

FATAL RESPONSE

An Investigation into the Preventable Death of Matthew Ryan Hines

Final Report
February 15, 2017



The Correctional Investigator
Canada

L'Enquêteur correctionnel
Canada

Canada

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PRINTED IN CANADA

NO DE CAT./ CAT. NO.: PS104-14/2017
ISBN: 978-0-660-07647-8

English PDF:
CAT. NO.: PS104-14/2017E-PDF
ISBN: 978-0-660-07645-4

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of Matthew Ryan Hines**

Office of the Correctional Investigator

Introduction

This is the *Final Report* of my investigation into the death of Matthew Ryan Hines, age 33, who died unexpectedly in federal custody following a series of use of force incidents at Dorchester Penitentiary on May 26, 2015. An *Interim Report* containing my preliminary findings in this case was shared with the Commissioner of Corrections on August 26, 2016. In response, the Correctional Service of Canada (CSC) addressed a number of concerns and questions arising from my *Interim Report* including discipline of front-line staff members involved in this case, the use of inflammatory agents in federal corrections and the quality of health care provided to Mr. Hines. This information, which I received in early October 2016, has been helpful in completing my investigation.

Matthew's death remains the subject of an ongoing police investigation, a process that is concurrent with but separate and independent from my own. On the cause of Matthew's death, the final post mortem report completed for the Chief Coroner's Office of New Brunswick states that: "the cause of death appears to be acute asphyxia due to extensive pulmonary edema following the administration of pepper spray."¹ At time of issuing my *Final Report*, the provincial Coroner's Office had not yet provided a final determination of cause of death or confirmed whether a public inquest into the manner and cause of Matthew's death will be called. It is quite possible that new or additional information may still come to light as a result of ongoing and concurrent police and forensic investigations. A civil proceeding could also be anticipated given the circumstances of Matthew's death.

¹ *Final Post Mortem Report*, Office of the Chief Coroner of New Brunswick, dated and signed March 8, 2016.

Though a definitive cause of Matthew’s death is still open to forensic determination, this should not preclude or otherwise prevent the Correctional Service from taking corrective action based on what is currently known. On August 24, 2016, Public Safety Minister Ralph Goodale issued a public statement on the death of Matthew Hines, noting that “there can be no tolerance for inappropriate use of force or other serious misconduct,” and that “any allegation of inappropriate behaviour must be thoroughly and transparently investigated, and the appropriate consequences must follow.”² The Service has since publicly admitted to staff errors and misconduct in Matthew’s death,³ prompting a series of changes in how it investigates deaths in custody, what it learns from these events, what information is shared with families of offenders who have died in custody and how it publicly reports on deaths in custody.⁴ To its credit, within CSC there appears to be a willingness to learn from Matthew’s death and I am encouraged that the necessary measures will be taken based on the findings of my investigation and whatever else may come forward in subsequent proceedings.

My *Final Report* reflects on these and other developments. It contains my assessment of what went wrong in this case, the adequacy of the corrective measures that have been taken to date and how such events might be averted in the future. Based on the information that has been made available and reviewed by my Office to this point in time, it is my conclusion that Matthew Hines’ death while in the care and custody of the federal Correctional Service was preventable.

Sources of Information

In an investigation of this nature and complexity, the production, timing and receipt of documentation is critical. The following sources of documentation identified by author/source, completion date and when received and/or reviewed by my Office, were used in preparing this report.

² *Statement from Minister Goodale on the death of Matthew Hines*, Public Safety Canada, August 24, 2016.

³ CBC News (posted September 23, 2016) <http://www.cbc.ca/news/canada/nova-scotia/correctional-service-staff-misconduct-hines-1.3774555>

⁴ Office of the Correctional Investigator, *In the Dark: An Investigation of Death in Custody Information Sharing and Disclosure Practices in Federal Corrections*, August 2, 2016 www.oci-bec.gc.ca.
Correctional Service of Canada’s response <http://www.csc-scc.gc.ca/publications/005007-1505-eng.shtml>

1. Warden's Situation Report (Warden of Dorchester Penitentiary, dated June 2, 2015).
2. CSC use of force package, which includes the CCTV/Range and hand-held video-recordings of the events under review and Officer Statement and Observation Reports (OSORs) – expedited national use of force review completed by CSC June 24, 2015.
3. Board of Investigation Into the Incident Involving an Inmate at Dorchester Penitentiary on May 26, 2015, and his Subsequent Death at the Outside Hospital on May 27, 2015 (convened by the Commissioner of Corrections on July 3, 2015 and completed November 4, 2015) – received June 24, 2016.
4. Final Post Mortem Report (dated and signed March 8, 2016), Neuropathology Report (dated and signed February 12, 2016) and Forensic Toxicology Report (June 29, 2015). Reports provided by the Office of the Chief Coroner of New Brunswick – received August 23, 2016.
5. *Sudden In-Custody Death Syndrome (SIDCS) – Participant Manual* – received July 8, 2016.
6. Medical records/files held by CSC inclusive of Mr. Hines' two federal sentences – received July 26, 2016.
7. *Statement from Minister Goodale on the death of Matthew Hines* – August 24, 2016.
8. Staff disciplinary investigation report (convened November 4, 2015 and completed December 4, 2015) – received September 21, 2016.
9. CSC's response to the Office's *Interim Report* and correspondence dated August 26, 2016 – received October 4, 2016.
10. ADDENDUM to the Board of Investigation Report – received October 20, 2016.

