

Investigation Report on  
**Use of Pepper Spray and Segregation  
in Manitoba's Youth Correctional  
Facilities**

February 2019

Manitoba  Ombudsman

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## EXECUTIVE SUMMARY AND RECOMMENDATIONS

This investigation was initiated in response to concerns raised in 2015 and 2016 by youth and youth criminal defence counsel with the Manitoba Advocate for Children and Youth, formerly the Office of the Children's Advocate, about the use of pepper spray and segregation at Agassiz Youth Centre (AYC) and Manitoba Youth Centre (MYC). The advocate raised the concerns with our office.

Our office reviewed AYC's and MYC's pepper spray and segregation use between September 1, 2015, to August 31, 2016, for compliance with the Correctional Services Act, the Correctional Services Regulation, policies and standing orders.

With respect to pepper spray use, our office made a number of findings and observations, including:

- AYC's and MYC's respective standing orders did not contain elements required by the Corrections policy ("divisional policy") on pepper spray use. MYC's standing orders did not fully incorporate the divisional policy's medical consultation requirements.
- Neither AYC's nor MYC's standing orders incorporated the divisional policy requirement for the manager who authorizes pepper spray use to include a report in the incident report.
- In many instances, our office was unable to assess AYC and MYC's compliance with pepper spray use standards because the facilities did not fully meet their reporting and documentation requirements. Given the significant use of force associated with pepper spray use, our office is of the view that AYC and MYC must ensure that they document the information required by divisional policy and their respective standing orders.
- In our view, facilities must minimize the potential for negative health consequences resulting from pepper spray use and document what steps they have taken. AYC'S and MYC'S pepper spray use procedures would be enhanced by including additional protections in their standing orders.
- While divisional policy and the facilities' respective pepper spray standing orders address the mental and emotional health of staff who deploy pepper spray, they do not do the same for youth.
- We are of the view that good information and data is essential to assessing the effectiveness of and compliance with policies and procedures. Further, good information and data can identify trends and areas for improvement.

Our office made the following recommendations related to pepper spray use:

1. That MYC amend its pepper spray standing order to reflect divisional policy requirements regarding medical consultation.
2. That AYC and MYC amend their standing orders to reflect the divisional policy requirement that the manager who authorizes pepper spray use must complete a written report for

inclusion in the incident report. The report should contain the reasons why pepper spray use was authorized and a record of the effects of its use.

3. That the report by the manager who authorizes pepper spray use clearly connect the reason(s) why pepper spray use is being authorized to the situations in which its use is permitted by divisional policy.
4. That AYC and MYC ensure that their incident reports contain completed information about “any injuries apparent and otherwise inflicted upon staff or residents, as well as treatment offered and administered” as required by their respective standing orders.
5. That AYC and MYC establish a definition and/or guidelines to standardize the meaning of “injuries apparent and otherwise inflicted” and “treatment offered and administered.”
6. That AYC and MYC expand their pepper spray standing orders to require incident reports to contain a full record of the facilities’ compliance with standing order requirements related to pepper spray deployment.
7. That AYC and MYC document in the incident report that health cautions have been checked for each youth who may be exposed to pepper spray. If a youth’s medical files are not checked, a detailed rationale for not doing so should be included.
8. That AYC and MYC document in the incident report whether air circulation was controlled in the affected areas prior to pepper spray use. Where air circulation is not shut down, the incident report should contain reasons for the decision not to do so.
9. That AYC incorporate being examined by medical staff (when available) and being provided with a change of clothing into its decontamination procedure.
10. That MYC incorporate removing exposed staff and youth from the contaminated area into its decontamination procedure.
11. That AYC and MYC document in their pepper spray incident reports whether exposed staff and youth have been offered each part of the decontamination procedure, as well as whether the offer is accepted.
12. That AYC and MYC incorporate into their pepper spray standing orders procedures to address the mental and emotional health of youth who are exposed to pepper spray or witness its use.
13. That Corrections, AYC and MYC track and review pepper spray use information going forward, allowing the facilities to assess among others, the reasons its use is authorized, the deterrence value and effectiveness of pepper spray and whether it is treated as a last resort, as well as any metrics Corrections considers important to pepper spray use.

With respect to segregation, our office made a number of findings and observations, including:

- Lakewood unit, AYC’s high security unit, operates in segregation conditions as youth are kept separate from each other, can only leave their cell with a staff escort and have restricted access to services and programming available to youth in other units. Despite these factors, Corrections and AYC advised that they do not consider Lakewood unit a segregation placement.
- There were instances where AYC’s and MYC’s respective standing orders were inconsistent with the Correctional Services Regulation. Both AYC’s and MYC’s standing orders referenced segregation for disciplinary reasons, though the regulation prohibits the use of disciplinary segregation for youth.



- The regulation requires that a segregated youth be reviewed at minimum intervals and sets out procedural requirements. AYC's and MYC's standing orders do not fully incorporate the regulation's review requirements.
- Clear, accurate and easily available segregation information enhances accountability and transparency. It can be used to guide individual segregation decisions, identify trends in segregation use and inform facility and departmental decisions for youth. Our office is concerned that Corrections does not maintain an accurate list of youth who have been segregated, when, for what reasons or for how long.
- Clear and accurate records also make it easier for managers and oversight bodies to assess compliance with segregation protections and requirements. In many instances, our office was unable to assess whether AYC and MYC fully complied with segregation regulations and standing orders because there was no requirement for the facilities to report or document their compliance.
- Youth's rights and access to services are altered when they are removed from their group and placed in segregation. In our view, facilities must advise youth of their rights and which services they can access while they are segregated, document what information was provided and document which rights and services were accessed by the segregated youth. Though some of these elements appear in AYC's and MYC's respective standing orders, we could not assess the facilities' compliance as the information was rarely documented in incident reports.
- In the interests of fairness, it is important that youth be given information to understand why they have been placed in segregation, how long they will be there, what they can do to get out and what it will be like while they are in segregation. MYC's standing order contains this requirement, but AYC's does not.
- Reviewing segregated youth provides them with human contact and the opportunity to be released from segregation as soon as it is reasonable to do so. Neither AYC nor MYC consistently complied with their respective standing orders relating to segregation reviews.
- AYC and MYC shift operations managers are entrusted with specific documentation responsibilities. However, managers met these responsibilities in fewer than half of the AYC segregation incidents reviewed and did not meet the requirements in any MYC segregation incidents reviewed.
- Our office notes that another 200 youth were segregated at MYC pursuant to the Intoxicated Persons Detention Act, in addition to the youth who were segregated while incarcerated at MYC. Though MYC's segregation standing order appears to apply to youth held pursuant to the act, none of the incident reports we saw met the segregation documentation requirements. Eleven of these youth were held for more than 24 hours in contravention of the Intoxicated Persons Detention Act.

Our office made the following recommendations related to the use of segregation:

14. That Corrections and AYC recognize and apply segregation regulations, policies and protections to Lakewood unit.
15. That AYC and MYC amend their respective standing orders to clarify that youth cannot be segregated for disciplinary reasons.

16. That AYC amend its Lakewood referrals and admissions standing order to include review hearings at the intervals required by the Correctional Services Regulation.
17. That MYC amend its use of observation units standing order to clarify whether the “personal contact” required by the standing order is the equivalent of the reviews required by the Correctional Services Regulation.
18. That AYC and MYC incorporate the Correctional Services Regulation procedural requirements for the review hearings, and the decision-making and appeal processes into their respective standing orders.
19. That Corrections, AYC and MYC compile, track and review segregation use information going forward, allowing the facilities to assess among others, who, when, for what reason(s) and for how long, as well as any metrics Corrections considers important.
20. That AYC and MYC expand their respective standing orders to require segregation incident reports to contain a full record of the facilities’ compliance with standing order requirements related to segregation.
21. That AYC and MYC amend their standing orders to require the manager who authorizes a youth’s segregation to include a report in the incident report. Their report should identify themselves as the authorizing manager and include clear reasons for the authorization.
22. That AYC and MYC amend their standing orders to require the incident report to include an entry documenting the outcome of the deputy superintendent’s 24-hour review(s).
23. That AYC amend their confinement of residents standing order to require segregation incident reports to record the reason(s) for a youth’s release from segregation.
24. That AYC and MYC amend their standing orders to require staff to document that youth were provided with the information specified by the standing orders when they are placed in segregation.
25. That AYC and MYC amend their standing orders to require that youth be informed of their rights and access to services while in segregation.
26. That AYC amend their standing order to require the incident report to document daily whether youth have received the rights and access to services to which they are entitled.
27. That MYC ensure the shift operations manager documents that youth have received the services they require in the segregation incident report.
28. That AYC amend its standing orders to ensure that in addition to the behavioural information youth are provided, they are also informed of the reasons they have been placed in segregation and the anticipated length of their segregation.
29. That AYC and MYC ensure that each review occurs, is documented and that the rationale for continuing to segregate the youth is recorded.
30. That AYC and MYC ensure that their shift operations managers fulfil their respective documentation requirements.
31. That MYC clarify whether its use of observation units standing order applies to youth held pursuant to the Intoxicated Persons Detention Act.
32. That MYC review its procedures for youth held at MYC pursuant to the Intoxicated Persons Detention Act to ensure they are released within 24 hours as required by the act.

Manitoba Justice accepted our findings and recommendations about pepper spray and segregation use. Manitoba Justice advised it has implemented the recommendations relating to pepper spray, and expects to implement the recommendations relating to segregation by March 1, 2019.

# INTRODUCTION

## Ombudsman jurisdiction and role

Under the Ombudsman Act, Manitoba Ombudsman may investigate administrative actions and decisions by Manitoba municipalities, government departments and agencies.

Ombudsman investigations typically assess actions and decisions against a benchmark established by government. Sometimes that benchmark is legislation. On other occasions, it is written policy or established procedures that give effect to legislation. We also examine the fairness of the action or decision in cases concerning an impact on individual rights or benefits.

One of the goals of ombudsman investigations is to identify areas requiring administrative improvement.

## The investigation

This investigation was initiated in response to concerns raised in 2015 and 2016 by youth and youth criminal defence counsel with the Manitoba Advocate for Children and Youth, formerly the Office of the Children's Advocate, about the use of pepper spray and segregation at Agassiz Youth Centre and Manitoba Youth Centre. Youth were reluctant to make specific allegations and indicated they feared reprisal if they made a complaint.

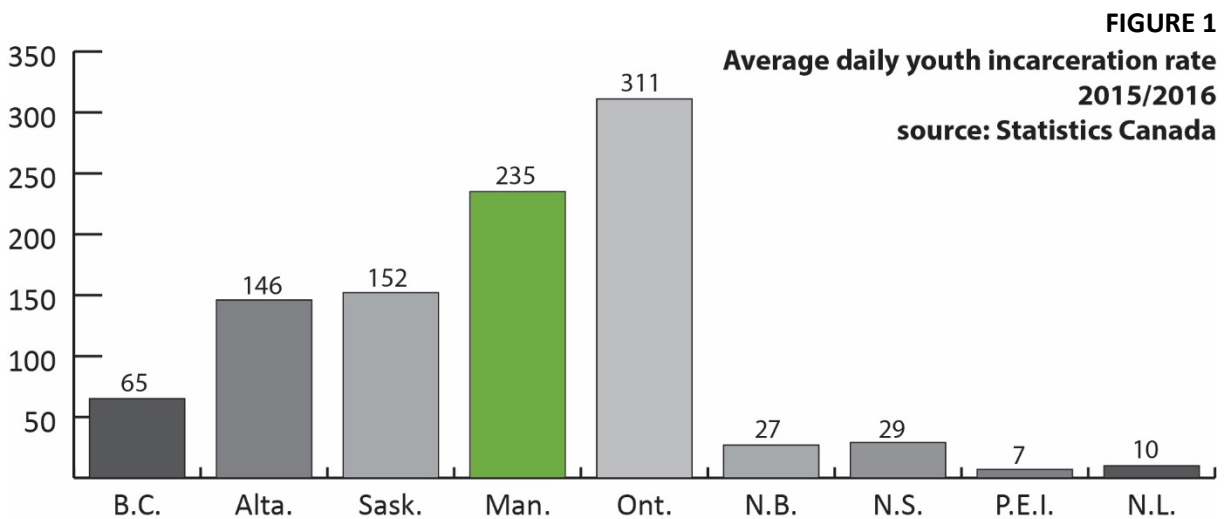
The advocate raised the concerns with the ombudsman. It was determined that both offices would do a joint investigation, with each office examining the use of pepper spray and segregation in youth correctional facilities from the perspectives of our distinct mandates. Our office reviewed the use of pepper spray and segregation for compliance with regulations and policies. The advocate reviewed the appropriateness of using pepper spray and segregation on youth. Each office published its own report.



## BACKGROUND: Youth Corrections in Manitoba

The Custody Corrections Branch, referred to in this report as “Corrections,” is part of Manitoba Justice’s Community Safety Division. Corrections runs two youth correctional facilities in the province, Agassiz Youth Centre and Manitoba Youth Centre, in addition to seven adult correctional facilities.

During our review, the average daily youth incarceration rate in Manitoba was the second highest in Canada<sup>1</sup> with Manitoba incarcerating more youth per capita than any other province:



### Agassiz Youth Centre

Agassiz Youth Centre (AYC) is located on 59 acres in Portage la Prairie. It has a rated capacity of 128 youth. AYC opened in 1977. However, the property has been a facility for male youth since 1910 when it opened as the Industrial Training School and took in 20 boys from the Central District Gaol.

Originally, youth at AYC were held in one of four “cottages,” Alpha, Beta, Charlie and Delta, built in the 1930s. The cottages look like big houses from the outside. The inside layout also resembles a

<sup>1</sup> Figures from Statistics Canada. Number for Quebec not available.

multi-level house. There is a small kitchen with a stove, sink, fridge and dishwasher. Youth eat meals, prepared in the main kitchen, together in the dining area of the cottage. Youth have dorm-style beds – there are wooden “cubicles” for 20 youth in the basement sleeping area. There is also a common room for various indoor activities. Only two of the four cottages are currently in use.

AYC also has a newer building, constructed in 2011. The one building houses two units: Echo and Foxtrot. The units are connected by a joint cafeteria/common area, with lots of natural light. The layout inside of this building is more institutional and modern than the cottages. There are designated spaces for a mud room, classrooms, staff offices and the youths’ rooms. All bedrooms in Echo and Foxtrot have an outside window, some bedrooms have toilets in them and some bedrooms have bunks rather than a single sleeping platform.

Lakewood, a high security unit, was built in 2001. There are two activity rooms located in Lakewood – one with books, toys, etc. and one with only tables and chairs. Additionally, there is a phone room for youth to contact legal counsel and/or family. Youth eat their meals in their rooms. Lakewood has 20 rooms divided into three “pods”: A pod, B pod and C pod. Each room has a platform for a mattress, a toilet and an outside window.

AYC has a small commercial kitchen, located in the main administration building, where meals are prepared for the whole facility. The kitchen used to be the staff lounge. When AYC began making its own meals again, it was converted into a commercial kitchen.

The property also has a power building, school building, a separate building used for various ‘trades’ classes and a barn. There are also allocated areas for gardens, fenced areas for livestock and activity areas for basketball and other outdoor sports.

## Manitoba Youth Centre

Manitoba Youth Centre (MYC) is located in Winnipeg. It has a rated capacity of 150 youth, both male and female.

MYC’s facilities are laid out in a semi-circle around an open courtyard. The administration section of the main building contains offices for correctional staff, as well as staff from a number of different services and agencies that connect with incarcerated youth. The main building also contains the admissions area, a gym/recreation area, an arts area, a cafeteria, a chapel, a courtroom, medical services and the observation unit with four “observation rooms.” Around the open central space are five buildings, each housing two units. There is a common room for various activities that connects the two units. New heating and ventilation systems have been installed in all units.

