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Statement from the Correctional Investigator on Release of Special Report to Parliament

Fatal Response: An Investigation into the Preventable Death of Matthew Ryan Hines

For Immediate Release

Ottawa, May 2, 2017 – Earlier today, my investigation into the death of Matthew Ryan Hines at Dorchester Penitentiary on May 26, 2015 was tabled as a Special Report in Parliament by the Minister of Public Safety, the Honourable Ralph Goodale. As my report concludes, Matthew's death in the care and custody of the Correctional Service of Canada (CSC) was preventable. In a brief but fatal encounter, correctional staff failed to recognize and respond to a medical emergency in a timely and competent manner following multiple uses of unnecessary and inappropriate physical and chemical force. The repeated administration of pepper spray at very close range, even as Matthew is clearly and fully under the control of numerous responding officers, appears to have contributed to rapid onset of compounding medical complications and ensuing death from acute asphyxia due to pulmonary edema.

Key findings of my investigation focus on issues of transparency and accountability in federal corrections, including lack of sufficient controls on the use of inflammatory agents (pepper spray), security-driven interventions to underlying mental health behaviours, as well as poor communication and inadequate information-sharing among security and clinical staff. As the report makes clear, CSC initially provided misleading and incomplete information to the public and Matthew's family concerning the cause and circumstances of his death.

My investigation raises additional questions and concerns regarding the adequacy and appropriateness of the Service investigating and disciplining itself. In this case, everything that could go wrong in a use of force intervention went wrong. Although the internal investigation identified 21 legal and policy violations in the staff response, subsequent staff disciplinary proceedings were inherently flawed and self-serving. Corrective measures taken after the fact failed to reflect the

nature and gravity of staff errors and omissions that contributed to this tragic, and, by my estimation, avertable death.

My report makes ten recommendations, several of which are directed to addressing systemic gaps in how CSC recognizes and responds to situations of medical emergency or mental health distress. In a detailed response, the Service acknowledges the areas of concern identified in my report and has accepted all ten recommendations. Significantly, the response contains an apology to the Hines family from CSC's Commissioner for inaccurate information that was shared with them following Matthew's death. While it is clear that much work remains in preventing deaths in custody, I am encouraged that the Service is committed to learning and making improvements based on the report's findings and recommendations.

Finally, I want to commend the resolve and conviction of Matthew's family in their continuing search for answers and accountability. They are adamant that they want Canadians to know how and why their loved one died in federal custody. They endorse and support my decision to make this report public in the hope that it will make a difference in ensuring the protection and preservation of human life and dignity in custody.

The report cited in this statement is available at: www.oci-bec.gc.ca.

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