Though disturbing to watch, the video records and the report of CSC's National Board of Investigation (NBOI) provide a reliable documentary record of the immediate events, chronology and circumstances leading to Matthew's

death. Together, these two sources provide compelling evidence that Matthew's death was proximate to two uses of physical force and several inappropriate uses of inflammatory spray (*Oleoresin Capsicum* spray, commonly referred to as OC or pepper spray).

Chronology of Events

The events in question unfold rapidly; in very quick succession, a series of errors, mistakes and omissions in the staff response develop into a life-threatening situation. In fact, from initial contact with four officers who use physical force to take Matthew to the ground outside his cell through to the point at which he appears to have the first of several convulsive seizures, eventually becoming unresponsive in the decontamination shower in the segregation unit of Dorchester Penitentiary and the subsequent removal of his body into the attending ambulance, takes just a little over 45 minutes. Critical points in the use of force incidents are captured on video.

The video begins at approximately 10:11 pm as the range is locking up for the night. Two officers are present on the range. Matthew is seen exiting the cell of another inmate. He is observed being playful with other inmates (even embracing one). He appears at points to be confused, incoherent and somewhat agitated, but not aggressive in any manner. Foreshadowing events to come, he is heard stating: "don't let them kill me;" "don't let them end my life;" "I don't want to die." (This was not the first time that Matthew had voiced fears about dying in federal custody). As Matthew arrives at his cell, he turns back and begins walking toward the cell he had just exited. Matthew and an officer are seen engaging in a discussion. Seconds later, two additional officers arrive. One officer takes hold of Matthew's lower arms to apply handcuffs. They physically take control of Matthew and direct him down the shower corridor of the range.

The initial use of physical force takes place at 10:13 pm. Matthew is observed standing surrounded by four officers at the shower corridor. Suddenly, with very little warning, Matthew is abruptly and aggressively taken to the ground after he appears to physically resist their attempt to apply handcuffs. On the ground, officers are seen delivering several open and close-handed and knee

strikes to Matthew's torso, jaw and upper body (so-called "distraction" techniques). As officers gain physical control, handcuffs are applied to the rear (hands behind his back) by three officers as Matthew lies immobile and face down on the floor. Blood is visible on the left side of Matthew's face and there is a blood stain on the floor.

According to the Board of Investigation report, none of the staff knew how Matthew sustained the cut on the side of his head and the Board itself could not determine whether the injury occurred during the fall to the ground or as a result of the use of force strikes. In any case, as the Board subsequently determined, "the use of distraction techniques in this situation was inappropriate and not congruent with training." In other words, the punches and knee strikes to Matthew's body were disproportionate and unnecessary. I agree.

A second use of physical force takes place at 10:16 pm as Matthew is being escorted from the living range into the kitchen area. After falling (or being taken to the ground), Matthew is seen lying prone, face down on the floor, handcuffed to the rear. He is being restrained by five officers when the first burst of pepper spray is discharged directly into his face. The use of an inflammatory agent under these circumstances was unnecessary as Matthew is fully under the control of staff. At one point, the video recordings show 13 officers present in the kitchen area. Even with this overwhelming display of force, no single officer appears to take charge of the incident, a finding subsequently confirmed by the Board of Investigation.

At 10:20 pm Matthew is rolled onto his side and is assisted to a sitting and eventually to a standing position. It appears that he has soiled himself as his pants are wet. Blood is visible on Matthew and pooling on the floor. An officer applies a paper towel to the cut on the side of Matthew's head.

Notwithstanding, Matthew's condition does not prompt a call for medical assistance nor was there a significant re-assessment as per the Situation Management Model. One minute later Matthew and escorting officers are seen leaving for the segregation unit. At this point, Matthew is still handcuffed from behind and is being frogmarched backwards. At 10:22 pm, surrounded by several officers, two more bursts of pepper spray are deployed, seemingly without

warning or reason, directly into Mathew's face. As they exit the building, it appears that Matthew is either resistive (he is pushed out of the building by two officers) or having difficulty keeping pace with the escort. He is not wearing any footwear as they enter the yard. While being escorted across the yard, in quick succession several more bursts of pepper spray are administered directly to Matthew's face by the same officer. In fact, this officer can be seen rushing toward Matthew with his pepper spray canister in his outstretched arms so that he can deploy a well-controlled burst at close range. At this point, Matthew is not acting aggressively and escorting staff seem to have him under full control. There is no correctional manager present.