Each youth’s room has an outside window and a bed. There are no toilets in the rooms. The girls’ rooms (buildings D & E) have been fitted with doors that can swing (180 degrees) either inward or outward. This allows staff to access rooms even when a youth tries to barricade the door. MYC would like to install these doors on the boys’ rooms (buildings A, B & C) and are waiting for funding to be made available.

# INVESTIGATION: Pepper Spray

## Pepper spray background

Oleoresin capsicum (OC) spray, also known as pepper spray, is a type of chemical restraint that is made of a naturally occurring substance found in the oily resin of cayenne and other chili peppers. Contact with pepper spray incapacitates individuals by inducing burning, swelling and tearing of the eyes, and an immediate burning sensation to exposed skin. When inhaled, pepper spray can inflame the respiratory tract, causing the mucous membranes lining breathing passages to swell and to temporarily restrict breathing to shallow, short breaths.

Pepper spray may be used in Manitoba youth and adult correctional facilities only if the failure to do so is likely to jeopardize the safety of staff members, offenders or others, or result in damage to government property. AYC and MYC advised that they consider pepper spray use as a last resort and pepper spray will not be used if it is possible to wait a youth out and gain their cooperation through patience.

Below is a chart of pepper spray use at AYC and MYC since 2010. It does not include incidents where pepper spray use was authorized, but was not actually used.

**TABLE 1: Pepper spray use at AYC and MYC, 2010-2018**

	2010	2011	2012	2013	2014	2015	2016	2017	2018
AYC pepper spray uses	29	8	0	2	7	5	9	2	1
MYC pepper spray uses	17	11	3	6	24	30	10	3	1

The chart reveals that pepper spray use fluctuates in Manitoba youth facilities. More recently, the 2017 and 2018 numbers show both AYC and MYC reduced their use of pepper spray from 2016.

Pepper spray was used in Manitoba youth facilities on 23 occasions between September 1, 2015, and August 31, 2016. A total of 43 youth and 269 staff were involved in the incidents, with 30 youth being sprayed. Pepper spray was deployed in nine incidents at AYC with 15 youth being sprayed. Pepper spray was deployed in 14 incidents at MYC with 15 youth being sprayed.

## Pepper spray key issue

- Is pepper spray being deployed at AYC and MYC in accordance with the legislation, regulations and policies that govern its use?

Our office reviewed AYC's and MYC's pepper spray use for compliance with statutory and procedural requirements. Given the operational nature of decisions to escalate the use of force to pepper spray use, which are based on the circumstances of each individual situation, it was not within the scope of our review to assess the appropriateness or reasonableness of the facilities' decision to use pepper spray in any specific instance. Rather, our office focused on whether the facilities met statutory and procedural requirements once the decision to use pepper spray was made.

## Scope of our review

We reviewed legislation, regulations, policies and standing orders relevant to the use of pepper spray at AYC and MYC:

- The Correctional Services Act
- The Correctional Services Regulation
- Corrections Division policies
  - Restraint Equipment
  - Use of Force Contingency
- AYC's standing orders, including
  - #974 Pepper Spray
  - #966 Use of Force / Physical Restraint Devices
  - #912 Violence Prevention
  - #701 Video Monitoring
- MYC's standing orders, including
  - #03-967 Pepper Spray (Oleoresin Capsicum)
  - #03-966 Use of Force / Physical Restraint Device
  - #03-983 Soft Cell Extraction

We interviewed:

- Executive director of Corrections
- Superintendent of AYC
- Superintendent of MYC
- Deputy superintendent of MYC
- Two staff at AYC
- Two staff at MYC

Our office assessed AYC's and MYC's compliance with legislation, regulation and policies governing the use of pepper spray between September 1, 2015, and August 31, 2016, by reviewing all the pepper spray incident reports we were provided by Corrections. We reviewed 27 incident reports where the use of pepper spray was authorized. Pepper spray was deployed in 23 of those incidents.

Incident reports have a cover page that sets out general information about the incident, including location, time, list of participants, list of injuries, etc. The rest of the incident report is comprised of written reports from each staff who were involved in the incident. Staff reports are written in a narrative style, with staff recording what they saw and experienced during their involvement in the

incident. There may also be supplementary reports to add additional information to the incident report. As pepper spray use is a significant event, there are usually many staff involved. Incident reports reviewed often contained 10 or more individual staff reports; the fewest staff involved in an incident was six, while the highest was 23.

## Pepper spray as part of the use of force continuum

Pepper spray is part of the use of force continuum in Manitoba youth and adult correctional facilities. The Correctional Services Act and the Correctional Services Regulation authorize the deployment of pepper spray in Manitoba correctional facilities. Corrections' policy ("divisional policy") on restraint equipment requires each correctional facility to establish "standing orders" for the use of pepper spray. Standing orders are the policies that each facility sets for itself. The standing orders must be consistent with the standards established by Appendix A "Restraint Equipment: Oleoresin Capsicum (OC) Spray Standards for Custodial Centres" of the divisional policy.

The Correctional Services Act authorizes correctional officers to use as much force "as is reasonably necessary" to maintain order and control and to prevent self-destructive behavior:

***Use of force etc.***

44 *A correctional officer employed in a custodial facility may use such force, including restraint, as is reasonably necessary and such equipment as is specified in the regulations,*

- (a) to maintain order in, and control of the inmates of, the facility; or*
- (b) to prevent self-destructive behaviour by an inmate of the facility.*

This applies to youth facilities where correctional officers are called "juvenile counsellors."

Specifically, divisional policy states that juvenile counsellors may use "reasonable force" to:

- prevent escapes
- defend themselves or others against an immediate threat to personal safety
- prevent or stop a disturbance
- prevent serious damage to property
- prevent self-destructive behaviour
- move an offender for preventive security or disciplinary purposes
- prevent any serious threat to the safety of the community
- respond to any other serious threat to the security and good order of the custodial facility

Staff are to exercise discretion and caution in the use of force. Force is not to be used as a means of punishment or discipline and should be discontinued as soon as it is safe to do so.

AYC's and MYC's use of force standing orders set out the following use of force continuum:

- juvenile counsellor presence

- verbal dialogue (lawful orders)
- soft empty hand control techniques (physical handling)
- mechanical restraint equipment (e.g. handcuffs, shackles, body chains, etc.)
- oleoresin capsicum (OC) spray
- less lethal force options (CERU [Corrections Emergency Response Unit] only)

AYC's and MYC's use of force standing orders require that, whenever possible, staff use alternatives to force, including verbal and non-verbal defusing techniques (crisis intervention and conflict management techniques), warning/cautioning the youth, calling for more staff presence and strategically withdrawing from the situation. Juvenile counsellors can "use force only with the authorization and under the direction of the Correctional Supervisor, except where circumstances do not permit."

An institutional response team is assembled and deployed by the shift operations manager at AYC or by the in charge person at MYC when other less forceful interventions, discussed above, have been unsuccessful in bringing youth into compliance with staff requests. Pursuant to Corrections' use of force policy, an institutional response team is "a team of staff members who are trained and certified in pepper spray and soft cell extraction." The policy notes that:

*An IRT, due to specialized training and equipment, is considered as best able to deal with certain situations, (i.e. soft cell extraction), that may occasionally arise in a custodial facility, increasing the likelihood of a successful resolution that limits injury to staff and offenders and minimizing property damage to the facility.*

Soft cell extraction is defined in the policy as "the removal of acting-out offender from a cell, room or area, who is presenting an immediate threat to self or others, and **complies** with verbal order with or without use of O.C. spray." In contrast, a hard cell extraction is one where the youth does not comply with verbal orders, whether pepper spray is used or not.

At AYC, it is the shift leader's responsibility to ensure that all possible de-escalation techniques and alternative interventions have been attempted before an institutional response team is assembled or pepper spray authorization is requested. The shift leader then reports their findings to the shift operations manager, who assesses whether an institutional response team is needed to address the situation. At MYC, it is the in charge person who must ensure that alternative interventions have been exhausted before assembling an institutional response team or requesting pepper spray authorization.

An institutional response team does not automatically have authorization to deploy pepper spray. While the shift operations manager at AYC has the authority to assemble an institutional response team, only the superintendent or the on call manager can authorize the team to use pepper spray. At MYC, the in charge person who assembles an institutional response team can authorize the team to use pepper spray in an emergency. MYC advised "the only time this would happen is if the Shift Leader walked into an emergent situation like a major assault of a person or was in immediate danger and there was no opportunity to get permission from their Shift Operations Manager and the



Super/Deputy.” MYC noted that this is an unlikely occurrence. In non-emergency situations, pepper spray use must be authorized by the superintendent or deputy superintendent at MYC.

Divisional policy limits the circumstances in which pepper spray may be deployed to those where “the failure to do so is likely to jeopardize the safety of staff members, offenders/young persons or others; or likely to result in substantial damage to government property.” AYC’s pepper spray standing order sets out a non-exhaustive list of such situations where pepper spray may be used:

***Use Situations***

*4. The use of OC spray shall be limited to the minimum necessary in order to gain control and will be discontinued at the earliest reasonable opportunity. Force may be used, including but not limited to the following situations:*

- 4.1. threat of violence to staff members, residents or others;*
- 4.2. prevention of serious bodily injury or loss of life;*
- 4.3. defence of a third party or facility property where injury or damage is imminent or has occurred;*
- 4.4. maintenance of security and control of the facility;*
- 4.5. prevention of escape;*
- 4.6. to prevent the continuation of a serious criminal act.*

MYC’s pepper spray standing order mirrors AYC’s and includes an additional listed situation:

*9.4 Removal of an aggressive or violent young person from a confined area where the use of physical intervention is likely to result in injury to staff, young persons or both*

AYC’s and MYC’s pepper spray standing orders require that before a youth is exposed to spray, they will be given the following warning:

- 1. Resident (name), under the authority of the (specify) you are ordered to (action). Will you comply?*
- 2. Resident (name), if you fail to comply, force or chemical agents may be used. Will you comply?*
- 3. Resident (name), if you fail to comply, force or chemical agents will be used. Will you comply?*

Their standing orders also state that pepper spray will be used as little as possible in any situation and will be discontinued “at the earliest reasonable opportunity.”

## **Deployment of pepper spray by an institutional response team**

Institutional response team equipment and pepper spray are kept in secure storage areas at AYC and MYC; they are not routinely carried by staff. The pepper spray inventory is monitored by the shift operations manager at AYC and by the preventive security officer at MYC. Institutional response

team equipment and pepper spray are provided to an institutional response team once they are assembled and pepper spray use has been authorized.

Corrections' use of force policy, with which AYC's and MYC's use of force standing orders must comply, sets out a three-step procedure for deployment of an institutional response team. The process is the same whether pepper spray use has been authorized or not.

Step one is the assembly and briefing the institutional response team members, of whom there must be at least four. Roles on the team are assigned and the team is briefed on the action plan and levels of force that will be used (i.e. whether pepper spray use has been authorized). When pepper spray use is authorized, the team leader is assigned the tasks of checking for health cautions, ensuring a decontamination area is prepared, medical staff is on standby, if available, and the ventilation system is shut down, if possible. At least two staff are assigned the role of "arrest and control" – they are responsible for applying restraints and escorting the youth to a new destination. A videotape officer is also assigned to record the events.

Step two is the extraction, removal and escort of the youth. With respect to the action plan established under step one, the policy gives the institutional response team leader discretion to modify the plan for "the best facilitation of the extraction and removal of the offender." MYC's soft cell extraction standing order goes further and leaves the final decision on whether pepper spray will be deployed to the discretion of the team leader.

Prior to deploying pepper spray, the institutional response team leader alerts the youth that force will be used if they do not cooperate:

*(State name of offender) by order of the (facility head, IC or SOM) you are to be removed to segregation. If you fail to comply with my orders, physical force and OC spray will be used. Will you comply? Yes or No?*

This warning can be repeated if the team leader is of the view that the youth did not hear it. If the youth cooperates, restraints are applied and the youth is removed from the area per the action plan.

If the youth does not cooperate, then pepper spray is deployed and the youth is again asked if they will cooperate. Depending on the circumstances, the institutional response team may be able to deploy pepper spray directly, or they may have to deploy it through a meal slot or under a door. Sometime youth try to minimize their exposure to pepper spray, for instance by barricading their door with their mattress or wrapping clothing over their head. Team leaders can decide to "to re-apply [pepper spray] to ensure contact, should initial application not be successful."

Where pepper spray exposure does not gain a youth's cooperation, the policy instructs institutional response team members to wait, as pepper spray may work over time. The team is also to notify the superintendent and request permission to activate the Corrections Emergency Response Unit (CERU) or the Female Cell Extraction Team (FCET). Our office observes that MYC's soft cell extraction standing order differs from the policy in that it instructs the institutional response team to enter the area, physically take control of the youth, restrain them and remove them from the area.

As soon as possible after the youth has been extracted, the third and final step is the assembly and debriefing of institutional response team members. The team leader is to address the following in the debriefing:

- 1. Check for physical injuries;*
- 2. Check for any emotional feelings related to the extraction plan, events or results;*
- 3. Check for any need for further assistance regarding Critical Incident Stress Management;*
- 4. Review any equipment that failed and seek recommendations; and*
- 5. Complete the mandatory written reports on use of force.*

Our office observes that two of the five debriefing items relate to the mental and emotional health of institutional response team members. This is discussed further in the “Additional observations” section later in this report.

### **Consistency of AYC’s and MYC’s standing orders with divisional policy**

As noted above, divisional policy, which applies to both youth and adult correctional facilities, requires each facility to establish standing orders for the use of pepper spray that are consistent with the standards in the policy. AYC’s pepper spray standing order is generally consistent with divisional policy. Many standards are reproduced word-for-word in AYC’s standing order. We did not find any instances where AYC’s standing order was less comprehensive (i.e. offered staff and youth fewer protections) than divisional policy.

Nonetheless, our office notes that divisional policy requires that the manager who authorizes the use of pepper spray write a report setting out the reasons for and effects of pepper spray use. However, AYC’s pepper spray standing order assigns reporting requirements to the shift operations manager, rather than to the manager who authorizes pepper spray deployment. The same is true for MYC’s pepper spray standing order. MYC assigns reporting requirements to the institutional response team leader rather than to the manager who authorizes pepper spray deployment.

Pepper spray use is significant use of force with significant health consequences – physical, mental and emotional – for youth and staff. While delegating reporting requirements frees up the superintendent/on call manager to handle other duties, it means that the incident report does not contain a first-hand account of the reasons for pepper spray authorization. It is important from accountability and public interest perspectives that clear and accurate reasons for the authorization of pepper spray be recorded in the incident report by the person who actually authorizes its use. For that reason, our office is of the view that, consistent with divisional policy, the person who authorizes the use of pepper spray should write a report documenting the reasons for and effects of its use.

In contrast to AYC, MYC’s standing order contained other inconsistencies with divisional policy in the areas of medical consultation and air circulation.

## Medical consultation

Divisional policy sets out that a facility's health services will be consulted and advised prior to pepper spray use, if time and circumstances permit:

### **6. Medical Consultation Prior to Use**

*6.1 If time and circumstances permit, prior to using OC spray, the OIC/SOM shall consult a health service staff member to determine whether the affected inmate(s) have any related health cautions.*

*6.2 If available, Health Services should be advised that an examination will be required following any deployment of OC spray.*

MYC's pepper spray standing order incorporates the above considerations:

*Whenever possible, and if time permits, the IC will notify the Medical Unit of their intention to employ pepper spray. The Medical Unit should standby to examine young persons contaminated with the pepper spray. If a review of the young person's medical history raises any concerns, the Medical Unit should notify the In-Charge person and the IR Team leader of his/her situation.*

However, the divisional policy also requires that when a medical staff is unavailable, the officer in charge/shift operations manager will review the young person's file for any health cautions. When a medical review is not done prior to spray use, the rationale for the lack of consultation must be clearly documented in the incident report:

*6.3 If a health service staff member is unavailable, the OIC/SOM shall review the offender/young person's file for any health cautions.*

*6.4 In the event that medical information is not sought prior to the application of OC spray, staff shall clearly document in detail the rationale under COMS Incident Report.*

These requirements are not reflected in MYC's pepper spray standing order.

