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January 20, 2011

Don Head
Commissioner of Corrections
Correctional Service Canada
340 Laurier Avenue West
Ottawa, Ontario
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Dear Mr. Head:

Subject: National Board of Investigation (NBOI) on the Death of Mr. Glen Edward Wareham on April 29, 2010 (Your File 1410-2-2010-13)

I would like to first take this opportunity to acknowledge that in response to my recommendation, you have extended the scope of the above NBOI by requesting that it review the entire federal custody of Mr. Wareham from his admission on November 24, 2003, until his death on April 29, 2010.

This NBOI report is comprehensive in scope, rich in analysis and excellent in quality. Drawing on clinical expertise, professional judgement, best practices and research, it is a comprehensive account of the challenges that chronic self-injurious behaviour presents in a custodial environment. This NBOI sets the standard for internal investigative reports involving serious bodily injury or death resulting from serious or cumulative self-harm. I commend the author and Chair of this NBOI, and recommend that the report be circulated to all CSC mental health care professionals.

Although its findings are often critical of the care and treatment received by Mr. Wareham, the report could be a roadmap for implementing lessons learned and improving CSC's capacity to meet the needs of challenging self-harming offenders. This report is especially important given that many of the documented failures in Mr. Wareham's case occurred two years after the death of Ashley Smith. Once again, it raises themes and concerns similar to other preventable deaths in custody, including Ashley's.

I have highlighted some of the more important findings of this NBOI. They are presented by thematic area of concern. These themes capture lessons learned from an individual case and suggest systemic improvements in the Service's capacity to manage serious/chronic self-injurious behaviour.

Adherence to Intake, Assessment, Transfer and Classification Policy

- The intake assessment process was completed without Mr. Wareham's participation or input. The absence of a comprehensive and accurate assessment impeded Mr. Wareham's subsequent care and treatment.
- Mr. Wareham's self-injurious behaviour resulted in a maximum-security classification (relying on over-rides between June 2007 and March 2010) that was not justifiable. The NBOI noted that while he was a danger to himself, he should not have been considered a danger to others.
- The NBOI concluded that "...his high-rating on Institutional Adjustment was largely based on his self-harming behaviour rather than violent or disciplinary incidents."
- His placement in an overly-restrictive and controlling environment with limited access to normal activities and association aggravated his self-harming behaviours. During his federal custody, Mr. Wareham was consistently frustrated by his limited access to programming, employment and other services.
- The transfer of Mr. Wareham from the Regional Treatment Centre (Pacific) back to the Atlantic Region did not meet the policy criteria for an Emergency Involuntary Transfer.

Adherence to Least Restrictive Measures

- Despite the successes and treatment gains made when Mr. Wareham was in less restrictive environments, CSC continued to rely on almost continuous use of restraints in a depriving environment. CSC's approach was inconsistent with research on protective factors for self-injuries, including less time locked in cell, access to employment, participation in programs, and regular contact with family.
- The NBOI documented that CSC relied for almost three and one-half years on involuntary treatment and restraint of Mr. Wareham "...despite the absence of any demonstrated efficacy." Alternative and more effective treatment approaches were simply not explored, and/or seldom initiated. Surprisingly, some successful individual counselling and treatment approaches were stopped or not subsequently reinitiated.