As they enter the segregation unit, Matthew is heard repeatedly pleading with officers to help him. He has a blue institutional t-shirt pulled up over his face, presumably to act as a makeshift spit mask. He is still being escorted backwards and handcuffed to the rear. At 10:26 pm, Matthew is physically moved into the decontamination shower. He falls backward landing on his back with his head propped up against the wall, t-shirt still pulled over his face. The water is turned on. Matthew appears to be making sounds consistent with spitting up or choking. At the instruction of the Duty Manager who had met the escort at the segregation unit, attending staff are directed to shut the water off so that the t-shirt can be removed from Matthew's head. At 10:29 pm Matthew appears to have the first of several seizures/convulsions. His last known recorded words from the locked shower stall where he is lying on the floor and handcuffed behind his back are "please, I'm begging you." The water is turned on again.

Matthew is dragged, by his feet, out of the decontamination shower. He is motionless, unresponsive and appears not to be breathing. The duty Nurse has arrived at this point. She fails to assess Mathew. At 10:31 pm, a 911 call requesting an ambulance is made. A few minutes later, Matthew is positioned onto an institutional stretcher and he begins to be moved toward Health Services. From that point onward, both security and health care staff fail to initiate essential life-saving measures even as Matthew experiences several more seizures/convulsions, is seen to be spitting blood, and his breathing is visibly laboured. At 10:37 pm, Matthew is brought into the treatment room on an

institutional stretcher still cuffed from behind. His breathing is extremely laboured; at various points he appears to stop breathing. At 10:47 pm, he appears to have another seizure. Paramedics arrive in the treatment room at 10:52 pm and receive a verbal update from the Nurse.

As documented in the Board of Investigation report, the attending Nurse failed to conduct any assessments (vital signs, neuro-vitals, oxygen saturation). Life-saving treatment was not initiated (contrary to the Nurse's documentation). At one point, the Nurse observes and states that Matthew is spitting blood. He appears to suffer another seizure just before he is loaded into the attending ambulance at 11:01 pm. The handheld camera is turned off. Approximately 46 minutes have elapsed since the initial use of physical force.

En route to the hospital, the ambulance stops on the side of the highway at or around 11:20 pm so that attending Paramedics could initiate emergency life-saving measures. The actual time and place of Matthew's death is recorded shortly after midnight by the attending physician at the Moncton General Hospital. An escorting officer notifies the Duty Correctional Manager (CM) that Matthew has been pronounced deceased. The Warden is notified at 00:23 am, and the Duty CM notifies the RCMP of Matthew's death at 00:27 am. Inexplicably, blood stains in Matthew's living range and segregation unit are ordered to be cleaned at 1:13 am, which is a serious breach compromising the preservation of a potential crime scene. The RCMP arrives on Matthew's unit at 2:41 am.

Assessment of Staff Response

It is almost certain that there was a catastrophic (and ultimately fatal) breakdown in the staff response. Security interventions dominate right up to point that Matthew is loaded onto the ambulance (he is still restrained with his hands behind his back despite being unresponsive). There is an overwhelming show of force resulting from the presence of several correctional officers who do not appear to have a legitimate reason or purpose for being present. Even though Matthew is clearly and sufficiently under the control of more than a dozen officers as he is being escorted from his range to the segregation unit, multiple bursts of pepper spray in short succession are inexplicably and

apparently without warning administered within inches of his face. It was subsequently determined by both the Warden and the Board of Investigation that these uses of force were 'inappropriate.'

There were obvious signs of medical distress throughout the incident: Matthew appears to have voided himself immediately following the second use of force; he was bleeding from the head as a result of the initial altercation, and at various points he appears disoriented, confused, fatigued and visibly convulsing. Despite his level of need, no responding officer steps forward to assume a leadership role. There is no Correctional Manager present during the crucial minutes leading up to Matthew's collapse. There is no attempt to pull back and reassess the situation even as there are obvious signs of physical and mental distress. As the situation worsens, Matthew's frequent cries of distress and pleas for help do not seem to overly concern or alert staff to an underlying health need. Notwithstanding, some staff observation reports document that Matthew was not responsive and/or incoherent when engaging with staff.

Just fifteen minutes after the initial physical altercation with staff when Matthew is pulled from the decontamination shower, he never again appears to regain full consciousness. The incident had now irrevocably turned from a routine use of force intervention to a full-blown medical emergency. Remarkably, the staff response remains exclusively security-driven. I would note, for example, that from the point at which Matthew went unresponsive in the decontamination shower, he remained handcuffed from the back, for which, even according to the Board of Investigation, "there was no apparent security reason to do so." Once Matthew becomes unresponsive, the use of handcuffs should have been reassessed from both an operational and medical perspective.