Our office is of the view that these sections of divisional policy offer important protections for youth. When health services are unavailable, there should be a process to ensure health cautions are still verified. Equally, it is important that when medical information is not obtained prior to pepper spray use, the reasons be clearly documented in the incident report.

MYC advised that medical staff are usually available at MYC 24/7, which is reflected in the standing order. MYC indicated it is willing to incorporate sections 6.3 and 6.4 of divisional policy into their standing order in the eventuality that health services are unavailable.

## Air circulation

In terms of air circulation, divisional policy requires that, where time and circumstances permit, ventilation systems be shut down to minimize contamination to staff or other youth:

### **9. Building Air Circulation**

*9.1 If time and circumstances permit, staff will attempt to shut down the ventilation system in the affected area/unit in order to minimize cross contamination to staff or other offenders/young persons.*

Our office observes that MYC's pepper spray standing order in effect during the time of review did not contain a section on controlling air circulation. However, MYC's soft cell extraction standing order did require the in charge person to ensure the ventilation system was shut down in the "problem" area prior to pepper spray deployment.

MYC advised that with their previous ventilation system, the procedure for shutting down ventilation was complicated. However, the ventilation system installed in October 2015 only requires staff to push a button to shut it down. MYC's pepper spray standing order was revised in 2016 to include a section on air circulation. It now specifies that "the Shift Leader will assign a staff to shut down the ventilation in the area where the pepper spray is to be deployed before the use of the spray."

Our office is of the view that it is important to minimize exposure of youth and staff to pepper spray, given its purpose and effects. We are satisfied that MYC has addressed this discrepancy between its previous pepper spray standing orders and divisional policy.

## Review of AYC's and MYC's pepper spray use

Our office requested that Corrections provide us with all incident reports involving pepper spray use at AYC and MYC between September 1, 2015, and August 31, 2016. We received nine incident reports from AYC and 17 incident reports from MYC.

Our office developed a list based on requirements related to pepper spray use found in divisional policy and AYC's and MYC's standing orders. We assessed the facilities' compliance by reviewing the pepper spray incident reports against the list. We used the same list for both facilities despite some differences in their respective standing orders. The assessment below identifies when a requirement does not apply to one of the facilities.

### AYC overview

In addition to AYC's pepper spray standing order, AYC's use of force and video monitoring standing orders contain additional requirements when pepper spray use has been authorized.

We received nine incident reports associated with pepper spray use at AYC between September 1, 2015, and August 31, 2016. Some incidents involved multiple youth, and some only one. Eighteen youth were involved in the nine incidents, with 15 of them exposed to pepper spray.

Six youth were extracted after one burst of pepper spray, five youth were extracted after two bursts of pepper spray and two youth were extracted after three bursts of spray. In one incident at AYC, two youth would not cooperate after each was separately exposed to three bursts of pepper spray. The Correction Emergency Response Unit (CERU) was called in and both youth were advised of this. While waiting for CERU to arrive, one youth decided to cooperate with staff. CERU succeeded in getting the other youth to cooperate through verbal dialogue.

See Table 2 for an overview of AYC's compliance with various policy requirements.

### MYC overview

In addition to MYC's pepper spray standing order, MYC's use of force and cell extraction standing orders contain additional requirements when pepper spray use has been authorized.

We received 17 incident reports from Corrections associated with pepper spray use at MYC between September 1, 2015, and August 31, 2016. Some incidents involve multiple youth, and some only one. Youth were exposed to pepper spray in 14 of those incidents. In the other three incidents, pepper spray use was authorized, but it was not used.

During our review of segregation incident reports from the same period, we found an additional incident where pepper spray was authorized, but not used at MYC. We included that report in our review of pepper spray use.

Ultimately, 25 youth were involved in 18 incidents, with 15 of them exposed to pepper spray. At MYC, three youth were extracted after one burst of pepper spray, eight youth were extracted after two bursts of pepper spray, one after three bursts and one after four bursts. One youth would not cooperate in two separate instances. The youth tied clothing around their neck after being exposed to two bursts of spray two separate times. The institutional response team entered the youth's room to remove the clothing from around the youth's neck without waiting for the youth's cooperation in both instances.

See Table 3 for an overview of MYC's compliance with various policy requirements.



**TABLE 2: AYC – Overview of compliance with policy requirements**

**Nine incidents of pepper spray use** (September 1, 2015 to August 31, 2016) were reviewed to determine compliance with pepper spray use requirements

Pepper spray use requirements	Number of times requirement was documented as met
Pepper spray use authorized by superintendent or on call manager	9
Person authorizing pepper spray use writes a report	0
Shift operations manager writes a report	9
Shift operations manager notified superintendent or on call manager	9
Each staff involved completes a written report for inclusion in the incident report	9
Health cautions checked prior to pepper spray deployment	1
Health services notified prior to incident	1
Air circulation was controlled	1
Incident was video recorded	9
Staff went through debriefing after the incident	6

**In the nine incidents, 18 youth were involved and 15 youth were pepper sprayed**

Pepper spray use requirements	Number of times requirement was documented as met
Warning given to youth prior to youth being exposed to pepper spray	15
Exposed youth were offered decontamination	14
Exposed youth were provided with a change of clothing	3
Youth received medical attention post-spray	0

**Injury documentation in the nine incidents of pepper spray use**

Documentation requirement	Number of times requirement was met
Injury fields completed (18 youth involved)	15
Injury fields completed (89 staff involved)	66

**TABLE 3: MYC – Overview of compliance with policy requirements**

**Eighteen incidents of pepper spray use (September 1, 2015 to August 31, 2016) were reviewed to determine compliance with pepper spray use requirements**

Pepper spray use requirements	Number of times requirement was documented as met
Pepper spray use authorized by superintendent, deputy superintendent or in charge person	18
Manager authorizing pepper spray use writes a report	0
Authorizing manager notified superintendent	0
Institutional response team leader completes a written report	18
Each staff involved completes a written report	17
Health cautions checked prior to pepper spray deployment	3
Health services notified prior to incident	3
Air circulation was controlled	5
Incident was video recorded	17
Staff went through debriefing after the incident	17

**In the 18 incidents, 25 youth were involved and 15 youth were pepper sprayed**

Pepper spray use requirements	Number of times requirement was documented as met
Warning given to youth prior to youth being exposed to pepper spray	14
Exposed youth were offered decontamination	15
Exposed youth were provided with a change of clothing	9
Youth received medical attention post-spray	1

**Injury documentation in the 18 incidents of pepper spray use**

Documentation requirement	Number of times requirement was met
Injury fields completed (25 youth involved)	3
Injury fields completed (180 staff involved)	65

## Authorization

Consistent with divisional policy, the superintendent or the on call manager must authorize an institutional response team to use pepper spray at AYC:

### **Authorized Application**

*2. Oleoresin Capsicum (OC) spray shall only be used on the direction of the Superintendent or the on call manager as requested by the Shift Operations Manager (SOM) at the time of the incident;*

MYC requires authorization from the superintendent, deputy superintendent or in charge person at MYC:

### **Procedures**

*1. The Superintendent, the Deputy Superintendent, or in emergency situations, the In-Charge Person of the Manitoba Youth Centre shall direct or authorize the use of pepper spray.*

The facilities obtained authorization for pepper spray use from an appropriate manager in each of the nine AYC and the 18 MYC pepper spray incidents.

## Notification

AYC's use of force standing order requires the shift operations manager to notify the superintendent/on call manager should the shift operations manager decide to deploy an institutional response team:

### **Notifications**

*17. If the SOM decides that an IRT shall be called out, the following notifications shall be made:*

*17.1 The SOM shall notify the on call manager of the situation **by phone immediately***

At AYC, the shift operations manager documented their call to the superintendent or on call manager in each of the nine incident reports.

In contrast, it is MYC's pepper spray standing order that requires "the authorizing staff" (which would be the deputy superintendent or the in charge person as discussed in the above section) to report the pepper spray use to the superintendent. The institutional response team leader (who is usually the shift leader) must record that the authorizing staff did so in their report:

*12. Whenever OC spray is use, the authorizing staff will report such use to the Superintendent. This will be included in the IRT Leader's report...*

At MYC, none of the incident reports recorded that the authorizing staff advised the superintendent when pepper spray was used.

## Reporting

As discussed above, while divisional policy requires that the manager who authorizes the use of pepper spray write a report setting out the reasons for and effects of pepper spray use, neither AYC's nor MYC's standing orders include that requirement. Rather, reporting requirements are assigned to the shift operations manager at AYC and the institutional response team leader at MYC. None of the incident reports from either facility contained a report written by the person who authorized pepper spray use.

### Manager/team leader documentation responsibilities

As noted, in AYC's pepper spray standing order, the shift operations manager is required to write a report including specific information: the events leading up to pepper spray use, a "precise" description of the incident, alternative interventions used and reasons for employing pepper spray, and a list of a injuries and treatment offered and administered.

#### **Reporting**

*17. Whenever pepper spray is used, the SOM shall open and submit an incident report on COMS. The report shall include:*

*17.1. the events leading up to the use of pepper spray*

*17.2. a precise description of the incident, alternative interventions considered and used, and reasons for employing pepper spray.*

*17.3. list of any injuries apparent and otherwise inflicted upon staff or residents, as well as treatment offered and administered*

MYC's pepper spray standing order requires the same information to be included in the incident report, though it is the institutional response team leader who must include the specified information. In addition to AYC's list, the institutional response team's report must also include a "list of all participants and witnesses":

*12. Whenever OC spray is use, the authorizing staff will report such use to the Superintendent. This will be included in the IRT Leader's report. The report will include:*

*12.1 The events leading up to the use of OC spray,*

*12.2 A precise description of the incident, alternative interventions considered and used, and reasons for employing OC spray,*

*12.3 List of any injuries apparent and otherwise inflicted upon staff or residents, as well as treatment offered and administered,*

*12.4 A list of all participants and witnesses.*

Additionally, both AYC and MYC require each staff involved in the incident to write a report to be included in the incident report.

In each of the nine pepper spray incidents at AYC, the shift operations manager created an incident report and all staff identified as being involved wrote reports for inclusion in the incident report. At MYC, institutional response team leaders created reports in each of the 18 pepper spray incidents. There was one pepper spray incident at MYC where the incident report did not contain a report from one staff person involved in the incident.

Our office observed that the combined shift operations manager or institutional response team leader and staff reports contained the information required in the first two parts of the reporting sections (the events leading up to the use of pepper spray, a precise description of the incident, alternative interventions considered and used, and reasons for employing pepper spray). However, the information was often spread across multiple staff reports rather than contained in the manager's or team leader's report as required by the standing orders. Many important details for contextualizing the use of pepper spray, such as the behaviour leading up to spray use, alternative interventions considered, reasons for requesting the use of pepper spray, whether warnings were given before pepper spray was used, how youth reacted to spray, decontamination and relocation, etc., were frequently in staff reports rather than in the manager's or team leader's report.

MYC acknowledged this can happen. In MYC's view, a report should reflect what staff saw and experienced. Some information required by the standing orders is more properly relayed by the staff who witnessed it rather than the institutional response team leader. Staff are given training about what to include in the report when they do their pepper spray training.

Our office notes that the shift operations manager or institutional response team leader is required to provide "a precise description of ...reasons for employing pepper spray." However, few incident reports explicitly linked the reasons for pepper spray authorization (i.e. behaviours displayed by the youth) to the situations in which pepper spray can be used pursuant to divisional policy, namely where "the failure to do so is likely to jeopardize the safety of staff members, offenders/young persons or others; or likely to result in substantial damage to government property." Further, as noted above, neither AYC's nor MYC's standing orders require the manager who authorizes pepper spray use to write a report for inclusion in the incident report. This means there is no first person account of the reasons pepper spray use was authorized in the incident reports.

Given the significance of pepper spray use, it is important from accountability and public interest perspectives that clear and accurate reasons for the authorization of pepper spray be included in the reports on its use. As previously noted, we are of the view that the manager who authorizes pepper spray use should complete a written report for inclusion in the incident report. The report should clearly connect the reason(s) why pepper spray use is being authorized to the situations in which its use is permitted pursuant to divisional policy.

### **Documenting injuries and treatment**

As discussed above, both AYC's and MYC's standing orders require injuries and treatments to be listed:

3. *List of any injuries apparent and otherwise inflicted upon staff or residents, as well as treatment offered and administered,*

MYC's also requires a list of participants and witnesses:

4. *A list of all participants and witnesses.*

MYC advised that it considers a "participant" to be any juvenile counsellor who was an institutional response team member or code responder. A "witness" would be staff in the unit who witnessed the incident. We observe that this means MYC documents staff who witness pepper spray use, but does not document when youth witness pepper spray use.

As previously discussed, there were cover pages for the 26 pepper spray incidents reports (nine from AYC, 17 from MYC<sup>2</sup>) provided to our office by Corrections. The cover pages list all "involved persons" in the incident, which we take to be "a list of all participants" as required by the pepper spray standing orders.

Under each listed name on the cover page, there are spaces (fields) in which the following information can be entered:

- the person's involvement (i.e. "participant (staff)", "Accused/subject")
- restraints/force used by staff or applied to youth
- injuries (e.g. bloody nose from spray, glass shards in arm)

Our office observes that while there is a field for information regarding injuries, there is no field to enter information about treatment offered and administered.

We reviewed the injury information provided in the fields for each "involved person." AYC's nine incident report cover pages list a total of 107 involved persons, with 89 "participants (staff)," 18 "Accused/Subject" and no witnesses. MYC's 17 incident report cover pages list a total 204 involved persons, with 180 "participants (staff)," 24 "Accused/Subject" and no witnesses.

Two incident reports from each facility listed injuries. At AYC, a total of two youth were listed as injured in two separate incidents. No injuries to staff were listed. At MYC, a total of six staff were listed as injured in two incidents. No injuries to youth were listed.

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<sup>2</sup> Our office had cover letters for 17 of the 18 incidents at MYC where pepper spray use was authorized – as noted above, the eighteenth incident, involving one youth, was provided to our office as a segregation incident report and did not have a cover page.



However, many of the injury fields did not have an entry to indicate whether the person had been injured or not. At AYC, three listed youth's injury fields did not indicate whether involved youth had any injuries. The other 15 of 18 youth had entries: 13 injury fields listed "NONE" and two fields had brief descriptions of injuries. For staff, 66 of 89 injury fields indicated no injuries, while 23 had no indication whether injuries were sustained or not.

None of MYC's 17 incident report cover pages listed any injuries to youth. However only three of 24 youth's injury fields had an entry; each of those indicating "NONE." The other 21 youth injury fields were blank. Of the 180 staff involved in pepper spray incidents, six had brief descriptions of their injuries, 59 indicated they had no injuries and 115 did not indicate whether the staff member had injuries or not.

Despite the requirement to provide a "list of any injuries apparent and otherwise inflicted upon staff or residents, as well as treatment offered and administered," not a single incident report from either AYC or MYC had fully complete injury fields for all "involved persons." Additionally, as noted above, there is no field to enter information about treatment offered and administered. Given that pepper spray is a significant use of force, we are of the view that it is important that AYC's and MYC's incident reports clearly list whether any "involved persons" were injured or not and what treatment, if any, injured persons received.

