globerman and Ms Hale that the psychiatrists contracted by Stony Mountain Institution were either not aware or only notionally aware of the IMHI Guidelines, and their liaison and primary contact within the Institution did not believe they had ever been implemented.

There is a significant reliance on inmate self-reporting in assessments of mental health which worked to the detriment of Devon Sampson

It was well documented that Devon was a poor historian, lacked insight into his mental illness, routinely denied the existence of his mental illness, and was otherwise routinely unreliable in any attempts at self-reporting.[59] Yet, the primary measures of ongoing mental health screening within the institution were based on inmate self-reporting.[60]

Warren Zimmerman testified that the CSC compliment of mental health assessment tools were voluntary and primarily based on self-reporting of the inmate. He stated that the intent behind the screening tools was to identify and flag people in need of service. He candidly acknowledged that whether the tools were really able to do so was an open question. It is telling that Devon screened out from requiring further psychological services based on unreliable self-reporting.

There was ample information available to the Institution concerning Devon's past-documented medical history, including his mental health concerns and diagnoses. Yet, correctional staff continually relied on Devon's own self-reporting in assessing his needs. What resulted were recurrent inaccuracies in reporting Devon's mental health concerns, particular in relation to segregation status review.

[59] See Correctional Service Canada, "Computerized Lifestyle Assessment Inventory", 30 June 2005, Exhibit 4B, Tab 111.

[60] See, e.g. the IMHI Screening Note or the Immediate Needs Checklist. Self-reporting would be inherently unreliable for someone like Devon, whose primary symptoms of schizophrenia included

There was a lack of information sharing between mental health professionals, other health care professionals, and correctional staff and that lack of information was not solely related to privacy concerns; and

Devon's incarceration was characterized by repeated reference to significant mental health concerns that did not appear to inform correctional planning for him.

A number of witnesses discussed or gave evidence that reflected the silos between corrections / case management, health care, and psychology / mental health care during the relevant time period. Dr. Somers observed that the various correctional departments were functioning with a high degree of autonomy and independence, without communicating with other departments. This also appeared to be true between CSC Institutions and had an impact on Devon as he transferred between Stony Mountain Institution and Saskatchewan Penitentiary.

There also did not appear to be processes utilized to ensure that treatment and correctional plans for individuals were made collaboratively:

> With information about Mr. Sampson's mental health needs and predicted behaviour clearly outlined through the completion of a formal mental health assessment, CSC's case management response to him is not significantly different from business as usual.[61]

A number of the correctional officers who were meant to be regularly interacting with Devon were not aware of his diagnosis of schizophrenia, his issues with medication compliance or in the last month of his life, his symptoms of psychosis.[62] Similarly, neither Devon's treating psychiatrist, nor the mental health nurse were members of his case management team and they did not have meaningful input into his correctional planning.

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[61] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 11.

[62] See e.g., Testimony of Matthew Robinson, 18 September 2017, Testimony of Orson Rowe, 18 September 2017 & Testimony of Kim Fines, 14 September 2017. IPO Brent Yarechewski had knowledge of Devon's diagnosis, but was not aware that he had not been complying with his medication regime in the 6 months prior to his death, or that he was experiencing psychosis in the month leading up to his death until he received the November 13 email from Dawn Hale.

Dr. Somers commented that:

> Of note with respect to Dr. Barbopoulos's report is that it appears to be the only in-depth assessment and explanation of his intellectual abilities, personal strengths, and areas of need with respect to his mental health and well-being. Even with that, nowhere in the documentation available to me is it conspicuous that schizophrenia has been defined or described for staff, nor is there discussion of its presumed impact on the individual or, in particular, its likely influence on that individual's stay within a correctional facility.[63]

When Brent Yareschewski (Institutional Parole Officer) was asked about his knowledge of schizophrenia and what that might mean for Devon, his answer was limited to "a sense that his mood, mood swings... he could be unpredictable."[64]

In fact, the first and only time he discussed the impact of Devon's mental illness on his overall well-being was one week prior to Devon's death, when Mr. Yareschewski reached out to psychiatric liaison nurse Ms Hale for comments on Devon's current mental health -- "Prior to that, I wasn't aware, other than file information, I wasn't aware of information psychology or psychiatric-wise."

There also appeared to be silos within the various fields of health care. Social worker Deanna Slobodian testified that in the time leading up to Devon's death, the physical health care and the mental health care providers were functioning in silos. Where Ms. Slobodian felt that there had been some recent improvements in communications – in particular that "nurses are more open to the idea that mental health and psychology are part of a team" this was not the case prior to Devon's death.

Dr. Globerman testified that Devon could have been meeting with mental health nurses and

[63] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit H at 10-11.
[64] Testimony of Brent Yarechewski, 12 September 2017.

psychology independent of meeting with him. He surmised that this could have come at his suggestion, or on the mental health nurse's own initiative, neither of which occurred in 2013.

Warren Zimmerman testified that the psychology department was not involved in Devon's treatment during his time at Stony Mountain Institution. That is not to say that there could not have been a role for psychology. For example, Mr. Zimmerman testified that there were a number of different interventions that psychology could offer someone with schizophrenia. Psychological treatment might be used in helping an individual with coping and learning new skills (psychological and social skills), and self-management. According to Mr. Zimmerman there were a wide variety of treatment options available.[65]

A well-functioning team approach -- between correctional and healthcare staff, and between mental and physical health service providers, may have also helped to address some of the privacy-related concerns that appeared to impede the treatment and correctional planning for Devon.

Exclusive reliance on medication as a treatment tool

In his testimony, Dr. Somers emphasized the necessity for cooperation between different departments in the treatment of individuals. With reference to the IMHI, he stated that "it seems clear that if someone is intensive or moderate, that psychology were among the leaders of the Mental Health Team. I see no evidence of the prescription that CSC made for itself; there are big gaps in CSC's services."[66]

Dr. Somers went further to highlight in his written report that:

> The ongoing assumption in case management and security reporting evident in Mr. Sampson's file material otherwise appeared to be that Health Services was

[65] Testimony of Warren Zimmerman, 13 September 2017.
[66] Testimony of Dr. Kent Somers, 6 November 2017.

> attending sufficiently to his "mental Health" needs, and that the concern of case management was merely (and sufficiently) that he was medication dependent, rather than that he was, more fundamentally, schizophrenic. However, treatment of Mr. Sampson's "intensive needs", according to CSC's IMHI Guidelines, was to occur "within a strongly integrated and coordinated approach linking all CSC staff involved" (page 6 of the 2009 Guidelines). Medication can be a reasonable and prudent component of mental health treatment but the repeated reference to it as though it were the only intervention required reveals a systemic neglect of the more extensive implications that the diagnosis of schizophrenia ought to communicate.[67] (emphasis added)

The lack of information sharing between departments was a symptom of the "silos" that had developed within CSC. The result was that corrections / case management were left without an adequate understanding of Devon's mental health needs and CSC made decisions based on the assumption that Devon's needs were attended to by a medication regime supervised by a psychiatrist.

One of the problems inherent in relying solely on a medication regime to address the mental health needs of an individual arises when that individual is regularly non-compliant with their medication regime, as Devon was.

Knowledge of and response to Devon's issues with medication compliance was limited to his treating psychiatrist (external) and Stony Mountain Institution's mental health nurse. There was no knowledge of or involvement from correctional staff or Devon's own Case Management Team.

Prior to Devon's final stay in Stony Mountain Institution, Saskatchewan Penitentiary had identified a need for Devon's Case Management Team to assist in monitoring medication

[67] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 34-35.

compliance and intervening if compliance became an issue.[68] This aspect of Devon's correctional plan contemplated an active role for correctional staff to assist in necessary aspects of Devon's treatment of his mental illness.

Back at Stony Mountain Institution, Mr. Yarechewski became Devon's Institutional Parole Officer on July 2, 2013. He testified that he wasn't aware of previous plans for case management team involvement and later updates to the correctional plan removed any mention of this expectation. Mr. Yarechewski testified that he believed that ongoing monitoring would be the responsibility of health services. He was not informed that Devon had not been compliant with his medication regime until after Devon assaulted the nurse in November 2013.

CSC had specific information sharing guidelines in place, however Ms. Hale testified that she was not familiar with them.[69] The guidelines contain examples of common information sharing dilemmas, including one in which a Parole Officer responsible for an inmate asks about the mental health status of an inmate.

Where the information guidelines suggested that a nurse would be able to provide a Parole Officer with information about an inmate's diagnoses resulting behaviour, Ms. Hale's testimony was that this was not consistent with her own understanding of what personal health information she could share. She did not agree with the recommended course of action from the guidelines. that if applied to Devon's situation would have led to more relevant and earlier coordinated communications between the mental health care professionals and Devon's Parole Officer.[70]

The fact that Devon was not taking his medication, which could and did lead to him experiencing psychosis was never specifically flagged for correctional staff who were responsible for Devon's care.

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68. Correctional Service Canada, "Correction Plan Updated", 8 April 2013, Exhibit 4B, Tab 93 at 7.
69. Testimony of Dawn Hale, 13 September 2017; Correctional Service Canada, *Guidelines for Sharing Personal Health Information*, October 2013, Exhibit 2, Tab 7(a).
70. Testimony of Dawn Hale, 13 September 2017; Correctional Service Canada, *Guidelines for Sharing Personal Health Information*, October 2013, Exhibit 2, Tab 7(a).

When segregation is available, it is too often used as a default.

As Dr. Somers observed: "In the matter of Mr. Sampson's death, it appears that CSC found itself at the limits of what it knew how to do..." In particular, he observed that the use of administrative segregation in response to Devon's assault on a nurse was "less than fully human and respectful of Mr. Sampson's needs as a person with "intensive needs", and more to the point it is not appropriate or sufficient as a treatment for schizophrenia."[71]

A more blunt assessment could be found in the testimony of correctional officer Matthew Robinson, who described the segregation unit as "the worst unit in the institution." When asked to explain how it was the worst, he simply said "think about being locked in a cell for 22 hours [a day]."[72]

When asked if he had any concerns about Devon's placement in segregation (immediately proceeding his death), Dr. Yaren testified:

> In general, individuals exhibiting severe mental illness, including psychosis, I wouldn't view segregation to be ideal placement because they are in a situation where the lack of stimulation and other factors, isolation itself, can aggravate the symptoms.
>
> In Mr. Sampson's case, I don't have a direct memory. He seemed settled, but in any case, I am sure <u>my assessment recognized the correctional officers' decision to place him</u> [in segregation]. It would have been safety concerns given his recent behaviour.
>
> <u>Yes, I would have had concerns, that is not ideal place for him to recover. ideally psychosis should be in a supported environment; more opportunity to</u>

[71] Dr. Kent Somers, "Re; Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 36.
[72] Testimony of Matthew Robinson, 18 September 2017.

> interact with professional staff to get them through it. (emphasis added)

When asked whether he was aware of Devon's cumulative history and repeated stays in segregation, Dr. Yaren testified that:

> I don't recall. I may or may not have been, but it wouldn't have made much difference. Corrections staff made the decision on where he was placed based on – and I am assuming the reason – safety of the individual and other individuals... trumps mental health. (emphasis added)

This feeling that security would trump mental health concerns was corroborated by Dr. Stuart Toews who testified that when he was starting at Stony Mountain Institution in 2011 and learning to understanding the processes, that:

> you seem to realize there is a hierarchy of decision-making and security trumps all. At some point, mental health services was low on the hierarchy of decision making power. (emphasis added)

The idea that "security trumps treatment" was also identified in a 2010 report prepared for the Office of the Correctional Investigator, within a section of the same name. Report author John Service (PhD) recognized that "security and mental health treatment are not polar opposites. In fact, the latter can aid the former...".[73]

The Office of the Correctional Investigator has also identified segregation as an independent risk variable in terms of suicide:

> A major finding of this review, one that is repeatedly supported by the literature, is that suicide rates in prisons are more prevalent in physically

[73] Office of the Correctional Investigator of Canada, *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's 'Mental Health Strategy'*, by John Service, (Ottawa: Office of the Correctional Investigator of Canada, 2010), online: <www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20100923-eng.pdf> at 38.