At the point in which Matthew is sufficiently and fully under the control of numerous officers and restraints have been applied, the repeated use of pepper spray seems particularly egregious, unnecessary and even callous. It appears that inappropriate and multiple uses of pepper spray were a significant factor in the confluence of errors and failures that ultimately contributed to Matthew's death. The Board of Investigation notes that pepper spray was used numerous times even though "Matthew was under sufficient control of staff, direct orders did not

appear to be given, the time between bursts was short and the proximity to his face was too close.” Given forensic opinion regarding probable contributing factors to Matthew’s death, these are critical findings.

Staff observation reports claim that Matthew was, at various points throughout the incident, “physically uncooperative,” “resistive” and/or “spitting.” (It is not clear from the video records whether the spitting is directed at, toward or in the direction of staff). In any case, once in control of officers, Matthew does not appear to be physically aggressive, though he stumbles at various points trying to keep pace with the escort. (Matthew is a heavy-set man, he is being awkwardly forced to walk backwards, in sock feet, with his hands restrained behind his back.)

The pulling of his shirt over his head in a make-shift attempt to prevent Matthew from spitting only served to further compromise his rapidly deteriorating mental and physical state. It is quite probable that Matthew’s spitting was caused by an attempt to clear his airways after being sprayed multiple times with pepper spray in his face. His hands, after all, are cuffed behind his back and he has no other means by which to clear his airways or clean his face of the noxious substance.

Matthew appears to be in an excited, anxious, frightened and possibly even delirious state. At various points, he can be heard literally crying for help and/or begging for his life. Keeping his shirt over his head as a man of his size is left to fall backward unsupported into the decontamination shower as the water is turned on is beyond explication. In his state, the sensation could conceivably feel like water-boarding.

The Board of Investigation report includes a fairly comprehensive review of Matthew’s physical and mental health status. It suggests that there were some undiagnosed and/or untreated physical and mental health risk factors present in this case (e.g. history of drug-induced psychotic episodes, history of poly-substance abuse, history of depression, significant and rapid weight gain, risk of hypertension). Matthew was a frequent user and seeker of health care. It was known that he had a pre-existing history of psychotic symptoms/episodes

(which seems to have been related to and possibly triggered by his poly-substance drug use). He had been on the methadone maintenance program since July 2012. In his current sentence, Matthew was twice admitted to the Atlantic Region's psychiatric treatment centre (Shepody Healing Centre), on both occasions for unusual/bizarre behaviour. He was twice admitted to outside hospital, in April 2013 and again in April 2015, for what appears to be symptoms of ongoing psychosis/seizures.

Matthew also experienced considerable weight gain while incarcerated (likely due to anti-depressants); his weight went from 190 to 313 pounds at time of death. At one point, Matthew was put on a low-fat diet, which was subsequently revoked by non-medical staff after it was determined that he had often "cheated" by consuming junk food from the canteen.

While I am generally satisfied with the thoroughness of the Board of Investigation's review and analysis of Matthew's health status at time of death, I cannot help but to think that there were some serious and significant gaps in information-sharing and communication between clinical and front-line staff. While a clear and present mental health diagnosis was hindered by Matthew's behaviours, the Office's review of CSC medical records reveals that front-line staff had frequently observed and reported on Matthew's "bizarre" behaviour. His mood and behaviour on the night of May 26, 2015 initially presented to staff as illicit drug use. However, as Matthew's mental and physical health deteriorated following the initial use of force, front-line staff should have had the experience, insight, knowledge and training to have responded to his needs and behaviour in a life-preserving manner.

Cause of Death

With respect to cause of death, the Board of Investigation, which completed its report on or about November 4, 2015, identified a series of risk factors consistent with *Sudden In Custody Death Syndrome* (SICDS). One of the four recommendations made by the Board seems to point to SICDS as a possible cause of Matthew's death. However, as is now known, not all of the post-mortem results were available to the Board when it had concluded its

investigation.⁵ Although the Chief Coroner of New Brunswick has still yet to issue a cause or manner of Matthew's death, according to the Pathologist's *Final Post Mortem Report* (this report is signed and dated March 8, 2016) "the cause of death appears to be acute asphyxia due to extensive pulmonary edema following administration of pepper spray."⁶

A major line of inquiry not comprehensively pursued by the Board of Investigation is the role that multiple and unwarranted uses of pepper spray may have played in contributing to and accelerating the rapid onset of respiratory distress and pulmonary failure. There were obvious and frequent risks for restraint asphyxia present throughout this incident, particularly as Matthew falls into unconsciousness. These risks included: Matthew's weight and size, physical restraint in the prone position, positioning of his head which affected airway management, risk of exhaustion, and being restrained behind his back for an extended period. The Board of Investigation infers, but does not specifically or directly link the multiple uses of pepper spray to Matthew's ensuing medical emergency. As the Board of Investigation notes:

There was sufficient information available to staff ... for them to have recognized the potential risks to HINES of the security interventions used yet HINES' repeated requests for assistance, complaints of inability to breathe, progressive exhaustion and multiple interventions which had the potential alone and combined to negatively impact his oxygenation level were not recognized by or reassessed by any staff involved in the incident both during or following.