We read the complete incident reports for all 27 incidents where pepper spray use was authorized to compare injuries listed on the cover pages with the information recorded in staff reports. We observe that there are inconsistencies in how the facilities record injuries to youth and staff.

AYC recorded a youth's self-harm injuries that occurred prior to pepper spray use as an injury on that incident's cover page. However, at MYC, there are two instances where a youth's self-harm injuries sustained prior to pepper spray use were not recorded on the incident report's cover page, though they were detailed in the written staff reports. At AYC, an institutional response team member's exposure to pepper spray was documented in staff reports, but it was not listed as an injury (the injury field entry indicated "NONE"). In contrast, MYC listed pepper spray exposure as an injury for three staff on the incident report cover pages. We observed that pepper spray exposure was not recorded as an injury to any of the youth exposed to pepper spray, even in the case where after pepper spray exposure, a youth is documented as vomiting by one staff and as coughing and spitting by another.

With respect to treatment offered and administered at AYC, staff reports record that one of the youth with listed injuries was offered medical attention and declined, though there was no mention of treatment for the second listed youth's injuries. In the incident where an institutional response team member was exposed to pepper spray, but it was not listed as an injury, staff reports documented decontamination. In an incident where no injuries were listed on the cover page, one staff report documents that a youth was offered and declined "medical attention for anything."

At MYC, written staff reports documented that injured staff received medical attention and those exposed to pepper spray, decontamination. In an incident where self-harm was not listed as an injury, staff reports record that the youth declined medical attention. As with AYC, there was one

incident where no injuries were listed on the cover page and the incident reports documents that a youth was offered and declined “medical attention for anything.”

In our view, AYC’s and MYC’s standing orders’ requirement to list “any injuries apparent and otherwise inflicted upon staff or residents, as well as treatment offered and administered” recognizes the significance of using pepper spray and the potential consequence for youth and staff. However, the protection is undermined by inconsistencies within and between AYC and MYC about how injuries are documented in the incident reports. The lack of documentation around treatment is also problematic. We are of the view that AYC and MYC should establish a definition and/or guidelines to standardize what is meant by “injuries apparent and otherwise inflicted” and by “treatment offered and administered.”

### Medical consultation

Both AYC’s and, as discussed above, MYC’s pepper spray standing orders require health services be notified that pepper spray may be deployed, if possible. This allows health services to check a youth’s medical information for health cautions regarding the use of pepper spray and to prepare to examine those who may be contaminated by the spray.

Medical staff is present at AYC every day from 7:30 a.m. to 9:45 p.m. Medical staff is not on call and if there is a medical issue, staff assess the situation and will call an ambulance if medical assistance is required. When pepper spray is deployed outside those hours, health services are not available. At MYC, health services are available 24/7.

Divisional policy and AYC’s pepper spray standing order require that if health services are unavailable, the shift operations manager verify the youth’s file. If the file is not checked for health cautions prior to pepper spray use, the shift operations manager must provide a detailed rationale for proceeding in their report. As discussed above, as health services are available 24/7 at MYC, the pepper spray standing orders do not contain these requirements.

Only one of AYC’s nine pepper spray incident reports and three of MYC’s 18 incident reports contained a reference to consulting with health services prior to the use of pepper spray. It is possible that health services were consulted in the other eight AYC and 17 MYC incidents, but it was not documented in the incident reports. None of the incident reports indicated that health services were not consulted prior to spray use, or contained a rationale for that decision if one was made.

As previously noted, pepper spray is a significant use of force which negatively impacts the health of those exposed to it. We are of the view that it is important that facilities verify whether youth have health cautions regarding pepper spray exposure prior to pepper spray use. Incident reports should document that health cautions have been checked for each youth who may be exposed to pepper spray, which will ensure that where a youth’s file is not checked, prior to pepper spray exposure, a detailed rationale is documented.

## Air circulation

It is important to minimize exposure of youth and staff to pepper spray. AYC's and MYC's current pepper spray standing orders require that, where time and circumstances permit, air circulation be shut down prior to spray being used. As noted above, MYC's pepper spray standing order in effect between September 1, 2015, and August 31, 2016, did not require air circulation to be controlled.

AYC advised our office that the standard practice is to shut down the air circulation before spray is used in the Echo, Foxtrot or Lakewood units. However, it is not possible to control the ventilation in the cottages (Alpha, Beta, Charlie, Delta). As a result, pepper spray is rarely deployed in a cottage. Only one of AYC's nine incident reports documented that air circulation was controlled prior to spray use. AYC advised that shutting down the ventilation is one of the first things staff do when pepper spray use is authorized. As it is just part of the process, it is rarely specifically mentioned in the incident reports.

As discussed above, MYC's pepper spray standing order in effect during the time of review did not contain a section on controlling air circulation (though MYC's soft cell extraction standing order did). Nonetheless, five of MYC's 18 incident reports documented controlling air circulation.

Our office is of the view that given the importance of minimizing compliant youth and staff exposure to pepper spray, incident reports should record whether air circulation was controlled or not. Where air circulation is not controlled, the report should contain reasons for the decision not to do so.

## Video recording

Recognizing that there is a possibility that force will be used once an institutional response team is assembled, AYC's and MYC's standing orders require that an institutional response team deployment be video recorded. The requirement is present in both AYC's video monitoring and use of force standing orders and in MYC's cell extraction standing order. The standing orders direct that the video recording can be used as part of the debriefing process after an institutional response team deployment. Pursuant to Corrections' policies, the video recordings are destroyed or erased after 120 days, unless one is kept as part of an investigative or review process.

Each of the nine AYC pepper spray incident reports documented that a staff member was assigned to video camera duty. Use of a video camera was documented in 17 of MYC's 18 pepper spray incidents.

## Warning given prior to pepper spray use

AYC's and MYC's standing orders require that youth be warned that they will be exposed to pepper spray if they do not comply with staff. The warning must be given unless it "jeopardizes a tactical advantage."

Our review of incident reports revealed that the required warning was documented as given to each of the 15 youth sprayed at AYC prior to their being exposed with pepper spray. The required warning was documented in incident reports for 14 of 15 youth sprayed at MYC.

We note that there is no explicit requirement for a pepper spray incident report to document that the required warning has been given. However, in our view, a “precise” description of the events, as required by both facilities’ pepper spray standing orders, includes recording whether the warning was given to each youth prior to their potential exposure to pepper spray.

## Decontamination

AYC’s pepper spray standing orders require that staff and youth exposed to pepper spray are to be removed from the contaminated area and be given the opportunity for decontamination as soon as is practical:

### **Decontamination**

*9. Once pepper spray contamination has taken place, the IRT leader shall ensure that decontamination is immediately undertaken. As soon as is practical and the situation is under control...*

*10. Exposed [staff and] residents shall be:*

*10.1. removed from the contaminated area*

*10.2. provided with relief from the effects of contamination (water rinse)*

*10.3. given opportunity to shower affected areas.*

AYC advised that their practice is to prepare a decontamination area as soon as pepper spray use is authorized. Exposed youth are offered a shower (in restraints) and then given a change of clothes. We note that AYC’s standing order does not mention providing a change of clothing to exposed youth, but that AYC advises it is its practice to do so. If a youth refuses decontamination, and they do not complain and are in no visible distress, then staff will wait and the youth will be decontaminated at the earliest opportunity.

The offer of decontamination was documented in incident reports for 14 of 15 youth sprayed at AYC, while the provision of new clothing was documented for three youth.

MYC’s decontamination section contains slightly different requirements from AYC’s:

### **Decontamination**

*13. Once OC spray contamination has taken place, the Shift Leader will ensure that decontamination is immediately undertaken as soon as practical and the situation is under control:*

*Exposed staff and youth are to be*

*i. Provided with relief from the effects of contamination (water rinse),*

*ii. Given an opportunity to shower affected areas,*

*iii. Examined by medical staff,*

*iv. Provided with a change of clothes.*

In addition to allowing exposed youth to shower (in restraints) affected areas, MYC's standing order states that exposed youth will be examined by medical staff and provided with a change of clothes. Though it is not specified in the standing orders, youth exposed to spray are moved to a different room.

MYC's incident reports documented that 15 of 15 youth exposed to pepper spray were offered decontamination and 14 of them accepted the offer. The fifteenth youth refused decontamination. Incident reports documented that nine of 15 youth exposed to pepper spray were offered a change of clothes and eight of 15 youth accepted. Only one incident report documented that a youth received medical attention after being exposed to pepper spray.

In total, we confirmed that 29 of 30 youth exposed to spray were offered decontamination, and one of those 29 refused it. Incident reports documented that 12 of 30 youth were offered a change of clothing and one of those 12 refused the offer. It is possible that all 30 youth were offered the opportunity to decontaminate and were offered a change of clothing, but there is no record of it in incident reports.

We note that AYC's standing order does not include the provisions that exposed youth will be examined by medical staff or given a change of clothes and MYC's standing order does not specify that exposed youth will be moved to a new room. In our view, these are all important actions to take given the potential health implications resulting from the intentional infliction of physical distress on a youth. As a result, incident reports should document whether all of the above actions have been taken with respect to youth exposed to pepper spray.

### **Medical attention post-spray**

AYC's pepper spray standing order requires that anyone who experiences physical distress after decontamination be seen by health-care staff as soon as possible.

#### ***Health Examination***

*12. Any individual exposed to OC spray who continues to exhibit significant physical distress symptoms after decontamination shall be examined by a health care staff member as soon as possible.*

MYC's pepper spray standing order also requires that anyone who experiences physical distress after decontamination be seen by health-care staff as soon as possible.

#### ***Medical Examination***

*14. Where OC spray has been employed staff and young persons exposed will be:*  
*14.1 Examined by medical staff as soon as possible after the incident and if deemed necessary, referred to a physician for further examination,*  
*14.2 Re-examined by medical staff until no further symptoms or effects remain.*

None of the incident reports we reviewed indicated that anyone continued to experience physical distress after decontamination.

### Staff debriefing

As noted previously, the third and final step of an institutional response team deployment is the assembly and debriefing of team members. The institutional response team leader is to address the following in the debriefing:

1. *Check for physical injuries;*
2. *Check for any emotional feelings related to the extraction plan, events or results;*
3. *Check for any need for further assistance regarding Critical Incident Stress Management;*
4. *Review any equipment that failed and seek recommendations; and*
5. *Complete the mandatory written reports on use of force.*

Staff debriefing was referenced in six of the nine incident reports at AYC and in 17 of the 18 incident reports from MYC. Our office is of the view that the requirement for a debriefing after an institutional response team deployment recognizes that such a significant use of force by staff can have physical and mental/emotional repercussions. In light of this, we are of the view that pepper spray incident reports should document whether a staff debriefing occurred.

### Additional observations

#### Psychological effects

While divisional policy references psychological effects of pepper spray – one of the components of pepper spray training is “psychological effects” – more importance is given to physiological (i.e. physical) health effects.

There are procedures for decontamination and medical exams post-spray, but no procedures for assessing a youth’s psychological health after being exposed to spray or witnessing spray being used. Further, none of the incident reports referenced or identified psychological effects of spray use in youth or staff.

This is in contrast to the procedures for staff. Divisional policy, and AYC’s and MYC’s standing orders, require institutional response team members to attend a debriefing after a youth has been extracted. Two of the five debriefing items set out in divisional policy address the mental and emotional health of institutional response team members:

2. *Check for any emotional feelings related to the extraction plan, events or results;*

### *3. Check for any need for further assistance regarding Critical Incident Stress Management;*

In addition, MYC's interpretation of the standing order requirement to list all witnesses means that MYC documents staff who witness pepper spray use, but does not document when youth witness pepper spray use.

The result is that divisional policy and the standing orders give more importance to the mental and emotional health of the staff who deploy pepper spray than to the youth who are exposed to it.

#### **No maximums for spray use**

Neither divisional policy nor AYC's or MYC's pepper spray standing orders limit the amount of pepper spray that can be used on a youth in one incident. The superintendents of both facilities indicated they will ask questions when more spray is used. They advised that sometimes youth are able to block the spray and so some bursts are ineffective and more is needed. Most institutional response teams stopped pepper spray use after three bursts. In one instance, four bursts were used. In that case, the incident report recorded that the first three bursts did not make contact with the youth. Though pepper spray is supposed to be used as little as possible and discontinued at the earliest reasonable opportunity, we observe that there is no maximum that may be used.

### **Findings and recommendations on pepper spray use in Manitoba youth correctional facilities**

Pepper spray use is significant use of force with significant health consequences – physical, mental and emotional – for youth and staff. Our office appreciates that AYC and MYC consider its use to be a “last resort” when other interventions have failed. Both facilities also expressed that over time, they have taken a more patient approach and are now more likely to attempt to “wait out” a youth, rather than using pepper spray, unless there is danger to youth or staff.

It is important that procedures and protections set out in divisional policy be followed when pepper spray use is authorized. MYC has revised its pepper spray standing order since our review to include a section on controlling air circulation. Nonetheless, MYC's pepper spray current standing order is not wholly consistent with divisional policy with respect to medical consultations, training and documentation.

When health services are unavailable, there should be a process to ensure that the files of youth who may be exposed to pepper spray are checked for health cautions. Equally, it is important that when this medical information is not verified prior to pepper spray use, the reasons be clearly documented in the incident report. Consequently, we make the following recommendation:

**Recommendation 1:** That MYC amend its pepper spray standing order to reflect divisional policy requirements regarding medical consultation.

Neither MYC's nor AYC's pepper spray standing orders reflect the divisional policy requirement that the manager who authorizes the use of pepper spray write a report setting out the reasons for and effects of its use. In the interests of accountability and transparency, we are of the view that the incident report should contain a first-hand account of the reasons for pepper spray use authorization and a record of the effects of its use. As a result, we recommend:

**Recommendation 2:** That AYC and MYC amend their standing orders to reflect the divisional policy requirement that the manager who authorizes pepper spray use must complete a written report for inclusion in the incident report. The report should contain the reasons why pepper spray use was authorized and a record of the effects of its use.

We observe that, as none of the pepper spray incident reports contained a report from the person who authorized pepper spray use, not a single pepper spray incident report from either AYC or MYC fully adhered to the reporting requirements found in divisional policy.

Further, few incident reports explicitly linked the reasons for pepper spray authorization (i.e. behaviours displayed by youth) to the situations in which it can be used pursuant to divisional policy (i.e. where "the failure to do so is likely to jeopardize the safety of staff members, offenders/young persons or others; or likely to result in substantial damage to government property"). It is important that clear and accurate reasons for the authorization of pepper spray be included in the reports on its use. Therefore, we make the following recommendation:

**Recommendation 3:** That the report by the manager who authorizes pepper spray use should clearly connect the reason(s) why pepper spray use is being authorized to the situations in which its use is permitted by divisional policy.

Continuing on the issue of reporting requirements, in our view, AYC's and MYC's standing orders' requirement to list "any injuries apparent and otherwise inflicted upon staff or residents, as well as treatment offered and administered" recognizes the significance of using pepper spray and the potential consequence for youth and staff. However, not a single incident report cover page from either AYC or MYC had fully complete injury fields for all "involved persons." Further, the cover pages did not contain a field for treatment, even when an injury was recorded. AYC and MYC should ensure that the above information is listed in the pepper spray incident reports as they are required to do. Consequently, we recommend:

**Recommendation 4:** That AYC and MYC ensure that their incident reports contain completed information about "any injuries apparent and otherwise inflicted upon staff or residents, as well as treatment offered and administered" as required by their respective standing orders.

Our office also observes inconsistencies within and between AYC and MYC about how injuries are documented in the incident reports. As a result, we make the following recommendation:

**Recommendation 5:** That AYC and MYC establish a definition and/or guidelines to standardize the meaning of "injuries apparent and otherwise inflicted" and "treatment offered and administered."