> isolated cells (segregation, observation and mental health cells) than in general population cells. The literature is also clear that physical isolation and separation increase the risk of suicidal behaviour. Placement of a mentally disordered inmate in segregation or in an observation or special suicide-resistant cells has both perceived and actual punitive aspects... As this Office has long advocated, long-term segregation of mentally disordered inmates or those at risk of suicide or serious self-injury should be prohibited. Such a prohibition would be more consistent with existing policy on managing suicide risk than the status quo.[74] (emphasis added)

In Devon's case, he was essentially parked in segregation following his assault of a nurse, with limited regard for his mental health status at the time he was segregated and in context of the possibly-related reasons for the assault. He was without many of his belongings and was waiting to hear more about "his situation" and what would happen to him next.

Mr. Yarechewski testified that it would have been an institutional goal to make a placement decision concerning Devon within 30 days.[75] This suggests that administrative segregation was being used as a default to allow for bureaucratic processes to take place as opposed to being responsive to the immediate needs of the inmate. It should be noted that Devon was not placed in segregation for disciplinary reasons, which would have attracted far more stringent oversight of his placement, as compared to administrative segregation.

There is also additional independent support for the proposition that administrative segregation has too often been used as a default. In the Office of the Correctional Investigator's 2014-2015 Annual Report, the Correctional Investigator said:

> For more than 20 years, the Office has extensively documented the fact that

[74] Office of the Correctional Investigator of Canada, *A Three Year Review of Federal Inmate Suicides (2011 – 2014)* (Ottawa, Office of the Correctional Investigator of Canada, 2014), online: <publications.gc.ca/collections/collection_2014/bec-oci/PS104-11-2014-eng.pdf> at 15-16.

[75] Testimony of Brent Yarechewski, 12 September 2017.

> administrative segregation is over used. With an average daily inmate population of just over 14,500 the CSC made 8,300 placements in administrative segregation in 2014-15. On April 1, 2014, there were 749 offenders in administrative segregation. There is no escaping the fact that administrative segregation has become the most commonly used population management tool to address tensions and conflicts in federal correctional facilities. During the reporting period, 27% of the inmate population experienced at least one placement in administrative segregation. It is so overused that nearly half (48%) of the current inmate population has experienced segregation at least once during their present sentence.[76] (emphasis added)

There was a lack of robust mental health training for front-line staff

While many witnesses testified to regularly receiving suicide prevention training from CSC, there was quite a bit of disagreement about the breadth of the training available to staff. A correctional officer had what might be characterized as the most generous description of mental health training. He said it was broad, and that staff "learn how to treat people with mental health issues basically, to look for signs of people in distress so we can get mental health people in to deal with it." He also seemed to recall that the training was either a 4 or 8 hour course held every year in-person.[77]

More consistently, witnesses described mental health training that was limited to suicide prevention training that was in-person every 2-3 years, and otherwise provided as an online "refresher" course annually.[78] There was no other mental health training – no mental health first aid or broader training around recognizing the signs of mental ill health.

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76 Correctional Investigator of Canada, *Annual Report of the Office of the Correctional Investigator 2014-2015*, (Canada: Ottawa, 2015) at 26, online: <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20142015-eng.pdf>.

77 Testimony of Orson Rowe, 18 September 2017

78 See e.g. Testimony of Brent Yarechewski, 12 September 2017; Testimony of Matthew Robinson, 18 September 2017; Testimony of Peter Gibson, 7 September 2017; Testimony of Kelly Campbell, 18 September 2017.

Peter Gibson described a "small amount" of training which provided that if you observe something "bizarre" you write it down – training to observe and report unusual behaviour and to let a mental health professional know. Whether this regularly happened in practice was not apparent from Devon's correctional file. Matthew Robinson could not recall if he had ever received any other mental health training, or if he ever learned any of the signs and symptoms of mental ill health. This suggests that front-line staff are not adequately equipped to deal with the mental health needs of the inmates in their care. It also suggests that they may not have the necessary training to identify when assistance from mental health services within the Institution may be required.

For a population with as many mental health needs as suggested in the rationale for the IMHI, one might expect that in addition to suicide prevention training, front-line staff should be adequately trained by formally qualified professionals (as opposed to peer-to-peer training) in mental health first aid, recognizing the signs and symptoms of mental ill health, and in trauma-informed care. These are all hallmarks of best practice in mental health training.

Outside of the Mental Health / Supportive Living Range, there is limited intermediate interventions available for someone who does not meet the certification requirements for involuntary placement at the Regional Psychiatric Centre, but who remains within general population with a serious mental illness.

While the Inquests heard that additional and more intensive mental health supports were made available to inmates who were placed on the Mental Health / Supportive Living Range, there were a number of reasons why an inmate might not be able to or want to be placed on this range.

First, it should always be understood that the range is bed limited – Dr. Toews testified that there are 22 beds available for moderate intensity intermediate care within the range. While not every inmate with mental health needs will require the intermediate support available on the Mental

Health / Supportive Living Range, contract psychiatrists carried a patient load of 120 inmates which suggests that need for intermediate level supports may outpace the availability of a bed on the range required to access such supports.

Secondly, as it relates to Devon's specific experiences, during a 2010 re-admission, staff were advised that Devon "specifically requested not to be placed on the Supportive Living Range" however, Devon had in fact explained that the last time he had been on the unit, "he was muscled for all of his food."[79] Not wanting to return to a range where one is in danger of losing all their food seems to be an entirely reasonable response to security issues within the range that may not have been appropriately managed by correctional staff.

There were also reports of a significant amount of drug activity on the range, including an inmate who had "threatened every person on the range at some point, muscling them for their medication." Another inmate was sexually assaulting inmates on the range. An informant also advised that an inmate had punched Devon in the head and someone (identities redacted) threw urine and feces on Devon.[80]

Mr. Yarechewski agreed that it was possible to need mental health supports despite being placed somewhere other than the Mental Health / Supportive Living Range. He also testified that while he canvassed placement on the range with Devon once, he did not canvas the placement with Devon again at any subsequent time.[81] It is also reasonable to infer that there may be some stigma associated with placement there, recalling that Devon routinely denied the severity or even the existence of his mental illness.

There is also no evidence to suggest that any correctional or health care staff considered an involuntary placement on the Mental Health / Supportive Living Range for Devon (which, according to questions posed by Inquest Counsel, could have been done for a period of up to 30 days).

[79] Email from Melissa Burns to Delaine Figur, 12 April 2010, Exhibit 4E, Tab 02.
[80] Kim Spiers, "Officer's Statement/Observation Report", 6 March 2008.
[81] Testimony of Brent Yarechewski, 12 September 2017.

The services and care available to inmates on the Mental Health / Supportive Living Range exceeded that which was available to inmates placed in general population ranges. For example, Mr. Yarechewski confirmed that Devon would not have had access to a "mental health primary" because he wasn't placed on the Mental Health / Supportive Living Range.[82]

Mental Health Services within the institution were under-resourced at the time of Devon's death.

There is a strong need for mental health supports within federal prisons. The IMHI Guidelines speak to a prevalence of mental disorders higher in the prison population than the general population.[83] This was consistent with Ms. Hale's own experiences as the Psychiatric Liaison Nurse and one of the Mental Health Nurses within Stony Mountain Institution.

The Inquests heard that there were approximately 800 inmates at Stony Mountain Institution (including both medium and maximum security) and the adjacent minimum-security prison (Rockwood Institution) that could potentially require health care services.

Both Ms. Hale and Dr. Yaren testified that there were approximately 120 inmates who required regular psychiatric care.[84] At the time of Devon's death, Dr. Yaren and Dr. Globerman split 4 half-day clinics per week to provide care for these approximately 120 inmates. Since that time, Dr. Yaren testified that psychiatry services has been "reduced to two half days and the populations' needs haven't gotten smaller, so we have been even further diluted."[85]

There was agreement among a number of witnesses well-placed to appreciate the mental health needs of inmates that more resources were required. For example, Ms. Hale testified that there

[82] Testimony of Brent Yarechewski, 12 September 2017.
[83] Correctional Service Canada, *Institutional Mental Health Service (Primary Care) Guidelines*, 5 November 2009, Exhibit 2, Tab 6 at 4.
[84] Testimony of Dawn Hale, 13 September 2017; Testimony of Dr. Stanley Yaren, 14 September 2017.
[85] Testimony of Dr. Stanley Yaren, 14 September 2017.

were cuts away from mental health services that redirected resources back into medical (or physical) health. She also testified to roster changes that resulted in a reduction of available mental health services.

It is reasonable to conclude that this would have impacted the level of care provided to inmates. This was supported by parole officer Josh Beatty's testimony that it would be advantageous to have more resources in order to have an increased level of care for inmates.

Dr. Stuart Toews, the current Co-Chief Psychologist for Stony Mountain Institution, testified that at the relevant time period while he was a psychological associate, staff were "stretched very thin" and it was "difficult to manage day-to-day services".[86]

Staffing shortages of mental health service providers within the institution were also identified as particularly difficult to manage. For example, there were only 2 mental health nurses and one position was only part-time. This was in contrast to at least a dozen physical health nurses.[87]

Mental health nurses could be asked to cover for physical health nurses, but the converse was not true. If mental health nurses were asked to provide physical health services, mental health services would be left short staffed.[88] There was no coverage for mental health nurses for sick or vacation leave and there were frequent staff shortages especially around vacation leave.[89]

Staffing within mental health services had been an ongoing issue prior to 2013. In reflecting upon his previous experiences as Chief Psychologist at Stony Mountain Institution, Dr. Somers testified that routine staff turnover within the psychology department was a constant struggle. He described a very limited number of staff available to do the wide variety of services that were necessary. He also testified that at one time, he petitioned senior management in order to have the number of staff that would be required to fulfill the requirements of relevant Commissioner's

[86] Testimony of Dr. Stuart Toews, 7 November 2017. Dr. Toews also testified that where Stony Mountain Institution was previously working with 7-8 psychological associates, there are now 17.
[87] Testimony of Dawn Hale, 13 September 2017.
[88] Testimony of Dawn Hale, 13 September 2017.
[89] Testimony of Dawn Hale, 13 September 2017.

Directives and in Dr. Somers' words "it was a number that we had never come close to having."

Devon's circumstances at the time of the assault on the nurse and his final placement in segregation called out for a response that recognized his mental illness and all of the potential concerns with which he presented.

According to the testimony of Dr. Somers:

- "[Devon's] placement in segregation might have contributed [to his death]. As an individual who did not have good insight to his own illness, he was not a good advocate, he was not one who could acknowledge what was going on. Being in segregation would further remove him from supports that he required."

- "He was not an active participant in his own treatment. So to have him removed from routine observation – that he is becoming agitated, lethargic, any of these presentations might have been observed by someone with a training to observe and diagnose this with schizophrenia. The brief interactions in segregation are not suited to diagnosing."

- Asked by Inquest Counsel how Psychology could have been more involved re Sampson after segregation, Dr. Somers explained that "the error is that people [from the psychology department] are not treating him. If the treatment is to provide him with a self-help book and say "That is what I have to offer you" that is entirely insufficient. A large part of the challenge is resources."

- "The emphasis of having a Mental Health Team is so the Institutional Parole Officer is working in concert, deliberating with psychology, security; that this individual is going into segregation, should have been a great topic of discussion among staff. I didn't see evidence of that. The view was that he was seen by healthcare and that seemed to be sufficient. The IMHI Guidelines say otherwise. CSC says that – even in segregation.