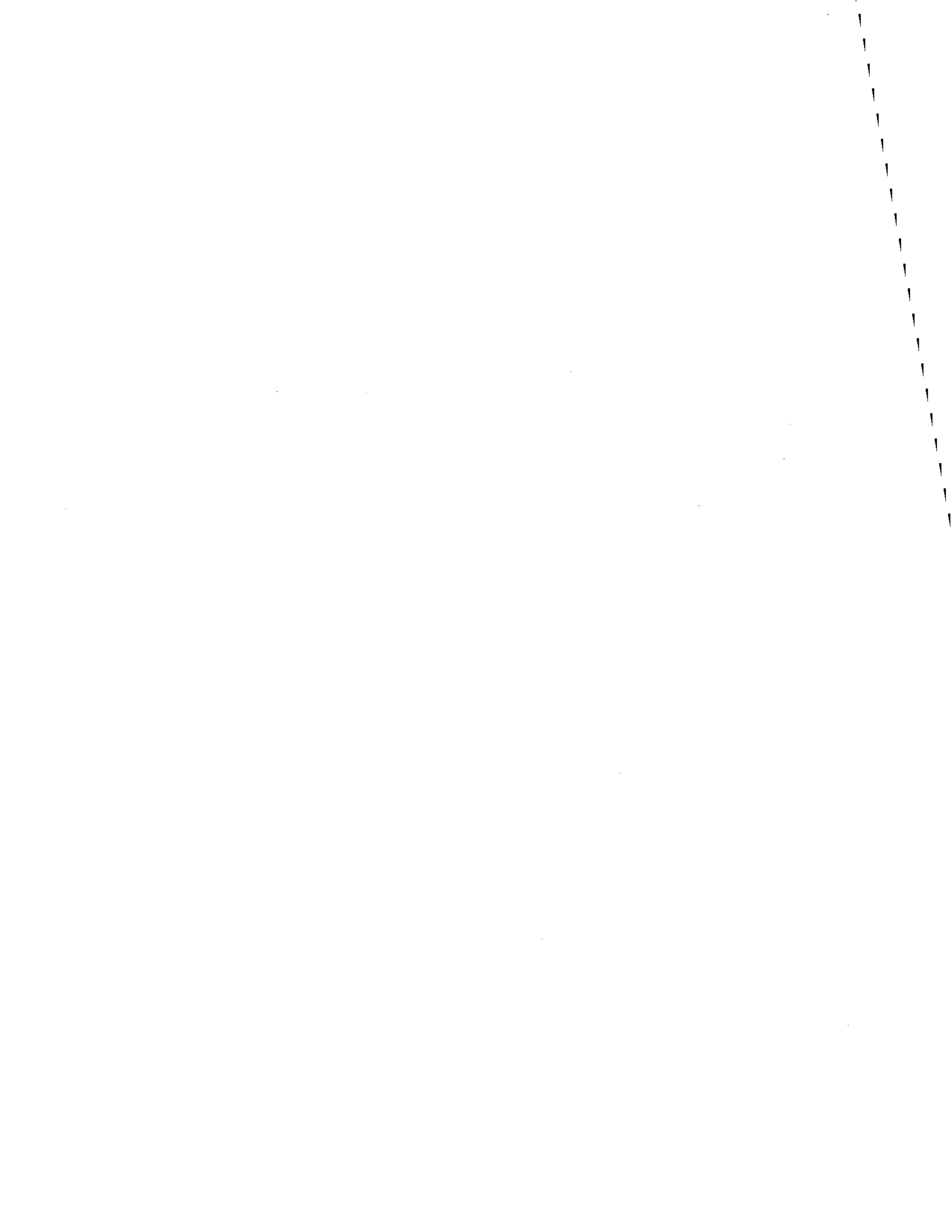
- The NBOI concluded that that the "...almost continuous use of restraints for the long term management of Mr. Wareham" violated CSC's policy requirements for least restrictive forms of management, and "...did not result in a reduction in self-injurious behaviour, actually demonstrating the contrary effect, i.e., an increase in self-injury." Despite the documented opinion of a psychiatrist that "...the frequency of self-injurious behaviour while restrained was greater than the frequency of self-injurious behaviour when he was not restrained," the Service continued to rely on Pinel-type restraints. While in restraint, Mr. Wareham was excluded from any meaningful intervention or communication – no individual counselling was provided.