Clear, accurate and easily available information would enhance accountability and transparency by making it easier to assess compliance with pepper spray requirements. It would also assist Corrections managers in assessing the use of pepper spray use in their facilities. Therefore, we recommend:

**Recommendation 6:** That AYC and MYC expand their pepper spray standing orders to require incident reports to contain a full record of the facilities' compliance with standing order requirements related to pepper spray deployment.

As pepper spray exposure can have negative health consequences, we are of the view that it is important that facilities verify whether youth have health cautions regarding pepper spray exposure prior to pepper spray use. Incident reports should document that health cautions have been checked for each youth who may be exposed to pepper spray. Further, it is important that when medical information is not obtained prior to pepper spray use, the reasons be clearly documented in the incident report. Consequently, we make the following recommendation:

**Recommendation 7:** That AYC and MYC document in the incident report that health cautions have been checked for each youth who may be exposed to pepper spray. If a youth's medical files are not checked, a detailed rationale for not doing so should be included.

Pepper spray use is significant and it is important to minimize exposure of youth and staff to it. Our office is of the view that incident reports should record whether ventilation systems were shut down and where not controlled, the incident report should contain reasons for the decision not to do so. As a result, we recommend that:

**Recommendation 8:** That AYC and MYC document in the incident report whether air circulation was controlled in the affected areas prior to pepper spray use. Where air circulation is not shut down, the incident report should contain reasons for the decision not to do so.

In our view, when youth and staff are exposed to pepper spray, as soon as is reasonable, they should be removed from the contaminated area, given the opportunity to shower/wash off affected parts, be examined by medical staff and provided with a change of clothes. Though neither facility's standing orders incorporate all of these actions, they are all important given the potential health implications for youth resulting from the use of spray. Therefore, we make the following recommendations:

**Recommendation 9:** That AYC should incorporate being examined by medical staff (when available) and being provided with a change of clothing into its decontamination procedure.

**Recommendation 10:** That MYC should incorporate removing exposed staff and youth from the contaminated area into its decontamination procedure.

**Recommendation 11:** That AYC and MYC should document in their pepper spray incident reports whether exposed staff and youth have been offered each part of the decontamination procedure, as well as whether the offer is accepted.

While divisional policy and pepper spray standing orders address the mental and emotional health of staff who deploy pepper spray, they do not do the same for youth. Consequently, we recommend that:

**Recommendation 12:** That AYC and MYC incorporate into their pepper spray standing orders procedures to address the mental and emotional health of youth who are exposed to pepper spray or witness its use.

Our office recognizes that increased documentation requirements increase the time needed to write a comprehensive report. This needs to be balanced with the need for staff to have time to do their jobs, an important part of which is interacting with youth. However, full accountability for such a serious use of force is of utmost importance. It outweighs the extra work of thorough documentation.

We note that neither Corrections, nor AYC or MYC track:

- The specific reasons pepper spray is authorized (e.g. staff safety, youth safety, etc.). This information could be useful in identifying trends or areas where improvements could be made.
- The effectiveness of pepper spray in gaining cooperation from youth. Pepper spray use gained the cooperation of 13 of 15 youth spray at AYC and 13 of 15 youth sprayed at MYC. Corrections, AYC and MYC expressed the view that the fact that pepper spray could be used was a deterrent for youth misbehaviour. However, they do not track whether the spray use was successful in gaining youths' compliance.
- The number of times pepper spray authorization is granted versus the number of times pepper spray is actually used once it has been authorized. This could be evidence to show that even when pepper spray use is authorized, staff treat it as a last resort, engaging in alternative interventions, and following the instruction to use it as little as possible and discontinue its use as soon as possible.

We are of the view that good information and data is essential to assessing the effectiveness of and compliance with policies and procedures. Further, it can identify trends and areas for improvement. As a result, we make the following recommendation:

**Recommendation 13:** That Corrections, AYC and MYC track and review pepper spray use information going forward, allowing the facilities to assess among others, the reasons its use is authorized, the deterrence value and effectiveness of pepper spray and whether it is treated as a last resort, as well as any metrics Corrections considers important to pepper spray use.

## Response to recommendations

Our office provided our recommendations on pepper spray use to Manitoba Justice on August 30, 2018. In a response dated September 17, 2018, Manitoba Justice advised that it viewed the recommendations as “fair and achievable” and would implement them by January 1, 2019. Justice has since advised that it has implemented the recommendations.

## INVESTIGATION: Segregation

### What is segregation?

“Segregation” is the general term used to describe when an inmate is held in conditions that prevent them from physically interacting with other inmates.

In Manitoba, the Correctional Services Regulation defines segregation as “the confinement of one or more inmates ... in a manner that prevents their physical contact with other inmates.” Terms such as “solitary confinement,” “isolation,” “separation” and “secured housing” are often used interchangeably with segregation. Corrections advised it prefers the term “observation” when referring to segregation in youth correctional facilities. Our office uses the term “segregation” in this report as it is the one used in the regulation.

Regardless of what it is called, the practice of segregation is one of the most restrictive methods of imprisonment that can be imposed. In addition to the restrictions on liberty that all youth experience when they are incarcerated, segregated youth are confined in a room alone, which affects their rights and access to services.

In Manitoba, conditions for youth vary depending on which room they are segregated in. They may or may not be able to get fresh air or exercise, have a toilet in their room or be able to have a shower. Their access to educational programming, training and recreation is restricted. As segregated youth do not normally have phone privileges, their access to supports such as their family, legal counsel, the advocate for children and youth or the ombudsman is also restricted. Table 4 on the following page compares the conditions of the various rooms that are used to segregate youth at AYC and MYC.

**TABLE 4: Overview of conditions of confinement at AYC and MYC**

	Agassiz Youth Centre			Manitoba Youth Centre	
	Alpha/Beta/ Charlie/Delta Quiet Rooms	Echo/ Foxtrot Quiet Rooms	Lakewood Unit	Observation Unit Room #1	Observation Unit Rooms #2-4
<b>Physical isolation</b>					
Enclosed physical space	X	X	X	X	X
Separate from other youth	X	X	X	X	X
<b>Duration</b>					
Extensive confinement in room	X	X	X	X	X
<b>Physical conditions</b>					
No outside window or natural light				X	X
Sealed air quality	X	X	X	X	X
No in-room access to toilet or washbasin <sup>3</sup>					X
No access to shower	X				
<b>Social isolation</b>					
Restricted interaction with peers	X	X	X	X	X
Restriction on visits with family and friends	X	X	X	X	X
<b>Reduced activity and stimulation</b>					
Restrictions on work, education and activities	X	X	X	X	X
Restrictions on fresh air and exercise	X	X	X	X	X
No access to fresh air or exercise	X				
<b>Restricted access to supports</b>					
Restrictions on access to legal counsel	X	X	X	X	X
Restricted access to the Manitoba Advocate for Children and Youth	X	X	X	X	X
Restricted access to the Manitoba Ombudsman	X	X	X	X	X

<sup>3</sup> In this respect, observation unit rooms #2-4 are not different from most rooms at MYC, which do not have a toilet in the room. However, unlike youth in MYC's general population, youth segregated in observation unit rooms #2-4 are dependent on the availability of reception staff to access the washroom.

Segregation has significant negative psychological health consequences. Canadian courts have recognized that segregation places inmates at risk of serious harm. Specifically, segregation can cause psychological harm and the risk of harm increases with the amount of time spent in segregation. The harm can be permanent. Segregation increases the likelihood that an inmate will self-harm or attempt suicide.

Few bodies have specifically looked at the impact of segregation on youth. However, in 2018 the British Medical Association stated that young people are particularly vulnerable to negative consequences:

*Solitary confinement of young people, at a critical phase of neurological, physiological, and social development, has a serious risk of long-term developmental impairment and psychological harm. The practice is known to be associated with increased risk of suicide and self-harm, and there is evidence that it creates problems with reintegration, failing to tackle the root causes of disruptive or violent behaviour.*

Internationally, segregation for youth is prohibited by numerous international agreements to which Canada is a signatory:

- Mandela Rules (United Nations Standard Minimum Rules for the Treatment of Prisoners)
- United Nations Convention on the Rights of the Child
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty
- United Nations Guidelines for the Prevention of Juvenile Delinquency

## Segregation in Manitoba youth facilities

In Manitoba, the Correctional Services Regulation authorizes the use of segregation for reasons of safety, security or order in the facility or the well-being or discipline of one or more inmates in the facility. In other words, the act authorizes the use of segregation for both administrative (safety, well-being) and disciplinary purposes (punishment).

However, only administrative segregation, not disciplinary segregation, can be used in youth facilities in Manitoba. The regulation specifically states that segregation for youth “should be applied only as a last resort and only to the extent necessary, and should not be applied as punishment.” The regulation recognizes that young persons in custody require supervision, discipline and control but because of their level of dependency, maturity and development, they have special needs and require guidance and assistance.

The regulation also requires the segregation to be periodically reviewed to determine if the reasons for keeping someone in segregation continue to exist. The result of the review can be appealed to the facility head who must either release the inmate from segregation or notify the inmate of the continuation of the segregation.

The regulation further sets out that the facility head or designate must visit every youth in segregation daily and must ensure that a nurse visits weekly. A youth in segregation must also be given the same rights, privileges and conditions of confinement as youth in the general population, with certain exceptions.

In Manitoba, 367 different youth were held in over 1,400 incidents of segregation between September 1, 2015, and August 31, 2016. The incidents lasted anywhere from one minute to 194 days, with 498 incidents lasting longer than 24 hours. When all the time youth were in segregation in that one-year period is added together, it is the equivalent of a single youth spending over 13 years in segregation.

### Segregation key issue

- Is segregation being used at AYC and MYC in accordance with the legislation, regulations and policies that govern its use?

Our office reviewed AYC's and MYC's segregations for compliance with statutory and procedural requirements. Given the operational nature of decisions to segregate youth from their unit, which are based on the circumstances of each individual situation, it was not within the scope of our review to assess the appropriateness or reasonableness of the facilities' decision to use segregation in any specific instance. Rather, our office focused on whether the facilities met statutory and procedural requirements once the decision to segregate a youth was made.

### Scope of our review

Our office reviewed legislation, regulations and policies relevant to the use of segregation at AYC and MYC:

- The Correctional Services Act
- The Correctional Services Regulation
- Corrections Division policies
  - Use of Force Contingency
  - Youth – Suicide Prevention
  - Youth Self-harm
  - Detention of Intoxicated Persons
- AYC's standing orders, including
  - #510 Lakewood Referrals and Admissions
  - #965 Confinement of Residents
  - #906A Medical Isolation
  - #968 Referral for Forensic Services
  - #840 Discipline
- AYC post order #215 Lakewood Procedure
- MYC's standing orders, including
  - #03-964 Segregation of a Young Person

- #03-965 Use of Observation Units
- #02-841 Temporary Restrictions
- #02-840 Discipline
- #02-602 Admission of Young Person to MYC

We interviewed:

- Executive director of Corrections
- Superintendent of AYC
- Superintendent of MYC
- Deputy superintendent of MYC
- Two staff at AYC
- Two staff at MYC

Our office assessed AYC's and MYC's compliance with legislation, regulation and standing orders governing the use of segregation between September 1, 2015, and August 31, 2016, by reviewing records from Corrections' computer system, COMS. We reviewed segregation incident reports, MART (movement) records and, in the case of MYC, running records.

Segregation incident reports are created to document information about segregations that occur in a quiet room at AYC or an observation room at MYC<sup>4</sup>. They are comprised of the written reports from each staff who was involved throughout the incident, as well as various managers' reports. Staff reports are written in a narrative style, with the staff recording their experience and observations during their involvement in the segregation. Managers are required to document specific information in the incident reports.

MART records are the movements in and out of a particular room or unit. Corrections records movement data for each unit, quiet room and observation room at AYC and MYC. Corrections provided us with the movement records for AYC's quiet rooms and Lakewood unit and MYC's observation rooms.

Running records are the ongoing record for each youth held at AYC or MYC. MYC's segregation of a young person standing order requires certain information about a youth's segregation to be documented in their running record. We reviewed running records from MYC, but not AYC as their confinement of residents standing order does not require information to be documented in running records.

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<sup>4</sup> There are no segregation incident reports for youth who are assigned to Lakewood as their primary unit, though, as discussed later, Lakewood operates in segregation conditions.



We closely reviewed a random sample of 84 segregation incidents lasting 24 hours or more for compliance with the act, regulations and standing orders.

## Consistency of AYC's and MYC's standing orders with the regulations

AYC and MYC's segregation standing orders must be consistent with the Correctional Services Regulation. However, unlike with pepper spray, there was no divisional policy setting out segregation standards between September 1, 2015, and August 31, 2016.

### Disciplinary segregation

The Correctional Services Regulation allows youth to be segregated for behavioural or safety concerns, but states that segregation "should not be applied as punishment." The regulation specifically identifies that the sections about disciplinary segregation – segregation as punishment for an offence – do not apply to youth facilities.

Nonetheless, AYC's and MYC's respective standing orders both allow segregation for disciplinary reasons. AYC's confinement or residents standing order states:

*Confinement of a resident prevents physical contact with other residents for **disciplinary** /preventative or protective measures.*

MYC's use of observation units standing order states:

*Young persons may be placed in an OU for **disciplinary** purposes; after all other measures have been exhausted.*

Our office concludes that AYC's and MYC's standing orders are inconsistent with the regulation. Our office notes that while the standing orders allow the possibility of segregation for disciplinary reasons, we found no evidence to suggest that segregation is used in this way at either AYC or MYC. Nonetheless, it is inappropriate for AYC's and MYC's standing orders to reference disciplinary segregation when the regulation prohibits its use for youth.

### Review requirements

The Correctional Services Regulation requires the decision to segregate someone to be periodically reviewed to determine if the reasons for keeping them in administrative segregation continue to exist. The regulation applies to all segregations at AYC and MYC and sets out that review hearings must occur:

- not later than seven days after the youth is first placed in segregation
- during the first 60 days of the youth's segregation, within 14 days after each immediately preceding hearing respecting the segregation
- after the first 60 days of the youth's segregation, within 30 days after each immediately preceding hearing respecting the segregation

AYC's confinement of residents standing order requires that youth segregated in a quiet room be reviewed by designated staff twice per daytime shift, for a total of four reviews per day. The purpose of the review is to determine whether it is safe for the youth to be released from segregation. This is more frequently than the review hearings required by the regulation.

However, our office notes that while AYC's confinement of residents standing order applies to youth who are segregated in a Lakewood room as a quiet room, it does not apply to youth who are assigned to Lakewood as their primary unit. Instead, AYC's Lakewood referrals and admissions standing order requires:

- a case planning meeting within three business days of a youth's admission to Lakewood
- a review by the case manager after 15 days
- a second review by the case manager after another 15 days (30 days after being admitted to Lakewood)

The standing order does not mention any further reviews after the 30-day review. This is inconsistent with the frequency of reviews required by regulation.

MYC's use of observation units standing order requires designated staff to "maintain personal contact" with segregated youth. The contact is to occur at least twice per daytime shift, for a total of four times per day. MYC's standing order does not specify that the purpose of the contact is to review whether the youth can be released from segregation or provide any other review opportunities. Our review of running records showed that these "contacts" often contained an assessment of the segregation placement. Nonetheless, it would be better if MYC's standing order was clear about whether the "contacts" are reviews as contemplated by the regulation.