Being in segregation should have been a flag for treatment."

- "Had all the pieces been connected – he is psychotic, he is seeking out the inmate welfare committee, the psychiatric nurse, he is back in segregation, any untoward behaviour could have, or should have been a flag. For me it goes back to the IMHI – they have an initiative for a team. Staff might have said, he's blocked his window, should we be concerned about that, and they could have consulted the team."

Dr. Somers and Dr. Yaren both agreed that segregation is not an appropriate tool for dealing with mental illness. They also agree that Devon should have been in a more supportive environment in order to meaningfully deal with his psychosis.[90]

The core messages of these Inquests, and in particular the Sampson Inquest, are mirrored in the ruling in *British Columbia Civil Liberties Association v Canada (AG)*.

It is also worth noting that in the recent class action lawsuit challenging the use of administration segregation in federal prisons, the Supreme Court of British Columbia considered the expert testimony tendered at trial and found that in practice, the mental health monitoring and supports that are in place for segregated inmates were "simply not up to the task".[91]

The Court found that segregation has serious adverse effects on inmates with mental illnesses, such as self-harm, suicide, and a significant worsening of mental health issues that in some cases continued after segregation ended. As a result, it was held that the impugned laws failed to respond to the actual capacities and needs of mentally ill inmates and instead imposed burdens in a manner that had the effect of reinforcing, perpetuating or exacerbating their disadvantage, and were therefore a breach of s.15 of the *Charter*.[92]

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[90] Testimony of Dr. Kent Somers, 6 November 2017; and testimony of Dr. Stanley Yaren, 14 September 2017.

[91] *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62 at para 521.

[92] The impugned laws were also found to be a breach of s. 7 of the Charter, however the more particular issues around the effects of administrative segregation on mentally ill inmates was a more prominent feature of the s. 15 analysis.

There are a number of findings of fact made by the judge in the *British Columbia Civil Liberties Association v Canada (AG)* ("*BCCLA*") case that are exemplified by Sampson's experiences within federal corrections. For example:

- Before an inmate is admitted to administrative segregation, a consultation will occur with the inmate's case management team, using a Segregation Assessment Tool ("SAT") which is a structured series of questions that determine whether segregation is recommended. This tool ensures that admission is justified and that all alternative options have been considered.[93]

- During the health care consultation, the health professional will meet with the inmate to determine if there are mental or physical health needs or concerns, including administering a Suicide Risk Checklist.[94]

- The Suicide Risk Checklist does not necessarily draw out the information it seeks and the results depend greatly on the inmate's relationship with the person asking the questions. If the inmate is not comfortable or believe that the answers to certain questions will land them in trouble or in segregation, they may not be as forthcoming.

- Although the SAT lists alternatives to segregation such as mediation with other inmates or inmate committees, contacting elders or Aboriginal liaison officers, assisting inmate to have contact with family members, or transferring inmates to other ranges, institutions or regions, in practice, transfers are onerous and bureaucratic processes that are not administered in a timely manner.[95]

- In effect, inmates placed in segregation have limited access to programming and meaningful human contact.[96]

[93] *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62 at para 89.
[94] *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62 at para 90.
[95] *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62 at paras 102-109.
[96] *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62 at paras 123-153.

- Although the average duration of placements in segregation has declined in recent years, unlike disciplinary segregation which is capped at 30 days, there is no time limit on administrative segregation and some inmates continue to remain in segregation for very lengthy periods.[97]

- The Court accepted the Plaintiff's expert evidence that administrative segregation as enacted by s. 31 of the *Corrections and Conditional Release Act* is a form of solitary confinement that places all Canadian federal inmates subject to it at significant risk of serious psychological harm, including mental pain and suffering, and increased incidence of self-harm and suicide. The risks of these harms are intensified in the case of mentally ill inmates. However, all inmates subject to segregation are subject to the risk of harm to some degree.[98]

- The indeterminacy of administrative segregation exacerbates the adverse effects. Further, negative health effects can occur after only a few days of segregation and while many of the acute symptoms may subside after termination of segregation, many inmates suffer permanent harm.[99]

These findings are particularly relevant in Devon's circumstances because while he had not been in segregation for very long at the time of his death, he had a history of lengthy/indefinite placements. There was no evidence to suggest that this would not also become a lengthy placement.

That the findings in January 2018 decision of the Supreme Court of British Columbia so closely mirror the circumstances around administrative segregation relating to the death of Devon suggests CSC has not been able to meaningfully address challenges associated with the use of administrative segregation and treatment of individuals with mental illness in the prison system.

97 *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62 at paras 154-159.
98 *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62 at para 247.
99 *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62 at paras 247-255.

Opportunities in Preventing Future Deaths

In considering the tragic circumstances of the death of Devon Sampson, it is important to also consider whether there are any lessons learned that could provide opportunities in preventing future deaths. JHSM and CMHA have identified 5 potential areas of opportunity for both the court and CSC to consider as we move forward:

1. **Independent Review**

The circumstances of Devon's death exemplify the need for independent review of the laws and policies relating to administrative segregation and the treatment of mental health in prisons, as well as periodic independent compliance with relevant laws and policies. In addition, the current legal landscape around the use of administrative segregation and the mental health needs of inmates within jails and prisons in Canada is in a complete state of flux. In what could also be described as a highly volatile environment, mixed messages abound as to whether there can be real progress made in meeting needs of inmates in federal prisons.

The federal government has introduced Bill C-56 aimed at changing the operations of administrative segregation and CSC has made a number of related policy changes around the use of administrative segregation.[100] At the same time, the federal government has filed an appeal of the Supreme Court of British Columbia's ruling that the federal laws around administrative segregation[101] were unconstitutional and could not be reasonably justified in a free and democratic society.[102]

The federal government is making tweaks to laws and policies that still serve to maintain a status quo of total institutional discretion without any attendant accountability. These laws (if passed)

[100] *An Act to amend the Corrections and Conditional Release Act and the Abolition of Early Parole Act*, 1st Sess, 42nd Parl, 2017, cl (f), (first reading 19 June 2017). See also, for example, Commissioner's Directive 709 effective 1 August 2017.

[101] In particular, sections 31-33 and 27 of the *Corrections and Conditional Release Act*, SC 1992 c 20, authorizing administrative segregation.

[102] *British Columbia Civil Liberties Association v Canada (AG)*, 2018 BCSC 62. The declaration of invalidity was suspended for 12 months. The Attorney General of Canada's appeal was filed on February 16, 2018.

and policy changes fly in the face of the ultimate findings of the British Columbia trial court that the federal correctional system is putting the health of prisoners at risk in a manner that is constitutionally indefensible. This suggests a need not to wait for or blindly trust in government, but rather reinforces the need for independent review and external accountability.

(a) Best Practices regarding Legislative and Policy Reforms

Emerging best practices suggest that administrative segregation should never be used, or at the least never used for persons with serious mental illnesses (including schizophrenia).[103]

While a number of recent policy amendments from CSC appear to be aimed at reducing the use of administrative segregation on persons with serious mental illnesses, concerns remain about whether these amendments go far enough to protect the rights of inmates with serious mental illnesses. The recent amendments do not address concerns around CSC's own history of an inadequate implementation of significant policy changes with the institutional setting.

The federal government has ignored repeated calls to reform its use of administrative segregation, including calls to place strict limits on time in segregation (from the 1996 Arbour Inquiry) and calls to prohibit use of administrative segregation for the seriously mentally ill (a longstanding recommendation from the Correctional Investigator, with similar recommendations from the high-profile inquest into the death of Ashley Smith also dismissed).

Both CSC and the federal government more broadly have also shown a resistance to change at the legislative level. For example, the recent appeal of the British Columbia Supreme Court's ruling in *BCCLA v Canada* suggests a continuing disconnect between CSC's stated intentions in its policy changes with CSC and the federal government's actual practices.

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[103] See, e.g. Office of the Correctional Investigator of Canada, *A Three Year Review of Federal Inmate Suicides (2011 – 2014)* (Ottawa, Office of the Correctional Investigator of Canada, 2014), online: <publications.gc.ca/collections/collection_2014/bec-oci/PS104-11-2014-eng.pdf> and Morgan et al, "Quantitative Syntheses of the Effects of Administrative Segregation on Inmates' Well-being," Psychology, Public Policy, and Law, 22(4), 2016, pp. 439-461.

(b) Compliance with existing laws and policies

While the state of the law around the use of administrative segregation is currently in flux, these Inquests have also shown that CSC has serious issues around the implementation of and compliance with existing correctional policies.

When segregation is available, many prison officials do not look for other ways to solve problems. There need to be fixed and effective controls on practices and policies that are always at risk of abuse.

Some form of improvement may come with the June 2017 introduction of the Integrated Mental Health Guidelines, which promises more effective and appropriate services for individuals with mental disorders who are housed in federal correctional settings.[104] However, as Dr. Somers observed, the IMHI guidelines introduced in 2009 were similarly laudable but "were not enacted sufficiently" and there is "no stated mechanism or policy within the new Guidelines to ensure that they are implemented."[105]

The misuse of administrative segregation and the lack of meaningful integration in mental health services has led to preventable death and suffering. Ensuring compliance with existing policies is a stepping stone towards ensuring a continuous model of improvement, organizationally.

In making these submissions, JHSM and the CMHA acknowledge that a Board of Investigation was conducted and a report with recommendation produced as a result.[106] While CSC repeatedly took the position that the Board of Investigation report was not relevant to these Inquests, the parties ultimately agreed that the report could be tendered as an exhibit under seal. CSC also put forward a witness to discuss the Board of Investigation process and the internal CSC response to these investigations as it related to both Devon Sampson and Dwayne Flett.[107]

[104] Correctional Service Canada, *Institutional Mental Health Service (Primary Care) Guidelines*, 5 November 2009, Exhibit 2, Tab 6(a)
[105] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at 38.
[106] Exhibit 8 (Sealed).
[107] Testimony of Kory Abrams, 8 November 2017.

The Board of Investigation consists of CSC employees and a community member selected and appointed by CSC. When the Board of Investigation makes recommendations, it is up to CSC as to whether those recommendations will be "supported".[108] There was also inconsistent evidence throughout the Inquests as to how the results of the Board of Investigation are communicated to staff who are either involved in the investigation or who may be implicated in certain recommendations arising from the Board of Investigation.

The Board of Investigation is ultimately a CSC process that is hardly independent and is shrouded in secrecy. It is of limited use with respect to the important considerations of transparency and accountability to the broader public in the wake of prison deaths.

Based on past practices, missed opportunities, and ongoing resistance to change, it is necessary to increase the measures of accountability and transparency within CSC by looking to subject-matter experts, like JHSM and CMHA, to provide an adequately resourced[109] and independent review from both a best practices and compliance-based perspective.

Any compliance reviews will be conducted 1 year following the introduction of new or changes to existing policies around administrative segregation and/or mental health services, with periodic reviews (at least every three years) thereafter.

Key Features:

- **Independent and adequately resourced review;**
- **1 year following introduction of new policies or amendment to existing policies in relation to administrative segregation and/or mental health services; and**
- **Periodic reviews (at least every three years) thereafter.**

[108] Testimony of Kory Abrams, 8 November 2017.
[109] Being adequately resourced includes, but is not limited to, having a budget that allows for independently contracting with those completing the review and other attendant subject matter experts.

2. Integration – Cooperation – Coordination

Even after the IMHI was implemented nationally, prior to Mr. Sampson's last federal sentence, its guidelines did not appear to inform correctional or clinical practice within Stony Mountain Institution at the time of Devon's death.

It should be clear from the evidence the clear communication and explicit partnership between Case Management, Security, Psychology / Institutional Mental Health, and Health Services as per the IMHI Guidelines was not evident in the experiences of Devon Sampson leading up to his death.

