



Unauthorized Force: An Investigation into the Dangerous Use of Firearms at Kent Institution Between January 8 and January 18, 2010



Final Report

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EXECUTIVE SUMMARY

1. Pursuant to Section 170 of the *Corrections and Conditional Release Act*, the Office of the Correctional Investigator (OCI) conducted an investigation into the use of firearms during a lockdown and series of searches at Kent Institution between January 8 and January 18, 2010. The firearms were deployed by members of an *extra-legal* Tactical Team (TAC), the only unit of its kind operating within the federal correctional system, in response to a suspected ballistic threat (*'zip gun'*)¹ that was alleged to have been smuggled into the maximum security facility.

2. For 10 days, the institution was locked down as riot-equipped personnel assumed a *'lethal over-watch'* function as the Region's Emergency Response Team (ERT) conducted cell extractions in which compliant and handcuffed inmates were removed from their cells at gunpoint. Following cell extraction procedures, inmates were then led down the ranges as charged and loaded weapons were pointed at them. They were taken to a common area where they were strip searched, often with little concern for dignity, modesty or privacy. During the lockdown, inmates were confined to their cells for days on end, some deprived of medication and the most basic necessities of hygiene and routinely denied fresh air exercise, even though meeting this legal requirement would not have increased the threat level.

3. As the lockdown continued and the search failed to turn up the alleged threat, the ERT and TAC

response adopted an increasingly provocative and intimidating posture. Legal and policy provisions regarding use of force interventions were routinely violated as members of the Tactical Team operated in the absence of any management presence or effective oversight for the duration of the crisis. In daily reports of their activities, team leaders denied that weapons were drawn or pointed directly at inmates, despite videotape evidence to the contrary.

4. To date, the 10 day lockdown of Kent Institution generated 379 known (or *'reportable'*) uses of force interventions. Hundreds more suspected use of force incidents have not yet been reviewed – documents are missing, the incidents deemed *'non-reportable'* (and therefore not counted officially) or never recorded, down-loaded or preserved in the first place, all contrary to use of force procedures and guidelines.²

5. The potential lethal nature of the threat, the duration and magnitude of the lockdown and the ensuing searches should have warranted the designation of a crisis or emergency situation by normal policy standards. The potential for a serious (and lethal) escalation of violence between inmates and armed staff was present at nearly every turn. While informed and aware of developments at Kent Institution, including the deployment of the Tactical Team, the National Headquarters (NHQ) of the Correctional Service of Canada (CSC) did not actively challenge the response of local (institutional) or Regional authorities. To date, no

¹ A *'zip gun'* is an improvised weapon, often crudely resembling a hand-held pistol.

² The full extent of the use of force interventions at Kent may never be known. At a certain point in the lockdown, a decision was made to rely on fixed range cameras (closed circuit television) rather than hand-held video-recording devices to capture use of force interventions. An undetermined quantity of video evidence was subsequently lost when the fixed video recording system overloaded. As internal reviews note, *'the decision not to video-tape ERT activities such as range walks, counts, meal delivery and medical rounds, represented a significant departure from policy.'*



formal disciplinary action has been taken against management or any of the ERT or Tactical Team members, although the twelve year *'pilot'* project that sustained the armed unit has been abandoned. The lack of management oversight raised in this investigation gives rise to serious questions regarding CSC's accountability and governance structures.

6. These events should concern Canadians as the issues and questions raised in this report are disturbing. They cannot simply be explained as a *'deviation from policy,'* contrary to the perspective of the CSC. Rather, what happened at Kent Institution amounts to an abuse of correctional power and authority, systemic breakdowns in management accountability and oversight, gaps in use of force review and reporting procedures, deterioration in dynamic security practices and principles, and violations of human rights law and policy. These are significant deficiencies that increasingly call into question the effectiveness of CSC's internal use of force review process.

7. In examining the documentary and video record of the events under investigation, the OCI concludes that the level of force used to conduct the two searches of Kent Institution in January 2010 was unwarranted, beyond what was authorized, and dangerous.

8. In concluding this investigation, the OCI calls for an independent and expert review of CSC's legal, policy and administrative frameworks governing use of force interventions in federal penitentiaries. This external review should identify gaps and deficiencies in the current use of force policy and review process, and include recommended measures to strengthen accountability, monitoring, oversight and corrective functions at the regional and national

levels of CSC administration. The independent review should be delivered to the Minister of Public Safety, together with an action plan setting out remedies, within six months. The action plan should be made public.



KENT INSTITUTION

9. In operation since 1979, Kent Institution is located near Agassiz, British Columbia, approximately 150 kilometres east of Vancouver. Considered a model new prison for the Pacific Region of the Correctional Service of Canada (CSC), Kent was commissioned to replace the old British Columbia penitentiary. It is the only federal maximum security facility in the Pacific Region. Kent originally had 240 cells divided into eight blocks of 24 cells, and two separate blocks of 24 cells which housed the segregation unit. In August 2009, a new 96-bed unit was opened, bringing the institution's overall rated capacity to 324 inmates. Kent Institution shares its 15-hectare federal compound with Mountain Institution, a 440 bed medium-security facility.

10. In practice, Kent Institution is divided into several distinct sub-populations and living units. The institution itself is divided into four main units: Unit I houses inmates in general population; Unit II holds inmates in protective custody; Unit III is the segregation unit, and; the new 96-bed complex (Unit IV), according to internal documents houses *“inmates who are generally motivated and compliant as opposed to those who are disruptive or have behavioural management issues.”* Occupants of Unit IV (referred to as the ‘96-man unit’ by Kent staff) are to some extent autonomous, given that dedicated programs are offered in this Unit. The living arrangements in this Unit follow an ‘open concept’ approach characterized by four pods surrounding a hub. Each pod is designed to be relatively self-sufficient integrating a kitchenette, laundry, showers and telephones. Each pod has two levels of 12 cells per floor and contains a common area for group dining and activities, easily observable by staff in an enclosed control post as well as an open station.

11. With the exception of the segregation unit, all cell blocks converge on an open square. The penitentiary is effectively managed as two distinct institutions given the large number of protective custody inmates who must be managed separately from the general population. The split population has unfortunately resulted in Unit III (segregation unit) being relied upon as a long term solution for inmates who cannot be effectively or safely maintained in either protective custody or general population. In practice, Unit IV serves as a kind of transition point for inmates who require a more structured living environment than can be offered in general population.

12. Over the years, Kent's relatively isolated location has had an impact on its capacity to attract and retain experienced correctional staff. Serving as a training facility for new staff in the Pacific Region has also led to higher staff turnover rates relative to other institutions. This last issue, coupled with an agreement to facilitate the transfer of Correctional Officers to other facilities based on seniority (as in other maximum security institutions), has contributed to a situation in which the staff complement at Kent has comparatively fewer overall years of experience and less retained corporate memory than other CSC operational sites.



13. Kent has had a problematic history since first opening its doors 30 years ago. Its first years were marked by a series of violent incidents, including a high number of hostage takings. One indicator of Kent's troubled history is the number of lockdowns that the institution has experienced.³ Between 2001 and 2010, Kent Institution recorded the highest number of *lockdowns* of any of the eight maximum security facilities for five out of nine years. Expressed as a percentage of total lockdowns for all maximum security facilities across the country, including the Special Handling Unit, Kent was responsible for 38% of all lockdowns in 2001-02; 41% in 2002-03; 29% in 2003-04; 30% in 2005-06; and 43% in 2007-08.⁴

14. More recently, Kent has experienced a number of serious, violent incidents, including a major riot in 2003, a hostage taking in 2007, an inmate murder in 2008, as well as several other disturbances. The aftermath of each of these incidents fuelled a predictable escalation of tension resulting in a cumulative breakdown in communication and constructive engagement between staff and inmates, deterioration in staff-management relations and a general climate of anxiety and mistrust among both staff and inmates. This institutional environment and the culture it has created culminated in the disturbing events of January 2010.

³ A *lockdown* refers to a decision taken by the Warden to control/restrict inmate movement. During a full lockdown, inmates are confined to their cells, usually in response to a serious incident such as an assault, escape attempt, death in custody, search for contraband, hostage taking or riot. Regular institutional routines, activities and inmate movements are suspended during a lockdown.

⁴ These statistics were accessed and extracted by the OCI from the CSC's Offender Management System (OMS) incident management data on December 16, 2010. In using this data, the Office is aware that although the occurrence of a lockdown incident can be noted electronically in OMS, the duration of the lockdown is not (normally) indicated. As CSC has acknowledged, OMS enhancements would be required to extract more consistent and reliable lockdown data.



SUMMARY OF EVENTS

15. Between January 8 and January 18, 2010, Kent Institution was placed on lockdown status to facilitate two ‘exceptional’ searches, authorized under section 53 of the *Corrections and Conditional Release Act* (CCRA). The searches were conducted to locate a suspected ballistic threat, specifically a ‘zip gun’, that was believed to have been introduced via an inmate’s cell effects upon admission. The lockdown and ensuing searches were carried out by the Pacific Region’s Emergency Response Team (ERT), comprised of both Riot and Tactical Team (TAC) members.⁵

16. Due to the potentially lethal nature of the threat, the operational search plans authorized by the Warden incorporated the deployment of armed tactical members to conduct cell extractions. According to pre-authorized use of force and intervention plans, tactical members were to provide a ‘lethal over watch’ function for other ERT members in contact with inmates in unsearched units. All range walks, medication dispensary, security rounds and patrols, and meal routine functions were to be carried out jointly by the ERT/TAC team members. In addition, the intervention plan called for videotaping of all interactions between the ERT/TAC response team and inmates.

17. The tactical component was supposed to provide cover and support for the ERT members as they removed inmates from their cells (a procedure

known as cell extraction), escorted them to a designated area to be strip-searched *en masse* and then moved them to the gymnasium until the search of the living ranges had been completed. In keeping with the intervention and search plans, tactical members were to assume their positions at the head of the range; in other words, TAC members were to be deployed at the entrance of the range of cells and not in or on the actual living areas. Importantly, their deployment did not specifically authorize the pointing of firearms at inmates, which would have constituted a use of force intervention and specifically required written pre-authorization of the Warden as per policy.

⁵ Unlike other parts of the country where Emergency Response Teams (ERT) are funded and managed locally within each institution, for cost and efficiency reasons Pacific’s Emergency Response Team is organized into a regional cluster consisting of five components – Riot (West), Riot (East), Tactical, Fraser Valley Institution (Regional women’s facility) and Crisis Negotiation. As detailed later, the Pacific’s Tactical and Riot teams had separate leaders which, according to internal CSC correspondence, created ‘dual command’ problems. Following dissolution of the Tactical Team in April 1, 2010, the Pacific’s ERT response capacity was brought under an integrated command structure. Separate ‘Riot’ and ‘Tactical’ designations have been eliminated with the integration of former tactical members into the Regional ERT structure.



18. During the 10 day lockdown, inmates housed at Kent Institution were confined to their cells, where they ate, slept and waited to be brought to a common area to be strip searched. All programs and visits to the Institution were suspended. There were no independent observers present or called in to monitor events as the lockdown progressed, although coincidentally two Office of the Correctional Investigator (OCI) staff members were conducting a previously arranged visit at Kent.⁶ Many inmates went several days without a shower, some without soap or toilet paper in their cells. By the end of the lockdown period, the physical conditions of confinement could best be described as mentally distressing and physically inadequate, even by maximum security standards.

19. Notwithstanding the severity of the threat or the circumstances which warranted the s. 53 searches, the OCI concludes that conditions of confinement and provision of basic necessities, including hygiene and fresh air exercise, were restricted beyond what was reasonable or necessary. As one internal review indicated, given the compliant nature of the population, the delivery of items and services to meet basic living needs, including the opportunity for fresh air exercise, “*would not have increased the threat or risk level of the existing situation.*”⁷

20. For the duration of the lockdown, the evidence reveals that there were numerous and serious

breaches to inmates’ privacy, human rights and dignity. Strip searches were conducted contrary to policy. Privacy barriers were often inadequate. In some cases, searches were videotaped showing full frontal nudity. Some searches were conducted when female officers were present or passing through common areas of the penitentiary where the majority of the strip searches and body orifice scans were performed.

21. As the videotape evidence of these events reveals, the majority of cell extractions were not conducted as per the Warden’s instructions. The actions of the Tactical Team were especially problematic as the lockdown progressed and the search regime intensified. Over the course of the second s. 53 search (January 12-17), TAC members are seen present during most cell extractions pointing semi-automatic weapons directly at, and only a few feet away from compliant inmates, most of whom were already handcuffed behind the back. In other cases, firearms were drawn and pointed as handcuffs were applied through a food slot opening or as a cell door was opened. These actions deviated from the Warden’s authorized intervention plan resulting in firearms being brought directly onto the living units in an unsafe manner. This potentially lethal and dangerous use of force stands in stark contrast to the videotaped evidence which shows that inmates were compliant and following verbal orders in virtually all cases.

⁶ The nature and scope of the OCI’s role during the visit of Kent Institution, which coincided with the lockdown, is addressed in detail later in this report. It is instructive to note that CSC’s response dramatically escalated shortly after the OCI members had concluded their visit of Kent Institution. In fact, deviations from the Warden’s approved search and use of force intervention plans – most crucially, the pointing of firearms directly at compliant inmates – were especially frequent and problematic after January 12, 2010 when the second (and more comprehensive) Section 53 search was initiated.

⁷ Correctional Service Canada, *Fact-Finding Review into the Two Section 53 Searches at Kent Institution Between the Period of January 8 and January 18, 2010*, (Final Report) dated October 20, 2010 (hereinafter referred to as the *Fact-Finding Review*, p. 127.