The regulation also sets out procedural requirements for the hearings:

- the segregated person must be present, subject to certain exceptions
- the person who held the hearing makes a recommendation about whether the segregation continues
- the segregated person has 48 hours to appeal the recommendation by writing to the head of the correctional facility
- the head of the facility makes a decision and either releases the segregated person or notifies them that they will remain in segregation

AYC's and MYC's segregation reviews do not meet the procedural requirements of the regulation. AYC's confinement of residents standing order requires the segregation review for youth in quiet rooms to take place in person, though it can be done through a closed door if there are safety concerns. However, neither the confinement or residents, nor the Lakewood referrals and admissions standing orders incorporate the recommendation and appeal process set out in the regulation. MYC's use of observation units standing order does not incorporate any of the regulation's procedural requirements. In addition, our office notes that none of the segregations we reviewed referenced review recommendations or the opportunity to appeal to the facility head.

Our office is of the view that AYC and MYC must ensure that their review processes meet the procedural requirements of the regulation to ensure procedural fairness and accountability for decisions to prolong segregation.

## Review of AYC's and MYC's segregation use

It was not possible for our office to build a complete and accurate record of segregations at either AYC or MYC during the period from September 1, 2015, to August 31, 2016. Corrections advised it could not provide a list of youth who had been segregated, when and for how long.

Instead, we received our information about the segregations mainly from two different kinds of records held by the Corrections COMS system: segregation incident reports and MART (movement) records. Incident reports are made up of multiple staff reports written in the form of a narrative. Movement records are the documented movements in and out of a particular room or unit.

The records did not necessarily match each other. We cross-referenced the records and the reports and determined that neither provided a full picture of segregations at AYC or MYC. We observed numerous factors that show that neither form of record on its own provides accurate information about who was segregated, when and for how long:

- Multiple youth may be segregated in a single segregation incident report.
- There can be multiple movement entries for one segregation, for instance where a youth was transferred between segregation rooms or was sent to a hospital.
- There were cases of multiple incident reports associated with a single segregation, for instance where staff opened a new incident report for an incident that occurs while a youth was already in segregation.
- In some cases, there were significant discrepancies relating to the time youth were placed in or removed from segregation between the segregation incident report and the movement record.
- There were incident reports for 32 quiet room segregations at AYC, but no corresponding movement record for the relevant room.
- AYC creates incident reports for youth who are segregated in a Lakewood room as a quiet room. However, AYC does not create incident reports for youth who assigned to Lakewood as their primary unit.
- There were incident reports for 30 observation room segregations at MYC, but no corresponding movement record for the relevant observation room.
- There were 40 MYC observation room uses for which there do not appear to be incident reports.
- Finally, there were 15 segregations at AYC and MYC where we were unable to determine the length of the segregation from either the incident report or the movement records.

Our office is concerned that Corrections does not maintain an accurate list of youth who have been segregated, when, for what reasons and for how long. Nor does Corrections track the total amount of time individual youth spend in segregation. This is problematic because the risk of negative health

consequences increases with the amount of time spent in segregation. From an accountability and transparency perspective, this kind of big picture information about youth segregation use should be readily available. It could be used to guide individual segregation decisions, identify trends in segregation use and inform facility and departmental decisions for youth.

Ultimately, our office created a spreadsheet incorporating information from the incident reports and the movement records. The combined data is the basis for our review of segregation incidents at AYC and MYC.

We determined that 367 different youth were held in 1,455 incidents of segregation, with 498 incidents (34 per cent) lasting longer than 24 hours. There were 763 incidents of segregation at AYC, 664 at MYC and a further 28 where youth were segregated at both AYC and MYC in the same incident. The longest segregation at AYC was 194 days, the longest at MYC was 14 days and the longest spanning both facilities was 56 days.

Our office developed lists based on requirements related to segregation use found in the Correctional Services Regulation and AYC's and MYC's respective standing orders. We assessed the facilities' compliance with requirements related to segregation use by reviewing a random sample of segregation incidents lasting 24 hours or longer – 48 at AYC and 36 at MYC – against the list for each facility. The assessment below identifies which requirements apply to which facility.

### AYC overview

In addition to AYC's confinement of residents standing order, other AYC standing orders interact with the use of segregation, including the medical isolation, discipline, suicide prevention and Lakewood standing orders.

Between September 1, 2015, and August 31, 2016, 298 different youth were held at AYC; some on multiple occasions. Of those 298 youth, 197 (66 per cent) were placed in segregation in a quiet room or in Lakewood at least once and 119 (40 per cent) were segregated for 24 hours or longer at least once.

The 197 segregated youth were involved in 791 segregation incidents at AYC, lasting from one minute to 194 days. Of those 791 segregations, 355 (45 per cent) lasted longer than 24 hours. Of the 197 different youth segregated, 199 (60 per cent) were segregated for 24 hours or longer at least once.

Our office reviewed a random sample of 48 segregations at AYC lasting 24 hours or longer for compliance with the act, regulation and AYC's standing orders. See Table 5 for an overview of AYC's compliance.

**TABLE 5: AYC – Overview of compliance with regulatory and policy requirements**

48 incidents of segregation (September 1, 2015 to August 31, 2016) were reviewed to determine compliance with segregation requirements	
Segregation requirements	Number of times requirement was documented as met
Manager authorizes segregation	46
Reasons for authorization included in report	22
Information about segregation provided to youth	32
Youth informed of rights and access to services in segregation	0
Incident report records which rights and services youth accessed	0
Youth given one hour per day fresh air/exercise	0
Youth’s segregation was reviewed twice each daytime shift	26
Deputy superintendent reviewed segregation after each 24 hour interval	2
Youth’s removal from segregation	24
Shift operations managers met documentation responsibilities	19

**Use of segregation at AYC**

Broadly, AYC’s confinement of residents standing order sets out that segregation is to be used only when there is no reasonable alternative and that it should end when it is no longer necessary:

*To establish procedures to segregate or to confine residents at AYC only when there are compelling reasons to do so and there are no reasonable alternatives available to segregation or confinement.*

*To ensure, for effective management of AYC residents, that the confinement is not more restrictive than is necessary and the segregation or confinement continues no longer than is necessary.*

More specifically, AYC’s standing order allows youth to be segregated when they pose a safety risk, when they are at high risk of suicide, as part of behaviour plans, for time-outs (which can be requested by youth) or for medical reasons. All segregated youth are placed in a quiet room, regardless of the reason they are segregated.

Risk is defined in the standing order as “the chance of injury, loss, hazard or escape.” The standing order requires staff to try “options such as verbal de-escalation techniques, use of another group or unit of the same custody level, etc., before considering placing a resident in a QR.” Staff request permission for segregation “when it becomes apparent that all other resources have been exhausted

and that allowing the [youth] to remain with his peer group has become an unacceptable risk for the [youth] or staff or his peer group.”

Youth will also be segregated in Lakewood when they are assessed to be at high risk of suicide. AYC’s suicide prevention standing order directs that “residents [at high risk of suicide] must be placed in camera monitored cells in Lakewood unit.”

At AYC, youth can be placed in segregation for medical reasons, as set out in the medical isolation standing order:

- 1. To protect the health of the residents and staff at Agassiz Youth centre, it is sometimes necessary to isolate residents with actual or suspected communicable illness.*

AYC expressed that segregation can be a helpful tool for youth. It can be part of a plan to help youth manage their behaviour and some youth request a time-out in a quiet room.

*2.2.1 A resident may be temporarily confined because of illness. He may need the quiet and isolation the QR provides or for a “time out” because of disturbing news he has received about his family...A resident may ask for this for himself and/or it may be part of his control plan as he is learning to adopt and set up internal behaviour controls.*

AYC also noted that segregation is sometimes used in situations where it is not ideal, for instance for youth with significant mental health challenges, cognitive difficulties or trauma. All segregated youth are placed in one of AYC’s quiet rooms or Lakewood rooms regardless of the reason why they are segregated. AYC would like there to be a better process or approach to dealing with these vulnerable youth.

### **Quiet rooms**

“Quiet room” is the term AYC uses for the rooms where it places youth that are being segregated from others. Each unit has at least one quiet room. In addition, any cell in Lakewood unit can be used as a quiet room. There are differences between quiet rooms in different units.

Each of the original cottages of Alpha, Beta, Charlie and Delta, houses one unit and has one quiet room. It is attached to the common room used for activities. The quiet rooms have an outside window covered with a metal security grid, an inside window to the common room, a toilet, and a sleeping platform. AYC advised it is not operationally feasible for youth segregated in a cottage quiet room to be moved from the room to get fresh air or to shower. AYC advised that they will move a youth segregated in a cottage quiet room to a quiet room where these activities are possible if the segregation lasts longer than a couple of days. There is a surveillance camera and the room is monitored by staff inside the cottage.





**FIGURE 2:** AYC quiet room in Delta (supplied by Corrections)

The building that houses the Echo and Foxtrot units has four quiet rooms, two for each unit. The quiet rooms are separate from the areas of the building that non-segregated youth access. Each quiet room has an outside window, an observation window for staff, a toilet and a sleeping platform. The quiet rooms are attached to an outdoor range in a set up that makes it possible to let a youth into the range without a staff escort. Youth are able to shower and brush their teeth daily. There are surveillance cameras and the rooms are monitored by staff inside the building.



**FIGURE 3:** AYC quiet room in Echo (supplied by Corrections)

As discussed below, any cell in Lakewood can also be used as a quiet room.

### **Lakewood**

Lakewood is AYC's high security unit for youth "who have demonstrated through their behaviour that they do not or cannot manage their behaviour in their regular cottages/units." The stated goal of placing youth in Lakewood unit is to address the youth's behaviour so that they can be reintegrated

back into a regular unit. AYC's Lakewood procedure and confinement of residents standing order allows Lakewood cells to be used as quiet rooms.

A youth transferred to Lakewood unit is called a "Lakewood primary," as opposed to someone who is there on quiet room status. There is a referral process for Lakewood. Youth are sent there for up to 15 days with specific and measurable outcome goals. The 15 days can be extended upon review. Lakewood unit operates in segregation conditions, which means any cell in Lakewood can also be used as a quiet room. Youth in Lakewood are kept separate from each other and do not physically interact. Movement of staff and youth in Lakewood unit is strictly monitored and controlled. Youth can only be outside their cell if they are accompanied by at least one and in some cases, two, staff.

Each youth has their own cell, which has a sleeping platform, a toilet, an outside window and an inside window. There is an outdoor range attached to Lakewood where youth can get their one hour of fresh air per day. Youth are able to shower and brush their teeth daily. They also have limited access to a phone. Twelve of the 20 cells in Lakewood are video monitored by staff in the building.

### MYC overview

In addition to MYC's segregation of a young person standing order, other MYC standing orders interact with the use of segregation, including the use of observation units, discipline and suicide prevention standing orders.

Between September 1, 2015, and August 31, 2016, 835 different youth were held at MYC; some on multiple occasions. Of those 835 youth, 238 (28 per cent) were placed in segregation in an observation room at least once and 72 (9 per cent) were segregated for 24 hours or longer at least once.

The 238 segregated youth were involved in 692 segregation incidents at MYC, lasting from four minutes to 14 days<sup>5</sup>. Of those 692 segregations, 171 (25 per cent) lasted longer than 24 hours. Of the 238 different youth segregated, 72 (30 per cent) were segregated for 24 hours or longer at least once.

Our office reviewed a random sampling of 36 MYC segregations lasting 24 hours or longer for compliance with the act, regulation and MYC's standing orders. See Table 6 for an overview of MYC's compliance.

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<sup>5</sup> There are 13 segregation incidents involving MYC that extend longer than 14 days, but those segregations also involved AYC. The longest segregation occurring only at MYC is 14 days.



**TABLE 6: MYC – Overview of compliance with regulatory and policy requirements**

36 incidents of segregation (September 1, 2015 to August 31, 2016) were reviewed to determine compliance with segregation requirements	
Segregation requirements	Number of times requirement was documented as met
Manager authorized segregation	34
Reasons for authorization included in report	27
Information about segregation provided to youth	0
Youth informed of rights and access to services in segregation	0
Incident report records which rights and services youth accessed	0
Youth given one hour per day fresh air/exercise	0
Youth's segregation was reviewed twice each daytime shift	11
Deputy superintendent reviewed segregation after each 24 hour interval	0
Youth's removal from segregation	3
Shift operations managers met documentation responsibilities	0

### Use of segregation at MYC

With respect to youth who are incarcerated at MYC, the segregation of a young person standing order sets out that segregation is to be used only when there are “compelling reasons” and that it should end when it is no longer necessary:

*To ensure that young persons residing at the Manitoba Youth Centre will only be segregated when there are compelling reasons to do so, and only as a result of a fair and impartial decision making process. The conditions of isolation will be no more restrictive, or the duration longer, than is necessary for effective young person management.*

More specifically, observation rooms are used to segregate youth when their “interaction with others presents a serious threat to the health, safety or property of self or others, or to the security and good order of the unit or institution.” MYC’s standing order includes a number of situations where youth can be segregated in an observation room:

- youth held for medical observation or quarantine
- youth at high risk of suicide when there is not a staff available to be with them one on one
- youth whose out-of-control behaviour needs to stabilize
- youth presenting a serious risk of escape

- youth who voluntarily request to be held in segregation
- youth being escorted or transferred to another facility

MYC explained that it has placed an emphasis on keeping youth within their unit, instead of sending them to an observation room, by bringing in more staff to interact with youth and help prevent them from escalating. MYC advised that it is using its resources to do what it can and it believes it is improving.

### **Temporary restrictions**

MYC advised that the facility has moved from its previous level-based system, where youth were assigned a level and privileges based on their behaviour, to using temporary restrictions. Youth can be segregated in a room in their unit up to a maximum of two hours and staff must check on the youth regularly during that time.

*Temporary Restriction Definition:*

*A temporary restriction may be imposed within a reasonable amount of time as an immediate preventative action for a young person's inappropriate behavior. Juvenile counsellors can impose a temporary restriction or series of restrictions over a 24 hour period.*

*Preventative Action Definition:*

*Initial measures that are non-punitive in nature, which can be used to correct a young person's behaviour that may threaten the facility's safety, security and good order.*

No incident reports are created for temporary restrictions. However, if the reasons for segregating the youth still exist after two hours, then the youth is moved to an observation room and an incident report is created. While MYC's standing orders contemplate that segregated youth can be held in a bedroom, MYC advises that in practice, youth segregated for two or more hours are always held in an observation room.

Our office did not include any temporary restrictions in our review of segregation at MYC as no incident reports or movement records are created for them.

### **Observation rooms**

At MYC, youth are placed in segregation in one of four "observation rooms" that make up the observation unit. Three of the observation rooms are the same size. Room #1 is the medical observation room, which has a toilet and observation window that medical staff can use; the other three rooms share two washrooms each located outside in a common area. Youth in three observation rooms must wait for staff to be available when they need to use the washroom. None of the observation rooms has an outside window. Rooms are lit during the day with daylights and dimmed to nightlights when the room has a youth in it. Lights in each room can be dimmed during

the day for medical reasons. Each observation room is video monitored by staff and has a window in the door where staff can observe segregated youth.



**FIGURE 4:** MYC observation unit room #1 (left) and room #2 (right) (supplied by Corrections)

### Authorization for segregation

In cases of segregation for medical purposes at AYC, the decision to segregate is made by medical staff, who are responsible for informing the shift operations manager and the youth's case manager or unit manager. None of the 48 incident reports we reviewed involved a segregation for medical reasons.

For other situations, AYC's standing orders set out that the shift operations manager or unit manager must give permission for a youth to be segregated in a quiet room. The decision should be made in consultation with staff working with the youth.

*2. The Shift Operations Manager [SOM] or Unit Manager [UM], of the unit in which the resident is assigned, may direct or authorize the placement of a resident in a unit's Quiet Room [QR] after having consulted with staff assigned to the resident.*

AYC's confinement of residents standing order also recognizes that in some urgent situations, staff may need to seek authorization after they have already segregated a youth.