Devon's incarceration was characterized by repeated reference to significant mental health concerns that did not appear to inform correctional planning. There were also obvious gaps in the implementation of IMHI and no evidence on why it was not championed within the institution.

There did not appear to be any processes in place to ensure that treatment and correctional planning occurred in a coordinated manner and that decisions were made collaboratively among relevant professionals. A consequence of a lack of coordination is that CSC staff responsible for the care of an inmate do not have all of the necessary information to review or assess all of the potential concerns that may arise with an inmate.

Integration, cooperation and coordination are all features of "wrap-around supports" as an appropriate model of care.

Wrap-around supports is a model of care with a defined assessment and planning process which builds on strengths and considers many life factors including physical health, mental health, addictions, culture, spirituality, support systems, recovery goals etc. The approach is team-based, collaborative, culturally responsive, individualized, trauma-informed, person-centred and recovery-oriented.

While some of the features of wrap-around supports are picked up in the assessment and planning tools used by CSC, the use of a trauma-informed, person-centred and recovery-oriented model of care is largely lacking.

Ensuring that privacy concerns do not impede treatment of inmates

In calling for more integration, coordination and cooperation among those responsible for inmates' health, safety and security, it is important that privacy concerns do not impede the necessary treatment and care of inmates. There is a very important balancing act that must occur around an inmate's right to privacy and the need for those who are responsible for correctional planning and/or have the most substantive or regular contact with an inmate to have information necessary for the safe and effective discharge of their duties and responsibilities.

Mental health care professionals – and all those who work in health care – must be trained to interpret privacy laws and regulations in an ethically robust way. It needs to be recognized that laws, regulations, and policies are often complex (rather than straightforward), sometimes contradictory, and require active interpretation and an ability to parse complex ethical questions. This is especially the case when inmates do not grant consent to share information more widely, but where it may be in the best interest of the inmate's health or safety to do so.

One example of best practice frameworks is Slade et al's 2007 "Framework for best clinical practice when consent is not given to share information with carers"[110] which could be adapted to reflect that a number of levels of correctional staff (correctional officers, correctional managers, institutional parole officers, managers of assessment and intervention, etc.) are part of a "carer" network when the patient is an individual who is incarcerated and not all would require the same level of patient health information for an inmate.

Information needs to be shared with the appropriate individual in the circumstances, in a manner

[110] Mike Slade et al, "Best practice when service users do not consent to sharing information with carers: National multimethod study", (2007) 190:1 British Journal of Psychiatry 148-155.

that respects an inmate's right to privacy and does not make them more vulnerable within the institution.

Key Features:

- **Level of integration, coordination, and cooperation between the various departments as it pertains to correctional and treatment planning; and**
- **Assessed within compliance review, as above.**

3. External Accreditation

As part of ensuring greater institutional accountability and a measure of independent oversight, Stony Mountain Institution should work to receive external accreditation, akin to a hospital or treatment centre. The importance of external accreditation is outlined in Dr. Somers report.[111]

Dr. Toews testified that an accreditation is currently underway regarding physical health care services – mental health cares services, not limited to psychiatric services, should be similarly accredited.[112]

This is also consistent with the key findings in *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's 'Mental Health Strategy'* where it was recognized in 2010 that "[a]ccreditation is important across the continuum of care and needs to be achieved as soon as possible for all of CSC's mental health services."[113]

It should also be recognized that while external accreditation is important, it does not automatically ensure that an organization is built to operate on a continuous model of improvement.

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[111] Dr. Kent Somers, "Re: Inquest in the death of Devon Sampson", 9 September 2017, Exhibit 11 at page 37.
[112] Testimony of Dr. Stuart Toews, 7 November 2017.
[113] Office of the Correctional Investigator of Canada, *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's 'Mental Health Strategy'*, by John Service, (Ottawa: Office of the Correctional Investigator of Canada, 2010), online: <www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20100923-eng.pdf> at 55.

Both measures are required to ensure the effective delivery of mental health care services.

Key Feature:

- **External Accreditation for mental health services; and**
- **Commitment to continuous model of improvement.**

4. Start with the presumption of mental health needs / active consideration of mental illness in correctional planning / augmented mental health services

CSC has recognized that there is a high prevalence of mental health needs within the inmate population, as compared to the general population. Rates of suicide within prisons also exceed those of the general population in Canada.[114]

At the same time, testimony revealed that attending to the mental health needs of inmates is low on the hierarchy of priorities within the institution. Also concerning were the comments from more than one doctor that suggested their professional opinions were not considered relevant by institutional decision-makers when it came to addressing what the institution perceived as a security concern.

A recognition that mental health issues and security concerns are not two separate watertight compartments is required in order for a better balancing of concerns to occur. Devon's death in an almost perfect illustration of the idea that if an institution does not appropriately attend to inmate's mental health needs it can quickly become a security risk – to both the inmate and the institution.

There is a need to recognize the reality of the population served by CSC and a need not to treat mental health as an afterthought. Instead, mental health care is an integral element of meeting the

[114] Correctional Service Canada, *Institutional Mental Health Service (Primary Care) Guidelines*, 5 November 2009, Exhibit 2, Tab 6(a).

needs of the inmate and an essential element of promoting a safe and secure institution.

In order to place the appropriate level of priority on the mental health needs of inmates, augmented mental health services will need to be provided.

There are a number of ways of doing so. For example:

- better mental health assessment tools should be used to provide a more robust analysis of inmate needs, and one which did not rely primarily on self-reporting (which can be fundamentally unreliable);

- mental health professionals who have access to the past documented histories of inmates should have a more prominent role in screening and placement decisions, providing a greater likelihood of consistent reporting of mental health concerns;

- staff responsible for the care and supervision of inmate with mental health concerns should be provided with a more complete / integrated representation of the individual in their care; and

- for more acute concerns, mental health services and programs should be provided within a psychiatric hospital wing of a prison in order to meet the therapeutic needs of the individual. This is different than the already existing Mental Health / Supportive Living Range, and could be one way of addressing some of the gaps in service that exist for inmates with serious mental illnesses who are housed outside of the Mental Health / Supportive Living Range.

At the same time as augmented mental health services are considered, it is necessary to ensure that current staff are properly resourced. Testimony revealed that there are frequent staff shortages as it related to mental health services and that psychiatry services had been cut without

what appeared to be a concomitant decrease in inmate needs.[115] There was a recognition from a number of witnesses that an increase in resources would be required in order to adequately meet the mental health needs of inmates.

Key Features:

- **recognition that good mental health practices and mentally healthy inmates are integral to institutional security;**
- **appropriately resourced mental health staff at levels that meet the actual mental health needs of inmates;**
- **improved mental health assessment tools that do not rely primarily on self-reporting;**
- **increased role for mental health professionals in screening and placement decisions;**
- **provision of complete/integrated information of inmate to staff responsible for care and supervision; and**
- **meeting therapeutic needs in a therapeutic setting like a psychiatric hospital wing.**

5. Enhanced mental health training for staff

There is a need for more robust mental health training for front-line staff to better meet the needs of inmates. Most correctional staff testified that their training was limited to suicide prevention and witnesses varied in their ability to explain what they had learned in their training. One witness summed up his training as essentially, if you see something "bizarre" you write it down so mental health care professionals can deal with it.[116] Other witnesses were clear that they had not received any training in recognizing the signs and symptoms of mental ill health, beyond the training they received in relation to suicide prevention.

Arguably, the standard of mental health care should be more robust than simply preventing

[115] Testimony of Dawn Hale, 13 September 2017; and testimony of Dr. Stanley Yaren, 14 September 2017.
[116] Testimony of Peter Gibson, 7 September 2017.

death. A person's right to life also includes a right to be mentally healthy.

In order to ensure that staff are adequately trained to encourage and support an inmate's mental health needs, all direct care staff should receive augmented and mandatory training in mental health first aid, suicide prevention, recognizing the signs and symptoms of mental ill health, and in trauma informed care.

Key Features:

- **Augmented and mandatory training in mental health first aid, suicide prevention, recognizing the signs and symptoms of mental ill health, and in trauma informed care.**

ALL OF WHICH IS RESPECTFULLY SUBMITTED THIS 22nd DAY OF FEBRUARY, 2018.

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John Howard Society of Manitoba
and the Canadian Mental Health
Association Manitoba and
Winnipeg**

Appendix A:

Jurisdiction:

Under the recently amended *The Fatality Inquiries Act*,[117] the purpose of an inquest is to offer a non-adversarial proceeding to establish the facts necessary to enable the presiding provincial judge to prepare a report into the death.[118] Under section 33 of the legislation, the presiding judge in an inquest must provide the minister with a written report that sets out his or her findings respecting the identity of the deceased; the date, time and place of death; the cause of death; the manner of death; and the circumstances in which the death occurred.[119]

The presiding judge may also make recommendations on "changes to provincial laws or programs, policies and practices of the provincial government or of public agencies or institutions to prevent deaths in similar circumstances."[120]

To the extent that the submissions of JHSM and CMHA identify opportunities to prevent future deaths, these opportunities are explored as much for CSC's benefit as for the presiding judge. While counsel to CSC has regularly reminded the Court that a provincial inquest cannot compel a federal body's operations and administration, the reality is that CSC has chosen to cooperate and participate fully in these inquests. CSC produced all of its records relating to both Devon Sampson and Dwayne Flett. They have made witnesses available to the proceedings, called their own evidence and allowed federal witnesses to provide full and complete evidence, including regarding policy, procedure and decision-making.

The question of jurisdiction between a federal institution and a provincial inquest has been canvassed previously, including by Provincial Court Judge Lerner in the Fiddler Inquest. In an interim decision on jurisdiction, Judge Lerner found that when dealing with a federal institution

[117] *The Fatal Inquiries Act*, CCSM c. F52.
[118] *Ibid*, s 26.2(1).
[119] *Ibid*, s 33(1).
[120] *Ibid*, s 33(1.1).

such as Stony Mountain Institution, the inquest cannot delve into its operation, management, administration or policy.

Ultimately in Fiddler, much like in this case, federal witnesses provided full and complete evidence including regarding policy, procedure, and decision-making and so Judge Lerner decided that any jurisdictional limitations would not prevent him from identifying, without recommendation, the problems or deficiencies within Federal departments and agencies that may have formed part of the material circumstances of the death. It would then remain within the purview of the federal government to decide what if any action to take as a result of findings of a provincial inquest.

If this Honourable Court is inclined to follow the Judge Lerner's line of reasoning in the Fiddler Inquest (which was decided under a previous incarnation of the governing statute), JHSM and CMHA would suggest that nothing precludes this Honourable Court from identifying problems or deficiencies within CSC that may have formed a part of the material circumstances of either Devon Sampson or Dwayne Flett's death.

JHSM and CMHA also suggest that nothing precludes the Court from recommending changes in keeping with preventing deaths in similar circumstances. The operative provisions of *The Fatality Inquiries Act* are not limiting, and where the references to laws, programs, policies and practices are modified by reference to the province, no similar modifications applies to the reference to "public agencies or institutions." It could be argued that CSC is a public agency or institution and had the legislature intended to remove federal institutions entirely from the purview of any provincial inquests, they could have done so more clearly.

Finally, both Devon Sampson and Dwayne Flett died in prison under tragic circumstances. To sit through weeks of evidence, review hundreds of documents and carefully consider the evidence of over 20 witnesses, including experts, and not offer any comment on preventing similar deaths is more than a lost opportunity.

Even when recommendations from the inquest are not binding, the inquest will still serve an important public purpose. As recognized by the Supreme Court of Canada in *Faber v The Queen*[21] these kinds of public proceedings "enables the community to be aware of the factors which put human life at risk in given circumstances" – which risks can occur within prisons, and it "resassures the public and makes it aware that the government is acting to ensure that the guarantees relating to human life are duly respected."