The Board erred in one other respect, namely in stating that intervening staff were not current with use of force training (including presumably the most recent 2014 modules on SICDS). An ADDENDUM to the Board's report, received by this Office on October 20, 2016, corrected this oversight noting that the responding front-line officers were in fact current and compliant with required use of force training. As first responders front-line staff are trained to recognize and respond to the risk that restraint asphyxia poses in an emergency situation.

⁵ The sequence of the post-mortem reports appears to be as follows: Forensic Toxicology Report (June 29, 2015); Neuropathology (February 12, 2016); Final Post Mortem (Pathology) Report (March 8, 2016).

⁶ Final Post-Mortem Report (Pathology), March 8, 2016.

In any case, a determination of SICDS is not required to link the actions of correctional officers to Matthew's ensuing medical distress.

The exact cause of Matthew's death is ultimately beyond the speculation or expertise of a prison ombudsman. This is rightly the purview of forensic determination. That said, as an additional accountability measure, at this Office's request the Service has agreed to undertake an independent review of the quality of health care that Matthew received in CSC's care and custody. CSC Health Services also subsequently issued a *Practice Reminder* informing institutional nurses of their responsibilities with respect to conducting post-use of force health care assessments. The memorandum provides information regarding symptoms which may be consistent with Excited Delirium Syndrome including: respiratory distress; elevated pulse, blood pressure and temperature; agitation, confusion, hallucinations; and, level of consciousness.⁷ All of these signs and symptoms appeared manifest in Matthew's case; however, there is little documentation on file or charting that would confirm what is ultimately a disputed psychological condition and contentious cause of death in both the medical and forensic communities.⁸

Areas of Non-Compliance

The Board of Investigation report identifies 21 areas of policy non-compliance and/or gaps in policy. The more serious policy violations identified by the Board include:

1. Failure to continuously assess and reassess security interventions and staff response.
2. Failure to protect a person handcuffed from behind from injury.
3. Failure of any one responding staff member to assume a leadership role.

⁷ Memorandum to Regional Directors, Health Services, "Post Use of Force Assessment: Practice Reminder for Health Care Professionals," September 23, 2016.

⁸ In Canadian context see, *Report of the Panel of Mental Health and Medical Experts Review of Excited Delirium*, June 2009, Advisory Panel appointed by the Minister of Justice and Attorney General and Minister of Health (Nova Scotia); Braidwood Commission on the Death of Robert Dziekanski, May 2010 (British Columbia).

4. “Inappropriate” uses of inflammatory spray.
5. Failure to adequately control and account for inflammatory agents.
6. Failure to maintain and control the integrity of a potential crime scene.
7. Failure to provide emergency health care.

Despite the serious and multiple breaches of policy identified in the Board of Investigation report, and the fact that a fatality occurred, it only makes four recommendations. Two of those recommendations are directed at the site level: Dorchester Penitentiary should “*consider*” evaluating the safety features of its institutional stretchers and for Regional Headquarters to “*consider*” conducting an audit of pepper spray procedures at Dorchester Penitentiary. Two other recommendations target national learning and training in the areas of arrest and control and SICDS.

I fail to see how these measures would have any discernible impact on CSC’s legal duty of care to take all reasonable steps to reduce, mitigate and prevent deaths in custody. While the quality of the Board’s report is above average, none of the recommendations substantively address the multiple and significant areas of non-compliance noted above. In fact, in this case, there is complete lack of congruence between the Board’s findings of non-compliance (significant and systemic) and its corrective measures (weak and unfocused).

More generally, the manner by which CSC investigates and reports on deaths in custody and what it learns from these events is inherently flawed. In its totality, the Board of Investigation into Matthew’s death finds that, on the night of May 26, 2015, responding staff did not follow existing policy and procedures already in place. The report notes obvious gaps, errors and mistakes in the use of force and health care responses, but it does not go the extra step to say how the multiple failures to follow policy and procedure may have contributed to Matthew’s ensuing medical distress and, ultimately, death.

Given that CSC investigates itself largely on the basis of compliance with policy and procedure rather than accountability, most Boards of Investigation do not issue recommendations of national significance. Consequently, at the site level, the Office sees the same mistakes repeated over and over again. Matthew's death was indeed tragic and unexpected, but from the Board of Investigation's perspective there is not a single finding to suggest that it could have been prevented – other than had staff followed policy and procedure.

Beyond the self-serving, unreflective and circular reasoning of this line of inquiry, there is simply little room for critical examination of how and why Matthew's death occurred or what could be done to prevent or avert similar outcomes in the future. In other words, an investigative process that does not concern itself with accountability or prevention will invariably fail to learn from repeated, and potentially, catastrophic failures in which the staff response was inadequate, flawed or inappropriate.

Separate from the Board of Investigation process, my Office was informed that Dorchester management initially identified the following 'compliance' issues:

1. The inmate was handcuffed during the decontamination shower.
2. Pepper spray was used in a manner inconsistent with policy and training.
3. Strike distraction techniques were used in a manner inconsistent with training.
4. The shift manager failed to take full control of the situation when he was on the scene.