22. Upon application of physical restraints (handcuffs behind the back) and at the point that the cell door was opened and a compliant inmate emerged, there was no further justification for the continued use of firearms. The pointing of firearms at compliant inmates already physically restrained in handcuffs was unauthorized, unwarranted and unsafe. After reviewing nearly 60 hours of videotape evidence the OCI concludes that this was an excessive and dangerous deployment of firearms.

23. As the search progressed, it was clear from post-reports that the pointing of charged firearms at compliant inmates was not considered to be a ‘reportable’ use of force by the ERT/TAC team leaders. The Team leader regularly denied active ‘target acquisition’ in his daily situation reports to the Warden. Several other reports signed off by the ERT team leader contained statements describing inmates’ behaviour as ‘verbally resistive’ or ‘physically uncooperative.’ This description directly contradicts the Warden’s assessment of the inmate population after the events, which he generally described as “quite compliant throughout the moves

and subsequent search.”⁸ Despite contradictory, incomplete and inaccurate reporting, it is significant that no one from the institutional or regional management administrations questioned the version of events they were provided by the ERT and TAC Team leaders on a daily basis.

24. The events reviewed in this investigative report were never officially designated a ‘crisis situation,’ nor was a crisis centre opened at either regional or national headquarters, measures which almost certainly would have prompted vigorous, active and diligent oversight and monitoring by senior managers of Kent Institution. In any case, it would not have been unreasonable to expect Kent senior management to closely oversee the cell extractions and searches and play a strong challenge function, especially given the deployment of an external response team. However, as one CSC internal review concluded: “... *the management supervision and monitoring of the ERT/TAC team activities, during both the first and second Section 53 searches, was for all intents and purposes non-existent.*”⁹

25. In effect, the ERT/TAC team assumed total control of a federal maximum security penitentiary. It operated in a virtual management vacuum and oversight void. The OCI concludes that the actions of the Tactical Team contravened law and policy governing the use of force in a federal correctional facility. The presence of tactical personnel, equipped with laser-sighted semi-automatic rifles, handguns, dressed in specialized riot, control and breaching gear (e.g. helmets, masks, and bullet-proof vests, physical and chemical restraints) was an intimidating, overwhelming and provocative display

⁸ Warden’s Situation Report – Addendum, dated April 15, 2010.

⁹ Fact-Finding Review, p. 138.



of force. For 10 days, this team followed its own rules of engagement with almost complete impunity.

26. As it turns out, the Pacific Region’s Tactical Team, the only unit of its kind operating in CSC, was part of an ongoing ‘*pilot*’ project first approved by national headquarters in 1998. Although the Pacific region’s tactical pilot was cancelled on April 1, 2010 (2.5 months after the events at Kent), there is still much for the CSC to account for, including its decision to forgo a formal national investigation into the events under review in this report. Moreover, the mechanisms selected by the CSC to review the Kent response after the fact, and the associated action plans that have been developed or implemented to date, fall considerably short of addressing fundamental accountability concerns for this dangerous and unwarranted use and display of force.

27. The OCI concludes that law and policy were routinely violated during the two s. 53 searches and lockdown of Kent Institution in January 2010. Conduct during these events amounted to an *extra-legal* use of force as the response was carried out by a team of armed Correctional Officers outside the control, direction and authority of CSC policy.



SCOPE OF INVESTIGATION

28. The issues at stake in this investigation do not turn on the decision to conduct two Section 53 ‘exceptional’ searches, or even the decision to deploy the Emergency Response and Tactical Teams to facilitate those searches (a deployment which, according to CSC’s own policy, constitutes a pre-authorized use of force intervention). In and of itself, a section 53 search is anything but an extraordinary occurrence in the federal correctional system, especially in a maximum security institution. As per the law, the Warden may authorize, in writing, such a search provided that s/he is satisfied that there are “reasonable grounds to believe that ... there exists, because of contraband, a clear and substantial danger to human life or safety or to the security of the penitentiary.” As CSC has noted, the “*information provided to the Warden was sufficient for him to be satisfied that there were reasonable grounds to authorize the searches in accordance with section 53 of the Act.*”¹⁰ These facts are not in dispute. To be very clear, this investigation is not about second-guessing the Warden, nor the right of CSC employees to a safe working environment.

29. That said, it is how decisions were reached and by whom, as well as the unlawful manner in which the tactical response was carried out, that are of concern to this Office. There are serious questions concerning the quality and corroboration of the security intelligence information upon which Kent management relied to authorize the initial and subsequent s. 53 searches of the institution. These questions are relevant to this investigation given the acknowledged deterioration in dynamic security practices and corresponding deficits in security intelligence information at Kent. In light of Union

demands to invoke a work stoppage over safety concerns, and given the dearth and questionable quality of the intelligence information upon which the Warden was forced to act, it is plausible that Kent management may have had little or no choice but to consent to the deployment of armed personnel to carry out the s. 53 searches in order to placate staff demands.

30. The OCI is principally concerned with reviewing ‘*what went wrong*’ during the two exceptional searches of Kent Institution that, although legally authorized, were carried out in contravention of use of force policy. It is not merely the deployment of an armed response unit that is at issue in this investigation. Indeed, given the suspected nature of the ballistic threat that confronted Kent staff and inmates alike, it would be reasonable to assume that consideration of a proportionate response would provide for the option to deploy lethal force, but only as a last and final resort, as per policy and the law. In this respect, the Office fundamentally disagrees with CSC’s ascribed position that the events at Kent are “*related to a Section 53 Search and not a use of force incident.*”¹¹ The unauthorized means and level of force by which the cell extractions were carried out, the failure to satisfy the legal obligation to apply the *least restrictive* use of force option possible to manage the threat, the physical and mental deprivations that resulted from the display and pointing of charged weapons at compliant inmates in a maximum security facility, the numerous violations of human rights, dignity and privacy that were incurred, and the apparent lack of any meaningful management oversight or answerability to any of these contraventions clearly

¹⁰ CSC’s *Factual Review* of an interim draft of this investigation dated 2011-01-28.

¹¹ This position is stated in CSC’s *Factual Review*.



places these events outside of routine practice and beg a use of force investigation.

31. In the OCI's view, these events represent systemic failures that go beyond the management of Kent Institution and cannot be isolated or restricted to the Pacific Region of CSC. In fact, what happened at Kent calls into question the adequacy and appropriateness of CSC's accountability, governance and review mechanisms which authorize use of force interventions in federal penitentiaries. In other words, while this investigation flows from the immediate context of the Kent lockdown and searches during January 2010, the findings, conclusions and recommendations of this investigation speak to more general areas of concern involving how use of force interventions are authorized, carried out and monitored within CSC operations, and the inadequacy of the review mechanisms and procedures that are used to learn from and correct use of force interventions that go wrong.



CHRONOLOGY OF EVENTS

January 4, 2010

- An inmate's 30 day personal effects were delivered to the principal entrance at Kent Institution under a provision that allows inmates to receive property from outside sources within 30 days of initial penitentiary placement or readmission after conditional release suspension.
- The personal effects, which included a stereo and a pair of running shoes, were placed in a protected storage cage in the Admission and Discharge area of the prison.

January 5, 2010

- The inmate's personal effects were retrieved from the cage, spread on the floor and searched using Kent Institution's drug detention dog. The dog did not indicate on any of the items.
- As per routine, the stereo was taken to the principal entrance to be examined under the X-ray machine. Although the initial examination raised some suspicion, the stereo was repositioned and re-examined by the Search Coordinator/Dog Handler (SC/DH) who was satisfied that no contraband was hidden in the stereo. The inmate's items were returned to the delivery shelf in the Admission and Discharge area.

January 6, 2010

- The personal effects were delivered to the inmate.

January 7, 2010

1545h

- Information was received in the form of a 'kite'¹² that a 'zip gun' and drugs may have been introduced within Kent Institution through an inmate's 30 day personal effects, specifically a stereo.

1600h

- The Officer who found the note, as well as a Security Intelligence Officer (SIO) and a Correctional Manager, met with the Warden and informed him of a potential security threat.

1615h

- The Warden ordered the lockdown of the institution and authorized an exceptional search under section 53 of the *CCRA*. The Regional Assistant Deputy Commissioner of Institutional Operations (ADCIO) was advised of the alleged threat and an exceptional search of the institution was planned.

1730h

- Due to the ballistic nature of the threat, the Union of Canadian Correctional Officers (UCCO) threatened to invoke a refusal to work provision under Section 128 of the *Canada Labour Code* (right to refuse dangerous work).
- Management and UCCO agreed to utilize the Regional Emergency Response Team (ERT) and Tactical component (TAC) with firearms and ballistic protection (vests and shields) to conduct inmate counts, as well as range security patrols, meal routines and emergency escorts, until the search was complete.

¹² Prison slang term used to refer to an anonymous inmate note or letter. In this case, the 'kite' was passed to Kent authorities.



2000h

• A *Situation, Mission, Execution, Administration and Communication (SMEAC) Action Plan* to authorize ERT/TAC team members to conduct cellblock patrols and required responses to emergency situations was prepared by a TAC team member and signed by the Warden.

2115h

• The Assistant Deputy Commissioner Institutional Operations (ADCIO), Pacific Region, was advised of the situation and of the plan to use the ERT and armed Tactical Team members.

2200h

• ERT/TAC members commenced cellblock security patrols and counts in Unit I, B and D blocks; Unit II, A and C blocks; Unit III, Segregation J and K blocks; and Unit IV, the 96-bed unit comprised of L, M, N and P blocks.

2208h

• Correctional Officers completed a search of the institutional kitchen, gymnasium washrooms, weight pit, chapel, multi-purpose room and the inmate committee room.

• The ADCIO sent an email to National Headquarters (NHQ) advising officials of the situation and of the planned ERT/TAC team response.

• A *“TAC team member with the support of the UCCO local invokes a refusal to work ... During discussions staff requests ballistic vests and TAC team presence on the cellblocks with firearms. The agreement reached is that ERT members with ballistic protection will conduct all range patrols*

*and inmate contact situations while two armed TAC team members are positioned at the head of the range to observe and intervene if necessary. This agreement results in the withdrawal of the refusal to work. The ADCIO advises NHQ that the Warden is convinced that any lesser option is unacceptable to staff.”*¹³

January 8

0700h

• The second *SMEAC-Action Plan* was completed and signed by the Warden.

0745h

• The ERT and TAC members began removing inmates from their cells: each inmate was cell-extracted, handcuffed, frisk/wand/strip searched and escorted to a common area for the search of the cell units to be conducted by regular line staff. This routine continued through to January 10, 2010.

1350h

• A local media release advising of the institutional lockdown and exceptional search was completed, approved and promulgated.

January 9

1815h

• The Tactical Team leader (second in command of the ERT/TAC team) submitted an Officer Statement/Observation Report (OSOR) on the activities of the TAC team in providing protective over-watch of the ERT team members. According to the report: *“At all times the weapons of the team members and myself were pointed in a safe direction with the safeties on in order to provide proper*

¹³ Fact-Finding Review, page 9.



support and coverage for the possible threat that existed in every cell and food slot that was opened.” The report concludes that “there was no uses of force by any TAC member during the events of the day.”¹⁴

January 10, 2010

0705h

- A new *SMEAC-Action Plan* detailing the ERT/TAC members’ activities in support of the s. 53 search in the Segregation Unit was prepared by the ERT team leader and signed by the Warden.

0800h

- ERT/TAC members began extracting inmates from their segregation cells in preparation for the search.

2000h

- The search of the Segregation Unit was completed.

- The TAC team leader submitted his report on the activities of the TAC team containing the same statement noted previously on January 9 referencing the ‘safe’ pointing of firearms. He also reported no uses of force on that day.

January 11, 2010

0800h

- The UCCO raised concerns over the quality and integrity of the searches conducted to date. The Drug Dog Handler (DDH) indicated that she did not search one of the blocks earlier in the search, which potentially compromised the entire search.

1000h

- After consultation with Security and UCCO representatives, the Warden authorized a second s.

53 search of Units I, II and III. The institution remained on lockdown status.

1351h

- The ADCIO received an email from institutional management on the status of the first s. 53 search, the mood of the inmates, and the staff concerns relating to the recently completed search. The ADCIO was advised that a second s. 53 search was approved for Units I, II and III based on due diligence concerns for staff and inmate safety.

1600h

- A fourth *SMEAC* Action Plan was prepared by the Regional ERT Leader and signed off by the Warden.
- ERT/TAC members began conducting the cell block security rounds.

January 12-17, 2010

- Cell extractions and strip searches were performed by ERT and Tactical Team members.

January 13, 2010

0848h

- The second search was expanded to include the 96-bed complex (Unit IV).

1111h

- The decision was made by the Warden, in consultation with regional authorities, that nurses would not be required to go on the ranges wearing ballistic vests. Health Services would work with management and the ERT to establish new medication delivery routines.

¹⁴ *Fact-Finding Review*, p. 19.



January 14, 2010

0902h

- The new routines for medication distribution and Health Services rounds were announced to staff.

January 17, 2010

- The search was completed with negative results; no ‘zip gun’ was ever found, however, a sizable quantity of other contraband, including drugs, hand-fashioned shanks (or knives) and other drug paraphernalia were retrieved during the searches.

January 18, 2010

0800h

- The search results were reviewed at morning lockdown meeting. Most of the institution remained on a ‘modified’ routine.

January 22, 2010

- The entire institution was back to normal operational routine.

April 1, 2010

- The tactical component of the Pacific’s Emergency Response Team was disbanded and the pilot project that sustained it was cancelled following a decision by CSC’s Executive Committee (or EXCOM).¹⁵ Most TAC team members were integrated back into the Riot component of the ERT.