[21] *Faber v The Queen*, [1976] 2 SCR 9, 65 DLR (3d) 423.

Inquest Death of Devon Sampson
Section I
Documents Provided by the Department of Justice Canada

A Case Management

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
A01	Email from Carole Degrood re: New Admission - Sampson, Devon			15-Dec-11	1	A663
A02	Custody Rating Scale			16-Dec-11	2	A664
A03	Preliminary Assessment Report			16-Dec-11	8	A667
A04	Sharing of Information Institutional Review			1-Feb-12	3	A686
A05	Correctional Plan Initial			13-Mar-12	10	A699
A06	Assessment for Decision			19-Mar-12	9	A700
A07	Criminal Profile Report Original			19-Mar-12	16	A701
A08	Memorandum re: Notification of Penitentiary Placement Recommendation			20-Mar-12	1	A704
A09	Memorandum from Cole			26-Apr-12	1	A717
A10	Immediate Needs Identification and Referral			31-May-12	1	A722
A11	Unit 6 & 7 Immediate Needs			31-May-12	3	A727
A12	Immediate Needs Identification and Referral			31-May-12	1	A723
A13	Statement/Observation Report	Saskatchewan Penitentiar	Klarenbach, Lori	23-Aug-12	1	A754
A14	Threat Risk Assessment for Security Escorts			13-Oct-12	4	A780
A15	Immediate Needs Identification and Referral			29-Jul-13	3	A838
A16	Statement/Observation Report		Blundell, J.	10-Nov-13	1	A864
A17	Statement/Observation Report		Fines, Kimberly - RN	10-Nov-13	1	A866
A18	Institutional Incident Report for SIO/RHQ/NHQ			12-Nov-13	3	A858
A19	Statement/Observation Report		K. O'Hara	13-Nov-13	1	A879
A20	Inmate's Request			15-Nov-13	1	A880
A21	Inmate's Request			15-Nov-13	1	A878
A22	Inmate's Request			16-Nov-13	1	A881
A23	Inmate's Request re: Property from Unit 2 M-1-14			21-Nov-13	1	A883

A Case Management

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
A24	Inmate's Request re: Property Which Was Left in Cell			22-Nov-13	1	A885
A25	Statement/Observation Report		Aube, T.	23-Nov-13	1	A887
A26	Statement/Observation Report		Bernardin, Paul	23-Nov-13	1	A888
A27	Statement/Observation Report		Bishop, Terri	23-Nov-13	1	A889
A29	Statement/Observation Report		Exercise Officer	23-Nov-13	1	A982
A30	Statement/Observation Report		Galloway, Allison - RN	23-Nov-13	1	A893
A31	Statement/Observation Report		Gibson, Peter	23-Nov-13	1	A894
A32	Statement/Observation Report		Gibson, Peter	23-Nov-13	1	A895
A33	Statement/Observation Report		Gouthro, Steven	23-Nov-13	1	A896
A34	Statement/Observation Report		Hohm, Dan	23-Nov-13	1 (x2)	A897
A35	Statement/Observation Report		Kazuk	23-Nov-13	1	A898
A36	Statement/Observation Report		Matheson, Peter	23-Nov-13	1	A899
A37	Statement/Observation Report		McGillis, Taylor	23-Nov-13	1	A900
A38	Statement/Observation Report		Monkman, Robert	23-Nov-13	1	A901
A39	Statement/Observation Report		Osborne, S.	23-Nov-13	1	A902
A40	Statement/Observation Report		Pavlic, Andrija	23-Nov-13	1	A903
A41	Statement/Observation Report		Piper, Mitch - RN	23-Nov-13	1	A904
A42	Statement/Observation Report		Robinson, Matt	23-Nov-13	1	A905
A43	Statement/Observation Report		Rowe	23-Nov-13	1	A906
A44	Statement/Observation Report		Ulrich, Brian	23-Nov-13	1	A907
A45	Statement/Observation Report		Sinclair, V.	23-Nov-13	1	A907
A46	Statement/Observation Report		Day, Miles	25-Nov-13	1	A910
A47	Institutional Incident Report for SIO/RHQ/NHQ			25-Nov-13	3	A884
A48	Statement/Observation Report		Mondor, C.	27-Nov-13	1	A911

A **Case Management**

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
	Addendum					
A49	Arrest Report			10-Jan-97	1	A2
A50	Arrest Report			17-Jan-97	1	A3
A51	Pre Disposition Report		Carter, Heather	10-Mar-97	9	A5
A52	Pre-Sentence Report		Heshka, Lisa	19-Sep-03	7	A6
A53	Preliminiary Assessment Report		Siemens, Carole	16-Jun-05	7	A11
A54	Community Assessment		Carleton, Willy	07-Jul-05	7	A19
A55	Correctional Plan		Laing, Marykay	26-Aug-05	10	A25/A26
A56	Assessment for Decision		Laing, Marykay	08-Sep-05	5	A30
A57	Criminal Profile Report		Laing, Marykay	08-Sep-05	10	A32
A58	Correctional Plan		Laing, Marykay	26-Sep-05	10	A51
A59	Case Documentation Checklist			03-Oct-05	1	A917
A60	Officer's Statement/Observation Report		Durand, L.	06-Jan-06	1	A54
A61	Intensive Reports Unit Inmate's Request			31-Jan-06	1	A58
A62	Email		Loewen, Jim	23-May-06	1	A64
A63	Detention Pre-Screening #1 Decision to Refer		Plowman, Shannon	14-Jun-06	2	A81
A64	Assessment for Decision		Loewen, Jim	25-Jul-06	10	A85
A65	Institution Transfer (Involuntary) Referral Decision Sheet		Erickson, Dan	08-Aug-06	3	A87
A66	Offender Security Level Referral Decision Sheet		Erickson, Dan	08-Aug-06	2	A88
A67	Correctional Plan Progress Report		Loewen, Jim	19-Sep-06	9	A126
A68	Memorandum		Mackenzie, Jason	26-Feb-07	11	A169
A69	Correctional Plan Progress Report		Zadravec, Joseph	27-Jun-07	6	A220
A70	Assessment for Decision		Kamenz, Nelson	23-Aug-07	6	A251
A71	Inmate's Request		Mackenzie, Jason	10-Jan-08	1	A294
A72	Officer's Statement/Observation Report		Mackenzie, Jason	29-Jan-08	1	A302
A73	Letter		Kinnarath, Nood	01-Feb-08	1	A303
A74	Clinical Discharge Assessment Checklist		Mackenzie, Jason	06-Feb-08	11	A304
A75	Statutory Release Certificate			12-Feb-08	4	A309
A76	Referral for Community Mental Health Specialist Services		Loewen, Jim	19-Feb-08	4	A311
A77	Email		Loewen, Jim	16-Oct-08	1	A368

A Case Management

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
A78	Email		Spiers, Kimberly	16-Jan-09	1	A370
A79	Notice of Punishment or Administrative Action			21-Dec-09	1	A421
A80	Referral Sheet Termintation of Membership/Assoc. w/ Criminal Org.		McLauchlan, Chris	19-Feb-10	1	A422
A81	Correctional Plan Progress Report		Fabris, Gayle	11-Feb-10	9	A430
A82	Email		Tooley, Ray	15-Jul-10	2	A431
A83	Email		Fabris, Gayle	01-Oct-10	1	A561
A84	Prevention of Suicide and Self-Inflicted Injuries		Zimmerman, Warren	13-Oct-10	1	A565
A85	Memorandum		Downie, Jennifer	25-Oct-10	7	A569
A86	Assessment for Decision		Hadaller, Dallas	18-Apr-11	4	A640
A87	Community Assessment		Sandelli, Jeff	18-Jan-12	7	A683
A88	Handwritten Note		Sampson, Devon	27-Mar-12	1	A706
A89	Inmate's Request		Wasnie, L	21-Apr-12	1	A708
A90	Double Bunking Placement Assessment Recommendation		Rodas, A	25-Jun-12	3	A741
A91	Email		Reilkoff, Treena	31-Aug-12	1	A761
A92	Double Bunking Placement Assessment Recommendation		McPherson, Michael	27-Sep-12	3	A771
A93	Correctional Plan Updated		Reilkoff, Treena	08-Apr-13	8	A808
A94	Assessment for Decision		Reilly, Joseph	24-Apr-13	12	A810
A95	Referral Decision Sheet for Offender Security Level		Tooley, Ray	02-May-13	3	A815
A96	Statement/Observation Report		Berry, Ryan	10-Nov-13	1	A862
A97	Statement/Observation Report		Berry, Ryan	10-Nov-13	1	A863
A98	Statement/Observation Report		Ewchuk, Greg	10-Nov-13	1	A865
A99	Statement/Observation Report		Gaucher, D	10-Nov-13	1	A867
A100	Statement/Observation Report		Gray, Tristan	10-Nov-13	1	A868
A101	Statement/Observation Report		Holowaty, M	10-Nov-13	1	A869
A102	Statement/Observation Report		Mondor, C	10-Nov-13	1	A870
A103	Statement/Observation Report		Olson, Heather	10-Nov-13	1	A871
A104	Statement/Observation Report		Potenza, Fabio	10-Nov-13	1	A872
A105	Statement/Observation Report		Sloane, Doug	10-Nov-13	1	A873
A106	Statement/Observation Report		Sommerfeld, Tyler	10-Nov-13	1	A874
A107	Statement/Observation Report		Thompson, Darwin	10-Nov-13	1	A875
A108	Statement/Observation Report		Davey, J	24-Nov-13	1	A891

A Case Management

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
A109	Statement/Observation Report		Mondor, C	27-Nov-13	1	A870

Inquest Death of Devon Sampson
Section II
Documents Provided by the Department of Justice Canada

B **Sentence Management**

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
B01	Offender Admission Form			19-Dec-11	3	B117
B02	Transfer Warrant Regional			13-May-13	1	B119
B03	Case Status			undated	4	B142
B04	Overview of Sampson's Version of Current Offence, Remand and Attitude			undated	1	B144

Inquest Death of Devon Sampson
Section III
Documents Provided by the Department of Justice Canada

C Psychology

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
C01	Psychological/Psychiatric Assessment Report			4-Jan-12	2	C61
C02	Psychological/Psychiatric Assessment Report			9-Feb-12	2	C60
C03	Psychological/Psychiatric Assessment Report			1-Mar-12	2	C62
C04	Psychological/Psychiatric Assessment Report			26-Apr-12	2	C66
C05	Immediate Needs Identification and Referral	Saskatchewan Penitentiary		1-Jun-12	3	C68
C06	Referral Form Psychological/Institutional Mental Health Services			1-Jun-12	1	C69
C07	Referral for Consultation and Report	Saskatchewan Penitentiary		8-Jun-12	3	C69
C08	Psychological/Psychiatric Assessment Report	Saskatchewan Penitentiary		20-Jun-12	2	C71
C09	Referral Form Psychological/Institutional Mental Health Services	Saskatchewan Penitentiary		12-Aug-12	1	C73
C10	Referral Form Psychological/Institutional Mental Health Services			26-Mar-13	1	C74
C11	Email from Shirlee Soulier to Treena Reilkoff			28-Mar-13	1	C76
C12	Clinical Progress Notes			15-Nov-13	1	C78
C13	Inmate's Request re: Getting Counselling			15-Nov-13	1	C79

Addendum

C14	IAU Referral for Psychological Intake Screening or Psychological Risk Assessment			22-Aug-05	2	C4
C15	Psychological/Psychiatric Assessment Report			24-Oct-05	9	C6
C16	Psychological/Psychiatric Assessment Report			12-Sep-06	2	C12
C17	Psychological/Psychiatric Assessment Report			6-Oct-06	2	C13
C18	Psychological/Psychiatric Assessment Report			1-Nov-06	1	C18