My investigation has confirmed the Dorchester Penitentiary management "discussed" these non-compliance issues with the personnel concerned. No formal disciplinary measures resulted from the local review of the correctional staff response.

In a separate process, the attending Nurse, who at the time of the incident was on probationary service, was not subsequently retained by the Service. My

Office has learned that this case was referred to the appropriate licensing and professional regulatory bodies for review. While this retroactive measure appears reasonable in light of what happened, it begs more troubling questions of how a relatively inexperienced Nurse, on probationary service, found herself working largely unsupported on the night shift in a large penitentiary.⁹ Though it is clear that she failed to provide basic nursing within her scope of practice and professional training, the failure to preserve life and prevent death in Matthew's case does not rest solely with this individual.

Matthew became unresponsive under the control and custody of several responding officers following multiple uses of inappropriate, unnecessary and possibly even, excessive force. Dragged unresponsive from the segregation shower, he was wheeled into the treatment room of Dorchester Penitentiary on a stretcher at 10:37 pm. On arrival he is unconscious, unresponsive and barely breathing. Contrary to policy, the attending Nurse failed to conduct vital sign assessments or provide life-saving treatment. The responding paramedics documented that Matthew was unresponsive from the time they made patient contact at 10:52 pm to the end of the call. Matthew stopped breathing and without a discernible pulse in the ambulance somewhere around 11:23 pm – effectively, he is lifeless one hour and 10 minutes after the initial use of force.

Following completion of the Board of Investigation report and subsequent to receiving my *Interim Report*, a more formal staff disciplinary investigation was convened on November 4, 2015 and completed one month later. Four front-line staff members were identified in relation to their actions with respect to the appropriateness and level of their use of force response. Convened by the Warden of Dorchester Penitentiary, these proceedings lacked functional independence much less credibility. Two officers received a reprimand letter, as did the Correctional Manager who was also imposed a one-day loss of pay penalty. There was “insufficient evidence” to formally discipline the fourth officer. The disciplined officers were all directed to “re-familiarize” themselves

⁹ At the time of the incident, the attending Nurse was assigned to the attached Regional Hospital (Shepody Healing Centre) but could respond to emergencies at the attached Dorchester Penitentiary – Medium Unit. There was another Nurse assigned to the Regional Hospital that night who could have also responded if called or required. According to CSC, this was the “normal” roster complement after 2200 hours for nursing coverage for both Shepody Healing Centre and the Dorchester Penitentiary complex.

with the contents of the *Standards of Professional Conduct* as well as the *Correctional Service of Canada's Code of Discipline*.

A Board of Investigation is not mandated to investigate or initiate a formal staff disciplinary process. Staff disciplinary matters are independent of and outside the scope of a Board of Investigation. As noted, a supplemental staff disciplinary process was convened shortly after the Board of Investigation report was completed and submitted to the Commissioner. The Office does not typically investigate or comment on internal CSC staff relations. However, in this matter, I do note that there is an irreconcilable difference between the findings and recommendations identified in the Board of Investigation report and the subsequent measures taken in the staff disciplinary process. Both fail to account for the seriousness or consequences of individual staff actions, omissions and organizational failure to preserve Matthew's life. In this case, given the catastrophic breakdown in the staff response it is appropriate to review and question the adequacy and appropriateness of CSC staff investigating and disciplining itself.

The outcome of the staff disciplinary process for the four officers is especially problematic as it seemed to fail to consider the compounding effects of the use of force and control measures which ultimately contributed to Matthew's medical emergency – the "distraction" blows, the resulting head injury, the impact of a rapid succession of close range pepper spray bursts, the shirt pulled over the face in the shower, the lack of medical attention, the failure to recognize a medical emergency and, ultimately, the failure to preserve life. From the outset, the nature and level of the use of force response is disproportionate and unnecessary. Staff failed to pull back or reassess the situation and their options as events unfold. Their errors were compounding and ultimately catastrophic. All this is made worse by the fact that up to 13 correctional officers were present. Certainly, someone should have known better.

Aside from the inherent shortcomings in CSC's investigative and disciplinary systems, there are other equally troubling aspects of this case that would seem to warrant a significant response from the national leadership of the CSC. Similar to the case of Ashley Smith, the lessons learned from Matthew's

death should be shared broadly across the Service. Nearly everything that could have gone wrong in a use of force response went wrong.

The case of Matthew Hines also demonstrates persistent deficiencies in an investigative and disciplinary process that narrowly focuses on the minutiae of compliance with policy and procedure rather than corporate responsibility and accountability. Disciplining a few individuals retroactively does little to prevent similar situations in the future. Individual staff members are hired, trained, mentored, supervised and supported by the organization. Proper supervision includes proper discipline. It is management's responsibility to ensure an adequate framework for and robust implementation of training, supervision and supports.