¹⁵ Chaired by the Commissioner of Corrections, EXCOM (or Executive Committee) is CSC’s most senior decision-making body. It is comprised of Executives from across the Service and includes Assistant and Deputy Commissioners at National Headquarters, as well as the five Regional Deputy Commissioners.



METHODOLOGY

32. As per procedure, the regional use of force review package of the Kent response, including videotape records, was shared with the OCI on May 3, 2010. Over the spring and summer, supplementary information was requested as the results of CSC's internal use of force and investigative review processes became available. In conducting this investigation, the OCI acknowledges access to and cooperation of CSC officials, especially in the Pacific Region inclusive of the Regional Deputy Commissioner.

33. Upon review of the videotape evidence, on July 6, 2010, the Office formally advised the Commissioner of Corrections that it had initiated its own investigation of the Kent lockdown and searches, pursuant to section 170 of the *Corrections and Conditional Release Act* (CCRA). The Office requested that CSC provide all internal documentation not previously disclosed relevant to the events under review.¹⁶ The Office reviewed Situation Reports (or *SITREPs*), press releases, official memoranda, internal reviews and reports and related action plans. In order to better understand weapons deployment and armed responses within CSC, the Office also reviewed relevant portions of the Service's *Security Manual*.

34. The Office also requested all available documentation relating to the ERT/TAC team in the Pacific Region, including meeting minutes, presentations, audits and evaluations. National Board of Investigation (NBOI) Reports relating to security incidents in the Pacific Region where the Tactical Team had been previously deployed were also requested and reviewed. The OCI reviewed eight such deployments occurring between 2003 and 2008. The full list of documents produced by CSC

and examined by the OCI is listed in the References section of this report.

35. Fifty-eight hours of videotape evidence, approximately half of the 120 hours available at that time for review, were scrutinized by the Office, allowing for visual assessment and corroboration of the events. In order to obtain additional contextual information and clarify certain points, the Office conducted three individual interviews with Regional staff, as well as one teleconference with CSC staff from the Region and National Headquarters (NHQ). Last but not least, the Office reviewed all inmate complaints and grievances submitted at the institutional level between November 2009 and March 2010 inclusively.

36. In accordance with the Office's duty to act fairly, on January 18, 2011 the CSC was provided a review copy of this report to identify errors and inaccuracies. The CSC provided the results of its *Factual Review* on February 4, 2011. The OCI investigative report was subsequently revised, as appropriate. In addition, the CSC was also notified in advance of the report's impending public release date.

Additional Context

37. Two OCI investigators were coincidentally on site as part of a regularly scheduled visit of Kent Institution on January 11, 2010. Given that the institution was on full lockdown status, the investigators were not able to conduct their scheduled interviews with inmates. The investigators were advised by institutional management that the searches were being carried out by the ERT and the Tactical Team, due to the potential threat of a *zip*

¹⁶ A copy of this correspondence is appended to this Report.



gun having been smuggled within the institution. The Tactical Team was described as an ERT team specializing in hostage taking and firearms deployments. Given that the Tactical Team members would be assisting with the searches while carrying 9mm carbines, the investigators advised the Office to expect an influx of calls from inmates.

38. On January 12, 2010, wearing bullet-proof vests and observing from peripheral areas, the OCI investigators witnessed some of the searches carried out in Unit II, Cellblock A. In keeping with the OCI's role as an impartial and neutral body, the investigators observed events from the sidelines to avoid any perception that they were associated with the search or the lockdown. The parameters of the search were discussed with the Warden during the visit. The dangerous use of firearms was not observed on this particular day, and in fact only came to light upon subsequent review of the videotapes as shared with the OCI on May 3, 2010.

39. The investigators regularly liaised with OCI senior management regarding events as they unfolded. In turn, OCI senior management contacted Pacific Regional authorities to seek additional information about the s. 53 searches. Upon returning to Ottawa, the Senior Investigator assigned to Kent Institution sought updates from the Warden on the state of the searches, including the gradual return to normal routine. The Investigator also questioned key players in the Pacific Region in order to gather more information on the Tactical Team.

40. On February 8, 2010, the Senior Investigator debriefed OCI senior management on information received about the Tactical Team, namely that it constituted a *'pilot'* project that had been in existence since 1998, and that it had been deployed on at least five other separate occasions in order to

deal with various crises, mostly hostage takings. On February 11, 2010, the Investigator informed OCI senior management that, at the request of the Assistant Deputy Commissioner Institutional Operations, a *'National Investigation'* had been convened into the s. 53 searches at Kent. This investigation would, among other issues, look into the decision to deploy the Tactical Team, as well as its conduct during the searches. This information proved to be incorrect.

41. The CSC did not initially report several displays and pointing of loaded firearms at inmates as uses of force. The Office subsequently learned of the loaded firearms deployment on April 24, 2010. Situation Reports (*SITREPs*) issued as the events were unfolding do not reveal the magnitude of the search, the involvement of the Tactical Team, nor the fact that inmates were removed from their cells at gun point.

42. The information provided by the CSC to the OCI with respect to their review and investigation procedures for the s. 53 searches was at times piecemeal and contradictory. For instance, the Office was informed by the Regional Deputy Commissioner (RDC) of the Pacific Region on February 10, 2010 that *'concerns'* regarding the use of the Tactical Team had been noted and that a review would be conducted. It was only on March 11, 2010, one month later, that CSC advised it had decided to set up a project team at RHQ to complete reviews for approximately 900 uses of force and 120 hours of video recordings. It would be another six weeks (April 24, 2010) before NHQ security confirmed that inmates had been cell extracted at gun point.

43. In addition to these time delays CSC provided conflicting information to the OCI on the level and



scope of their internal review and investigative processes. NHQ Security and Kent Institution initially advised that a national level investigation, what is referred to as a *National Board of Investigation*, had been convened, which was later refuted by the NHQ Investigation Branch. After much questioning and discussion with the CSC, the OCI learned on May 11, 2010, from an official at Pacific Region, that a regionally convened *Fact-Finding Review* had been initiated under the authority of the Regional Deputy Commissioner of the Pacific Region to ‘*inquire*’ about the s. 53 searches at Kent Institution.¹⁷

¹⁷ Part of the confusion and contradictory information that was exchanged in the aftermath of the Kent response appears to stem from the fact that the review convened by the Regional Deputy Commissioner is referred to as a ‘national fact-finding review’ in the convening order and terms of reference. The recommendations, action plans, findings and corrective measures conducted at the regional level were also subject of an Executive Committee (EXCOM) meeting, perhaps indicating the national significance of the Kent response.



ASSESSMENT OF CSC'S RESPONSE

44. In the wake of these events, CSC initiated a two-part internal review process. The *Collaborative Review Team (or CRT)* report was prepared jointly by Pacific Regional Headquarters (RHQ) and Kent Institution staff.¹⁸ According to CSC, the decision to complete a *joint* review (i.e. involving both Kent Institution and Regional officials, and therefore, a 'collaborative' review) was taken to *expedite* the use of force review process, an exercise which normally involves three levels of administrative review – institutional, regional and national. The joint use of force review is dated April 30, 2010, and was shared with the OCI on May 03, 2010 as part of the regional use of force review package. While this collaborative approach may have had some operational benefits, it diminished the challenge function of a more independent review.

45. A regional *Fact-Finding Review (or FFR)* was convened on February 26, 2010, under the general powers of management of the Regional Deputy Commissioner (RDC) for Pacific Region. The RDC appointed three individuals, two from National Headquarters (NHQ) and one former Regional Administrator, to conduct a separate review of the events, including issues of compliance with the law, policies and procedures. They were tasked to provide the RDC with their findings. Broader in scope than the *Collaborative Review*, an interim copy of the *Fact-Finding Review* was received by the OCI on May 25, 2010. The Final Version of the *Fact-Finding Review* was received in this Office on October 20, 2010.

46. For its part, the *Collaborative Review* identified

several areas of non-compliance relating to firearms deployment, breaches of use of force policy, incident recording, documentation and reporting requirements. It noted gaps with respect to process and procedures related to video recording, strip searches, inmate privacy and dignity, and follow-up of inmate complaints alleging excessive use of force. The report outlined a dozen areas of non-compliance, and requested action plans from Kent Institution and Pacific Region to address each of these areas.

47. Kent Institution submitted its response to the *Collaborative Review* on May 6, 2010. Most of the action items involve staff information measures and training to ensure greater compliance with use of force policy and procedures. The Pacific ERT leader submitted the Region's action plan on June 25, 2010, indicating all items would be completed by September 30, 2010. It indicated that the Tactical Team had been 'disbanded,' remaining members 'integrated' back into East or West riot teams, and the pilot project that had sustained the tactical component 'cancelled' as of April 1, 2010. Significantly, there was no reference provided that could trace the mechanics of this decision, other than it was taken at the national (EXCOM) level. The remainder of the action plan included measures such as staff training and email reminders on various processes and procedures related to video-taping, strip searches, documentation and communications during use of force interventions. To date, there has been no formal staff disciplinary investigation initiated at either the regional or national levels of CSC.¹⁹

¹⁸ Strictly speaking, the *Collaborative Review* was a regional use of force review.

¹⁹ In providing CSC's factual response of an interim review copy of this investigation, the Commissioner of Corrections specifies that he has 'the right to have any matter investigated at any time.' This correspondence, dated February 04, 2011, is appended to this report.



48. The OCI received a copy of the final action plan in relation to the findings of *Fact-Finding Review* on November 22, 2010, fully 11 months after the events. This action plan contains numerous commitments to address areas of non-compliance contained in the *Fact-Finding Review*, notably the appointment of an ‘*On-Scene Controller*’ who would be present during future deployments of Emergency Response Teams at Kent to verify that its actions are indeed carried out according to the Warden’s authorization. The *FFR* action plan also contains specific corrective measures to address endemic problems that precipitated the events of January 2010, including lack of dynamic interaction between staff and inmates. Reviewed by EXCOM members, the anticipated date of completion for all outstanding action items is March 31, 2011.

49. There are clear policy guidelines describing when and how the three levels of the use of force administrative review exercises – institutional, regional and national – are to be conducted and completed. More than 15 months after the events under review in this investigation occurred, and close to one year after the joint Institutional/Regional use of force package was originally submitted to National Headquarters (NHQ), the files and videotapes of the January 2010 use of force incidents at Kent Institution are still being reviewed by NHQ with no confirmed completion date.

50. The two internal reviews and the associated action plans developed by Kent Institution and Pacific Region are disappointing in that they essentially focus on the mechanical points of improving compliance with the existing use of force review process and procedures. Given this focus, there is the expected commitment to provide more training. In the view of this Office, these measures

are inadequate because the internal reviews pass over important issues, specifically, the existence and reliance on an *extra-legal* Tactical Team to manage the crisis, and the absence of management accountability related to its deployment. At various points during the lockdown, the Tactical Team took decisions to circumvent law and policy, and, in so doing, essentially disregarded the obligation to report on its activities. The internal reviews are inadequate because they fail to address critical accountability issues.

51. What is perhaps most perplexing about the internal reviews of these matters is the fact that no level of CSC administration – institutional, regional or national – has yet accepted responsibility for the unwarranted, unjustified and dangerous use of force at Kent Institution during the January lockdown. At nearly every point, law and policy authorizing and governing the use of force in a federal penitentiary was violated, seemingly without management review, control or consequences. As the Warden attests in his post-assessment review of the events, Tactical Team members did not follow the search and intervention orders that were drawn to specifically authorize their activities. Contrary to policy, the ERT/TAC team did not videotape certain activities, including range walks, security rounds and counts, meal delivery and dispensing of medications. As both internal reviews indicate, Tactical Team members routinely over-stepped the limits of their authority, failed to complete use of force reports, and denied that their weapons were used or handled in an unsafe manner. Significantly, as the *Fact-Finding Review* reports:

Camera footage has shown that TAC members were pointing their weapons directly at the body mass of compliant inmates. Certain members were particularly aggressive with their weapons and took



risks with their weapons when walking by inmates who were not handcuffed.



52. Although Kent Institution management acknowledged that the need for the s. 53 searches was due (at least in part) to staff performance issues, no formal disciplinary sanction was taken against any CSC staff member for lapses prior to the lockdown or for deficiencies during the events under review. The series of individual and cumulative deficiencies and missed opportunities that contributed to both the need to conduct two searches of the institution and the prolonged lockdown are not examined in the kind of detail that would seem warranted. Noted deficiencies in specific staff performance issues include:

- Due diligence in searching the personal property effects of a readmitted inmate suspected of introducing contraband (drugs) and (potentially) the suspected ‘zip gun’ into the institution.
- The Union’s ‘threat’ to invoke a work stoppage and subsequent staff-management negotiations and agreement to deploy the ERT (riot and tactical) components to respond to the potential danger.²⁰

- Failure (or perhaps inability) to corroborate the source and reliability of initial and subsequent security intelligence information regarding the potential risk.

- Lack of planning, quality and thoroughness that compromised the integrity of the first search and required a second search to be conducted.

53. Many of the staff performance issues highlighted would only come to light after the fact. It is known that there were serious deficiencies in the planning and execution of the initial s. 53 search which required the entire process to be repeated. As detailed later, these deficiencies were indicative of a cumulative decline in dynamic security practices at Kent and reflect significant labour-management relations issues.

54. The action plan to the *Fact-Finding Review* notes that the stand-alone Tactical Team has been ‘disbanded’ or ‘restructured’ and that its members ‘integrated’ back into the regular ERT regional cluster. It is not clear how these can be considered ‘corrective’ measures or provides reasonable assurances that deliberate violations of law and policy, including the Tactical Team’s denial of pointing weapons directly at compliant inmates along with its failure to submit daily use of force reports on its actions, will not be repeated. The internal review process fails to provide insight into the critical question of *why* the actions of an *extra-legal* armed unit were not actively monitored or subject to any management review (and potentially therefore) correction over the course of 10 days.