C Psychology

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
C19	Psychological/Psychiatric Assessment Report			23-Nov-06	1	C20
C20	Psychological/Psychiatric Assessment Report			6-Dec-06	1	C22
C21	Psychological/Psychiatric Assessment Report			15-Dec-06	1	C25
C22	Psychological/Psychiatric Assessment Report			8-Jan-07	2	C28 & C30
C23	Psychological/Psychiatric Assessment Report			2-Feb-07	1	C30
C24	Psychological/Psychiatric Assessment Report			1-Mar-07	2	C33
C25	Psychological/Psychiatric Assessment Report			23-Mar-07	2	C34
C26	Psychological/Psychiatric Assessment Report			16-Apr-07	2	C36
C27	Psychological/Psychiatric Assessment Report			9-May-07	1	C39
C28	Psychological/Psychiatric Assessment Report			4-Jun-07	1	C41
C29	Psychological/Psychiatric Assessment Report			26-Jun-07	2	C43
C30	Psychological/Psychiatric Assessment Report			24-Jul-07	2	C45
C31	Psychological/Psychiatric Assessment Report			17-Aug-07	2	C46
C32	Psychological/Psychiatric Assessment Report			9-Jan-08	2	C48
C33	IAU Referral for Intake Psychological Risk Assessment			20-Apr-09	1	C51
C34	Psychological/Psychiatric Assessment Report			19-Jun-09	2	C53
C35	Memorandum - Suicide Crisis Intervention Team Minutes			19-Oct-10	2	C55
C36	IAU Referral for Intake Psychological Risk Assessment			20-Dec-11	1	C57
C37	Computerized Mental Health Intake Screening System			22-Dec-11	5	C58
C38	IAU Referral for Intake Psychological Risk Assessment			15-Mar-12	3	C64
C39	Psychological Services Clinical Progress Notes			23-Oct-13	1	C77

Inquest Death of Devon Sampson
Section IV
Documents Provided by the Department of Justice Canada

D **Health Care**

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
D01	Dental Record Folder			12-Aug-05	1	D249
D02	Emails re: Request for Involuntary Transfer Consultation Comments of Devon Sampson			14-Apr-10	2	D83
D03	Letter from Dawn Hale, R.N. to Dr. J. Waldman			29-Jul-10	1	D103
D04	Community Mental Health Integration Checklist			25-Aug-10	11	D108
D05	Memorandum re: Community Mental Health Integration Final Report			14-Sep-10	8	D110
D06	Letter from Dawn Hale, R.N. to Dr. Vattheuer			10-Feb-11	1	D130
D07	Health Services Discharge Summary Report			15-Feb-11	2	D132
D08	Intake Health Status Assessment			24-Mar-11	1	D135
D09	Inmate's Request			18-Apr-11	1	D145
D10	Non-Formulary Mediation Request			21-Dec-11	1	D160
D11	Email between Chris Hidlebaugh and Maria Allan			21-Feb-12	1	D159
D12	Non-Formulary Mediation Request			28-Feb-12	2	D160
D13	Health Services Transfer Summary			25-May-12	3	D175
D14	Intake Health Status Assessment			31-May-12	2	D176
D15	Medication Order Form			11-Jun-12	1	D178
D16	Medication Order Form			18-Jun-12	1	D180
D17	Psychiatric Consultation Report			18-Jun-12	2	D181
D18	Referral Form Psychology/Institutional Mental Health Services			18-Jun-12	2	D182
D19	Referral for Consultation and Report			06-Jul-12	1	D186
D20	Medication Order Form			20-Aug-12	1	D191
D21	Psychiatric Consultation Report			20-Aug-12	1	D192

D Health Care

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
D22	Psychiatric Consultation Report			15-Oct-12	2	D195
D23	Medication Order Form			05-Nov-12	1	D199
D24	Psychiatric Consultation Report			05-Nov-12	1	D200
D25	Psychiatric Consultation Report			07-Jan-13	1	D204
D26	Radiography Requisition and Report			04-Apr-13	1	D214
D27	Psychiatric Consultation Report			15-Apr-13	1	D215
D28	Doctor's Orders			24-Apr-13	4	D251
D29	Inmate's Request			26-Apr-13	1	D218
D30	Inmate's Request			27-Apr-13	1	D219
D31	Health Services Transfer Summary			13-May-13	3	D220
D32	Email from Dawn Hale			14-May-13	1	D221
D33	Medication Reconciliation			15-May-13	3	D221
D34	Intake Health Status Assessment			15-May-13	2	D222
D35	Referral for Consultation and Report			29-May-13	1	D227
D36	Email between Dawn Hale and Chris King			31-May-13	1	D228
D37	Medication Order Form			07-Jun-13	1	D229
D38	Inmate's Request			15-Jun-13	1	D230
D39	Doctor's Orders and Progress Notes			20-Jun-13	49	D253
D40	Inmate's Request			13-Oct-13	1	D234
D41	Memorandum			13-Oct-13	1	D235
D42	Radiography Requisition and Report			13-Oct-13	1	D237
D43	Dental Record			14-Oct-13	2	D247
D44	Medical Consent			14-Oct-13	1	D238
D45	Inmate's Request			21-Oct-13	1	D239
D46	Psychological Services Clinical Progress Notes			23-Oct-13	1	D240
D47	Medication Administration Record			01-Nov-13	4	D265
D48	Inmate's Request			01-Nov-13	1	D241
D49	Doctor's Orders			12-Nov-13	6	D252

D Item ID	Health Care Document	Institution	Author	Date	Number of Pages	Formally Indexed
D50	Progress Notes			25-Nov-13	10	D276
D51	Response to Incidents Involving a Medical Emergency			25-Nov-13	6	D242
	Addendum					
D51	HSC Letter from Susan Lucko to Dr. Yaren together w/ enclosures			11-Jul-05	6	D7
D52	Memorandum - Clinical Discharge Final Report			03-Mar-08	11	D33
D53	Men's Health Status Admission Assessment			15-Jun-07	2	D35
D54	Men's Health Status Admission Assessment			17-Jun-07	7	D36
D55	Men's Health Status Admission Assessment			28-Jun-07	1	D37
D56	Intake Health Status Assessment			27-Feb-08	1	D47
D57	Inmate's Request			07-Sep-09	1	D69
D58	Email from Christine Neufeld to Dawn Hale			22-Mar-10	1	D81
D59	Referral for Community Mental Health Specialist Services			04-Aug-10	4	D106
D60	Consent to Participate in Institutional or Community Mental Health Services			17-Aug-10	1	D106
D61	Community Mental Health Integration Checklist			25-Aug-10	11	D107
D62	Intake Health Status Assessment			30-Sep-10	1	D109
D63	Email from Warren Zimmerman to Dawn Hale			24-Oct-10	2	D116
D64	Prevention of Suicide and Self-Inflicted Injuries			19-Oct-10	1	D117
D65	Health Status at Discharge: GIST Report			06-Jan-11	1	D121
D66	Health Services Discharge Summary Report			27-Jan-11	2	D133
D67	Health Care Discharge Package Confirmation Form			14-Feb-11	1	D131
D68	Referral for Community Mental Health Specialist Services			23-Feb-11	4	D134
D69	Correctional Services of Canada Referral to Dr. Frank Vattheuer				1	D134

D Health Care

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
D70	Non-Formulary Medication Request			30-Mar-11	2	D139
D71	Email from Sarah Enzlberger and Dawn Hale			16-Dec-11	1	D150
D72	Referral for Consultation and Report			21-Jun-12	2	D183
D73	Referral for Consultation and Report			06-Jul-12	1	D190
D74	Dr. Yaren's transcription of his entries of Mr. Sampson's Medical Chart				1	

Inquest Death of Devon Sampson
Section V
Documents Provided by the Department of Justice Canada

E Discipline & Dissociation

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
E01	Immediate Needs Checklist Suicide Risk			16-Dec-11	3	A665
E02	Segregation Log			16-Dec-11	3	A792
E03	Segregation Log			16-Dec-11	3	A668 & A793
E04	Segregation Log			16-Dec-11	3	A669
E05	Segregation Log			16-Dec-11	3	A670
E06	Involuntary Segregation Placement			16-Dec-11	4	A791
E07	Sharing of Information Fifth Working Day Review			19-Dec-11	3	A675
E08	Review of Offender's Segregated Status Fifth Working Day Review			23-Dec-11	7	A676
E09	Sharing of Information Institutional Review			5-Jan-12	3	A681
E10	Review of Offender's Segregated Status Fifth Working Day Review			12-Jan-12	7	A682
E11	Review of Offender's Segregated Status Institutional Review			9-Feb-12	7	A687
E12	Review of Offender's Segregated Status Regional Review			13-Feb-12	9	A689
E13	Sharing of Information Institutional Review			28-Feb-12	3	A691
E14	Review of Offender's Segregated Status Institutional Review			8-Mar-12	8	A697
E15	Sharing of Information Institutional Review			28-Mar-12	3	A707
E16	Review of Offender's Segregated Status Institutional Review			5-Apr-12	8	A711

E17	Review of Offender's Segregated Status Regional Review			15-Apr-12	10	A712, A713 & 714

E Discipline & Dissociation

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
E18	Sharing of Information Institutional Review			24-Apr-12	3	A716
E19	Sharing of Information Institutional Review			23-May-12	3	A719
E20	Review of Offender's Segregated Status Institutional Review			30-May-12	8	A721
E21	Notice of Offender's Release from Segregation			31-May-12	1	A724
E22	Segregation Log	Saskatchewan Penitentiary		31-May-12	3	A726
E23	Voluntary Segregation Placement	Saskatchewan Penitentiary		31-May-12	4	A728
E24	Review of Offender's Segregated Status Fifth Working Day Review	Saskatchewan Penitentiary		1-Jun-12	4	A733
E25	Sharing of Information Fifth Working Day Review	Saskatchewan Penitentiary		4-Jun-12	2	A732
E26	Review of Offender's Segregated Status Regional Review	Saskatchewan Penitentiary		5-Jun-12	5	A729 & A730
E27	Review of Offender's Segregated Status Fifth Working Day Review	Saskatchewan Penitentiary		8-Jun-12	8	A735
E28	Notice of Offender's Release from Segregation	Saskatchewan Penitentiary		20-Jun-12	1	A738
E29	Involuntary Segregation Placement			29-Jul-13	4	A839
E30	Segregation Log			29-Jul-13	3	A840
E31	Segregation Log			29-Jul-13	3	A841
E32	Sharing of Information Fifth Working Day Review			1-Aug-13	3	A847
E33	Notice of Offender's Release from Segregation			6-Aug-13	1	A849
E34	Notice of Release from Segregation			6-Aug-13	1	A851
E35	Involuntary Segregation Placement			10-Nov-13	4	A859
E36	National Cell Condition Checklist			10-Nov-13	1	A860
E37	Immediate Needs Checklist Suicide Risk			10-Nov-13	3	A860
E38	Segregation Log			10-Nov-13	3	A861

E39	Review of Offender's Segregated Status Fifth Working Day Review			12-Nov-13	4	A876
E40	Sharing of Information Fifth Working Day Review			12-Nov-13	4	A877
E41	Review of Offender's Segregated Status Fifth Working Day Review			18-Nov-13	8	A882
E42	Notice of Release from Segregation			23-Nov-13	1	A655

E Discipline & Dissociation

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
E43	Review of Offender's Segregated Status Institutional Review			25-Nov-13	6	A886