On the night in question, there was a breakdown in the chain of individual staff responsibility and management accountability. No single responding officer stepped forward to assume leadership and command of an incident that escalated and spiraled out of control in a matter of minutes. Even still, the vacuum in leadership at the response level and the failure to preserve life on that fateful night ultimately rests with management. So far as this Office is aware, no senior manager, at the institutional, regional or national levels, has ever been retroactively disciplined or held to account for the documented deficiencies that, directly and indirectly, contributed to Matthew's death.

Transparency and Accountability Issues

As this case demonstrates, there is much room for improvement in how CSC investigates deaths in custody, what it learns from these events and how it publicly reports on them. I am particularly disturbed by the lack of public transparency in this case, including misleading information/statements that were initially provided to the media and next of kin in the immediate aftermath of Matthew's death. There is a broader, and much more compelling, interest to be satisfied in this case. As the Minister of Public Safety has stated, the family and the public deserves to know how and why Matthew Hines died in CSC's care and custody. The Service needs to provide answers.

More than a year later, the family is only now beginning to piece together the events and circumstances that unfolded during Matthew's brief but fatal encounter with staff on May 26, 2015. I am satisfied that the Service has finally provided the family with a relatively complete Board of Investigation report; it was not, as I have seen many times before, unnecessarily or heavily redacted. This is encouraging. At the same time, as with other deaths in custody that I have investigated, there were numerous opportunities for the Service to share information with the Hines' family in a more timely, transparent and considerate manner. I would note, for example, that the Warden's situation report on this incident was completed June 2, 2015. Even at that point, concerns were identified regarding the appropriateness and adequacy of the use of force and health care responses, but this information was not properly shared.

While there are some serious discrepancies in the Warden's initial account of the events and the Board of Investigation report (particularly with respect to the quality and adequacy of health care provided by the attending Nurse), there was certainly no shortage of information that could have been preliminarily shared with the family even as the internal investigation continued. The forensic toxicology report is dated June 29, 2015. It indicates that while there was THC (marijuana), methadone and bupropion (an antidepressant) present in Matthew's blood at time of death, none of these drugs either in isolation or in combination were at toxic/lethal levels. In other words, cause of Matthew's death does not appear to be drug overdose.

While the family was initially informed by CSC that Matthew died of a seizure, it is not clear on what basis or on whose authority such a claim could have been substantiated. The family has, until very recently, been led to believe that Matthew's death could not have been prevented. My findings in this case suggest otherwise.

Findings

Based on my investigation of Matthew's death in federal custody, I find:

1. Multiple uses of unnecessary and inappropriate force contributing to ensuing medical emergency and death.
2. Lack of sufficient controls and accountability for the use of inflammatory agents in federal penitentiaries.
3. The need for a separate and distinct intervention and management model to assist front-line staff in recognizing, responding and addressing medical and/or mental health emergencies.
4. Lack of rigour in the use of force review process.
5. Inattention to maintaining the integrity of a potential crime scene.
6. Poor communication and information sharing among clinical and front-line staff.
7. Questions about quality, timeliness and adequacy of health care response.
8. Misleading public statements concerning cause of death and staff response.
9. Inaccurate and inadequate sharing of information with designated family members following an in-custody death.
10. Responding staff not sufficiently trained, equipped or supported to manage bizarre, erratic and/or defiant behaviours associated with mental health issues.

These issues have been repeatedly identified by my Office. Despite repeated assurances that CSC's death in custody framework is robust and sound,

a number of significant recommendations from my Office and those arising from Coroner inquests have still not been acted upon:

1. A dedicated senior management executive responsible for monitoring Safe Custody practices.
2. A National Advisory Forum to lead a focused effort to share information to reduce and prevent deaths in custody.
3. Comprehensive public accountability and annual performance reporting on CSC's efforts to prevent deaths in custody.
4. 24/7 health care coverage at all maximum, medium and multi-level facilities.
5. Patient advocate system for federal corrections.

These are missed opportunities that could foster a more accountable, open and transparent correctional system.

I conclude that Matthew's death in federal custody was preventable. It was proximate to multiple uses of inappropriate force. CSC ultimately failed in its duty to protect and preserve Matthew's life. The implications of this case extend far beyond the immediacy of Dorchester Penitentiary or the tragic events of May 26, 2015.