*2.4 As a result of a resident's behaviour, a code call or other incident, it may be deemed critical to the immediate physical safety of staff and/or residents to directly place a resident in a QR and then contact the UM or SOM.*

Of the 48 segregation incident reports we reviewed, 46 recorded that the segregation placement was authorized by the shift operations manager or the unit manager. Our office notes that it was often difficult to determine which manager ultimately authorized segregation use in situations where staff responded to urgent situations. By the context of the incident reports, it would be clear that the unit manager and/or the shift operations manager had approved the segregation placement, but the

incident report would fail to document which manager. The other two incident reports did not reference authorization for segregation by either manager.

AYC's standing order requires the incident report to document the reasons the unit manager or shift operations manager authorizes the use of segregation, though it does not specify who must record the manager's justification.

*2.1 The UM's or SOM's justification to direct or authorize the placement of a resident in a unit's QR must be documented in the incident report that details the confinement of the resident.*

At AYC, 22 of the 48 segregation incident reports we reviewed contained clearly stated reasons for a youth's segregation placement. However, the authorizing manager's justification for segregation was unclear in the other 26 incident reports. There can be multiple staff reports with differing descriptions of behaviour in each incident report. It is not always clear what behaviour is the foundation for the decision to segregate the youth.

AYC advised that the superintendent reviews the incident report when a youth is placed in segregation. She questions staff to get additional details, but that detail does not get always added to the report after the fact.

At MYC, the shift operations manager is responsible for managing the observation rooms. The shift operations manager "has the overall responsibility to ensure that the daily needs of each young person in an OU are met..." and the use of observation units standing order directs that observation rooms may only be used to segregate a youth with the shift operations manager's authorization.

*10.1 Young persons may only be placed in an OU with the prior authorization of the On-Duty SOM.*

Some situations automatically result in youth being segregated, such as youth held pursuant to the Intoxicated Persons Detention Act or youth at high risk of suicide when there is no staff person available to be with them one on one. In other situations, staff have discretion about whether to segregate a youth.

The shift operations manager has discretion to decide when a youth must be segregated for medical reasons, in consultation with medical staff and the deputy superintendent.

*8. The decision to segregate a young person in an O.U. for medical quarantine will be made by the SOM in consultation with the Medical Unit staff, the attending physician (if available) and the Deputy Superintendent.*

The unit manager, in consultation with unit staff and the deputy superintendent, decides when to segregate a youth for behavioural or safety reasons.

*4. The decision to segregate a young person for reasons of behaviour, or to ensure proper safety and security, will be made by the Unit Manager, in consultation with Unit staff and the Deputy Superintendent.*

The segregation of a young person standing order also sets out that the unit manager will consult with the shift operations manager when the youth will be segregated in an observation room (as opposed to a room in their unit).

*5. Where segregation in an O.U. is being considered, the Unit Manager will consult with the Shift Operations Manager (SOM).*

At MYC, authorization for segregation by the unit manager or the shift operations manager was documented in 34 of the 36 segregation incident reports we reviewed. As with AYC, it was sometimes unclear which manager actually authorized the segregation. Two segregation incident reports did not document authorization for segregation from any manager.

Our office notes that MYC's standing order does not require the manager who authorizes segregation use to record their reasons in the incident report. Nonetheless, reasons for authorization were recorded in 27 of the 36 MYC segregations we reviewed. Documenting the reason(s) for a youth's segregation is an important aspect of the administration of and accountability for segregation use, which necessarily further restricts youths' rights. Our office is of the view that MYC's managers should document the reason(s) why they authorized segregation in the incident report.

We conclude that neither AYC nor MYC fully complied with their respective standing orders relating to authorization for segregation. AYC's unit manager and/or shift operations manager either did not authorize or did not document the authorization for a youth's segregation in two of the 48 segregations reviewed and the reason(s) for the segregation were unclear in 26 segregations. MYC either did not authorize or did not document the authorization for a youth's segregation in two of the 36 segregations reviewed. In addition, it was often unclear which manager authorized a youth's segregation and for what reasons.

Our office is of the view that a clearly documented authorization, which includes reasons for the decision to segregate youth, is essential to demonstrate that AYC and MYC use segregation in a manner consistent with the requirements in regulation and segregation standing orders.

### **Information provided to youth upon segregation**

AYC's confinement of residents standing order sets out that segregated youth will be told what behaviour they need to demonstrate while in the quiet room. They must also be told how their behaviour needs to change in order to be released from segregation.

*6. Confined residents shall be advised by the attending staff as to what changes in behaviour need to occur to cause their release from confinement and what behaviour they must exhibit to comply with the QR expectations.*

The standing order does not require staff to document that youth have been informed about the behavioural adjustments they need to make.

MYC's segregation of a young person standing order requires that youth who are segregated be informed of:

- the reason for their segregation
- the anticipated length of their segregation
- normal routines during segregation
- any conditions for rejoining the group

If youth are segregated for behavioural or safety reasons, the unit manager or designated staff is responsible for informing the youth of this information. When youth are segregated for medical reasons, it is the responsibility of medical unit staff. The standing order does not require staff to document that youth have been provided the required information.

Our office was unable to assess whether AYC and MYC fully complied with their respective standing order requirements relating to information provided to youth when they are placed in segregation. Neither facility requires staff to document that youth have been provided with the required information. At AYC, 32 of 48 segregation incident reports recorded that staff reviewed quiet room expectations with youth when they were segregated, while none of the 36 MYC segregations we reviewed documented the provision of required information.

Canadian courts have explained that a fair decision-making process in a correctional setting can include the right to know the case against you and the right to be informed of the reasons for a decision that affects you. It is also important that youth understand the rules that apply while they are in segregation. Our office of the view that when a youth is placed in segregation, they should be told the reason(s) why, how long they can expect to be in segregation and what the rules are while they are there.

Our office is also of the view that AYC and MYC should document that the information specified by their respective standing orders has been provided to youth upon their segregation. When the correct documentation has been completed and provided, it can substantiate the reason(s) for segregation and ensures accountability. In addition, it will help ensure that youth have information to understand the basis for the decision to segregate them.

### **Rights and access to services in segregation**

When youth are segregated, they continue to have the same rights and privileges as non-segregated youth, except for those things that are necessarily limited by the fact of being in segregation.

#### ***Rights, privileges and conditions in segregation***

*22 An inmate in segregation shall be given the same rights, privileges and conditions of confinement as the non-segregated inmate population except for those rights, privileges and conditions that*

*(a) can be enjoyed only in association with other inmates;  
(b) cannot reasonably be given or applied, or be given or applied to the full extent, because of limitations specific to the segregation area or because of safety or security requirements;*

AYC's confinement of a resident standing order lists specific rights for segregated youth. However, our office notes that the standing order does not require staff to advise youth of their rights when placed in segregation, nor to document whether they are advised of them.

The standing order specifies that all segregated youth receive a mattress, as well as bedding if the segregation is expected to last longer than an hour.

*7. Residents confined in any QR or a room in Echo, Foxtrot or a cell in Lakewood unit for QR purposes or for other reasons, shall be allowed use of a mattress. Bedding, including a single sheet and a single blanket, is given if it is expected that the period of confinement will last over one hour.*

The shift operations manager can authorize the removal of a youth's mattress and bedding "for good reason," for instance when used for self-harm or in an attempted suicide. The reason must be reported to the deputy superintendent or, in their absence, the on call manager. The removal and the reason(s) must be documented in the incident report as well as the return of the mattress and bedding.

*7.1 Removal of the bedding and the mattress before the resident is released from room or cell or QR confinement shall only be authorized by the SOM for good reason. That reason must be reported to the Deputy Superintendent by email or, in their absence, the on call manager. These actions and the reasons must be documented by the SOM in the incident report associated with the confinement.*

*7.2 The return of the mattress and bedding must also be documented.*

The standing order does not require the incident report to record that bedding and a mattress were provided in the first place, only when they are removed and returned. The provision of a mattress and bedding was referenced in five of the 48 segregation incident reports we reviewed. One incident report documented the removal and return of a mattress and bedding, including the shift operations manager's reasons.

At AYC, the standing order specifically sets out that segregated youth who are allowed access to a pencil and paper have an opportunity to contact a lawyer or the ombudsman in writing.

*8. Residents who are permitted the use of pencil and paper while in the QR shall be permitted written communication with their lawyer and/or the Ombudsman...*

None of the 48 incident reports documented that any youth requested or were given an opportunity to contact their lawyer or the ombudsman.



At AYC, youth segregated in a quiet room in Lakewood, Echo or Foxtrot are offered at least 30 minutes of fresh air per daytime shift, for total of one hour per day.

*9. Residents in the QR's of Lakewood, Echo and Foxtrot units shall be offered at least one half hour of fresh air in the unit's recreation yard each shift (twice per day) except for the night shift.*

As noted previously, youth segregated in a quiet room in a cottage (Alpha, Beta, Charlie, Delta) do not get fresh air time as it is not operationally feasible to do so. None of the 48 segregations we reviewed documented whether youth got their outdoor time as required by the standing order. AYC's standing order does not reference any other rights for segregated youth.

MYC's segregation of a young person standing order requires segregated youth to be advised of "normal routines during segregation," but does not specify that youth must be advised of their rights while held in segregation.

MYC's standing order sets out that segregated youth get:

- three meals per day, one of which is a hot meal
- the opportunity to brush their teeth and shower daily, when it is safe and operationally feasible
- the opportunity to use a washroom for those segregated in an observation room without one
- bedding and a mattress
- clothing appropriate for warmth and modesty
- the opportunity for at least 30 minutes of fresh air or exercise daily, when it is safe and operationally feasible
- access to medical attention
- access to a chaplain or elder
- access to legal counsel
- access to the advocate for children and youth
- access to the ombudsman

MYC's standing order further sets out general restrictions on opportunities for youth segregated for behavioural or safety reasons. It also identifies restrictions for youth segregated for medical reasons or youth segregated due to their risk of suicide.

The shift operations manager must document in the incident report the services that have been provided to each youth who has been segregated in an observation unit room for longer than 24 hours.

*18. The SOM will ensure and document that all required services are provided to young persons segregated in an OU.*



However, our review revealed that the shift operations manager did not document that youth received the required rights and access to services in any of the 36 segregations we reviewed. In some instances, staff referenced a right or service in the incident report or in the youth's running records. Three segregations documented that the youth got some fresh air/exercise time, 10 segregations referred to bedding and a mattress and 22 mentioned the opportunity for a shower.

Our office was unable to assess whether AYC fully complied with its confinement of residents standing order requirements relating to information provided to youth when they are placed in segregation. Neither facility requires staff to document that youth have been provided with the required information.

Youth's rights and access to services are changed when they are removed from their group and placed in segregation. Our office notes that segregated youths' rights and access to services differ within and between AYC and MYC. Our office is of the view that facilities need to ensure that youth are informed of their rights and the services they can access while they are in segregation. AYC and MYC should also document that youth were advised of this information.

### Deputy superintendent reviews

AYC's standing order requires the deputy superintendent to review a youth's segregation after each 24-hour period. If the deputy superintendent is not available, then the shift operations manager contacts the on call manager.

*10. Any use of a quiet room longer than 24 hours and every 24 hours thereafter are to be reviewed by the Deputy Superintendent.*

*10.1 The Unit Manager, or in their absence the ranking Case Manager, shall inform the Deputy Superintendent via email the reasons for the continued use of the QR after the first 24 hours and every 24 hours thereafter.*

*10.2 The On-Call Manger shall be called by the SOM if the Deputy Superintendent is unavailable.*

For AYC, of the 48 segregation incident reports we reviewed, only two documented that the deputy superintendent had been contacted after 24 hours. None of the incident reports recorded the information provided to the deputy superintendent or the conclusions reached as a result of the review.

MYC's standing order requires the deputy superintendent to review a youth's segregation in consultation with the unit manager and/or medical staff after each 24 hour period.

*10. The status of any young person in segregation for any reason will be reviewed by the Deputy Superintendent, in consultation with Unit Manager, and/or SOM and/or Medical Unit Staff, every 24 hours*

There is no requirement for the deputy superintendent's review to be recorded in the incident report. Of the 36 segregations reviewed, only one incident report documented that the deputy

superintendent reviewed the youth's status. That segregation lasted seven days and the deputy superintendent's review was documented only once.

Our office notes that neither AYC's nor MYC's respective standing orders require the deputy superintendent's review to be documented in the incident report. Given the potential negative health consequences of segregating youth, it is appropriate that there be a higher level of review once the segregation reaches 24 hours. Incident reports should record whether the deputy superintendent reviewed the segregation after each 24-hour period and document the result to ensure that facilities are accountable for their segregation decisions.

### Segregation reviews

At AYC, specific staff are required to visit segregated youth and review their segregation placement twice per morning and twice per evening shift, for a total of four reviews per day.

*13. Confined residents shall be reviewed at least **twice** each A.M. shift and twice each P.M. shift by at least one of the following: Unit Manager, SOM, Support Team or Case Manager and any other staff (preferably unit) available as well as the resident's group if appropriate. This review should be in person, however, if the resident poses a physical threat, the review may take place through the closed door or via the intercom. Each review shall be documented on COMS under same incident report number indicating resident's reason for confinement.*

The reviews are documented in the incident report.

We note that incident report entries rarely referenced the position of the staff conducting the review, and as a result, we were unable to verify that the reviews were conducted by the required staff. At AYC, of the 48 segregation incident reports reviewed, 26 documented that youth were reviewed at least twice per shift during their segregation placement. There were insufficient documented reviews for the other 22 segregated youth.

AYC's standing order sets out that the purpose of the reviews is to determine whether it is safe to remove the youth from segregation. During the reviews, staff are supposed to communicate with youth about the behavioural changes they need to show in order to be released from segregation.

*13.1 The purpose of the review shall be to determine the safety level of removing the resident from QR and this shall be done in consultation with the staff from the confined resident's unit.*

*13.1.1 behaviour of resident leading up to the confinement*

*13.1.2 the concerns the unit staff had when placing the resident in the QR*

*13.1.3 the concerns the unit staff have now*

*13.1.4 the Case Manager direction concerning the resident and the affected group*

*13.1.5 the attitude the resident is currently displaying*

*13.1.7 the sincerity of the commitment the resident is willing to give if released*

Our office observes nearly all documented reviews at AYC recorded staff communicating with youth about safety and behavioural expectations.

At MYC, staff are required to visit segregated youth and review their segregation placement twice per morning and twice per afternoon shift, for a total of four reviews per day. At MYC, the reviews are documented on the youth's running record in the COMS system.

*17. Unit staff, or another person designated by the SOM will personally speak with the young person **twice** on the morning and **twice** on the afternoon shifts.*

*17.1 The staff making the contact with the young person will review the conditions of segregation, assess the young person's well-being, and document relevant details and findings in the appropriate log book and in 'Running Records' in COMS.*

MYC advised that the superintendent or the deputy superintendent will also visit youth separately from the review process.

We reviewed the running records associated with the 36 MYC segregation incidents we reviewed. Our office notes that it was sometimes unclear whether a particular running record was one of the required segregation reviews or a different review required for another reason, for instance by the suicide prevention standing order. Running records documented that youth were reviewed the required number of times in 11 of the 36 segregation incidents. There were insufficient documented reviews for the other 25 segregated youth.

Our office concludes that neither AYC nor MYC fully complied with their respective standing orders relating to segregation reviews. Based on our review of segregation incident reports, AYC either did not perform or did not document the required number of reviews in 22 of the 48 segregation incidents reviewed. MYC either did not perform or did not document the required number of reviews in 25 of the 36 segregation incidents reviewed.

Reviewing youth in segregation provides human contact and the opportunity to let youth out of segregation as soon as it is reasonable to do so. If youth are not reviewed as required, they could be in segregation longer than they should be, increasing the risk that they will experience negative health consequences.