Addendum

E44	Memorandum - Receipt for Release of Segregation Documents			23-May-06	1	A65
E45	Voluntary Segregation Placement			23-May-06	3	A72
E46	Review of Offender's Segregated Status First Working Day Review			24-May-06	4	A122
E47	Sharing of Information Fifth Working Day Review			25-May-06	2	A75
E48	Review of Offender's Segregated Status Fifth Working Day Review			30-May-06	5	A74 & A77
E49	Memorandum - Segregation Review Board Hearing/Review Sharing of Information			30-May-06	1	A76
E50	Notice of Offender's Release from Segregation			12-Jun-06	1	A80
E51	Involuntary Segregation Placement			21-Aug-06	3	A92
E52	Memorandum - Receipt of Release of Segregation Documents			21-Aug-06	1	A93
E53	Sharing of Information Fifth Working Day Review			23-Aug-06	2	A120
E54	Review of Offender's Segregated Status Fifth Working Day Review			28-Aug-06	6	A120

E55	Review of Offender's Segregated Status Institutional Review			17-Oct-06	6	A134
E56	Review of Offender's Segregated Status Regional Review			18-Oct-06	7	A112 & A138
E57	Review of Offender's Segregated Status Institutional Review			09-Nov-06	6	A144

E Discipline & Dissociation

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
E58	Review of Offender's Segregated Status Institutional Review			07-Dec-06	7	A146
E59	Review of Offender's Segregated Status Regional Review			14-Dec-06	9	A154
E60	Review of Offender's Segregated Status Institutional Review			04-Jan-07	7	A157
E61	Review of Offender's Segregated Status Regional Review			02-Feb-07	10	A163
E62	Review of Offender's Segregated Status Institutional Review			27-Feb-07	5	A161
E63	Sharing of Information Institutional Review			21-Mar-07	4	A177
E64	Review of Offender's Segregated Status Institutional Review			27-Mar-07	7	A179
E65	Review of Offender's Segregated Status Regional Review			03-Apr-07	11	A180
E66	Sharing of Information Institutional Review			18-Apr-07	5	A181
E67	Review of Offender's Segregated Status Institutional Review			26-Apr-07	8	A182
E68	Sharing of Information Institutional Review			16-May-07	5	A183
E69	Review of Offender's Segregated Status Institutional Review			22-May-07	8	A185
E70	Review of Offender's Segregated Status Regional Review			01-Jun-07	13	A188

E71	Notice of Offender's Release from Segregation			12-Jun-07	1	A193
E72	Review of Offender's Segregated Status Institutional Review			12-Jun-07	7	A195
E73	Memorandum - Receipt of Release of Segregation Documents			15-Jun-07	1	A227
E74	Involuntary Segregation Placement			15-Jun-07	3	A204
E75	Review of Offender's Segregated Staus First Working Day Review			18-Jun-07	4	A211
E76	Sharing of Information Fifth Working Day Review			19-Jun-07	3	A214
E77	Review of Offender's Segregated Status Fifth Working Day Review			22-Jun-07	5	A218
E78	Notice of Offender's Release from Segregation			26-Jun-07	1	A215

E Discipline & Dissociation

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
E79	Notice of Release from Segregation			26-Jun-07	1	A216
E80	Memorandum - Receipt of Release of Segregation Documents			28-Jun-07	1	A205
E81	Involuntary Segregation Placement			28-Jun-07	3	A226
E82	Review of Offender's Segregated Status First Working Day Review			29-Jun-07	4	A233
E83	Sharing of Information Fifth Working Day Review			03-Jul-07	3	A234
E84	Review of Offender's Segregated Status Fifth Working Day Review			06-Jul-07	6	A235
E85	Review of Offender's Segregated Status Institutional Review			26-Jul-07	6	A222
E86	Review of Offender's Segregated Status Institutional Review			23-Aug-07	6	A246
E87	Review of Offender's Segregated Status Regional Review			28-Aug-07	8	A247
E88	Notice of Offender's Release from Segregation			30-Aug-07	1	A248
E89	Notice of Release from Segregation			30-Aug-07	1	A249

E90	Review of Offender's Segregated Status Institutional Review			04-Sep-07	6	A246, A250
E91	Involuntary Segregation Placement			17-Dec-07	4	A282
E92	Memorandum - Segregation Placement Checklist			17-Dec-07	1	A284
E93	Memorandum - Receipt of Release of Segregation Documents			17-Dec-07	1	A285
E94	Sharing of Information Fifth Working Day Review			19-Dec-07	4	A292
E95	Review of Offender's Segregated Status Fifth Working Day Review			24-Dec-07	8	A293
E96	Sharing of Information Institutional Review			11-Jan-08	4	A298
E97	Notice of Offender's Release from Segregation			14-Jan-08	1	A299
E98	Notice of Release from Segregation			14-Jan-08	1	A300
E99	Review of Offender's Segregated Status Institutional Review			14-Jan-08	8	A301

E Discipline & Dissociation

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
E100	Notice of Punishment or Administrative Action - Disciplinary Court/Minor Offence Court			23-Jan-08	1	A296
E101	Involuntary Segregation Placement			10-Apr-10	4	A458
E102	Review of Offender's Segregated Status First Working Day Review			12-Apr-10	4	A485
E103	Sharing of Information Fifth Working Day Review			13-Apr-10	4	A488
E104	Notice of Offender's Release from Segregation			14-Apr-10	1	A491
E105	Review of Offender's Segregated Status Fifth Working Day Review			14-Apr-10	5	A495
E106	Memorandum - Sharing of Segregating Report			15-Apr-10	1	A498
E107	Involuntary Segregation Placement			17-Apr-11	4	A631
E108	Review of Offender's Segregated Staus First Working Day Review			18-Apr-11	4	A642
E109	Sharing of Information Fifth Working Day Review			19-Apr-11	4	A644

E110	Review of Offender's Segregated Status Fifth Working Day Review		26-Apr-11	8	A647
E111	Notice of Offender's Release from Segregation		04-May-11	1	A650
E112	Notice of Release from Segregation		04-May-11	1	A651
E113	Review of Offender's Segregated Status Institutional Review		04-May-11	6	A652
E114	Review of Offender's Segregated Status Institutional Review		03-May-12	8	A720
E115	Immediate Needs Checklist Suicide Risk		10-Nov-13	3	A857
E116	Notice of Release from Segregation		23-Nov-13	1	No #
E117	Notice of Offender's Release from Segregation		25-Nov-13	1	A909
E118	Statement/Observation Report	C. Novak	03-Dec-13	2	A912

Inquest Death of Devon Sampson
Section VI
Documents Provided by the Department of Justice Canada

F Segregation Log Book & Silverguard Rounds for Segregation

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
F01	Segregation Log Book			19-Nov-13 to 25-Nov-13	7	N/A
F02	Segregation Log Book - Visitor			4-Nov-13 to 28-Nov-13	19	N/A
F03	Silverguard Report			24-Nov-13	3	N/A

Inquest Death of Devon Sampson
Section VII
Documents Provided by the Department of Justice Canada

G Materials Provided by RCMP

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
G01	Advance Report - Human Deaths			23-Nov-13	2	
G02	Preliminary Report of Death			23-Nov-13	1	
G03	Photos of Decedent			23-Nov-13	4	

Inquest Death of Devon Sampson
Section VIII
Documents Provided by the Department of Justice Canada

H Office of the Chief Medical Examiner

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
H01	Toxicology Report			09-Dec-13	2	
H02	Autopsy Report Form		C. Littman	19-Dec-13	1	
H03	Report of Medical Examiner		Dr. S. Nelko	07-Jan-14	1	
H04	Medical Certificate of Death Application					

Inquest Death of Devon Sampson
Section IX
Documents Provided by the Department of Justice Canada

I **Addendum**

Item ID	Document	Institution	Author	Date	Number of Pages	Formally Indexed
	Re: Preventative Security					
I01	Statement/Observation Report		K. Fines	10-Nov-13	1	A866
I02	Statement/Observation Report		C. Mondor	10-Nov-13	1	A870
I03	Statement/Observation Report		F. Potenza	10-Nov-13	1	A872
I04	Statement/Observation Report		D. Sloane	10-Nov-13	1	A873
I05	Immediate Needs Indentification and Referral			10-Nov-13	3	
I06	Email exchange between Brent Yarechewski and Lee Vandenbroeck			25-Nov-13	2	
I07	Offender Management System			21-Aug-14	31	
I08	Email exchange between Lee Vandenbroeck and Kory Abrams			17-Oct-14	2	
I09	Email exchange between Dawn Hale and Kory Abrams			26-Feb-15	2	

Inquest Death of Dwayne Flett
Section I
Documents Provided by the Department of Justice Canada

A Case Management

Item ID	Document	Institution	Author	Date	Number of Pages
A1	Correctional Plan Initial			2-Sep-11	9
A2	Note/Memo		H. Playford	4-Dec-12	2
A3	Program Performance Report Interim			7-Jan-13	3
A4	Program Performance Report Interim			11-Jan-13	3
A5	Referral Decision Sheet for Inst. Transfer (Voluntary)			24-Jan-13	2
A6	My Wellness Plan			N/A	6
A7	Program Performance Report Final			20-Apr-13	4
A8	Program Performance Report Final			5-Jul-13	8
A9	Psychological/Psychiatric Assessment Report		G. Fisher	30-Sep-13	4
A10	Program Performance Report Final			4-Oct-13	2
A11	Psychological/Psychiatric Assessment Report		R. Howes	19-Feb-14	4
A12	Detention Pre-Screening #2 Recommendation			24-Feb-14	10
A13	Detention Pre-Screening #2 Decision to Refer			24-Feb-14	2
A14	Assessment for Decision			24-Feb-14	8
A15	Note/Memo		T. Ryan	4-Mar-14	2
A16	Referral Decision Sheet for Inst. Transfer (Voluntary)			26-Mar-14	2
A17	Note/Memo		M. Krone	21-Apr-14	6
A18	Letter w/ attached PBC decision sheet			30-Apr-14	6
A19	Referral Decision Sheet for Inst. Transfer (Voluntary)			2-May-14	2
A20	Statement/Observation Report		K. Campbell	1-Jun-14	1
A21	Statement/Observation Report		K. Campbell	6-Jun-14	1
A22	Modified Suicide Watch Obseration Form			26-Aug-14	2
A23	Referral Decision Sheet for Inst. Transfer (Voluntary)			26-Aug-14	2
A24	Inmate's Request			25-Sep-14	1

A Case Management

Item ID	Document	Institution	Author	Date	Number of Pages
A25	Note/Memo		J. Petrishen	25-Sep-14	4
A26	Inmate's Request			19-Oct-14	1
A27	Inmate's Request			27-Oct-14	1
A28	Note/Memo		N. Klempp	5-Nov-14	5
A29	Referral Decision Sheet for Inst. Transfer (Voluntary)			25-Nov-14	2
A30	Note/Memo		C. Smalldon	2-Dec-14	4
A31	Letter from PBC - Prairies (Saskatoon)		C. Gaucher	5-Dec-14	2
A32	Waiver			16-Dec-14	2
A33	High Suicide Watch Observation Form			16-Dec-14	2
A34	Statement/Observation Report		BL. Nordin	15-Jan-30	1
A35	Statement/Observation Report		L. Campbell	31-Jan-15	1
A36	Statement/Observation Report		K. Traub	31-Jan-15	1
A37	High Suicide Watch Observation Form			31-Jan-15	3
A38	Modified Suicide Watch Obseration Form			31-Jan-15	2
A39	Statement/Observation Report		M. Tulkov	7-Feb-15	1
A40	Statement/Observation Report		N. Godlein	8-Feb-15	1
A41	Statement/Observation Report		P. Anderson	8-Feb-15	1
A42	Modified Suicide Watch Obseration Form			8-Feb-15	2
A43	Institutional Incident Report for SIO/RHQ/NHQ		H. Clark	9-Feb-15	1
A44	Institutional Incident Report for SIO/RHQ/NHQ		H. Clark	9-Feb-15	1
A45	Elder Review (Progress)			9-Feb-15	2
A46	Statement/Observation Report		M. Ladobruk	10-Feb-15	1
A47	Statement/Observation Report		S. Hildebrand	20-Feb-15	1
A48	Statement/Observation Report		A. Rees-Bergen	23-Feb-15	1
A49	Statement/Observation Report		W. Hamisi	23-Feb-15	1
A50	Statement/Observation Report		M. Kopilas	23-Feb-15	1
A51	Modified Suicide Watch Obseration Form			24-Feb-15	2
A52	Statement/Observation Report		C. Lao	8-Mar-15	1
A53	Statement/Observation Report		B. Smith	8-Mar-15	1