55. In fact, as the *Fact-Finding Review* notes, we know that these events “went un-observed ... and

²⁰ The term ‘threat’ is used in the Warden’s post-Situation Report.



were not identified until the ERT video tapes were reviewed approximately ten days after the searches ended.” For a system that can authorize interventions up to and including the use of lethal force, this is a disturbing finding.



ANALYSIS

56. In the course of our investigation, the OCI identified five thematic areas of concern:

1. Use of force issues, including improper and unwarranted deployment of firearms, inadequate review and inappropriate reporting requirements.
2. Breaches of law and policy regarding inmate privacy and dignity.
3. Lack of management oversight and accountability.
4. The existence of an *extra-legal* TAC team that had no formal policy authority.
5. Health care non-compliance.

Use of Force Issues

57. Use of force is the most serious and highest risk intervention that the CSC may take toward an offender. Due to its inherent risks, use of force is governed by procedures and practices that must be rigorous, responsive and in conformity with law and policy. The Service's use of force review framework must allow for reasonable and legal force, be able to inhibit inappropriate uses of force, set minimum standards for compliance and allow for timely and effective corrective measures when violations occur.

58. The *Corrections and Conditional Release Act* (CCRA) requires that “*the Service use the least restrictive measure consistent with the protection of the public, staff members and offenders.*”

Commissioner's Directive 567-1 (*Use of Force*) specifies the roles and responsibilities, procedures, reporting requirements and review mechanisms related to all uses of force within CSC. The policy defines use of force as: “*any action by staff, on or off of institutional property, that is intended to obtain the cooperation and gain control of an inmate, by using one or more of the following measures:*

- a. non-routine use of restraint equipment;*
- b. physical handling/control;*
- c. use of inflammatory and/or chemical agents*
- d. use of batons or other intermediary weapons;*
- e. use of firearms; and*
- f. deployment of the Emergency Response Team (ERT), in conjunction with at least one of the use of force measures identified above.”*

59. Within this policy framework, the use of firearms is deemed a “*last resort,*” in conformity with the legal principle of the “*least restrictive*” measure and CSC's *Situation Management Model* or (SMM).²¹ Commissioner's Directive 567 (*Management of Security Incidents*) further specifies the rules governing the management and control of use of force within CSC:

- 8. The management and control of situations must be accomplished through a framework which includes but is not limited to:*
 - a. the use of force, ensuring that the response and the manner in which force is used are appropriate and in accordance with CSC policy*

²¹ The *Situation Management Model* (or SMM) is used by CSC staff to prevent, respond and resolve situations using the safest and most reasonable intervention. The *Model* requires continuous assessment and reassessment of the situation and response, including consideration of possible use of force options, such as restraint equipment, inflammatory spray and physical handling. The deployment of firearms is recognized to be an option of ‘*last resort.*’ A copy of the *Situation Management Model* is appended to this report.



- and applicable legislation (CD 567-1)*
- b. the use of and responding to alarms to provide a secure environment and ensure the protection of staff, inmates, visitors and the public (CD 567-2)*
- c. the appropriate use of restraint equipment to ensure the safety of the inmate and the institution (CD 567-3)*
- d. the safe and secure use of chemical agents and inflammatory sprays when required (CD 567-4)*
- e. the use of firearms as a last resort to protect the lives of staff, other inmates and the public (CD 567-5).*

60. In the case of the Kent searches, given the deployment of the ERT/TAC team, an intervention strategy was required. Accordingly, a *Situation, Mission, Execution, Administration and Communications Action Plan* or *SMEAC* was drawn up during the evening of January 7, 2010 by the Warden in consultation with a Tactical Team member, the ERT Leader and a Union of Canadian Correctional Officers (UCCO) representative.²²

61. Due to the potentially lethal nature of the threat, it was agreed that tactical members would be armed and present during all inmate movements within unsearched areas. Although subsequent *SMEACs* would contain more detail, the original *SMEAC Action Plan* dated January 7, 2010 stated:

Two Tactical Team members will be present to provide lethal over watch of the six man cell extraction team deployed to conduct the patrol in the living units. The IERT members will use

protective ballistic body armor and ballistic shields for further protection.

62. The authorized deployment of armed tactical members was to provide ‘*lethal over watch*’ for ERT members in contact with inmates in unsearched units. The tactical unit was to take up a physical position in the cellblock common areas at the head of the ranges. As the Warden pointed out in his post-assessment review, the deployment of the Tactical Team did not specifically authorize the pointing of firearms, which would have constituted a use of force, nor did the *SMEAC* authorize the presence of firearms on the living units, ranges or in common areas of the penitentiary. The only force pre-approved by the Warden was deployment of the ERT and the application of restraints to perform cell extractions and escorting duties.

63. Notably, the original *SMEAC* was signed off by a Tactical Team member (and not the ERT Team Leader as required), the Warden (acting as crisis manager/Institutional Head) as well as a Correctional Supervisor who was designated the role of ‘*on-scene controller*.’ As will be noted, these positions and titles carry precise meaning, as they designate the roles, responsibilities and authorities of staff authorized to respond to and manage an emergency or crisis situation. For the most part, the responsibilities of the ‘*crisis manager*’ and ‘*on-scene controller*’ were either ignored or not properly executed throughout the duration of the lockdown resulting in a near total lack of management oversight and monitoring of ERT/TAC team activities.

²² A *SMEAC Action Plan* specifies the roles and responsibilities of staff members responding to an emergency. It provides for pre-authorized use of force measures and specifies the equipment, up to and including firearms and ammunition, that can be used during the intervention. A template copy is appended to this report.



64. Eventually, six (6) other *SMEACs* would be developed to authorize the use of force during various phases of the s. 53 searches. They specified the procedures by which the response team would extract offenders from their cells. The basic ‘*cell extraction*’ procedure involved:

1. Verbal order to the offender to move backwards towards the cell door
2. Application of handcuffs by ERT members through the food slot opening
3. Cell door opened and inmate removed from the cell
4. Inmate frisk searched and a metal detector wand passed over the body
5. Inmate escorted to a designated common area for the purpose of conducting a strip search behind a modesty barrier

65. For non-compliant inmates, the *SMEACs* authorized the following procedure in accordance with the *Situation Management Model*: verbal orders and warnings, then inflammatory spray followed by more verbal orders and warnings. In cases where these use of force options would prove ineffective, the *SMEACs* further specified that tactical intervention and ‘*dynamic entry*’ into the cell would be utilized and that the *Crisis Manager*²³ would be consulted prior to ‘*dynamic entry*.’²⁴ After entry into the cell, the ERT/TAC team would gain control over the offender using approved physical handling techniques consistent with CSC policy and the *Situation Management Model*: verbal direction,

restraint equipment, inflammatory spray, special handling, and baton/other intermediary weapons. The *SMEACs* also specified that all range walks, medication dispensary and meal routines would be carried out by ERT/TAC personnel, and that all interactions with inmates would be videotaped.

66. As the videotapes reveal, the cell extractions were not performed as per the instructions in either the initial or subsequent *SMEACs*. The video evidence showed two Tactical Team members present with firearms on either side of the cell door for almost every cell extraction. In many cases, tactical members are seen pointing firearms directly at compliant inmates as handcuffs are being applied. In other cases, firearms are pointed directly at inmates after handcuffs have been applied, and as cell doors are opened. The video evidence shows that inmates were compliant and following instructions during nearly all cell extraction procedures.



²³ In all *SMEACs*, the Warden was designated and signed off as the “*Crisis Manager*,” an authority delegated to the Acting/Assistant Warden in the *SMEAC* dated 2010-01-16.

²⁴ Some of the technical terminology used in the *SMEACs* may not have had a clear meaning for responders or management alike. For instance, the *SMEACs* use terms such as ‘*tactical intervention*,’ ‘*dynamic entry*,’ ‘*high or low profile escort*,’ all of which may have meaning to the ERT/TAC response team, but do not adequately convey whether and how firearms will be used in carrying out the stated response.



67. There are significant departures and discrepancies in the level of detail and accuracy of the reporting captured in the *SMEACs*, especially evident as the lockdown advanced. The six *SMEACs* that were prepared after January 7th are largely duplicative cut-and-paste efforts, containing only minor variances between them. However, to be effective, the *Situation Management Model* requires continuous assessment and reassessment of the evolving situation and response options, not the kind of repetition found in the *SMEACs*.

68. Notably, the first *SMEAC* observes that the inmate population was ‘quiet.’ In contrast all subsequent *SMEACs* report the emotional and physical state of the population as ‘verbally resistive/physically uncooperative.’ This latter description directly contradicts the Warden’s post-assessment of the population, which he described as ‘compliant.’ The Office’s review of the video record confirms, with one or two exceptions, that inmates were indeed compliant and generally responsive to staff directions/commands. Indeed, if anything, the inmates are seen to be remarkably restrained in their behavior, given that firearms were often directly pointed at them, only a few feet away.



69. The *Collaborative Review* and the *Fact-Finding*

reports made a number of important observations regarding the ERT/TAC team response. For instance, the *Collaborative Review* concluded that although the use of firearms was consistent with the options supported in the *Situation Management Model*:

... the manner in which the ERT Tactical component deployed the firearms appears to have been outside the scope of authorization granted by the Warden in the *SMEACs*, was not the least restrictive measure available to the situation, and in some cases constituted an excessive and dangerous deployment of firearms.

70. The *Collaborative Review* also determined that “the *SMEACs* completed during the incident were vague, contained blanket statements as well as inaccurate information. They did not contain adequate detail with respect to the deployment of firearms during the incident.” The report assessed that there had been 379 ‘reportable’ uses of force. Of these:

- More than one quarter (100 instances) involved the direct pointing of firearms at inmates, including:
 - Several cases where a firearm was pointed at the food slot while handcuffs were being applied to compliant inmates; and
 - Several cases where a firearm was pointed at compliant inmates as the door opens.
- For one third of cases (128 instances), the position of the firearms could not be determined due to video camera placement or as a result of missing video footage
- More than half (193 instances) were partially or completely missing video footage.



71. For its part, the *Fact-Finding Review* determined that the Warden's decision to implement the exceptional searches was in conformity with law and policy. However,

Inappropriate and unwarranted levels of force were practiced by armed TAC members while on the ranges with ERT members pointing their weapons directly at compliant inmates who were amenably following the directions of the lead ERT team member.

The review recognized that the initial and subsequent SMEACs did not authorize Tactical Team members to escort ERT members down the range:

The authorized deployment of armed TAC members contained in the first SMEAC to provide lethal over watch for ERT in contact with inmates in unsearched units was from a position in the cellblock areas at the head of the range. This was not followed with armed TAC members escorting ERT members down ranges.



72. Furthermore, the *Fact-Finding Review* found that the Tactical Team leader not only failed to submit use of force reports, but also provided daily situation reports that directly contradicted the

videotape evidence:

The Tactical Team overstepped their authority on the deployment of firearms and failed to report force used in support of the Emergency Response Team Members.

Tactical Team members did point firearms directly at compliant inmates and thus did use force on a routine basis. The Tactical Team Leader submitted a daily report attesting that firearms were not pointed with target acquisition and that the Tactical Team members did not use force that day. Tactical Team members did not submit any use of force report.



73. Pacific Region Headquarters provided the following explanation with respect to tactical members deploying inappropriate and unwarranted levels of force:

The TAC Team established an intervention strategy under the belief that they were in imminent danger from a firearm smuggled into the Living Unit. This resulted in actions that were not known and approved by the Crisis Manager nor RHQ. KI and RHQ later deemed that the actions were unsafe and inappropriate.

It was not within the Tactical Team's role or mandate to establish its own intervention strategy or deviate from the approved intervention plans. While the *SMEACs* were indeed sparse in terms of detail, they did not authorize Tactical Team members to establish an intervention strategy by which they would be directly involved in cell extractions and/or escorting inmates down the ranges at gunpoint. Over the course of several days, policy and human rights violations occurred routinely without any member of the Warden's senior management team ever questioning whether legal or policy boundaries were being overstepped during operations. The Tactical Team leader repeatedly submitted reports that would later be contradicted by videotape evidence.

74. Given this ensemble of facts, the OCI is of the view that the ERT/TAC Team chose to circumvent the law and CSC use of force policy. The pointing of firearms at inmates who were, with very few exceptions, compliant with verbal orders and already physically restrained in handcuffs was unnecessary and unsafe. Upon application of physical restraints and at the point when the cell door is opened and a compliant inmate emerges, there was simply no reason to require the continued use of potentially lethal force. Notwithstanding the *vagueness* of the *SMEACs*, the OCI believes the law and current Commissioner's Directives provide sufficient instruction and direction that must be observed by all CSC employees during use of force interventions. Legal principles, statutory requirements and policy directives cannot be abandoned for convenience or to achieve labour/management peace. The 'least restrictive' principle, as well as use of force policy objectives, were violated *en toute connaissance de cause*.

75. The *Collaborative Review* notes that due to other circumventions of policy the 379 uses of force generated over the 10 day duration of the lockdown were grossly underestimated:

*The site made the decision that the modified routine of having the ERT complete all routine tasking during this incident became the new institutional routine; therefore, some activities were not deemed to be reportable uses of force. This is not in accordance with CD 567-1 Use of Force (...). There is no provision in policy for any use of force to be deemed as routine.*²⁵

A number of activities were not recognized as reportable uses of force and as a result Form 0754 Use of Force Reports was not generated for all uses of force. Given the lack of documentation and video footage, the number of activities of this nature cannot be determined.