Our office is of the view that facilities must ensure that segregation reviews occur twice per daytime shift as required by their respective standing orders, that the review is documented and that it includes the rationale for continuing to segregate the youth, unless the youth is released. In this way, facilities can ensure they are in compliance with the Correctional Service Act's purpose of providing "safe, secure and humane accommodation" of youth in custody. Documenting the reviews, including reasons, also ensures transparency and accountability.

## Removal from segregation

AYC's standing order requires the incident report to include an entry for the youth's removal from segregation.

*12. When a resident is removed from a QR, a [COMS] incident report must be completed (if a staff person has already made a general report under the original report number then the additional entry describing the removal from the QR must be in a Supplementary Report. If the staff person has not previously made any entry under the original report number then a General Report describing the removal from the QR must be recorded; under the original report number).*

At AYC, 29 of 48 incident reports documented that youth were removed from segregation. Five of those 29 entries for removal did not include a time of removal, only a date. The other 19 incident reports did not document the youth's removal from segregation.

MYC's standing order requires the shift operations manager to document the youth's removal from segregation and the reasons for the removal.

*5. The On-Duty SOM will document in the Daily Roster and in a Supplementary Report in the Incident Report in COMS:*

*5.5 When the young person was removed from the OU and the reasons for removal.*

At MYC, the shift operations manager documented a youth's removal from segregation in only three of 36 incident reports. Staff other than the manager documented a youth's removal in another four incidents of segregation. Only two segregation incident reports included reasons for the youth's removal from segregation.

Our office finds that neither AYC nor MYC fully complied with their respective standing orders relating to a youth's removal from segregation. AYC did not document the youth's removal from segregation in 19 of 48 segregation incidents reviewed, and did not document the time of removal in another five incident reports. The shift operations manager at MYC did not document the youth's removal from segregation in 33 of 36 segregations reviewed and did not provide reasons for the removal in 34 of them. In our view, the incident report is a record of the youth's segregation and it is not complete if it does not document when the segregation ended.

In addition, our office notes that MYC's standing order requires that reasons for the youth's removal be included in the incident report, while AYC's does not. Just as reasons for keeping a youth in segregation should be recorded as discussed previously, our office is of the view that in the interests of procedural fairness, accountability and transparency, reasons for removal from segregation should also be recorded. AYC and MYC must ensure that segregation incident reports include an entry for the youth's removal from segregation, as well as the reasons for the removal.

## Shift operations manager reporting requirements

AYC's and MYC's standing orders assign reporting requirements to the shift operations manager.

At AYC, the shift operations manager is responsible for ensuring that documentation required by AYC's confinement or residents standing order, namely segregation reviews and removals, is included in the segregation incident reports.

*17. The SOM ensures each QR review, outcome and QR release are documented in the COMS incident report for the confinement.*

It is not the responsibility of the shift operations manager to write the actual report entry, rather it is to ensure that the segregation incident report includes the required information.

At AYC, 19 of the 48 segregation incident reports we reviewed contained the required number of segregation reviews and an entry for the youth's removal from segregation. As noted previously, there were insufficient documented reviews for 22 of the segregations, 19 segregations where the youth's removal was not documented at all and five segregations where a date, but no time of removal was documented. The shift operations manager did not comment on or otherwise correct the inadequacies of the 29 segregation incident reports that did not contain the required information.

MYC's use of observation units standing order requires the shift operations manager to document the following information about youth held in segregation in an observation room:

- the youth's name
- when the youth was placed in an observation room
- which observation room was used
- the estimated length of time the youth will be held in an observation room
- the conditions for the youth's release from segregation
- when the youth was removed from segregation
- the reasons for the youth's removal

As noted previously, MYC's standing order also requires the shift operations manager to document daily that youth in segregation have received all the rights and services to which they are entitled.

Our review of 36 segregations at MYC showed that there is not a single incident report where the shift operations manager fully met the reporting requirements. The shift operations manager documented:

- the name of the youth in 23 of 36 incident reports
- the time the youth was placed in segregation in 14 of 36 incident reports
- in which observation room the youth was placed in 5 of 36 incident reports
- the youth's estimated length of stay in segregation 0 of 36 incident reports

- the conditions under which the youth could return to their unit in 0 of 36 incident reports
- when the youth was removed from segregation in 3 of 36 incident reports
- the reasons the youth was removed from segregation in 2 of 36 incident reports
- youth received the required rights and access to services in 0 of the 36 segregations reviewed

Our office concludes that shift operations managers at AYC and MYC have not complied with reporting requirements set out in standing orders. AYC's shift operations manager did not comment on or otherwise correct the inadequacies of the 29 segregation incident reports that did not comply with documentation for segregation reviews and/or release. MYC's shift operations manager did not fully comply with MYC's documentation requirements in any segregation incident reports.

Managers are entrusted with reporting responsibilities to ensure that segregations are compliant with the rules that govern them. In the interests of accountability, AYC and MYC must ensure that their shift operations managers meet their responsibilities.

### Additional observation

#### **The Intoxicated Persons Detention Act**

Two hundred youth were segregated in observation rooms at MYC pursuant to the Intoxicated Persons Detention Act, in addition to the youth who were segregated while incarcerated at MYC. The act allows peace officers to bring people who are intoxicated in a public place to a detoxification centre, and MYC is listed as a detoxification centre for youth.

Our office has previously raised concerns with Manitoba Justice about the practice of holding intoxicated youth in segregation at a youth correctional facility. This review has raised additional concerns.

Eleven youth were held for more than 24 hours in contravention of the act, which requires that a person held in custody in a detoxification centre be released within 24 hours. We were also unable to determine the length of segregation for three youth held pursuant to the act. Further, though MYC's use of observation units standing order appears to apply to youth held pursuant to the act, none of the incident reports we saw met the standing order's documentation requirements.

### Findings and recommendations

A segregated youth's rights and liberties are curtailed above and beyond the restrictions imposed because they are incarcerated. Segregation separates youth and prevents them from having physical contact with other youth in the facility. In Manitoba, they can face additional obstacles accessing services from basic hygiene, such as a washroom or brushing their teeth, to programming, such as education, training and activities. Segregation also limits a youth's access to their family by phone and prevents in person visits.

While there are few studies focusing on the impact of segregation on youth, studies on adults show they experience heightened levels of physical and psychological harm as compared to non-segregated inmates. In particular, segregated individuals are more likely to self-harm and/or attempt suicide.

Segregation for youth is banned by international agreements to which Canada is signatory, as is segregation lasting more than 15 days. Nonetheless, Manitoba permits youth to be segregated at AYC and MYC and explicitly allows youth to be segregated for longer than 15 days.

Our office finds that Lakewood unit, AYC's high security unit, operates in segregation conditions as youth are kept separate from each other, can only leave their cell with a staff escort and have restricted access to services and programming available to youth in other units. Despite these factors, Corrections and AYC advised that they do not consider Lakewood unit a segregation placement. We therefore recommend:

**Recommendation 14:** That Corrections and AYC recognize and apply segregation regulations, policies and protections to Lakewood unit.

As segregation can have significant negative consequences for a youth, it is important that AYC and MYC ensure that each youth segregation complies with the requirements of the act, regulations and policies (standing orders). The Correctional Services Regulation is clear that disciplinary segregation – segregation that is imposed as a punishment for an offence – cannot be used on youth. Nonetheless, both AYC's and MYC's standing orders inappropriately reference disciplinary segregation as a reason why youth may be segregated in a quiet room or observation room. Consequently, we make the following recommendation:

**Recommendation 15:** That AYC and MYC amend their respective standing orders to clarify that youth cannot be segregated for disciplinary reasons.

The procedural requirements set out in the Correctional Services Regulation must be followed when youth are placed in segregation to ensure a fair process and accountability for decisions to prolong segregation. The regulation requires segregation review hearings to be held at specified minimum intervals and sets procedural requirements for those hearings.

AYC's confinement of residents standing order provides four reviews per day for youth segregated in a quiet room, which is more frequent than the intervals specified in the regulation. However, the review intervals for youth assigned to Lakewood are inconsistent with the regulation. As a result, we recommend:

**Recommendation 16:** That AYC amend its Lakewood referrals and admissions standing order to include review hearings at the intervals required by the Correctional Services Regulation.

MYC's use of observation units standing order requires staff to "maintain personal contact" with youth four times per day, but does not otherwise contain a procedure for a youth's segregation to be

reviewed. It is unclear whether these “contacts” are meant to be the reviews required by the regulation. Therefore, we make the following recommendation:

**Recommendation 17:** That MYC amend its use of observation units standing order to clarify whether the “personal contact” required by the standing order is the equivalent of the reviews required by the Correctional Services Regulation.

As noted above, the regulation contains procedural requirements for the segregation review hearings and decision-making and appeal processes that must be met to ensure a fair process. AYC and MYC have not incorporated those procedural requirements into their respective review processes. Consequently, we recommend:

**Recommendation 18:** That AYC and MYC incorporate the Correctional Services Regulation procedural requirements for the review hearings, and the decision-making and appeal processes into their respective standing orders.

Clear, accurate and easily available segregation information enhances accountability and transparency. It can be used to guide individual segregation decisions, identify trends in segregation use and inform facility and departmental decisions for youth. However, Corrections was unable to readily provide big picture information about segregations at AYC and MYC – such as who has been segregated, when, why and for how long – between September 1, 2015, to August 31, 2016. Our office had to compile this information from records provided by Corrections. As a result, we make the following recommendation:

**Recommendation 19:** That Corrections, AYC and MYC compile, track and review segregation use information going forward, allowing the facilities to assess among others, who, when, for what reason(s) and for how long, as well as any metrics Corrections considers important.

Clear and accurate records also make it easier for managers and oversight bodies to assess compliance with segregation protections and requirements. Therefore, we recommend that:

**Recommendation 20:** That AYC and MYC expand their respective standing orders to require segregation incident reports to contain a full record of the facilities’ compliance with standing order requirements related to segregation.

At AYC and MYC, multiple staff are involved in the decision to segregate a youth and it was often unclear who authorized it. The facilities’ standing orders ultimately give specific managers the authority to authorize a youth’s segregation. To ensure proper administration of and accountability for a practice that further restricts youths’ rights, our office is of the view that incident reports should clearly identify who authorized the youth’s segregation and their reasons for doing so. Consequently, we make the following recommendation:

**Recommendation 21:** That AYC and MYC amend their standing orders to require the manager who authorizes a youth’s segregation to include a report in the incident report. The



report writer should identify him or herself as the authorizing manager and include clear reasons for the authorization.

Given the potential negative health consequences of segregating youth, it is appropriate that there be a higher level of review once the segregation reaches 24 hours. Incident reports should record whether the deputy superintendent reviewed the segregation after each 24-hour period and document the result to ensure that facilities are accountable for their segregation decisions. Neither AYC's nor MYC's respective standing orders require the deputy superintendent's daily review to be documented in the incident report. As a result, we recommend:

**Recommendation 22:** That AYC and MYC amend their standing orders to require the incident report to include an entry documenting the outcome of the deputy superintendent's 24-hour review(s).

While both AYC's and MYC's standing orders require segregation incident reports to document when youth are released from segregation, only MYC's standing orders also require the incident report to contain reasons for the release. In our view, documented reasons for a decision enhance transparency and accountability. Therefore, we make the following recommendation:

**Recommendation 23:** That AYC amend their confinement of residents standing order to require segregation incident reports to record the reason(s) for a youth's release from segregation.

AYC's and MYC's standing orders require staff to provide youth with specific information when they are placed in segregation. However, there is no corresponding requirement to document that youth have been provided with the required information. To ensure that AYC and MYC comply with their obligation, our office is of the view that the facilities should document that the information has been provided to youth. Consequently, we recommend:

**Recommendation 24:** That AYC and MYC amend their standing orders to require staff to document that youth were provided with the information specified by the standing orders when they are placed in segregation.

Youth's rights and access to services are altered when they are removed from their group and placed in segregation. Some of their rights and access to services depend on which room a youth is segregated in. In the interests of fairness, our office is of the view that facilities need to ensure that youth are informed of their rights and the services they can access when they are placed in segregation. As a result, we make the following recommendation:

**Recommendation 25:** That AYC and MYC amend their standing orders to require that youth be informed of their rights and access to services while in segregation.

Segregated youths' rights and access to services differ within and between AYC and MYC. In the interests of transparency and accountability, the facilities should document which rights and services

segregated youth were able to access. MYC requires this, but AYC does not. Consequently, we recommend:

**Recommendation 26:** That AYC amend their standing order to require the incident report to document daily whether youth have received the rights and access to services to which they are entitled.

Though MYC's segregation of a young person standing order requires the shift operations manager to document that youth have received the services they require in the segregation incident report, this was not done in any of the MYC segregations we reviewed. Therefore, we make the following recommendation:

**Recommendation 27:** That MYC ensure the shift operations manager documents that youth have received the services they require in the segregation incident report.

Segregation places additional restrictions on a youth's liberty above and beyond those imposed by the fact of being incarcerated. In the interests of fairness, it is important that youth be given information to understand why they have been placed in segregation, how long they will be there, what they can do to get out and what it will be like while they are in segregation. Unlike MYC, AYC does not require youth to be informed of why they are in segregation and how long they are going to be there. Consequently, we recommend:

**Recommendation 28:** That AYC amend their standing order to ensure that in addition to the behavioural information youth are provided, they are also informed of the reasons they have been placed in segregation and the anticipated length of their segregation.

Reviewing segregated youth provides them with human contact and the opportunity to be released from segregation as soon as it is reasonable to do so. AYC and MYC's standing orders require staff to review segregated youth four times per day and to document the reviews. However, in our review of segregations, neither AYC nor MYC consistently complied with their respective standing orders relating to segregation reviews. Facilities must ensure that segregation reviews occur twice per daytime shift as required by their respective standing orders, that the review is documented and it includes the rationale for continuing to segregate the youth, unless the youth is released. In this way, facilities can ensure they are in compliance with the Correctional Service Act's purpose of providing "safe, secure and humane accommodation" of youth in custody. Documenting the reviews, including reasons, also ensures transparency and accountability. As a result, we make the following recommendation:

**Recommendation 29:** That AYC and MYC ensure that each review occurs, is documented and that the rationale for continuing to segregate the youth is recorded.

Documentation enhances transparency and accountability and at AYC and MYC shift operations managers are entrusted with specific documentation responsibilities. However, AYC shift operations managers did not comply with their documentation responsibilities in over half of the AYC segregations reviewed and MYC shift operations managers did not fully comply with their

documentation requirements in any segregations reviewed. In the interests of accountability and transparency, AYC and MYC must ensure that their shift operations managers fulfill their documentation responsibilities. Therefore, we recommend:

**Recommendation 30:** That AYC and MYC ensure that their shift operations managers fulfill their respective documentation requirements.

Our office additionally notes that 200 youth were segregated in observation rooms at MYC pursuant to the Intoxicated Persons Detention Act, in addition to the youth who were segregated while incarcerated at MYC. Though MYC's use of observation units standing order appears to apply to youth held pursuant to the Intoxicated Persons Detention Act, none of the incident reports we saw complied the standing order's documentation requirements. Consequently, we make the following recommendation:

**Recommendation 31:** That MYC clarify whether its use of observation units standing order applies to youth held pursuant to the Intoxicated Persons Detention Act.

Finally, 11 youth were held in observation rooms for more than 24 hours in contravention of the Intoxicated Persons Detention Act. As a result, we recommend:

**Recommendation 32:** That MYC review its procedures for youth held at MYC pursuant to the Intoxicated Persons Detention Act to ensure they are released within 24 hours as required by the act.

## Response to recommendations

Our office provided our recommendations about segregation to Manitoba Justice on December 7, 2018. In a response dated December 20, 2018, Manitoba Justice advised that it accepted our recommendations and expects to have implemented them by March 1, 2019.