RECOMMENDATIONS

1. Individual CSC managers at the institutional, regional and national levels should be held answerable and accountable for the deficiencies identified in the inappropriate, unnecessary and multiple uses of force that directly contributed to Matthew's medical emergency and ensuing death.
2. The case of Matthew Hines should be used as a national teaching and training tool for all existing and future CSC staff and management. The case study

would include analysis and understanding of the gaps in the use of force and health care responses proximate to Matthew's death in federal custody.¹⁰

3. CSC should immediately develop a separate and distinct intervention and management model to assist front-line staff in recognizing, responding and addressing situations of medical emergency and/or acute mental health distress.
4. CSC should review and revise the channels, methods and flow of information between clinical and front-line staff to ensure first-response staff members are adequately prepared to safely manage medical and mental health needs.
5. A scope of practice review should be undertaken to ensure Registered Nursing staff are adequately trained, supported and prepared to work in a correctional environment and include specific instruction in use of force, inflammatory agents and provision of emergency trauma care.
6. CSC should ensure clarity in the leadership role of the officer in charge in situations where no Correctional Manager is present.
7. CSC should review institutional, regional and national controls on the use of inflammatory agents in federal penitentiaries. Policy direction should be issued to provide clear instruction that inflammatory agents can only be used after all other means of conflict resolution have been exhausted and only when there is a clear and present risk of imminent harm.
8. CSC front-line staff members should receive regular refresher and upgraded training in conflict de-escalation. Training should emphasize how to manage oppositional/defiant behaviours in situations where underlying mental health issues are present or previously identified.

¹⁰ A Lessons Learned bulletin for staff – “*What does a Medical Emergency Look Like?*” – was published by CSC’s Incident Investigations Branch in November 2016. The learning scenario derives from the Matthew Hines case. It is appended to this report.

9. CSC should immediately develop mechanisms to reconcile Board of Investigation findings with the staff disciplinary process.
10. Boards of Investigation into deaths in custody should be required to examine and clearly state whether and how the death in question could have been prevented.

APPENDIX

1. Incident Investigations Branch (IIB): Information Bulletin for Staff 4th Edition (November 2016)



Incident Investigations Branch (IIB): Information Bulletin for Staff 4th Edition (November 2016)

LESSONS LEARNED – WHAT DOES A MEDICAL EMERGENCY LOOK LIKE?

An inmate may appear to be uncooperative and/or under the influence of intoxicants but may actually be experiencing a medical emergency.

This bulletin will provide information on a medical condition called Altered Level of Consciousness (ALOC)

Scenario: ALOC & Use of Force



Don't

Scenario #1: While inmates were returning to their cell for the stand-to-count, Correctional Officers ordered an inmate, who appeared to be acting “out of it” and behaving oddly, back to his cell for the count. They assumed he was likely intoxicated and touched the inmate’s arm to gain compliance which caused the inmate to become agitated, resulting in a spontaneous use of force. This inmate, who was a large man, was cuffed from the rear and left in an awkward position. He struggled and OC spray was used several times, after which he complained he was having difficulty breathing. The inmate later died.



Do

Scenario #2: While inmates were returning to their cell for the stand-to-count, Correctional Officers ordered an inmate, who appeared to be acting “out of it” and behaving oddly, back to his cell for the count. When he did not respond to their requests to return to his cell, Officers spoke to him calmly in an attempt to assess why he was not following direction. As they tried to interact with him, they assessed that he did not appear to be aware of his surroundings or understand the direction provided. The Correctional Officers then contacted Health Services. The inmate was assessed by Health Services who determined that he required medical intervention. He was then assessed and treated by Health Services and returned to his range.

Refer to [GL 800-4 Guidelines on Response to Medical Emergencies](#) for more information and direction on how to respond to medical emergencies.





What is an Altered Level of Consciousness (ALOC)?

ALOC may vary from minor thought disturbances and confusion to unconsciousness and unresponsiveness.

Examples include:

- A person with diabetes with abnormal low blood sugar level may present with an ALOC and display symptoms of intoxication.
- A person who has taken medication (or other substance) may appear disoriented, sluggish, and/or agitated.
- A person experiencing a mental illness may have stopped taking their medication or may not be stabilized yet on medication.
- A person fell and hit his/her head and is experiencing slow but progressive confusion and is unable to respond to questions or follow directions.
- A person has an unwitnessed seizure and when it is finished, he/she seems unable to stay awake, is unsteady on his/her feet, and is wandering on the Range.

How do I recognize someone with ALOC?

While interacting with the person you will sense that they seem unable to respond to your attempts at conversation in a typical way. They may seem like they are:

- 'not there'
- 'not making sense'
- 'mentally absent'
- unable to follow simple directions
- uncoordinated in their movements

Overall, you may simply get the impression that **'something is not right with this person'**.

What should I do if I come across someone I think has ALOC?

Do

- Treat all persons who present with ALOC as a medical emergency.
- Keep the individual as calm as possible.
- Call for medical assistance immediately, whether it be Institutional Health Services or 9-1-1.
- Remember to stay calm yourself.
- If possible, try to maintain the person in the location they are found until help arrives if there are no immediate threats to the person or to you.
- Continuously monitor the person's ability to breathe.

Don't

- Agitate the person or seem threatening to the person.
- Restrain persons with ALOC unless it is a last resort. If the person must be restrained, the minimal amount of force should be used in accordance with policy.
- Use restraints without considering body position and body weight. If the person must be restrained ensure they are supported and can breathe.
- Ever make an assumption as to why the person may be experiencing an ALOC.