76. Paragraphs 46 to 48 of Commissioner's Directive 567-1 *Use of Force* specify the criteria and procedures for preliminary and expedited use of force reviews:

46. Upon completion of any incident involving the use of force, a preliminary review must be completed by the Institutional Head, Deputy Warden, Assistant Warden of Operations, Correctional Manager of Operations, or equivalent or any combination thereof, within two (2) working days, in order to identify any serious concern or deficiency.

47. In cases where the preliminary review indicates possible serious violations of legislation or policy,

²⁵ The use of the Emergency Response Team (ERT) for routine inmate escorts, for example, was deemed a 'non-reportable' use of force due to this decision.

or any other aspects which may cause serious concerns, the Assistant Deputy Commissioner, Institutional Operations, the Director General, Security, and when applicable the Deputy Commissioner for Women, the Assistant Commissioner, Health Services, and the Director General, Aboriginal Initiatives, must be informed immediately in writing by the Institutional Head with a description of the incident, a summary of any concerns, and a plan to address the noted concerns (e.g. a use of force incident that involved excessive use of force or resulted in the death of or serious injury to an inmate or staff member).

48. In these cases, the Director General, Security, in consultation with the Assistant Deputy Commissioner, Institutional Operations, and the Assistant Commissioner, Correctional Operations and Programs, must decide if an expedited review of the incident, as defined in paragraph 14, should commence immediately and, if so, notify Regional Headquarters, the Institutional Head and the Office of the Correctional Investigator accordingly.

77. Given the early indications that there had been significant law and policy breaches, it was perhaps reasonable to expect the Service to conduct an expedited use of force review, as per revised policy directions. Citing the extraordinary volumes of use of force incidents and videotape footage to be reviewed (anywhere between 120 and 200 hours of video footage that was not date stamped, not in chronological order and where inmates were not clearly identified to the camera, all contrary to policy), Kent and Pacific Region officials established the “Collaborative Review Team” to conduct a joint institutional and regional use of force review. This decision was taken to ‘expedite’ the

review process.

78. The OCI acknowledges the large volume of documentation and video recordings for review in this case. Although *joint* (institutional and regional) use of force reviews have been completed for large incidents in the past, the decision to adopt a streamlined ‘collaborative’ review process is problematic in this case given the deployment of an armed response unit. When placed in context of the Service’s recent attempts to reduce its use of force review and reporting requirements and procedures, this decision seems especially ill-advised. In recent years, several Commissioner Directives have been amended to effectively and cumulatively diminish the number and type of use of force incidents subject to review. Under new guidelines, the deployment of an Emergency Response Team (ERT), the charging of a firearm, the pointing of inflammatory (pepper) spray as a weapon and the application of physical restraints in the case of a ‘compliant’ inmate with mental health issues are all now considered ‘non-reportable’ uses of force.²⁶

79. This situation is unacceptable and untenable. It appears that operational demands, limited resources and competing priorities – and not legal requirements, accountability and oversight concerns – are driving this series of so-called use of force policy ‘reforms.’ In the Kent case, when law and policy were routinely violated by an *extra-legal* unit operating with apparent impunity, we must question the CSC’s decision to dilute, reduce and streamline the rigour and diligence of its use of force review and reporting procedures.

80. The disregard of ERT/TAC members for the legal requirement for using the ‘least restrictive’

²⁶ The OCI does not share CSC’s view that these should be ‘non-reportable’ uses of force.



measure and for policy obligations is disturbing. After reviewing the video-tape evidence of these events, as well as the *Collaborative* and *Fact-Finding Reviews* and follow-up action plans, the OCI questions how hundreds of other uses of force can be considered ‘*non-reportable*.’²⁷ At the operational level, lack of clarity on use of force policy can lead to confusing, potentially contradictory understanding of what constitutes a ‘*reportable*’ versus ‘*non-reportable*’ use of force. There are indications that this confusion allowed the Tactical Team to simply not consider many of their activities, up to and including pointing loaded weapons at inmates, to be a ‘*reportable*’ use of force.

81. It bears reminding that the OCI made the following recommendation in its most recent Annual Report:

All incidents that involve the use of chemical or inflammatory agents, or the displaying, drawing or pointing of a firearm up to and including its threatened or implied use, should be considered a reportable use of force.

In response to this recommendation, the Service stated that it will “*clarify which uses of force are reportable and non-reportable by October 2010.*” The OCI is still awaiting CSC’s ‘clarification.’²⁸

82. In the events under investigation, a series of deliberate management decisions were taken that effectively collapsed levels in the post-use of force

review exercise and diminished rigour in the investigative process. The decision to first proceed with a joint (Kent Institution and Regional Headquarters) ‘*Collaborative*’ use of force review followed by a ‘*Fact-Finding*’ review into the two s. 53 searches rather than conducting a formal *National Board of Investigation* into the entire scope of events at Kent is perhaps indicative of larger administrative and governance issues within the CSC. Although the Regional Deputy Commissioner has the authority under the general powers of management to review and report upon any matter relating to the operations of the Service, given the seriousness of the breaches already known to Regional officials it would have been appropriate for the Commissioner of Corrections to have convened a National Board of Investigation under Section 20 of the *CCRA*. In the absence of a strong centralized review and quality control function at national headquarters, there was erosion in the quality of the use of force reviews undertaken and only limited attention paid to adherence to the least restrictive principle. These issues are indicative of a more generalized failure to learn and apply lessons and sustain corrective measures over time and by Region. In other words, what happened at Kent could happen elsewhere in the system.

Breaches to inmate privacy and dignity

83. Not surprisingly, few inmates raised concerns about the use of force as the events were unfolding. Subsequently, a number of inmates raised concerns

²⁷ According to National Headquarters (NHQ) estimates shared with this Office in correspondence dated July 13, 2010, there were approximately 981 uses of force and about 200 hours of video footage generated during the Kent response. The discrepancy between what was officially reported/reviewed at the Regional level (379 uses of force) and NHQ estimates can be attributed to the poor quality and fragmented nature of the video and documentary records.

²⁸ CSC was provided a draft copy of the OCI’s 2009/2010 Annual Report on May 30, 2010. It was tabled in Parliament on November 4, 2010 and contains CSC’s response.



with the Warden via the Inmate Committee, the internal complaints and grievance process, Prisoner Legal Services, as well as with this Office during an institutional visit on April 14-15, 2010. The main inmate concerns relayed during this visit related to the level of fear and anxiety that the events generated, especially for mentally ill offenders. Many inmates felt the exceptional display of force was designed to instil fear and intimidate the population, not respond to the perceived risk.



84. In addition to the fear generated, the *Collaborative Review* made it clear that “*the privacy and dignity of inmates was not consistently respected throughout the search process.*” Specifically, it underlined that: “*of the 379 uses of force, privacy and dignity was not respected for 70 offenders and it was not possible to determine if it was for an additional 97 offenders.*” It took nearly one month for Kent Institution to solicit the inmates’ version of the searches and lockdown. The Institution utilized a template use of force form which most inmates refused to sign, indicating that they either disagreed with its contents or did not want to be perceived as cooperating with the ERT/TAC response.

85. Non-segregated inmates, after being removed from their cells, were escorted to one of three rooms located in the hospital control post area of the institution where strip searches could be conducted. Each inmate was escorted by two ERT members to the control area to be strip searched and body cavity scanned utilizing the Body Orifice Security Scanner (BOSS) chair. Inmates were then escorted to the gymnasium to be held until the search of their cellblock was complete. The strip searches of inmates housed in the Segregation Unit were carried out in a separate common cellblock area, behind adequate privacy barriers.

86. The *Collaborative Review* noted serious privacy and dignity concerns regarding the strip searches conducted in the Hospital Control Post area:

In many cases, staff were allowed to pass through hospital control and other ERT members were routinely allowed to walk freely through hospital control, which is noted to be the main hub of the institution, while strip searches were in progress. No privacy barrier was used over the doorways, which were left open.



Upon reviewing a sample of videotapes of the events, the OCI witnessed several instances of the situation described above, including some where female officers were present in an area where inmates were being strip searched contrary to policy.



87. For its part, the *Fact-Finding* report acknowledged that basic legal conditions of confinement were not met:

Greater efforts should have been expended to meet some of the basic living condition requirements outlined in Section 83 of the CCRA, especially: clean clothes; clean beddings; toilet articles necessary for personal health and personal cleanliness; and a more rapid return to the provision of even short periods of fresh air exercise.

Major concerns from the inmate population surrounded the lack of communication from management on the reason for the search and the search timeframe.

Inmates indicated that they went without showers for days and were not provided with soap, and, in some cases, toilet paper in their cells. As the *Fact-Finding Review* commented, given the compliant nature of

the institutional population, the delivery of items and services to meet basic living needs, including the opportunity for fresh air exercise (a legal requirement), “*would not have increased the threat or risk level of the existing situation.*” In other words, the most basic necessities of life were restricted beyond what was reasonable or necessary, contributing to conditions of unnecessary physical deprivation, and, in some instances, mental anguish.

88. The *Fact-Finding Review* reported that some inmates, located in cellblocks that were on full lockdown for up to six (6) days, “*went without showers and exercise or change in bed linens and towels for an extended period.*” The exact length of this extended period cannot be determined because of a lack of documentation. The *Collaborative Review* noted, however, that “*towards the end of the incident, a number of inmates were visibly agitated due to a reported lack of hygiene routine.*”

89. It is clear that basic standards of dignity and privacy were not respected during the lockdown and ensuing searches. Many locked-down inmates were held in their cells for days on end with no clear indication when this state of deprivation would end. In addition to the unjustifiable fear, intimidation and anxiety generated by having loaded firearms pointed at their person, there were numerous and serious breaches to inmates’ privacy and dignity during the strip searches. The OCI concludes that this was an unnecessary, excessive and arbitrary abuse of correctional power and authority.

Lack of Management Oversight and Accountability

90. In addition to examining questions about the *what* and *how* of these events, the OCI was also focused on finding out about *why* these events



happened in the first place. While the *Collaborative Review* focused solely on the uses of force, the *Fact-Finding Review* delved a bit deeper into the precursors to the events. The OCI's investigation revealed two contextual long-term risk factors contributing to the s. 53 searches: the historical lack of dynamic interaction between staff and inmates at Kent Institution and the associated deficit in the gathering and analysis of security intelligence over the last several years. These are critically important in understanding the events of January 2010.

91. The *Fact-Finding Review* made the following observations with respect to the decline in dynamic security at Kent Institution:

Compared to a dynamic interaction baseline, established by a Board of Investigation conducted approximately a year before the Section 53 searches currently under review, the extent of dynamic interaction between staff and inmates at KI had declined further from the previously established inadequate level.

The new rostering system creates a situation whereby Correctional officers spend less time on their assigned cellblocks and thereby restricts opportunities to access knowledge of the cellblock inmates or cellblock events and politics. Consequently, the system does not facilitate the dynamic interaction between line staff and inmates.

The review underlined the fact that dynamic security at Kent Institution had been steadily deteriorating since the 2003 major riot. The review team's interviews with Kent Institution staff also indicated, with one exception, that the interaction between correctional staff and inmates had progressively declined in both quantity and quality over the past year. In addition, the team stated their belief that the

local Union of Canadian Correctional Officers (UCCO) executive actively encouraged and supported static security. It even went so far as to suggest that Kent management over-reacted to the danger because of Union concerns:

Management was responsive - perhaps overly so in some of their decisions - to the apprehensions of line staff and their union, and through a thorough and comprehensive search of the institutions addressed their concerns.

92. The review also noted that prior to the *zip gun 'kite'* being found, there was no other security intelligence that would have led staff to believe that a lethal, ballistic threat might have been introduced in the institution. It directly attributed the deficit in security intelligence information at Kent to the erosion of staff/offender interactions, and therefore dynamic security, over the years:

A consequence of the extremely low dynamic interaction between the staff and inmate at KI was the depleted level of security intelligence information that was being gathered and analysed. This finding was congruent with the judgement of the Board of Investigation conducted approximately a year prior to the current review.

Although institutional management and the Security Intelligence Officers were making efforts to improve both the dynamic interaction between staff and inmates and the gathering and analysis of security intelligence; still, their interventions were not, as of yet, perceived by the staff interviewed to have improved either of these critical areas.

93. Commissioner's Directive 560 (*Dynamic Security*) is clear on the critical role that constructive relations between inmates and staff play in ensuring



institutional safety and security:

1. *To optimize a safe environment for employees, offenders and the public through meaningful interactions between these parties.*

2. *It is the responsibility of all staff who interact directly with offenders to enhance their knowledge-base of the offenders' activities and behaviours by increasing awareness of the factors that contribute to, or may compromise the safety and security of employees, offenders and the public.*

94. In recent years, the Office has placed an emphasis on the importance of dynamic security principles and practices to the overall safety of staff and inmates. The OCI's 2009-10 Annual Report, for instance, observed:

As we see it, a general decline in dynamic security practices has led to an over-reliance on more static methods of exercising custodial control and compliance. A more restricted and austere prison regime does not necessarily lead to safer working conditions for staff or a more positive living environment for offenders.

In addition to the noted deficiencies in dynamic security at Kent Institution, the OCI is preoccupied with management's failure at all levels of the Correctional Service to recognize and treat the events under review as an emergency or crisis situation, in accordance with policy. This failure, in our view, contributed to the intimidating and provocative display of armed force.