Clinical Management Plans/Interdisciplinary Management Plans

- CSC did not complete a comprehensive functional analysis of Mr. Wareham's self-injurious behaviour to better understand and more effectively address his behaviour. The CSC instead relied on "...anecdotal information from file notes and staff observations," and, as a result, CSC decreased its chances of preventing self-harming behaviour.
- Although Mr. Wareham was in federal custody for more than six years, the NBOI concluded that "...no comprehensive clinical management plan (integrating key psychology, security and case-management components) had been completed." The absence of such a clinical management plan impeded the ability of CSC's staff to intervene effectively, consolidate and sustain treatment goals.
- There were several occasions where members of the multi-disciplinary treatment team were split with respect to the most effective management strategies for addressing Mr. Wareham's needs.
- Few, if any, clinical interventions were initiated to address the underlying issues of Mr. Wareham's self-harming motivations and post-traumatic stress.

Quality of Care and Staff Performance Issues

- The NBOI identified instances of inadequate observations and monitoring of Mr. Wareham by correctional staff, some of which resulted in disciplinary action.
- The NBOI noted that contrary to policy, "...nursing staff frequently used Mr. Wareham's participation in the Methadone Maintenance Program as a tool to gain compliance in other areas," such as wound care or the cessation of self-injury. Furthermore, Methadone was used as pain medication in violation of CSC policy.
- Front-line security and health care staff were ill-equipped, trained and supported (e.g., Critical Incident Stress Management) to address the challenging needs of Mr. Wareham. While some staff felt connected to him "...others felt emotionally traumatized and expressed feelings of failure."



- The NBOI noted several non-compliance issues related to reporting and documenting of incidents of self-injurious behaviour.
- The NBOI concluded that CSC did not learn from its numerous previous BOI reports related to Mr. Wareham. Promising treatment options did not inform subsequent management strategies or treatment options.
- The transfer was motivated to offer staff "one year of respite," and not motivated by the best available treatment option to address Mr. Wareham's health care needs.

I concur with the NBOI that CSC staff responded to Mr. Wareham in a compassionate manner, and did what they perceived to be in his best interests with respect to ensuring safety and preventing self-injury. Unfortunately, the actions of CSC were often misguided, not informed by clinical practice or unsuccessful and fell short of meeting professional standards in effectively and humanely addressing Mr. Wareham's mental health care needs. The potential for lessons learned in this NBOI should not go unaddressed, and CSC must capitalize on this opportunity to improve performance in this area of corrections.

Finally, I would like to bring to your attention that Ms. Heather Locke, mother of Mr. Wareham, contacted my Office on several occasions and voiced her frustrations about the lack of information she received from the CSC about the circumstances leading to the death of her son.

I therefore recommend the following:

1. That CSC endorses and implements the recommendations of the National Board of Investigation (NBOI) on the Death of Mr. Glen Edward Wareham on April 29, 2010.

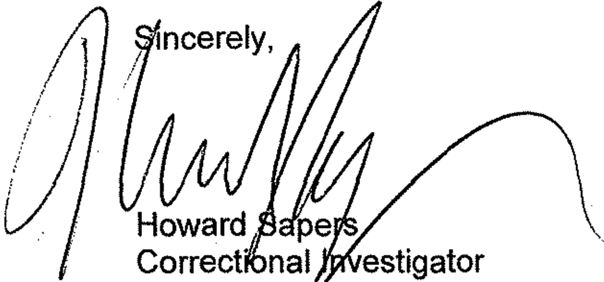
2. That the CSC uses this NBOI's findings and recommendations to inform a comprehensive review of its policies and practices in the following related areas:

    a. finalization of its draft *National Strategy and National Action Plan to Address the Needs of Offenders who Engage in Self-Injury*;
    b. revised policy on the use of restraints for health care purposes;
    c. operational management plan and best practices for the Complex Needs Unit pilot, inclusive of how this NBOI may inform the development of a Complex Needs Unit for women offenders;
    d. training and support for front-line health care and security staff managing self-injurious inmates;
    e. the availability of effective treatment options for all offenders who self-injure, consistent with the least restrictive principle;
    f. placement, classification and transfer procedures for repeat self-harmers.

3. That CSC provides written confirmation that all offenders in its custody who repeatedly self-injure have a Clinical Management Plan/ Interdisciplinary Management Plan in place.

4. That CSC expedites the family request for a copy of this NBOI.

Sincerely,



Howard Sapers
Correctional Investigator

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