A Case Management

Item ID	Document	Institution	Author	Date	Number of Pages
A54	Statement/Observation Report		B. Giesbrecht	14-Mar-15	1
A55	Addendum to Assessment for Decision			26-Mar-15	2
A56	Statement/Observation Report		R. Bilugan	15-Apr-15	1
A57	Statement/Observation Report		D. Rutledge	15-Apr-15	1
A58	Statement/Observation Report		S. Vandale	15-Apr-15	1
A59	Statement/Observation Report		J. Balbon	15-Apr-15	1
A60	Statement/Observation Report		V. Laroche	15-Apr-15	1
A61	Statement/Observation Report		H. Klausen	15-Apr-15	1
A62	Statement/Observation Report		BL. Nordin	15-Apr-15	1
A63	Statement/Observation Report		Unknown	15-Apr-15	1
A64	Statement/Observation Report		J. Beatty	15-Apr-15	1
A65	Statement/Observation Report		Stott	15-Apr-15	1
A66	Institutional Incident Report for SIO/RHQ/NHQ			15-Apr-15	2
A67	Death Certificate from Vital Statistics			12-May-15	1

Addendum

A68	Statement/Observation Report		Stott	23-Feb-15	1
A69	Casework Record Log		Beatty, Josh	07-Jul-14	8

Inquest Death of Dwayne Flett
Section II
Documents Provided by the Department of Justice Canada

B Sentence Management

Item ID	Document	Institution	Author	Date	Number of Pages
B1	Letter for Federal Offenders			21-Nov-12	4
B2	Transfer Warrant Regional			7-Mar-12	1
B3	Transfer Warrant Regional			24-Jan-13	1
B4	Transfer Warrant Regional			26-Mar-14	1
B5	Transfer Warrant Regional			2-Feb-14	1
B6	Transfer Warrant Emergency			27-Aug-14	1
B7	Transfer Warrant Regional			25-Nov-14	1
B8	Death Certificate of Dwayne Flett			12-May-15	1

Inquest Death of Dwayne Flett
Section III
Documents Provided by the Department of Justice Canada

C Psychology

Item ID	Document	Institution	Author	Date	Number of Pages
C1	Psychological/Psychiatric Assessment Report		W. Zimmerman	7-Jun-11	3
C2	Psychological/Psychiatric Assessment Report		K. Somers	16-Dec-11	4
C3	Referral Form Psychology/Institutional Mental Health Services			11-Apr-13	1
C4	AIS-IV Score Report			25-Sep-13	6
C5	Psychological/Psychiatric Assessment Report			26-Sep-13	4
C6	Psychological/Psychiatric Assessment Report		C. Birchwood	19-Nov-13	4
C7	Psychological Services Clinical Progress Notes			21-Nov-13	1
C8	Psychological Services Clinical Progress Notes			4-Dec-13	1
C9	Psychological Services Clinical Progress Notes			11-Dec-13	1
C10	Psychological Services Clinical Progress Notes			17-Jan-14	1
C11	Psychological Services Clinical Progress Notes			22-Jan-14	1
C12	Psychological Services Clinical Progress Notes			29-Jan-14	1
C13	Psychological Services Clinical Progress Notes			30-Jan-14	1
C14	Regional Treatment Centre Referral		M. Monkman	4-Feb-14	3
C15	Psychological Services Clinical Progress Notes			4-Feb-14	1
C16	Psychological Services Clinical Progress Notes			6-Feb-14	1
C17	Psychological Services Clinical Progress Notes			13-Feb-14	1
C18	Psychological/Psychiatric Assessment Report		R. Howes	19-Feb-14	4
C19	Psychological Services Clinical Progress Notes			19-Feb-14	1
C20	Psychological Services Clinical Progress Notes			22-Feb-14	1
C21	Modified Suicide Watch Observation Form			24-Feb-15	2
C22	Psychological Services Clinical Progress Notes			27-Feb-14	1
C23	Psychological Services Clinical Progress Notes			3-Mar-14	1
C24	Psychological Services Clinical Progress Notes			6-Mar-14	1

C Psychology

Item ID	Document	Institution	Author	Date	Number of Pages
C25	Psychological Services Clinical Progress Notes			8-Mar-14	1
C26	Psychological Services Clinical Progress Notes			14-Mar-14	1
C27	Psychological Services Clinical Progress Notes			15-May-14	1
C28	Psychological Services Clinical Progress Notes			17-May-14	1
C29	Discharge Summary		J. Kirkham	26-May-14	2
C30	Psychological Services Clinical Progress Notes			6-Jun-14	1
C31	Psychological Services Clinical Progress Notes			7-Jun-14	1
C32	Statement/Observation Report		P. Bernardin	15-Aug-14	1
C33	Referral for Health Services			15-Aug-14	3
C34	Modified Suicide Watch Observation Form			16-Aug-14	2
C35	Psychological Services Clinical Progress Notes			18-Aug-14	1
C36	Modified Suicide Watch Observation Form			26-Aug-14	2
C37	Note/Memo			25-Sep-14	4
C38	AIS-IV Score Report			2-Oct-14	5
C39	Referral for Health Services			3-Dec-14	2
C40	Email		J. Downie	N/A	1
C41	Psychological Services Clinical Progress Notes			13-Jan-14	1
C42	Psychological Services Clinical Progress Notes			14-Jan-15	1
C43	Psychological Services Clinical Progress Notes			21-Jan-15	1
C44	Psychological Services Clinical Progress Notes			23-Jan-15	1
C45	Referral for Health Services			27-Jan-15	2
C46	Modified Suicide Watch Observation Form			31-Jan-15	2
C47	Psychological Services Clinical Progress Notes			2-Feb-15	1
C48	Psychological Services Clinical Progress Notes			2-Feb-15	1
C49	Email		W. Zimmerman	3-Feb-15	1
C50	Modified Suicide Watch Observation Form			8-Feb-15	2
C51	Email		W. Zimmerman	10-Feb-15	1
C52	Email		K. Rinn	11-Feb-15	1
C53	Psychological Services Clinical Progress Notes			11-Feb-15	1

C Psychology

Item ID	Document	Institution	Author	Date	Number of Pages
C55	Psychological Services Clinical Progress Notes			18-Feb-15	1
C56	Modified Suicide Watch Observation Form			24-Feb-15	2
C57	Modified Suicide Watch Observation Form			24-Feb-15	2
C58	Psychological Services Clinical Progress Notes			25-Feb-15	1
C59	Email		W. Zimmerman	27-Feb-15	2
C60	Email		W. Zimmerman	2-Mar-15	1
C61	Psychological Services Clinical Progress Notes			4-Mar-15	1
C62	Modified Suicide Watch Observation Form			9-Mar-15	2
C63	Psychological Services Clinical Progress Notes			9-Mar-15	1
C64	High Suicide Watch Observation Form			14-Mar-15	2
C65	Email		W. Zimmerman	18-Mar-15	1
C66	Psychological Services Clinical Progress Notes			23-Mar-15	1

Inquest Death of Dwayne Flett
Section IV
Documents Provided by the Department of Justice Canada

D Health Care

Item ID	Document	Institution	Author	Date	Number of Pages
D1	Final Program Performance Assessment		T. Mensink	19-Jan-13	4
D2	Medication File Review			4-Nov-13	1
D3	Progress Notes (Problem Oriented)			22-Apr-14	2
D4	RTC Discharge Summary		S. Salzl	3-May-14	2
D5	Note/Memo			16-May-14	5
D6	Discharge Summary		M. Mansfield	26-May-14	2
D7	Modified Suicide Watch Observation Form			26-Aug-14	2
D8	Note/Memo			25-Sep-14	4
D9	Intake Health Status Assessment			3-Dec-14	3
D10	Email		B. Irvine	3-Dec-14	1
D11	Referral for Health Services			3-Dec-14	3
D12	Progress Notes (Problem Oriented)			3-Dec-14	2
D13	Progress Notes (Problem Oriented)			15-Dec-14	2
D14	Clinical Discharge Assessment Checklist			N/A	11
D15	Medication Administration Record			1-Jan-15	1
D16	Email		K. Campbell	6-Jan-15	2
D17	Email		D. Hale	21-Jan-15	1
D18	Psychological Services Clinical Progress Notes			21-Jan-15	1
D19	Progress Notes (Problem Oriented)			22-Jan-15	2
D20	Psychological Services Clinical Progress Notes			23-Jan-15	1
D21	High Suicide Watch Observation Form			31-Jan-15	1
D22	Medication Administration Record			1-Feb-15	2
D23	Psychological Services Clinical Progress Notes			2-Feb-15	1
D24	Email		J. Downie	2-Feb-15	1

D Health Care

Item ID	Document	Institution	Author	Date	Number of Pages
D25	Modified Suicide Watch Observation Form			8-Feb-15	2
D26	Email		K. Rinn	11-Feb-15	1
D27	Psychological Services Clinical Progress Notes			18-Feb-15	1
D28	Email		K. Campbell	20-Feb-15	1
D29	Progress Notes (Problem Oriented)			21-Feb-15	2
D30	Modified Suicide Watch Observation Form			23-Feb-15	2
D31	Email		J. Downie	23-Feb-15	1
D32	Email		J. Downie	24-Feb-15	1
D33	Email		J. Downie	24-Feb-15	1
D34	Email		K. Rinn	27-Feb-15	2
D35	Medication Administration Record			1-Mar-15	1
D36	Email		W. Zimmerman	2-Mar-15	1
D37	Email		C. Lao	8-Mar-15	1
D38	High Suicide Watch Observation Form			7-Mar-15	2
D39	Modified Suicide Watch Observation Form			9-Mar-15	2
D40	Email		C. Lunn	9-Mar-15	6
D41	Psychological Services Clinical Progress Notes			9-Mar-15	1
D42	High Suicide Watch Observation Form			14-Mar-15	2
D43	Psychological Services Clinical Progress Notes			23-Mar-15	1
D44	Email		D. Caille	26-Mar-15	3
D45	Progress Notes (Problem Oriented)			30-Mar-15	2
D46	Medication Administration Record			1-Apr-15	1
D47	Progress Notes (Problem Oriented)			9-Apr-15	2
D48	Email		K. Campbell	9-Apr-15	1

Addendum

D49	Autopsy Report Form	Rivera, R	19-Jun-15	1
D50	Report of the Medical Examiner	Redekop, T	13-Jul-15	1
D51	Toxicology Report	Rivera, R	15-Apr-15	2
D52	Advance Report - Human Deaths	Fearn, C. D.	15-Apr-15	2
D53	Preliminary Report of Death	Fearn, C. D.	15-Apr-15	1
D54	Suicide Note	Sampson, Devon		1

Inquest Death of Dwayne Flett
Section V
Documents Provided by the Department of Justice Canada

E Discipline & Dissociation

Item ID	Document	Institution	Author	Date	Number of Pages
E1	Seclusion and Restraint Observation Report			7-Feb-15	1
E2	Voluntary Segregation Placement			20-Feb-15	4
E3	Review of Offender's Segreated Status: First Working Day Review		J. Boychuk-Bell	20-Feb-15	4
E4	Notice of Offender's Release from Segregation			20-Feb-15	1
E5	Segregation Log			20-Feb-15	3
E6	Review of Offender's Segreated Status: Fifth Working Day Review			27-Feb-15	5
E7	Sharing of Segregation Report			24-Feb-15	2