Applicable policy

95. The relevant policy that governs staff responses to emergency situations is detailed in the Service's

Security Manual and Commissioner's Directive 600 (*Management of Emergencies*). The *Security Manual-Part II-Glossary of Terms* defines a crisis in the following manner:

10. *A crisis is a situation with the potential to:*
 - a. *Endanger the public, staff or inmates,*
 - b. *Damage or destroy public property, and*
 - c. *Affect the public image of CSC, and thus the Government of Canada.*

11. *Crises can result from natural and human causes. They may affect a single individual or cause complete and uncontrolled disruption of Service operation Invariably, they have the potential for disastrous consequences.*

12. *The terms crisis, emergency and incident are used interchangeably in these guidelines.*

96. Paragraphs 7 and 37 of Commissioner's Directive 600 (*Management of Emergencies*) clearly state that, in the event of a crisis, a senior officer (normally the Institutional Head or Warden) assumes responsibility for the management and resolution of the crisis and only that person can authorize the use of force during an emergency. The *Collaborative Review* recognized that the incident was not officially deemed a 'crisis situation' under the Crisis Management Model. It noted that the ERT Leader had appropriated the term 'Crisis Manager' throughout the *SMEACs*, instead of the appropriate reference to the Institutional Head (or Warden).

97. The policy provisions of CD 600 were not followed, as the *Fact-Finding Review* indicated in its findings: "*The management supervision and monitoring of the ERT/TAC team activities, during both the first and second Section 53 searches, was*



for all intents and purposes non-existent.” It would have been reasonable to expect management to closely oversee the searches and play a strong challenge function, given the armed presence of TAC team members. In addition, as both the Collaborative and Fact Finding Reviews note, the written documentation relative to the searches contained repetitive cut and paste statements, as well as inadequate level of detail, which by themselves should have triggered a management response:

The SMEACs completed by the team leader and presented to the Warden appeared to be based on a template. This format, although a time saver in emergency situations, should not be a blanket statement for every situation.

The SMEACs completed during this incident were vague, contained blanket statements and contained inaccurate information throughout. They did not contain adequate detail with respect to the deployment of the firearms during this incident.

The TAC team leader (2 I/C of the ERT/TAC team) submits the Officer Statement/Observation Report on the activities of the TAC team in providing protective over-watch of ERT team members. This report also contains the statement noted previously on January 9th referencing the safe pointing of firearms and reporting no use of force.

98. The OCI also raises concerns with CSC’s internal review and reporting of the events. It was only on March 11, 2010, nearly six weeks after the initial review of the videotapes, that the Service advised the Office that it had decided to set up a project team at Regional headquarters to complete reviews for potentially 900 uses of force and 200 hours of video records. CSC also provided conflicting information to the OCI on their

investigative process. The Security Branch at national headquarters and Kent Institution initially advised the OCI that a *National Board of Investigation* (NBOI) had been convened. This was later refuted by the Investigation Branch at national headquarters. Ultimately, the Office was advised on May 11, 2010 that a regional level of review had been convened by the Regional Deputy Commissioner of the Pacific Region.

99. This series of internal decisions falls considerably short of the OCI’s expectation that a National Board of Investigation, and not a regional review, should have been convened under section 20 of the *Corrections and Conditional Release Act*. Commissioner’s Directive 041 (*Incident Investigations*) states that the convening authority for use of force or a major disturbance investigation is National Tier I (Commissioner) or National Tier II (Director General of Investigations). The Correctional Service opted instead to convene a regional *Fact-Finding Review* presided over by the Regional Deputy Commissioner of the Pacific Region. This departure from the legal process established under Section 20 of the *CCRA* does not provide the same degree of procedural safeguards, and, in the view of the OCI, significantly downplays the seriousness of the events, including the accountability gaps in their reporting and review.

100. The Office concludes that the long-standing decline in dynamic security at Kent Institution created the culture, conditions and environment for the January 2010 lockdown. In our view, the ascribed lethal nature of the threat and the duration and magnitude of the search should have warranted the designation of a crisis or emergency situation. The handling of the crisis would then have been governed by clear policy direction. Instead, in consultation with the ERT and the Union,



management decided to dispatch what was essentially an *extra-legal* response team to manage the situation. Over the course of several days, this team effectively operated in a policy and management void.

101. The role and decision-making of CSC's national headquarters in these events should not escape scrutiny. Given the serious violations of law and policy, the decision at the national level to forego a formal section 20 National Board of Investigation into these events is inappropriate.

The *extra-legal* Tactical Team

102. This section of the report examines the history and role of the Pacific Region's Tactical Team, including questions surrounding its designation as a '*pilot*' project, the only such specially armed entity in the Correctional Service of Canada. On these issues, both the *Collaborative* and the *Fact-Finding Reviews* provide little insight.

103. The OCI requested all documentation from the CSC concerning the history, mandate, and role of the Pacific Region's Tactical Team, with a view to assessing the extent to which this armed unit was properly and appropriately subject to regular accountability, performance and evaluation reviews. The official records provided by CSC on these matters are sketchy and incomplete at best; at worse, they are inconsistent and even misleading. Prior to its cancellation on April 1, 2010, the Tactical Team had been a '*pilot*' project operating for over 12 years solely in the Pacific Region of CSC. According to one internal CSC document, "*the Tactical Team is still a pilot project, and technically a deviation from policy.*"

104. As mentioned earlier, for economy and

efficiency reasons, the Pacific's Emergency Response Team (ERT) was based on a Regional cluster model consisting of five components: Riot (East), Riot (West), Tactical, Fraser Valley Institution (regional women's facility) and Crisis Negotiation. The 12-man Tactical Team was drawn from members of the Pacific Region's ERT structure (ERT - Riot). The Region's five maximum and medium security institutions contributed to a centralized fund that provided training, equipment and personnel. The ERT teams were managed regionally (East and West) by a designated Wardens' group, and was overseen by a Regional Management Committee. As a common resource, the ERT teams were trained to complement one another and to provide a *Crisis Manager* with a number of response options in an emergency or crisis situation.

105. The Tactical Team was regionally-based and was not separated by East or West geographic distinctions. It was specially trained in hostage rescue, high security escorts, covert surveillance, and breaching. According to documents, "*during riots, tactical members normally provided protective 'over-watch' under the command of the ERT (Riot) leader.*" Although the tactical component trained and deployed jointly with the ERT team, it also engaged in very specialized training emphasizing "*stealth, speed and firearms marksmanship.*"

106. In the course of this investigation, the OCI could find no evidence of any defined or set end date for the Tactical Team pilot project and no specific evaluative criteria, timelines or milestones anywhere on official record. Although the documentary record is far from complete, the following decision points emerge:

- The Pacific's Tactical Team was reviewed and '*approved*' by EXCOM in 1998, following



discussions first initiated in 1994/1995 (although the OCI could find no official document recording this decision).

- In March 2003, the decision was made at a national level ERT meeting to include tactical components within the ERT, following a complete analysis of the two teams. Notably, ‘*national standards*’ for tactical deployments were to be developed and implemented.
- The Pacific Regional Executive Committee minutes of February 3-4, 2009 indicate that national headquarters would develop a “*pilot project (sic) to evaluate the tactical ERT for the 1st time.*”
- In March 2009, a consultant’s report is tabled entitled: *Final Report: Review of Pacific Region Emergency Response Team (ERT) Pilot Project*. The review concluded that the ERT structure is a viable, cost effective and model practice for the Pacific Region.
- On February 10, 2010, one month after the Kent events, EXCOM tasked one of its Assistant Commissioners to develop a ‘*national approach*’ to tactical capabilities within the CSC by June 2010. The Office is not aware whether such a review was ever conducted or whether such an approach exists.
- On April 1, 2010, following an EXCOM decision, the Pacific’s Tactical Team was officially disbanded and the pilot that had been operating since 1998 was cancelled. All but four of the former Tactical Team members resign. Most members are simply integrated back into the Regional ERT structure. Significantly, there is no further reasoning provided

to support this decision, although Regional correspondence indicates that, as a result of this decision, “*there will be no more ‘dual command’ problems during incidents.*”

107. In reviewing the records made available, the OCI expected the Correctional Service to provide a comprehensive accounting for how and why the Pacific’s tactical unit, the only self-described unit of its kind could evade virtually all forms of evaluation and accountability for twelve years. Even though records as far back as 2003 indicate that the Pacific’s stand-alone Tactical Team was ‘*not supported*’ at the national level, this team continued to train and deploy for another seven years. The Office found no evidence that so-called ‘*national standards*’ for tactical deployments had ever been developed, although this too was a commitment made in 2003 and repeated again in June 2010 after the Tactical Team pilot had been abandoned.

108. There is no doubt that the Tactical Team was known to CSC administrators at National Headquarters as various deployments over the years – e.g. the 2003 riot at Kent Institution, 2005 hostage taking at the Regional Treatment Centre, 2008 riot and hostage taking at Mountain Institution – were reviewed by National Boards of Investigation. A review of these investigations indicates that since its inception the Tactical Team operated in an environment that fundamentally lacked transparency and accountability. Many unauthorized activities and non-compliant behaviors observed in the Kent response are documented in previous internal investigations, notably: failure to record/capture use of force interventions on video; failure to approve or report unauthorized use or carriage of firearms, and;

²⁹ Eight (8) *National Boards of Investigation* reports referencing or mentioning the Pacific Region’s Tactical Team between 2003 and 2008 were reviewed by the OCI.



lack of clarity in the Tactical Team's role and command structure in the crisis response.²⁹ Consistent with the current incidents under investigation, use of force reporting was often vague, incomplete, contradictory or ambiguous. There appears to have been little in the way of a sustained effort to improve or correct these noted deficiencies, although the need for additional training and better communication and understanding of the Tactical Team's role are unifying themes in these internal reviews.

109. Moreover, the record indicates that Pacific Region security personnel attended national level Emergency Response Team meetings where tactical requirements for the Correctional Service as a whole would have been discussed. There were, therefore, a number of opportunities to review and assess the Pacific Region's Tactical Team operations. Considering it was a pilot project that had operated for 12 years and given that it was the only armed response unit of its kind within CSC, one could reasonably expect a comprehensive review to have been initiated. Unfortunately, this appears to have never happened.

110. The OCI reviewed the March 2009 *Final Report: Review of Pacific Region Emergency Response Team (ERT) Pilot Project*. Although Pacific Region officials commonly, if mistakenly, refer to this Report as a *National Audit* or an *Evaluation*, in fact it was neither. It was a review completed by a self-described 'Tactical Consultant.' The personal opinions contained in the review are far from national, exhaustive or authoritative in scope. The author did not challenge the notion or need for a tactical response unit in the Pacific Region (or indeed across CSC), determine how such a team could fit into the existing policy and legal framework, or examine accountability implications

of a dedicated armed unit at the institutional, regional and national levels. Strictly speaking, this review was limited to "*training material, equipment and weapons inventories*." Given the extraordinary use of force powers granted to Tactical Team members, the terms of reference for this review constitute a major legal and policy lacuna.

111. The consultant's report does contain a few important insights. According to the author:

With regard to the use of tactical intervention within the Crisis Management Model, it appears that the majority of managers are comfortable in using the ERT/Riot Teams to respond to incidents within the institutions but not nearly as confident in using their Tactical Team... Historically, firearms within institutions have been viewed as taboo and including them in option planning during a crisis may be perceived as inviting disaster (emphasis added).

It goes on to note the importance of establishing clear chain of command and communication channels between ERT and Tactical Team leaders, including an unambiguous understanding of *primary* versus *support* roles in responding to a particular crisis/emergency situation.



112. On this point, it is not clear from the *SMEACs*, review of the video evidence or examination of written post-assessment reports and reviews which component of the ERT team (Riot or Tactical) was leading or supporting the response at any particular time, nor indeed who was designated the role of ‘*Crisis Manager*.’ According to a Regional ‘*protocol*,’³⁰ in protective over-watch operations, the Tactical Team would normally fall under the overall command of the ERT (Riot) team leader who, in turn, would report to the *Crisis Manager* (presumably the Warden). Although command could switch during an incident as events dictate (e.g. the Tactical Team leader might assume command of a hostage taking, for example), the important point is that there is only one leader responsible for overall response command at any given time.

113. Importantly, also according to the Regional ‘*protocol*,’ the “*Tactical Team is called in after recommendation from the ERT (Riot) leader, however the Crisis Manager may call them directly. In either case the Regional Deputy Commissioner must be consulted prior to calling out the Tactical Team.*” As noted earlier, the first *SMEAC* dated 2010-01-07 was signed by a Tactical Team member, which appears to contravene the established ‘*protocol*,’ such as it is. The Warden’s post-Situation Report observes that the Regional ADCIO (Assistant Deputy Commissioner Institutional Operations) was ‘*updated*’ of the plan to use the Tactical Team at 1900 hours on January 7, 2010, after being ‘*informed*’ of the situation earlier that day at 1615 hours.

114. It is not clear whether these actions would

fulfill the requirement to ‘*consult*’ the Regional Deputy Commissioner (or presumably his/her designate) “*prior to calling out the Tactical Team.*” Both time and circumstances would seem to have permitted proper degree of consultation to have occurred at appropriate levels of approval and authority, delegated or otherwise. Precisely who was informed, when and under whose authority the Tactical Team was called out cannot be definitively determined from a review of the records made available to this Office. These are important chain of command and accountability issues as the decision to deploy weapons in a maximum security environment requires a careful, proportionate and calibrated response. It is not a decision that any Warden would take lightly; firearms are considered to be a weapon of ‘*last resort*’ in use of force options, and rightly so.

115. According to the Warden of Kent, the original decision to deploy the Tactical Team was made in response to the Union’s ‘*threat*’ to invoke a refusal to work provision under the *Canada Labour Code* in response to the danger of a suspected ballistic threat. In other words, the decision to deploy the Tactical Team was the result of a negotiated compromise to satisfy working conditions concerns.

116. As the searches of the institution advanced both in their duration and intensity, there was a change in the overall posture adopted by the Tactical Team, which differed significantly from the Warden’s initial authorization. Although use of force contraventions were observed from the outset, the tone and posture of the Tactical Team moved from providing lethal ‘*over-watch*’ from a position in the cellblock common areas at the head of the ranges to

³⁰ The only evidence the OCI could find of a Regional ‘*Protocol*’ refers to a singular, five-bullet slide contained in an undated presentation entitled, *Pacific Region Emergency Response Team: Power point training for CSC managers.*



an armed presence directly in the living areas. This degree and deployment of lethal force was never contemplated, much less authorized, by the Warden.³¹ Nor was this apparent change in Tactical Team posture and command structure reported by the ERT team leader to Kent management.

117. As the *Fact-Finding* action plan acknowledges, “the Tactical Team (TAC) and ERT had separate leaders which created a problem with accountability and communication.” Significantly, all but the first SMEAC was signed off by the ERT Team leader. As events progressed, however, it would appear that the Tactical Team leader assumed much of the features of overall command position, even if the SMEACs were dutifully signed off by the ERT team leader. In any case, there is no doubt that the actions and activities of the Tactical Team were not carried out as per the intentions and understanding of the *Crisis Manager* (Warden) and were possibly indicative of what regional authorities referred to as a problem of ‘dual command.’³¹

118. Unfortunately, neither the Warden nor any member of his senior management team attended to or observed ERT/TAC team activities to ensure their instructions were properly and appropriately carried out. It was not until videotape recordings of the events were reviewed ten days after the fact that it was determined that “*inappropriate and unwarranted levels of force were practiced by armed TAC members while on the ranges with ERT members by pointing their weapons directly at compliant inmates who were amenably following the directions of the lead ERT team member.*”

119. It is clear that the Tactical Team received little

internal or external scrutiny. Nominally considered a pilot and known to be a ‘*deviation from policy,*’ remarkably, this project had no end date, no evaluation criteria and no set target dates for review. Over the course of its 12-year evolution, the Tactical Team was discussed at the national level only a handful of times and was *reviewed* only once, in 2009. The OCI finds this situation unacceptable.

120. These facts point to the lack of consistent managerial oversight and accountability for an armed unit operating under CSC authority. We conclude that the Pacific Region’s Tactical Team was not sanctioned under national policy guidelines or legal authorities and therefore operated in a quasi or *extra-legal* capacity. Members of the Tactical Team displayed a cavalier attitude and disregard for use of force law and policy, for which there were no apparent disciplinary consequences.

Areas of healthcare non-compliance

121. During the two section 53 searches, the ERT/TAC team was the first point of contact for inmates requiring healthcare. Inmates receiving methadone were removed from their cells by the ERT/TAC team, escorted to the cellblock common area, provided their methadone and then retained in the cellblock common area for the required wait time before being returned to their cells by the ERT/TAC team. With respect to general medication, these were initially provided to the inmates through the food slots in their cell doors by health care officials (HCOs) wearing ballistic vests and escorted by ERT/TAC team members. However, several concerns arose with this practice and it was changed. Subsequently, inmates were extracted from their

³¹ In reaching the ‘dual command’ conclusion, the OCI relies on internal Pacific Region memorandums dated 2010-03-05 and 2010-06-25.



cells by the ERT/TAC team and escorted to the cellblock common area where the medical interaction and the delivery of medication occurred with normally attired HCOs.

122. Inmates receiving healthcare were first asked if they would follow instructions and orders. When they replied in the affirmative, they were ordered to stand in the middle of their cell and demonstrate they did not have concealed weapons by lifting their shirts front and back. They were then ordered to face the back wall and walk backwards to the cell door and present their hands through the food slot for handcuffing in the rear. Once handcuffed, they were ordered to stand where they could be observed until the door opened. They then had to back out of the cell, a wrist lock was applied and they were escorted off the range for frisking and searching with a metal detection wand. *The Fact-Finding Review* (FFT) determined the following:

When the FFT reviewed portions of the video record they were unanimously convinced that they observed compliant inmates obeying all instructions in a complete and peaceful manner having charged weapons pointed directly at them as they came out of their cells without protest and escorted off the cellblock range. The FFT also observed that on some occasions firearms were pointed directly at open food slots when inmates were amenably yielding their hands for handcuffing.



123. The review determined that the delivery of methadone was delayed by several hours on the first day of the search, while delivery/administration procedures were being worked out, but that there were no noted negative medical consequences or disruptive inmate reactions as a result of the delay. However, there was also an individual case that the ERT/TAC team denied a Health Care Officer entry to a unit, and therefore access to an inmate, near the beginning of the search period. The HCO indicated to the ERT/TAC team that the inmate would have a seizure if he did not receive his medication in the next few hours. The inmate did not receive his prescribed medication on time, had a seizure and was taken to an outside hospital.

124. The *Fact-Finding Review* determined there were no long-term negative consequences resulting from these incidents. It concluded that the delivery of healthcare services, prescription medications, and methadone were generally appropriately maintained

during the two Section 53 searches. The OCI holds a different view. First, the several hour delay for methadone and the inmate suffering a seizure could have been avoided had the ERT/TAC team not taken over the entire institutional routine and HCOs



allowed to perform their duties. Clearly, health care obligations, and the need to meet professional standards of care demanded in sections 86 and 87 of the *Corrections and Conditional Release Act* were violated, as per the following provisions:

Obligations

86. (1) The Service shall provide every inmate with
(a) essential health care;

Standards

(2) The provision of health care under subsection
(1) shall conform to professionally accepted standards.

Service to consider health factors

87. The Service shall take into consideration an offender's state of health and health care needs

(a) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and

(b) in the preparation of the offender for release and the supervision of the offender.

125. In addition, the *Fact-Finding Review* remains silent on a major point, which is that lockdown conditions are basically the same as those in administrative segregation. Inmates who are administratively segregated are entitled to a daily visit by an HCO, for physical as well as obvious mental health reasons. Segregation and prolonged lockdowns are physically and mentally draining, and can have profound and lasting impacts on mental health. During lockdowns, healthcare staff should be allowed daily contact with affected inmates as there are distinctions to be made between security requirements and meeting basic health care standards and obligations.



CONCLUSION

126. The two s. 53 searches at Kent Institution between January 8 and January 18, 2010 are a prime example of ‘*things gone wrong.*’ The response was managed by members of a Tactical Team that the Correctional Service itself characterized as a ‘*deviation from policy.*’ Tactical members, working in conjunction with an Emergency Response Team, basically assumed control of a maximum security facility and followed their own rules. The disregard that the Tactical Team displayed for the law and established policies and procedures resulted in serious human rights breaches, in the form of inappropriate, unwarranted and dangerous use of force, serious infringements to privacy and dignity and unnecessary physical and mental deprivation over several days.

127. On the surface, these events may appear to be isolated to Kent Institution, or viewed as a product of the Pacific Region’s unique Emergency Response Team (ERT) structure. The fact that the Tactical Team has been disbanded and the pilot that sustained it has been cancelled might provide a degree of assurance that these events could not be repeated elsewhere in the federal correctional system. From CSC’s point of view, the events at Kent appear to be viewed in this light; as an aberration, a ‘*deviation*’, or just a few bad apples operating outside what is otherwise a robust and rigorous use of force framework.

128. The OCI disagrees. These events, including the existence of an unauthorized Tactical Team, are not easily explained as a simple *deviation* from CSC’s use of force framework, nor do they represent deficiencies unique to Kent Institution or the Pacific Region. Rather, they are the product of a system that does not adequately account for or learn from non-compliant use of force interventions. Indeed, Kent falls within a series of administrative decisions and

practices that have progressively compromised the reporting and review of certain uses of force interventions, such as the dangerous display and use of firearms in a federal penitentiary.

129. Ultimately, there are larger accountability issues within the Correctional Service of Canada that permit use of force interventions which are in contravention of law and policy. Despite numerous legal and policy violations that are documented in two internal reviews of the lockdown and searches, no disciplinary measures have been taken against any staff member at any level within the organization. The Office concludes that the chain of accountability that extends from staff members, the Warden and managers at the operational level and runs through several layers of regional and national levels of authority has been weakened by a governance system that effectively devolves answerability down to the lowest denominator possible. While the Tactical Team was nominally considered a ‘*pilot*,’ it does not justify contraventions of use of force policy and law, nor does it excuse maladministration.

130. The decisions, events and circumstances that created, sustained and ultimately dismantled the Pacific’s Tactical Team are a case study in CSC’s layered, but increasingly inadequate use of force governance. CSC’s national governing body – EXCOM – nominally approved a tactical unit for the Pacific Region in 1998. For the next 12 years this unit operated as an exception to CSC’s policy framework, seemingly with little regard to use of force rules. It was not subject to regular use of force review and oversight processes. It was not until video evidence was discovered, surfacing several days after the events of January 2010, that two internal *reviews* (not a *National Board of Investigation*) were launched. In the midst of this



internal review process, authorities in the Pacific Region were informed that EXCOM had taken the decision to *cancel* the pilot and *disband* the Tactical Team, effective April 1, 2010. No other details or justification for this Executive-level decision are provided. Former Tactical Team members were simply integrated or absorbed back into a unified ERT regional command structure.

131. As mentioned, various uses of force review mechanisms and corrective processes have been streamlined, collapsed or entirely eliminated in recent years, reportedly due to an increased work load pressures and inadequate resourcing levels to carry out an increasing number of uses of force reviews. Beyond resource, priority and volume issues that these decisions necessarily raise, they appear internally consistent with other policy and administrative changes that effectively eliminate so-called “*duplicative*” levels of internal review and oversight within the CSC. By intent or default, decision-making (with reduced checks and balances) has been moved down to the operational site levels. National levels of administrative review have been weakened, largely reduced to issuing policy instructions that, in all likelihood, will not be subject to any follow-up compliance review.

132. With respect to use of force reviews, the practical effect of this decentralized model is that literally hundreds of use of force files accumulate at Regional Headquarters only to be passed on to a review team in Ottawa that lacks the resources or authority to correct long-standing compliance problems. In addition, many former types of use of force interventions, including the display and charging of a firearm, are now considered *non-reportable* and therefore not subject to a national level of review or correction.

133. During the searches and lockdown at Kent, several areas of long-standing non-compliance with established use of force procedures were noted, including:

- failure to video-record, properly date and review hundreds of use of force interventions;
- failure to maintain dignity and respect privacy while conducting strip-searches of inmates;
- failure to report certain uses of force, such as pointing loaded and charged weapons directly at compliant inmates;
- failure to ensure proper medical follow-up to use of force procedures and;
- numerous other human rights violations and physical deprivations, including failure to provide adequate personal hygiene or opportunity for outdoor fresh air exercise.

134. The already tense and volatile environment created by a potential lethal threat was exacerbated by the failure to clearly communicate the intention of the searches and fully explain the procedures to inmates, leaving many to question the methods, safety and necessity of deploying charged firearms in a maximum security institution.

135. Other changes in policy, procedure and climate have contributed to the kind of challenging environment and escalated response witnessed at Kent Institution in January 2010. Correctional officers now carry inflammatory chemical agents as routine standard issue, the result of a protracted labour challenge first initiated by correctional officers at Kent Institution. As this case illustrates, dynamic security principles and practices have been eroded, replaced by static modalities that rely on electronic gates and barriers and remote detection and surveillance technologies. Front-line staff, especially in higher security institutions such as



Kent, have moved from positions of direct observation and interaction with inmates to more secure command posts or security bubbles. Along with changes to deployment and rostering standards comes a corresponding deficit in an officer's ability to take note of and appropriately respond to changes in inmate behaviour.

136. The s. 53 searches became necessary, in the first place, as a result of extremely low interaction between staff and inmates and a depleted level of security intelligence information. The poor quality of the first search resulted in the need to conduct a second search. This progressive decline in dynamic security practices, a development which extends well beyond Kent, renders CSC facilities and those living and working within them less, not more, safe.



FINDINGS

137. The OCI notes the following key findings:

- A. Law and policy governing use of force interventions were routinely violated during the two s. 53 searches and lockdown of Kent Institution in January 2010.
- B. The management of these events was inadequate and allowed for the unauthorized use of force.
- C. The disregard that the Tactical Team members displayed regarding the law and established policies and procedures resulted in serious and numerous breaches of inmate rights, privacy and dignity.
- D. The deployment of firearms to carry out the two s. 53 searches constituted an unwarranted, unjustified and dangerous use of force.
- E. Physical conditions of inmate confinement were unreasonably and unnecessarily restricted over several consecutive days.
- F. The ERT and Tactical Team members circumvented use of force law and policy and their reports failed to properly inform management.
- G. The CSC has been reducing its use of force incident criteria for '*reportable*' uses of force, as well as streamlining its use of force review and reporting procedures in recent years.
- H. The potentially lethal nature of the alleged threat should have warranted the designation of a crisis situation and should have been managed as such by the CSC.
- I. The decision to conduct a regionally convened

'*Fact-Finding Review*' instead of a formal section 20 National Board of Investigation was inappropriate.

- J. The CSC consistently failed to appropriately oversee, manage and evaluate the Pacific Region's Tactical Team, which constituted an unauthorized and therefore *extra-legal* deployment of force operating outside CSC's legal and policy framework.

138. Many of the findings and conclusions reached in this investigation, especially as they relate to problems in CSC's use of force reporting and review mechanisms, have been previously reported upon by this Office. Successive OCI annual reports, a series of supporting recommendations as well as exchanges of correspondence between this Office and the CSC on these issues have highlighted the need for more transparency, rigour and accountability in the reporting and review of use of force interventions inside federal penitentiaries. It is concerning that the number of use of force incidents is actually increasing at the same time as the Service is diluting its reporting criteria, reducing the overall number of *reportable* use of force interventions and eliminating or streamlining administrative review mechanisms.

139. The issues and problems that led to the dangerous and unauthorized deployment of firearms at Kent are not unique to that institution or that particular region of CSC operations. This Office has often noted serious deficiencies in CSC's capacity to apply the '*least restrictive*' use of force option as per the legislative requirement. Other long-standing areas of non-compliance with use of force procedures – video-tape policy, use of privacy barriers, decontamination procedures, follow-up health care monitoring and reporting requirements



call into question what appears to be an increasingly ineffective and inadequate use of force review process.

140. We have come to a point where confidence in CSC's ability to identify and correct deficiencies through its internal use of force review framework has been seriously eroded. There does not appear to be sufficient resources or sustained management attention to ensure decidedly high-risk use of force interventions are conducted within legislative and policy requirements. Even when breakdowns are detected (internal reviews concluded that the Kent incidents constituted both a *dangerous* and *unwarranted* use of force), the so-called '*corrective*' measures that are identified in the findings and review process often do not seem to adequately address or match the seriousness of the breach in question.

141. As the Kent case illustrates, it is exceedingly rare for a manager at any level in the Service to be held accountable for the actions of subordinates, or for any staff member to be reprimanded or disciplined for authorizing or engaging in an inappropriate use of force. In the context of rising use of force interventions, these events, and the mechanisms by which CSC chose to review them, suggest that the internal use of force review process is unequal to the task of providing reasonable assurances that they will not be repeated elsewhere in the system.—call into question what appears to be an increasingly ineffective and inadequate use of force review process.



RECOMMENDATIONS

142. In light of the findings contained in this and previous investigations and reports, and considering that CSC's use of force review and accountability mechanisms are called into question, the OCI is compelled to make only two recommendations:

1. The Service should commission an expert and independent review of its legal, policy and administrative frameworks governing use of force interventions in federal penitentiaries. This review should identify gaps and deficiencies in the use of force review process, and include recommended measures to strengthen accountability, monitoring, oversight and corrective functions at the regional and national levels.
2. In the interests of transparency, the Service should make its response to this investigative report public in the form of an action plan provided to the Minister of Public Safety and posted on its website within six months from March 21, 2011.

REFERENCES

List of Documents Cited and Files Reviewed

- Warden's Situation Report – Addendum*, dated April 15, 2010
- Collaborative Review Team report*, dated April 30, 2010
- Institutional Action Plan to the Collaborative Review*, dated May 6, 2010
- Regional Action Plan to the *Collaborative Review*, dated June 25, 2010
- Interim and Final Report of the Fact-Finding Review into the Two Section 53 Searches at Kent Institution Between the Period of January 8 and January 18, 2010*, dated May 25, 2010 (Revised Edition) and October 20, 2010, respectively
- Recommendations, Action Plans, Findings and Corrective Measures – Fact Finding Review into the Two Section 53 Searches at Kent Institution Between the Period of January 8 and January 18, 2010*, Executive Committee Meeting / Conference Call (undated)
- Final Action Plan of the Kent Section 53 Recommendations and Findings with Corrective Measures*, signed by the Assistant Deputy Commissioner Institutional Operations, dated November 15, 2010
- A sample of 58 hours of videotape evidence of the two Section 53 searches at Kent Institution, January 8 - 18, 2010
- Kent inmate complaints and first level grievances, dated from November 2009 to March 2010
- Seven (7) *Situation, Mission, Execution, Administration and Communications Action Plans (SMEACs)*, dated January 7, 8, 10, 11, 12, 15 and 16, 2010
- Regional Management Committee meeting minutes relating to the ERT/TAC team, dated from 2003-2010
- EXCOM Management Committee meeting minutes relating to the ERT/TAC team, dated from 2003-2010
- Pacific Region Emergency Response Team *Power point training for CSC managers*, undated presentation
- Unclassified memo from ADCIO Pacific to Pacific Wardens and Pacific Region ERT members (all components) on the *Integration of the Tactical Team into the Riot Team*, dated March 5, 2010
- Unclassified memo for the Emergency Response Coordinator to Pacific Assistant Deputy Commissioner Institutional Operations, Pacific Acting/DO and Pacific Regional Administrator Security on the ERT Action items from *January 2010 section 53 search investigation at Kent Institution*, dated June 25, 2010
- Final Report: Review of Pacific Region Emergency Response Team (ERT) Pilot Project*, dated March 30, 2009
- Security Equipment Manual and Security Manual Part II*, May 1997 Edition
- Memos, emails and National Security Equipment Committee Meeting Minutes relating to Tactical

Team weapons and equipment
CSC Press Clippings and News Releases, January
2010

VIII. Board of Investigation into the Hostage Taking
of an Inmate at Mountain Institution on October , 15,
2008

CSC Situation Reports (SITREPs), January 2010

National Board of Investigation (NBOI) reports of
Tactical Team deployments between 2003 and 2008:

I. Board of Investigation into the Major Disturbance
at Mountain Institution on May 16, 2003

II. Board of Investigation into a Staff Hostage
Taking at Mountain Institution on October 2, 2003

III. Board of Investigation into a Staff Hostage
Taking by Two Inmates at the Regional Treatment
Centre, Pacific Region, on June 22, 2005

IV. Board of Investigation into the Hostage Taking of
an Inmate on February 26, 2007 and the Attempted
Suicide of the Inmate on March 5, 2007 at Fraser
Valley Institution

V. Board of Investigation into the Hostage Taking of
an Inmate at Kent Institution on May 3, 2007

VI. Board of Investigation into the Series of
Disturbances that Occurred Between September 26,
2008 and November 10, 2008, and the Inmate
Murder and Related Serious Bodily Injuries of Two
other Inmates that Occurred on November 13, 2008
at Kent Institution

VII. Board of Investigation into the Riot on March
29, 2008 at Mountain Institution and the Related
Deaths of Two Inmates and the Serious Bodily Injury
to Another Inmate

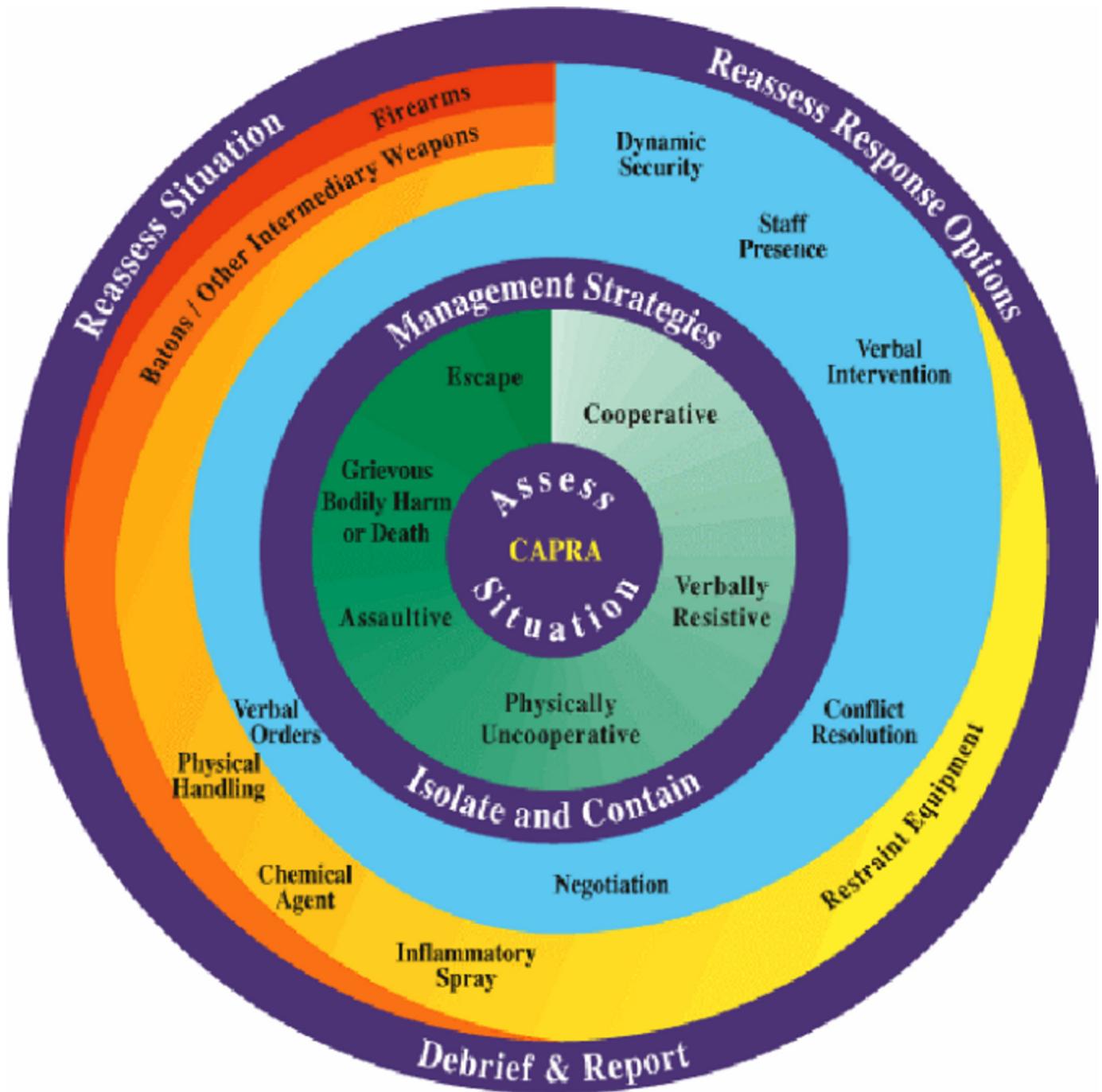
APPENDICES

- I. Correctional Service Canada, *Situation Management Model*

- II. Office of the Correctional Investigator, Correspondence requesting CSC documents pursuant to an investigation under Section 172 of the *Corrections and Conditional Release Act*, dated July 6, 2010

- III. Correctional Service Canada, Commissioner's correspondence dated February 04, 2011, providing the Service's *Factual Review* of an interim copy of the OCI's Kent use of force investigation

Appendix I: Situation Management Model
CSC Staff and Management will prevent, respond and resolve situations using the safest and most reasonable intervention.



**Appendix II: OCI Correspondence requesting production
of CSC documents pursuant to an investigation under
Section 172 of the *Corrections and Conditional Release
Act*, dated July 6, 2010**

July 6, 2010

Mr. Ian McCowan
Assistant Commissioner, Policy
Correctional Service Canada
340 Laurier Avenue West,
Room 2A-11
Ottawa, Ontario
K1A 0P9

Dear Mr. McCowan,

The Office of the Correctional Investigator has initiated an investigation into the deployment of the Pacific Tactical Team during two (2) section 53 searches at Kent Institution that occurred between January 8-18, 2010.

Pursuant to Section 172 of the *Corrections and Conditional Release Act*, I am therefore requesting any and all documentation, including but not limited to: internal briefing notes; emails; regional and national senior management meeting notes and minutes; regional and national correspondence, reports, evaluations, reviews, and; all other documentary records that are relevant to this investigation.

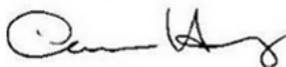
This documentation includes records relating to the following set of issues:

- Authorization for the Tactical Team intervention at Kent Institution between January 8-18, 2010, including all notes, emails and correspondence between Kent Institution and Tactical Team members and between regional and national headquarters pertaining to the Tactical Team deployment
- 2003 working group review of the Tactical Capacity of CSC and related recommendations and decisions of Excom
- 2009/2010 review, recommendations and decisions of Excom which relate to the Pacific Region Tactical Team or CSC's tactical capacity
- A copy of convening orders of Investigations into any incident where the Tactical Team was deployed since its creation
- NHQ security equipment committee review, recommendations and decisions pertaining to the Tactical Team, inventory and/or master register of firearms which have been issued to the Tactical Team since its inception

It would be appreciated if the information requested above could be provided to this Office by July 16, 2010.

If you have any concerns with this request, please do not hesitate to contact me at the number below.

Sincerely,



Ivan Zinger
Executive Director

Cc. Sylvie Fanash, OCI Liaison
Chris Price, Assistant Commissioner
Anne Kelly, Regional Deputy Commissioner Pacific Region

**Appendix III: Commissioner's Response accompanying
the Factual Review, dated February 04, 2011**



Correctional Service Canada / Service correctionnel Canada

Commissioner Ottawa, Canada K1A 0P9 / Commissaire

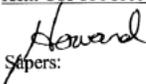
Your file / Votre référence

Our file / Notre référence

FEB 04 2011

Mr. Howard Sapers
Correctional Investigator
Office of the Correctional Investigator
P.O. Box 3421, Station D
Ottawa, Ontario
K1P 6L4

Subject: Kent Use of Force Investigation – CSC Review Copy

Dear Mr.  Sapers:

In response to your correspondence dated January 17, 2011, please find attached a grid containing CSC's factual review grouped by the five (5) themes below.

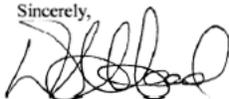
1. Use of force issues, including improper and unwarranted deployment of firearms, inadequate review and inappropriate reporting requirements.
2. Breaches of law and policy regarding inmate privacy and dignity.
3. Lack of management oversight and accountability.
4. The existence of an *extra-legal* TAC team that had no formal policy authority.
5. Health care non-compliance.

As well, I want to point out that I continue to reserve the right to have any matter investigated at any time. Given the reviews initiated locally, regionally and by your office, I deferred any further investigation into this matter until all the reports become available. Subsequently, I have asked the Senior Deputy Commissioner to examine all the reports and advise me as to whether there are any outstanding issues which have not been properly investigated. That advice is due to me by February 28, 2011.

Canada

Thank you for sharing your draft report and the opportunity to review it. If you have any questions or comments, I would be glad to meet with you.

Sincerely,



Don Head

Attachment